

OVERSIGHT OF THE U.S. DEPARTMENT OF
JUSTICE

HEARING
BEFORE THE
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE
ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

NOVEMBER 8, 2011

Serial No. J-112-50

Printed for the use of the Committee on the Judiciary



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OVERSIGHT OF THE U.S. DEPARTMENT OF JUSTICE

TUESDAY, NOVEMBER 8, 2011

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The Committee met, pursuant to notice, at 10:07 a.m., in room SD-226, Dirksen Senate Office Building, Hon. Patrick J. Leahy, Chairman of the Committee, presiding.

Present: Senators Leahy, Kohl, Feinstein, Schumer, Durbin, Whitehouse, Klobuchar, Franken, Coons, Blumenthal, Grassley, Hatch, Graham, Cornyn, Lee, and Coburn.

OPENING STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Chairman LEAHY. I understand we will have a lot of attendance this morning, so I will probably run the clock a little bit more diligently than usual, including for myself. I am glad to have Attorney General Holder back with us as we continue our important focus on oversight.

When Attorney General Holder was here in May, details were just emerging about the successful military and intelligence operation that killed Osama bin Laden, which did provide a measure of justice and closure for Americans resulting from the horrific attacks of September 11th. That was not an isolated success; during the last few years, the Obama administration has successfully reinvigorated, retooled, and refocused our National security efforts.

Now, the Attorney General, as he is in any administration, is a key member of that national security team. Under his leadership, the Justice Department last month foiled an assassination attempt in the United States of the Saudi Ambassador to the United States and prevented a major act of terrorism on U.S. soil. Last week, four men in Georgia were arrested in a domestic terrorism plot, accused of planning to use guns, bombs, and the toxic poison ricin to kill Federal and State officials. Earlier this year, the Christmas Day bomber, who was convicted in Federal court, pled guilty and faced a possible life sentence.

Now, we have to ensure that we do all we can to assist efforts to bring terrorists to justice by providing the administration with the full array of authorities and options we need in our counterterrorism efforts. In my view, and a view that I know is shared by the Director of National Intelligence and the Attorney General, it is, of course, shortsighted for Congress to hamstring those efforts. As we proceed, we should remember that between September 11,

2001, and the end of 2010, 438 suspects were successfully prosecuted by the Bush and Obama administrations on terrorism charges in Federal courts. Now, at the same time, six have been convicted in military commissions—only six. Five of those were from plea bargains.

Now, the record over the last 3 years with respect to crime has also been outstanding. Over the past 3 years, crime rates have fallen rather than risen, which is contrary to normal experience during such difficult economic times. So as we proceed, each one of us is going to have questions about matters that concern us, but we should not lose sight of the big picture and the fact of what the Justice Department is doing to keep us safe and secure.

This morning there will be more questions about the Bureau of Alcohol, Tobacco, Firearms, and Explosives' gun-trafficking investigations along our southern border. Attorney General Holder, it should be noted, has reiterated and reinforced that longstanding Department of Justice policy prohibits the transfer of firearms to known criminals without the proper monitoring or controls by law enforcement. Administration officials have testified at 17 Congressional hearings about these matters, including six held before this Committee.

I urge that as they engage in important oversight, Senators respect the need for law enforcement and prosecutors to do their jobs to address the serious threat of violence posed by these brutal drug cartels. I do not think anyone wants to hamper the efforts of law enforcement agents against the Mexican cartels, including the ongoing criminal investigation and prosecution related to the tragic murder of Agent Brian Terry.

So I thank the men and women of the Department of Justice who work hard every day to keep us safe and uphold the rule of law. I thank the Attorney General for returning to the Committee. I look forward to his testimony. And I have kept within my time as I will fully expect everybody else to.

Senator Grassley?

**STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR
FROM THE STATE OF IOWA**

Senator GRASSLEY. This is a very important hearing, Mr. Chairman. There are a lot of issues to bring up. However, over the time that the Attorney General was last here, I have concentrated my oversight on Operation Fast and Furious. Just over 9 months ago, Attorney General Holder sat in my office, and I handed him two letters I had written to Acting Director Kenneth Melson of ATF. My letter mentioned: one, the death of Border Patrol Agent Terry; two, the allegations that ATF had sanctioned the sale of hundreds of assault weapons to straw buyers; three, the allegations that two of those weapons had been found at the scene of Agent Terry's death; and, four, the allegations that the whistleblowers who provided this information were already facing retaliation from the agency.

Just 4 days later, the reply from the Department explicitly stated that the whistleblower allegations were false. It also claimed that, "ATF makes every effort to interdict weapons that have been purchased illegally and prevent their transportation to Mexico."

In the 9 months since then, mounting evidence has put the lie to that claim. Documents contradicting the Department's denials came to light. Then six ATF agents testified powerfully at two House oversight hearings. They also confirmed that gun walking occurred in Operation Fast and Furious.

Just last week, Assistant Attorney General Lanny Breuer admitted in this room that the Department's letter to me in February was absolutely false. But it gets worse. Mr. Breuer also admitted that he knew all along it was false. He could not recall whether he helped edit it. However, he knew it was false because he was aware of previous a gun-walking operation called Wide Receiver. Yet he remained silent for 9 months. He was aware that Congress had been misled, yet made no effort to correct the Department's official denial.

Much has been said recently about guns being walked in Operation Wide Receiver during the Bush era. It does not matter for me when it happened. We need answers. Bush era prosecutors refused to bring the case; however, under Mr. Breuer's leadership, headquarters revived it despite the gun-walking issues. It was Mr. Breuer's responsibility to clearly communicate that gun walking was unacceptable and to institute oversight and safeguards to ensure that it did not happen again. He did not do that.

Mr. Breuer admitted before this Committee last week that one of his deputies informed him of gun walking in Wide Receiver in April of 2010. He also admitted that the same deputy approved at least one of the wiretap applications in Operation Fast and Furious. In order to justify tapping the phone of a private citizen, the law requires that agencies show they have tried everything else first. But the very same facts that would show the need to obtain the wiretap would also show that the Department knew these individuals were trafficking in weapons.

The Government should have stopped the flow of guns to these criminals. Anyone reviewing the wiretap affidavits would probably know that was not happening. I would also add that this tragedy should not be used to call for new gun control. The straw buyers in Fast and Furious were already breaking the law. They should have been interdicted and arrested nearly a year earlier than they were. The faulty statistics cited by some about U.S. guns in Mexico include U.S. weapons sold to foreign militaries, weapons that were transferred in to Mexico years ago, guns from Fast and Furious, stolen weapons, and many other sources.

As we learn more about the utter failure to enforce our existing gun laws in Fast and Furious, I am eager to hear from the Attorney General whom he plans to hold accountable. I also want to know how he plans to prevent another tragedy like this in the future.

But let me be clear. The bottom line is that it does not matter how many laws we pass if those responsible for enforcing them refuse to do their duty, as was the case in Fast and Furious.

Thank you, Mr. Chairman.

Chairman LEAHY. Well, thank you very much.

Attorney General Holder, would you please stand and raise your right hand? Do you swear that the testimony you are about to give

before this Committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Attorney General HOLDER. I do.

Chairman LEAHY. Thank you. Please go ahead, sir.

STATEMENT OF HON. ERIC H. HOLDER, JR., ATTORNEY GENERAL, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Attorney General HOLDER. Thank you. Chairman Leahy, Ranking Member Grassley, and distinguished members of this Committee, I appreciate the opportunity to appear before you today.

Over the last 3 years, I have been privileged to address this Committee on numerous occasions—and to partner with many of you—in advancing the goals and the priorities that I think we all share. I am extremely proud of the Department's historic achievements over the last 2 years.

Despite significant financial constraints, we have effectively confronted a range of national security threats and public safety challenges, and I am especially pleased to report that our efforts to combat global terrorism have never been stronger.

Since I last appeared before this Committee in May—just 3 days after the decade-long hunt for Osama bin Laden came to a successful end—the Department has achieved several additional milestones. For example, last month, we secured a conviction against Umar Farouk Abdulmutallab for his role in the attempted bombing of an airplane traveling from Amsterdam to Detroit on Christmas Day 2009. We also worked closely with our domestic and international partners to thwart an attempted plot—allegedly involving elements of the Iranian Government—to assassinate the Saudi Arabian ambassador to the United States on American soil. We have also disrupted numerous alleged plots by homegrown violent extremists, including one targeting a military recruiting center in Washington State and another targeting U.S. soldiers in Texas. Meanwhile, in one of the most complex counterintelligence operations in history, we brought down a ring involving ten Russian spies. And just last week, a Federal jury in Manhattan convicted Viktor Bout, one of the world's most prolific arms dealers, for his efforts to sell millions of dollars' worth of weapons—including 800 surface-to-air missiles and 30,000 AK-47s—for use in killing Americans.

On other fronts, the Department has made extraordinary progress in protecting civil rights, combating financial fraud, safeguarding our environment, and advancing our fight against violent crime. We have filed a record number of criminal civil rights cases. And in the last fiscal year, our Civil Rights Division's Voting Section opened more investigations, participated in more cases, and resolved more matters than in any other similar time period in the last dozen years. This section is also immersed in reviewing over 5,500 submissions for review under Section 5 of the Voting Rights Act, including redistricting plans and other proposed State and local election law changes that would impact the access that some Americans would have to the ballot box.

We have also worked to ensure that States do not institute an unconstitutional patchwork of immigration laws. In recent months, the Department has challenged immigration-related laws in several

States that directly conflict with the enforcement of Federal immigration policies. Not only would these laws divert critical law enforcement resources from the most serious public safety threats, they can lead to potentially discriminatory practices and undermine the vital trust between local jurisdictions and the communities that they serve.

The Department has also focused its efforts on the fight against financial fraud over the last 2 years by spearheading the inter-agency Financial Fraud Enforcement Task Force and successfully executing the largest financial and health care fraud takedowns in history. In addition, we secured a conviction in the biggest bank fraud prosecution in a generation, taking down a nearly \$3 billion fraud scheme. And through our aggressive enforcement of the False Claims Act, a law significantly strengthened in recent years by this Committee, we have secured record-setting recoveries that have exceeded \$8 billion since January of 2009.

Now, I am proud of these and many other achievements, and I am committed to building on this progress. Although I hope to spend much of our time together discussing the work that is ongoing throughout the Department, I would like to take a moment to address the public safety crisis of guns flowing across our border into Mexico and the local law enforcement operation known as “Fast and Furious” that has brought renewed public attention to this shared national security threat.

Now, I want to be very clear: Any instance of so-called gun walking is simply unacceptable. Regrettably, this tactic was used as part of Fast and Furious, which was launched to combat gun trafficking and violence on our Southwest Border. This operation was flawed in its concept and flawed in its execution. And, unfortunately, we will feel the effects for years to come as guns that were lost during this operation continue to show up at crimes scenes both here and in Mexico. This should never have happened. And it must never happen again.

To ensure that it will not, after learning about the allegations raised by ATF agents involved with Fast and Furious, I took action. I asked the Department’s Inspector General to investigate this matter, and I ordered that a directive be sent to the Department’s law enforcement agents and prosecutors stating that such tactics violate Department policy and will not be tolerated. More recently, the new leadership at ATF has implemented reforms to prevent such tactics from being used in the future, including stricter oversight procedures for all significant investigations.

Now, today I would like to correct some of the inaccurate and, frankly, some of the irresponsible accusations surrounding Fast and Furious. Some of the overheated rhetoric might lead you to believe that this local, Arizona-based operation was somehow the cause of the epidemic of gun violence in Mexico. In fact, Fast and Furious was a flawed response to and not the cause of the flow of illegal guns from the United States into Mexico.

As you all know, the trafficking of firearms across our Southwest Border has long been a serious problem—one that has contributed to the approximately 40,000 deaths in Mexico in the last 5 years. As Senator Feinstein highlighted last week, of the nearly 94,000 guns that have been recovered and traced in Mexico in recent

years, over 64,000 of those guns were sourced to the United States of America—64,000 of 94,000 guns sourced to this country.

The mistakes of Operation Fast and Furious, serious though they were, should not deter or distract us from our critical mission to disrupt the dangerous flow of firearms along our Southwest Border. I have supported a number of aggressive, innovative steps to do so, and our work has yielded significant successes.

We have built crime-fighting capacity on both sides of the border by developing new procedures for using evidence gathered in Mexico to prosecute gun traffickers in U.S. courts; by training thousands of Mexican prosecutors and investigators; by successfully fighting to enhance sentencing guidelines for convicted traffickers and straw purchasers; and by pursuing coordinated, multi-district investigations of gun-trafficking rings.

This year alone, we have led successful investigations into the murders of U.S. citizens in Mexico, created new cartel-fighting prosecutorial units, and secured the extradition of 104 defendants wanted by U.S. law enforcement—including the former head of the Tijuana Cartel.

Now, this work has undoubtedly saved and improved lives in the United States as well as in Mexico, and I am personally committed to combating gun trafficking and reducing the alarming rate of violence along the Southwest Border by using effective and appropriate tools.

Now, like each of you, I want to know why and how firearms that should have been under surveillance could wind up in the hands of the Mexican drug cartels. But beyond identifying where errors occurred and ensuring that they never occur again, we must be careful not to lose sight of the critical problem that this flawed investigation has highlighted: We are losing the battle to stop the flow of illegal guns to Mexico. This means, I believe, that we have a responsibility to act. And we can start by listening to the agents, the very agents who serve on the front lines of this battle and who testified here in Congress. Not only did they bring the inappropriate and misguided tactics of Operation Fast and Furious to light, they also sounded the alarm to Congress that they need our help.

ATF agents who testified before a House Committee this summer explained that the agency's ability to stem the flow of guns from the United States into Mexico suffers from a lack of effective enforcement tools. One critical first step should be for Congressional leaders to work with us to provide ATF with the resources and the statutory tools it needs to be effective. Another would be for Congress to fully fund our request for teams of agents to fight gun trafficking.

Unfortunately, earlier this year the House of Representatives actually voted to keep law enforcement in the dark when individuals purchase multiple semi-automatic rifles and shotguns in Southwest Border gun shops. Providing law enforcement with the tools to detect and to disrupt illegal gun trafficking is entirely consistent with the constitutional rights of law-abiding citizens, and it is critical to addressing the public safety crisis along the Southwest Border.

As someone who has seen the consequences of gun violence firsthand—and who has promised far too many grieving families that

I would do everything in my power not only to seek justice on behalf of their loved ones, but also to prevent other families from experiencing similar tragedies—I am determined to ensure that our shared concerns about Operation Fast and Furious lead to more than headline-grabbing Washington “gotcha” games and cynical political point scoring.

We have serious problems to address, and we have sacred responsibilities to fulfill. We must not lose sight of what is really at stake here: lives, futures, families, and communities. When it comes to protecting our fellow citizens—and stopping illegal gun trafficking across the Southwest Border—I hope that we can engage in a responsible dialog and work toward common solutions. And I hope that we can begin that discussion today.

[The prepared statement of Attorney General Holder appears as a submission for the record.]

Chairman LEAHY. With that, I think we will begin the discussion. We have a number of issues besides that one, and I agree with you that if we are going to stop that flow of guns into Mexico—and I have heard the same thing from the Mexican authorities—we are going to have to take some steps here in this country. We cannot expect it all to be done across the border.

Let me take up a few questions. I joined with Senator Feinstein and some other members of this Committee in the Intelligence Committee to ask the Majority Leader to refrain from bringing certain provisions in the defense authorization legislation before the Senate until significantly improved. I know the administration expressed serious concerns with the military detention and intervention provisions of the bill as reported from Armed Services. The way it was reported, it would significantly reduce the options for investigating terrorist threats. It actually lets all terrorists know which options are off the table, including those that have been most successful in bringing about convictions. Even the Heritage Foundation has argued the bill would deny the President needed flexibility.

Would you agree that we need to keep our options open in countering terrorists and not start taking options off the table?

Attorney General HOLDER. Yes, I would totally agree. We need to use all elements of American power in the fight against terrorism—our military power, our political power, the power that we have in our judicial system, military commissions. We need maximum amounts of flexibility, and we also have to be practical when it comes to the measures that Congress asks us in the executive branch to follow.

Chairman LEAHY. And the vast majority of our, almost by 100:1, certainly by 90:1, convictions have been in our courts, not before military tribunals. Is that correct?

Attorney General HOLDER. That is correct. There is no question that if one looks dispassionately at the history, our Article III system of courts has shown that they are fully capable of handling any matter that is brought before them.

Chairman LEAHY. And that was the same in both the Bush administration and the Obama administration.

Attorney General HOLDER. That is correct.

Chairman LEAHY. Thank you.

On September 30, 2011, it was reported that Anwar al-Awlaki was killed in an operation conducted by the United States in Yemen, and according to media accounts, the operation was conducted following the issuance of a secret memorandum issued by the Department of Justice which authorized the targeted killing of a U.S. citizen abroad. Without going into the facts of that particular operation, I had written to you last month asking for a copy of that memorandum. Is there any problem with providing this Committee with a copy of that memorandum even if it is required to be in a classified session?

Attorney General HOLDER. Well, I first want to indicate that I will not address, cannot address whether or not there is an opinion in this area, but I understand, Mr. Chairman, your interest in this subject, and we are committed to working with you to answer your questions in an appropriate setting and to the extent that we can.

Chairman LEAHY. Thank you.

In February, you notified Congress that the Department of Justice would no longer defend the so-called Defense of Marriage Act, DOMA, in legal circumstances in two cases. I had agreed with you, and I joined Senator Feinstein and others when she introduced the Respect for Marriage Act, which would repeal DOMA. This would allow all lawful marriages, provided the marriage was lawful in the State where it occurred, with equal access to Federal protections.

In July, the President expressed his support for our Respect for Marriage Act. It is going to be considered by our Committee in a markup on Thursday of this week.

Do you support the Respect for Marriage Act which would repeal DOMA?

Attorney General HOLDER. The administration does. It is consistent with the policy that the Government has taken as a result of the position that we took in court, I guess in the Fourth Circuit, so the administration does support the passage of that bill.

Chairman LEAHY. And the Violence Against Women Act, which helped to transform our society and be more responsive to domestic violence and sexual assaults, focused on criminal justice system on more effectively investigating and prosecuting those serious crimes. We have had a lot of hearings in this Committee on that. It is now time to reauthorize it. Actually, this legislation began when Vice President Biden was Chair of this Committee.

Do you agree that reauthorizing and strengthening the Violence Against Women Act is a top priority, especially in tough economic times with State and local budgets reducing the resources that are available to protect victims of domestic violence, sexual assault, dating violence, and stalking?

Attorney General HOLDER. Yes, I think that is a priority for this administration. I would hope that this would be a priority for not only this Committee but for Congress as a whole to reauthorize VAWA. It has transformed our Nation in a variety of ways, not only with regard to programs that are funded but the way in which we have viewed the subject matter of that act. That is among the top priorities for this administration.

Chairman LEAHY. And then in keeping with my own rule on time, this will be my last question before turning to Senator Grassley, who has already indicated he wants to ask you about Oper-

ation Fast and Furious. The subject has been explored during six previous Judiciary Committee hearings. I just want to raise with you your testimony at the House Judiciary Committee hearing on May 3rd. When Congressman Issa asked you then when you first knew about the Fast and Furious program, you responded, "I am not sure of the exact date, but I probably heard about Fast and Furious for the first time over the last few weeks."

Now, as you know, there has been a lot of talk about your reference to a few weeks, but those critics tend to not put the question in there along with your answer, and the fact you said in your answer you were not being precise, you were basically giving your recollection.

I recall that by February 28th you had asked the Inspector General to begin an investigation of Fast and Furious. You also testified about the operation on March 10th at the Senate Appropriations Committee.

So let me ask you a fundamental question and give you a chance to be more precise. When did you first learn of the operational tactics being used in Operation Fast and Furious? And what did you do about it?

Attorney General HOLDER. I first learned about the tactics and the phrase Operation Fast and Furious at the beginning of this year, I think, when it became a matter of public controversy. In my testimony before the House Committee, I did say "a few weeks." I probably could have said "a couple of months." I do not think that what I said in terms of using the term "a few weeks" was inaccurate based on what happened. I got, as Senator Grassley indicated, a couple of letters from him at the end of January. I believe it was January 31st. These letters talked about a connection between an operation and the death of Agent Terry and did not mention Fast and Furious. It referenced Operation Gunrunner. I asked my staff to look into this, and during the month of February, I became aware of Fast and Furious from press reports and other letters that I received from Senator Grassley. I asked my staff to get to the bottom of that matter.

We received information from the ATF and from the United States Attorney's Office in Phoenix that contradicted some of these public reports, and it became clear to me that the matter needed to somehow be resolved. And so as you indicated, Mr. Chairman, on February 28th, I asked the Department of Justice Inspector General to investigate Fast and Furious. On March 9th, I directed the Deputy Attorney General to instruct all prosecutors and agents throughout the Justice Department not to engage in these flawed tactics that we found in Operation Fast and Furious. On March 9th, I also confirmed the existence of the IG investigation. On March 10th, I testified about this matter before the Senate Appropriations Committee.

So, clearly, by the time I testified in May before the House Committee, I had known about Fast and Furious for several weeks, as I indicated, a couple of months. But the focus on which day of which month I think in some ways is a bit of a distraction that does nothing to address what I think ought to concern us most, and that is, the flow of weapons from the United States across the Southwest Border.

Chairman LEAHY. Thank you.

Senator Grassley.

Senator GRASSLEY. I was going to start with those letters that you just referred to that I gave you on January 31st. You have introduced my question, so I will go immediately to the question.

When we met that day, did you know that the guns connected to an ATF operation had been found at the Terry murder scene?

Attorney General HOLDER. I did not.

Senator GRASSLEY. Thank you. Less than 48 hours after Agent Terry died, your deputy was informed that guns found at the Terry scene traced back to Fast and Furious. We have e-mails and detailed briefing papers that went to Grindler on December 17th. Did Mr. Grindler ever say anything to you in December or January about the connection between the ATF and the guns found at Terry's murder scene?

Attorney General HOLDER. No, he did not, but I think it is understandable in the sense that the information that was shared with him did not indicate that any of the tactics that we find in the flawed Operation Fast and Furious operation were actually mentioned in the e-mail that you reference. So he did not share that information with me.

Senator GRASSLEY. OK. Documents produced by the Department suggests that your deputy chief of staff spoke with U.S. Attorney Dennis Burke about Fast and Furious shortly after Agent Terry's death. Did Mr. Wilkinson say anything to you about the connection between Agent Terry's death and the ATF operation?

Attorney General HOLDER. No, he did not. The conversations that they had were about a variety of things. I have looked at the e-mails now: the possibility of me coming out at some point to engage in a press conference, other matters, but there was no discussion between them of the tactics that are of concern with regard to Fast and Furious, and as a result of that, Mr. Wilkinson did not share information with me about his contacts with former U.S. Attorney Burke.

Senator GRASSLEY. Last week, the head of the Criminal Division, Lanny Breuer, said that he deeply regrets his failure to tell you earlier about gun walking in Operation Wide Receiver. But what about his failure to tell Congress and correct false statements in the Department's letter to me on February 4th? Is that acceptable to you that he did not tell us about those false statements in the letter of February 4th?

Attorney General HOLDER. Well, let me clear something up. The information that was shared with you on February 4th in that response, there was information in that letter that was inaccurate. The letter could have been better crafted. In the crafting of that letter, people were relying on information provided to them by people who were, we thought, in the best position to know what was accurate, people in the U.S. Attorney's Office, people at ATF, people who themselves have now indicated in their congressional testimony before the House that they were not aware of the tactics that were employed.

As a result of that, the information that is contained in that February 4th letter to you was not, in fact, accurate, and I regret that.

Senator GRASSLEY. Did he offer you his resignation because of that?

Attorney General HOLDER. No, he has not, and I do not expect to hear a resignation offer from Mr. Breuer.

Senator GRASSLEY. You are refusing to provide drafts of that February 4th letter and e-mails about the drafts even though they have been subpoenaed by the House. Without a valid constitutional privilege, that, of course, risks contempt of Congress. Why would you risk contempt of Congress to prevent us from finding out who reviewed the drafts of that letter and whether they knew that they contained false statements?

Attorney General HOLDER. Well, I will certainly try to work with you in providing you all the relevant information that we can. We will, however, act in a way that is consistent with what other Attorneys General have made determinations as to what information can be shared with Congressional oversight committees, and these are Republican as well as Democratic Attorneys General, and I will act in a manner that is consistent with the history and the tradition of the Department.

Senator GRASSLEY. If those documents show that Mr. Breuer reviewed a draft of the letter before it went out and failed to correct the statement that he knew was false, would that be a reason for his resignation?

Attorney General HOLDER. That would be a reason for a concern, but I think the facts show that the people who were responsible for the drafting of the letter did not know at that time that the information that was contained in that letter was inaccurate. We do now know, looking back, that the information provided to you was inaccurate, and as I said, that is something that I regret.

Senator GRASSLEY. Mr. Breuer's deputy, Jason Weinstein, was also aware that ATF walked guns. He approved the wiretap application for Fast and Furious, and he briefed Judiciary Committee staff on February 10th in response to my letters. Did Mr. Weinstein review a draft of the February 4th letter before it was sent to me?

Attorney General HOLDER. I do not know.

Senator GRASSLEY. Who will be held accountable for allowing a letter to Congress with a statement that many people in the Justice Department knew was false?

Attorney General HOLDER. Well, again, I have to dispute with due respect the assertion that people in the Justice Department knew it was false. People in the Justice Department who were responsible for the creation of that letter, again, relied on information provided to them that they thought was accurate. We only know that the information was inaccurate in hindsight. At the time the letter was prepared, our best thought was that the information supplied was, in fact, correct.

Senator GRASSLEY. Someone in the Justice Department leaked a document to the press along with talking points in an attempt to smear one of the ATF whistleblowers who testified before the House. This document was supposed to be so sensitive that you refused to provide it to Congress, but then someone provided it to the press. The name of the criminal suspect in the document was deleted, but the name of the ATF agent was not. This looks like a

clear and intentional violation of the Privacy Act as well as an attempt at whistleblower retaliation.

In a private phone conversation with me, you already told me that someone has been held accountable for this, but your staff refused to provide my staff with any details. Who was held accountable and how?

Attorney General HOLDER. You know, it almost pains me—and please do not take this away from Senator Grassley's time. As you said, we had a private conversation. You sent me a handwritten note that I took very seriously. You and I have worked together on a variety of things. I think I have a good relationship with you. You sent me a handwritten note that I looked at, took seriously, referred that letter to OPR or the IG—I am not sure which of the two—and asked them to try to find out what happened.

I called you to try to indicate to you that I had taken that matter seriously, that action had been taken. You know, in a different time in Washington, I am not sure that what you just said necessarily would have been shared with everyone here, but, you know, so be it. It is a different time, I suppose.

In response to your question—

Senator GRASSLEY. You understand that I told you over the phone conversation if you wanted me not to ask this question, that I said, "Have your staff inform my staff," because I work very closely with my staff, and give the details so that I would know that this would be an inappropriate question to ask at this hearing.

Chairman LEAHY. We will let the Attorney General answer, and then we will go to Senator Kohl, keeping the same rule that I applied to myself.

Senator GRASSLEY. You went 1 minute and 40—

Chairman LEAHY. No, I did not on my questions.

Senator GRASSLEY. You asked a question, but he answered 1 minute and 40 seconds—

Chairman LEAHY. I finished my question before my time was up. Go ahead. You can answer his question even though he asked it after his time was up.

Attorney General HOLDER. With regard to the question, the matter is under investigation. There were a couple of leaks, and those leaks are under investigation by the Inspector General, by the Office of Professional Responsibility, and I am not in a position to comment on ongoing investigations.

Chairman LEAHY. Senator Kohl.

Senator KOHL. Thank you, Mr. Chairman.

Attorney General Holder, before I turn to my questions, I would like to thank you for working with us on our law enforcement officers who exhibit exceptional courage in the line of duty. In 2008, Congress passed the Law Enforcement Congressional Badge of Bravery Act in order to honor these brave men and women. I am sure that it was no easy task to choose only 21 award recipients from so many qualified nominees all across the country.

So 2 weeks ago, I was pleased to present the first of these awards to two deserving officers in Wisconsin: Onalaska Police Officer James Page and La Crosse County Deputy Sheriff Daniel Baudek. These officers made their community and the entire State

of Wisconsin proud, and I look forward to continuing to work with you to honor these deserving public servants.

Attorney General Holder, my office has been informed of an FBI proposal to close three of its six Wisconsin satellite offices. If these closures go through, the Western District of Wisconsin will lose half of its FBI offices, and they have to work with fewer agents. I have serious concerns about the ability of the remaining two offices to adequately support already underserved rural areas. Our chief law enforcement officer in the Western District, U.S. Attorney John Vaudreuil, strongly opposes these closures. People who live in rural Wisconsin have a right to expect that the FBI will be able to investigate crime in their communities. I am sure you would agree. After all, a multimillion-dollar bank fraud in Wausau is at least as important as a million-dollar bank fraud in Milwaukee or Chicago.

According to the agency, these closures will lead to a "stronger and more effective FBI presence in Wisconsin." However, how can this be the case when agents will be located 4 hours away by car from the communities that they serve. I understand that the final decisions will be made soon, so will you commit to working with me right now in order to address these concerns and modify the proposal if necessary in order to ensure that Wisconsin is not negatively impacted?

Attorney General HOLDER. I will certainly work with you and look at the proposed closures and make sure that they do not have a negative impact on the ability of the FBI to perform the services to which the citizens of Wisconsin are entitled. We are dealing with tough budgetary times. We are trying to make sure that we are configured in a way where we can be most efficient and still be most effective. But I have heard the concerns you have raised about the closure of those three offices, and I will work with you in that regard.

Senator KOHL. Thank you, Mr. Holder.

Attorney General, the Justice Department recently announced plans to close four of its seven antitrust regional offices: the offices of Atlanta, Cleveland, Dallas, and Philadelphia. The Justice Department asserts that this will save \$8 million annually mainly by saving the cost of office leases. We are aware of reports that some career staff in these offices are opposed to these closures. They argue that these offices are responsible for collecting hundreds of millions of dollars in fines for criminal antitrust violations, far outweighing the savings from the office closures.

On October 19th, the Washington Post reported that the Dallas regional office won a \$500 million fine in a case brought against an international vitamins cartel, and the Philadelphia office obtained a \$134 million fine. A career attorney in the Atlanta office stated that his office collected about \$20 million in fines annually on a budget of just \$2 million.

So I am interested in your response to these reports. Are you sure that these office closures will really be cost-effective? And will the Department have sufficient resources to prosecute antitrust cases in regions not fully served by the four offices that you plan to close?

Attorney General HOLDER. Yes, that was a tough decision that we had to make, but we thought, given limited budgets that we have, that we could continue to do the work of the Antitrust Division in spite of the fact that those offices would close. None of the investigations that those offices were handling will be closed. We will work from the remaining offices in other parts of the country to make sure that we maintain the kind of vigilance and intense antitrust presence that has been provided in the past.

So I do not think that the reconfiguring of the Antitrust Division and these field offices will have a negative impact on our ability to handle the very things that you have mentioned. These offices have been effective in the past, but I think that we can continue to be effective even under the reconfigured structure that we have proposed.

Senator KOHL. I have my doubts. I thought I would voice them to you.

Attorney General HOLDER. Sure.

Senator KOHL. Mr. Attorney General, we were pleased when the Justice Department filed an antitrust lawsuit in August to block the proposed AT&T/T-Mobile merger. As I stated to you in my letter of July 20th recommending this merger be blocked, I believe this would be a dangerous merger for competition and for consumers. If allowed to proceed, this merger would combine two direct competitors and reduce the number of national cell phone companies in an already highly concentrated industry from four to three. Millions of consumers across the country would likely face higher cell phone bills and fewer choices.

Some commentators have expressed concern that the Justice Department might not be in this case for the long haul and agree to a settlement that will allow the merger to proceed. I do not believe that to be true, but can you reassure us on this point? I understand that you have recused yourself in this case, but, nevertheless, can you confirm that DOJ is committed to pursuing its lawsuit, if necessary through trial?

Attorney General HOLDER. Yes, I am recused from this matter. James Cole, who is the Deputy Attorney General, is the person who is ultimately in charge of this, and I am sure that Jim and the people in the Antitrust Division are committed to seeing this through.

The Justice Department does not file matters in court, does not file suits challenging proposed mergers unless we are prepared to follow them all the way through, and that is the structure that has been put in place. There is a trial team—I know about this just from what I have heard. There is a trial team that is in place, and they are ready and eager to go to court.

Senator KOHL. Good. Finally, as Chair of the Special Committee on Aging, I held a hearing earlier this year on elder abuse and neglect and financial exploitation. In that hearing we heard heart-wrenching stories of physical, emotional, sexual, and financial abuse of elders.

According to GAO, over 14 percent of our senior citizens living outside of nursing homes or assisted living facilities have been injured, exploited, or otherwise mistreated by someone on whom they depend for care and protection. Sadly, elder abuse often goes unreported, indicating the true number of victims is much higher. In

addition to causing the victims of elder abuse and their families great personal harm, the financial exploitation of seniors costs the Nation an estimated \$2.5 billion a year.

Despite the terrible harm it causes, there is a lack of leadership at the Federal level when it comes to stopping elder abuse. That is why I introduced the Elder Abuse Victims Act with Senators Leahy, Blumenthal, and Whitehouse. Our bill would create the Office of Elder Justice within the Justice Department. The office would centralize the response to elder abuse by coordinating Federal, State, and local agencies. Can we count on your support for this legislation?

Attorney General HOLDER. I certainly want to work with you with regard to that legislation. The Justice Department has tried to focus on the abuse that those people who are most vulnerable are forced to endure: those at the beginning of their lives, children, and those toward the end of their lives, our seniors. And the bill that you have introduced I think probably goes a long way to helping us in that regard, so I would be glad to work with you in looking at that legislation because this is a concern that I have and those of us in the Justice Department do have.

Senator KOHL. Thank you very much.

Thank you, Mr. Chairman.

Chairman LEAHY. Thank you.

Senator Hatch.

Senator HATCH. Well, thank you, Mr. Chairman. Welcome, Mr. Attorney General. We appreciate you testifying here today.

Two years ago, you made a very controversial decision to reopen criminal investigations of CIA interrogations that took place following the September 11th attacks. Now, you made this decision even while admitting that you had not read the declination report from career prosecutors in the Eastern District of Virginia. This decision prompted seven former Directors of the CIA to write a letter to the President opposing this action. Now, there are reports that almost all of the reinvestigations that have now been closed.

Now, do you agree that you should have read those declination reports before deciding to reopen the investigations, especially now that you are reaching the same decision as the career prosecutors did? And just one last question. What message do you have for those CIA employees whose lives have been in limbo for the past 2 years because of that failure to look at the declination report?

Attorney General HOLDER. I think the decision that I made to order that investigation was an appropriate one. I reviewed a series of reports, among them an Inspector General report and other matters that are classified, and came to the conclusion that there was a basis for a re-examination of the incidents. I was concerned about the way in which people, American people working either at our behest or people working for our Government, had engaged in these interrogation techniques. I appointed—or I expanded the jurisdiction of John Durham, a very experienced prosecutor who had been appointed to look at the tapes matter by Attorney General Mukasey. His work is continuing. I think we are pretty close to the end of the work that he has been asked to do.

But I stand by my decision. I think the decision that I made was a correct one. The results are what they are, but I think going

through the process that I asked him to do was, in fact, the right thing to do.

Senator HATCH. My point is that you had the advice of people who really knew what was going on saying you should not do this, and then you have seven former Directors of the CIA who really were offended by this. Plus the problem with this is that I think it hampers the work that they do in many areas if they are going to be brought into court years later.

So, you know, it is a decision you made. I just disagree with it. And I think it was something that should not have been done, and to have these people in limbo for 2 years is a wrong thing, too.

Attorney General HOLDER. Well, we did——

Senator HATCH. It kind of takes me back to the Ted Stevens litigation. I have not seen much in the way of correction for those who did what were really offensive prosecutorial approaches—not only offensive, but I think there should have been some real serious corrections done because of what they did to a great U.S. Senator. Frankly, the way I understand it, to use as an excuse that they had just plain overlooked some of the most exculpatory evidence that has to be given to defendants that would have acquitted him, that should have been used to stop any prosecution to begin with, is something that really—I have to say it. It really bothers me, and I think it has bothered an awful lot of people on both sides of the aisle. I am not necessarily blaming you on that, but I am saying——

Attorney General HOLDER. Well, it clearly bothered——

Senator HATCH. I do not see anything being done about it, to be honest with you, and, frankly, if we have that kind of prosecution going on in this country—and I know you share my view on this to a large degree. If we have prosecutors running wild like that and ignoring the law itself, something as important as exculpatory evidence that has to be given to the defendant in a criminal case, you can see why some people are losing confidence in what goes on.

Let me change the subject.

Attorney General HOLDER. Well, if I could just say one thing.

Senator HATCH. Sure, go ahead.

Attorney General HOLDER. I was bothered by what happened there, and I made the decision——

Senator HATCH. You had to be.

Attorney General HOLDER. I made the decision to drop the case. The matter has not, however, been dropped. OPR, the Office of Professional Responsibility, is looking into this matter. They are at the last stages of their examination of what happened in connection with the Stevens case. There is a multi-hundred-page report that is just about finalized, and I think we will see what their conclusions are——

Senator HATCH. Will you share that with us?

Attorney General HOLDER. That is up to the people at OPR. What I have indicated was that I want to share as much of that as we possibly can given the very public nature of that matter and the very public decision that I made to dismiss the case. So my hope is that we will be able to share as much of that report as we possibly can.

Senator HATCH. I hope so. I hope you are able to share every aspect of it.

Six months ago, I, along with several members of this Committee, wrote to you expressing a recommendation that Ali Musa Daqduq, who is a senior Hezbollah field commander currently in our custody, be tried in the U.S. military tribunal. Now, remember, this terrorist was captured on the battlefield and was responsible for the kidnapping and execution of five American soldiers.

Now, has the decision been made to put him before a military commission or a civilian trial in the U.S.—the decision is going to be made—or even a release to the Iraqis? Is that even possible? And my only question is this: Have you prepared for the fallout in the event you bring him to the U.S. for a civilian trial and if somehow or other he is found not guilty? Five Americans were killed by this guy.

Attorney General HOLDER. That is a matter that is still under discussion, and a decision will be made as to where the trial can occur or where he can most effectively be tried. But it is something that is still being discussed.

Senator HATCH. Well, thank you, sir. As you know, the issue of enforcing the laws against obscenity and laws protecting children is very important to me. In April, you received a letter signed by me and House Judiciary Committee Chairman Lamar Smith. It asked specific questions about the Department's efforts to enforce both the obscenity laws and the law requiring producers of sexually explicit material to keep records about the age and identity of performers. It has been more than 6 months without an answer. Are you going to get us an answer on that? I hope we receive it soon.

Attorney General HOLDER. After this hearing, I will speak to the people at the Department, and we will try to get you a response to that letter.

Senator HATCH. I would appreciate it, General. Your job is a tough job, and I am the first to admit it. I appreciate your testimony.

Thank you, Mr. Chairman.

Chairman LEAHY. Well, thank you. And I just should note, in connection with what Senator Hatch said, I, too, feel that there is some serious misconduct on the part of the prosecutors in the Stevens matter, and I—

Senator HATCH. You are right, Mr. Chairman. I have to say I have looked at that pretty carefully, and I have never seen a greater injustice to a Member of Congress.

Chairman LEAHY. I would note to the senior Senator from Utah that while I understand OPR normally does not make public their findings, I would hope that as much of that could be made public as possible. It does not right whatever wrongs were done then, but let us hope that it might preclude future wrongs.

Now, I mention this just so nobody would think this is a partisan thing.

Senator HATCH. It is not partisan.

Chairman LEAHY. Senator Stevens was a Republican. I have stated publicly a number of times I felt that was badly handled, and I want you to know that both of us agree on this.

Senator HATCH. Well, thank you, Mr. Chairman. I appreciate your comments.

Chairman LEAHY. Senator Feinstein.

Senator FEINSTEIN. Thank you very much, Mr. Chairman. And I might add the tragedy of the Stevens situation is that Senator Stevens is no longer here to be able to see the result of your examination. So I would just like to agree, Mr. Attorney General, with what my colleagues have said. I think this is very important that whatever happened be made fully public and never, ever happen again.

Mr. Chairman, if I may, I would like to put in the record the official firearms trace data from the Department of Justice from 12/1/2006 to 9/30/2011. This is on guns to Mexico.

Chairman LEAHY. Without objection.

Senator FEINSTEIN. Thank you very much.

[The information referred to appears as a submission for the record.]

Senator FEINSTEIN. Mr. Attorney General, welcome. You mentioned that you became aware of Fast and Furious in 2011. You spoke to us about the Grassley letters in the end of January and February. You asked the IG to investigate in April. My—

Attorney General HOLDER. In February.

Senator FEINSTEIN. Oh, February. Thank you. My understanding is that the practice of letting guns walk first occurred in 2006 as part of Operation Wide Receiver and again the next year as part of the Hernandez investigation.

As you reviewed the records of this, as I am sure you would, did the Attorneys General at that time—I believe there were two of them—in 2007 know about this practice? And what was done about it then?

Attorney General HOLDER. I do not know about the knowledge that the Attorneys General had at that point. I have read reports that a memo was sent to Attorney General Mukasey. I do not know what action they took, but I do know that when I saw the indications that guns had walked, I was bothered by it, offended by it, concerned about it, and ordered the Inspector General to investigate it, and also issued a directive to the field to make clear that gun walking was not appropriate, was inconsistent with Justice Department policy, and should not occur.

Senator FEINSTEIN. Do your records indicate that this operation began in 2006 and continued virtually unabated since that time?

Attorney General HOLDER. Operation Fast and Furious began in 2009, I believe. Wide Receiver began in 2006 or 2007. I am not sure. That matter was investigated and lay fallow for some time until the Criminal Division and the Obama Justice Department looked at it and decided to try to bring the cases that had been just lying there.

Senator FEINSTEIN. Thank you very much.

Since July of this year, the ATF has instituted a requirement that Federal firearms licensees in the four States that border Mexico—California, Arizona, New Mexico, and Texas—report whenever a single purchaser buys multiple, meaning two or more, assault rifles within a 5-day period. I pulled the Federal Register and looked at that, and it says that Federal firearms licensees must report multiple sales or other dispositions whenever the licensee sells or

otherwise disposes of two or more rifles with the following characteristics: A, semi-automatic; B, a caliber greater than 22; C, the ability to accept a detachable magazine to the same person at one time; or during any five consecutive business days. This requirement will apply only to Federal firearm licensees who are dealers and/or pawnbrokers in Arizona, California, New Mexico, and Texas.

Can you tell us a little bit about how that section has functioned, whether it is being carried out, if there are lapses, or if you believe it can be strengthened in any way?

Attorney General HOLDER. I think that that regulation or requirement is an extremely reasonable one. It has all of the features that you have described, and I think significantly exactly what we have been doing for years with regard to the sale of handguns. And the notion that somehow or other we are in litigation now, being sued trying to do the very same thing that we have done with handguns for years with regard to weapons that are far more dangerous is really beyond me. I do not understand how that can be opposed given the fact that this would provide ATF and other Federal agencies with useful information in trying to stop the problem that has been the subject of so much discussion.

Some of the harshest critics of ATF have voted against this very, very sensible regulation. The House has voted to block it. I guess over 270 Members of the House voted against what I think, as I said, is a very reasonable regulation and one that is totally consistent, exactly consistent with what we have been doing with handguns for years, I think since the mid-1980s.

Senator FEINSTEIN. Well, I feel, as you probably know, very strongly about this, and the tens of thousands, I guess, at least 30,000 people that have been killed by guns in Mexico, we know these guns go into the hands of the cartels, and we know how they are used.

So the question that I have is: Do you believe this is being carried out today in an acceptable manner—let me change that—in an effective manner to stop the flow of guns to Mexico?

Attorney General HOLDER. Yes, I think it is. We are only at the beginning stages of it. It has not been in effect for an extremely long period of time, but I think it is the tool that over time will prove to be extremely useful and help us in our efforts to stop the flow of weapons from the United States to Mexico.

Senator FEINSTEIN. Well, this Senator is certainly going to watch it. I would like to extend through you a real compliment to the FBI, particularly in the Saudi case, in the Abdulmutallab case, in the Najibullah Zazi case. I was one who was not quite sure that the FBI had the culture to really develop the intelligence portion to the extent that they have, and I follow this in Intelligence and believe they have really done an excellent job and that we all should be very proud of those plots that have been stopped, the successful prosecutions that have been brought in Federal cases. And I just want to say thank you for that. I think the FBI really has achieved—my time has run out—major, major prosecutions for us, and so thank you very much.

Thanks, Mr. Chairman.

Chairman LEAHY. Thank you.

I will also put into the record a letter I sent to the Acting Inspector General about Operation Fast and Furious, the fact that I understand she is investigating allegations on that, and asked whether she also has with that in connection with that an investigation of Operation Wide Receiver, a similar thing involving Mexico and Arizona, now that we have heard that former Attorney General Mukasey may have been briefed on this similar operation back in 2007. I will put that in the record.

[The letter appears as a submission for the record.]

Chairman LEAHY. Senator Graham, you have been waiting patiently. You are next. And just so people will know the order, after Senator Graham would be Senator Schumer, then Senator Cornyn.

Senator GRAHAM. Thank you, Mr. Chairman.

Mr. Attorney General, I want to congratulate you and all those who are risking their lives in the war on terror and fighting crime for very serious and substantial tactical successes against a very vicious enemy, and I think it is appropriate that we all acknowledge the hard work that has gone into keeping the country safe.

Now, from a strategic point of view, I think we are coming to some crossroads here as a Nation about what we need to be doing in the future. Now, I embrace trying to find a new confinement facility other than Guantanamo Bay. Senator McCain did when he ran for President, and Senator Obama and President Bush. But I have come to conclude—and I may not be the best vote counter in the world—that we are not going to close Gitmo anytime soon.

In September of this year, you were in Brussels, and I think you stated to the European Parliament, “We have an election that is coming up in 2012, in November 2012. We will be pressing for the closure of the facility between now and then,” being Gitmo. “Then after the election we will try to close it as well.”

Am I wrong in assuming that there is not the votes here to close Gitmo before November of 2012?

Attorney General HOLDER. Well, you can certainly count votes better than I can in this body and probably in the House as well, you having served there. But it is the administration policy to try to close Guantanamo. We think it would be an appropriate thing to do for a whole variety of reasons. We have certainly run into opposition, but—

Senator GRAHAM. Let me, if I may, just interrupt. I understand where you are coming from, and I have embraced the idea of trying to find a new confinement facility. But certain legal changes had to occur for that to be viable that have not occurred. We do not need to blame each other, but from now going forward, we do live in a real practical world. Do you agree with that?

Attorney General HOLDER. A real practical world.

Senator GRAHAM. Yes, we have got to make practical decisions here.

Attorney General HOLDER. It is not as practical as I would like it to be all the time, but it is somewhat practical.

Senator GRAHAM. But I buy into the idea of all-of-the-above approach that sometimes Article III courts may be the best venue in trying terrorists. I have never said that Article III courts do not have a place in this war. And I have been very passionate about military commissions, and I think we see that the same, that we

should have an all-of-the-above approach and be as flexible as possible.

But I guess my point, Mr. Attorney General, is that we do not have a jail in the war on terror for future captures, and I think that makes us less safe. Where would we put someone if we caught them tomorrow, a high-value target? Where do we confine them?

Attorney General HOLDER. It is something that we are discussing.

Senator GRAHAM. Would you put them in Afghanistan?

Attorney General HOLDER. Well, there are a number of options that we are discussing and we are trying to work our way through to come up with a proposal that would be both effective and that would generate the necessary—

Senator GRAHAM. I just honestly cannot see an option that makes sense. The idea of putting them on ships for a limited period of time is not a viable substitute because ships were never meant to be permanent confinement facilities. I do not see Afghanistan accepting new war on terror captures that would bring the Afghan Government down. Certainly the Iraqis are not going to do it. So if we do not use Gitmo, what are we going to do?

Attorney General HOLDER. Well, as I said, those are the options that we are trying to discover. The President has made clear, the administration has made clear that we are not going to be using the Guantanamo facility, so we have to come up with options that can be funded and support the—

Senator GRAHAM. OK. Mr. Attorney General, I have tried to be as supportive as I know how to be in creating flexibility for the executive branch and not micromanage the war. But I have come to conclude Gitmo is not going to close, and there is no viable option other than Guantanamo being used, that the Iraqi legal system is not going to allow us—they are not going to become the jailer for the United States. Afghanistan is not going to become the jailer for the United States. Naval ships are not a good option. So I just really believe that we need to embrace reality, and the reality is we need a jail, we do not have one, and Gitmo is the only jail available.

Now, this Daqduq guy who is being held by the Iraqis, he is a Hezbollah capture in Iraq, an Iranian basically inspired person who was training Shiite militias and is charged with killing five Americans. If we do not put him in Gitmo, where are we going to put him?

Attorney General HOLDER. Well, those are options we have been discussing. How he will be dealt with are topics of conversation that I have engaged in with my counterparts on the National Security—

Senator GRAHAM. We had a conversation about Khalid Sheikh Mohammed and how I thought it would be ill advised to put him in New York City civilian court, Federal court, because he was an enemy combatant who would be—and I think that did not go over well simply because it was an ill-suited case choice, not the fact that we cannot use Article III courts, just not for somebody like him.

Mr. Attorney General, if you try to bring this guy back to the United States and put him in civilian court or use a military com-

mission inside the United States, holy hell is going to break out. And if we let him go and turn him over to the Iraqis, that is just like letting him go. I think this would be a huge mistake. He is charged with killing five Americans, and at the end of the day—I try to be as practical as I know how to be—it would be a national disgrace to allow this guy to escape justice. And the only option available to this Nation is Gitmo because there is bipartisan opposition to creating a confinement facility in the United States, and I just beg and plead with this administration to create an option that is viable, and the only viable option is to use Guantanamo Bay.

Now, let us talk about Guantanamo Bay. Do you believe it is a humanely run prison?

Attorney General HOLDER. I have been to Guantanamo, and as the facility is now run, I believe that the men and women down there conduct themselves in an appropriate way and that prisoners are treated in a humane fashion.

Senator GRAHAM. Isn't it true that every detainee at Guantanamo Bay will have access to our Federal courts to make a habeas petition for their release?

Attorney General HOLDER. Right, there are a number of cases that we, in fact, are handling here in the D.C. courts.

Senator GRAHAM. Isn't it true that any conviction that comes from a military commission will be automatically appealed to our civilian court system?

Attorney General HOLDER. I think that that is true. I am not sure, but I think that is true.

Senator GRAHAM. I think that is true. So the bottom line is that we all agree that Guantanamo Bay is a humane detention facility being well run and that we have civilian oversight of what happens at Guantanamo Bay. So my view is that we are less safe if we do not have a prison, and please tell me in the next 30 days, submit to this Committee or me individually a plan, because we are running out of time, that would be reasonable, sound, and has political support to confine future captures and to move people out of Iraq and Afghanistan who are too dangerous to let go. Could you do that in 30 days?

Attorney General HOLDER. I do not know. This is a decision that will be made by—I will be a part of the decisionmaking process, but the decision itself will be made by, I think, people higher up the ladder.

Senator GRAHAM. Well, could you tell those people higher up that we are about to withdraw from Iraq—and these people in Iraq are going to be let go, and we are running out of the ability to hold people in Afghanistan—that time is not on our side, the war is an ongoing enterprise, and we need a jail. So I urge and will have other Senators urge you to find a solution to this problem within 30 days.

Thank you very much for your service.

Attorney General HOLDER. Sure. The one thing I would say is—and I go back to what you started with. Whatever the proposal is, whatever the administration works its way through, I hope that it will be viewed in a practical manner by Members of Congress and take into account the history that we have with regard to our abil-

ity to safely detain people, to try people, and understand that whatever is the proposal that we make—

Senator GRAHAM. I try to be practical, sometimes to my own detriment, but I promise you I will be practical.

Attorney General HOLDER. Thank you.

Chairman LEAHY. Senator Schumer.

Senator SCHUMER. Thank you, Mr. Chairman.

I am going to go back to the Fast and Furious issue, and there has been, of course, a lot of focus on the present administration's dealings with Fast and Furious, but what has been sort of missing certainly in the House investigation is that it did not start with the Obama administration. It started with Alberto Gonzales and then continued with General Mukasey. And if we want to get to the bottom of it and find out what went wrong, I think we have to look at the whole things. So my questions are somewhat related to that.

Mr. Attorney General—and thank you for being here—as we learned last week, some briefing material on Operation Wide Receiver, the Bush era version of Fast and Furious, was prepared for Attorney General Mukasey shortly after he took office in preparation for a November 16th meeting with Attorney General Eduardo Medina Mora of Mexico. That was not the beginning. It is clear now that ATF agents and line prosecutors in Tucson as early as 2006 discussed an ATF proposal to provide guns to criminals “without any further ability by the U.S. Government to control their movement or future use.” We know this operation was likely part of Operation Wide Receiver in which 350 guns were purchased by straw purchasers, and as your production of material continues, it is plausible we will find out that this strategy was discussed maybe even before 2006.

The briefing material from 2007 which was prepared for General Mukasey stated that, “ATF has recently worked jointly with Mexico on the first-ever attempt to have a controlled delivery of weapons being smuggled into Mexico by a major arms trafficker. While the first attempts at this controlled delivery have not been successful, the investigation is ongoing. The ATF would like to expand the possibility of such joint investigations and controlled deliveries since only then it will be possible to investigate an entire smuggling network rather than arresting a single smuggler.” That is in the memo from General Mukasey, which I think was made public Friday.

Then e-mails indicate that ATF's Assistant Director for Enforcement reviewed this briefing language. So I want to try and figure out who saw the briefing material, so I am going to ask you about some of the names there that are listed. These are listed at the top of the briefing memo prepared for General Mukasey for the November 16th meeting with Mora.

My first question is a simple one. What position did Matthew Friedrich hold on the date that is on the meeting memo? Do you recall that? You may not.

Attorney General HOLDER. I do not know, Senator.

Senator SCHUMER. He was deputy chief of staff to Attorney General Mukasey. And Kevin O'Connor, I will not ask you that one, he was Associate Attorney General. You may have recalled that.

So I think we can infer that both Mr. Friedrich and Mr. O'Connor were likely to have received the material either before or at the

meeting with Attorney General Mora, and given that, as well as the fact that the meeting was with General Mukasey's counterpart in Mexico, I think we can infer that General Mukasey is highly likely to have attended the November meeting and seen this material.

Are you aware of whether General Mukasey reviewed the memo?

Attorney General HOLDER. I do not know if he did or not.

Senator SCHUMER. OK. And I do not want to vouch for anyone's attendance at the meeting. Obviously, you were not there. I want to be clear about that premise. But with that caveat, are you currently able to say whether there were any other high-ranking DOJ officials who attended the November 7, 2007, meeting?

Attorney General HOLDER. I just do not know, Senator, who attended the meeting.

Senator SCHUMER. OK. But it would not have been beyond the pale for other top officials to have been briefed on this, either in preparation for the meeting or otherwise. Is that correct?

Attorney General HOLDER. It is certainly possible. I just do not know.

Senator SCHUMER. Right. OK. Another one: Do you have any knowledge whether Deputy Attorney General Craig Morford was briefed on the program or tactics?

Attorney General HOLDER. I do not know that either.

Senator SCHUMER. Knowledge of any other members of other departments with border responsibility, DHS or State, briefed on the program or these tactics?

Attorney General HOLDER. I do not know how extensively it was briefed.

Senator SCHUMER. OK. Lanny Davis, the current Criminal Division head, testified he was briefed after it was closed, after Wide Receiver was closed in 2010. Do you think if his predecessor, Alice Fisher, was similarly briefed or took part in meetings?

Attorney General HOLDER. I do not know.

Senator SCHUMER. OK. Here is what—yes, Lanny Breuer, right. What did I say? I get those two mixed up, the two Lannys I read about.

OK. Here is what I would ask: Could you go back and look at the files or have someone do that and get us information on whether these people were part of briefings, part of meetings that might have related to that program, Wide Receiver?

Attorney General HOLDER. As part of the process in responding to requests for information from the Hill, we are trying to gather information, and we may be able to gather from the e-mails and other materials that we are gathering some better sense of who was actually briefed with regard to Wide Receiver.

Senator SCHUMER. OK. And one other thing. In the prepared remarks made by Attorney General Mukasey regarding the trip to Mexico which he made on January 16th, he said, "I reiterated for the Attorney General, as I do now, the United States is committed to addressing the flow of illegal guns into Mexico. . . . I indicated we would also be deploying additional resources to arrest and prosecute violent criminals, to trace the firearms—the 'tools of the trade'—used by criminal gangs." This indicates that gun walking might have been discussed at this meeting as well.

So once again, is there anything you are able to say without vouching for anybody's attendance about that 2008 trip to Mexico, what was discussed, who might have attended? And if not, can you get us that information?

Attorney General HOLDER. We will attempt to obtain that information. I simply do not have that information right now.

Senator SCHUMER. OK. What I am getting at here and why I think it is important to have answers to this question is because there has been a selective way in which this investigation has been pursued so far. It is sort of one-sided outrage about the whole issue when we know now that it began—or its progenitor began before you took office, before President Obama took office. And the House Committee Chair has said he would look at both sides, wrongdoing on both sides. That has not happened.

It appears—it is a pretty good bet that top officials at the Bush Justice Department, perhaps the Attorney General himself, learned of this operation in its early stages. We know a memo was prepared for him. We do not know what he knew. At the very least, they let it continue. For all we know, they have endorsed it. And so I think it is important that we look at both sides, and my suggestion, Mr. Chairman, is if the House will not do that, we should.

Chairman LEAHY. I agree, and I thank you for the questions.

Senator Cornyn, and then we will go to Senator Whitehouse.

Senator CORNYN. Mr. Chairman, for what it is worth, I agree with Senator Schumer that we need all the information about these programs and the distinctions, if any, between Wide Receiver and Fast and Furious.

General Holder, I note that Fast and Furious has had a significant spillover effect in my State of Texas where 119 of these weapons of the 2,000 weapons that were walked into the hands of the cartels, 119 of them have shown up at crime scenes in my State. Investigations by Senator Grassley have also revealed that the ATF agents have ordered clerks at a Houston-based business called Carter's Country to go through with sales of weapons to suspicious purchasers, some of which may have been working as agents of the cartels.

On August 7th, I sent you a letter asking you about the Texas connections, and I got a letter back last Friday from your subordinates saying that you were unable to provide more information at this time.

I am hopeful you will be able to provide more information because we know that the weapons from Fast and Furious have shown up at 11 different crime scenes in the United States, and this is far from, as you stated earlier, local law enforcement operation in terms of its impact. Many of these weapons, of course, ended up in Mexico, one we know at the crime scene where Brian Terry was murdered by the cartels. So let me ask you a little bit about some of this timeline.

First of all, on February 4th, Assistant Attorney General Weich wrote a letter denying gun walking, and it was not until November 1st of 2011 when Lanny Breuer testified that that letter was false, that throughout that whole period, from February 4, 2011, and November 1, 2011, your Department left the impression on Congress that the allegation that the Department had engaged in gun-walk-

ing operations was false, when, in fact, Mr. Breuer came in on November 1, 2011, and said that that letter sent to Senator Grassley in response to his inquiry was false.

How do you account for the fact that the Department had for the period of time from February 2011 until November 2011 had misled Congress about the accuracy of that allegation?

Attorney General HOLDER. I think there is some validity in the concern that you raise. As I indicated before, with regard—

Senator CORNYN. I do, too.

Attorney General HOLDER. Well, I hope so. It is your question, so I assume you did. February 4th, the information that was contained in that letter was thought to be accurate. It was not until some time after that that we had a sense that the information was not, in fact, accurate. So it was not as if the data upon which we knew the information was inaccurate was on February 4th. It comes some time after that.

I received things as late as March of 2011 from people at ATF who assured me that gun walking did not occur.

Senator CORNYN. But your Department—you said you learned about Fast and Furious—on May 3rd, you said you learned probably over the last few weeks, today you say it was over the last couple of months.

Attorney General HOLDER. Well, I said over the last few weeks or it could be expressed as over the last couple of months. I think the last few weeks I said is consistent with the timeline that you have out there.

Senator CORNYN. But the fact is the Department's official response to Senator Grassley as part of his investigation was that it did not happen until you came before the House and said that you had learned about it over the last few weeks. That was May 3, 2011. Is that correct?

Attorney General HOLDER. I am not sure I understand that question.

Senator CORNYN. OK. Well, let me go on to something else.

Do you still contend this was a local law enforcement operation?

Attorney General HOLDER. It is a Federal—no, do not misinterpret that. It is a Federal law—

Senator CORNYN. Those are your words. You said it was a local law enforcement operation—

Attorney General HOLDER. Well, then, that is my fault.

Senator CORNYN [continuing]. In your opening testimony.

Attorney General HOLDER. No, that is my fault. It is a Federal law enforcement operation that was concerned—that was of local concern. It was not a national operation.

Senator CORNYN. Well, it metastasized, didn't it, to Mexico, it metastasized to Texas, and obviously in Arizona, so it was not certainly local in effect. You would agree with that.

Attorney General HOLDER. Well, as I indicated in my opening statement, the impact of the mistakes made in Fast and Furious are going to be felt in Mexico, in the United States, and probably for years to come.

Senator CORNYN. A lot of those guns have still not been accounted for, correct?

Attorney General HOLDER. A number of those guns have not been accounted for, and that is why it is incumbent upon us and why I have taken the steps that I have taken to try to ensure that the mistakes that happened there are not repeated.

Senator CORNYN. This is the organization chart for the Department of Justice. You would agree with me that the Bureau of Alcohol, Tobacco, Firearms, and Explosives is an agency in the Department of Justice of which you are head. Correct?

Attorney General HOLDER. Yes, that is correct.

Senator CORNYN. And that is your signature right here attesting to this organization chart, April 30, 2010. So you are not suggesting, are you, General Holder, that it is not your responsibility to have known about this operation, is it?

Attorney General HOLDER. Well, there are 115,000 employees in the United States Department of Justice. There are—

Senator CORNYN. And the buck stops with you.

Attorney General HOLDER. I have ultimate responsibility for that which happens in the Department. But I cannot be expected to know the details of every operation that is ongoing in the Justice Department on a day-to-day basis. I did not know about Fast and Furious, as is indicated in the chart that you now have up there, until it became public.

Senator CORNYN. You cannot be expected to have known about the operation known as Fast and Furious, despite the fact that we know that you received an NDIC memo on July 5, 2010? You received another memo on Fast and Furious November 1, 2010, and you say you cannot be expected to have known about it because of the size of your agency?

Attorney General HOLDER. No, there are a couple problems with that chart, colorful though it is. The “AG Holder receives NDIC memo,” incorrect. “AG Holder receives significant recent events memo,” that is incorrect.

Senator CORNYN. Those are memos with your name on it addressed to you, referring to the Fast and Furious operation. Are you just saying you did not read them?

Attorney General HOLDER. I did not receive them.

Senator CORNYN. You did not receive them.

Attorney General HOLDER. What happens is that these reports are prepared, these weekly reports or whatever, they are prepared with my name on them, with the Deputy Attorney General’s name on them. They are reviewed by my staff and a determination made as to what ought to be brought to my attention. If you look at those memos, there is nothing in any of those memos that indicates any of those inappropriate tactics that was of concern to us were actually used, and my staff made the determination that there was no reason to share the content of those memos with me. So “AG Holder receives memo,” incorrect. “AG Holder receives significant recent events memo on Fast and Furious,” also incorrect.

Senator CORNYN. Have you apologized to the family of Brian Terry?

Attorney General HOLDER. I have not apologized to them, but I certainly regret what happened.

Senator CORNYN. Have you even talked to them?

Attorney General HOLDER. I have not.

Senator CORNYN. Would you like to apologize today for this program that went so wrong that took the life of a United States law enforcement agent?

Chairman LEAHY. Just before you answer, that will have to be your last question, keeping to the time.

Attorney General HOLDER. I certainly regret what happened to Agent Brian Terry. I can only imagine the pain that his family has had to deal with, in particular his mother. I am the father of three children myself. We are not programmed to bury our kids. It pains me whenever there is the death of a law enforcement official, especially under the circumstances that this occurred.

It is not fair, however, to assume that the mistakes that happened in Fast and Furious directly led to the death of Agent Terry. Again, my feelings of sympathy and regret go out to the Terry family, and I hope that the steps that we have put in place, the measures that I have called for, will prevent other Federal agents, local and State agents from being the subject of this kind of violence, as well as civilians, both in the United States and in Mexico.

Chairman LEAHY. And I would put into the record a letter from the Fraternal Order of Police praising Attorney General Holder for his commitment to law enforcement rank-and-file officers, especially on the question of the safety of officers, and the work he has done following the spike in attacks on police officers around our country.

Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Chairman. Welcome, Attorney General Holder.

I spent 4 years as the United States Attorney for the District of Rhode Island, and while some time has gone by since then, my recollection is that there was, I guess you would call it, kind of a convention in the Department of Justice that a lot of people got to write memos that were nominally designated to the Attorney General. And there was some value in that because it kind of made you feel good to be writing a memo to the Attorney General of the United States, and it was fairly widely accepted that that was a common practice—that was my recollection, anyway—and that the filtration of that flood of e-mails and memoranda nominally designated for the Attorney General was filtered by the Deputy Attorney General and that office, and that then what went actually through to the Attorney General was kind of on what the deputy perceived to be a need-to-know basis for then-Attorney General Reno. And I am wondering, is my recollection correct? And does that remain the convention within the Department that there is a large number of e-mails that are nominally directed toward the Attorney General that, as a matter of standard Department practice, the Attorney General never actually sees?

Attorney General HOLDER. That is correct. There are a number of what I will call filters that exist so that we can respond in a timely fashion to things that are raised to the attention, nominally to the attention of the Attorney General. You have Assistant Attorneys General who have subject matter responsibility in a variety of areas. You have the Deputy Attorney General. We have an Assistant Attorney General for Legislative Affairs who responds to memos and things that come from members of the Hill. So there

are a whole variety of things that will say, "To the Deputy Attorney General," "To the Attorney General," that neither of us would ultimately see.

Senator WHITEHOUSE. Well, I guess I would only -even though it appears to have created some misunderstanding in this particular matter, I would urge you not to depart from that, because my recollection is that the senior staff that U.S. Attorneys and others work very, very hard and that the feeling when you are preparing a document that it is going to the Attorney General of the United States is an important one. And if that got shut off so that, you know, mail had to be sent to more junior officials in the Department, I think it—other than the confusion that this has created, I think that it is a good thing for the 93 U.S. Attorneys and others to be able to write memoranda with the feeling that this is going to the Attorney General, and I think it calls up a higher level of performance and public spiritedness. So I would urge you to leave that in place even though there has been this misunderstanding.

Attorney General HOLDER. Sure, and I think one thing let me make clear. My staff as well as the staff in the Deputy Attorney General's office reviews a large volume of this material, and some of the things that do say "To the Attorney General" actually do get brought to my attention if they make the determination that it is something that needs to be brought to my attention as opposed to something that is more routine or something that can be handled at a lower level.

I get a fair amount of information that I have to look at. I have to stay up at night to try to keep up with it. It is just not the things that were in the chart, I guess, that Senator Cornyn had. Those things were not brought to my attention, and my staff I think made the correct decision in that regard.

Senator WHITEHOUSE. And that is consistent with longstanding Department practice.

Let me switch topics to the vulnerability that our country faces to a cyber attack. A lot of the committees of Congress have done a lot of work on this subject. Bills I think are out of Committee and ready to go. There was a long pause while the administration did its work of its interagency process, which has now concluded, and many of us believe that it is time for Congress to move forward in a bipartisan fashion with meaningful cybersecurity legislation. And in that vein, I would like to ask you to make your recommendation to us today as to how quickly and with what urgency you believe we should be going forward to pass cybersecurity legislation. That is going to be part one of the question.

Part two of the question is that sometimes we pass legislation around here, and it is not clear whether or when it will have an effect. The prime area of real national security risk is to privately owned national critical infrastructure. Do you have any information that you can give us on how quickly, once we pass meaningful cybersecurity legislation, the critical infrastructure that is in private hands in this country can have its cybersecurity level dramatically increased so that the risk to our country to that critical infrastructure is commensurately reduced?

Attorney General HOLDER. I think that you are right to focus on this whole question of cybersecurity. It is something that I think,

frankly, we have waited too long to act upon. It has military implications. It has civilian infrastructure implications. It has intelligence-gathering capability implications. It has obviously just criminal fraud problems that can result from our lack of focus on this issue.

With regard to that first question, I think this has to be a priority, that there are a variety of things that this Committee has to consider. But as we in the executive branch focus on those things that are of most concern to us, we spend a huge amount of time focusing on this cyber issue, and I would hope that we can work with this Committee and Members of Congress to come up with the necessary legislation to deal with what is a real and present danger to this Nation.

Senator WHITEHOUSE. And the effect of getting it done?

Attorney General HOLDER. The effect, I think, will be seen—it is interesting because I think when you pass bills, frequently you do not see the results of those bills for years sometimes, a huge number of months. But with regard to civilian infrastructure and other things that I talked about in the first part of my answer, I think that you would see the ability to protect that infrastructure in a relatively short period of time.

One of the values that we have, one of the kind of unique things about the cyber area is that the protections that can be raised can be done relatively quickly because you are dealing with switches and electronic stuff that I do not totally understand, but that can be changed relatively quickly. So the impact, the positive impact of this legislation would be something that we would feel relatively soon.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Chairman LEAHY. Thank you.

The list from Senator Grassley has Senator Coburn next, but he is not here. Senator Lee. And then after Senator Lee, we will go to Senator Franken or, if he is not here, Senator Coons.

Senator LEE. Thank you, Mr. Chairman. Thank you, Mr. Holder, for joining us today.

I understand that the House Judiciary Committee has issued a request—I believe it was this past Friday—for documents and with interviews related to Justice Kagan's involvement in the health care legislation and related litigation during her service as Solicitor General. Will the Department of Justice comply with that request?

Attorney General HOLDER. I am not familiar with that request. I would have to look at it. I am just not familiar with the request that has been made or what materials have been sought in that regard.

Senator LEE. OK. I believe the intent of the request is to get any documents or any other indication that Justice Kagan while serving as Solicitor General may have participated in discussions related to actual or contemplated anticipated litigation involving the constitutionality of the Affordable Care Act.

Attorney General HOLDER. I can tell you that certainly one of the things that we did while she was Solicitor General was to physically, literally, move her out of the room whenever a conversation came up about the health care reform legislation. I can remember specific instances in my conference room where, when we were

going to discuss that topic, we asked Justice Kagan to leave, and she did.

Senator LEE. So that being the case, there should not be a problem responding, complying with this request?

Attorney General HOLDER. Again, I do not know what the nature of the request is. I will certainly look at it.

Senator LEE. OK. There were letters. One was sent on Friday from the Chairman of the House Judiciary Committee.

Attorney General HOLDER. OK.

Senator LEE. You have acknowledged today that mistakes were made, obviously, within the Department of Justice related to the Fast and Furious program but without specifying who made those mistakes. I would be curious. What mistakes have you made that you can identify, things that you wish you had done differently, any mistake that you personally have made.

Attorney General HOLDER. Well, I think that as I look at the information as it was brought to me, I think that I acted in a responsible way by ordering the Inspector General investigation, by issuing the directive to the field. We have an Inspector General report that will look at this matter, and I think that we will glean from that report a better sense of what people did, who should be held accountable. And I want to make clear that on the basis of that report and any other information that is brought to my attention, those people who did make mistakes will be held accountable.

Senator LEE. And you have reiterated several times that people within the Department of Justice believed that the initial statements denying knowledge of Fast and Furious were accurate. They believed they were accurate. Obviously, these were some people and not all people.

Attorney General HOLDER. Right.

Senator LEE. Because clearly some people knew.

Attorney General HOLDER. Exactly.

Senator LEE. What can be done, then, to bridge this gap in the future to make sure that the some communicate with the others, particularly those at the top?

Attorney General HOLDER. Well, one of the things I hope will be as a result of the directive that I issued with regard to this whole question of gun walking, that people understand that is simply not acceptable. But the Inspector General report—I think you make a good point. The Inspector General report I think will ultimately answer a question that I do not know the answer to right now: Who actually thought this was a good thing to do? And why didn't people discover sooner than they did that, in fact, what we thought was occurring, in fact, was not? I think that will be the result of the Inspector General report.

Senator LEE. You know, I have been curious about some statements made recently by Lanny Breuer, the head of the Criminal Division, that are at once indicative of a broader concern and also I think in some ways likely to implicate some questions related to Fast and Furious.

Mr. Breuer has stated that although he and/or his top deputies approved several ATF wiretap applications for Operation Fast and Furious, as is required under Federal law consistent with Title 18 U.S. Code, Section 2518, et seq., Main Justice has only one role in

reviewing the sufficiency of wiretap applications: to ensure that there is legal sufficiency to make an application to interrupt communications, that is, to ensure that the Government's petition to the Federal judge is, in his words, a credible request.

He went on to explain that it is the responsibility of the district offices carrying out the investigation "to determine that the tactics that are used are appropriate and that Main Justice has to rely on those prosecutors in the field and not to second-guess them."

I find this interesting in the sense that here the requirement outlined in Section 2518 of Title 18 requires an analysis at the Department of Justice level. It requires an analysis of you or of your deputy or of the Assistant Attorney General in charge of the Criminal Division, one of those officials essentially. And one of the things that they have to do there is rather than simply regurgitate, back out the same facts and say, well, yes, it looks like they cite the right statute, they have to undertaken an assessment as to such issues as: Have other investigative tactics proven inadequate? And if so, why is a wiretap—which is a pretty extraordinary remedy, it is a pretty invasive investigative tool, and that is why Congress has, understandably, required that the Department of Justice at the top levels approve these.

So if he, in fact, approved multiple wiretap applications, then one of two things I think is happening: he is either not complying with that duty to assess each one independently to make sure that there was this representation made that the Department established the case for a wiretap application; or, on the other hand, he was doing his job and was, therefore, made aware of what was going on with Operation Fast and Furious, but did not disclose that. Or when he saw initial denials by the DOJ about Fast and Furious, failed to raise the flag that said, hey, this is a concern. So which is it?

Attorney General HOLDER. Well, first off, Lanny Breuer would not have approved, he would not personally approve these requests, these wiretap requests.

Senator LEE. Would it have been one of his deputies?

Attorney General HOLDER. One of the Deputy Assistant Attorneys General.

Senator LEE. Who report directly to him.

Attorney General HOLDER. Who report directly to him, but my guess would be that given the volume of these things, the conversations about those kinds of things, it probably does not exist. The only one that the Assistant Attorney General is required to approve personally is if it is for a roving wiretap. There were no roving wiretaps in connection with Fast and Furious.

Senator LEE. But given that they report directly to him, wouldn't they be in a position, once they saw that the Department of Justice and its good name were on the line, to have said, hey, you know, the Department of Justice did, in fact, know about this program; in fact, we have approved a significant series of wiretap applications on this point?

Attorney General HOLDER. Yes, I do not think the wiretap applications—I have not seen them. I have not seen them. But I do not have any information that indicates that those wiretap applications had anything in them that talked about the tactics that have made this such a bone of contention and have legitimately raised the con-

cern of Members of Congress as well as those of us in the Justice Department. I would be surprised if the tactics themselves about gun walking were actually contained in those applications. I have not seen them, but I would be surprised if that were the case.

Chairman LEAHY. Senator, your time is up, and I will note that Mark Shurtleff, who is Utah's Attorney General and a Republican, and Terry Goddard, former Arizona Attorney General, a Democrat, in an op-ed published in Sunday's Salt Lake Tribune—and I would ask that be put in the record. They conclude that, "It would be tragic if the furor over Fast and Furious causes our country to abandon Mexico to the cartels. The cartels are our enemy, not the ATF or Department of Justice. We need to provide the men and women fighting this...battle with the tools they need."

[The op-ed appears as a submission for the record.]

Chairman LEAHY. Senator Coons.

Senator COONS. Thank you, Chairman Leahy, and I would like to thank you, Attorney General Holder, for being here today. The oversight function of this Committee is one of the most important roles we have, and I thank you for your service but also for your detailed and thorough testimony here today. And before I begin my questioning, I just wanted to highlight that, like Chairman Leahy and Senator Whitehouse who have asked about this previously, I am keenly concerned about the very real and emerging threat of cyber criminals. And to meet this threat, I think we need to use all of our resources at our disposal. My home State of Delaware happens to have a unique or, I believe, a promising National Guard unit in network warfare, a squadron, and last Friday, the Chairman and I sent you a letter asking for your position on whether the National Guard might in the future provide a pathway for the DOJ to make some use of their sophisticated cyber defense resources as the DOJ expands its law enforcement resources. And I just want to thank you in advance for your consideration of that, and I look forward to the Department's response.

On the topic of industrial espionage, which was also previously addressed, last week the Office of the National Counterintelligence Executive released a fairly alarming report accusing China and Russia of aggressive and capable collections of sensitive U.S. economic information and technologies through cyberspace. Frequently, IT software developers know about exploitable bugs in their software months before a security patch is issued, and corporations running software often do not apply patches that are necessary to protect against vulnerabilities.

Do we have the right incentives in place to encourage the private sector to respond quickly and appropriately to emerging security threats to defend themselves from fraud and to promote our Nation's security for our IP infrastructure?

Attorney General HOLDER. I think the issue that you highlighted is one that, again, should be of great concern to us. I took a trip to China, last year I believe it was, to have a very frank conversation with them about the concerns we had about intellectual property, the theft of intellectual property, the stealing of industrial secrets. We are going to have to compete with them in the 21st century, and we should be doing so on a level playing field. And so

that is a big concern that we have. It is one that we have expressed to the Chinese.

Senator COONS. One follow-on question I have got is about resources for the Department. The Economic Espionage Act was passed 15 years ago, and as of October, there have only been eight cases tried under this. And so the last time that you testified before us, I asked whether you thought the DOJ needed additional resources, either financially or statutorily, to more successfully criminally prosecute those who steal sensitive IP.

Given this report, and given the very real prospect that we are losing vast amounts of national treasure, is the DOJ ramping up its efforts to enforce the Economic Espionage Act? Do you see a need for more statutory or financial resources for the Department in light of this report?

Attorney General HOLDER. I think it is a priority for the Department, but I do think that even in these tough economic times, and given the nature of the threat and what is at stake, both for the safety of this Nation and for its economic well-being, this is an area that we have to focus on. This is an area that will require—as I deal with limited numbers of people, some decisions have to be made by me and by others in the Department, hopefully with the support of Members of Congress, to ramp up our abilities to deal with these issues.

It is not too much to say, it is not an overstatement, it is not hyperbolic to say that the future of this Nation is really dependent on, in part, how we resolve the issues that you are raising.

Senator COONS. On a related point, the Customs and Border Patrol, at least in my view, has interpreted the Trade Secrets Act to bar it from sharing with trademark rights holders either photos or documents or samples related to seized goods that could be counterfeit. There is a Senate Armed Services Committee hearing, I believe today, on the grave threat posed to our servicemen and -women by counterfeit Chinese microchips that have made their way into United States weapons systems in apparently significant quantity, and many of the counterfeits may be examined by CBP, but they are not consulting with sources that I think could make it possible for them to more rapidly determine whether what is being intercepted in counterfeit or not.

Has the DOJ ever or do you believe it would ever prosecute a Customs and Border Patrol agent for sharing information where the intention is to simply certify whether something that has been seized is or is not counterfeit?

Attorney General HOLDER. We have something that is called, as you know, prosecutorial discretion. It would be hard for me to imagine that we would bring such a case. But I also think that, to the extent that that impediment exists between the sharing of that kind of information and given the need for a public-private partnership to deal with these issues, that that might be a legislative fix that perhaps we could discuss and somehow deal with.

We are only going to be successful in this if we have the public sector working with the private sector to deal with these issues. We cannot do it alone. We cannot do it alone in Government. The private sector cannot do it alone as well. And to the extent there are

barriers to information sharing, I think we have to try to knock those down.

Senator COONS. Thank you, and I would be happy to work with you and your office on finding a legislative fix. I do think that we are hamstrung in border enforcement around these vital issues.

Last, as part of the CR to fund the Government for the remainder fiscal year 2011, many programs at DOJ took fairly deep cuts. Especially hard hit in my view were those designed to support State and local law enforcement. It was cut I think by more than \$430 million. The COPS technology program in particular I was concerned was zeroed out, where many other programs took double-digit cuts. For my home State, where I previously supervised a county police department, it means less money for regional information sharing, less money for youth and criminal diversion programs, less money for officer protection and protective equipment.

In your view, how are the cuts to OJP affecting your ability to provide cost-effective support that has a multiplier effect for State and local law enforcement? And what will the impact be if the House 2012 appropriations bill, which zeroes out the entire COPS hiring program, were to actually be enacted?

Attorney General HOLDER. Let me be very, very clear. Those proposed cuts are simply unacceptable and place this Nation at risk. Though we are enjoying historically low crime rates, we have 30,000 vacant law enforcement positions in this country. We have lost 12,000 officers over the course of the last year, and we put at risk the possibility that these historically low rates will not remain there forever.

There have been high rates of shootings of police officers. Although the rates have been coming down generally in terms of crime, the amount of violence directed at police officers is up over 20 percent over the last 2 years. The number of deaths this year is outpacing that which we saw last year. And the notion that somehow, some way we would, at a time when we are trying to create jobs, take people who are sworn to protect the lives of the American people off the line is to me illogical and unacceptable and dangerous.

Senator COONS. Thank you, Mr. Attorney General. I look forward to working with you to sustain the COPS program and other vital partnerships with State and local law enforcement.

Thank you, Mr. Chairman.

Chairman LEAHY. Thank you very much.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you, Mr. Attorney General, for being here today. I have listened to all the questions and all of your answers, and I want to thank you for effectively addressing many of the questions surrounding Fast and Furious and dispelling any doubt that you are determined to uncover all the facts surrounding some of the very regrettable circumstances here. And just so we understand, a lot of names have been mentioned here: Attorney General Mukasey; Kevin O'Connor, who happens to be a former United States Attorney in Connecticut; and others in the Department now. There is no evidence before us here that they knew or participated in any wrongdoing, is there?

Attorney General HOLDER. Yes, I hope my testimony was clear. I do not know.

Senator BLUMENTHAL. And it has been. Thank you. And also that there is an ongoing investigation which eventually will disclose whether or not and who knew about what was going on. And I want to thank you for being so candid and straightforward on that point.

I want to join my colleague Senator Coons in expressing my determination that there should be more assistance and sufficient support for our police on the streets of Connecticut, in our neighborhoods, as well as the firefighters and other personnel that I would regard as law enforcement, which are really in more than one sense the cops on the beat who protect us day in and day out. Despite the very excellent performance of the FBI, they are the ones who do the bulk of law enforcement for our Nation, and I appreciate and thank you for your support.

I think perhaps for me one of the most important aspects of your testimony today is really the vigor and intensity that the Department of Justice is devoting now to stopping gun trafficking and drug dealing and gang violence on our borders and throughout the country, but most particularly in connection with the Mexican gangs that pose such a threat to Americans as well as Mexicans. And as I understand your testimony, there have been record numbers of seizures, arrests, prosecutions, convictions, and extraditions. Is that correct?

Attorney General HOLDER. That is correct. We have moved substantial numbers of resources to the border in an attempt to stop the flow of guns into Mexico, to stop the violence along the border. We have worked in the interior of Mexico with our Mexican counterparts in training and trying to come up with ways in which we could fight the cartels. Our Mexican counterparts have sacrificed a great deal, and even with their lives, in this fight, and we have tried to be good partners in that struggle.

Senator BLUMENTHAL. And would it be fair to say that the Mexicans are increasingly becoming good partners in this effort?

Attorney General HOLDER. Yes, I think so. I think through the use of vetted units, through the use of other techniques that we have shared with them, through their growing sophistication with the use of electronic devices, I think they are becoming more proficient in this battle.

Senator BLUMENTHAL. And there is no question that the Department of Justice under your leadership will continue to work on disrupting and dismantling these gang-led efforts or other efforts on drug trafficking and gun dealing and so forth?

Attorney General HOLDER. Yes, this will continue to be a priority. Too often we describe this as a Southwest Border problem, when the reality is it is a national problem. What happens along the Southwest Border can have an impact in Connecticut, can have an impact in Chicago. And the person whose name has been mentioned a lot—and I think he deserves a little bit of credit here. The person who has been leading the effort for the Department of Justice is Lanny Breuer, the head of our Criminal Division, who has devoted an inordinate, a huge amount of time to this fight, has established good relationships with his counterparts in Mexico, and

has been a person who has really stood for this country in developing good techniques to reduce that level of violence and the danger that the cartels pose to this country.

Senator BLUMENTHAL. I would like to turn to another subject that I think is equally important, not necessarily at this point a topic of criminal investigation, but the mortgage foreclosure crisis I know has been very much on your mind and the Department's focus. I wonder whether we can expect criminal investigations or other investigations that will be aimed at going after fraudulent documents that have been submitted in court, inconsistent and contradictory information of homeowners that have sought and sometimes received loan modifications, a series of practices and abuses that I know have been under investigation by my former colleagues, the State Attorneys General, with the cooperation of the Department of Justice and the Department of Treasury.

Attorney General HOLDER. Yes, there are a number of investigations that are underway. We are working with our counterparts, with State AGS, who have been extremely helpful and who have been, I think, extremely effective. And so we will be looking at these matters to see if criminal cases can be made, if there are other ways in which we can hold accountable organizations or people, perhaps using civil remedies as well. But it is our intention to make sure that those who are responsible for this mortgage crisis are, in fact, held accountable.

Senator BLUMENTHAL. And I would like to pursue this area in greater detail. My time is close to expired, but I hope that perhaps with your staff or yourself I can do so in that regard.

Attorney General HOLDER. I would be glad to.

Senator BLUMENTHAL. And I want to ask on a related topic, I know that so far the Department of Justice has declined to intervene in a lawsuit that has been brought by two mortgage brokers in Georgia alleging that a number of the largest lending institutions in the country have been in effect cheating veterans and taxpayers out of hundreds of millions of dollars by charging them illegal fees in home refinancing loans. I am particularly concerned about the effect on veterans and the possibility that they may have been treated illegally. And I wonder whether the Department may be reconsidering, which I would urge, along with two of my colleagues, Senators Brown and Tester, that it become involved in what I view as a whistleblower action and intervene to protect the interests of these veterans and other taxpayers.

Attorney General HOLDER. That is something that I will have to review. I am not as familiar with that as, obviously, you are, but I will check with the appropriate people within the Department and see whether our decision to decide to not become involved is, in fact, an appropriate one. But I will take that pledge to you, and we will get something back to you.

Senator BLUMENTHAL. I appreciate it. I am not going to give you a 30-day deadline to come back to us, and I join, by the way, with Senator Graham more seriously in the concern about the detainee issues. I know you take it seriously as well, but I very much appreciate your getting back to me on that issue, and thank you for your service.

Attorney General HOLDER. We will. Thank you.

Chairman LEAHY. Thank you very much.
Senator KLOBUCHAR.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman, and thank you, Mr. Attorney General. Again, many of my colleagues have mentioned the work that the Justice Department and FBI have done to avert terrorist attacks on our own soil, including the recent assassination attempt with the Saudi Ambassador. I want to thank you for that and urge you also to continue to support our local law enforcement. I cannot tell you the difference the COPS program has made in our State. Minneapolis was once known as "Murder-apolis" in the New York Times. That all changed around in part because of some tougher law enforcement, but also because of the help from the COPS program, so thank you.

I was going to first ask you here about some intellectual property issues. Recently, Senator Cornyn and I introduced a bill that passed through the Senate Judiciary Committee on a bipartisan basis. The bill is designed to go after people who steal other people's works, whether it is books or commercial music or movies, including foreign piracy. It only covers intentional commercial theft, not people posting their own personal work on the Web. It is about protecting everyone's rights, from a children's writer in Minneapolis to a first-time guitarist with their first CD in Nashville. And as far as I can see, America is not a country where people can write a song or a book only to have someone copy it and sell it and make money off it without permission.

And so that is what this is about. I know that members of your Department have expressed their support for this legislation, and, in fact, the idea for it came from the administration when they suggested the U.S. law enforcement agencies to combat infringement have to be able to be as sophisticated as the crooks that are breaking the laws.

I appreciate the recent letter we got from your Department in which you talked about how the provision of the bill regarding streaming does not criminalize conduct that is not already criminal, because right now it is a misdemeanor. And my only question is if you would commit to work with us to take any necessary steps to make crystal clear that the bill does not criminalize any new conduct with the streaming issue, that we are not seeking to criminalize YouTube or harmless posting of personal videos.

Attorney General HOLDER. Sure, we will work with you on that legislation. The issue that you raise is an important one, and we will do what we can in conjunction with you to make sure that people understand what the aim of the bill is and to put people's minds at ease with regard to what actually is covered and, I guess most importantly, what is not covered.

Senator KLOBUCHAR. That would be very helpful, some kind of guidelines. I appreciate that.

Another important topic that we have been working on in this Committee is the growing problem of synthetic drugs. I have been shocked at the doubling and tripling of calls to the poison control centers in just the last 6 months compared to the same time a year ago with these drugs. We had a young man die in Blaine, Minnesota, from 2C-E, which is a synthetic hallucinogen, and we have also had bills passed through this Committee not just for that drug

but also for bath salts, Senator Schumer's bill, and synthetic marijuana, Senator Grassley's bill. These bills are unfortunately stalled. I think there was unanimous support in this Committee, but they are stalled, Senator Durbin, because one Senator—not Senator Durbin—has put a hold on these bills. And so I just ask for your help in getting them through, and maybe you could talk a little bit about what we are seeing in terms of a whole new phenomenon with these designer drugs.

Attorney General HOLDER. Yes, I think that is something that is of great concern. The DEA has taken emergency action with regard to the regulation of bath salts, and we have seen, tragically and unfortunately, instances around the country where people, young people in particular, using these substances have had negative health consequences, sometimes even died.

I am not familiar with the hold, but I think that the legislation is clearly needed, and we will work with you on that to try to get it passed. I was not aware of the hold.

Senator KLOBUCHAR. Yes, it is a new phenomenon. Not a new phenomenon to hold things in the Senate, but on this bill we were surprised, and so we are trying to work with the Senator who has put on the hold. And then we also have an issue with some of the House bills that we need to work out. I just think it is incredibly important talking to law enforcement in our State, particularly in smaller communities where they are having to bring in chemists and people to try to prove that it is an analog substance.

That actually gets me to the second point. One of the things I have realized is they keep changing the compounds, and while we will put these on the list and it will be helpful, it is not the end-all, be-all. And one of the things I am going to start doing, just so you know, is looking at that analog statute to see if there are some changes that we can make to it to make it simpler to explain that a drug, when you have a simple change in a compound, there are three factors or four factors that maybe we need to look at the standard differently. And so I will be working with your attorneys and law enforcement on that issue as well.

Do you have any views on the analog statute?

Attorney General HOLDER. I think that is actually very important because as these things are made synthetically, I do not know all the terms, but you can change the elements in these things, and it should not be the case that we have to come back to Congress to get a new statute in order to deal with this new compound. There ought to be some discretion, I would hope, perhaps within the executive branch, to recognize that something is maybe a derivative of something that has been previously banned, dealt with, and that we can take emergency action, appropriate action, so that we can deal with these things as they come up, because we know that the reality is that these chemical compounds, substances, can be changed relatively quickly, and we have to have the flexibility and the ability to respond as rapidly as we can.

Senator KLOBUCHAR. Well, thank you, and I still think there are a lot of people in America—I know when I was a prosecutor, I did not even know about this issue. It was not a big deal. And suddenly this switch where, because of people buying it easily, they think maybe it is legal because it is on the computer, it is getting

to be a huge problem. So I appreciate that, and I think we need to look at that statute. Obviously, it is a harder haul than just adding the drugs to the list, but I think it will make it simpler so we can literally fit the crime here, because right now it is just too tough and has been too hard of a haul simply to even get these drugs on the list. It is something that I had hoped would happen automatically.

The last thing, last month I introduced a bill with Senator Bill Nelson of Florida on guardianship. So many good guardians in our country are doing their jobs, but, unfortunately, including several reports by the GAO have shown that some of them are using their positions of power for their own gain. And I heard dozens of heart-breaking stories at a hearing that I held on the Judiciary Committee as well as meetings I had at home. Are you familiar with this issue? We are trying to make some changes to the statute.

Attorney General HOLDER. I am not familiar with the bill. I have heard about this issue, this problem, and we would be more than glad to work with you both on the exploration of the problem and what the solutions to it might be.

Senator KLOBUCHAR. Yes, we are looking at, first of all, just some guidelines, which is always helpful, background check systems using examples of States where it is actually working to do background checks. It is unbelievable, but there are a number of States that do not even require criminal background checks. And so while we are not swooping in with Federal law enforcement on this, we are looking at how can we show best practices in some of the States so that we can do a better job of oversight. We are going to see a doubling of the senior population by 2030, the baby-boom generation, and we need to get ahead of the curve here. So thank you very much.

Chairman LEAHY. Thank you very much, Senator Klobuchar.

Did you want to say anything to that?

Attorney General HOLDER. Just an observation. I will be a member of that baby-boom generation that is going to be getting—I guess I might already be there at this point.

Senator KLOBUCHAR. I thought of saying that, but I decided to hold off.

Chairman LEAHY. I am trying to show a great deal of sympathy for you, knowing the difference in our ages.

[Laughter.]

Chairman LEAHY. Senator Durbin.

Senator DURBIN. Thank you, Mr. Chairman, and thank you, Attorney General. I noticed in your opening testimony you talked about the efforts to extradite those in Mexico responsible for the killing of Americans. I would like to take you to another aspect of this issue.

Recently, the Chicago Tribune did a series relating to those fugitives, criminal fugitives, who fled the country; 129 criminal suspects have fled Illinois, according to DOJ data, and many of them have been charged with crimes as serious as murder and rape and child molestation. And what we found in cases over and over again—and this Tribune series has reflected on one case in particular. In 1996, it is alleged that Pedro Aguilar gunned down a single mother and restaurant owner, Maria Rodriguez, in Chicago

for spurning his romantic advances and then fled. Within 2 months, the relatives disclosed his whereabouts to Chicago police, his whereabouts in Mexico, even giving local detectives the name of the street where he was staying with his parents in Mexico and supplying a telephone number where he could be reached. No action was taken.

In fact, what has happened since 1996 is the family of Ms. Rodriguez, her daughter, has found that there has been no help in trying to locate him. The Chicago Tribune reporters found him in 48 hours in Mexico. Unfortunately, in the ensuing 15 years, virtually all of the witnesses to the crime are either unavailable or incapacitated.

This is repeated over and over again in this series, and it raises serious questions about the level of communications between local law enforcement and the Department of Justice and efforts at extradition.

First, I would like to ask you, if you would, please, to join me in trying to bring all agencies of law enforcement at every level together to resolve this breakdown in communication. And, second, I would like to give you a chance to respond to this.

Attorney General HOLDER. Yes, I think the issue that you have raised is one of concern. The extradition relationship that we have with Mexico is today much better than it was. Quite frankly, it was not good in the past, but we are in a much better place. Our Marshals Service is the primary agency within the Justice Department that has a responsibility of apprehending fugitives, but I think the point you make is a good one, that the Federal Government can only do so much. We need to work with our State and local counterparts to get information about people like the one that you have described, and we probably have to do a better job in interacting with our Mexican counterparts about who these people are, where they are, and then try to get them back, because the fact situation you have just laid out is something that is simply unacceptable.

Senator DURBIN. I might add that the series also spoke of a fugitive in Syria, which is a different circumstance altogether when it comes to extradition, but I thank you for your willingness to join in that effort.

Mr. Attorney General, how does the Department of Justice view Muslim Americans in our National effort to keep America safe from terrorism?

Attorney General HOLDER. We view that community as essential partners in the fight against terrorism. They are an essential part of our counterterrorism fight, have proven to be reliable sources of information. A great many of the successes that we have had and that I have talked about or that attention has been brought to came as a result of leads that we got from members of the Muslim American community. We have had extensive outreach efforts in the Department and the investigative agencies within the Department, particularly the FBI, to reach out to the Muslim American community to put at rest the concerns they have, the fears they have about their interaction with law enforcement. And I have to say that I have been very encouraged by the response we have generally gotten from that community.

Senator DURBIN. I thank you for your answer. It is consistent with the statements made by the previous administration. After 9/11, I thought President Bush's statements were right on, spot on, in reminding people that our enemy is not those of the Muslim faith but those who would corrupt it into violent extremism.

The reason I raise this issue is that guidelines were established on profiling in the Department of Justice, and the guidelines are explicit that neither race nor ethnicity shall be used to any degree. And, of course, that is obvious. Using racial profiling to arrest African-Americans or using ethnic profiling to arrest those who appear to be Hispanic is totally inconsistent with our values in this country. But, notably, religion was excluded from that list; only race and ethnicity were included. And we have found that the FBI agents who were given counterterrorism training were, unfortunately, subjected to many stereotypes of Islam and Muslims.

For example, FBI agents in training were told that, "Islam is a highly violent, radical religion." "Mainstream American Muslims are likely to be terrorist sympathizers." And, "The Arabic mind is swayed more by ideas than facts."

We also found, for example, one public FBI intelligence assessment claims that wearing traditional Muslim attire, growing facial hair, and frequent attendance at a mosque or prayer group are all indicators of possible extremism.

Recently released documents show the FBI is engaged in widespread surveillance of mosques and innocent American Muslims with no suspicion of wrongdoing. Can you reconcile that activity and those training guides with your initial statement concerning your view that I share on the role of Muslim Americans? And can you comment on how someone who is Muslim in America reads of these things and believes that the actual training under way and the actual surveillance under way are inconsistent with the stated principles?

Attorney General HOLDER. Well, the information that you have just read is flat out wrong and is inconsistent with what we have been trying to do here at the Department. Those views do not reflect the views of the Justice Department, the FBI. It is regrettable that that information was, in fact, a part of a training program. That person is not being used anymore by the FBI, and we are reviewing all of the materials, all of our training materials to ensure that that kind of misinformation is not being used, because that can really undermine—can really undermine—the very substantial outreach efforts that we have made and really have a negative impact on our ability to communicate effectively as we have in the past with this community.

I almost hesitate to say "this community" because the reality is when we say Muslim Americans, we are talking about Americans, American citizens who have the same desires that we all have, who want their kids to be safe, who want the opportunities that this great country has to offer them. And that kind of information, that kind of training sets back those efforts, and so we have distanced ourselves from that person, those statements, and have a process under way to review the materials to make sure that that mistake does not happen in the future.

Senator DURBIN. Mr. Chairman, could I prevail for 30 seconds? Thank you very much, and thanks to the other Senators who are here.

The last question I would like to ask I know you cannot answer, but there are several States, including the State of Florida, which have recently changed their State voting laws to restrict opportunities and access to vote relative to presenting photo identification cards, limiting the early voting in the States, and making it more difficult, including penalizing those who are engaged in the voter registration process, to the point where the League of Women Voters for the first time has pulled out of the State of Florida and is not engaging in voter registration because of their new law and the penalties associated with it.

I know that under the Voting Rights Act in two different articles the Department of Justice has the authority to review these State laws to determine whether they have, in fact, or would, in fact, disenfranchise voters. Can you tell me whether this is under way or whether or not it will be reviewed in a timely manner?

Attorney General HOLDER. You are correct in two instances. I cannot answer that question specifically, but I can say that with regard to Section 5 and Section 2 of the Voting Rights Act, this Department of Justice will be aggressive in looking at those jurisdictions that have attempted for whatever reason to restrict the ability of people to get to the polls.

I think a fundamental question is really raised: Who are we as a Nation? Shouldn't we be coming up with ways in which we encourage more people to get to the polls to express their views? And I am not talking about any one particular State effort, but more generally, I think for those who would consider trying to use methods, techniques to discourage people from coming to the polls, that is inconsistent with what we say we are as a Nation. And I would hope that those kinds of efforts would not be engaged in. Again, that is separate and apart from what we have to do as the enforcers with regard to Section 5 and Section 2 of the Voting Rights Act.

Senator DURBIN. Thank you, Attorney General. I yield back the balance of my time.

Chairman LEAHY. Thank you. I would note that Senator Grassley and others have asked for a second round. We have a second round of 5 minutes for questions. Senator Coons—there is a vote on right now. I will ask mine, and Senator Coons is coming back to chair. If Senator Grassley is here, he will be recognized next after me, otherwise Senator Cornyn.

Mr. Attorney General, I remain very concerned that the Senate Commerce-Justice-Science appropriations bill considered by the Senate last week completely eliminates funding for the Second Chance Act programs, but the Bureau of Prisons' budget was increased by \$300 million. Now, I know prisons are overpopulated. I understand funding is vital to keep prison guards and surrounding communities safe. But I think we have to focus on re-entry and rehabilitation. Unless somebody has a real life sentence, which are very, very rare, at some time they are going to come back out. And when you consider the fact it costs \$35,000 or more a year to keep them there, the idea of spending a tiny fraction of that to keep them from going back makes a lot of sense. We want to make sure

that we have a re-entry and rehabilitation program when prisoners rejoin society and stay out. I think Second Chance Acts allow that. It is a tiny fraction of what we spend in our prisons. Sometimes it is a far better investment than just sending people back to prison.

Will you support restoration of Second Chance Act funding as Congress finishes its work this year on appropriations bills?

Attorney General HOLDER. Yes. The investment of money in that way is ultimately financially smart. It will save money down the road. But also I think there is a moral component to this, and that is that we have to try as best we can to rehabilitate people. And it is only through the techniques, the support that the Second Chance Act provides, that we can be effective, I think, in that regard. So I think that the decision not to fund that effort does not make a lot of sense.

Chairman LEAHY. Thank you. The Violence Against Women Act gave the Department of Justice some important tools to improve the response to the complex issue of domestic and dating violence, sexual assault, and stalking. One of these shows that the U-visa makes it easier for law enforcement to apprehend violent criminals.

Now, law enforcement is requesting more of these visas than are allowed under the law. I am considering, as are some others, proposing an increase in the number of U-visas that might be available. Would that help law enforcement?

Attorney General HOLDER. I think it could. We certainly want to work with you in that regard and look at all the ways in which we can deal with this issue, but I think that is certainly one of the things we ought to be considering.

Chairman LEAHY. And, last, Senator Grassley and I worked together this Congress on the Fighting Fraud to Protect Taxpayers Act. It is an important measure to give the Department of Justice additional resources to fight fraud at no cost to taxpayers. We joined a bipartisan effort, got the bill out, and it is now stalled in the Senate. Of course, it asked for an increased number of investigators and prosecutors that would be paid for by fines and reimbursements, and the Department of Justice could hire them if we pass the Fighting Fraud to Protect Taxpayers Act. Would the American people benefit by that?

Attorney General HOLDER. I think obviously, Mr. Chairman, and that is something that we want to work with you on and would support. That clearly is a benefit to the American people.

Chairman LEAHY. Senator Grassley and I will keep on pushing on that.

Lastly, I keep reading, even after the facts came out, or keep seeing on some of the TV programs about \$16 muffins. Now, the Inspector General issued a corrected version of that report, which apparently some of the media never saw, even though everybody else did. We want to make sure what money you have is spent correctly. I know you do. I know Deputy Attorney General Cole will. I will ask that a copy of the cover letter to the corrected report, which pointed out that the first one of \$16 muffins was incorrect.

[The letter appears as a submission for the record.]

Chairman LEAHY. What steps have you taken to make sure that in conferences money is spent appropriately?

Attorney General HOLDER. Well, first I want to say that we have a very good Inspector General, and I think that they are to be lauded for the fact that they did admit that they made an error in that calculation, that the \$16 muffin, in fact, does not exist. We are in the process of reviewing all requests for conferences to make sure that they adhere to the guidelines that we have set out, that they are done efficiently in a cost-effective way.

But I also want to point out that conferences serve a useful purpose. It is a way in which teaching occurs. It is a way in which thoughts are shared, ideas are shared, policy is developed, and we should not simply cast a wide net and think that conferences are not a good use of our resources. But we are committed to doing it in an appropriate way.

Chairman LEAHY. Thank you very much. I yield to Senator Grassley for his 5 minutes.

Senator GRASSLEY. Thank you, Attorney General, for your patience. I have a couple statements I want to make before I ask a question.

Before the Justice Department produced documents on Wide Receiver, my staff asked for additional information on previous cases of gun walking. However, on September 30th the Department declined to provide a briefing on such cases, so I have not limited my questions to Obama era operations, and it is hard to get straight answers, though, if you do not get these briefings. Now that the majority is interested in gun walking after 9 months and they are in the majority, they will probably help us get our questions answered. But that is one reason that I do not want the inference to be left that I am only interested in overseeing Democrat Presidents on gun walking.

I want to speak to something Senator Schumer brought up, and I think his facts are entirely accurate, but he referred to Wide Receiver where I think he was—well, he referred to Wide Receiver, but all the facts are in regard to the Hernandez case. I just wanted to make clear something that has been widely misunderstood. The memo to Attorney General Mukasey referred to what is known as a “controlled delivery” in the case called Hernandez, not gun walking. The U.S. coordinated with the Mexican law enforcement, which was supposed to be waiting on the other side of the border to interdict these weapons. And so this is distinct from Fast and Furious and Operation Wide Receiver in which no effort was made to work with Mexico and guns were clearly walked.

The first question to you: Your Justice Department stood by its February 4th denial to me even after I sent the first set of documents that showed otherwise. So the question for you, General Holder: You say that you were relying on others to correct the misstatements in the February 4th letter, yet Mr. Breuer himself admitted that he first knew firsthand that those misstatements were false at the time that they were made. Shouldn't he then have notified either you and/or Congress at that time?

Attorney General HOLDER. Well, I think that is one of the things that he admitted, as I remember his testimony. He said he made a mistake in not bringing to my attention the fact of his prior knowledge. And, you know, he admits that he made a mistake in that regard.

Senator GRASSLEY. OK. Your deputy received a lot of details about Fast and Furious in March 2010 briefing details that I believe should have raised red flags. For example, he was informed that just three straw buyers bought 670 guns. He was informed that the ATF followed them to stash houses, and he was informed that the guns ended up in Mexico. So you can look at the charts with Grindler's own handwriting on these things here. Yet you said in a recent letter that Acting Deputy Attorney General Grindler was not told of the unacceptable tactics employed in Operation Fast and Furious during that briefing. If by unacceptable tactics you mean watching straw buyers illegally buy guns without seizing them before they get to Mexico, isn't that exactly what he was told?

Attorney General HOLDER. I do not know exactly what he was told, but as I understand what he was told, it is that he got this briefing as part of a monthly interaction that he had with ATF. The person who did the briefing was Ken Melson, the Acting Director of ATF, who at that point indicated that he did not know about these inappropriate tactics. Melson was also the person who briefed Chairman Issa and, as I understand it, gave him pretty much the same briefing.

So I am not sure I would draw the conclusions that you do on the basis of that from what I understand about what the nature of the interaction was. One of the things that I have been told is that during the course of that briefing, the question of guns walking was not briefed to then-Acting Deputy Attorney General Grindler.

Senator GRASSLEY. Well, one of the ATF briefing papers explicitly says that the strategy was "to allow the transfer of firearms to continue," and one of the e-mails forwarding that paper says that it is "likely to go to DAG," which I assume is Deputy Attorney General. You cannot know for sure that no one informed of that strategy, can you?

Attorney General HOLDER. Well, as I have understood it, he was not told of the tactics, the gun-walking tactics. As I have also been told, the picture that you have up there is of guns that were recovered in the United States. This is what, again, I have—that were delivered in the United States. This is, again, what I have been told. I am not as intimately familiar with that interaction as perhaps you are, but what I have been told is that the fact is that Acting Deputy Attorney General Grindler was not told about guns walking. He got the same briefing that Congressman Issa got from the same person—that is, Ken Melson—and Ken Melson has indicated that at the time that he did that briefing, he was not aware of the gun-walking techniques. In fact, he did not know about it, as best I can remember, I think until March of 2011, when he talks about his stomach turning.

Senator GRASSLEY. My time is up.

Senator COONS [presiding.] Thank you, Senator Grassley.

Chairman Leahy has gone to a vote, which many of the members of the Committee are currently at, so in his stead, if I might, I am going to begin a second round of questions from me, and then we have other Senators who will be returning to ask additional questions.

One of the central issues you spoke about in previous questions was aid to State and local law enforcement, and one of the things that is of great concern to me is officer safety. You had spoken earlier about how we are seeing significant reductions in crime overall, yet increases in violence directed against officers—obviously, as has been discussed at length here, tragic losses in the line of duty of officers.

I wondered if you might comment on what sorts of programs the Department is currently funding, what sorts of funding challenges these programs face. I am particularly personally familiar with the vest program, the officer vest program, but I would be interested in other comments you would care to make about officer safety programs and grants available through the Department to State and local law enforcement.

Attorney General HOLDER. Well, it is something that we have tried to focus on. I had what we have come to call a summit meeting after there were a number of deaths of local law enforcement officers in shootings. And as a result of that, we developed something we called the Officer Safety Initiative where we are trying to channel information to our State and local counterparts so that they have ways in which they can receive training in how to handle themselves in violent situations. As you indicated, we have supported the bulletproof vest program to get these vests out there. And we also have something called the valor program that deals, again, with this whole notion of how officers can protect themselves in these situations. We try to educate them, try to make them familiar with ways in which they can protect themselves, and also try to isolate what are the things that tend to result in these kinds of officer shootings.

One of the things we have found is that when officers are trying to break into houses, that is oftentimes when you see shootings occur. So by sharing this kind of information, getting information from our State and local counterparts, and then sharing that with them, we hope that we will have an impact on what I think is a very disturbing trend of officer shootings.

Senator COONS. We recently had the first ever loss of life by the county police department I used to be intimately connected with through an assault on an officer by an individual who was reported in our local newspaper—it has not been finalized through toxicology reports, but was reported to be on these bath salts that were discussed previously. Can you speak to the path forward we might take federally to ensure that legislation that a number of us are cosponsoring actually proceeds that would criminalize these allegedly but I think realistically dangerous substances?

Attorney General HOLDER. Well, we certainly want to work with you in that regard, and not the least reason, which is that, you know, it puts, as you have indicated, tragically, potentially, law enforcement officers at risk. The people who use these substances obviously are putting themselves at risk. And we do not want to have a situation where we are being effective with regard to the more traditional drugs, and then we have these new ones, these new synthetic drugs popping up that have the same impact or the same possibility of devastating communities in a way that the more traditional drugs have.

So we want to work with you to identify what the current problems are. I think we always have to be mindful of new situations, new trends. We have to be flexible. We have to be responsive. And I think one of the ways in which we can do that is to interact with certainly members of this Committee, but our State and local counterparts to get a sense of what is going on out there and how can we in the Federal Government assist.

Senator COONS. Well, our Governor in Delaware has taken decisive action to deal with this, and I would be happy to share with you and your Department what results we have seen.

Let me last ask, in the Hernandez case that Senator Grassley was just asking about or referring to in regards to the 2007 Mukasey memo that has been discussed here, do you know if the ATF actually lost track of weapons that got to Mexico in that instance?

Attorney General HOLDER. I do not know. I have focused on Fast and Furious and that which happened while I was Attorney General. I am just not as familiar with the Hernandez case. I am just not as familiar.

Senator COONS. Thank you very much for your testimony.

Senator Cornyn.

Senator CORNYN. Thank you, Mr. Chairman.

Mr. Holder, let me just try to tie up some loose ends. You agree that on February 4th, the letter that was written to Senator Grassley with the allegation that ATF sanctioned or otherwise knowingly allowed the sale of assault weapons to a straw purchaser who then transported them into Mexico was false. That letter dated February 4, 2011, is itself false we now know.

Attorney General HOLDER. Actually what I said is it contains inaccurate information.

Senator CORNYN. Well, isn't that false?

Attorney General HOLDER. Well, false, I do not want to quibble with you, but false I think implies people making a decision to deceive, and that was not what was going on there. People were in good faith giving what they thought was correct information to Senator Grassley. We now know that that information was not correct.

Senator CORNYN. If you will not agree with me it was false, it is not true. You agree with that, right?

Attorney General HOLDER. It is not accurate.

Senator CORNYN. It is not accurate.

Attorney General HOLDER. Yes.

Senator CORNYN. Did the person who wrote this letter on February 4, 2011, have they ever been disciplined or otherwise been held accountable for providing false information to a United States Senator?

Attorney General HOLDER. Well, as I indicated, the people who wrote the letter acted in good faith, thought that what they were sending was, in fact, accurate information. The people who were supplying the information thought that it was accurate. At some point somebody in that chain did not give good information, and that is one of the things that the Inspector General I hope will be able to determine.

Senator CORNYN. Did Lanny Breuer know better than what was represented in the February 4th letter? Was he privy to either of these two memos, the July 5, 2010—you said he was briefed April 2010. By the way, what office does Lanny Breuer hold in the Department of Justice?

Attorney General HOLDER. He is the Assistant Attorney General for the Criminal Division.

Senator CORNYN. And why would Lanny Breuer, knowing as he did back in April 2010 about Operation Fast and Furious, allow a letter that went out on the Department's stationery February 4, 2011, why would he let a letter that was false represent the position of the Department of Justice?

Attorney General HOLDER. Well, first off, the briefing, the AAG Breuer brief, that was about Wide Receiver. That was not about Fast and Furious.

Senator CORNYN. By the way, do you know the differences between Wide Receiver and Fast and Furious?

Attorney General HOLDER. They are different operations.

Senator CORNYN. Right. And so do you know the differences, the factual differences between Wide Receiver and Fast and Furious?

Attorney General HOLDER. Well, there are a number of differences both, I think, in scope, both in terms of time. The Bush administration was the one that started Wide Receiver. The Obama administration is where Fast and Furious began.

Senator CORNYN. Are you winging this or do you actually know?

Attorney General HOLDER. I know this.

Senator CORNYN. You know this? Do you know that Wide Receiver was done in conjunction with the Government of Mexico and the intention of the plan was to follow the weapons, and neither was there the intention to follow the weapons on Fast and Furious nor did Mexico know that the U.S. Government was allowing guns to walk into the hands of the cartels? Did you know that?

Attorney General HOLDER. Senator, I have not tried to equate the two—I have not tried to equate Wide Receiver with Fast and Furious.

Senator CORNYN. I am just asking you if you know the differences between the two.

Attorney General HOLDER. Sure. What I know about Wide Receiver, what you have said is, in fact, correct. There are memos that talk about gun walking that are related to Wide Receiver, but, again, I am not trying to equate the two.

Senator CORNYN. When you got Senator Grassley's letter on January 30, 2011, why didn't you investigate?

Attorney General HOLDER. I did. I asked people on my staff to look into the materials or the concerns that were raised in the letters. There was a January 27th letter, I believe, and a January 30th letter. They are the two letters that he gave me on, I think, the 30th or 31st, something like that. I asked people on my staff to look into that, and they did, and they started asking questions within the Department about the matters, the material that was contained in the Senator Grassley letter.

Senator CORNYN. And, of course, that was just shortly after—the letter that Senator Grassley gave you was shortly after the well-

publicized murder of Brian Terry, the United States law enforcement agent.

Attorney General HOLDER. Right. And to be clear, the letters were addressed to the acting head of ATF, Ken Melson, but he gave them to me—

Senator CORNYN. Who works for you.

Attorney General HOLDER. He gave them to me on January 31st.

Senator CORNYN. Right. And so I believe that you told Senator Whitehouse that you thought your staff made the right decision in not bringing Fast and Furious tactics to your attention. Is that correct?

Attorney General HOLDER. No, that is not correct.

Senator CORNYN. OK.

Attorney General HOLDER. What I said was that there was no indication in the materials that they reviewed that contained anything about the tactics that were used in Fast and Furious, and as a result, there was no need for them to bring to my attention the reports. If, in fact, there was in those reports indications of gun walking or something like that, I think they should have brought that to my attention, but that was not contained in the reports. And that is what Assistant Attorney General Breuer said was the mistake that he made. When he heard about gun walking, he should have brought that to my attention or to the attention of the Deputy Attorney General.

Senator CORNYN. Can you name me one person who has been held accountable for this Fast and Furious operation, just one in the Department of Justice?

Attorney General HOLDER. Well, we have made a number of changes with regard to personnel both in the Phoenix U.S. Attorney's Office, also at the ATF headquarters here, and I will certainly await the report that comes out of the Inspector General, and I will assure you and the American people that people will be held accountable for any mistakes that were made in connection with Fast and Furious.

Chairman LEAHY. [presiding.] Thank you. Thank you, Senator Cornyn. Thank you for coming back.

Senator Franken, do you have any questions?

Senator FRANKEN. Yes, I do, and I am sorry I have not been here. We had a HELP Committee meeting, so I missed the last 2½ hours. I trust it has been going well.

Before I begin, I just want to take a moment to align myself with what I heard Senator Kohl's comments were on the AT&T and T-Mobile merger. The Antitrust Division sat largely dormant under the previous administration, and I am very pleased that under your leadership the Department was willing to send the message that antitrust law is still relevant and should be applied to block large anti-competitive mergers, so thank you.

I know you have had a long day, so I will just have one question. As you know, there is an epidemic of bullying against lesbian, gay, bisexual, and transgendered students in our Nation's schools. Nine out of ten LGBT kids are bullied in school. A third skipped school in the last month because they felt unsafe. These kids are missing school. They are going as far as committing suicide because of this, and they are literally being bullied to death. Yet our Nation does

not have a law that explicitly prohibits discrimination on the basis of sexual orientation or gender identity in our public schools.

General Holder, I have a bill, the Student Non-Discrimination Act, that would fix this. It has been cosponsored by 34 Senators, including the Chairman and almost all of the Democratic members of this Committee and the HELP Committee. In its past appearances before this Committee, the Department of Justice has lauded the goals of this act, the Student Non-Discrimination Act. In fact, it even acknowledged that LGBT bullying was the greatest growth area in the civil rights docket.

But even though this administration has publicly and formally supported other LGBT rights bills like the Employment Non-Discrimination Act and the Respect for Marriage Act, it has not yet publicly supported the Student Non-Discrimination Act.

General Holder, does this administration support this bill or does it not?

Attorney General HOLDER. I think the operative word that you used is "yet." I will go back and try to see where we stand and why we are not in a place where I think we ought to be formally, because I think you are right. As you look at the steps that this administration has taken with regard to similar issues, we have been, I think, in an appropriate place, in the right place. And with regard to the bill that you are talking about, I hope that we can get to that appropriate place relatively soon.

Senator FRANKEN. Well, thank you very much, and I hope that is before we get to the floor with it on the ESEA bill. Thank you very much, General Holder.

Attorney General HOLDER. Thank you.

Chairman LEAHY. Attorney General Holder, I want to thank you for being here. I know we have gone a long time, but everybody has had a chance to ask their questions. Everything has been said, sometimes more than once, or twice or three times, but I appreciate you being here. As I said at the beginning of my statement, you are part of the President's national security team, and I will let you go so you can get back to those issues that really affect us. Thank you very much.

Attorney General HOLDER. Thank you, Mr. Chairman.

[Whereupon, at 12:49 p.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS



U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
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August 24, 2009

The Honorable Jon Corzine
Governor of New Jersey
Office of the Governor
P.O. Box 001
Trenton, NJ 08625-0001

Re: CRIPA and ADA Investigation of Ancora Psychiatric Hospital,
Winslow, New Jersey

Dear Governor Corzine:

I am writing to provide the Civil Rights Division's report of findings regarding our investigation of conditions and practices at the Ancora Psychiatric Hospital ("Ancora") in Winslow, New Jersey, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997a. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of persons confined to public institutions, including psychiatric hospitals such as Ancora.

On September 4, 2008, we notified you that we were initiating an investigation of conditions and practices at Ancora. We conducted an on-site inspection on January 12-15, 2009. After deferring our investigation several months to accommodate the State's request, we conducted our on-site review with the assistance of expert consultants in the fields of psychiatry, psychology and discharge planning, psychiatric nursing, and protection from harm. While on-site, we interviewed administrative staff, mental health care providers, and patients and examined documents, patient records, and physical plant conditions. In addition to our on-site inspection, we reviewed a wide variety of documents, including policies and procedures, incident reports, and patient records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and concerns about Ancora to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation pertaining to Ancora, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at Ancora violate the constitutional and statutory rights of its patients. In particular, we find that (A) Ancora fails to provide adequate discharge planning to ensure placement in the most integrated setting and to provide adequate supports and services necessary for successful discharge and (B) Ancora's policies and practices subject patients to an excessive risk of serious harm by (1) providing inadequate systems to identify and reduce risks of harm, (2) providing inadequate clinical management and nursing care, (3) failing to use restraints appropriately, and (4) failing to provide appropriate mental health assessments and treatment. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XVIII and Title XIX of the Social Security Act, 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid); 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d); Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; see also Olmstead v. L.C., 527 U.S. 581 (1999).

Many of the findings we make here have also been made by other agencies in the past. See, e.g., U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Survey of Ancora State Hospital (March 31, 2008) ("CMS Survey"); Rutgers Center for State Health Policy, "Barriers to Discharge, Optimal Housing and Supportive Mental Health Services for Residents with Conditional Extension Pending Placement Legal Status Final Report" (May 2006) ("Rutgers CEPP Report"). Throughout this letter, we include specific references to past findings by these entities, where appropriate. We found that these conditions remain unabated, despite the fact that the State and Ancora have been notified about the deficiencies.

On the issue of discharge services, a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities is discrimination and violates the law. Olmstead, 527 U.S. at 587. Olmstead involved two women with developmental disabilities and mental illness who were inappropriately confined at a state psychiatric hospital. Id. at 593, 597. The Supreme Court held that states are required to provide mental health treatment to persons in the most integrated, appropriate settings. See id. at 596-97. Despite the mandate by the Supreme Court, our review of discharge planning at Ancora finds that New Jersey frequently fails to ensure that patients receive

appropriate and sufficient services to enable them to live in the most integrated setting consistent with their needs, as required by federal law.

I. BACKGROUND

Ancora, operated by the New Jersey Department of Human Services, Division of Mental Health Services (“DMH”), is located in rural southeastern New Jersey. Ancora provides mental health services to approximately 580 adults. The population includes patients with dual diagnoses of both mental illness and either developmental disabilities or substance abuse. The vast majority of the patients at Ancora have been committed there by a court. Approximately one third of the patients are forensic commitments. Ancora also houses some voluntary patients.

II. LEGAL STANDARDS

The State of New Jersey must provide services to qualified patients with disabilities in the most integrated setting appropriate to their needs. ADA, 42 U.S.C. § 12132 (“[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”), and its implementing regulations; 28 C.F.R. § 35.130(d); see Olmstead, 527 U.S. at 607 (holding that a State is required to provide community-based treatment for persons with mental disabilities when that State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated); Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995) (holding that the ADA was violated where a person with disabilities was offered personal care services in an institutional setting but not at home); see also Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (Announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”).

In construing the anti-discrimination provision contained within the ADA, the Supreme Court held that “[u]njustified [institutional] isolation . . . is properly regarded as discrimination based on disability.” Olmstead, 527 U.S. at 597, 600. Specifically, the Court established that states are required to provide community-based services and supports for persons with mental disabilities when treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected patient, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. Id. at 602, 607.

The regulations promulgated pursuant to the ADA provide: “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d) (the integration mandate). The courts have endorsed a straightforward reading of this regulation:

[t]he proper interpretation of the regulations’ definition of “most integrated setting” is set forth in the regulations themselves: whether a particular setting “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”

Disability Advocates, Inc. v. Paterson, 598 F. Supp. 2d 289, 320 (E.D.N.Y. 2009).

The Fourteenth Amendment due process clause also requires a state mental health care facility to provide “adequate food, shelter, clothing, and medical care,” Youngberg, 457 U.S. at 315, along with “conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests,” Id. at 324. More particularly, a state mental health hospital is constitutionally required to provide reasonable, adequate mental health treatment. See, e.g., Torisky v. Schweiker, 446 F.3d 438, 448 (3d Cir. 2006) (concluding that plaintiffs may be able to prove that they were deprived of their constitutional liberty interest and of Youngberg’s duty of care and protection when they were transferred, against their will, to an inappropriate institution); Scott v. Plante, 691 F.2d 634, 636-38 (3d Cir. 1982)(affirming that state psychiatric hospital patients have a right to adequate treatment, a right to reasonable care, and a right to be free from unreasonably restrictive confinement); Fournier v. Corzine, No. 07-1212, 2007 WL 2159584, at *11 (D.N.J. 2007) (“The Fourteenth Amendment Due Process Clause requires state officials to provide civilly committed persons . . . with access to mental health treatment that gives them a realistic opportunity to be cured or to improve the mental condition for which they were confined.”).

Treatment is not adequate if it substantially departs from generally accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23; Rennie v. Klein, 720 F.2d 266, 269-70 (3d Cir. 1983) (applying the professional judgment standard to the decision to administer, and the administration of, antipsychotic drugs to involuntarily committed, mentally ill patients against their will). States are also compelled by the Constitution to ensure that patients are free from hazardous drugs that are “not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects.” Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff’d, 902 F.2d 250 (4th Cir. 1990). Medicare/Medicaid regulations governing psychiatric hospitals

also require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483.

Patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16; Shaw v. Strackhouse, 920 F.2d 1135, 1139, 1149 (3d Cir. 1990) (applying Youngberg professional judgment standard to primary care professionals, supervisors, and administrators named as defendants and holding that a jury could reasonably find that these defendants' failure to increase plaintiff's security or separate him from employee(s) suspected of sexually assaulting plaintiff constituted a failure to exercise professional judgment); United States v. Dise, 763 F.2d 586, 589 (3d Cir. 1985) (holding that the jury "certainly could have concluded" that an aide at a state institution for persons with developmental disabilities deprived residents of their liberty interests in personal security and freedom from bodily restraint when the aide intentionally battered the residents).

Generally accepted professional standards also require that patients in state psychiatric hospitals remain free from undue bodily restraints. In Youngberg, the Supreme Court also recognized that an individual who is involuntarily committed to an institution retains a liberty interest in freedom from bodily restraint. 457 U.S. at 316. Youngberg requires that restraints be imposed only to the extent required by the judgment of professionals. Id. at 321-25; Kirsch v. Thompson, 717 F. Supp. 1077, 1080-1081 (E.D. Pa. 1988) (holding that plaintiff's Fourteenth Amendment rights were violated when he was restrained at a state hospital in four-point physical restraints for an extended period). "It is a substantial departure from professional standards to rely routinely on . . . restraint rather than . . . behavior techniques such as social reinforcement to control aggressive behavior." Thomas S., 699 F. Supp. at 1189. Moreover, "restraint should only be used as a last resort." Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980).

III. FINDINGS

The many deficiencies in care that exist at Ancora can be summarized in two overarching findings. First, Ancora segregates far too many patients for whom a hospital setting is not the most integrated setting appropriate, in violation of Olmstead and federal law. In particular, Ancora's discharge planning is inadequate, as are the supports and services that would otherwise facilitate the discharge of many patients. Second, while confined, patients at Ancora suffer an undue risk of harm, stemming from the facility's failure to treat aggressive and self-abusive behaviors and its failure to implement systems to protect patients from harm. Conditions and services at Ancora that substantially depart from generally accepted professional standards and contribute to violations of the constitutional and federal statutory rights of patients include: (1) inadequate systems to identify

and reduce risks of harm, including self-harm and assault by peers; (2) inadequate clinical management and nursing care; (3) frequent and inappropriate use of restraint; and (4) inadequate mental health treatment. In some of these areas, notably assessments, nursing, and discharge planning, Ancora has in place adequate policies and procedures that are not faithfully implemented. In other areas, notably incident and risk management and quality improvement, Ancora has neither adequate policies nor an adequate number of trained supervisory, professional, and direct care staff to provide appropriate care.

A. Ancora Segregates Many Patients Who Do Not Require Institutional Care

The State fails to provide services to Ancora patients in the most integrated setting appropriate to their needs. As detailed below, hundreds of patients currently confined at Ancora do not require institutional care, but nonetheless have not been discharged to the community or another more integrated setting.

Patients initially come to Ancora in one of four ways – they are committed by civil courts because they are a danger to themselves or others; they are committed by criminal courts after having been found to be not guilty by reason of insanity (“NGRI”); they are committed by criminal courts to be evaluated for fitness to proceed with a criminal trial; or, on rare occasions, they voluntarily admit themselves. When a civilly committed patient or an NGRI patient is found to be no longer a danger to himself or others but remains institutionalized because there is no place to which the patient can be safely discharged, under New Jersey state law, the patient’s commitment status is changed by the courts. The court places these patients under a commitment status unique to New Jersey, known as Conditional Extension Pending Placement (“CEPP”).

Nearly half of the patients at Ancora remain institutionalized under a CEPP commitment status. CEPP status was created by the New Jersey Supreme Court over 25 years ago and 15 years before the U.S. Supreme Court decided Olmstead. The New Jersey Supreme Court sought to balance patients’ due process liberty interests in not being institutionalized when no longer an imminent danger to themselves or others against the reality that discharge of vulnerable patients without appropriate community supports could threaten their survival. The compromise crafted by the New Jersey Supreme Court allows patients to be confined “on a provisional or conditional basis to protect their essential well-being, pending efforts to foster the placement of these individuals in proper supportive settings outside the institution.” See In re S.L., 94 N.J. 128, 140 (1983). For each patient who is committed and is in CEPP status, at mandated hearings at 60 days and then every six months, the State must demonstrate that it continues to make

reasonable efforts to improve the patient's ability to function in a community setting and to make a good faith effort to ensure placement. Id. at 141.

In practice, we find that CEPP status at Ancora is neither conditional nor pending any suitable placement. Of the 284 patients confined on CEPP status at Ancora in November 2008, nearly 22% had been on the list for more than two years, including A.A.¹, who has been on CEPP status for five years.

Being placed on CEPP status is an acknowledgment by the State and by Ancora staff – and requires a court finding – that a patient does not require institutional care. N.J. R. 4:74-7(h)(2) (describing court procedures for placing patient on CEPP status); see also In re S.L., 94 N.J. at 140-41 (requiring court determination to place patient on CEPP status). For these patients, continued institutionalization without provision of necessary services is unjustified segregation by reason of a psychiatric disability – the very discrimination clearly forbidden by the ADA. Olmstead, 527 U.S. at 597, 600. The continued institutionalization of persons who demonstrably do not require institutional care violates the integration mandate of federal law. Implicitly promising patients imminent discharge with appropriate supports without offering a real chance at attaining discharge is a particularly cruel deception.²

We also find that the State fails to provide patients at Ancora – whether during their initial civil or forensic commitment or once patients have been placed on CEPP status – with treatment services that address the patients' underlying disabilities and improve the patients' ability to function in a community setting and that are consistent with generally accepted professional standards. The State also does not provide adequate discharge services to facilitate placement in a more integrated setting.

¹ To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

² We are aware that the State recently settled Disability Rights New Jersey, Inc. v. Velez, Civ. No. 05-1784 (D.N.J. 2005) and committed to a number of important reforms to address Olmstead concerns throughout New Jersey's psychiatric hospital system. The case was filed in 2005 by Disability Rights New Jersey challenging the confinement of nearly 1,000 individuals on CEPP status in New Jersey's state psychiatric hospitals.

1. Inadequate Discharge Planning

The discharge plans we reviewed do not describe, identify, or secure the community resources necessary to serve patients in the community. Underpinning a court's decision to place a patient on CEPP status is a determination that this patient requires some additional support to live successfully in the community and that a discharge without this support is likely to fail and place the patient at risk of harm and/or re-institutionalization. Moreover, an essential component of an adequate discharge plan for any patient, whether on CEPP status or not, is linkage to necessary community supports. State and facility policies, procedures, and strategic plans confirm the critical importance of community coordination, yet we saw no evidence that these policies are implemented. Failure to ensure continuity of care in the community has resulted in failed discharges and in long delays for placement into the community. Examples include:

- A.A. has been on CEPP status for five years. The CEPP tracking document notes that A.A. was re-institutionalized because he lacked transportation to a methadone clinic in the community.
- B.B. has previously been discharged ineffectively to motels, has been on CEPP status since July 2008, and in November 2008 was awaiting a community placement.
- C.C. was admitted to Ancora for the twentieth time on November 17, 2008, and discharged just under one month later, on December 12, 2008. On her nineteenth admission, C.C. had been discharged and re-admitted within only one week. C.C. lives at home with her mother and has a job, two important community linkages. However, she was discharged with a referral but without a planning meeting between C.C., hospital staff, and the community provider of intensive case management services to which she was referred. Given her diagnosis of schizophrenia and her history of multiple admissions, the connection to intensive case management services should be in place prior to her discharge, so that intensive case management services would have been available on the first day of her return to the community.

2. Inadequate Services and Supports

The State has known for years of barriers to discharge for specific sub-groups of patients confined on CEPP status but has not taken effective steps to address them. The 2006 Rutgers Study identified subgroups of patients with significant barriers to discharge, including: (1) those who resisted discharge, (2) those with major behavioral problems coupled with psychiatric symptoms, (3) those with co-morbid medical complications, (4) those with a dual diagnosis of developmental

disability, and (5) those with a history of sexual offenses. Yet three years after the Rutgers Study, we found egregious lapses in the discharge planning and support for each of these populations. Ancora's CEPP population includes many patients with these previously-identified barriers, and little or no evidence that the barrier has been addressed in treatment, in violation of generally accepted professional standards. For example:

- Nearly half of the patients on a list that the facility identified as resisting placement – 25 of 59 patients – had refused placement more than a year ago. We saw no evidence that patients whose refusal was over a year old had been re-assessed, counseled, or provided education that could lessen their resistance to leaving the institution.
- A third of the patients on the facility's November 2008 CEPP Tracking Document ("CEPP List") faced one of these previously identified barriers to discharge in addition to mental illness: 25 also had a developmental disability, 24 had co-morbid medical concerns, 17 had co-occurring substance abuse diagnoses, and 29 had a history of sexual offenses. Yet, there is little or no evidence that these barriers to discharge have been addressed in treatment.

The 2006 Rutgers study identified patients with ongoing problematic behaviors as facing particular barriers to discharge, yet we find that Ancora consistently fails to provide effective treatment to these patients. Examples of Ancora's failure to treat maladaptive behaviors include:

- D.D., a young woman with diagnoses of schizophrenia and mild developmental disability, has been on CEPP status for more than three years. The CEPP List in November 2008 notes that she will be referred to placement upon stabilization of her maladaptive behaviors, yet she receives numerous PRN³ medications and is frequently restrained, indications that neither her underlying symptoms nor her problematic behaviors have been addressed.
- E.E., also a CEPP patient, was restrained 26 times from June through November 2008. Frequent restraint, like frequent PRN use, is often an indicator of failed treatment.

³ Pro re nata ("PRN"), or as-needed medications, are administered in response to exigent circumstances.

- F.F. was subject to 59 reported episodes of restraint in a 14-month period, and progress notes in his chart refer to his head-banging and restraint being “an everyday occurrence.” His chart contained a letter from his treatment team urging that he be transferred to a different hospital for treatment that, evidently, was not provided at Ancora.

The State’s DMH in January 2008 announced the “Home to Recovery CEPP Plan to Facilitate the Timely Discharges of CEPP Patients in New Jersey’s State Psychiatric Hospitals” (“CEPP Plan”). Parallel changes to Ancora’s policies and procedures were also announced in Administrative Order 1:91, May 29, 2008. The CEPP Plan’s proposed actions include policy reforms and the creation of a new community-based infrastructure to support discharge opportunities. The CEPP Plan calls for the creation of hospital-based Olmstead committees to be comprised of hospital staff, community-based providers, and regional DMH staff to locally plan, implement, track, and evaluate existing discharge policies and procedures. The CEPP Plan addresses the collection of data on community capacity and on individual patients’ adjustment to the community following discharge. The CEPP Plan also outlined steps to address discharge barriers for some of the hardest-to-place populations, including the creation of Utilization Review and Intensive Case Review Committees to address timely discharges of patients on CEPP status. Specific steps included development of a survey of consumer housing preferences, and use of the Level of Care Utilization Scale (“LOCUS”) to enhance discharge assessments. In addition, New Jersey’s October 2007 Wellness and Recovery Transformation Action Plan affirms the need for Ancora to develop wellness and recovery-oriented, strength-based programming. From our review of Ancora discharge records, we saw no indication that Ancora has established these committees, referred any of its difficult cases to these committees, implemented any other aspect of the CEPP Plan, or implemented wellness and recovery-oriented programming. It is not surprising, then, to find so many patients segregated in this institution, without effective treatment and without adequate plans for discharge. In short, the State identified the legal obligation, created a plan, and yet, failed to implement it.

B. Ancora Patients are Subject to Serious, Frequent, and Recurrent Harm

Patients at Ancora have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. Yet patients at Ancora are not reasonably safe. Statistics published on the State’s website show that in the first half of 2008, although Ancora accounted for only one third of the State’s institutionalized patients, it accounted for a disproportionate share of reported assaults – 48% – almost half of the reported incidents in the State system. There were almost 1,500 reported patient-on-patient assaults in the 14-month period from September 2007 through November 2008.

Ancora patients engaged in repeated high-risk behaviors, including self-injury and aggression, without appropriate treatment and intervention by the facility. We find that both Ancora's failure to treat these high risk behaviors and its failure to implement systems to identify and minimize risks contribute to this excessive level of harm at the facility.

1. Ancora Has Inadequate Systems To Identify and Reduce Risks of Harm

Ancora patients suffer serious, frequent, and recurrent harm. Generally accepted professional standards require Ancora to take affirmative, strategic efforts to protect patients from harm by reducing risk. The essential elements of a risk management system include assessing and monitoring risk for each patient through accurate incident reporting, identification of actual or potential risks of harm, tracking and trending of data, adequate investigations, and quality assurance monitoring and reviews. Ancora substantially departs from these standards of care by failing to adequately protect patients from recurring and serious harm, including harm from frequent patient assaults, self-injurious behaviors, an unduly unsafe environment, and abuse and neglect.

a. Inadequate Incident Management

Our review of incidents indicated that while reports appear routinely to be filled out, incident reporting at Ancora fails to capture critical information. To comply with generally accepted professional standards, incident reporting systems must include patient-centered accounts and causal analysis of events, including: the injured party's account of the incident; witness statements; critical review of statements; and a review of the patient's rates of injury, treatment, and safety over the course of his or her stay at the facility. Ancora does not track incident data regarding harm resulting from different causes, such as poor staff supervision, failure of 1:1 staff to supervise and protect a single patient, and neglect by denial of treatment. In addition, Ancora's incident reporting system does not adequately capture information on administrative failures to adequately supervise and train staff to perform their duties. Nor does Ancora's incident system adequately collect information regarding fiscal exploitation of patients. The failure to collect such information renders Ancora managers unable to identify specific trends and respond appropriately to protect patients.

After unit staff submit incident information, Ancora fails to adequately review incidents. The Risk Management Director confirmed that the Incident Review Committee does not analyze incidents with a view to developing prevention plans to eliminate or minimize recurrences. In the Communication Meeting, where Section Chiefs present information on daily occurrences, some incidents are

reported in a very rapid fashion but without any critical analysis. The absence of interdisciplinary analysis of harm suffered by patients impedes the development of deliberate efforts to prevent future harm and indicates a significant deficit in the administration's operational oversight. For example:

- On November 8, 2008, staff reported G.G.'s assault, self-injurious behavior, and property destruction that resulted in placement in four-point restraints. The treatment team noted in the incident only that the patient "was seen by the team and will remain on 1:1 supervision." There were no Treatment team instructions to prevent similar future harm.
- On December 2, 2008, a patient slapped and kicked H.H., yet the treatment team resolution noted only "no significant injury noted." H.H.'s Treatment team failed to document any analysis of how the incident occurred and how best to prevent reoccurrence.
- I.I. assaulted a peer on December 22, 2008, while on 1:1 supervision; the treatment team noted only that he was "agitated and unpredictable." This "resolution" fails to analyze the antecedents of the assault, what could have been done to prevent the episode, or how best to prevent similar future harm.

We noted repeated examples where treatment teams failed to develop preventive interventions that are necessary to ensure patient safety. Consequently, the incident management system at Ancora falls significantly short of generally accepted standards. As a result, patients continue to be exposed to actual and potential harm.

b. Inadequate Management of Risk

Incident management focuses on the collection and analysis of data that are meaningful to protect a particular person from harm, while risk management focuses on identifying potential harms and taking timely action to prevent the harm from systematically occurring or recurring. Both are essential to an adequate protection-from-harm system. Although Ancora develops lists of persons identified to be at risk of aggressive and self-injurious behaviors, its response to those risks with treatment is inadequate. We found widespread patient-on-patient assaults and unchecked self-injurious behaviors. As noted above, Ancora reported almost 1500 patient-on-patient assaults in the 14 months prior to our visit. Examples of

serious patient-on-patient assaults, resulting in injuries to the following patients, include:

- J.J., with a fractured jaw;
- K.K., with a fractured kneecap;
- L.L., with a fractured ankle;
- M.M., with a fractured skull;
- N.N. and O.O., with fractured hands;
- P.P., with eight sutures to his elbow;
- Q.Q., with five sutures to his left eye area;
- R.R., with five sutures to his head; and
- S.S., with six sutures to his head.

Between September 2007 and November 2008, numerous Ancora patients suffered significant harm requiring hospitalization, including:

- T.T., with a fractured jaw after jumping from a balcony while on an outing;
- U.U., with both rib and nose fractures;
- V.V. and W.W., for sutures to treat lacerations;
- X.X., with a fractured arm; and
- Y.Y., for repair of a head laceration.

Other patients were hospitalized for repeated episodes of serious harm. Among such patients were:

- Z.Z., with more than ten hospitalizations for ingesting foreign objects, to rule out displacement of lower jaw, and for head trauma after falls;
- A.B., with separate hospitalizations for right leg and right arm hematomas due to possible trauma;

- B.C., who was transferred to the hospital for a head laceration from a fall and, separately, to rule out a hip fracture; and
- F.F., who was transferred to the hospital on separate occasions for sutures to a head laceration, to rule out a hip fracture, for other head trauma including contusion, and for an injury characterized as a facial “avulsion” (i.e., forcible tearing).

The frequency of this harm supports our finding that treatment teams at Ancora fail to address the root causes of patients’ inappropriate behavior and consequently fail to intervene adequately to prevent future incidents. We found no effective risk management program that documented comprehensive individualized risk assessments and planned responses to avoid bad outcomes. There was no evidence of periodic monitoring to assess whether patients’ risk of harm is decreasing. Ancora may report the occurrence of injuries, but it does not take deliberate, effective steps to prevent recurrence, placing patients at ongoing and unreasonable risk of harm.

Our review of the mortality review process also confirms the facility’s failure to analyze the root cause of adverse incidents. We reviewed records of the mortality review process for the one-year period before our January 2009 tour and found that the reviews were cursory and routinely made no recommendations for improvements in care. In fact, we could not discern that any specific recommendations for improvements in patient care were made and followed through, even in cases where generally accepted professional standards would have required them.

Although the Risk Management Committee (“RMC”) in 2008 identified a number of areas of harm it planned to address, our investigation revealed no evidence that the RMC followed up on its plans. In February 2008, the RMC described plans to survey patients to ask what patients thought would help reduce violence, but we saw no such survey. In March 2008, the RMC supported staff “reenactment training” to address better approaches to patient care, but we saw no evidence that the RMC took steps to establish that program before our January 2009 visit. The RMC consistently fails to follow up on areas identified as in need of improvement:

- CMS cited the danger of non-suicide-proof door handles in early 2008, and Ancora’s Plan of Correction submitted to CMS proposed to develop a plan by April 2008 to replace this hardware. Despite the urgency of this task, during our visit nearly a year later, protruding door handles that could be used to commit suicide by hanging were present throughout patient areas.

- In April 2008, the RMC reported that 25 per cent of staff fail to bring a diet instruction list to meals, yet the RMC took no steps to correct the problem and ensure mealtime safety. During our visit nine months later, we observed patients with mealtime precautions for aspiration and choking risk and those with restricted diets still not appropriately supervised and still not receiving diets consistent with physician orders, which placed these patients at significant risk of harm. Pursuant to policy, dieticians conduct monthly observations which documented many instances of patients at risk for immediate harm during mealtime.⁴ Despite the clear risk for significant, lethal harm to patients, improvement plans apparently were written only if compliance was below 90% overall, and these plans were reactive. They did not address systemic issues or proactive prevention.
- The RMC identified concerns about staff speaking languages other than English around patients, but it prepared no plan to remedy the issue.

In order to provide adequately safe conditions at Ancora, the RMC must take prompt affirmative steps to address serious safety issues that it identifies. Of equal importance, the RMC must establish a process that ensures that additional risks are brought to the attention of the Risk Manager and individual patient's treatment team. Examples of predictable risk not managed proactively by the risk manager, the RMC, or a patient's Treatment team include decubitus ulcers, or pressure sores, in bed-bound patients, and insufficient monitoring and supervision of patients with particularly high risk at mealtime, due to dietary restrictions, swallowing difficulty, or pica behavior. Examples include:

- D.E. is bed-bound, is supposed to be re-positioned by staff every two hours to relieve pressure areas, and was prescribed a special air mattress as an additional precaution against developing pressure sores. In September 2008, a physical therapist found that D.E. had developed multiple new bedsores and concluded that the air mattress had not been working for some period of time. No staff had proactively monitored the air mattress to ensure that it was working – the only note in D.E.'s chart was a nursing note the day before the physical therapist's visit, noting that the mattress had been repaired.

⁴ Pursuant to policy, nursing is also required to observe mealtime and document any findings. We requested aggregate data reports from this required monitoring but did not receive them. Because the risk of harm from aspiration is predictable and the harm can be significant, generally accepted professional standards require that prescribed monitoring for this risk be completed, the data aggregated and analyzed, and proactive corrective plans implemented and monitored.

There was no documentation about when it was discovered to be broken, when a repair was requested, whether any supervisory staff were notified, and whether any additional precautions were taken to address the risk to D.E. during the time the mattress was broken. The physical therapist concluded that the additional bedsores were a result of the non-functioning of the air mattress.

- Despite D.E.'s ongoing risk of developing bedsores, the facility's management of this risk continued to be poor. During our January 2009 visit, there was no positioning schedule posted in D.E.'s room, as prescribed by her plan, and one could not be located by the assigned staff. The problem was corrected once it was identified by our consultant, demonstrating only reactive, not proactive care to manage the identified risk to this patient.
- We observed several patients on the Birch A unit with aspiration and choking precautions who were unsupervised at mealtime. Staff interviewed during our visit could not uniformly articulate the level of supervision required for patients with choking risk, or high choking risk, as outlined in Ancora policy.

Many patients at Ancora engage in repeated pica behavior, the ingestion of inedible objects, without appropriate intervention:

- E.F. ingested a crayon piece and three metal screws on two occasions in March 2008 and a piece of a broken toothbrush in April 2008;
- F.G. ingested a piece of glass from a door she had broken in March 2008;
- G.H. ingested numerous items in a 10-month period ending in October 2008, including eyeglass arms, a fork, two pens, and, incredibly on one occasion in August 2008 during which he was on a 2:1 staffing, a plastic fork, spoon, and knife;
- H.I., J.K., L.M., and N.O. ingested batteries.
- In April 2008, P.Q., who was on 1:1 staffing at the time, consumed, from a trash can, the vomit of another patient who had a life-threatening illness.

The facility's typical response to patients at risk of pica was "verbal prompting to not eat inedible items." This is not sufficient treatment for a behavior with such serious health consequences. At a minimum, these cases required a professionally competent functional analysis of behavior. In the case of patient X.Y., who has had several behavior plans over the course of several years, the

record contained no functional analysis at all, and in no patient records did we find functional analyses that met generally accepted professional standards.

Even in those instances where Ancora officials make recommendations to address protection-from-harm issues, we saw no evidence that such recommendations are communicated to living-unit staff and implemented; and there is no evidence that staff are responsible for monitoring implementation of any such recommendations. Without an adequate data-driven system to identify and address patterns of harm to patients and record whether incidents of harm abate or increase in response to interventions, Ancora cannot adequately identify patient risks and prevent recurrent harm.

A structural problem underlies these many failures in protecting Ancora patients from harm. The job description for Ancora's "Risk Management Director" does not specify risk management responsibilities. There is no evidence that Ancora has appointed any other manager with the responsibility to act as gatekeeper to oversee risk management. As a result, risk management information is fragmented across different disciplines and is uncoordinated. Information to support appropriate preventive intervention is not collected and operationalized, and patients continue to suffer preventable injury.

c. Inadequate Investigative Practices

Generally accepted professional standards dictate that facilities like Ancora investigate serious incidents, such as alleged abuse, neglect, mistreatment, serious injury, and deaths. During the investigation, evidence should be systematically identified, preserved, analyzed, and presented. Investigators generally should visit the scene of the event, review any videotapes of the incident, obtain adequate accounts of the event from all credible witnesses, maintain confidentiality, and present timely, written conclusions based upon analysis of the findings. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements, such as policies and procedures. The investigative report should set forth the evidence considered, including all interviews conducted and documents reviewed, and it should clearly state the conclusions reached and the reasons for those conclusions. The investigative process at Ancora is deficient in each of these important respects.

Timeliness is paramount in order to elicit accurate information about the event. Delays in initiating investigations can compromise the ability of eyewitnesses to provide accurate accounts. Case closing dates in the investigative files we reviewed in many instances were as long as nine months or more after the underlying incidents had occurred, suggesting that there is no immediacy to the

outcome of the investigation. Most important, the failure to initiate promptly an investigation places the patient at continued risk of harm. We noted many instances of unacceptably delayed investigations:

- Fifteen days passed after a November 11, 2008 alleged physical abuse incident before investigators reviewed the videotape and conducted the first interview;
- More than two weeks passed following two separate alleged physical abuse incidents in October 2008 before investigators interviewed the first staff about the incidents;
- Forty days passed after another alleged physical abuse incident in October 2008 before investigators conducted the first interview; and
- Two weeks passed after an alleged sexual abuse incident in October 2008 before investigators conducted the first interview.

We noted numerous deficiencies in the investigative files we reviewed regarding employee disciplinary actions. In 2008, Ancora substantiated 45 cases of neglect and 35 cases of abuse. However, there was no evidence that all employees involved in those substantiated cases received disciplinary actions. Also, there appears to be no system in place to impose progressive disciplinary actions. The facility's failure to include information on employee disciplinary actions in investigative files impairs the facility's ability to effectively track and take appropriate action in the case of repeat employee perpetrators, thus placing patients at continued risk of harm. These practices deviate from generally accepted professional standards.

Ancora investigations also do not follow generally accepted practices with respect to gathering available physical evidence. It appears that Ancora investigators do not routinely visit the scene of the incident; case files frequently note "there is no scene to secure or physical evidence to collect." In incidents where physical injuries were sustained, there was no evidence that photographs of the injuries were taken.

More concerning, our review of investigations raised questions about whether investigators consistently conduct their inquiries independently and without influence from other staff.⁵ For example, ongoing case investigations are discussed

⁵ A related issue is whether staff at Ancora are intimidated into silence, or into positions that protect other staff at the expense of patients. The Risk

in detail with the Risk Management Director and the Incident Management Review Committee prior to their completion. In one case of alleged physical abuse, the investigator documented that the Section Chief, rather than the investigator, reviewed the video surveillance and informed the investigator regarding what was seen on the tape on which the investigator later relied. Reliance on other parties, who operate close to the incident, to conduct portions of the inquiry is unacceptable because it undermines the independence of the investigative findings.

Ancora investigations appear to consistently follow a format of 3-4 standard questions of interviewees, *i.e.*, where were you and what were you doing at the time of the incident; describe what you saw and heard. This approach is inadequate because it fails to elicit case-specific information or additional pertinent information. We saw no evidence that Ancora investigators reviewed the patient's treatment plan, recent incidents, or other recent investigations. Such a review can generate case-specific questions and allows the investigator to know what services should have been provided to this patient and whether they were provided. Nor is there evidence that the investigator evaluated the credibility of the alleged perpetrators by reviewing information such as performance history, disciplinary actions, supervisor interviews, repeat-offender status, and training. These lapses constitute significant departures from standard investigative practices and contribute to ineffective protection of Ancora patients.

d. Inadequate Quality Assurance

Generally accepted professional standards for quality assurance programs require a system to protect patients from abuse, neglect, preventable injuries, and unnecessary restraint and restrictive procedures. Databases are essential to allow analyses in order to identify trends, assist in developing corrective actions, and monitor the effectiveness of corrective actions.

Ancora officials reported that the facility does not have the capability to conduct trend analyses of various relevant data. There is no system to identify patterns related to types of incidents, times when patterns of incidents occur, or incidents in which the perpetrator has been repeatedly involved. Reportedly, the

Management Committee noted in April 2008 that supervisory staff are intimidated to not correct subordinate staff. We received similar allegations from several different line and supervisory staff. Although determining the validity of these allegations is beyond the scope of this report, the perception, shared by staff in these separate instances, is that they would be retaliated against for speaking out. The perception alone, if not rebutted forcefully by facility leadership, can be enough to affect investigations.

facility compiles incident information in the State's unusual incident reporting system but is not able to query that database to determine specific trends at Ancora. However, the State only recently provided us data requested during and shortly after our tour concerning patient-on-patient and employee-on-patient assaults and incident summaries. It appears that the State is attempting to demonstrate that Ancora adequately tracks and analyzes incidents. We find the State's delayed analysis to be untimely and severely compromised. Reliance on such a limited data system impairs the ability of risk managers to analyze incidents comprehensively and in a timely manner and to compare the frequency and severity of incident trends to determine effective plans of correction. In any event, the incident reports recently provided to us support our finding that investigations of alleged abuse are often delayed and can take months – even up to a year – to reach finality. The reports also include a significant number of substantiated claims of abuse and neglect, often resulting in self-harm or patient-on-patient violence, further evidencing the inadequacy of prevention efforts.

In conclusion, Ancora's system to protect patients falls egregiously short of generally accepted professional standards of care: it fails to analyze effectively incident data to manage risk and prevent recurring harm; relies on inconsistent and incomplete investigations; and fails to analyze its performance to ensure safety.

2. Inadequate Clinical Management and Nursing Care

Inadequate clinical management of patients with known high-risk conditions illustrates the absence of a system for tracking and proactively managing the medical needs of patients at risk. We found nursing documentation to be incomplete, inadequate, unreliable, inconsistent, and fragmented. Adequate nursing documentation is essential to ensure timely and appropriate follow-up and treatment and to communicate to treatment teams the emergence of risk factors that must be addressed in a patient's plan of care. Generally accepted professional standards require proactive monitoring for known risks, including medical risk.

Although we found that adequate primary care and outside specialists are available to treat the medical needs of Ancora patients, we found that emergent medical concerns are not adequately identified and brought to the attention of supervisors and the treatment team to enable the team to address medical risk proactively. Poor management of D.E.'s risk of pressure sores, discussed previously, is one example. Another is the management of patients at risk for painful and dangerous fecal impaction and bowel obstruction. These conditions are a known and frequent complication associated with many common psychiatric medications, yet in response to our pre-tour document request, the State asserted that Ancora does not maintain a list of patients at risk for impaction or bowel obstruction. We found deficient nursing documentation for those patients requiring bowel

management. The monitoring form on which bowel monitoring information is recorded is missing clinically significant information. In addition, as with nursing documentation throughout the facility, the documentation on the forms reviewed by our consultant was blank in many instances, inconsistent with other documentation, vague, and unreliable. This protocol reflects deficient nursing policy and training, because it does not put into measurable and useable terms the type of data required to be collected. As a result, data collection is necessarily subjective from nurse to nurse. The minimal documentation in these records also does not confirm that physicians are timely notified of concerns that require intervention.

Another example of these deficiencies is present in diabetes management. Diabetes is a manageable condition if properly monitored and treated but can have serious complications if it is not. Our consultant's review of E.E.'s chart unfortunately found evidence that E.E.'s treatment team is not adequately addressing his diabetes. As discussed above regarding bowel management, E.E.'s chart also was missing clinically significant information, such as changes in the patient's hemoglobin levels. Hemoglobin levels must be monitored to detect dangerous drops that may lead to harmful complications. E.E. is currently suffering from several complications, and his diabetes must be managed to prevent these complications from worsening. Ancora's failure to monitor these known medical risks is a significant departure from generally accepted professional standards.

In addition to inadequate nursing documentation, nursing supervision is an ongoing concern. CMS surveyors in February 2008 identified 15 shifts in Holly Hall in a ten-day period where there was no evidence that nursing supervisors conducted required rounds and reviewed precaution sheets as they should have. Moreover, surveyors identified that, during the same week, Cedar Hall units lacked any supervisory nursing rounds for whole days over all three shifts. Nearly a year later, we observed continuing lapses in supervision. With the exception of mealtime monitoring, we generally observed that patients on precautions were assigned additional staff and that the direct care staff documented additional checks of those patients. Staff did not have a uniform understanding of what was required by different levels of supervision, however. Moreover, we found that assigned charge nurses did not consistently document additional assessments of these patients, as required by policy. Policy also requires nursing staff to conduct environmental safety checks. We found six instances on a shift during our visit where environmental safety checks were not conducted, and staff noted on the monitoring form, "no staff to cover." We asked to review a sample of monitoring check sheets for additional dates to determine if this was an isolated occurrence, or a pattern of failure. The facility could not make this data readily available, we were told, because these monitoring sheets are not filed in an organized manner. This, of

course, also impedes the facility's ability to determine whether there was a pattern that could jeopardize patient safety or merely an isolated instance of poor staff performance. The facility's inattention to monitoring of nursing supervision – an area previously identified by other reviewers as deficient – is concerning. Failure to ensure nursing supervision of seriously ill patients places them at risk of continuing harm and inadequate treatment.

Generally accepted professional standards require that nursing staff properly complete Medication Administration Records ("MARs"). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently, which could result in serious harm. Our review of the MARs revealed numerous instances in which Ancora administered medicine in a manner that substantially deviates from generally accepted professional standards. Consistent with the observations of Ancora's pharmacy contractor, we found many failures to administer medications at the proper time and many failures to verify the medication three times, as required by policy. Consistent with poor nursing documentation in other areas, we also found documentation errors on the MARs. Ancora's pharmacy contractor reported a chaotic environment during medication administration, which was consistent with our observations. This concern was discussed at facility medication safety meetings more than six months before our visit, yet a plan of correction has not rectified this problem. These inadequate nursing practices place Ancora patients at undue risk of harm.

Ancora's psychopharmacology practices also substantially deviate from generally accepted professional standards in several important respects. Extensive PRN use reflects reactive care and sub-therapeutic treatment of the patient's underlying condition. Although Ancora's pharmacy contractor is supposed to audit high PRN usage, the audit described to us has a retrospective design that is unlikely to provide timely and useful data to psychiatrists to better manage the treatment of these patients. Moreover, in November 2008, a month when several patients experienced continued excessive PRN use, including D.D., who had 92 PRNs, not even this retrospective audit was conducted, and thus, pharmacy failed to provide data about this important indicator that should have been considered in patient care. Another important safeguard in psychopharmacology is the monitoring of adverse drug reactions ("ADRs"). Plans were described to us for improvements in the reporting system to make it less punitive, although these and other proposed changes are not yet evident in facility records. Staff described a system where physicians have electronic access to current information about potential drug interactions at the point of care, that is, on the units, however, we

saw no evidence that this safeguard is in place or used by physicians. It also appears that pharmacy does not trend or aggregate data on ADRs and share that information with physicians in order to improve patient care and patient outcomes. In each of these respects, psychopharmacology practices at Anroca substantially deviate from generally accepted professional standards.

3. Restraint Use is Excessive

The right to be free from undue bodily restraint is “the core of the liberty protected by the Due Process Clause from arbitrary governmental action.” Youngberg, 457 U.S. at 316 (quoting Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part)). Thus, the State may not subject Ancora patients to restraint “except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all patients and personnel within the institution] or to provide needed training.” Id. at 324. Generally accepted professional standards require that restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. Ancora’s use of restraints substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of restraint, and the fact that restraints restrict patients’ rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like Ancora reduce their use of restraint by addressing behavior problems with less intrusive and restrictive strategies. We found that use of physical restraint at Ancora is high.⁶ In the 14 months from September 2007 to November 2008, data show 837 reported uses of highly-restrictive four-point restraints, an average of two episodes every day. Two-point restraints were used almost as frequently, an average of 54 times per month.

CMS surveyors cited a pattern of increased use of restraint in March 2008, and Ancora’s own restraint reduction committee identified continued increases in restraint use in September 2008. In the 14 months prior to our visit, 24 Ancora

⁶ Types of restraints used at Ancora include four-point restraints, two-point restraints, and manual holds. In a four-point restraint, hospital staff use cloth or leather straps to tie an individual’s wrists and ankles to a bed or a chair. In a two-point restraint, staff tie an individual’s wrists to a bed or a chair. In a manual hold, staff physically hold an individual’s head, limb(s), and/or body.

patients had more than 20 reported restraint episodes, and an additional 51 patients were restrained five times or more. We found that many patients who were repeatedly subject to restraint and/or administration of PRN medications – measures that should be reserved for emergency crisis intervention – have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Examples of reactive care and failure to provide adequate behavior management services include:

- F.F. was restrained 18 times in an eight-week period during September and October 2008. In 48 incident reports involving F.F. from this period, the treatment team makes no mention of antecedent, or precipitating events prior to incidents involving head-banging, aggression, and, frequently, restraint. There is no mention of proactively supporting this patient by teaching him coping strategies, or coaching or intervening in advance of the crises.
- D.D., a young woman and long-term patient with a diagnosis of schizoaffective disorder, mild mental retardation, and borderline personality disorder. In the months prior to our visit, she experienced escalating episodes of self-harm by head-banging and loud and aggressive outbursts, which were frequently followed by restraint and administration of PRN medications. She was reportedly restrained 43 times in the 14 months from September 2007 to November 2008; she received 92 PRNs in November 2008 and 108 PRNs in December. Although the record shows some attempt to de-brief after these crises, there was no evidence that the team analyzed antecedent conditions, taught D.D. coping skills to avert a crisis, or consulted with staff or experts outside the treatment team. Each of these concepts had been suggested in the reduction of restraint committee meetings, but none of these methods were used to intervene on behalf of this patient frequently in crisis. No treatment interventions addressed the problematic behaviors that contribute to her prolonged hospitalization.
- E.E. was restrained 26 times from June to October 2008. On September 29, an incident report noted that E.E. was restrained for yelling and the inability to be re-directed. On its face, yelling is not a behavior that places a person in risk of imminent harm, and generally accepted professional standards require that restraint be used only if there is such an imminent risk. The treatment team held a restraint review in October and reviewed medications, counseled the patient about the importance of maintaining safety, and documented that the patient “could not state his reasons for becoming agitated.” There was no documentation to suggest that the team analyzed the antecedents to this patient’s outbursts or addressed alternatives to restraint use.

Generally accepted professional standards also require treatment teams to monitor and revise behavior plans as necessary. We noted numerous instances of continuing or escalating problem behaviors in which treatment teams took no effective action to revise the treatment. For example:

- F.F., discussed earlier, had an ineffective behavior contract.⁷ F.F.'s progress notes refer frequently to his breaking the behavior contract and to head-banging and restraint being "an everyday occurrence," despite the continued loss of privileges. There was no indication in his treatment records that his treatment team collected data about antecedents to this disruptive behavior, and, indeed, there is no place on the reporting form for unusual incidents to record that relevant information. The clear risk of harm to patient F.F. was acknowledged, belatedly, by his treatment team in a letter to the hospital administration dated December 2008, which urged the administration to transfer F.F. to another facility, where he could receive dialectical behavior therapy ("DBT"). DBT is the primary evidence-based treatment protocol for F.F.'s borderline personality disorder. The absence of DBT at Ancora is consistent with our observation that Ancora provides insufficient evidence-based treatment.
- D.D., with 46 incidents between October 3 and December 30, 2008. D.D. had a crisis plan to be implemented after her incidents, typically head-banging or aggression, but no specific, individualized behavioral plan.

It is a violation of generally accepted professional standards to permit dangerous, maladaptive behaviors to continue for months without collecting objective data about antecedents, using that information to inform a functional analysis of this behavior, and implementing a revised behavioral support plan. The failure to provide this care places these patients at continued risk of harm.

In addition to excessive numbers of restraint episodes, we also find that Ancora fails to ensure that restraints are terminated as soon as the patient no longer presents a risk of imminent harm to himself or others, in part because the criteria for release from restraint are not routinely written in measurable or observable terms, as required by generally accepted professional standards. Because the criteria are vague, e.g., patient should be "calm," it is not clear whether the patient was released as soon as appropriate. In three cases, D.E., F.F., and

⁷ A behavior contract is an agreement between a patient and his or her treatment team that the patient will not engage in certain behaviors.

T.U., nursing notes stated that the patients' psychological status was "adequate", but the restraint was continued. Because "calm" and "adequate" are not described in specific, operational terms, it is not clear that staff understood to terminate these episodes of restraint as soon as the patients were no longer a danger to themselves or others.

Finally, contrary to generally accepted professional practices, we found insufficient and, in some cases, no review of, restrictive programs by the facility's human rights committee. These examples evidence an egregious departure from generally accepted professional standards:

- V.W.'s plan contains a planned restraint, instructing staff that if he engages, or even attempts to engage, in physical aggression or property destruction, he should immediately be placed in restraint for one minute. If he fails to calm after one minute, or persists in physical aggression, he is to be placed into four-point restraint. Planned restraint is an outdated and discredited practice. It has also proven ineffective – despite repeated restraint, V.W.'s problematic behaviors persist, and this "plan" has nonetheless not been revised by his treatment team.
- X.Y.'s plan to address pica incidents includes a contingency to restrict brief off-unit visits with his family. His family requested that the brief visits be continued regardless of whether X.Y. displayed this behavior. His family was told by the treatment team that they would have to seek permission from the administration – precisely the opposite of accepted practice. Instead, the team should have sought permission from the human rights committee to restrict X.Y.'s rights in this manner.

4. **Ancora Fails to Provide Adequate Mental Health Treatment, particularly for Patients with Aggressive and Self-Injurious Behaviors**

Ancora patients have a constitutional right to receive adequate mental health treatment that provides "a reasonable opportunity to be cured or to improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975). The mental health services at Ancora, however, substantially depart from generally accepted professional standards. Psychiatric practices are marked by inadequate assessments, which, in turn, lead to inadequate treatment planning and delivery of inadequate treatments and interventions. Although Ancora professes that it has adopted the principle of person-centered care, treatment planning is not person-centered, individualized, or integrated across disciplines and thus fails to comply

with generally accepted professional standards. These failures affect the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Many of these deficiencies also directly threaten patients' physical health and well being. Moreover, as noted in the discussion of discharge planning, failure to treat a patient's mental health needs while hospitalized can frequently lead to failed discharges and to repeated hospitalizations. The reactive approach to treatment at Ancora and frequent use of restraint further condition patients to become institution-dependent, rather than develop and strengthen individualized symptom-management skills that they can use in both community and hospital settings.

a. Assessments are Inadequate

Ancora's mental health treatment is deficient, in part, because incomplete and inadequate assessments routinely fail to identify patients' presenting problems, strengths, and needs. Appropriate treatment begins with a thorough assessment of all factors relevant to the patient's situation at the time of admission. Assessments should address the presenting problem, the patient's medical and psychosocial history, and vocational, educational, social, and daily living skills. The assessments should also include contributions from psychiatry, nursing, psychology, and social work. Although Ancora's policies describe an adequate process for initial assessments, in practice, many of the assessments our consultants reviewed were critically deficient, in some cases omitting entire areas of relevant inquiry, and in other cases containing only cursory and insufficient attention to these areas.

In the majority of the cases we reviewed, assessments do not meet generally accepted professional standards. Deficient assessments lead to deficient case formulations; treatment teams that have incomplete understanding of the strengths and needs of individual patients do not provide the treatment and supports these individual patients require. The absence of relevant information impedes both development of a treatment plan that addresses all of the patient's treatment needs, and preparation of an adequate plan for discharge to the most integrated setting appropriate.

Initial assessments that are completed at the time of admission must be updated with relevant information gained through additional observation of the patient, testing, as indicated, and collaboration with family and community resources. We found that assessments at Ancora show little evidence of being updated with relevant information as required by generally accepted professional practices.

The assessments for patients with behavioral problems were particularly deficient, with most lacking a functional assessment that is critical to

understanding the causes of the problem behavior and developing a treatment plan to reduce or eliminate it.

b. Treatment and Interventions Are Inadequate

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

Ancora's treatment planning substantially departs from these standards. From initial diagnosis and assessment to the development of skills and functioning necessary for recovery and community reintegration, Ancora's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive interventions; and patients are at increased risk of relapses and repeat hospitalizations. Further, patients' options for discharge are significantly limited, resulting in unnecessarily prolonged hospitalization and, with respect to forensic patients, prolonged involvement in the criminal justice system.

Ancora does not provide sufficient treatment programming to patients, a finding that repeatedly has been brought to the facility's attention. Ancora's own February 2008 audit by outside consultants found inadequate levels of active treatment and a non-therapeutic environment in the day areas. See also Centers for Medicare and Medicaid Services ("CMS") Survey report dated April 11, 2008 (finding that staff unaware of individual patients' treatment schedules and patients not receiving treatment aligned with treatment plans). Yet precisely these same conditions existed during our site visit in January 2009, nearly one year after these prior audit findings.

At the time of our review, groups were offered at a central Psychosocial Treatment Mall, in building-based treatment malls, and in the dayrooms of some living units. There were a few patients involved in a sheltered workshop at the

Treatment Mall and a few patients working in facility maintenance and housekeeping. Only a handful of groups at the facility offered psychosocial treatment consistent with generally accepted professional standards. The majority of the groups offered were recreational or diversionary, without sufficient content or structure to be considered treatment programming. Of the groups we observed, use of evidence-based practice was apparent in only one group, in the Psychosocial Treatment Mall. Moreover, we observed no instances in which program participation was individualized and tied back to the treatment plans of participants. The only data collected was attendance at group; treatment teams received no data related to patients' progress on individual treatment goals.

Although Ancora professes to have adopted a recovery-oriented plan of care, the majority of treatment plans we reviewed were deficit-based. For example, behavioral plans are frequently punitive. Plans are based on generic losses of privileges in response to a maladaptive behavior, and frequently do not specify any positive reinforcement if the patient refrains from that behavior for a set period of time. Thus, F.F. loses smoke breaks if he bangs his head. V.W. loses visits with his family if he does not refrain from physical aggression or destructive behavior.

Ineffective behavioral plans at Ancora often reflect a lack of coordination between disciplines. For example, patient Z.A.'s plan included both deficit-based and positive reinforcers. However, the plan reflected a lack of coordination between team members, and a lack of expertise in designing the plan. The rewards could be earned only if Z.A. refrained from aggressive behavior for a week, which was too long an interval because Z.A. typically engaged in this behavior twice a week. Even more concerning, the goal of his treatment plan, to return to a cottage where he previously lived, was not an outcome Z.A. wanted, as noted in his record: "since [Z.A.] does not want to return to Cottage 18 . . . it may result in aggressive behavior in an attempt to remain at APH. [Z.A.] engaged in this behavior during his last admission to APH." These goals and rewards were, not surprisingly, ineffective.

Ancora does not typically collect baseline and monitoring data to inform continued treatment. Without relevant data, it is difficult to measure progress toward even the most generic of goals articulated in the treatment plans. For example, Y.B., a patient readmitted to the hospital after leaving a group home because she was unable to comply with its rules, has a treatment goal of reducing the influence of her psychotic symptoms and an intervention that provides diversionary activities and encourages her attendance. The "data" collected to evaluate her progress was attendance at activities. Diversionary activities are not treatment, and inpatient hospitalization is not the most integrated setting in which diversionary activities can be provided.

The few behavioral assessments in place at Ancora substantially depart from generally accepted professional standards. In their review, our consultants found patients with problem behaviors who lacked functional assessments, the most fundamental tool necessary to understand and treat maladaptive behaviors. For example, X.Y., whose problematic behavior includes pica, or swallowing inedible items, had behavioral plans for several years, although he was twice returned to 1:1 staffing because the plan failed to control his pica. His chart contains no evidence that a functional assessment of this behavior was undertaken prior to developing a behavior plan, a gross violation of professional standards. In other cases, the functional analysis was deficient in one or more significant ways: many failed to hypothesize the function of the challenging behavior; did not consider antecedent, environmental, or health factors that influence a behavior; did not contain sufficient baseline data; and failed to identify target or appropriate replacement behaviors. An adequate functional assessment is an essential predicate to understanding the motivation for a problematic behavior and the antecedents that may trigger the behavior or increase its frequency. The inadequacies in behavioral assessments at Ancora undermine all subsequent treatment planning.

Ancora makes extremely limited use of neuropsychological testing in developing treatment plans. While on site, we saw only one patient with evidence of neuropsychological testing to assess cognitive ability.⁸ The testing suggested that his level of function is greater than his actual ability, an incongruence that would affect his interactions with peers and staff. Goals articulated by his psychologist in an annual report were appropriately patient-centered and specific but were neither incorporated into the treatment plan nor, seemingly, considered by the treatment team. This failure to incorporate relevant information from all disciplines, and, in particular, this relevant information about the patient's cognitive ability, compromised the team's ability to provide individualized and effective treatment.

Generally accepted professional standards require that treatment plans for patients be measurable, specific, and appropriately patient-centered. However, the majority of treatment plans we reviewed contained non-measurable, generic, vague, and deficit-based goals. Examples of goals typical of those in the records we examined include:

- patient's thoughts will be more reality-based and less influenced by psychotic symptoms;

⁸ A second patient record, with evidence of neuropsychological testing to assess cognitive ability, was provided to us in late July, six months after our site visit.

- patient's thought process will not interfere with obtaining and keeping Level 2 (referring to degree of off-unit privileges) within the next 90 days;
- patient will refrain from ingesting foreign objects;
- increase patient socialization skills and increase reality orientation;
- improve thought process; and
- patient will improve impulse control and diminish aggressive outbursts.

Treatment options for patients with co-occurring substance abuse diagnoses are particularly deficient. This is despite the acknowledgment by the Risk Management Committee, in June 2008, of a correlation between drug abuse and the potential for violence and the barrier that substance abuse presents to successful community residence. During our visit, the treatment options specifically addressing substance abuse included one group at the Psychosocial Treatment Mall, observed during our visit to include approximately five patients, and a patient-run group known as the Mentally Ill and Chemically Addicted Club ("MICA"). Patients with unmet need for substance abuse treatment include:

- X.C., who has a diagnosis of schizophrenia and a history of substance abuse, initially received substance abuse treatment through the MICA club. X.C. subsequently eloped from a brief visit and was then denied enrollment in the MICA Club.
- W.D., who also has a diagnosis of schizophrenia and a history of substance abuse, was referred to the MICA club but denied enrollment.
- V.E., who has diagnoses of chronic schizophrenia and polysubstance abuse, was denied enrollment in the MICA club.
- G.G. and U.F., both with diagnoses of schizoaffective disorder and polysubstance abuse, are on a waiting list for services. T.H., with a diagnosis of schizoaffective disorder and alcohol abuse, is on a waiting list for services.

c. Inadequacy of Treatment is Enhanced for Limited English Proficient (LEP) Patients

There are a significant number of patients at Ancora whose ability to speak, understand, read, or write in English is sufficiently limited to be a factor in how they are treated. It appears that bilingual staff or professional interpreters are not consistently being used to facilitate communications with patients or their families.

In some cases, staff are allowing language to act as a barrier to placement for limited English proficiency ("LEP") patients. For example, patient S.I. was admitted six years ago, in January 2003, and placed on CEPP status almost five years ago, in September 2005. The CEPP tracking report notes that she "does not speak English and requires interpreter[.] This has been a barrier to placement." A psychologist's progress note confirms this: "The patient [S.I.] speaks Mandarin Chinese and it is difficult to communicate with her, on occasion, when an interpreter is present an attempt is made to communicate with her. Requests have been made to schedule an interpreter to meet with her on an individual basis and to have some phrases translated from English to Mandarin for when an interpreter is not available." We note that consent forms, treatment plans, and other documents critical to a patient's treatment have not been translated into languages other than English.

Failure to treat patients in a language appropriate manner can affect all phases of patient care and is likely to enhance the inadequacy of care afforded to LEP patients in particular. Impaired communication between LEP patients and staff undermines effective diagnosis, treatment, health care, investigation, and planning. Insufficient language support may interfere with good patient care, place LEP patients at greater risk of harm, or needlessly extend the duration of segregated treatment.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at Ancora, the State of New Jersey should promptly implement the minimum remedial measures set forth below:

A. Support For Discharges to the Most Integrated Setting

1. Assess each patient, including those specific sub-groups of patients with significant barriers to discharge, to determine whether the patient is receiving services in the most integrated setting appropriate for his or her needs.
2. If it is determined that a more integrated setting would appropriately meet the patient's needs and the patient does not oppose community placement, promptly develop and implement a transition plan that specifies actions necessary to ensure safe, successful transition from the facility to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames. Develop a waiting list showing the date on which a more integrated setting was found appropriate for each patient and how long the

patient has been on the waiting list. Identify the particular barriers for each such patient that are preventing discharge to a more integrated setting.

3. Implement the State's plan to improve supportive housing by issuing a request for proposals to serve discharge-ready patients.
4. Ensure the participation in all aspects of care and treatment planning by the patient, his or her guardian, family, and friends, as appropriate, and staff who know the patient best.
5. Conduct and update as necessary interdisciplinary assessments of each patient. Assessments should be adequate to develop treatment goals and intervention strategies while at Ancora and upon return to the community. Ensure that professional staff performing assessments obtain and document sufficiently detailed information regarding patients' strengths, preferences, needs, and history.
6. Provide education and counseling to patients, their guardian, and/or families as necessary to address any opposition to placement in the most integrated setting.
7. Ensure continuity of care at discharge so that the patient has direct contact with specific community providers who have been identified to provide services to patients upon discharge.
8. Monitor community-based programs to which patients are discharged to ensure program adequacy and the full implementation of each patient's treatment and service plan.
9. Develop and implement initiatives to address barriers to placement in the community.
10. Expand and modify community services so that patients can be discharged to the community in a timely manner. Ensure that such services for hard-to-place patients are expanded and modified. Expand and modify community capacity where there are gaps in service.

B. Protection from Harm

1. Immediately replace all potential environmental suicide risks in patient areas.

2. Develop and implement a comprehensive incident management, risk management, and quality assurance system to collect information related to adequacy of safety, identify and monitor implementation of corrective and preventative actions, and assess effectiveness of the actions in the areas of Olmstead planning; protection from harm, including use of restraints; mental health care; and medical care.
3. Develop and implement adequate policies and procedures regarding timely and complete incident reporting and the conduct of investigations of serious incidents. Train staff and investigators fully on how to implement these policies and procedures. Include recommendations in investigation reports and ensure the prompt implementation of remedial measures to prevent future occurrence of incidents and injuries.
4. Cease discussion of open investigations to ensure that the investigatory process is not compromised.
5. Centrally track and analyze trends of incidents and injuries, so as to develop and implement remedial measures that will prevent future events.
6. Ensure that independent and thorough investigative practices are followed when reviewing alleged employee misconduct or wrongdoing. Investigative practices must be free from retaliation, undue influence, or intimidation from any party.
7. Ensure that information regarding employee disciplinary actions is included in investigative files to effectively track and take appropriate action in the case of repeat employee perpetrators.
8. Ensure that recommendations for corrective action are distributed to staff in all disciplines as well as direct care staff to ensure responsive actions are implemented and documented. Ensure that corrective actions are monitored and reviewed to ensure effectiveness.
9. Ensure that staff receive adequate competency-based training to provide adequate supervision of patients and implementation of treatment plans.
10. Develop criteria for conducting risk reviews and monitor those at risk.

11. Enhance critical review of mortalities so that opportunities for performance improvement and reducing recurrent adverse events is a part of each review. Assure documentation of the review with emphasis on reporting recommendations for improvement.

C. Clinical Management and Nursing Care

1. Provide adequate medical care, nursing, and therapy services consistent with generally accepted professional standards to patients who need such services.
2. Provide each patient with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs. Conduct an adequate nursing assessment and reassessments as needed, according to generally accepted professional standards. Ensure that nursing staff notify relevant treatment team members of assessment and reassessment findings and clinically significant events as indicated.
3. Ensure administration of medications consistent with professional standards, with particular attention to developing a reporting system to encourage reporting of medication errors and to monitor adverse drug reactions.
4. Reconcile discrepancies between nursing policies and practices, particularly concerning medication administration and patient supervision.
5. Establish a formalized mechanism for identifying patients with enhanced medical, nutritional, or physical support needs, including but not limited to persons who are at risk of choking/aspirating; have swallowing difficulties; require assistance to eat or drink; receive enteral feedings; are at risk for constipation or bed sores; or are likely to require such services.
6. Ensure nurses and direct care staff receive competency-based training in the provision of care and individualized treatment plan interventions. Evaluate and document effectiveness of interventions.
7. Ensure adequacy of nursing documentation.

D. Restraint Use and Behavioral Supports

1. Ensure that highly restrictive interventions or restraints are never used in lieu of treatment programs, for the convenience of staff, or as punishment.
2. Develop and implement a protocol that places appropriate limits on the use of all restraints as well as the routine use of PRNs or other emergency chemical restraints. Ensure that only the least restrictive restraint techniques necessary are utilized and that restraint use is minimized.
3. Eliminate the use of planned restraints.
4. Develop appropriate observable, measurable, and individualized release criteria for patients in restraints.
5. Eliminate use of crisis plans in lieu of behavioral supports.
6. Document and analyze antecedent factors that contribute to maladaptive behaviors. Record behavioral antecedents, including precipitating causes and any coping skills used by the patient, in the incident and/or crisis de-briefing forms. Train staff to observe and record behaviors in the forms. Coordinate with psychology in development of adequate behavioral supports.
7. Ensure that ineffective behavior programs that may contribute to the use of restraints are modified or replaced in a timely manner. For those patients subjected to chronic use of restraint associated with difficult behavior problems, obtain outside expertise to help the facility address those patients' behavior problems in an attempt to reduce both the behaviors and the use of restraint.
8. Provide advance review and approval by a Human Rights Committee or its equivalent of all proposed restrictions of patient rights.

E. Treatment Planning and Mental Health Services

1. Provide patients with adequate treatment, including mental health, behavioral, and rehabilitative services needed to meet the patients' ongoing needs. These services should be developed by qualified professionals consistent with generally accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate

unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every patient.

2. Ensure that adequate assessments are used to develop a comprehensive, interdisciplinary treatment plan for each patient for the provision of necessary treatment, services, and supports. Ensure that the plans address the patients' needs, preferences, and interests in an integrated fashion that utilizes the patients' existing strengths. Ensure that staff are trained in how to implement the written plans and that the plans are implemented properly. Update assessments as additional information is gained.
3. Ensure that all patients receive individualized treatment programming consistent with generally accepted professional standards. Ensure that plans include measurable goals.
4. Develop and implement comprehensive, individualized behavior plans for the patients who need them. Through competency-based training, train the appropriate staff how to implement the behavior plans and ensure that they are implemented consistently and effectively. Record relevant behavioral data and document patients' progress on the plans.
5. Provide patients who have behavior problems with an adequate functional assessment so as to determine the appropriate treatments and interventions for each patient. Ensure that this assessment is interdisciplinary and incorporates medical, neuro-psychological, and other unaddressed conditions that may contribute to a patient's behavior.
6. Ensure sufficient neuropsychological testing as indicated.
7. Ensure adequate treatment programming for patients with substance abuse diagnoses. Ensure sufficient programming to enable patients to work off campus or attend off-campus programming or activities when that is the most integrated setting appropriate to each patients' needs.
8. Monitor adequately the patients' progress on the programs and revise the programs when necessary to ensure that patients' behavioral needs are being met. Provide ongoing training for staff whenever a revision is required.
9. Review applicable law, Title VI LEP guidance issued by the U.S. Departments of Justice and Health and Human Services and available

literature on standards of care for LEP patients. Many resources are available at www.lep.gov (see, for example, <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlepguidance.pdf>) and www.hhs.gov/ocr/office/index.html.

10. Ensure that an appropriate language access management plan, policies, and protocols are in place; that they are being implemented by staff; and that LEP patients are not receiving care that is slower, less effective, or that results in hospitalization of longer duration than other patients.
11. Perform a comprehensive review of all patient care systems and support services, existing policy and practices, and available resources to determine what changes are needed to provide appropriate and legally required care and treatment for LEP patients.

F. Psychiatric Services

1. Provide adequate psychiatric services consistent with accepted professional standards to patients who need such services.
2. Ensure that each patient with mental illness is provided with a comprehensive psychiatric assessment, a diagnosis consistent with generally accepted professional standards, appropriate psychiatric treatment including appropriate medication at the minimum effective dose that fits the diagnosis, and regular and ongoing monitoring of the psychiatric treatment to ensure that it is meeting the needs of each patient. Ensure that the psychiatrist(s) provide new assessments and/or revisions to any aspect of the treatment regimen whenever appropriate. Ensure that psychiatric services are developed and implemented in collaboration with facility psychologists and other disciplines, when warranted, to provide coordinated behavioral care.
3. Ensure that psychotropic medication is only used in accordance with generally accepted professional standards and that it is not used as punishment, in lieu of a treatment program, for behavior control, in lieu of a psychiatric or neuropsychiatric diagnosis, or for the convenience of staff.
4. Eliminate undue use of PRN medications. Assure that the pharmacy contractor's audits include review of PRN medication in a timely manner and that PRN audit information is shared with treatment teams in a timely manner so as to inform treatment.

5. Provide physicians with regular reports on facility-wide pharmaceutical consultation so that they can benchmark their own practice and the practice of their units with other physicians and units.

V. CONCLUSION

We appreciate the cooperation we received from the facility staff, the New Jersey Division of Mental Health, and the State's Attorney General's Office during our visit to Ancora. We wish to thank the administration and staff at Ancora for their professional conduct, their generally timely responses to our information requests, and the assistance they provided during our tour. Further, we wish to especially thank the hospital's staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment and who improve the lives of patients at Ancora. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Assuming there is continued cooperation from the State, we would be willing to send our expert consultants' reports under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obliged to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this matter will be contacting the State's attorneys to discuss this matter in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: Honorable Anne Milgram
Attorney General
State of New Jersey

Allan Boyer
Chief Executive Officer
Ancora Psychiatric Hospital

Ralph J. Marra, Jr.
Acting United States Attorney
District of New Jersey



U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
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November 9, 2009

The Honorable Pat Quinn
Governor
Office of the Governor
207 State House
Springfield, Illinois 62706

Re: Investigation of the Clyde L. Choate Developmental Center,
Anna, Illinois

Dear Governor Quinn:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Clyde L. Choate Developmental Center ("Choate"), in Anna, Illinois. On February 27, 2007, we notified then Governor Blagojevich of our intent to conduct an investigation of Choate pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of persons with developmental disabilities who are served in public institutions.

On July 23-26 and September 17-20, 2007, we conducted an on-site review of care and treatment at Choate with expert consultants in various disciplines. During our visits, we interviewed Choate administrators, professionals, staff, and consultants, and visited residents in their residences, at activity areas, and during meals. Before, during, and after our site visits, we reviewed a wide variety of relevant State and facility documents, including policies and procedures, incident reports and investigations, and medical and other records relating to the care and treatment of Choate residents. In keeping with our pledge of transparency and to provide technical assistance, where appropriate, we conveyed our preliminary findings to State counsel and to certain State and facility administrators and staff during exit briefings at the close of our on-site visits.

We would like to express our appreciation to Choate administrators, professionals, and staff and to the State officials who participated in our visit for their assistance, cooperation, professionalism, and courtesy throughout our

investigation. We hope to continue to work with the State and Choate officials in the same cooperative manner going forward.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). In doing so, we note that many of the findings we make in this letter are due to or exacerbated by Choate's failure to focus its treatment and care on moving individuals into the most integrated settings appropriate to their needs in violation of Olmstead v. L.C., 527 U.S. 581 (1999), including failures in: (A) behavioral, intellectual, communication, and psychiatric assessments; (B) behavioral interventions; (C) treatment planning; and (D) habilitation, communication, and special education programs and services. These deficiencies place individuals at greater risk of injuries related to their or others' maladaptive behaviors and make restrictions on their liberty due to use of seclusion or restraint more likely, undermining the treatment provided at Choate and potentially leading to prolonged institutionalization.

Based upon our investigation, we have concluded that certain conditions and practices at Choate violate the constitutional and federal statutory rights of its residents. In particular, we find that Choate fails to provide its residents with adequate: (A) transition planning and placement in the most integrated setting; (B) protection from harm; (C) health care, including psychiatric care and physical and nutritional management; (D) behavioral, habilitation, and communication services; (E) special education services; and (F) integrated treatment planning. See Olmstead v. L.C., 527 U.S. 581 (1999); Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, 12132 et seq.; 28 C.F.R. § 35.130(d); Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401 et seq.; and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794.

Despite these deficiencies, we wish to note several positive aspects of the care that Choate provides to its residents. Choate's grounds and buildings are well kept, and the living units are clean and presentable. Beyond these aesthetics, we also found that many of the staff members we interacted with showed genuine care and respect for Choate's residents, and we were impressed with clinical abilities of many of Choate's medical professionals, including the Director of Nursing and the Medical Director. Likewise, the forensic unit at Choate is impressive in many respects, particularly in its focus on habilitating its forensic residents so that they can move as expeditiously as possible to less restrictive settings appropriate to their needs.

Nevertheless, two significant concerns underlie many of the findings we set forth in this letter. First, we found a critical lack of oversight and supervision pervading most aspects of the care and treatment provided at Choate. This derived, in part, from vacancies in certain key positions. More fundamentally, however, we found that Choate is not collecting, analyzing, and synthesizing information adequately so that its administrative and clinical leadership can accurately determine whether Choate's residents are safe, whether their needs are being met, and whether the treatment and habilitation provided at Choate are effective. The failure to collect and analyze information adequately has also undermined Choate's ability to integrate information across disciplines and provide coordinated and collaborative care. These failures have led to substantial constitutional violations.

Second, we noted a profound inattentiveness to Olmstead's requirement of placing residents at Choate in the most integrated setting consistent with their needs. Generally accepted professional standards and federal law require that the treatment of individuals with developmental disabilities be focused on the development of skills and abilities that aid those individuals in overcoming their personal barriers to living as independently as possible. Thus, a focus on helping individuals move to live successfully in more integrated settings should underlie all aspects of the care and treatment provided at Choate. Unfortunately, unlike Choate's forensic unit where movement to more integrated settings appears to be emphasized, we found that this emphasis did not characterize the provision of treatment at Choate generally. As previously noted, many of the findings we make in this letter are aggravated by Choate's failure to focus its treatment and care on moving individuals into the most integrated settings appropriate to their needs.

I. BACKGROUND

Located in Anna, Illinois, approximately 105 miles outside of St. Louis, Missouri, Choate is a licensed 200-bed intermediate care facility for individuals with developmental disabilities. Choate is one of nine residential developmental centers operated by the Illinois Department of Human Services ("DHS"). Choate also operates the State's only forensic unit for individuals with developmental disabilities, which has a total bed capacity of 30 residents. At the time of our visits in July and September 2007, Choate housed approximately 175 residents. In addition, DHS operates a psychiatric hospital on the Choate campus, but that hospital was not included in our review.

II. FINDINGS

A. Choate's Transition and Discharge Planning Is Inadequate

Choate fails to provide transition and discharge planning consistent with federal law. This failure to provide adequate transition and discharge planning was made evident when we requested a "list of all residents with community placement goals" during our visit, and we were provided a list that only included the names of six individuals out of the 175 individuals residing at Choate. Moreover, the monthly review meetings we attended and the monthly review summaries we reviewed included virtually no discussion of discharge planning, and when they did discuss it, they cited inappropriate barriers to discharge, such as weight management and management of diabetes, neither of which prevent community placement. The failure to provide adequate discharge planning deprives the individuals confined at Choate of their rights under Olmstead. The State's failure to comply with Olmstead also contributes significantly to the constitutional violations we identify in the remainder of this letter.

Federal law requires that Choate actively pursue the timely discharge of residents to the most integrated, appropriate setting that is consistent with the residents' needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a resident's stay, Choate should: (1) identify, through professional assessments, the factors that likely will foster viable discharge for the resident; and (2) use these factors to drive treatment planning, habilitation, and intervention. Without clear and purposeful identification of such factors, residents will be denied habilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The Choate discharge planning process substantially deviates from generally accepted professional standards and federal law. The inadequacies in Choate's discharge planning process are intertwined with the other deficiencies in the care and treatment provided at Choate: the failures in other disciplines undermine Choate's ability to place individuals in the most integrated setting, while the failure to move individuals to the most integrated setting consistent with their needs is a fundamental cause of the constitutional violations in the care and treatment provided at Choate. As discussed in further detail in Section II.D.1.a, infra, Choate's behavioral, intellectual, and communication assessments are inadequate, undermining Choate's ability to determine the strengths and needs of individuals so they can be placed in the community. Choate does not appear to be performing these assessments on a timely basis, nor does it appear to be focused on determining the barriers to returning the individual to a community setting.

Relatedly, Choate's psychiatric assessments, diagnoses, and monitoring of psychotropic medications are inadequate, suggesting that the use of these medications may be counter-therapeutic in some instances, as discussed in further detail in Section II.C.2. In particular, the failure to attempt to determine minimally effective dosages suggests that individuals may be receiving inappropriately high dosages of medications that are being used to restrain, rather than treat, maladaptive behaviors, and that inhibit the ability to treat the maladaptive behavior through appropriate behavioral interventions. The unjustified use of psychotropic medications can significantly impair the other treatment and habilitation provided at Choate, and hinder an individual's ability to move to a more integrated setting.

Because Choate fails to provide adequate behavioral, intellectual, communication, and psychiatric assessments, the behavioral interventions based on those assessments are inadequate as discussed in further detail in Section II.D.1.b, and the interventions do not assist individuals in developing the skills they need to be able to live in a more integrated setting. Indeed, as discussed in further detail in Section II.D.1.b, we found many instances where individuals were receiving inappropriate or insufficient behavioral interventions, including multiple examples where individuals had been identified as having significant maladaptive behaviors but were not receiving any structured behavioral interventions. The failure to implement timely and appropriate behavioral interventions often leads to regression in the functional abilities necessary to live in a more integrated setting and, as discussed in further detail in Section II.B.3, may lead to further restrictions on an individual's liberty, including seclusion and restraint. Further, the failure to implement appropriate behavioral interventions places these individuals at risk of injuries related to their or others' maladaptive behaviors, which may hinder their treatment at Choate and lead to prolonged institutionalization.

Moreover, we found that the habilitation programs at Choate do not meet constitutional standards as discussed in further detail in Section II.D.2. Choate's provision of continuous active treatment is infrequent and is not designed to meet the habilitation needs of the individuals residing at Choate adequately. Relatedly, in our review of the Personal Service Plans ("PSP") at Choate, as discussed in further detail in Sections II.D.2 and II.F.1, *infra*, we found that they lacked any section devoted to discharge planning. Treatment of individuals at Choate should be focused on the barriers to community placement and the provision of skills to overcome those barriers. Therefore, while Choate does identify some barriers to community placement in the PSPs, the PSPs do not list specific plans to address those barriers. Relatedly, the monthly review meetings of the treatment teams do not routinely address discharge planning and barriers to placement. The failure to focus treatment planning, habilitation, and interventions on enabling the individual

to return to the community is a substantial departure from generally accepted professional standards and the requirements of Olmstead.

We also found that Choate's provision of communication services, including speech and language programming and services for individuals with hearing impairments, did not meet generally accepted professional standards, as discussed in further detail in Section II.D.3. The development of communication skills greatly facilitates movement toward more integrated settings for individuals with developmental disabilities, as it is these skills that enable them to communicate their needs and concerns and to avoid engaging in maladaptive behavior that may lead to prolonged institutionalization. Effective communication skills enable the individual to become less dependent on others for their basic needs, including medical care, and to access essential services at the time of their choosing, which are required for living in less restrictive settings.

Finally, Choate's failure to provide adequate special education services hinders individuals' ability to live in more integrated settings, as discussed in further detail in Section II.E. Education is both an aspect of living in the most integrated setting and an essential means of obtaining the skills necessary to live in such a setting. Individuals residing at Choate have a right to special education services under federal law, and the failure to provide those services impairs their ability to participate and integrate into more integrated settings.

B. Choate Does Not Adequately Protect Individuals From Harm

The Supreme Court has recognized that persons with developmental disabilities who reside in state-operated institutions have a "constitutionally protected liberty interest in safety." Youngberg, 457 U.S. at 318. Therefore, as the Court explained, the state "has the unquestioned duty to provide reasonable safety for all residents" within the institution. Id., at 324. In our judgment, Choate fails to provide a living environment that complies with this constitutional mandate.

Choate does not adequately protect its residents from harm and risk of harm and does not provide its residents with a reasonably safe living environment. Specifically, individuals residing at Choate are subject to repeated injuries of similar nature, unchecked self-injurious behavior, abuse, and neglect. The harm Choate residents experience as a result of these deficiencies is multi-faceted and includes physical injury; psychological harm; excessive and inappropriate use of restraints; and inadequate, ineffective, and counterproductive treatment. This harm undermines the other care and treatment provided at Choate, prolongs the time period spent by individuals in the institution, and delays the movement of individuals to more integrated settings in violation of Olmstead. The facility's

ability to address this harm is hampered by inadequate incident, risk, and quality management and deficient investigative practices.

1. Incident and Risk Management Is Inadequate

Choate's incident and risk management systems are inadequate to protect its residents from harm. To ensure that residents' constitutional right to safety is protected, generally accepted professional standards require that residential developmental disability facilities maintain an incident and risk management system that seeks to prevent incidents and requires appropriate corrective action when incidents do occur. Effective incident and risk management depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. The incident and risk management system at Choate falls significantly short of these standards and, as a result, residents are exposed to actual and potential harm.

a. Incident Reporting Is Deficient

Our review of Choate's incident reporting process found significant deficiencies resulting in substantial underreporting of incidents, events, and risks that affect the health and safety of residents at Choate. These deficiencies are caused by a procedural and policy failure to require that all incidents are reported to quality assurance personnel, as well as a lack of understanding of incident reporting guidelines by Choate staff.

First, according to policy, Choate only collects and analyzes incident data when an injury occurs. Choate limits incident types to accidents, peer-to-peer aggression, self-injurious behaviors, and injuries of an unknown origin. Therefore, for an incident to be included in an individual's data, and thus in the facility's aggregate data, an individual must have been harmed to such an extent that an Injury Report was warranted. The failure to include incidents that do not include an injury precludes Choate from being able to conduct analyses before an injury occurs, anticipate potential areas of harm, and take corrective action. To the extent that Choate's incident reporting policies only require incidents that result in injury to be reported, they substantially depart from generally accepted professional standards and promote constitutional violations.

Second, during our tour of Choate, we also found a lack of staff awareness about the current incident reporting policy. We were initially advised that the incident reporting policy had either just been revised or was under revision, but nevertheless all staff had been trained on the new policy and were expected to

implement it. When we requested a copy of the policy, we were informed that the policy was not yet available. During our tour of the facility, however, a unit director indicated that a policy notebook had just recently been provided, but it was kept in the unit director's office, not on the unit. According to the unit director, training on the new policy was to begin the following week. When asked about the contents of the new policy notebook, the unit director indicated that he had not yet reviewed it. The level of confusion regarding incident reporting suggests that incident reporting is not being performed uniformly, casting considerable doubt on the reliability of the data collected in these reports.

Our review of Choate's incident report data in conjunction with individuals' clinical records, external notification reports, and similar sources indicated that the incident reporting data were unreliable. A significant number of incidents and injuries are not being received and reported in the facility's aggregate data used for tracking and trending.¹ For example, the following incidents were found in clinical records or external notification reports, but were not included in an individual's or the facility's aggregate data:

- On April 3, 2007, an individual complained of ear pain and a plastic object was discovered in the ear canal, requiring removal by an Ear, Nose, and Throat Specialist;
- On April 6, 2007, an individual fell and sustained two lacerations to his forehead that required sutures;
- On July 11, 2007, a resident's lip was lacerated after being punched by another resident; and
- On July 17, 2007, a resident threw a chair at a peer, hitting him in the face, and first aid was necessary.

¹ We also found that Choate's aggregate data on restraint usage is not an accurate reflection of actual restraint use at the facility. For example, we were provided with a report purporting to show restraint usage by person from January 1, 2006 through July 26, 2007, but we found a number restraints documented elsewhere in facility records that were not included in this report.

Over time, the failure to properly report all incidents is even more troubling, as demonstrated by the following examples:

- Between April 1, 2007, and July 23, 2007, an individual was reportedly injured on three occasions, but a thorough record review revealed injuries on at least eleven separate occasions; and
- Between April 1, 2007, and July 23, 2007, according to the report data, a resident only had one incident of “attempted pica,”² while other records, including radiology reports and three internal investigations into alleged neglect, revealed that the resident had successfully ingested a necklace on May 20, 2007, and a metal screw on May 21, 2007. In several other instances recorded in progress notes, the resident threatened pica behavior, and in one instance punched a staff member in the mouth when the staff member attempted to redirect him. None of these “threatening pica” incidents was recorded in his behavioral tracking data.

Choate’s failure to properly report these incidents jeopardizes its ability to identify potential risks of harm and institute appropriate intervention strategies. Indeed, in the latter example, if some of the “threatening pica” behaviors had been correctly reported and tracked in the resident’s behavioral data, it is possible that the ingestion of the necklace and screw could have been prevented through timely intervention. Choate’s failure to report adequately incidents and injuries departs substantially from generally accepted professional standards and violates the constitutional rights of the individuals who reside at Choate.

b. Choate Fails to Identify Risk of Harm and Implement Preventive Actions

While incident management focuses on the collection and aggregation of data that are meaningful to protect an individual from harm, risk management focuses on identifying actual or potential harm from that data and taking timely action to prevent the harm from occurring. Specifically, risk management involves: (1) identification of actual or potential risks of harm based on historical data, diagnoses, and co-morbid conditions; (2) timely and appropriate intervention strategies designed to reduce or eliminate the risks of harm; and (3) monitoring of the efficacy of the intervention strategies and modifying the strategies in response to further data. Choate fails to provide adequate risk management to its residents.

² Pica is a medical condition in which a person ingests or attempts to ingest nonfood substances such as clay, chalk, hair, or glue.

The rate at which harm is occurring, combined with the patterns of the harm, indicate that Choate is failing to identify risks of harm and intervene in a timely manner. Although Choate's incident and injury data are significantly underreported, as described in the previous section, even the data that are reported show that incidents and injuries are frequent and severe. For example, from January 1, 2007, to March 31, 2007, a 90-day period, one individual suffered 42 injuries from self-injurious behaviors, "accidental events," or assaults by peers. The number of injuries increased each month, from 11 in January, 14 in February, to 17 in March. Another individual, a forty-three-year-old blind resident with severe mental retardation, sustained injuries on ten different occasions from April 2007 to June 2007, including a head laceration, a fractured thumb, and multiple abrasions and bruises. Incidents and injuries occurring with such regularity and severity suggest a failure to identify actual or potential risks to individuals and to respond with appropriate interventions.

Even where risks have been identified, however, Choate has inadequately addressed these risks. During our tour, we discovered one individual, A.A.,³ whose September 2006 Individualized Program Plan ("IPP") noted that she had sustained several injuries during the past year during transfers, because she is not cooperative with the procedure. The Physical Therapy section of the September 2006 IPP noted that "it is harder for one person to transfer" A.A. Nevertheless, no plan was instituted to prevent further injuries, and one-person transfers continued. Throughout 2007, A.A. continued to suffer injuries during transfers, including bruises, scratches, and lacerations. Only after A.A. suffered a head laceration from a fall during a one-person transfer in July 2007 did a physician order that all future transfers be performed by two people. Having identified that A.A. was at risk of harm during transfers in September 2006, ten months before the physician's order, Choate's failure to intervene in a timely and appropriate manner deviates substantially from generally accepted professional standards and violates A.A.'s constitutional rights.

The intervention strategies that Choate has implemented are also not monitored sufficiently to ensure that they prevent recurrences of potentially harmful behavior. For example, a resident who inserted a metal needle and a plastic pick into her ears in response to ear irritation, causing bleeding in her ears, was placed on 24-hour supervision and had all personal belongings confiscated that could potentially be placed in her ears. Approximately ten days later, after the ear

³ To protect individuals' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with individuals' names.

infection subsided, all monitoring ceased and her belongings were returned. The individual continued to complain about ear irritation for the next two months, but no measures were taken. The resident was then found bleeding from one ear, and an object was discovered deep inside the inner ear canal which had to be removed by an Ear, Nose, and Throat Specialist. The short-term intervention of 24-hour supervision and removal of certain objects was insufficient to prevent the potential for future harm, and no further intervention was devised despite the resident's ongoing ear complaints.

In short, we found that individuals suffer harm as a result of Choate's substantial departure from generally accepted professional standards in the three main components of risk management: risk identification, timely interventions, and monitoring of outcomes. These conditions violate the Constitution.

c. Investigative Practices Are Deficient

Constitutional mandates and generally accepted professional standards dictate that facilities like Choate investigate serious incidents such as alleged abuse and neglect, serious injury, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures. Such investigations are necessary to comply with an institution's duty to provide reasonable safety.

The investigative process at Choate substantially departs from these standards. As an initial matter, we noted during our tour that, in many cases, Choate permits staff against whom allegations have been made to return to duty before the investigation is complete or a well-supported, preliminary determination that the employee poses no risk to individuals or the integrity of the investigation has at least been made. Even though Choate indicates that this is only done when there is no credible evidence immediately available to support the allegation, this practice is still troubling. It permits a staff member who has been accused of abuse or neglect to potentially commit further abuse or neglect if the preliminary decision to return them to their normal job was incorrect. Furthermore, it affords the staff member the opportunity to contaminate the investigation through coercion of potential witnesses, whether that coercion is real or merely perceived. Choate should not continue to permit this practice.

Moreover, Choate's actual investigations substantially depart from generally accepted professional standards in violation of the Constitution. Our review of Choate's investigations from November 2006 to July 2007 revealed that, out of 81 investigations conducted, not a single one of the allegations of abuse or neglect was

substantiated. Although there is an option for reconsideration of investigative findings, Choate has not requested reconsideration since 2005. The complete lack of substantiation of abuse and neglect allegations is suggestive of incomplete and inadequate investigations.

Our review confirmed that the investigations are indeed inadequate. We found numerous cases where questionable inferences were drawn based on the facts presented, and many in which relevant questions were left unanswered. For example, an individual who eloped from Choate in March 2007 was aided in that effort by a staff member with whom he had an ongoing relationship. After the elopement, the individual and staff member went to the staff member's home and had sexual relations. According to the resident, sometime following his elopement, but while he was still at the staff member's home, someone from Choate called the staff member to inform her that the resident had eloped. While it is possible that this was merely a routine phone call to a staff member who knew the resident, it strongly suggests that someone at Choate was aware of the relationship between the staff member and the resident. There is no indication in the investigative record that anyone sought to determine who the caller was, or why that person would place a call to the staff member's home. Since the staff member has now been charged with sexual assault of a minor, it is possible that the caller was an accessory to the alleged crime, yet no follow-up was performed. This is a serious oversight in the investigative process. It is also noteworthy that neither of the staff members responsible for checking the resident's bed every 15 minutes had an allegation of neglect substantiated by investigators, even though the State regulatory agency required Choate to retrain both of them on this process.

Another example of inadequate investigations involves a pica incident, referenced earlier, in which an individual ingested a necklace. Despite two eyewitness accounts by Choate residents stating that they observed a nurse leave the necklace on a table and then saw the individual pick it up and swallow it, Choate's investigators credited the testimony of the nurse, who denied placing a necklace on the table, and another staff member, who simply stated that he never saw the necklace in the room during a room sweep. The reasons given for doubting the witnesses' accounts were weak, while the staff members had a clear motivation to deny their involvement. Even if the inferences drawn were correct, however, the failure to include sufficient detail to support these inferences in the investigative record demonstrates that the investigative process is inadequate.

We also saw evidence that the investigations were result-driven and were not a full inquiry into the circumstances that led to the incident or injury. For instance, the individual involved in the pica incident noted above was the subject of two other investigations of pica incidents, and all three were determined to be unsubstantiated. In one of the incidents, the investigator reported to Choate that

“[a]t this point, with no negative outcome for the client, there is no credible evidence.” This suggests that the outcome of the investigation hinged more on whether the individual suffered harm than whether neglect actually took place. This is a troubling approach to investigations, especially in light of the individual’s ongoing pica behaviors, which a detailed investigation may have aided in preventing.

Finally, we observed that investigations at Choate tend to ignore trends in allegations. For example, we noted that, between November 2006 and June 2007, one staff member was alleged to have smothered the faces of three different residents. This is a highly specific allegation, and its repetition by different individuals warranted further investigation. Similarly, during the same time period, another staff member was alleged to have threatened four separate individuals with physical harm, including death, if they did not do as directed. Choate’s apparent failure to detect these trends and perform further inquiry is a significant departure from generally accepted professional standards for investigations.

Choate’s deficient investigative practices undermine its ability to respond to situations of abuse and neglect, and increase the likelihood that harm will continue. Because investigations are not thorough, staff members who may have potentially abused or neglected residents at Choate were permitted to continue interacting with and caring for residents, leading to the potential for future harm. The failure to take adequate steps to prevent this harm violates the constitutional rights of the individuals who reside at Choate.

2. Quality Management Is Inadequate

Constitutional requirements and generally accepted professional standards mandate that a facility like Choate develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of corrective actions taken in response to problems that are discovered.

Choate substantially departs from these standards. We found that Choate’s quality management system was highly compartmentalized rather than integrated, and there was a lack of communication among departments. Often, multiple forms must be filled out for the same incident, but they are sent to different departments, increasing the likelihood of discrepancies among the data reported. As discussed earlier in this report, there were significant discrepancies between data reported in the progress notes, clinical records, or external agency notifications and the

individual's and facility's aggregate data. When asked, Choate's quality assurance administrator was unable to explain why these discrepancies existed. The administrator was unable to account for why numerous incidents found in the progress notes or agency notifications were not found in the aggregated data maintained in the quality management department. The inadequacies of the current quality management system have resulted in an environment where harm has occurred without recognition or resolution and will continue to occur if better systems are not put into place.

3. Seclusion and Restraint Usage At Choate Violates Constitutional Standards

Constitutional mandates and generally accepted professional standards require that, in an institution like Choate, restraints only be used when imminent risk of harm to oneself or others is present. Our review of Choate's records indicate that Choate's restraint practices substantially depart from this standard.

Despite recent efforts to reduce use of restraints, Choate continues to use restraints routinely, and often places individuals in four-point and even five-point restraints⁴ for unreasonably long periods of time, frequently without ever having attempted to use less intrusive measures. Choate's records indicate that several individuals were restrained in this manner, on average, for more than two and a half hours. Some restraints were much longer; we found examples of individuals who were placed in mechanical restraints for more than six consecutive hours, including:

- A.A., who was restrained for approximately four hours and eight hours, separated by a two hour and 15 minute time of release, in July 2007;
- B.B., who was held in mechanical restraints for seven consecutive hours in December 2006; and
- C.C., who was restrained for nearly six consecutive hours in October 2006.

⁴ In a four-point restraint, an individual is placed on his bed on his back and his wrists and ankles are secured by nylon straps; a five-point restraint includes all the elements of a four-point restraint, with the addition of a strap placed across the individual's chest.

Most egregiously, during his last ten days at Choate before discharge, D.D. was held in four-point or five-point restraints for nine consecutive hours on two occasions, twelve consecutive hours on another occasion, and approximately sixteen consecutive hours on yet another occasion. In total, this individual spent more than 45 hours in restraints during his last ten days at Choate. This high-level of restraint use departs substantially from generally accepted professional standards and violates the restrained individuals' constitutional rights.

C. Choate Does Not Provide Adequate Health and Psychiatric Care

1. Health Care Is Reactive and Uncoordinated

The Supreme Court has determined that institutionalized persons with developmental disabilities are entitled to adequate medical care. Youngberg v. Romeo, 457 U.S. at 324. The Court labeled this as one of the "essentials of care that the State must provide." Id. There are many positive aspects of medical care at Choate. In particular, the facility has the benefit of clinically competent, dedicated physicians and nursing leadership. These disciplines, however, are currently not structured in a manner allowing them to be sufficiently responsive to the population they serve, exposing individuals to risk of harm.

Foremost, health care at Choate is reactive rather than forward-looking. Reactive health care occurs when an individual's access to care depends upon the person presenting themselves for assessment and treatment, while proactive health care requires medical professionals to identify individuals at risk, to perform assessments, and to provide appropriate treatment. In a residential disability center setting such as Choate, individuals are often unable to articulate their health status to staff or request medical attention due to intellectual or developmental disabilities. Given these conditions, constitutional mandates require Choate to ensure that the health care provided is sufficiently proactive to identify potential health issues, to intervene before harm or suffering occurs due to illness or injury, and to provide access to health care as soon as possible once symptoms indicating a health problem arise. Regrettably, due to reactive health care delivery, Choate often fails to do enough to identify, assess, treat, and monitor its residents, especially those with complex and high-risk conditions. Choate's provision of reactive medical care undermines the other care and treatment provided at Choate and may unnecessarily prolong individuals' stay at Choate. A.A., discussed in Section II.B.1.b, had 24 injury reports from October 13, 2006 to July 11, 2007, for an average of 2.6 per month. A significant number of these injuries occurred during transfers of A.A. to and from her wheelchair. While Choate responded appropriately to each individual injury when it occurred, we could not find any evidence that her treatment team recognized this high rate of injury and formulated a plan to address it. Only after a fall in July 2007 did A.A.'s physician order all

transfers be performed by two people. Choate's failure to take steps to prevent harm to A.A. is a substantial departure from generally accepted professional standards and violates A.A.'s constitutional rights.

Choate's medical staff primarily utilizes a "sick-call" system to respond medically to individuals once direct care staff or a nurse has identified a resident with symptoms that warrant further assessment by a physician. Once identified as needing a physician's care, Choate residents are typically examined and evaluated by a physician at one of the clinical examination rooms on the facility's campus. Choate's use of clinic-based treatment is standard community practice and is acceptable in a developmental disability center setting. However, this model is not a substitute for methods necessary to ensure that health care providers are adequately monitoring the health status of residents and responding in a timely fashion. In this regard, attending physicians at Choate should also conduct clinical rounds on the residential units to facilitate routine interaction with direct care staff knowledgeable about residents' medical status. Furthermore, clinical rounds would provide attending physicians an opportunity to assess residents in their living environment, where they are likely to learn about and address health related matters with residents before more serious signs of illness occur.

Choate's reactive approach to health care is compounded by the ineffective coordination of health care services at the facility. There is often inadequate collaboration and coordination between and among the various health care disciplines. Failure to coordinate health care appropriately increases the likelihood that health professionals will pursue a course of treatment that may negatively impact another health care provider's treatment and jeopardize the overall care that a resident ultimately receives. Risk to residents is further increased as residents' charts often do not adequately reflect the health care decision-making process or reveal clearly what is happening with residents. Current and future plans of care are difficult to discern from the charts, placing residents at risk of harm because of poor communication and lack of coordination about their care and treatment. The following examples demonstrate the poor communication and lack of coordination in the provision of health care services at Choate, as well as the serious omissions from the medical charts, and emphasize the constitutionally significant harm that can occur from these deficiencies:

- E.E.'s May 2007 monthly review indicates that his neurologist recommended increasing the amount of one medication he received, until he was informed by E.E.'s primary physician that a higher dose of that medication had, in the past, produced ataxia, an inability to control voluntary muscular disorders. This suggests that this information was not in his medical chart, was not in a part of his chart that his neurologist typically would have reviewed, or was not

communicated from one discipline to the other, as his primary physician had clear knowledge of these past effects. Had E.E.'s primary physician not discovered this recommendation, E.E. would likely have suffered further harm. E.E.'s physician's knowledge of E.E.'s medical history is impressive and speaks well of his competence. Nevertheless, a health care system's reliance on an individual's recollection, rather than an accurate, accessible medical record, is inappropriate and unsafe;

- F.F. was found unresponsive in his room on April 14, 2007, and was taken to the local hospital. According to the admitting doctor at the local hospital, his "history is extremely sketchy, most of the information is available from the Emergency Room." This statement strongly suggests that the information Choate provided to the local hospital was inadequate; and
- Similarly, on February 23, 2007, G.G. was admitted to the local hospital for treatment of pneumonia. Her January 25, 2007, Behavior Intervention Plan indicates that she was receiving 500 milligrams of Clozapine, but the admitting note does not indicate that she was on this medication when listing her medications, despite indicating that the admitting doctor had a conversation with her primary physician at Choate. There is no indication in the record that the medication had been discontinued before her admission to the hospital. If this medication was in fact inadvertently discontinued at the time of her admission, she would have gone from receiving a significant dose of the medication to none at all in one 24-hour period.

Other factors also serve to diminish the level of coordinated health care at Choate. For instance, Choate's medical, psychiatric, and psychology staff rely heavily on informal meetings and conversations to relay information about residents' health care status. Unfortunately, in many instances, the underlying facts of these discussions are never recorded as part of the individual's medical history. As a result, Choate health professionals have failed to identify situations where individuals required additional health consultations with other Choate or community-based health care providers. For example, E.E. has an active psychotic disorder and a seizure disorder that have been well-documented for several years. Choate's past trials of antipsychotic medications have produced an increase in seizures, so they were suspended. While the suspension of the trials may be reasonable, it does not appear that Choate professionals have considered obtaining a specific neuropsychiatry consultation to attempt to identify an antipsychotic agent that would not lower his seizure threshold. In our review, we also noted that residents' charts and records often did not contain discharge summaries from

outside hospitals or emergency room visits, and that documentation of discussions with external specialty consultations was inconsistent, ranging from excellent to non-existent. This is a substantial departure from generally accepted professional standards.

These deficiencies in overall medical care place residents at risk, but there is even greater risk for residents in two discrete areas of care: (1) the administration of psychotropic medication; and (2) physical and nutritional management services.

2. Administration of Psychotropic Medication Departs Substantially From Generally Accepted Practices

Psychotropic medications are not dispensed in accordance with generally accepted professional standards at Choate. Constitutional and professional standards dictate that psychotropic medications are prescribed consistent with a documented psychiatric diagnosis and empirically-based evidence of the medications' efficacy. Moreover, psychiatric professionals should record empirically-based evidence of the psychotropic medications' efficacy, along with all attempts to determine the minimum effective dose of the medication for the resident. Without this information, treating professionals are unable to conduct an adequate risk analysis to determine whether the medication's inherent side effects are outweighed by the efficacy of the drug. The inappropriate use of psychotropic medications may undercut the other care and treatment provided at Choate, making it more difficult for the individual to move to a more integrated setting.

During our tour, we discovered that several individuals at Choate were receiving psychotropic medications, including first generation psychotropics, at dosages well-above accepted therapeutic dosages without any empirical evidence of the medications' efficacy or any attempts to identify the medication's minimum effective dose. The medications for the following individuals are illustrative of these problems:

- H.H. has been prescribed 75 milligrams of Haloperidol per day, a much higher dose than is usually utilized. Our review of his records indicated that there is no documentation of psychotic symptoms, and the frequency of his monitored behaviors is low. Moreover, his behavioral difficulties appear to be, in part, secondary to a closed head injury in childhood. Nevertheless, Choate has not made any attempt to decrease the amount of Haloperidol he receives; and
- I.I. was given 50 milligrams of Haloperidol per day until May 3, 2007, at which time her prescription was reduced to 48 milligrams of Haloperidol per day. Our consultant could not find any empirical data

to support this large of a dose of Haloperidol. Indeed, when I.I.'s dose was reduced from 50 milligrams to 48 milligrams, no clinical deterioration appears to have resulted. This suggests that no effort has been made to find the minimum effective dose of Haloperidol for I.I.

These residents are at unjustifiable risk of harm due to excessive and long-term exposure to these medications, including tardive dyskinesia.⁵

We also found a significant diagnostic-therapeutic disconnect at Choate and a lack of detailed documentation in records where the resident's diagnosis does not clearly explain the psychotropic regimen in place. This therapeutic-disconnect results in insufficient explanation or justification in individual records for current and future clinical decision-making. Therefore, the potential harm to residents is two-fold: the person may be treated with inappropriate and/or unnecessary medications and, at the same time, will not receive proper treatment for the underlying mental illness. Similarly, our expert reviewed a number of cases where exemptions from scheduled reductions in antipsychotic medications have been requested and granted absent concurrent empirical evidence that the scheduled reduction in medication would be harmful to the resident. This diagnostic-therapeutic disconnect impairs other aspects of the treatment provided at Choate, unnecessarily prolongs individuals' institutionalization at Choate, and accordingly contributes to violations of the Constitution and Olmstead. The following examples illustrate the diagnostic-therapeutic disconnect present at Choate:

- J.J. was prescribed the psychotropic medications Pimozide, Haloperidol, and Clonazepam, the stated goal for which was to reduce or eliminate symptoms of Tourette's syndrome.⁶ According to her records, the dosage of all three of these medications has been increasing, but no empirical evidence of the efficacy of these medications at reducing the severity of the Tourette's disorder is included in her records;

⁵ Tardive dyskinesia is a muscular side effect of anti-psychotic drugs and is primarily characterized by random movements in the tongue, lips, or jaw as well as facial grimacing, movements of arms, legs, fingers, and toes, or even swaying movements of the trunk or hips.

⁶ Tourette's syndrome is a neurological disorder characterized by multiple involuntary movements and vocalizations, or tics, which are frequent, repetitive, and rapid.

- K.K. occasionally displays inappropriate behaviors, including, most notably, physical aggression that involves pulling the hair of staff members. He is currently prescribed Perphenazine, a psychotropic medication. According to our consultant's review of his record, however, there is an absence of any description of psychotic symptoms, and there is a notation that a behavior program developed for K.K. in the 1990s was effective in reducing the frequency of the physical aggression and hair pulling. It is therefore not clear that the Perphenazine is being used to treat a psychotic disorder rather than to suppress aggression, which may be occurring on a behavioral basis. Moreover, there is evidence in the record that K.K. has manifested motor side effects that have required treatment with Bzotropine, and that he has also developed dysphagia,⁷ potentially related to the Perphenazine;
- L.L. is 44-year-old male who weighed 236 pounds in April 2007, which is 137 percent of his ideal body weight. He is currently on Risperidone, and one of the known side effects of this medication is weight gain. Nevertheless, the section of the record that primarily addresses potential negative side effects focuses primarily on the possible effect on his motor skills. While Risperidone can have some effect on motor skills, the most significant side effects are its metabolic side effects and the potential for weight gain. Especially given L.L.'s obesity, his treatment should at least acknowledge the potential for Risperidone to be exacerbating this problem and consider transitioning him to a more weight-neutral medication. Moreover, the frequency and intensity of his behaviors, as recorded, are not significant enough to bar consideration of a reduction in his Risperidone dosage; and
- M.M. has a long history of violent outbursts, physical aggression, self-injurious behaviors, and inappropriate sexual behaviors. During our review of his records, we found that, although he has been on many different psychotropic medications, it was noted that none of them have been effective at controlling his maladaptive behaviors. We also found no documentation of symptoms related to a psychotic disorder. Nevertheless, M.M. is currently on 600 milligrams of Lithium and 40 milligrams of Haloperidol per day, despite a May 9, 2005, consultation that recommended decreasing the Lithium until discontinued, and a lack of any empirical evidence that the Haloperidol has been helpful, especially at the given dosage, which is higher than usually used.

⁷ Dysphagia is the medical term for difficulty in swallowing.

Furthermore, we could find no documentation in the record that a sustained attempt has been made to determine the lowest effective dose of Haloperidol for M.M.

The continuation of these individuals on psychotropic medications that are not clinically justified by their symptoms, especially in unusually high dosages, or that may be having significant side effects when other medication options have not been attempted, exposes these individuals to unjustifiable risk of harm from the potential side effects inherent in the use of these medications.

During our review, we noted that Choate routinely documents data regarding the frequency of monitored behavioral symptoms. There was no documented evidence, however, that Choate routinely measures the intensity of monitored symptoms. To make appropriate dosage changes and assess the overall efficacy of the psychotropic medication administered, both frequency and intensity must be routinely measured and recorded. In the example of M.M., above, we could only find data on the frequency of his maladaptive behaviors, and none on their intensity.

Finally, as discussed in the previous section, Choate fails to ensure the adequate documentation of interdisciplinary collaborations between psychiatry, psychology, and medicine and here again relies too heavily on informal conversations to relay information necessary for adequate treatment decisions. Choate's psychiatrist and medical doctors indicated during interviews with our consulting expert that extensive discussions between psychiatry and medical occur before psychotropic regimes are implemented or changed. However, the subsequent record review by our expert revealed only infrequent and cursory documentation of these discussions. Furthermore, where discussions and empirical data do exist in the resident's record, this information does not appear to be used to inform the clinical decision-making process on a regular basis.

3. Physical and Nutritional Management Are Not Adequately Individualized

Physical and nutritional management services are a significant aspect of adequate health care services for persons with developmental disabilities. These supports should minimize risks associated with swallowing and digestion dysfunctions that predispose an individual to an increased risk of bowel impaction, choking, and aspiration, including aspiration pneumonia. In this area particularly, vulnerable residents need forward-looking care to prevent problems that can lead to illness, hospitalization, and death.

Choate, to its credit, does ensure that some aspects of physical and nutritional management are adequate. Generally accepted professional standards require that Choate assess residents for risk of dysphagia and implement appropriate dietary and programmatic safeguards based on these assessments to prevent the occurrence of harm from swallowing dysfunction. Choate's risk assessments are generally adequate. Barium swallowing studies are consistently conducted by off-ground community providers when initial assessments suggest this is necessary. Further, there is appropriate consultation between the attending physician and speech pathologist to perform initial swallowing evaluations and identify significant swallowing problems that develop in individual residents.

Nevertheless, there are significant deficiencies in Choate's physical and nutritional management, which pose serious risks to residents. Choate does not ensure that appropriate dietary and programmatic safeguards are implemented to prevent the risk of harm from dysphagia. First, the administration of the correct meal to the correct individual relies too heavily on staff recognition of the individual without a back-up system, such as picture cards, to facilitate resident identification. The current system creates the potential for a resident to receive the food tray of another individual in error. During dining, it is imperative that residents receive the correct dining tray to ensure proper nutritional needs are met and to ensure the health and safety of individuals who require foods of a certain texture or consistency.

Second, because Choate employs family-style dining, which normalizes the dining atmosphere, individuals with dysphagia are at greater risk and need to be closely monitored to prevent them from eating too rapidly or from impulsively taking food from another resident's tray. Although many of Choate's residents are currently functioning at a level that does not put them at risk of choking and aspiration, there is a distinct population of individuals whose physical status renders them vulnerable to dysphagia, choking, and aspiration. Choate's meal cards and monitoring plans, however, are not sufficiently individualized for those residents who have empirically-determined risks for dysphagia, choking, and aspiration to provide guidance to staff members on how they should interact with the individual, including interactions such as prompting the individual regarding pacing of food intake. The failure to provide adequately individualized meal plans, along with failure to provide sufficient identification of individuals with meal plans, departs substantially from generally accepted professional standards and places these individuals at risk of harm, including aspiration pneumonia and death, in violation of these individuals' constitutional rights.

D. Choate's Behavioral, Habilitation, and Communication Services Are Deficient

Choate's residents are entitled to "the minimally adequate training required by the Constitution . . . as may be reasonable in light of [the residents'] liberty interests in safety and freedom from unreasonable restraints." Youngberg, 457 U.S. at 322. The purpose of this training is to enable of the movement of individuals into the most integrated setting appropriate to their needs as required by Olmstead, 527 U.S. at 607. Generally accepted professional standards of care require that appropriate psychological interventions, such as behavior programs and habilitation plans,⁸ be used to address significant behavior problems and assist residents to live in more integrated settings. Choate has the benefit of a competent staff of psychologists. However, as of the time of our visit, the facility lacked a chief of psychology and lacked sufficient psychologists to meet the various needs of Choate's residents. Many of the deficiencies addressed below relate to these staffing problems and to the absence of rigorous clinical oversight. In any event, Choate fails in important respects to provide adequate psychology services to meet the needs of its residents.

1. Behavior Programs Are Ineffective

Use of challenging, even harmful ("maladaptive") behaviors frequently can be an issue for persons with developmental disabilities, and are often one of the reasons the individual is placed in an institutional setting. The harm from such behaviors can be severe, even fatal. Examples include punching, slapping, scratching oneself or others, intentionally destroying property, or pica. The causes of these behaviors often reflect the primary characteristic of developmental disability – difficulty learning, in this case, learning effective and healthy ways to meet one's needs and wants.

Indicia that a facility is having difficulty addressing challenging behaviors include high rates of harm to oneself or others, and indicia that a facility lacks adequate behavioral interventions include high rates of restraints and clinically unjustified psychotropic medications. Regrettably, these indicia are present at Choate. The failure to address challenging behaviors adequately inhibits the movement of individuals to a more integrated setting in compliance with Olmstead.

⁸ Habilitation includes, but is not limited to, individualized training, education, and skill acquisition programs developed and implemented by interdisciplinary teams to promote the growth, development, and independence of individuals.

As noted in Section II.C.2, supra, Choate substantially departs from generally accepted professional standards concerning the use of psychotropic medication for individuals with intellectual disabilities. There are a number of individuals at Choate who are receiving dosages of psychotropic medication that are above what are usually thought to be effective therapeutic dosages. There also does not appear to be an attempt to determine minimally effective dosages (“MEDs”) for many of these individuals. Furthermore, our review found a pattern of continuing individuals on high dosages of antipsychotic agents, despite the lack of any empirical evidence that the medication has been helpful.

Similarly, Choate substantially departs from generally accepted professional standards regarding restraint use. As described supra at Section II.B.3, we found numerous instances where individuals were held in mechanical restraints for excessive periods of time, and the manner in which many of the restraints were used, as well as the repeated use of restraints on the same individual, indicate that staff members were unable to respond appropriately to the behaviors that the individual was manifesting.

Further, Choate fails to use appropriate behavioral interventions. Generally accepted professional standards of practice provide that behavioral interventions should be: (1) based upon adequate assessments of the causes and “function” (i.e., purpose) of the behavior; (2) be implemented as written; and (3) be monitored and evaluated adequately. Ineffective behavioral interventions increase the likelihood that residents engage in maladaptive behaviors, subjecting them to unnecessarily restrictive interventions and treatments. Choate’s behavioral interventions are often not effective, based on deficiencies that depart from generally accepted professional standards. In particular, they often are not based on adequate assessments, and often are not monitored, evaluated, and revised adequately. The failure to provide adequate behavioral interventions violates these individuals’ constitutional rights and may unnecessarily prolong these individuals’ institutionalization at Choate.

a. Behavioral Assessments Are Inadequate

Without a thorough assessment of the function of an individual’s maladaptive behavior, including clearly identified, appropriate replacement behaviors, behavioral interventions will not be successful in modifying the maladaptive behavior. In this regard, a functional assessment identifies the particular positive or negative factors that prompt or maintain a challenging behavior for a given individual. By understanding the precursors and, separately, the purposes or “functions,” of challenging behaviors, professionals can attempt to reduce or eliminate these factors’ influence, and thus reduce or eliminate the challenging behaviors. Without such informed understanding of the cause of behaviors,

attempted treatments are arbitrary and ineffective. Choate's functional assessments are not adequate for this purpose. They do not effectively guide selection of replacement behaviors or intervention procedures, frequently resulting in a weak relationship between assessment results and intervention programs. For example, N.N.'s behavior intervention plan ("BIP") indicates that his "problematic behavior is maintained by him trying to escape⁹ staff requests, gaining attention, and access to tangible items." His replacement behaviors are defined as: "Unit Incentive Program," "Empathy Skill," and "Social Skills." On their face, these programs would not teach N.N. how he can escape requests or gain attention or tangibles in more socially acceptable ways. The lack of an adequate behavioral assessment leading to an appropriate behavioral intervention plan to address his maladaptive behaviors inhibits N.N.'s ability to move to a more integrated setting.

Separately, as Choate's policies reflect, it is important to conduct intellectual assessments of individuals at regular intervals. Particularly as persons with developmental disabilities age (especially persons having Down Syndrome) and are exposed to long-term doses of cognition-altering psychotropic medications, their cognitive abilities can change significantly. Such changes affect their habilitation needs, as discussed in Section II.D.2, *infra*, but they also affect their needs for, and the nature of, the behavioral interventions that they receive. Similarly, these assessments are sometimes a requisite for discharge planning. Yet, in practice, Choate is not conducting such assessments when needed. For instance, at the time of our visit, O.O.'s PSP notes that his last intellectual assessment occurred in March of 2002. As of the time of our visit, he was past due for reassessment, according to the policy of the facility and generally accepted professional standards of care. P.P.'s PSP, dated April 19, 2007, notes that his most recent intellectual assessment was on August 15, 2001, which again departs from Choate's policies and generally accepted professional standards. Similarly, the psychometric (i.e., intellectual aptitude) assessment section of Q.Q.'s BIP (dated April 7, 2005, and revised June 14, 2007) indicates that he was last assessed on May 9, 1996. These examples demonstrate Choate's failure to conduct intellectual assessments as necessary.

Maladaptive behavior is frequently a form of communication for persons with developmental disabilities who lack the tools to communicate more conventionally. Consequently, although a complete functional assessment should address communication, a separate, reliable communication assessment should be routinely used to identify the role of communication in an individual's maladaptive behaviors and, separately, as discussed below regarding habilitation, to identify appropriate

⁹ "Escape" is a term used in psychology to describe certain types of avoidance behavior.

learning objectives and interventions that enable the individual to move to a more integrated setting. Relatedly, another common cause of maladaptive behavior is pain. Failure to respond timely to pain obviously leads to avoidable suffering and is recognized as contributing to increases in maladaptive behaviors. Choate's communication assessment inventories reflect an understanding of the linkages between communication and behavior. However, it appears from our review that communication assessments at Choate are performed only infrequently.

Further, where assessments did occur, we found breakdowns in the diagnoses that were subsequently rendered. For instance, the psychometric assessment section of Q.Q.'s BIP (dated April 7, 2005; revised June 14, 2007) indicates that he has a full scale IQ of 58. However, his Axis II diagnoses include "Moderate Mental Retardation," a diagnosis that would require a significantly lower IQ score. Failure to reflect assessment results accurately in Clinical Diagnoses may lead to an inaccurate perception of individuals and inappropriate treatment planning. In this regard, our consultants found a repeated lack of support for psychiatric diagnoses where assessments from psychologists would be warranted. For instance, Q.Q.'s same BIP includes an Axis II diagnosis of personality disorder, NOS (not otherwise specified). The narrative does not offer any justification for this diagnosis, nor does it reference any observable behavioral criteria obviously associated with this psychiatric diagnosis. Interventions premised upon clinically unsupported diagnoses will be effective only by happenstance and easily can be counter-therapeutic, particularly the unwarranted use of psychotropic medication, which is a significant issue at this facility.

b. Behavioral Interventions Are Inappropriate, Insufficient, or Non-Existent

According to generally accepted professional standards, effective behavioral interventions should target the function of the maladaptive behavior to the maximum extent possible and be built on replacing the maladaptive behavior with a healthy alternative behavior that serves the same function. To a lesser extent, behavioral interventions may include modifying the environmental causes of the maladaptive behavior. Although effective behavioral interventions typically include a means of redirecting an individual from a maladaptive behavior, this is distinct from seeking only to control or suppress the maladaptive behavior.

Behavioral interventions at Choate substantially departs from generally accepted professional standards in important respects. As noted above, the facility is relying excessively on psychotropic medications and physical restraints to control behaviors. This is, in part, due to the fact that Choate's behavioral assessments do not lead to effective behavioral interventions, as discussed in the previous section of this letter. Nevertheless, in several instances where assessments, coupled with

observations and record review, pointed to an environmental factor (distinct from mental illness) as the function of a behavior, it appeared that Choate did not use this information to identify appropriate replacement behaviors or to attempt to modify the environmental factor. Further, the identified replacement behaviors were often too broadly stated to be useful, as in the above example of N.N.

Moreover, we found multiple examples of individuals who had been identified as having significant maladaptive behaviors but who nevertheless were not receiving structured behavioral interventions to address these behaviors. For instance, our consultant noted that two individuals on the forensic unit (R.R. and S.S.) were noted to be at risk for self-injurious behavior ("SIB") but neither had a behavior intervention plan. Further, a treatment team presented data at E.E.'s transition meeting regarding behaviors of "noncompliance," "property destruction," "physical aggression," and "verbal aggression." Yet, E.E. did not have a behavior intervention plan to address them.

Further, there should be a clinical congruence among targeted behaviors, assessments, and interventions. Yet, we found instances of inconsistency, even as to what an individual's target maladaptive behaviors were. For instance, N.N.'s behavior improvement plan did not identify the same target behaviors as were listed in his individual education plan ("IEP"). Physical aggression, teasing/provoking, and self-injurious behavior are included on his BIP but not on his IEP.

More fundamentally, we found repeated examples of Choate's failure to revisit behavioral interventions in response to compelling evidence that an individual's maladaptive behaviors were not improving, or were even deteriorating. This was true even at mandatory annual reviews that are expressly structured to address such issues. For instance, T.T.'s PSP of February 13, 2007, states that, "[o]verall, [M.] has shown an increase in the frequency or intensity of the target behaviors." In fact, our review found that all of T.T.'s challenging behaviors for which there was data from the previous year showed an approximately four-fold increase during the first part of the year. Yet, the recommendation was to "[c]ontinue current Behavior Intervention Plan." Between December 2006 and March 2007, Choate conducted four "Special Program Reviews" for T.T. due to injuries caused by SIB. The facility added interventions consisting of body checks at shift change, one-to-one supervision of T.T. at night, and use of restraints. However, these interventions are focused exclusively on restricting behavior, not modifying it. Significantly, T.T.'s monthly summary reviews for this period stated that the behavior program "[c]ontinues to meet individual's needs." Our consultant concluded that, apart from continuing a reduction of this individual's psychotropic medication, "there was no indication of a team response to his behavioral status." Additionally, repeated use of restraints at Choate do not lead to meaningful

reassessments of behavioral interventions or to warranted revisions in interventions. Our consultant further opined that, “[t]he failure to revise behavioral intervention plans in response to a lack of progress or to significant events is perhaps the most serious indictment of behavioral treatment at Choate.”

As noted previously, the failure to implement timely and appropriate behavioral interventions undermines the other care and treatment provided at Choate, prolongs these individuals’ use of maladaptive behaviors that led to their institutionalization, and impairs their ability to move to more integrated settings.

c. Implementation of Behavioral Treatment Is Not Documented or Observed

Consistent and correct implementation of appropriate behavioral interventions is essential. Choate uses a “Behavior Drill Procedure,” that “requires that the staff person demonstrate/role play rather than discuss how to implement procedures outlined in the Behavior Drill.” However, it appears that Choate frequently fails to meet this standard. As an initial matter, training records did not reveal which staff should have been trained on BIPs using the Behavior Drill, when the training should have been completed, or which staff have yet to be trained on any given program. Moreover, the facility’s practice, as of the time of our review, does not include observation of staff implementing any aspect of the behavior plan. This is a significant deficiency; without relative certainty that plans are being implemented as designed, it is impossible to determine whether a behavioral plan is effective.

d. Monitoring and Evaluation of Behavioral Programs Is Inadequate

Generally accepted professional standards of care require that facilities monitor residents who have behavior programs to assess the residents’ progress and the program’s efficacy. Without the necessary monitoring and evaluation, residents are in danger of being subjected to inadequate and unnecessarily restrictive treatment, to avoidable injuries related to untreated behaviors, and to unnecessarily prolonged institutionalization, all in violation of the Constitution and Olmstead.

As a threshold matter, Choate does not assess, for clinical purposes, critical aspects of psychological services at the facility, such as the use of restraints, the use of emergency procedures, the development and update of functional assessments, and staff implementation of programs. There is no systemic tracking and analysis of the type of restrictive components contained in BIPs. In fact, as noted previously, we found several instances of restraint use that were not recorded in Choate’s

restraint database. Thus, Choate's current reliance on restraint data for clinical purposes would likely lead to flawed assessments of treatment efficacy on both an individual and a systemic basis.

Further, as noted in Section II.C.2, supra, Choate relies heavily on psychotropic medications as a primary form of behavioral intervention, although it is seeking to reduce the use of psychotropics. As for traditional behavioral interventions, although Choate gathers some data to assess the interventions' efficacy, the facility lacks a standard, clinically justified method to gather data and confirm its accuracy. Additionally, the presence or absence of replacement behaviors, which mitigate or prevent the maladaptive behavior's occurrence, is rarely tracked. In short, Choate lacks a means to ensure that appropriate data are accurately and consistently reported.

Moreover, the BIPs we reviewed failed to provide adequate strategies for measuring the effectiveness of the plan. The outcomes currently emphasized by Choate to measure effectiveness focus on reducing the frequency of problem behaviors but fail to address improving skills or increasing independence adequately so that individuals can be moved to more integrated settings. Although the BIPs all mention collecting data regarding the occurrence of problem behaviors, plans fail to describe clearly, or in some cases to mention, the methods used to promote positive replacement behaviors. Teams routinely fail to monitor data regarding the individual's use of such behaviors.

e. Quality Assurance and Oversight of Behavioral Support Services Are Insufficient

Further, the safeguard of professional review and monitoring of behavior support services, as of our tour, is not taking place at Choate. These responsibilities largely fall on an adequate peer review process (an assessment of a practitioner's work by other professionals in the field to foster compliance with the generally accepted professional standards of the discipline) and a functioning behavior intervention committee ("BIC"). Neither of these important safeguards are functioning at Choate. In particular, we found that the BIC is not appropriately evaluating the content and quality of the behavior programs, or whether they meet professional standards. The BIC's failure to provide critical and substantive review of behavior intervention plans permits behavior programs to continue when these programs are ineffective, inefficient, and inconsistent. The BIC nearly universally approved every plan submitted to it during the time of our review. In particular, after reviewing approximately 120 pages of the BIC's minutes, our consultant did not find any instance where the BIC rejected a BIP, and only found a single instance where the BIC approved a BIP "pending incorporation of required change," although the required change was not identified in the BIC's minutes. We learned

during our visit that the State's chief psychologist for developmental disability services was being dispatched to Choate on an interim basis, in part to address the lack of oversight in Choate's behavioral support services.

Separately, although the behavior intervention process includes an assessment of the individual's rights, our review indicated that restrictive behavioral interventions were being implemented without prior approval from either of Choate's BIC or its Human Rights Committee ("HRC"). We found repeated examples of restrictive interventions that apparently were not subject to such oversight. For instance, O.O. received a "special program review" on

January 5, 2006, at which the treatment team recommended property searches on return from off-grounds activities. Such searches were not included in O.O.'s BIP. Our consultant determined from record review that "there is no indication that they were approved by the BIC or HRC." In fact, our record review did not uncover instances where the HRC provided any substantive review or discussion of restrictive behavioral interventions prior to approving them.

2. Habilitation Programs Do Not Meet Generally Accepted Professional Standards

Persons with developmental disabilities are to receive adequate habilitation training and related vocational and day program services and supports so that they may acquire new skills, grow and develop, and enhance their independence so they can move to more integrated settings. Federal regulations require that:

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a). Choate's habilitation programs do not meet these requirements and are inconsistent with generally accepted professional standards. The failure to provide adequate habilitation programs violates the mandates set forth in Olmstead, 527 U.S. at 607.

As an initial matter, and as noted above, Choate does not conduct cognitive assessments of its residents on a regular basis. Moreover, Choate does not have a coherent method for selecting habilitation learning objectives based on appropriate assessments, and functional and relevant objectives are not being targeted. Our

consultant noted that a great number of the training activities at Choate appear to be nonfunctional, occupying individuals' time but not addressing critical, functional objectives. Specifically, the training objectives at Choate do not appear to address whether the objective facilitates a smoother and more immediate transition to community placement, supports the individual's independent functioning, or improves the individual's quality of life. Similarly, we found PSPs that contained inappropriate goals or objectives when considered in conjunction with other information contained in the PSP. In particular, we found learning objectives that are inappropriate or irrelevant, such as U.U.'s learning objective of identifying his medications, when elsewhere in his PSP it states that he is not currently on any medications. In other PSPs, we found goals and objectives that contradicted the individual's stated or expressed preferences and personal goals. For example, V.V.'s PSP reveals that, from December 2006 to March 2007, a four-month period, he was in a shaving skills program, but V.V. refused to participate because he wanted to keep his facial hair. There is no indication in the PSP that the team questioned the appropriateness of his placement in the program or considered dropping the shaving skills objective. V.V.'s PSP also notes that he continually refuses to work in his vocational program and has, at times, displayed significant disruptive behaviors and "maladaptive behaviors towards peers." The PSP nevertheless concludes that he is appropriately placed in the program without any apparent consideration of alternatives.

Furthermore, individuals at Choate spend little time in habilitation activities. According to the daily activity charts for the first 24 days of July 2007, a review of 49 individuals revealed the following:

- 23 individuals had 10 to 18 days with no activities;
- 23 individuals had 1 day to 9 days with no activities; and
- Only 3 individuals appeared to be involved in activities each of the 24 days.

Training of such infrequency for persons with learning disabilities is not consistent with the requirement of continuous active treatment so that individuals can increase their independence. Moreover, of the habilitation activities provided to these individuals, a large percentage are described as "Music," "Movie," or "News/Weather." These activities are largely passive, and it is unclear how these activities are designed to meet the habilitation needs of the participating individuals. For example, data sheets revealed U.U.'s learning objectives for four weeks yielded a single data sheet indicating that he had "correctly achieved the task" (sorting colored paper from white paper), a total of nine times in the month of June. This suggests that U.U. spends very little time involved in tasks associated

with learning objectives that increase his independence. W.W.'s PSP includes an objective to "describe what activities are occurring in a picture," but it is unclear how this objective aids W.W. in acquiring skills that support independent functioning and facilitate transition to community placement. The failure to provide meaningful habilitation activities on a consistent basis is a substantial departure from generally accepted professional standards. Moreover, Choate's failure to provide adequate active instruction and treatment denies individuals the opportunity to increase their independence and makes community placement difficult.

In addition, the interdisciplinary team does not address whether the amount of training and vocational activity for individuals constitutes adequate active treatment to support an expeditious move to a less restrictive environment, increase independence, and improve quality of life. Nor are there written protocols describing the methodology by which the interdisciplinary team should evaluate and monitor individuals' progress on training objectives. Such analysis is not included in the development and annual review of the PSP. For example, T.T.'s monthly review summaries from October 2006 through May 2007 indicate that no progress was made on any skill over the entire eight month period, but there did not appear to be any effort to alter the programs or address the lack of progress in any fashion. Failure to substantively review development and monitor progress deprives individuals of effective treatment and prevents them from achieving personal goals.

As discussed in Section II.A.1, supra, a serious deficiency in the PSPs is the absence of a discharge plan. While Choate identifies barriers to community placement, it does not clearly specify actions the facility should take to overcome those barriers. Generally accepted standards of practice suggest the focus of treatment in a facility should address the barriers that prevent individuals from living successfully in community settings. An important part of habilitation is learning and using skills in the environment in which those skills are useful. This is one of the most powerful motivators for skill acquisition, and this often will be in a community setting. In fact, generally accepted professional standards of care are increasingly emphasizing use of community settings for skills acquisition. Choate's lack of active instruction, treatment and training in a community setting, coupled with the absence of a discharge plan, greatly hinders success in this area and violates federal law.

3. Communication Services Are Not Adequate

If communication skills deteriorate or are not developed, individuals are more likely to be unable to convey basic needs and concerns, are more likely to engage in maladaptive behavior as a form of communication, and are more likely to

be at risk of bodily injury, unnecessary psychotropic medications, and psychological harm from having no means to express needs and wants. Lack of communication skills will also make it more difficult for staff to recognize and diagnose health issues, such as pain, and hinders an individual's ability to move into more integrated settings as required by Olmstead. Choate fails to provide its residents with adequate and appropriate communication services and currently lacks the resources to address this deficiency.

More specifically, Choate provides limited speech and language programming to residents. At the time of our visit, we noted a single speech and language pathologist available for the facility, who is also responsible for speech and language services for individuals in the mental health facility. Without an adequate number of full time speech and language pathologists on staff, Choate will continue to provide poor communication services for individuals with developmental disabilities.

In addition, Choate's interdisciplinary collaboration with respect to communication and behavior intervention is relatively weak. Our review suggests that Choate is aware that challenging behaviors can serve as a means of communication. This awareness could provide the basis for interdisciplinary collaboration between speech and language services and behavior support services, but we did not find any evidence that this collaboration was occurring. For example, P.P.'s BIP includes a replacement behavior for inappropriate behaviors that involves prompting him to ask for a break and for preferred items, but his language program instead focuses on receptive identification of common objects. The relationship between the objectives in his behavior program and his language program is unclear, and there is no evidence of collaboration between the two disciplines in producing these plans.

Similarly, we also noted the facility serves individuals with hearing impairments, who are dependent on sign language as their primary form of communication. However, staff on their units were not proficient in sign language or able to communicate effectively with hearing-impaired individuals. Choate's failure to provide consistent access to staff with signing expertise denies these individuals their voice, limits their ability and opportunity to express preferences and choices, and deprives them of an opportunity to participate in their treatment.

E. Choate's Special Education Services For Qualified Students Are Insufficient

Choate fails to provide sufficient education services to individuals as required by the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401 et seq., Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and the

Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* Students eligible for services under the IDEA are required to have an Individualized Education Plan (“IEP”), developed by the responsible education agency, and the IEP must be implemented. 20 U.S.C. § 1414(d). The failure to provide adequate education services also impairs individuals’ ability to move to more integrated settings as required by Olmstead. 527 U.S. at 607.

During our review, we found that certain individuals at Choate, who qualified for special education services and had an IEP in place, were not receiving the services required by the IEP. For example, N.N.’s IEP indicates that Extended School Year services are needed. However, the “Program Schedule” for forensic residents updated on July 19, 2007 indicated that N.N. was not receiving any special education summer services. The failure to ensure that the services required by an individual’s IEP are being implemented violates federal law and departs from generally accepted professional standards.

F. Supports, Services, and Planning Are Not Integrated

Many of Choate’s difficulties in providing adequate supports and services to its residents stem from the facility’s failure to ensure that information is communicated to, and considered by, the disciplines for whom that information is relevant. Persons with developmental disabilities residing in state institutions have a constitutional right to adequate treatment, training, and medical care, Youngberg, 457 U.S. at 315, 319, 322, that is designed to enable an individual to live in the most integrated setting consistent with their needs, Olmstead, 527 U.S. at 607, and a critical aspect of any care and treatment is the integration of information to obtain a holistic understanding of the individual. Without a comprehensive understanding of the person, the services provided to that person are necessarily deficient. Choate does not effectively synthesize information about the individuals it serves in its Personal Service Plans, and the interdisciplinary team process at Choate is inadequate.

1. Personal Service Plans Do Not Meet Generally Accepted Professional Standards

At Choate, the development of a Personal Service Plan (“PSP”) is intended to integrate information about an individual across disciplines. Our review of the PSPs, however, revealed that integration of information is not taking place. The PSPs are not a comprehensive summary of and plan for an individual’s treatment at Choate. The “Summary of Last Year and Current Status” included in the PSPs, while extensive, simply collects reports from individual disciplines, but does not integrate the information from those reports. Moreover, the reports themselves do not reflect collaboration between the disciplines. One example is the PSP of T.T.,

which reports in one section that his challenging behaviors have grown substantially worse over the past year. Nevertheless, the PSP does not include any changes to the Behavior Intervention Plan to address the increasing behaviors, and it also calls for a further reduction of his psychotropic medication without addressing the increasing behaviors. We found another individual with a Behavior Intervention Plan that was not referenced anywhere in his PSP, and thus was not taken into account by other disciplines. Other examples of lack of integration include individuals who are taking psychotropic medications but do not have behavioral intervention programs, and individuals who have personal goals listed in their PSP but have no learning objectives associated with these goals. The failure to integrate information from various disciplines in the PSP undermines the treatment that Choate is attempting to provide and inhibits the ability of Choate's residents to move to more integrated settings.

Our review discovered other omissions from PSPs that substantially depart from generally accepted professional standards. First, we found that, on the whole, PSPs at Choate do not reflect individualized planning. They do not describe the individual's goals, and they contain little information about an individual's personal preferences. Without this information, the PSPs necessarily fail to plan treatment that takes into account the individual's strengths and preferences, as required by generally accepted professional standards. Second, we found that the "Strengths and Needs" section of the PSP lacks a social skills section. This is a troubling omission, as one of the primary reasons individuals reside at Choate is their inability to relate to others in a socially appropriate manner. Third, PSPs lack any section devoted to discharge planning. Generally accepted professional standards dictate that a major focus of an individual's treatment at Choate should be addressing the barriers that prevent the individual from living in the community. The failure to require the inclusion of this information in the PSP is a significant omission.

Finally, PSPs are intended to document an individual's plan of care in language that is understandable to the individual served or their guardian. Indeed, the PSPs at Choate include a specific section entitled "Parents/Guardians Comments" that requires an affirmation by the parent or guardian that he or she "understands and approves the Personal Service Plan." Despite this affirmation in the PSPs at Choate, we found that the PSPs often contained highly technical language and professional jargon that is unlikely to be understood by the individuals or their guardians. Without informed input from individuals and/or their guardians, PSPs will not be what they are intended to be—person-centered.

2. Treatment Teams Are Not Integrated

Choate's treatment teams are not integrated across disciplines, resulting in care that does not meet the individuals' needs. This is a substantial departure from generally accepted professional standards.

During our visits, we attended numerous monthly review meetings held by treatment teams for individuals at Choate, and they were uniformly characterized by a lack of collaboration across disciplines. Moreover, the summaries of those meetings consistently fail to document an interdisciplinary approach to the challenges an individual presents, as well as any substantive team discussion about those challenges. For example, O.O. had a target behavior added to his behavior intervention plan on January 18, 2007, but the summary of the monthly review meeting for January 2007 does not include any discussion of the behavior or provide any rationale for adding it as a target behavior. V.V.'s monthly review summaries for August through November 2006, a four-month period, contained no evidence that any discussion was taking place by the team regarding his Money Skills and Vocational Skills programs. In each of the four summaries, the only included language regarding his progress in these programs was: "He is currently working on a money objective. He will continue to work on this objective." and he "is working on a vocational program. He will continue to work on this program." A more egregious example is that of T.T., who had multiple injuries due to self-injurious behaviors from December 2006 through March 2007. The injuries triggered four Special Program reviews, but the summaries of the monthly review meetings for January, February, and March 2007 all indicate that the behavior program "continues to meet individual's needs." The failure to exchange information adequately and integrate that information into meaningful treatment is a substantial, and very significant, departure from generally accepted professional standards. Furthermore, without accurate and complete documentation of the interdisciplinary team process, it is impossible to evaluate treatment teams' actions and build upon successful interventions.

We also found the monthly review meetings and summaries had several significant omissions. One troubling omission was the lack of action plans that were developed through the monthly review process. None of the monthly review meetings that we attended while at Choate produced any action plans to address an individual's needs, and the monthly review summaries that we reviewed routinely failed to include any action plans. A second omission that we observed was the failure to review and discuss restraint data during monthly reviews meetings. We found several examples where a restraint occurred during the time period for the monthly review, but the monthly review summary did not make any reference to the restraint, nor was there any documentation of whether the team had considered whether changes to the active treatment plan were necessary to prevent the need

for further restraints. A third omission in the monthly review process was a routine failure to address discharge planning and barriers to placement. The monthly review meetings we attended did not include any substantive discussion of discharge planning or barriers to placement in the community, and the monthly review summaries we reviewed similarly failed to address these issues. These omissions diminish Choate's ability to provide adequate treatment to its residents.

Choate also fails to include critical individuals in the interdisciplinary team process. We found that direct care staff are not included in team meetings, undermining the team process. Direct care staff provide information based on direct observations of the individual that is critical to effective treatment planning. The failure to involve direct care staff in treatment decisions also undercuts Choate's ability to ensure that consensus is reached on appropriate treatment and that treatment is uniformly implemented. Additionally, we found that the individuals themselves are not consistently present at monthly review meetings. At least four individuals - X.X., G.G., Y.Y., and Z.Z. - did not attend their monthly review meetings during our visit. We do note, and appreciate, that when individuals were present at meetings, effort was made to engage them actively in their treatment and the individuals were treated with dignity and respect. Nevertheless, generally accepted professional standards dictate that an individual be actively involved in their treatment planning, and effort should be made to ensure that individuals are more consistently involved in this process.

III. MINIMUM REMEDIAL MEASURES

To remedy the identified deficiencies and protect the constitutional and statutory rights of Choate residents, the State should promptly implement, at a minimum, the remedial measures set forth below. Many of these deficiencies could be remedied, in part, by focusing the care and treatment at Choate on moving individuals into the most integrated settings appropriate to their needs:

A. Transition and Discharge Planning

1. Ensure that each individual residing in Choate is served in the most integrated setting appropriate to meet each person's individualized needs. To this end, the facility should take these steps:
 - a. Provide transition, discharge, and community placement services consistent with generally accepted professional standards of care to all individuals residing at Choate;
 - b. Actively pursue the appropriate discharge of individuals residing at Choate and provide them with adequate and

appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object;

- c. Set forth in reasonable detail a written transition plan specifying the particular protections, supports, and services that each individual will or may need in order to safely and successfully transition to and live in the community;
- d. Develop each transition plan using person-centered planning principles. Each transition plan should specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the individual in the alternative community setting, including their scope, frequency, and duration. Each transition plan should include all individually-necessary protections, supports, and services, including but not limited to:
 - i. housing and residential services;
 - ii. transportation;
 - iii. staffing;
 - iv. health care and other professional services;
 - v. specialty health care services;
 - vi. therapy services;
 - vii. psychological, behavioral, and psychiatric services;
 - viii. communication and mobility supports;
 - ix. programming, vocational, and employment supports; and
 - x. assistance with activities of daily living.
- e. Include in each transition plan specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports;

- f. Emphasize the placement of residents into smaller community homes in its transition planning;
- g. Avoid placing residents into nursing homes or other institutional settings whenever possible in its transition planning;
- h. Identify in each transition plan the date the transition can occur, as well as timeframes for completion of needed steps to effect the transition. Each transition plan should include the name of the person or entity responsible for:
 - i. commencing transition planning;
 - ii. identifying community providers and other protections, supports, and services;
 - iii. connecting the resident with community providers; and
 - iv. assisting in transition activities as necessary.

The responsible person or entity shall be experienced and capable of performing these functions.

- i. Develop each transition plan sufficiently prior to potential discharge so as to enable the careful development and implementation of needed actions to occur before, during, and after the transition. This should include identifying and overcoming, whenever possible, any barriers to transition. Choate should work closely with pertinent community agencies so that the protections, supports, and services that the individual needs are developed and in place at the alternate site prior to the individual's discharge;
- j. Update the transition plans as needed throughout the planning and transition process based on new information and/or developments;
- k. Attempt to locate community alternatives in regions based upon the presence of persons significant to the individual, including parents, siblings, other relatives, or close friends, where such efforts are consistent with the individual's desires;

- l. Provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each individual. Choate should modify the transition plans, as needed, based on these community visits;
- m. Establish in each individual transition plan a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the individual are being met. Each plan should specify more regular visits in the days and weeks after any initial placement;
- n. Ensure that each individual residing at Choate be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers;
- o. Use person-centered planning principles at every stage of the process. This should facilitate the identification of the individual's specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs;
- p. Give each individual residing at Choate the opportunity to express a choice regarding placement. Choate should provide individuals with choice counseling to help each individual make an informed choice and provide enhanced counseling to those individuals who have lived at Choate for many years;
- q. If any individual residing at Choate opposes placement, Choate should document the steps taken to ensure that any individual objection is an informed one. Choate should set forth and implement individualized strategies to address concerns and objections to placement;
- r. Educate individuals residing at Choate about the community and various community living options open to them on a routine basis;
- s. Provide each individual with several viable placement alternatives to consider whenever possible. Choate should provide field trips to these viable community sites and facilitate

overnight stays at certain of the community residences, where appropriate;

- t. Provide ongoing educational opportunities to family members and/or guardians with regard to placement and programming alternatives and options, when family members and/or guardians have reservations about community placement. These educational opportunities should include information about how the individual may have viable options other than living with the family members and/or guardians once discharged from Choate. Choate should identify and address the concerns of family members and/or guardians with regard to community placement. Choate should encourage family members and/or guardians to participate, whenever possible, in individuals' on-site, community home field trips;
- u. In coordination with the State, develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms should serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight shall include regular inspections of community residential and program sites; regular face-to-face meetings with residents and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records;
- v. Serve individuals who are placed in the community with an adequate number of service coordinators to meet individuals' needs. The State's service coordination program should provide for various levels of follow-up and intervention, including more intensive service coordination for those individuals leaving Choate with more complex needs. To encourage frequent individual contact, individuals leaving Choate should be served by service coordinators who carry a caseload of no more than 25 individuals at a time. Service coordinators involved with individuals from Choate with more complex and intensive needs will carry a caseload of no more than 20 individuals at a time.

All service coordinators should receive appropriate and adequate supervision and competency-based training;

- w. Provide prompt and effective support and intervention services post-placement to residents who present adjustment problems related to the transition process such that each individual may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to:
 - i. providing heightened and enhanced service coordination to the individual/home;
 - ii. providing professional consultation, expert assistance, training, or other technical assistance to the individual/home;
 - iii. providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and
 - iv. developing and implementing other community residential alternative solutions for the individual.
- x. Regularly review various community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State should develop and implement effective strategies to any gaps or weaknesses or issues identified.

B. Protection From Harm

- 1. Provide incident, risk, and quality management services consistent with generally accepted professional standards to all residents at Choate. To this end, the facility should take these steps:
 - a. Ensure that residents are supervised adequately by trained staff and that residents are kept reasonably safe and protected from harm and risk of harm;
 - b. Develop and implement adequate policies and procedures regarding timely and complete incident reporting and the

conduct of investigations of serious incidents. Train staff and investigators fully on how to implement these policies and procedures. Centrally track and analyze trends of incidents and injuries so as to develop and implement remedial measures that will prevent future events. Include systemic recommendations in investigation reports and ensure the prompt implementation of remedial measures to prevent future occurrence of incidents and injuries; and

- c. Develop and implement mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, Choate staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending either the investigation's outcome or at least a well-supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.
2. Ensure that any device or procedure that restricts, limits, or directs a resident's freedom of movement (including, but not limited to, mechanical restraints, physical or manual restraints, or chemical restraints) be used only in accordance with generally accepted professional standards. To this end, the facility should take the following steps:
 - a. Ensure that restrictive interventions or restraints, including seclusion, are never used as punishment, in lieu of training programs, or for the convenience of staff. Ensure that only the least restrictive restraint techniques necessary are utilized, and that restraint use is minimized;
 - b. Develop and implement a protocol that places appropriate limits on the use of all restraints, especially the use of physical holds and one-point, two-point, three-point, four-point, and five-point restraints, as well as the routine use of chemical restraints; and
 - c. Ensure that ineffective behavior programs that may contribute to the use of restraints are modified or replaced in a timely manner. For those individuals subjected to chronic use of restraint associated with difficult behavior problems, obtain outside expertise to help the facility address the persons'

behavior problems in an attempt to reduce both the behaviors and the use of restraint.

C. Health and Psychiatric Care

1. Provide medical care, nursing, and therapy services consistent with generally accepted professional standards to residents who need such services. To this end, the facility should take these steps:
 - a. Provide each resident with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs;
 - b. Develop and implement an adequate system that ensures timely, accurate, and thorough recording of all medical care provided to each resident including consultation with outside medical providers, emergency room visits, and hospitalizations; and
 - c. Establish an effective physical and nutritional management program for residents who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, interventions for mealtimes and other activities involving swallowing, and monitoring to ensure that interventions are effective. Ensure that staff with responsibilities for residents at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.
2. Provide psychiatric services consistent with generally accepted professional standards to residents who need such services. To this end, the facility should take these steps:
 - a. Ensure that each resident with mental illness is provided with a comprehensive psychiatric assessment, a DSM-IV diagnosis, appropriate psychiatric treatment including appropriate medication at the minimum effective dose that fits the diagnosis, and regular and ongoing monitoring of psychiatric treatments to ensure that it is meeting the needs of each person. Ensure that psychiatrist(s) provide new assessments and/or revisions to any aspect of the treatment regimen whenever appropriate. Ensure that quality behavioral and other data is provided to psychiatrists in making their assessments. Ensure

that psychiatric services are implemented in close collaboration with facility psychologists and others such, when warranted, to provide coordinated behavioral care; and

- b. Ensure that psychotropic medication is only used in accordance with generally accepted professional standards and that it is not used for punishment, in lieu of a training program, for behavior control, in lieu of a psychiatric or neuropsychiatric diagnosis, or for the convenience of staff. Ensure that no resident receives psychotropic medication without an accompanying behavior program.

D. Behavioral, Habilitation, and Communication Services

1. Provide residents with training, including behavioral and habilitative services, consistent with generally accepted professional standards to residents who need such services. These services should be developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every resident. To this end, the facility should take the following steps:
 - a. Procure adequate psychology staffing and hours to meet the needs of the residents, including adequate leadership and oversight of psychological services;
 - b. Provide residents who have behavior problems with an adequate functional assessment so as to determine the appropriate treatments and interventions for each person. Ensure that this assessment is interdisciplinary and incorporates medical and other unaddressed conditions that may contribute to a resident's behavior;
 - c. Develop and implement comprehensive, individualized behavior programs for the residents who need them. Through competency-based training, train the appropriate staff how to implement the behavior programs and ensure that they are implemented consistently and effectively. Record appropriate behavioral data and notes with regard to the resident's progress on the programs;

- d. Monitor adequately the residents' progress on the programs and revise the programs when necessary to ensure that residents' behavioral needs are being met. Provide ongoing training for staff whenever a revision is required;
 - e. Ensure that all residents receive meaningful habilitation daily. Ensure that there is a comprehensive, interdisciplinary habilitative plan for each resident for the provision of such training, services and supports, formulated by a qualified interdisciplinary team that identifies individuals' strengths, needs, preferences, and interests. Ensure that the plans address the residents' needs, preferences, and interests in an integrated fashion that utilizes the individuals' existing strengths. Ensure that staff are trained in how to implement the written plans and that the plans are implemented properly; and
 - f. Provide an assessment of all residents and develop and implement plans based on these assessments to ensure that residents are receiving vocational and/or day programming services in the most integrated setting appropriate to meet their needs. Ensure that there is sufficient staffing and transportation to enable residents to work off campus or attend off-campus programming or activities when necessary.
2. Provide communication services consistent with generally accepted professional standards to residents who need such services. To this end, the facility should take these steps:
- a. Procure adequate staffing and hours of speech and language services to meet the needs of residents; and
 - b. Ensure that speech and language services are developed and implemented in collaboration with facility psychologists and other services to provide coordinated care.

E. Special Education Services

1. Provide education and special education services consistent with generally accepted professional standards to residents who need such services. To this end, the facility should develop and implement IEPs consistent with the requirements of the IDEA.

F. Integrated Supports, Services, and Planning

1. Provide supports, services, and planning that are integrated across disciplines, consistent with generally accepted professional standards, to all residents at Choate. To this end, the facility should take these steps:
 - a. Ensure that PSPs integrate information across disciplines and reflect collaboration among disciplines. Ensure that PSPs demonstrate individualized planning, including the individual's needs, strengths, goals, and preferences. Develop and implement PSPs that include a section on transition and discharge planning, including the barriers to community placement and the facility's plan to address those barriers. Ensure that PSPs are understandable to the individual served or their guardian; and
 - b. Ensure that interdisciplinary and treatment team meetings integrate information across disciplines and reflect collaboration between disciplines, and that the integration and collaboration is appropriately documented. Ensure that individuals necessary to obtaining a comprehensive understanding of the resident, including direct care staff and the individual who is the subject of the meeting or their guardian, are included in the interdisciplinary team process. Ensure that action plans are developed and implemented to address the needs and/or issues identified in those meetings, including but not limited to inappropriate behaviors or use of restraint. Ensure that transition and discharge planning, including barriers to placement, are routinely discussed at team meetings.

IV. CONCLUSION

We appreciate the cooperation we received from the Illinois Department of Human Services and the State's Attorney General's Office. We also wish to thank the administration and staff at Choate for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tours. Further, we wish especially to thank those individual facility staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of residents at Choate. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the State in an amicable and cooperative manner to resolve our outstanding concerns with regard to Choate.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to

do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Thomas E. Perez
Assistant Attorney General

cc: The Honorable Lisa Madigan
Illinois Attorney General
Office of the Attorney General of Illinois

The Honorable Michelle R.B. Saddler
Secretary
Illinois Department of Human Services

Mary-Lisa Sullivan, Esq.
General Counsel
Illinois Department of Human Services

Lilia Teninty, Director
Illinois Department of Human Services
Division of Developmental Disabilities

Jan Farmer, Director
Clyde L. Choate Developmental Center

The Honorable A. Courtney Cox
United States Attorney
Southern District of Illinois



U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
Washington, DC 20530

February 10, 2011

The Honorable Robert F. McDonnell
Office of the Governor
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Re: Investigation of the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center

Dear Governor McDonnell:

We write to report the findings of the Civil Rights Division's investigation of the Central Virginia Training Center ("CVTC") and of the Commonwealth of Virginia's ("State" or "Commonwealth") compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999), requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs. Our investigation was conducted pursuant to Title II of the ADA, U.S.C. § 12133, and the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights, including those under the ADA, of institutionalized individuals.

We write to provide you notice of the Commonwealth's failure to comply with the ADA and of the steps Virginia needs to take to meet its obligations under the law. 42 U.S.C. § 2000d-1 (incorporated by 42 U.S.C. § 12133). This letter also serves as formal notice under CRIPA of the findings of our investigation, the facts supporting them, and the minimum steps necessary to remedy the deficiencies. 42 U.S.C. § 1997b(a). The Commonwealth's implementation of the remedies discussed in this letter will correct the identified deficiencies in its compliance with the ADA, fulfill its commitment to individuals with disabilities, and protect the public fisc.

I. SUMMARY OF FINDINGS

We have concluded that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA. The inadequacies we identified have resulted in the needless and prolonged institutionalization of, and other harms to, individuals with disabilities in CVTC and in other segregated training centers throughout the Commonwealth who could be served in the community. Systemic failures causing this unnecessary institutionalization include:

- The Commonwealth's failure to develop a sufficient quantity of community-based alternatives for individuals currently in CVTC and other training centers, particularly for individuals with complex needs;
- The Commonwealth's failure to use resources already available to expand community-based services and its misalignment of resources that prioritizes investment in institutions rather than in community-based services; and
- A flawed discharge planning process at CVTC and other training centers that fails to meaningfully identify individuals' needs and the services necessary to meet them and address barriers to discharge.

The Commonwealth also places individuals currently in the community at risk of unnecessary institutionalization at CVTC and other training centers, in violation of the ADA. Systemic failures causing this violation include:

- The Commonwealth's failure to develop a sufficient quantity of community services to address the extremely long waiting list for community services, including the 3,000 people designated as "urgent" because their situation places them at serious risk of institutionalization; and
- The Commonwealth's failure to ensure a sufficient quantity of services, including crisis and respite services, to prevent the admission of individuals in the community to training centers when they experience crises.

Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration will permit the Commonwealth to support people with disabilities in settings appropriate to their needs in a more cost effective manner.

II. INVESTIGATION

On August 21, 2008, we notified then-Governor Tim Kaine of our intent to conduct an investigation of CVTC, pursuant to CRIPA, 42 U.S.C. § 1997. We conducted on-site tours of CVTC on November 18-21, 2008, December 17-18, 2008, and April 27-29, 2009, with the assistance of expert consultants in the fields of protection from harm, habilitation, and treatment programming.

On April 23, 2010, we notified the Commonwealth that we were expanding our investigation to focus on the State's compliance with the ADA and Olmstead with respect to individuals at CVTC. On August 17-20, 2010, we conducted a tour to examine whether the State is serving individuals confined to CVTC, and those discharged from CVTC, in the most integrated setting appropriate to their needs. We were assisted by consultants with expertise in discharge planning and serving individuals with intellectual and developmental disabilities in the community.

During the course of the expanded investigation, however, it became clear that an examination of the Commonwealth's measures to address the rights of individuals at CVTC under the ADA and Olmstead implicated the statewide system and required a broader scope of

review. We received information regarding the Commonwealth's efforts both to discharge individuals to more integrated settings and to prevent unnecessary institutionalization. While much of our review focused on CVTC, many of the policies and practices we examined are statewide in their scope and application. For example, the same community-based services are necessary to facilitate discharge of individuals from the other training centers, and individuals are discharged from CVTC to regions throughout the State.

While on site, we interviewed persons in statewide leadership positions in the Department of Behavioral Health and Developmental Services ("DBHDS"); CVTC administrators, professionals, staff, and residents; community providers; Community Service Board directors; and individuals receiving services in more integrated settings in the community. We observed individuals receiving services in a variety of settings, including in their residences and day activity areas. Before, during, and after our visits, we reviewed policies, procedures, individual records, and other material related to the care and treatment of individuals at CVTC. At the end of each of our inspections, consistent with our pledge of transparency and to provide technical assistance where appropriate, we provided an exit presentation at which our consultants conveyed their initial impressions and concerns about CVTC – and Virginia's system for providing services to individuals with intellectual and developmental disabilities – to the Commonwealth's counsel, CVTC administrators and staff, and other Commonwealth officials.

III. BACKGROUND

CVTC is a State-operated institution in Madison Heights, Virginia, operating as an intermediate care facility for persons with developmental disabilities (ICF/DD). CVTC is the largest of Virginia's five State-operated institutions, with approximately 400 individuals there. A total of approximately 1,100 individuals are in these five ICF/DDs. CVTC and the other training centers are operated by DBHDS. Approximately 8,600 individuals receive services through two different types of Medicaid "waivers"¹ in the community, and another 6,400 are on a waitlist. Services are coordinated through the 40 locally-run community service boards ("CSBs") that provide direct services and link consumers to services provided by other direct providers.

The average cost of institutionalizing a person at CVTC and other training centers is approximately \$194,000 per year. By contrast, the cost of services to people in the community through the use of a waiver averages \$76,400. Virginia can serve nearly three people in the community for each person in a training center.

Commonwealth officials are aware of the deficiencies that we identified during our investigation and have acknowledged the need for significant improvements. We are encouraged that Virginia leadership, both at CVTC and at DBHDS, acknowledged the problems and indicated a strong desire to work with the United States Department of Justice toward an amicable resolution. We are further encouraged by your recent statements and by positive measures in your budget proposal that support a transition to a community-based system for

¹ Section 1915(c) of the Social Security Act permits the waiver of certain Medicaid statutory requirements to enable states to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization.

servicing individuals with intellectual and developmental disabilities as an alternative to institutionalization.

IV. FINDINGS

We conclude that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs as required by the ADA. The quantity of available services in the community is deficient, preventing individuals from being discharged from CVTC and other institutions and placing others at risk of unnecessary and expensive institutionalization. Discharge and transition planning is plagued with deficiencies, resulting in very few discharges from CVTC and the other training centers in the last several years. These inadequacies have resulted in needless and prolonged institutionalization of individuals with disabilities who could be served in the community with more independence and dignity at a fraction of the cost. While needlessly institutionalized, these individuals suffer harms and are exposed to the risk of additional harm.

Congress enacted the ADA in 1990 “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. § 12101(b)(1). Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. “The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.” Helen L. v. DiDario, 46 F.3d 325, 335 (3rd Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the “integration mandate.” The integration mandate arises out of Congress’s explicit findings in the ADA, the regulations of the Attorney General implementing Title II,² and the Supreme Court’s decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607.

² The regulations provide that “a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities.” 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA “integration regulation” explains that “the most integrated setting” is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.” 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

In so holding, the Court explained that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Id. It also recognized the harm caused by unnecessary institutionalization: “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” Id. at 601.³ The Fourth Circuit has also clearly stated that federal law requires “plac[ing] the recipient in the least restrictive environment.” Doc v. Kidd, 501 F.3d 348, 358 (4th Cir. 2007) (citing Olmstead, 527 U.S. 581), cert. denied, 522 U.S. 1243 (2008).

The Commonwealth is failing to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs, in violation of its obligations under the ADA and Olmstead. Individuals are unnecessarily institutionalized at CVTC and the other training centers, and individuals in the community are placed at risk of unnecessary institutionalization. The principal causes of Virginia’s departure from the ADA’s integration mandate are a lack of services in the community, particularly for individuals with complex needs, and a slow and muddled discharge and transition planning process.

A. Individuals with Intellectual and Developmental Disabilities Are Unnecessarily Institutionalized at CVTC and Other Training Centers

The Commonwealth is violating the ADA by unnecessarily institutionalizing hundreds of individuals at CVTC and other training centers who could be served in more integrated settings. Olmstead, 527 U.S. at 607.

1. CVTC and the Other Training Centers are Segregated, Institutional Settings that Expose Individuals to Harm

CVTC is a segregated, institutional setting. Approximately 400 individuals with intellectual disabilities are congregated together at CVTC. Individuals are assigned to units of eight to 12 people. Bathroom areas are congregate, with towels and other items often stored in separate areas not readily available to residents. As a result, individuals have very limited privacy. CVTC has the physical appearance of an institution, not a home. Day rooms are bare and impersonal, with minimal decorations and little home-like furniture. Accord Disability Advocates Inc. (DAI) v. Paterson, 653 F. Supp. 2d 184, 200-07 (E.D.N.Y. 2009) (describing characteristics of institutions to include, *inter alia*, large numbers of individuals with disabilities congregated together, an institutional appearance, and lack of privacy).

Individuals at CVTC live segregated lives. Most spend their entire day in the institution, with the vast majority participating in facility-based day activities. Individuals are offered very

³ Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (In announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”).

limited opportunities for meaningful employment and have virtually no opportunities to interact with their non-disabled peers. CVTC limits individuals' autonomy and provides few opportunities for individuals to make choices. Individuals eat together in dining areas at set mealtimes, where they cannot choose what or when they eat. Staff determine what programs individuals watch on the television set in the day room. *Id.* (institutional characteristics include, *inter alia*, regimented daily activities, little autonomy and opportunity for choices, and limited opportunities to interact with individuals outside the institution); *Benjamin v. Dep't of Pub. Welfare of the Commonwealth of Pa.*, Memorandum and Order, Case No. 09-1182 (Docket Entry 88) (M.D. Pa. Jan. 27, 2011) (finding that the Commonwealth of Pennsylvania unnecessarily institutionalizes individuals in large ICF/DDs in violation of the ADA and holding that such placements are segregated, where individuals are congregated together in living units, primarily receive day services on the grounds of the facilities, and have limited opportunities to interact with non-disabled peers and limited access to community activities). The Commonwealth has acknowledged, in interviews with officials and in reports, that nearly all individuals at the training centers could and should be served in smaller community-based settings.

Individuals are harmed at CVTC. Unnecessary segregation not only violates individuals' rights under the ADA, but also causes irreparable harm. "[O]ne of the harms of long-term institutionalization is that it instills 'learned helplessness,' making it difficult for some who have been institutionalized to move to more independent settings." *DAI*, 653 F. Supp. 2d at 265; *accord Marlo M. v. Cansler*, 679 F. Supp. 2d 638 (E.D.N.C. 2010) (finding unnecessary institutionalization leads to regressive consequences that cause irreparable harm); *Long v. Benson*, 2010 WL 2500349 (11th Cir. June 22, 2010) (affirming district court's granting of preliminary injunction based on irreparable injury of unnecessary institutionalization).

Moreover, CVTC compounds this harm by exposing individuals to unsafe conditions while they are needlessly institutionalized. *See Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (finding that the Fourteenth Amendment's due process clause requires an institution to provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests"). Individuals at CVTC are subjected to significant harms, including repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports. An overarching cause of these harms is CVTC's failure to identify individuals' needs, identify root causes of bad outcomes, and respond to prevent their recurrence. These harms not only evidence the need for CVTC to put in place adequate quality assurance mechanisms, but underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements.

Particularly concerning during our initial tours in 2008-09 was CVTC's use of restraints. The right to be free from undue bodily restraint is the core of the liberty interest protected from arbitrary governmental action by the Due Process Clause. *Id.* at 316. Restraints may only be applied in emergency situations necessary to prevent harm and for only the length of time necessary for the emergency to subside. 42 U.S.C. § 290ii(b) (federal rules regulating the use of restraints on individuals in ICF/DDs). Yet, at CVTC, restraints were not limited to emergency situations. Instead, planned restraints were part of many individuals' treatment plans, where they were used as an intervention of first, rather than last, resort. We also found evidence that several

individuals resisted efforts of staff to get them to use what CVTC termed “voluntary” restraints, raising questions about whether these restraints are voluntary at all.

2. Individuals at CVTC and the Other Training Centers Could be Served in More Integrated Settings

Individuals at CVTC and the other training centers could be served in more integrated settings. The Commonwealth has acknowledged this both explicitly and implicitly through its efforts, albeit incomplete, to serve individuals in the community who have needs similar to those of individuals at CVTC and the other training centers. We conclude that the vast majority of individuals could be – and have a right to be – living in community settings with appropriate services and supports but are instead languishing in the institution.

Virginia already has a range of community-based services for individuals with intellectual and developmental disabilities. These community services cost substantially less than institutional care. *See supra*. Virginia has developed a Medicaid-funded waiver program, known as the ID Waiver, to provide home and community-based services to individuals with intellectual disabilities who meet the level of care for ICF/DDs (which include the training centers) and are in or at imminent risk of entering such facilities. Waiver services include assistive technology; companion services; crisis stabilization and crisis supervision; day support; environmental modifications; in-home residential support services; residential support services; respite services; personal assistance; personal emergency response system; prevocational services; skilled nursing; supported employment;⁴ therapeutic consultation; and transition services.⁵

Residential options under the waiver include small group homes, sponsored homes where a licensed provider contracts with a family to provide services for up to two individuals, in-home residential support programs to serve individuals in their own homes or their families’ homes, and adult foster care programs that are similar to sponsored homes and provide room and board, supervision, and services in the provider’s home for up to three adults.⁶ We found that, among

⁴ While we recognize that the State provides integrated supported employment opportunities, our tours raised serious initial concerns about the over-reliance on segregated, sheltered workshops for individuals with intellectual and developmental disabilities in the community. Many of the day programs we visited also did not provide individuals with opportunities for meaningful work. These deficiencies place individuals at risk of continued segregation even once they are discharged.

⁵ Virginia has a separate waiver for individuals who have a developmental disability (such as autism), but not an intellectual disability, called the Individual and Family Developmental Disabilities Support Waiver (DD Waiver). Like the ID waiver, the DD waiver contains a range of support services including in-home residential support, day support, skilled nursing, crisis services, respite, personal attendant care, and supported employment.

⁶ Virginia also offers congregative, more institutional-like settings in the community, including ICF/DDs that serve between five and 12 individuals and assisted living facilities that provide or coordinate personal and health care services with 24 hours per day of supervision in a

the placements we visited, individuals were generally kept safe and provided appropriate supports and services.⁷

The Commonwealth has acknowledged that most people at the training centers, including nearly every individual at CVTC, could be served in the community. In its recent study, *Creating Opportunities: Plan for Advancing Community-Focused Services in Virginia* (June 25, 2010), the Commonwealth noted, "Individuals in training centers could be served in the community if adequate supports, including targeted medical and behavioral interventions, were available to them." Similarly, the Director of Developmental Services, Lee Price, told us during our August 2010 visit that he believed that everyone at CVTC could be served in the community. CVTC staff has already determined that more than 170 individuals at CVTC could be served in more integrated settings, and the number is undoubtedly far higher due to CVTC's inadequate discharge assessment process.

The needs of individuals at CVTC – including individuals with complex medical or behavioral needs – are the same as the needs of other individuals who are currently served in the community in Virginia and in other states, including in states that have no institutional settings. Community providers confirmed that the vast majority of individuals from CVTC could be served in the community with appropriate supports and services. They also stated that they currently serve individuals who have similar needs to people at CVTC, including individuals with complex medical or behavioral needs. While the pace of discharge to the community of individuals from CVTC and the other training centers has been unacceptably slow, *see infra*, the individuals who have transitioned have similar needs to those individuals who remain at CVTC.⁸ Thus, providers and the Commonwealth have already demonstrated an ability and a willingness

larger group setting. These placements are not funded using waivers. For many individuals, these are not the most integrated settings appropriate to their needs.

⁷ Recently, most individuals have been discharged into sponsored homes or small group homes, with only a small number of individuals moving to larger ICF/DD facilities. While our sample size was too small to make any firm conclusions, we were encouraged by the overall quality of the community placements we visited. However, we had concerns regarding two of the residential placements, including one larger congregate setting. In that case, the Commonwealth had investigated reports of abuse, the primary responsible staff member was terminated, but the Commonwealth did not provide adequate follow-up to ensure that appropriate corrective action was taken with respect to other staff who may have been present during or known about the abuse. Just as it must do at the training centers, the Commonwealth must ensure that its investigation, monitoring, and licensing procedures adequately address any potential harms at community-based placements. *See infra*.

⁸ The Commonwealth's own reports have indicated, and other information confirms, that individuals at other institutions have similar needs and could be served in the community and that individuals with needs similar to individuals at other training centers are likewise receiving services in the community. *See* Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010; Information Brief: Virginia SIS Comparisons for SEVTC and Comprehensive Community Waiver Populations, Human Services Research Institute (on behalf of DBHDS), June 23, 2009.

to serve people with complex needs in community settings. Accord Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 6 (“With appropriate community services, all of the named Plaintiffs [with developmental disabilities] could live in more integrated community settings rather than institutions because they would still have available all services and supports that are currently available to them.”).

During our tours, we met former CVTC residents living and otherwise participating in more integrated settings. The needs of these former CVTC residents are no different than those of the individuals currently at CVTC. Many of them have complex medical and/or behavioral needs but nonetheless are successfully living in community-based settings, where they live with more independence, dignity, and self-determination. We observed that these individuals were living in home-like environments; were able to make choices like how to spend their day, what to eat, and how to decorate their rooms; had access to community-based services and activities; and were safe from harm. Former CVTC residents whom we met included:

- AA, whom we met in a sponsored home and who owns his own bowling shoes and bowling ball, has a membership at the local “Y,” has lunch at a senior center twice a week, frequently visits a friend in a nursing home, and goes to a recreation center each week.⁹
- BB, a deaf woman whom we met in a sponsored home who goes into the community nearly every day. Her sponsored family includes her in family life through their use of modified sign language.
- CC, who engages in community activities, including church several days a week.
- DD, whom we met at a day program, who volunteers at a local fire department.
- EE, who enjoys bowling despite having cataracts and hearing impairment.

3. Few Individuals Are Discharged from CVTC or the other Training Centers to More Integrated Settings

Virginia relies heavily on institutional care for individuals with intellectual and developmental disabilities. Despite the Commonwealth’s recognition that individuals at CVTC and the other training centers could be served in more integrated settings, Virginia citizens with intellectual and developmental disabilities remain institutionalized, and very few individuals are actually transitioned into the community. This use of institutional care has significant financial costs for the Commonwealth.

The Commonwealth continues to spend far more proportionally on institutional than community care, in large part due to the substantially higher average cost of serving individuals in institutions than in the community. It continues to invest millions of dollars in new construction and remodeling of its training centers instead of seriously investing in the

⁹ To protect individuals’ privacy, we identify them by initials other than their own. We will separately transmit to the Commonwealth a schedule that cross-references the initials with individuals’ full names.

community services necessary to transition people. The Commonwealth's long-range plan for CVTC is that it maintain a census of 300. As noted earlier, however, CVTC staff already have determined that 170 of the 400 current residents are ready for discharge. Virginia is one of only five states that continue to operate multiple large (16+ beds) state-run institutions for individuals with intellectual and developmental disabilities and of only a handful of states that has yet to close a single state-operated facility.

Individuals who could be served in more integrated settings languish at CVTC. Between July 1, 2008, and July 1, 2010, there was a net reduction in the CVTC population of only 10 individuals, a reduction rate of approximately five people annually. There were only 31 discharges in that two year period,¹⁰ despite CVTC itself designating another 170 individuals as being capable of being served in more integrated settings. This unreasonably slow rate of discharge has remained fairly steady since 2004. Between July 1, 2008, and July 1, 2010, there were nearly as many admissions (21 individuals) as discharges, caused in large part by the Commonwealth's failure to develop sufficient community services to prevent unnecessary institutionalization. Out of the 31 people discharged since July 2008, half of those individuals were people who had been admitted during that same time period. Thus, virtually no one who has been institutionalized long-term in CVTC ever leaves.

Moreover, the large majority of individuals who have been designated as ready for discharge have been waiting for placement for a significant amount of time. Approximately 140 of the 170 so designated were placed on the list in 2007 or earlier. Some individuals have been "ready for discharge" for a decade or more. At the current rate of discharge, the vast majority of individuals at CVTC will not move into the community during their life time. Even those who will ultimately have the chance to move must first endure many more years of unnecessary institutionalization. The other training centers have seen similarly slow discharge rates. Under any standard, this does not constitute discharging at a reasonable pace.

B. A Lack of Services and a Flawed Discharge and Transition Planning Process Cause Unnecessary Institutionalization at CVTC and the Other Training Centers

Our experts identified two primary reasons why so few individuals are discharged from CVTC, and the other training centers, into the community. First, the Commonwealth has failed to develop sufficient community-based services, particularly for individuals with complex needs. Second, the Commonwealth's process for assessing and transitioning individuals into the community is flawed, creating unreasonable barriers to discharge.

1. The Commonwealth's Failure to Develop Sufficient Community Services is a Barrier to the Discharge of Individuals at CVTC and the Other Training Centers Who Could Be Served in More Integrated Settings

The lack of sufficient services in the community constitutes one of the primary barriers to discharging individuals from CVTC and other training centers. The Commonwealth already provides the types of services that individuals at CVTC would need to live successfully in the community. *See supra*. However, existing community services are inadequate and not available in sufficient supply. The Commonwealth should expand existing community programs that

¹⁰ At least one of these discharges was made to another training center.

already provide effective services and reject dated models that do not provide opportunities for full integration and self-determination. Community provider agencies have both the capacity and the willingness to develop additional services for individuals at CVTC.

First, the Commonwealth needs additional waiver slots to serve individuals who can be discharged from CVTC and other training centers. The Commonwealth has acknowledged the need for additional waiver slots. See Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010. But few slots are available, and none are specifically designated for individuals leaving the training centers. When a waiver slot becomes available, one of the now 3,000 individuals on the “urgent” wait list – who generally are individuals in the community experiencing crises that put them at risk of entering an institutional setting¹¹ – generally receives it, while individuals at CVTC or other training centers have lower priority. We understand that the Commonwealth makes waiver slots more readily available to those already in the community because it wishes to prevent further admissions. But the Commonwealth may not neglect the institutionalized population. Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 21 (holding that the State “cannot continue to [prevent admissions] by relegating institutionalized individuals to second-class status” and that the State’s aim cannot “be achieved by discriminating against individuals who have equal rights to community support”). A sufficient number of additional slots, beyond the 275 in the current budget proposal and even beyond the 400 that the Commonwealth has said are the minimum required to address the waitlist, should be allocated to ensure that the institutionalized population is discharged at a reasonable pace.

The Commonwealth continues to direct resources to institutions at the expense of community-based programs, particularly as it underfunds its community-based waiver program. On average, it spends almost \$120,000 more per year to serve a person confined to CVTC than in the community using a waiver. Virginia could serve nearly three people in the community for each person in a training center. Even individuals with significant medical needs can be served in the community at approximately half the cost of a training center (\$92,000). The provision of community-based services to an individual with the most complex medical and/or behavioral needs, including services 24 hours a day, seven days a week, still costs \$64,000 less per year than confining the same individual to a training center.

At the same time that the Commonwealth fails to allocate more resources to community-based services, it has failed to use a large number of slots made available through the Money Follows the Person (“MFP”) program, which is specifically aimed at facilitating discharge from large institutions like CVTC and benefits from a higher rate of federal matching funds. Based on our experts’ record reviews, there are individuals currently at CVTC who could have been transitioned to the community using MFP program funds. However, while using MFP slots would be a start, more is required.

¹¹ The primary reasons for being placed on the “urgent” waitlist include an aging caregiver, a primary caregiver who can no longer care for the person, risk of abuse or neglect of the individual, or that the individual’s behavioral or physical care needs are putting persons at risk.

Finally, the design of the waiver program has made it difficult to develop sufficient services for individuals with complex needs. This is particularly important for individuals in CVTC and other training centers, many of whom have complex medical and/or behavioral needs and will need significant levels of supports in the community. The Commonwealth itself has acknowledged that “[t]he current ID Waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals with needs for high intensity services,” *Creating Opportunities: Plan for Advancing Community-Focused Services in Virginia*, at 25 (June 25, 2010), and that a more flexible waiver is necessary in order to serve individuals with complex needs, *Northern Virginia Training Center Diversion Pilot*, DBHDS, Nov. 1, 2010.¹²

Providers with whom we spoke confirmed this finding. Some providers indicated that the only way to develop adequate services for many people with complex physical, medical, or behavioral needs is for a CSB or private provider agency to create an ICF/DD facility, where funding is provided through an inclusive annual cost adjusted rate instead of through a waiver. This encourages the development of ICF/DD models that tend to be larger than other residential settings, have less community integration, are less homelike (e.g., large “exit” signs, crash bars on doors, and sometimes even nursing stations or staff offices), and provide less flexible programming. These homes are frequently more expensive than smaller, more integrated community residences or sponsored homes. Indeed, the Commonwealth’s own practices appear to prefer the smaller group or sponsored homes, as only a small number of recent CVTC discharges have been made to ICF/DD facilities. Still, this structural problem in the Commonwealth’s services improperly impedes individuals with more complex needs from living in community settings.

2. CVTC’s Inadequate Discharge Planning and Transition Process is a Barrier to the Discharge of Individuals at CVTC Who Could Be Served in More Integrated Settings

CVTC’s inadequate discharge planning and transition process is another significant barrier to serving individuals at CVTC in the most integrated setting appropriate to their needs. The discharge planning process fails to identify individuals who could be served in more integrated settings and creates unreasonable barriers to discharge that lead to an unacceptably slow discharge process. The process also fails to ensure that adequate information is provided to families about community-based options and fails to address families’ questions or concerns.

a. The Commonwealth’s Treatment and Discharge Planning Process Does not Meaningfully Identify People’s Needs, Barriers to Discharge, and Ways to Address Those Barriers

The purpose of the discharge planning process is to identify individuals’ needs, identify what services are necessary to meet those needs in a more integrated setting, and identify barriers

¹² Some aspects of the rate system that impede appropriate service development for this complex population include: very short time limits for crisis stabilization services, barriers to funding 24 hour nursing services or supervision, and difficulty obtaining environmental modifications, assistive technology, and adaptive equipment.

to discharge and strategies to address them. See *Kidd*, 501 F.3d at 358 (holding that the State “must determine the services required because it must insure that it meets the needs of the recipient and that it places the recipient in the least restrictive environment, as required by state and federal law”) (citing *Olmstead*, 527 U.S. 581). Discharge planning should start from the presumption that every individual is capable of being served in a more integrated setting. Planning for discharge must begin from the moment of admission and drive treatment planning. Discharge planning and treatment are inextricably tied; the purpose of treatment must be to address the underlying issues that led to the admission and to resolve barriers to discharge to a more integrated setting. We found that significant inadequacies in CVTC’s treatment and discharge planning processes are creating unnecessary barriers to discharging individuals at CVTC who could be served in more integrated settings.

First, we found that treatment plans frequently reflect an outdated view of disability, emphasizing individuals’ deficits rather than identifying needed supports. A team cannot make a determination of the most integrated setting appropriate for an individual unless they meaningfully understand the individual’s needs and the supports necessary to meet them. We also found that many treatment plans do not reflect individualized planning and are not integrated across disciplines. They do not describe the individual’s goals or personal preferences, including goals and desires regarding living in a more integrated setting.¹³ When goals are listed, they typically are framed as generic treatment goals. Likewise, the discharge planning process inappropriately focuses on the individual’s “readiness” rather than on identifying the community services necessary to meet the individual’s needs.

The monthly review meetings we attended did not include substantive discussion of discharge planning or barriers to placement, and monthly review summaries similarly failed to address these issues. Additionally, we found that the individuals and their families or guardians were not consistently present at monthly review meetings.¹⁴ At least two individuals – FF and GG – did not attend their monthly review meetings during our visit. Further, when individuals were present at meetings that we attended, no effort was made to engage them actively in their treatment.

Many of the treatment plans that our expert reviewed failed to provide adequate opportunities to engage in activities aimed at facilitating independence and preventing the regression of skills while the individual is institutionalized.¹⁵ We observed individuals who did

¹³ In addition, on our tours in 2008-09, we found that CVTC failed to provide individuals with appropriate communication services, hindering their ability to express personal goals and preferences and to participate meaningfully in their treatment and discharge, and also creating barriers to community integration. That review revealed that many individuals with significant communication impairments did not have formal communication goals and programs and that CVTC’s speech and language professional resources were inadequate. This deficiency also has implications for individuals’ ability to participate in the discharge planning process and to provide input regarding preferred placements in the community.

¹⁴ We use the term “guardian” loosely to apply to the legal guardian or to the “Legally Authorized Representative.”

¹⁵ Federal regulations require that:

not appear to be meaningfully engaged in active treatment, and reviewed individual schedules that included minimal meaningful activities, at best. During our visit, CVTC staff reported that the facility has an expectation that all individuals will participate in four hours of day programming and in two hours of recreation or community activities each day. Our review revealed that this minimum expectation was not met for a significant number of individuals. We also found that only a small number of individuals were actually engaged in meaningful work. For instance, at the time of our visit staff reported that only a total of 42 individuals received pay for work and that there was no wait list for participating in work opportunities. This suggests that CVTC is not actively promoting work opportunities or seeking to ensure that individuals are offered such opportunities.

Further, we found that CVTC's process for determining the appropriateness of community placement, as set forth in written policy and described by staff, is inconsistently applied.¹⁶ As a result, individuals who, according to CVTC's own criteria, are ready for discharge, remain unnecessarily institutionalized. Our expert reviewed cases in which individuals had identical scores on the "Protocol for Placement of Clients on the Ready for Discharge List," yet some were placed on the discharge ready list while others were not. In addition, the decision about placement reached on the "Training Center/Community Service Board Needs Upon Discharge Form" was inconsistent with the score on the Protocol. There was no evidence that Quality Assurance activities were in place to ensure consistency. The following examples are illustrative of the ambiguity inherent in determining which individuals are appropriate for discharge:

- HH was admitted to CVTC on April 16, 1956, at age 15. She has met the Discharge Ready Criteria since November 19, 2009; however, for reasons that are unclear, she was not placed on the Discharge Ready List.
- II was admitted on February 19, 1985, at age 36. A progress note on January 27, 2010, indicates that the team would agree that, with necessary supports, II would be able to function in a community setting. Two days later, on a separate form, II did not meet the discharge readiness criteria.

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a).

¹⁶ The practices that are in place at this facility are the same Policies and Procedures that are used at all of the Virginia training centers. The issues and barriers that were found at CVTC are likely to exist at the other training centers, as well.

- JJ was admitted to CVTC on August 13, 1962, at age 8. On March 16, 2010, she was listed as meeting the Discharge Ready Criteria, and the guardian agreed to consider community placement; however, she was not placed on the Discharge Ready list.

While clarifying the process is advisable, the fundamental point is that the overwhelming majority of individuals at CVTC can be served in the community, including those who have not been formally identified as eligible for discharge. See DAI, 653 F. Supp. 2d at 258-59 (holding that Olmstead does not “create a requirement that a plaintiff alleging discrimination under the ADA must present evidence that he or she has been assessed by a ‘treatment provider’ and found eligible to be served in a more integrated setting”); Joseph S. v. Hogan, 561 F. Supp. 2d 280, 291 (E.D.N.Y. 2008) (noting that “the language from Olmstead concerning determinations by ‘the State’s treatment professionals’ appears to be based on the particular facts of the case and not central to the Court’s holding”) (internal citation omitted); Frederick L., 157 F. Supp. 2d at 541 (“[The court]do[es] not read Olmstead to require a formal ‘recommendation’ for community placement.”). Indeed, “Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities.” Id. at 540. See also DAI, 653 F. Supp. 2d at 259; Long v. Benson, No. 08-cv-26 (RH/WCS), 2008 WL 4571905, at *2 (N.D. Fla. Oct. 14, 2008) (noting that the State “cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community”).

b. CVTC Staff are Not Adequately Knowledgeable of Available Community Services and Do Not Sufficiently Coordinate with Providers

CVTC staff lack knowledge of community services and fail to coordinate with community providers. As a result, CVTC staff do not have the information they need to be able to make recommendations about how an individual’s needs could be met in a more integrated setting, to present families with specific proposals for community residences and services, or to answer families’ questions about community living. Cf. 28 C.F.R. pt. 35, App. A, p.450 (1998) (requiring an individual to have an “option of declining to accept a *particular* accommodation”) (emphasis added). CVTC staff often fail to explain even the types of services available in the community or the benefits of community living, though such a discussion “could make a substantial difference in the number of referrals for placement.” Messier v. Southbury Training Sch., 562 F. Supp. 2d 294, 338 (D. Conn. 2008).

The lack of coordination between CVTC staff and community providers contributes to the long delays in the transition from CVTC to the community. Providers do not have sufficient information about the needs of people at CVTC to develop services for them. Moreover, CVTC staff fail to utilize community providers as resources to educate individuals and their families about community living, such as having providers speak with them, coordinating visits for individuals considering community placement and their families, and facilitating conversations with individuals currently living in the community and their families. Providers want to be more involved in the service development and transition planning process and are more effective when they are.

We identified individuals for whom discharge took many months, even after a provider and a residence were selected. Several people are still at CVTC despite a provider and residence being selected more than two years ago, and despite guardian approval. The following examples illustrate a pattern of CVTC failing to make meaningful efforts to coordinate discharge, even where the individual has been identified as discharge-eligible and the guardian is in agreement:

- KK was admitted to CVTC on August 30, 1962, at age five. KK met the Discharge Readiness Criteria in May 2006 after the guardian agreed to support placement in April 2006. KK was placed on the Discharge Ready List on June 30, 2006. After three years of being “discharge ready” but not discharged, in May 2009, the guardian changed her mind about community placement. There was no evidence that the team addressed the guardian’s concerns regarding how KK’s health needs would be met in the community.
- LL was admitted to CVTC on October 12, 1959, at age six. He was listed as ready for discharge on June 12, 2007, and also had guardian approval. He was placed on the Discharge Ready List on November 2, 2007. LL’s residential placement has been delayed four times. As of May 2010, he continued to meet the criteria in the placement protocol, including the fact that he can participate in discharge planning. There are no funds available for needed adaptive equipment, so the CSB Case Manager is looking for grants to fund this item. There was no indication that the team considered the Money Follows the Person program that provides funds for start-up services.
- MM was admitted to CVTC on March 1, 1972, at age 12. She was placed on the Discharge Ready List in April 2006 with an indication that the family was in support of discharge. The State form indicated that in March 2008 “nothing is available at this time.” A State form on June 9, 2009, indicates “Nothing available at this time.” The record does not demonstrate any efforts to make something available.

C. Individuals with Intellectual and Developmental Disabilities Currently Being Served in the Community Are At Risk of Unnecessary Institutionalization

The ADA’s integration mandate applies both to people who are currently institutionalized and to people who are at risk of unnecessary institutionalization. See Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Okla. Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same); Helen L., 46 F.3d at 325 (holding that the ADA was offended where a person with disabilities was offered personal care services in an institutional setting but not at home). We found that individuals in the community are at risk of unnecessary and costly institutionalization because of the Commonwealth’s failure to provide sufficient community-based services. As Virginia discharges individuals from the training centers, as discussed above, it must redirect expenditures from costly institutional care to address these deficiencies in community services.

More than 6,000 individuals are on a waitlist for services in the community. Nearly 3,000 of those individuals are on the “urgent” list, meaning that they are in situations that place them at significant risk of institutionalization. See fn 11. Some of these individuals have been, and will continue to be, forced into institutions when a crisis arises while they wait for community services. As evidence of this, CVTC has had nearly as many admissions as it has had discharges over the last several years. See supra.

An inadequate number of waiver slots and the inflexibility of the waiver, particularly for individuals with complex needs, place individuals in the community at risk of unnecessary institutionalization. The Commonwealth admits that “[w]ithout significant changes to [the] waiver program’s services, payments rates, and structure, little more can be done to divert admissions to training centers for the most medically fragile and behaviorally challenging individuals.” Northern Virginia Training Center Diversion Pilot, DBHDS, at 11, Nov. 1, 2010; *id.* at 10 (“The ability of CSBs to divert an admission to [a] training center can be limited because of insufficient resources to purchase care in the community.”). The Commonwealth must expand slots to address the needs of individuals who face the real threat of unnecessary institutionalization. The Commonwealth’s own reports recommend between 400¹⁷ and 1,000 new slots each year over the next several years to address the waitlist alone. *Id.* at 9; *The Cost and Feasibility of Alternatives to the State’s Five Mental Retardation Training Centers*, at 4, 18 (2005). The current proposal of 275 waiver slots, while commendable, is far from adequate.

The Commonwealth’s lack of capacity places individuals at risk of unnecessary institutionalization. The number of short term admissions for crisis services underscores the gap in Virginia’s system.

We found that a primary cause of admissions to CVTC is the lack of crisis services for individuals with acute medical or behavioral issues. The Commonwealth recognizes that “additional crisis intervention and crisis response resources are needed to divert behavioral crisis admissions to training centers,” Northern Virginia Training Center Diversion Pilot, DBHDS, at 6, Nov. 1, 2010, and that “[t]here is a documented need for additional crisis intervention and crisis stabilization services,” including to prevent admissions to the training centers or other forms of institutionalization, *id.* at 8. Respite services are also essential to diverting unnecessary admissions. A shortage of available respite services “may create situations where individuals have no choice but to be admitted” to a training center for respite care. *Id.* at 10. The Commonwealth’s current budget proposal to significantly cut respite care will make it more difficult for families to keep their loved ones at home and in the community.¹⁸

...

In summary, the Commonwealth violates the ADA by unnecessarily institutionalizing individuals at CVTC and other training centers who could be served in the community and by placing individuals currently in the community at risk of unnecessary institutionalization.

¹⁷ An increase of 400 slots per year averages to just ten slots per CSB, or less than one per month per CSB.

¹⁸ Supported employment and other integrated day activities can also help prevent unnecessary institutionalization by helping individuals build a natural support system and by minimizing boredom and feelings of isolation that can contribute to behaviors that require crisis responses. Moreover, meaningful day activities, including supported employment, help individuals pursue their preferences and goals and feel challenged and stimulated. As discussed above, the State appears to be overly reliant on segregated sheltered workshops and day programs that offer little opportunity for real community integration, even though the State also offers more integrated supported employment opportunities.

Individuals suffer harm and are placed at risk of harm while needlessly institutionalized. The Commonwealth has failed to ensure an adequate supply of community-based services, particularly for individuals with complex needs, necessary for the discharge of individuals from the training centers and for the prevention of unnecessary admissions of individuals waiting for services in the community. Moreover, the rate of discharge of individuals from CVTC and other training centers into the community is far too slow, caused in significant part by a flawed discharge planning process and the lack of sufficient community-based alternatives. The Commonwealth's violations of the ADA come at a huge financial cost to all of its citizens.

V. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of both individuals in CVTC and, where appropriate, other training centers, and those at risk of being institutionalized at CVTC and other training centers, the Commonwealth should promptly implement the minimum remedial measures set forth below:

A. Serving Individuals with Intellectual and Developmental Disabilities in the Community

The Commonwealth must increase community capacity by allotting additional waivers and expanding community services to serve individuals in or at risk of entering the training centers. A sufficient number of waivers – far more than what the Commonwealth has currently budgeted – must be available to address both individuals confined to the training centers and those on the waitlist in the community. The Commonwealth should also take full advantage of opportunities available to it, including the Money Follows the Person program, to develop services for individuals being discharged from CVTC and the other training centers. As the State downsizes its institutional population, the State should realign its investment in services for individuals with intellectual and developmental disabilities away from institutions to prioritize community-based services.

As a means of preventing institutionalization, the Commonwealth should develop crisis services, preserve the respite services it has been providing, and provide integrated day services, including supported employment. The Commonwealth should move away from its reliance on sheltered workshops.

Virginia should make modifications to its Medicaid waivers or explore the development of additional waivers to facilitate the development of integrated and individualized community services for people with complex physical, medical, and behavioral needs. New targeted waivers for specialty populations could also be developed.

The Commonwealth should ensure that its quality management systems are sufficient to reliably assess the adequacy and safety of treatment and services provided by community providers, the CSBs, and CVTC. The systems must be able to timely detect deficiencies, verify implementation of prompt corrective action, identify areas warranting programmatic improvement, and foster implementation of programmatic improvement.

B. Discharging Individuals from CVTC and the Other Training Centers

The Commonwealth must implement a clear plan to accelerate the pace of transitions to more integrated community-based settings. The Commonwealth must overcome what has become an institutional bias in its system.

Discharge planning must begin at the time of an individual's admission. The process should be improved and simplified and should focus on needed services. Rather than determining whether an individual is "ready" for discharge, the Commonwealth must focus on which services each individual will require in the community and should begin constructing a plan for providing such services and facilitating discharge. The default cannot be institutionalization. The discharge and transition plan should include the individual's preferences, a discussion of how the individual will access services, and a plan on how to coordinate care among multiple providers, if applicable.

Assessment teams must become knowledgeable about community living options and services. During the treatment planning process and in implementing individual treatment plans, the Commonwealth should ensure that barriers to discharge are identified and addressed and, for individuals with a history of re-admission, that factors that led to re-admission are also analyzed and addressed. Treatment planning should be individualized, person-centered, and multidisciplinary, and it should include the individual and his family.

In order to ensure an appropriate transition upon discharge, the Commonwealth should engage identified community providers in the discharge planning process as far in advance of discharge as possible and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. The community-based service agencies must be made full partners in the process of planning, developing, and preparing services for individuals, much like the CSBs are currently. The Commonwealth cannot rely primarily on staff at the institution. The Commonwealth must develop a process to clearly identify existing vacancies and explicitly review the physical or programmatic adjustments needed in those vacancies to match this capacity with an individual's needs as part of individualized discharge planning and to facilitate long-range planning. The Commonwealth should emphasize placement into smaller community homes in its transition planning.

The Commonwealth should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community as prescribed at discharge; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

If any individual or guardian opposes placement, the training center should document the steps taken to ensure that they are making an informed choice. The training centers should implement strategies to address individual concerns and objections to placement. Families should be provided the opportunity to visit potential placements and to speak with provider agency staff and with other families whose loved ones live in the community.

The Commonwealth should make all efforts to prevent new admissions to the training centers, including expanding community services necessary to divert individuals and stabilize them in the community. If an individual is referred to a training center, however, Virginia must ensure that, before an individual is admitted, the person receives a professionally-based assessment to ensure that admission is necessary and that the institution is the most integrated setting appropriate to serve the needs of that individual.

VI. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the Commonwealth in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the Commonwealth provides to persons with intellectual and developmental disabilities at CVTC and other settings across the Commonwealth. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations – which are not public documents – under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them.

We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to the ADA once we have determined that we cannot secure compliance voluntarily, 42 U.S.C. § 2000d-1, and pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them, 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with the Commonwealth and are confident that we will be able to do so. The Department of Justice attorney assigned to this investigation will be contacting the Commonwealth's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

s/Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc: James W. Stewart, III
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November 9, 2010

The Honorable Jack Markell
Governor of Delaware
Tatnall Building
Dover, DE 19901

RE: Investigation of the Delaware Psychiatric Center

Dear Governor Markell:

We write to report the findings of the Civil Rights Division's investigation of conditions and practices in the Delaware Psychiatric Center ("DPC") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and the State of Delaware's ("State") compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted in *Olmstead v. L.C.*, 527 U.S. 581 (1999), with respect to the services the State provides to persons with mental illness at DPC and other settings across the State.

CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights (including those under the ADA) of individuals with mental illness or developmental disabilities who are in public institutions. The Department also has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C. § 12133.

We notified then-Governor Ruth Ann Minner in November 2007 that we were initiating an investigation of conditions and practices at DPC pursuant to CRIPA. We conducted an on site inspection of DPC on April 28-May 2, 2008, with the assistance of expert consultants in the fields of psychiatry, psychology, psychiatric nursing, and fire safety. On July 29, 2010, we notified Delaware's Deputy Attorney General that we were also focusing our investigation on community integration issues in the State. On August 4-6, 2010, we toured DPC and the community to examine whether the State is serving individuals confined to DPC and statewide in the most integrated setting appropriate to their needs.

While on site, we interviewed persons in statewide leadership positions, hospital administrative staff, community providers of mental health services, and individuals confined to DPC, and examined the physical plant conditions throughout the facility. We also reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Our most recent tour included interviews with leadership from DPC and

the Delaware Department of Health and Social Services (“DDHSS”) and a review of hospital clinical records and administrative documents, as well as substantial interviews with providers who are responsible for community-based mental health services to individuals discharged from DPC or at risk of admission. In addition, we had an opportunity to interview consumers who are currently served by the community system. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tours with an extensive debriefing at which our consultants conveyed their initial impressions and concerns about the DPC to counsel, administrators, staff, and State officials.

Before discussing our findings, we wish to express our appreciation for the hospitality, cooperation, and professionalism of the statewide leadership and hospital staff and administrators throughout our investigation. We hope to continue to work with Delaware officials and the staff at DPC in the same cooperative manner going forward.

In accordance with our statutory requirements under CRIPA, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum steps necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). This letter also serves to provide you notice of your failure to comply with the ADA and of the steps you should take to voluntarily comply with the law. 42 U.S.C. § 2000d-1 (incorporated by 42 U.S.C. § 12133).

Specifically, we have concluded that the State’s current mental health system fails to provide services to individuals with mental illness in the most integrated setting appropriate to their needs, as required by the ADA. This has resulted in needless prolonged institutionalization of many individuals with disabilities in DPC who could be served in the community. It also has placed individuals currently in the community at risk of unnecessary institutionalization. Moreover, individuals confined to DPC not only are harmed by unnecessary and prolonged institutionalization itself, but they also suffer significant harm and risk of harm, in violation of the U.S. Constitution, due to numerous other deficient practices while at DPC, including: inadequate risk assessments; inadequate mental health treatment, especially the failure to provide appropriate behavioral interventions for individuals with identified risks; inadequate restraint and seclusion practices; inadequate investigations of serious incidents; and inadequate discharge planning/community integration to ensure individuals live in the most integrated setting. These deficiencies have contributed to the untimely deaths of individuals confined to DPC as well as led to other preventable illnesses, injuries, and harm from a variety of sources.

Delaware has been on notice of many of the findings we make in this letter. In November 2007 – shortly after we notified Delaware of our CRIPA investigation – the Delaware Department of Justice (“DDOJ”) initiated its own investigation to determine whether DPC had violated individuals’ statutory rights guaranteed by Delaware law. On March 7, 2008, the DDOJ issued its own findings citing significant deficiencies and concluded that numerous conditions, practices, acts, and failures to act by DPC administrators and staff resulted in systemic and pervasive violations of the state statutory civil rights of individuals confined to DPC, including: failure to develop appropriate treatment plans; failure to prepare adequate discharge plans; failure to ensure safety; physical and emotional abuse of individuals by staff; mistreatment of individuals by staff through inappropriate use of medications, isolation, and physical and chemical restraints; neglect of individuals by staff; failure to protect individuals from assaults by other patients; and failure to protect individuals from self-inflicted abuse due to inadequate

supervision and monitoring. In May 2008, the DPC entered into a memorandum of agreement with DDOJ to address these findings. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (“CMS”) has made similar findings.

Current Delaware leadership acknowledge and recognize that an effective remedy for unconstitutional conditions at DPC is inseparable from an effective effort to place in community settings all the individuals who are inappropriately institutionalized. Leadership from both DPC and the DDHSS acknowledge that Olmstead requires the delivery of public services in the least restrictive, most integrated settings appropriate to individuals served by the State’s mental health system and the freedom of these individuals from unwarranted institutional isolation. They recognize that any remedy that focuses merely on the conditions at DPC will direct resources away from building the necessary community capacity and toward a focus on DPC – an inequity that will only perpetuate the inappropriate and harmful institutionalization of Delaware citizens with mental disabilities.

We are, accordingly, encouraged by our meetings with current Delaware leadership, both at DPC and DDHSS, who acknowledged the problems and indicated a strong desire and interest in working with the United States Department of Justice (“USDOJ”) both in relation to our overall investigation and in working toward an amicable resolution.

We recognize that the current leadership of the DDHSS has been actively addressing many of the deficiencies at DPC since our initial 2008 tour. Though still problematic, these efforts have resulted in improvements in treatment planning, in reducing the dependence on inappropriate interventions such as seclusion and restraint, and in creating a shift toward developing person-centered recovery plans that reflect individuals’ personal goals. We are therefore encouraged that the DDHSS leadership both recognizes the continuing deficiencies at DPC and have a workable, and realistic vision, of the undertakings necessary to ensure that individuals are served in the most integrated setting while addressing the issues at DPC required to be kept individuals there safe.

I. BACKGROUND

Located in New Castle, Delaware, the DPC is the only public psychiatric hospital in Delaware for adults. The DPC is operated by the Delaware Division of Substance Abuse and Mental Health, and has a current capacity of 170 civil and 42 forensic beds. The hospital is divided into several separate units, based upon gender, diagnosis, age, and, in one unit,

involvement in the Delaware criminal justice system.¹ At the time of our most recent tour, DPC's civil census was 161.

II. FINDINGS

A. Delaware Is Violating the ADA By Failing to Serve Individuals with Mental Illness In The Most Integrated Setting

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing Title II,² and the Supreme Court's

¹ The separate units at the DPC are: (1) Kent-3, a 32-bed extended care unit serving individuals with serious psychiatric diagnoses; (2) Kent-2, a 45-bed unit for male and female adults with behavior problems; (3) Sussex-3, a 43-bed unit for aggressive males; (4) Sussex-2, a 45-bed long-term unit for males and females with mental illness; (5) Sussex-1, a 35-bed unit for male and female geriatric patients; and (6) Jane Mitchell, a 42-bed forensic psychiatric unit for males and females involved in the Delaware criminal justice system, including people charged with crimes and awaiting psychiatric evaluation, prisoners serving sentences in the Delaware Department of Corrections facilities, and individuals adjudicated as criminally insane.

² The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607. In so holding, the Court explained that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Id. It also recognized the harm caused by unnecessary institutionalization: “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” Id. at 601.³ As the Third Circuit Court of Appeals has made clear, the ADA “favor[s] integrated, community-based treatment over institutionalization.” Frederick L. v. Dept. of Public Welfare, 364 F.3d 497, 491-92 (3rd Cir. 2004).

1. Individuals Remain Unnecessarily and Inappropriately Institutionalized in DPC in Violation of the ADA

DPC is violating the ADA by unnecessarily institutionalizing individuals who are appropriate for community-based treatment. Olmstead, 527 U.S. at 607. Based on the information we reviewed during our tours of DPC, including our review of patient records and interviews with statewide leadership and hospital staff and administrators, it is clear that the vast majority of individuals confined to DPC could be—and have a right to be—living in community settings with appropriate services and supports. DPC staff has already determined that over 70 percent of the individuals being treated at DPC are clinically ready to leave the hospital and to be served in more integrated settings. The percentage of individuals ready for discharge likely is even higher, according to our experts, due to DPC’s inappropriate discharge assessment process, as discussed below. In fact, during an interview, the State’s Director of the Division of Substance Abuse and Mental Health Services (“DSAMHS”) acknowledged that “pretty much everyone at DPC would be appropriate for community placement.”

DPC maintains and keeps current a central roster, entitled “DPC Discharge Assessment,” which lists all individuals in DPC and their status with respect to discharge. This list indicates which individuals are ready for release and summarizes barriers to discharge.

³ Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”).

At the time of our August 2010 visit, approximately 85 individuals were designated as clinically ready to leave the hospital—either immediately or within a short time span—and to be served in more integrated settings. The most significant barriers to their discharge reflect not their individual needs but rather, the level of DDHSS resources and categorical restrictions on these funds.

As the State acknowledges:

The average length of stay at DPC for civil units should run from 3-6 months but due to lack of community based placements the average length of stay is approximately 3 years. As of February 2010, 71 individuals were ready to be discharged to supervised living in the community but were unable to be placed due to lack of funding for additional community based programs.

Delaware Memorandum of Agreement Compliance Committee Report, at 8 (February 2010).

These individuals, at minimum, remain institutionalized in the hospitals in violation of their rights under the ADA and Olmstead. A hospital, by definition, is a segregated setting, where individuals with mental illness are congregated together with little to no opportunity to interact with their non-disabled peers. 28 C.F.R. § 35.130(d), App. A. at 571 (an “integrated setting” “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible”). Individuals in DPC are deprived of many of the personal freedoms that citizens in the community enjoy. They live a regimented life tied to the needs of the institution, such as waking up and going to sleep at set hours, not being able to choose with whom they associate and live, having set mealtimes with little to no choice of content, and having limited to no contact with the community outside the four walls of the facility. Accord DAI v. Patterson, 653 F. Supp.2d 184, 200-207 (E.D.N.Y. 2009) (describing characteristics of institutions to include regimented daily activities, lack of privacy, and few choices). Yet the State continues to provide services to far too many individuals with disabilities in the most segregated setting imaginable—the hospital.

Our investigation shows that DPC’s discharge planning process is inadequate, causing individuals who could be served in the community to remain inappropriately and needlessly institutionalized and leading to individuals who are discharged being placed in more restrictive settings than appropriate to their needs in violation of the ADA.

DPC’s treatment professionals inappropriately assess an individual’s readiness for discharge in terms of “compliance” with a number of factors that are clearly hospital-focused and often irrelevant to community living, notably among them: unit routine, unit rules, privilege levels and participation in treatment mall activities/therapies. Tellingly with regard to the importance assigned to an individual’s functioning as a *patient*, DPC’s protocol for discharge readiness explicitly emphasizes “compliance,” but does not reference whether treatment at DPC has resolved the specific issues that caused an individual to be hospitalized in the first place. In contrast, effective discharge assessments focus on the individual’s specific capacities to function

in a more integrated setting and to meet the demands of community living. They also identify the supports and services necessary for the individual's successful community living.

DPC's inappropriate discharge assessment process has kept many individuals in DPC from receiving a treating professional's recommendation of community placement. Moreover, individuals who can show the level of hospital "compliance" required to be considered ready for discharge often continue to languish at DPC because their discharge planning process fails to identify the supports necessary to address barriers to discharge. The result is that individuals who could live in integrated community settings with appropriate supports remain at DPC because they have not received adequate assessments of the supports and services necessary to allow them to succeed in the community. Accord Frederick L. v. Dept. of Public Welfare, 157 F. Supp.2d 509, 540 (E.D. Pa. 2001) ("Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with disabilities."); DAI, 653 F. Supp.2d at 259 (same).

DPC's discharge planning process also fails to ensure that individuals are discharged to the most integrated setting appropriate to their needs. DPC has no clear criteria for determining the most integrated setting appropriate for an individual, and discharge teams often recommend discharging individuals to more restrictive settings than necessary. Specifically, our expert found that the default recommendation of most discharge teams was to discharge the individual to a group home without first examining whether that person could be served in a more integrated setting, like an apartment with supportive services. This problem is exacerbated by DPC discharge team's limited familiarity with community living options and services and their failure to engage community providers until after they have already made a decision about a placement for the individual being discharged.

2. Individuals in the Community are At Risk of Unnecessary Institutionalization in Violation of the ADA

The ADA's integration mandate not only applies to individuals who are currently institutionalized but also to individuals who are at risk of unnecessary institutionalization by the State's administration of its healthcare delivery system. See, Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995) (holding that the ADA was offended where a person with disabilities was offered personal care services in an institutional setting but not at home); Accord Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same). We found that individuals in the community are at risk of unnecessary hospitalization and placement in other institutions, such as privately-operated Institutions for Mental Disease (IMDs), because of the State's failure to provide sufficient community-based services, particularly crisis services. Individuals in the community in crisis have no choice but to go to local emergency rooms, where they are directed to DPC or IMDs. Our expert estimates, based on conversations with state officials, DPC personnel and community providers, that the State could dramatically reduce unnecessary admissions to DPC and IMDs, perhaps by as much as 50%, by expanding crisis services such as mobile crisis and crisis stabilization programs. Not

only would an expansion of such crisis services avoid unnecessary institutionalization, but it would lead to a significant cost savings for the State.

3. Expansion of Services Would Not Require A Fundamental Alteration Of Delaware's Community Service System

A state's obligation to provide services in the most integrated setting may be excused only where a state can prove that the relief sought would result in a "fundamental alteration" of the state's service system. Olmstead, 527 U.S. at 603-4. Because it is not a fundamental alteration to expand existing community programs to include currently institutionalized individuals, see, e.g., DAL, 653 F. Supp.2d at 305, Delaware cannot meet its burden of proving the fundamental alteration defense.⁴

Within their service array, Delaware's existing community system is already providing services such as Assertive Community Treatment programs ("ACT") and scattered site supported housing that are essential to achieving the requirements of Olmstead. Thus, in most respects, what is needed is not new to the system, but rather a phasing out of dated models to be consistent with appropriate practices and bringing to scale those community programs that are already providing effective integrating services. Accordingly, providing community services individuals in or at risk of entering DPC would work only a "reasonable modification" of the State's program. Olmstead, at 603.

The State already provides to individuals in the community services of the type the individuals in or at risk of entering the hospitals would need to live successfully in the community. Funded services include supported housing, crisis stabilization, substance abuse treatment, supported employment, peer support, mental health mobile crisis, transportation, psycho-social rehabilitation and more. But those services are inadequate to meet the needs of those individuals. We found existing community services to be inadequate and not available in sufficient supply to enable individuals who are currently inappropriately segregated in DPC to be discharged from that setting into the community and provided appropriate services there. As a direct result of Delaware's actions and inactions, state-funded community health service providers fail to provide adequate community services necessary to avoid needless institutionalization. For example, case managers' case loads have risen dramatically, rendering this core service unable to provide needed attention to each client. ACT teams have been reduced or diluted. Currently, there are no ACT teams specializing in co-occurring disorders for mentally ill persons with specialized needs. In addition, we found an inadequate crisis system, with too few mobile crisis teams and crisis stabilization programs spread out geographically throughout the State. The result is that individuals in crisis are now seen in DPC and local

⁴ Moreover, general allegations of short-term costs or budgetary constraints alone are insufficient to establish the defense. Pa. Prot. and Advocacy, 402 F.3d at 380; Frederick L., 364 F.3d at 495.

emergency rooms. There is also a shortage of residential services for individuals with mental illness, including an inadequate supply of integrated, permanent supported housing.

Other core community mental health programs are inadequate. Only some of the regional mental health centers operate residential programs and some of these have reduced services. Inadequate resources has limited mobile crisis and diversion programs. The result is that many individuals with severe mental illness are provided with insufficient supports to remain in the community and find themselves institutionalized or at risk of institutionalization.

Moreover, a state cannot prove this affirmative defense unless it can show that it has developed and is implementing a comprehensive and effective plan to move individuals with disabilities into the community, with any individuals waiting for services moving at a reasonable pace. Olmstead, 527 U.S. at 584; Frederick L. v. Dept. of Public Welfare, 422 F.3d 151 (3rd Cir. 2005) (“[A] comprehensive working plan is a necessary component of a successful ‘fundamental alteration’ defense.”); Pa. Prot. and Advocacy, Inc. v. Dept. of Public Welfare, 402 F.3d 374, 381 (3rd Cir. 2005) (“[T]he only sensible reading of the integration mandate consistent with the Court’s Olmstead opinion allows for a fundamental alteration defense only if the accused agency has developed and implemented a plan to come into compliance with the ADA.”). Delaware’s own admission that individuals languish for years longer than necessary at DPC, Delaware Memorandum of Agreement Compliance committee Report at 8, is evidence that it is not implementing a working Olmstead plan, with a waiting list moving at a reasonable pace. Accord DAI, 563 F. Supp.2d at 302-305.

Both Delaware leadership and community providers report a positive cultural change within DPC and DDHSS, and a new emphasis on community integration that could move Delaware’s public mental health system substantially toward compliance with ADA. However, notwithstanding this stated goal, the State has failed to provide sufficient community-based services to ensure that Delaware citizens with mental illness are served in the most integrated setting appropriate to their needs in violation of the ADA.

B. Prolonged Institutionalization Has Resulted in Unconstitutional Harms

Unnecessary segregation not only violates individuals’ rights under the ADA but also causes irreparable harm:

[O]ne of the harms of long-term institutionalization is that it instills ‘learned helplessness,’ making it difficult for some who have been institutionalized to move to more independent settings.

Disability Advocates, Inc., 598 F. Supp.2d at 320; Accord Marlo M. v. Cansler, 679 F. Supp.2d 638 (E.D.N.C. 2010) (finding unnecessary institutionalization leads to regressive consequences that cause irreparable harm; Long v. Benson, 2010 WL 2500349 (11th Cir. Jun 22, 2010) (affirming district court’s granting of preliminary injunction based on irreparable injury of unnecessary institutionalization).

States also have a constitutional obligation to provide adequate care and keep individuals safe while they are confined in institutions. The Fourteenth Amendment's due process clause requires a state mental health care facility to provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests." Youngberg v. Romeo, 457 U.S. 307, 315, 324 (1982). A state psychiatric hospital is constitutionally required to provide reasonable, adequate mental health treatment. See, Torisky v. Schweiker, 446 F.3d 438, 448 (3d Cir. 2006) (concluding that plaintiffs may be able to prove that they were deprived of their constitutional liberty interest and of Youngberg's duty of care and protection when they were transferred, against their will, to an institution inappropriate to serve their needs); Scott v. Plante, 691 F.2d 634, 636 (3d Cir. 1982) (affirming that individuals in state psychiatric hospitals have a right to adequate treatment, a right to reasonable care, and a right to be free from unreasonably restrictive confinement); Fournier v. Corzine, No. 07-1212, 2007 WL 2159584, at *11 (D.N.J. 2007) ("The Fourteenth Amendment Due Process Clause requires state officials to provide civilly committed persons ... with access to mental health treatment that gives them a realistic opportunity to be cured or to improve the mental condition for which they were confined."). Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23.

Unnecessary institutionalization, particularly when protracted, is itself an irreparable harm. It creates learned helplessness and reinforces institutional behaviors, and the congregate environment often exacerbates the very behaviors for which individuals were admitted in the first place. The harm of unnecessary institutionalization in DPC is compounded by—and contributes to—the unconstitutional and life-threatening conditions at the hospital.⁵ These conditions underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements. The Constitution requires that Delaware provide reasonable care and safety to individuals in DPC. The State fails to meet this obligation.

1. DPC Fails to Provide Reasonable Safety in DPC in Violation of the Constitution

Individuals in DPC have the constitutional right to live in reasonably safe conditions. See, Youngberg, 457 U.S. at 315. DPC is failing to ensure that they are reasonably free from harm or unnecessary risk of harm.

Confinement in an institution leaves individuals vulnerable to harm and abuse. Unnecessary confinement of individuals who are ready for discharge diverts staff resources that should be focused on individuals with the most significant clinical needs and creates congregate conditions that increase risks of harm and can exacerbate maladaptive behaviors. On our most recent visit, we found several instances of individuals who were awaiting placement who had

⁵ As noted previously, there have been substantial improvements in the past year under new DPC leadership.

been victims of patient-on-patient abuse. While most of these incidents appeared to be a result of congregate life, where people with various levels of adjustment live in close quarters, many of the risk factors for the harms now occurring would dissolve if individuals were not left languishing in DPC while awaiting discharge to the community.

On our earlier visit, we found that DPC staff failed to identify and provide appropriate treatment and supervision for individuals engaged in the very behaviors which led to their admission to DPC, including suicide attempts, self-injury, and aggression. Initial suicide and violence risk assessments often are not completed at all or, if they are completed, lack critical information. This is a violation of individuals' constitutional rights. Youngberg, 457 U.S. at 315. Reassessments are similarly inadequate and untimely. Even when risks are identified, treatment plans fail to include appropriate behavioral interventions to address those risks and DPC staff fail to appropriately supervise individuals at high risk of harm, again in violation of the Constitution. Id. DPC's failure to identify and provide appropriate interventions and supervision places individuals at risk of harming themselves or others, as illustrated by the serious injuries and deaths of individuals described below:

- On April 6, 2009, C.X.⁶ collapsed in the hallway of her unit at DPC. She lay there for several minutes without moving while staff walked past her without checking on her. Even more troubling, a DPC staff member pointed out C.X. to a nurse, who replied that C.X. "always does that" and did not respond further. By the time staff did check on C.X., she was unresponsive, and attempts to revive her failed.⁷ This utter failure to provide care amounts to deliberate indifference and is an egregious violation of C.X.'s constitutional rights.
- On January 31, 2009, N.T. committed suicide by hanging herself with a bedspread. She was found by the staff member assigned to check her every 15 minutes. Despite her documented history of suicidal ideation and multiple serious episodes of self-harm, there had been no significant change to her treatment plan. In fact, N.T. herself warned DPC staff that its response to these incidents – placing N.T. temporarily on heightened observation – would not keep her safe. DPC's failure to provide appropriate treatment and supervision violated N.T.'s constitutional rights.

⁶ To protect individuals' identities, we use fictitious initials throughout this letter. We will separately transmit to counsel a schedule cross-referencing the fictitious initials with the individuals' names.

⁷ To its credit, DPC reported two nurses involved in this incident to the state nursing licensing board.

- U.L. was assaulted by another individual on the unit while she was on 1:1 close observation status. After the assault, she attempted suicide by hanging herself. U.L.'s risk for self-injurious behavior and victimization was well-documented. Her treatment plan, however, contained only vague goals relating to her self-injurious behavior, for example, that she will "remain free of suicidal gestures, attempts or behaviors" and "will communicate thoughts of self-harm as experienced to others who can help" and contained no steps to help her avoid victimization. Indeed, even staff whose job was to keep U.L. safe from others failed to provide that protection. DPC's failure to provide appropriate treatment and protection from harm violated her constitutional rights.
- On August 27, 2009, C.P. died after swallowing a half-gallon of cleaning fluid that was left in an unlocked supply closet. C.P. was able to gain access to the cleaning fluid without being observed by staff. Despite his documented history of attempting to ingest dangerous chemicals while at DPC, including chlorine bleach, there had been no significant change in his treatment plan to address this behavior and to keep him safe while confined at DPC. Again, DPC's failure to provide appropriate treatment and supervision violated C.P.'s constitutional rights and was a direct cause of his death.

Moreover, DPC's incident, risk, and quality management systems fail to manage the risks of abuse, neglect, physical harm, self-injurious behavior, and suicide, in violation of the Constitution. Youngberg, 457 U.S. at 315-16. Internal investigations into abuse, neglect, and suspicious injuries in the hospitals systematically fail to include information that is necessary to finding the root cause of an incident or to delve sufficiently into the possible origins of incidents. DPC fails to reliably and adequately analyze the data that they collect, rendering State and hospital officials incapable of recognizing adverse trends and correcting issues that directly lead to harm and death of individuals confined to DPC. And, for risks that they do identify, DPC fails to implement corrective and preventive actions in a timely manner, if at all, or to monitor those actions as necessary to reduce or eliminate the risk of harm.

DPC's failure to appropriately identify and manage these risks substantially increases the chances that individuals, including those who are awaiting discharge and no longer should even be in DPC, will be subjected to harm. In addition, DPC's failure to provide a reasonably safe living environment compromises the other care and treatment provided to individuals, prolongs the duration of hospitalizations, leads to frequent and unnecessary re-hospitalizations, and delays the movement of individuals to more integrated settings, in violation of both the constitution and Olmstead.

2. DPC Improperly Restrains and Secludes Individuals in Violation of Their Constitutional Rights

The right to be free from undue body restraint is the core of the liberty interest protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Seclusion and restraint are emergency responses to failures in treatment; they are not treatment interventions that address the underlying behaviors for which the individual was hospitalized. To rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior, violates the Fourteenth Amendment. Kirsch v. Thompson, 717 F. Supp. 1077, 1080-1081 (E.D. Pa. 1988) (holding that plaintiff's Fourteenth Amendment rights were violated when he was restrained at a state hospital for approximately three years in four-point physical restraints). Seclusion and restraint should be used only as a last resort. Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990), cert. denied, 498 U.S. 951 (1990); Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980) (holding that the Constitution minimally requires that alternatives be considered before putting an individual in restraints)..

We found that DPC uses restraints too frequently, and keeps individuals in restraints for excessive periods of time in violation of their constitutional rights.⁸ Youngberg, 457 U.S. at 316. Further, DPC uses inappropriate criteria to place individuals in restraints, inappropriate criteria to release individuals from restraints, and does not monitor individuals adequately while they remain in restraints. Finally, in some instances, DPC pre-planned the use of restraints. We believe that DPC's improper use of seclusion and restraint not only violates individuals' constitutional rights, but also is a symptom of its inadequate assessment and treatment of risks, as described above.

Below are examples of individuals being subjected to undue bodily restraint:

- F.X. was placed in restraints at least 26 times and into seclusion at least 13 times over a 13-month period. A review of his record indicates DPC used, or threatened to use, restraint and seclusion as a form of punishment instead of exploring treatment interventions to address F.X.'s history of aggression.
- K.O. was placed in restraints over 40 times over a 13-month period. Our review of her record indicated some instances where she was placed in restraints more than once in a single day. Her record indicated no attempt to explore less intrusive approaches.

⁸ As noted, we understand that there has been a reduction in appropriate usage of seclusion and restraint in the past year under new DPC leadership.

3. DPC Unconstitutionally Abuses Individuals

Individuals' constitutional liberty interests in reasonable protection from harm in mental health hospitals includes protection from abuse by staff. United States v. Disc, 763 F.2d 586,589 (3d Cir. 1985). The very nature of institutional settings—that staff are in a position of authority with complete control over every aspect of people's lives and that institutionalized individuals are isolated from the outside world—creates a high risk for abuse and neglect. Individuals in DPC, including the vast majority of people who are awaiting discharge to the community, are subjected to this significant risk of abuse. In our review of DPC documents and records, we noted numerous incidents in which staff abused individuals, either verbally or physically.⁹

Examples include:

- A DPC employee hit K.X. on his head with a set of keys, resulting in a laceration that required sutures and staples to close.
- A DPC employee assigned to care for K.Q. on 1:1 precautions hit him on the head.
- A DPC employee assigned to take care of N.X. on 1:1 precautions sexually assaulted her.

4. DPC's Unconstitutional Conditions are Exacerbated By Its Inadequate Investigation of Serious Incidents

We found that DPC does not consistently investigate injuries to individuals confined there and, when it does investigations, critical features, such as witness interviews and medical documentation, are often lacking. We found no evidence that DPC uses the historical data from investigations to: (1) identify actual or potential risks of harm; (2) develop timely and appropriate interventions designed to minimize or eliminate risks of harm; or (3) monitor the efficacy of interventions used and modify them as necessary in response to further data, as required by the constitution.

We reviewed 63 reports of injuries occurring while the individual was on 1:1 or 2:1 close observation during the fifteen-month time period between January 2007 and March 2008. The majority of those incidents were not properly or fully investigated. For example, there was only occasional evidence that staff were interviewed and that records were reviewed. In some reports, only the involved individuals were interviewed, and when they were, the results of the interview

⁹ The DDOJ report included additional examples of staff abuse, including multiple sexual assaults of a patient by a DPC worker for which the worker was arrested and prosecuted.

were in some cases dismissed as unreliable due to the individual's mental status. Findings from patient interviews should not be wholly dismissed because of the individual's mental status; all staff and individuals with direct as well as indirect information about the event should be interviewed; and records should be reviewed.

In addition, the reports reflected an inadequate and inconsistent investigative methodology that is ineffective to protect individuals' constitutional right to a safety, because the circumstances that caused harm to one or more individuals are not understood and remedied. For example, when nursing interventions were documented, the documentation typically reflected that the person willfully did something wrong despite "re-direction." There was no evidence in the records of interactions or activities implemented to prevent the circumstances that might have caused or contributed to the individual's behavior.

The fact that so many injuries were sustained by individuals who were placed on 1:1 close observation to keep them safe, makes DPC's failure to adequately investigate serious incidents more alarming. The failure of DPC to have a transparent and effective system for identifying, tracking, and correcting problems, adverse events, faulty treatment, and staff adherence to policies and procedures, increases the actual and potential harm due to prolonged institutionalization.

As indicated, the constitutional violations at DPC pose a serious threat to the life, health, and safety of individuals who are confined there. They make more urgent the need to move individuals in DPC out of inappropriate placements in the hospital to more appropriate integrated settings in the community.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of both individuals in Delaware Psychiatric Hospital ("DPC") and those at risk of being institutionalized at DPC, the State should promptly implement the minimum remedial measures set forth below:

A. Serving Individuals with Mental Illness in the Most Integrated Setting

In order to remedy its failure to serve individuals in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulation, Delaware should take the following steps:

Delaware should ensure that, before an individual is admitted to DPC, the individual receives a professionally-based assessment to ensure that admission to DPC is necessary and that DPC is the most integrated setting appropriate to serve the needs of that individual. Expanding Delaware's community-based crisis system is essential to diverting unnecessary admissions to DPC (and other institutions).

For those individuals for whom DPC is determined to be the most integrated setting appropriate to their needs, the State should revise its treatment and discharge planning process to focus, from the time of admission, on the appropriate discharge of individuals residing at DPC. During the treatment planning process and in implementing individual treatment plans, DPC should ensure that barriers to discharge are identified and addressed, and for individuals with a history of re-admission, that factors that led to re-admission are also analyzed and addressed.

Discharge planning should begin at the time of an individual's admission to DPC. The State should revise its discharge assessment process to focus on individuals' capacities to function in a more integrated setting and meet the demands of community living—not their compliance with hospital regimens—and identify the services and supports necessary for successful community living. DPC's assessment teams should become knowledgeable about community living options and services and should engage community providers early in the discharge planning process. Discharge plans should set forth in reasonable detail a written transition plan specifying the particular supports and services that each individual will or may need in order to safely and successfully transition to and live in the community. The plan should include, at a minimum: the individual's (and where relevant, family's) preferences for care; a discussion of how the individual (and where relevant, family) will access and pay for such services; the names and positions of those responsible for the individual's care, making appropriate referrals when necessary; a plan on how to coordinate care among multiple providers, if applicable; identification of the individual's specific needs after discharge; a discussion of how the individual (and, where relevant, family) need to prepare for discharge; and corresponding time frames for completion of needed steps to effect transition.

In order to ensure an appropriate transition upon discharge, DPC should engage identified community providers in the discharge planning process as far in advance of discharge as possible, and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. DPC should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community as prescribed at discharge; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

B. Serving Persons With Mental Illness In The Community

To prevent the unnecessary institutionalization of individuals with mental illness, the State should develop and arrange for sufficient supports and services to ensure that those individuals are served in the most integrated setting appropriate to their needs. This included, but is not limited to, defining the target population for community services to include all individuals who are in or at risk of entering DPC or other restrictive institutional settings. To promote the community integration of the target population, the State should increase community capacity by expanding the following services to the target population: assertive community treatment (“ACT”), supported housing, supported employment, family and peer support services, community crisis services, and appropriate case management services.

The State should ensure that the ACT services deliver comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work and operate with fidelity to the Dartmouth ACT model. The ACT services should be provided through a multidisciplinary team with services that are individualized and customized, and address the constantly changing needs of the individual over time. ACT teams should have the full array of staff on each their team, including at least one peer specialist, necessary to provide the following services: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live successfully in the community. ACT teams should provide crisis services, including helping individuals increase their ability to recognize and deal with situations that may otherwise result in hospitalization, increase and improve their network of community and natural supports, and increase and improve their use of those supports for crisis prevention. ACT teams should provide services to promote the successful retention of housing, including peer support and services designed to improve daily living skills, socialization, and illness self-management. ACT teams that serve individuals with co-occurring substance abuse disorders should provide substance abuse treatment and referral services to those individuals. Such ACT teams should include on their staff a clinician with substance abuse expertise. ACT services should be available 24 hours per day, 7 days per week. Finally, the number of individuals served by an ACT team should be no more than 10 individuals per ACT team member.

The State should provide supported housing to the target population in the form of housing, housing subsidies, or housing vouchers. Supported housing provides individuals with their own leased apartments or home, where they can live alone or with a roommate of their choosing. The housing is permanent (e.g., not time-limited) and is not contingent upon participation in treatment. The supported housing provided by the State should be scattered-site, meaning in an apartment building or housing complex in which no more than ten percent of the units are occupied by individuals with a disability. Personal care homes, group homes, and community living homes do not constitute supported housing. The State should ensure that individuals in supportive housing have access to a comprehensive array of services and supports necessary to ensure successful tenancy and to support the person's recovery and engagement in community life, including through ACT services.

The State should provide supported employment services to the target population through supported employment programs, the access to which is facilitated by ACT teams. Supported employment services should assist individuals in finding competitive employment in an integrated setting based on the individual's strengths and interests. Support employment programs assist individuals in identifying vocational interests and applying to jobs and should provide services to support the individual's successful employment, including social skills training, job coaching, benefits counseling, and transportation. Supported employment services are integrated with the individual's mental health treatment. Enrollment in congregative day programs should not constitute supported employment.

The State should provide family and peer support services. Family support services are designed to educate and train an individual's family to better support the individual's treatment and successful community living, including by educating family members about the individual's mental illness, and about strategies for assisting with treatment and recognizing and addressing crises. Peer support services are delivered by peers to improve an individual's community living

skills, including their ability to cope with and manage symptoms and to develop and utilize existing community supports. Peer support services may be provided by face-to-face or telephone contact and include outreach, wellness training, and training in self-advocacy.

The State should develop a statewide crisis system that includes a crisis call center, mobile crisis services, regional crisis centers, crisis stabilization programs, and crisis apartments. The Crisis Call Center is staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile teams. The State should provide mobile crisis services to respond to crises anywhere in the community (e.g., homes, schools, or hospital emergency rooms) 24 hours per day, 7 days per week. The services are provided by clinical staff members (including staff with substance abuse expertise) and by peers. The State should also develop regional walk-in crisis centers that are clinically staffed 24 hours per day, 7 days a week, to receive individuals in crisis and to assess and provide them services and support, including evaluation, observation, triage, and referrals. The State should provide crisis stabilization programs that are community-based residential services operated by community providers that provide psychiatric stabilization and detoxification services as an alternative to psychiatric hospitalization. Finally, the State should provide crisis apartments in the community to serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.

The State should require that community care programs and community providers assess the adequacy of the individualized supports and services provided to persons by such providers in the community. These assessments include, but are not limited to, whether the community service boards and community providers' efforts are: reducing repeated admissions to DPC and other institutional settings; increasing stability of community residence; increasing housing services to individuals who have serious mental illness and who are homeless; retaining employment and/or schooling; increasing supported housing; and increasing supported employment.

The State should provide appropriate oversight of Community Service Boards and/or Community Providers by: establishing the responsibilities of community care programs and/or community providers; identifying qualified providers, including providers in geographically diverse areas of the State; performing a cost rate study of provider reimbursement rates to determine whether current provider reimbursement rates are adequate; requiring community care programs and/or community providers to develop written plans describing services to be provided, in consultation with community stakeholders; requiring and/or providing training to community service boards and/or community providers so that services can be maintained in a manner consistent with evidence-based standards and this Findings Letter; and monitoring the performance of the community care programs and/or community providers.

C. Safety in DPC While Transitioning Individuals to Community Placements

In order to protect the safety of individuals currently residing in DPC, the State should transition individuals who can be served in more integrated settings from DPC and should provide safety, treatment, and services for individuals in DPC that are consistent with generally accepted professional standards. Generally accepted professional standards require that facilities appropriately monitor, supervise, and provide treatment to individuals in order to ensure their reasonable safety.

At a minimum, DPC should, consistent with generally accepted professional standards, appropriately monitor and supervise individuals, especially those at risk. All persons will have an individualized treatment plan formulated by qualified mental health professionals consistent with generally accepted professional standards. Individuals will be provided the degree of individualized treatment as will afford them a reasonable opportunity to improve in social, behavioral, and mental functioning, to diminish symptoms related to their psychiatric illness, and to function as independently as possible. The treatment team will review and follow-up on each individual's care and treatment at appropriate intervals, and whenever an individual's condition requires. Risks (e.g. suicide, self-injury, aggression, other behavioral problems) requiring special observations/precautions will be appropriately addressed consistent with generally accepted professional standards.

To ensure that each individual is being treated in the most integrated setting, discharge planning will be given high priority and will begin on admission. The State should revise its discharge assessment process to focus on the individual's specific capacities to function in a more integrated setting and to meet the demands of community living and to identify the supports and services necessary for the individual's successful community living. DPC discharge teams should become knowledgeable about community living options and services and should engage community providers in the discharge planning process as soon as is practicable. During the assessment and treatment planning phases, discharge criteria will be established, included in the treatment plan, and regularly reviewed by the treatment team. The individual's progress toward discharge criteria and any barriers to discharge will be monitored in treatment plan updates and progress notes. The role of each treatment team member in assisting the individual to meet discharge criteria and achieve the level of functioning necessary for a successful discharge will be delineated in the treatment plan. Treatment will be directed toward helping the individual achieve the level of functioning necessary to be ready for discharge and to live in a community setting.

The State should institute a risk management program to identify high risk situations that require corrective action in an appropriate and timely manner and to develop and implement timely interventions that remedy the identified risks to prevent or minimize harm to the individuals in DPC. The risk management program will include, but not be limited to, the following processes: incident reporting, data collection, and data aggregation to capture information regarding high risk situations; identification of individuals at risk that require review by the appropriate clinical disciplines and the interdisciplinary team, as well as a hierarchy of interventions that correspond to the level of risk; identification and analysis of trends in high risk situations; and the development and implementation of corrective action in response to trends.

DPC should review and analyze all mortalities and incidents of serious injuries to reduce the risk of harm to other individuals, and identify and correct causative and contributing factors to the mortality.

The State should institute a quality management system. The system will collect information related to the adequacy of safety, treatment, and services provided by community providers and DPC.

V. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the State provides to persons with mental illness at DPC and other settings across the State. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations -- which are not public documents -- under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them.

We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them, 42 U.S.C. § 1997b(a)(1), and pursuant to the ADA once we have determined that we cannot secure compliance voluntarily, 42 U.S.C. § 2000d-1. We would prefer, however, to resolve this matter by working cooperatively with the State and are confident that we will be able to do so. The DOJ lawyer assigned to this investigation will be contacting the State's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

s/Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc:

Beau Biden
Attorney General
State of Delaware

Rita Landgraf
Secretary
Delaware Department of Health and Social Services

Kevin Huckshorn
Director
Delaware Department of Substance Abuse and Mental Health
Acting Director
Delaware Psychiatric Center

The Honorable David Weiss
United States Attorney
District of Delaware

Roger M. Lukoff
Certification Officer
Centers for Medicare & Medicaid Services



U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D.C. 20530*

JUL 15 2009

The Honorable Chris Collins
County Executive
Rath Building - 16th Floor, Rm. 1600
Buffalo, NY 14202

RE: CRIPA Investigation of the Erie County Holding Center
and the Erie County Correctional Facility

Dear Mr. Collins:

We write to report the Civil Rights Division's investigative findings of conditions at the Erie County Holding Center ("ECHC") and the Erie County Correctional Facility ("ECCF"). On November 13, 2007, we notified then Erie County Executive Joel Giambra that we had initiated an investigation of these facilities pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, which authorizes the Department of Justice to seek remedies for any pattern or practice of conduct that violates the constitutional rights of incarcerated persons. Initially, we informed Executive Giambra that our investigation would focus on medical care, mental health care, and protection from harm; however, in the course of our investigation, we also became aware of environmental health and sanitation conditions that warranted investigation.

We note that, initially, the County of Erie (the "County") cooperated with our investigation, providing the United States with some of the requested documents from January 1, 2007, through March 1, 2008. Specifically, the County provided ECHC incident reports; some grievances; state and national corrections reports; and ECHC and ECCF policies and procedures. However, the County did not produce corresponding medical reports, which limited our ability to assess the number and severity of injuries that inmates suffered following incidents of self-injurious behavior, attempted suicides, actualized suicides, inmate-on-inmate violence, and excessive use of force by staff.

Initially, we planned to tour ECHC and ECCF in March 2008, but we re-scheduled our tour to August 2008 at the County's request, due to the appointment of a new County Attorney. In the months leading up to the scheduled August tour, the County broke off all communication with us despite our repeated outreach and offers to meet and discuss the County's concerns. On June 16, 2008, the new County Attorney notified us that the County would no longer cooperate with our investigation. The County refused, and continues to refuse, to allow us access to the facilities, staff, or inmates.

The County's unreasonable denial of our request for access is especially troubling, given that inmates committed suicide on March 31, 2008, and April 30, 2008, well after we placed the County on notice that our investigation would review allegations of deficient suicide prevention measures. If the County had agreed to our proposed investigation procedures, County officials would have had an early opportunity to work directly with our experts and staff, in an effort to improve conditions at the facilities with the hopes of avoiding such incidents. They also would have had an opportunity to address any identified problems on a voluntary, proactive basis at an early stage of this investigation.

Furthermore, while we strongly disagree with the County's decision to deny us access to the facilities, the County's denial of our request for access to Erie County inmates, even during regular visiting hours, is unreasonable and devoid of any legal or penological support. Inmates have a First Amendment right to speak with government representatives about the conditions of their confinement and the County has no legitimate penological basis to deny the inmates access to United States government representatives.

In December 2008, we informed the County of our plans to travel to the County to interview inmates at ECHC and ECCF. The County again denied us access to ECHC and ECCF inmates. Despite the County's refusal to cooperate, during our December 2008 visit to the County of Erie, we were able to communicate with a number of current and recently transferred ECHC inmates through an arrangement with the United States Marshals Service ("USMS") and various state facilities.¹

¹ We appreciate the assistance provided to us by the New York State Department of Correctional Services and the staff at the Attica, Orleans, and Wende facilities.

We later learned that the County interviewed some of the ECHC inmates with whom we communicated. We were told that these interviews were videotaped, that the inmates were asked what we had spoken to them about, and that they were required to sign a form.² We stressed to the County that such interviews could be construed as retaliation, which is unlawful under CRIPA, but we were given no assurances that the County would desist from such behavior. Notably, we repeated our offer to meet with the County, in order to explain our investigative process, instead of having the County attempt to secure this information from inmates in a manner the inmates might find troubling. Again, our offer was rejected.

By law, our investigation must proceed regardless of whether officials choose to cooperate. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigation. See H.R. CONF. REP. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. Such non-cooperation is a factor that may be considered adversely when drawing conclusions about a facility. See id. We now draw such an adverse conclusion.³

Consistent with the statutory requirements of CRIPA, we write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial measures that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that the conditions of confinement violate the constitutional rights of inmates confined at ECHC and ECCF. In particular, we find that, based on constitutionally deficient practices, the Erie County Sheriff's Office ("ECSO"), the Jail Management Division ("JMD"), and the Erie County Department of Mental Health ("ECDMH"), through the Adult Forensic Mental Health Clinic, fail to protect inmates from serious harm or the risk of serious harm.

² We requested copies of any videotapes from these interview sessions and any forms signed by the inmates, but our request was denied by the County.

³ The County's non-cooperation constitutes only one factor that we consider in preparing our statutory findings and recommendations. We also have considered the documentation provided by the County, reports issued by the National Commission on Correctional Health Care and the New York State Commission on Corrections, news articles, and interviews with private attorneys, inmates, and local law enforcement officers.

I. BACKGROUND

A. Facility Description

ECHC is a pre-trial detention center located in Buffalo, New York; ECCF is a correctional facility located in Alden, New York. Both facilities are under the authority of Erie County Sheriff Timothy B. Howard, and are managed by the Superintendent of the County's JMD.⁴ ECHC is the second largest pre-trial detention facility in New York. ECHC was built to house 680 inmates with the combination of "pod," open bay "dorm," and traditional linear-type cells. ECCF was built to house 1,070 convicted prisoners, parole violators, and ECHC overflow inmates. Approximately 23,000 people are processed through the two facilities each year, with a daily population of approximately 1,600. The ECSO provides medical and dental services to both facilities, while the Erie County Department of Mental Health Services, through the Adult Forensic Mental Health Clinic, provides the mental health services for both facilities.⁵ ECHC and ECCF inmates may also be admitted to the Erie County Medical Center's secure Psychiatric Service Unit, guarded by in-hospital sheriff's deputies.

B. Legal Standards

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail inmates and detainees subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997.

When a jurisdiction takes a person into custody and holds him there against his will, the Constitution imposes upon the jurisdiction a corresponding duty to assume some responsibility for the inmate's safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)). Generally, county governments must provide persons confined in a jail with reasonably safe conditions of

⁴ The Superintendent of the Holding Center oversees the Administration, Security, and Programs of both facilities and reports directly to the Undersheriff, who reports directly to the Sheriff.

⁵ National Commission on Correctional Health Care, Health Services Study: Erie County Corrections Facilities ("NCCHC 2008 Erie Report"), at 2 (Jan. 10, 2008, revised, Feb. 11, 2008).

confinement. See Bell v. Wolfish, 441 U.S. 520 (1979). Specifically, the Eighth and Fourteenth Amendments require that inmates, both pre- and post-trial, "receive adequate food, clothing, shelter, and medical care." Farmer v. Brennan, 511 U.S. 825, 832 (1994); Benjamin v. Fraser, 343 F.3d 35 (2d Cir. 2003).

The Eighth Amendment protects prisoners from present, continuing, and future harm. See Helling v. McKinney, 509 U.S. 25, 33 (1993). Prison officials have a duty to protect inmates from harm caused by other inmates and from excessive physical force by correctional staff. See Farmer, 511 U.S. at 833; see also, Ayers v. Coughlin, 780 F. 2d 205, 209 (2d Cir. 1986). The Eighth Amendment further requires that inmates receive access to adequate medical and mental health care. See Farmer, 511 U.S. at 832; Benjamin, 343 F.3d at 50. Deliberate indifference to the serious medical needs of inmates, including pre-trial detainees, constitutes an unnecessary and wanton infliction of pain contrary to contemporary standards of decency and violates the Eighth Amendment. See Estelle v. Gamble, 429 U.S. 97, 104 (1976); Koehl v. Dalsheim, 85 F.3d 86, 88 (2d Cir. 1996).

The Fourteenth Amendment protects pre-trial detainees from being punished or exposed to conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell, 441 U.S. at 535-37, 547-48; Benjamin, 343 F.3d at 50. Although the Eighth Amendment does not apply to pre-trial detainees, they "retain at least those constitutional rights . . . enjoyed by convicted prisoners [under the Eighth Amendment]." Bell, at 545; Benjamin, 343 F.3d at 50 ("under the Due Process Clause, [pre-trial detainees] may not be punished in any manner - neither cruelly and unusually nor otherwise"); Weyant v. Okst, 101 F.3d 845 (2d Cir. 1996).

1. Protection From Harm

The Eighth and Fourteenth Amendments forbid excessive physical force against inmates and pre-trial detainees. See Hudson v. McMillian, 503 U.S. 1 (1992), Farmer, 511 U.S. at 832; see also, United States v. Walsh, 194 F.3d 37, 48 (2d Cir. 1999) ("the right of pre-trial detainees to be free from excessive force amounting to punishment is protected by the Due Process Clause of the Fourteenth Amendment.") (citing Bell, 441 U.S. at 535 [citations omitted]). This is true even when the use of force does not result in significant injury. Id. A jail or prison official who inflicts force maliciously and sadistically to cause an inmate harm violates the Eighth and Fourteenth

Amendments. See Livingston v. Griffin, 2007 U.S. Dist. Lexis 36941, at *30 (May 21, 2007) (citing Hudson, 503 U.S. at 9); Walsh, 194 F.3d at 47-48 (applying Fourteenth Amendment protections to pre-trial detainees in criminal case against corrections officer accused of violating inmate's constitutional rights). Courts have "applied the same Eighth Amendment standards to the deliberate indifference claims of pre-trial detainees." Patrick v. Amicucci, 2007 WL 840124, at *3 (S.D.N.Y. Mar. 19, 2007).

In determining whether excessive force was used, courts examine a variety of factors, including:

"[T]he need for the application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response."

Hudson, 503 U.S. at 7-8.

In determining whether conduct rises to the level of a constitutional violation, the Second Circuit requires that the "prison official have 'knowledge that an inmate faces substantial risk of serious harm and disregard[ed] that risk by failing to take reasonable measures to abate the harm.'" Patrick, 2007 WL 840124 at *3 (citing Lee v. Artuz, 2000 WL 231083, at *5 (S.D.N.Y. Feb. 29, 2000)), quoting from Hayes v. N.Y. City Dep't of Corr., 84 F.3d 614, 620 (2d Cir. 1996). The Second Circuit also requires that "an injured inmate . . . show not only that he was exposed to a substantial risk of serious harm but also that the defendant officials acted with deliberate indifference to his health or safety." Patrick, 2007 WL 840124 at *3, (citing Farmer, 511 U.S. at 837). Liability arises where an official knew of and disregarded "an excessive risk to inmate health or safety [and is both] aware of facts from which the inference could be drawn that a substantial risk of harm exists, and he must also draw the inference." Id. Prison officials have been found liable when "they are on notice of a substantial risk of serious harm to an inmate and fail to take reasonable steps to protect him [or her]." Id.

The right to be protected from harm includes the right to be reasonably protected from constant threats of violence. See Farmer, 511 U.S. at 833. This includes protecting inmates from sexual assault from other inmates and correctional officers. See Boddie v. Schnieder, 105 F.3d 857, 861 (2d Cir. 1997) (finding the "sexual abuse of a prisoner by a corrections officer has no

legitimate penological purpose, and is 'simply not part of the penalty that criminal offenders pay for their offenses against society.'" (citing Farmer, 511 U.S. at 834)); Villante v. Dep't. of Corr., 786 F.2d 516, 522-23 (2d Cir. 1986) (finding inmate stated a cause of action for deliberate indifference where guards failed to protect inmate from sexual threats and abuse by other inmates); Rodriguez v. McClenning, 399 F. Supp. 2d 228, 236-238. (S.D.N.Y. 2005) (finding officer's sexual assault of prisoner constituted an Eighth Amendment violation); Noquera v. Hasty, 2001 WL 243535, at *2 (S.D.N.Y. Mar. 12, 2001); Colman v. Vasquez, 142 F.Supp. 2d 226, 237 (D.Conn. 2001).

Lastly, "a corrections officer bears an affirmative duty to intercede on behalf of an inmate when the officer witnesses other officers maliciously beating that inmate in violation of the inmate's Eighth [and Fourteenth] Amendment rights." Jones v. Huff, 789 F. Supp. 526, 535 (N.D.N.Y. 1992) (citing O'Neill v. Krzeminski, 839 F.2d 9, 11 (2d Cir. 1988)); see also, Walsh, 194 F.3d at 48 (holding "Hudson analysis is applicable to excessive use of force claims brought under the Fourteenth Amendment."). "The duty arises if the officer has a reasonable opportunity to intercede." Id. (citing O'Neill, 839 F.2d at 11).

2. Medical and Mental Health Care

The Constitution requires that prison officials address inmates' serious medical and mental health needs. Estelle, 429 U.S. at 104. Officials act with deliberate indifference when an inmate needs serious medical or mental health care and the officials fail to, or refuse to, obtain or provide that care. Id.; see also, Hathaway v. Coughlin, 37 F. 3d 63 (2d Cir. 1994); Kaminsky v. Rosenblum, 929 F. 2d 922 (2d Cir. 1991); Chance v. Armstrong, 143 F. 3d 698 (2d Cir. 1988). The "deliberate indifference to a prisoner's serious medical needs constitutes the 'unnecessary and wanton infliction of pain'" in violation of the Eighth Amendment. Estelle, at 104 (citation omitted). This includes protecting prisoners whose health problems are "sufficiently imminent" and "sure or very likely to cause serious illness and needless suffering in the next week or month or year." Young v. Coughlin, 1998 U.S. Dist. LEXIS 764, at *11 (S.D.N.Y. Jan. 29, 1998) (citing Helling, 509 U.S. at 33).

The constitutional responsibility to provide minimally sufficient medical care includes treatment of psychiatric or mental health illnesses. Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989). Prison officials have an obligation to protect an inmate from self-inflicted injury where the prison official

knew or had reason to know "of a potential suicide risk to an inmate" Eze v. Higgins, 1996 WL 861935, at *7 (W.D.N.Y. 1996) (citing Hudson, 468 U.S. at 526-27 (1984)). Prison officials act with a deliberate indifference to the risk of suicide when they fail "to discover an individual's suicidal tendencies . . . [or] could have discovered and have been aware of the suicidal tendencies, but could be deliberately indifferent in the manner by which they respond to the recognized risk of suicide" Kelsey v. City of New York, 2006 U.S. Dist. LEXIS 91977, at *16 (E.D.N.Y. Dec. 18, 2006) (citing Rellergert v. Cape Girardeau County, 924 F.2d 794, 796 (8th Cir. 1991)).

3. Sanitation

Inmates are constitutionally entitled to environmental conditions that do not pose serious risks to health and safety, including deficient sanitation, inadequate fire safety, inadequate ventilation, and pest infestation. Benjamin, 343 F.3d at 52 (affirming district court findings that "inadequate ventilation, lighting, and exposure to extremes of temperature violated the detainees' constitutional rights"); Harris v. Westchester County Dep't of Corr., 2008 U.S. Dist. LEXIS 28372, at *18 (S.D.N.Y. Apr. 2, 2008) (finding a leaking ceiling an "unsafe prison condition").

In the Second Circuit, "challenges by pre-trial detainees 'to the environmental conditions of their confinement are properly reviewed under the Due Process Clause of the Fourteenth Amendment, rather than the Cruel and Unusual Punishment Clause of the Eighth.'" Harris, 2008 U.S. Dist. LEXIS at *17, citing Benjamin, 343 F.3d at 49-50. "Where a pre-trial detainee alleges 'a protracted failure to provide safe prison conditions, the deliberate indifference standard does not require the detainees to show anything more than actual or imminent substantial harm.'" Harris, 2008 U.S. Dist. LEXIS at *17, citing Benjamin, 343 F.3d at 51 (emphasis omitted). Challenges by sentenced inmates to environmental conditions of confinement, however, are protected by the Eighth Amendment, and in order for an inmate to prevail on an environmental conditions of confinement claim, an inmate must meet the deliberate indifference standard. See Hathaway, 37 F.3d at 66.

II. FINDINGS

The ECSO and JMD's administration of ECHC and ECCF is woefully inadequate and has resulted in a pattern of serious harm to inmates, including death. We find that the County, ECSO, JMD,

and ECDMH fail to provide adequate suicide prevention; mental health care; medical care; protection from harm; and safe and sanitary environmental conditions. In making these findings, we are cognizant that the County has received similar notice regarding conditions in ECHC and ECCF from the New York State Commission on Corrections ("NYSCC") and the National Commission on Correctional Health Care ("NCCHC") on multiple occasions, but has yet to remedy these issues.⁶

A. Inadequate Suicide Prevention

Constitutional requirements mandate the development of suicide prevention standards. These standards require: (1) an appropriate policy and procedure; (2) education and training for all staff members; (3) appropriate screening to assess suicide risk; (4) appropriate housing for those identified as at risk; (5) appropriate supervision, observation, and monitoring of those inmates so identified; (6) appropriate referrals to mental health providers and facilities; (7) appropriate communication between correctional health care personnel and correctional personnel; (8) appropriate intervention addressing procedures of how to handle a suicide in progress; and (9) appropriate notification, reporting, and review if a suicide does occur.

ECHC and ECCF's current suicide prevention practices do not comport with generally accepted standards of correctional mental health care. Although the policies we reviewed appear sound, it is clear by the number of recent suicides and attempted suicides that there are serious problems with how the policy is

⁶ See, e.g., New York State Commission on Corrections, Minimum Standards Evaluation - Erie County Jail Management Division ("NYSCC 2006 Evaluation") (2006); New York State Commission on Corrections Erie County Holding Center Cycle 2 Evaluation, Apr. 30, 2007 ("NYSCC ECHC Cycle 2 Evaluation Apr. 2007"); New York State Commission on Corrections Erie County Holding Center Cycle 2 Evaluation, Aug. 6, 2007 ("NYSCC ECHC Cycle 2 Evaluation Aug. 2007"); New York State Commission on Corrections ECHC Phase 2 Evaluation, Apr. 2008; National Commission on Correctional Health Care, Health Services Study: Erie County Corrections Facilities ("NCCHC 2008 Erie Report") (Jan. 10, 2008, revised, Feb. 11, 2008); and numerous letters from the NYSCC to Erie officials, cited throughout.

implemented and followed.⁷ Moreover, despite a 2008 NCCHC warning, the County continues to house suicidal inmates in unsafe cells that allow an inmate multiple ways to facilitate committing suicide, including: using steel beds, wall plates removed from the wall, accessible grab bars, and bars on windows.⁸ ECHC inmates have exploited cell deficiencies, incorporating them into their suicide attempts. Since 2003, at least 23 inmates either committed, or attempted to commit, suicide, or took steps that demonstrated suicidal ideation. Between 2007-2008 there were three suicides and at least ten attempted suicides. Below, we provide examples of the County's inability to supervise inmates, identify inmates at risk for suicide, correct deficiencies in cells that facilitate suicide attempts, and prevent likely suicide attempts.

- ECHC inmates have committed suicide by hanging themselves from air vents using bed sheets. In 2008 alone, two inmates died in such a manner, raising the total to over 15 inmates who have committed, or attempted to commit, suicide in a similar fashion since 2002.
- In the past two years, more than five inmates who attempted suicide by hanging or self-strangulation were unsuccessful only because a guard or another inmate discovered the attempt and cut down the self-made noose or otherwise removed the fabric from around the inmate's neck. In one instance, ECHC deputies discovered a distraught inmate in his cell only after the rope broke during his attempt to hang himself.

⁷ For example, the Suicide Prevention Policy requires that inmates housed in Constant Observation receive uninterrupted, personal visual observation. Yet, inmates held in constant observation are still finding ways to hide contraband, such as a bullet. Similarly, the policy requires that the dispensation of psychotropic medication be adequately monitored, yet one inmate attempted suicide by ingesting another inmate's medication, while yet another inmate hoarded his medication for weeks without notice.

⁸ NCCHC 2008 Erie Report, *supra*, n. 5, at 10 ("The cells used to house suicidal inmates were not 'suicide-proof.' There were multiple ways to facilitate committing suicide, including using the steel beds, wall plates that are lifted from the wall, handicapped bars, bars on windows, etc.").

- In December 2008, an ECHC inmate attempted suicide by hanging. This was the inmate's third suicide attempt.
- In March 2008, an ECHC inmate committed suicide by hanging, despite a warning from the inmate's family that the inmate could be suicidal.
- In February 2008, a 17-year-old ECHC inmate attempted suicide by hanging. Two other inmates grabbed his legs and successfully untied the sheets from the bars.
- In November 2007, an ECHC inmate attempted suicide while under constant observation. Despite the suicide attempt, ECHC officials released the inmate into general population, where he again attempted suicide six days after his earlier attempt.
- In May 2007, ECHC deputies found an inmate unconscious on the floor of his cell after he attempted suicide by ingesting a dangerous quantity of another inmate's quetiapine.⁹ Deputies found a suicide note in his cell, and ECHC documents do not indicate whether the inmate ever regained consciousness.
- In January 2007, an ECHC inmate committed suicide in view of deputies by diving off a 15-foot railing in the common area. Upon admission to ECHC, the inmate was reportedly evaluated by forensic staff and determined not to be a suicide risk.

In addition to suicides and attempted suicides, we found many examples of inmates who engaged in self-injurious behavior, including banging their heads against the wall, cutting themselves with metal and glass objects, and verbally expressing a desire to die. Documentation provided by the County fails to indicate that these inmates were referred for mental health assessments or further suicide screening. Furthermore, despite prior warnings from the NYSCC, the County's facilities provide ready access to a number of environmental hazards such as screws,

⁹ A psychotropic medication used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.

nuts, and bolts on chairs that could cause injury or be removed and used as a weapon.¹⁰ For example:

- In October 2007, ECHC deputies found an inmate, who had attempted suicide on a prior occasion, holding a broken light bulb to his neck.¹¹
- In September 2007, deputies witnessed an inmate smash his cell window and cut his arm with a broken piece of glass.¹²
- In June 2007, an ECHC inmate verbally threatened self-harm after he flooded his cell and smeared feces on himself and the cell wall. Deputies sent the inmate for a medical examination regarding injury to his eye. There is no indication in the materials provided by the County that the inmate received any psychiatric evaluation.
- In February 2007, ECHC deputies discovered an inmate hoarding 38 pills he was to be taking three times each day to treat high blood pressure. Deputies did not refer the inmate for a psychiatric evaluation because the inmate reportedly indicated he did not wish to harm himself.

The availability of dangerous implements and numerous examples of self-injurious behavior amplify the County's inability to monitor and supervise inmates. The examples also illustrate the County's inability or unwillingness to refer inmates for appropriate mental health treatment. Given the number of suicides and attempted suicides at these facilities, at least five of which occurred following the release of the NCCHC 2008 Erie Report placing the County on notice of such issues, it is evident that County officials are deliberately indifferent and have not taken these incidents or the recommendations of the NYSCC and NCCHC seriously.

¹⁰ NYSCC ECHC Cycle 2 Evaluation Aug. 2007, *supra*, n. 6, at 4; NYSCC ECHC Cycle 2 Evaluation Apr. 2007, *supra*, n. 6, at 6.

¹¹ Subsequently, this inmate was interviewed by forensic staff, who placed the inmate on constant observation.

¹² Subsequently, this inmate was interviewed by forensic staff, who placed the inmate on constant observation.

B. Inadequate Mental Health Care

ECDMH fails to provide inmates with adequate mental health care. ECHC and ECCF inmates require mental health assessments and treatment to avoid the unnecessary suffering of acute and chronic episodes of mental illness. Generally accepted correctional mental health care standards require that a physician see an inmate usually before, but clearly shortly after, a prescription for psychotropic medication is written so that the physician can evaluate whether the medication should be maintained and to assess the medication order for proper dosage and effectiveness. Inmates who remain untreated, or who are treated without being seen by a physician, may suffer from a worsening of their symptoms, including suicidal and homicidal thoughts, or from the potentially lethal side effects of medication.

An alarming example of deficient mental health care is the death of inmate Jimmy Roberts.¹³ On May 19, 2007, Mr. Roberts died of pneumonia brought on by starvation and dehydration after spending four months in ECHC. ECHC staff ignored Mr. Roberts' deteriorating behavior despite clear signs of mental illness and decompensation, such as splashing urine and spreading feces on his face. The NYSCC investigation of Mr. Roberts' death found that ECHC officials failed to identify Mr. Roberts' medical condition and take the necessary steps to prevent self-injurious behavior.¹⁴ Moreover, the NYSCC cited several incidents that should have alerted the medical staff to Mr. Roberts' decompensation (e.g., throwing food, rolling in feces). NYSCC also found that despite Mr. Roberts' increasing psychotic behavior, the ECHC physician failed to take any action to arrange for critically needed care.¹⁵ The NYSCC found ECHC's care of Mr. Roberts inadequate, rising to the level of professional misconduct.¹⁶ The NYSCC concluded that the current medical department at the facility is "incapable of providing medical

¹³ The name "Jimmie Roberts" is a pseudonym.

¹⁴ New York State Commission on Corrections, Findings in the Matter of the Death of [Jimmie Roberts], Jan. 10, 2008 ("NYSCC [Roberts] Report").

¹⁵ Id. at 6-9.

¹⁶ Id. at 6.

evaluation and treatment" sufficiently to treat inmates who are seriously ill.¹⁷

C. Inadequate Protection From Harm

Corrections officials must take reasonable steps to provide "humane conditions" of confinement. Farmer, 511 U.S. at 832. Providing humane conditions requires that a corrections system satisfy inmates' basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

To ensure reasonably safe conditions, officials must take measures to prevent the unnecessary and inappropriate use of force by staff. Officials must also take reasonable steps to protect inmates from violence at the hands of other inmates. In addition, officials must provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. Finally, a jail has an obligation to protect vulnerable inmates from harm, such as those who are at risk of suicide or at risk of harm from other inmates. For the reasons set forth below, ECHC and ECCF fail to meet constitutional standards in all of these regards.

1. Deficient Policies and Procedures

a. Overall Content and Structure of ECHC and ECCF's Policies and Procedures

Policies and procedures are the primary means by which jail management communicate their standards and expectations. Thus, policies and procedures should be current, accessible to all correctional officers and staff, and consistent with relevant legal standards and contemporary correctional practices. Typically, correctional institutions have a uniform policy that governs the Jail Administration. The uniform policy may contain post orders, much like the ECHC Manual contains, that are specific to areas such as intake booking and court hold. Most importantly, however, the uniform policy would provide operational guidance on, inter alia, the use of force, use of restraints, use of chemical agents, suicide prevention, and the grievance process. These uniform policies would be enforced throughout both facilities and all Jail Staff would be trained on one set of operational guidelines. Failure to do so may allow for informal practices to flourish, thus making it difficult to

¹⁷ Id. at 7.

monitor the appropriate application of the institution's governing policies.

ECSO provided us with a copy of the Policies and Procedure Manuals (collectively, the "Manuals") for both ECHC ("ECHC Manual") and ECCF ("ECCF Manual"). The ECHC Manual is dated January 29, 2005, while the ECCF Manual is dated October 7, 2003. A review of the Manuals indicates that many sections are outdated, and many have not been updated in several years. For example, the ECCF use of force policy, Policy 04-09-00 (Physical Force/Corporal Punishment), was last updated in 1991. Similarly outdated are ECCF's suicide prevention screening guidelines, 09-03-01, updated in 1990; restraint policy, 04-09-01, updated in 1997; and grievance policy, 04-11-00, updated in 1999. ECHC policies are similarly dated (i.e., Use of Firearms/Force Report, JMD 04.03.01, updated in 2002; and Contraband Control, JMD 05-03-90, updated in 2003). Notably, in 2004, the ECSO's JMD enacted JMD 02.20.00, requiring the annual review of JMD Policy and Procedures concerning "Classification," "Grievance," and "Suicide Prevention." We are unable to determine, based on the documents that were produced by the County in February 2008 and the County's continued refusal to cooperate with our investigation, whether the County has reviewed or updated these manuals; the date on the materials we received suggests that they have not. Accordingly, we must assume that they have not been updated.

Moreover, the organization of the Manuals is confusing. It is our understanding that the ECSO has custodial responsibilities over both ECHC and ECCF and that the JMD oversees the operation of the facilities. Given this arrangement, it is unclear why there are individual, and dissimilar, manuals for ECHC and ECCF. For example, while the ECCF Manual contains policies on the Use of Force, the ECHC Manual does not,¹⁸ and while Spanish-speaking inmates at ECHC are not provided a translated Inmate Handbook, Spanish-speaking inmates at ECCF are. See infra, Section II.C.9. Similarly, it is unclear why there are different inmate handbooks for each facility.¹⁹ The NYSCC noted this discrepancy in its April 2008 Jail Evaluation, finding deficiencies in the disciplinary sanctions of unsentenced inmates who were housed at ECCF, stating that these inmates who were "transferred to the

¹⁸ The ECHC Manual has a Use of Firearms/Force Report Policy, JMD 04.03.01; however, it is less a policy on appropriate uses of force and more a policy on reporting the use of force.

¹⁹ ECHC has an Inmate Handbook and ECCF has an Inmate Code of Conduct. See infra, Section II.C.9.

Holding Center for disciplinary reasons were having their disciplinary hearing at the Holding Center,"²⁰ subject to ECHC's inmate rule book and not the ECCF inmate rule book. It further found that the two rule books differed in classes of violations and sanctions.²¹ The NYSCC recommended that JMD "consider developing and implementing a single inmate rule book" for both facilities.²²

b. Deficient Use of Force Policies and Procedures

While the use of force is sometimes necessary in a correctional facility, the Constitution forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted correctional practices provide that appropriate uses of force in a given circumstance should include a continuum of interventions, and that the amount of force used should not be disproportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions. This guidance is typically found in a use of force policy. Failure to provide staff with operational guidance on when the use of force is appropriate is a gross departure from generally accepted correctional standards.

The ECHC's Manual fails to provide operational guidance on the use of force. In contrast with generally accepted corrections practices, ECHC has no operating policy governing the application of force at ECHC, and no system in place to monitor the use of force. The ECHC Manual makes several vague references to a "Response Team," apparently utilized to quell emergency inmate disturbances; however, there is no policy governing the team's assembly. ECHC's use of force and its use of the Response Team, without any operating policies and procedures, fails to

²⁰ New York State Commission of Correction ECHC Phase 2 Evaluation, Apr. 2008, supra, n. 6, at 4.

²¹ Id.

²² Id.

provide inmates with sufficient protection from harm and creates a climate where the unfettered use of force is permissible because there are no operating guidelines holding anyone accountable.

While the ECHC Manual makes several vague references to the "Response Team," the Manual itself does not provide a policy describing the composition of this team, how it is assembled, its purpose and specific use, or how members of this team are trained, if at all. It is also unclear what the exact purpose of the Response Team is; however, JMD 04.03.01 provides that a use of force report must be prepared whenever the Response Team is "required to control an inmate situation wherein force may be used to quell the situation." The policy, however, does not explain what is meant by "control" and "inmate situation," nor does it discuss the appropriate or permissible uses of force by the Response Team. See JMD 04.03.01. Moreover, JMD 06.01.02 makes reference to a "secondary response team" that will be assembled in the event of a riot or hostage situation; again, limited guidance is given on the composition of this "secondary response team." See JMD 06.01.02. Employing a special operations team, like the Response Team, that is to be used in emergency situations without operational guidance as to its structure and use, is a gross departure from generally accepted correctional standards.

Our review of the ECHC Manual did not reveal a Use of Force policy that directs Jail Staff as to when the use of force is appropriate, and what types of force should be used. By contrast, as discussed above, the ECCF manual provides guidance on the use of force, albeit dated. See ECCF Manual, Physical Force/Corporal Punishment, 04.09.00. While the ECHC Manual does contain guidance on the planned use of force, Policy JMD 06.01.03, this policy is strictly limited to planned uses of force initiated by the Quick Entry Team ("QET"). Moreover, this policy is located in the Emergency Preparedness section of the ECHC Manual, further limiting its application to situational necessity. The ECHC Manual also contains guidance on the reporting of force; however, this policy fails to provide operational guidance on when the use of force itself is appropriate. See ECSO Use of Firearms/Force Report, JMD 04.03.01. The ECHC Manual should provide written operational guidance on what are legally acceptable uses of force, in keeping with Constitutional, federal, and state guidelines, as well as generally accepted correctional standards. However, the ECHC Manual does not provide any language for when the use of force, absent an emergency situation, is permissible.

2. Excessive Use of Force

Our investigation revealed that inmates at ECHC and ECCF are regularly subjected to inappropriate, excessive and degrading uses of physical force. The following are illustrative examples:

- Inmates we interviewed consistently reported that ECSO deputies would take ECHC inmates on "elevator rides," during which deputies would reportedly physically assault inmates. Inmates consistently described incidents in which deputies would take handcuffed inmates to an isolated elevator (which was not equipped with a security camera) where they would be beaten and had their heads slammed against the elevator walls.
- In August 2008, an ECHC inmate was handcuffed, stripped, and cavity searched by a deputy who then used the same rubber gloves to search other inmates. When the inmate requested that the deputy change his gloves, which were dirty with blood and fecal matter, the deputy struck the inmate on the head and forcibly performed the search, stating that he "did not have to do a damn thing."
- In 2008, according to inmate interviews, ECSO deputies ordered other inmates to go into the cell of an inmate who refused to shower, pull the inmate out of the cell, strip him and wash him on the floor of the pod common area with rags and a bucket of water.
- In January 2008, ECSO deputies reportedly targeted inmates who were screaming as a result of the New Year. Inmates told us that, in the case of one of the inmates, the deputies punched, kicked, and reportedly tied a sheet around the inmate's neck, threatening to hang him. The inmate was then shackled and taken to an isolation cell, where the deputies continued to punch and kick him.
- In August 2007, during the booking process, ECHC deputies struck a pregnant inmate in the face, threw her to the ground, and kneed her in the side of her stomach. When she informed deputies that she was pregnant, the deputies allegedly replied that they thought she was fat, not pregnant. The inmate lost her two front teeth as a result of the assault.

- An ECCF inmate died of a stroke in March 2007, after suffering a brain injury when ECCF deputies smashed his head against a wall. The inmate requested medical help following the incident, but was ignored despite noticeable signs of injury (dragging his foot when walking and continually dropping things).
- In April 2006, an ECHC inmate (held in the facility for urinating in public) was knocked unconscious and sustained a collapsed lung, fractures to six ribs, and a spleen injury (resulting in removal) as a result of a beating by County deputies. The inmate alleges that the incident arose from his attempt to air out his cell from the odor of other inmates' defecation and vomit.

3. Inadequate Reporting of Use of Force

Effective measures to prevent excessive and inappropriate uses of force include the adequate reporting of information to permit the identification of potential problem cases and effective internal investigations. We find that ECHC fails to elicit adequate information about use of force incidents, making management review ineffective. Generally accepted correctional standards require written reports of uses of force. These reports should be submitted to administrative staff for review. Although the County of Erie produced incident reports for ECHC, it did not produce any of the use of force forms that reportedly accompany these reports. The incident reports themselves indicate whether a use of force report was filed under the "Action Taken" section of the Incident Report. While most of the incident reports where force was used indicated that a use of force form was submitted, there were several incidents where force was clearly used, but the submission of a use of force form was not indicated. For example:

- An October 2007 report indicates that two deputies were injured subduing an inmate who attempted to strike a deputy. While the report indicates that the deputies secured the inmate on the floor with handcuffs, there is no indication what type or level of force the deputies used to achieve compliance.
- Similarly, a September 2007 incident report describing an incident in which two deputies were injured subduing an inmate who struck a deputy, indicates only that the deputies took the inmate to the ground and secured him in handcuffs. There is no indication what type or level of force the deputies used to achieve compliance.

assaults, including sexual assaults. In many of the incidents of inmate-on-inmate violence, ECSO deputies on duty were not present, giving inmates ample opportunity to fight. The following examples are illustrative:

- On December 1, 2007, an inmate was held down by another inmate and punched and kicked by a third inmate. The victimized inmate indicated that he was attacked because he was held on sodomy charges.
- On April 12, 2007, an inmate was grabbed by the throat and punched in the face by three other inmates, suffering a swollen right eye and left cheek as a result of the attack. According to the County's records, the deputy on duty was taking a "bathroom break" when the assault occurred.
- On March 28, 2007, deputies discovered an inmate, who had been in a fight with another inmate, lying on the floor, bleeding from a head wound.
- On February 2, 2007, an inmate was stabbed with a broken broom handle. The deputy on duty reported that he did not see the assault because he was moving a box into the elevator at the time.
- On January 24, 2008, an inmate was sexually harassed and assaulted by three inmates who pulled his pants down, slapped him on the buttocks, called him "honey," grabbed towards his genitalia in a teasing manner, and grabbed his nipples. There is no indication from this incident report whether any of the aggressors were disciplined for their actions.

ECSO deputies do not appear to consistently intervene to stop inmate violence. There have been several incidents in which deputies either watched an altercation escalate from a verbal disagreement to a physical altercation, or allowed other inmates to break up a fight and detain the inmates until additional deputies arrived. For example:

- On November 26, 2007, a deputy witnessed an inmate throw a chair across the law library at another inmate because he thought the other inmate was a "snitch."
- On November 19, 2007, a deputy witnessed two inmates arguing and then fighting. He also witnessed a third inmate join the fight and punch and kick another inmate

- An August 7, 2007 report indicates that an ECHC inmate who struck a deputy was secured by the response team, placed in mechanical restraints, and put into an isolation cell. However, there is no information on the force used to secure the inmate or the length of time he was restrained, nor is there any indication whether medical clearance was secured before the inmate was placed in restraints.

JMD's failure to ensure complete use of force reporting prevents adequate monitoring of the use of force within its facilities. As a result, the ECSO is unable to accurately gauge the amount of force used and whether such force is appropriately used.

4. Inadequate and Ineffective Inmate Supervision

a. Deputy-Encouraged Violence

ECSO deputies not only fail to protect inmates from harm, but, as our investigation revealed, they affirmatively place inmates in harm's way by pitting inmates against one another in combat. We have received reports of ECSO deputies relying on inmates to discipline other inmates with force. These inmates, sometimes referred to as the deputies' "pet," receive extra privileges, such as extra meals and hygiene products. Alarming, we have learned of ECSO deputies harassing inmates charged with a sexual offense. We have received numerous reports of deputies openly announcing the charges of alleged sexual offenders, including describing inmates as "Rape-Os." Deputies would reportedly announce an inmate's charge in the presence of other inmates and then leave the room, allowing the other inmates an opportunity to physically assault the alleged sexual offender.

b. Inmate-on-Inmate Violence

Insufficient inmate supervision is a serious problem at ECHC and ECCF. The County is well aware of this issue. Undersheriff Brian D. Doyle has publicly stated that ECHC does not have sufficient "security staff."²³ Indeed, our review of the County's own incident reports confirms this admission. Incident reports revealed that between January 1, 2007 and February 9, 2008, there were over 70 reported incidents of inmate-on-inmate

²³ Gene Warner, Inmate Well-Being Comes Under Scrutiny; Medical Care Limited at County Facilities, Buffalo News, Aug. 5, 2007.

in the head. There is no indication in the report whether this deputy attempted to break up the fight or even intervened during the argument, before it escalated to a fight.

- On October 30, 2007, a deputy witnessed an inmate strike another inmate who had been knocked to the ground. When the attacking inmate refused the deputy's order to stop fighting, two other inmates interceded to restrain the attacker until additional deputies arrived on the scene.

As the incident reports demonstrate, and as our interviews consistently confirmed, inmates who are not adequately supervised have opportunities to engage in fights. The situation in the County facilities appears so volatile that minor slights appear to instigate physical altercations. We noted numerous instances in which inmates fought one another for inconsequential reasons, such as: one inmate denied another inmate access to a newspaper, an inmate cut ahead of another inmate in the lunch line, and one inmate told another inmate that he had "smelly feet." Each of these exchanges led to fights among inmates. As the above examples demonstrate, ECSO and JMD are not meeting constitutional obligations to provide for the safety and well-being of inmates.

**c. Unprofessional and Provocative Attitude
Towards Inmates**

Establishing a professional environment in a correctional setting is critical to maintaining the safety and security of inmates and staff. In addition to reports that deputies have encouraged inmate violence, we have also learned that deputy supervisors at ECCF have permitted a culture of unprofessional and provocative attitude towards inmates to flourish within the facility.²⁴

Notably, in June 2008 the NYSCC cited ECCF Jail staff for "unprofessional and provocative attitude toward the inmate population"²⁵ for posting informational sheets labeled "Frequently Asked Questions" within the dormitories housing pre-trial detainees that contained such comments as "Deputies are here to tell you what to do;" "Deputies decide when you go to

²⁴ Letter from NYSCC to Sheriff Timothy Howard, dated June 5, 2008, Cycle 3 Evaluation, at 12.

²⁵ Id.

exercise;"²⁶ and "How do you become a Lima unit porter? Don't ask we will ask you."²⁷ The NYSCC found these sheets to be unprofessional and that ECSO should view these statements "as an embarrassment to the corrections profession."²⁸ Moreover, the NYSCC found that the "condescending tone ... perpetuates a negative work environment,"²⁹ and the failure of "deputy sheriff supervisors ... to remove such posting and take further action is unconscionable."³⁰ These "informational sheets," coupled by the reports of deputy encouraged violence (see Section II.C.4.a, supra) and sexual misconduct (see Section II.C.6, infra) further illustrates a culture that undervalues the safety and well-being of inmates housed within its facility. Indeed, a condescending attitude towards an inmate population may lead security staff to believe that they have an unfettered control over inmates that allow them to engage in unconstitutional behavior, such as encouraging inmate violence and engaging in inappropriate sexual conduct with inmates.

d. Inadequate Division of Supervisory Responsibility

ECCF houses both pre- and post-trial inmates. ECSO employs two separate work forces to supervise "unsentenced" and "sentenced" inmates at ECCF. Specifically, deputies are assigned to "unsentenced inmates," while correctional officers are assigned to "sentenced inmates."³¹ The NYSCC found this arrangement "jeopardizes the safety and security of staff and inmates at the Correctional Facility."³² According to NYSCC, because the security staff are members of two distinct unions, based on their work assignment, there is confusion over which union or security detail has specific control over a particular inmate. Indeed, NYSCC's staff "witnessed members of both unions

²⁶ Id.

²⁷ Id.

²⁸ Id.

²⁹ Id.

³⁰ Id.

³¹ Id.

³² Letter from NYSCC to Sheriff Timothy Howard, dated June 5, 2008, Cycle 3 Evaluation, at 11.

openly debating and arguing [over] which union has authority over an inmate."³³ The NYSCC further noted that each work force has different break schedules and different work hours, "affect[ing] the lock-in time of inmates during the count." Moreover, while both work forces are "accountable to the Chief and Superintendent of the Correctional Facility," "each union member is only accountable to the supervisors in their respective unions."³⁴ Accountability and supervisory responsibility was a noted problem where, for example, "during evening, nights, and weekends" the highest ranking employee for deputies "is a Sergeant" whereas the highest ranking corrections officer is "the Tour Commander."³⁵ This confusion in supervisory responsibilities amplifies the deficiencies in inmate supervision.

5. Inadequate Classification

ECHC and ECCF have an inadequate classification system, and it contributes to unsafe conditions at the facilities. Generally accepted correctional standards require separation of problematic inmates and those who are more vulnerable to violence and abuse from the general population. ECHC and ECCF's failure to do so makes supervision more difficult and increases the risk of harm to both staff and inmates.

The County's classification system is flawed and fails to adequately assess critical factors such as an inmate's criminal history while in custody, escape history, and likelihood of victimization. While the County's classification instrument does identify these areas, the JMD fails to provide operational guidance on how to address such issues. As the NYSCC noted, this is a major concern because the classification instrument influences how inmates are classified at ECHC and ECCF; "the quality of any classification determination and subsequent housing assignment is suspect" because "classification reviews and housing assignments are substantially based on outcomes of a flawed classification system."³⁶ While officials at ECHC and ECCF cannot be expected to prevent all altercations between inmates, the Constitution requires correctional officers and County officials to take reasonable steps to protect inmates

³³ Id.

³⁴ Id.

³⁵ Id.

³⁶ NYSCC 2006 Evaluation, supra, n. 6, at 21, 24.

from violence. Disturbingly, the County was made aware of the inadequacies of its classification through an April 2007 NYSCC report, followed by an August 2007 NYSCC report indicating that the issues remained unaddressed.³⁷

As an example of the problems that an inadequate classification system can lead to, we learned of a situation in August 2008 in which a 16 year-old boy was reportedly placed in the "bullpen" at ECHC with adults. Placed among an adult population, this vulnerable youth was reportedly attacked and sexually assaulted in the middle of the night.

6. Sexual Misconduct

Our review of investigative reports revealed incidents of sexual misconduct at ECHC and ECCF resulting from staff-on-inmate and inmate-on-inmate interaction. For example:

- On September 16, 2008, a male ECCF deputy resigned after engaging in inappropriate sexual conduct with a female inmate.
- A male ECCF deputy reportedly sexually harassed several inmates in his unit by staring at the male inmates while they were in the shower. This deputy reportedly engaged in this conduct frequently and regularly. In at least one instance, the deputy placed his hand on an inmate who attempted to leave the shower. The deputy reportedly admired the inmate's physique and told him, "we should work out together."
- A male ECCF deputy reportedly engaged in lewd conduct with an inmate, placing his fingers through his uniform pants zipper to simulate fellatio and asking the inmate "do you want to suck it?"
- On September 9, 2007, a female inmate accused a male deputy of rape. The inmate was sent to the hospital and subsequently moved to a different unit within ECHC. There is no indication of whether an investigation was conducted following the report of rape, nor whether the deputy was, or would be, moved from the women's ward while the charges were being investigated.

³⁷ NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 5; NYSCC ECHC Cycle 2 Evaluation Apr. 2007, supra, n. 6, at 8.

7. Contraband and Vandalism

Another indicator of inadequate inmate supervision is the amount of dangerous contraband recovered from the housing units and the ease with which inmates can fabricate homemade weapons. Due to the dilapidated condition of scores of cells, shower areas, and various dayroom features, inmates have ample material for fabricating weapons, including floor tiles, metal from light fixtures, metal from the ventilation system, glass from cell light bulbs, electrical wiring, and plumbing fixtures. Inmates have been found with shanks of varying size that are made of broken glass and metal rods. Inmates have also been found with handcuff keys and a syringe, and in March 2007 an inmate handed deputies a 40-caliber hollow point bullet he found under his cellmate's bed. At the time, both inmates were assigned to a cell designated for "constant observation." While it is virtually impossible for any correctional facility to completely deter inmates from obtaining materials for weapons, the problem at ECHC and ECCF is exacerbated by inadequate supervision.

8. Grievance System

An inmate grievance system is a fundamental element of a functional jail system, intended to provide a mechanism for allowing inmates to raise concerns and issues to the administration. If viewed as credible by inmates, it can also serve as a source of intelligence to staff regarding potential security breaches as well as staff excessive force or other misconduct. The grievance system should be readily accessible to all inmates. Inmates should be able to file their grievances in a secure and confidential manner and without the threat of reprisals. Staff responsible for answering inmate grievances should do it in a responsive and prompt manner. We note a number of serious deficiencies with the inmate grievance process at ECHC and ECCF.

The grievance system at ECHC and ECCF is inadequate and open to abuse. NYSCC questioned the integrity of the grievance program, finding the system informal, the policies inadequate, and jail officials unwilling to investigate allegations or quick to categorize grievances as disciplinary and therefore non-grievable, even when they were.³⁸ We note that the NYSCC has cited the County for such problems in 2007 and 2008. Because the

³⁸ See generally NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 6; NYSCC ECHC Cycle 2 Evaluation Apr. 2007, supra, n. 6, at 10; NYSCC 2006 Evaluation, supra, n. 6, at 28-33.

County provided us with only a very limited number of grievances for review, it is unclear whether the County has remedied these deficiencies. Therefore, we must conclude that the NYSCC findings remain unremedied. In June 2008, the NYSCC found that no grievances had been filed by pre-trial detainees housed at ECCF.³⁹ This clearly indicates that the grievance system is not functional, thus depriving the JMD of a valuable source of information concerning questionable constitutional treatment.

One partial explanation for this is the bifurcated grievance system that the JMD employs. Specifically, inmates are instructed to utilize an informal grievance process that encourages inmates to raise their grievance with Jail Staff and allow Jail Staff an opportunity to informally resolve the grievance, rather than submit a formal grievance that is reviewed by the grievance officer. Although inmates are told that they may file a formal written grievance at any time, it is impossible for JMD to account for whether a request for a formal grievance is actually met. Encouraging an inmate to pursue a grievance informally can be problematic in some circumstances, especially in those instances in which unlawful actions have occurred. Inmates who may have been subjected to unlawful conduct will, most likely, be reluctant to seek resolution from those who may have witnessed or been involved in the very actions that would be the basis for the grievance. The ECSO's failure to monitor the application of the grievance system makes it deliberately indifferent to serious allegations of force, harassment, and medical care to be ignored. Numerous inmates reported submitting a grievance, only to have it taken out of the mail slot and destroyed by deputies.

9. Access to Information

Generally accepted correctional standards require that newly admitted inmates receive an opportunity to learn about the facility rules and regulations, services that are available, policies and procedures that affect the inmate, and facility schedules. Each inmate should receive a facility handbook, containing all the relevant information, and should have an opportunity to have the information explained to him or her if the inmate cannot read. Typically, facilities have an orientation procedure as a part of the intake processing.

³⁹ Letter from NYSCC to Sheriff Timothy Howard, dated June 5, 2008, Cycle 3 Evaluation, at 9.

It is our understanding that inmates are provided a copy of either the ECHC Inmate Handbook or the ECCF Code of Conduct upon arrival at the respective facility. However, these handbooks are not necessarily made available in Spanish. While ECCF offers a Spanish translation of the ECCF Code of Conduct, the translated version we received in February 2008 was last updated on November 20, 1992; the English version was revised on August 21, 2007. The County of Erie did not produce a Spanish translated version of the ECHC Inmate Handbook in response to our request. In order for inmates to avail themselves of the programs a facility offers or familiarize themselves with the rules and regulations within a given facility, to which they will be held accountable, inmates must be made aware of facility rules and protocols. Failure to do so is inconsistent with generally accepted correctional standards.

D. Inadequate Medical Care

ECHC and ECCF officials are responsible for providing adequate medical care to inmates. A jail may not deny or intentionally interfere with medical treatment. A delay in providing medical treatment may be so significant that it amounts to a denial of treatment. Our investigation revealed that medical care provided at ECHC and ECCF falls below constitutionally required standards of care.

One key deficiency is the lack of on-site health care administrators to manage healthcare services at the facilities. Although a physician is assigned to all Erie County Detention facilities, the physician does not monitor the "appropriateness, timeliness and responsiveness of care and treatment or review[] the recommendations for treatment made by health care providers in the community," and "[t]he physician is not involved in quality improvement reviews, training staff, or reviewing policy and procedures."⁴⁰ This level of oversight is critically important to ensure constitutionally adequate medical care. For example, adequate oversight and management would identify problems in inmate medical records, provide advice on training, and assist in the development of policies that are consistent with generally accepted correctional healthcare standards. Without this oversight, it is impossible for ECSO and JMD to attest to the adequacy of medical care within their facilities. Indeed, the NCCHC could not adequately determine the quality of

⁴⁰ NCCHC 2008 Erie Report, supra, n. 5, at 8.

health care for its 2008 review, because the inmate health records were incomplete.⁴¹

The administration of health care services in ECHC and ECCF is inadequate, as there are no quality improvement programs or monitoring procedures in place to internally assess the quality of health care at the facilities.⁴² Moreover, ECHC and ECCF medical policies and procedures fail to provide staff operational guidance on quality of care.⁴³ The NYSCC cited both the ECHC and ECCF in 2007 and 2008 for violating state law and employing licensed practical nurses⁴⁴ ("LPN") without the direction or supervision of a registered nurse, as required by state law.⁴⁵ Specifically, the NYSCC cited the "incompetent assessment" of an LPN for returning inmate John Jackson,⁴⁶ who was suffering from congestive heart failure, to his cell -- Mr. Jackson later

⁴¹ Id. at 7.

⁴² Id. at 9.

⁴³ Id. at 8. NCCHC noted that the policies were "under revision using the NCCHC Standards to revise the manual." (Emphasis in the original).

⁴⁴ LPNs care for people who are sick, injured, convalescent, or disabled under the direction of physicians and registered nurses. LPNs are not to perform "physical assessments of patients" or make "independent clinical decisions [or] patient dispositions without direction from a registered professional nurse or licensed physician." Letter from the NYSCC to Sheriff Timothy Howard, dated Mar. 29, 2007 (regarding the use of LPNs at ECCF, citing Article 139, New York State Education Law, Section 6902).

⁴⁵ Letter from the NYSCC to Sheriff Timothy Howard, dated May 28, 2008 (regarding the use of LPNs at ECHC); Letter from the NYSCC to Sheriff Timothy Howard, dated Mar. 29, 2007 (regarding the use of LPNs at ECCF, citing Article 139, New York State Education Law, Section 6902); Letter from the NYSCC to Anthony J. Billittier III, M.D., Commissioner, Erie County Department of Health, dated Mar. 29, 2007 (regarding the death of inmate [John Jackson]).

⁴⁶ The name "John Jackson" is a pseudonym.

died.⁴⁷ Following an investigation into Mr. Jackson's death, the NYSCC found that the use of LPNs at ECCF, without the supervision of a registered nurse, was "commonplace."⁴⁸ The NYSCC also criticized ECSO's response to their letter notifying the Jail that the "medical care that Mr. Jackson received was negligent and inadequate."⁴⁹ The NYSCC's Medical Review Board found that ECSO's "flagrantly indifferent and dismissive attitude in response to a critical incident with a fatal outcome and to the requirements of state law and regulations are in no small part causative factors in such outcomes."⁵⁰ In May 2008, a little over a year after this finding, the NYSCC once again cited ECSO for similar professional misconduct. This time, ECHC was cited for employing LPNs without adequate supervision.⁵¹

Through our review of incident reports, documents provided by the County, and recent state oversight reports, we find ECHC and ECCF document management of inmate medical records poor and often incomplete. We note that these problems have persisted for years, despite the NYSCC placing the County on notice of such deficiencies since 2005.⁵² As recently as early 2008, the NCCHC similarly concluded that the County has not addressed this issue.⁵³ In addition to the 2008 NCCHC finding, we draw

⁴⁷ Letter from the NYSCC to Sheriff Timothy Howard, dated Mar. 29, 2007 (finding the ECSO "summarily disregarded the facts that the medical care that Mr. [Jackson] received was negligent and inadequate"); Letter from the NYSCC to Anthony J. Billittier III, M.D., Commissioner, Erie County Department of Health, dated Mar. 29, 2007.

⁴⁸ Letter from the NYSCC to Anthony J. Billittier III, MD, Commissioner, Erie County Department of Health, dated Mar. 29, 2007.

⁴⁹ Letter from the NYSCC to Sheriff Timothy Howard, dated Mar. 29, 2007.

⁵⁰ Id.

⁵¹ Letter from the NYSCC to Sheriff Timothy Howard, dated May 28, 2008.

⁵² Letter from the NYSCC to Sheriff Timothy Howard, dated Sept. 27, 2005 (citing deficiencies in the maintenance of inmate medical records).

⁵³ NCCHC 2008 Erie Report, supra, n. 5, at 7, 24-25.

additional negative inferences from the County's lack of cooperation with our investigation by failure to provide us with the requested inmate medical documents and access to the facilities.

Inmates at ECHC and ECCF suffering from serious medical conditions require continual observation and consistent treatment and care in order to protect them from harm. The following examples illustrate that inmates at these facilities are not receiving adequate medical care.

- In December 2007 and January 2008, four inmates suffered multiple seizures. At least two of the inmates were told to sleep on the floor, and there is no indication that any of the inmates received medication after being treated at the hospital. One of the four inmates with a seizure history was transferred to the hospital after deputies found him lying unresponsive on the floor. An additional inmate, with a seizure history prior to detention, was found shaking on the floor of her cell and was not immediately sent for a medical evaluation.
- In April 2007, ECCF was cited for providing inadequate dental care to an inmate suffering from pain and a sensitivity to food and liquids.⁵⁴ The Citizens Policy and Complaint Review Council found that ECCF took too long to respond to the inmate's request to see a doctor regarding his pain, finding 21 days unreasonably long.⁵⁵
- In March 2007, an ECHC nurse, while delivering prescribed medication to an inmate, discovered that the inmate had died due to unknown causes. Earlier in the day, the inmate had refused food and requested that his cell window be opened.

1. Inadequate Administration of Medication

It appears that ECHC and ECCF nursing staff who store and administer medication may be untrained in critical areas of security, accountability, common side effects of medications and

⁵⁴ Letter from the NYSCC to Sheriff Timothy Howard, dated Apr. 24, 2007.

⁵⁵ Id.

documentation of administration of medicines. Alarming, the County was made aware of this deficiency through NYSCC evaluations in 2005 and 2006, as well as the NCCCHC 2008 evaluation.⁵⁶ Further, we received consistent reports from ECCF inmates that County deputies withhold inmate medication as a source of intimidation or punishment. The following examples illustrate the gravity of the situation:

- Despite receiving warnings from State oversight agencies as recently as 2008, nursing staff fail to ensure that inmates swallow their medication and fail to check inmate identification prior to administering medication. We reviewed incidents from 2007 in which an inmate attempted suicide by ingesting another inmate's psychotropic medication; another inmate hoarded his medication for several weeks before deputies located it on his shelf; and a third inmate admittedly faked a seizure in order to obtain his prescription medication.
- The NYSCC's review found controlled substances "placed in a paper bag and stored in the narcotic cabinet after they have been discontinued or when the inmate has been discharged ... [and that] ... [t]hese controlled substances are not counted each shift," in violation of Federal and State laws.⁵⁷

⁵⁶ Letter from the NYSCC to Sheriff Timothy Howard, dated July 17, 2006 ("There is an inadequate system for the management of pharmaceuticals, including controlled substances"); Letter from NYSCC to Sheriff Patrick Gallivan, dated Apr. 18, 2005 (citing ECSO for not screening detainees); see also, Letter from the NYSCC to Sheriff Patrick Gallivan, dated Feb. 22, 2005 and Letter from the NYSCC to Sheriff Timothy Howard, dated Sept. 27, 2005 (both addressing the inadequacy of ECHC's management of pharmaceuticals).

⁵⁷ Letter from the NYSCC to Sheriff Timothy Howard, dated July 17, 2006. In February 2005 ECSD was cited for leaving "two large boxes of controlled substances unattended in an unsecured area in the medical unit," in violation of Federal and State laws that require the restriction of controlled substances "to a secure area under double lock." Letter from the NYSCC to Sheriff Patrick Gallivan, dated Feb. 22, 2005.

The above examples indicate that procedures for medication administration at the ECHC and ECCF are not consistent with generally accepted correctional standards.

2. Inadequate Infection Control

ECHC and ECCF fail to adequately treat, contain, and manage infectious disease. ECHC and ECCF's management of Tuberculosis ("TB"),⁵⁸ Methicillin-resistant Staphylococcus aureus ("MRSA"),⁵⁹ and other infectious diseases deviates from generally accepted correctional medical standards. This failure is dangerous and places inmates, staff, and the community at unnecessary risk of serious health problems.

Generally accepted correctional standards for the management of communicable diseases in correctional facilities require the development of a management plan. This plan, at a minimum, should address the screening, diagnosis, and treatment of HIV/AIDS; Sexually Transmitted Diseases; Hepatitis; MRSA; TB; and outbreaks of communicable diseases. ECHC and ECCF, however, have no written exposure control plan approved by the responsible physician.⁶⁰ The lack of a written exposure control plan has resulted in deficiencies related to the containment and treatment of TB and MRSA. For example, the nursing staff at ECHC have confirmed that TB PPD testing is not performed on detainees at

⁵⁸ TB is a life threatening respiratory ailment commonly found in correctional facilities. TB is prevalent in correctional facilities because of poor circulation or inadequate ventilation, and the close quarters of a transient population.

⁵⁹ MRSA is a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death. A MRSA infection is sometimes confused by detainees and medical staff as a spider or insect bite, causing treatment to be delayed while the infection has time to worsen or spread. See <http://www.aafp.org/fpr/20041100/10.html>. MRSA is resistant to common antibiotics, such as methicillin, oxacillin, penicillin, and amoxicillin. MRSA is almost always spread by direct physical contact. However, spread may also occur through indirect contact by touching objects such as towels, sheets, wound dressings, and clothes. MRSA can be difficult to treat and can progress to life-threatening blood or bone infections. See http://www.medicinenet.com/staph_infection/page2.htm.

⁶⁰ NCCHC 2008 Erie Report, supra, n. 5, at 10.

the Holding Center, in contradiction to generally accepted correctional medical standards.⁶¹ Indeed, we have received numerous reports from inmates housed at ECHC between 2007 and 2008, confirming that they were not tested for TB upon arrival at the facility. Similarly deficient is ECHC's and ECCF's medical staffs' failure to identify symptoms clinically associated with a MRSA infection (e.g., red bumps, rashes, and the "spider bite"). We have received numerous reports from inmates held at these facilities who exhibited commonly known signs associated with MRSA and did not receive treatment.

Moreover, jail medical staff not only fail to screen inmates when they arrive at the facility and provide adequate surveillance of infectious diseases; medical staff also do not provide discharge planning, therefore providing no monitoring for inmates with communicable or infectious diseases, understood to be a basic part of generally accepted correctional practices.⁶²

E. Environmental Health and Safety Deficiencies

ECHC has severe environmental health and safety problems at numerous levels of operation.⁶³ Despite repeated NYSCC citations for poor sanitation and maintenance, ECSO and JMD have repeatedly failed to correct the problems. In 2007, NYSCC found maintenance and sanitation categorically inadequate throughout ECHC, exposing inmates and staff to unhealthy and unsafe conditions. State regulators cited ECSO and JMD on several occasions for overall poor sanitation, finding sanitation conditions "deplorable," with walls covered in toothpaste and cell bars covered in towels

⁶¹ Letter from NYSCC to Sheriff Timothy Howard, dated Oct. 10, 2007; Letter from NYSCC to Sheriff Patrick Gallivan, dated Apr. 18, 2005.

⁶² NCCHC 2008 Erie Report, supra, n. 5, at 10.

⁶³ Given our limited access to inmates held at ECCF, we are unable to assess whether similar sanitation problems exist at ECCF to the degree to which they exist at ECHC. We have received reports, however, that conditions at ECCF are also unsanitary.

and sheets.⁶⁴ NYSCC staff, for example, found a significant accumulation of Styrofoam food trays and other clutter in the cells. This is a serious problem, as it can attract insects and other vermin, as well as allow for the spread of disease. Maintenance and sanitation are categorically inadequate throughout the facility, exposing inmates and staff to unhealthy and unsafe environments as a result. We learned of one inmate who indicated he was housed, for at least one month, in an ECHC cell with four inches of standing water due to toilet flooding.

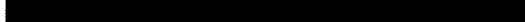
In a correctional setting where inmates and staff are dependent on maintenance staff for their water, heat, lighting, and ventilation, it is expected that these issues would be addressed in a timely manner in order to reduce risks of illness and injury to inmates and staff alike. That is not the case here. NYSCC has cited ECSO and JMD for electrical hazards that neither correctional officers nor maintenance staff seemed to be concerned about, despite the potential for harm being readily apparent. In both April and August 2007, the NYSCC found ECHC supervisors were "not holding staff accountable for the sanitation of their assigned housing areas."⁶⁵ Critical sanitation deficiencies included the failure of jail staff to properly secure sanitation equipment and supplies when not in use. Inmates have used sanitation equipment, like a broom, as a weapon. In one case, the handle was broken and used to stab another inmate.

ECSO and JMD were also cited for poor facility maintenance. The NYSCC found the padding and cushion material on chairs in the day room were torn or removed, exposing screws, nuts, and bolts that could be used to cause injury.

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⁶⁴ NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 5; NYSCC ECHC Cycle 2 Evaluation Apr. 2007, supra, n. 6, at 9. The covering of cell bars with towels and sheets results not only in poor sanitation but also in security risks, as correctional officers are unable to see into cells when the bars are covered with towels.

⁶⁵ NYSCC ECHC Cycle 2 Evaluation Apr. 2007, supra, n. 6, at 9; NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 5.

 This is a serious security risk that should be corrected immediately.

Laundry services at ECHC and ECCF are similarly inadequate. As of August 2007, "[i]nmates [were] required to either wash their facility-issued and/or personally owned undergarment in a cell sink or arrange for the pick-up and washing of these items by family or friends."⁶⁷ This poses a serious problem, as soiled and/or improperly washed clothing can retain bacteria and other contagion that can cause infection or spread disease. Moreover, inmates are forced to dry their clothes by hanging them in their cells, thereby obstructing a deputy's view into the cell, thus compromising security. Lastly, the NYSCC noted that no clothing exchange was provided to inmates, as required under New York law.⁶⁸

III. RECOMMENDED REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of inmates confined at ECHC and ECCF, ECSO and JMD should implement, at a minimum, the following remedial measures:

A. Suicide Prevention Measures

1. Provide adequate treatment for inmates with self-injurious behavior.



⁶⁷ NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 4. Again, this inadequacy in sanitation also represents a security risk.

⁶⁸ NYSCC ECHC Cycle 2 Evaluation Aug. 2007, supra, n. 6, at 4; NYSCC ECHC Cycle 2 Evaluation Apr. 2007, supra, n. 6, at 7; NYSCC 2006 Evaluation, supra, n. 6, at 13.

2. Develop policies and procedures to ensure appropriate management of suicidal inmates and the establishment of a suicide prevention program.
3. Ensure that all staff are educated and adequately trained on suicide recognition, intervention, and management, including pre-service and annual in-service suicide prevention training, and that, prior to assuming their duties and on a regular basis thereafter, all staff who work directly with inmates have demonstrated competence in identifying and managing suicide.
4. Ensure that ECHC and ECCF have written suicide prevention policies that include an operational description of the requirements for both pre-service and annual in-service training.
5. Screen all inmates upon intake, including questioning to assess current and past suicide risk.
6. Document inmate suicide attempts at ECHC and ECCF in the inmate's correctional record in the classification system, in order to ensure that intake staff will be aware of past suicide attempts if an inmate with a history of suicide attempts is admitted to ECHC and ECCF again in the future.
7. Ensure that intake staff are sufficiently experienced and qualified to identify inmates who pose a risk for suicide, and that such inmates are promptly referred to the appropriate mental health professionals and provided appropriate housing.
8. Ensure that follow-up evaluations by mental health professionals of all new inmates are conducted within 14 days of intake.
9. Ensure that inmates on suicide precautions receive adequate mental status examinations by a mental health clinician.
10. Ensure that suicidal inmates are housed in an area that is safe for them with appropriate supervision and observation by staff.

11. Ensure that 15- and 30-minute checks of inmates under observation for risk of suicide are timely performed and appropriately documented.
12. Provide different levels of supervision of an inmate based on the presenting risk factors for suicide.
13. Ensure that detainees placed on suicide watch are assessed adequately, monitored appropriately to ensure their health and safety, and released from suicide watch as their clinical condition indicates, according to professional standards of care.
14. Ensure that cut-down tools are readily available to staff in all housing units. Train staff in the use of cut-down tools.
15. Ensure a component of administrative review is implemented following a suicide or a suicide attempt to identify what could have been done to prevent the suicide.

B. Mental Health Care

1. Timely and Appropriate Evaluation of Inmates
 - a. Ensure ECHC and ECCF properly identify inmates with mental illness through adequate screening, and that such screening is incorporated into each inmate's medical record.
 - b. Ensure that inmates with potentially serious chronic mental health illness are referred for prompt mental health evaluations and examinations by a psychiatrist.
 - c. Provide adequate mental health assessment and treatment in accordance with generally accepted correctional standards of mental health care.
 - d. Ensure that adequate crisis services are available to address the psychiatric emergencies of inmates.
 - e. Provide staffing adequate for inmates' serious mental health needs. Provide adequate on-site psychiatry coverage. Ensure that psychiatrists see inmates in a timely manner. Ensure that

psychotropic medication prescriptions are reviewed by a psychiatrist on a regular, timely basis.

2. Assessment and Treatment

- a. Ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses and problems, consistent with generally accepted correctional practices. Provide therapy services where necessary for inmates with serious mental health needs. Provide adequate opportunities for inmates and staff to have confidential communications related to mental health treatment, while maintaining appropriate security precautions.
- b. Ensure that mental health evaluations done as part of the disciplinary process include recommendations based on the inmate's mental health status.
- c. Ensure that medications are provided to inmates in a timely manner and that they are properly monitored.
- d. Provide staffing adequate for inmates with serious mental health needs. Ensure that services, such as distribution of medications, are performed by nurses or other properly trained staff.
- e. Provide policies and procedures that require the appropriate assessment of inmates with mental illness.
- f. Ensure adequate medical documentation and general procedures as part of the mental health assessments that account for inmates' psychiatric histories.

3. Psychotherapeutic Medication Administration

- a. Ensure timely responses to orders for medication and laboratory tests, and prompt documentation thereof in inmates' charts.
- b. Ensure that adequate psychotherapeutic medication administration is provided in accordance with

generally accepted correctional mental health care standards.

- c. Ensure that changes to inmates' psychotropic medications are clinically justified. Screen inmates on psychotropic medications for movement disorders and provide treatment where appropriate.
4. Other Mental Health Issues
- a. Ensure that administrative segregation and observation status are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.
 - b. Ensure that ECHC and ECCF mental health records are centralized, complete, and accurate.
 - c. Ensure that ECHC and ECCF quality assurance system is adequate to identify and correct serious deficiencies with the mental health system.
 - d. Ensure that a psychiatrist or physician conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. Seclusion or restraint orders should include sufficient criteria for release.
 - e. Ensure that all staff who directly interact with inmates (including Correctional Officers) receive competency-based training on basic mental health information (e.g., diagnosis, specific problematic behaviors, psychiatric medication, additional areas of concern); recognition of signs and symptoms evidencing a response to trauma; and the appropriate use of force for inmates who suffer from mental illness.
- C. Protection from Harm
1. Use of Force
 - a. Develop and maintain comprehensive and updated policies and procedures, in accordance with generally accepted correctional standards, regarding permissible use of force.

- b. Develop and maintain comprehensive policies and procedures, consistent with generally accepted correctional standards, regarding the establishment and deployment of the Response Team and Quick Entry Team, including permissible uses of force, use of force reporting, and necessary training specific for membership on this team.
 - c. Establish effective oversight of the use of force.
 - d. Develop an effective and comprehensive training program in the appropriate use of force.
2. Safety and Supervision
- a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates.
 - b. Ensure that inmate common areas are adequately supervised whenever inmates are present.
 - c. Ensure frequent, irregularly timed, and documented security rounds by correctional officers inside each housing unit.
 - d. Ensure that staff adequately and promptly report incidents.
 - e. Develop a process to track all serious incidents that captures all relevant information, including: location, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
 - f. Establish a procedure to ensure that inmates do not possess or have access to contraband. Conduct regular inspections of cells and common areas of the housing units for contraband.
 - g. Conduct regular inspections of cells and common areas of the housing units to identify and prevent rule violations by inmates.

- h. Review, and revise as applicable, all security policies and Standard Operating Procedures on an annual basis.
 - i. Provide formal training on division-specific post orders each time a correctional officer is transferred from one division to another.
 - j. Develop and implement specialized training for officers assigned to special management units, which include the Special Incarceration Units, disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be regularly assigned to these units for stability purposes.
 - k. Develop and implement appropriate training for corrections staff addressing security administration regarding:
 - (1) Identification, prevention, and intervention in inmate-on-inmate violence; and
 - (2) Professionalism and appropriate interaction between corrections staff and inmates.
 - l. Ensure that adequate supervisory staff is in place to prevent staff provocation and staff encouragement of inmate violence.
 - m. Develop and implement adequate policies and procedures to ensure appropriate investigation of staff-on-inmate violence and to ensure that appropriate corrective actions are taken.
 - n. Ensure the adequate division of supervisory responsibility at ECCF, including, the establishment of clear lines of authority per shift, irrespective of union affiliation.
3. Classification
- a. Develop and implement policies and procedures for an objective classification system that separates inmates in housing units by classification levels.

- b. Update facility communication practices to provide officers involved in the classification process with current information as to cell availability on each division.
 - c. Update the classification system to include information on each inmate's history.
4. Sexual Misconduct
- a. Ensure that staff is trained and/or retrained on the Prison Rape Elimination Act.
 - b. Establish a zero tolerance standard regarding any form of sexual harassment or sexual misconduct that involves inmates, staff or any other individual that has contact with inmates.
 - c. Prompt written corrective action must follow any deficiency or negative finding that is revealed in either an administrative or criminal investigation surrounding sexual misconduct or sexual harassment.
5. Inmate Grievance Procedure
- a. Develop and implement policies and procedures to ensure inmates have access to an adequate grievance process. Such process should ensure that grievances are processed and legitimate grievances addressed and remedied in a timely manner, responses are documented and communicated to inmates, inmates need not confront staff prior to filing grievances about them, and inmates may file grievances confidentially.
 - b. Ensure that grievance forms are available on all units.
 - c. Ensure that inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, referred for investigation.

6. Access to Information

- a. Ensure that newly admitted inmates receive information they need to comply with facility rules and regulations, report misconduct, access medical and mental health care, and seek redress of grievances.
- b. Ensure that inmates who are not literate are afforded the opportunity to have information on facility rules and services explained to them orally.

D. Medical Care

1. Intake Screening

- a. Ensure that adequate intake screening and health assessments are provided for inmates in accordance with generally accepted correctional standards of care. Develop and implement an appropriate medical intake screening instrument that identifies observable and non-observable medical needs, including infectious diseases, and ensure timely access to a physician when presenting symptoms require such care.
- b. Ensure that acute and chronic health needs of inmates are identified in order to provide adequate medical care.
- c. Ensure that medical screening information is reviewed in a timely manner by trained and appropriate medical care providers.
- d. Ensure that tuberculosis ("TB") screening is conducted in a timely manner. Provide adequate treatment and management of communicable diseases (e.g., TB and Methicillin-resistant Staphylococcus aureus ("MRSA"), HIV, and Hepatitis).

2. Acute care

- a. Provide timely medical appointments and follow-up medical treatment. Ensure that inmates receive treatment that adequately addresses their serious medical needs. Ensure that inmates receive acute care in a timely and appropriate manner.

- b. Provide adequate acute care for inmates with serious and life-threatening conditions.
 - c. Ensure that staff are adequately trained and prepared to handle emergency situations in accordance with generally accepted correctional standards.
3. Chronic care
- a. Ensure that inmates receive thorough assessments for, and monitoring of, their chronic illness. Develop clinical practice guidelines for inmates with chronic and communicable diseases. Ensure that standard diagnostic tools are employed to administer the appropriate preventative care in a timely manner.
 - b. Adopt and implement appropriate clinical guidelines for chronic diseases such as HIV, hypertension, diabetes, asthma, and elevated blood lipids, and policies and procedures on, among other things, timeliness of access to medical care, continuity of medication, infection control, medicine dispensing, intoxication/detoxification, record-keeping, disease prevention, and special needs.
 - c. Ensure that medical staff are adequately trained to identify inmates in need of immediate or chronic care, and provide timely treatment or referrals for such inmates.
 - d. Ensure that inmates with chronic conditions are routinely seen by a physician to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.
 - e. Ensure adequate follow-up treatment and medication administration concerning all inmates with chronic conditions.

4. Treatment and Management of Communicable Disease
 - a. Provide adequate treatment and management of communicable diseases, including TB and Methicillin-resistant Staphylococcus aureus.
 - b. Ensure that inmates with communicable diseases are appropriately screened, isolated, and treated.
 - c. Ensure that HVAC and negative pressure systems are properly maintained and functioning.
 - d. Develop and implement an adequate TB control plan in accordance with generally accepted correctional standards of care. Such should provide guidelines for identification, treatment, and containment to prevent transmission of TB to staff or inmates.
 - e. Develop and implement policies that adequately manage contagious skin infections. Develop a skin infection control plan to set expectations and provide a work plan for the prevention of transmission of skin infections, including drug-resistant infections to staff and other inmates.
 - f. Develop and implement adequate guidelines to ensure that inmates receive appropriate wound care.
5. Follow-Up Care
 - a. Provide adequate care and maintain appropriate records for inmates following hospitalization. Ensure that inmates who receive specialty or hospital care are evaluated upon their return to the facility and that, at a minimum, discharge instructions are noted and appropriately provided.
6. Record Keeping
 - a. Ensure that medical records are adequate to assist in providing and managing the medical care needs of inmates at ECHC and ECCF.
 - b. Ensure that medical records are complete, accurate, readily accessible, and systematically organized. All clinical encounters and reviews of

inmates should be documented in the inmates' records.

7. Medication Administration
 - a. Ensure that treatment and administration of medication to inmates is implemented in accordance with generally accepted correctional standards of care.
 - b. Ensure that administration of medication is accurate and adequately documented. Develop policies and procedures for the accurate distribution of medication and maintenance of medication records. Provide a systematic review of the use of medication to ensure that each inmate's prescribed regimen continues to be appropriate and effective for his condition.
 - c. Ensure that medicine distribution is hygienic and appropriate for the needs of inmates.
8. Staffing, Training, and Supervision
 - a. Provide adequate staffing, training, and supervision of medical and correctional staff necessary to ensure adequate medical care is provided.
 - b. Ensure that medical staffing is adequate for inmates' serious medical needs and that physicians adequately monitor their patients.
 - c. Provide adequate physician oversight and supervision of medical staff, including supervision for LPNs.
 - d. Ensure that there is an adequate number of correctional officers to escort inmates to medical units.
9. Quality Assurance Review
 - a. Ensure that ECHC and ECCF's quality assurance system is adequate to identify and correct serious deficiencies with the medical system.

- b. Ensure that ECHC and ECCF's quality assurance system is capable of assisting in managing and treating inmate medical needs. At a minimum, such a system should be reliable and capable of tracking medically-related incidents.

E. Sanitation and Environmental Conditions

1. Sanitation and Maintenance of Facilities

- a. Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.
- b. Ensure prompt and proper maintenance of shower, toilet, and sink units.
- c. Ensure proper ventilation and airflow in all cells and housing units.
- d. Ensure adequate lighting in all housing units and prompt replacement and repair of malfunctioning lighting fixtures, so that officers and inmates are not exposed to the security danger that lack of visibility presents.

2. Environmental Control

- a. Ensure adequate control and observation of ECHC and ECCF cells, particularly with regard to razors, fire loading materials, commissary items, and cleaning supplies.
- b. Repair electrical shock hazards; develop and implement a system for maintenance and repair of electrical outlets, devices, and exposed electrical wires.

3. Sanitary Laundry Procedures

- a. Ensure that laundry delivery procedures protect inmates from exposure to contagious disease, bodily fluids, and pathogens by preventing clean

laundry from coming into contact with dirty laundry or contaminated surfaces.

- b. To limit the spread of MRSA and other infectious disease, require inmates to provide all clothing and linens for ECHC and ECCF laundering and prevent inmates from washing and drying laundry outside the formal procedures.
- c. To limit the spread of MRSA and other infectious disease, ensure that clothing and linens returned from off-site laundry facility are clean, sanitized, and completely dry.
- d. Provide all inmates with properly cleaned and adequate bedding and clothing

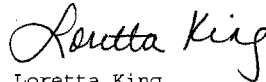
* * *

IV. CONCLUSION

Please note that this letter is a public document and will be posted on the Civil Rights Division's website.

We invite the State to discuss with us the remedial recommendations, with the goal of remedying the identified deficiencies without resort to litigation. In the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202)514-0195.

Sincerely,



Loretta King
Acting Assistant Attorney General

cc: Timothy B. Howard
Erie County Sheriff

Robert Koch
Superintendent
Erie County Sheriff's Department,
Jail Management Division

Cheryl A. Green
County Attorney
Erie County

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U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

June 4, 2009

The Honorable Ed Emmett
County Judge
1001 Preston
Suite 911
Houston, TX 77002

RE: Investigation of the Harris County Jail

Dear Judge Emmett:

On March 7, 2008, we notified your office of our intention to investigate conditions at the Harris County Jail (Jail) pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with statutory requirements, we write to report the findings of our investigation and to recommend remedial measures needed to ensure that conditions at the Jail meet federal constitutional requirements. See 42 U.S.C. § 1997b.

During our investigation, correctional experts in the fields of penology, medicine, psychiatry, and life safety, assisted us in reviewing records, interviewing staff, interviewing detainees, and inspecting facility living conditions. Before, during, and after our on-site inspections, we received and reviewed a large number of documents, including policies and procedures, incident reports, medical and mental health records, and other materials. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided debriefings at the conclusion of two on-site inspections conducted in July and August 2008. During the debriefings, our consultants provided their initial impressions and tentative concerns.

Throughout this process, County and Jail officials cooperated fully with our review. We appreciate the assistance that they provided us and the candor of their response. Indeed, we were impressed by the level of professionalism exhibited by staff at all levels and with the sophistication of many Jail systems. While we use individual incidents throughout this letter to illustrate systemic deficiencies, we are aware that this facility has a very difficult task handling large numbers of

detainees, many of whom have serious medical and mental health problems. The examples we cite should not necessarily be construed as a criticism of particular staff. In many cases, such incidents may be more reflective of inherent systemic problems with Jail procedures or resources than the professionalism or dedication of staff and administrators.

We are pleased to advise you that Harris County Jail complies with constitutional requirements in a number of significant respects. The Jail's operational infrastructure includes the existence of written policies and procedures, clearly designated security and medical supervisors, training programs, a booking and intake assessment process, infection control programs, and fire safety precautions. At the same time, however, we also conclude that certain conditions at the Jail violate the constitutional rights of detainees. Indeed, the number of inmates deaths related to inadequate medical care, described below, is alarming. As detailed below, we find that the Jail fails to provide detainees with adequate: (1) medical care; (2) mental health care; (3) protection from serious physical harm; and (4) protection from life safety hazards.

I. DESCRIPTION OF THE JAIL

Harris County Jail includes four major jail facilities constructed between the 1980s and the 1990s. At the time of our site visit, the Jail housed over 9400 detainees.¹ The Jail's design capacity is reportedly 9800 detainees. The Harris County Sheriff's Department also places detainees at various satellite locations. If those detainees are also counted, the Sheriff's Department is responsible for a total of nearly 11,000 detainees. In 2007, the Jail processed over 130,000 admissions.

II. LEGAL FRAMEWORK

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail detainees and detainees subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. The rights of pre-trial detainees are protected under the Fourteenth Amendment which ensures that these detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). Under

¹ The Jail houses mainly pre-trial detainees, but also houses some post-adjudication inmates. For the purpose of this letter, both groups will be referred to as detainees.

the Eighth Amendment, prison officials have an affirmative duty to ensure that detainees receive adequate food, clothing, shelter, and medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994). The Eighth Amendment protects prisoners not only from present and continuing harm, but also from future harm. Helling v. McKinney, 509 U.S. 25, 33 (1993).

Detainees have a constitutional right to adequate medical and mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832. Detainees' constitutional rights are violated when prison officials exhibit deliberate indifference to their serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 102 (1976). Detainee living conditions must be "reasonably sanitary and safe." Farmer 511 U.S. at 832.

III. CONSTITUTIONAL DEFICIENCIES

As a large urban detention facility, Harris County Jail faces a number of significant problems including a high detainee census and complex funding and logistical challenges. In many ways, the Jail actually performs quite well. Jail policies and procedures provide for a comprehensive detainee housing assignment process, medical sick call procedures, and regular facility maintenance. Staff receive broad training on Jail operations, supervision of detainees, and detainee rights. Unfortunately, in a number of critical areas, the Jail lacks necessary systems to ensure compliance with constitutional standards.

A. Medical Care

The Jail has functional systems in place to provide medical care and treatment to a large population of detainees. These systems include an initial screening process, a more comprehensive health assessment for longer-term detainees, a sick call process, a modern clinic, qualified medical staff, a professional management structure, and mechanisms to obtain outside specialty care. Despite the general quality of such systems, the Jail fails to provide consistent and adequate care for detainees with serious chronic medical conditions. We found specific deficiencies in the Jail's provision of chronic care and follow-up treatment. These deficiencies, in themselves and when combined with the problems in medical record-keeping and quality assurance discussed below, are serious enough to place detainees at an unacceptable risk of death or injury.

1. Inadequate Chronic Care

Detainees who suffer from chronic medical conditions require assessment and ongoing treatment to prevent the progression of their illnesses. As part of the treatment process, detainees with chronic medical conditions require routine follow up to monitor the progression of their illness and the potentially hazardous effects of medication. Because of crowding, administrative weaknesses, and resource limits, the Jail does not provide constitutionally adequate care to meet the serious medical needs of detainees with chronic illness.

Generally accepted standards of correctional medical care require that medical staff identify detainees with chronic conditions such as - diabetes, tuberculosis, and heart disease - and provide timely treatment for such conditions. Unfortunately, the Jail does not have an assessment process to adequately identify detainees with serious chronic medical conditions. In particular, we found that the Jail has delegated screening to nurses who are in need of additional training and more administrative oversight by physicians. For instance, we found assessment forms completed by nursing staff who had not actually completed the assessments. We also found that physicians do not routinely see detainees with chronic conditions to assess the status of their health. Moreover, Jail staff do not conduct periodic surveys of the housing units to identify detainees who may have chronic medical conditions, but who may not necessarily be identified by the normal sick call process or the screening procedures conducted during detainee booking. Such deficiencies result in gaps in the system for identifying detainees with serious chronic medical conditions. For instance, staff may miss some detainees who are degenerating mentally or physically, but who are unable or unwilling to utilize the normal sick call process.

Problems with chronic care assessments are particularly pronounced in the assessment of detainees receiving medications. Generally accepted correctional medical standards require that once medical staff identify a medical condition, they need to order appropriate medications and then periodically re-assess those medications to determine their effectiveness and to monitor side effects. The Jail medical staff are not adequately

conducting such periodic assessments. Examples from 2007-2008 include:

- Detainee AA had a history of hypothyroidism and seizures.² Medical staff administered two medications, each of which could have had potentially toxic side effects. After the initial medication order, dosages and blood levels of these medications were not monitored.
- Detainee BB suffered from a deep venous thrombosis (blood clot) in his lower extremity. Medical staff administered an unsafe dosage of blood thinning medication, placing the detainee at an increased risk of clot formation. Such clots can cause serious medical complications including sudden death. Staff conducted lab tests which showed that the dosage might be unsafe, but then failed to follow up on the test results.
- Detainee CC had a history of heart failure. Medical staff administered two medications with potentially toxic side effects. Our record review suggests that medical staff did not check CC's blood levels for several months.

2. Inadequate Continuity of Medical Care

Chronic and some acute medical conditions require appropriate ongoing treatment and continuity of care. Failure to address detainee medical conditions over time can lead to an increased risk in morbidity and mortality. Systems and practices, such as adequate record-keeping and follow-up exams by qualified staff, must be in place to manage the serious medical conditions of detainees during the length of their incarceration. The Jail does not have a system in place to provide such continuity of care for some of the detainees with the most serious medical conditions.

The Jail's medical clinic serves as a makeshift emergency room, stabilizing detainees with acute conditions. This model, however, is problematic in a large urban detention facility with

² To protect the identity of detainees, the initials used in this letter are not the actual detainees' initials.

hundreds of sick detainees. Many of the detainees with serious medical conditions cannot be adequately identified or treated solely through an acute care process.

In the absence of a chronic care program or other systems for ensuring follow-up care, the sick call process serves as the primary mechanism for the Jail to provide continuity of care. This system is not capable of providing such continuity of care. The sick call process itself is seriously strained due to crowding, staffing limits, and some problematic practices. For instance, we received a number of complaints about delays in care at the Jail's 1200 Baker facility. Because of the way care is organized at the Jail, the 1200 Baker housing units seem to be particularly affected by any bottlenecks in access to the main intake clinic, despite the fact that the clinic is also located at 1200 Baker. Because the main clinic also serves as the main intake facility and emergency treatment center, the 1200 Baker detainees must effectively share the same clinic resources as newly admitted detainees, emergency cases, and detainee transfers from other units who require additional medical supervision. This puts a heavy strain on 1200 Baker medical staff and impedes detainee access to care.

More generally, the Jail's administrative procedures allow delays in care to be easily overlooked. Jail procedures require that detainees complete forms to request medical care. The Jail disposes of these forms, however, just after they are processed. Once the forms are destroyed, the Jail apparently cannot track detainee requests for medical care in order to determine whether they have been fulfilled. Another peculiar Jail practice involves the process for responding to requests for specialty care. As a matter of routine practice, Jail detainees submit requests for specialty care to a clerk. This process has apparently little or no physician oversight, which means that access to specialty care is not initially reviewed by qualified personnel. This lack of oversight means that individuals who may need more intensive or immediate care receive the same level of attention as those with relatively low priority needs.

These problems would be troublesome enough for a clinic dealing only with detainees who have acute medical complaints. For detainees with chronic conditions, barriers to care can cause them more difficulties than experienced by those inmates with more typical medical complaints. Detainees with chronic illness may need care to be much more timely and routine than some detainees with acute conditions. At present, however, the detainees have a difficult time first accessing the clinic, and then receiving continuity of care. Detainees with mental illness

are an especially high risk group. Other detainees with chronic conditions may at least have the capacity to seek care. Detainees with mental illness, especially those who are acutely psychotic or suicidal, may not even try to use the sick call process to obtain continuing treatment of their conditions. Such detainees may need regular follow-up visits and more consistent access to medical staff.

Examples of the Jail's failure to provide appropriate follow-up treatment and continuity of care include the following examples from 2007-2008:

- DD was a 74-year-old detainee with a history of open heart surgery. When DD visited the clinic presenting complaints of incontinence, medical staff failed to give DD a physical exam or take his vital signs. Staff sent DD back to DD's unit. The following day, DD returned to the clinic with incontinence and elevated blood pressure. Clinic staff sent DD to the hospital, where he died shortly thereafter.
- EE had a documented history of diabetes that received inadequate medical attention. When EE complained of symptoms, staff merely prescribed pain medication. Initially, EE complained of leg pain and knee swelling. In response, staff provided EE with pain medication. EE complained again 5 days later about her symptoms. The medical notes were essentially illegible, but apparently staff again just provided pain medication. The detainee complained of her symptoms once more that same day. While waiting to be seen in the clinic, EE collapsed and died shortly afterwards. The documentation suggests that after EE collapsed, staff failed to provide an appropriate emergency response. For instance, the records show that EE had a low blood sugar level at the time of her collapse, but staff failed to respond to the symptoms. Medical records also suggest that the staff did not try to use an automatic emergency defibrillator during the incident.
- FF had a history of cirrhosis. Over several weeks, FF's liver condition worsened, but staff repeatedly failed to respond in a manner consistent with generally accepted correctional medical standards. FF initially presented to the clinic with a complaint of swelling to his legs. Jail staff prescribed blood pressure medication, even though FF's blood pressure was normal. FF complained of chest pain and other conditions over

the next several weeks. Jail staff repeatedly sent FF to the hospital but repeatedly failed to change his medications, treatment plan, or conduct other appropriate follow-up. For instance, on one of these occasions, a deputy reported that FF was having trouble walking. The staff sent FF to the hospital, and an undated medical note indicates that FF needed fluid removed from his stomach. Again, however, staff did not alter FF's treatment plan; nor was there any apparent documentation of vital signs. Approximately one month after his initial complaint, FF died during his last hospital stay. One troubling additional note about this case is that during the period in question, FF apparently spent much of his time at the Jail in a housing unit instead of the infirmary. Given the seriousness of FF's medical condition, he needed to be in an infirmary in order to receive the level of care required by generally accepted correctional medical standards. The discontinuity of care and a lack of follow-up by staff are of serious concern in this case.

3. Inadequate Medical Documentation and Quality Assurance

Medical record-keeping and quality assurance are basic components of a clinical practice that is consistent with generally accepted correctional medical standards. These systems help identify and correct potential problems with patient care. Harris County has deficiencies in both areas, and these deficiencies contribute to problems with chronic care and continuity of care.

A complete and adequate medical records system is critical to ensuring that medical staff are able to provide adequate care. The Jail's process for maintaining medical records and processing medical orders often leaves medical records unavailable to nurses and doctors. Medical staff have little or no access to the records when the pharmacy staff are filling out medication orders, because the pharmacy staff have custody of the records when completing those orders. During our fact-gathering, we also found various record-keeping problems such as a lack of compliance with professional record-keeping formats, illegible physician notes, and factually inaccurate documentation. These deficiencies affect the quality of care and the medical staff's ability to meet Constitutional requirements.

As a matter of technical assistance, we should note that correctional facilities often benefit from having an adequate quality assurance process. Such a process can help

administrators self-identify and correct any deficiencies. A large facility may have particular difficulty addressing systemic constitutional deficiencies without such a process. The Jail does engage in some effective quality improvement activities in order to track and trend medical-related incidents at the facility. The activities do not, however, include adequate mechanisms to review and evaluate Jail physicians; nor does the process include mechanisms that could help ensure more consistent and adequate record-keeping. The mortality review process does not include feedback to appropriate physician staff.

B. Mental Health Care

Many of the Jail detainees require mental health care. Approximately 2000 Jail detainees reportedly receive psychotropic medications each day. Of the detainees receiving psychotropic medications, approximately 200 are considered by the Jail to be part of the mental health program. These detainees often cannot be housed in general population because of their mental health condition. The Jail needs a range of housing options to handle such detainees, because detainees with mental illness have very different needs depending on their circumstances. Instead, the Jail only has a limited number of on-site housing options for detainees with mental illness. These basically consist of some single cells and specialized dormitories.

Housing practices for detainees with mental illness are problematic. For example, even though the ratio of male to female mental health patients is about 2:1, the number of male single cells to female single cells appears to be 32:1. Thus, female detainees with mental illness are much more likely to be left in inappropriate housing conditions while awaiting care. As with medical care generally, the clinic in the 1200 Baker building serves as the primary mental health resource. As noted previously, the 1200 Baker clinic is overwhelmed. The Jail also has access to some other treatment facilities, such as the Harris County Psychiatric Center (Center), but these facilities have limited resources. For example, the Center can house only 24 Jail detainees.

Many of the problems noted previously regarding chronic care and medical care generally also apply to detainees with mental illness. For example, the Jail's process for assessing and treating detainees is focused on acute symptoms and does not adequately identify detainees with serious mental health needs. The mental health clinic functions like a hectic emergency room,

and detainees with serious mental health conditions often cannot obtain timely and appropriate care. These deficiencies violate generally accepted correctional mental health standards.

As a practical matter, while the general medical clinics can meet the serious acute care needs of many detainees, the mental health system does not adequately address the serious mental health care needs of detainees. Mental health policies designed to cover a range of conditions exist, but overwhelmed staff often do not implement them as written. A host of serious mental health conditions cannot be adequately handled at the Jail because of significant housing and treatment limitations. While the Jail devotes additional resources to dealing with the most acutely suicidal, even the basic care and supervision of the most seriously mentally ill appears inadequate.

1. Inadequate Access to Mental Health Treatment

The Jail's written policies include a process for screening and prioritizing detainees with serious mental illness, but in practice, the Jail does not adequately treat detainees based on the seriousness of their condition. The Jail staff classify requests for mental health care into four basic categories. Category 1 includes detainees who are acutely suicidal or have expressed homicidal complaints. Category 2 includes detainees who have expressed some suicidal ideation but have not indicated imminent action. Category 3 includes detainees with medication issues. Category 4 includes detainees who need to see a case manager. Because of limitations on facility housing, staffing, and treatment options, the Jail can only address detainees in Category 1. Other detainees must wait for treatment, often for significant periods of time, if they receive mental health treatment at all.

Given that mental health staff received about 17,000 requests in 2007, the existing system for allocating mental health resources is inadequate. The Jail does not provide access to mental health care for many inmates with serious needs. Examples from 2007-2008 include:

- GG entered the facility with a mental health history. At the time, GG apparently was withdrawing from alcohol, but staff failed to provide appropriate medication and initial intervention. Five days later, someone observed GG in his cell, with blood seeping out under the door. Security arrived, and they discovered that GG had lacerated his hand and appeared to be hallucinating. Staff transferred GG to the infirmary,

but they did not complete an initial psychiatric assessment until five days later. Staff discharged GG two days later.

- HH's medical record suggested that he had a history of not eating, but staff did not initially refer him to a psychiatrist for assessment. After six months in the Jail, HH complained of depression, and staff finally referred HH to a psychiatrist. Mental health staff, however, did not conduct an initial psychiatric evaluation until three weeks after HH complained of depression. Mental health staff noted that HH appeared to be depressed. During the next two months, HH received medication but did not see a psychiatrist. HH ended up in an altercation and had to be placed in isolation. Two days later, he began vomiting blood. At the time of our tour, HH had been housed in administrative separation for more than 18 months and had been involved in various altercations with staff. Given the nature of HH's mental health condition, the Jail's delays in providing mental health treatment and evaluation likely contributed to HH's continuing mental decline and behavioral disturbances.
- II entered the Jail with a history of seizures, but apparently did not receive seizure medications at intake. II experienced a seizure 19 days after arrival at the Jail. II also had a history of cutting. There was no follow-up on this psychiatric issue at all.
- JJ served time in the Jail on multiple occasions. Staff medicated JJ without following generally accepted correctional medication standards. Without an initial screening, the Jail staff involuntarily medicated JJ and housed him in the mental health department's acute treatment cellblock. Staff then repeatedly treated JJ with both anti-psychotic and mood-stabilizing medications without adequate laboratory studies or proper monitoring, placing the detainee at risk of sudden death.
- KK was identified as bipolar upon admission. Psychiatry did not see KK for nearly a month, and KK received no medication for his illness until about six weeks after his admission. In the interim, KK was involved in altercations on four occasions, resulting in the fracture of his arm. Staff renewed KK's medication order over this period without further

patient examination by a psychiatrist. Even after KK's altercations, there appears to have been little follow-up by staff to deal with KK's mental health symptoms.

- During intake, LL reported a mental health history that included risk factors for suicide. The Jail staff did not refer LL to mental health services. Approximately 3 weeks later, LL lacerated his neck.

2. Inadequate Treatment and Psychotropic Medication Practices

In a large urban detention center with a heavy mental health caseload, staff need to have access to a variety of treatment resources. Such resources include an array of different types of therapy, medication, and intensive supervision in order to address different types of mental illness, and varying levels of patient acuity.

Jail mental health staff have access to some mental health resources, but those resources are not sufficient given the size of the mental health caseload. The Jail has few treatment program options available for detainees with mental illness. The Jail uses medications, additional staff monitoring, and some structured housing for detainees with mental illness. For most mental health conditions, the primary intervention is a medication order, often with inadequate follow-up even for the most seriously ill. Indeed, once medical staff prescribe medications, they often cannot or do not routinely follow-up on those detainees unless the detainees themselves request care. This is a substantial departure from generally accepted correctional standards. Notably, detainees also reported that there are significant delays when they request care.

In our document review, some of the treatment orders appeared to depart significantly from generally accepted professional mental health standards. Some of these orders suggest that staff may be utilizing medications in a clinically inappropriate or unsafe manner. Examples of improper chemical restraints and unsafe medication practices during the period from 2006-2008 include the following:

- MM was in an acute psychotic state for nearly two weeks before he died. At intake, staff prescribed medications but they were never dispensed. As MM became increasingly uncooperative, staff injected MM with an intramuscular drug. Medical records suggest significant problems with basic medication

documentation and staff approaches to medication non-compliance. Soon after MM was injected, MM's breathing grew shallow, and he became unresponsive. MM died shortly afterwards.

- NN spent the better part of a year in a State Hospital. NN was found not competent and not restorable. For some reason, he was sent back to the Jail. Despite his competency status, Jail staff nevertheless placed the detainee in general housing and allowed him to keep various medications on his person. NN was not a good candidate for self-medication. NN appeared to suffer a seizure and he was sent to the clinic. The clinic staff suspected the detainee was "sleepy" due to his psychotropic medications. They released the detainee from the clinic, and he died shortly afterwards.
- A Jail psychiatrist diagnosed OO with schizoaffective disorder (a situation where both mood and schizophrenic symptoms exist). OO also had a history of mental illness. OO's mental health deteriorated, and staff repeatedly renewed his medications without having him seen again by a psychiatrist. OO ended up in two altercations, including one in which he struck a deputy.
- PP reported a history of seizures. PP suffered at least one seizure in the Jail, but according to the Jail's medical records, there was no proper follow-up. Medical staff placed PP on four benzodiazepines, but not a long-term anti-convulsant.³ This suggests that the purpose of the medications prescribed was more likely to sedate the inmate, rather than to treat his seizures.
- QQ required treatment for seizures. QQ experienced a series of seizures, but on at least two clinic visits, documentation suggests that QQ's chart was unavailable

³ If used at all for seizure disorder, benzodiazepines are typically prescribed for short-term treatment. They are more commonly used for acute detoxification. In the context of this individual's history and record, the use of four medications of the same class to sedate a detainee appears to be a misuse of the medications.

to the staff during the exams. This resulted in a number of delays in care despite QQ's repeated seizures.

3. Inadequate Suicide Prevention

In general, a comprehensive system for providing adequate mental health care should also include policies, procedures and practices to prevent detainee suicides. Because suicide prevention is itself an important legal concern, we note specifically that the Jail has a number of conditions that are dangerous for suicidal detainees.

First, the Jail lacks adequate video surveillance and supervision in various holding areas. Some of the cells used for housing newly arrested detainees include unsafe physical fixtures (e.g., exposed bars) that can be used to facilitate suicide. While the Sheriff's Department was in the process of retrofitting these cells during our tour, such efforts need to be broadened. Many of the mental health holding areas throughout the Jail appear to be clinically inappropriate. For instance, padded rooms in administrative separation and maximum security units are difficult to supervise and the conditions are so stark, they can cause a detainee with mental illness to degenerate.

Second, the detainees' generally limited access to mental health care can be especially dangerous for suicidal detainees, since suicidal detainees may not be particularly inclined to seek care on their own. Thus, adequate screening and pro-active efforts to identify and treat suicidal detainees are necessary to ensure compliance with minimum standards of care.

C. Protection from Harm

We evaluated the Jail's detainee supervision procedures, security classification process, housing practices, grievance procedures, disciplinary process, and training program. We found that many Jail policies and practices are consistent with minimum correctional standards. Yet, at the same time, we also found some significant and often glaring operational deficiencies. For security matters in particular, the Jail lacks: (1) a minimally adequate system for deterring excessive use of force, and (2) an adequate plan for managing a large and sometimes violent detainee population.

1. Excessive Use of Force

We have serious concerns about the use of force at the Jail. The Jail's use of force policy is flawed in several regards. First, neither written policy nor training provide staff with clear guidance on prohibited use of force practices. For example, Harris County Jail does not train staff that hogtying and choke holds are dangerous, prohibited practices. Indeed, we found a significant number of incidents where staff used inappropriate force techniques, often without subsequent documented investigation or correction by supervisors. Second, use of force policies fail to distinguish between planned use of force (e.g., for extracting an detainee from a cell) and unplanned use of force (e.g., when responding to a fight). In many planned use of force situations, staff should be consulting with supervisors, and possibly medical staff, before using force. Third, Jail policies do not provide for routine videotaping of use of force. Fourth, the Jail does not have an appropriate administrative process for reviewing use of force. Jail policy does not clearly require the individual using force to file a use of force report; nor does Jail policy provide for routine, systematic collection of witness statements. When supervisors review use of force incidents, they do not have ready access to important evidence. Instead, they appear to rely excessively on officer statements to determine what happened during an incident. While Jail staff were helpful and willing to assemble use of force documents requested by our review team, we found it troubling that the Jail did not collect such documents as a matter of course. In other words, use of force occurs at the Jail without adequate review, and Jail data regarding use of force levels cannot be considered reliable. We believe that the incidents noted during our review may only reflect part of what is really occurring within the facility.

As a result of systemic deficiencies including a lack of appropriate policies and training, the Jail exposes detainees to harm or risk of harm from excessive use of force. In a particularly troubling January 2008 case, staff applied a choke hold to a detainee, who subsequently died. The autopsy report identified the manner of death as homicide. Our review of the Jail's records suggests that such improper force technique is being used with troubling frequency. For instance, our consultant found a pattern of such incidents when reviewing use of force reports dated from January through June 2008. These incidents included the following:

- An officer reported that he "grabbed inmate RR by the front of his jumpsuit top and the back of his neck and

forcibly placed inmate RR on the ground. Once on the ground, I continued to apply pressure to inmate RR's neck and placed my right knee in the small of his back."

- An officer used both a headlock and multiple strikes to SS's rib cage.
- Officers "grab[bed] the front of [TT's] shirt and place[d] him on the wall to gain control of the incident."
- Officers used force on UU that resulted in a laceration requiring eleven staples to the scalp. Yet, the use of force incident was not reported by either of the officers who applied the force. Instead, another officer initiated the "inmate offense report."

These and other similar incidents suggest that staff use hazardous restraint and force techniques without appropriate guidance or sanction. In some cases, medical records confirm that detainees may have suffered notable injuries, such as lacerations to the scalp or eye. Notably, when force was investigated by supervisors, it appears that the supervisors often determined that staff's use of force was appropriate without obtaining independent medical review or multiple witness statements.

At the time of our inspection, the Jail was already making some effort to improve use of force reviews. At the time of our tour, the Office of the Inspector General was in the early stages of developing a use of force review process. We also understand that the Jail continues expanding this process in ways that may address some of the concerns noted in this letter. Nevertheless, work must continue in this area before we can conclude that the Jail meets minimum constitutional standards.

2. Overcrowding

With a population approaching 10,000 detainees, the Jail is one of the largest detention facilities in the country. The Texas Jail Commission's decision to grant the County waivers to house approximately 2000 detainees more than the Jail's original design capacity is concerning on its face. At the same time, however, a large detainee population, even if over design capacity, does not itself necessarily violate minimum legal standards. Moreover, the Sheriff's Department has adopted a number of measures to alleviate crowding issues, such as

transferring detainees to outside facilities and providing "portable bunks." Conditions would likely be much worse if the detainees at outside contract facilities had to be housed in the Houston Jail complex. The Sheriff's Department is clearly trying to manage its population, and we acknowledge its efforts. While crowded conditions may not, in and of themselves, violate the Constitution, we are compelled to raise our concerns here because (1) the Jail's crowded conditions currently exacerbate many of the constitutional deficiencies identified in this letter; and (2) the Jail needs a more comprehensive, systemic approach to dealing with a large and growing Jail population.

Jail crowding affects multiple Jail systems. For instance, it impedes detainee access to medical care, indirectly affects detainee hygiene, and reduces the staff's ability to supervise detainees in a safe manner. How the Jail handles inmate supervision and violence illustrates some of the complexities associated with overcrowding. The Jail has already adopted a number of useful strategies for dealing with detainees who are dangerous to themselves or others. These strategies include an objective classification process for deciding where to house detainees and contracts with outside facilities to handle crowding pressure. Despite such strategies, the Jail is so large, violence still breaks out frequently. In one recent ten month period, the Jail reported over 3000 fights, and 17 reported sexual assaults. Also, as discussed above in the mental health section of this letter, the Jail has had particular difficulty managing violent detainees with behavioral and mental health issues. Because crowding makes it difficult to supervise detainees and prevent violence, additional Jail staffing or more jail diversion programs could reduce the risk of detainees coming to harm in the facility.

Managing a large population is a complex problem, and requires both short-term administrative approaches and long-term strategies. For instance, changes to administrative processes and better technology can help alleviate violence and supervision problems associated with crowding. The Jail staff have limited options to address violence and other serious incidents through internal administrative and supervisory mechanisms. At the time of our tour, the Jail did not have the ability to routinely investigate violent incidents. Instead, the Jail staff had to rely heavily on more cumbersome criminal prosecutions to deal with such incidents. In such a large facility, criminal prosecutions may not be a sufficient deterrent to violence. More structured administrative procedures for reviewing incidents, identifying dangerous inmates, and correcting hazardous situations are needed. The Jail also did not have procedures in

place that could more appropriately distinguish between disturbances caused by detainees with mental illness and other detainees. The response to the former often needs to be more nuanced in order to avoid exacerbating the detainees' mental illnesses and to ensure fairness. Instead of referring detainees for structured treatment, the Jail staff instead often have to rely on placing detainees with mental illness in isolation. Isolation can actually make a detainee with mental illness worse and is not as therapeutic as a properly designed, dedicated treatment unit. Other administrative deficiencies include a lack of staff control over hazardous contraband (e.g., detainee razors), and a disciplinary process that lacks safeguards to protect witness confidentiality. Similarly, physical plant and technology issues affect the Jail staff's ability to supervise housing areas. The four main facilities do not have video surveillance in critical areas. The satellite facilities also lack adequate video surveillance.

More generally, while clearly the use of outside facilities and other tactics have helped to alleviate some of the population pressures at the Jail, it is less clear whether the Jail actually has a workable long-term plan for dealing with the types of systemic problems noted in this letter, especially in light of potential population growth. The County is reportedly working to address many of the specific issues raised in this letter, but at this early remedial stage, it is difficult to determine how much progress will eventually be made. For instance, if the Jail increases staff, but then the Jail population simultaneously increases, those staff could quickly become overwhelmed. In other words, when dealing with crowding and its effects on security, medical care, and various Jail operations, the Sheriff's Department should evaluate issues and remedies in a systemic manner. Otherwise, it may be much more difficult to resolve deficiencies in a complete and long-term manner.

D. Sanitation and Life Safety

The Jail buildings are generally modern and adequately maintained. Staff receive training on a variety of emergency procedures. The Jail lacks, however, certain necessary structured maintenance, sanitation, and fire safety programs. Given stresses upon Jail infrastructure crowding, the lack of such programs raises concerns about sanitation and fire safety in the Jail.

1. Sanitation and Hygiene

While the Jail generally appeared to be clean and many systems seemed to be well-maintained, certain deficiencies in the Jail's hygiene practices and maintenance programs expose detainees to an unacceptable risk of injury, disease, or other harm. Jail crowding contributes to these deficiencies.

First, the Jail does not have systems in place to ensure adequate detainee personal hygiene. For example, the facility's laundry facilities and procedures are currently inadequate given the size of the Jail population. As a general matter, the Jail does not even have a "par level" of clothing or linen available for detainees. In other words, the Jail does not maintain enough accessible clothing or linen on-hand for the number of detainees housed at the facility. Moreover, the laundry operation does not meet minimum sanitary standards. The laundry operation does not properly wash and sanitize clothing. The laundry has only a few machines, and a number of those were inoperative during our tour. The staff also use a variety of inconsistent, and often inadequate, schedules and procedures for handling and cleaning laundry. As a result, we found a significant amount of unsanitary bedding, clothing, and mattresses throughout the facility. Such unsanitary conditions can expose detainees to a serious risk from infectious disease.

Another example of poor hygiene practices involves detainee grooming and shaving equipment. The Jail's barbers practice their trade in an unhygienic manner. Clipper blades, guards, and supply boxes appeared to be dirty and had not been cleaned between uses. Detainee barbers did not keep their equipment in disinfectant solutions. As discussed previously in this letter's section on protection from harm, razor blades are not well controlled in the facility. The availability and use of dirty, shared razors and blades is a serious risk, both in terms of disease transmission and as a security matter.

Finally, the Jail's plumbing and mechanical systems require improved maintenance in order to ensure hygienic conditions in certain housing units. While most of the Jail is properly maintained, the Jail's population size and gaps in the Jail's maintenance program result in unsanitary conditions in the intake and mental health units, where the Jail utilizes archaic flushable floor drains, essentially holes in the floor, instead of toilets. Using such grossly inadequate facilities for long periods of time is itself problematic because they are

unhygienic. Moreover, when we tested some of the drains, they back-flushed into the cells. Elsewhere throughout the Jail, we found drains clogged with significant accumulations of debris.

2. Fire Safety

The Jail is a modern facility with a number of fire safety features, such as alarm systems and fire suppression equipment. The main problem with the Jail's fire safety program is that staff training and oversight appear to be inadequate. During our site inspection, we found inadequate numbers of personnel trained to perform emergency tasks. The Jail has a level of constant staff turnover that makes it difficult to ensure that there are fully trained staff on duty in the housing units. As a result, when we randomly questioned staff about emergency procedures, we found that a number of them did not know how to use emergency equipment or how to respond during a drill. We also discovered inconsistencies in safety documentation that further suggest a lack of staff training. Finally, we found that the Jail staff did not have adequate access to emergency keys in the event of a failure in the Jail's electronic door control system. Commendably, the Sheriff's Department immediately took a number of steps to address our fire safety concerns. Importantly, these efforts should be incorporated into ongoing, system-wide safety reviews.

IV. **RECOMMENDED REMEDIAL MEASURES**

In order to address the constitutional deficiencies identified above and protect the constitutional rights of detainees, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice:

A. Medical care

1. The Jail should develop a chronic care program consistent with generally accepted correctional medical standards. This program should include a process that will identify detainees who should be enrolled in a chronic care program; a roster of detainees enrolled in the program; a schedule of medical visits for each detainee enrolled in the program; a system for determining which diagnostic tests will be required for each chronic condition; and record-keeping which includes documentation of lab work and medical orders.
2. The Jail should update and improve the medical and mental health quality assurance and training programs to ensure

compliance with generally accepted correctional medical standards. These improvements should include additional internal self-auditing to ensure that staff conduct appropriate assessments, provide timely treatment, and document care in a manner consistent with generally accepted correctional medical standards.

3. The Jail should develop a system to monitor the effects of medications and to ensure appropriate follow-up for detainees with serious medical or mental health conditions.
4. The Jail should develop a system to track sick call requests and identify barriers to timely access to medical or mental health care. Sick call requests need to be triaged by appropriate personnel to ensure appropriate and timely access to medical care.
5. The Jail should ensure that medical consultation and specialty services receive physician oversight.
6. The Jail should employ sufficient qualified staff to ensure detainees have adequate access to medical and mental health care.

B. Mental Health Care

1. The Jail should create a mental health program that will allow the Jail to identify, treat, and monitor detainees with chronic mental illness. As part of this development process, responsible Jail personnel may wish to consider evaluating mental health programs in a variety of outside institutions and adopt useful policies and procedures from appropriate models.
2. The Jail should continue with efforts to assess the mental health caseload in the facility, and develop a variety of housing and treatment options to address the needs of the mentally ill. This system will need to organize treatment options so that the Jail can deal with those across the entire spectrum of care. The Jail's mental health treatment policies need to meet generally accepted standards of correctional health care. These policies should provide for the development of individual treatment plans and timely access to levels of care appropriate to detainees' mental health needs. Such care should address detainees who are stable and can be housed in general housing, detainees who are highly unstable and require intensive supervision, detainees who are stable but may require step-down services

before returning to general population, detainees who are actively suicidal, and detainees who are at risk of suicide but may not have expressed an immediate intent to commit suicide.

3. Restraints should not be used as punishment, for the convenience of staff, or in lieu of treatment. The Jail should provide a variety of psycho-therapeutic treatment options and adopt appropriate safeguards to avoid the inappropriate use of chemical sedation.
 4. The Jail should implement policies for monitoring detainees at risk of suicide that meet generally accepted correctional mental health standards. The Jail should retrofit cells used for suicidal detainees or detainees requiring intensive supervision. The Jail should eliminate fixtures that can be used to facilitate suicide (e.g., exposed bars or bath fixtures) while at the same time avoid creating a non-therapeutic environment (e.g. bare cells or extensive use of isolation for psychotic detainees).
 5. The Jail should include mental health staff and administrators as part of medical quality assurance and other administrative management processes.
- C. Protection from Harm
1. The Jail should ensure that there are a sufficient number of adequately trained staff on duty to supervise detainees and to respond to serious incidents.
 2. The Jail should prohibit the use of chokeholds and hogtying.
 3. The Jail should increase video surveillance in critical housing areas and alter staffing patterns to provide additional direct supervision of housing units.
 4. The Jail should develop and implement policies and procedures to improve control over razors or other dangerous items.
 5. The Jail should develop and implement additional policies and procedures for the investigation of serious incidents, including excessive use of force and detainee-on-detainee violence. These policies and procedures should include administrative responses to violence and a detainee disciplinary process conducted in a confidential manner. They should also include routine interview and document

collection procedures that will allow investigators to complete their inquiries in an objective manner consistent with generally accepted correctional standards.

- 6. The Jail should alter its procedures for cell extractions and other use of force situations to ensure that staff are utilizing appropriate force techniques. Such alterations should include routine videotaping of planned use of force.

D. Sanitation and Life Safety

- 1. The Jail should develop and implement a long-term plan for addressing Jail crowding and population growth.
- 2. The Jail should develop and implement policies and procedures to improve detainee hygiene to a level consistent with generally accepted health standards. The Jail should specifically improve laundry practices and facilities to ensure that the Jail can adequately wash and sanitize detainee laundry. The Jail should also maintain, at all times, a sufficient supply of sanitary bedding, linen, clothing, razors, and other hygiene materials.
- 3. The Jail should increase staff training to ensure that staff is prepared to implement emergency procedures and operate emergency equipment the event of an emergency. Jail supervisors shall periodically test and drill staff on their knowledge of emergency procedures, and provide corrective instruction as part of a Jail-wide safety program. The Jail should continue with its ongoing effort to develop a qualified Jail safety team to help conduct staff training and oversee facility safety programs.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding the Jail. Since we toured, the County has reported that it has adopted a number of improvements, many of which appear to be designed to address issues raised during our exit interviews. We appreciate the County's pro-active efforts.

Assuming there is continued cooperation from the County and the Jail, we would be willing to send our consultants' reports under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the County's attorney to discuss this matter in further detail. If you have any questions regarding this letter, please contact Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Loretta King

Loretta King
Acting Assistant Attorney General

cc: Vince Ryan, Esq.
Harris County Attorney

Adrian Garcia
Sheriff
Harris County

The Honorable Tim Johnson, Esq.
United States Attorney
Southern District of Texas



U.S. Department of Justice
Civil Rights Division

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November 9, 2009

The Honorable Pat Quinn
Governor
Office of the Governor
207 State House
Springfield, Illinois 62706

Re: Investigation of the W.A. Howe Developmental Center,
Tinley Park, Illinois

Dear Governor Quinn:

We are writing to report the findings of the investigation of the Civil Rights Division and the United States Attorney's Office for the Northern District of Illinois of conditions and practices at the W.A. Howe Developmental Center ("Howe"), in Tinley Park, Illinois. On July 25, 2007, we notified you of our intent to conduct an investigation of Howe pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA authorizes the Department of Justice to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of persons with developmental disabilities who are served in public institutions.

On December 3-7, 2007, we conducted an on-site review of care and treatment at Howe with expert consultants in various disciplines. Before, during, and after our tour, we reviewed a wide variety of relevant State and facility documents, including policies and procedures, as well as medical and other records relating to the care and treatment of Howe residents. During our tour, we also interviewed Howe administrators, professionals, staff, and consultants, and visited residents in their residences, at activity areas, and during meals. In keeping with our pledge of transparency and to provide technical assistance, where appropriate, we conveyed our preliminary findings to State counsel and to certain State and facility administrators and staff during exit presentations at the close of our on-site review.

We would like to express our appreciation to Howe administrators, professionals, and staff, as well as to the State officials involved in our investigation, for their assistance, cooperation, professionalism, and courtesy throughout our investigation. We hope to continue to work with the State and Howe officials in the same cooperative manner going forward.

We have concluded that numerous conditions and practices at Howe violate the constitutional and federal statutory rights of its residents. Many of the findings we make in this letter are due to or exacerbated by Howe's failure to focus its treatment and care on moving individuals into the most integrated settings appropriate to their needs. In particular, we find that Howe fails to provide its residents with adequate: (1) protection from harm; (2) health care; (3) psychiatric care; (4) behavioral treatment and habilitation; (5) integrated treatment planning; and (6) transition planning and placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act ("ADA"); 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

We are aware that, on September 5, 2008, the State announced its intention to close Howe by June 30, 2009. We are furthermore aware that the State temporarily halted closure planning earlier this year, before announcing on August 28, 2009, its final decision to close Howe, and to complete all resident transitions by April 2010. While the Department of Justice acknowledges the State's closure deliberations and decision, the purpose of this letter is advise you formally, in accordance with CRIPA, of the findings of our investigation, the facts supporting them, and the minimum remedial measures necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Even as the closure of Howe proceeds, the constitutional violations at the facility will have continuing effects, for which the State must provide relief in whatever setting a Howe resident eventually resides. As it closes Howe, the State retains a statutory obligation to move the facility's residents to the most integrated setting appropriate for them as individuals.

I. BACKGROUND

Located in Tinley Park, Illinois, approximately 30 miles outside of Chicago, Howe is a licensed 500-bed intermediate care facility for individuals with developmental disabilities. Howe is one of nine residential developmental centers operated by the Illinois Department of Human Services. At the time of our tour in December 2007, Howe housed 349 adult residents. The Howe campus consists of 40 residential group homes, 35 of which were occupied during our tour. Most of the group homes housed between 8 and 11 individuals. The campus also includes an

administration building, a professional services building, and a social habilitation building.

In 2006, the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") placed Howe in "immediate jeopardy" of losing Medicaid certification due to serious deficiencies identified at the facility by CMS surveyors.¹ In 2007, prior to our investigation, CMS terminated Howe's Medicaid contract. At the time of the termination, Medicaid funding provided approximately one-half of Howe's \$53 million annual budget. To date, Howe remains decertified.

In addition to the deficiencies identified by CMS, several prominent statewide disability advocacy organizations in Illinois expressed concern over the quality of care provided to the residents at Howe. These organizations routinely cited to a number of resident deaths during 2005-2007, alleging substandard care as a contributing factor to those deaths. At the time we notified the State in July 2007 of our investigation, at least fourteen residents had died in the previous 18 months. Since our tour in December 2007, sixteen more residents have died.

This is the second CRIPA investigation of Howe undertaken by the Department of Justice. In 1992, after a multi-year investigation of Howe, we entered into a consent decree with the State of Illinois regarding necessary improvements to the facility. The consent decree, filed in the United States District Court for the Northern District of Illinois, specifically required Howe to make improvements in the areas of resident assessment, evaluation, and training; use of restraints; medical care; medication administration; record keeping; and staffing. In 1996, we stipulated to an agreed order to terminate the consent decree and dismiss the case. Unfortunately, we received substantial allegations of new or continuing violations and therefore, as noted above, opened a new CRIPA investigation in 2007. This letter provides our findings from the current investigation.

II. FINDINGS

A. TRANSITION PLANNING

Federal law requires that a state actively pursue the timely discharge of institutionalized residents to the most integrated, appropriate setting that is consistent with the resident's needs. Howe is failing to place residents in the most

¹ CMS surveys are conducted by a designated State Survey Agency ("SSA"). The SSA in Illinois is the Illinois Department of Public Health ("IDPH").

integrated setting appropriate to their individual needs, in violation of Title II of the Americans with Disabilities Act (“ADA”), and the regulations promulgated thereunder. In construing the anti-discrimination provision contained in Title II of the ADA, the Supreme Court has held that “[u]njustified [institutional] isolation . . . is properly regarded as discrimination based on disability.” Olmstead v. L.C., 527 U.S. 581, 597, 600 (1999). Specifically, the Court established that states are required to provide community-based services and supports for persons with developmental disabilities when the state’s treatment professionals have determined that community placement is appropriate, provided that the transfer is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. Id. at 602, 607.

Successful transition of residents into a more integrated setting is a fundamental obligation of an institution such as Howe. Howe’s failure to meet this obligation is caused in part by the breakdowns in care noted in the below sections of this letter. The State’s decision to close Howe does not relieve the State from its obligation to provide federally mandated adequate transition planning. To the contrary, the State’s decision to close Howe intensifies the facility’s poor record of successful transitions. Howe’s deficiencies detailed below – to protect residents from harm (section B), provide adequate health care (section C), psychiatric care (section D), behavioral treatment and habilitation (section E), and integrated treatment planning (section F) – all hinder the residents’ opportunities to live in a more integrated setting and unnecessarily prolong institutionalization.

The result of Howe’s failure to move residents to community placements is to deprive residents of the most integrated appropriate treatment setting, to exacerbate challenging behaviors, and to foster institutionalized behaviors and attitudes. Among the staff at Howe, we observed a culture that accepts movement toward community placements at a glacial pace. Often there is no movement at all. Transition to community placement, when considered, is viewed as a distant possibility.

Of the residents present at Howe for some portion of the period between September 1, 2006, and September 30, 2007, only 80 residents were recommended for placement by their treatment team. Although persons with disabilities can live in community-based settings with proper supports, fewer than one-fourth of the individuals at Howe were recommended for community placement by their treatment team. During this same 13-month period, only 32 residents (approximately 9% of the census at the time of our tour) were discharged to community placements. This rate of community placement is low and results in a large number of individuals remaining at the facility for long periods of time.

For example, B.L., a resident who has no challenging behaviors, no psychiatric symptoms, can dress herself, complete all morning grooming, eating, and bedmaking activities before leaving for her workshop placement, and has few health problems, was not referred to any community agencies in the past year. This failure clearly maintains B.L. in an overly restrictive setting and deprives her of meaningful choices about where to live.

According to Howe's list entitled, "People Recommended for Community Placement by Treatment Team - 9/1/06 - 9/30/07," residents recommended for placement in the community in 2004 still have not been placed. Of residents who have requested community placement, some have remained at Howe even longer, despite evidence that there is no serious obstacle to such movement. For example, B.M., whose "one issue is his anger," had anger management replacement behavior consistently above 90 percent and, at times 100 percent, for the last 11 of 14 months. Although there is also a note about B.M. having mobility problems, B.M.'s ISP does not even address steps toward community placement.

Staff at Howe hold incorrect beliefs as to prerequisites for community living, which further restricts residents' progress toward living in a less restrictive setting. For example, staff expressed to our expert consultant the belief that residents needed to be successful in a community day program before actively pursuing community living. Further, staff consider success in the development of social, vocational, and basic living skills to be requirements for community placements, which they are not. Those skills increase residents' options for living in the community, but social deficits, vocational deficits, and basic living deficits are not inherently barriers to community living. Staff also expressed the belief that a failure to develop certain skills necessitates postponing target dates for placement by a matter of years. For example, A.A.'s Qualitative Monthly Review Summary acknowledges that he has the goal of moving into a community placement, but states that "at the pace he is going[,] the target dates may need to go up a few years." (Emphasis added).

As barriers to placement are not identified in ISPs, and there are no goals aimed at overcoming those barriers, the transition process is simply not a focus for staff. Where goals regarding placement are included, they are vaguely stated and monitoring information is obscure. Sometimes the goals rely on external agencies or outside persons to move the process forward. For example, C.P.'s ISP states that her goal of moving to a community-based residence was not met "due to guardian's lack of interest and knowledge to seek placement at this time."

Transition plans, when generated at all, come too late and lack sufficient information to generate useful, proactive planning. Too often, the section entitled, "What will make this person successful in community living environment?" is blank.

Transition plans are not included in residents' records, so they are not readily available to the treatment team.

We did note that, once a resident is referred, the process becomes more proactive and effective. This was evidenced by the fact that, at the time of our tour, placements had increased. Nevertheless, Howe residents are institutionalized far longer than necessary due to deficient transition planning. This deficiency is of great concern as Howe proceeds with closure plans and transitions residents to new settings.

B. PROTECTION FROM HARM

The Supreme Court has recognized that persons with developmental disabilities who reside in state-operated institutions have a "constitutionally protected liberty interest in safety." Youngberg v. Romeo, 457 U.S. at 318. Therefore, as the Court explained, the state "has the unquestioned duty to provide reasonable safety for all residents" within the institution. Id. at 324. In our judgment, the State of Illinois fails to protect Howe residents from harm and risk of harm, and to provide residents with a reasonably safe living environment. Failure to provide a reasonably safe living environment undermines the other care and treatment provided at Howe, prolongs the time periods spent by individuals there, and delays the movement of individuals to more integrated settings in violation of Olmstead.

Generally accepted professional standards to protect persons with developmental disabilities from harm in an institutional setting, which are necessary to prevent constitutional violations, utilize a two-pronged approach: (1) identifying and responding quickly to occurrences of harm by collecting pertinent information, and (2) implementing affirmative measures to effectively manage the risk of future occurrences of harm. The processes of responding to and preventing harm are generally understood as "incident management" and "risk management" respectively.

1. Incident and Risk Management

The term "incident management" can be understood as the immediate responses taken by the facility when an individual has incurred actual harm or wherein the proclivity for such harm is real and/or imminent. Although Howe maintains an Incident Management Committee to review reportable incidents and injuries, as explained in further detail below, individuals at Howe are at significant risk of harm and injury due to the facility's ineffective incident management.

Additionally, generally accepted professional standards for facilities like Howe require implementation of a risk management system that identifies an individual's risks of harm and develops preventative interventions through skill acquisition, environmental changes, and therapeutic interventions. Interdisciplinary treatment teams must thoroughly assess residents to determine individual risks and develop effective strategic interventions to reduce risk. Moreover, facilities must utilize objective data to measure the success of the strategic interventions in preventing harm, and when necessary modify the interventions to improve outcomes.

We find that Howe's risk management practices do not provide the level of protection necessary to reasonably prevent harm, substantially depart from generally accepted professional standards, and consequently fail to meet constitutional and federal standards. Howe residents continue to be at significant risk of harm and injury due to the facility's absent or ineffective responses to ongoing harm. Below, we discuss three areas of incident and risk management: (1) reportable incidents and injuries; (2) risk assessment and intervention; and (3) abuse and neglect investigations.

a. Reportable Incidents and Injuries

Generally accepted professional standards require that facilities like Howe maintain a reporting system to identify all reportable incidents and injuries accurately and responsibly. A "reportable" incident will commonly include incidents such as falls, peer aggression, accidents, restraints, self-injurious behaviors, injuries of unknown origin, and abuse and neglect allegations.

To its credit, Howe's criteria for collecting reportable incident information appears to align with generally acceptable standards. Howe's procedures for actually reporting and reviewing these incidents, however, substantially depart from those standards. Indeed, the procedures have not been revised for nearly 20 years. More troubling than the procedures being simply outdated is our finding that there are significant inconsistencies in the staff's adherence to the procedures. These inconsistencies result in under-reporting of reportable incidents, which in turn, results in insufficient responses to occurrences of harm.

Despite the evidence of under-reporting, the number of reportable incidents at Howe is disturbing. For example, for the period of September 2006 through September 2007, Howe reported nearly 3,000 incidents, including 8 deaths and more than 100 allegations of abuse and neglect. Many of these incidents describe harm suffered by individual residents that could have been avoided had the facility taken preventive measures to manage the risk of harm.

Our expert consultant concluded that among the types of reportable incidents, aggression and assault are “rampant” at Howe. From September 2006 to September 2007, more than 150 individuals – about half of all residents at the facility – were assaulted by their peers. The injuries suffered as a result of these aggressive incidents included: scratches, abrasions, human bites, head trauma, and in more than 20 instances, lacerations that required the use of staples, sutures, or Dermabond² to close the wounds. Human bites alone account for 25 percent of all aggressive incidents at Howe, a trend that our expert consultant found to be “staggering” in comparison with other institutions with similar populations.

Other notable examples of reportable incidents of harm during the period of September 2006 through September 2007 included residents who suffer from pica³ successfully obtaining and ingesting foreign objects such as mechanical restraint devices, plastic bags, keys, metal coils, and puzzle pieces, as well as some 22 individuals who reportedly sustained fractures, including one resident who suffered three fractures, and three residents who had two fractures.

Many Howe residents suffered significant personal injury during the occurrences of reportable incidents of harm. For example:

- In June 2007, A.A.⁴ displayed increasingly intense aggressive behavior until he punched through a window with his hand and arm. He required 23 sutures at the local emergency room to close the wound.
- In July 2007, when a Howe physician referred B.B. to the local hospital due to her coughing and respiratory distress, x-rays identified three rib fractures. Investigators concluded that she may have suffered the fractures when she tripped over a misplaced chair the previous day. At the time of the fall, however, staff reported only that her foot was sore.

² Dermabond is the brand name of a liquid bonding agent used as an alternative to stitches for closing wounds.

³ Pica is a medical condition in which a person ingests or attempts to ingest nonfood substances such as clay, chalk, hair, or glue.

⁴ To protect the identity of residents, we use coded initials throughout this letter. We will transmit separately a schedule cross-referencing the coded initials with the actual names of the residents.

- Similarly, in October 2007, staff found C.C. with significant bruising on her shoulder and back, and reported that she “may have fallen from her bed or chair.” Twenty-two hours later, a Howe physician examined C.C. and sent her to the local hospital for x-rays. There, the emergency room physician diagnosed a fractured clavicle, and reported the matter to the Illinois State Police because the physician concluded that it was hard to believe that her injury came from a fall.

Alarming, 7 of the 10 most frequently injured residents had been assigned intensive staffing at the time of their injuries. The intervention strategy of assigning enhanced individual supervision for a time after injuries occur, as we saw at Howe, is often ineffective to ensure residents’ daily safety. For example, during the period of September 2006 through September 2007:

- Tragically, D.D. suffered significant injuries while on 1:1 supervision,⁵ prior to his unexpected death in April 2007. These injuries included multiple lacerations requiring 40 sutures, injuries to his face and head, human bites to his chest, and an abrasion to his penis requiring closure with Dermabond. When the frequency of harm to D.D. escalated in late 2006, strategies to protect him remained relatively unchanged. His record reflects that substantive changes were limited to psychoactive medication adjustments and the cancellation of his daily program schedule.
- E.E. suffered 37 injuries while on 1:1 supervision, including a fracture in September 2006, and lacerations requiring Dermabond on January 19, January 26, and February 23, 2007.
- F.F. injured himself on at least 40 separate occasions while on intensive supervision during the one-year period examined. Some injuries were so severe as to require treatment at a hospital, including the need for sutures or Dermabond on at least four occasions.
- G.G. had an intensive staffing assignment during the one-year period reviewed until her unexpected death in November 2007. Yet during this time, G.G. sustained at least 25 injuries, including two self-inflicted lacerations requiring closure by Dermabond.

⁵ The term “1:1 supervision” refers to a heightened level of supervision in which the facility will order a staff person to continually supervise one particular resident.

- Similarly, H.H. was placed on 1:1 supervision in November 2001 due to her unsteady gait and risk of falling. Yet from September 2006 through November 2007, H.H. suffered 28 injuries, including two lacerations in July 2007 requiring closure by Dermabond.
- I.I. was placed on 1:1 supervision nearly 10 years ago to prevent him from intentionally harming himself. Despite the heightened supervision level, I.I. caused injury to himself 13 times in the one-year period examined.

In addition to the reportable incidents identified by Howe, we are concerned, as stated above, about the problem of under-reporting of incidents of harm. Howe does not have a firm grasp on the actual numbers of reportable incidents, injuries, and uses of restraints⁶ at the facility. The pervasive (and self-admitted) under-reporting of incidents of harm at Howe minimizes the extent of the actual harm occurring, which in turn results in insufficient responses to the occurrences of harm to residents. In a review of Acute Care Logs for just one week, we found more than twenty instances of injury to residents that were treated by medical staff but had not been reported on either the individual's injury history or the facility's aggregate injury totals. These omissions included serious injuries such as head injuries, fractures, and lacerations requiring sutures and staples.

Compilation of accurate information regarding occurrences of harm is a critical first step in maintaining an adequate incident management system. On the basis of our examination, Howe falls substantially short of accepted standards of practice in reporting incidents and compiling data regarding resident harm. This dereliction has contributed to violations of residents' constitutional rights.

b. Risk Assessment and Intervention

Howe has not implemented policies or procedures to identify and reduce risk of harm to residents. The Risk Management Committee, Howe's primary vehicle for managing risk, does not address resident risks from a systemic standpoint. Rather, the committee limits its focus to strategies to reduce enhanced staffing assignments to individuals currently assigned intensive staffing. Our expert consultant found that "for all intents and purposes, [Howe] had no formal risk management system as late as December 2007."

⁶ The use of restraints at Howe is discussed below in section II.D.2 of this letter.

Effective risk management requires that assessments and intervention strategies be taken prior to harm whenever possible, yet Howe only identifies residents at risk of harm after the occurrence of actual harm. This practice underscores Howe's lack of prevention efforts, which leads to constitutionally inadequate protection of residents.

Although Howe has identified some residents at risk of harm, even if that identification only happened after the actual occurrence of harm, Howe fails to identify residents at risk of harming others. In some cases, Howe has failed to identify such residents even after the occurrence of actual harm. The following residents, among many others, were not identified as being at risk of harming others despite the serious and recurring injuries they inflicted on their peers:

- J.J. injured peers on four occasions between October 2006 and August 2007. When J.J. pushed K.K. out of her wheelchair, she caused K.K. to fracture her maxillary spine. Three days after the incident with K.K., J.J. struck and injured L.L.
- M.M. assaulted N.N. in October and December 2006, and January 2007. The latter assault caused N.N. a laceration deep enough to require sutures.
- O.O. injured five peers on six separate occasions from November 2006 to June 2007, including an assault on P.P., and a laceration to Q.Q. requiring sutures.
- From October 2006 through July 2007, R.R. attacked and injured S.S. four times, and injured three other peers at least once.
- T.T. injured seven different individuals, causing bite wounds on at least two occasions, during the one-year period of September 2006 through September 2007.
- In November 2006, U.U. assaulted V.V., causing a laceration requiring sutures to close. The following month, U.U. assaulted W.W., causing a laceration that required staples to close.

Howe's failure to provide adequate intervention to address residents' aggressive behaviors places residents at continued risk of serious harm and substantially departs from generally accepted professional standards.

Additionally, although we note that Howe opened a special residence to safely house women with pica just prior to our tour in December 2007, many ingestion

hazards remained evident, including metal shower curtain rings, dried and plastic flowers, and stereo speaker wires. Though preventive measures at this residence are a good starting point, additional steps must be implemented to reduce opportunities to engage in pica.

c. Abuse and Neglect Investigations

Based on extensive record and mortality reviews, we find that abuse and neglect of residents is pervasive at Howe. This conclusion is consistent with the findings of CMS and the State's protection and advocacy organization. The facility investigated approximately 100 allegations of abuse and neglect in the year ending in September 2007. Nearly 75 percent of those incidents alleged physical or sexual abuse. Based on our review, Howe's system to investigate alleged harm is not sufficient to hold accountable those who engage in abuse and neglect, and thus promotes constitutional violations.

Generally accepted professional standards for investigative practices require that investigations be timely, thorough, and logical. The extent to which an investigation is thorough is measured in part by the degree to which the investigator probes for answers, researches facility documents, and challenges discrepant accounts of events. This includes gathering all relevant evidence, and interviewing and re-interviewing witnesses. Logical investigative conclusions are reached when the investigator is able to apply critical thinking to the information he or she has gathered, and synthesize that information into a coherent report.

The overall quality of Howe's investigations falls substantially below generally accepted professional standards because investigations fail to reach logical, well-reasoned conclusions. In some instances, the investigative files were in such disarray that it was difficult, if not impossible, to discern the process and outcome of the investigation. The disorganized manner in which the investigative records are maintained at Howe reflects the disorganized and incomplete quality of the investigations themselves.

Of the 100 abuse and neglect investigations Howe initiated⁷ from September 2006 to September 2007, only six were substantiated, while the outcomes of 43 others were not indicated on facility reports. The two examples presented below

⁷ Illinois' Office of Inspector General ("OIG") also conducts investigations of alleged abuse and neglect at state-operated facilities for individuals with developmental disabilities. We do not address those investigations in this Findings Letter.

from the period examined illustrate Howe's lack of thoroughness in conducting abuse and neglect investigations:

- The investigation of X.X.'s sudden death in July 2007 revealed that two attending staff members failed to provide cardiopulmonary resuscitation ("CPR") after finding X.X. unresponsive in his bed because the staff members simply "did not think to do it." Reportedly, when a staff member found X.X. unresponsive, lying face down in his bed, she unsuccessfully attempted to wake him. She then allegedly yelled for another staff member to call an emergency code. Reportedly, instead of immediately calling the code, the staff member ran to the room and attempted to wake X.X. without success. The staff member then allegedly reported the incident to the facility operator, who in turn paged the nurse. When one of the staff members later told the investigator that she had tried to obtain a CPR facial mask for X.X., the investigator did not probe further to find out why she was looking for a CPR mask when she stated previously that she "did not think" to initiate CPR. The lack of critical thinking applied during this investigation may have exonerated staff negligence that may have contributed to X.X.'s death. More troubling, we found evidence in this matter that indicated Howe records may have been falsified, because bed check notes for X.X. were entered after he went to the local hospital. The administrative review of the investigation does not indicate that document falsification was identified or addressed.
- The investigation of alleged verbal abuse by a staff member, who was watching television while on duty, had obvious flaws. In October 2007, two family members were in a residence retrieving the personal belongings of their brother who had recently died. When entering the home the family members allegedly saw a staff member sitting alone in the living room watching television. Reportedly, while in the brother's room, the family members heard the staff member verbally abuse a resident in an effort to make the resident stop what he was doing and sit down. The investigators of this incident, however, failed to interview the alleged victim, other residents in the area at the time of the alleged abuse, or the alleged perpetrator's peers or supervisors. Moreover, the investigation failed to address why a staff member was sitting alone watching television while she was on duty. After the alleged perpetrator simply denied the allegation and a second employee denied hearing anything at all, Howe investigators determined that there was insufficient evidence to support the allegation and closed the investigation.

Based on our review of Howe investigations over a twelve-month period, we find that Howe's inadequate investigative practices must improve significantly to meet the constitutional rights of the individuals who live at Howe.

2. Quality and Records Management

Generally accepted professional standards require that a facility like Howe develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of corrective actions taken in response to problems that are discovered.

Additionally, generally accepted professional standards in record documentation require that an institution's official record be an accurate and thorough account of the care of the resident, allowing access to the individual's most current medical, behavioral, social, and habilitative information. Failure to keep the record in a timely, organized fashion compromises the integrity of the record and provides an opportunity for erroneous clinical decision-making by treatment teams.

a. Quality Management

Howe substantially departs from generally accepted quality management standards. Howe conducts a biannual injury analysis that is largely dependent upon staff providing timely information, which often does not occur. Because the necessary information is not timely provided, the injury analysis is completed months after injury trends occur. With such extensive delays, it is virtually impossible to identify and address significant current trends. As a result, we find that Howe's process for quality management falls substantially short of meeting generally accepted professional standards.

b. Records Management

In each of our record reviews, both on-site and after our tour, we found significant deviations from generally accepted professional standards. For example, we saw illegible entries by numerous staff; progress notes placed in the record out of order; and outdated assessments and support plans. According to our expert consultant, the records at Howe are "maintained haphazardly at best." Howe's failure to maintain a generally acceptable documentation system poses significant risks for its residents, and promotes constitutional violations.

3. Use of Restraints

Generally accepted professional standards and constitutional mandates require staff to release a resident from physical and mechanical restraints when he or she no longer presents an imminent threat to him/herself or others. Moreover, restraints are only to be used in the presence of imminent danger, and the level of intrusiveness of the restraint is to be graduated with the least restrictive manner necessary to prevent harm. For example, if a resident begins to show aggression toward another person, but ceases the aggressive behavior after being restrained, then the threat of imminent harm to self and others is eliminated, and the restraint must be released.

Restraint practices at Howe deviate substantially from generally accepted professional standards, specifically in the facility's use of four, five, and six-point restraints. Residents at Howe are subject to such restraints too frequently and for too long. From September 2006 to September 2007, Howe staff placed more than 700 restraints on residents. Many of these restraints were applied consecutively, resulting in individuals being restrained for hours at a time. For example, residents Y.Y., Z.Z., A.B., J.J., A.D., and F.F. spent between three and eight hours at a time in restraints. In 60 percent of Howe's uses of restraints, residents were immobilized with their wrists and ankles strapped in place. In many cases, individuals were also strapped across their chests (five-point restraint) and placed in a helmet or face-mask (six-point restraint).

Moreover, Howe's procedures to review the appropriateness of restraint were frequently untimely and cursory. Examples of inappropriate restraint use at Howe include:

- Staff placed resident D.D., who died suddenly in February 2007, in four, five, and six-point restraints with increasing frequency during the last months of his life. Staff mechanically restrained D.D. on nine occasions between October and December 2006, despite serious health concerns regarding his hypertension and erratic behavior. On November 29, 2006, D.D. was mechanically restrained for two hours without evidence that his vital signs were checked at all. On December 4 and 10, 2006, when staff again mechanically restrained D.D. for two hours, his blood pressure rose to 138/90 and 190/120, respectively. On December 29, 2006, when D.D. was again mechanically restrained, the nurse contacted the Howe physician, reported elevated pulse and blood pressure (180/100) readings, yet the physician did not order D.D.'s release from the restraints. Ninety minutes later, D.D.'s blood pressure reached 200/100 while still in five-

point restraints, and staff finally released him and gave him hypertension medication.

- In March 2007, A.B. became upset when her sweater zipper broke; staff personally held her for five minutes, and then placed her in five-point restraints for 35 minutes. When documenting what justified this intrusive response, staff wrote that A.B. “began [hitting] self on hand. Blocking, verbal prompt did not stop the behavior.” The psychologist and Qualified Mental Retardation Professional (“QMRP”) reviewed this restraint more than 40 days later, but noted that no changes were needed to the resident’s behavior program.
- In October 2007, when staff told A.B. to stop picking her teeth, she began to yell and hit her face. When verbal prompts and physical blocks of her arms were unsuccessful in stopping the self-injurious behavior, staff physically held A.B. for ten minutes, and then placed her in five-point restraints for 55 minutes. The QMRP reviewed the restraint two weeks later and concluded that the resident’s behavior intervention plan remained appropriate.

Howe’s indiscriminate use of restraints, and untimely and cursory reviews of whether they are appropriate, constitute an unlawful deprivation of residents’ constitutionally protected liberty interests.

C. HEALTH CARE

The Supreme Court has determined that institutionalized persons with developmental disabilities are entitled to adequate health care. Youngberg v. Romeo, 457 U.S. at 324. The Court labeled this as one of the “essentials of care that the State must provide.” Id. Identifying a resident’s health care needs and providing adequate health care is a basic component of the planning necessary for an individual to live in the most integrated setting appropriate to the individual’s needs. Failure to provide adequate health care undermines the other care and treatment provided at Howe and may unnecessarily prolong individuals’ stay at Howe.

Plainly stated, the health care provided to Howe residents is inadequate, falling well below constitutional and other federal standards. Timely access to necessary medical care often is dangerously delayed. Medical assessments occur too infrequently, the documentation of medical charts is lacking, and effective communication between medical providers is absent. These deficiencies have resulted in residents experiencing worsening of symptoms, progression of illnesses, and death.

Health care at Howe is reactive rather than forward-looking. Reactive health care occurs when an individual's access to care depends upon the person presenting themselves for assessment and treatment, while forward-looking health care requires medical professionals to identify individuals at risk, to perform assessments, and to provide appropriate treatment. In a residential disability center setting such as Howe, individuals are often unable to articulate their health status to staff or request medical attention due to intellectual or developmental disabilities. Given these conditions, it is incumbent upon Howe to ensure that the health care provided is sufficiently proactive to identify potential health issues, to intervene before harm or suffering occurs due to illness or injury, and to provide access to health care as soon as possible once symptoms indicating a health problem arise. Below, we address eleven areas of health care we find to be problematic at Howe.

1. General Medical Care

Among the generally accepted professional standards of care in developmental facilities like Howe is the requirement that access to necessary medical care be timely. Delays in assessments, progress reporting, and treatment put residents at risk of experiencing complications and avoidable suffering. We found numerous examples of delays in residents receiving necessary medical care, and observed that there are no clear standards or expectations for the Howe medical staff regarding the frequency of physician assessments and progress reporting. These problems have led to violations of the Constitution.

While monthly physician progress notes appeared to be the standard in the past, our expert consultant's review of Howe's medical charts revealed that this was not the practice during the period of September 2006 through September 2007. Some medical charts showed gaps of three to five months between physician progress notes, while several others showed gaps as large as seven to eight months. The examples below illustrate Howe's problems regarding delayed access to necessary medical care and infrequent physician assessments and progress reporting:

- The medical chart of X.X., a 30-year-old resident who died in July 2007, contained a physician progress note and order dated April 6, 2007, requesting a neurological consultation. The medical chart does not indicate, however, that any consultation ever took place in the three months prior to X.X.'s death. According to the autopsy report, the cause of X.X.'s death was "seizure disorder, secondary to congenital

hydrocephalus/natural.”⁸ According to Howe’s medical records, X.X. was last examined by a neurologist on January 20, 2005, more than two years earlier. A note in his medical record on February 2, 2007, reported bizarre behavior including, “spitting in shoes and inside his pants, urinating on the floor . . . was redirected; told to stop and also blocked . . . will continue to observe and monitor throughout the day.” Numerous other notes indicated inappropriate urination, which can be suggestive of worsening hydrocephalus, yet this behavior was not recognized as potentially reflecting a worsening medical condition. Further, there is an eight-month gap in physician progress notes from August 2006 through April 2007. Not only did X.X. not see a neurologist in a timely manner, but the only medication prescribed to him was a cream to treat dry skin.

- A.E. died in July 2007 from hydrocephalus. The last physician progress note was entered into A.E.’s medical chart more than a month before her death, and her last physical examination was in January 2007. There is no record of neurological consultation, and the documentation for her physical examination noted that no neurological exam was completed at that time, except for checking deep tendon reflexes. Moreover, A.E.’s vital signs were occasionally not recorded, and at times when her vital signs were poor, there was no documentation of pulse oximetry⁹ results.
- A.F. is a resident with chronic active Hepatitis C. A.F.’s medical chart indicates that in January 2006, it was recommended that a liver ultrasound exam be completed. The ultrasound did not occur, however, until 15 months later, in April 2007. An assessment in July 2007 recommended a colonoscopy and an esophagogastroduodenoscopy

⁸ Hydrocephalus is an abnormal condition in which cerebrospinal fluid accumulates in the ventricles of the brain because of blockage of normal fluid outflow from the brain or failure of fluid to be absorbed into the bloodstream quickly enough.

⁹ Pulse oximetry is a noninvasive diagnostic test used for detecting oxygen levels in the blood.

(“EGD”),¹⁰ but at the time of our tour in December 2007, some five months later, we saw no evidence that either test had been completed.

These examples also indicate, in particular, that the medical staff at Howe do not provide ongoing assessments of residents’ neurological problems, which is exacerbated by the fact that there is no on-site neurology service at the Howe clinic. Residents must be transported to a hospital approximately one hour away. The time from referral to appointment ranged from one to three months to see the neurologist. This dramatically limited the continuity of care and overall involvement of neurologists in resident care. In two of the examples noted above, residents died from complications associated with hydrocephalus, a serious, yet manageable condition. Hydrocephalus can be fatal in cases when the diagnosis is not early, and the symptoms are not regularly monitored and appropriately treated. If treated early and appropriately, however, individuals with hydrocephalus can recover with a good quality of life.

Additionally, generally accepted professional standards require that there be effective communication between medical providers and specialists in order to ensure that findings and recommendations are addressed. A review of Howe’s medical charts reveals that consultation reports do not show when, or if, the primary treating physician reviewed the results of the consultation.

The lack of effective communication and sharing of information between multiple medical providers working with the same patient can result in delays in treatment, duplication of treatment, and complications due to conflicting approaches to care. In some cases, the breakdown in communication results in tragedy, as illustrated below:

- In February 2007, C.D. died of a heart attack. On the day she died, C.D. underwent an unscheduled gynecological exam without the necessary anti-anxiety medication she typically received prior to gynecological exams, mammograms, and dental visits. Witness accounts of the exam describe C.D., who was blind and non-verbal, as being extremely upset, restrained by staff, and repositioned frequently during the exam. C.D.’s medical chart indicates that she was sensitive and resistant to touch, and contains a “desensitization plan” to reduce

¹⁰ An EGD is a diagnostic procedure in which an endoscope (a long, flexible, lighted tube with an attached videocamera) is guided down a patient’s mouth, throat, esophagus, stomach, and duodenum (the beginning of the upper intestine). The endoscope allows a physician to visually detect abnormalities in the organs of the upper gastrointestinal tract.

anxiety during medical examinations, which includes the administration of anti-anxiety medication. In fact, her medical record documented successful procedures, including mammograms, when the plan was closely followed, as well as prior unsuccessful procedures conducted without the benefit of sedation. C.D.'s medical chart did not reveal any documented urgent or emergent need for the gynecological exam to be conducted that day, nor was there any documentation that the interdisciplinary team or primary care physician approved the departure from C.D.'s desensitization plan. The lack of communication and coordination regarding C.D.'s exam resulted in her undergoing an unnecessary and avoidable traumatic procedure. Eyewitnesses to the exam reported that C.D. constantly struggled during the procedure and was held down by several staff members. The resulting effects on her heart rate, blood pressure, and other sympathetic nervous system responses potentially contributed to her fatal arrhythmia.

While we address C.D.'s tragic death as an example of Howe's ineffective communication between medical providers, we are compelled to note also the glaring inconsistencies in the documentation of this incident. Particularly troubling in this regard is the physician's note for the procedure itself; the note omits any mention of any problems with cooperation or agitation by C.D. The discharge transfer summary completed after C.D.'s death is similarly silent regarding the struggle of her exam, indicating only that C.D. "was undergoing a medical procedure, had a heart attack, and was provided life-saving services and rushed to the hospital." It was only in a CMS survey conducted shortly after C.D.'s death that the facts surrounding C.D.'s extreme agitation during the procedure are first documented.

Generally, we have found that the primary focus of the medical care provided at Howe is acute care. This type of "reactive" approach to providing medical care accounts for Howe's poor record of assessments, progress reporting, and communication. Our expert consultant's review of Howe's medical charts did not locate any efforts directed at providing preventative care, routine screening, or holistic treatment of Howe's developmentally disabled residents. Although we observed that physicians at Howe were able to verbally provide detailed summaries of residents' acute medical issues during medical staffing meetings and when visiting residents, irregular physician evaluations or assessments that only address an acute need in isolation from the complete individual increases the risk of overlooking important information that affects care and the residents' quality of life. For example:

- A.A.'s medical chart shows regular monthly physician progress notes until April 2006, at which point the notes appear only in regard to

acute issues. Those notes make no mention of A.A.'s bipolar disorder, and the sleep record in the chart is from 2005, with no information for 2006 or 2007. Individuals diagnosed with bipolar disorder should have ongoing monitoring of sleep patterns in order to detect the emergence of hypomania/mania as early as possible. In A.A.'s case, this monitoring did not occur, or at least was not provided to the physician; the physician progress notes are reactive to acute issues, and do not regularly track the status of A.A.'s overall health.

- Howe's Assessment Initial/Annual Comprehensive Physical Exam form adds to the facility's lack of individualized and continuous care, as the form contains pre-populated responses for the treating physician to check. This form prevents a truly individualized assessment and increases the risk that a physician reviewing the chart will assume that incomplete areas of the form mean that the findings were normal.

2. Medical Emergencies

The medical emergency response system at Howe falls substantially below generally accepted professional standards and places residents at risk of suffering serious complications or death. Howe staff is slow to recognize medical emergencies, and is often disorganized in its response. Moreover, information concerning medical emergencies, including follow-up documentation and incident reporting, is often incomplete, disorganized, and untimely. In some cases, the reports are simply inaccurate and misleading. Competency-based training with regard to medical emergencies is also inadequate. This is problematic in cases where a physician is not present during the emergency, because a direct care staff or an unskilled nurse will have to delay providing emergency treatment until a skilled nurse, an Emergency Medical Technician, or a physician arrives. This delay of potentially critical treatment places residents at risk of severe injury or even death. The following are just a few tragic examples of Howe's ineffective management of medical emergencies:

- As discussed earlier in section II.A.1.b, the investigation of X.X.'s sudden death in July 2007 revealed that two attending staff members failed to provide CPR after finding X.X. unresponsive in his bed because they simply "did not think to do it." Reportedly, when a staff member found X.X. unresponsive, laying face down in his bed, she unsuccessfully attempted to wake him. She then allegedly yelled for another staff member to call an emergency code. Reportedly, instead of immediately calling the code, the staff member ran to the room and attempted to wake X.X. without success. The staff member then

allegedly reported the incident to the facility operator, who in turn, paged the nurse.

- Despite a documented history of swallowing difficulties, A.S., a 67-year-old resident, died in February 2008 after choking on a food bolus. The Emergency Center Nursing Flowsheet from St. James Hospital indicated, “did not attempt the Heimlich.” The Medical Emergency/CPR Case Review form indicated that it “took over 5 minutes to activate” emergency notification procedure. “No idea,” was the documented answer for the form questions, “Was the emergency intervention initiated within 2 minutes of the occurrence?” and “Was the intervention implemented correctly?” Progress notes from the physician responding indicated the Heimlich maneuver was tried, but no details were included. Progress notes from direct support staff were not available for review.
- A.G. died at Howe in January 2008. Staff found her unresponsive on a couch in a common area, already blue/grey in color. Four months before her death, A.G. had fallen to the floor from her bed, but despite the seriousness of her fall, Howe failed to send her to the emergency room until the next day, when she began to develop a change in consciousness and shortness of breath. At that time she was noted to have four fractured ribs and a large pneumothorax,¹¹ requiring placement of a chest tube. Additionally, A.G. was also noted to have lost a significant amount of weight in the months prior to her death – more than 10 percent of her body weight in a three-month period – yet there were no documented concerns or plans to address the weight loss.

3. Nursing Assessments

We find the nursing assessments at Howe generally to be incomplete and fragmented. It also appears that in many cases, nurses are not conducting assessments at all, but instead are simply duplicating the results of prior assessments. Of particular concern are assessments of residents with acute illnesses and injuries. For example, in January 2007, Howe staff measured Z.Z.’s blood pressure to be 145/86 while in restraints. Z.Z. remained in restraints for two hours, but the attending nurse did not flag this high blood pressure reading, and did not conduct an appropriate physical assessment. Below, we detail several areas

¹¹ Pneumothorax is a collection of air or gas in the pleural cavity, which can cause the lungs to collapse.

in which the nursing assessments at Howe substantially depart from generally accepted professional standards.

Nursing assessments at Howe are not adequately integrated into the residents' individualized support plans ("ISPs"). Part of the ISP should be an individual health care plan ("IHCP"). The IHCP should be periodically updated throughout the year to reflect changes in the resident's health status and goals. The goals and outcomes of the IHCPs at Howe, however, are updated only once a year. Of all the IHCPs our expert consultant reviewed, only three were updated prior to the resident's annual interdisciplinary assessment. This means that the individual's treatment team is not provided with the individual's current health status when determining necessary supports and services. Treatment of residents' health care is an ongoing process and such infrequent evaluation of the nursing needs of residents fails to meet acceptable standards of care.

Additionally, the participation by the nurses in the interdisciplinary treatment team meetings that produce the ISPs is inadequate. Information obtained from nursing assessments and nursing diagnoses is not reflected within the ISP process. The nurses' role in the care and desired outcomes of Howe's residents is fragmented at best. In general, nurses are not proactive with regard to the health care outcomes of residents. Preventative care is particularly important for residents at Howe with diminished communication skills who cannot easily identify and convey health issues.

Nursing care plans at Howe are general and non-specific, and often do not include individualized interventions to prevent recurrence of illnesses. We find the recommendations contained in the nursing care plans fail to delineate individual-specific signs and symptoms to be monitored. This is particularly concerning for residents identified at high risk for injury or illness. Moreover, nurses at Howe are not providing consistent monitoring and complete documentation regarding chronic health care issues, such as constipation and aspiration, which are life-threatening conditions for many health-compromised residents at Howe.

Further, pain assessment and individual manifestations of pain are not documented in the nursing care plans. Residents' pain may manifest in behavioral symptoms, such as depression, anxiety, aggression, or decreased socialization. All of these may lead to a decrease in pain tolerance, or unnecessary administration of psychotropic medications that treat the behavioral symptoms of the pain, but do not address the cause of the pain.

The recognition and documentation of individual manifestations of pain is particularly important, given Howe's heavy reliance upon temporary, part-time nurses to provide care. Indeed, our expert consultant asked Howe's Director of

Nursing how a temporary part-time nurse would know whether a particular resident was in pain. The Director replied that the incoming nurse would have to obtain such information from the direct care staff. If the documentation were adequate, then any nurse could rely on residents' charts to better understand their needs and behaviors, and would not need to rely on the assessments of the direct care staff, who are often not medically trained professionals.

Inadequate documentation by Howe nurses is also problematic. When notes are made in the flow sheets and logs, they are often incomplete, failing to fully describe the health event, and hindering adequate follow-up care. For example:

- Menstrual cycle records are often incomplete, particularly in Z.Z.'s case, where no explanation is provided for long gaps in the record.
- Long gaps appear in the sleep records of residents, particularly in the case of G.G.

Inadequate documentation is also present in the nursing progress notes. A nursing progress note should fully describe the condition presented, and each subsequent progress note should address the condition until resolution. The majority of nursing progress notes reviewed by our expert consultant, however, did not contain a description, action taken, or follow-up action, for the conditions presented. Moreover, Howe progress notes are disconnected – failing logically to flow from shift to shift – and result in a lack of appropriate follow-up care to the condition presented. Progress notes also include vague expressions and relative terms with little diagnostic value, such as “good day,” “ate well,” or “quiet night.” Further, dated progress notes are often not in chronological sequence, hindering review even when the progress notes are adequate.

4. Physical Therapy and Nutritional Management

Howe does not provide sufficient physical therapy services. Physical therapy is critical to the residents of Howe in order to maintain their motor skills, joint range of motion, gait training, and posture. Many residents at Howe remain in Individual Positioning Devices (“IDPs”), such as wheelchairs, without a specific medical indication that such confinement is necessary. Confining residents unnecessarily to IPDs greatly increases the risk of osteoporosis, atrophy, scoliosis, skin breakdown, and muscle weakness over time, and needlessly complicates placement in a more integrated setting. Some Howe residents are ambulatory, but nevertheless use IDPs to prevent falls or to facilitate transport. This practice will foster regression of ambulation skills. These deficiencies violate the Constitution.

Due to a high and unmanageable caseload, the physical therapists at Howe do not have time to conduct ongoing training and evaluation of direct care staff to ensure that physical therapy programs are being adequately implemented. Direct care staff is responsible for the majority of the motor skill needs of residents, but are inadequately trained for this responsibility. It appears that Howe provides new direct care staff with minimal training on only transfers and positioning.

Again, due to a high and unmanageable case load, the physical therapists at Howe reactively address the most serious cases, leaving many residents with physical therapy needs untreated. In addition, the caseload is likely causing other issues that we observed, such as:

- Physical therapists do not routinely review positioning plans.
- Evaluations do not routinely include long-term physical therapy goals to optimize or maintain residents' independence. Evaluations also do not routinely include a baseline functioning assessment.
- Physical therapists rarely attend interdisciplinary treatment team meetings, and consequently, have been unable to communicate to other Howe professionals the physical therapy needs of the majority of residents.

Of particular concern regarding physical therapy is Howe's failure to conduct adequate root-cause analysis of resident falls. This failure places Howe residents at risk of injury. Successful fall prevention requires a thorough clinical assessment of residents who fall (or have a history of falls) and their environment. After a fall, clinical staff should evaluate orthostatic blood pressure; extrinsic factors (e.g., wet floor, loose rug); intrinsic factors (e.g., seizure disorder); and medications. A thorough assessment of gait and balance should be included in the evaluation. Further, the appropriateness of mobility devices, such as walkers and wheelchairs, and the need for personal assistance should be reviewed regularly and re-evaluated as necessary. Such steps, which will decrease the risk of future falls, are not currently being taken at Howe.

Another area of concern is Howe's general nutritional management, and its physical and nutritional management of residents with swallowing difficulties. Howe has an Interdisciplinary Nutritional Management Committee that meets at regular intervals to discuss the nutritional management needs of residents and the current meal plan. The outcomes of these committee meetings, however, are not effectively communicated across disciplines. For example, a Howe nutritionist stated that the nutritionists were not routinely informed of changes or additions of medications, particularly antibiotics.

Additionally, individuals at Howe with dysphagia (swallowing disorder), and those at risk of aspiration are not assessed on a routine basis, and the nutritional management team has not developed levels of care to prioritize residents with the most serious and acute needs for services. Similarly, Howe residents diagnosed with Gastro-Esophageal Reflux Disease (“GERD”) do not have detailed positioning plans. Howe does not have a comprehensive positioning program, which is critical for proper swallowing, adequate digestion, and nutritional management. Further, there does not appear to be a process at Howe to reassess or modify a positioning program should a swallowing event occur (e.g., choking, gagging, or coughing).

We reviewed meal plans at Howe and found them to be easy to read and understand. Our observation of meals, however, revealed that positioning is not implemented on schedule. Physical and nutritional plans are not adequately individualized (i.e., no choices are provided), and do not address varied settings where swallowing difficulties occur. These concerns in physical and nutritional management place residents at Howe at risk of significant injury.

5. Infection Control

The Howe Infection Control Committee (“Committee”) plans for and manages the facility’s response to outbreaks of infectious illness, specifically in critical areas regarding the current guidelines for methicillin-resistant *Staphylococcus aureus* (“MRSA”) treatment and management. Our expert consultant reviewed the minutes of the Committee’s meetings from 2006 and 2007, as well as the Howe Infection Control Manual. The Committee adequately discusses current infection control issues and anticipates and plans for seasonal patterns of infectious disease. We note, however, that a centralized record showing the updated immunization status of each resident and employee was not available at the time our tour.

6. Pharmacy Services

We have found Howe’s pharmacy services to be constitutionally inadequate. Generally accepted professional standards regarding pharmacy services for a facility such as Howe require routine review of medication regimens by pharmacists, and effective communication between the pharmacists and the prescribing clinicians. Howe substantially departs from these standards. Reviews of medication regimens are irregular and infrequent. When the reviews do take place, identified issues are not effectively communicated to the prescribing clinician.

Our expert consultant reviewed the “Medication Quarterly Reviews by Client” for the period of March 1, 2007 through November 30, 2007, and found that all of the reviews were conducted in either June or November. That is to say, there was not a single medication review during the 5-month period between June and

November. Some residents were identified as having even longer gaps between medication reviews, such as A.J. (19 months), C.G. (13 months), C.H. (8 months), and A.K. (7 months). In A.L.'s case, the combination of medications prescribed put A.L. at risk of a fatal rash (Stevens-Johnson Syndrome) and required careful monitoring that, as evidenced by the 13-month gap in review, did not happen. Our expert consultant similarly reviewed the Drug Regimen Review Findings forms from January 1, 2007, through November 30, 2007, and most of the reviews occurred in either February or November. With only a few exceptions, no reviews were conducted during the nine-month period between February and November.

In reviewing the "Medication Quarterly Reviews by Client" and the "Drug Regimen Review Findings," it is apparent that the communication between the pharmacist and the prescribing clinicians is ineffective. Many reviews included comments or requests for clarification by the pharmacist, who identified serious concerns with the choice or dosage of prescribed medication. It is not clear from the reviews, however, what, if any, action was taken by the prescribing clinician in response. For example, in one review a request for clarification was noted because A.M. shares a last name with another resident, and it appears that a medication prescribed to A.M. was actually meant for the other resident. In another example, a request for clarification was made regarding C.I.'s prescription of non-enteric-coated aspirin, which could be dangerous if C.I. has a history of gastrointestinal bleeding, stomach ulcers, reflux, or gastric sensitivity.

In addition, there had been no Pharmacy and Therapeutics Committee meetings at Howe for at least the six months prior to our tour in December 2007. There appears to be a state-level Pharmacy and Therapeutics Committee, but it does not appear Howe is represented on this Committee.

The substantial departure from generally accepted professional standards of care at Howe regarding pharmacy services places the residents at risk for significant medical complications, adverse drug reactions, and potentially even death. Individuals with developmental disabilities are at great risk for adverse drug reactions and side effects from medications. The need for dedicated and frequent oversight of all medication use is imperative for patient safety.

7. Medication Administration

Currently, Howe has no formal system in place to track medication error data adequately, or to analyze such data to identify problems, plan for improvements, implement changes, and evaluate the effect of changes. Moreover, there are no regular forums at Howe in which such data are shared and discussed with the nursing staff. These absences are a substantial departure from generally accepted professional standards.

During our tour, Howe's Director of Nursing stated that medication errors were rare at Howe. We have found, however, that the medication error reporting system at Howe is ineffective, and communication at all levels of the nursing staff is poor. The lack of an effective reporting system and poor communication suggest that medication errors may not be accurately identified and reported.

Additionally, two other medication administration issues at Howe suggest the potential for medication errors. First, nurses at Howe are responsible for administering medication to several housing units, and often to so many residents as to exceed what can safely be managed. Second, because of Howe's low retention rate among nurses, newly hired and temporary nurses are reassigned frequently and are unfamiliar with residents' identities.

8. Dental Care

Dental care at Howe falls substantially below generally accepted professional standards and places residents at an unjustifiable risk of harm. Generally accepted professional standards require that residents receive routine dental care every six months, and that oral x-rays be completed annually. Routine dental care facilitates early detection and treatment of oral disease. Such care is particularly critical for individuals with developmental disabilities because they may be nonverbal or may have difficulty communicating pain or discomfort.

Generally accepted professional standards also require that individuals with disabilities be positioned appropriately when receiving dental care services. Proper positioning is important to ensure residents' safety because they may have a higher risk for aspiration, have skeletal conditions that must be taken into account, or exhibit combative behavior because of their disabilities.

Substantially departing from generally accepted professional standards, 215 of the 332 Howe residents we reviewed were not receiving any routine dental care. For these residents, dental care consisted only of emergency care and/or necessary extractions. These residents received dental care under general anesthesia only. Another 100 residents received comprehensive dental care, also under general anesthesia. Only 17 residents participated in limited dental exams and treatment on site without anesthesia. Even in the small number of instances where the facility did provide routine dental assessments, the assessments tended to be annual instead of every six months. Moreover, x-rays were conducted rarely, only when "absolutely necessary," even where residents' records noted that they had serious dental problems like moderate to severe gingivitis, periodontitis, or bleeding gums. Further, and again contrary to generally accepted professional standards, residents at risk for dysphagia were positioned at a uniform angle for dental work,

despite the recommendations of speech pathologists, who indicated that more individualized positioning was necessary.

Howe's failure to provide routine dental care to the majority of its residents and position them properly when they receive dental services places residents at risk of serious harm. Lack of routine dental care may result in delays in treatment, which may lead to infections, abscesses, need for extractions, and systemic disease, including heart disease and bacterial infections in the blood. Dental pain can also manifest itself in a variety of other types of harm, including behavioral and nutrition problems, choking, and aspiration. Finally, among other complications, improper positioning places residents at risk of aspiration.

9. Nursing Staffing and Training

Shortages of nurses have led Howe to rely heavily upon temporary part-time nurses, and have forced many nurses to work excessive overtime. For example, our expert consultant reviewed the staffing schedules for July and August 2007, and found that 68 shifts were "doubles" – that is, a nurse worked a 16-hour double shift, and 81 shifts during the month of August were staffed by temporary part-time nurses. During this period there were 67 medical incidents or injuries that required transfer from Howe.

Staffing information at Howe is fragmented and logged manually within the separate residences. The scheduling and planning of nurses across residences is conducted by the Director of Nursing, and does not appear to account for the individual needs and levels of care of residents within each of the residences. For example, House 105 is the residence with Howe's most medically fragile residents, yet until just prior to our tour, it was understaffed by nurses.

Howe's system of staffing nurses is inadequate and jeopardizes resident safety and quality of care. Howe lacks a centralized, computer-based staffing information system, and at the time of our tour, was unable to present us with complete information regarding staffing minimums and ratios of nurses to residents. Howe's information regarding staffing is disorganized, and therefore, provides very little meaningful data necessary for appropriate staffing planning and scheduling.

Furthermore, Howe lacks an adequate nursing training program. The training provided at Howe is not uniformly competency-based. Nurses are not routinely evaluated on whether they are capable of competently performing the skills presented in the training and necessary for their duties at Howe.

Howe's nursing staffing is insufficient, and Howe's system of nurse training programs are inadequate. Both of these deficiencies are major contributing factors to the constitutionally inadequate nursing care provided at Howe.

10. Medical Records

Howe's record keeping practices substantially depart from generally accepted professional standards that medical records be organized, accurate, and up to date. Facilities like Howe should maintain all medical records in a uniform organizational format; enter notes legibly; clearly mark sections of the medical chart to delineate the contents within each section; note documentation errors properly; indicate the type of note being entered; indicate date and time; sign notes; file documents properly into the correct patient's chart; and, timely add documents to residents' charts to keep records current. Following these protocols is critical because medical records are vital in capturing, sharing, and storing necessary information to provide timely, appropriate, and potentially life-saving medical care.

At Howe, residents' medical records are poorly organized and extremely difficult to follow. Instead of maintaining one master chart for each resident in one easily accessible place, Howe keeps two charts for each resident in two separate locations; a resident's medical chart is located in the healthcare home, while the rest of the chart is located in the home in which the resident lives. In addition, different functional areas use separate sections of residents' charts. These practices create a disjointed record that makes it challenging to get an accurate and complete picture of the residents' condition at any particular time.

Additionally, Howe fails to audit its medical records to ensure that they are organized, accurate, and current. Our review indicated that records contain filing errors, including instances in which documents for one resident are erroneously filed in another resident's chart. Progress notes and consultations are frequently out of order or misfiled, some notes reference notes that are missing from the file, and other notes are illegible or inconsistently signed. Further, Medication Administration Records ("MARs") and Treatment/Procedure forms from previous months that should have been included in residents' medical charts had not yet been filed as of the time of our tour.

Moreover, although Howe maintains 24-hour nursing logs that contain valuable information about residents, these logs are shredded after three months. Unfortunately, prior to the destruction of these records, Howe makes no effort to transcribe relevant information into individual files; at most, staff verbally report the information in the nursing logs, making it likely that this information will be lost permanently.

Finally, the lists we were provided that named residents who had identified health risks and conditions (e.g., choking, pica) did not consistently correlate with risks identified in these residents' medical records. For example, residents whose medical records clearly identified and addressed specific risks for a particular condition did not appear on the list of individuals at risk for that condition. In other instances, residents were on the at-risk lists provided to us, but their medical charts did not reflect that the identified risk had been noted or addressed.

Howe's substantial departure from generally accepted professional standards in medical record keeping places its residents at risk of harm. Inconsistent organization, documentation, and filing in medical records can prevent health care providers from being able to find needed information about a resident. This can lead to potentially fatal errors, duplication of care, and inaccurate diagnosis and treatment. For example, if a resident's disjointed and inaccurate record prevents a physician from becoming aware of a prior serious problem, like a bowel impaction, the physician may not be able to recognize the early signs of discomfort upon a recurrence of the problem. This could result not only in unnecessary pain and discomfort for the resident, but could also progress to severe impaction - an emergency that may result in bowel rupture and death.

11. Quality Assurance

Howe's "reactive" approach to medical care is further evidenced by the facility's shortcomings in the area of quality assurance. Effective quality assurance management is vital to identifying deficiencies that can be corrected through changes in policies, procedures, or other corrective actions. Ineffective quality assurance management leads to preventable negative outcomes, which result in residents suffering unnecessarily.

Central to effective quality assurance management in a facility such as Howe is continuous communication between the members of the health care team. The communication at Howe between the various members of the medical staff is inadequate. Generally accepted professional standards require that communication between members of the health care team occurs, not only through residents' medical charting and progress reporting as discussed in several sections above, but it must also occur through quality assurance committees and through clear policies and procedures.

Howe does not have quality assurance committees in place. For example, there is no quality assurance and improvement committee, utilization review committee, or peer review committee. The absence of such committees prevents the development of proven quality assurance measures such as: (1) systematic

monitoring of the quality of care being provided; (2) identification of the underutilization and overutilization of health care interventions being provided; (3) assurance of timely access to needed care when indicated; and (4) prompt identification of systemic issues or trends that require intervention.

Further, Howe's policies and procedures are not regularly reviewed and updated to reflect current, generally accepted practices. Clinical policies and procedures at Howe do not appear to have been reviewed for many years.

D. PSYCHIATRIC CARE

Constitutional and other federal standards require that state-operated facilities like Howe provide adequate mental health care for their residents with mental illness. Below, we discuss the psychiatric care at Howe, and conclude that the facility is violating those standards. In particular, for residents with psychiatric care needs, Howe substantially departs from generally accepted professional standards in: (1) conducting adequate initial comprehensive psychiatric assessments, as well as follow-up assessments; (2) providing adequate psychiatric involvement and coordinated care with other treating professionals; (3) regularly monitoring for movement disorders in residents who are on antipsychotic medications; and, (4) providing psychotherapy services.

1. Psychiatric Assessments

Generally accepted professional standards require facilities like Howe to provide residents needing psychiatric care with an adequate initial comprehensive psychiatric assessment. Among other things, this assessment should include presenting concerns; current, past, family, social, and medical histories; current medications; allergies; a mental status exam; and a diagnosis. This assessment also should provide recommendations and a treatment plan, and should indicate when the resident will be seen for follow-up. Follow-up assessments should take place based upon clinical need, typically between one and three months after the assessment. Adequate comprehensive assessments are important for improving accuracy in diagnoses, preventing the prescription of inappropriate or unsafe medications, and assisting the psychiatrist in developing an effective treatment plan. Routine follow-up appointments allow psychiatrists to assess the effectiveness of treatment and address concerns quickly and effectively.

In substantially departing from these generally accepted professional standards, Howe fails to conduct adequate psychiatric assessments of residents. The assessments our expert consultant reviewed consistently failed to contain all the elements necessary to indicate that a comprehensive assessment had been completed. Specifically, at Howe, assessments do not contain necessary details

regarding medical history, family history, and relevant social and environmental issues that could be contributing to a resident's present illness. Assessments routinely fail to document the need for follow-up care and when it should occur. They also fail to indicate whether previous psychiatric notes were reviewed or state who was interviewed as part of the assessment, often even where a resident is nonverbal. Additionally, progress notes in charts consistently indicated "none" next to "medical concerns relevant to this psychiatric consultation," which is unusual as residents undergoing a psychiatric consultation will often have medical conditions relevant to the psychiatric diagnosis and/or treatment options.

Our expert consultant also observed that the information contained in assessments did not provide a clinical basis for the resulting diagnosis, medication, and treatment recommendations. For example, A.N. was diagnosed with pica during an annual psychiatric assessment, yet the psychiatric note contained no documentation supporting how the diagnosis was made or how it would be addressed. Another resident, A.O. had diagnoses of psychotic disorder not otherwise specified ("NOS") and mood disorder NOS, but these diagnoses were inconsistent with other diagnoses listed in A.O.'s records. Moreover, none of the psychiatric diagnoses supported the need for the medication the psychiatrist recommended for A.O. in the progress notes.

Howe's failure to provide adequate, comprehensive psychiatric assessments places residents at risk of serious harm. The lack of important information regarding family, medical, social, and environmental history may result in inaccurate diagnoses and the worsening of symptoms because of inappropriate, ineffective, or delayed treatment. Moreover, the lack of routine follow up leads to crisis-oriented care in which the psychiatrist is consulted only where behavioral concerns escalate.

2. Coordination of Care and Psychiatric Involvement

Generally accepted professional standards require coordination of residents' care between psychiatrists and other treating professionals, including primary care providers, psychologists, and therapists. Such coordination decreases the risk that multiple clinicians may not be aware of what their counterparts may be prescribing or treating. For example, some psychiatric medications may not be appropriate for individuals who have certain health conditions. Moreover, because individuals with developmental disabilities may have difficulty communicating directly with care givers, it is particularly important for treating professionals to collect information about individuals from one another. For psychiatrists in particular, generally accepted professional standards dictate that they should communicate their findings and recommendations with clinical teams and should be readily available for consultation and prompt follow up regarding, for example, medication changes.

Finally, primary treating physicians should respond to psychiatric recommendations promptly.

Our expert consultant's review concluded that Howe fails to provide coordinated care to its residents with psychiatric needs, fails to provide adequate psychiatric involvement, and fails to respond promptly to psychiatric recommendations. These failures express a substantial departure from generally accepted professional standards. Psychiatric assessments often do not include any indication that the psychiatrist reviewed the resident's medical chart or consulted with other individuals involved in the resident's care. For example, the records of resident, E.E., had no indication of such review even though E.E. has "no intelligible speech;" the records of A.P. had no such review even though this resident was "talking nonsense to himself;" and the records of A.Q. had no such review even though this resident is "nonverbal."

Additionally, even where a resident, C.H., had a history of four psychiatric hospitalizations, his records contained no indication that psychiatry professionals at Howe had discussed his case with psychology or other treatment team staff, or that progress in obtaining desired outcomes was addressed. Similarly, the initial psychiatric assessment of A.R., a resident who had recently been admitted to the hospital, contained no indication that her hospital records had been reviewed.

In addition to failing to coordinate care, Howe fails to provide adequate psychiatric involvement for residents who have psychiatric needs. Even where residents exhibit extremely challenging behaviors, the frequency of psychiatric involvement at Howe is minimal. Part of Howe's failure in this regard appears to be a result of staffing difficulties. Since Howe's psychiatrist left approximately one and a half years prior to our tour, the facility has been providing only rotating psychiatric coverage.

Examples of Howe's failure to provide adequate psychiatric involvement to residents include:

- In 2003, C.J. was prescribed Risperdal¹² at a dosage that exceeds the FDA-approved dosage. This resident also was noted to have constipation, seizures, hyperlipidemia, and cardiac concerns – all of these are conditions to which Risperdal is known to contribute. A psychiatric note dated April 27, 2007 indicated that C.J. did not tolerate lower dosages of the medication. As of the time of our visit –

¹² Risperdal is a medication used to treat conditions such as schizophrenia and bipolar disorder.

more than seven months after this note was written – the chart contained no indication of additional psychiatric involvement for this resident, despite his clear need for much closer monitoring.

- C.H. was referred for a psychiatric evaluation. A note in his record indicated that the psychiatrist tried to see him on September 22, 2007, but was unable to do so because the resident was on a home visit. The psychiatrist noted that he spoke with staff and that he planned to see the resident later. As of our tour, approximately two and a half months later, C.H.'s record contained no indication that he received the psychiatric evaluation for which he had been referred. This is particularly concerning given that, as noted above, this same resident had a long history of psychiatric hospitalizations.

Additionally, we found an instance where the psychiatrist made numerous recommendations regarding changes to a resident's medications without ever examining the resident and without taking into account medication changes that may have been occurring while that resident was admitted to the hospital. Specifically, while resident A.S. was in the hospital for mania, the psychiatrist wrote in A.S.'s record that the psychiatrist's report was based on "chart review and discussion with interdisciplinary teams. I have not examined [A.S.]. The following nonetheless is based on thorough review and current scientific thinking." The psychiatrist proceeded to make multiple recommendations to adjust medications, without any regard as to what changes were being made at the hospital, and without any mention of a plan for a consultation once the resident returned from the hospital. The only other psychiatric note in the record was dated more than three and a half years prior.

We also found that Howe's primary treating physicians fail to respond promptly to psychiatric recommendations, thereby delaying care for residents, sometimes for months or longer, and placing them at risk of serious harm. For example, on March 16, 2007, the psychiatrist recommended that F.F. be started on Depakote.¹³ The order for this medication, however, was not written for nearly three months. Moreover, approximately two and a half months after the order was finally written, the psychiatrist recommended that the dosage be increased, the resident's blood level re-checked, and that the resident be started on Risperdal. It appears that none of this was done at the time of the recommendation. Instead, approximately two and a half months after the second recommendation, Depakote was finally increased and an order was written to check the resident's blood levels

¹³ Depakote is a medication that may be used to treat conditions such as seizure disorder and bipolar disorder.

in another two weeks. The only other psychiatric note in the record was from three years prior.

In short, Howe's failure to provide coordinated care and sufficient psychiatric involvement, as well as the failure of treating physicians to timely implement psychiatric recommendations, substantially departs from generally accepted professional standards and places residents at risk of serious harm. As noted above, the lack of routine follow-up and continuity leads to crisis-oriented care where the psychiatrist is consulted only when behaviors have escalated. Delays in responding to recommendations contribute to continued symptoms and potentially worsening of the behavioral health condition, which can lead to unnecessary hospitalization, increased injury to self or others, and increased use of physical or chemical restraints. These deficiencies may undercut the other care and treatment provided at Howe, making it more difficult for the individual to move to a more integrated setting.

3. Monitoring of Residents on Antipsychotic Medications for Movement Disorders

Contrary to generally accepted professional standards, Howe routinely fails to adequately monitor residents who are on antipsychotic medications for movement disorders. Generally accepted professional standards require facilities like Howe to provide such monitoring, using standard assessment tools, every six months. Monitoring for movement disorders is critical because antipsychotic medications may cause tardive dyskinesia.¹⁴ Howe's failure to regularly assess residents on such medications for these disorders places residents at risk of serious harm for severe, chronic, and unremitting movement disorders.

4. Psychotherapy Services

The need for psychotherapy services is not being identified in many residents, and when it is identified, psychotherapy services are almost never provided. Group psychotherapy is non-existent. Unfortunately, while it is clear that psychotherapy services are lacking, our expert consultant could not discern exactly what mental health services are being provided at Howe. For example, we received conflicting information as to whether services are provided on-site or off-site, and as to how many residents are receiving services.

¹⁴ Tardive dyskinesia is a muscular side effect of anti-psychotic drugs and is primarily characterized by random movements in the tongue, lips, or jaw as well as facial grimacing, movements of arms, legs, fingers, and toes, or even swaying movements of the trunk or hips.

E. BEHAVIORAL TREATMENT AND HABILITATION

Howe's residents are entitled to "the minimally adequate training required by the Constitution . . . as may be reasonable in light of [the residents'] liberty interests in safety and freedom from unreasonable restraints." Youngberg, 457 U.S. at 322. A fundamental purpose of this training is to enable the movement of individuals into the most integrated setting appropriate to their needs as required by Olmstead, 527 U.S. at 607. Generally accepted professional standards require that appropriate psychological interventions, such as behavioral treatment and habilitation plans, be used to address significant behavior problems and significant learning deficiencies. Howe fails to provide such psychological interventions to meet the needs of its residents. As described in more detail below, Howe's deficiencies in this regard substantially hinder treatment of residents' problem behaviors, exposing residents to an increased risk of abuse, and compromising residents' opportunities for placement in a more integrated setting. Specifically, Howe: (1) provides residents with ineffective behavioral treatment; (2) exposes residents to undue restraints; and, (3) provides inadequate habilitation treatment and communication therapy.

1. Behavioral Treatment

Behavioral treatment services at Howe substantially depart from generally accepted professional standards of care for individuals with developmental disabilities. As a result, residents are suffering harm because of untreated self-injurious behavior and untreated peer aggression. Further, residents are failing in day treatment services and are being deprived access to community placement because of inadequately treated challenging behaviors. Below, we discuss two areas of behavioral treatment: (a) functional behavioral assessments and treatment planning; and (b) implementation and evaluation.

a. Functional Behavioral Assessments and Treatment Planning

Functional behavioral assessments at Howe are seriously deficient. Generally accepted professional standards dictate that there be an adequate and current functional behavioral assessment in all cases prior to the initiation of behavioral treatment. Functional behavioral assessment is a professional assessment technique that identifies the particular positive or negative factors that prompt or maintain a challenging behavior for a given individual. By understanding the causes or "functions" of challenging behaviors, professionals can attempt to reduce or eliminate those factors and thus reduce or eliminate the challenging behaviors.

Without an accurate assessment of the functions of behaviors targeted for change, those behaviors will persist and become exacerbated, which can result in danger both to the resident and to those around the resident, and can needlessly complicate opportunity for placement in a more integrated setting. It is critical that the function served by the target behavior is defined accurately when choosing a replacement behavior for that target. Inaccurate functional behavioral assessments lead to a choice of replacement behaviors that is unlikely to have any impact on the occurrence of the target behaviors. Howe, however, relies too heavily on a single written screening tool, leaving room for inaccuracy in defining the function of the target behavior. Extensive observational analysis of the behavior problem is needed to verify functional behavioral assessments. Only a proper functional behavior assessment can lead to appropriate treatment options and follow-up services and supports, and Howe, consequently, is failing to make use of critical information about residents.

In fact, replacement behaviors are entirely missing in some behavior plans and are grossly inappropriate in others. For example, several residents have a program simply to teach “waiting.” One of these residents, A.O., has a program in which staff are instructed to approach him, ask him if there is anything that he wants or needs, and then inform him that it will be brought to him, but that he must wait for a set period of time. “Waiting” as a replacement behavior is not operationally defined and, in any event, is not a replacement behavior; it does not serve the same functions as a behavior that promptly produces demanded items. Moreover, we have a serious concern about the appropriateness of simply teaching a developmentally disabled resident to wait, as it perpetuates the attitude that individuals with disabilities should be passive recipients of whatever their environment is able to offer them. A “person-centered” approach¹⁵ to treatment planning would suggest, by contrast, teaching individuals to ask appropriately for what they want, to occupy themselves safely and appropriately if their request cannot be met immediately, and to accept some alternative if the request cannot be met at all. Even if “waiting” was considered an appropriate replacement behavior, the intervention used for A.O. – deliberately asking A.O. if he wants or needs something and then telling him he has to wait a certain period of time – is far more likely to induce challenging behaviors than to produce any positive effect.

Similarly, we have observed “compliance” as a replacement behavior, which we find to be vague and subject to abuse. For example, the objective set for A.T. – to “comply 100% for three weeks” – is an unworkable goal. Complicating the issue is the fact that A.T.’s individualized support plan (“ISP”) states that

¹⁵ “Person-centered” treatment planning is discussed in further detail in Section II.E.1.

“noncompliance” is his means of letting staff know that he is not satisfied with his environment. Given that noncompliance has this identified function, mere reinforcement of compliance is unlikely to have any effect and, indeed, A.T.’s data demonstrate that it has not.

Inappropriate or ineffective replacement behaviors are not recognized as such at Howe, and are therefore not reevaluated, even when it is obvious that they are not succeeding. For instance, after a period of months in which A.B. displayed marked dangerous self-injurious behavior and required mechanical restraints, the replacement behavior devised was to teach A.B. to “sign ‘hi’ independently.” The choice of this behavior was completely inappropriate given the nature and extent of her dangerous behavior, and there is little reason to think that signing “hi” would have an effect on her self-injurious behaviors. In fact, the replacement behavior program had been in place for 18 months at the time of our tour, and the current success rate for the behavior was 5 percent. The success rate was 32 percent when the program started. These low and decreasing success rates obviously indicate that the training program was not working. Notably, the target behavior – dangerous self-injurious behavior – had actually increased.

In general, the goals set for behavioral treatment of Howe residents are far too simplistic to adequately respond to the complexity of the residents’ issues. Thus, residents’ fundamental needs are not being addressed. For example:

- M.M. engages in the following target behaviors: physical aggression, verbal aggression, property destruction, inappropriate sexual and self-injurious behavior, teasing/provoking, and weapons possession. To address his issues, the procedure adopted is to ask him two questions every evening about the rules for getting along with others and what to do if someone does something he does not like. Establishing the behavior of correctly answering these questions is unlikely to have any significant impact on his dangerous and disturbing target behaviors.
- For A.U., the intervention to establish and maintain “anger management,” is for staff, twice a day, to prompt A.U. to count to 10 and then inform him that the counting will help him relax. These interventions are unlikely to teach A.U. to manage his anger, particularly because the prompts are not given when A.U. is angry or likely to become angry, but rather are given on a set schedule.

The inadequate behavioral treatment approaches to self-injurious behavior and pica are particularly troubling at Howe. The primary approach to managing these self-injurious behaviors is to block or redirect the behaviors, rather than to establish an alternative behavior. For pica, the treatment appears to be primarily

environmental, removing or blocking access to things that might be ingested. As a safety plan, maintaining an environment free of suspected pica items is appropriate, although it is extremely difficult to implement comprehensively. That approach, however, is inherently restrictive as a behavioral plan, and it is a barrier to community placement where such environmental modifications cannot be readily provided. If behavior plans are not developed whereby environmental modifications are gradually removed as pica is eliminated, residents will be destined to live in artificially restrictive environments forever.

b. Implementation and Evaluation

Generally accepted professional standards require that facilities like Howe monitor residents who have behavior plans to assess the residents' progress and the program's efficacy. Without accurate monitoring and evaluation, residents are in danger of being subjected to inadequate and unnecessarily restrictive treatment and settings, as well as avoidable injuries due to untreated behaviors.

At Howe, the monitoring and evaluation of behavior plans substantially depart from generally accepted professional standards. The plans are unduly lengthy, routinely employ complicated medical terminology not readily understood by staff, and are not subject to peer review for quality improvement. For example, C.K.'s behavior drill is seven pages long and contains 84 items that staff are supposed to learn.

The Behavior Intervention Committee at Howe, which is supposed to provide oversight of behavior plans, does not accomplish its function. In particular, it does not adequately address the effectiveness of behavioral interventions when approving psychotropic medications or restraint procedures. In many cases dealing with restraints, it does not even discuss the behavior interventions in place to address the behaviors that led to the use of restraints. Minutes from the January 9, 2007, committee meeting illustrate this point:

- Meeting minutes indicate that an antipsychotic medication was to be initiated with C.G. There is no indication, however, of what sign or symptom the medication is intended to target, or any indication of discussion regarding what behavioral interventions were in effect to address that sign or symptom.
- Meeting minutes indicate that an antipsychotic medication and the use of restraints were approved for C.H. There is no mention, however, of any behavioral interventions to address the behaviors that led to the need for restraints or medication.

- Meeting minutes indicate that a medication, mobility restriction, personal property restriction, person and room search, enhanced supervision, and the use of 5-point restraints, were approved for A.A. There is no mention, however, of any behavioral interventions to address the behaviors that led to any of the restrictive interventions.

Moreover, staff training on behavior plans is not competency-based at Howe. Staff training on behavior plans is currently documented by means of a sign-in sheet indicating who was present for the training. Behavior drills that are prepared to allow trainers to document trainees' knowledge of each aspect of the behavior plan are in some cases scored 100 percent correct, although none of the individual items are scored as correct or incorrect. Moreover, the residents' actual behavior drills do not appear to be occurring, as indicated by the relevant line on the behavior plan form, "Number of Behavior Drills (frequency over past six months)," being routinely left blank.

The data collected on behavioral treatment at Howe are unreliable. We noted both missing data sheets and significant mismatches between the recorded data and staff narratives about a resident's behaviors for the same period. For example, while data collected on A.B. showed only a single instance of self-injurious behavior for October 2007, notes from a Special Interdisciplinary Team Meeting stated that A.B. had "increased self-injurious behavior to the point of bleeding, restraints often needed." The Qualitative Monthly Review Summary for October also noted that A.B. "has had many injuries as a result of her [self-abusive] behavior."

Members of the Behavior Intervention Committee acknowledge that behavior data are not reliable. Even dangerous behaviors are not being adequately tracked. For example, the data for A.V.'s pica behavior indicate "zero" instances for November 2006 through February 2007. Yet an x-ray taken during that period showed a metal spring in her digestive tract.

Howe's data collection and analysis regarding "progress toward behavior goals" are not meaningful. There is no reflection of movement toward independence, improved quality of life, or community placement. Data regarding the success of training programs are missing or ignored when decisions are made about continuing the programs. Seriously dangerous behaviors continue or increase without a judgment regarding the need to revise the behavioral intervention plan. Monthly reviews, for example, compare only the current month with the previous month, without interpretation, analysis of data, or any attempt to draw conclusions or make recommendations. There is no consideration of long-term trends. Training on the same replacement behavior persists despite lack of progress over long periods, such as in A.T.'s case, where his baseline success rates for two replacement

behaviors were each 10 percent, and changed very little over four years. Despite these clear failures, Howe maintained A.T.'s program.

In cases in which it is recognized that a resident is not making progress or is experiencing significant deterioration, Howe tends to respond with additional restrictions, as opposed to responding with increased intensity of training, a change in positive intervention, or a new perspective on the problem. For example:

- A.W. has monthly reviews that show 0-3 percent independence for the pica exchange program. The monthly conclusion has always been to "continue program as written." A psychologist's note states that A.W. is making little progress with the pica exchange program, but recommends no revisions.
- A.B. (also discussed earlier in Section D.1.a. of this letter) required multiple meetings because of her dangerous self-injurious behavior, but not a single meeting resulted in a recommendation to revise the behavior plan, which was to sign "hi" independently. Additional restraints were ultimately authorized.
- M.M. had six holding restraints, six mechanical restraints, and one transport restraint in the six months preceding our tour. The behavior plan, however, had remained unchanged for the previous 22 months, although it clearly was not effective in establishing a replacement for the target behaviors.

2. Habilitation

Habilitation includes, but is not limited to, individualized training, education, and skill acquisition programs developed and implemented by interdisciplinary teams to promote the growth, development, and independence of individuals. Habilitation at Howe substantially departs from the minimally adequate training required by the Constitution, in light of residents' liberty interests. Residents are being harmed because, due to inadequate habilitation assessments and active intervention, they are not able to build skills for success in a more integrated environment. While residents should be learning skills and supports that they will need to pursue their personal goals and improve their quality of life, they are instead being trained in skills that have no real-world application.

At Howe, habilitation assessment results are not being used to select goals. For example, C.L.'s chart states that he "has all grooming, dining, dressing, toileting and domestic skills," but he had active programs for showering and tooth-

brushing. Moreover, the skills to be mastered are not chosen on the basis of movement toward independence. For instance, A.X.'s vocational training program was to sit in a chair for 30 minutes. The purpose of this program is unclear and no supporting assessment data is provided.

In some cases, the training programs do not provide sufficient active treatment. On A.Y.'s individualized support plan, only one program is functional and appropriate ("maintain a shared greeting"). Two other programs teach nonfunctional skills ("matching basic objects" and "responding appropriately to simple questions") that do not foster independence, promote community placement, or improve quality of life.

Vocational services at Howe are limited. Consequently, residents are deprived of opportunities to experience more rewarding vocational activities in more integrated settings. Current generally accepted professional standards increasingly require that individuals receive habilitation services in community settings where the training skills are called into use. For example, a resident would learn money management skills by banking at a bank within the community. Staff at Howe report that vocational and day treatment options are limited because residents attend day activities according to which residence they live in rather than by interest, strength, or goal. Moreover, there are few employment opportunities and job coaches.

When a resident goes to a community-based work setting, active support is necessary for success. The Howe residents who do move to community-based work settings, however, do not receive the support they need. We learned of several residents who quickly lost their jobs because of inappropriate behavior. Residents who fail in community-based work settings are not offered appropriate alternative or remedial programming.

Additionally, the data collection on training programs is deficient. During our November 2007 tour, we saw many blank training program data sheets for programs initiated as early as February 2007. Where there were data, the graphs drawn from the data sometimes did not relate to the data on the data summary. Each of the data graphs drawn for A.Z., for example, showed a steady upward trend, although the number of "steps correct" was consistently zero.

Further, habilitation is a safety issue, and an individual's safety is largely dependent upon the meaningful activity present in his or her life. It is commonly understood that stimulating and challenging activities not only enhance one's quality of life through skill acquisition, but also serve as a deterrent to dangerous and destructive behaviors. Skill development programs at Howe are grossly outdated, some by more than 20 years, adding little meaning to individuals' lives.

Additionally, our expert consultant's extensive record review revealed that the majority of residents' skill development programs were identical from person to person, with only the name being inserted for clarity. For example, B.A. was assigned a grooming goal in 1988, with no revisions indicated, which read identically to others' grooming goals. According to the objectives written, B.A. had spent nearly 20 years learning how to use a towel to dry her body.

Repetitive or monotonous activities will not typically prevent individuals from engaging in harmful behaviors. As the examples below illustrate, sending individuals to programming sites without structured, meaningful activity will not prevent dangerous behaviors or serious injuries:

- In September 2007, while at an off-site day programming activity, C.M. ran up to C.N. while C.N. was seated in her wheelchair, and flipped the wheelchair, causing C.N. to fall and be severely injured. Staff documented that in the future, engaging C.M. in an activity may prevent a similar incident from recurring.
- Upon arriving at her workshop site in October 2007, C.O. began striking herself in the head and banging her head on the floor. Efforts to redirect her were unsuccessful and after 50 minutes of self abuse she was transported to the local hospital for head trauma and numerous self-inflicted bite wounds to her arms.
- In September 2007, during sensory stimulation activities, B.C. fell asleep and tumbled from his wheelchair onto the floor. He incurred injuries to his head and knee, including a laceration on his forehead that required Dermabond closure.

Finally, an important component of habilitation, as well as behavioral treatment, is effective communication therapy. When communication skills deteriorate or are not developed, residents are more likely to be unable to convey basic needs and concerns, more likely to engage in maladaptive behaviors as a form of communication, and are more likely to be at risk of bodily injury, unnecessary psychotropic medications, and psychological harm as a result of having no means to express needs and wants. Failure to provide effective communication therapy serves to perpetuate or exacerbate individuals' challenging behaviors, reduces their ability to express their choices and preferences, and complicates their opportunity for community placement. Howe fails to provide its residents with adequate and appropriate communication therapy.

Many Howe residents lack effective means of communication and are not receiving any communication training at all. In addition, alternative and

augmentative communication systems appear to be underutilized and in some cases inappropriately implemented. Documentation in the charts of residents who engage in dangerous behavior often indicates that the team has abandoned efforts to teach communication skills. Some residents have assessments stating a need to improve communication but have no communication training programs.

Moreover, communication assessments do not identify the most important functional communication goals for the resident, and instead result in programs teaching non-functional skills. For example, B.E. has a program that proposes four months of teaching B.E. to “point to the circle.” That is a skill with no functional value at all.

Communication programs that do attempt to teach functional communication skills often do not succeed. This is likely because skills are taught in an artificial context. When skills are not taught in their natural context to persons with developmental disabilities, the behavior learned will not be generalized to the natural context because of the individual’s disability. For example, F.F.’s program teaches him to sign “eat” by showing him pictures or giving him verbal prompts rather than by teaching him to use the sign in the natural context of eating.

F. INTEGRATED TREATMENT PLANNING

Many of Howe’s difficulties in providing adequate supports and services to its residents stem from the facility’s failure to provide integrated treatment planning. The purpose of integrated treatment planning is to ensure that the various disciplines within the facility staff receive, communicate, and consider relevant information about an individual resident when providing supports and services to that resident. Persons with developmental disabilities residing in state institutions have a constitutional right to adequate treatment, training, and medical care, Youngberg, 457 U.S. at 315, 319, 322, that is designed to enable an individual to live in the most integrated setting consistent with their needs, Olmstead, 527 U.S. at 607, and a critical aspect of any care and treatment is the integration of information to obtain a holistic understanding of the individual. Without a comprehensive understanding of the person, the services provided to that person are necessarily deficient. Below, we discuss two important components of integrated treatment planning: (1) individualized support plans; and (2) interdisciplinary treatment teams. We find that Howe is experiencing significant difficulties in both of these components, resulting in residents being deprived of constitutional and statutory guarantees.

1. Individualized Support Plans

Howe's individualized support plans ("ISPs") do not reflect person-centered planning, which is the generally accepted standard in intervention and integrated treatment planning for individuals with developmental disabilities. Person-centered planning begins with the individual, examines his or her needs and desired life outcomes, and captures all goals and objectives. Person-centered planning is based on preferences and strengths of individuals. The failure to provide a person-centered approach to integrated treatment planning deprives individuals of opportunities to express choice and preference in selecting goals, undermines efforts to address challenging behaviors, compromises the effectiveness of habilitation programs, and inhibits the ability of Howe residents to move to more integrated settings.

ISPs at Howe frequently do not include a resident's personal goals and preferences, which are the hallmark of person-centered planning. Instead, ISPs at Howe often contain statements such as: "[Resident's name] does not have a personal goal for [this area];" or "[Resident's name] also doesn't have desired outcome for this area." Even where a goal is mentioned, the ISP often does not provide the necessary supports or honor preferences or interventions that will achieve the resident's goal. The ISP for B.G, for example, lists as a personal goal, "to live with a family member." The plan, however, does not state the barriers to achieving that goal, and does not provide any programs that might reasonably be expected to allow B.G to take steps toward reaching that goal.

The assessment process used to develop ISPs at Howe fails to identify skills that are relevant to a resident's progress toward his or her goals. The routine inclusion in ISPs of a self-medication and monetary savings goals were admitted by staff to be driven by the perception that those were goals required for CMS re-certification of the facility.

In general, ISPs fail to include consideration of barriers to the goal of community placement. Without an understanding of the barriers preventing a resident from being placed in the community, it is impossible to identify and implement training that could move the resident closer to placement. Many residents have ISPs that fail to identify any barriers to community placement or any training goals that could move residents forward.

ISP meetings or reviews at Howe, which are held only annually, too often take place without the resident involved, or a guardian or advocate present. This is a critical omission in person-centered planning. When Special Interdisciplinary Team Meetings were held to discuss A.B.'s frequent and serious self-injurious behavior resulting in serious injuries, her guardian requested that an advocate

attend on her behalf. Yet three meetings were held without an advocate or guardian, and without A.B. present.

Additionally, our expert consultant found the structure of ISPs at Howe to be exceedingly difficult to follow. Assessment results, goals and objectives, training programs, and data sheets are scattered throughout the document. As a result, it is difficult to consider the sum total of training, skill development, and overall services. This general disorganization contributes to Howe's failure to produce ISPs that reflect individuals' choices, preferences, and needs.

2. Interdisciplinary Treatment Teams

Howe does not use interdisciplinary treatment teams in its integrated treatment planning. As a result, Howe residents are deprived of coordinated treatment, making intervention efforts ineffectual or inefficient. The only scheduled interdisciplinary treatment team meetings at Howe are held annually as part of the annual ISP meetings noted in the section above. Otherwise, there is no process for holding regular interdisciplinary team meetings to review a resident's progress. Generally accepted professional standards require that each individual's interdisciplinary team meet at least four times a year. Although staff reported that there are "Special Interdisciplinary Team Meetings," which are called on an "as needed" basis, having only regularly scheduled interdisciplinary treatment team meetings once a year is contrary to both generally accepted professional standards and Howe's own policy. Howe's Standard Operating Policy and Procedure No. 433 states: "Each month, starting from the date of the ISP, the support plan will be reviewed using a trans-disciplinary process to assess each person's progress toward achieving the personal goals and objectives specified in the Support Plan." (Emphasis added).

The Interdisciplinary Treatment Team Annual Meetings that we observed during our tour consisted largely of reports by individual disciplines with no interdisciplinary discussion, no interdisciplinary problem solving, and no interdisciplinary action planning. Sometimes the meetings failed to include any action planning at all, even to address problems that had been clearly identified. For instance, a Special Interdisciplinary Team Meeting called specifically to address B.H.'s threats of harm to a peer, a staff member, and himself, resulted in no action plan except observation.

Interdisciplinary Treatment Team Annual Meetings do not demonstrate collaboration between disciplines on assessment, program design, or intervention. Moreover, Howe's Qualitative Monthly Review Summaries are not interdisciplinary in nature and as a result, lack critical information about the resident.

Fragmentation in these records reflects the absence of a functional interdisciplinary process in treatment planning and implementation.

When interdisciplinary treatment team meetings are held, essential team members are not present. For example, when a Special Interdisciplinary Treatment Team Meeting was held on November 6, 2007, to address B.I.'s exclusion from a workshop because of her behavior, only residence staff and the speech therapist attended. The team psychologist did not attend, although a behavior plan was reportedly in development. Advocates, even when requested by a resident's parent or guardian, often are not present.

Further, interdisciplinary treatment team meetings at Howe are not responsive to the resident's expressed preferences or concerns. During A.W.'s Annual Interdisciplinary Meeting, for example, A.W. stated a desire to move. That request was completely ignored, and the team members made no attempt to determine what factors were motivating the request. While it appears that Special Interdisciplinary Team Meetings are held when the staff requests them, we found no instance in which an interdisciplinary treatment team meeting was held because of a concern raised by a resident.

III. REMEDIAL MEASURES

To remedy the identified deficiencies and protect the constitutional and statutory rights of Howe residents, the State of Illinois should implement promptly, at a minimum, the remedial measures set forth below. Despite the decision to close Howe, the constitutional violations at the facility will have continuing effects, for which the State must provide relief. The State retains a statutory obligation to transition residents to the most integrated settings appropriate to their needs. Many of these deficiencies could be remedied, in part, by focusing the care and treatment at Howe on moving individuals into the most integrated setting appropriate to the residents' needs:

A. TRANSITION PLANNING

Provide transition, discharge, and community placement services consistent with generally accepted professional standards to all residents at Howe. Even as Howe proceeds to close, the State must guarantee the residents a safe transition to the most integrated setting appropriate to their needs. To this end, the facility should take these steps:

1. Actively pursue the appropriate discharge of individuals residing at Howe and provide them with adequate and appropriate protections, supports, and services, consistent with each person's individualized

needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object;

2. Set forth in reasonable detail a written transition plan specifying the particular protections, supports, and services that each individual will or may need in order to safely and successfully transition to and live in the community;
3. Develop each transition plan using person-centered planning principles. Each transition plan should specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the individual in the alternative community setting, including their scope, frequency, and duration. Each transition plan should include all individually-necessary protections, supports, and services, including but not limited to:
 - a. housing and residential services;
 - b. transportation;
 - c. staffing;
 - d. health care and other professional services;
 - e. specialty health care services;
 - f. therapy services;
 - g. psychological, behavioral, and psychiatric services;
 - h. communication and mobility supports;
 - i. programming, vocational, and employment supports; and
 - j. assistance with activities of daily living.
4. Include in each transition plan specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports;
5. Emphasize the placement of residents into smaller community homes in its transition planning;

6. Avoid placing residents into nursing homes or other institutional settings whenever possible in its transition planning;
7. Identify in each transition plan the date the transition can occur, as well as timeframes for completion of needed steps to effect the transition. Each transition plan should include the name of the person or entity responsible for:
 - a. commencing transition planning;
 - b. identifying community providers and other protections, supports, and services;
 - c. connecting the resident with community providers; and
 - d. assisting in transition activities as necessary. The responsible person or entity shall be experienced and capable of performing these functions.
8. Develop each transition plan sufficiently prior to potential discharge so as to enable the careful development and implementation of needed actions to occur before, during, and after the transition. This should include identifying and overcoming, whenever possible, any barriers to transition. Howe should work closely with pertinent community agencies so that the protections, supports, and services that the individual needs are developed and in place at the alternate site prior to the individual's discharge;
9. Update the transition plans as needed throughout the planning and transition process based on new information and/or developments;
10. Attempt to locate community alternatives in regions based upon the presence of persons significant to the individual, including parents, siblings, other relatives, or close friends, where such efforts are consistent with the individual's desires;
11. Provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each individual. Howe should modify the transition plans, as needed, based on these community visits;

12. Establish in each individual transition plan a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the individual are being met. Each plan should specify more regular visits in the days and weeks after any initial placement;
13. Ensure that each individual residing at Howe be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers;
14. Use person-centered planning principles at every stage of the process. This should facilitate the identification of the individual's specific interests, goals, likes and dislikes, abilities and strengths, as well as deficits and support needs;
15. Give each individual residing at Howe the opportunity to express a choice regarding placement. Howe should provide individuals with choice counseling to help each individual make an informed choice and provide enhanced counseling to those individuals who have lived at Howe for many years;
16. If any individual residing at Howe opposes placement, Howe should document the steps taken to ensure that any individual objection is an informed one. Howe should set forth and implement individualized strategies to address concerns and objections to placement;
17. Educate individuals residing at Howe about the community and various community living options open to them on a routine basis;
18. Provide each individual with several viable placement alternatives to consider whenever possible. Howe should provide field trips to these viable community sites and facilitate overnight stays at certain of the community residences, where appropriate;
19. Provide ongoing educational opportunities to family members and/or guardians with regard to placement and programming alternatives and options, when family members and/or guardians have reservations about community placement. These educational opportunities should include information about how the individual may have viable options other than living with the family members and/or guardians once discharged from Howe. Howe should identify and address the concerns of family members and/or guardians with regard to community placement. Howe should encourage family members and/or guardians

to participate, whenever possible, in individuals' on-site, community home field trips;

20. In coordination with the State, develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms should serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight shall include regular inspections of community residential and program sites; regular face-to-face meetings with residents and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records;
21. Serve individuals who are placed in the community with an adequate number of service coordinators to meet individuals' needs. The State's service coordination program should provide for various levels of follow-up and intervention, including more intensive service coordination for those individuals leaving Howe with more complex needs. To encourage frequent individual contact, individuals leaving Howe should be served by service coordinators who carry a caseload of no more than 25 individuals at a time. Service coordinators involved with individuals from Howe with more complex and intensive needs will carry a caseload of no more than 20 individuals at a time. All service coordinators should receive appropriate and adequate supervision and competency-based training;
22. Provide prompt and effective support and intervention services post-placement to residents who present adjustment problems related to the transition process such that each individual may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to:
 - a. providing heightened and enhanced service coordination to the individual/home;
 - b. providing professional consultation, expert assistance, training, or other technical assistance to the individual/home;

- c. providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and
 - d. developing and implementing other community residential alternative solutions for the individual.
23. Regularly review various community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State should develop and implement effective strategies to any gaps or weaknesses or issues identified.

B. PROTECTION FROM HARM

The decision to close Howe does not relieve the State of its obligation to protect resident from harm. Therefore, Howe must provide incident, risk, and quality management services consistent with generally accepted professional standards to all residents. More particularly, Howe should:

1. Ensure that incidents involving injury and unusual incidents are tracked and analyzed.
2. Ensure that analyses are transmitted to the relevant disciplines and direct-care areas for responsive action, and responses are monitored to ensure that appropriate steps are taken.
3. Develop and implement an adequate system for identifying residents at high risk of being injured or causing injuries to others, and those residents who instigate incidents or who are aggressive. Develop and implement plans to address the high risk situations.
4. Ensure that all staff and (to the extent possible) residents are trained adequately on processes for reporting abuse and neglect.
5. Ensure that all abuse and neglect investigations are conducted thoroughly and accord with generally accepted professional standards.
6. Impose appropriate discipline and corrective measures with respect to staff involved in substantiated cases of abuse or neglect including staff who fail to carry out their responsibilities while providing enhanced supervision.

Regarding the use of restraints, Howe must ensure that any device or procedure that restricts, limits, or directs a residents' freedom of movement (including, but not limited to, mechanical restraints, physical or manual restraints, or chemical restraints) be used only in accordance with generally accepted professional standards. To this end, Howe should take the following steps:

1. Ensure that restrictive interventions or restraints are never used as punishment, in lieu of training programs, or for the convenience of staff, and that the least restrictive restraint techniques necessary are utilized, and that restraint use is minimized.
2. Develop and implement a policy on restraints and restrictive measures that comports with current, generally accepted professional standards.
3. Prohibit the use of mechanical restraints as part of behavioral treatment plans and programs, and limit the use of mechanical restraints to true emergency situations in which there is no other means of protecting the resident or others.

C. HEALTH CARE

Provide medical care, nursing, and therapy services consistent with generally accepted professional standards to residents who need such services. Howe must provide adequate health care even as it proceeds toward closure. To this end, Howe should take these steps:

1. Provide each resident with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs.
2. Develop and implement strategies to secure and retain adequate numbers of trained nursing staff.
3. Clarify policies and procedures regarding communication and coordination of care between medical providers and specialists to ensure that findings and recommendations are addressed promptly.
4. Develop and implement an adequate system of documentation to ensure timely, accurate, and thorough recording of all medical and nursing care provided to Howe's residents.

5. Conduct regular audits to assess the quality of all medical documentation, timeliness of filing documents, and the overall organization of the chart.
6. Provide competency-based training, consistent with generally accepted professional standards, to staff in the areas of: basic emergency response and first aid, infection control procedures, skin care, and meal plans.
7. Ensure that medical staff is capable of recognizing, assessing, and managing the physical pain of the residents.
8. Develop and implement criteria by which residents with the highest nutritional and physical risks are identified, assessed, and provided the appropriate nutritional and physical therapy and supports.
9. Conduct a comprehensive assessment of all residents using mobility, therapeutic positioning, or other assistive technology supports, to determine appropriateness of the technology support and to set measurable outcome goals.
10. Clarify policies and procedures regarding prompt communication between pharmacy staff and prescribing physicians when medication concerns arise, so that modifications in the medication regimen can be made without unnecessary delay.
11. Ensure that residents have routine dental examinations every six months, with oral x-rays being completed on an annual basis.
12. Ensure that comprehensive dental assessments are recorded in the medical record.
13. Provide adequate positioning to residents at risk of dysphagia during dental visits.
14. Provide quality assurance programs, including medical peer review and quality improvement systems, to regularly evaluate the adequacy of medical care.

D. PSYCHIATRIC CARE

Provide psychiatric services consistent with generally accepted professional standards to residents who need such services. The State's decision to close Howe

does not alter the obligation of Howe to provide adequate psychiatric care to its residents. To this end, Howe should take these steps:

1. Develop standard psychological and psychiatric assessment and interview protocols for reliably reaching a psychiatric diagnosis, and use these protocols to assess each resident upon admission for possible psychiatric disorders.
2. Undertake a thorough psychiatric evaluation of all residents currently residing at Howe, provide a clinically justifiable current diagnosis for each resident, and remove all diagnoses that cannot be clinically justified.
3. Clarify policies and procedures regarding communication and coordination of care between medical providers and psychiatric care specialists to ensure that findings and recommendations are addressed promptly.
4. Conduct adequate monitoring of individuals on antipsychotic medications for movement disorders.
5. Develop and implement a system to assess and refer individuals for individual and group therapy, as necessary.

E. BEHAVIORAL TREATMENT AND HABILITATION

Provide residents with training, including behavioral and habilitative services, consistent with generally accepted professional standards to residents who need such services. These services should be developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every resident. These services should be developed and received by residents despite the State's to close Howe. To this end, Howe should take the following steps:

1. Develop standard protocols for efficient, accurate collection of behavioral data, including relevant contextual information.
2. Develop standard psychological assessment and interview protocols. Ensure in these protocols that possible medical, psychiatric, and or other motivations for target behaviors are considered.

3. Use these protocols to ensure that functional behavioral assessments and findings about behaviors are adequately substantiated, current, and complete.
4. Ensure that behavioral treatment plans are written at a level that can be understood and implemented by direct-care staff.
5. Ensure that outcomes of behavioral treatment plans include fundamental objectives, such as reduction in use of medication, enhanced learning opportunities, and greater community integration.
6. Ensure that outcomes are frequently monitored, and that assessments and treatments are re-evaluated promptly if target behaviors do not improve.
7. Ensure that all residents receive meaningful habilitation daily.
8. Provide a habilitation assessment of all residents and develop and implement plans based on these assessments to ensure that residents are receiving vocational and/or day programming services in the most integrated setting appropriate to meet their needs.

F. INTEGRATED TREATMENT PLANNING

Provide supports, services, and planning that are integrated across disciplines, consistent with generally accepted professional standards, to all residents at Howe. To this end, Howe should take these steps even while it moves toward closure:

1. Ensure that ISPs integrate information across disciplines and reflect collaboration between disciplines.
2. Ensure that ISPs demonstrate individualized planning, including the individual's needs, strengths, goals, and preferences.
3. Develop and implement ISPs that include a section on transition and discharge planning, including the barriers to community placement and the facility's plan to address those barriers.
4. Ensure that ISPs are understandable to the individual served or their guardian.

5. Ensure that interdisciplinary treatment team meetings integrate information across disciplines and reflect collaboration between disciplines, and that the integration and collaboration are appropriately documented.
6. Ensure that individuals necessary to obtaining a comprehensive understanding of the resident, including direct care staff and the individual who is the subject of the meeting or their guardian, are included in the interdisciplinary treatment team process.
7. Ensure that action plans are developed and implemented to address the needs and/or issues identified in those meetings, including but not limited to inappropriate behaviors or use of restraint.
8. Ensure that transition and discharge planning, including barriers to placement, are routinely discussed at interdisciplinary treatment team meetings.

* * *

We hope to continue working with the State of Illinois in an amicable and cooperative fashion to resolve our outstanding concerns with regard to Howe.

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

Provided our cooperative relationship continues, we also would be willing to send one or more of our expert consultant evaluations of Howe under separate cover. These reports are not public documents. Although the reports are our expert consultants' work and do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses, and recommendations may provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See

42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you. Accordingly, we will soon contact State officials to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195, or Joan Laser, Assistant United States Attorney, at (312) 353-1857.

Sincerely,

Thomas E. Perez
Assistant Attorney General

Patrick J. Fitzgerald
United States Attorney
Northern District of Illinois

cc: The Honorable Lisa Madigan
Illinois Attorney General
Attorney General's Office

The Honorable Michelle R.B. Saddler
Secretary
Illinois Department of Human Services

Mary-Lisa Sullivan, Esq.
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Illinois Department of Human Services

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U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
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January 29, 2010

The Honorable Mitch Daniels
Governor, State of Indiana
Office of the Governor
State House, Room 206
Indianapolis, IN 46204-2797

Re: Investigation of the Indianapolis Juvenile
Correctional Facility, Indianapolis, Indiana

Dear Governor Daniels:

I am writing to report the findings of the Civil Rights Division's investigation of conditions at the Indianapolis Juvenile Correctional Facility ("IJCF") in Indianapolis, Indiana. On January 28, 2008, we notified you of our intent to conduct an investigation of IJCF, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA") and the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). As we noted, both CRIPA and Section 14141 give the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youths in juvenile justice institutions.

From April 22 to 25 and July 21 to 24, 2008, we conducted on-site inspections of IJCF. We were accompanied by expert consultants in mental health care, juvenile justice, sexual misconduct, and special education. We interviewed staff members, youth residents, mental health care providers, teachers, and administrators. Before, during, and after our visit, we reviewed an extensive number of documents, including policies and procedures, incident reports, youth detention records, mental health records, grievances from youth residents, unit logs, orientation materials, staff training materials, and school records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, at the conclusion of each of our tours, we conducted an exit conference

with facility and Indiana Department of Correction (“IDOC”) officials, during which our consultants conveyed their initial impressions and concerns.

At the outset, we commend the staff of IJCF for their helpful, courteous, and professional conduct throughout the course of the investigation. We also wish to express our appreciation for the cooperation of IDOC officials. We hope to continue to work with the State and IJCF officials in the same cooperative manner going forward.

Consistent with our statutory obligation under CRIPA, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). We have concluded that certain conditions and practices at IJCF violate the constitutional and federal statutory rights of its residents. In particular, we find that IJCF fails to provide its youth residents with adequate: (1) protection from harm; (2) mental health care; and (3) special education services. See Youngberg v. Romeo, 457 U.S. 307 (1982); Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974); Individuals with Disabilities Education Act (“IDEA”), 20 U.S.C. §§ 1400-1482.

I. BACKGROUND

A. Description of the Facility

IJCF is a maximum security juvenile facility located in Indianapolis, Indiana.¹ Until March 2008, the facility housed both boys and girls, and the average total population was approximately 270 youths. A few weeks prior to our April 2008 tour, however, the State transferred all boys out of IJCF. Accordingly, at the time of both of our tours, the facility housed only girls; the population was approximately 158 and the girls ranged in age from 13 to 19 years old. IJCF is the only IDOC juvenile facility that houses girls. Consequently, it also serves as IDOC’s intake and diagnostic facility for girls, and houses all girls committed to IDOC, regardless of age or offense.²

¹ In July 2009, the State announced plans to relocate the facility to Madison, Indiana, approximately two hours south of Indianapolis. This move occurred in early November 2009; all the girls in the State’s juvenile system are now housed at the Madison Juvenile Correctional Facility.

² IJCF is the most recent of several IDOC juvenile facilities into which we have opened investigations pursuant to CRIPA and Section 14141. In addition to IJCF, we have opened investigations of, and reached resolution regarding, the South Bend

The site upon which IJCF sits has served as a juvenile facility for many years; the physical plant, however, has changed over time. The entire IJCF campus is surrounded by a security fence. The campus comprises of an older section and a newer section, and the two areas are separated by a second security fence. Before the State moved the boys out of IJCF in March 2008, they were all housed in the newer section, and the girls were all housed in the older section. By the time of our tours, most of the girls had been moved into the newer section.

The living units in the newer section consist of single occupancy sleeping rooms that open into large day rooms. The sleeping rooms do not have plumbing. Instead, communal bathrooms are connected to the day rooms. The bathrooms have open windows to a toilet area, and the shower areas have no doors. The toilet and shower areas therefore are clearly visible from the staff duty station desk, which is located just outside the bathroom doorway and window.

The older section of the campus contains eight living units. At the time of our tours, only one of those living units was still in use. This living unit consists of double occupancy rooms and a day room. We were informed that the remaining seven living units in the older section either were undergoing or scheduled to undergo renovations.

During the course of our ongoing compliance monitoring at South Bend, the State has provided us with revised policies in some of the areas discussed below, including, for example, satisfactory policies in the areas of grievances and suicide prevention. We understand that these policies are intended to apply to all IDOC facilities, including IJCF. Our findings below are based on our on-site tours of IJCF in April and July 2008; we have not had an opportunity to evaluate whether, and to what extent, any revised policies are being implemented at IJCF. We understand that positive changes may be occurring at the facility based on the revised policies, and we look forward to evaluating their implementation in the future.

B. Legal Background

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional and federal statutory rights of

Juvenile Correctional Facility (“South Bend”), Plainfield Juvenile Correctional Facility (“Plainfield”), and Logansport Juvenile Intake/Diagnostic Facility (“Logansport”) (our Rule 41 settlement agreement with the State regarding South Bend is set to terminate on February 8, 2010). We also have opened an investigation of the Pendleton Juvenile Correctional Facility (“Pendleton”); our findings regarding Pendleton will be provided by separate letter.

juveniles in juvenile justice facilities. 42 U.S.C. § 1997. Section 14141 prohibits any governmental authority responsible for incarcerating juveniles from engaging in a pattern or practice of conduct that deprives those juveniles of constitutional or federal statutory rights. 42 U.S.C. § 14141. Section 14141 grants the Attorney General authority to file a civil action to eliminate any pattern or practice.

The Constitution requires states to provide reasonably safe conditions of confinement to individuals held in its institutional care in a non-penal context, like juveniles confined in a juvenile facility who have been adjudicated delinquent but not convicted of a crime. See Deshaney v. Winnebago County, 489 U.S. 189, 200 (1989) (“[W]hen the State . . . so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.”); Youngberg, 457 U.S. at 315-16 (recognizing that a person with mental retardation held in state custody has substantive due process rights under the Fourteenth Amendment, including the right to safe conditions of confinement); Bell v. Wolfish, 441 U.S. 520, 535-36 & n.16 (1979) (applying the Fourteenth Amendment standard to a facility for adult pre-trial detainees); K.H. ex rel. Murphy v. Morgan, 914 F.2d 846, 851 (7th Cir. 1990) (“Youngberg v. Romeo made clear . . . that the Constitution requires the responsible state officials to take steps to prevent children in state institutions from deteriorating physically or psychologically.”);³ Nelson, 491 F.2d at 357, 360 (recognizing that “the use of disciplinary beatings and tranquilizing drugs” violated juveniles’ Fourteenth Amendment right to protection from cruel and unusual punishment and Fourteenth Amendment right to rehabilitative treatment, including a “right to minimum acceptable standards of care and treatment”).⁴ The proper inquiry into whether the

³ K.H. also notes that the holding in Nelson “anticipated” Youngberg. K.H., 914 F.2d at 851.

⁴ The Seventh Circuit has not directly addressed the constitutional standards applicable to juveniles confined in state facilities. Where, as here, confined persons have not been formally convicted of a crime, the Fourteenth Amendment and its coordinate development in case law is generally the source of constitutional protections, although the protections of the Eighth Amendment may be incorporated where appropriate. See Bell, 441 U.S. at 535-36; Ingraham v. Wright, 430 U.S. 651, 669 n.37 (1977); Nelson, 491 F.2d at 357, 360 (applying both the Eighth Amendment and substantive elements of the Due Process Clause of the Fourteenth Amendment in determining the rights of juveniles in a medium security facility); see also Doe v. Strauss, No. 84C2315, 1986 WL 4108, at *4 (N.D. Ill. Mar. 28, 1986) (unreported) (“[W]hat we have here is a long elevated Fifth, Eighth and

constitutional rights of institutionalized juveniles have been violated focuses on whether conditions substantially depart from generally accepted professional judgment, practices, or standards. See Youngberg, 457 U.S. at 323.

In providing safe conditions, the State may not subject confined juveniles to undue restraint and its staff may not use excessive force. See Youngberg, 457 U.S. at 316; Nelson, 491 F.2d at 356 (holding that beating juveniles with a paddle violates their constitutional rights); see also Milonas v. Williams, 691 F.2d 931, 942-43 (10th Cir. 1982) (invalidating the use of undue physical force); Morales v. Turman, 364 F. Supp. 166, 173 (E.D. Tex. 1973) (issuing a preliminary injunction where the court found that juvenile facilities' widespread practice of beating, slapping, kicking, and otherwise abusing juveniles in the absence of exigent circumstances violated juveniles' rights). The State also must keep juveniles in its institutions reasonably safe from harm inflicted by third parties, including by other juveniles in the facility. See J.H. ex rel. Higgin v. Johnson, 346 F.3d 788, 791 (7th Cir. 2003) ("[C]hildren in state custody have a constitutional right not to be placed in a foster home where the state knows or suspects that the children may be subject to sexual or other abuse."); B.H. v. Johnson, 715 F. Supp. 1387, 1395 (N.D. Ill. 1989) ("[A] child who is in the state's custody has a substantive due process right to be free from unreasonable and unnecessary intrusions on both its physical and emotional well-being."); see also K.H., 914 F.2d at 851.

When subjecting a confined juvenile to disciplinary procedures, the State must provide the accused juvenile with procedural due process, including an opportunity to present evidence in his or her defense. See Mary v. Ramsden, 635 F.2d 590, 599 (7th Cir. 1980) (holding that juveniles have a right to present evidence and call witnesses on their behalf in the context of a disciplinary proceeding); see also Gary H. v. Hegstrom, 831 F.2d 1430, 1433 (9th Cir. 1987) ("To the extent that the court ordered due process hearings prior to confinement in excess of 24 hours, . . . the decree was clearly within the power of a federal court to assure minimum constitutional standards taught by Youngberg."); H.C. ex rel. Hewett v. Jarrard, 786 F.2d 1080, 1088 (11th Cir. 1986) (holding that procedural

Fourteenth Amendment right decisionally recognized in this state and many others. It protects juveniles when they are placed by state action in special custody, management and control because of their homeless, their delinquent conduct, and their unmonitored living. It is a right to care, management and therapy reasonably designed and calculated to effect rehabilitation, moral restoration and proper development."). But see Viero v. Bufano, 925 F. Supp. 1374, 1381 n.15 (N.D. Ill. 1996) (stating summarily, in a footnote, that Eighth Amendment protections apply to juveniles in the context of a Section 1983 damages case where a juvenile in a facility committed suicide).

due process violations that result in solitary confinement for a juvenile can give rise to compensatory damages); Santana v. Collazo, 714 F.2d 1172, 1179 (1st Cir. 1983) (citing Youngberg and holding that juveniles in a juvenile facility, “who have not been convicted of crimes, have a due process interest in freedom from unnecessary bodily restraint which entitles them to closer scrutiny of their conditions of confinement than that accorded convicted criminals”). This right extends to proceedings determining whether a juvenile is to be subjected to disciplinary segregation. See Mary, 635 F.2d at 594. If used, throughout the duration of confinement, the segregation must be closely regulated; the choice to use segregation must be an informed one; the juvenile must be aware of the reason for the detention; the facility must demonstrate that segregation is in the juvenile’s best interest; the segregation must be subject to regular, periodic review by professionals; and the juvenile must be given reasonable access to peers and treatment staff, a reasonable amount of reading or recreational material, and opportunities for daily physical exercise. Nelson v. Heyne, 355 F. Supp. 451, 456 (N.D. Ind. 1972), aff’d, 491 F.2d 352 (7th Cir. 1974); see Youngberg, 457 U.S. at 322 (holding that the Due Process Clause includes the right to be free from unreasonable bodily restraint); see also Milonas, 691 F.2d at 942-43 (upholding an injunction limiting the use of isolation rooms in a juvenile facility where district court found that the facility permitted the rooms to be used unreasonably).

Additionally, both inmates and detained youths have a right to file grievances with the facility regarding their treatment, as well as a right not to be punished for using the grievance system. Bradley v. Hall, 64 F.3d 1276, 1279 (9th Cir. 1995); Thaddeus-X v. Blatter, 175 F.3d 378, 394 (6th Cir. 1999); D.B. v. Tewksbury, 545 F. Supp. 896, 905 (D. Or. 1982); Morales, 364 F. Supp. at 175; see also Bounds v. Smith, 430 U.S. 817, 828 n.17 (1977) (“Our main concern here is protecting the ability of an inmate to prepare a petition or complaint.”); Walker v. Thompson, 288 F.3d 1005, 1009 (7th Cir. 2002) (holding that an inmate’s grievance is constitutionally protected speech and that a prison’s retaliation for filing the grievance is unconstitutional); Hasan v. U.S. Dep’t of Labor, 400 F.3d 1001, 1005 (7th Cir. 2005) (holding that, unless frivolous, prisoners’ grievances are entitled to First Amendment protection).

The State also is limited in the cross-gender supervision and searches it may conduct in its juvenile facilities. For example, in the context of adult prisons, although pat-down searches and occasional or inadvertent sightings of male inmates in their cells or showers by female staff do not violate the inmates’ right to privacy, observation that is “more intrusive (like a strip search, in the absence of an emergency) or a regular occurrence” does violate inmates’ right to privacy. Canedy v. Boardman, 16 F.3d 183, 185-86, 188 (7th Cir. 1994) (holding that a prison may not ignore a prisoner’s right to privacy and must accommodate that right where

reasonable);⁵ see also Henry v. Milwaukee County, 539 F.3d 573, 584-85 (7th Cir. 2008) (holding that sex is not a bona fide occupational qualification in a juvenile justice facility for the purposes of maintaining same-gender supervision during the nighttime shift, but leaving open the possibility that, in other circumstances, a juvenile facility could show that single-sex supervision is necessary for promoting the goals of rehabilitation, security, and privacy). In addition, although Title VII of the Civil Rights Act prohibits gender-based discrimination in the workplace, in particularized circumstances, “the goals of security, safety, privacy, and rehabilitation can justify gender-based assignments in female correctional facilities.” Everson v. Mich. Dep’t of Corrections, 391 F.3d 737, 750, 761 (6th Cir. 2004) (citing Torres v. Wis. Dep’t of Health & Soc. Svcs., 859 F.2d 1523, 1532 (7th Cir. 1988) (en banc)) (upholding the State’s considered decision that sex as a bona fide occupational qualification for female housing units in Michigan correctional facilities was necessary to address the sexual abuse of female inmates by male correctional officers but “emphasiz[ing] the limited nature of [the court’s] holding”).

It is well established that juveniles held by the state should enjoy at least the same protections as prisoners. See Nelson, 355 F. Supp. at 457 (noting, in the course of finding cruel and unusual treatment of juveniles, that “there is a legal distinction in the nature of treatment appropriate to a convicted felon and that accorded one adjudged a juvenile delinquent”); Belloti v. Baird, 443 U.S. 622, 634 (1979) (plurality opinion) (noting recognition of three reasons justifying the different treatment of juveniles: “the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing”); Schleiffer v. Meyers, 644 F.2d 656, 660 (7th Cir. 1981) (relying on Belloti to determine the rights of a minor in a custody dispute); Swansey v. Elrod, 386 F. Supp. 1138, 1143 (N.D. Ill. 1975) (“In effect, the Supreme Court has held that a juvenile is entitled to a higher standard of custodial care in return for a more limited set of rights during the adjudication process under the due process clause.”).

⁵ Compare Johnson v. Phelan, 69 F.3d 144, 145, 147 (7th Cir. 1995) (holding that the anonymous inspection of a male pretrial detainee by female guards did not violate the Constitution and characterizing Canedy as an Eighth Amendment case solely addressing tactile searches), with id. at 156 (Posner, J., dissenting) (noting that there was “no basis in the record” showing that prison officials had weighed accommodation in their decision-making), and Calhoun v. DeTella, 319 F.3d 936, 939-40 (7th Cir. 2003) (holding that allegations of direct cross-gender monitoring could state an Eighth Amendment claim because the allegations included a claim that the monitoring served no legitimate purpose).

Moreover, as to strip searches specifically, in the analogous school context, the Supreme Court has held that a search of a student in school must be justified in its inception and must be reasonably related in scope to the reason for the search. Safford v. Redding, 129 S. Ct. 2633, 2639 (2009); New Jersey v. T. L. O., 469 U.S. 325, 341-42 (1985). The Supreme Court places a strip search in “a category of its own” that requires specific suspicions of hiding evidence of wrongdoing in underwear or of danger, rather than mere knowledge that youth sometimes hide contraband in their underwear. Safford, 129 S. Ct. at 2643.

In addition to keeping juveniles safe from harm, the State must provide juveniles held in its facilities with rehabilitative treatment. Nelson, 491 F.2d at 359-60. Rehabilitative treatment, in turn, includes mental health services. See id. at 360 (noting that “the juvenile process has elements of both the criminal and mental health processes”); see also Youngberg, 457 U.S. at 323 n.30; K.H., 914 F.2d at 851; A.M. ex rel. J.M.K. v. Luzerne County Juvenile Det. Ctr., 372 F.3d 572, 585 n.3 (3d Cir. 2004). Like all services that the state provides to confined juveniles, mental health services may not depart substantially from generally accepted professional standards. See Youngberg, 457 U.S. at 323; In re Cole v. Fromm, 94 F.3d 254, 262 (7th Cir. 1996).

Facilities further must ensure that juveniles who pose a risk to themselves are adequately protected. See Youngberg, 457 U.S. at 315-16; K.H., 914 F.2d at 851; Myers v. County of Lake, 30 F.3d 847, 850 (7th Cir. 1994) (“Indiana requires institutions to use reasonable care to prevent their wards from committing suicide”); Dohilite v. Maughon ex rel. Videon, 74 F.3d 1027, 1042-43 (11th Cir. 1996) (applying to the juvenile context the rule that, “[w]here prison personnel directly responsible for inmate care have knowledge that an inmate has attempted, or even threatened, suicide, their failure to take steps to prevent that inmate from committing suicide can amount to deliberate indifference”).

Finally, as to special education services, students with disabilities have federal statutory rights to such services under the IDEA, 20 U.S.C. §§ 1400-1482. See Honig v. Doe, 484 U.S. 305, 310 (1988) (noting that the Education for All Handicapped Children Act, as amended by the IDEA, “confers upon disabled students an enforceable substantive right to public education in participating States”). The IDEA requires states that accept federal funds to provide educational services to all children with disabilities between the ages of 3 and 21, even if the children have been suspended or expelled from school. 20 U.S.C. § 1412(a)(1)(A). Accordingly, the State must provide such services to youths in juvenile justice facilities. See id. (conditioning funds on the availability of services to “all children with disabilities” (emphasis added)); 34 C.F.R. § 300.2(b)(1)(iv) (applying IDEA requirements to “all political subdivisions of the State that are involved in the education of children with disabilities, including . . . State and local juvenile and

adult correctional facilities”); see also Donnell C. v. Ill. State Bd. of Educ., 829 F. Supp. 1016, 1020 (N.D. Ill. 1993) (finding the IDEA applicable to “school-aged pretrial detainees” in county jail); Handberry v. Thompson, 92 F. Supp. 2d 244, 248 (S.D.N.Y. 2000) (“Just like the general entitlement to a free public education, the [IDEA] entitlement to special education services is not trumped by incarceration.”); Alexander S. ex rel. Bowers v. Boyd, 876 F. Supp. 773, 800 (D.S.C. 1995) (“The [IDEA] regulations make it clear that the reference to all programs includes state correctional facilities and that the requirements of the IDEA apply to such facilities.”). The IDEA also requires schools to have procedures for identifying and testing students with disabilities. 34 C.F.R. § 300.111(a)(1)(I).

Section 504 of the Rehabilitation Act of 1973 (“Section 504”), 29 U.S.C. § 794, similarly obligates the State to provide juveniles confined in its institutions with educational services. Section 504 requires that “[n]o otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Id. § 794(a).

II. FINDINGS

A. PROTECTION FROM HARM

The State must provide juveniles housed at IJCF with reasonably safe conditions of confinement. See Youngberg, 457 U.S. at 315-16; Bell, 441 U.S. at 535-36 & n.16; K.H., 914 F.2d at 851; Nelson, 491 F.2d at 360.

The State fails to keep the youths at IJCF safe from harm in a number of respects. Specifically, the State: (1) fails to protect youths from staff sexual abuse and misconduct; (2) fails to conduct adequate abuse and misconduct investigations; (3) fails to provide adequate staffing; (4) uses inappropriate and excessive force; (5) uses isolation excessively and without adequate due process; (6) fails to provide an adequate grievance system; (7) fails to provide adequate programming; and (8) fails to provide adequate access to toilets.

1. Staff Sexual Abuse and Misconduct

The State fails to adequately protect IJCF youths from staff sexual abuse and misconduct. In the three-week period prior to and during our April 2008 tour, the following serious incidents occurred:

- On April 18, 2008, an officer was caught engaging in sexual activity with one of the girls he was supposed to be supervising in the campus kitchen.

When confronted, the officer admitted his conduct and, on April 21, 2008, his employment was terminated.

- On April 6, 2008, in two separate incidents, an officer engaged in sexual intercourse with two girls, including a 15-year-old girl. The facility referred the matter to the State police for further investigation. The officer subsequently plead guilty to one count of sexual misconduct and one count of sexual misconduct with a minor.

Although in some instances, like those described above, sexual abuse is discovered by or reported to the facility's administration, and appropriate steps are taken in the aftermath, our investigation revealed that the frequency of staff sexual abuse and misconduct at the facility is significantly higher than officially reported or investigated by the administration, as discussed below. Indeed, the sexualized environment at the facility appears rampant.

Many of the girls we interviewed consistently and independently described incidents of staff making sexual advances toward girls, including attempting to kiss or otherwise inappropriately touch the girls, and incidents of staff making sexually inappropriate comments to the girls. For example, one IJCF youth told us that a male officer repeatedly came to her room and asked to see or touch her breasts.⁶ Another girl described an incident in which a male staff member told another youth, who was on her hands and knees cleaning, "I bet you like it on your knees." Another girl summed up her fears about living at IJCF by saying: "Kids have sex with kids, staff have sex with kids, staff have sex with each other. This place is messed up."

As discussed below, the facility superintendent acknowledged that the staffing pattern at the facility likely contributes to the frequency of sexual encounters between officers and residents. Indeed, as of April 2008, nearly half of IJCF's officers were male, and we observed numerous occasions on which a single male officer was supervising a unit of approximately 25 girls.

Our findings of a rampant sexual environment at IJCF are further confirmed by a recent Bureau of Justice Statistics Special Report, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-2009*, released on January 7, 2010 ("BJS Report"). According to the BJS Report, 22.8% of girls at IJCF reported having experienced at least one incident of sexual victimization by another youth or

⁶ With the girl's consent, we reported this incident to the facility superintendent, who informed us that he would initiate the investigative process. We do not have information regarding the outcome of this investigation.

staff member at the facility in the prior year. IJCF's rate of 22.8% is nearly double the national average of 12.1%. It is also nearly double the national average of 14% for facilities housing only girls and is more than double the national average of 9.6% for facilities housing both sexes. These numbers place IJCF among the thirteen facilities with the highest rates of sexual victimization nationally. An astounding 16.3% of girls at IJCF reported unwanted sexual activity with another youth. This is more than six times the national average of 2.6%, and is nearly double the national average of 9.1% for girls in juvenile facilities nationwide. It also far exceeds the national average of 11% in facilities housing only girls. Additionally, 8.7% of girls at IJCF reported sexual activity with facility staff. Although slightly below the national average of 10.3%, this rate is nearly double the national average of 4.7% for girls in juvenile facilities nationwide, and nearly double the national average of 5% in facilities housing only girls.

2. Inadequate Abuse Investigations

The State also fails to ensure that allegations of staff abuse and misconduct are adequately reported and investigated. Indeed, allegations of staff sexual abuse and misconduct are not investigated in accordance with the facility's own policy. For example:

- In an incident report dated June 27, 2008, Officer A reported that an IJCF youth had made allegations of sexual misconduct to Officer A against Officer B. Officer A, however, did not refer the matter for investigation, nor did the officer complete a Report of Alleged Child Abuse or Neglect (the facility's official form for reporting abuse and neglect allegations). Instead, Officer A and Officer B together confronted the youth about her allegations. The youth then recanted, and Officer B wrote a conduct report charging her with "false accusations," which resulted in disciplinary action against the girl. Under these circumstances, there is no way of knowing whether the youth's allegations were false or whether, when confronted by the very staff member who reportedly assaulted her, she was too afraid to press the matter. In any case, the handling of her complaint was grossly inappropriate and well outside the bounds of what is generally accepted in the field.
- In an incident report dated June 9, 2008, an officer reported finding a note passed under a girl's door stating, "he keeps coming into my room, and I tell him not to and he does anyway." The note was appropriately turned over to the facility investigator. According to the incident report, however, two male staff attempted to talk with the girl about the note, and she refused, stating that she did not "want to talk to a man." No Report of Alleged Child Abuse or Neglect was completed, nor did we find any other evidence that this matter was investigated any further.

- On April 13, 2008, an IJCF counselor filed a Report of Alleged Child Abuse or Neglect, reporting an IJCF youth's allegations that an officer had been sexually abusing her during the night shift. Reportedly, the youth alleged that the officer had been touching her inappropriately and showing her his body parts. Although the cover page of the report contains a handwritten note that the girl's allegations were found to be unsubstantiated, the report offers no explanation regarding the basis of this finding, nor any other evidence that the allegations were investigated.

Our investigation also revealed instances where IJCF failed to adequately investigate alleged youth-on-youth sexual abuse and misconduct. For example:

- On June 2, 2008, a youth reported that another girl had touched her breast on a number of occasions. There was no report of a follow-up investigation of this allegation of sexual misconduct.
- On June 23 and 25, 2008, an IJCF school staff member asked for assistance in responding to a student who was upset after she was accused of raping a peer and was fearful that other girls would gang up to harm her. Despite efforts to obtain guidance, the staff member later wrote: "I'm hoping that someone . . . can talk to [the youth] or provide me with some info to help her out." We found no report of an investigation of the alleged rape or improper advances made between the youths.

3. Inadequate Staffing

Constitutional standards require that juvenile facilities have a sufficient number of adequately trained staff members to ensure the safety and security of residents. Without an adequate number of officers on duty, staff cannot adequately supervise the youths in their care. IJCF fails to provide adequate numbers of staff to keep girls safe, and fails to provide adequate female staff to protect girls' privacy. The staffing pattern likely exacerbates IJCF's problems with incidents of sexual abuse and misconduct, as well as with other program functions.

The living units at IJCF generally house approximately 25 youths. Both staff and youths reported to us, and our own observations confirmed, that usually, one or two officers were present on the living units. To the extent that one staff member is required to supervise 25 youths, this is well outside the bounds of generally accepted professional standards and is not adequate to ensure the safety of IJCF youths.

To protect due process rights, female staff must provide direct supervision to girls in juvenile facilities when the girls are engaged in private activities such as

showering, toileting, dressing, and undressing.⁷ As noted above, as of April 2008, nearly half of the officers at IJCF were male. We observed during our tours that it is not uncommon for a single male officer to supervise a unit of approximately 25 girls, including when the girls are engaged in private activities. Such staffing patterns not only lead to violations of girls' privacy and facilitate staff misconduct, but they also expose staff members to false allegations of staff misconduct. Indeed, the superintendent at the time of our April 2008 tour acknowledged that this staffing pattern was problematic and likely contributed to the frequency of sexual encounters between officers and residents.

Moreover, the physical layout of the facility undoubtedly increases the likelihood of sexual misconduct by staff members. As described above, the showering and toileting areas of the living units are visible from the staff duty station desk on each unit. Thus, male staff easily can observe girls at these vulnerable times. The facility's failure to provide same-gender supervision for private activities is contrary to the National Prison Rape Elimination Commission's proposed Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities ("Proposed Standards") and places IJCF residents at risk of invasions of privacy, embarrassment, and potentially humiliating situations. For girls in juvenile facilities, the vast majority of whom have histories of physical and/or sexual abuse, such loss of privacy may be particularly traumatic and may trigger fears about their safety.

Deployment of female staff to cover girls' private activities would better protect privacy of these teen girls. Both staff and residents recognize this need. Indeed, one supervisor acknowledged to us that he would like to have more female staff because "it's uncomfortable for male staff with the [bathroom] windows." And, one youth told us that male officers can see tall girls when they are in the bathroom or shower and added, "I dread showers."

⁷ Consistent with these standards, except in cases of emergency or other extraordinary unforeseen circumstances, the National Prison Rape Elimination Commission's proposed Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities ("Proposed Standards") require facilities to prohibit non-medical staff from viewing opposite gender juveniles who are nude or who are performing bodily functions. *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities*, 11 (Nat'l Prison Rape Elimination Comm'n, Proposed Standards, Jun. 23, 2009), available at http://nprec.us/publication/standards/juvenile_facilities/ (last visited Aug. 3, 2009) ("Proposed Standards"). As of the issuance of this letter, the Proposed Standards have been submitted to the Attorney General for review and promulgation of final rules.

4. Inappropriate and Excessive Use of Force

The State inappropriately and excessively uses force on girls at IJCF, in violation of their Constitutional right to be free from excessive use of force. See Youngberg, 457 U.S. at 316; Nelson, 491 F.2d at 356.

The State uses a number of highly intrusive and drastic measures, ostensibly in an effort to control its juvenile population. Such measures – including cell extractions, Oleo Resin Capsicum chemical spray (“OC Spray”) and restraint chairs, – typically are used only in adult correctional facilities. Although not unprecedented in juvenile facilities, the use of these measures is uncommon. Each such use in a juvenile facility must be scrupulously managed to ensure that the measure is employed only when absolutely necessary for the safety and security of the facility, residents, and staff, and only when less drastic measures have been attempted and failed. IJCF failures to manage the use of these drastic measures lead to abuse, including a forcible strip search of a teenage girl with severe mental illness, as described below. Indeed, instead of establishing an atmosphere of care, cooperation, and rehabilitation, IJCF uses intrusive and drastic control measures that foster an atmosphere of excessive force, high stress, fear, and crisis in a facility whose residents are abused and traumatized teenage girls.

a. Cell Extractions of Teenage Girls by Staff Dressed in Swat Gear

IJCF employs cell extraction techniques that involve excessive uses of force. The facility assembles and uses teams of staff heavily dressed in swat gear (protective vests, helmets, and pads) who forcibly extract girls from their cells. As with the other measures described above, the use of cell extractions in this manner in a juvenile facility is highly unusual; the use of such a tactic may be acceptable, if at all, only in the most extreme emergency situations, when absolutely necessary for safety and security, and after other, less intrusive methods have been attempted and failed. Specifically, rather than resorting to a forceful cell extraction, well-trained and competent staff typically can achieve compliance with the security needs of a facility by using a subtle approach of explaining the situation and seeking the juvenile’s cooperation. This generally begins by staff demonstrating a caring, concerned, and respectful attitude toward residents in the routine day-to-day living activities of the facility.

In a particularly egregious incident, on January 10, 2008, senior management at IJCF ordered the activation of a cell extraction team consisting of male officers dressed heavily in swat gear to search for a missing piece of porcelain that had broken off from a toilet in the segregation unit, which houses the facility’s most troubled and vulnerable girls. The five-man team searched the first side of

the unit by forcibly entering each cell in a single-file formation, extracting each girl, and having a female staff member strip search her. After finding most of the missing porcelain on the first side of the unit, the cell extraction team continued the search, on the second side of the unit as a shakedown, or “spring cleaning,” to find additional contraband.

According to video of this incident, the general process of the extractions consisted of the cell extraction team ordering each girl to “cuff up” (submit her hands for handcuffing through a slit in their cell doors), handcuffing her through her cell door, and then ordering her to get on her knees in front of the back wall of the cell, with her back to the cell door. For some girls, the five-man team then entered the cell and walked out with the girl. For other girls, the men entered the cell, placed the girl in the prone position on the floor, held her down at her upper back and each arm and leg, and shackled her legs before removing her from her cell. For two of the girls, as discussed below, the team used OC spray after the girls refused to cuff up. The team then brought each girl into another cell for the strip search, again placed her on the floor in the prone position, and removed her restraints. The team then left the girl on the floor and warned her that if she got up or moved, the team would return to “do it all over again.” The video we observed provides no indication of why the cell extraction team shackled some girls’ legs in addition to handcuffing them. Moreover, as is evident from the video, the girls apparently did not know the reason for the extractions, and many shouted questions such as “what the fuck?” “what [sic] you all doing?” and “why are you doing this shit?” during the extraction process.

Although accepted juvenile corrections practice requires facility staff to first attempt to secure residents’ cooperation, it appears that IJCF made no effort to do so. Although the vast majority of the girls were non-violent, non-threatening, did not pose a risk to themselves, staff, or other girls, and complied with staff’s order to cuff up, move to the back of their cells, and get on their knees, the facility nonetheless used the cell extraction team to forcibly remove them, often further restraining them in the process. Moreover, the cell extractions violated the facility’s policies, which do not provide for cell extractions for shakedown purposes or where a youth complies with an order to be restrained. Indeed, the facility’s own post-event analysis concluded that this use of the cell extraction team was inappropriate; the analysis notes that the team is altogether unnecessary when a girl complies with staff orders to submit to a restraint. That same analysis also notes that the use of the cell extraction team as a shakedown team is inappropriate. Accordingly, the team never should have been deployed for this purpose. In short, staff used clearly excessive and abusive force in an incident that likely could have been avoided entirely. Such practices are a gross departure from generally accepted professional standards and expose girls to grave risk of both physical and emotional harm, including bodily injury and re-traumatization.

We were unable to ascertain the precise frequency with which cell extractions occur. It appears that IJCF's reporting of such incidents is unreliable because IJCF inexplicably appears to consider an incident a cell extraction only where the cell extraction team uses additional force during the extraction. As part of our review of the January 10 incident in which at least 17 girls were extracted from their cells,⁸ we requested a list of all girls who have been extracted by the cell extraction team since the team's inception. The list IJCF provided included only three of the girls who had been extracted during the January incident. These three were the ones on whom the cell extraction team used additional force; as discussed below, the team sprayed two of them with OC spray and forcibly cut off all of the third girl's clothing.

b. Unjustified Strip Search of a Teenage Girl by Male Staff

As noted above, the January 10, 2008 cell extractions described above resulted in an additional alarming incident that exposed a particularly vulnerable girl to serious harm and risk of harm. Specifically, while on site, we reviewed a video showing the cell extraction and forceful strip search of B.B.,⁹ a 17-year-old girl with serious mental illness.¹⁰ The cell extraction team, consisting of five male staff, extracted B.B. from her cell and forcefully cut off all of her clothing to strip search her, in clear violation of both the law and generally accepted professional standards.

The video shows that B.B. quietly cooperates with the cell extraction team's directive to exit her cell, and the team then takes her to another cell. When directed to remove her clothing for the strip search, B.B. refuses. Staff make several additional demands for B.B. to remove her clothing, but she repeatedly refuses, telling staff that she does not have any contraband. According to IDOC's own internal affairs report, the video "clearly shows [B.B.] sitting on the floor being passive, none [sic] threatening, no indication that she possessed a weapon . . ."

⁸ IJCF indicated that all the girls on the unit that was searched on January 10, 2008 were extracted from their cells and searched. When we requested a full list of the extractions, the facility provided us with the unit roster. The roster listed 24 names, with seven names inexplicably crossed out.

⁹ The initials used to refer to youth are pseudonyms to protect their privacy.

¹⁰ In fewer than three total years at the facility, B.B. had been placed on suicide precautions at least eight times and, by the time of our second visit to IJCF in July 2008, she had been civilly committed to a mental health facility.

Nonetheless, the five male officers storm into the room and surround B.B. The only female present is the officer recording the incident on video. The five male officers restrain B.B. in a prone (face down)¹¹ position on the floor, handcuff her, and shackle her ankles. Although the facility's own report indicates that B.B. "took to the floor with little to no resistance," one officer holds down her head and neck, forcing her head and forehead against the floor. Other officers hold down her arms and legs and bend her legs backward so that her feet touch her buttocks. While B.B. wails and cries that the men are hurting her arm, the men silently cut off all of her clothing using a seat belt cutting tool, a rescue tool designated only to cut down youths during a suicide attempt. The men then unsnap B.B.'s bra using their gloved hands, tear off her bra straps, remove her bra, and cut off her underwear. The video ends with B.B. lying on the floor wearing nothing but her socks, being held down by the five men in swat gear. The only item between her and the dirty floor is a fragment of her torn underwear.

This seemingly arbitrary, forceful strip search of a girl with mental illness, when the facility did not have individualized suspicion that she possessed contraband, is a clear violation of the law and of generally accepted professional standards. Both the courts and generally accepted professional standards prohibit cross-gender strip searches, except in cases of emergency. Canedy, 16 F.3d at 187 (holding that an inmate's right to privacy is violated where observation of the inmate by an opposite-gender employee is not occasional or inadvertent but "is more intrusive (like a strip search, in the absence of an emergency) or a regular occurrence"); Proposed Standards at 11 (requiring facilities to prohibit cross-gender strip searches and visual body cavity searches, except in cases of emergency).¹²

As noted above, the Supreme Court places a strip search in "a category of its own." Safford, 129 S. Ct. at 2643. The Supreme Court has held that a lawful

¹¹ The use of prone restraints is controversial and has been banned by many facilities nationwide due to the high risk of serious injury or death. The danger of prone restraints is that if the individual's airway is constricted, he or she is unable to express physical distress. Further, the restrained individual's struggle for air may be misconstrued by staff as resistance, resulting in increased force on the individual being restrained.

¹² The Proposed Standards emphasize protecting the privacy and dignity of residents and reducing the potential for staff sexual abuse of residents: "Performance of these more intrusive strip searches and body cavity searches should be undertaken only by specially trained, designated employees of the same gender and conducted in conformance with hygienic procedures and professional practices." Proposed Standards at 12.

search of a student must meet two criteria. First, the search must be justified in its inception, that is, an official must have knowledge of at least a moderate chance of finding evidence of wrongdoing. *Id.* at 2639. Second, the search must be reasonably related in scope to the reason for the search. *Id.*; *T. L. O.*, 469 U.S. at 341-42. The scope of the search is permissible “when it is ‘not excessively intrusive in light of the age and sex of the student and the nature of the infraction.’” *Safford*, 129 S. Ct. at 2639 (quoting *T.L.O.*, 469 U.S. at 342) (noting that “adolescent vulnerability intensifies the patent intrusiveness of the exposure”). Accordingly, given the threshold necessary to justify a strip search of a teenage girl, a cross-gender strip search is justified only where the youth poses an immediate risk of danger and no one of the same gender is available to conduct the search.

Both the facility’s video and internal documentation confirm that the situation with B.B. was not emergent; in fact, B.B. was calm, non-violent, and presented no danger to herself or to anyone else. In addition, the facility’s documentation confirms that B.B. was not suspected of having contraband; she apparently was forcefully strip searched by virtue only of the fact that she was housed on the unit being searched and she refused to submit voluntarily to a strip search that would reveal nothing. Indeed, this search was so far outside the bounds of accepted juvenile justice practice that our juvenile justice consultant noted that this is one of the most disturbing videos he has seen during his thirty-six-year professional career, which has included visits, reviews, and assessments of more than 100 facilities in approximately 25 states.

IDOC’s own internal affairs investigation concluded that the incident was unjustified and violated the facility’s own policy, which also prohibited cross-gender strip searches. The report further noted that the facility’s cell extraction procedures do not provide for cutting clothes off of noncompliant youths. The report concluded that, because B.B. was non-violent and did not constitute a threat to anyone, she should have been secured to allow for a pat-down search and left alone until she complied with the strip search orders.

Disturbingly, although the State took personnel action against the staff members involved and reported the incident to the Indiana State Police and Child Protective Services, the forcible cutting off of a youth’s clothing apparently is not an isolated incident at IJCF. According to the facility’s internal affairs report, most members of the cell extraction team, as well as other staff witnesses, stated that the “forceful removing of an offenders [sic] clothing by cutting them [sic] off the body was a long standing practice dating back years.” Specifically, staff recalled a similar incident in November 2007, in which a cell extraction team restrained a male youth in the prone position and forcibly cut off his clothing after he blocked his cell window with his clothes. Similarly, on January 19, 2008 – just nine days after

the strip search incident described above – five staff, including male staff,¹³ held down a girl in the prone position on her bed and forcibly removed her shorts, bra, and underwear after the girl apparently had made a suicide gesture and refused to remove her remaining clothing to be placed in a suicide gown.

c. OC Spray

Further exacerbating the facility's culture of force and intimidation, IJCF fails to adequately manage and supervise its use of OC spray, in violation of generally accepted professional standards. OC spray contains the concentrated oil extracted from hot peppers. When inhaled, or when it comes into contact with a person's eyes, nose, or skin, OC spray typically causes intense burning pain, redness, shortness of breath, and gagging. Inhaling OC spray can cause acute hypertension, which may cause headache and increased risk of heart attack or stroke. Certain individuals should not be sprayed with OC spray, including those who have asthma or other kinds of respiratory problems, are obese, suffer from certain cardiovascular conditions, or are pregnant. Any time OC spray is deployed, decontamination should occur as soon as practicable, and the affected youth should be examined by medical personnel as soon as possible, but at least within two hours.

As with other extreme measures, OC spray may be used only when absolutely necessary for the safety and security of the facility, residents, and staff, and only when less drastic measures have been attempted and failed. See, e.g., Soto v. Dickey, 744 F.2d 1260, 1270 (7th Cir. 1984) (use of chemical agents in quantities greater than necessary or for the sole purpose of punishment or the infliction of pain in an adult facility violates the Constitution); Alexander S. v. Boyd, 876 F. Supp. 773, 786 (D.S.C. 1995), aff'd in part and rev'd in part on other grounds, 113 F.3d 1373 (4th Cir. 1997), cert. denied, 118 S. Ct. 880 (1998) (use of chemical spray on juveniles is counterproductive and such spray may be used only where there is a "genuine risk of serious bodily harm to another" and less intrusive methods are unavailable); Morales v. Turman, 364 F.Supp. at 173-74 (E.D. Tex. 1973); 383 F.Supp. 53, 77 (E.D. Tex. 1974), rev'd on other grounds, 535 F.2d 864 (5th Cir. 1976), rev'd, 430 U.S. 322 (1977); remanded for rehearing, 562 F.2d 993 (5th Cir. 1977) (use of chemical agents in a juvenile facility absent an imminent threat to human life or an imminent and substantial threat to property violates the Constitution).

¹³ From the reports, the complete gender breakdown of the team that removed the girl's clothing is unclear, but it is clear that the team included one or more males and likely included at least one female.

The spraying of two girls as part of the “spring cleaning” incident on January 10, 2008, described above provides an example of the facility’s inappropriate use of OC spray, in violation of both legal standards and its own procedures. Specifically, videos of the incident show that two girls who were to be extracted from their cells were sprayed with OC spray because they refused orders to cuff up. As was described to us on site, the girls were sprayed with OC “in an effort to convince them to cooperate.” Neither girl, however, presented a threat to herself or another. Notably, the facility’s internal review concluded that neither girl should have been sprayed because, according to facility procedures, when a youth who does not have a weapon needs to be removed from the cell, the cell extraction team should be used first, if necessary. This revelation makes the spraying of the two girls on January 10 even more disturbing, because the cell extraction team already had been assembled, albeit inappropriately, to remove the girls from their cells in the first instance. Rather than following facility policy, the team itself inappropriately sprayed the girls, who presented no danger to themselves or others.

The facility also fails to ensure that youths with certain health conditions are not subjected to OC spray; the facility’s policy fails to address this important health issue. And, in fact, we found instances where girls who had medical conditions such as asthma were sprayed. We also found no evidence that IJCF ensures that youths who are sprayed with OC are promptly seen by medical personnel. The failure to address these important issues exacerbates the constitutional violations at the facility.

d. Restraint Chair

IJCF also fails to adequately manage and supervise the use of its restraint chair, in violation of constitutional standards. A restraint chair is a full-body restraint device that immobilizes a youth in the seated position. As noted above, the use of restraint chairs in juvenile facilities is highly unusual. This is, in large part, because the restraint chair is an extreme measure that, when not carefully controlled, invites misuse. Accordingly, when a juvenile facility chooses to include a restraint chair in its behavior management system, accepted juvenile justice practices require that the facility develop, and strictly enforce, a comprehensive policy to govern the chair’s use. This policy should: limit the use of the chair to only the most critical situations where less restrictive measures fail to control the youth’s behavior, and then only under medical supervision; prohibit the use of the chair for punitive purposes; and require that a youth be released from the chair as soon as her behavior permits.

According to facility reports, IJCF’s restraint chair had been used once in the four months preceding our April 2008 visit. Unfortunately, this use of the chair did

not comply with IDOC's own policy to adequately document the use of the chair. For example, contrary to IDOC policy, the incident was not preserved on video.¹⁴ Second, the staff members involved in the incident submitted confusing and inconsistent written reports. For example, staff members provided conflicting reports regarding what time the use started. Moreover, it is not clear how long the youth was in the restraint chair before she was evaluated by a medical professional, or when the youth was released. When we inquired as to how long the restraint actually lasted, a staff member told us that it had been one hour. Some of the written reports, however, suggest that the youth was not released for several hours. Thus, the facility failed to follow its own policy regarding the restraint chair, and neither we nor IJCF administrators have any way of knowing whether or to what extent the chair may have been misused. The facility's failure to follow policy and adequately monitor the use of the restraint chair increases both the risk of injury to the youth and the risk that the youth was subjected to an abusive disciplinary technique.

5. Excessive Use of Isolation

The State also subjects IJCF youths to excessively long periods of isolation and fails to provide adequate due process to youths placed in isolation. Generally, isolation or segregation in a juvenile justice facility may be used for two main purposes. First, it may be used as an emergency intervention to control a resident who is a current threat to herself, other youths, staff, or other persons. Second, isolation may be used as a sanction for a major rule violation.¹⁵

In a juvenile facility, segregation is typically the most severe disciplinary sanction available. Generally accepted juvenile justice practices dictate that it should be used only in the most extreme circumstances, and only when less restrictive interventions have failed or are not practicable. If isolation must extend beyond twenty-four hours, a due process mechanism should be in place to ensure that the continued use of isolation is necessary. Accepted juvenile justice practices

¹⁴ In response to our request, the facility provided us with what it represented was a video of the incident, reportedly captured on a handheld recorder. The video, however, was only three seconds long. The video also did not even show a youth; instead, it depicted a few staff members standing in a hallway. Notably, although the restraint chair is housed in a room that contains a mounted, stationary camera, we were informed that no video from this camera had been preserved.

¹⁵ To a lesser extent, isolation may be used as a protective measure for a resident such as a medically ordered suicide precaution or to protect the youth from other youths (e.g., protective custody).

also limit the maximum amount of time a resident can remain in isolation to five days, although most juvenile facilities in the country cap the period at three days.

IJCF keeps youths in segregation for excessive periods – well beyond three or five days. For example, just prior to our April 2008 tour, three girls had spent 53 consecutive days in isolation each. Another girl spent approximately 52 consecutive days in isolation; two other girls spent 48 consecutive days; and one girl spent 45 consecutive days.

The examples above describe just a few of the girls who have been placed in isolation at IJCF for excessive lengths of time. In fact, we found dozens of examples of girls who were isolated for excessive periods just in the three-month period leading up to our April 2008 tour. These long lengths of stay serve no rehabilitative or therapeutic purpose and are a short-sighted way to attempt to control behavior. In the long run, placing a youth in isolation for an excessive period is likely only to exacerbate the existing problem and to create additional adjustment problems when the youth finally is released from segregation.

IJCF not only excessively isolates youths, but it also fails to provide them with adequate due process in connection with its use of segregation. See *Mary*, 635 F.2d at 594, 599. The State should provide a youth with a due process hearing if her segregation exceeds 24 hours. When we inquired about due process procedures for IJCF youths held in segregation, administrators provided us only with a daily summary sheet, setting forth the youth's behaviors for the previous day. The review sheet indicates that the superintendent reviewed the document, but the facility failed to provide us with any documentation regarding what, if any, action should or might have occurred as a result of the superintendent's review. Likewise, we were given no documentation regarding the justification of continuing or halting the segregation and no indication that youths are given an opportunity to be heard. In short, the due process procedures the facility purports to have in place for IJCF youths in segregation are perfunctory and inadequate.

6. Inadequate Grievance System

IJCF's inadequate grievance system also contributes to the State's failure to ensure a reasonably safe environment at the facility. An adequately functioning grievance system ensures that youths have an avenue for bringing serious allegations of abuse and other complaints to the attention of the administration. It also provides an important tool for evaluating the culture at the facility, and for alerting the administration about dangers and other problems in the facility's operations.

IJCF's grievance system at the time of our April 2008 tour was wholly dysfunctional. For example, to submit a grievance, a girl had to request a grievance form from a staff member. If the staff member is the subject of the girl's intended grievance, this practice would have an obvious chilling effect.

At the time of our tour, IJCF also required girls to attempt to resolve their grievances informally before permitting them to file a formal grievance. In appropriate circumstances, encouraging a youth to attempt to resolve his or her problem informally may provide the youth with an opportunity to work on her problem-solving skills. The requirement that youths attempt informal resolution, however, should not be a prerequisite to filing a formal grievance. Youths must have a direct avenue through which they can bring allegations of abuse and other serious complaints to the attention of the administration. Requiring youths to attempt an informal resolution of such serious allegations potentially exposes the youth to further abuse, as well as retaliation. Moreover, in practice, because IJCF has no system for tracking "informal" grievances, it is impossible to determine their effectiveness in resolving problems.

At the time of our tour, the policy governing IJCF's grievance system was cumbersome and overly bureaucratic, providing for a number of trivial, technical reasons a grievance could be rejected. For example, a youth's failure to include her IDOC number was grounds to reject a grievance. Likewise, including more than one issue on a single grievance form, or bringing a grievance on behalf of a group, were grounds to reject a grievance, regardless of the severity of the substantive complaint. Restrictions such as these appear to be designed to deter the submission of grievances, rather than to ensure that youths have an avenue through which to bring concerns to the attention of the administration. Indeed, according to the data provided by the State, nearly 60% of all formal grievances filed at IJCF between 2007 and March 2008 were rejected.

The State has advised us that, following our tours of IJCF, IDOC adopted a new grievance policy for its juvenile facilities. We are pleased with the new policy and look forward to assessing its implementation in the future.

7. Inadequate Programming

Youths confined in facilities like IJCF have a right to adequate rehabilitative treatment. Nelson, 491 F.2d at 357. IJCF fails to provide adequate rehabilitative programming to its residents.

Many of the youths with whom we spoke described being bored and having little motivation to behave well. Adolescents in juvenile facilities often have poor impulse control and lack the ability to make good behavioral choices. Unlike adult

prisoners, for adolescents, release from incarceration in six to twelve months is not an adequate incentive to make good choices and behave appropriately. Accordingly, it is critical that a juvenile facility have in place a behavior management system that provides immediate, consistent, and tangible reinforcement of desired behaviors. While on site, we were informed that IDOC was looking into revamping its daily behavior management program. At the time of our April 2008 tour, however, IJCF did not have a functional or effective behavior management system. This failure results in extended stays for girls at the facility, as well as an increased risk of recidivism, because systems are not in place to help girls manage their behavior.

Adequate rehabilitative programming requires that juvenile facilities for girls provide adequate assessment, case plans, and behavior management that target girls' individual competencies and special needs in the areas of education, family relationships, trauma recovery, health, substance abuse, employment, and parenting for girls who are pregnant or are parents. IJCF's rehabilitative services fail to provide adequate attention to such issues, which disproportionately affect girls. This in turn breeds an increased risk of self-harming behaviors and suicidal ideation, inappropriate sexual activity, aggressive acting out, and frequent emotional crises. Indeed, the facility had more than 600 incidents that resulted in incident reports in the three-month period between April and June 2008.

The dearth of adequate rehabilitative services is directly related to the lack of adequate staff orientation and training on psycho-social development of adolescent girls, many of whom have histories of abuse and trauma, and on appropriate behavior management, de-escalation of conflicts, and treatment of Post Traumatic Stress Disorder. We found significant deficits in the facility's staff training modules. For example, IJCF fails to provide staff with adequate information on understanding the impact of trauma and abuse on incarcerated females and the often resulting self harm, eating disorders, and mistrust of adults. The facility also fails to provide adequate staff training on suicidal ideation among teenage girls. Moreover, staff training contains gaps in relevant information about how to mitigate problems of prior abuse and trauma and how to assist girls with coping skills. IJCF also lacks training to address maintenance of a safe environment for girls who have experienced abuse and trauma in past placements. Failure to adequately train staff to address gender-specific needs of incarcerated female youths increases the risk of youth and staff injuries, exacerbates girls' mental health and trauma-related issues, and increases self harm and other aggressive behaviors.

8. Inadequate Access to Toilets

IJCF fails to ensure that youths have reasonable access to toilets. Generally accepted professional standards require that youths have unimpeded access to toilets 24 hours a day. At IJCF, however, most of the sleeping rooms do not have toilets and, therefore, youths must request that staff let them out to use the toilet. We received numerous and consistent reports from youths that staff fail to provide reasonably prompt access to toilets. Many girls described urinating in cups in their rooms out of desperation. One girl admitted defecating on herself when staff did not let her out in time to get to the toilet. Another girl described vomiting in her room when staff failed to respond to her request to go to the restroom. She also noted that a girl could get a conduct report for using the intercom button, which is the method by which a girl can seek staff's attention to ask to use the restroom. Access to restroom facilities is a basic human need. IJCF should ensure such access for all youths.

B. MENTAL HEALTH CARE

The Constitution requires that youth in juvenile justice facilities receive adequate mental health care. Youngberg, 457 U.S. at 323 n.30; Nelson, 491 F.2d at 359-60; see also K.H., 914 F.2d at 851; Luzerne County Juvenile Det. Ctr., 372 F.3d at 585 n.3.

We find that mental health care at IJCF is constitutionally inadequate. Specifically, we found serious deficiencies in the following areas: (1) mental health screening and assessment; (2) suicide risk screening and assessment; (3) provision of mental health treatment; (4) staffing; and (5) recordkeeping.

1. Inadequate Mental Health Screening and Assessment Process

IJCF's screening and assessment process contributes to the unconstitutional conditions at the facility. According to accepted juvenile justice practice, all youths entering secure facilities should receive a reliable, valid, and confidential initial screening and assessment to identify psychiatric, medical, substance abuse, developmental, and learning disorders, and suicide risks. The screening process should be sufficiently sensitive to identify cases at a level of risk, and staff then should examine those cases in further detail to determine what, or whether, further assessment is indicated.

The assessment process should be underway during the girl's initial weeks in the intake unit. It should include aggressive pursuit of previous behavioral health records; careful review of those records and assimilation of their content; contact with the girl's family to obtain developmental, clinical, and educational history;

consultation with the facility's custody, recreational, and educational staff; and several individual interviews covering the broad range of the girl's background and current condition. When indicated, the assessment also should include specialized testing to clarify ambiguous issues of cognition and/or personality functioning, as well as medical consultation in cases where previous illness or injury may affect a girl's functioning or may affect decisions about treatment.

This assessment should be documented in a full report and should conclude with a summary of relevant clinical data and a diagnostic formulation, including consideration of alternative diagnostic hypotheses and support for a specific diagnostic opinion. It also should include initial suggestions regarding treatment planning, including what specific concerns need attention, and what specific interventions are likely to be effective. Based on screening and assessment, staff should refer youth for any required care.

Additionally, because girls may develop mental health problems at any point during their detention, facilities need to have a routine method for recognizing emerging mental health issues that may not have been present upon intake. Generally, such methods include repeated formal screenings of residents or informal means, such as setting a low threshold for further mental health screening and assessment when residents are not adequately progressing through the program.

The combined screening and assessment process at IJCF fails to meet these generally accepted professional standards. Although the intake screening process is reasonably effective, the facility fails to provide any formal subsequent screening, assessment, or follow-up.

Intake screening at the facility is reasonably effective in discovering the presence of mental health disorders in girls at IJCF. All youths undergo a series of intake screenings upon admission. These screenings address overall mental health needs and suicide risk. The process includes a brief interview and the administration of the Massachusetts Youth Screening Instrument ("MAYSI-2"), a self-report checklist widely used in juvenile facilities. As of the time of our July 2008 visit, approximately half of the youths at the facility were being treated with psychotropic medication, suggesting at least that their mental needs had been noticed. This number is consistent with the general incidence of mental disorder in female juvenile populations, which is approximately two-thirds to one-half.

The assessment process at IJCF, however, is deficient, exposing girls to risk of serious harm resulting from a lack of attention to their mental health needs. Although the total sum of information the facility gathers in the intake behavioral health assessment is generally broad, it lacks a number of critical elements. The facility fails to adequately gather previous records of past assessments and

treatment, to obtain information from families and establish alliances with them, and to pay adequate attention to the specifics of girls' cognition or to the implications of learning problems for successful school functioning, self-esteem, problem solving, or growth in treatment. Interviews with mental health staff tend to ignore or gloss over the specific impacts of the many traumatic experiences girls have had, and of how the girls have coped with them. Documentation of interviews also reveals that interviews pay inadequate attention to fostering a girl's sense of commitment to change, or to generating a treatment alliance with the facility's practitioners. Moreover, the structure of the intake assessment process is too condensed and does not allow sufficient time for the mental health assessment to gather information from other sources, to consider information generated in the other intake assessments, or to take into account the girl's initial course in the facility.

As a result of these deficiencies, in most cases, the assessment process at IJCF actually constitutes only a screen and is far from an adequate assessment. When the initial screen identifies important areas of ambiguity and complexity that would take additional time and extensive inquiry to clarify, the facility fails to provide any routine, more comprehensive assessment. Although mental health staff reported that the facility's understanding of a girl's mental health needs does not rest only on the information gathered at intake, the facility fails to provide any plan for gathering additional important information, such as records, family input, the girl's initial adaptation to the facility, and results of specialized testing, into a more complete assessment that would be adequate for planning individualized treatment.

In addition to failing to provide adequate assessments at intake, IJCF fails to provide any formal mental health screening or assessment beyond the intake process. And, although behavioral staff respond to girls who take the initiative to submit health care requests, staff's actual responses do not reliably include careful attention to and assessment of presenting problems. For example, we reviewed the records of a girl who had four contacts with mental health staff over approximately 11 months. She complained first of possible bipolar disorder and later of sleeping difficulties. Although mental health staff responded to her concerns by meeting with her, our consultant found that their responses were cursory and did not adequately attend to her complaints. When she saw mental health staff for suspected bipolar disorder, the mental health professional with whom she met did not include any record review or historical inquiry of the girl or of other staff with respect to past problems that may suggest or rule out bipolar disorder. Two months later, when she saw mental health staff for trouble sleeping, staff opined that she simply appeared to be trying to get medication. During that visit, staff failed to pay any attention to her sleep. And, although the mental health staff member who saw her performed a cursory mental status evaluation, she did not document any

inquiry into the girl's emotional state or into what might be interfering with her sleep.

2. Inadequate Suicide Risk Screening and Assessment

To protect residents' constitutional right to safety and protection from harm, facilities like IJCF provide adequate suicide risk screening and assessment to girls.¹⁶ At least as of the time of our tour, the facility failed to do so. As part of the risk screening and assessment process, the facility should follow up as appropriate where a girl receives high scores on suicide risk indicators during the screening process. Where indicated as a result of the screening, the facility should provide an adequate, consistent, well-organized, and well-documented assessment. IJCF fails in this regard.

Although IJCF administers the MAYSI Suicide Ideation Scale and asks girls questions related to suicide during the medical screening process, the facility fails to follow up as appropriate or provide a targeted assessment of suicide risk where girls receive high scores on these indicators. Moreover, even when the facility does identify a girl as being at risk for suicide and refers her for assessment, the assessment is inadequate, inconsistent, poorly organized, and poorly documented. To document an assessment, the facility uses its electronic medical record ("EMR") template for a suicide observation visit. As structured in the EMR, this template is inadequate because it fails to require critical elements of the suicide risk assessment process. Specifically, the template does not require: (1) the clinician to review specific staff observations of the girl's behavior that generated the concern about her suicide risk; (2) specific inquiry into, or documentation of, the girl's current stresses, her sense of hope, and her current emotional connections with her family, staff members, or other girls, particularly including romantic connections or disappointments; or (3) a detailed mental status assessment of agitation, peaceful resolve, guilt, delusions, or hallucinations. Although some IJCF clinicians sometimes document such elements, too often, the mental status examination states: "student does not express suicidal ideation." This is grossly insufficient.

3. Inadequate Provision of Mental Health Treatment

As part of their constitutional responsibility to provide medical care, juvenile facilities must provide youths with adequate mental health treatment. Unfortunately, current provision of mental health treatment at IJCF falls far short

¹⁶ Since our tour, the State has provided us with a satisfactory new suicide prevention policy, which addresses, among other things, suicide risk screening. We look forward to reviewing the implementation of this policy at IJCF.

of those standards and, as a result, exposes girls to great risk of harm by failing to address their mental health needs. Specifically, as described below, IJCF fails to provide adequate: (1) treatment planning; (2) psychosocial treatment, including psychoeducational rehabilitation programming, mental health counseling, psychotherapy, and family therapy; and (3) psychiatric care, including psychiatric assessment and medication management.

a. Inadequate Treatment Planning

As generally accepted professional standards recognize, adequate treatment planning is essential to the provision of adequate mental health treatment for youth in juvenile facilities. Treatment planning requires the identification of symptoms and behaviors that need intervention and the development of strategies to address them. Treatment plans should be individualized and should articulate specific planned behavioral interventions. At a minimum, such interventions should consist of regularly scheduled individual psychotherapy, which should be aimed at establishing a supportive and reliable treatment alliance between the girl and mental health staff. Without adequate treatment planning, a facility cannot provide effective treatment of serious mental illness, ensure that youths are receiving appropriate services, or adequately track youths' progress.

Treatment planning at IJCF fails to meet generally accepted professional standards and contributes to the unconstitutional conditions at the facility. First, treatment plans are generic and vague, and do not adequately address girls' individual characteristics, strengths, weaknesses, and needs. For example, the treatment plan for one girl diagnosed with a series of mood disorders, including bipolar disorder, as well as substance abuse, lists generic objectives for dealing with chemical dependence and shows no individualization to help this particular youth. The treatment plan for another girl remained unchanged throughout the course of her stay, despite significant deterioration in her condition in the approximately ten and a half months she had been at the facility prior to our tour. This girl's plan failed to include her manipulative self harm as a problem and failed to include any plans to address this behavior or otherwise develop a behavior management plan for her. Her plan also failed to take into account her recognized cognitive limitations, which may preclude her from gaining any benefit from the generic program groups contemplated by her plan. Moreover, because this girl had been living primarily in isolation, it is unlikely that she even could participate in many of those groups.

Second, treatment plans at IJCF lack genuine articulation of any specific, planned behavioral health intervention. Most of the interventions offered are not specific mental health services; instead, treatment plans often list generic program groups offered by case managers as interventions. Moreover, treatment plans fail

to specify information such as the type of therapy and/or medication that should be used to address particular problems. Notes of treatment sessions generally do not show specific interventions, and treatment plans do not make clear what type of orientation should be used for mental health services (e.g., cognitive-behavioral therapy). With the exception of the area of medication management, none of the plans our consultant reviewed offered mental health treatment with any regularity, and none took into account the results of the girl's assessment in considering what particular approach to therapy was likely to be most successful.

b. Inadequate Psychosocial Treatment

The facility fails to provide adequate psychoeducational rehabilitation programming, mental health counseling and psychotherapy, and family therapy.

First, the facility fails to provide adequate psychoeducational rehabilitation programming. The main treatment the facility offers to residents in this context is standard psychoeducational programming, primarily in group contexts. Groups feature a variety of topics, including anger management, coping skills, and substance abuse. Although some girls stated that they had improved on their own in behavioral and emotional control, none of the girls we interviewed reported that they had gained anything from these groups. For example, one girl noted that, although she felt she had become more self aware and considerate, she had to "teach [her]self. [Staff who run the groups] don't explain, and half the staff are disrespectful." She noted that she continues to cut herself regularly. Girls also reported that, although they are supposed to have at least three groups per week, often, they have only one, or none.

Second, IJCF fails to provide girls with adequate mental health counseling and psychotherapy. Behavioral health staff fail to provide regularly scheduled counseling or psychotherapy; as a result, mental health care consists primarily of crisis-oriented visits. As staff explained to us, "usually, it's left up to the student to make contact."

We found that the only girls who receive regularly scheduled appointments are those on psychotropic medications, and their appointments consist only of brief medication management sessions with the psychiatrist, with no other counseling or psychotherapy. In fact, during the three months prior to our July 2008 tour, only five girls in residence at the time of our tour had participated in ten or more meetings with a mental health professional. Although two additional girls had had relatively frequent meetings, they had been discharged prior to our tour, one of them by civil commitment to a psychiatric hospital.

It is unreasonable to expect that girls at IJCF would have the assertion capacity to establish an effective therapy relationship with mental health staff without the structure of regularly scheduled appointments. Rather than proactively attending to girls' critical mental health needs, IJCF's practice of leaving to the girls the decision to make contact with a mental health clinician contributes to a crisis atmosphere at the facility. In this atmosphere, emotionally unstable, traumatized girls have no reliable expectation of attention from mental health staff, and have no opportunity to learn and practice patience and self management skills. Instead, they learn to rely on crisis-based communication, such as using suicide gestures and threats, as a basis for establishing contact with mental health staff. Further, they develop habits of marked emotional and behavioral regression, which exacerbate their existing problems, such as poor self-esteem, anxiety, and depression.

Finally, by way of technical assistance, IJCF fails to provide adequate family therapy. Family therapy often is an important part of mental health treatment for adolescents, both for addressing past family difficulty and for preparing girls to successfully transition from the facility to the community. Although one or two girls mentioned having had a family therapy meeting at some point, the records we reviewed included no accounts of any family therapy sessions at IJCF.

c. Inadequate Psychiatric Care

The Constitution requires facilities like IJCF to provide adequate psychiatric care to their residents. A psychiatrist should evaluate youths who have been identified as needing a psychiatric assessment and should appropriately manage the conditions and responses to medication for youths on psychotropic medications. To facilitate necessary communication between and among mental health staff and treatment teams and to provide adequate mental health treatment to youths, it is critical that the psychiatrist adequately document his or her assessments and medication management sessions. Psychiatric care at IJCF fails in both areas.

The psychiatric evaluations our consultant reviewed were inadequate and were missing important information. Although the psychiatrist we observed is pleasant, engaging, supportive, and elicits much useful information from girls, the documentation of many of these assessments is sparse and often fails to convey the critical information gathered in the interviews. For example:

- An initial psychiatric evaluation of a girl who arrived at the facility on four different psychiatric medications fails to include her clinical history, a mental status examination, or any summary or explanation of the psychiatrist's diagnostic findings. The evaluation further fails even to mention three of the girl's four medications or her response to them. Moreover, the evaluation is

confusing; it does not explicitly discontinue her medications because it does not acknowledge that she has been taking them. It also fails to provide any explanation for a change in her medications that apparently occurred on the day before her psychiatric assessment.

- An initial psychiatric evaluation of another girl who had Attention Deficit Hyperactivity Disorder (“ADHD”), depression, and sleep disturbance fails to include history from any source to support these diagnoses, fails to include information about the onset or course of her symptoms, and fails to discuss her history of, or response to, treatment. Although the mental status examination notes that the girl reports sleeping problems, the report contains no further characterization of these problems. It also fails to include any information about her history with, or the effectiveness of, her current medication. The report offers no opinions, but merely continues the girl’s admission medications with one change.
- An initial psychiatric evaluation of another girl who had anger, depression, and post traumatic stress disorder includes no history other than a notation of her and her parents’ previous diagnoses and her prior medications. The report contains no basis for any of the information about her prior diagnoses, no explanation of a recommendation to discontinue her medications, no attention to the possibility of an adverse reaction to the discontinuation of the medications, and no attention to the meaning or treatment of her other problems.

Similarly, medication management visits are inadequate. Most psychiatric notes of those visits lack appropriate subjective history from the girl, adequate mental status, and objective staff observations. They further fail to include any explicit attention to assessment of the girl’s condition or response to the medications prescribed. Instead, they provide only superficial, incomplete EMR template check-offs.

Indeed, using the EMR’s check-off format without additional narrative responses lends itself to documentation errors because of the ease with which a practitioner inadvertently may check off an incorrect box. For example, a note from a segregation visit with a particularly challenging girl stated:

Student was sitting on the floor of her feces-smear room, facing away from the door. She had torn clumps of hair out of her head and had made a figure out of it. She had placed the figure on the floor and had made a circle of toilet paper and corn flakes around it. She chanted

unintelligibly, and occasionally screamed that the figure was trying to kill her.

Despite this disturbing scenario, the EMR documentation associated with this visit inexplicably characterized the girl's intellect as average and her self-perception as realistic.

4. Inadequate Mental Health Staffing

IJCF's failure to provide adequate mental health care to girls appears, at least in part, to stem from grossly inadequate mental health staffing. At the time of our July 2008 visit, the facility employed two psychologists, one licensed mental health professional, and a psychiatric technician (assistant). The psychiatrist visited one day per week. In light of the high prevalence of mental health disorders in the female juvenile population, the relatively high acuity of symptoms, and the ongoing high-stress security environment, the level of mental health staffing in this facility falls far below the generally accepted professional standards for similar facilities.

In the professional opinion of our mental health consultant, adequate clinical staffing for this facility would require more than tripling the current mental health staffing. Specifically, the facility should have nine or ten psychologists, one or two additional clinical supervisors, and approximately ten days per month of psychiatry time.

5. Inadequate Recordkeeping

Adequate recordkeeping is critical to the provision of adequate mental health care to juveniles in facilities. As discussed above, the psychiatrist fails to adequately document evaluations and medication management sessions. Moreover, as discussed above, IJCF's use of the EMR results in inadequate documentation of behavioral health assessments, treatment planning, and treatment provision.

Additionally, because behavioral health staff communicate about residents largely through notes that they enter into the EMR after treatment team meetings, it is critical that the behavioral health staff member who attends a particular treatment team meeting adequately and thoroughly document the team's observations and conclusions. The behavioral health record of treatment team attendance in the EMR, however, consists of a superficial note that includes only the results of the team discussion and a mental status evaluation. This is not adequate communication to enable a behavioral health clinician to understand and respond to a resident's condition and needs.

Facility records also contain confusing and contradictory information regarding medications girls had been taking prior to their arrival at IJCF, medications they had brought to the facility with them, and orders regarding continuation of these medications.

Finally, facility records are inconsistent regarding documentation for consent for medications. Although some records indicate that information about medications is conveyed to families, records generally fail to include any careful, specific documentation of whether a parent approves of the proposed treatment. Moreover, because the facility superintendent has the ultimate authority to consent to medications on behalf of each girl, facility records should include the corresponding documentation, particularly documentation that the superintendent or his or her designee has been informed of the proposed treatment, of the girl's attitude toward the treatment, and of the risks and potential benefits of the treatment.

C. SPECIAL EDUCATION SERVICES

IJCF violates the federal statutory rights of students with disabilities. Students with certain disabilities have federal statutory rights to receive special education services under the IDEA, 20 U.S.C. §§ 1400-1482.¹⁷ In states that accept federal funds for the education of youths with disabilities, as Indiana does, the requirements of the IDEA apply to juvenile justice facilities. See 20 U.S.C. § 1412(a)(1)(A); 34 C.F.R. § 300.2(b)(1)(iv). IJCF consistently fails to provide its students with the educational services that the IDEA guarantees. On a systemic level, IJCF does not adequately attend to or measure its students' academic or behavioral progress. As a result, the facility is limited to an often unjustified and ad-hoc, rather than data-driven, approach to its students. Because of this, students at IJCF often do not receive appropriate special education services, as required by the IDEA. More particularly, IJCF is noncompliant with the IDEA with respect to: (1) child find; (2) general education interventions; (3) Individual Education Plans ("IEPs"); (4) access to the general education curriculum; (5) student behavior; (6) staffing; and (7) transition services.

1. Inadequate Child Find Procedures

The IDEA requires that the State have in place policies and procedures to ensure that all children with disabilities who are in need of special education and

¹⁷ We note that the IDEA was reauthorized and amended by the Individuals with Disabilities Improvement Act of 2004, Pub. L. No. 108-446, 118 Stat. 2647, effective July 1, 2005.

related services and who reside in the state have been identified, located, and evaluated. 34 C.F.R. § 300.111(a)(1)(I). This is known as Child Find. IJCF does not satisfy this requirement. Although IJCF initiates both general education interventions and the process for evaluation, IJCF does not adequately observe its students, collect academic and behavioral data, or make general education interventions prior to evaluating students for special education, as detailed below.

IJCF's difficulties in Child Find begin with its Intake Questionnaire, which simply gives three options to students regarding their past education: "regular, advanced, or special education." "Special education" is not a sufficiently familiar term to assist students with identifying their past educational services; students should be asked additional questions, such as whether they previously received extra help in school or attended separate classes. IJCF's questionnaire therefore inadequately assists in identifying students in need of special education and related services.

2. Inadequate General Education Interventions

The IDEA requires that, prior to evaluation of a student for special education, the state must consider whether the student is being provided appropriate instruction by a highly qualified teacher and review data-based documentation of the student's progress. 34 C.F.R. § 300.309(b)(1)-(2). The state must further document the student's behavior in that student's learning environment, including the regular classroom setting. We found no evidence that IJCF engages in these required activities, or in any general education or pre-referral interventions, data collection, or observations.

As a result of the above deficiencies, students in need of and qualified for special education are at risk of not receiving the services guaranteed to them by federal law.

3. Inadequate IEPs

The IDEA requires that each student with a disability have an IEP to ensure that the student receives adequate special education. IJCF's IEPs and the procedures surrounding them are not in compliance with the IDEA in several areas: (1) inadequate records obtained at intake and sent out at exit; (2) timeliness of IEP reviews; (3) inadequately justified divergences between previous and current levels of special education; (4) missing parent/guardian and IEP team signatures; and (5) inadequate IEP implementation and data collection.

First, the IDEA requires that IJCF promptly obtain educational records from a student's former place of enrollment once she has entered IJCF. 34 C.F.R.

§ 300.323(g). Nearly one third of the files we reviewed at IJCF, however, were missing transcripts from the student's previous placement. Transcripts are critical in ensuring that students are enrolled in appropriate coursework. The absence of these transcripts therefore places students at substantial risk of being denied appropriate education opportunities.

Second, IJCF is not completing IEP reviews in a timely manner. Under the IDEA, the timelines for initial IEP reviews vary based on one of three possible scenarios: an initial determination of disability at a given facility; transfer of a student to the facility from within the state, and transfer of the student to the facility from another State Education Agency. See 34 C.F.R. § 300.323(c)(1), (e), (f). In any case, IEP reviews and implementation of IEPs for students with disabilities should be conducted as quickly as possible upon intake.

Nearly one third of IJCF's IEP conferences were not completed in a manner consistent with the IDEA. The facility held some conferences as late as one or two years after they were supposed to have occurred. It also recorded other conferences as having been held before enrollment had even occurred, calling into question the accuracy of IJCF's recordkeeping.

The IDEA also requires at least annual reviews of IEPs. 34 C.F.R. § 300.324(b)(1)(I). Only one third of the IEPs we reviewed satisfied this requirement. IJCF's failure to review IEPs in a timely manner is in violation of the IDEA.

Third, the IDEA requires IJCF to provide educational services comparable to those described in a student's IEP from her previous placement or to provide an adequate justification for any change in services. We found significant and inadequately justified disparities between previous and current IEPs. For example, one student, A.B., received special education more than 50% of the school week in her previous placement but, as of the time of our April 2008 tour, she was receiving special education only on a consultation basis. Similarly, A.A. was previously receiving 100% special education services in her previous placement, but at IJCF receives only 15-20 minutes of services twice a month. Another student, T.D., had been classified as having a communication disorder but had no IEP addressing this issue. And C.B. previously had an IEP that included a Behavior Intervention Plan ("BIP"), but her current IEP does not. Two students, A.A. and J.E., are classified as emotionally disturbed, which by definition means that they have behaviors that interfere with learning. Their IEPs, however, note that their behaviors do not impede their learning, a glaring inconsistency. These disparities and inconsistencies are not adequately justified by any of the students' IEPs, and therefore place the students at risk of not receiving appropriate services, in violation of the IDEA.

Fourth, the IDEA requires that IEP meetings include, to the extent possible, a student's parents or guardians and IEP team members. 34 C.F.R. §§ 300.321(1)(a); 300.322. We encountered a pervasive lack of parental and IEP team member signatures on student IEPs, far beyond the absences that could be expected due to parental decisions not to attend. Indeed, of the eleven IEPs we reviewed, nine had no signatures whatsoever, and two had only parent signatures.

Fifth, and finally, we found no evidence that student IEPs are actually being implemented. Despite our request, IJCF provided us with no student grades, and we received at least one report from a student indicating that classwork is not graded. Additionally, we found no data concerning student academic and behavioral IEP goals. The absence of grades and other monitoring data is in direct violation of the IDEA's requirements that data on student progress on annual goals be collected and reported. 34 C.F.R. § 300.320(a)(3).

4. Inadequate Access to the General Education Curriculum

The IDEA guarantees students with disabilities access to the general education curriculum. 34 C.F.R. §§ 300.304(b)(1)(I); 300.305(a)(2)(iv); 300.320(a)(2)(i)(A). IJCF fails to comply with this requirement in a number of ways.

First, IJCF delays students' enrollments in school for 14 days after intake without adequate justification. Reportedly, this time is spent in idle activities, such as listening to music, watching movies, general recreation, and cleaning, with only a few hours devoted to general orientation activities such as visiting a doctor and completing educational and other testing.

Second, IJCF fails to provide some required courses, in violation of the IDEA's requirement that students with disabilities be given access to the general education curriculum. Students with disabilities at IJCF do not have access to certain elements of the Core 40, the basis for general education in Indiana, nor do they have access to vocational education courses. IJCF also fails to provide appropriate coursework. For example, at the time of our tour, one student was enrolled in Pre-Algebra, despite the fact that she already had taken and passed Pre-Algebra 1 and Pre-Algebra 2. And, as noted above, a number of students' files are missing transcripts, making it difficult to ensure that these students are enrolled in proper coursework.

Third, students with disabilities are denied access to the general education curriculum at IJCF as a result of inadequate teacher planning, a lack of instructional adaptations, and inadequate recordkeeping. Our observations of several classes revealed no instruction taking place. Where instruction was

observed, the purpose of the lessons and their relationship to State standards was all but impossible to discern. The inadequacy of the lessons may be explained by the many reports we received that instruction had only begun approximately two weeks before our observations took place. Prior to that time, when boys also were housed at the facility, instruction had not been taking place because of the high student-to-teacher ratios in the classrooms.

IJCF should enable adequate lesson planning by giving teachers a daily planning period that is not interrupted by other duties. Teachers then should be held accountable for conducting lessons that meet State standards and are consistent with the scope and sequence of courses taught at IJCF.

Even where we observed some direct instruction, students with disabilities were denied access to the general education curriculum because of IJCF's failure to employ instructional and behavioral adaptations. The IDEA requires that teachers implement each child's IEP, including specific accommodations, modifications, and supports. 34 C.F.R. § 300.323(d)(2)(ii). Indeed, the IDEA guarantees appropriate instructional adaptations. 34 C.F.R. § 300.39(b)(3)(i)-(ii). And we note that teachers should not be developing individualized curricula, but should instead use appropriate supports and adaptations to permit access to the general education curriculum. Additionally, to comply with the IDEA, IJCF must keep records regarding the effectiveness of its instructional adaptations. Teachers must maintain accurate and complete grade books, as well as evidence of student progress with instructional adaptations. But, reportedly, class assignments at IJCF are not graded and we found no evidence to the contrary.

Fourth, IJCF fails to provide adequate instructional minutes on a daily and weekly basis. The IDEA guarantees students with disabilities the same number of instructional minutes per day and week as other students in Indiana schools. See 34 C.F.R. § 300.11. Students in Indiana schools receive six hours of instruction time per day and 30 hours per week. But IJCF provides no instructional time on Thursday afternoons so that it can hold "team meetings." To comply with the IDEA, IJCF should provide a full day of school on Thursdays.

Fifth, and finally, IJCF's treatment of students in segregation fails to comply with the IDEA requirement that it provide comprehensive educational services to students, even when the student is moved from her current placement. 34 C.F.R. §§ 300.101(a); 300.530(d)(1)(i)-(ii). Specifically, students with disabilities do not receive work in all academic subjects while in administrative segregation, and, reportedly, no school is provided to students in disciplinary segregation. Again, all students with disabilities should have ongoing and appropriate access to educational services.

Relatedly, students with disabilities in SNU, SAC, and BIC are not provided instruction in all academic content areas. Further, instruction in these placements is not provided by licensed and highly qualified teachers. Where safety or other penalogical interests are involved, IJCF should make individualized adaptations and return the student to class as quickly as is safely possible.

5. Inadequate Behavioral Supports

IJCF also fails to provide adequate behavioral supports to students with disabilities, in violation of the IDEA.

For example, because IJCF's system-wide behavior plan is not fully developed or implemented, the plan does not adequately address the needs of students with disabilities, in violation of the IDEA. 34 C.F.R. § 300.324. IJCF should work proactively to motivate students and ensure that students with emotional disturbance and other disabilities are provided with the supports they need to be educated with peers that do not have these disabilities. Our classroom observations showed that IJCF fails to meet this standard: teachers have limited options for addressing misbehaving students and must rely on in-school suspension and segregation. The documentation we reviewed does make some reference to a token system for promoting positive pro-social behavior, but the token system had yet to be enacted at the time of our April 2008 visit. As detailed below, this absence is emblematic of deficiencies in the system-wide behavior plan.

IJCF also does not make adequate use of in-school suspension ("ISS"). The token system described above is referenced in ISS documentation, but, as of our visit, had not been implemented. Nor is ISS used in a way that would benefit students with disabilities. In our direct observations of regular classrooms, ISS procedures were not employed, despite sleeping or otherwise unengaged students. Moreover, the ISS instructor does not appear to be aware of the special needs of students with disabilities, nor does IJCF have in place a method for alerting ISS instructors to these needs. The absence of adaptations for students with special disabilities, such as a parallel cognitive processing form for students with lower reading levels, further complicates this communication difficulty. IJCF also does not adequately gather and analyze data to determine whether students view ISS as a means to avoid their work, teachers, or other aspects of regular programming at the facility.

The exclusionary behavioral programs in IJCF's system-wide behavior plan do not adequately meet the needs of students with disabilities because they serve indistinct purposes. While employing ISS, SNU, SAC, and BIC as varied levels of behavior support is theoretically sound, in practice these programs have greatly diminished usefulness because IJCF has not clearly articulated a principle for

assigning a student to a given program or for moving students between programs. IJCF also has failed to clearly articulate any difference between general education students and special education students in terms of the function and purpose of these programs, increasing the risk that students with disabilities are being assigned to these programs without the supports in place to benefit them. For these students, the risk is high that they are being placed in these restrictive programs unnecessarily because IJCF lacks general education interventions, has inadequate behavioral interventions in general education classrooms, and does not provide adequate academic instruction, as described above.

Second, to adequately address student behavior, IJCF should implement secondary interventions for students who do not need individual behavior programs but need behavioral supports beyond those offered in the facility plan. Such interventions typically take place in the context of small groups, such as group counseling for rape victims, a reported need at IJCF.

Third, IJCF does not comply with the IDEA with respect to the facility's implementation of individual interventions. Specifically, IJCF again has insufficient data collection. The IDEA requires that IJCF conduct a manifest determination when it decides to change the placement of a student with disabilities because of that student's violation of the code of conduct. 34 C.F.R. § 300.530(e)(1). But IJCF does not collect or analyze the data crucial to making such a determination regarding a student with disabilities who is unsuccessful in the general population.

The IDEA also requires IEP teams at IJCF to use positive behavioral interventions and supports for students who exhibit behaviors that inhibit them from learning. The BIPs used at IJCF do not satisfy this requirement. Effective BIPs that promote positive behavior should be based on functional assessments of student behavior ("FBA"). The FBAs we reviewed at IJCF offer little useful information for behavioral interventions. The FBAs that exist at IJCF were completed shortly before our inspection and lacked accompanying BIPs. Indeed, we found a complete lack of BIP implementation and data on student behavior, a necessary element of effective BIP implementation.

Several examples illustrate the absence of, and need for, effective BIPs at IJCF. Several students noted that, prior to IJCF, they had been on medication for ADHD, a classified disability. These students now have no access to ADHD medication. Similarly, other students reported that they had behavior plans in their previous settings, but had none at IJCF. Finally, one student reported being put in segregation for eight days, despite IJCF's stated commitment to limiting disciplinary segregation to five days.

Finally, IJCF inappropriately uses segregation, in violation of the IDEA. IJCF repeatedly places students in segregation because of the facility's failures to provide adequate educational services, rather than any particular failure on the part of the students. Specifically, students should not be placed in segregation because of a lack of appropriate instruction and instructional adaptations, an adequate facility-wide behavior plan, adequate general education interventions, adequate FBAs and BIPs, manifestation determination hearings, and safety in the open population. But segregation for precisely these reasons is the consistent experience of IJCF students.

An analysis of the patterns in segregation use shows that IJCF employs segregation without attending to the needs of students with behavioral issues. Specifically, a number of students have spent between 10 and 40 total days in segregation. The time that these students spend in segregation demonstrates that they are unable to function behaviorally in the general education classroom. As such, they should be considered both for general education interventions and evaluations for special education services. No general education interventions have been implemented for these students, however. IJCF therefore has failed to appropriately address the needs of these students and identify their behavior as possibly arising from a disability.

IJCF's use of segregation for students with disabilities is particularly disturbing. Students with disabilities accounted for 43% of all segregations, but comprise only 30% of the total IJCF population. The IDEA requires that students with disabilities who are excluded through segregation receive functional behavior assessments and behavioral interventions that will address the behaviors causing their segregation. 34 C.F.R. § 300.530 (d)(1)(ii). But students with disabilities at IJCF do not receive these mandated services and have no data collected on their behaviors. We found that the students with the most segregations are generally those that are classified as emotionally disturbed; consequently, segregation is being used as a primary means to address students' behavioral disability.

The IDEA requires that students placed in segregation in excess of ten days or in a manner indicating a pattern of segregations receive manifestation determination hearings. 34 C.F.R. § 300.530(e). These hearings assess whether the conduct resulting in a student's segregation was caused by, or had a direct or substantial relationship with, the student's disability or was the result of the school's failure to implement the student's IEP. Id. But students at IJCF are segregated repeatedly and for longer than ten days without these hearings, in violation of the IDEA. Further, the IDEA requires IJCF to contact parents if students have been segregated in these circumstances. 34 C.F.R. § 300.530(d)(5),(e). IJCF also fails to comply with this IDEA requirement.

6. Inadequate Staffing

Records we reviewed at IJCF established that the student-teacher ratio is 20:1. This ratio is insufficient for providing youth with disabilities with appropriate access to the general education curriculum. Both the severity of student behavior and the high percentage of students with disabilities require a maximum of ten to twelve students for every teacher. Indeed, the efficacy of lower ratios has been demonstrated at IJCF: teachers and students consistently noted positive changes resulting from the departure of male students from the facility and have attributed greater instructional opportunities in the classroom to the consequently lower student-teacher ratio. IJCF should institute a staffing plan that ensures a student-teacher ratio between 10:1 and 12:1.

Commendably, the teachers at IJCF are appropriately licensed and highly qualified. IJCF should ensure that its teachers maintain this status and that it retain highly qualified teachers in those content areas that require them. IJCF also should create and implement a staff development plan that includes provision for announced and unannounced observation and evaluation of teachers. We found, however, no evidence that IJCF is currently formally observing or evaluating its teachers; such evaluations are necessary to ensure that teachers are providing appropriate instruction, following both the facility and individualized behavior plans, and implementing IEPs.

7. Inadequate Transition Services

The IDEA includes two major components in its definition of the group of activities labeled as “transition services.” First, transition services should be located within a results-oriented process focused on preparing students for a fruitful life outside of the school context. Second, the transition services a given student receives should be based on the individualized needs of that student. 34 C.F.R. § 300.43(a)(1)-(2). Contrary to this standard, IJCF does not make a clear and coordinated set of activities, including vocational education, available to its students. And, as in academics and student behavior, IJCF does not include methods for evaluating student progress in its transition plans and activities. As a result, the transition services at IJCF are not a “results-oriented process,” as the IDEA requires.

III. REMEDIAL MEASURES

A. Protection of Youths From Harm

1. Ensure that youths are provided with safe living conditions and are protected from sexual abuse and misconduct by staff.

2. Ensure that serious incidents, allegations of abuse, and allegations of staff misconduct are adequately and timely investigated by neutral investigators with no involvement or interest in the underlying event. Ensure that staff who are the subject of an allegation of abuse be removed from direct youth supervision pending the outcome of the referral or investigation.
3. Ensure that IJCF has sufficient, adequately trained staff, including adequate numbers of female staff, to safely supervise the residents at all times and provide residents with the requisite level of privacy. Ensure that such training includes training regarding the specific needs of female youths.
4. Except in cases of emergency involving an immediate and serious threat to life, health, or safety of youth or staff, ensure that cross-gender strip searches are not conducted.
5. Except in cases of emergency involving an immediate and serious threat to life, health, or safety of youth or staff, ensure that staff do not forcibly remove or otherwise cut clothing off youths.
6. Develop and implement adequate policies and procedures to ensure that youth are protected from use of excessive force, including force associated with the use of cell extractions, OC spray, and the restraint chair.
7. Develop and implement adequate policies and procedures to ensure that staff are adequately trained in safe restraint practices, that only safe methods of restraint are used, and that restraints are used only in appropriate circumstances.
8. Develop and implement adequate policies and procedures to ensure the appropriate use of isolation, to include due process protections.
9. Develop and implement adequate policies and procedures to ensure that youths have an effective and reliable process to raise grievances without exposing youth to retribution from staff, and to ensure that all grievances are reviewed and addressed in a timely manner that provides youth with notification of the final resolution.
10. Develop and implement adequate policies and procedures to ensure the availability of adequate rehabilitative programming, including gender-specific programming tailored for the needs of female youths.

11. Ensure sufficient, unimpeded, 24-hour access to toilets for all youths.

B. Mental Health Care

1. Provide adequate, comprehensive, and reliable screening and assessment services to identify youths with serious mental health needs, both at intake and throughout youths' time at IJCF.
2. Develop and implement adequate policies and procedures to provide adequate suicide risk screening and assessment in accordance with generally accepted professional standards.
3. Establish and maintain adequate formal treatment planning in accordance with generally accepted professional standards.
4. Establish and maintain adequate mental health programming and rehabilitation programming in accordance with generally accepted professional standards.
5. Establish and maintain adequate mental health counseling and psychotherapy in accordance with generally accepted professional standards.
6. Establish and maintain adequate family therapy in accordance with generally accepted professional standards.
7. Establish and maintain protocols to monitor youths who are on psychotropic medications and adequately document such monitoring, in accordance with generally accepted professional standards.
8. Establish and maintain adequate psychiatric assessments in accordance with generally accepted professional standards.
9. Establish and maintain adequate mental health care staffing.
10. Establish and maintain adequate mental health recordkeeping and communications between and among mental health staff.

C. Special Education

1. Provide prompt and adequate screening, and ongoing re-screening and referral, of youth for special education needs and ensure that all

students requiring special education services receive services in compliance with the IDEA within a reasonable time following intake.

2. Develop and implement adequate Child Find policies and procedures, as required by the IDEA.
3. Develop and implement adequate pre-referral and general education interventions, as required by the IDEA.
4. Develop and implement an adequate individualized education program, as defined in 34 C.F.R. 300.340, for each youth who qualifies for an IEP and provide necessary related services in a reasonable time period.
5. Ensure students with disabilities have sufficient access to an adequate curriculum.
6. Provide adequate behavioral supports to students with disabilities.
7. Develop and implement an education staffing plan that ensures adequate staffing to comply with the IDEA.
8. Provide adequate transition planning and services for all eligible youth with disabilities.

IV. CONCLUSION

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the State in an amicable and cooperative manner to resolve our outstanding concerns with regard to IJCF.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily reflect the official conclusions of the Department of Justice – the observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist you in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to institute a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. Accordingly, the lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc: Thomas Quigley, Deputy Attorney General
Special Counsel to the Commissioner
Indiana Department of Correction

Edwin G. Buss, Commissioner
Indiana Department of Correction

Angela Sutton, Superintendent
Madison Juvenile Correctional Facility

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U.S. Department of Justice
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*Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530*

January 15, 2009

Mayor Michael R. Bloomberg
City Hall
New York, NY 10007

Re: CRIPA Investigation of Kings County Hospital Center

Dear Mayor Bloomberg:

We are writing to report the findings of the Civil Rights Division and the United States Attorney's Office for the Eastern District of New York regarding our joint investigation of conditions and practices at the inpatient psychiatric units and psychiatric emergency room at Kings County Hospital Center ("KCHC") located in Brooklyn, New York. On December 7, 2007, we notified you that we were initiating an investigation pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and a parallel investigation of the KCHC Hospital Police pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("§ 14141"). The Department of Justice is authorized under CRIPA to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness who are treated in public institutions. Section 14141 authorizes the Department of Justice to seek a remedy for a pattern or practice of police misconduct that violates citizens' constitutional rights.¹

As part of our investigation, during the spring, summer and fall of 2008, we conducted three on-site reviews of care and treatment at KCHC and of the Hospital Police. On these tours, we were aided by expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, life

¹ Section 14141 does not mandate issuance of "findings." We have not, however, concluded our review of incidents involving the Hospital Police and therefore have not yet determined whether Hospital Police are engaging in a pattern or practice of excessive use of force.

safety, discharge planning and community placement, and hospital police and security. While on-site, we interviewed administrative staff, mental health care providers, hospital police staff and patients, and examined the physical living conditions at the facility. Additionally, before, during, and after our on-site inspection tours, we reviewed an extensive array of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct transparent investigations, we concluded our tours with extensive debriefings at which our consultants conveyed their initial impressions and concerns to counsel, KCHC administrators and staff, and City officials.

We appreciate the cooperation we received from the New York City Health and Hospitals Corporation ("HHC") and the New York City Corporation Counsel's office. We also wish to thank the administration and staff at KCHC for their professional conduct, their responsiveness to our information requests, and the extensive assistance they provided during our tour. Further, we wish to especially thank those individual KCHC staff members, both newly appointed and longstanding employees, who make daily efforts to provide appropriate care and treatment. Those efforts were noted and appreciated by the Department of Justice, the United States Attorney's Office and our expert consultants. We hope to continue to work cooperatively with HHC, KCHC and the City of New York to address the deficiencies found at the facility.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a).

We note, at the outset, however, that conditions at KCHC are particularly disturbing. Substantial patient harm occurs regularly due to KCHC's failure to properly assess, diagnose, supervise, monitor, and treat its mental health patients. We are particularly troubled by the patient death that occurred in June 2008, where a patient was left unattended and died face down on the floor as staff and security guards ignored her. Further, we find that the number of incidents of patient-on-patient aggression is extraordinarily high and is continuing with little or no abatement. Conditions at KCHC are highly dangerous and require immediate attention. As a result, we issued three immediacy letters (see attached) during the course of our

investigation.² In the first, dated June 18, 2008, we wrote to express our concerns regarding serious fire safety and sanitation issues in the mental health units. On August 22, 2008, we sent a second immediacy letter, which cited several policies and practices at KCHC which posed imminent risks of serious harm to patients, including inadequate mental health assessments, inappropriate drug combinations, and inappropriate use of drugs solely for their secondary sedative effect. Each of these deficiencies resulted in no treatment, or minimal treatment, for mentally ill patients. We also identified in this letter inadequate care for patients with diabetes, inadequate medical emergency responses due to inadequate supervision and monitoring of patients and poorly trained personnel that contributed to the death of a patient in the psychiatric emergency room, and the falsification of medical records.

We issued a third immediacy letter on November 7, 2008. That letter detailed three recent serious incidents in the inpatient mental health units which posed imminent risk of serious harm to patients. That risk of harm was generated in large part by inadequate, ineffective, and counterproductive treatment and the resulting failure to identify and control patient aggression and to address suicidal ideation and attempts.³ Actual harm resulted from the incidents described in the letter. In one, a 14-year-old adolescent patient was sexually assaulted by another adolescent patient. In the other, six patients engaged in a brawl which resulted in one patient requiring surgery to fix a fractured finger.

Moreover, in addition to the notice we provided while on-site, KCHC has been on notice for some time of many of the findings we make in this letter, having been notified previously of deficiencies in the mental health service by other agencies. For example, the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in August 2008, surveyed KCHC and described KCHC's failure to meet federal regulatory standards regarding: (1) protection from harm;

² In each of the letters, we noted that we had not yet reached a conclusion as to whether KCHC was engaging in a pattern or practice of violating the constitutional and federal statutory rights of patients, but nevertheless, the issues were being raised at that time due to the imminent risks of serious harm to patients that required immediate attention.

³ We note that once notified, KCHC began to take action to address the deficiencies.

(2) mental health treatment; (3) nursing and health care; and (4) specialized needs services, resulting in injuries to patients, including death. See also Denial of Recertification of KCHC by New York State Office of Mental Health ("OMH") (November 2008) (describing failure to meet state regulatory standards in protection from harm, mental health treatment, and nursing and health care); New York State Department of Health ("DOH") Statement of Deficiencies (July 2008); Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") Survey Findings (July 2008); New York State Commission on Quality of Care and Advocacy for Persons with Disabilities ("CQCAPD") review (September 2006); OMH survey of KCHC child and adolescent inpatient psychiatric services (May 2006).

We note also that conditions at KCHC are the subject of a lawsuit filed by Mental Hygiene Legal Services of New York State ("MHLS"), the Protection and Advocacy agency⁴ for the State of New York (see Hirschfeld o/b/o L.D. et al. v. New York City Health and Hospitals Corp., et al., Civil Action No. CV-07-1819 (KAM) (E.D.N.Y. May 2, 2007)). This lawsuit challenges conditions of confinement at KCHC, including staff violence, failure to provide adequate psychiatric and medical care, the use of physical and chemical restraints for punishment, and physical conditions. In addition, the news media has reported on conditions at KCHC.⁵ Throughout this letter, we include specific references to past findings by these entities, where appropriate.⁶

⁴ The Protection and Advocacy ("P&A") system is a nationwide network of federally mandated disability rights agencies. In each State and through a national office, these organizations are required by law to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of persons with disabilities. 42 U.S.C. § 10801. Mental Hygiene Legal Services is a duly authorized agency of the State of New York and is responsible for providing protection and advocacy services for individuals receiving services for mental disabilities. N.Y. Mental Hygiene Law Article 47.

⁵ See, e.g., John Marzulli, Brooklyn Psych Ward a Snake Pit, N.Y. Daily News, Dec. 16, 2008.

⁶ In addition to surveys of KCHC by federal and state regulatory agencies, we also reviewed a self-initiated survey of KCHC's mental health facilities by Caldwell Management Associates. The August 2007 findings and recommendations of the consulting group reflected similar and often identical concerns.

I. BACKGROUND

KCHC is a public acute care hospital operated by HHC, a public benefit corporation created by New York State legislation in 1970 to oversee the public health system throughout the five boroughs of New York City.⁷ The psychiatric facility at KCHC consists of: (1) a dedicated psychiatric emergency department, with a maximum capacity of 25 patients, as well as six Extended Observation Beds, known as the Comprehensive Psychiatric Emergency Program ("CPEP"); (2) a 160-bed adult inpatient unit; and (3) a 46-bed child and adolescent inpatient unit. For purposes of this findings letter, "KCHC" refers to only these three units, although the hospital itself provides a full range of other medical services.

II. LEGAL STANDARDS

The Fourteenth Amendment Due Process Clause requires state mental health care facilities to provide patients with "adequate food, shelter, clothing, and medical care," along with conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such treatment as may be reasonable in light of their constitutionally-based liberty interests. Youngberg v. Romeo, 457 U.S. 307, 315, 319, 322, 324 (1982); see Woe v. Cuomo, 638 F. Supp. 1506, 1516 (E.D.N.Y. 1986) ("[t]he involuntarily committed patient has a right to decent and humane conditions") reversed on other grounds, 801 F.2d 627 (2d Cir. 1986); see also P.C. v. McLaughlin, 913 F.2d 1033, 1044 (2d Cir. 1990) quoting Doe v. New York City Department of Social Services, 649 F.2d 134, 141 (2d Cir. 1981) ("[t]he law makes clear that '[w]hen individuals are placed in custody or under the care of the government, their governmental custodians are sometimes charged with affirmative duties, the non-feasance of which may violate the constitution'"); Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1245, 1247 (2d Cir. 1984).

⁷ HHC provides medical, mental health and substance abuse services through its 11 acute care hospitals, which include Kings County Hospital Center, four skilled nursing facilities, six large diagnostic and treatment centers and more than 80 community based clinics. HHC Health and Home Care division also provides home health care services, including nursing, physical therapy, speech pathology, personal care, and housekeeping services. HHC is a \$5.4 billion corporation, the largest municipal hospital and health care system in the country, and serves 1.3 million New Yorkers, nearly 400,000 of whom are uninsured.

Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23. Patients have a due process right to have all major decisions regarding their treatment made in accordance with the judgment of qualified professionals acting within professional standards. Messier v. Southbury Training School, 562 F. Supp.2d 294, 301 (D. Conn. 2008); see also Hughes v. Cuomo, 862 F. Supp. 34, 37 (W.D.N.Y. 1994).

In addition, patients' constitutional right to reasonable safety compels public entities to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16. The Due Process Clause requires individualized treatment that will give patients "a reasonable opportunity to be cured or improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975). Public entities are also compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, states may not rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188. Further, it is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Thomas S., 699 F. Supp. at 1189. Seclusion and restraint should be used only as a last resort. Id.

Federal Medicare/Medicaid regulations governing certified psychiatric hospitals, such as KCHC, also require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483.

Finally, KCHC must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); see Olmstead v. L.C., 527 U.S. 581 (1999).

III. FINDINGS

Significant and wide-ranging deficiencies exist with respect to KCHC's provision of care to its mental health patients. Certain conditions and services at KCHC substantially depart from generally accepted professional standards, and therefore violate the constitutional and federal statutory rights of patients who reside there.

A principal example of KCHC's failure to provide care consistent with generally accepted professional standards is the well-publicized collapse and death of 49-year-old patient Esmin Green.⁸ Ms. Green was admitted to the CPEP on June 18, 2008. She remained there for almost 24 hours, without a bed, until approximately 5:30 a.m. on June 19, 2008. At that time, she collapsed from her chair and lay prone on the floor, limbs askew. She remained face down on the floor for approximately one hour without any attention from staff.

During that hour, surveillance video shows that several staff members, including one doctor and two Hospital Police officers, entered the waiting area, appeared to observe Ms. Green lying on the floor, and then left without offering any assistance. In addition, although the video image was broadcast to surveillance monitors, the monitors' images were either ignored or unwatched by staff.

Although Ms. Green can be observed on the surveillance video moving occasionally while she lay on the floor, she appears to have died before a medical code was called. When staff responded to the code, the surveillance video shows a disorganized, and largely medically inappropriate, emergency response. Further, after the incident, it was discovered that medical documents regarding the circumstances of Ms. Green's death had been falsified.⁹

While perhaps unique in the extent of the harm that resulted, the tragic case of Ms. Green typifies the patterns of inadequate care and treatment of patients at KCHC. In particular, we find that KCHC: (1) fails to adequately protect its patients from harm; (2) fails to provide adequate mental health care; (3) fails to provide adequate behavioral management

⁸ We use Ms. Green's full name herein because the circumstances surrounding her death are matters of public record.

⁹ We describe different aspects of KCHC staff's handling of Ms. Green's collapse and death throughout this letter.

services; (4) fails to provide adequate medical and nursing care; (5) has inadequate quality management practices; (6) fails to provide a safe physical environment; (7) has inadequate clinical leadership; and (8) fails to adequately develop discharge plans. Many of these deficiencies stem from a system that has neither clear, specific standards of care nor an adequately trained supervisory, professional, and direct care staff.

A. Inadequate Protection From Harm

Patients at KCHC have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315-16, 322. Generally accepted professional standards require that facilities appropriately monitor and supervise patients in order to ensure their reasonable safety. KCHC fails to provide a living environment that complies with this constitutional mandate or generally accepted professional practices. There are widespread patient-against-patient assaults and unchecked self-injurious behaviors. In addition, the housing units contain environmental hazards, some of which pose risks of serious injury, illness, and death. The harm KCHC patients experience as a result of these deficiencies is multi-faceted, and includes physical injury; psychological harm; excessive and inappropriate use of restraints; inadequate, ineffective, and counterproductive treatment; and frequent re-admissions leading to excessive hospitalizations. The facility's ability to address this harm is hampered by inadequate incident management and quality assurance systems.

In addition, KCHC's policies and practices with respect to monitoring and supervising patients in its custody, especially patients assessed to be at risk, are inappropriate, ineffective, and often cause patient harm. As discussed below, KCHC largely uses close ("one-to-one") observation and physical and chemical restraints to control patients who exhibit dangerous behavior, often to the exclusion of techniques which are less intrusive, less harmful, and often more effective. The frequency and extent of use of these measures also is inappropriate.

1. Failure to Control Patient Aggression and Assaultive Behaviors

Patient aggression is not adequately controlled on many of the units at KCHC.¹⁰ Indeed, physical and sexual assaults are

¹⁰ We notified counsel for KCHC of our concerns about patient aggression and assaultive behaviors not being adequately controlled in our November 7, 2008 immediacy letter.

not uncommon at KCHC. Several recent incidents reported to us by KCHC counsel are illustrative:

- On September 25, 2008, two 14-year-old youths, A.Z. and B.Y., engaged in reportedly consensual anal and oral sex in the room of a third patient, C.X., even though both B.Y. and A.Z. were supposed to be checked every fifteen minutes by staff.¹¹ The next morning, A.Z. was assaulted by a 16-year-old youth, E.V., who allegedly forced A.Z. to engage in oral sex with him. E.V. was reportedly assigned to constant one-to-one supervision by KCHC staff. Notably, staff learned of their activity only after another patient disclosed the information two days after the first event.¹²
- On October 15, 2008, six patients on Unit G-41, all on different levels of observation, engaged in a brawl. One of the patients, D.W., sustained an injury to his forehead and a compound fracture of his thumb which required surgery.
- On August 21, 2008, staff discovered a male patient standing in the activity room of Unit G-33 behind a female patient, F.A., engaged in sexual intercourse. During patient interviews by staff following the incident, the female patient reported that she had not consented to the sex. The male patient was arrested and charged with rape.
- On November 22, 2008, patient G.B., an 18-year-old male patient with mental retardation and autism, was admitted to the CPEP. On November 30, 2008, eight days later, he remained in the CPEP.¹³ On that date G.B. was found

¹¹ As we noted in our November 7, 2008 immediacy letter, although the medical records described this sexual behavior as consensual, we believe this classification is questionable given the ages of the boys and their mental status.

¹² To protect the patients' identities, we use fictitious initials throughout this letter. We will separately transmit to counsel a schedule cross-referencing the fictitious initials with the patients' names.

¹³ We note that the length of this patient's stay in the CPEP violates the New York State Mental Hygiene Law and the Preliminary Injunction Consent Order dated July 2, 2008 issued by United States District Judge Kiyo A. Matsumoto in the Hirschfeld action. Section 9.40 of the New York State Mental Hygiene Law prohibits a hospital from keeping a patient in a CPEP for more than 24 hours without either an assignment to one of the six Extended Observation beds in the CPEP, or admission to one of the inpatient units.

kneeling in a restroom in the CPEP in front of another male patient, apparently performing oral sex. From the reports we have received, G.B. did not consent to the sex; indeed, he may not have had the mental capacity to consent.

In each of the incidents described above, our review of incident reports and patient records indicated that staff failed to properly monitor patients and failed to proactively address potentially aggressive behavior. This problem requires immediate attention.¹⁴

2. Failure to Protect Patients Expressing Suicidal Ideation and Attempting Self-Harm

A significant number of patients are admitted to KCHC for stabilization and protection because of suicidal ideation or suicide attempts. Our review reveals a troubling number of such patients who nonetheless obtained the means to attempt suicide and/or who inflicted serious self-harm.¹⁵

The medical record of one of the youths involved in the sexual incident which occurred on September 25 and 26, 2008, is illustrative of the problem. A.Z., a 14-year-old youth, was assessed on admittance as being "suicidal." He had a history of six previous psychiatric admissions at KCHC, most recently from March to May 2008. A.Z.'s medical record details a history of A.Z. threatening to hurt himself, including threats to end his life. His most recent admission, on August 21, 2008, lists "aggressive and impulsive behaviors" and "danger to himself and others" as the reason for his admission to KCHC.

¹⁴ KCHC informs us that it has recently instituted a new "Violence Reduction Program" ("VRP"). The VRP fails to promote an understanding of the etiology of the violent behavior or to guide the treatment of aggressive patients accordingly. Instead, it focuses on patient self-management skills and serves as an advance directive regarding medications that might be used pro re nata ("PRN") or "as needed" as opposed to regularly scheduled medications. Violence prevention is not integrated into routine assessment, reassessment, and treatment planning.

¹⁵ We notified counsel for KCHC of these serious concerns in our November 7, 2008 immediacy letter.

On September 21, 2008, A.Z. was involved in a physical altercation with E.V., the 16-year-old patient who would later sexually assault him. No actions or changes were made to his treatment plan¹⁶ until the next day, when A.Z. was placed on constant one-to-one observation.¹⁷ Later that day, September 22, 2008, A.Z. attempted suicide by wrapping a video game controller wire around his neck.

On September 25, 2008, A.Z. was taken off constant one-to-one observation and placed on 15-minute observation. Although generally accepted professional standards require that such a change in status, including the rationale for the change, be documented in the patient's medical record, there is no such explanation in the chart. That same day, September 25, 2008, A.Z. was involved in the sexual incident described above. The following day, September 26, 2008, E.V. forced A.Z. to engage in sexual conduct with him.

On September 27, 2008, after KCHC officials learned of the sexual incidents, A.Z. was again placed on constant one-to-one observation. Later that same day, A.Z. again attempted to kill himself by wrapping a video game controller wire around his neck. The incident reports state merely that the patient was upset due

¹⁶ A treatment plan is essentially a detailed roadmap of a patient's entire course of treatment. Generally accepted professional standards require that an adequate treatment plan be developed under the direction of the treating psychiatrist, with input from all disciplines involved in the treatment of the patient, as well as from the individual patient. The treatment plan should contain, at a minimum: (1) an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) a list of problems caused by the patients' illnesses; (3) clearly articulated goals for the patient, designed to ameliorate problems and promote functional independence; (4) a list of appropriate interventions to guide staff in helping the patient achieve his or her stated goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. See Section III.B.2 infra for a more detailed discussion of treatment planning issues.

¹⁷ Constant one-on-one observation is a form of supervision in which a staff member must continually keep a patient in view. DOH's July 2008 survey and CMS' August 2008 survey note several incidents in which patients classified as suicidal appeared to be unsupervised in the CPEP for hours. No evidence could be found showing contact between the suicidal patients and physician or nursing staff eleven to twelve hours after admission.

to a "previous incident earlier that day" but fails to describe or analyze the assault incidents, note the fact that patient was on constant observation, or that the patient had previously attempted suicide.

Moreover, our review of recent KCHC reports and incidents revealed several other incidents of attempted suicide, some of which occurred while patients were on constant one-on-one observation. Examples include:

- H.C., a patient diagnosed with "psychosis NOS" and "rule out schizoaffective disorder,"¹⁸ began cutting herself with a paper clip and then swallowed the clip the morning of May 28, 2008, while under close observation. Later that day, while under constant one-to-one observation, H.C. was observed tying a torn hospital gown around her neck. The gown was taken away by staff and H.C. walked away, took staples from a desk and then swallowed the staples in the presence of staff. Both incidents were not labeled as a suicide attempt but rather as a "minor self-inflicted injury." Her record reflects no change in her treatment plan. Changes to the treatment plan are necessary when these types of incidents occur, to eliminate or address the self-destructive behavior.
- I.J. is a 47-year-old male with a history of drug abuse who was brought to the CPEP on August 7, 2008 for psychiatric evaluation after reports were received that he was suicidal. I.J. was subsequently admitted to the adult inpatient

¹⁸ "Psychosis NOS" means "psychosis, not otherwise specified." This means that the patient's symptoms fit within a general diagnosis of psychosis (a severe mental disorder that involves a profound loss of contact with reality, including delusions and hallucinations), but that the evaluating physician is unable to come up with a more specific diagnosis based on the patient's symptoms. "Rule out schizoaffective disorder" is not an official diagnosis, but rather a directive to assess the patient for symptoms of schizoaffective disorder in order to eliminate it, or "rule it out," from the list of possible diagnoses. (Schizoaffective disorder is a disorder in which a patient exhibits symptoms of two diseases at once: (1) a mood disorder, such as depression; and (2) schizophrenia, which is a complex collection of symptoms persisting over time that include delusions, hallucinations, disorganized speech and behavior, etc. See Section III.B.1 *infra* for further discussion of the problems associated with "NOS" and "rule out" diagnoses.

service and was placed on constant one-to-one suicidal observation. On August 11, 2008, I.J. attempted to tie a sheet around his neck and kill himself. Although the staff member assigned to the one-to-one observation ultimately intervened and removed the sheet, no action was taken to prevent the patient from tying the sheet around his neck in the first instance. During a post incident interview, I.J. stated that "he wanted to take his life." A subsequent review by the Special Incident Review Committee (October 2, 2008) concluded that the patient was appropriately monitored and that staff intervention was immediate and accordingly closed the case with no recommendations for further actions.

The repeated and significant level of both aggressive and self-injurious behavior on the units suggests a fundamental failure to address the root causes of patients' inappropriate behavior and demonstrates that KCHC fails to intervene adequately to prevent future incidents. Moreover, despite the overuse of close observation noted in Section III.C.1 infra, these incidents highlight the inadequate oversight and monitoring of those with aggressive or self-injurious behavior.

3. Inadequate Incident Management and Recordkeeping

Generally accepted professional standards require that facilities have transparent and effective systems for identifying, tracking, and correcting problems, adverse events, faulty treatment, and staff adherence to policies and procedures. To protect its patients, KCHC should have in place an incident management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur. An effective incident management system consists of several elements, including accurate reporting, thorough investigations, tracking, trending, analysis of data, and implementation and monitoring of effective corrective and/or preventive actions. The incident management system at KCHC falls significantly short of these standards.¹⁹ As a result, patients continue to be exposed to actual and potential harm.

¹⁹ As noted above, CMS, OMH, and DOH cited KCHC for its lack of adequate incident management and review systems. Specifically, in its August 2008 survey, CMS cited KCHC for failing to analyze data collected regarding adverse patient events. OMH's November 2008 letter finds KCHC noncompliant with standards requiring, inter alia, identification of "patterns and trends through the compilation and analysis of incident data" and reviewing "patterns and trends to identify appropriate preventive or corrective action." This is a repeat citation by OMH from its May 2007 survey. Finally, DOH also cited KCHC for the same problem in its July 2008 survey.

In addition, we note that KCHC's incident investigations are inadequate. The documentation of investigations that we have reviewed is cursory, incomplete, and lacks critical information necessary to address clinical deficiencies. Further, we found no documentation or other evidence to indicate that KCHC systematically tracks staff adherence to policies and procedures, such as use of one-to-one observation and chemical or physical restraints. Similarly, we found no evidence that adverse events, such as use of Code Orange calls (KCHC terminology for calling for emergency assistance) or staff or patient injuries, are uniformly tracked and that corrective actions are taken where needed.

B. Failure To Provide Adequate Mental Health Care

KCHC patients have a constitutional right to receive adequate mental health treatment. Donaldson, 493 F.2d at 520. The mental health services at KCHC, however, substantially depart from generally accepted professional standards.

Generally accepted professional standards require that the treatment planning process incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) identification of the problems caused by patients' illnesses; (3) establishment of goals designed to ameliorate problems and promote functional independence; (4) identification of appropriate interventions to guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, as well as the individual patient, where appropriate, under the active direction and guidance of the treating psychiatrist.

KCHC treatment planning substantially departs from these standards and fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; patients are at increased risk of relapses and repeat hospitalizations; and patients' options for discharge are significantly limited, resulting in unnecessary hospitalization.

1. Inadequacy of Psychiatric Assessments and Diagnoses
 - a. Inadequate Psychiatrist Assessments

Mental health treatment begins at the time of admission. The admissions process is designed to establish the initial diagnosis and sets forth the course of treatment. Thus, an accurate assessment is crucial to proper treatment. Clinicians must perform thorough assessments to identify patients' problems, strengths and needs. Proper assessment also is vital to identify potential risks from patients who are aggressive or may engage in self-injurious behavior, who are potential victims, or who present high risks due to substance abuse or certain medical conditions. Adequate assessments are essential to the development of a person-centered plan that can direct rehabilitation, treatment, and care while the patient resides in the hospital, and to formulate an adequate discharge and transition plan for the patient's return to the community. Generally accepted professional standards require that psychiatry, medicine, nursing, psychology and social work all provide an assessment.

At a minimum, an initial assessment should include: (1) an adequate review of the patient's symptoms and mental status; (2) a provisional diagnosis and differential diagnosis that permits diagnosis and treatment options to be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the patient and others.

As more information becomes available, the assessment must be updated to include: (1) a history of the patient's presenting symptoms; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's biopsychosocial (biological, psychological and social) functioning; (4) a review and critical examination of diagnostic conclusions made in the past in light of new information; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

Numerous deficiencies exist in the initial assessments we reviewed at KCHC. In many cases, initial assessments are cursory and untimely. Patient histories and medical status are often incomplete and inadequate. In addition, they are devoid of common psychiatric symptoms such as insomnia or loss of appetite

and fail to document mania, depression, or anxiety. They fail to identify the strengths of the patient. They also frequently fail to assess substance abuse history, vocational and educational history, and history of community living and prior placements. The absence of this important information in the medical record seriously impedes or limits the treatment team's ability to create an effective and appropriate treatment plan, which can lead to serious harm.

As a result of these flawed assessments, diagnoses are routinely tentative, unspecified, or inconsistent with the patient's symptoms. We found many diagnoses listed as "rule out" or "not otherwise specified" ("NOS"). These diagnoses are used by KCHC merely as catch-all categories. They are not appropriate long-term substitutes for genuine individualized assessments. However, in many cases, rule out and NOS diagnoses persist with no further diagnostic refinement. We also saw evidence of misdiagnoses which have not been adjusted to conform to patient behavior and symptoms. The medical record of patient J.P. is illustrative:

- J.P., who has had multiple re-admissions to KCHC, exemplifies the inadequacy of KCHC's assessments. He was originally brought to the CPEP by police on December 21, 2007, when he received a diagnosis of Psychosis NOS, and after denying "suicidal and homicidal ideas...hallucinations and delusions," was released. He returned to KCHC on January 26, 2008, after talking about jumping out a window. After again denying suicidal or homicidal ideation, J.P. was released. He returned to KCHC on June 13, 2008 and was given a diagnosis of mood disorder NOS. There is no accompanying psychiatric note or evaluation of his prior admissions. Several days later, pursuant to KCHC's treatment plan for him, he began receiving medication that he failed to take and had failed to take previously. He was released again on July 3, 2008 after denying suicidal or homicidal ideation. Ten days later, on July 13, 2008, J.P. was readmitted. Even though he was diagnosed as manic, with a mood disorder, he was diagnosed upon this admission with psychosis NOS and rule out bipolar disorder. The absence of a definitive diagnosis has perpetuated a generic treatment approach that has repeatedly failed this patient. J.P.'s record reflects the absence of meaningful assessment, reassessment, or targeted treatment. The patient was repeatedly discharged and readmitted with no reflection on the reasons for his recidivism and no change in treatment.

b. Inadequate Nursing Assessments

We found that nursing assessments also were deficient. Nurses are a primary source of information regarding patients who need medical attention, as they are often the first clinician to see and evaluate the patient. We found that initial nursing assessments at KCHC are cursory, and the assessment process and the nursing assessment form used by KCHC do not permit for comprehensive or individualized assessments. The assessment form does not have sufficient space to allow nurses to write individualized findings, and there is no summary section for risk factors that would prompt nurses to think about the patient's needs in a comprehensive way.

Some examples of inadequate nursing assessments, which in turn often leads to inadequate treatment, include:

- The nursing assessments we reviewed for patient H.C. lacked critical information. Upon her admission to the inpatient unit, there were no notes in her assessment indicating social or medical problems. However, other documentation contained in H.C.'s chart raised clear concerns about her social history and medical problems. She was noted to be assaultive, abusive, electively mute, upset about her roommate, and had been sexually abused by her brother in the past. In addition, she has asthma, Hepatitis C, and seizure disorder. None of these are noted in the nursing assessments.
- Thirty-seven-year-old W.H. was admitted with a history of mental illness and substance abuse. The CPEP nursing assessments of W.H. were largely illegible. Where they were legible, the assessments were not adequate in that they provided insufficient detail. For example, her speech was described merely as "incoherent" with no further details. Her thought content was described as "unable to assess" although W.H. was apparently communicating on some level. The rest of the nursing assessment stated "unable to assess," though the record indicates that the social worker elicited information the nurse failed to capture.
- Patient X.I. was admitted in July 2008 for disorganized behavior and delusions. Most of the nursing assessment was left blank, even in sections where staff could have assessed X.I. without his cooperation.

KCHC's failures in the preliminary stages of assessment and diagnosis, as well as its failure to reassess patients to refine diagnoses, grossly depart from generally accepted professional standards. Patients receive, or are at risk of receiving, treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses. The result is that the actual mental illness is often unaddressed, placing patients at risk of prolonged institutionalization and/or repeated admissions to the facility.

2. Inadequate Treatment Plans

Generally accepted professional standards require that treatment plans be individualized and specifically connected to patient problems and needs. The KCHC population presents severe psychopathology and behavioral disturbances that require individualized and intensive treatment programs that are customized to address the cognitive disabilities that are a key part of their illnesses. However, just as KCHC does not conduct assessments that address patients' specific problems or needs, it also uses boilerplate forms and checklists which require staff only to check off problems and treatment recommendations or briefly fill in blanks, rather than write individualized narratives.²⁰

As a result, treatment plans do not specifically address problems that have led patients to be hospitalized. Many of the charts our experts reviewed reflected that patients with very different problems, which by generally accepted professional standards would require individualized treatment plans, instead receive exactly the same treatment plans. Moreover, patients with specialized needs do not have treatment plans specifically tailored to their needs and are not being adequately treated, including those with severe behavioral problems, those with suicidal ideation and self-injurious behaviors, and those who are dually diagnosed with mental illness and substance abuse or developmental disabilities.

Moreover, just as KCHC's assessments do not properly generate appropriate treatment plans, treatment plans do not link

²⁰ Various treatment planning failures by KCHC were cited in OMH's September 2004, June 2005, January 2006, September 2007, and August 2008 reports, such as lack of treatment goals in treatment plans, pre-dated treatment plans, failure to identify activity and therapy groups in treatment plans, missing treatment plan reviews, and a lack of interdisciplinary involvement in treatment planning.

to discharge needs.²¹ Discharge plans, in turn, focus almost entirely on placement options and neglect what the patient needs in order to get placed and to reduce the risk of re-hospitalization.

Failure to provide appropriate and effective treatment targeted to specific patient needs is harmful in a number of ways. It permits dangerous behaviors to persist, it fails to address behavioral and psychiatric problems that led to hospitalization, it lengthens stays unnecessarily, it leads to the use of chemical and mechanical restraints, and it increases the likelihood of relapse and re-hospitalization.

Nursing involvement is particularly important in the treatment planning process. Yet, nurses at KCHC do not appear to hold a central or consistent role in treatment planning. Nurses are largely relegated to medication management and assuring implementation of close observations, which are often deficient, as described in Section III.C.1 *infra*. There is also a lack of professional nurse interventions in any consistent manner, or in a manner that reflects nursing leadership in the care and treatment of patients.

Examples of inappropriate treatment include:

- R.E. is a 46-year-old male with schizoaffective disorder. Over the course of a one month stay, he had ten episodes that led to placement in four-point restraints and the use of STAT medications.²² Notably, there was no change in his treatment plan to address his behavior, and the plan was limited to a boilerplate reference to a number of individual contacts with nursing staff and a small number of unit-wide treatment groups.
- V.O. is a 37-year-old male diagnosed with bipolar disorder with mania. The medical record contains the standard treatment plan: mandating of twenty minutes of individual and group therapy three times per week. His treatment plan reflects no changes over time, despite nursing and doctor's

²¹ An adequate treatment plan will address goals and plans for a patient after he or she is discharged from the hospital, both to aid the patient in making a successful transition to the community, and to prevent or minimize future hospitalizations. KCHC's treatment plans fail to adequately cover these elements.

²² STAT is a medical term meaning "immediate." A STAT medication is one that is to be given immediately in response to an emergency or other urgency.

notes that consistently indicate that V.O. remains agitated, disorganized, and threatening to staff and others.

- Z.U. is a 49-year-old male with schizophrenia, multiple hospitalizations and a history of substance abuse. His treatment plan states that "pt. will participate in groups 3xs per week for at least 45 min to improve reality orientation." Our medical record review covered three separate admissions. His diagnosis changed across the admissions, but there was no substantive change in his treatment plan upon each admission to address his specific mental illness.
- R.Q. is a 20-year-old male diagnosed with schizoaffective disorder and mental retardation. He has had multiple admissions and a previous diagnosis of autism. R.Q. has a history of violence and his medical record documents multiple episodes in which he was assaulted by other patients or he assaulted others. There is no specific treatment plan to deal with his acting out or being victimized, except that he was transferred between units on multiple occasions. The treatment plan does not address his diagnoses of mental retardation and autism or his history of violence.
- L.R. is a 33-year-old male diagnosed as psychotic and delusional. Nursing notes consistently report he spends excessive time in the bathroom and he was seen repeatedly inducing vomiting, but his treatment plan fails to address these behaviors. The record also notes multiple falls, but there was no treatment response. A medical consult, conducted after L.R. was on the unit for almost three weeks, documented polydipsia²³ (excessive drinking of water). However, there were no nursing notes in his treatment plan regarding his water consumption. He was transferred to the medical unit and then to an inpatient psychiatric unit, where notes indicate he was incontinent of urine and feces. There is no specific treatment plan for these behavior problems, either.

We also reviewed the records of ten other patients who were dually diagnosed with mental illness and substance abuse. These patients were not provided any specific substance abuse

²³ Polydipsia is a common disorder characterized by drinking excessive amounts of water to quench a constant thirst. This condition is prevalent in patients who spend significant amounts of time in psychiatric facilities, particularly those patients diagnosed with schizophrenia. This condition may cause incontinence, vomiting, seizures, water intoxication, or even death.

treatment. They were provided only once a week, unit-wide substance abuse groups. This treatment is not sufficiently frequent or individualized to address the needs of individuals with substance abuse problems.

3. Lack of Systematic, Ongoing Assessment

Generally accepted professional standards require that all patients be assessed not just at admission, but on an ongoing basis. It is extremely difficult to diagnose patients fully at time of admission when they are acutely ill, uncooperative, and may be under the influence of alcohol or street drugs. Accordingly, diagnoses and problem lists should change as patients stabilize and become more comfortable admitting problems and symptoms.

Appropriate updating and revisions of diagnoses is uncommon at KCHC. KCHC has no systematic review or evaluation process for preparing diagnoses, and boilerplate forms make it too easy for staff to copy the language of previous diagnoses. Indeed, intake diagnoses and problem lists are often unmodified throughout patient stays, even as new information about patients becomes available over time. This contributes, as noted in the next section of this letter, to unmodified treatment plans, even as patients' conditions change.

4. Failure to Modify Treatment Plans

A direct result of KCHC's failure to conduct ongoing assessments is that it does not modify treatment plans to address changes in patient behavior or condition. Generally accepted professional standards require regular review of treatment plans with adjustments contingent on progress or the lack of progress. KCHC medical records contain updated treatment planning forms, but the updates generally do not reflect substantive clinical reviews with modifications based on patient response. We found a number of charts in which patients exhibited significant, persistent behavior problems over time, but no changes were made in the treatment plan. In many cases, regardless of their efficacy, treatment plans for various patients used exactly the same language repeatedly, despite clear notations in the progress notes that there was no change in inappropriate behavior. Overall, the records do not suggest a sense of urgency to provide active treatment to deal with recurrent problems, and there is no evidence that treatment teams explore options or seek consultations with colleagues or outside experts.

Examples of non-responsive treatment planning include:

- N.S. is a 14-year-old male. The medical record notes more than 20 episodes of four-point restraint and administration of IM (intramuscular) medication for threatening behavior and verbal abuse during his more than seven-month stay at KCHC. On August 15, 2008, his attending psychiatrist reported that "[N.S.'s] continued stay in the acute setting is detrimental to his well-being. He will likely continue to have acting out behavior. It is recommended that he be in a program that is able to meet his special needs." Nonetheless, his treatment plan was identical for the entire seven-month stay.
- T.F. is a 46-year-old female with paranoid schizophrenia. She is unable to care for herself and needs an interpreter as she speaks no English. The treatment plan we reviewed was minimal and not suited to her illness or her inability to speak English. While the treatment plan updates note a lack of progress, there is no substantive change in the treatment plan that could lead to such progress or improvement.
- M.M. is a 16-year-old male with a diagnosis of schizophrenia or bipolar disorder. He was on the child and adolescent unit for six months with repeated reports of aggressive acting out and disruptive behavior. He was placed in restraints multiple times for assaultive behavior, but there was virtually no change in his treatment plan.

5. Ineffectiveness of Treatment Team Process

A significant reason for the deficiencies cited above is that KCHC's treatment team process does not comport with generally accepted practices. Generally accepted professional standards call for treatment to be guided by a multi-disciplinary team in which diverse professional expertise and observations are employed, in an inter-disciplinary process, to evaluate patients and develop treatment plans.

Also, contrary to generally accepted professional standards, it appears that, at KCHC, treatment planning by the different disciplines is done in isolation rather than in an integrative manner. Staff members spend most of their time in treatment team meetings describing events that occurred the previous day or entering notes into patient's charts. There is little discussion of treatment or substantive discussion of patients' conditions. Patients do not regularly participate. There is little inter-disciplinary interchange.

The fact that team meetings are not used to share expertise and ideas significantly limits the ability of staff to develop suitable treatment plans and contributes to the failure of many plans. It also diminishes the ability of staff to effectively revise plans that are not working.

We also find that nurses' involvement in treatment activities was not adequate. We found that treatment on the adult inpatient units appears to be largely generic and custodial. Additionally, the nursing activity schedule for the units does not reflect treatment groups run by other disciplines. Patients' records also fail to consistently reflect participation in such groups. Further, there was no documentation summarizing an individual patient's treatment activities reflected in either the treatment plan or the discharge plan summary.

Finally, KCHC does not appear to track or review individual patients who are not making progress or who repeatedly exhibit the same problematic behaviors. This lack of oversight permits ineffective treatment to continue without detection or correction. This presents a clear danger to patients and staff because it permits faulty practices to be repeated, with no corrective action taken. We were told that new policies, systems, and procedures were being put in place by some of the new administrative and supervisory staff, but there is no evidence as to when and how these changes will be implemented.

6. Inadequate Medication Management and Monitoring

Medication practices at KCHC substantially depart from the generally accepted professional standards. Generally accepted professional standards require that the pharmacological component of a treatment plan reflect the exercise of professional judgment for medication treatment including: diagnosis, target symptoms, risks and benefits of particular medications, and consideration of alternate treatments. The rationale for each patient's course of treatment should be included in the physician's progress notes. Psychotropic medications should be used as an integral part of a treatment program to manage specific behaviors in the least restrictive manner, to eliminate targeted behaviors/symptoms, and to treat specific psychiatric disorders. Additionally, medications should be integrated with any behavioral intervention plan. Medications should be carefully monitored and tracked. Medication changes, as well as the rationale for the changes, should be documented in a physician's order. All lengthy administrations of medication should be

periodically re-evaluated to assess their efficacy. KCHC's practices fall far short of all of these requirements.²⁴

KCHC's practices have led to the inappropriate use of medication. As noted above, assessments are deficient. As a result, the rationale justifying why certain medications are prescribed is not stated in patients' charts or is stated very generally (e.g., "psychosis"). In addition, medications at KCHC are frequently prescribed in reaction to events without an assessment or modification of the treatment plan. KCHC therefore frequently administers PRN (pro re nata or "as needed") medication that is not targeted to specific symptoms of mental illness, and lacks adequate justification. For example, T.Z. is a 16-year-old adolescent with an IQ of 40. He has been both a victim and perpetrator of violence prior to and during his hospital stay. Most recently, he was admitted due to assaultive behavior. T.Z. continues to receive a variety of PRN medications that are not targeted to alleviate or address any specific symptoms.

In addition, KCHC contemporaneously uses multiple medications in the same class to treat the same condition (usually referred to as intraclass polypharmacy) without a clinical justification. This falls outside of generally accepted professional standards. The problem is recognized by KCHC in a memorandum to "All Prescribers" dated March 28, 2008 on the subject "Applied Psychopharmacology." The memorandum prohibits the then-common practice of simultaneous intramuscular injection of two antipsychotics. Nonetheless, KCHC physicians continue to routinely use drug combinations of anticholinergics, antipsychotics, and benzodiazapines that are not clinically justified. This can cause substantial patient harm, including overdose and serious side effects.

Moreover, rather than prescribing antipsychotic medications and benzodiazepines for their specific purpose -- medications to alleviate or minimize symptoms of psychosis and anxiety -- it appears that clinicians inappropriately prescribe these medications to sedate and control patients, and as a substitute for appropriate therapeutic interventions. This too is

²⁴ Notably, CMS's August 2008 letter cites KCHC's failure to provide appropriate evaluation of care -- including medication monitoring -- for each patient. As an example, it notes that a nurse responsible for entering progress notes on six patients acknowledged to CMS surveyors that she did not know the diagnosis or medications of any of those patients.

inappropriate, and can cause patient harm, by subjecting patients to unnecessary medication.

Additionally, generally accepted professional standards require that facilities like KCHC adopt and incorporate the necessary protections and safeguards to ensure that patients are afforded safe and effective pharmacological treatment. Hospitals such as KCHC must have mechanisms to: (1) monitor practitioners' adherence to specific and current guidelines in the use of each medication; (2) report and analyze adverse drug reactions; and (3) report, analyze, and document actual and potential variations in the prescription, transcription, procurement/storage, dispensing and administration of medications. To the extent that these mechanisms exist at KCHC, they are inadequate. Because KCHC's psychiatrists rarely analyze the use of PRN and STAT medications or patients' reactions to them, they cannot refine patients' diagnoses and adjust routinely administered medications. Without such monitoring, patients are at risk of being overly and/or improperly medicated. This practice constitutes chemical restraint, which violates federal regulations. See 42 C.F.R. § 482.13. This practice also substantially departs from generally accepted professional standards.

KCHC's current system to track and analyze adverse drug reactions also is deficient and seriously under-reports problems. No data is compiled regarding basic components, such as a definition of an adverse drug reaction, a severity scale, a probability scale, or a description of patient outcome. There are no established thresholds triggering analysis of adverse drug reactions. There is no data analysis to indicate individual or group practitioner trends. And, there is no evidence that any data on adverse drug reactions have been used for performance improvement activities. For example, drug utilization evaluations ("DUEs") are not used to track and analyze adverse drug reactions.

C. Inadequate Behavioral Management Services

Behavioral management is the use of systematic behavioral (social learning) strategies. These are often the best, and only, non-intrusive approaches to eliminate dangerous behaviors and teach patients more adaptive ways to behave. Accordingly, behavioral plans should, in accordance with generally accepted professional standards, contain certain basic elements, including an analysis of the reasons for the behavior and its frequency, and its causes. The plan should also identify specific interventions by trained staff in order to address and modify the

behavior. The behavior plan should thereafter be integrated with the patient's overall plan of care.

KCHC fails to provide adequate behavioral management. Behavioral management plans are not well integrated into overall treatment, and staff lacks the skills and training necessary to handle the large number of very impaired patients who are dangerous to themselves or others or who have specialized needs. Contrary to generally accepted professional standards, staff at KCHC is focused primarily on controlling patients with inappropriate behavior rather than treating them and teaching them alternative, adaptive behavior. Accordingly, in lieu of appropriate treatment, staff resort to close observation (which is often lax as demonstrated by serious incidents described in Section III.A.2 supra), restraint, and inappropriate medication practices. Indeed, KCHC fails to use systemic behavioral (social learning) strategies to eliminate dangerous behaviors and teach patients more adaptive ways to behave. This problem is exacerbated by KCHC's failure to provide a centralized system of oversight, review, feedback, and expert consultation, where necessary, to protect patients and ensure that adequate treatment is provided. The result is that patients with the most severe needs receive inadequate therapeutic care and treatment.

1. Inappropriate Use of Close Observation

Generally accepted professional standards require that close observation of mental health patients be used only when necessary. It is sometimes appropriate for patients who are at high risk of engaging in self-harm or harm to others. However, it is costly to use and removes staff from other therapeutic activities, is stigmatizing for patients, it restricts privacy and freedom, and it is often disruptive to clinical units. Moreover, it is a management procedure, not a treatment procedure, and does not teach patients more adaptive ways to behave.

KCHC does not use close observation consistent with these principles. Rather, it purportedly uses close observation excessively and performs it incorrectly. At KCHC, close observation is initiated for almost all new patients who have suicidal ideation or are potentially violent. A large proportion of patients are maintained at this level of observation throughout their stay at KCHC whether or not warranted by their behavior. Indeed, it appears to be standard operating procedure at KCHC to use one-to-one in lieu of proper treatment; however, its use has been ineffective. For example (as described above):

- The three adolescent youths who were involved in sexual activity on September 25, 2008 and September 26, 2008 were all on close observation by a different staff member prior to the incident. Each observation of the patients was indicated in the patients' charts with the initials of the staff members responsible for the observation, presumably signifying that the required observation had occurred. However, neither incident was detected at the time it occurred. In fact, the incidents became known to staff only when another boy reported it two days later. Based on the incidents that transpired, it is implausible that KCHC staff was appropriately performing the required observations.

2. Inappropriate Use of Four-Point Restraints and Emergency (STAT) Medications To Manage Patient Behavior

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, KCHC may not restrain mental health patients "except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training." Id. at 324.

Generally accepted professional standards require that restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures have been attempted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. KCHC's use of restraints substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

New York Mental Hygiene Law § 33.04 and generally accepted professional standards require that restraints be used only when less restrictive procedures have not been effective. We found that KCHC does not consistently follow these standards. KCHC excessively relies upon four-point restraints and STAT medications to deal with patients who aggressively act out, regardless of whether the patients pose a continuous threat. Our experts also found little evidence that less restrictive means were employed before restraints were applied, such as proactive assessment to identify risky situations, moving patients to quiet areas, or calming conversations with trained staff. It also appears that restraints are often used even though the patient

has changed his or her behavior and does not pose any further risk.

KCHC policy also requires that restraints may not be applied for more than two hours and that patients should be released sooner if they are no longer agitated or dangerous. Most examples we reviewed indicate that patients remained in restraints for two full hours regardless of changes in their behavior. There is also no indication in the progress notes or restraint orders that patients are clearly told why they are being put in restraints and what the criteria are for release. Absent clear communication to the patient and absent evidence of continued risk, four-point restraint serves as a punishment for acting out rather than as a therapeutic vehicle or a safety strategy.²⁵

3. Inappropriate Transfers of Patients In Lieu of Treatment

Instead of providing appropriate behavioral interventions, KCHC resorts to inappropriate transfers of patients between units as a response to inappropriate behaviors. Moving patients is stigmatizing, clinically disruptive, and generally does not improve patient behavior. Although moving a patient can be clinically appropriate at times, the medical records we reviewed do not indicate that transfers at KCHC are implemented with any clinical rationale. Rather, transfers appear to be used largely to remove a patient who engages in aggressive behavior or who is a victim of patient aggression. Moreover, patients are being transferred in lieu of providing appropriate treatment. The following examples are illustrative:

- V.G. is an 18-year-old woman with a diagnosis of bipolar disorder with mania who has been admitted to KCHC four times in six months. She was repeatedly agitated, intrusive, hostile, and sexually preoccupied. While there is no specific treatment plan for these problems or her sexual preoccupation, V.G. has repeatedly transferred from unit to unit due to these problems.
- M.T. is a 52-year-old male with a diagnosis of schizoaffective disorder. In six weeks at KCHC, he resided

²⁵ OMH cited KCHC for its overuse of restraints in its November 2008 and April 2006 surveys. Specifically, OMH found that restraints are not used "only when absolutely necessary to protect the patient or others from injury."

in three different units. He was admitted to one unit, but transferred to a second unit after an altercation with staff. He was then transferred to a third unit for assaultive behavior on the second unit. While on the third unit, he attacked a peer. M.T.'s treatment plan fails to address his aggressive behavior.

D. Failure to Provide Adequate Medical and Nursing Care

1. Inadequate Assessments and Monitoring

As with psychiatric treatment, effective medical services depend on timely, thorough assessments and monitoring. KCHC staff often fail to provide even the most basic care, opting instead for a reactive approach in which they address patients' medical needs only after problems develop. This exposes patients to a significant risk of harm and causes patients often to suffer preventable injuries and illnesses.

For example, we found that patient weights, although taken on admission, do not seem to be monitored consistently. Nor do nurses appear to note Body Mass Index values with any consistency, despite a KCHC policy requiring the capture and recording of this data. Monitoring weight gain in psychiatric patients is particularly important because many medications can produce rapid weight gain, which in turn can lead to medical problems, including diabetes and hypertension, that are exacerbated by excess weight.

We highlighted one example of KCHC's failure to provide adequate basic medical care in our August 22, 2008 immediacy letter (attached). In that letter, we described a patient on Unit G-53 who had uncontrolled diabetes. Her blood sugar readings ranged from 40 to 400 over the course of one 24-hour period.²⁶ Her chart indicated that nothing was done to stabilize her condition. This put the patient at immediate risk of harm, including diabetic shock or stroke.

Additional examples include:

- Patient R.R. was admitted on October 2, 2007 with a psychiatric diagnosis of bipolar, mixed with psychotic

²⁶ The normal/safe range for blood sugar is 100 or less. The failure to control sugar levels can result in blindness, stroke and other serious or even life-threatening conditions.

features, and a history of substance abuse. R.R. also had other serious medical issues, including obesity (he weighs 425 lbs.), hypertension, lipidemia (the presence of excess fat in the blood), and diabetes. R.R.'s treatment plan did not address any of his medical issues. Eight days after his admission, he was taken to the medical emergency room after he suffered a stroke. Only after he returned to the behavior health service was his medical record corrected to note his history of hypertension and diabetes.

- O.L. is a 41-year-old man who has been admitted to KCHC 55 previous times since 1983 and has multiple medical records. Although he has a history of hypertension and heart arrhythmia, the medical section of his treatment plan was blank. Accordingly, he failed to receive an adequate medical assessment.
- Q.M. walked into to the CPEP and reported that he was hearing voices telling him to hurt someone, and that the previous week voices told him to jump in front of a subway. The assessment performed by KCHC personnel did not find any risk for self harm.

2. Failure to Provide Adequate Emergency Responses

Another essential component of adequate medical care is the ability to provide sufficient care in emergency situations. Generally accepted professional standards require that all staff should be well-trained in emergency preparedness, know what emergency materials are available and where they are located, and conduct sufficient practice emergency drills (called "Mock Code Drills" at KCHC) to be able to perform adequately when confronted with an actual emergency. Appropriate emergency medical response also includes physical plant readiness, e.g., having the proper equipment available at all times.

KCHC practices and procedures regarding emergency preparedness deviate substantially from generally accepted professional standards.²⁷ This deficiency was brought very clearly into focus by the death of patient Esmin Green in the CPEP on June 19, 2008 (described above). Our review of records and materials, including surveillance video, in connection with the death of Ms. Green indicated that, contrary to generally

²⁷ The August 2008 CMS survey of KCHC documented numerous deficiencies with KCHC's emergency response to medical codes, specifically in the case of Ms. Green's death.

accepted professional standards, no one was clearly in charge of coordinating or directing the code for several potentially crucial minutes. From the video, it also appears -- contrary to generally accepted medical practice -- that medical staff failed to immediately address airway, breathing or cardiac issues ("ABCs"), but rather, first took a "finger stick" to assess Ms. Green's blood sugar.²⁸

KCHC's lack of emergency preparedness goes beyond this single event, however. For example, we found a significant lack of Mock Code Drills at KCHC. There were no Mock Code Drills run in 2007, and none occurred during the first quarter of 2008. Two Mock Code Drills were run in the third quarter of 2008. However, both clearly reflected a failure to meet professional standards of practice. The following deficiencies were noted: (1) delays in initiating CPR; (2) staff had to be reminded to use the Automatic Emergency Defibrillator ("AED") and delayed using it; (3) staff did not call for assistance, and a physician failed to adequately respond when called; (4) ABC's were not followed; and (5) staff responder forgot to bring the crash cart. Notably, many of these same deficiencies were present in the Esmin Green incident.

Given the multiple deficiencies noted on the two Mock Code Drills run since Ms. Green's death, KCHC's medical emergency preparedness is clearly inadequate.

3. Failure to Provide and Maintain Adequate Medical Documentation

Generally accepted professional standards require that clinical records be complete, accurately documented, readily accessible, and systematically organized. The records should be sufficiently detailed to provide for continuity of care. KCHC fails to ensure that patients' medical records completely and accurately reflect their care. Our investigation revealed numerous instances of inadequate or absent documentation by medical and nursing staff, leading to harm or the risk of harm to KCHC patients.²⁹ For example:

²⁸ In addition, as we pointed out in our August 22, 2008 immediacy letter, the video also shows a nurse, when she first responds to Ms. Green, nudging her with her foot.

²⁹ KCHC has been cited for inadequate or missing documentation in other surveys. In September 2006, the New York State Commission on Quality of Care and Advocacy for Persons with

- H.C.'s chart indicated no medical problems even though this patient, who apparently has been admitted multiple times to KCHC, has asthma, Hepatitis C, and a seizure disorder. Her nursing assessments were incomplete on earlier admissions.
- P.K. arrived in the CPEP in an acute psychosis, and exhibiting paranoia and poor hygiene. He was noted to be HIV-positive, to have a seizure disorder, and a history of substance abuse. The nursing assessment documentation was incomplete, and there were no social problems or treatment discharge issues noted, despite P.K.'s obvious history of psycho-social problems.

As noted above in the section on treatment planning, treatment plans were also inadequately documented by nursing staff. We reviewed a number of records where the treatment goals were omitted even though the patient's particular problem had been identified. This was especially true with those patients whose social problems increase the likelihood of repeat hospitalizations.

Further, nurses do not consistently record information in patients' charts properly. Notes are not made directly below the last entry, nor do nurses commonly use hand drawn lines to cross out blank space within the record. This kind of charting creates a situation where, as noted below, post-dating the record becomes possible.

4. Falsification of Medical Records

Disturbingly, we have become aware of at least three instances of falsification of records.³⁰ The need for accurate,

Disabilities, an independent New York State governmental agency charged with improving the lives of people with disabilities, noted irregularities between KCHC's report to OMH of the number of hours between patients' arrivals at the CPEP and their departure or admission to an inpatient unit for 2005 and 2006. It requested an explanation of "how this misrepresentation was able to occur." In addition, JCAHO found progress notes and medical records with illegible entries which it described as "precluding effective written communication between caregivers regarding the patient's condition and progress."

³⁰ Falsification of documents related to the death of patient Esmin Green was also cited in CMS's August 2008 letter and DOH's July 2008 letter.

truthful record-keeping should be self-evident. Without accurate records, it is impossible for patients to receive appropriate clinical intervention, and substantial harm can arise. Moreover, given the pattern of false records that we have observed, we cannot be certain of the veracity or reliability of the records that have been presented to us. The following constitutes three known instances of falsification:

- When Esmine Green died on the morning of June 17, 2008, after lying unattended on the floor of the waiting area in the CPEP between 5:30 and 6:30 a.m., nursing notes asserted that, during that hour, Ms. Green was repeatedly observed alert and awake. Video surveillance tapes we reviewed demonstrated that this was patently false, and that no one attempted to assist her throughout the time she lay on the floor.³¹
- During our site visit in July 2008, we requested the records of patient H.C. We were told that one of the nurses responsible for delivering the chart to us had altered the record at the direction of her supervisor, an Associate Director of Nursing.³²
- The medical records for patient G.B., who was found on his knees in a bathroom in the CPEP apparently engaged in oral sex with another patient indicate that the Psychiatric Health Associate ("PHA") had, as per policy, conducted regular 15 minute checks on both patients. However, KCHC has informed us that surveillance video of the CPEP shows that the PHA falsified the records, and did not, in fact, conduct the 15 minute checks.

E. Inadequate Quality Assurance and Performance Improvement

Generally accepted professional standards require that a facility like KCHC develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program

³¹ We notified counsel for HHC of this serious concern in our August 22, 2008 immediacy letter.

³² The fact that this patient's medical record was altered was brought to our attention by HHC officials at the end of our site visit in July 2008.

also should include a process for developing a corrective action plan and a process for monitoring the effectiveness of corrective measures that are taken. Throughout this letter, we have enumerated various failures by KCHC to provide adequate care and treatment for its patients. With few exceptions, KCHC has failed to identify these problems independently, or formulate and implement remedies to address them. Consequently, actual and potential sources of harm to KCHC's patients continue unaddressed.

An adequate quality management program has two components: (1) quality assurance ("QA"), which focuses on evaluating compliance with basic standards of quality that are either internally or externally imposed; and (2) performance improvement ("PI"), which focuses on identifying missed opportunities to improve care, identifying preventive actions, and delineating remedial measures to improve the care and delivery of treatment and services provided to patients.

KCHC has failed to implement an appropriate quality assurance and performance improvement program. As a result, KCHC often does not identify or analyze deficiencies in the treatment and services provided to patients or in systems and procedures designed to protect patients from harm in a timely or adequate manner.

KCHC's quality assurance and performance improvement programs often are poorly organized and fail to establish priorities to identify the particular issues that need to be addressed. The hospital does not establish criteria for analyzing the variety of data that they routinely collect, and fails to analyze appropriately the data for trends and underlying causes.

Moreover, as indicated above, KCHC also lacks adequate procedures for investigating untoward events, serious injuries, and important or critical events. Our consultants found that staff conduct little or no follow-up to determine the cause of an incident, its effect on the patient, or how similar incidents might be avoided in the future. As a result, patients continue to be exposed to actual and potential harm.³³

³³ Our interview with a consultant recently hired by KCHC to review the QA/PI process confirms our findings. The consultant found the current QA/PI process to be inadequate and recommended a review and revision of all QA/PI to conform to generally accepted professional standards: "real time" monitoring, with the

F. Unsafe Physical Environment

The Fourteenth Amendment Due Process Clause requires public mental health care facilities to provide patients with "adequate food, shelter, [and] clothing," along with conditions of reasonable care and safety. Youngberg, 457 U.S. at 324.

1. Inadequate Fire Safety Planning and Training

In accordance with generally accepted professional standards, KCHC must have an adequate fire safety plan and provide adequate training to its staff to respond to fire emergencies. Hospital staff must be adequately trained to respond to reports of fire or smoke, and be able to safely evacuate the patients within their care. We find that the present fire safety planning and training is wholly inadequate and exposes both patients and staff to an unnecessarily high risk of harm, including death.

Staff are critically deficient in their training and response to fire. We observed two unannounced mock fire drills during which all involved staff made potentially life-threatening errors. For example, staff failed to inquire about the location of the fire, failed to pull a fire alarm to alert others to respond to the location, and, when other staff did respond, they failed to bring portable fire extinguishers to the site. Moreover, actions to evacuate patients were woefully inadequate.³⁴ The staff also were unaware of any policy or procedure as to how to address patients who refused to leave the building in an emergency.³⁵ Moreover, KCHC's fire safety documentation is poorly designed, inapplicable to the areas used for behavioral health services, and lacking in appropriately

requirement of contemporaneous documentation of activities; in-service training of KCHC staff on QA/PI; a massive culture change that needed to be built into all levels by all disciplines; and strong leadership and commitment.

³⁴ During the course of the drills, we observed a physician leading patients down the hallway toward the fire location, and patients wandering unchecked by staff down the hall toward the fire. One unit supervisor did not know how to access the locked emergency exit stairwell, although we were told that the supervisor should have a key to the stairwell.

³⁵ We notified counsel for KCHC of these serious concerns in our June 18, 2008 immediacy letter.

critical assessments or feedback to improve the fire safety program.

2. Inadequate Handling and Disposal of Hazardous Materials

KCHC's present system for handling and disposing of hazardous materials, including medical waste materials, exposes patients, staff, and the Kings County community to risk of harm. Generally accepted professional standards require that discarded materials saturated in blood or other potentially infectious materials be placed in red biohazard bags, and securely stored to prevent access.

During our tour, we found several red biohazard waste bags as well as a clear plastic bag that appeared to contain bloody linens outside in open waste carts. These bags were not secured, and were accessible to anyone who might walk by. In fact, a homeless person was observed sleeping approximately fifty feet from the carts. This is a violation of biohazard waste storage and handling practices and places individuals who may come in contact with these wastes at serious risk of injury or disease transmission.³⁶

3. Inadequate Environmental Infection Control

KCHC fails to take appropriate steps to prevent the spread of infectious agents through laundering practices, storage of patient clothing, linen replacement, and basic housekeeping measures. We learned during our site tour in May 2008 that methicillin-resistant staphylococcus aureus ("MRSA") has been identified at KCHC, although not at high levels.³⁷ Environmental considerations, such as laundry, are critical in preventing the spread of this organism.

³⁶ Id.

³⁷ MRSA is a highly contagious bacteria commonly found in institutional settings that is resistant to certain antibiotics, including methicillin. Centers for Disease Control and Prevention, at http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca_public.html. The disease presents itself at first as a boil or sore on the skin, and is easily spread through contact with an infected person or with a surface the person has touched. Id. In some cases, MRSA can lead to serious complications, including surgical wound infections, bloodstream infections, and pneumonia. Id.

The Centers for Disease Control ("CDC") recommend that laundry be washed in water at least 160 degrees Fahrenheit. The washing machines on units available for patients provide water at only 107 degrees. This creates a significant risk that patients' personal clothing may spread MRSA or other pathogens even after being laundered. Moreover, KCHC does not properly store patients' clothing. Patients' stored clothing is not routinely laundered or disinfected before being stored. In the CPEP, patients' clothing is stored on the floor. On the child and adolescent unit, patients' clothing is stored in mesh bags, closely packed together in a closet, where mouse excrement was later observed.

In addition, KCHC uses worn bedding which cannot be properly cleaned and disinfected between uses. For the purpose of infection control, bedding and similar items should be replaced regularly once they reach the end of their service lives.

4. Unsafe Food Handling and Preparation Practices

Pursuant to generally accepted professional standards, KCHC is obligated to provide adequate food to patients consistent with safe preparation and handling practices. Proper cooking, holding, and serving temperatures and time frames are critical to prevent the risk of food borne illness. We found deficiencies in food handling at KCHC that put patients at risk for transmission of food borne illnesses.

Food temperatures are not being routinely monitored at serving locations. The pantry in the second floor of the adult inpatient building lacked a thermometer and temperature logs. When questioned about this, food service staff members indicated that thermometers were missing from several pantries, and the food service director was unable to produce any temperature logs from serving locations for the month of May 2008. Patients who were served this food were placed at risk of food borne illness.

5. Failure to Address Suicide Hazards in Patient Areas

Due to the nature of the patient population, KCHC should proactively address suicide hazards and vigilantly observe patients to minimize the risk of suicide. We acknowledge that KCHC has taken some steps to reduce suicide hazards, but many of the problems still remain, especially in the CPEP.

The CPEP is a high risk area for suicides due to its building fixtures and overpopulation. For example, the male and female bathrooms both have sink handles and shower control knobs

that could easily be used by a patient to tie a shoelace or some other ligature around, place the other end in a noose around his or her neck, and sit down, asphyxiating him or herself. In addition, these areas are not constantly visible to staff nor regularly monitored by staff.³⁸

G. Inadequate Clinical Leadership

The major role of clinical leadership in any institution is to ensure that professional standards of practice and accountability are maintained. Specifically, clinical leadership should respond, in a timely manner, to identified problems and offer stable, consistent administrative guidance and supervision. KCHC fails to provide such adequate clinical leadership. Leadership in all of the major disciplines at KCHC appears to be overwhelmed and reacts primarily to escalating crises. Repeated failure by leadership to implement timely appropriate corrective action plans have led to significant harmful situations.

Agencies such as CMS, OMH and other outside consultants have cited deficiencies at KCHC, including inadequate programming, the excessive use of seclusion and restraint, and unsafe clinical situations that have resulted in injuries to patients, including death. Despite these clear findings of repeated deficiencies, these conditions remain unabated. Despite repeated "plans of correction" and leadership's verbalization of an understanding of the extant deficits, the system of care remains in disarray with no sense of urgency of the need for things to change. Patient and staff injuries continue to occur with an alarming regularity without adequate leadership intervention. The critical incidents that occurred in the CPEP and on the child and adolescent unit reflect the egregious consequences of the failure of the existing leadership to address effectively burgeoning problems.

³⁸ KCHC has been notified on many prior occasions about the presence of suicide hazards. The September 2004, January 2006, May 2006, May 2007, and November 2008 OMH surveys described various suicide hazards in patient areas. Similarly, JCAHO's July 2008 survey also noted the presence of suicide hazards. We do note that KCHC plans to move all of its mental health patients to a new building commencing sometime in early 2009, which may ameliorate some of these physical plant defects.

H. Inadequate Discharge Planning And Placement In The Most Integrated Setting

Within the limitations of court-imposed confinement, federal law requires that KCHC actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patients' needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a patient's stay, KCHC should: (1) identify, through professional assessments, the factors that likely will foster viable discharge for the patient, and (2) use these factors to drive treatment planning and intervention. Treatment planning must be directed toward returning the patient to the community as quickly as possible. Consequently, generally accepted professional standards call for assessment of the recovery environment, identification of problems related to adaptation in the community and efforts to enhance the prospects for recovery. This must begin at admission and include important members of the individual's natural and professional support system. Readmission within a brief time should be treated as a failure of the discharge planning process and should be tracked as part of the hospital's outcome measures. Without clear and purposeful identification of such factors and related issues, patients will be denied rehabilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The discharge planning process at KCHC falls significantly short of these generally accepted professional standards of care. Treatment teams typically do not consider or integrate criteria for discharge into treatment planning. Consequently, many patients whose psychiatric conditions are largely under control remain hospitalized because of poor daily living skills, aggressive conduct, incontinence, inadequate dietary management, failure to take medication, and/or other behaviors that prevent discharge and community reintegration. Although such behaviors often can be resolved with proper treatment, KCHC rarely addresses these issues in patients' treatment plans or in the facility's discharge planning. This leads to frequent re-admissions, which in turn suggests a failure of discharge planning. Examples include:

- S.D., who has been admitted to KCHC 12 times in nine years and has made another seven visits to the CPEP during that time period.
- J.P., who had been repeatedly admitted and discharged during the past year without any meaningful assessment, reassessment, or targeted treatment.

- W.H., who has had five admissions in less than three months. Her record reflects KCHC's failure to: adequately assess prior admissions; reach a clear differential psychiatric diagnosis; adequately assess the clinical efficacy of past medication interventions; adequately address her repeated aggressive behavior and its relation to mania or mixed states and resulting poor judgment; and conduct appropriate mental status exams. Accordingly, W.H. has been subjected to a range of shifting combinations of anti-psychotics and discharges to settings that are inappropriate for her needs.

The failure to provide adequate, individualized treatment and discharge planning for these and other patients deviates from generally accepted professional standards and contributes to extended hospitalizations, unsuccessful community placements, and a high likelihood of readmission. Patients are harmed or exposed to the risk of harm by the effects of prolonged institutionalization and by being denied a reasonable opportunity to live successfully in the most integrated, appropriate setting.

IV. FINDINGS PURSUANT TO § 14141

In furtherance of our investigation pursuant to § 14141, we and our expert consultants in police and hospital security practices reviewed relevant documents, including policy memoranda and training materials. As in the case of our CRIPA investigation, we toured KCHC with our expert consultants, and interviewed a cross-section of Hospital Police supervisors and officers as well as clinical staff, including hospital administrators, doctors, nurses, and other behavioral health staff. We also interviewed representatives from HHC.

Our investigation has revealed a number of serious policy and procedure deficiencies in the KCHC Hospital Police Department.³⁹ Most significantly, the Department lacks a comprehensive, coherent set of policies and procedures and those policies which do exist are not effectively communicated to officers. As a result, there is confusion among Hospital Police officers and clinicians regarding the role of Hospital Police. This can result in inappropriate conduct by officers. One clear example is the complete failure by two Hospital Police officers to assist patient Esmin Green as she lay on the floor of the CPEP on the morning of June 19, 2008.

³⁹ We will be sending under separate cover a Technical Assistance letter regarding the KCHC Hospital Police Department.

In addition, we have determined that supervision and training of new officers is inadequate. As will be detailed in our Technical Assistance letter, new officers are poorly trained, particularly with respect to engaging mental health patients, and supervision is lax. Finally, KCHC lacks a coherent and effective system for receiving, reviewing and investigating incidents and complaints involving the Hospital Police.

VI. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of the patients at KCHC, KCHC should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

KCHC should provide its patients with a safe and humane environment and protect them from harm. At a minimum, KCHC should:

1. Create or revise, as appropriate, and implement, in accordance with generally accepted professional standards, policies and procedures for the monitoring and supervision of patients, especially patients at risk, and ensure that all policies and procedures are integrated into routine assessment, re-assessment, and treatment planning.
2. Create or revise, as appropriate, and implement policies and procedures that comport with generally accepted professional standards to address:
 - a. patient aggressive and assaultive behaviors;
 - b. patients expressing suicidal ideation and attempting self harm.
3. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury; patient aggression; abuse and neglect; and suicidal ideations and suicide attempts;

4. Create or revise, as appropriate, and implement policies and procedures regarding the creation, preservation, and organization of all records relating to the care and/or treatment of patients, including measures to address improper removal, destruction, and/or falsification of any record;
5. Create or revise, as appropriate, and implement thresholds for patient injury/event indicators, including patient-against-patient assaults, self-injurious behavior, and falls, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level and that will be documented in the patient medical record with explanations given for changing/not changing the patient's current treatment regimen;
6. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents. Such policies and procedures shall include requirements that investigations of such incidents be undertaken and that they be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;
7. Require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;
8. Monitor the performance of staff charged with investigative responsibilities, and provide technical assistance and training, whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents;
9. Develop and implement a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations;
10. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from patient aggression and abuse and neglect allegations, to ensure that such incidents are properly investigated and appropriate

corrective actions are identified and implemented in response to problematic trends; and

11. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards of care. At a minimum, such a system should:
 - a. collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by KCHC, as well as the outcomes being achieved by patients;
 - b. analyze the information collected in order to identify strengths and weaknesses within the current system; and
 - c. identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.
12. Conduct a thorough review of all units to identify any potential environmental safety hazards, and develop and implement a plan to remedy any identified issues. At a minimum, KCHC should:
 - a. Ensure that suicidal patients are housed in an area that is safe for them with appropriate supervision and observation by staff.
 - b. Identify and eliminate all suicide hazards in all areas accessible to patients, including patient bedrooms and bathrooms.

B. Mental Health Care

1. Assessments and Diagnoses

KCHC shall ensure that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, KCHC shall:

- a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments; and ensure that assessments include

- a plan of care that outlines specific strategies, with rationales, including adjustment of medication regimens and initiation of specific treatment interventions.
- b. Ensure that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of all patients requiring restrictive interventions.
 - c. Develop diagnostic practices, consistent with generally accepted professional standards, for reliably reaching the most accurate psychiatric diagnoses.
 - d. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards, and ensure that nursing assessments in particular are adequately thorough and individualized. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, maladaptive behaviors and substance abuse problems.
 - e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.
 - f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.
 - g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.

- h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries, and require each clinical discipline's peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action.

2. Treatment Planning

The KCHC shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, the KCHC shall:

- a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards of care;
- b. Review and revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, factors in the patient's particular strengths, is outcome-driven, emanates from an integration of each discipline's assessments of patients, and that goals and interventions are consistent with clinical assessments. Revise each patient's treatment plan if it is not effective.
- c. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs, goals and interventions as well as discharge criteria.
- d. Ensure that individualized treatment plans are implemented in a consistent manner in accordance with generally accepted professional practices.
- e. Ensure that the medical director timely reviews high-risk situations such as individuals requiring repeated use of seclusion and restraints.

- f. Provide adequate and appropriate psychiatric and other mental health services, including adequate psychological services and behavioral management, in accordance with generally accepted professional standards. Behavioral management should focus on teaching alternative, adaptive behaviors.
- g. Develop and implement psychological evaluations to assess each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.
- h. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.
- i. Develop and implement policies to ensure that patients who are dually diagnosed as mentally ill/developmental disabilities or mentally ill/substance abuse, and patients with behavioral problems, are appropriately evaluated, treated, and monitored in accordance with generally accepted professional standards.
- j. For patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.
- k. Ensure that staff receive adequate training to serve the needs of patients requiring specialized care.

Such training shall include:

1. competence in performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors;
2. the development and implementation of clear thresholds for behaviors or events that trigger referral for a behavioral assessment;
3. timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and

documentation of the team's review in the patient's record;

4. the development and implementation of protocols for collecting objective data on target and replacement behaviors; and
 5. assessments of each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.
- l. Ensure full participation by the patient in the treatment planning process.
 - m. Ensure that treatment plans address repeated admissions and adjust the plans accordingly to examine and address the factors that led to re-admission.
 - n. Ensure that treatment plans are consistently assessed for their efficacy and reviewed and revised when appropriate.
 - o. Ensure that the treatment planning process is guided by a multi-disciplinary team in which diverse professional expertise and observations are employed, in an inter-disciplinary process, to evaluate patients and develop treatment plans.

3. Medication Management and Monitoring

KCHC shall provide adequate psychiatric supports and services for the treatment of its patients, including medication management and monitoring of medication side-effects in accordance with generally accepted professional standards. More particularly, KCHC shall:

- a. Develop and implement policies and procedures requiring clinicians to document their analyses of the benefits and risks of chosen treatment interventions;
- b. Ensure that the treatment plans at KCHC include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, and possible side effects. KCHC should also reassess

the diagnosis in those cases that fail to respond to repeat drug trials.

- c. Ensure that all psychotropic medications are:
 1. prescribed in therapeutic amounts;
 2. tailored to each patient's individual symptoms;
 3. monitored for efficacy against clearly-identified target variables and time frames;
 4. modified based on clinical rationales; and
 5. properly documented.
- d. Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, KCHC shall:
 1. Develop, implement, and continually update a complete set of medication guidelines in accordance with generally accepted professional standards that address the indications, contraindications, screening procedures, dose requirements, and expected individual outcomes for all psychiatric medications in the formulary;
 2. Ensure that the pharmacological component of a treatment plan reflects the exercise of professional judgement for medication treatment including: diagnosis, target symptoms, risks and benefits of particular medications, and consideration of alternate treatments;
 3. Ensure that the rationale for each patient's course of treatment is included in the physician's progress notes;
 4. Ensure that psychotropic medications are used as an integral part of a treatment program to manage specific behaviors in the least restrictive manner, to eliminate targeted behaviors/symptoms, and to treat specific psychiatric disorders;
 5. Develop and implement a policy and procedure governing the use of PRN medications that includes requirements for specific identification of the

behaviors that result in PRN administration of medications, a time limit on PRN uses, a documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely, critical review of the patient's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;

6. Develop and implement a policy and procedure, in accordance with generally accepted professional standards, governing clinical justification of polypharmacy, which should include attention to the special risks associated with the use of benzodiazepines, anticholinergic agents, and conventional and atypical antipsychotic medications;
7. Ensure that all medications, in accordance with generally accepted professional standards, are being prescribed for their specific purpose and not solely for their secondary effects.
8. Adopt and incorporate the necessary protections and safeguards to ensure that patients are afforded safe and effective pharmacological treatment. To this end, KCHC shall, at a minimum, establish mechanisms to:
 - a. monitor practitioners' adherence to specific and current guidelines in the use of each medication;
 - b. report and analyze adverse drug reactions; and
 - c. report, analyze, and document actual and potential variations in the prescription, transcription, procurement/storage, dispensing and administration of medications.

C. Behavioral Management

KCHC should ensure the use of systematic behavior (social learning) strategies. To this end, KCHC should:

1. Ensure that behavioral plans, in accordance with generally accepted professional standards, contain certain basic elements, including:

- a. an analysis of the reasons for the behavior and its frequency and causes;
 - b. identification of specific interventions developed and implemented by trained staff in order to address and modify the behavior; and
 - c. full integration of the behavior plan into the patient's overall plan of care.
2. Ensure that close observation and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances -- i.e., when a patient poses an imminent risk of injury to himself or a third party -- any device or procedure that restricts, limits or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, time out procedures, and over-reliance on the use of close observation) should be used only after other less restrictive alternatives have been assessed and exhausted. To this end, KCHC should:
 3. Ensure that restraints:
 - a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;
 - b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;
 - c. Are not used as part of a behavioral intervention;
 - d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and
 - e. Are used in a reliably documented manner.
 4. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:
 - a. The range of restrictive alternatives available to staff and a clear definition of each; and

- b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.
 - c. Limitations on the use of four-point restraints and STAT emergency medications to address patient behaviors.
5. Ensure that if restraint is initiated, the patient is assessed within an appropriate period of time and an appropriately trained staff member makes a determination of the need for continued restraint.
6. Ensure that a physician's order for restraint includes:
 - a. The specific behaviors requiring the procedure;
 - b. The maximum duration of the order; and
 - c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.
7. Ensure that the patient's attending physician is promptly consulted regarding the restrictive intervention.
8. Ensure that at least every thirty minutes, patients in restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.
9. Ensure that immediately following a patient being placed in restraint, the patient's treatment team reviews the incident, and the attending physician documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, or psychosocial treatment.
10. Comply with 42 C.F.R. § 483.360(f) as to assessments by a physician or licensed medical professional of any resident placed in restraints.
11. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

12. Ensure that, with respect to the use of close observation:
 - a. Develop and implement a comprehensive policy and procedure that would restrict the use of close observation to only those situations where it is necessary to protect a patient from self-harm or harm to others;
 - b. Ensure that staff successfully complete competency-based training on the correct application of close observation.
 - c. Develop a quality improvement mechanism to monitor the use of close observation.
13. Ensure that KCHC will not transfer patients between psychiatric units in lieu of proper treatment. To this end, KCHC shall:
 - a. develop and implement a comprehensive policy and procedure that would limit the transfer of patients from one unit to another in lieu of proper treatment and require that all such transfers be approved centrally;
 - b. review and assess the necessity of all transfers with members of the treatment teams and the patient. In this review, the problem behaviors and effective and ineffective intervention strategies should be discussed and the efficacy of transfer be evaluated.

D. Medical and Nursing Care

KCHC shall provide medical and nursing services to its patients consistent with generally accepted professional standards. Such services shall result in KCHC patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, KCHC shall:

1. Ensure adequate clinical leadership to ensure that professional standards of practice are maintained.

2. Ensure that patients are provided adequate medical care in accordance with generally accepted professional standards.
3. Develop and implement appropriate policies and procedures, in accordance with general accepted professional standards, to ensure adequate medical and nursing assessments and monitoring.
4. Ensure that, before they work directly with patients, all nursing staff have successfully completed competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.
5. Ensure that nursing staff monitor, document, and report accurately and routinely, patients' symptoms and target variables in a manner that enables treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.
6. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.
7. Ensure that each patient's treatment plan identifies:
 - a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;
 - b. The related symptoms and target variables to be monitored by nursing and other unit staff; and
 - c. The frequency by which staff need to monitor such symptoms.
8. Establish an effective infection control program to prevent the spread of infections or communicable diseases.
9. Establish an effective emergency preparedness program, including appropriate staff training; staff awareness of emergency materials and their location; and conducting sufficient practice codes to be able to

perform in a competent fashion when confronted with an actual emergency.

10. Provide and maintain adequate medical documentation in accordance with generally accepted professional standards. Ensure that all clinical records are complete, accurately documented, readily accessible, and systematically organized.
11. Develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment, including adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program also should include a process for developing a corrective action plan and a process for monitoring the effectiveness of corrective measures that are taken.

E. Fire and Life Safety

In order to provide patients with the environmental safety and security that generally accepted professional standards require, KCHC shall, at a minimum:

1. Develop and implement adequate policies and procedures regarding fire prevention including emergency planning and drills.
2. Ensure that emergency drills are conducted on a regular basis.
3. Implement competency based testing for staff regarding fire/emergency procedures.
4. Ensure that emergency keys are appropriately marked, available, and consistently stored in a quickly accessible location.
5. Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.
6. Destroy any linens that cannot be sanitized sufficiently to kill any possible bacteria. Inspect and replace all worn linens as often as necessary.
7. Develop and implement policies and procedures for laundering, disinfecting, and appropriately storing patients' extra personal clothing until the patients' discharge.

8. Ensure that laundry is washed and dried at the proper temperatures and the laundry delivery procedures protect patients from exposure to contagious disease, bodily fluids, and pathogens by preventing clean laundry from coming into contact with dirty laundry or contaminated surfaces.
9. Develop and implement policies and procedures to ensure adequate cleaning of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and supervision, as well as establish daily cleaning requirements for toilets, showers, housing areas, and other areas accessible to patients.
10. Provide training for food service workers in the areas of food safety and food handling to reduce the risk of food contamination and food-borne illnesses.
11. Ensure that foods are served and maintained at proper temperatures.

F. Discharge Planning

KCHC shall actively pursue the appropriate discharge of patients and ensure that patients receive services in the most integrated, appropriate setting that is consistent with their needs. More particularly, KCHC shall:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:
 - a. The individual patient's symptoms of mental illness or psychiatric distress;
 - b. Any other barriers preventing that specific patient from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and
 - c. The patient's strengths, preferences, and personal goals.
2. Include in treatment interventions the development of skills necessary to live in the setting in which

the patient will be placed, and otherwise prepare the patient for his or her new living environment.

3. Provide the patient adequate assistance in transitioning to the new setting;
4. Ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.
5. Ensure that the patient is an active participant in the placement process.
6. Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services.
7. Ensure that appropriate steps are taken to provide continuity of care with appropriate community providers in order to prevent decompensation and reinstitutionalization.

G. KCHC Hospital Police Policies, Procedures and Practices⁴⁰

KCHC shall provide policing services that comport with the requirements of the United States Constitution and laws, as well as with generally accepted professional standards for hospital security services. To that end, KCHC should:

1. Develop a coherent, comprehensive, integrated set of Hospital Police policies and practices that provides clear guidance for officer conduct, including but not limited to policies to guide Hospital Police officers' interactions with psychiatric inpatients, and Hospital Police officers' use of force;
2. Develop a comprehensive training program, including adequate field training for new officers and adequate in-service training for all officers;
3. Develop comprehensive policies and procedures on

⁴⁰ This is a general list of remedies as a more specific assessment will be provided under separate cover.

supervisory oversight of line officers, including supervisory review of use of force and other incidents; and

4. Establish an adequate record management system whereby all incidents involving the Hospital Police, including but not limited to uses of force, as well as all other types of interactions with patients, are documented, recorded, assigned discrete control numbers, and investigated where appropriate.

V. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website.⁴¹ Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the City, HHC, and KCHC in an amicable and cooperative fashion to resolve our concerns expressed in this letter. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations -- which are not public documents -- under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue addressing the areas that require attention.

⁴¹ <http://www.usdoj.gov/crt/split/>

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA and § 14141 to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with the City and are confident that we will be able to do so. The DOJ lawyers assigned to this investigation will be contacting the City's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Tammie M. Gregg, Deputy Chief of the Civil Rights Division's Special Litigation Section, at (202) 616-2009, or Michael J. Goldberger, Chief of Civil Rights, Civil Division, in the United States Attorney's Office, Eastern District of New York, at (718) 254-6052.

Sincerely,

/s/ Benton J. Campbell

Benton J. Campbell
United States Attorney
Eastern District of New York

/s/ Loretta King

Loretta King
Acting Assistant Attorney
General

cc: Michael A. Cardozo, Esq.
Corporation Counsel

Alan D. Aviles
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December 7, 2009

Roosevelt Allen, Jr., Commissioner, 1st District
Gerry Scheub, Commissioner, 2nd District
Frances DuPey, Commissioner, 3rd District
Board of Commissioners
Lake County, Indiana
2293 North Main Street
Building A, 3rd Floor
Crown Point, Indiana 46307

RE: Investigation of the Lake County Jail

Dear Commissioners Allen, Scheub, and DuPey:

On September 12, 2008, we notified your office of our intention to investigate conditions at the Lake County Jail ("LCJ") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with CRIPA's requirements, we now write to report the current findings of our investigation and to recommend remedial measures needed to ensure that conditions at the LCJ meet federal constitutional requirements. See 42 U.S.C. § 1997b.

On December 15-17, 2008, the Department of Justice toured LCJ with correctional experts in the fields of suicide prevention and mental health care, medical care, and environmental conditions. These experts assisted us in reviewing records, interviewing staff, interviewing inmates, and inspecting facility living conditions. Before, during, and after our on-site inspection, we reviewed a large number of documents, including policies and procedures, incident reports, medical and mental health records, and other materials. During this investigation process, Lake County, Sheriff Roy Dominguez, and other LCJ officials cooperated fully with our review. We appreciate the assistance of Sheriff Dominguez and the LCJ staff and their level of professionalism and courtesy.

Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided a exit debriefing at the conclusion of our on-site inspection. During this debriefing, our experts provided their initial

impressions and tentative concerns. Some of the concerns we expressed during the exit debriefing regarded LCJ's dangerous and inadequate suicide prevention practices. We reiterated those concerns in a letter to Sheriff Dominguez dated January 7, 2009, regarding the urgent need to address suicide prevention measures.

We now write to advise you of the current overall findings of our investigation, the facts supporting them, and the minimum remedial measures that Lake County needs to take to address the deficiencies we identify. Pursuant to 42 U.S.C. § 1997b, we conclude that certain conditions at the LCJ violate the constitutional rights of inmates. We find that the LCJ engages in a pattern or practice of conduct that subjects inmates to systemic violations of federal constitutional rights, specifically in regard to: (1) suicide prevention, (2) mental health care, (3) the medical care, and (4) sanitary and safe living conditions.

I. BACKGROUND

A. FACILITY DESCRIPTION

The LCJ is located in Crown Point, Indiana, approximately twenty miles south of Gary, Indiana, and is operated by the Lake County Sheriff's Office.¹ The Chief Warden of the LCJ works for the Sheriff's Office's Corrections Division.² The LCJ houses adult male and female inmates who are felons, gross misdemeanants, misdemeanants, pre-trial detainees, juvenile offenders, witnesses, or others being detained in protective custody.³ The LCJ has an inmate capacity of approximately 1040,⁴ and employs approximately 179 sworn merit correctional officers and 26 civilian employees.⁵ During our December 2008 tour, the LCJ inmate population counted at approximately 1053. The LCJ comprised two buildings labeled the old and new jail and situated on five floors.

¹ <http://www.lakecountysheriff.com>.

² <http://www.lakecountysheriff.com>.

³ <http://www.lakecountysheriff.com>. Throughout this letter we use the term "inmates" to refer to those persons confined at the LCJ, regardless of status.

⁴ Lake County Jail Annual Report 2007.

⁵ Lake County Jail Annual Report 2007.

B. LEGAL FRAMEWORK

CRIPA authorizes the United States Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail inmates subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. The Fourteenth Amendment mandates that jails must provide pre-trial inmates “at least those constitutional rights . . . enjoyed by convicted prisoners,” including Eighth Amendment rights. Bell v. Wolfish, 441 U.S. 520, 545 (1979). Under the Eighth Amendment, prison officials have an affirmative duty to ensure that inmates receive adequate food, clothing, shelter, and medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994). The Constitution imposes a duty on jails to ensure an inmate’s safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dep’t of Soc. Servs., 489 U.S. 189, 199-200 (1989)). This duty includes the duty to prevent the unreasonable risk of serious harm, even if such harm has not yet occurred. See Helling v. McKinney, 509 U.S. 25, 33 (1993). Thus, jails must protect inmates not only from present and continuing harm, but also from future harm. Id. This protection extends to the risk of suicide and self-harm. See Matos v. O’Sullivan, 335 F.3d 553, 557 (7th Cir. 2003); Hall v. Ryan, 957 F.2d 402, 406 (7th Cir. 1992) (noting that prisoners have a constitutional right “to be protected from self-destructive tendencies,” including suicide).

The Constitution also mandates that jails provide inmates adequate medical and mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832. Prison officials violate inmates’ constitutional rights when the officials exhibit deliberate indifference to inmates’ serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 102 (1976).

Jails must provide “reasonably sanitary and safe” living conditions. Farmer 511 U.S. at 832. The Constitution requires jails to ensure that environmental conditions do not pose serious risks to inmates’ health and safety, such as deficient sanitation, inadequate fire safety, inadequate ventilation, and pest infestation. Vinning-El v. Long, 482 F.3d 923, 924-25 (7th Cir. 2007).

II. FINDINGS

A. SUICIDE PREVENTION

The Constitution requires the LCJ to protect inmates from suicide and self harm. See, e.g., Hall, 957 F.2d at 406. This constitutional requirement mandates adequate suicide prevention measures, including appropriate screening by a qualified mental health professional to assess suicide risk, appropriate supervision,

observation, and monitoring of those inmates identified as at risk of suicide, appropriate communication between correctional health care and correctional staff, and appropriate multi-disciplinary treatment plans. The suicide prevention and management process at the LCJ is grossly inadequate.

Staff we interviewed reported that there have been seven completed suicides in the past four years. Five completed suicides occurred in the past two years, a rate which is more than five times the national average.⁶ As we explain in further detail below, the LCJ lacks the appropriate structure, staff, and training to adequately protect inmates at risk of self-harm.

At intake, unqualified non-mental health clinicians conduct suicide screenings. These screenings fail to provide any estimate of risk of self-harm or to document any management plans. Screenings are not reviewed by a licensed and credentialed mental health professional for quality and timeliness. Moreover, access to appropriate mental health professionals is poor, as is communication between correctional and mental health staff. The following example highlights inadequate and contradictory initial suicide risk assessments, inadequate psychotropic medication management, inadequate treatment and overall attention from mental health staff, and inadequate mental status exams and suicide reassessments:

- On February 27, 2008, the LCJ conducted an initial suicide risk assessment of inmate A.A.,⁷ with contradictory findings. One portion indicated no past psychiatric history (medication or treatment) and no previous suicide attempts, while other portions simultaneously listed three current psychotropic medication prescriptions, and described his medical complications as “bipolar/depression.” The assessment found “no need for mental health treatment indicated at this time.” Thus, the inmate was not provided with a psychiatric assessment or psychotropic medications.

Unqualified staff made a similarly flawed second, March 10, 2008, suicide risk assessment, again indicating no current or past psychotropic medications, and no treatment history. Compared to the

⁶ The national average suicide rate in jails in the United States is 0.47 suicides per 1000 inmates per year. Thus for the LCJ's average inmate population of 1000, 7 suicides in 4 years equals an average of 1.75 suicides per year, and 5 suicides in 2 years equals an average of 2.5 suicides per year.

⁷ To protect inmates' privacy, we have used fictional inmate initials.

first assessment, the March assessment changed medical complications to “none/unable to confirm anxiety with doctor.” Again, the second assessment found “no need for mental health treatment indicated at this time.” Contradicting this assessment, however, a medical screen conducted the same day indicated that A.A. had been admitted to the LCJ previously in 2005 and 2007, had been taking psychotropic medications, and the LCJ had previously treated him for “depression/anger.”

A.A. was not seen by a psychiatrist until March 18, 2008, nearly three weeks after his admission. The psychiatrist’s assessment described a bipolar disorder for the past six years, listed a history of several psychotropic medications, and a history of suicidal ideation/attempt, including an incident where the inmate cut his wrists related to family issues a few months earlier in December 2007. The psychiatrist ordered psychotropic medications and a return to the clinic in four weeks. Thus, the record shows that the inmate was not seen by a qualified mental health professional or given psychotropic medications until at least three weeks after his admission.

The inmate’s record indicates that, throughout April 2008, the inmate made multiple requests for counseling regarding changing his medications (because he was only sleeping two to three hours a night), and made several suicidal statements, which staff assessed as ploys to get out of his present unit. In one suicidal note, the inmate concludes with “last night when everybody was sleeping I tried to hang myself but my string broke. Tonight I’m going to try with my blanket. I will succeed.”

On April 29, 2008, a counselor put the inmate on full suicide precautions. The inmate’s record reveals that two days later, on May 1, 2008, the psychiatrist performed a cursory assessment, concluding that the inmate was on medication, was not depressed, did not have suicidal ideation, but had a history of suicidal ideation/attempt. Based on this cursory assessment, the psychiatrist took the inmate off suicide precautions and returned him to general population. Three days later, on May 5, 2008, the inmate hanged himself in his cell.

If the LCJ identifies an inmate at intake as possibly representing a suicidal or self-harm risk, staff may place the inmate on “full suicide,” which requires an LCJ correctional officer to monitor the inmate. Because a physician or qualified mental health professional often does not review this designation, it results in the LCJ placing many inmates on suicide watch who do not require that level of

supervision, which places an unreasonable demand on LCJ staff to supervise a large number of inmates. The LCJ monitors inmates on suicide watch with staff making visual checks every 15 minutes or by remote video camera. The LCJ fails to adequately monitor inmates with both these systems.

Regarding the visual 15 minute checks, LCJ custody staff should be making these checks at least every 15 minutes and noting the check on the inmate's suicide check log. We observed that staff failed to make these checks every 15 minutes, yet they would inaccurately record on the inmate's suicide check log that such checks were completed every 15 minutes. We also reviewed log sheets with multiple blanks and log sheets with single signatures purporting to cover several 15 minute periods. One inmate, B.B., reported that staff failed to check on her every 15 minutes, but rather would "take the sheet with them."

We also found inadequate LCJ's camera supervision. We observed one correctional officer attempt to monitor up to 18 cameras at any given time from a control office where that officer had multiple, additional responsibilities. The example below highlights the deadly consequences of the LCJ's failure to properly monitor its cameras:

- Shortly after his arrest in September 2006, C.C. committed suicide by hanging himself with his T-shirt in an LCJ intake cell. The EMTs who initially assessed C.C. stated that C.C. told them that he suffered from anxiety and depression, and was currently taking Xanax. Our review of the LCJ camera video of the intake cell shows C.C. tying his T-shirt into a ligature and securing the T-shirt ligature around his neck and a bathroom stall. The video further shows C.C. hanging from the bathroom stall for approximately eighteen minutes before LCJ staff discovered him. The video further reveals that staff let another inmate out of the holding cell - after C.C. had already been hanging for approximately eight minutes - and still did not discover C.C. hanging from the stall for an additional nine minutes.

As detailed below, we note that even after this tragic incident, the LCJ has not rectified its substandard monitoring of inmates at risk of suicide. Beyond the obvious failure to monitor surveillance cameras, this example further highlights that the LCJ needs to assess an inmate's suicide risk with a qualified mental health professional. A qualified mental health professional might have placed the recently arrested inmate, who indicated that he took Xanax and suffered from anxiety and depression, on suicide precautions.

In addition to the alarming number of recent past suicides, we found that the inadequate suicide management processes and inherently dangerous care of

inmates with a risk of suicide continues at the LCJ. The following examples show that, like the completed suicide examples above, the LCJ continues to ignore inmates on full suicide watch and fails to properly assess inmates with suicidal ideation:

- During our December 2008 tour, we observed medical, mental health, and custody staff ignore inmate D.D., who was screaming for assistance while on “full suicide” camera watch. Additionally, this inmate had just been discharged from a hospital the previous day. When a counselor eventually visited the inmate, and alerted both the Director of Nursing and the mental health manager, the staff still did not promptly assess the inmate for her mental health needs and suicide potential. Instead, staff responded that the psychiatrist, who happened to be at the LCJ for one of the psychiatrist’s two four-hour shifts per week, would eventually see the inmate. Beyond this potentially harmful delay, this procedure fails to account for who would see inmates in obvious acute distress if the psychiatrist happened to not be on site that day.
- In November 2008, a correctional officer found E.E. standing on a toilet stating that he wanted to kill himself. The correctional officer called a mental health counselor, who after speaking only with the correctional officer, agreed that the inmate was “just kidding.” The counselor conducted no face-to-face assessment and completed no suicide risk assessment form.

The LCJ’s inadequate medication administration, further detailed in the medical section below, also increases the danger to inmates at risk of suicide. The LCJ’s medication administration system improperly gives inmates all of their medications for the day at a single time, expecting inmates to self-administer their medication throughout the day. This inherently dangerous practice provides inmates with medications to be taken at whatever time the inmate chooses, and allows the inmate to hoard, trade, or overdose their medications. The LCJ does administer medications to a few inmates on a “split and watch,” basis, where the nurse splits the inmate’s daily medication, and watches the inmate take a morning dose and an evening dose, however this practice is inconsistent.

While the documents LCJ produced did not identify suicide attempts related to inadequate medication management practices, our interviews with inmates and staff revealed that inmates have attempted to overdose on their medications and possibly the medications of other inmates, and that the clinical staff and custody staff routinely fail to watch inmates take their medications, placing those at risk of suicide in significant peril. We found many dangerous examples, including:

- Inmate F.F. reported that he was in the mental health crisis unit because he attempted to kill himself by overdose on numerous psychotropic medications in December 2008. Despite his record indicating that he previously attempted suicide by overdose in 2004, and that he indicated “yes” on his suicide screening to a past history of attempted suicide, LCJ’s self-administration practice allowed him to hoard his medications and attempt suicide. This inmate told us “I stored it up, took it all - tried to kill myself.”
- The LCJ gives G.G. all his medications once a day to take as he chooses, despite his self-reported suicidal ideation and being placed on suicide watch.
- Inmate H.H. reported that LCJ gives him five different psychotropic medications, to self-administer throughout the day. LCJ has given him as much as 1300 mgs of Haldol at a single time, a potentially lethal amount if ingested all at once.⁸ His medication administration record shows nursing initials that inaccurately indicate that nurses personally administer his medication twice a day.
- Inmate J.J. attempted to hang himself approximately two months before our visit. Despite this suicide attempt, his counselor sees him only once a month, and the LCJ gives him psychotropic medications to self-administer throughout the day.
- Inmate K.K. reported that she has a chemical dependency problem and had just attempted suicide in August 2008. She stated that a counselor does not see her on a regular basis and that she did not see a counselor until two weeks after her admission. Despite her suicide attempt and a self-reported chemical dependency problem, LCJ gives her psychotropic and other medications to self-administer.

In addition to the risk of self-overdose, this practice allows inmates to take dangerous medications without a prescription. One inmate confirmed that he saves his psychotropic medications and makes them available to other inmates.

⁸ The maximum dose of Haldol is 100 mgs per day, but prescriptions over 60 mgs per day are extremely rare, and appropriate only in a hospital setting. Overdose dangers include seizures, respiratory depression, and possibly death.

Overall, the LCJ's suicide prevention and management processes fail to properly screen and assess inmates, and fails to adequately monitor and treat inmates with suicide risks.

B. MENTAL HEALTH CARE

The Constitution requires LCJ to provide inmates adequate mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832. Our investigation revealed that the LCJ's mental health care and suicide prevention practices fall below the minimum constitutionally required standards of care. Particularly, we found the LCJ's mental health care services were constitutionally deficient in the following areas: (1) staffing; (2) intake and referral process; (3) sick call process; (4) treatment planning and services; (5) medication management; and (6) quality improvement and quality management program. These deficient LCJ practices cause inmate harm and create an unreasonable risk of harm.

1. Inadequate Staffing

We found that the LCJ employs an inadequate number of staff to provide inmates with a constitutionally adequate mental health program. At the time of our tour, the LCJ employed the full time equivalent ("FTE") of 3.2 mental health staff, comprised of 3 mental health counselors and 0.2 (i.e., 8 hours per week) of a psychiatrist's services.⁹ This allocation of staffing is inadequate for LCJ's average daily population of approximately 1,000 inmates, and an intake service that processes 15,000 intakes per year. For its population, the LCJ needs at least 7-10 mental health counselors and 1.5-2.0 FTEs in psychiatry.

Under-staffing currently limits the LCJ to a response-oriented, crisis management mental health program, rather than the preventive program that the Constitution requires. This under-staffing causes gaps in care, for example:

- Inmate H.H. reported that he currently was taking five different psychotropic medications, but that he had not seen the psychiatrist in three months.
- Inmate L.L., a juvenile, reported that he has only seen a counselor "three or four times" despite being incarcerated at the LCJ for the previous seven months. Mental health staff should have counseled

⁹ We also note that the LCJ was unable to produce credentialing records for its counselors and psychiatrists.

this juvenile inmate at least monthly, according to LCJ policy and the generally accepted professional standard.

- Inmate J.J., reported that he had attempted to hang himself in the last four months, has Bipolar disorder, and currently was taking two different psychotropic medications. Despite these special needs, the counselor sees him only once a month, and the psychiatrist does not regularly see him to monitor his medication compliance or his symptoms of mental illness.

Compared to LCJ's crisis response-oriented program, an adequate proactive mental health program includes comprehensive assessments, psychosocial evaluations, multi-disciplinary treatment planning, individual and group therapies, and services specific to special need inmates, such as juveniles and women.

2. Inadequate Intake and Referral Process

EMTs and psychology technicians perform the intake mental health screenings and evaluations. These intake functions should be performed by qualified mental health staff. Consequently, the LCJ appears to fail to identify many inmates who need mental health services. The LCJ identifies 14% of inmates as needing mental health services, but the national average for its population is 18-30%.

In addition, the staff who do perform the screenings fail to adequately complete them. Staff take these screenings at booking, usually in a non-confidential setting. This process conflicts with professional standards that require confidential mental health evaluations to be completed after the inmate has been in jail for up to 14 days. Further, no qualified mental health staff review the screenings for adequacy. These flawed screening evaluations hurt the adequacy of the referral process, which is based on these evaluations.

Referrals between mental health and medical staff suffer serious communication problems. Our interviews revealed that both groups expect the other group to perform direct patient assessment and care duties, for which both groups should take responsibility. For example, as detailed above, we witnessed medical staff ignore a screaming inmate who was clearly in distress and on suicide camera watch because they claimed the inmate had a "mental health" problem, and mental health staff ignored this inmate because the inmate had a "medication problem." Custody staff monitoring the camera called for neither medical nor mental health staff. These types of collaboration and communication failures can cause serious injury or death.

3. Inadequate Sick Call Process

The LCJ sick call process is not consistent with generally accepted correctional standards of triaging and responding to sick call requests within 24 hours. Contrary to this 24-hour standard, documents we reviewed showed that the LCJ's sick call process envisioned that medical staff should respond to sick call card requests within 48 hours. We found that the process relies on custody staff giving inmates sick call cards upon request, custody staff delivering these cards to a central location, nursing staff triaging the sick call cards and then providing them to mental health staff. While documents envisioned the completion of this process within 48 hours, an LCJ audit revealed that the delay in medical receiving sick call requests ranged from 72 hours to several days. Moreover, this delay simply marked the receipt of the sick call card and did not consider the additional delay of actually responding to the sick call request. Therefore, this process allows for harmful extended treatment delays for inmates in serious crisis and in need of emergency or urgent evaluation. Further, the LCJ does not track whether responses are as prompt as necessary, addressed by the appropriate provider, or resulted in a reasonable outcome such as modification or assignment of services or treatment.

The flawed intake and referral process described above compounds this problematic sick call process, because the flawed intake and referrals leave inmates with only this flawed sick call process to alert staff to their needs.

4. Inadequate Treatment Planning and Services

Generally accepted correctional standards require that the LCJ develop and use comprehensive multi-disciplinary treatment plans and services. Documents and interviews with staff and inmates revealed that the LCJ violates this standard by having no treatment plans, other than an initial treatment plan that the psychiatrist may author for the few individuals that he may see during the eight hours per week that he works at the LCJ. We found no comprehensive treatment planning process, no scheduled treatment planning conferences, and no special needs treatment plans for juveniles. Policies and procedures fail to require: (1) that a treatment plan begin as an initial plan when the mental health clinician first sees the inmate; (2) the completion of a more comprehensive treatment plan within 10-14 days of admission; and (3) the periodic reevaluation of treatment plans for those inmates residing at the LCJ for extended periods.

A multi-disciplinary comprehensive treatment model includes mental health, medical, and nursing staff because of the essential roles that they play in the treatment and management of inmates in a correctional environment. Compared to this multi-disciplinary comprehensive model, the LCJ's current practice is for counselors to write a "Diagnostic Formulation," without a qualified mental health

staff completing a mental health evaluation, and without the psychiatrist writing a progress note/medication review. Medical records that we reviewed contained no problem list to allow a reader to easily ascertain for what a specific inmate is being treated, including mental health problems, such as Schizophrenia or Depression, but also medical problems such as asthma, diabetes, or hypertension. Examples of inmates with inadequate treatment plans include:

- Inmate M.M., who had been at LCJ for four months, reported that he had been taking psychotropic medications for approximately the previous nine years, and received residential treatment for approximately the last two years. LCJ's mental health suicide risk assessment and psychiatric screening of this inmate list "no" as answers to medications before admission and a past history of treatment. The medical history and screening listed similar "no" answers, and failed to refer him to the mental health department. After approximately three months, a mental health professional completed a Diagnostic Formulation. The LCJ eventually diagnosed him with Schizophrenia, and put him on suicide precautions. LCJ discontinued his suicide precautions with no indication that a physician interviewed the inmate in-person. The record contained no evidence of a long or short-term treatment plan, with the only treatment references dealing with medications and placement on suicide precautions when the inmate was in a crisis.
- We interviewed inmate G.G. on the mental health crisis unit. He reported that LCJ placed him on the crisis unit for the previous 15 days because he had stated he was suicidal. His record indicated that back in April 2008 he answered "yes" on his suicide risk assessment, but that no one referred him to mental health staff. Eventually, a nurse practitioner saw him a month later. A November 2008 psychiatric note was illegible, and therefore unhelpful in determining what treatment LCJ provided to this inmate. This inmate's record contained no comprehensive treatment planning or discussion of his needs.
- Inmate N.N.'s record indicated he entered the LCJ on December 11, 2007, with an incomplete suicide screening and no mental health evaluation. On December 22, 2007, a progress note labeled him as a "full suicide" risk. His medication records indicated orders for Paxil and Trazodone in January, June, July, and September 2008, without a psychiatrist ever seeing him. His record contained no evidence of a comprehensive or multi-disciplinary treatment plan.

Regarding actual treatment services, the LCJ improperly delegates most services to the nursing staff, including medication management, the “split and watch” process for administration of medication, the writing of “full suicide” designations for inmates, and the discontinuation of medications if nursing staff believes that an inmate may be hoarding medication. The mental health staff conduct limited psychosocial “contact” or “rounds,” but they fail to give any form of individual therapy or group therapy, despite the policies and procedures that state that the LCJ will provide group therapy, individual therapy, and psychosocial interventions.

5. Inadequate Medication Management

As described above with regard to the management of potentially suicidal inmates and also detailed in the medical care section below, the LCJ practices seriously flawed and dangerous medication management, including nurses improperly writing and discontinuing medical orders and inadequate security controls.

6. Inadequate Quality Improvement and Quality Management Program

Generally accepted correctional mental health standards call for adequate quality assurance review and quality improvement tools. These tools are necessary to examine the effectiveness of the mental health care delivered and to implement corrective action so that the quality of care is improved.

The LCJ poorly manages its existing Continuous Quality Improvement (“CQI”) process. While the quality improvement committee’s membership includes the mental health manager, no psychiatrist or licensed independent mental health professional sits on the committee. Moreover, our review of the minutes of meetings revealed that the committee meets only quarterly, that even these meetings do not consistently take place as scheduled, and that the discussion topics primarily deal with medical issues, rather a balance between medical and mental health issues. This quality improvement committee does not produce meaningful corrective action plans, nor does it assign these action plans to specific personnel with a requirement to report and document plan implementation.

Specifically related to mental health issues, the LCJ does not meaningfully measure, follow, or document the quality or timeliness of important mental health processes such as assessments, suicide prevention evaluations, suicide management, treatment planning, medication management, and treatment services. The LCJ needs to completely revise its quality improvement and quality management program.

C. MEDICAL CARE

The Constitution requires that LCJ provide adequate medical care to address inmates' serious medical needs. Farmer, 511 U.S. at 832; Estelle, 429 U.S. at 102. The LCJ must employ functional systems to provide adequate medical care and treatment to its inmates, particularly in a jail the size of LCJ. These systems should include an initial screening process, a comprehensive health assessment for longer-term inmates, a sick call process, acute and chronic care clinics, infection control mechanisms, medical record keeping, medication administration, qualified medical staff, a professional management structure, and a quality assurance component to evaluate and improve the above systems. Our investigation revealed that the LCJ's medical care practices fall below the minimum constitutionally required standards of care. Particularly, we found constitutionally inadequate LCJ's: (1) medical staffing; (2) access to medical care; (3) acute and chronic medical care; (4) comprehensive health assessments; (5) medication administration; (6) medical records; and (7) quality improvement. These deficient practices cause inmate harm and create an unreasonable risk of harm.

1. Inadequate Medical Staffing and Organization

Medical care at LCJ is disorganized and understaffed. Consequently, the LCJ inadequately trains and supervises the clinical staff. Many of the issues relating to the LCJ's inadequate medical care discussed below derive from this poor organizational structure, low level of professional staffing, and lack of professional health care oversight of clinical employees and contractors.

LCJ provides medical care for its inmates through several personnel each reporting to separate entities: EMTs who report to Lake County; psychology technicians, nurses, dentists, and physicians who report to a contractor; and counselors and psychiatrists who report to a different contractor. In January, the LCJ planned to move the EMTs onto the Med Staff contract. The aforementioned providers engage in little formal communication, and each provider reported through a different deputy warden. None of these wardens had any health care administration experience.

The above chaotic health care structure results in inadequate supervision of the system's health care providers. Outside of non-health care related administrative functions such as patient counts, the LCJ does not monitor the performance of any clinical activities. The director of nursing does not supervise the EMTs, who are responsible for intake screening, and these EMTs receive little training and supervision. The mental health staff do not supervise the psychology technicians, and these technicians receive little training and supervision. We found no lesson plan for training and supervision of the EMTs and psychology technicians.

A physician does not formally supervise the nurse practitioner. Furthermore, the LCJ does not provide inmates a copy of the inmate handbook, and has established a co-payment system at least double that of a typical similar sized jail.

The current number of LCJ staff cannot accomplish the critical clinical and administrative objectives of an adequate health care system. LCJ has only 1 to 5 hours of physician time per week, 2 hours of dentist time, and 1.2 FTE nurse practitioners. Similar sized facilities employ at least 2 FTE licensed independent practitioners and a full-time dentist. At the time of our tour, the LCJ had failed to fill a nurse practitioner vacancy for more than a year.

Insufficient dentist time inappropriately limits dental care to prescription for antibiotics and extractions. Similarly deficient, the infectious disease physician visits the LCJ for only two hours, two to four times per month.

In sum, poor organization, the absence of communication between disparate health care providers, the lack of appropriate supervision of clinical staff, and overall inadequate staffing contribute substantially to the LCJ's inadequate medical care practices.

2. Inadequate Access to Medical Care

We found that the LCJ provides inmates constitutionally inadequate access to medical care. As detailed below, we found problems with medical screenings and sick call, poor training, long waits for medical attention, infection control, high co-payments, confidentiality, and poor and non-existent documentation

Inmates' access to medical care through screening and sick call requests is inadequate. As stated above, untrained and unsupervised EMTs conduct the initial screening of inmates. Once booked, inmates' only access to medical care comes through sick call requests. The mental health section above detailed the overall flaws with access to, processing, and tracking of sick call slips. Particular to medical care, we further note that a health care clinician only sees inmates once per week. This sick call process falls well below nationally-accepted standards of correctional care.

Consequently, this wait for medical care violates constitutional minimums, leaving significant inmate medical needs inadequately addressed or completely unmet. For example, inmates wait approximately eight weeks for dental care. This wait is significantly too long, particularly for urgent problems such as abscesses and pain. From our records review, we found that several inmates had up to a four-day lag for care for skin abscesses and received no follow-up care. In another instance, an inmate acquired a skin infection in LCJ and waited five days for medical staff to

see him. The LCJ never provided follow-up care to several other inmates with skin wounds. Another inmate had a lump that the LCJ never addressed. Still another inmate suffered a two-month lag for care of symptoms suggesting a sexually transmitted disease. In all these cases, the LCJ provided substandard and poorly documented care.

With regard to the care and treatment of skin infections, the LCJ fails to maintain any logs. This absence of logs makes it impossible to track the incidences of skin infections within the LCJ to appropriately monitor the frequency and prevalence of such infections. Additionally, the LCJ fails to take the vital signs of the inmates it monitors for potentially life-threatening withdrawal from alcohol or other substances.

Nurses do not adequately review inmates whom staff electrically shock with TASERs during use of force incidents. We reviewed the use of TASER force on ten inmates over a three month period. Nursing evaluations were missing in five of those records and the LCJ could not find two of the records. Furthermore, the LCJ knew that seven of the ten inmates had mental illnesses, but their records contained little information regarding their mental illness or mental health interventions. We found that the LCJ could have possibly avoided at least six of these use of force incidents if the LCJ had adequately evaluated these inmates for mental health issues.

The LCJ's medical record progress notes from sick calls are poor or non-existent. When we showed the director of nursing the progress notes for eight inmates seen by the nurse practitioner, the director of nursing found the notes illegible. Medical records for several inmates contained no progress reports or documented examination at all. Regarding primary physicians, we reviewed numerous medical records of inmates scheduled for sick call. Over half of these records contained no progress note, and the LCJ's unacceptably high no-show rate of over fifty-percent makes it likely a physician never saw these inmates. Furthermore, the inmates were not seen within seven days following the scheduled visit. Finally, we found that the physician interviewed several patients with significant health care needs such as HIV infection and/or viral hepatitis, but the physician failed to document findings in the medical records. This lack of documentation made it impossible to evaluate access to or quality of care for these inmates. We did note several inadequate infection control practices dangerous to the health and safety of both staff and inmates. For example, the examination room in the booking area contained unsecured hazardous waste, chemicals, and sharps. Medications laid unsecured in the clinic area. Many of the mattresses in the housing units were cracked, making them impossible to disinfect.

LCJ's co-payment system departs from minimally accepted correctional standards. LCJ's co-payment is at least double that of a typical similar sized jail. These high co-payments along with the lack of adequate waivers in specialized circumstances bar inmates' access to care. Jails similar to LCJ typically waive co-payments for communicable disease (such as skin infections), chronic disease care, comprehensive health assessments, and pregnancy care. LCJ does not waive these co-payments. Several inmates indicated that these high co-payments barred their access to care. Thus, this non-waiver and high co-payment system forces inmates to go without necessary care for serious medical problems. Moreover, in the case of communicable diseases, not only does this system harm the inmate, but it also puts the general public at risk of harm.

Finally, inmates are often interviewed in the clinic areas in the presence of, or within earshot of, correctional officers, thus compromising inmates' privacy and ability to communicate their medical needs.

3. Inadequate Acute and Chronic Medical Care

LCJ fails to provide inmates constitutionally adequate acute and chronic medical care. Regarding inadequate acute care, LCJ records revealed several instances of jail-acquired skin infections. Jails should provide inmates with skin infections daily documented wound care and regular follow-ups by a physician or mid-level practitioner. The LCJ diagnosed and treated the majority of these infected inmates without a physician evaluation or physician order for the antibiotic prescribed. The LCJ's documentation of wound care and physician follow-up was nearly absent.

We noted a startling case of an inmate, O.O., with a history of prostate disease who had difficulty urinating without medication. He waited three days until a physician saw him, even when nursing staff had already catheterized him on at least two occasions. Proper medication, which was never ordered, could have prevented this unnecessary catheterization. Further, the inmate, who was withdrawing from alcohol, is another example of the LCJ's failure to document vital signs during withdrawal. Moreover, we reviewed the charts of ten inmates whom the LCJ had treated for withdrawal from alcohol or other substances and only two records showed documented vital signs and appropriate treatment for the withdrawal.

We also reviewed the medical record of an inmate, P.P., diagnosed with syphilis, based upon a test that indicated an old infection or, alternatively, liver disease. The LCJ improperly gave him three unnecessary intramuscular injections as if he had acute syphilis. Furthermore, the clinical staff never checked with the county health department's database for his history of treatment.

Regarding chronic care, LCJ fails to follow generally accepted correctional care practices for treating chronic illnesses, which causes inadequate care for inmates' chronic conditions. LCJ has no system to track and monitor inmates with chronic care conditions nor a chronic care clinic to adequately manage inmates needing chronic care treatment and follow-up. From our record reviews and interviews, we discovered that the LCJ failed to give inmates with asthma a comprehensive health assessment, even though these inmates had stayed in the LCJ for more than 30 days, nor had the LCJ appropriately measured or monitored their condition. Another inmate with known hypothyroidism, Q.Q., did not receive a comprehensive health assessment and had no prescription for life-sustaining thyroid medication. The LCJ also fails to adequately monitor inmates with diabetes. Of the records we examined of inmates with diabetes, the LCJ had measured the hemoglobin of only 67% within the past 3 months and measured the cholesterol of only 58% within the past 12 months. Furthermore, only 1 inmate had any documentation of a urinary measurement within the past 12 months. These practices fall well below generally accepted minimal standards for correctional care for diabetes. For inmates with seizure disorders, despite inmates reporting medication at booking, the LCJ failed to place these inmates on seizure medications, and their records showed no clinical documentation justifying the discontinuation of these medications. Medical records for inmates with HIV and viral hepatitis C had no progress notes, which prevents other clinical staff from coordinating or providing continuity of care or from evaluating the inmate's care.

4. Inadequate Comprehensive Health Assessment

The LCJ fails to perform comprehensive health assessments that generally accepted correctional practices require. Longer term inmates require a more comprehensive health assessment in addition to the screening at booking. The generally accepted profession standard of care in jails is for a jail to conduct a physical examination, including a comprehensive medical history, within 14 days of booking. Longer-term juveniles also should have immunization records.

We reviewed the medical records of 33 inmates in custody beyond fourteen days. None of the 33 inmates had a comprehensive health care assessment. As noted above, this lack of a health assessment can have increased harmful risks for inmates with acute or chronic illnesses. We also evaluated the records of all of the juveniles at the LCJ; none had a comprehensive health assessment, immunization record, or mental health evaluation.

5. Inadequate Medication Administration

The LCJ practices seriously flawed and dangerous medication management. The LCJ's medication administration staff engage in several inappropriate

medication administration practices, including inappropriate nursing decisions and inadequate security controls.

Interviews and the LCJ's medical records revealed that nurses practice beyond the scope of their licenses by improperly writing and discontinuing medical orders without specific direction from a physician. Regarding improperly writing orders, the LCJ has standing orders authorizing nurses to diagnose illnesses, and to prescribe and administer non-emergency medications without a physician's order. These standing orders authorize nurses to record administration of these medications as "T.O. [telephone order] Dr. Pierce/nurse's name." These practices go well beyond the scope of a nurse's license and misrepresent that the administration of the medications was pursuant to a direct and individualized telephone order.

Regarding discontinuation of medication, nursing staff automatically stop medications, without a physician's order, for patients who do not adhere to their prescriptions. Rather than automatically stopping the medications, generally accepted correctional standards counsel that any patient who does not follow his or her prescription regimen should be counseled and asked to sign a refusal form for medications missed on three consecutive days and should be reported to the prescribing physician. Again, these nurses falsely designate these orders "as per physician" because LCJ policy requires that they write that designation on the order.

This practice obviously puts inmates at risk of harm from ill-advised medical orders. We found many examples where nurses improperly discontinued medications, not for medical reasons, but because the nurse thought an inmate was hoarding medication. For example:

- Inmate R.R.'s record indicated a history of suicide watch, diagnosis of Schizophrenia, and a prescription for a psychotropic medication. His record showed that a nurse unilaterally discontinued his medication as "per Dr. Robbins," based on finding 14 tablets of the psychotropic medication hoarded in his cell. This inmate's record failed to document any psychiatrist involvement in the discontinuation of his medication or any psychiatric progress note describing any assessment or treatment of his suicide risk.

Beyond nurses practicing outside their licenses, we found medication security problems. The medication room was unsecured. Staff leave the room unlocked, giving inmates access to drugs and sharps. Medications laid loose in a box on the floor of the nursing stations. We note that these loose medications included controlled substances, a particularly dangerous substandard practice. Staff also inappropriately used the medication refrigerator to store food.

We also reiterate that, as explained in the suicide prevention section above, LCJ generally administers medications only once per day. This practice encourages hoarding and diversion of medications. The staff also inaccurately document that they have directly observed inmates taking these medications throughout the day.

Finally, LCJ lacks a Pharmacy and Therapeutics Committee or a process to determine whether certain types of medications may be appropriately prescribed at LCJ. This process would correct the conflicts we noted between the medical director and the corporate administrator of Med Staff over the use of particular drugs prescribed by the medical director.

6. Inadequate Medical Records

Medical records are disorganized and lack essential information. At the time of our visit, LCJ had a two to three-month lag in filing medication administration records. The psychiatrist and nurse practitioner wrote illegible notes, making their clinical notes unhelpful. The infectious disease physician did not document his clinical encounters in the records at all. Furthermore, staff did not organize notes in any coherent fashion, such as the standard format of Subjective information, Objective information, an Assessment, and a Plan ("SOAP"). The records also did not contain an index sheet, which medical professionals generally refer to as a problem list. As stated earlier, because LCJ fails to provide a sufficient number of sick call forms for the inmates, inmates use scraps of paper that staff often randomly staple into the medical records. These scraps are often undated and contain no indication of when they were reviewed or of the clinical disposition. Finally, we reviewed over 150 medical records and never encountered a single record with a plan of care for an inmate with special needs (e.g., inmates with chronic conditions, acute illnesses, infectious diseases and/or skin conditions, etc).

7. Inadequate Quality Improvement

As noted above in the mental health section, the LCJ's quality improvement program is poor. While the LCJ has begun quarterly quality management meetings, the LCJ has no quality management plan and has no set performance measures regarding access and quality of medical care. The Department of Health conducts quarterly reviews of ten medical records; these reviews have found problems similar to the aforementioned lack of comprehensive health assessments, chronic care clinics, and insufficient psychiatric attention.

D. FIRE SAFETY AND SANITATION

The Constitution grants inmates the right to reasonably sanitary and safe living conditions. Farmer 511 U.S. at 832; Vinning-El, 482 F.3d at 924-25. Our

investigation revealed that the LCJ's fire safety and sanitation programs fall below the minimum constitutionally required standards of care. Particularly, we found constitutionally inadequate the LCJ's: (1) fire safety; (2) housing and maintenance; (3) housekeeping; (4) laundry service; and (5) food service. These deficient practices cause inmate harm and create an unreasonable risk of harm.

1. Inadequate Fire Safety

Inadequate fire safety at LCJ presents a grave risk of harm from smoke, fire, and the serious security concerns that arise during an emergency. We found no active fire safety program at the LCJ. The LCJ could not produce any fire drill logs. As detailed in the inadequate laundry service section below, we observed fire extinguishers in the laundry building that no one had inspected for at least ten years. For other LCJ areas, fire extinguisher inspections were spotty and inconsistent. We witnessed an automated cell block locking mechanism fail to work, which demonstrates that the LCJ needs to have pre-prepared reliable alternate life safety measures when these normal procedures fail. Thus, LCJ staff need readily accessible emergency keys that, according to fire codes, staff can easily identify by both sight and touch. The set of emergency keys we observed were not marked for identification by touch.

2. Inadequate Housing and Maintenance

Maintenance problems permeated throughout the housing units and covered a wide range of deficiencies. We observed that shower walls and ceilings were in poor repair, shower control valves did not function properly, if at all. For example, in a 32 bed housing unit (3-C), only one of four showers functioned. In the Geriatric Unit, only one of three showers worked. We also found uncovered light switches in shower rooms, which exposed inmates to live electrical wires in a wet environment. We observed numerous totally or partially-blocked floor drains, and stopped-up and inoperable sinks. These plumbing issues generally existed throughout the LCJ.

While we found ventilation generally satisfactory, we did observe supply ducts that were either plugged with paper or had heavy accumulations of dust or debris that inhibited the air movement through the housing units. For example, a significant amount of dust blocked the exhaust duct grates in the Intake Center, effectively blocking air movement through the cells.

We found many mattresses and pillows that were torn or worn beyond their ability to be cleaned and disinfected between users. These deteriorated mattresses cause security problems, because inmates can easily conceal contraband under the mattress cover, and they create a risk of disease transmission because the mattresses cannot be adequately disinfected.

3. Inadequate Housekeeping

LCJ's housekeeping operations are grossly understaffed and conducted poorly. Only 1 officer and 1 civilian worker cover housekeeping duties for the entire jail; they supervise approximately 50 inmate workers. The LCJ also charges the housekeeping officer with responsibility for re-supplying control rooms, and maintaining adequate cleaning supplies in each janitor's closet.

The LCJ fails to properly control chemicals. The LCJ essentially fails to supervise all inmate workers' use of chemicals. No uniform mixing system for chemicals exists. For example, inmate workers use pine cleaner for cleaning the "old jail." The LCJ fails to supervise these inmates' dilution of this pine cleaner before these inmates take the chemical to the floors. Moreover, the LCJ generally leaves chemical closets unsecured specifically to enable inmate workers to go in and out at will. Beyond being a cleaning safety hazard, inmates could potentially fashion these chemicals into a weapon.

Beyond this inmate access problem, we found that the LCJ fails to properly label chemicals. Jails must properly label chemicals, whether the chemicals are in the original container or not. We frequently found ready-to-use spray bottles with cleaning chemicals that were mislabeled or not labeled at all. Any chemical that has a caution, danger, or warning label must have a material safety data sheet ("MSDS") wherever the LCJ chooses to store the chemical. Most jails typically keep these MSDS in an organized binder or folder so that staff can easily access the sheets in emergencies. We could not locate any MSDS's at the LCJ, and the housekeeping officer was not even aware of them. He also indicated that LCJ does not maintain a master list of all chemicals the LCJ uses. Nor does the LCJ maintain a running inventory of chemicals used in the LCJ. Without this inventory, the LCJ cannot account for its use of chemicals. As a result, we found inmates who were hoarding chemicals in their cells because they never knew when they would get cleaning supplies for their cells.

The LCJ fails to provide adequate supplies to the inmates for cell cleaning. The housing officer stated that he puts cleaning supplies into the housing units one time per week, but that he had not done so in the last two weeks. He also stated, "it's up to them what they do with it." Regarding procedures for cleaning sinks, staff reported that "if inmates want to take a hand towel and dip it in the mop bucket and clean the sink, that's okay to do." While the LCJ can use inmates to help with sanitation tasks, the LCJ needs to ensure proper procedures and supervision of these inmates.

No policy or procedure regarding housekeeping duties and schedules appears to exist. Staff put mop buckets into the housing areas for floor mopping each

morning. Showers and toilets are cleaned only once a week. We found showers in the female intake and dress-out areas especially unsanitary. We observed feces and a used tampon on the shower floor in the dress-out area, and the walls were in bad condition with peeling paint and what appeared to be mold growth. Generally throughout the LCJ, we found what appeared to be mold and mildew prevalent in the shower areas. Trash and other debris clog drains. Moreover, the LCJ's inadequate housekeeping practices have enabled drain flies to infest several floor drains.

The LCJ also documents housekeeping with logs that were extremely inconsistent or non-existent. According to the housing officer, the LCJ does not conduct regular inspections for quality assurance purposes, and has no quality assurance policies and procedures in place.

Housing Unit 3-C merits special mention. This unit stood, by far, as the worst of the housing units. The electric unlocking system was dysfunctional and staff had to manually unlock cell doors. We found three showers and one toilet were broken. Sinks were stopped up and the ceiling needed repair. Inmates in 3-C complained about their inability to get cleaning supplies on a regular basis. They also indicated that they washed their clothes in the toilet, rather than sending them to the facility laundry.

4. Inadequate Laundry Service

Adequate laundry operations are essential to a sanitary jail environment. According to the LCJ inmate handbook, inmate clothing and bedding are laundered weekly upon request and blankets are exchanged monthly. Interviews with both inmates and staff revealed that the LCJ does not enforce the laundry policy's services and schedules. One officer stated that inmates had discretion about what laundry to send on collection day. With this discretion, many inmates refuse to send their items to the laundry and will wash their personal clothing in their cells, using sinks, toilets, or showers. We observed, and several LCJ inmates indicated, that inmates laundered their clothing in toilets and sinks. Several inmates indicated that the LCJ had not washed their blankets in six months or longer. These laundry practices create an unacceptable risk that disease causing pathogens can survive and be passed from inmate to either inmate or staff.

Beyond this inadequate enforcement of laundry policy, the LCJ's laundry center is unsanitary and contains fire hazards. The LCJ uses laundry carts to transport both clean and soiled laundry to the LCJ without disinfecting them between uses. We observed gross amounts of dust and dirt throughout the center.

We also found serious fire risks in this laundry center. Statistically, more jail fires occur in laundry areas than in any part of the jail. We found heavy accumulations of dust on top of dryers, which use gas burners, creating a severe fire hazard. The most recent fire extinguisher inspection tag that we observed in the laundry dated back to 1999. Another extinguisher located near the electrical panel box indicated a very low pressure that made the extinguisher virtually useless. The tag had deteriorated so badly that we could not read the date on it. Another extinguisher located in the basement near the compressor room had a 1997 tag and had lost adequate pressure.

5. Inadequate Food Service

The LCJ fails to properly track or document food service, provides inadequate meals, and uses a kitchen with numerous health and safety violations.

The LCJ feeds inmate workers in a common dining room and all other inmates in their housing areas. The food service director indicated that the LCJ makes out a menu list weekly, but that this menu includes only the evening meal. The only menus that the LCJ could provide dated back to the summer and fall of 2007. No records of a qualified dietician approving menus for nutritional analysis were produced. Menu substitutions are not tracked.

Inmates and the food service director confirmed that inmates held in the intake area only got cold bag meals. Some inmates are held in this area for 48 hours or longer. Several inmates in the female intake unit (H-7) reported being housed there for more than a week.

Our tour of the kitchen revealed numerous health violations. The kitchen had only one hand wash sink, and access to the sink was blocked. We also found inadequately cleaned equipment, inoperable lights, and unsecured tools. Only knives are kept under lock and key, and the food supervisor could not say when inventory counts were conducted. For security purposes, the LCJ should secure all knives, utensils, and instruments, including table-mounted can openers.

III. MINIMUM REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of inmates confined at LCJ, the LCJ should implement, at a minimum, the following remedial measures:

A. Suicide Prevention

- a. Rewrite policies and procedures for suicide prevention and management with the duties reassigned to appropriately licensed and credentialed staff.
- b. Institute direct physical observation of persons on suicide watch, rather than the current practice of custody staff watching multiple inmates on multiple camera monitors.
- c. Institute an adequate suicide risk assessment instrument or form that a qualified mental health professional completes prior to an inmate's placement on suicide watch, and again prior to release from suicide watch or precaution.
- d. Administer prescription medications on a directly-observed basis for each dose, (unless the physician's order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.
- e. Ensure proper follow-up care for inmates with a known history of suicide watch or precaution protocols. Include documentation of comprehensive multidisciplinary treatment planning for those inmates.
- f. Ensure suicide watch cells are suicide-resistant (e.g., suicide resistant vents).

B. Mental Health Care

1. Staffing

- a. Enhance staffing to meet the demands for timely access to an appropriate mental health professional.

- b. Ensure qualified mental health staff perform intake mental health screenings and evaluations.
 - c. Ensure adequate staff to perform comprehensive assessments and comprehensive multidisciplinary treatment planning.
 - d. Ensure mental health staff collaborate with appropriate medical staff.
 - e. Verify mental health staff have appropriate credentials.
2. Intake and Referral Process
- a. Ensure qualified mental health staff perform the intake and referral process.
 - b. Ensure inmates who show positive answers on suicide prevention screening are routinely referred to mental health.
 - c. Change the current “crisis response” mental health care model to a system that proactively identifies inmates who are in need of treatment or at risk of harm.
 - d. Ensure collaboration with medical and custody staff in those areas that overlap, such as intake assessments, confidentiality for interviews, suicide prevention and management, and treatment planning.
3. Sick call
- a. Provide inmates with a sufficient number of sick call request forms.
 - b. Ensure appropriate staff pick up and evaluate sick call slips at least five days per week. Triage slips for emergent conditions.
 - c. Ensure slips are adequately logged and tracked.
 - d. Institute quality improvement system for adequacy of the sick call process.

4. Treatment Planning
 - a. Ensure adequate and appropriate treatment planning, which includes comprehensive multidisciplinary treatment team conferences. This team should include medical, nursing, and custody staff, and the inmate.
 - b. Institute appropriate individual therapy or group therapy, rather than the current psychosocial “contact” and “rounds.”
 - c. Ensure mental health records contain problem lists that allow the reader to quickly ascertain for what condition a specific inmate is being treated, including medical problems.
5. Medication Management
 - a. Prevent nurses from improperly writing and discontinuing medical orders without specific direction from a physician.
 - b. Administer prescription medications on a directly-observed basis for each dose, (unless the physician’s order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.
6. Quality Improvement and Quality Management Program
 - a. Institute effective quality improvement and quality management policies and procedures. These policies and procedures should address:
 - i. effectiveness of the intake assessment, referral, and sick call process;
 - ii. management and utilization of psychotropic medications;
 - iii. suicide prevention, including assessment of suicide risk, review and tracking of suicide attempts, monitoring of inmates on suicide observations or precautions;
 - iv. appropriate physical plant facilities such as safe cells for management of at risk inmates, and follow-up and

treatment for those who may have engaged in suicidal or self-harm activities;

- v. appropriate treatment planning and treatment interventions for inmates in the mental health program;
 - vi. discharge planning for the effective management and continuity of care for inmates leaving the system; and
 - vii. review and audits of medical records for quality and appropriateness of documentation.
- b. Ensure quality improvement committee meets on a monthly basis and that this committee includes representatives from medical, mental health, and custody staff.

C. Medical Care

1. Staffing

- a. Ensure that health care structure is organized with clear lines of authority for operations.
- b. Clarify training and supervision. Ensure oversight includes performance monitoring of access to care and quality of care. Ensure accountability of staff and contractors for access and quality of care.
- c. Enhance staffing to meet the demands for timely access to an appropriate health professional, including physicians, psychiatrists, and mid-level practitioners.
- d. Provide an inmate handbook to each incoming inmate.

2. Access to Medical Care

- a. Institute effective sick call process. See Mental Health Care remedies outlined in Section III.B.3.
- b. Decrease missed appointments. Document reasons for missed appointments.

- c. Ensure medical records adequately document sick call with appropriate and legible progress notes. Ensure appropriate follow-up care.
 - d. Ensure dental hours accommodate the need for dental care.
 - e. Ensure physician and mid-level staffing hours accommodate patient needs.
 - f. Ensure physicians adequately supervise nurses.
 - g. Revise co-pay system in terms of amount and waivers.
 - h. Ensure better confidentiality of medical examinations.
 - i. Ensure medical records document all appropriate medical information.
 - j. Track and appropriately treat patients with skin infections.
 - k. Maintain a clean and safe environment in the medical areas, including the proper handling of waste, biohazards, sharps, chemicals, and medications.
3. Acute and Chronic Medical Care
- a. Ensure timely access to appropriate care, including physician evaluations and prescribed medications, for inmates with acute medical problems. Ensure adequate acute follow-up care.
 - b. Take and document vital signs of inmates with acute medical conditions, including withdrawal from alcohol and other substances.
 - c. Adequately manage inmates with chronic conditions in a chronic care clinic that adequately identifies, tracks, treats, and monitors such inmates.
 - d. Appropriately document chronic care in medical records.

4. Comprehensive Health Assessments
 - a. Provide a comprehensive health evaluation to all inmates and juveniles within 14 days of booking that includes vital signs, a comprehensive medical history, and, for juveniles, immunization records.
5. Medication Administration
 - a. Secure the medication room. Discontinue allowing food in the medication refrigerator.
 - b. Prevent nurses from discontinuing medications without a physician's order. Ensure that a prescribing practitioner counsels all patients who refuse medication.
 - c. Administer prescription medications on a directly-observed basis for each dose, (unless the physician's order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.
 - d. Abolish standing orders for non-emergency medication. Stop nurses from inaccurately documenting medication orders as being ordered via telephone.
 - e. Ensure nurses practice within the scope of their licensures.
 - f. Create some formal mechanism, such as a Pharmacy and Therapeutics Committee, to assist in creating guidelines for the prescription of certain types of medications.
6. Medical Records
 - a. Ensure the uniformity and organization of medical records. Institute the use of a problem-oriented format with problem lists and SOAP format notes.
 - b. Ensure nursing staff record the date and disposition of all requests for medical care.
 - c. Ensure clinical notes are entered into the medical record and are legible.

- d. Ensure an up-to-date, legible, treatment plan for patients with special needs, including chronic conditions, acute illnesses, and infectious diseases and skin conditions.

7. Quality Improvement

- a. Develop a quality management plan that addresses the medical deficiencies, sets forth performance criteria, conducts data analysis (both quantitative and qualitative), and implements corrective measures to improve performance.

D. Sanitation and Fire Safety

1. Fire Safety

- a. Institute an active fire safety program.
- b. Improve fire drill logs documentation.
- c. Ensure timely regular inspection of all fire extinguishers.
- d. Ensure staff have readily accessible emergency keys that staff can easily identify by both sight and touch.

2. Housing and Maintenance

- a. Address maintenance problems with damaged or inoperable showers, toilets, drains, and sinks. Cover all light switches with exposed wires.
- b. Clear air supply ducts.
- c. Ensure proper air temperatures in cell blocks and that inmates have appropriate access to blankets.
- d. Ensure all mattresses and pillows are not damaged to the point where they cannot be properly cleaned and disinfected between users.

3. Housekeeping

- a. Ensure adequate numbers of staff to perform housekeeping duties.

- b. Ensure proper control of chemicals, including supervision of inmate workers handling chemicals, uniform chemical mixing systems, secure chemical storage, proper chemical labeling, and accessible MSDS sheets.
 - c. Institute a master list of all chemicals the LCJ uses and maintain a running inventory of these chemicals.
 - d. Provide inmates adequate supplies for cell cleaning.
 - e. Institute a policy regarding housekeeping duties and schedules.
 - f. Improve housekeeping documentation.
 - g. Institute quality assurance policies and procedures.
4. Laundry Service
- a. Improve enforcement of laundry policy to ensure that inmates send their laundry to the laundry service facility rather than washing their laundry in their cells.
 - b. Ensure inmates' clothing is laundered at least weekly.
 - c. Ensure blankets are laundered at least monthly or between uses by different inmates.
 - d. Improve the laundry facility's unsanitary environment and fire safety hazards.
5. Food Service
- a. Properly track and document food service.
 - b. Provide inmates adequate meals.
 - c. Eliminate kitchen's health and safety violations, including unlocked access to knives, utensils, and instruments, including table-mounted can openers.

* * * * *

Please note that this findings letter is a public document. We will post it on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding the LCJ. Assuming the present spirit of cooperation from Lake County is continuing, we also are willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them.

CRIPA obligates us to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the LCJ's attorney to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc: Roy Dominguez
Lake County Sheriff

John S. Dull
County Commissioner Attorney

David A. Capp
United States Attorney
Northern District of Indiana

John Kopack
Attorney for Sheriff Dominguez



U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D.C. 20530*

MAR 31 2011

The Honorable Robert Moore
Chair, Leflore County Board of Supervisors
306 West Market Street
Greenwood, Mississippi 38930-4355

Re: Investigation of the Leflore County Juvenile Detention Center

Dear Chairman Moore:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Leflore County Juvenile Detention Center ("LCJDC") in Greenwood, Mississippi. On August 14, 2009, we notified Leflore County, Mississippi, of our intent to conduct an investigation of LCJDC pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). Both CRIPA and Section 14141 give the United States Department of Justice ("DOJ") authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions.

We thank the staff members at LCJDC for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation and appreciate their receptiveness to our consultants' on-site recommendations. Staff assisted our investigation by providing access to records and personnel and by promptly responding to our requests in a transparent manner. We have every reason to believe that the County and the staff of LCJDC are committed to remedying deficiencies at the facility.

I. SUMMARY OF FINDINGS

The youth confined to LCJDC are subjected to conditions that violate their constitutional and federal statutory rights. Our investigation revealed systemic, egregious, and dangerous abuses perpetuated by a lack of accountability and controls. LCJDC fails to prevent unconstitutional harms, or minimize the risk of such harms, through undue use of restraints, arbitrary imposition of punishment, inadequate grievance procedures, failure to report and investigate abuse, inadequate classification systems, inadequate rehabilitative treatment, inadequate medical and mental health care, inadequate suicide risk protections, inadequate environmental safety, inadequate staffing, and inadequate educational services. We found that:

- Youth are dangerously and routinely shackled to metal beds for discipline and punishment;
- Staff have unfettered discretion to immediately administer punishment, and isolation is used excessively for punishment and control;
- Suicidal youth are not assessed by mental health professionals despite known risks;
- Internal investigations dismiss abuse complaints against staff as manipulative; and
- No accommodations exist for children with learning disabilities.

These systemic deficiencies exist because generally accepted juvenile justice standards are not followed. We found that LCJDC staff members do not receive minimally adequate training and that existing policies and procedures are inadequate to ensure constitutionally adequate care and custody of the youth confined to the facility. Staff members fail to report allegations of abuse to the State and appear to routinely violate youths' rights with impunity.

The widespread and significant deficiencies at the facility are a result of significant departures from accepted juvenile justice standards and violate the Fourteenth Amendment's mandate that youth in custody be protected from harm. In this letter, we provide recommendations that are minimally necessary to bring the facility into compliance with the Constitution and federal law.

II. INVESTIGATION

On November 11-12, 2009, we conducted an on-site inspection of LCJDC accompanied by expert consultants in the areas of protection from harm and education. Before, during, and after our tour, we reviewed extensive documentation provided by the County, including policies and procedures, incident reports, unit logs, and training materials. Additionally, we interviewed LCJDC administrators, staff, and youth. We observed youths in a variety of settings, including their living units, dining areas, and in the facility's only classroom. Consistent with our commitment to conduct a transparent investigation and provide technical assistance, our expert consultants conveyed their initial impressions and concerns to the County during exit conferences held at the conclusion of the tour.

III. BACKGROUND

The LCJDC is a 30-bed short-term facility owned and operated by Leflore County for the detention of youth. Male and female youth between 10 and 17 years of age are detained at LCJDC for periods ranging from a few hours to more than 30 days. In addition to detaining youth from Leflore County, the facility contracts with 19 other Mississippi counties to detain youth.¹ As required by state statute, LCJDC and other juvenile justice facilities in Mississippi are monitored by the State Department of Public Safety's Juvenile Detention Facilities Monitoring Unit on a quarterly basis. Despite the relatively limited bed capacity of LCJDC, the number of youths detained at the facility, over time, is significant. During the period between

¹ The counties that contract with Leflore County for juvenile detention include Attala, Bolivar, Calhoun, Carroll, Choctaw, Coahoma, Grenada, Holmes, Humphrey, Leake, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tate, Tunica, Yalobusha, and Webster.

July 2008 and September 2009, 544 different youths were held at the facility. Notably, some of these 544 youths were detained at the facility multiple times during the time period. During our on-site visit in November 2009, the facility had a youth population of seven males and six females who were from eight different counties.

The two-story LCJDC building was converted from a mental health facility to a juvenile facility in 1995, with the original construction dating back to the 1950s. In addition to LCJDC, the building houses the Leflore County Youth Court and offices for the court's counselors. The juvenile detention portion of the building consists of two floors and is outfitted like an adult jail. The layout is primarily double-bunked cells with metal frame beds, built-in desks or tables, and stainless steel toilets and sinks. Each cell has a metal door with a small window, and lighting is controlled externally by a switch near the door. The upper level customarily houses female youths and includes the facility's only classroom, which is outfitted with books, desks, and an adjacent computer lab. The lower level of LCJDC customarily houses male youths and has a small dayroom for programming in addition to cells. An external door on the lower level hallway connects the cells to a very small outdoor "recreation area" that is completely enclosed by tall brick walls. This outdoor recreation area is designated as the point of egress in case of fire or other emergency.

IV. FINDINGS

In violation of their constitutional rights, youth at LCJDC are inappropriately and dangerously restrained, arbitrarily punished, denied adequate medical and mental health care, not protected from suicide risk, inadequately supervised, and inadequately educated. Unsafe conditions of confinement, combined with a paucity of meaningful programming, education and other activities, create an environment at LCJDC that is dangerous and detrimental to youth development and well-being. The environment is especially harmful for those youth who spend long periods of time at LCJDC or who frequently return to the facility.

A. LEFLORE COUNTY IS FAILING TO PROTECT YOUTH FROM HARM AT LCJDC

CRIPA and Section 14141 authorize DOJ to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions. 42 U.S.C. § 1997; 42 U.S.C. § 14141. Youth detained at LCJDC are protected by the Fourteenth Amendment and have a substantive due process right to reasonably safe conditions of confinement and freedom from unreasonable bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982) ("If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily [detained] - who may not be punished at all - in unsafe conditions."). The Fourteenth Amendment, rather than the Eighth Amendment, applies because the youth are held for detention or rehabilitation,

not punishment.² The Mississippi youth delinquency statute's statement of purpose provides that "each child coming within the jurisdiction of the youth court . . . become a responsible, accountable and productive citizen, and that each such child shall receive such care, guidance and control, preferably in such child's own home as is conducive toward that end and is in the state's and the child's best interest." Miss. Code Ann. § 43-21-103.

To determine whether the Fourteenth Amendment was violated, a balancing test must be applied: "[I]t is necessary to balance 'the liberty of the individual' and 'the demands of an organized society.'" Youngberg, 457 U.S. at 320 (quoting Poe v. Ullman, 367 U.S. 497, 542 (1961)). The Youngberg Court went on to hold that "If there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury." Id. at 321. Instead, the Court held that there is a constitutional violation if detaining officials substantially depart from generally accepted professional standards, and that departure endangers youth in their care. See id. at 314.

As a general matter, the Supreme Court has held that corrections officials must take reasonable steps to guarantee detainees' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir. 1996) (recognizing a duty to provide detainees with basic human needs including protection from harm). In addition, an official's failure to maintain adequate policies, procedures, and practices for the prevention of suicides may violate a detainee's due process rights. Silva v. Donley County Texas, 32 F.3d 566, 1994 WL 442404, *5-7 (5th Cir. 1994) (unpublished) (holding sheriff's failure to establish suicide detection and prevention training for jail personnel, condoning de facto policy of sporadic cell checks, and absence of a policy for observing "at-risk" detainees may rise to deliberate indifference to known risk of suicide in detention settings).

Finally, conditions of confinement claims may be based not only upon existing physical harm to youth, but also on conditions that threaten to cause future harm. Helling v. McKinney, 509 U.S. 25, 33 (1993) (stating "[i]t would be odd to deny [relief to detainees] who plainly proved an unsafe, life-threatening condition in their [facility] on the ground that nothing yet had happened to them."). In Helling, the court recognized various circuit courts holding that "a [detainee] need not wait until he is actually assaulted before obtaining relief" and that the Constitution "protects against sufficiently imminent dangers." Id. at 33-34; see also Herman v. Holiday, 238 F.3d 660 (5th Cir. 2001) (recognizing Helling standard); Gates v. Collier, 501 F.2d 1291, 1308-11 (5th Cir. 1974) (holding that failure to provide adequate systems to protect inmates against future harm including physical assaults and abuse constituted cruel and unusual punishment).

² In Ingraham v. Wright, the Supreme Court rejected application of the Eighth Amendment deliberative indifference standard in a non-criminal context. 430 U.S. 651, 669 n.37 (1977) ("Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions."). In addition, the Court held that the Due Process Clause of the Fourteenth Amendment was the proper constitutional gauge to determine the rights of adults detained by a state, but not yet convicted of any crime. Bell v. Wolfish, 441 U.S. 520 (1979). See also, Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996). At a minimum, youth should be accorded the same constitutional protections.

1. Youth at LCJDC are subjected to undue restraint.

Our investigation revealed numerous uses of dangerous and unnecessary restraints at LCJDC. The justifications offered by staff for the use of the restraints were ambiguous or clearly inappropriate. Youth are frequently shackled to the bed in their cell in response to non-dangerous actions and for punishment. Documentation of the application of restraints failed to adequately describe the reasons for or the duration of the uses of restraint.³

Youth at LCJDC may not be unduly restrained or subjected to excessive use of force by staff. See Youngberg, 457 U.S. at 316; Morales v. Turman, 364 F. Supp. 166, 173 (E.D. Tex. 1973) (issuing a preliminary injunction where the court found that juvenile facilities' widespread practice of beating, slapping, kicking, and otherwise abusing youth in the absence of exigent circumstances violated youths' rights). In determining whether a violation exists under the Eighth Amendment, courts consider whether "force was applied in a good faith effort to maintain or restore discipline or maliciously and sadistically for the very purpose of causing harm" to determine whether force was excessive. Hudson v. McMillian, 503 U.S. 1, 6 (1992) (citing Whitley v. Albers, 475 U.S. 312, 320-21 (1986)). Prison officials "may take all reasonable steps to insure proper prison discipline, security and order" but must ensure "that inmates are not subjected to any punishment beyond that which is necessary for [] orderly administration." Gates v. Collier, 501 F.2d at 1309. Hence, the use of force after an inmate has been subdued and an emergency has dissipated, or which is disproportionate to the force needed to regain control, violates the Eighth Amendment. Hope v. Pelzer, 536 U.S. 730, 738 (2002) (leaving an inmate handcuffed to a post after order had been regained constituted cruel and unusual punishment); Valencia v. Wiggins, 981 F. 2d 1440, 1447 (5th Cir. 1993) (applying a chokehold on disruptive inmate who refused to exit cell and striking inmate while handcuffed, kneeling, and non-resisting was malicious and sadistic, causing harm). The use of mechanical restraints should be limited to circumstances where a youth presents a clear danger to herself or others. See H.C. by Hewett v. Jarrard, 786 F.2d 1080, 1086 (11th Cir. 1986) (disproportionate response of guard to juvenile detainee, which included shackling to bed, "amounted to punishment in violation of due process clause").

Generally accepted professional standards require that staff only use physical force or mechanical restraints to the degree and duration necessary to bring a situation under control. Every application of mechanical restraints – including handcuffs, leg shackles, belly chains, or other such restraints – must be fully documented, including the circumstances leading to the application of restraints and the duration that the restraints were applied. Any restrained juvenile should be constantly observed by staff to ensure safety.

³ The facility's policy manual is ambiguous about the County's expectation for documenting uses of force. One section states that the "use of force resulting in injury to staff or youth and the use of mechanical restraints will be fully documented and reported," suggesting that only use of force incidents involving injury should be documented. Several pages later, however, the manual states that a "written report ... will be completed no later than seventy-two (72) hours following the incident depending on the circumstances of the incident." There is no explanation of the determinative circumstances, and the quote suggests that incident reports are required even where there is no injury. Regardless of which part of the policy manual is the County's official policy, neither is consistent with generally accepted professional standards, which provide that facility staff document all incidents, except for handcuffs used in transportation, in which physical force or mechanical restraints are used.

Examples of excessive or undue restraints and lack of adequate documentation at LCJDC include:

- In October 2008, A.A.,⁴ a 13 year old detainee, began kicking his cell door and cursing. Two officers entered the youth's cell and "chained" A.A. to the bed. There is no documentation of the precise manner or length of time that the youth was restrained. Staff later entered A.A.'s room to discover that he had defecated and thrown feces on the cell window. He was restrained a third time in November 2008 for 15 minutes as punishment for kicking and beating on the door.
- B.B. was placed in leg restraints in October 2008 as punishment for flooding the toilet in his cell. He was released once he promised to stop flooding the cell.
- In February 2009, C.C. was removed from class and isolated in his cell for failure to follow classroom rules. Once C.C. entered his cell, he began beating on the doors and walls. Two officers then entered the cell and placed C.C. in leg shackles.
- In June 2009, leg irons were placed on D.D. to prevent him from banging on the cell door. There is no documentation regarding the duration of this restraint.
- In May 2010, a youth banged on his door to request hygienic tissue. A detention officer denied the request, and detention staff subsequently went from room to room restraining youths with shackles and handcuffs. One youth was hogtied to the bed after he argued with detention officers, and all youths remained in the restraints for approximately one hour.

In none of the circumstances described above were the youths a danger to themselves or to others. Banging or kicking doors or walls, cursing, shouting, and flooding a cell are annoying behaviors, but none present a danger. Instead, in each of the incidents described above, LCJDC's practice of shackling served a primarily punitive purpose. Therefore, each restraint described above was undue and unconstitutional.

Staff members at LCJDC freely admit that they restrain youth to beds. According to facility staff, youth are restrained to the bed when staff cannot de-escalate a youth's misbehavior through talking (although none of the incidents described above evidence attempts by staff to de-escalate the situation before restraints were applied). The facility manual places a time limit of 15 to 30 minutes on the use of restraints. We were also told that staff usually link restraint devices together to provide enough length for youth to use the toilet while shackled to a bed. Neither the purported time constraint nor extending the length of the shackling restraint makes this practice acceptable.

We conclude that the restraint practices of LCJDC detention staff violate the Constitution and egregiously deviate from generally accepted professional standards.

⁴ Fictional initials are used throughout the letter to preserve the anonymity of youths.

2. **LCJDC violates the due process rights of youth by arbitrarily imposing punitive measures.**

Our investigation revealed numerous instances where LCJDC staff imposed sanctions without following any disciplinary process. LCJDC must provide youth with procedural due process if they are charged with a disciplinary violation while detained. See Wolff v. McDonnell, 418 U.S. 539, 563-65 (1974) (finding that prison disciplinary hearings require due process with respect to presentation of charges, evidence, and witnesses).

There are no processes at LCJDC for notifying youth of facility rules or for imposing discipline. The absence of an established disciplinary system results in an informal system of control based on the unfettered discretion of individual detention officers; sanctions are immediately imposed by staff for whatever actions staff deem punishable. These practices are unconstitutional. For example:

- In August 2008, staff recorded in a facility log that E.E. and F.F. had fought each other and were therefore not allowed out of their cells for any reason other than showering.
- In September 2008, G.G. allegedly started a fight in class and was therefore isolated in his cell. According to the facility log, the youth was “to not come out of his cell . . . for any reason.” It is unclear how long this restriction was in place.
- In November 2008, H.H. reportedly became disruptive and threatened to kill himself while in court. Two detention officers forcibly removed H.H. from the courtroom and placed him in his cell. After the youth struck the door of his cell, “disciplinary actions were taken.” We have no indication of what is meant by “disciplinary actions.”
- In February 2009, some youths were allegedly overheard plotting to attack a detention officer. Consequently, “all juveniles were disciplined by no showering.”
- Thirteen-year-old I.I. stated during our November 2009 interviews that one of the detention officers at LCJDC had whipped him with a belt in his room as punishment for being disruptive in class.

The lack of any disciplinary system or due process protections for youth at LCJDC violates their constitutional rights.

3. **LCJDC is unlawfully failing to report and investigate abuse.**

LCJDC also unconstitutionally places youth at risk of repeated harm by failing to properly report and investigate abuse by staff. When an allegation of child abuse is made, the allegation should be reported to the proper authorities for investigation. Juvenile justice facility staff are typically mandated by statute to report allegations of child abuse to the state’s child

protective services agency. In Mississippi, “any person having reasonable cause to suspect that a child is a neglected child or an abused child shall cause an oral report to be made immediately ... to the Department of Human Services” which in turn initiates an investigation. Miss. Code Ann. § 43-21-353 (1) (2010). As such, LCJDC staff must report all instances of alleged abuse, without regard to credibility, to the State Department of Human Services. This is not occurring.

In addition to reporting allegations of abuse to the proper state agency, LCJDC must conduct internal investigations of alleged abuse in order to keep youth reasonably safe. Once an allegation of abuse has been made, a proper investigation is required to protect youth from staff abuse by collecting evidence to verify or disprove the allegation. These investigations are essential to identify staff in need of training and/or discipline, as well as to clear staff who have been wrongfully accused. The investigation process must have reasonable integrity, preserve all physical evidence (e.g., videotape footage, documentation and photographs of injuries, clothing, etc.), obtain statements from all youth and staff involved in the incident and those who witnessed the incident, and utilize other sources of information to corroborate or refute the allegations (e.g., logbooks, other sources of facility documentation).

To ensure that youth are provided adequate safety, youth subjected to a use of force must be seen, and treated if necessary, by a medical professional, and all injuries should be documented. Medical staff can also be an avenue for youth to report abuse or mistreatment. Further, even when youth do not report abuse or mistreatment, medical staff members are mandated reporters of child abuse if abuse is suspected due to the nature of an injury.

LCJDC unlawfully fails to provide these protections. The facility does not have adequate procedures for properly reporting and investigating allegations of child abuse. When asked about procedures that staff follow upon receiving an allegation of abuse, staff members were unaware of their duty to report abuse allegations to the State. Further, internal investigations are cursory and do not include examination by medical staff, photographs of alleged injuries, or other basic elements necessary for accurate investigations. Indeed, it appears that the underlying assumption of any facility investigation of abuse is that the complaining youth is attempting to manipulate others. The following examples illustrate the deficiencies with LCJDC investigations:

- In February 2008, youth J.J. alleged that he was sexually assaulted by a staff member and later attempted suicide at the facility. Facility management conducted an egregiously deficient investigation by speaking with the youth, then speaking with the staff member, and then simply concluding that there was no evidence of a sexual assault. There is no indication that the State was contacted regarding the abuse allegations. In a memorandum notifying a local police chief of the results of the investigation, LCJDC’s director stated that J.J. was “using the system against the system to gain sympathy” in order to avoid a possible felony charge. The memo concludes with the exhortation: “Do not let this troubled young man’s false allegations stop [the County] from allowing Leflore County to serving [sic] your Juvenile Detainment Needs.”

- A January 2009 memorandum reports the conclusion of the facility's grossly inadequate investigation into youth K.K.'s allegations that he was assaulted by an LCJDC custody officer. The investigation consisted of the director and assistant director interviewing the accused officer and the officer's supervisor, both of whom denied the assault. The memorandum notes that K.K. bore no visible signs of assault but does not contain any alleged details of the incident, including the date it allegedly occurred. The director asserts in the memorandum that "[t]hese juvenile(s) will say and do anything to shift the concerns away from what they did or are doing." There is no evidence indicating that these allegations were referred to the State.

We find that LCJDC's reporting and investigation of alleged abuse is wholly deficient and unlawfully violates the rights of the young people detained in the facility.

4. LCJDC's unlawful classification system places youth at great risk.

Youth at LCJDC are not safe due to the facility's inadequate classification system. The Constitution requires that youth be provided a reasonably safe environment. In a juvenile justice facility, a critical piece of keeping youth safe turns on a classification system to determine where and with whom a youth should be housed. The classification should take into account a youth's age, charge offense, history of violence and escape, vulnerability to victimization, gang membership or affiliation, health and mental health concerns, and institutional history.

LCJDC only considers a youth's size, age, and county of residence when making housing assignments. The failure to account for other obviously relevant factors places youth at grave risk of harm. During our interviews with youth at the facility, for example, we discovered that youths L.L. and M.M. were both arrested and sent to LCJDC for fighting each other but were inexplicably assigned to share a cell together upon arrival at LCJDC. In addition, youths N.N. and O.O. independently told us that they were sharing a cell despite a conflict between them. Both youths had repeatedly asked staff to separate them but no action had been taken.

We find that the lack of an adequate classification system at LCJDC places youth at an unacceptably high risk of victimization, does not keep youth reasonably safe, and is therefore unconstitutional.

5. LCJDC lacks adequate medical and mental health care.

Reasonable protection of confined youths' physical and mental safety requires adequate medical treatment, mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & 323 n.30; Morales, 364 F. Supp. at 175. Appropriate care for youths' mental health needs is as important as caring for their medical needs. Gates v. Cook, 376 F. 3d 323, 332-33 (5th Cir. 2004) (citing Partridge v. Two Unknown Police Officers of City of Houston, Texas, 791 F.2d 1182, 1187 (5th Cir. 1986)). Further, providing only medication to youth with psychiatric disabilities, in the absence of additional or other mental health services, violates their constitutional rights. Gates, 376 F. 3d at 335 (holding that the confinement of inmates with severe mental illness on Mississippi's death row with no mental health care other

than medication was “grossly inadequate” and constituted deliberate indifference in violation of the Eighth Amendment).

While we did not include experts in medical and mental health services in our investigatory tour, the obvious dearth of even the most basic medical and mental health care at LCJDC leads us to conclude that the constitutional rights of detained youth to adequate medical and mental health care are being violated.

a. LCJDC provides inadequate medical screenings and fails to seek appropriate medical treatment, placing youth at significant risk of serious harm.

By failing to properly screen youth for medical conditions, LCJDC remains deliberately indifferent to potentially serious harm. In accordance with generally accepted juvenile justice standards, Mississippi state law requires that youth undergo a health screening upon admission to a juvenile detention center, within one hour or as soon thereafter as reasonably possible, in order to obtain information about the juvenile’s mental health, suicide risk, alcohol and other drug use and abuse, physical health, aggressive behavior, family relations, peer relations, social skills, educational status, and vocational status. See Miss. Code Ann. § 43-21-321. This statutory requirement is acknowledged in LCJDC’s manual, but documentation showed that facility staff members do not comply with this legal requirement.

Documentation purported to show that the 13 youth detained at the time of our investigation tour had been screened in compliance with State law with respect to physical health. However, upon close examination, that same documentation noted that four youth entered the facility at 12:23 p.m. on November 10, 2009 and that medical screening for each of the four youth was also completed at 12:23 p.m. that same day. It is not credible that all four youth were admitted and medically screened within the space of one minute.

We found no evidence that LCJDC’s officers are trained by medical professionals on how to conduct initial medical screenings. Generally accepted professional standards require that detention officers receive training from a health authority on conducting initial medical screenings of youth. Without proper medical screening by appropriately qualified staff, youth are subjected to a high risk that medical or mental health problems will be undetected and unaddressed at the facility.

During individual interviews, our experts specifically noticed two youths, P.P. and Q.Q., who exhibited behaviors consistent with neurological impairments (e.g., Traumatic Brain Injury, tic disorders) and/or other health issues. The records for these two youths did not document these explicit behaviors, and when we asked the facility director about the youths’ medical status, he stated he had not noticed these signs. Significantly, P.P. had been detained at LCJDC on multiple occasions without any treatment for the possible disability.

Because there are no medical personnel on-site, facility policy requires staff to take youth to see a physician if a medical screening indicates a need for emergency care or if a parent, guardian, or youth court designee makes a written request for medical care. We found that, instead, untrained custody officers often provide basic medical care and improperly make decisions on treatment. For example:

- In March 2008, R.R. began vomiting in her room. Custody officers offered an over-the-counter stomach medication to the resident, but she refused. No other medical action was taken.
- In June 2008, S.S. reported to a detention officer that he fell in his room and dislodged his tooth. The detention officer and another staff member looked in S.S.'s mouth and reported that "you could see that he pull[ed] the tooth out and he was OK." No further action was taken.
- In December 2008, T.T. complained to facility staff that he was having chest pains. The youth was taking lithium, a psychoactive drug often used for the treatment of bipolar disorder. Like many psychoactive drugs, lithium may reach dangerously toxic levels if not appropriately monitored by a medical professional and has a number of potentially serious adverse side effects. We could find no evidence that E.U. was examined by a medical professional following his complaint of chest pain.
- In July 2009, U.U. complained that his stomach was upset on the same day that his mother called and advised the facility that U.U. did not have his asthma medication. The next day, when U.U. complained of chest pain and began throwing up blood, a custody officer reviewed the unit log and noted that no action had been taken the previous day regarding the youth's illness. U.U. was then taken to the hospital by custody staff and diagnosed with bronchitis.
- In May 2010, a juvenile at the facility was suffering from tooth pain and could not get attention from a detention officer until he began banging on the cell door. One of the detention officers entered the cell and beat the youth until the juvenile was wailing and crying. The youth did not receive medical attention for the tooth.

b. LCJDC is deliberately indifferent to suicide risks and the related serious mental health needs of youth, placing them at significant risk of serious harm.

Among the most dangerous practices at LCJDC is the facility's failure to meaningfully screen or monitor potentially suicidal youth. Youth at great risk of harm are exposed to conditions that are not reasonably safe and are therefore unconstitutional.

In order to provide reasonable safety to potentially suicidal youth, all youth placed on suicide precautions must be regularly monitored by mental health professionals. Any staff person may place a youth on suicide precautions initially, but the precautions should only be

removed following an assessment by a mental health professional. At LCJDC, if a youth's screening indicates a need for additional assessment, staff members are supposed to schedule an appointment with the local mental health clinic and transport the youth to the clinic. This does not occur. Indeed, records demonstrate instances where youth who are placed on suicide precautions by staff are never assessed by mental health professionals at any time during their detention.

Detention staff should also provide consistent monitoring of youth on suicide precautions to observe behavior and ensure the youth's safety and welfare. LCJDC does not regularly monitor youth while they are on suicide precautions, and it is unclear who decides when youth may be removed from precautions. For example:

- In May 2008, V.V. was discovered tying a sheet around a pipe in his cell in an attempt to commit suicide. Detention staff monitored the youth and required him to wear only a paper gown. However, despite his suicidal behavior, no mental health professional ever assessed or treated V.V.
- In June 2008, an officer bribed W.W. and X.X. to keep them quiet about an attempted suicide. W.W. reportedly knocked on her cell door continuously during X.X.'s attempted suicide in an effort to get the attention of staff but was ignored by the two officers on duty, one of whom ("Officer 1") was smoking a cigarette. The officers continued to ignore W.W. until they heard her screaming. Staff discovered that X.X. had tied a blanket tightly around her neck and a railing on the ceiling. After the noose was removed by staff, Officer 1 told the two youths not to tell anyone about the incident, and allowed them to spend several hours eating snacks and playing computer games. Officer 1 also told the other officer not to tell anyone about the incident, especially the director. The incident was eventually reported and investigated. Despite the facility director's recommendation that Officer 1 be terminated, Officer 1 remains at LCJDC.
- In September 2008, Y.Y. began banging his head against the cell door and tied his uniform shirt around his neck. Y.Y.'s cellmate notified two detention officers who then entered the cell, removed the shirt, and placed Y.Y. in mechanical restraints. The officers later returned to the cell after Y.Y. managed to tie a sheet around his neck despite the restraints. The officers then removed the restraints, "stripped" Y.Y., placed him in a paper gown, and re-applied mechanical restraints. Y.Y. then attempted to tie the paper gown around his neck and stuffed tissue in his nose and mouth. The incident report concludes by stating that the officers took away both the gown and the tissue. No further action was taken.
- A March 2009 mental health assessment of Z.Z. described him as "suicidal and psychotic" and in need of "immediate attention." He was placed in a paper gown and put on suicide watch after the assessment. Five days later, though still on suicide precautions, Z.Z. was observed in full clothing after staff returned his clothing in

violation of a facility directive. It is unclear when or if Z.Z. was ever removed from suicide watch during his 18-day detention at LCJDC.

- In May 2009, A.B. was observed in his room crying, with a torn blanket tied tightly around his neck. Detention staff removed the blanket and placed A.B. in a suicide gown, but he was not assessed by a mental health professional until three days later. A suicide watch log purportedly showed that the youth was observed by detention staff every four minutes while on suicide watch, but the observational times and detention officer's initials were typed in for the entire shift, calling into question the veracity of the observations. Given the physical set-up of the facility, it is highly unlikely that the detention officer could have observed A.B. as reported on the suicide watch log and typed in the information every four minutes.
- In September 2009, A.C. was placed on suicide watch after a local mental health professional determined that he expressed suicidal ideations, intent to self harm, and auditory hallucinations. The suicide watch log indicates that a detention officer observed A.C. every four minutes. The veracity of the observations is dubious, however, given that the times and officer's initials are all typed.

Finally, suicide hazards remain in youth cells. While the County has removed exposed metal piping in many of the cells, some protrusions and tying off points still remain. In sum, LCJDC's grossly inadequate suicide prevention practices violate youths' constitutional rights to adequate safety and adequate mental health care, and place these youths at life-threatening risk.

6. LCJDC's fails to provide adequate programming.

Youth at LCJDC have a constitutional right to adequate treatment. Youngberg, 457 U.S. at 323; Morgan v. Sproat, 432 F. Supp. 1130, 1146-55 (D. Miss. 1977) (holding that juvenile facility must provide adequate treatment, including proper behavior management and recreation programs, among others). That right is abrogated by LCJDC's failure to provide adequate programming and behavior management systems. In order to provide constitutional care, juvenile justice facilities must provide rehabilitation programming and treatment while youth are confined. Thus, generally accepted professional standards require that juvenile justice facilities provide education, recreation, and meaningful activities such as group and individual therapy, social skills training, and other programming. LCJDC fails to provide these services, and the lack of structure and meaningful programming activity is not only violating the youths' rights but is predictably resulting in behavior problems.

Youth at LCJDC spend an inordinate amount of time playing cards or dominos while in the small dayroom or while locked in their cells. Besides schooling, the only regularly scheduled activity for youth is a two-hour arts and crafts class held in the evenings twice per week. On weekends, youth are allowed to watch television if they have behaved during the week and may attend religious programming on Sundays. However, youth spend most weekend time locked in their cells. Furthermore, recreational logs indicated long gaps between opportunities for youth to engage in large muscle exercise. Although there is a small outdoor recreation yard outfitted with

a basketball hoop, it appears to be rarely used and was not used during our November 2009 tour. During an interview, youth A.D. stated that he had been permitted outside for recreation only twice during his 36-day period of detention. Without activities to keep youths mentally and physically occupied, youth at LCJDC create their own activities, including beating and kicking walls and doors, yelling, cursing, picking fights, and other negative behavior.

The problems resulting from the paucity of programming activity are exacerbated by the lack of a behavior management program at LCJDC. Children and adolescents typically lack strong impulse control, and youths at juvenile detention facilities are often particularly affected by their lack of impulse control and lack of an ability to make good choices to control their behavior. Therefore, it is critical that a juvenile facility have in place a behavior management system that provides immediate, consistent, and tangible reinforcement of desired behaviors. Although LCJDC once purchased a behavior management system manual, it was never used. According to staff, LCJDC officials delayed implementing the system because they expected the facility to move to a new building.

We find that LCJDC's failure to provide adequate programming activity – regardless of the facility's physical limitations – contributes to increased risk of suicide, violence and excessive discipline and violates the youths' constitutional rights.

7. LCJDC fails to provide adequate staffing levels for supervision of youth.

Some of the above described problems appear to have resulted from inadequate staffing. LCJDC's serious deficiencies in staffing places youth at risk of harm because of reduced accountability, overreliance on restraints, inadequate youth supervision, and inadequate suicide prevention practices. This deficiency contributes to violations of youths' constitutional rights to reasonably safe conditions of confinement. See *Youngberg*, 457 U.S. at 324.

LCJDC operates with three detention officers for a population of up to twenty-four youths of both genders. The facility has no means to electronically monitor youth in their rooms in addition to visual checks. With two floors and two control rooms, the current staffing pattern is inadequate for LCJDC, particularly when one or more youths are placed on suicide watch.

8. LCJDC fails to provide youth a reasonably safe living environment.

LCJDC's physical environment poses an unreasonable risk to the safety and welfare of detained youths. The Fourteenth Amendment Due Process Clause requires juvenile justice facilities to provide youth with conditions of reasonable care and safety. *Youngberg*, 457 U.S. at 324. LCJDC's failure to adequately address the risk of the spread of infectious diseases, coupled with its inadequate fire safety practices, exposes youths detained there to great risks.

Cells are extremely dirty, contain torn mattresses, and the toilets in the cells were not adequately cleaned. The showers were similarly filthy; such environmental considerations are

critical in preventing the spread of infectious agents such as methicillin-resistant staphylococcus aureus ("MRSA").⁵

LCJDC's fire safety and emergency planning is also inadequate and exposes both youth and staff to an unnecessarily high risk of harm, including death. Documentation showed that although the facility conducts monthly fire drills, the facility's plan for evacuating youth and staff is dangerous. LCJDC's plan is to evacuate everyone to a small outdoor recreation area that is directly adjacent to the detention area and is enclosed with tall brick walls. This would be dangerous in the event of a fire. LCJDC also fails to have a plan for evacuation in the event of a tornado or other emergency.

9. **LCJDC violates the due process rights of youth by failing to provide a grievance system.**

A grievance system provides detained youth with a mechanism to resolve disputes regarding their detention. Given the arbitrary discipline process and the other deficiencies noted in this letter, the absence of a grievance process contributes to the unconstitutional conditions in the facility. LCJDC does not provide any forms for filing grievances or any confidential means for filing grievances, such as a locked drop box. According to the facility manual, the grievance process consists of a juvenile writing a statement of his or her grievance and handing that statement to the shift supervisor. The shift supervisor then submits the statement to the assistant director, who then conveys it to the facility director. There is nothing confidential about any aspect of this process.

Youth at LCJDC have a right to file grievances with the facility regarding their treatment, as well as a right not to be punished for using the grievance system. See Decker v. McDonald, No. 5:09 Civ. 27, 2010 WL 1424322, *15 (E.D.Tex. Jan. 11, 2010) (noting that the law is well established that prison officials may not retaliate against an inmate who exercises his right of access to the courts or use of the grievance system); see also Hasan v. U.S. Dep't of Labor, 400 F.3d 1001, 1005 (7th Cir. 2005) (holding that, unless frivolous, prisoners' grievances are entitled to First Amendment protection).

Basic due process and generally accepted professional standards for juvenile facilities require a grievance process that affords youth confidentiality, protects them from retaliation by staff, is unimpeded, and offers a level of review for appeals. At the time of our tour, the director of LCJDC had not received a grievance since October 2005 – a period of more than four years. The fact that no grievances have been received by the director since October 2005 is testament to

⁵ MRSA is a highly contagious bacteria commonly found in institutional settings that is resistant to certain antibiotics, including methicillin. Centers for Disease Control and Prevention, at http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca_public.html. The disease presents itself at first as a boil or sore on the skin, and is easily spread through contact with an infected person or with a surface the person has touched. Id. In some cases, MRSA can lead to serious complications, including surgical wound infections, bloodstream infections, and pneumonia. Id.

the inadequacy of the process. We find that LCJDC's grievance process is a contribution factor to unconstitutional conditions.

B. YOUTHS' RIGHTS TO ADEQUATE EDUCATIONAL SERVICES ARE BEING VIOLATED AT LCJDC

LCJDC consistently fails to provide youth with adequate general education services. Although the County has asserted that complying with the law is difficult due to the transient nature of the youth population and limited resources, these challenges are not unique to this facility and do not excuse the County from providing proper educational services to detained youth. Specifically, Mississippi state law requires that youth receive a minimum of five hours of educational instruction each weekday during the academic year. Miss. Code Ann. § 37-13-91(d), as amended.

The denial of education services to detained youth that are comparable to those provided by the State to non-detained youth violates due process and equal protection rights. Plyler v. Doe, 457 U.S. 202, 224 (1982) (deprivation of basic educational services must be rationally related to a substantial goal of the state); Donnell C. v. Illinois State Bd. of Educ., 829 F. Supp. 1016, 1018-19 (N.D. Ill. 1993) (a juvenile facility's denial of education services and provision of education services inferior to those of non-detained youth violated due process and equal protection claims of youth at the facility). In cases discussing the provision of education to detained youth, courts have recognized the essential function of education. See, e.g., Morgan v. Sproat, 432 F. Supp. 1130, 1150-51 (D. Miss. 1977) (holding that juvenile facility must provide sufficient education and vocational training to residents in order to reduce recidivism and promote successful reintegration into society).

Furthermore, students with disabilities have federal statutory rights to special education services under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §§ 1400-1482. See Honig v. Doe, 484 U.S. 305, 310 (1988) (noting that the Education for All Handicapped Children Act, as amended by IDEA, "confers upon disabled students an enforceable substantive right to public education in participating States"). IDEA requires states that accept federal funds to provide educational services to all children with disabilities between the ages of three and twenty-one years, even if the children have been suspended or expelled from school. 20 U.S.C. § 1412(a)(1)(A). Accordingly, the State must provide such services to youth in juvenile justice facilities. See id. (conditioning funds on the availability of services to "all children with disabilities"); 34 C.F.R. § 300.2(b)(1)(iv) (applying IDEA requirements to "all political subdivisions of the State that are involved in the education of children with disabilities, including . . . State and local juvenile and adult correctional facilities"); see also Alexander S. By and Through Bowers v. Boyd, 876 F. Supp. 773, 788 (D.S.C. 1995) (finding IDEA applicable to school-age detainees in juvenile detention facilities). IDEA also requires schools to have procedures for identifying and testing students with disabilities. 34 C.F.R. § 300.111(a)(1)(i).

Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794, similarly obligates the State to provide youth confined in its institutions with educational services. Section 504 requires that "[n]o otherwise qualified individual with a disability in the United States, as

defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” 29 U.S.C. § 794(a).

Although the County is obligated to provide free and appropriate education to qualified students with disabilities under both the IDEA and Section 504, special education services are virtually non-existent at LCJDC. The facility does not appropriately collect and analyze academic and behavioral data for students. Because of this, students at LCJDC often do not receive appropriate special education services as required by IDEA. Specifically, LCJDC is noncompliant with IDEA with respect to: 1) Child Find (see infra, below); 2) general education interventions; 3) Individual Education Programs (“IEPs”); 4) access to the general education curriculum for students receiving special education services; 5) behavioral supports; 6) staffing; and 7) transition services.

1. **LCJDC violates the due process and equal protection rights of youth confined there by failing to provide them with appropriate general educational services.**

Youth at LCJDC do not receive adequate educational services during detention, in violation of their equal protection and due process rights. Under State law, youths are entitled to a minimum of five hours of educational instruction each weekday during the academic year, Miss. Code Ann. § 37-13-91(d), as amended. Students at LCJDC reported receiving instructional class only Monday through Wednesday until the week of our November 2009 tour. Beginning with the week of our tour, students and staff stated that instruction occurs Monday through Thursday, with Friday reserved for television or movies. Youth detained at LCJDC are not receiving educational services consistent with the State’s mandatory minimum of 5 hours each weekday.

LCJDC fails to maintain any educational records and coursework does not align with that required for a student in the community to obtain a high school diploma. During classroom observation, one female student in her mid-teens was seen completing a worksheet reviewing elementary addition (e.g., $2 + 3 = 5$). Such instruction does not allow students to access grade-level curriculum available to non-detained youth. Additional inadequacies of LCJDC’s general educational services are mentioned throughout the discussion of special educational services below.

2. **LCJDC violates federal law by failing to provide adequate Child Find procedures.**

IDEA requires that the State have in effect policies and procedures to identify, locate, and evaluate youth suspected of having a qualifying disability that would entitle them to special education services. 34 C.F.R. 71 § 300.111(a)(1)(i). This is known as “Child Find.” Child Find can sometimes be as simple as asking a detained youth whether he or she has ever received special education services at the community school.

Although a structured intake assessment form exists at LCJDC, Child Find is significantly limited by inadequate or non-existent assessments and faulty scoring. LCJDC's intake forms do not capture data regarding special education status or history. Rather, the basic screening forms are limited to evaluating the educational and vocational status of youths. In our individual interviews, we identified two youths, A.E. and A.F., who had previously received special education services elsewhere but had not been identified by LCJDC as possibly having a disability entitling them to special education services. LCJDC's intake forms do not capture data regarding special education status or history necessary for Child Find.

Even if an assessment form utilizes popular evaluative tools, such as the Massachusetts Youth Screening Instrument Version 2 ("MAYSI-2") used by LCJDC, such tools are only effective for Child Find if properly analyzed and disseminated in a timely fashion. The current evaluative tools fail to satisfy these criteria. Basic scoring of intake assessments is not properly completed, and data is not used to properly guide instructional accommodations. After a student completes a basic screening, LCJDC scores the assessments using percentages and not grade level. However, given the nature and purpose of these forms, reporting the assessment as a percentage score is ineffective in guiding the teacher towards determining whether special education modifications are necessary. Moreover, score forms based on the assessments are only completed when a student is exiting the facility. Accordingly, even if the assessments were scored in a manner that would allow the teacher to make proper adjustments to a youth's curriculum or to evaluate a youth for special education services, the data would be unavailable for this purpose until the student has left the facility. LCJDC's intake and screening procedures, therefore, inadequately assist in identifying students in need of special education and related services.

3. **LCJDC violates federal law by failing to provide general instructional and evaluative interventions.**

Prior to evaluation of a student for special education, IDEA requires that the State review data-based documentation of the student's progress and consider whether the student is being provided appropriate instruction by a highly qualified teacher. 34 C.F.R. 71 § 300.309(b)(1)-(2). The State must further document the student's behavior in that student's learning environment, including the regular classroom setting.

There is no evidence that LCJDC engages in academic or behavioral pre-referral/general education interventions, data collection, or observations. Both academic and behavioral pre-referral/general education interventions should include specific methods for data collection in order to objectively evaluate student progress and the possible need for special education services. LCJDC's data collection processes are inadequate. This incomplete data is particularly troubling for students at the warning level for suicidal ideation, traumatic experiences, or anger. These youths may be entitled to special education services, but they are not being identified at LCJDC. During our tour, 6 of the 13 youths tested at the warning level on the facility's tests but were not receiving any special education services.

4. **LCJDC violates federal law by failing to provide Individualized Education Programs for youth in need of special education services.**

IDEA requires that each student with a disability have an Individualized Education Program ("IEP") to ensure that the student receives adequate special education services. 34 C.F.R. 71 § 300.323(a). No IEPs were available during our tour, and although several IEPs were provided post-tour, none were for students present at the facility during our visit. During our tour, we discovered a student with special needs who had been housed at LCJDC for 36 days with no IEP. This is a violation of IDEA.

IDEA also requires that LCJDC take reasonable steps to promptly obtain a youth's records, including IEPs or documents relating to a youth's special education status, from the previous public agency in which the child was enrolled. 34 C.F.R. 71 § 300.323(g)(1). LCJDC was unable to produce educational records for any student enrolled at the time of our tour, and staff stated that IEPs are often received after a youth has already left the facility. No data concerning student academic and behavioral IEP goals was available while on site, nor was there any indication that parents/guardians and IEP team members had met regarding any student. The absence of this data is a gross violation of IDEA.

In addition, IDEA requires that teachers implement each child's IEP, including specific accommodations, modifications, and supports. 34 C.F.R. 71 § 300.323(c)(2). No instructional adaptations were observed at LCJDC nor were any adaptations listed on lesson plans. Moreover, lesson plans were incomplete, there was no evidence of academic or behavioral-related record keeping, and lesson plans did not differentiate assignments for students at various levels. The inadequacy of lesson plans and instructional adaptations may be partly attributed to the failure to provide the teacher with IEPs until after a youth has left the facility. Without an IEP, it is impossible for the teacher to properly instruct students according to their individual needs as is required under IDEA.

LCJDC's failure to maintain IEPs violates several federal requirements, notably that: 1) adequate records are not obtained at intake or sent out at exit from LCJDC; 2) IEPs are not developed, reviewed, or reevaluated in accordance with federal law; 3) there is a high risk of inconsistencies between previous and current levels of special education service for youths; 4) there is a lack of parent/guardian and IEP team signatures; 5) there is a lack of IEP implementation and data collection; and 6) there is a possible lack of relationship between the disability of an individual youth and the IEP goals. 34 C.F.R. 71 § 300.320(a)(2)(i-ii).

5. **LCJDC violates federal law by failing to provide access to the general education curriculum for youth in need of special education services.**

LCJDC's common practice of segregating youths for discipline problems during school fails to comply with IDEA's requirement that LCJDC provide comprehensive educational services to students. 34 C.F.R. 71 § 300.304(b)(1). Specifically, no education services are available to students who are sent to their cells for discipline problems. When a student misbehaves, LCJDC routinely returns the youth to his/her cell for the remainder of the day with

no school work, even when the youth's behavior has improved. This is a patent violation of IDEA. During our tour, 13-year-old youth A.H. was in his cell without any schoolwork for the entire school day because he had refused to do schoolwork in the classroom. Our interview with R.S. revealed a calm and compliant youth who should have been returned to the classroom. Pursuant to federal law, educational services should be comprehensive so as to enable youths to continue to participate in the general education curriculum even if they must be temporarily segregated. Where safety or other penalological interests are involved, LCJDC should make individualized adaptations and return the student to class as quickly as safely possible.

6. **LCJDC violates federal law by failing to provide adequate behavioral supports for youth.**

LCJDC fails to provide positive behavioral interventions, supports and other strategies to address negative behavior, as required by IDEA. 34 C.F.R. 71. § 300.324(a)(2)(i). Positive behavioral interventions and supports include interventions for youth at the facility level, secondary interventions for youth with additional needs, and tertiary interventions for youth who require individualized behavioral interventions.

Although LCJDC employs a school-wide social skills curriculum, the primary approach to behavioral problems is reactive. As noted above, LCJDC inappropriately segregates students in cells for the remainder of the school day rather than correcting problematic behavior in the classroom. Segregation is inconsistent with IDEA, and there is no evidence that a youth's disability is considered when students are sent back to their cells or in the administration of consequences for behavioral misconduct. During our tour, we observed an announcement stating: "Any juvenile found to be disruptive to the orderly running of this facility will be recommended to 90 days detention or training school." Such reactive and sporadic disciplinary measures fail to adequately remedy or deter problematic behavior and are particularly inappropriate for youth with disabilities. Two out of seven students we interviewed regarding education reported that no reinforcement was provided as an incentive for positive behavior. Moreover, no rules or consequences were posted in the classroom as guidelines for behavior.

Perhaps the most egregious concern regarding LCJDC's use of segregation is the failure to maintain any data regarding youth segregation. No data is available regarding length of time or frequency of segregation; reason for segregation; youth behavior while segregated; or guidelines for use of segregation. Without such data, "manifestation determination" hearings cannot occur.⁶ Further, failing to chronicle segregation use prevents development of, and implementation of, modifications to general education interventions and behavior intervention plans ("BIPs"). IDEA requires that LCJDC conduct a manifest determination when it decides to change the placement of a student with disabilities because of that student's violation of the code

⁶ Manifestation determination hearings are employed when a student who receives special education services is considered for suspension, expulsion or any alternative placement due to some behavioral concern. The process is used to determine if the actions that resulted in the consideration of some disciplinary action against the student were manifestations of the student's disability.

of conduct. LCJDC's failure to log this data regarding youth segregation is a patent violation of IDEA.

Based on our review of teacher reports, it appears that students who missed up to two days of school per week were allowed to watch movies on Fridays as incentive for positive behavior. This reward system is problematic because it disengages students from instruction during the movies and permits an excessive number of absences. LCJDC's system to address student behavior is ineffective and places youth with disabilities at a significant disadvantage for maintaining access to the general education curriculum. More specific behavioral reinforcements should be implemented throughout each day as part of a facility behavior management program.

To adequately address student behavior, LCJDC should implement secondary behavioral interventions for youth who do not need individual programs but need support beyond the facility plan. Under IDEA, when a youth's "behavior impedes the child's learning or that of others, consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior," 34 C.F.R. 71 § 300.324(a)(2)(i). An effective behavioral intervention plan is an intervention that is designed to promote positive, pro-social student behavior.

Pursuant to IDEA, behavior that is a manifestation of a disability should result in a functional behavior assessment and the development or modification of the current behavior intervention plan. Teachers and staff should be held accountable for consistently and accurately evaluating student behavior, recording data, and using student behavioral data, as per individualized programs. At LCJDC, no evidence of any functional behavior assessment or individual behavior plans exists. Further, it is not apparent that teachers and staff are held accountable for consistently and accurately evaluating student behavior, recording data, and using student behavioral data.

7. LCJDC violates federal law by failing to provide adequate educational staffing for youth in need of special education services.

Although the student-teacher ratio at the time of our tour of LCJDC was acceptable at 13 students per 1 teacher, the current teacher is neither appropriately licensed nor qualified, in violation of IDEA. Additional teachers who are licensed and qualified are needed to meet the requirements set forth in IDEA. A staffing plan should be devised and implemented based on these current needs, and in light of federal requirements.

8. LCJDC violates federal law by failing to provide adequate transition services for youth in need of special education services.

Although IDEA requires that facilities provide transitional services, none exist at LCJDC. IDEA includes two major components in its definition of the group of activities labeled as "transition services." First, transition services should be located within a results-oriented process focused on preparing students for a fruitful life outside of the school context. Second, the

transition services that a given student receives should be based on the individualized needs of that student.

Vocational technology courses may help provide transitional services for youths. We reviewed a LCJDC memorandum about a vocational technology program that was supposedly implemented in Fall 2009. The curricula listed classes in auto mechanics and repair, brick masonry, wood shop, refrigeration and air conditioning, culinary instructions, cosmetology, and computer technology. In reality, however, no vocational education courses exist at the facility. If the facility had vocational programs, they would need to be offered in accordance with transition services outlined in a student's IEP. Since there were no IEPs available, it is unclear whether some students have vocational education listed on their IEPs.

An additional concern regarding transition services is the lack of comprehensive and formal information concerning academic progress, which is necessary to report back to a student's home school upon exiting the facility. Although general transition procedures were provided, the lack of appropriate education and special education services, as well as academic and behavioral data, makes communication of youth progress impossible except for very general statements.

V. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional and federal statutory rights of youth confined at Leflore County Juvenile Detention Center, the County should implement the minimal remedial measures set forth below. Implementation of the measures should comply with generally accepted professional standards in order to ensure that youths are adequately treated, protected from harm, and provided with appropriate educational services.

A. PROTECTION FROM HARM

1. Restraints

Generally accepted professional standards require that restraints never be used to punish youth. Every application of mechanical restraints or use of force -- including handcuffs, leg shackles, belly chains, or other such restraints -- should be fully documented, including the circumstances leading to the application, efforts used to de-escalate the situation, the specific manner or technique in which force was applied, and the duration of the incident. The current facility practice of restraining residents to the bed should be immediately stopped. Any restrained juvenile should be constantly observed by staff to ensure safety.

LCJDC should develop and implement written policies and procedures that establish a graduated set of interventions that avoid the use of physical force or mechanical restraints. Generally accepted practices for juvenile justice facilities require that physical force be used by staff only in exceptional circumstances when all other pro-active, non-physical behavior management techniques have been unsuccessful and the youth presents a danger to himself or

others. In the limited circumstances when physical force is appropriate, staff should employ only the minimum amount necessary to stabilize the situation and protect the safety of the involved juvenile or others. Therefore, detention staff should be trained in non-physical, verbal interventions to de-escalate potential aggression from youth.

Youth who have been subject to force or mechanical restraints should be assessed by a medical professional following the incident regardless of whether there is a visible injury or the youth denies any injury. Subsequently, management should conduct a formal review of the incident to determine whether staff acted appropriately. The post-incident review should also be utilized to identify any training needs and debrief staff on how to avoid similar incidents through de-escalation.

2. Disciplinary Due Process

Youth detained at juvenile justice facilities have a right to due process protections in the event that they are subjected to discipline or punishment. LCJDC should establish a disciplinary system, including notification to all youth of the facility rules, the consequences for violating those rules, and their rights if they are charged with a rule violation. Youth should receive instruction on the facility rules and the disciplinary process during orientation. This information should also be provided in a facility handbook provided to each youth during orientation and should be displayed in the youths' living and program areas. If a youth is charged with a violation, minimally adequate due process protections should include: 1) the provision of written notice of the alleged violation to the detainee/youth/resident at least 24 hours prior to a hearing; 2) a written statement by the fact-finder(s) as to the evidence relied upon and the reasons for the disciplinary action taken; and, 3) unless it interferes with institutional safety, the youth should have the opportunity to present witnesses and evidence at the hearing.

Administrative and disciplinary segregation should be used appropriately. Administrative segregation should only be used as an emergency measure to control a youth whose behavior poses an immediate risk of harm to himself or others or who requires protective custody, either at the youth's request or the facility's assessment. Youths who are placed in administrative segregation for behavioral reasons should be removed from segregation as soon as their behavior no longer poses an immediate risk of harm to themselves or others. Youths placed in administrative segregation for behavioral reasons should also be provided with a due process hearing every 24 hours any time their segregation exceeds 24 hours. Disciplinary segregation should only be used as a sanction for a major rule violation, and each youth should receive a due process hearing prior to being sent to disciplinary segregation. No youth should be placed in segregation for longer than three consecutive days except for protective custody purposes.

3. Reporting & Investigating Abuse

LCJDC should adopt and implement a zero-tolerance policy for staff abuse of youths, and staff should be consistently held accountable when policy violations occur. Serious incidents, allegations of abuse, and allegations of staff misconduct should be adequately and timely investigated by neutral investigators with no involvement or interest in the underlying event.

Staff conducting these investigations should receive adequate competency-based training on the investigation process, which should be completed in a timely fashion and no later than 30 days after an incident or allegation. In the rare cases where an exception to this time frame is warranted, the exception should be documented and not granted on the basis of inadequate investigator staffing. LCJDC should also develop and implement a written process to report resident's allegations of staff abuse to the State as mandated reporters.

4. Classification

LCJDC should develop a written classification policy that takes into account: 1) separation of older residents from younger residents; 2) separation of males from females; 3) separation of violent from non-violent youth; 4) maturity; 5) presence of mental or physical disabilities; 6) suicide risk; 7) offense; and 8) case-specific information about youth who should be separated from each other. The policy should address plans to protect youth who have been victimized at the facility or who have concerns about their safety.

5. Medical and Mental Health Care

a. Screenings and Treatment

In order to comply with generally accepted professional standards to provide adequate health care services to youths in need of medical and mental health care attention, LCJDC should provide adequate, comprehensive, and reliable screening and assessment services to identify youths with serious medical and mental health needs, both at intake and throughout the youths' time at LCJDC. All youth should undergo a health screening within one hour of admission to LCJDC, or as soon thereafter as reasonably possible, in order to obtain accurate information about the youth's medical and mental health. Screenings should include information about, physical health, suicide risk, alcohol and other drug use and abuse, aggressive behavior, family relations, peer relations, social skills, educational status, and vocational status. Corrections staff who conduct screenings should be trained by a health authority. Youth requiring routine, urgent, or emergency care should receive timely referrals to qualified health professionals.

A qualified mental health professional should complete an initial mental health assessment form that summarizes the youth's prior mental health history and includes a current mental status examination, suicide risk inquiry, provisional diagnosis, and treatment plan, if applicable. Youths should be referred for mental health services where such services are indicated as a result of the mental health screening and assessment process, or where a youth demonstrates symptoms of mental illness that significantly interfere with his or her ability to complete the facility's treatment program. Mental health assessments should be adequately documented and, where indicated, should begin during the youth's time in the intake unit and include: pursuit and review of prior behavioral health records; contact with the youth's family; consultation with facility staff; interviews with the youth; and, where indicated, specialized testing and medical consultation. Medical and mental health staffing should be sufficient to provide adequate medical and mental health care services to all youths requiring such services.

LCJDC should establish and maintain adequate, formal, individualized treatment planning that articulates specific planned behavioral interventions. At a minimum, interventions should consist of regularly scheduled individual counseling. LCJDC should attempt to involve families in the treatment planning process, and treatment plans should be periodically reviewed and revised as appropriate. Treatment plans for youths who are prescribed psychotropic medications should specify the medication, its target symptoms, and the basis for using it. Qualified mental health professionals should provide and adequately document individual counseling for youths who require counseling. Documentation of counseling sessions should include clinical data regarding the youth's subjective expressions or mental status, problems addressed and the means of addressing them, the clinician's impressions of the youth's progress, and any plan for continuing treatment. LCJDC should also establish and maintain adequate transition planning. At a minimum, mental health staff should provide a written summary of the youth's mental health treatment, his response to treatment, and a recommendation regarding further care.

The provision of adequate medication management should ensure that: 1) a prescribing professional performs and adequately documents an assessment supporting the prescription; 2) the prescribing professional adequately monitors youths on psychiatric medications by conducting and adequately documenting medication monitoring visits at least monthly, or more frequently as indicated; and 3) appropriate consent is obtained prior to starting a youth on a medication.

b. Suicide Prevention and Related Mental Health Care

In order to comply with generally accepted professional standards to provide adequate services to potentially suicidal youths and take appropriate action to prevent youths from engaging in self-injurious behavior, including suicide, the County should establish a comprehensive suicide prevention program. All staff members who interact with youths should receive at least eight hours of initial, competency-based suicide prevention training and two hours of annual competency-based training thereafter. The initial training should cover the following topics: 1) avoiding obstacles to suicide prevention, juvenile suicide research; 2) why facility environments are conducive to suicidal behavior; 3) warning signs and symptoms of suicide; and 4) components of the agency's suicide prevention program. The annual training should review any changes in the facility's suicide prevention policy and update staff on any serious suicides and/or attempts, not simply repeat initial training.

LCJDC should ensure ongoing identification of suicide risk for youths. Immediately upon their arrival at the facility, newly admitted youths should receive adequate intake screening for suicide risk before leaving the intake area. Any staff member should be able to place a youth on suicide precautions. All potentially suicidal youths should be placed on suicide precautions unless a qualified mental health professional determines, following a face-to-face evaluation, that the youth is not suicidal. Youth who are admitted to segregation should receive a written assessment of suicide risk by mental health staff or by medical staff if mental health staff members are unavailable. LCJDC should ensure adequate communication among staff regarding youths' potential suicidality. Correctional, medical, and mental health staff should participate in

treatment team meetings, and all staff should understand facility policies regarding communication.

Potentially suicidal youths should be placed in rooms that are free of suicide hazards, including protrusions and tying off points, and should not be placed in isolation. Removal of youths' clothing, other than belts and shoelaces, use of restraints, and suspension of routine privileges such as visits, phone calls, and recreation, may only be employed by a qualified mental health professional as a last resort if a suicidal youth is engaging in self-destructive behavior. LCJDC should maintain sufficient staffing levels to supervise youths who require constant observation.

Youths who are removed from suicide precautions should receive regular follow-up assessments by mental health staff, including individualized treatment plans for suicidal youths that address relapse prevention and initiate a risk management plan. The risk management plan should describe: the likely signs, symptoms, and circumstances for a recurrence of suicide risk, prevention of suicidal thoughts, and actions the youth or staff can take in response to the recurrence of suicidal thoughts.

Adequate mortality-morbidity reviews should be conducted, separate from any other necessary formal investigations, after a completed suicide or a serious suicide attempt. The reviews should include: 1) review of the circumstances surrounding the incident; 2) review of procedures relevant to the incident; 3) review of all relevant training provided to involved staff; 4) review of pertinent medical and mental health services/reports involving the youth victim; 5) review of any possible precipitating factors that may have caused the youth to attempt or commit suicide; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. The mortality-morbidity review team should be multidisciplinary and include management and line staff from the direct care, medical, and mental health areas. The reviews should focus on the incident and what the facility can learn to prevent future incidents.

Furthermore, LCJDC should develop an adequate plan for intervening in suicide attempts, including ensuring that staff members notify emergency medical personnel immediately after the discovery of a life-threatening emergency; ensuring that all housing units contain adequate emergency equipment, including rescue tools; and ensuring annual mock drills for suicide attempts and annual competency-based instruction in the use of emergency equipment for staff. The facility should also establish and maintain an adequate quality assurance program to measure compliance with the facility's suicide prevention program, including the remedial measures outlined above.

6. Programming

LCJDC should ensure the availability of adequate rehabilitative programming, including, but not limited to, education, counseling, and mental health services. LCJDC should provide for evening and weekend programs and activities that allow youth to engage in meaningful activities. In addition, LCJDC should develop and implement a behavior management system

that outlines prohibited behaviors (major and minor) and the sanctions or consequences for these behaviors. Written policies and procedures should allow youth at least one hour of large muscle exercise daily.

7. Staffing and Supervision

LCJDC should ensure that staffing and supervision levels are appropriate to adequately supervise all youths. The staffing pattern should consider the structural design of the LCJDC, the need to monitor residents on suicide watch, and other day-to-day operations. For youths who are locked in their cells, staff should make and document visual checks of the youths at random intervals at least every 15 minutes with youths sufficiently visible to permit staff to verify their well-being. Documentation of monitoring should be accurate and contemporaneous.

LCJDC should develop and implement appropriate training for staff. Newly hired staff should receive the requisite hours of competency-based training and all staff should receive appropriate additional hours of annual training after the first year of employment. All such trainings should include, but should not be limited to, training in use of force, including safe crisis management and de-escalation techniques; training specific to the supervision of youths, including training on adolescent development; and training in identifying and responding to fights, assaults, and sexual activity.

8. Environmental Safety

LCJDC should develop written housekeeping and emergency preparedness plans to ensure that youth are provided reasonable conditions of care and safety. The housekeeping plan should address daily cleanliness and sanitation issues. Linens, mattresses and clothing should be routinely inspected and replaced as needed. Written policies and procedures should also be developed to address facility readiness for fires and other emergencies, including modifying the current evacuation plan to ensure safe egress during emergencies.

9. Grievance System

Youths should have an effective and reliable process to raise grievances. The process should protect youth from possible retribution by staff. A grievance coordinator should track, categorize, and tabulate all grievances, which should be reviewed and addressed in a timely manner within five days of receipt. Youths should be provided with notification of the final resolution of their grievances, and bureaucratic responses to grievances should be prohibited. Grievance forms should be freely accessible in all areas frequented by youths, and youths should have access to a grievance box from which grievances are retrieved daily.

B. EDUCATION**1. General Education**

In order to comply with federal constitutional and state statutory requirements for providing adequate general education services to youths, the County should provide youth in disciplinary confinement with the full range of educational services, provide all youth reasonable access to reading and writing materials in their cells, and ensure youths at LCJDC receive the same type and number of daily and weekly instructional minutes as other youths in the State's schools.

2. Child Find Procedures

In order to comply with federal statutory requirements for providing adequate special education services to youths with disabilities, the County should provide adequate screening of youth for special education needs. This includes obtaining prior education records from school systems in a timely fashion. Special education services should be provided to all youth with disabilities who are in need of special education and related services after they are identified, located, and evaluated in accordance with Child Find. Youths should be asked about previously offered special education during intake, and LCJDC should ensure documentation of academic interventions for youths who are struggling.

3. General Instructional and Evaluative Interventions

LCJDC should develop, implement, and maintain adequate pre-referral and general education interventions. LCJDC should also collect and maintain comprehensive educational records for all youth at the facility. Prior to evaluating a youth for special education, LCJDC should determine whether the youth is being provided appropriate instruction by a highly qualified teacher and review data-based documentation of the youth's progress, including adequate documentation of the youth's behavior in his learning environment and regular classroom setting.

4. Individualized Education Programs

Pursuant to IDEA, LCJDC should develop, implement, and maintain an adequate IEP for each youth who qualifies for an IEP and provide necessary related services. IEPs should be updated and/or completed as quickly as possible upon intake and reviewed at least annually. Services provided to youths with IEPs should be comparable to those described in the youth's IEP from his previous agency in the absence of adequate justification for changes in services. Parents and/or guardians should be included in IEP meetings to the extent possible. IEPs should be adequately implemented and include collection and reporting of data on youth progress and individual accommodations.

5. **Access to General Education Curriculum for Youth in Need of Special Education Services**

In order to ensure that youths with disabilities have sufficient access to special education services, LCJDC should provide that: 1) youths are enrolled in school within two days of intake; 2) youths are provided with access to the general education curriculum; 3) youths with, and at risk for, disabilities are provided with adequate direct instruction using research-based instructional approaches; 4) youths with disabilities receive not less than five hours of instruction daily, the same number of daily and weekly instructional minutes as other youths in the State's schools; 5) youths with disabilities are provided appropriate instructional adaptations; and 6) adequate attendance records are maintained.

6. **Behavioral Supports**

Youths with disabilities should also receive adequate behavioral supports through a systemic behavior plan that does not permit the use of segregation and exclusionary settings. Manifestation determination hearings should occur for youths with disabilities who are removed or segregated from their stated appropriate educational setting for disciplinary, administrative, or other reasons, in excess of ten days or in a pattern of removals. Secondary interventions should be implemented for youths who do not need individual behavior programs but need behavioral supports beyond those offered in the facility plan.

7. **Staffing**

LCJDC should provide adequate special education staffing by developing, implementing, and maintaining an education staffing plan and ensuring an adequate number of licensed and highly qualified teachers, as well as qualified substitute teachers, to provide instruction in all necessary courses.

8. **Transition Services**

Results-oriented, individualized, coordinated transition services should be provided for youths with disabilities who are 16 years old or older to facilitate the youths' movement from school to post-school activities.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 5 calendar days from the date of this letter.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns. Provided that our cooperative relationship continues, we will

forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA after forty-nine days of your receipt of this letter to correct deficiencies of the kind we have identified. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, the lawyers assigned to this matter will be contacting the attorney for the County to discuss next steps in further detail. If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5401.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: Joyce Chiles, Esq.
Board Attorney
Leflore County Board of Supervisors

Robert Fitzpatrick
Director
Leflore County Juvenile Detention Center

John Marshall Alexander, Esq.
United States Attorney for the
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U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Ave. NW - RFK
Washington, DC 20530*

January 25, 2011

The Honorable Lyndon Bode
Presiding Commissioner
Marion County Courthouse
100 South Main Street
Palmyra, Missouri 63461-1661

Re: Investigation of the Maple Lawn Nursing Home, Palmyra, Missouri

Dear Commissioner Bode:

We write to report the findings of the Civil Rights Division's investigation into the conditions, practices, care, and treatment of individuals at the Maple Lawn Nursing Home ("Maple Lawn") in Palmyra, Missouri. On July 1, 2009, the Department of Justice ("Department") notified you of its intent to investigate Maple Lawn pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999). CRIPA authorizes the Department to seek remedies for any pattern or practice of conduct that violates the constitutional and federal statutory rights (including those under the ADA) of persons who reside in public institutions. The Department also has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C. § 12133.

I. SUMMARY OF FINDINGS

We find that Maple Lawn violates the constitutional and federal statutory rights of people in the nursing home. Maple Lawn fails to provide services to persons with disabilities in the most integrated setting appropriate to their needs, as required by the ADA. In addition, Maple Lawn fails to prevent unconstitutional harms, or minimize the risk of such harm, from inadequate medical and nursing care; inadequate nutritional and hydration services; improper and dangerous psychotropic medication practices; inadequate pressure sore treatment and skin care; inadequate pain management and end-of-life care; and, inadequate protection from harm due to falls. Maple Lawn has inadequate quality assurance systems to identify and cure these deficiencies. Examples of these systemic deprivations of individuals' constitutional and federal statutory rights, include:

- Failure to divert individuals who could be served in more integrated settings from being admitted to the nursing home in the first place;
- Failure to have in place an adequate process to identify and plan for the discharge of individuals who could be served in more integrated settings instead of remaining at Maple Lawn;
- Inadequate emergent care for individuals suffering life-threatening, and in some cases, life-ending medical crises;
- Failure to treat known communicable diseases;
- Shockingly inadequate nutrition practices that caused at least one individual to lose as much as 20 pounds in one month, and in other cases to suffer untimely and needless deaths;
- Dangerous psychotropic medication practices, including overmedication, combining contraindicated drugs, and failing to note adverse drug reactions;
- Woefully inadequate pressure sore care and prevention, resulting in painful and needless sores;
- Exceedingly long periods of unaddressed pain, where individuals sometimes wait weeks for proper pain assessment and care; and,
- Inadequate protection from falling that has led to excessively high fall rates, where some at-risk individuals have fallen five or more times.

These system-wide deficiencies not only contribute to individuals remaining at Maple Lawn instead of being served in more integrated settings, but also result in untimely deaths and other preventable illnesses, injuries, risks, and harms.

II. INVESTIGATION

The Department and its expert consultants in relevant disciplines conducted an on-site review at Maple Lawn from October 26 through October 30, 2009. The review focused on the general care and treatment of individuals at Maple Lawn as well as on the facility's discharge planning and community integration practices. Before, during, and after our site visit, we reviewed a wide variety of relevant facility documents, including policies and procedures, medical records, and other records relating to the care and treatment of individuals at Maple Lawn. During our visit, we also interviewed Maple Lawn administrators, professionals, staff, and individuals residing at Maple Lawn. In keeping with our pledge to share information and to provide technical assistance, we conveyed our preliminary findings to Maple Lawn's counsel and to facility administrators and staff during exit briefings at the close of our on-site visit.

Despite that we identified very serious concerns, the Facility Director expressed a genuine interest in reform. Many staff members genuinely care for the well-being of those who reside at the facility. Lastly, the Department appreciates the assistance, support, professionalism, and courtesy that Maple Lawn's administrators and staff showed. We look forward to working with the County and Maple Lawn officials in the same cooperative manner we have thus far enjoyed.

III. BACKGROUND

Maple Lawn nursing home is owned and operated by Marion County, Missouri. Maple Lawn is located in Palmyra, about 120 miles from St. Louis. Maple Lawn has licensures under both Medicare and Medicaid. The facility is certified by the Centers for Medicare and Medicaid Services ("CMS") to serve up to 140 individuals. Maple Lawn is made up of four wings, one of which is the locked Special Care Unit, designed for individuals with dementia. At the time of our tour, there were 101 individuals in the facility.

IV. FINDINGS

A. MAPLE LAWN IS VIOLATING THE ADA BY FAILING TO SERVE INDIVIDUALS IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

Many individuals at Maple Lawn are not being served in the most integrated setting appropriate to their needs, as required by the ADA. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

One form of discrimination prohibited by Title II of the ADA is violation of the “integration mandate.” The integration mandate arises out of Congress’s explicit findings in the ADA, the regulations of the Attorney General implementing Title II,¹ and the Supreme Court’s decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607. In so holding, the Court explained that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Id. It also recognized the harm caused by unnecessary institutionalization: “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” Id. at 601.² As the Eighth Circuit Court of Appeals has made clear, there is a “consensus among health care professionals that community access is not only possible, but desirable for individuals with disabilities.” See Lankford v. Sherman, 451 F.3d 496, 512 (8th Cir. 2006) (quoting letter received from the Center for Medicaid and State Operations).

Maple Lawn is a segregated setting where individuals with serious illnesses or disabilities are congregated together with little to no opportunity to interact with their healthy and non-disabled peers. 28 C.F.R. § 35.130(d), App. A. at 571 (stating that an integrated setting “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible”). Individuals at Maple Lawn cannot choose with whom they associate and live, have set mealtimes with little to no choice of content, and have limited contact with the community outside the four walls of the facility. Accord Disability Advocates Inc. (DAI) v. Paterson, 653 F. Supp. 2d 184, 200-207 (E.D.N.Y. 2009) (describing characteristics of institutions to include

¹ The regulations provide that “a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities.” 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA “integration regulation” explains that “the most integrated setting” is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.” 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

² Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, “President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities” (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed “one of the most fundamental rights of Americans with disabilities: having the choice to live independently.”).

regimented daily activities, lack of privacy, and few choices). Yet the County continues to provide services in the segregated setting of Maple Lawn to too many individuals with illnesses and disabilities who could be served in the community.

This failure was made evident when we asked Maple Lawn staff to provide the names of individuals they felt could transition into the community. Staff identified only four out of the 101 individuals at Maple Lawn. In contrast, after speaking to individuals at Maple Lawn, reviewing their charts, and comparing them to similarly situated individuals who are being served in the community, our expert consultant identified additional individuals who could reside in more integrated settings.

While Maple Lawn has developed policies and procedures that could help to ensure that individuals live in more integrated settings, they do not routinely follow these policies and procedures. Maple Lawn is not taking sufficient steps to assess, identify, and prepare individuals for discharge to programs in the community. First, Maple Lawn does not have an adequate process to avoid inappropriate admissions. The Preadmission Screening and Resident Review ("PASRR") screening process employed by the facility is inadequate. Second, we found that Maple Lawn fails to adequately develop and implement transition and discharge plans for the individuals whom it has identified as ready for discharge. Finally, we found that Maple Lawn fails to engage in discharge planning for individuals who could and wish to live in more integrated settings.

1. Maple Lawn Is Violating the ADA by Failing to Avoid Inappropriate Admissions.

We find that Maple Lawn is violating the ADA by failing to have adequate processes in place to avoid inappropriate admissions. The ADA's integration mandate not only applies to individuals who are currently institutionalized but also to individuals who are at risk of unnecessary institutionalization. See, e.g., Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same). A nursing home's admission process must include a determination of whether individuals' needs could be served in a more integrated setting than the nursing home and of whether the individual is aware of and interested in community-based alternatives to nursing home care. For nursing homes that receive Medicaid funding, implementation of the federally-mandated PASRR is an essential component of an adequate admissions process.

PASRR is designed to ensure that persons with mental or developmental disabilities,³ are not inappropriately placed in nursing facilities and is an important tool for diversion from admission of individuals who could be served in more integrated settings. See 42 U.S.C. §§ 1396r(b)(3)(f)(i) & (ii), 1396r(e)(7)(A) & (B), and 42 C.F.R. § 483.128; see also Letter from the Centers for Medicaid and Medicare Services to State Medicaid Directors (May 20, 2010), available at <https://www.cms.gov/smdl/downloads/smdl10008.pdf>. PASRR requires that individuals with mental or developmental disabilities being considered for admission to a nursing facility are evaluated to determine the most integrated setting to meet their needs. Specifically, PASRR mandates a two-level screening procedure. 42 U.S.C. §1396r(e)(7)(A). Level I screening is designed to identify individuals with mental illnesses or developmental disabilities prior to their admission to a nursing home. Level I screens are done for any person for whom placement in a Medicaid certified bed is being sought, and private pay individuals must be screened as well as those on Medicaid. Level II screening is completed on those persons identified at Level I who are known or suspected to have mental illnesses or developmental disabilities. Level II screens examine whether the identified individuals' needs could be met in a more integrated setting and, if it is determined that admission to the nursing home is necessary, whether specialized services are needed, including services to help the individual gain the skills necessary to move to a more integrated setting.

PASRR is also an important tool for identifying individuals in a nursing home who can be transitioned to more integrated settings. See Letter from the Centers for Medicaid and Medicare Services to State Medicaid Directors (May 20, 2010), available at <https://www.cms.gov/smdl/downloads/smdl10008.pdf>. In that regard, PASRR mandates regular reviews of nursing home individuals' needs, including whether they could be served in a more integrated setting, upon any change in their condition. 42 C.F.R. §§ 482.116(b)(2), 483.130(n).

Our tour of Maple Lawn and review of its clinical files revealed that implementation of PASRR at Maple Lawn is inadequate, causing admission of individuals who could be served in more integrated settings. According to Maple Lawn, few individuals have mental or developmental disabilities. However, we observed instances where Maple Lawn failed to identify individuals with these disabilities prior to their admission or failed to conduct Level II screens when such individuals were identified:

- Medical information in A.A.'s⁴ file states that her medical history is "significant for schizophrenia." However, the PASRR Level I screening checked the box "no" for major mental disorder. Because Maple Lawn failed to identify A.A. as an individual with

³ Developmental disabilities covered by PASRR are broadly defined and include intellectual disabilities as well as conditions such as cerebral palsy, traumatic brain injury, and epilepsy, or any other conditions that result in impairment of general intellectual functioning or adaptive behavior.

⁴ To protect residents' privacy, we identified residents by initials other than their own. We will separately transmit to the County a schedule that cross references the initials used in this letter with the residents' actual names.

mental illness on a Level I screen, a Level II screen was never completed. Thus, no determination was ever made whether A.A. could be served with community-based mental health services.

- B.B.'s file indicates she has schizophrenia and a mild intellectual disability. A Level I screening was completed, but there was no evidence in her file that a Level II screening was completed, including an assessment of whether B.B.'s needs could be met with community-based services. Moreover, there is no evidence that Maple Lawn has contacted either the State or local developmental disability office to arrange for an assessment of B.B.'s capabilities and needs.

Maple Lawn's failure to have an adequate admissions process in place, including its failure to adequately conduct PASRR screens, is leading to individuals being served in more restrictive settings than appropriate to their needs, in violation of the ADA.

2. Maple Lawn is Violating the ADA by Failing to Provide Adequate Transition and Discharge Planning for Individuals It Identifies As Ready for Discharge

Maple Lawn is violating the ADA by failing to have an adequate process to identify and plan for the discharge of individuals who could be served in more integrated settings instead of remaining at Maple Lawn. Maple Lawn's discharge planning process is causing individuals who could be served in the community to remain inappropriately and needlessly institutionalized in violation of the ADA. *Olmstead*, 527 U.S. at 607. Effective discharge planning must focus on the individual's specific capacities to function in a more integrated setting and identify and address any barriers to discharge. It should identify the supports and services necessary for the individual's successful community living. Planning for discharge must begin upon admission.

Our review of Maple Lawn's discharge plans shows that they are deficient. They do not describe, identify, or secure the community resources necessary to serve individuals in the community, despite the fact that the facility has a written discharge planning policy that requires these issues to be addressed. Maple Lawn's written policy requires two essential processes to be completed for each individual: a discharge summary and a post-discharge plan of care.

- Maple Lawn's discharge policy requires a summary of the individual's status, including medical information, physical and mental functional status, sensory and physical impairments, mental and psychosocial status, discharge potential, activities potential, rehabilitation potential, cognitive status, and drug therapy. According to the policy, this information is to be filed in the individual's medical record.
- Maple Lawn's post-discharge plan requires a description of how the individual and family will access and pay for needed services, a description of how the care should be coordinated if continuing treatment involves multiple caregivers, and the identification of specific needs after discharge including personal care, Activities of Daily Living ("ADLs"), self-administration of medications, diet,

sterile dressings, and physical therapy. Appropriate referrals, when necessary, are to be made by social services and documented in the medical record. The policy also requires the institution to: discuss preferences for care with the individual and his or her family; discuss how the individual and family need to prepare for discharge; and review the post-discharge plan with the individual and family.

The documentation in the files of individuals at Maple Lawn, however, routinely revealed a failure to complete both a discharge summary and a post-discharge plan. Essential components of adequate discharge planning are not developed or shared with the individuals and their families. This failure occurred in both files of persons recently discharged and in individuals who were identified by staff as persons who could return to the community. There was no documentation of an individual's preferences for care, how such care is to be paid for, how care is to be coordinated, what specific care needs have to be addressed after discharge, and what preparation has to be done before discharge. In almost all instances, the documentation on the summary concerning discharge planning simply states that the individual requires 24-hour care and supervision.

Examples of deficient discharge planning for individuals whom Maple Lawn staff identified as ready for community placement include:

- C.C. is at Maple Lawn to recuperate from complications following surgery. C.C. stated that he plans to return home soon and have his ex-wife care for him, as he is starting to feel better from the hospitalization, attending rehab, and working on getting his strength back. However, a review of C.C.'s file provided no indication that Maple Lawn staff had discussed with C.C. the capacity of his ex-wife to provide care or explored the services and supports necessary to meet his needs in the community.
- D.D. was admitted to Maple Lawn as a result of a hip fracture that required rehabilitation. D.D. ambulates with a wheelchair and a walker, and needs limited assistance in bed mobility, transferring, and toileting. Yet, we were unable to find any documentation regarding discharge planning even though D.D. had multiple admissions to Maple Lawn for rehabilitation. This is particularly troubling, as a lack of discharge planning that addresses an individual's specific needs increases the likelihood that the individual will be readmitted to Maple Lawn in the future. It is possible that adequate discharge planning on previous admissions would have prevented D.D.'s subsequent readmission.

Moreover, in order for discharge planning to be adequate, Maple Lawn staff involved in discharge planning should be knowledgeable about community-based services and supports. During our tour of Maple Lawn and review of clinical files, it became clear that staff responsible for discharge planning were not aware of and were not sufficiently utilizing these potential resources to place individuals in more integrated, appropriate settings, in violation of the ADA.

Missouri has a range of community services that could support individuals discharged from Maple Lawn to the community. For example, the Aged and Disabled Waiver and the Independent Living Waiver (“ILW”) are two sources that may be utilized by individuals at Maple Lawn to move to a more integrated, community-based setting, including into their own home. The Aged and Disabled Waiver provides community-based services to Medicaid-eligible elderly individuals who meet a nursing home level of care, including homemaker services, chore services, respite care, advanced respite care, nurse respite care, institutional respite care, and adult day healthcare. The Missouri ILW provides community-based services to Medicaid-eligible persons between the ages of 18 and 64 who meet a nursing home level of care, including personal care services, case management, specialized medical equipment and supplies, and environmental accessibility adaptations. Missouri also provides for an array of services in the community through their Medicaid State Plan, including the Consumer-Directed Services (“CDS”) program which provides personal care assistance services for Medicaid-eligible consumers with physical disabilities who need assistance with activities of daily living to live independently. Finally, according to staff at the Marion County Division of Senior and Disability Services Office, persons needing more complex assistance in their home can receive Advanced Personal Care. These services can include catheter care, bowel and bladder assistance, and assistance that requires the use of lift equipment.

In sum, even the individuals that Maple Lawn believes are ready for community placement remain improperly institutionalized in the nursing home in violation of their rights under the ADA because of Maple Lawn’s inadequate discharge planning process.

3. Maple Lawn’s Discharge Planning Process Violates the ADA Because It Fails to Identify Many Individuals Who Could Be Served in More Integrated Settings

Maple Lawn’s discharge planning process also violates the ADA because it fails to identify and plan for many individuals who could be discharged to a more integrated setting. Maple Lawn does not meaningfully engage in the discharge planning process until its treating professionals have recommended community placement. Instead of using the discharge planning process as a means to identify and address barriers to discharge, we found that Maple Lawn keeps many individuals (including those who have expressed a desire for community placement) from even reaching the point where Maple Lawn staff will explore discharge options with them. As a result, individuals who could live in integrated community settings remain at Maple Lawn because they have not received adequate assessments of the supports and services necessary to allow them to succeed in the community. Accord Frederick L. v. Dept. of Public Welfare, 157 F. Supp. 2d 509, 540 (E.D. Pa. 2001) (“Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with disabilities.”); DAI, 653 F. Supp. 2d at 259 (same).

For example, our consultant’s review of individual’s files revealed that Maple Lawn engaged in no meaningful discharge planning for numerous individuals who had expressed a strong desire to be discharged and who, in our expert’s opinion, likely could be served in more integrated settings. The fact that these individuals have indicated they wish to return to the

community should trigger a detailed analysis of how this can be accomplished or why it is not appropriate and what needs to occur so that goal can be met. For example:

- A.A. is a 75-year-old woman who came to the facility in April 2009 as a result of a motor vehicle accident that caused head and leg injuries. Her diagnoses included organic brain damage and schizophrenia. A.A.'s husband, who was also in the accident, visits regularly and stated that he has prepared their home to accommodate her physical needs when she returns home. There is no assessment in her file, however, that documents his efforts or identifies what services and supports A.A. would need to return to the community.
- E.E., a 79-year-old retired school teacher who lives in Quincy, Illinois, plans on returning there when she is ready for discharge. She came to the facility in September 2009. E.E. requires limited assistance in transferring, mobility, toileting and bathing, but is independent in dressing, eating, and personal hygiene. Despite the fact that E.E.'s needs are relatively light, there has been no determination of what services are available to meet her needs in the community once her medical condition is stabilized, and there have been no arrangements made to see that these services are delivered.

We also found examples where Maple Lawn staff failed to examine all options for community-based supports and services for individuals who had expressed a clear preference to live in the community but whose family members or other significant persons indicated that they could not themselves handle some of the individuals' needs. Instead, Maple Lawn simply determined that these individuals were not able to be discharged. However, our expert consultant identified a variety of supports that Maple Lawn failed to explore, including Advanced Personal Care through the Medicaid program, that might be able to meet these individuals' needs. For example:

- F.F., a 77-year-old, was admitted in February 2009 with chronic renal failure and advanced peripheral vascular disease. F.F. uses a wheelchair and needs assistance with his ADLs. The social service notes indicate that F.F. wants to go home, but his wife and son cannot provide 24-hour care and supervision. F.F. told us that he would rather be "someplace else" other than the nursing facility. There is no evidence in F.F.'s file that Maple Lawn staff have examined what services are available, including those through Medicaid that could meet his care needs in the community.
- G.G., a 71-year-old, was admitted in June 2009 with diabetes, hypertension, and difficulty moving muscles on one side of his body. G.G. does not require significant help with his ADLs, although he needs tube feeding and supervision with bathing, walks with the assistance of a cane, and is occasionally incontinent. G.G. is adamant that he wants to return home, and told us that he has spoken to the social service staff about this desire, but says he cannot return to the community until the feeding tube is removed. G.G. told us that he has a girlfriend who can help him with his needs. However, his file contained a doctor's note that states his girlfriend had concerns

regarding taking G.G. home because of the tube feeding and the blood testing required for his diabetes. There is no evidence in G.G.'s file indicating whether or not Maple Lawn's staff have followed-up with G.G.'s girlfriend to discuss her concerns, or indicating whether staff have examined whether other services, such as intensive personal care through Medicaid, would be able to address his needs.

Finally, we found that Maple Lawn's discharge planning process fails to provide the information individuals need to make an informed choice regarding moving to a more integrated setting. Maple Lawn should provide information to individuals in order to enable them to make an informed choice, as ambivalence among individuals about their ability to reside in the community is frequently based on a lack of information and counseling concerning alternatives. Cf. DAJ, 653 F. Supp. 2d at 267 (“[W]ith accurate information and a meaningful choice, many . . . residents would choose to live and receive services in a more integrated setting”); Letter from the Center for Medicaid and State Operations Health Care Financing Administration to State Medicaid Directors (Jan. 14, 2000), available at <https://www.cms.gov/smdl/downloads/smd011400c.pdf> (advising states that their Olmstead plans must “address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices”).

We found the following examples where Maple Lawn's failure to inform individuals about community-based alternatives to nursing home care is leading to individuals for whom discharge may be appropriate remaining at Maple Lawn:

- H.H. is 87 years old and was most recently admitted to the facility in April 2009. H.H. states that he would rather be home with his nearby family but is resigned to being in the facility. However, H.H.'s file contains no documentation of discussions with H.H. regarding the possibility of moving to the community or discussions to ascertain the reason for his resignation, and no indication of what, if any, barriers prevent his return to the community.
- I.I. is 60 years old and was admitted to the facility in April 2009. She has Parkinson's disease and coronary artery disease, needs the assistance of one person to transfer her from her bed to her wheelchair, and needs limited assistance in dressing, toileting, and bathing. In July 2009, I.I. indicated a preference to return to the community. Her daughter lives in the community and supports the discharge. When we spoke to I.I. during our visit, however, she was ambivalent about moving to the community. There is no evidence in I.I.'s file, however, that Maple Lawn staff have addressed I.I.'s ambivalence towards a return to the community through counseling or through the provision of information on what services are available to address her needs in the community.

Thus, Maple Lawn's deficient discharge planning process is leading to individuals who could be served in more integrated settings unnecessarily remaining at Maple Lawn in violation of the ADA.

B. MAPLE LAWN DEPRIVES INDIVIDUALS OF THEIR CONSTITUTIONALLY PROTECTED RIGHTS TO RECEIVE ADEQUATE HEALTHCARE SERVICES

Unnecessary segregation of individuals at Maple Lawn not only violates the ADA, but subjects them to a high risk of harm from unconstitutional conditions. Individuals residing in a county-owned nursing home such as Maple Lawn have a Fourteenth Amendment Due Process right to adequate healthcare. See Youngberg v. Romeo, 457 U.S. 307, 315 (1982); Goodman v. Parwatikar, 570 F.2d 801, 804 (8th Cir. 1978) (holding that once admitted, an individual with mental illness “had a constitutional right to a basically safe and humane living environment”). A governmental entity that holds people in confinement for care and treatment violates the Due Process Clause when it provides medical care that substantially departs from professional standards. See Morgan v. Rabun, 128 F.3d 694, 697-98 (8th Cir. 1997).

We find a number of conditions and practices at Maple Lawn that violate individuals’ constitutional right to adequate healthcare services. In particular, individuals at Maple Lawn suffer significant harm and risk of harm due to Maple Lawn’s: (1) failure to provide adequate medical care; (2) failure to provide adequate nutritional and hydration care; (3) allowing dangerous psychotropic medication practices; (4) failure to provide adequate pressure sore treatment and skin care; and (5) failure to provide adequate pain management and end-of-life care. These failures not only result in unconstitutional harms, they also contribute to a regression in individuals’ skills, leading to their prolonged institutionalization at Maple Lawn.

1. Maple Lawn’s Inadequate Medical Care Practices Are Resulting in Unconstitutional Harm.

Maple Lawn fails to provide adequate healthcare. We consistently found examples where Maple Lawn failed to properly treat the healthcare needs of individuals. As a result, individuals unnecessarily suffered falls, declined in functional abilities, and lost excessive amounts of weight without proper intervention. These failures resulted in unconstitutional harm.

At Maple Lawn, we found assessments that were inaccurate, inadequate, and inconsistent. We found care plans that were boiler-plate, did not contain measurable outcomes, and failed to address individuals’ needs. As a result, care plans appeared useless as a guide to address individual care. In our nursing consultant’s opinion, the major cause of the inadequate delivery of healthcare was inadequate nursing training, with staff unable to recognize and react to changes in individuals’ conditions. Moreover, Maple Lawn does not have an adequate quality assurance or quality improvement mechanism that would identify the deficient medical care.

The inadequate medical care of the following individuals illustrates these problems:

- J.J., who had a history of diabetes, died in November 2008. According to J.J.’s medical records, she experienced unstable blood sugars on November 11, 2008. Yet, nursing staff failed to notify her physician, failed to assess her change of condition, failed to update her care plan, and failed to timely intervene. When

J.J.'s blood sugar rose to 502 mg/dl⁵ and she began foaming out the mouth, it appears that nursing staff left J.J. in her room unattended as she was gasping for breath. When nursing staff finally returned to her room, J.J. was not breathing and did not have a pulse. Nursing staff failed to initiate life saving efforts despite clear indications to do so. According to our nursing expert, the nurse who was assigned to J.J.'s unit on the evening when J.J. died was neither properly trained to handle J.J.'s declining condition nor properly supervised while J.J.'s condition declined. Ms. J. needlessly suffered before she died. Staff's utter failure to act to treat Ms. J. can only be seen as deliberate indifference to her serious medical condition and is therefore a violation of her constitutional right to adequate medical care.

- In May 2009, K.K., who had been fairly independent and able to walk without assistance, exhibited symptoms of a stroke (left side limp and unable to ambulate). Despite this change in K.K.'s condition, nursing staff waited over five hours before they finally contacted her physician. Even then, her physician failed to evaluate her condition and K.K. continued to decline. In reviewing K.K.'s records, it also appears that nursing staff failed to reassess and document her declining condition as she worsened. Further, nursing staff continued to administer medication that increased K.K.'s risk for bleeding even though she was already at risk for bleeding. Less than seven days after her change of condition, K.K. had to be rushed to the emergency room where she was treated for a large ventricular hemorrhage and was placed in the Intensive Care Unit. When K.K. was returned to Maple Lawn on June 9, her condition had drastically deteriorated. She was unresponsive and totally dependent on nursing staff to assist with her daily needs. The facility's failure to treat Ms. K's worsening condition likely contributed to her hospitalization and decline, and again, bespoke of deliberate indifference to her serious medical needs.
- Even though L.L. had a condition identifying him as a high risk for falls, his care plan did not include specific interventions designed to reduce the risk of falls. Nursing staff thus failed to provide adequate supervision and assistance. In January 2009, L.L. fell and fractured his hip. It appears that a Maple Lawn employee witnessed the fall but did not intervene. Maple Lawn's failure to identify specific interventions given his medical history and his known proclivity for falls likely contributed to Mr. L.'s fracture that required surgery to repair.
- M.M. had a history of falls. In reviewing M.M.'s records, we found that he had a medical condition that likely contributed to several falls at the facility, but nursing staff failed to address this risk. In fact, his care was so deficient that it failed to address his known previous falls as well as his risk for future falls. As a result, he continued to fall without any intervention.

⁵ The normal blood sugar level is 70-100 mg/dl.

- N.N., whom Maple Lawn identified as a fall risk, fell 11 times between August and October 2009. Despite its knowledge, the facility made no attempt to monitor, evaluate, or revise her care plan even though she continued to fall. The misadministration of medication contributed to the increased falls during the period of August to October 2009. Nursing notes revealed that Ms. N.'s psychotropic medication was incorrectly increased during this time, and she exhibited poor balance, unsteady gait, and was lethargic; despite this, staff failed to reassess her care. Further, it appears that during this time, N.N.'s physician did not evaluate her after multiple falls and failed to detect the medication error that likely increased her fall risk.
- O.O. was prescribed a potent pain medication that could cause sedation and respiratory depression and required close monitoring. In reviewing Mr. O.'s record, it appears that he had an adverse reaction to the medication, yet nursing staff failed to monitor him closely and failed to treat him despite his negative reaction to his medication. Again, Maple Lawn failed to act to treat known risks of harm.

Maple Lawn's nursing staff did not appear to monitor individuals for any of the known side effects of drugs. For example, none of the nursing notes that our consultants reviewed suggested that staff rule out, or even consider, the role of an individual's drug protocol in contributing to falls. It is likely that a substantial number of fall-related incidents occur from polypharmacy, or the use of multiple and often unnecessary medications.

Maple Lawn also fails to adequately assess, manage, and treat communicable diseases. We learned during our on-site visit that Maple Lawn did not have a dedicated Infection Control Nurse, which likely contributed to inadequate staff training and poor facility practices. Even more alarming, Maple Lawn lacked adequate policies and procedures regarding infection control and infection surveillance and tracking. Notably, nursing staff admitted that, even though infections were a current and past problem, in-service training on infection control was never provided. The following examples illustrate the facility's failure to adequately treat communicable diseases:

- Even though P.P. complained of rectal pain and diarrhea, nursing staff failed to test for a bacterial infection. Nursing staff waited nearly five weeks before they finally ordered a lab test that confirmed a potentially life-threatening and highly contagious bacterial infection. In our nursing consultant's opinion, Maple Lawn's failure to timely treat P.P.'s condition unnecessarily exposed individuals and staff to an unreasonable risk from infectious disease.

- Q.Q. was diagnosed with Methicillin Resistant Staph Aureus (“MRSA”)⁶ in her urine in September 2009. In reviewing Q.Q.’s records, we found that nursing staff failed to maintain proper contact isolation to prevent the spread of MRSA to other individuals.
- R.R. was diagnosed with MRSA in his respiratory tract yet staff did not isolate him. In fact, we learned that R.R. was placed in a semi-private room where there were no isolation carts or supplies readily available for the staff.
- Another individual, S.S., was diagnosed with MRSA in his respiratory tract and nursing staff failed to use isolation carts and failed to have supplies readily available for the staff to prevent the spread of MRSA.

A major contributing factor to the nursing home’s inability to prevent the spread of infectious diseases stems from the fact that the Maple Lawn does not have policies or procedures that address isolation to prevent the spread of these prevalent and serious infections, and the facility staff have not been properly trained to address these issues. In any event, the facility’s failure to adequately treat highly contagious and potentially life threatening communicable diseases exposes individuals to unconstitutional harm.

2. Maple Lawn’s Inadequate Nutrition and Hydration Practices Expose Individuals to Unlawful Harm.

Individuals at Maple Lawn have a constitutional right to adequate food. Youngberg, 457 U.S. at 315. Nursing facilities, such as Maple Lawn, are also obligated by federal regulation to provide individuals with adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 C.F.R. § 483.25 (i-j).⁷ Maple Lawn’s inadequate nutrition and hydration practices have resulted in unlawful harm. In particular, we found that staff and physicians fail to adequately treat individuals with significant weight loss or poor oral intake. As a result, individuals have suffered, and sometimes, have died untimely and needless deaths. In cases where there was clear evidence that individuals had inadequate oral intake, we noted that licensed nurses did not determine the reasons why intake was poor.

We reviewed weight records for the month of September 2009 and were alarmed to find that staff did not weigh any individuals during this period. This is an egregious departure from generally acceptable professional standards of care. In our discussion with the facility dietician,

⁶ Methicillin Resistant Staph Aureus (“MRSA”) are drug-resistant bacteria that can cause different kinds of illness, including skin infections, bone infections, pneumonia, and severe life-threatening bloodstream infections. MRSA is particularly prevalent and virulent in institutions where many people are housed in close proximity and basic hygiene may be lacking.

⁷ Federal nursing home regulations require a high quality of care and establish generally accepted professional standards.

she confirmed that weights likely were not taken in September and emphasized the importance of having members of the nursing department participate in monitoring and tracking individuals' nutritional status. Yet, we learned during our site visit that the nursing department had abdicated its responsibility for monitoring individuals' weights to the restorative department. When we reviewed weight loss records, we were unable to find any evidence that restorative staff were involved in tracking weight changes, nutritional intake, or overall nutritional status. The failure to weigh individuals for the entire month of September calls into question Maple Lawn's avowed practice of accurately monitoring individuals' weights, and undermines data concerning nutritional and hydration status as well.

The following are examples of dangerously inadequate nutritional and hydration care for individuals at Maple Lawn. Many of these examples, again, demonstrate staff's utter failure to treat serious, and in some cases, life threatening conditions.

- T.T. is 105 years old and was admitted to the nursing home in May 2008. She had a history of diabetes, glaucoma, depression, and dementia. In reviewing her weight logs, we noted that Ms. T. lost nearly 20 pounds in one month. Nursing staff did not report this significant loss to her physician or evaluate her condition to determine the cause of the weight loss. As a result, this potentially life-threatening weight loss went unaddressed by the facility.
- J.J. was 75 years old and died in November 2008. Ms. J. had an extensive medical history; most notably, she had brittle diabetes⁸ and required strict monitoring. Despite her medical history, it appears that Maple Lawn staff failed to adequately monitor her condition. As J.J.'s condition declined and she apparently stopped eating, nursing staff failed to contact her physician, failed to assess her changing condition, failed to monitor her blood sugar levels, failed to follow physician's orders for insulin, and failed to intervene in any way. Even though Ms. J. consumed no food on the day that she died, nursing staff continued to administer long-acting and fast-acting insulin until she had irregular breathing and was foaming at the mouth. When Ms. J.'s heart and respiration ceased, nursing staff failed to initiate life saving efforts to resuscitate her despite clear direction in her chart to do so. In our medical consultant's opinion, Ms. J. likely died from hypoglycemic shock -- excessive insulin administration leading to severely low blood sugar and death.
- In another example, U.U., a 91-year-old, was admitted from Maple Lawn to the hospital in July 2009 after she lost a great deal of weight and became severely anemic. While at the hospital, Ms. U. received a blood transfusion, which significantly improved her condition. Thereafter, she returned to the nursing home and again, lost a significant amount of weight -- nearly 11 pounds in one

⁸ Brittle diabetes is a term used to describe a type of diabetes when a person's blood glucose (sugar) level often swings quickly from high to low and from low to high.

month. This significant weight loss was not reported to her physician for several weeks. When the doctor finally evaluated her, he noted a “rapid deterioration,” yet he did not make any changes to her medications. One week later Ms. U. died. The lack of medical and nursing interventions and monitoring likely contributed to her death.

- In October 2009, I.I. lost 18 pounds, yet Maple Lawn staff failed to adequately assess and monitor his condition. The failure to assess and respond to Mr. I.’s declining nutritional status and weight loss is emblematic of the unlawful actions of Maple Lawn staff.

In summary, due to Maple Lawn’s failure to consistently weigh, monitor, assess, and evaluate individuals’ nutritional needs, many individuals have unnecessarily suffered avoidable weight loss, compromising their individual conditions, and in some cases these failures have hastened these deaths. In all cases, the resulting harm was unconstitutional.

3. Maple Lawn’s Psychotropic Medication Practices are Causing Unconstitutional Harm

Maple Lawn is providing unnecessary psychotropic medications in violation of the law. Both federal law and generally accepted professional standards require that nursing home individuals be free from unnecessary anti-psychotropic medication. 42 C.F.R. § 483.25(1)(1). Psychotropic medications are widely prescribed at Maple Lawn. Over half of those who live at Maple Lawn receive multiple psychotropic medications, many without clinical justification. Even more alarming, we found in almost every case that we reviewed, the treating physician did not monitor the effectiveness of the prescribed medication and nursing staff failed to monitor changes in individuals’ condition. When we asked about the shockingly high numbers of psychotropic medications administered to individuals, the facility’s consultant pharmacist told us that he is “trying to reduce the number of prescriptions,” but his efforts have been ineffective because his recommendations for medication reduction are rarely accepted by the treating physicians. Problems with psychotropic medication practices may stem from Maple Lawn’s failure to appropriately divert individuals with mental illnesses from admission to the nursing home in the first place, as discussed in Part IV(A)(1) above.

We found numerous examples of unnecessary medication use at Maple Lawn, where little or no apparent effort had been made to reduce dosage and little or no monitoring had been undertaken of the appropriateness of the dose or drug interactions. For example:

- N.N., discussed above, was prescribed a psychotropic medication. Her records revealed that in July 2009, nursing staff took a verbal order to decrease her dosage, but instead, increased the dosage by 25 mg. For nearly three months, nursing staff failed to recognize the medication error and failed to monitor the side effects that the medication was causing. During this period, N.N. fell 11 times, a potential side-effect from the medication, yet nursing staff failed to complete an evaluation.

- V.V. has a history of Alzheimer's disease and was prescribed antipsychotic medications since at least May 2009. Although he was prescribed medications for agitation, there was no documentation in his record of any recent symptoms that required the medication. Further, we noted that his physician refused to reduce his medication dosage despite clear indications that Mr. V. exhibited no signs of agitation or restlessness for several months.
- Q.Q. was admitted to Maple Lawn in November 2008. Q.Q. was prescribed four antipsychotic medications, two anti-anxiety medications, two pain medication drugs, and one drug for Parkinson's symptoms. In September 2009, nursing staff notified the physician that Q.Q.'s hands were shaking, a potentially adverse reaction to the antipsychotic medication, yet the physician neither reduced nor changed her medication for nearly one month. Her medical records indicate that, during this period, nursing staff failed to properly assess her changing condition or to monitor the side effects that her medication caused.
- W.W., an 89-year-old resident who died prior to our visit, was prescribed 29 different drugs up until his death. It appears that his physician failed to consistently review the list of drugs that W.W. was taking. According to our expert consultant, the excessive numbers of drugs likely contributed to W.W.'s decline in condition.
- X.X. had been taking psychotropic medication without adequate monitoring and assessment. It was not until his family intervened that Maple Lawn staff finally assessed and reduced his medication.

Finally, we found a concerning pattern of prescribing a medication used to treat urinary urge incontinence without records that could explain the rationale for prescribing this medication. Even more troubling, we learned that despite the facility pharmacist's request to discontinue this medication because of possible adverse effects, Maple Lawn's physicians continued to prescribe the medication without addressing the pharmacist's concern.

In summary, the nurses' and physicians' failures with regard to psychotropic medication practices are unlawful and are causing unconstitutional harm.

4. Maple Lawn Fails to Adequately Treat Individuals with Pressure Sore and Skin Care Needs

We find that individuals at Maple Lawn are suffering painful and preventable pressure sores due to unlawfully inadequate services. Federal law and generally accepted professional standards require that nursing homes ensure that individuals with pressure sores receive necessary treatment. See 42 C.F.R. § 483.25(c)(1). Maple Lawn's unacceptable pressure sore care and skin care place individuals at risk of harm. We found several instances where staff failed to take basic steps necessary to adequately care for pressure sores. Staff failed to turn and reposition individuals, failed to assess and report changes in individuals' condition, and failed to

accurately document individuals' records. In our expert consultant's opinion, these failures likely occurred because nursing staff are not adequately trained in pressure sore prevention and treatment.

In reviewing the in-service training records for the six months prior to our on-site investigation, we noted minimal training sessions devoted to identifying and treating pressure sores and skin care. Even more troubling, Maple Lawn did not have a clearly defined set of policies and procedures guiding pressure sore prevention and treatment. In addition, Maple Lawn's pressure sore treatment and prevention program lacks multidisciplinary involvement. Adequate nutritional care is critical in the prevention and treatment of pressure sores. Unfortunately, there is no evidence that the dietitian participates in any team effort on prevention or treatment of pressure sores. Similarly, medical staff and therapy staff are not involved in a group effort to address pressure sore prevention and treatment.

The combined deficiencies in nurse training and lack of multidisciplinary involvement in pressure sore treatment and prevention is causing grievous harm. The following are examples of the harm suffered because of inadequate pressure sore treatment:

- L.L. fell and fractured his hip at the facility in January 2009, and staff noted that he was at high risk of skin breakdown. Because of the fracture, L.L. had limited mobility and was dependent on nursing staff for repositioning in his bed and wheelchair and for removing his stockings and boots every evening. However, nursing staff failed to adequately provide this care. As a result, Mr. L. developed a Stage II pressure sore⁹ on his heel and Stage I pressure sore on his coccyx. Even after staff noted the facility-acquired sores, they waited two days before they finally notified his physician or the wound care nurse. When the wound care nurse finally saw him, she noted his Stage II pressure sore and recommended treatment. Nursing staff, however, waited four days before they finally attempted to treat the sores on Mr. L.'s heel and coccyx.
- Y.Y. was at risk of skin breakdown and required daily skin inspections. In reviewing Y.Y.'s records, we found that in May 2009 nursing staff noted a skin breakdown on Y.Y.'s heel but failed to document it in the weekly skin report. For two months, staff failed to conduct daily skin inspections of Mr. Y. As a result of Maple Lawn's absence of care, Mr. Y.'s wounds were not identified until July 2009 when they were advanced (Stage III or IV) and had become infected.

⁹ Pressure sores are staged I - IV according to severity as follows: stage I - intact skin but reddened, non-blanching; stage II - partial thickness injury like an abrasion or blister; stage III - full-thickness pressure damage extending into subcutaneous tissue; stage IV - full-thickness tissue destruction to muscle, tendon or bone. It is critical that pressure sores be "staged" accurately, as the type and frequency of treatment depends on the wound being accurately assessed.

Discolored drainage from his heel indicated that his wound was infected and painful.

- P.P. was known to be at risk for skin breakdown and was totally dependent on staff for her care. In reviewing P.P.'s records, we found that she developed a facility-acquired pressure sore that nursing staff neither identified nor treated. In fact, it was not until P.P. was admitted to a local hospital that the pressure sore on her buttocks was identified and treated. It is most likely that the wound was present in some stage prior to her hospital admission, yet Maple Lawn nursing staff failed to assess, develop a care plan, or treat P.P.'s condition.
- Z.Z., another totally dependent individual who was known to be at risk for skin breakdown and required repositioning in her bed, developed a facility-acquired pressure sore. In reviewing Z.Z.'s records, we found that nursing staff failed to turn and reposition her, failed to conduct daily inspections, and failed to update and individualize her care plan. As a result, Z.Z. developed a pressure sore on her coccyx that became infected. In our expert consultant's opinion, the staff's failures to provide care likely caused the development of her skin breakdown.

5. Maple Lawn's Inadequate Pain Management and End-Of-Life Care is Causing Unlawful Harm

Maple Lawn does not provide adequate pain management and end-of-life care practices to those in residence. Federal regulations require nursing homes to assess individuals for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d). Diagnosing and treating pain is essential to the practice of medicine and is especially urgent in caring for elderly individuals and those with terminal illnesses. During our review, we found several examples where the nursing home failed to adequately manage or assess individuals' pain. Examples of inadequate pain management that are causing grave harm include:

- A.B. was admitted to Maple Lawn in July 2009 after suffering a fractured spine. Although she was admitted for short-term rehabilitation, she died less than three weeks after admission. From the outset, Ms. B. complained of pain yet staff waited nearly two weeks before they finally contacted her physician to address her continued complaints of pain. During this period, Ms. B. refused to eat, threatened to "let self go," and stated that she was "tired of the pain." Even then, Ms. B.'s physician did not come to the facility to assess her condition; rather, he simply increased her medications and quadrupled the strength of her fentanyl patch¹⁰. Thereafter, Ms. B. became unable to eat or drink and increasingly nonresponsive and died within a week.

¹⁰ A fentanyl patch is a narcotic (opiod) pain medicine applied to the skin for treating persistent moderate to severe pain.

- A.C. was admitted to Maple Lawn in April 2009 after suffering from breast cancer complications. Despite clear indications that A.C. required pain management, it appears that nursing staff failed to adequately address her pain. Nursing staff mistakenly administered a short-acting form of morphine rather than a long-acting form to address her pain. According to our medical expert, this medication error likely contributed to an escalation of pain that went untreated. In reviewing the nurse's notes, it appears that Ms. C. suffered laboring breathing, twitching, shaking, and moaning when staff attempted to reposition her in her bed, yet we were unable to find any indication that Ms. C.'s drug regime was adjusted to address her pain.
- A.D. was admitted to Maple Lawn in June 2009 after suffering from obstructive pulmonary disease and a prior stroke. Mr. D. steadily declined in the three months before his death. In reviewing Mr. D.'s records, we found that A.D.'s care plan lacked specific direction for comfort measures, symptom management during this terminal illness, and any social services assessment and plan for his needs. Further, his physician ordered a series of painful and futile interventions that likely exacerbated his discomfort. The nurses notes state that Mr. D. "was rubbing his stomach and grimacing," "restless," "gaggy," "drawing up legs," and "whispered 'ow,'" yet his physician did not increase his medication dosage. In our expert consultant's opinion, Maple Lawn's treatment of Mr. D. is a gross deviation from lawful practices.

C. MAPLE LAWN SUBJECTS INDIVIDUALS TO HARM IN VIOLATION OF THEIR CONSTITUTIONAL RIGHTS AND FEDERAL LAW

Through Maple Lawn's acts or omissions, individuals suffer harm, or are at risk of harm from preventable deaths, preventable falls, fractures, unexplained injuries, skin tears, and bruises. The Due Process Clause of the Fourteenth Amendment requires a county-run facility to protect individuals from harm when it affirmatively places those individuals in danger. Tinder v. Lewis County Nursing Home District, 207 F. Supp. 2d 951, 955-57 (E.D. Mo. 2001) (holding that the nursing home violated plaintiffs' substantive due process rights because it had a duty to protect or care for an individual when it affirmatively placed that individual "in a position of danger the individual would not have otherwise faced"). The facility must deliver services with "reasonable care and safety." Youngberg, 457 U.S. at 324. It must also take all reasonable steps to protect those who live at the facility from harm. Id. at 315-16. Maple Lawn violates the constitutional rights of those who reside at the facility when it affirmatively places them in dangerous positions they otherwise would not have otherwise faced. Tinder, 207 F. Supp. 2d at 955-56.

1. Fall Risk

Individuals at Maple Lawn suffer serious injuries from preventable falls, where staff fail to reasonably mitigate known fall risks. More than 50 individuals at Maple Lawn suffered 166 documented falls between January and September 2009. Almost 20% of these individuals fell

more than five times, many resulting in serious injuries. The following 12 individuals suffered a total of 108 documented falls during this period; in each case, staff response was so cursory or delayed, it amounted to a deliberate indifference to their needs for care and resulted in unnecessary pain. See Estelle v. Gamble, 429 U.S. 97, 104 (1976) (concluding that deliberate indifference to medical needs constitutes an unnecessary infliction of pain (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976) (joint opinion))).

- A.E. fell six times between January and September 2009. Following one fall, Maple Lawn staff described A.E.'s left hand as "purple." Over the next five days, A.E. fell twice more. Staff noted her falls, but provided her with no medical care. After complaining of pain in her right leg and being unable to bear weight, it was discovered that A.E. had fractured her left wrist and right foot.
- A.F. had seven falls and three injuries over three months, including from tripping over another individual, and walking with closed eyes. Staff did not change the care provided to A.F. after any of the seven events.
- A.G. fell nine times over a six month period, with no record of follow-up or care.
- A.H. fell, first, from a sitting position, and later, after attempting to stand. There is no indication that staff changed his mobility protocol as a result.
- A.G. had 22 falls in six months, including eight in one month, yet there is no documented follow-up or care.
- A.I. had 13 falls while walking in socks, trying to sit, or trying to "fly," and in no case did staff note preventive intervention.
- N.N. had 11 falls in 12 weeks, where staff failed to take measures to prevent additional falls.
- I.I. had ten falls over four months, yet again, there is no documented response of a change in his care plan to prevent further harm.
- A.J. had had nine falls, with no appropriate staff intervention or follow-up documented.
- A.K. had six falls, with no appropriate staff intervention or follow-up documented.
- A.L. had six falls in 90 days, with no appropriate staff intervention or follow-up documented.
- A.M. had five falls, with no appropriate staff intervention or follow-up documented.

By failing to take action to prevent falls when falls risks are not just known but obvious, Maple Lawn acted with deliberate indifference to individuals' needs. See, e.g., Snow v. City of Citonelle, et al., 420 F.3d 1262, 1270 (11th Cir. 2005) (finding sufficient evidence of deliberate indifference where custodian failed to act in response to known risk of serious harm).

2. Risk of Preventable Injury

Individuals at Maple Lawn also suffer from harm from fractures, bruises, and skin tears. In many of these situations, staff creates a danger by failing to provide adequate nursing assistance and supervision. Further, Maple Lawn creates a serious risk of harm from hazardous environmental conditions. For example, Maple Lawn nursing and facility staff exposed people in the facility to harmful, and even potentially fatal, toxins on at least four occasions during our review. Facility staff left the cleaning utility room unlocked and unobserved, even though staff left a large bucket containing cleaning solution on the counter. Staff left the storage room unlocked, where cabinets contained hazardous solutions.

Maple Lawn also fails to investigate unknown injuries, even when they continue. In a particularly disturbing example, U.U., discussed above, had a number of unexplained injuries that Maple Lawn staff failed to investigate. Staff discovered U.U. with a large bruise under her right eye. Within days of that discovery, U.U.'s nurse found both of her eyes "blackened," and U.U. crying and "very tearful." Thereafter, staff regularly found skin breaches and "muscle knots" on U.U.'s back, and she was crying almost daily. U.U.'s charts also showed that blood was seeping from her right ear canal. U.U. slowed, and then stopped eating altogether, and soon died. Maple Lawn's failure to investigate these injuries likely contributed to their continuation.

3. Risk of Harm Created by Improper Drug Storage and Inadequate Care

Maple Lawn also creates a serious risk of harm by failing to properly monitor and secure dangerous drugs. Maple Lawn has no system to safely monitor, store, and control dangerous drugs. For example, nurses neither count nor record the number of Demerol or Morphine Sulfate on their units. Both Demerol and Morphine Sulfate are highly addictive and severely restricted narcotics. We also learned that nurses pre-sign blank or partially completed control sheets, which deviates so substantially from accepted professional standard of having two nurses count and sign a control log together that it evidence a deliberate indifference to care. Maple Lawn's failure to track controlled medications increases the likelihood for medication to become lost, misappropriated, or misused.

Maple Lawn also creates a serious risk of harm to its individuals from inadequate repositioning and continence care, which increases an individual's risk of harm from pressure sores and infections. Maple Lawn's own nurses and nursing assistants report that weekend unit staffing is particularly inadequate. As a direct result, staff do not deliver incontinence care, and individuals sit in feces and urine for long periods of time. Aides do not routinely turn or reposition individuals as required. These lapses deprive individuals of their constitutional right to adequate care. Youngberg, 457 U.S. at 315.

4. Inadequate Nursing Policies

Maple Lawn creates a serious risk of harm because it had no nursing services policy and procedure manual. When our nursing consultant requested Maple Lawn's manual, the Director of Nursing ("DON") provided internet print-outs of policies that staff had included in generic guidelines written by Maple Lawn within the past day. Maple Lawn's Assistant Director of Nursing ("ADON") assembled a smaller, unit-based policy and procedure manual that contained some of the same policies as the DON's manual but that also had completely different policies. Maple Lawn's manual was inadequate in both scope and implementation. For example, it failed to address infection control. It contained procedures on hand washing, but no isolation procedures to prevent the spread of highly infectious contagious infections, though they have been found at Maple Lawn. Finally, because the policies did not consistently reflect implementation or review dates, the nursing staff was unable to determine which policies were current.

All of these failures to provide basic care are resulting in serious injuries and violating the constitutional rights of the individuals at Maple Lawn.

V. MINIMAL REMEDIAL MEASURES

To remedy the deficiencies discussed above, and protect the constitutional and statutory rights of individuals at Maple Lawn and those at risk of being institutionalized at Maple Lawn, the County should promptly implement the minimum remedial measures set forth below.

A. MOST INTEGRATED SETTING

In order to remedy its failure to serve its individuals in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulation, it is essential for Maple Lawn to provide transition, discharge, and community placement services to ensure that all individuals residing at Maple Lawn are served in the most integrated setting appropriate to their needs.

Maple Lawn should have an admissions process in place that examines whether individuals could be served in more integrated settings and that provides individuals information about alternatives to nursing home care. As part of this process, and in order to ensure that persons with mental or developmental disabilities are not inappropriately placed in a nursing facility, Maple Lawn should adequately complete PASRR screenings, including regular individual reviews, to examine whether the individual could be served in a more integrated setting.

Maple Lawn should also have in place a discharge planning process that ensures that individuals who could be served in more integrated settings are identified and that appropriate plans are developed and implemented. Maple Lawn should actively pursue, from the time of admission, the appropriate discharge of individuals residing at Maple Lawn and provide them with adequate and appropriate supports and services consistent with each person's individualized

needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object. Maple Lawn should assume that every admission is temporary until there is overwhelming medical and psychosocial evidence that the placement is going to be for a long period of time. It must clearly understand individuals' desires concerning where they would ultimately like to reside after their stay in the facility. While it is important to recognize and document the need for the current level of care, there also needs to be an ongoing conversation about what the individual's plan is for the future.

During the treatment planning process and in implementing individual treatment plans, Maple Lawn should ensure, for all individuals, that barriers to discharge are identified and addressed, and for individuals with a history of re-admission, that factors that led to re-admission are analyzed and addressed. Discharge planning should begin upon admission and should be an on-going process for all individuals, not only for individuals Maple Lawn's staff have deemed imminently ready for discharge. Treatment plans should set forth in reasonable detail a written transition plan specifying the particular supports and services that each individual will or may need in order to safely and successfully transition to and live in the community. The plan should include, at a minimum: the individual's and families' preferences for care; a discussion of how the individual and family will access and pay for such services; the names and positions of those responsible for the individual's care, making appropriate referrals when necessary; a plan on how to coordinate care among multiple caregivers, if applicable; identification of the individual's specific needs after discharge; a discussion of how the individual and family need to prepare for discharge; and corresponding time frames for completion of needed steps to effect transition. In order to Maple Lawn staff to be able to develop and implement adequate discharge plans, they should become knowledgeable with the range of community-based services available to individuals being discharged from Maple Lawn, including the Aged and Disabled Waiver, Independent Living Waiver, Consumer Directed Services program, and Advanced Personal Care.

In order to support individuals in making an informed choice regarding discharge, Maple Lawn should ensure the participation in all aspects of care, treatment and discharge planning by the individual, his or her guardian, family, and friends, as appropriate, and staff who know the individual best. Staff should provide information and counseling to individuals, their guardians, and/or families regarding community supports and services that could support the individual's discharge to a more integrated setting, and information about the transition process. Further, staff should provide counseling and information to address any objections from individuals to being discharged to a more integrated setting, and document those efforts. If an individual opposes placement, Maple Lawn should document the steps taken to ensure that any individual objection is an informed one.

Finally, in order to ensure continuity of care upon discharge, Maple Lawn should require contact with identified community providers prior to discharge, and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. Maple Lawn should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged

individuals to determine if they receive care in the community as set forth in their discharge plan; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

B. HEALTHCARE SERVICES

Medical Care

In order to provide adequate medical care, Maple Lawn should develop and implement comprehensive care plans for each individual that specifically address her or his needs. 42 C.F.R. § 483.20. Each care plan should include: an initial assessment; nursing diagnosis; care planning; interdisciplinary intervention; and an evaluation. The initial assessment is arguably the most important step in developing adequate and appropriate care plans. Care plans should be comprehensive and focused to address specific needs.

Maple Lawn should implement procedures to ensure that nursing staff timely recognize and identify problems and needs. Nursing staff should then devise care plans, evaluate the plans for effectiveness, and update and change the plans when goals and outcomes are not achieved. Maple Lawn should ensure that interdisciplinary teams consisting of nursing, dietary, social services, activities, and rehabilitation staff are established to ensure that all care plans have measureable outcomes, have time-limited goals, and reflect changes in an individual's condition. Generally accepted professional standards require Maple Lawn to provide individuals necessary care and services to attain or maintain highest practical physical, mental, and psychological well-being. 42 C.F.R. § 483.25.

Nutrition and Hydration Care

In order to provide adequate food and basic care, and meet generally accepted professional standards, Maple Lawn should implement procedures that ensure that individuals receive adequate nutrition, including sufficient fluids, to maintain their health and well-being. See 42 CFR § 483.25(i-j). All individuals should be assessed and care plans should be devised with measureable and time-limited goals. Each assessment should track and calculate calories, proteins, carbohydrates, and specific nutrition and hydration needs. Individuals should be weighed on admission and readmission weekly for four weeks, then monthly unless there is a change in an individual's condition. Any individual who loses five percent of total body weight in one month or 10 percent in six months should be re-evaluated and nursing staff shall contact the attending physician.

Nursing staff, along with assistance from restorative staff, should conduct daily monitoring of each individual's food and fluid intake. Nursing staff should be responsible for ensuring that each individual's daily food and fluid intake is documented and maintained in each individual's medical record.

Finally, Maple Lawn should ensure that the facility's dietitian oversees nutrition and hydration services. The dietitian should be responsible for educating Maple Lawn staff

regarding nutritional needs and developing clinical guidelines to ensure that nutrition and hydration services comport with generally accepted professional standards.

Psychotropic Medications

Maple Lawn should ensure that its psychotropic medication practices comport with generally accepted professional standards. Federal law strictly regulates the prescription of psychotropic medications for people in nursing homes, and generally accepted professional standards require that they be free from unnecessary antipsychotic medication. See 42 C.F.R. § 483.25(l)(1). “Unnecessary medication” is defined by federal law as any medication that is excessive in dose, excessive in duration, without adequate monitoring or indication for use, or without specific target symptoms. Id.

Maple Lawn should ensure that the use of psychotropic drugs is professionally justified, carefully monitored by physicians and nursing staff, documented by nursing staff, and reviewed, as needed, by physicians and nursing staff. Maple Lawn should also ensure that prescribed medications are based on clinical needs and not used in a manner that exposes individuals to undue risks to their health and safety.

Finally, Maple Lawn should document that, prior to using psychotropic medications, other less restrictive techniques have systematically been tried and have been demonstrated to be ineffective.

Pressure Sore Treatment and Skin Care

Maple Lawn should develop and implement procedures that ensure that individuals do not develop pressure sores that are clinically avoidable and ensure that existing pressure sores receive necessary treatment and services to promote healing. See 42 C.F.R. § 483.25. Maple Lawn should ensure that staff conduct risk assessments for skin breakdown for all individuals at least quarterly. Maple Lawn should also ensure that staff develop and follow an individualized plan of care for each individual at risk for skin breakdown and for each individual with existing pressure sores.

Maple Lawn should develop and implement procedures that ensure that individuals with pressure sores are appropriately positioned, turned and repositioned, and monitored on a daily basis. Maple Lawn staff should ensure that physicians are notified within 24 hours of signs of new skin breakdown or deterioration of existing pressure sores. Finally, Maple Lawn should develop and implement a protocol to track all individuals with pressure sores, all outstanding physician orders regarding pressure sores, and all recommended pressure sore treatments.

Pain Management and End-of-Life Care

Maple Lawn should develop and implement procedures that ensure that its pain management and end-of-life care practices comport with generally accepted professional standards of care. Federal regulations and generally accepted professional standards require

nursing homes to assess individuals for pain as part of the comprehensive care planning process. 42 C.F.R. § 483.20(d). Maple Lawn should ensure that nursing staff are conducting pain assessments, implementing appropriate interventions, and monitoring individual pain to ensure that medications are administered as needed. Maple Lawn should also ensure that changes in each individual's condition are documented and placed in the comprehensive care plan. Finally, Maple Lawn should ensure that physicians review medication usage and analyze pain data consistent with generally accepted professional standards.

C. PROTECTION FROM HARM

Investigation Process

In order to identify threats to safety and care, Maple Lawn should conduct thorough investigations of individual incidents. 42 C.F.R. § 483.13(B)(3); Grace Healthcare v. United States HHS, 589 F.3d 926, 927 (8th Cir. 2009). Maple Lawn should thoroughly investigate incidents, and promptly report the results of investigations to the facility's administrator and to other officials in accordance with state law within 5 working days of [an] incident." Grace, 589 F.3d at 930 n.6. Specifically, Maple Lawn investigators should visit the scene of an alleged incident, collect physical evidence, and obtain witness accounts. Investigators should also identify, preserve, and record evidence, and then conduct a reasoned analysis of all evidence received. In addition, Maple Lawn investigators should issue a report of their findings, detailing: (1) interviews conducted; (2) evidence considered; (3) staff compliance with care guidelines and facility policies; (4) the basis for each conclusion; and (5) recommended corrective measures. The facility should promulgate policies or procedures addressing basic investigative principles such as collecting biological, video, or other physical evidence; conducting sensitive staff and individual interviews; and navigating the difficult inquiry into possible peer misconduct.

Maple Lawn should investigate all serious injuries, deaths, and suspected cases of abuse, neglect, and maltreatment. 42 C.F.R. 483.13(B)(3). See also 42 U.S.C. § 1396r(g)(4)(A) ("Each state shall maintain procedures ... to investigate of violations of requirements by nursing facilities."). Maple Lawn may not limit its investigations to a single category of injury falls. Investigators should evaluate possible cases of abuse, neglect, or inadequate care following a questionable individual death, or when an incident resulted in severe individual injury. Maple Lawn should investigate, for example, injuries from staff, self-injurious behaviors, supervisory neglect, treatment neglect, or failure train and supervise care staff.

Lastly, Maple Lawn should use trained investigators to conduct its investigations. Maple Lawn tasked two staff persons with conducting incident investigations, yet neither has had any investigative training.

Fall Prevention Program and Practices

In order to minimize harm from preventable falls, Maple Lawn should actively ensure that each individual receives adequate assistance to prevent accidents and falls. See generally 42 C.F.R. § 483.25(h). First, Maple Lawn should assess physical functioning and structural

problems at least annually. Thereafter, Maple Lawn staff should assess fall risks within 14 calendar days after staff have determined, or should have determined, a change in an individual's condition likely to go unresolved without intervention. 42 C.F.R. § 483.20(b)(1)(viii), (b)(2)(ii)-(iii). Staff should consider the circumstances leading to falls. For many individuals with a high fall risk, staff should do more than a generic assessment, and should adjust intervention plans to decrease their likelihood of falling.

Next, within seven days of completing the comprehensive assessment, Maple Lawn should develop a comprehensive care plan with measurable objectives and timetables for medical, nursing, and mental health needs. 42 C.F.R. 483.20(k). The plan should be developed by an "interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the individual, and other appropriate staff in disciplines as determined by the individual's needs." 42 C.F.R. 483.20(k)(2)(ii). Lastly, Maple Lawn should also maintain all assessments completed within the past 15 months of active treatment and use the results to revise individuals' plan of care. 42 C.F.R. 483.20(d).

Maple Lawn's physicians should monitor drugs used during treatment for their likelihood to increase risk to fall, and review the drug regime of any at-risk individual who ultimately falls. See 42 C.F.R. § 483.40(b)(1) (noting that physicians should review medications when assessing care programs). Maple Lawn should ensure that such assessments occur at each visit, which should take place, at a minimum, once every 30 days for the first 90 days after an individual's admission, and once every 60 days thereafter. 42 C.F.R. § 483.40(c)(1). Physicians should properly monitor and chart drug side effects, especially when using medication known to contribute to falls. In addition, physicians should review drug regimens and eliminate drugs to decrease fall risks.

Finally, Maple Lawn's pharmacist should advise care teams about any medications in an individual's regimen that increase the likelihood of a fall. See 42 C.F.R. § 483.60 ("The pharmacist should report any irregularities to the attending physician and the director of nursing, and these reports should be acted upon."). Maple Lawn has pharmacists on staff, and physicians should incorporate pharmacists' recommendations where medically indicated to eliminate or reduce drugs and drug combinations specifically for their potential to contribute to falls.

Quality Assurance Program

In order to identify and reduce sources of recurrent harm, Maple Lawn should implement a quality assurance program to: (1) make certain its senior staff respond appropriately to issues placing individuals at risk; (2) provide its nursing staff with clear policies and procedures that define adequate direct care; and (3) share findings and recommendations so its various disciplines can avoid recurrent or potentially harmful incidents.

Maple Lawn's senior clinical administrators should ensure that care is appropriate. MO. CODE REGS. ANN. tit. 19, § 30-86.042(42). Maple Lawn should develop and implement written policies and procedures preventing mistreatment, neglect, abuse, and misappropriation. 42 C.F.R. § 483.13(c). To ensure proper individual care, nursing and facility staff should have

ready access to those policies; management should enforce the policies through regular supervision and training; and, staff should be trained on new or revised policies.

Maple Lawn should also develop and “maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.” 42 U.S.C. § 1396r(b)(1)(B); 42 C.F.R. § 483.75(o). This does not exist at Maple Lawn. Instead, Maple Lawn had a number of “stand alone” review teams, comprised primarily of its Quality Assurance, Fall Prevention, Weight, and Safety Committees. Each team narrowly and independently considers the staff, individual, or environmental events relevant to its focus; nothing suggested that individual disciplines either formally or informally shared data, evidence, findings, recommendations, or even their basic understanding of the events themselves. Maple Lawn should employ a collaborative, interdisciplinary analysis to prevent harm or recurrence at any level, thus mitigating risk of individual harm. Finally, Maple Lawn should “ensure that all allegations of abuse or neglect are reported to the facility's administrator and to other officials in accordance with state law.” *Grace*, 589 F.3d at 930 n.6.

Risk Management Practices

In order to reduce harm from inadequate staffing, substandard care, hazardous environmental conditions, and dangerous narcotics control practices, Maple Lawn should establish a comprehensive risk management system.

Maple Lawn should provide a sufficient number of qualified nurses to meet the total nursing care needs within the facility twenty-four hours per day, seven days a week. 42 C.F.R. § 483.30(a)(1). In keeping with State law, Maple Lawn's staffing pattern should be “one (1) staff person for every fifteen (15) individuals or major fraction of fifteen (15) during the day shift, one (1) person for every fifteen (15) residents or major fraction of fifteen (15) during the evening shift, and one (1) person for every twenty (20) residents or major fraction of twenty (20) during the night shift.” MO. CODE REGS. ANN. tit. 19, § 30-86.045 (4)(A) (2009). There shall be a licensed nurse employed by the facility to work at least eight (8) hours per week at the facility for every thirty (30) residents” or fraction thereof. *Id.* at § 30-86.047 (61)(E).

Maple Lawn should ensure that its nurses, aides, technicians, and care staff are able to function at the level required by the State. 42 C.F.R. § 483.75(g)(2). Maple Lawn should discontinue its current practice of hiring staff and failing to provide ongoing training and supervision for nurses and aides.

Maple Lawn should provide a safe environment, with appropriate services to maintain a sanitary and orderly interior. 42 C.F.R. 483.15(h). Its rooms should be designed and equipped such that safety is provided for at all times. MO. CODE REGS. ANN. tit. 19, § 30-86.032(22). In addition, generally accepted professional standards require Maple Lawn staff to take affirmative, strategic efforts to protect individuals from environmental harm. Maple Lawn staff

should evaluate hazards, implement interventions, monitor effectiveness, and make needed modifications to minimize preventable risk. See generally 42 C.F.R. § 483.25(h)(1) (“The facility should ensure that the resident environment remain free of accident hazards as is possible.”).

Finally, Federal and State laws require Maple Lawn care staff to tightly control narcotics through facility oversight and management. See MO. CODE REGS. ANN. tit. 19, § 30-86.047(41)(A)-(B) (“All medication . . . shall be kept in a secured location behind at least one (1) locked door or cabinet. . . . Schedule II controlled substances shall be stored in locked compartments separate from non-controlled medications”); 42 C.F.R. § 483.60(e) (requiring that facilities store general in locked, access controlled compartments, and Schedule II substances in separate, locked, permanently affixed compartments). A Maple Lawn pharmacist or registered nurse should review the controlled substance record keeping quarterly, including reconciling the inventories of controlled substances. MO. CODE REGS. ANN. tit. 19, § 30-86.042(57).

* * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division’s website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division’s website until 10 calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns with regard to Maple Lawn. Provided that our cooperative relationship continues, we will forward our expert consultants’ reports under separate cover. The reports are not public documents. Although their reports are the work of each expert consultant and do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses, and recommendations provide further elaboration of the relevant concerns and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

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Accordingly, we will contact County officials shortly to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5401.

Sincerely,

s/ Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc: Thomas Redding, Esq.
Prosecuting Attorney
Marion County, Missouri

Lowell Pearson, Esq.
Maple Lawn Nursing Home Counsel

Jeff Funkenbusch
Administrator
Maple Lawn Nursing Home

The Honorable Richard G. Callahan
United States Attorney
Eastern District of Missouri



U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530*

January 15, 2009

Mr. Stephen Nodine
President
Mobile County Commission
205 Government Street
Mobile, AL 36644

Sam Cochran
Sheriff
Mobile County
510 South Royal Street
Mobile, AL 36601

Re: Mobile County Metro Jail

Dear Mr. Nodine and Sheriff Cochran:

We write to report the findings of the investigation of the Civil Rights Division into conditions at the Mobile County Metro Jail ("MCMJ"). On March 12, 2003, we notified officials of Mobile County ("County") and the Mobile County Sheriff's Office ("Sheriff") of our intent to conduct an investigation of MCMJ pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On May 27-30, 2003, and July 6-7, 2003, and again on September 22-25, 2003, we conducted on-site inspection tours with expert consultants in the fields of corrections, custodial medical and mental health care, and safety and sanitation. We interviewed administrative and security staff, medical and mental health care providers, and inmates. We reviewed an extensive number of documents, including policies and procedures, incident reports, grievances, medical records, and use of force records.

In keeping with our pledge of transparency and to provide technical assistance where appropriate, our expert consultants conveyed their preliminary impressions and concerns to the County and the Sheriff.

As you are aware, at the conclusion of our tours, the County and the Sheriff approached us to begin negotiating a means to correct the deficiencies present at MCMJ as identified by our expert consultants. Although we would not normally engage in negotiations prior to the issuance of our statutorily-required written findings, we found the desire of the County and the Sheriff to correct the deficiencies at MCMJ sincere enough to warrant our accommodation, and we immediately began negotiations while continuing our investigation and preparing our written findings. During these negotiations, we contacted the County and the Sheriff in 2006 to request cooperation in conducting a fourth tour of MCMJ to update and inform our factual findings. In continuing our pledge of transparency and to provide technical assistance, we also provided, at that time, copies of the written reports prepared by our consultants that identified deficiencies at MCMJ and recommendations on how to correct the identified deficiencies.

It was while negotiating mutually agreeable terms and conditions of our tour that the County and the Sheriff took the extraordinary and unexpected step of ceasing all communications with the Department of Justice regarding this investigation. Accordingly, and as we advised you after each of our attempts to reinstate communications throughout 2007, we were forced to continue our investigation absent your cooperation. Specifically, since that time, we have examined state and federal survey information, media reports, and other publicly available data, as well as conducted interviews of former inmates, family and friends of inmates, attorneys, advocates, and other persons familiar with present conditions at MCMJ. In addition, as warned, we considered the failure of the County and the Sheriff to cooperate with our investigation as an adverse factor when preparing our written findings.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b. We conclude that certain conditions at MCMJ violate the constitutional rights of the inmates confined there. As detailed below, we find that MCMJ engages in a pattern or practice of subjecting inmates to egregious or flagrant conditions, specifically in regard to: (1) the medical care of

inmates; (2) the mental health care of inmates; (3) the use of restraints; (4) the right of inmates to be protected from physical harm from other inmates; and (5) the right of inmates to be confined in sanitary and safe conditions.

I. BACKGROUND

The MCMJ is operated by the Sheriff of Mobile County. The Sheriff has appointed a Warden to be responsible for the day-to-day operations of MCMJ. The Sheriff employs approximately 230 corrections officers and a civilian support staff at MCMJ, as well as a medical staff which includes several nurses, a physician, and a part-time psychiatrist.

The MCMJ houses a mix of pretrial detainees and convicted prisoners ("inmates") and houses both male and female inmates. The MCMJ is comprised of two facilities - the main facility, known simply as "the Jail," and a minimum security annex, referred to as "the Barracks." The main facility ("Jail") at MCMJ was built in sections, with the first portion completed in the mid-1980s and the final sections completed in 1991. The Jail has a design capacity of 816 inmates. The Jail is constructed as a remote supervision facility, in which staff work in control areas observing inmates housed in ten semi-circular "pods." Eight pods house male inmates, and two pods house female inmates. The eight pods housing male inmates are subdivided into six eight-cell "wedges," designed to house 16 inmates in each wedge. The two pods housing female inmates are subdivided into two twelve-cell wedges. For male inmates, two wedges are designated for administrative segregation; two wedges are designated for protective custody; one wedge is designated for medical housing; and one wedge is designated for potentially suicidal inmates. The Jail also has a medical clinic and a booking area with holding cells for recent arrestees.

The MCMJ's minimum security annex ("the Barracks"), is located across the street from the Jail. The Barracks opened in September 2002, with a design capacity of 325 inmates. The Barracks contains eight dormitory-style housing units that resemble military barracks.

The population of the Jail steadily remained at approximately 1,000 inmates during 2007, while the Barracks averaged close to 300 inmates. Prior to 2007, the population in the Barracks had been significantly below design capacity. For example, at the time of our first tour in May 2003, there were only 113 inmates in the Barracks. By contrast, the Jail has frequently exceeded design capacity. For example, in the six

months prior to our first tour in May 2003, the average daily population for each month was over 1300 inmates for the Jail and Barracks combined.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. The Eighth Amendment affords convicted prisoners protection from cruel and unusual punishment. U.S. Const. amend. VIII. This protection is incorporated into the Due Process Clause of the Fourteenth Amendment and binding upon the states. Robinson v. California, 370 U.S. 660, 667 (1962). Moreover, the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to an inmate of a jail incarcerated prior to trial, as it would to a convicted prisoner. City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239, 244 (1983). As defined by the Supreme Court, this constitutional protection from cruel and unusual punishment requires corrections officials to provide "humane conditions" of confinement to jail inmates. Farmer v. Brennan, 511 U.S. 825, 832 (1994).

When a jurisdiction takes a person into custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)).

The duties imposed and rights conferred by the Eighth Amendment apply to the unreasonable risk of serious harm, even if such harm has not yet occurred:

We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is reasonable safety.

Helling v. McKinney, 509 U.S. 25, 33 (1993) (internal citations and quotations omitted).

A. Medical Care

A corrections official's "deliberate indifference" to an inmate's serious medical needs is a violation of the Eighth Amendment. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Farrow v. West, 320 F.3d 1235, 1243-46 (11th Cir. 2003); Steele v. Shah, 87 F.3d 1266, 1269 (11th Cir. 1996). Corrections officials act with deliberate indifference when an inmate needs serious medical care and the officials fail to, or refuse to, obtain or provide that care. Farrow, 320 F.3d at 1246. Said another way, a corrections official will violate the protections of the Eighth Amendment when the official "knows of and disregards an excessive risk of inmate health." Farmer, 511 U.S. at 837. The corrections official must "both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." Id. Providing only cursory care is insufficient when the need for more serious treatment is obvious. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999).

B. Mental Health Care

The constitutional requirement imposed on corrections officials to provide adequate medical care includes a duty to provide adequate mental health care. Farmer, 511 U.S. at 832; see also Campbell v. Sikes, 169 F.3d 1353, 1362 (11th Cir. 1999) ("proper medical care" in question consisted of mental health care provided by defendant corrections psychiatrist); Steele, 87 F.3d at 1269 (same). Delay in providing hospitalization to a prisoner in need of immediate psychiatric care may constitute deliberate indifference. See e.g., Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1190-91 (9th Cir. 2002).

Furthermore, corrections officials have a constitutional obligation to act when there is a strong likelihood that an inmate will engage in self-injurious behavior, including suicide. Snow ex rel. Snow v. City of Citronelle, AL, 420 F.3d 1262, 1268-69 (11th Cir. 2005). In corrections suicide cases alleging constitutional violations, "the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." Cook ex. rel. Tessier v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting Cagle v. Sutherland, 334 F.3d 980, 986 (11th Cir. 2003)). In order to establish 'deliberate indifference' in a corrections suicide case, the plaintiff must demonstrate: "(1) subjective

knowledge of a risk of serious harm; (2) disregard for that risk; (3) by conduct that is more than mere negligence." Cook, 402 F.3d at 1115 (quoting Cagle at 986).

C. Use of Restraints

The Eighth Amendment protection from cruel and unusual punishment forbids the use of excessive physical force against inmates. Hudson v. McMillian, 503 U.S. 1, 5 (1992); Skrnich v. Thornton, 280 F.3d 1295, 1301 (11th Cir. 2002). The use of mechanical restraints is a type of physical force, and the initial decision to employ such restraints is evaluated under Eighth Amendment standards. See Williams v. Burton, 943 F.2d 1572, 1575 (11th Cir. 1991) (initial decision to place inmate into four-point restraints evaluated under Eighth Amendment use-of-excessive-force standards). The use of force by a corrections officer will violate the Constitution when it is not applied "in a good-faith effort to maintain or restore discipline," but instead is administered "maliciously and sadistically to cause harm." Hudson, 503 U.S. at 6-7; Campbell, 169 F.3d 1353, 1374 (11th Cir. 1999); Harris v. Chapman, 97 F.3d 499, 505 (11th Cir. 1996); Williams, 943 F.2d at 1575. Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; and, (4) any efforts made to temper the severity of a forceful response. Hudson, 503 U.S. at 7-8; Campbell, 169 F.3d at 1375; Harris, 97 F.3d at 505; Williams, 943 F.2d at 1575. Additionally, courts will also factor into the analysis the extent of the inmate's injury at the hands of the corrections officers. Id.

Further, "once the necessity for the application of force ceases, any continued use of harmful force can be a violation of the Eighth and Fourteenth Amendments, and any abuse directed at the prisoner after he terminates his resistance to authority is an Eighth Amendment violation." Williams, 943 F.2d at 1576 (citing Ort v. White, 813 F.2d 318, 324 (11th Cir. 1987)). In addition to the Eighth Amendment standards applicable to the use of restraints, Fourteenth Amendment procedural due process considerations must be accounted for when the restraint is employed as punishment, defined as "a penalty administered after reflection and evaluation and intended to deter similar conduct in the future," distinct from restraints employed as immediately necessary "to bring an end to an ongoing violation." Id.

D. Security, Supervision, and Protection From Harm

The Supreme Court in Farmer made clear that inmates have a constitutional right to be protected from harm. Farmer, 511 U.S. at 832. Accordingly, corrections officials have a duty "to protect prisoners from violence at the hands of other prisoners." Farmer, 511 U.S. at 833 (internal quotation marks and citations omitted). Not every injury suffered by an inmate at the hands of another inmate, however, will constitute an Eighth Amendment violation. The inmate invoking the right must demonstrate that (1) he or she was "incarcerated under conditions posing a substantial risk of serious harm," and (2) that corrections officials were "deliberately indifferent" to the risk. Farmer, 511 U.S. at 834. A corrections official's failure to supervise inmates, particularly inmates known to be violent, may result in unconstitutional conditions of confinement where assaults between inmates occur due to the lack of supervision. Cottone v. Jenne, 326 F.3d 1352, 1360 (11th Cir. 2003).

E. Safety and Sanitation

The Eighth Amendment guarantees that prisoners will not be "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). Accordingly, corrections officials are required to provide "reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (e.g., hot and cold water, light, heat, plumbing)." Chandler v. Baird, 926 F.2d 1057, 1065 (11th Cir. 1991) (citations omitted). Conditions will violate the Constitution when they pose an unreasonable risk of serious damage to an inmate's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling v. McKinney, 509 U.S. 25, 33-35 (1993); Chandler v. Crosby, 379 F.3d 1278, 1289 (11th Cir. 2004).

III. FINDINGS**A. Medical Care**

Our investigation revealed constitutional inadequacies in the level of care provided by MCMJ in responding to inmates' serious medical needs. In 2007, we shared with the County and the Sheriff the written findings and concerns of our expert medical consultant regarding the inadequate medical care at MCMJ. Information we have obtained since that time, however, strongly suggests that MCMJ has done little to correct the identified deficiencies.

Specifically, we found that MCMJ failed to provide adequate acute care, chronic care, treatment of infectious diseases, intake screening, and general access to medical care. As explained below, such deficiencies primarily result from inadequate staffing, lack of proper supervision, and the lack of adequate written medical policies and protocols.

1. Acute Care

At the time of our tour in September 2003, MCMJ had failed to provide timely and appropriate responses to the acute medical needs of inmates. Three inmate deaths that occurred near that time exemplify these failures. Our expert medical consultant reviewed the medical circumstances surrounding the three inmate deaths and concluded that the lack of timely and appropriate response to the inmates' acute medical needs may have contributed to their deaths. For instance:

- In June 2002, an inmate complained of fever, shakes, and acute pain in her leg and foot. This inmate was not evaluated by a MCMJ physician. A licensed practical nurse examined her and found swelling, bruising, and sores. Generally accepted corrections medical practices call for a physician to evaluate any acute onset of leg pain to evaluate for blood clots or deep infection, which can pose a serious risk of harm. Instead, this inmate received an antibiotic and Motrin¹ by telephone order from the physician. Although MCMJ reports that this inmate was transported to the hospital at this time and then returned to MCMJ, there were no records of the hospital visit in the inmate's medical record. The next day, her leg was tender and warm, and she was so sick that she was incontinent of feces. She then went into cardiac arrest, MCMJ staff performed CPR, and she was transported to the hospital, where she died soon thereafter. This inmate's deep vein thrombosis was not timely recognized or treated.
- Another inmate upon arrival at MCMJ in December 2002 reported a history of high blood pressure and hepatitis C. The inmate was not evaluated or treated by a physician. Six days later, corrections staff took him to see the nurse because he was disoriented, shaking, and incoherent, which are signs of a

¹ "Motrin" is a brand name for the anti-inflammatory medication ibuprofen.

life-threatening emergency requiring immediate care. He did not receive immediate care, but instead the licensed practical nurse placed his name on the list to see a psychiatrist and sent him back to his unit. The next day corrections staff again took the inmate to the nurse after he was observed vomiting blood. He remained disoriented and had substantially elevated blood pressure. The nurse placed his name on the list to see the physician during regular sick call, six hours later. She left him alone for 90 minutes, and when she returned to the clinic she sent him to the hospital emergency room. The inmate died in the hospital. Timely medical treatment may have prevented this death.

- In August 2003, an inmate arrived at MCMJ with an acute trauma to his left eye and a paralysis of the right side of his face. He reportedly refused to see the physician, although his chart contained no signed refusal and no documentation of any attempt to convince him to agree to medical care. Even if the inmate refused medical care at intake, he should have been housed in the infirmary and observed. Instead, this inmate was placed in the general population. Five days later, when he requested medical care, his left eye was dilated, his speech slurred, and he was unable to walk. His condition had deteriorated to such an extent that he was sent to the hospital, where he was diagnosed with a heart valve infection - which could have caused his facial paralysis - congestive heart failure, and sepsis (infection of the blood). He died before he could receive surgery to replace his heart valve. If this inmate had received treatment several days earlier, his chance of survival would have been much higher.

Since our September 2003 tour, we have learned of at least six more in-custody deaths at MCMJ. In three of those cases, it is alleged that MCMJ's poor response to the inmates' serious acute medical needs contributed to the inmates' deaths.² We have requested the opportunity to examine the medical circumstances surrounding those deaths, but the County and the Sheriff have denied our request.

² We are equally concerned about the other three cases which are reportedly suicides, and discussed in section III.B.4 of this letter.

Furthermore, since our 2003 tour, we have learned of allegations regarding the MCMJ's inadequate treatment of serious injuries suffered by inmates while incarcerated at MCMJ. For example, in July 2005, an MCMJ inmate reportedly suffered serious spine and neck injuries after a fall during a work-shift. It is alleged that after waiting an hour to receive emergency medical treatment, the inmate was given aspirin to relieve his pain. Reportedly, no other treatment was provided, and no further medical appointments were scheduled, despite the inmate's request to see a physician. Allegedly, after several weeks, the inmate's condition worsened as he began to lose weight, become frail and non-ambulatory. By the time the inmate eventually saw a physician in a hospital, it is reported that his injuries had already begun to heal improperly and the inmate suffered permanent damage to his spine and neck.

We found that MCMJ's problems in providing acute medical care were caused or exacerbated by inadequate protocols, supervision, and training. The protocols for nurses did not provide adequate guidance regarding treatment of inmates who exhibited common acute symptoms. In addition, nurses did not receive training in taking medical history or in conducting physical assessments. Thus, the nurses had no guidance on when it was appropriate to seek a higher level of care from a physician.

2. Chronic Care

Generally accepted corrections medical practices require inmates with chronic conditions to receive ongoing, coordinated care and monitoring to prevent or minimize the progression of their diseases. After completing our 2003 tour, we concluded that MCMJ failed to identify and treat adequately inmates with chronic conditions such as asthma, diabetes, hypertension and HIV. The MCMJ did not separately track inmates with chronic diseases as required by generally accepted corrections medical practices. We therefore had to review medication administration records to attempt to identify inmates with chronic conditions. We found the number of inmates being treated for diabetes, hypertension, and asthma to be one-third of what is expected for jails in the United States.³ This finding indicates that MCMJ was likely failing to identify inmates with chronic diseases,

³ National Commission on Correctional Health Care, Health Status of Soon-to-Be-Released Inmates, http://www.ncchc.org/pubs/pubs_sbbr.html (last visited September 2, 2008).

which probably stemmed from an inadequate screening and assessment process discussed in further detail in section III.A.4 of this letter.

Chronic conditions are progressive, and require proper monitoring and treatment to prevent conditions associated with end-stage organ failure, such as blindness, heart disease, kidney failure, and lung disease. For example, generally accepted corrections medical practices require that asthmatic inmates receive peak flow monitoring to measure the volume of air flowing out of the lungs, which can reveal narrowing of the airways well in advance of an asthma attack. This monitoring should be done on a quarterly basis, or more frequently if the inmate is short of breath. However, at the time our tour, MCMJ did not conduct peak flow monitoring unless inmates provided their own peak flow meters.

Similarly, diabetic inmates did not receive simple laboratory tests of their insulin levels to monitor their status. As the example below illustrates, we found the monitoring of inmates with chronic conditions at MCMJ to be deficient.

- In August 2003, an inmate with diabetes reported a sudden onset of blurry vision, which indicates potential acute retinal disease that can lead to blindness without prompt evaluation and treatment. This inmate did not receive an adequate eye examination and had not been referred to an ophthalmologist at the time of our third tour, over one month later.

Several recent allegations regarding diabetic inmates suggest that the chronic care deficiencies present at MCMJ at the time our tour remain. For example, in 2005, an inmate who was Type I diabetic alleged that she made repeated requests for insulin and glucose tests. Corrections officers reportedly assumed that the inmate was "detoxing" from a drug addiction and denied all of the inmate's requests for medical attention, despite the inmate's insistence that she was not a drug-addict. After several days without insulin, the inmate's condition allegedly worsened to a life-threatening level. Reportedly, the medical staff at MCMJ transferred her to a local hospital and the inmate spent the next six days in the hospital, the first four days of which she remained in the intensive care unit.

Moreover, at the time our tour, MCMJ did not stock the basic medications necessary to treat chronic diseases such as asthma, diabetes, hypertension, major depression, and schizophrenia. As a result, inmates with chronic diseases routinely waited three to

five days from prescription to the administration of the first dose of medication. Such a period of time is unacceptably long in light of the severity of the issues. Other inmates with

chronic diseases waited longer to receive their medications, and some never received prescribed medications at all. For example:

- During one of our tours in 2003, an inmate was exhibiting severe respiratory compromise from acute and chronic asthma. Although she had been prescribed prednisone, a steroid that would reduce the inflammation in her lungs and allow her to breathe, she had not received the medication. Without prednisone, she was at risk of developing respiratory failure.

3. Infectious Diseases

We found that MCMJ did not adequately identify or treat infectious disease. Failure to adequately identify and treat infectious disease places inmates, staff, and the community at unnecessary risk of serious health problems. Our review of MCMJ records indicated MCMJ ordered purified protein derivative ("PPD") skin tests, which test for tuberculosis, for only about half of the inmates, and documented test results for less than 10 percent of inmates. Similarly, we found syphilis screening results in less than 10 percent of inmate records. Both PPD tests and syphilis screening are required by MCMJ policy and by generally accepted corrections medical practices. Furthermore, MCMJ has inadequate policies in place to recognize and prevent the transmission of blood-borne (e.g., HIV and viral hepatitis) and air-borne (e.g., tuberculosis) pathogens. For example, the policies failed to address post-exposure protocols for blood exposures, maintenance of respiratory isolation, and vaccination against Hepatitis B.

During our September 2003 tour, we concluded that MCMJ failed to treat properly inmates with tuberculosis. For example:

- We identified at least three inmates who were receiving a particular antitubercular medication - Rifampin - alone, a medication that should never be used without other antitubercular medications. Using Rifampin alone can result in the development of drug resistance, which not only threatens the health of the inmate, but also poses a serious public health danger.

- An inmate who had HIV was clearly receiving Rifampin in error. His prescription was written for Rifabutin, a medication used in late stage HIV; instead, he received Rifampin.
- The MCMJ also apparently failed properly to isolate inmates with potentially contagious tuberculosis. An inmate with suspected tuberculosis was housed in a reported negative pressure room, which is designed to contain contagious tuberculosis. Consistent with generally accepted corrections medical practices, such rooms must be tested monthly to ensure proper functioning. However, the room did not appear to be in operation and the health services administrator was not aware if the room had ever been tested. Such a failure places staff and other inmates in the infirmary at risk of tuberculosis infection.

Furthermore, our expert corrections medical consultant identified a widespread skin infection, which had not been identified by MCMJ medical staff. Numerous inmates exhibited large boils on various parts of their bodies that they contracted well after reception into MCMJ, and these inmates faced long delays in treatment. The MCMJ had not conducted cultures which likely would have assisted in identifying the outbreak, and MCMJ had not contacted local health officials to provide notice of the contagious infection or to receive assistance or guidance. The skin infection was likely *Staphylococcus aureus*, a bacteria that can cause septicemia (blood infection), myocarditis (heart valve infection), infections of the tissues surrounding the brain, and death.⁴

4. Intake and Initial Assessment

When we evaluated MCMJ's intake process and initial medical assessments in 2003, we found that MCMJ failed to identify inmates with serious medical needs and thus put inmates at an unreasonable risk of harm. At MCMJ, corrections officers

⁴ We note that at the Sheriff's request, we have provided technical assistance to MCMJ regarding the skin infections. We understand that MCMJ was working with the Mobile County Department of Health to address this outbreak. The MCMJ reports taking several measures to address this outbreak, including purchasing new laundry machines and cleaning inmate-occupied areas. The MCMJ did not, however, provide the Department of Justice information regarding the final status of the outbreak.

conducted intake screening as each inmate was received. However, the officers received no training concerning health screening, and many serious medical issues were ignored at intake. For example, the Jail Receiving Screening Form utilized by corrections officers failed to collect the following basic information: all current illnesses, past serious infectious disease, recent symptoms of infectious diseases, past mental illness, legal or illegal drug use, and specific drug withdrawal symptoms.

The MCMJ policy required a nurse to perform a supplemental medical history within 72 hours of each inmate's intake. For more than half of the current and recently-released inmates whose files we reviewed, MCMJ failed to comply with this policy, even for inmates with very serious medical needs. The health services coordinator confirmed that the medical clinic was not adequately staffed to review each inmate within 72 hours, and estimated that 30 to 35 percent of inmates are not seen within 72 hours of admission. Even if MCMJ complied with its own policy, 72 hours is too long a delay for an assessment of inmates with acute or chronic medical needs, continuity of medication requirements, or infectious diseases. Generally accepted corrections medical practices require that inmates with acute or chronic medical conditions be seen by a nurse within four hours of intake for evaluation and referral to a physician, if necessary.

Moreover, the 72-hour supplemental nursing assessment at MCMJ was inadequate to identify inmates' serious medical needs, as the assessment consisted of nothing more than recording basic vital signs. For example:

- An inmate incarcerated in August 2003 with diabetes did not have a documented blood sugar test on intake, which placed this inmate at risk of ketoacidosis, a potentially fatal complication of diabetes.

Although MCMJ policy was consistent with generally accepted corrections medical practices by requiring a complete health assessment to be conducted within 14 days of an inmate's arrival, we noted unreasonable delays in conducting these assessments and a lack of appropriate referrals. For example, during our September 2003 tour, an inmate reported that he was incontinent of urine, but was not referred to a physician for diagnosis and treatment.

In addition, MMCJ did not properly identify and treat serious drug and alcohol intoxication and withdrawal symptoms,

placing inmates at risk of potentially life-threatening symptoms such as seizures and delirium. For example:

- In May 2003, MCMJ did not identify, evaluate, or treat an inmate at intake who was at risk of experiencing benzodiazepine withdrawal.⁵ The inmate subsequently made at least seven requests for medical evaluation due to her withdrawal symptoms, but received no treatment for her potentially serious drug withdrawal.
- Another inmate, who was in restraints, apparently was suffering from alcohol withdrawal and had purple extremities, was sweating profusely, and was "jerking badly." A note in the inmate's medical file quotes the nurse as responding, "That's part of DTs and there isn't nothing we can do." Delirium tremens, a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - sometimes called the "DTs" - can cause serious hallucinations and potentially life-threatening seizures. By generally accepted corrections medical practices, this inmate should have received Librium, a medication helps prevent the symptoms of delirium tremens from worsening, as well as fluids, and close monitoring of his vital signs.

We have since learned that in February 2008, a MCMJ inmate died of an apparent drug overdose. The inmate was reportedly found unconscious in his cell on the same day he was arrested on drug possession charges. The MCMJ allegedly transported the inmate to the hospital where he was pronounced dead, and preliminary tests reportedly indicated the presence of drugs in his system. This recent death suggests that the problems we identified in 2003 have not been resolved, despite the fact that we provided the County and the Sheriff our expert medical consultant's written report in 2007.

5. General Access to Medical Care

At the time of our tour, MCMJ's sick call process failed to provide adequate access to medical care. The MCMJ inmates

⁵ Benzodiazepine is a medication that depresses the central nervous system and is used, for example, to treat certain seizure disorders and anxiety. Withdrawal from benzodiazepine can result in potentially life-threatening symptoms such as seizures and delirium if not appropriately treated.

accessed medical services by completing sick call requests.⁶ Inmates reported making multiple requests before receiving medical care. Our review of medical files confirmed that many inmates made between two and six requests for treatment of serious medical needs before receiving care, such as the inmate in benzodiazepine withdrawal discussed above in section III.A.4. Other examples include:

- Medical staff failed to respond to three requests for care from an inmate with vaginal discharge. Failing to evaluate this inmate put her at risk of serious infection, and created a potential public health risk, as such symptoms are consistent with a venereal disease.
- In August 2003, an inmate complained he was incontinent of urine, which may be caused by an infection or a serious, but treatable, neurologic problem. There was no indication in his file that he was referred to a physician for treatment.

Additionally, at the time of our tour, MCMJ charged a \$10.00 co-payment for each visit to a licensed practical nurse. The MCMJ policy also required that indigent inmates be provided free medical care and MCMJ appeared to be implementing this policy. Nevertheless, while this policy does not violate inmates' constitutional rights, we are concerned that numerous inmates told us that requests for medical care by indigent inmates are ignored. Apparently this alleged practice of ignoring the medical requests of indigent inmates is so pervasive as to result in indigent inmates not requesting medical care for serious medical needs. We flag this finding because, although not a constitutional violation, the perception that indigent inmates will not be provided medical care is a barrier to accessing such care.

⁶ Inmates submitted sick call requests to corrections staff, who delivered them to the medical unit. Allowing corrections staff to serve as gatekeepers for medical services potentially compromises timely access to medical care. We understand that the MCMJ has recently installed lock boxes for inmates to file grievances and we encourage a similar system for sick call requests.

6. Staffing

The above-noted deficiencies in acute care, chronic care, intake services, and identification and treatment of infectious diseases were likely caused or aggravated by inadequate medical staffing. At the time of our tour, MCMJ provided its 1,000 to 1,300 inmates with only 20 hours per week of physician staffing for their primary medical care needs. This is grossly insufficient to meet the acute and chronic needs of this large population, and health care provided to inmates was compromised by this significant shortage.⁷ In addition, the nursing staff was inadequately supervised, which led to the deficiencies noted above in acute care, intake assessment, sick call, and medication errors.

B. Mental Health Care

Our investigation revealed that mental health services at MCMJ were grossly inadequate to meet the serious mental health needs of inmates. At the conclusion of our tours in 2003, our expert corrections mental health consultant identified specific concerns in MCMJ's delivery of mental health care. In 2007, we provided the County and the Sheriff with a written report prepared by our expert corrections mental health consultant outlining the mental health care deficiencies at MCMJ. Despite our several requests to revisit the facility and evaluate MCMJ's progress on improving the mental health care provided to its inmates, neither the County nor the Sheriff have provided us with access or any documentation to suggest that the deficiencies we identified in 2003 and 2007 have been addressed or corrected. In fact, three MCMJ inmate suicides that have occurred since 2003 strongly suggest the problems present at the time of our tour remain unresolved.

Specifically, we identified problems and deficiencies in intake screening; access to mental health care; assessment, management and treatment of mental illnesses; and suicide prevention. As explained below, such deficiencies result in part from inadequate mental health care staffing and the lack of a mental health care program, as well as inadequate policies and procedures.

⁷ In the opinion of our expert corrections medical consultant, a facility of MCMJ's size requires a minimum of 60 hours per week of physician staffing to provide adequate medical care.

1. Intake and Initial Assessment

Failure to identify and respond appropriately to inmates' serious mental health needs can lead to significant medical deterioration, and in some cases can even lead to death by suicide. We found that MCMJ's intake process failed to identify adequately inmates with serious mental health needs.

Intake screening should be used to identify inmates with histories of mental health treatment, major mental illness, and suicide potential, as well as inmates who need psychiatric medications. As discussed above in section III.A.4 of this letter, corrections officers conducted initial intake screening on incoming inmates by filling out Jail Receiving Screening Forms. The officers received no training on mental health screening. In addition, the screening forms themselves did not require officers to gather adequate mental health information; for example, the forms lack screening questions regarding major mental illness or developmental disability.

The MCMJ also failed to record consistently or respond adequately to the mental health information in the screening form. The forms were often incomplete, completely blank, lacking pertinent information such as current medications, or contained no information about an inmate's mental health status or history. Other forms contained pertinent mental health information, but medical records indicated there was no, or significantly delayed, follow-up by MCMJ staff. For instance:

- The intake screening of one inmate in May 2003 revealed that he had possible suicidal ideation, yet some four months after his intake, there was no documentation that he was ever referred for, or received, an evaluation by MCMJ mental health care staff.
- Although an inmate in August 2003 was identified as potentially suicidal at intake, the inmate did not see the psychiatrist until 10 days later.
- One inmate's custody screening in July 2003 revealed a history of past mental problems, including a history of treatment with Zyprexa, an antipsychotic. Nevertheless, she was not seen by the psychiatrist for two months, by which time her condition had worsened to the point that she had become psychotic.

As will be discussed further below, we noted similar failures to identify or respond to inmates taking psychotropic medications. Such failures delay the continuity of medications and create a serious risk of harm for inmates with psychosis and mood disorders. Left untreated due to interrupted or discontinued medications, such inmates may harm themselves or others.

The first step in providing inmates with proper mental health care is identifying and diagnosing inmates with serious mental health needs. At the time of our tour, however, MCMJ significantly under-diagnosed serious mental illnesses. Without proper diagnoses, mentally ill inmates risk receiving inadequate or inappropriate medication and treatment, or no medication or treatment at all. This can lead to psychiatric decompensation, that is, the inmate's psychiatric symptoms can worsen and lead to depression, psychosis, or other acute problems. Such inmates are often subject to heightened victimization or to violent outbursts which can impact jail staff and other inmates.

As with inmates with chronic illnesses, MCMJ should, but did not, keep lists of inmates with mental health needs. Accordingly, we had to examine medication administration records to attempt to identify inmates with psychiatric needs. At the time of our tour, national studies indicated that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.⁸ At MCMJ, however, only six percent of male inmates were being treated with psychotropic medications, which is about one-third of the number of male

⁸ Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (last visited September 2, 2008) (This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). We note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf> (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

inmates with mental illness typically found in jails in the United States. Seventeen percent of female inmates were on such medications, about two-thirds of the number of female inmates with mental illness typically found in jails in the United States. These findings indicate that many inmates in need of mental health care, particularly male inmates, likely were not identified and as a consequence did not receive necessary mental health treatment. Indeed, the problem of under-diagnosing mentally ill inmates at MCMJ is likely worse than we estimate, as our examination of the medication administration records to identify mentally ill inmates consequently excludes those mentally ill inmates who are not being treated with psychotropic medications.

This observation was corroborated by reviewing individual inmate records, which indicated widespread under-diagnosis of mental illness. For example:

- One inmate's intake screening in June 2003 did not indicate any mental illness. Although he was placed in administrative segregation for suicidal ideation the day after being taken into custody, his 72-hour nursing assessment also did not indicate any mental illnesses and he did not see the psychiatrist until after he submitted a request over two weeks later. The psychiatrist concluded the inmate had a bipolar disorder and prescribed the antipsychotic medication Zyprexa.
- Another inmate's intake assessment in June 2003 did not note any mental health care concerns, but a nursing assessment twenty days later revealed that the inmate had a history of treatment with the psychotropic medications Prozac and Ritalin. The intake assessment failed to identify this inmate's mental health care needs, and thus delayed any mental health treatment the inmate may have required.

2. Access to Mental Health Care

In September 2003, we found that MCMJ did not provide adequate access to mental health care. Inmates typically made numerous requests to see the psychiatrist, and were faced with significant delays in response to their requests. Our review of records indicated that the delays ranged from weeks to many months, even for inmates with very serious mental health needs. We also noted many instances where follow-up care ordered by MCMJ mental health staff did not occur. For example:

- An inmate with a documented diagnosis of Schizoaffective Disorder⁹ and a history of treatment with four antipsychotic medications made five written requests in July 2003, to see the psychiatrist before she was seen, five weeks after her arrival at MCMJ.
- In July 2003, a nurse made a referral for an inmate to see the psychiatrist due to depression. Almost two months later, he still had not seen the psychiatrist and had become suicidal. It still took an additional three weeks for the inmate to receive an initial psychiatric evaluation.
- In April 2003, a nurse referred an inmate for a psychiatric consult as a result of the inmate's fearfulness, hyperactivity, and sleeplessness, but this inmate was not seen by the psychiatrist until three weeks after the nurse's referral. These delays are far too long, and are a substantial departure from generally accepted corrections mental health practices, especially when inmates are experiencing acute mental health symptoms. Without adequate access to mental health care, serious mental health needs may go undiagnosed and mentally ill inmates who present a risk of harm to themselves and others may be left untreated.

All of the information we have collected since our review of the records strongly suggests that this problem continues. Appropriate, timely mental health treatment is critical to regulate the symptoms of mental illness and to minimize psychiatric decompensation.

3. Assessment, Diagnosis, and Treatment

Our investigation revealed that when MCMJ identified and responded to inmates with serious mental health needs, it failed to provide adequate treatment. All aspects of the mental health care delivery system were inadequate, including assessment and diagnosis, treatment planning, and pharmacological interventions. These problems, as will be discussed below, were exacerbated by

⁹ Schizoaffective Disorder is a condition in which a person meets the criteria for both schizophrenia and a mood disorder. Such a person may experience psychosis such as hallucinations or delusions commonly associated with schizophrenia, while concurrently experiencing symptoms of depression.

inadequate psychiatric staffing. In addition, MCMJ did not provide non-psychiatric mental health care services, such as group therapy or other services provided by social workers, counselors, or other mental health care workers.¹⁰ Providing these types of services are in accordance with generally accepted corrections mental health practices.

Additionally, many psychiatric progress notes lacked diagnoses, which are essential to determining the appropriate treatment for an inmate's mental health needs. For example:

- In May 2003, one inmate was treated with several psychotropic medications but did not have a specific psychiatric diagnosis.
- Another inmate who entered MCMJ in April 2003, had significant periods of self-injurious behavior, including head-banging and swallowing glass, but never received any psychiatric diagnosis. Nonetheless, he was treated with increasing doses of antipsychotic medications.
- Still another inmate was treated with antipsychotic medications, although he had no history of treatment for mental illness or other clear indications of the need for antipsychotic medication. Antipsychotic medications have a number of potentially serious side-effects, including tardive dyskinesia.¹¹ Failing to appropriately diagnose inmates with mental health needs, but treating them with psychotropic medications, is grossly inappropriate and unnecessarily places inmates at risk of harm.

Moreover, MCMJ frequently prescribed Elavil, an antidepressant medication, to address inmates' sleeping difficulties. Elavil has significant and potentially serious side effects, and can be lethal in overdose. Elavil therefore should not be used for sleep disturbances without appropriate evaluation or medical assessment.

¹⁰ Reportedly, MCMJ has hired a psychiatric nurse who accompanies the psychiatrist to MCMJ for six hours a week.

¹¹ "Tardive dyskinesia" is a potentially irreversible movement disorder characterized by repetitive involuntary movements.

Inmates also experienced serious delays in receiving psychiatric medication. For example:

- One inmate in June 2003 waited 23 days after intake, including five days after seeing the psychiatrist, before receiving two psychotherapeutic drugs, Remeron and Buspar.
- Another inmate went at least three weeks without treatment with the psychotropic medications that she had been taking when she arrived at MCMJ, and had no documented psychiatric evaluation.

Delays in the continuity of psychiatric medications pose a serious risk for mentally ill inmates, and may cause the inmate to experience psychotic decompensation or cause the inmate to harm himself or others.

We further identified inmates who received no treatment for their psychiatric needs. For instance:

- One inmate's initial assessment, which occurred three weeks after his arrival in March 2003, revealed a history of treatment with the antipsychotic medications Zyprexa and Thorazine during a recent prior incarceration at the MCMJ. Despite this recent history, five months later, when we examined his medical chart, he had not been evaluated by the psychiatrist or received psychotropic medication.
- Another inmate in July 2003 requested a psychiatric evaluation to continue his treatment for depression. At the time of our examination of this inmate's medical chart, almost three months later, the inmate had not been seen by a psychiatrist and had received no psychiatric treatment.

4. Suicide Prevention

At the time of our tour, MCMJ failed to provide adequate assessment, monitoring, and housing of suicidal inmates. Suicide is a form of mental illness constituting a serious medical need for which MCMJ must provide adequate treatment. We have learned that at least three MCMJ inmates committed suicide since our September 2003 tour. According to a recent public statement by the MCMJ Warden in the Mobile-Register, "about six inmates a year

attempt suicide, and about one a year is successful."¹² One suicide a year is approximately twice the national average for facility the size of MCMJ.¹³ Thus, it would appear that MCMJ has not resolved its very serious suicide prevention problem.

All three of the recent suicides were reportedly hangings, two of which allegedly occurred with bedsheets. Two of the three suicides occurred within three months of each other. The most recent suicide was committed by a male inmate who at the time of his arrest at his home, according to police, doused himself with gasoline and threatened to set himself afire in front of his wife and children. Despite this conduct at the time of his arrest, it does not appear that the inmate was put on suicide watch at MCMJ until four days after intake. More troubling still, the inmate was reportedly removed from suicide watch by medical staff prior to his death.

As noted above, we observed unreasonable delays in providing mental health care to suicidal inmates in MCMJ. In addition, MCMJ did not assess properly the severity of an inmate's suicide risk and did not provide treatment specific to the inmate's risk of suicide. Instead, suicidal inmates were frequently asked to sign behavioral contracts promising not to harm themselves. These contracts were simply forms that state that the inmate "promise[s] not to harm myself while incarcerated at the Mobile County Jail." After an inmate signed a contract, the inmate was usually placed in the general population without any suicide precautions. These contracts are not an adequate method of preventing suicide or self-harm and appear to provide a false sense of security for staff, and an excuse not to monitor regularly inmates who sign the contracts.

Additionally, we found that MCMJ improperly monitored suicidal inmates. We specifically brought this urgent matter to the attention of MCMJ during our tour. Suicidal inmates who refuse to sign behavior contracts are housed in the medical unit or in the "suicide wedge." Although we note that corrections staff performed adequate 15-minute checks of inmates in the

¹² Dan Murtaugh, Jail to Revamp Suicide Cells, Mobile-Register, May 30, 2007, at B1.

¹³ Bureau of Justice Statistics, Deaths in Custody Statistical Tables: Local Jail Deaths 2000-2005, <http://www.ojp.usdoj.gov/bjs/dcrp/tables/jailstab3.htm> (last visited September 8, 2008) (average annual suicide rate for 2000 - 2005 is 45 per 100,000 local jail inmates).

suicide wedge, the physical attributes of the cells in the suicide wedge presented dangers to inmates. The cells had solid metal doors and thus their interiors, as well as inmates in the cells, were not directly visible to corrections staff. The cells had not been modified to remove sharp edges or other items that could be used for self-harm. Many cells had writing on the walls, indicating that suicidal inmates had access to writing utensils that could be used for self-harm. In addition, inmates in the suicide wedge did not receive regular and periodic evaluations by mental health staff. Some inmates who had been placed on suicide watch were never seen by a psychiatrist.

The MCMJ relied on an inmate "buddy system" to monitor suicidal inmates housed in both the medical area and in the suicide wedge as a supplement to the monitoring by corrections staff. These inmates sat with and monitored suicidal inmates. While this is an acceptable procedure, MCMJ must provide adequate monitoring, training, and select inmates who can be relied upon to perform this service. We found that MCMJ provided little or no training to these inmate workers and some showed little motivation or interest in performing their duties.

5. Policies and Procedures

The failures of MCMJ's mental health services were caused in part by MCMJ's lack of adequate policies and procedures, as well as its failure to implement some policies and procedures that appear to be adequate. A number of MCMJ policies and procedures did not address fundamental components of the topic they cover. For example, the policy regarding suicide prevention did not include instructions on how to assess suicide risk. Similarly, the policy on the use of forced psychotropic medications was silent on basic tenets of the use of forced psychotropics, such as duration of use and monitoring of the inmate. Other MCMJ policies on mental health appear adequate, yet in practice the policies were ignored. For example, the policy on chemically dependent inmates required MCMJ to refer these inmates to an outside treatment center. The actual practice revealed that numerous chemically dependent inmates were not referred for treatment; in fact, chemically dependent inmates were not properly identified, and many received no treatment from MCMJ, which is a substantial departure from generally accepted corrections mental health practices.

6. Staffing

The absence of sufficiently qualified mental health staff at MCMJ contributed significantly to the inadequacy of mental health care. At the time of our tour in September 2003, the MCMJ psychiatrist was required by contract to provide on-site services six hours per week. Six hours a week is grossly inadequate and insufficient to address the mental health care needs of MCMJ's inmate population, which ranges from 1,000 to 1,300 inmates. As stated above in section III.B.1, national studies suggest that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.¹⁴ Further, despite having a psychiatrist under contract, our review indicated that there were weeks, and sometimes months, with no psychiatric coverage at all. The inadequate psychiatry schedule also directly contributed to the failure to provide inmates with timely psychiatric medications.

The lack of adequate psychiatric staff caused MCMJ to rely on improperly trained staff to identify and address inmates' psychiatric needs. For example, MCMJ used untrained corrections officers to conduct intake screening, which contributed to the failure to identify initially inmates with psychiatric problems. This problem was compounded by MCMJ's reliance on licensed practical nurses who lacked psychiatric training, which contributed to the failure to identify inmates in need of immediate psychiatric care. Such care is crucial in preventing psychiatric decompensation and potential harm to self or others.

¹⁴ Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (last visited September 2, 2008). This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). Again, we note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf> (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

C. Use of Restraints

We found that MCMJ's use of four- and five-point restraints,¹⁵ raised significant concerns. In appropriate circumstances, the proper use of such restraints is an effective tool to prevent inmates from harming themselves or others. However, we concluded that MCMJ's monitoring of restrained individuals to be constitutionally deficient, and found serious concerns regarding MCMJ's decisions to apply such restraints. We shared these concerns with the County and the Sheriff in 2003 and in 2007.

1. Monitoring of Restrained Individuals

Restraining inmates, although necessary at times, is a dangerous activity for both inmates and staff because of the force that may be necessary to restrain the inmate. Restrained inmates must be monitored appropriately. The dangers of inadequate monitoring were evidenced by the July 2000 death of a restrained MCMJ inmate from complications caused by necrotizing fasciitis, commonly referred to as "flesh-eating bacteria." According to the Mobile County Special Grand Jury Report regarding this incident, during the 14 days this inmate was at MCMJ, he was stripped naked, handcuffed, and shackled almost continuously. The inmate was reportedly restrained because he clogged the toilet with his clothes, causing it to overflow, and also spread excrement on himself and the cell. Typically, the limbs of a person infected with necrotizing fasciitis will swell and may develop a purplish rash within three to four days of infection. Within four to five days, an infected person will experience critical symptoms, during which the body will go into toxic shock and the person may lose consciousness. Thus it appears that either checks were not performed or, if they were performed, no action was taken. Although this incident occurred several years ago, it informs our review of the MCMJ's current policies and practices regarding the use of restraints. Indeed, the Special Grand Jury Report concluded that "a massive systemic failure in the administration of the Mobile County Metro Jail resulted in" this inmate's death.

Although MCMJ revised its policies following this incident, at the time of our tour, MCMJ policies regarding checks of

¹⁵ Using four-point restraints means the inmate is placed in a prone position and his or her arms and legs are secured. Five-point restraints also includes restraining the inmate's head.

restrained inmates' welfare ("welfare checks") were inadequate. The revised policies required welfare checks every 15 to 30 minutes, but only required a check of the restrained inmate's extremities for visible injuries. Although some inmates were restrained in the medical clinic, MCMJ did not require checks of vital signs, range of motion, neurological condition, or other physiological checks of the restrained inmate's condition, which are required by generally accepted corrections practices. The limited evaluation required by MCMJ is a substantial deviation from generally accepted corrections practices and unreasonably places inmates at risk of harm. For example, an inmate in restraints who appeared to have delirium tremens - a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - apparently received no treatment for this condition and did not have his vital signs monitored. In addition, restrained inmates may go into respiratory distress, which may be interpreted as agitation or resistance and would not be revealed by a simple check of the inmate's extremities for visible injuries.

The paucity of documentation regarding welfare checks of restrained inmates at MCMJ raised serious concerns that these checks were not performed or were not performed with sufficient frequency to protect inmates from harm. Documenting the basis and duration of the use of restraints and the condition of the restrained inmate is generally accepted corrections practice. However, the only documentation of the basis for, and duration of, the use of restraints by MCMJ were brief notations on the Inmate Restraint Log. The MCMJ policy does not require documentation of welfare checks or the health condition of the restrained person, although we noted a few checks on the Inmate Restraint Log. For example, a welfare check for one restrained inmate was noted at 3:56 p.m., and there was a notation that the inmate was briefly released from restraints to eat at 5:10 p.m., then restrained again at 5:25 p.m. The log does not indicate any other welfare checks were performed, although generally accepted corrections practices require range of motion, neurological and vital signs checks every 15 minutes. In addition, in a number of instances the first notation that an inmate had been placed in restraints occurred when staff noted a welfare check.

The limited content of the welfare checks that were documented reinforces our concerns regarding the scope of the welfare checks performed by MCMJ. For example, most such notations simply indicated "checked," without further elaboration. This does not reflect an adequate evaluation of the physical condition of the restrained inmate and places inmates at risk of harm.

2. Application of Restraints

At the time of our 2003 tour, MCMJ policy provided that officers may use restraints as a "preventative measure" if the officer believed the inmate was a threat to himself or herself or to others. The MCMJ policy did not require supervisory approval for the use of restraints, although the Inmate Restraint Log did have a column to record the name of the supervisor who was notified of the use of restraints. There were numerous examples of the use of restraints for medical purposes, such as for potentially suicidal inmates. Although MCMJ policy required physician approval for the use of restraints for medical reasons, it did not require documentation of the physician's basis for approving the restraints. Thus, we were not able to evaluate whether physician approval was obtained or if the use of restraints was appropriate.

The notations on the Inmate Restraint Log provided only cursory descriptions of the basis for the use of restraints, such as "breaking sprinkler" or "suicidal." In addition, the log was frequently incomplete, and commonly failed to note the date and time that restraints were applied or were removed. In fact, upon our request for completed restraint logs for a one-year period, MCMJ could only provide completed Inmate Restraint Logs for ten non-consecutive days.

Even based on this extremely limited documentation, it was clear that MCMJ utilized restraints successively on the same individuals for extended periods of time, raising concerns regarding the need for the use of restraints. Indeed, our expert corrections consultants noted that the frequency of the use of restraints at MCMJ was atypically high for a jail of its size. Inappropriate use of restraints can be dangerous for both inmates and staff, and MCMJ's failure to document and review the use of restraints was inconsistent with generally accepted correctional practices and put inmates at risk of harm.

The prolonged and successive use of restraints is an improper practice and indicative of a failure to manage disruptive or mentally ill inmates. For example, a particular inmate at MCMJ was placed in five-point restraints in May 2003 for "breaking sprinkler head" at 11:30 p.m. and remained in restraints until 8:30 a.m. the following morning. The inmate was again placed in five-point restraints for "breaking sprinkler head" at 9:15 a.m. and was not released until 6:00 p.m. This inmate was placed in five-point restraints a third time for "breaking sprinkler head" at 6:39 p.m. and the date and time of his release from restraints was not noted. This cyclical use of

five-point restraints indicates that MCMJ failed to either identify and treat an inmate who possibly had serious mental health needs or, if he was not mentally ill, to manage appropriately this inmate's behavioral issues.¹⁶

D. Security, Supervision, and Protection From Harm

During our tours, we found that MCMJ failed to protect inmates from harm adequately. We noted a high, and increasing, level of inmate-on-inmate violence at MCMJ. For example, in 2003, MCMJ reported 89 fights in four months, an increase of 36 percent over the same period in the prior year. While this statistic alone does not evidence a pattern or practice of deliberate indifference to inmate-on-inmate violence, it is an example of the deficient security practices that subject MCMJ inmates to an unreasonable risk of harm. Our expert corrections consultant concluded that the increasing inmate-on-inmate assaults stem from a variety of deficient MCMJ practices.

Specifically, our review revealed that MCMJ failed to: take adequate measures to limit the introduction of contraband into the facilities; classify inmates appropriately based on their anticipated in-custody behavior; and supervise inmates adequately. Such failures significantly increases the risk of violence, placing both inmates and staff at risk of serious harm. The security, supervision, and protection from harm deficiencies at MCMJ were exacerbated by a lack of adequate policies, procedures, training, and staffing.

1. Control of Contraband

Inmates reported a significant problem with contraband, including illegal drugs, at MCMJ. Our review of MCMJ documents, such as Shakedown Forms, confirmed these reports. The shakedowns revealed inmates possessed various shanks, razors, bleach, and other contraband. For example:

¹⁶ Furthermore, our review of MCMJ records did not indicate that this inmate's limbs were exercised during this period of time. Failure to attend to a restrained inmate's physical needs during such extensive periods of restraint, such as the range of motion of the inmate's arms and legs, can cause serious medical harm.

- A shakedown conducted in one wedge¹⁷ in February 2002, revealed six razors/shanks, a maintenance screw tip, two metal ceiling pieces, and an ink pen for tattooing, along with other contraband items.
- Similarly, a shakedown of a pod¹⁸ in April 2003, uncovered 13 containers of bleach, which could be used as a weapon.

We also noted some inadequate responses to the discovery of contraband. For example, in April 2002, when staff found an inmate smoking marijuana, the only action indicated in the file was the suspension of the inmate's commissary privileges for one week.

Despite the apparent presence of significant amounts of contraband, MCMJ conducted too few shakedowns. Indeed, although the Cell Condition Check List, last modified in 1999 at the time of our 2003 tour, contained a directive from the MCMJ Warden that shakedowns should be performed once per week, our review indicated they were performed significantly less frequently. One potential source of this problem is a lack of sufficient staffing. According to MCMJ policy, inmates are to be taken to the recreation yard during shakedowns of entire housing wedges, a procedure that requires intensive staffing. However, both MCMJ staff and records indicated that staffing shortages have largely prevented MCMJ from allowing inmates to use the recreation yard, and consequently resulted in fewer shakedowns.

2. Classification of Inmates

Adequate classification systems are a fundamental component of providing a reasonably safe environment in a corrections institution. The primary goal of a classification system is to predict in-custody behavior so that appropriate security measures can be utilized to minimize the risk of violence. Generally accepted corrections practices for classification systems utilize a variety of objective, behavior-based factors to determine the

¹⁷ A wedge is designed to house 16 inmates. However, MCMJ routinely exceeds this number and therefore it is unclear the total number of inmates housed in this wedge at the time of the shakedown.

¹⁸ Pods housing male inmates consist of six eight-cell wedges. Pods housing female inmates consist of two twelve-cell wedges.

appropriate level of custody. Typically, inmates are divided into high, medium, and low custody, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted corrections practices, MCMJ inmates were housed based almost exclusively on whether they have been convicted or whether they are charged with a felony or a misdemeanor. At the time of our tours, male inmates were separated into six groups,¹⁹ and were still housed based primarily on their legal status, not on whether they were objectively dangerous. Female inmates were reportedly separated into two groups, misdemeanants and all others, but our review revealed that female inmates were housed according to available space.²⁰

Although the MCMJ classification form collected various behavior-based information, this information was not utilized to classify inmates. Such practice unreasonably increases the risk of harm by failing to perform a meaningful evaluation of anticipated behavior, particularly violent behavior. The MCMJ failed to separate adequately predatory inmates from vulnerable inmates. For example:

- One inmate repeatedly stabbed another inmate in June 2002, with a pen while incarcerated at MCMJ causing multiple puncture wounds to the inmate's head, arms, and back and requiring treatment at a hospital emergency room. However, during a subsequent incarceration at MCMJ in August 2003, the assailant was housed in the protective custody wedge with MCMJ's most vulnerable inmates. This inmate was moved to

¹⁹ Specifically: 1) inmates charged or convicted in the federal system; 2) inmates convicted of felonies in the state system; 3) inmates charged with "low" and "medium" felonies; 4) inmates charged with "high" felonies; 5) inmates charged with or convicted of misdemeanors; and 6) special management inmates (including sex offenders and disciplinary and protective segregation). We understand that since our tours, the U.S. Marshal's Service has clarified that MCMJ is not required to separate federal inmates from other inmates. However, this does not impact the lack of an adequate behavior-based classification system.

²⁰ Since our tours, MCMJ reports that it has begun housing some female inmates in the Barracks.

disciplinary segregation after altercations with another inmate and staff.

- In another incident in July 2003, an inmate was taken to the disciplinary wedge because he had just been involved in a fight with another inmate. However, he was not isolated, but was placed in a cell with an inmate. He assaulted this inmate almost immediately, and the assaulted inmate required hospital treatment for a cut above his eye.

While the factors considered in an objective classification system include whether the inmate has been convicted of the current offense and the nature of that offense, numerous other behavior-based factors also must be considered. As there are violent misdemeanor offenses²¹ and misdemeanor arrestees and offenders who have known predatory histories, as well as the fact that there are many non-violent felonies, basing custody levels solely on an inmate's legal status does not adequately predict in-custody behavior. A meaningful classification system is even more important in crowded facilities like MCMJ. For example, our expert corrections consultant noted that it is safer for staff and inmates for MCMJ to increase the population density of low or medium custody inmates, rather than high custody inmates. An appropriate classification system would permit MCMJ to allocate scarce space and resources appropriately to provide a reasonably safe environment. Without such a classification system, inmates and staff at MCMJ face an unacceptably high risk of harm.

3. Supervision

We found that MCMJ failed to supervise inmates adequately. The MCMJ is a remote-supervision jail, in which staff observe inmates from a control area and are separated by glass walls from the inmates in the six wedges.²² An officer assigned to the control area cannot leave the post, except in emergencies, and therefore floor officers are needed as additional security staff

²¹ Some examples of violent misdemeanors include the following: assault in the third degree, Ala. Code § 13A-6-22 (2007); sexual abuse in the second degree, Ala. Code § 13A-6-67 (2007) (includes sexual contact with a person who is legally incapable of consent for reasons other than age); and reckless endangerment, Ala. Code § 13A-6-24 (2007).

²² This is in contrast to direct-supervision jails, where staff are stationed in the housing unit.

to inspect the pods, perform shake-downs for contraband, and ensure inmates' safety.

The MCMJ policies required a welfare check of the inmate population every 30 minutes. However, such checks were only occasionally noted in the pod logs, which raised concerns that they were not being conducted. In addition, there were no guidelines for the conduct of such checks and no consistent documentation of what staff observed during such checks. Such inadequate supervision practices place both inmates and staff at risk. For example, in April 2002, three inmates were assaulted in their cell by two other inmates, with one of them suffering bruising to his neck, face, and arm and a split lip. Although the cells at MCMJ are in the line of sight of the pod officer's station, security staff did not notice the assault in the cell, and the assault was only brought to light when one of the assaulted inmates approached an officer.

The floor officers at MCMJ were required to inspect the condition of each pod once per shift. However, staff failed to identify many deficiencies during these inspections. For example, during one of our tours in 2003 we noted that several windows to the outside of the facility were cracked or had holes in them, and had apparently been broken for some time. This poses a significant security risk.

The MCMJ's security regarding escape prevention is also of concern. We have learned that in 2007, a 19-year-old female inmate at MCMJ allegedly attempted an escape, and reportedly was only discovered when she was badly cut trying to climb the razor fence surrounding the facility. It appears that MCMJ does not know how this inmate made her way outdoors to be in a position to charge the fence, or why she was not discovered until she had suffered an injury on the fence.

4. Policies, Procedures, Training, and Staffing

The deficiencies we identified in security administration at MCMJ stemmed in large part from a lack of adequate policies, procedures, training, and staffing. The MCMJ policies did not adequately address the operation of the facility. For example, as noted above, the policies regarding facility inspections and inmate welfare checks did not establish standards for these evaluations and did not provide for a systematic mechanism to address deficiencies identified by staff, thereby greatly reducing their efficacy. Similarly, MCMJ policies did not provide for adequate documentation of significant events, such as

the use of force, the use of restraints, and facility inspections.²³

In addition, although the corrections officer who was in charge of inmate discipline at the time of our tour in 2003 was striving to administer discipline fairly, the disciplinary procedures at MCMJ had significant problems. While these problems did not violate the Constitution, our expert corrections consultant noted that they significantly increased the tension in the facility and fostered inmate-on-inmate violence.

The MCMJ policy allowed for informal "sanctioning" of inmates, including locking-down inmates for up to 72 hours with no opportunity for the inmate to be heard or appeal the decision.²⁴ Our review indicated that the same type of violation would at times be referred for formal disciplinary proceedings, and other times the inmate would be sanctioned informally. While not a constitutional violation, we flag these practices because they give the perception that discipline is imposed arbitrarily, which increases the risk of inmate-on-inmate violence.

We observed that MCMJ staff did not receive adequate training. At the time of one of our tours, a number of the corrections officers hired in the last few years did not receive pre-service training. In addition, until recently, MCMJ staff were not receiving any in-service training.²⁵ Thus, a number of officers only received training through the Field Training Officer ("FTO") program, where officers are paired with an experienced officer for two weeks. In addition, we identified significant deficiencies with the FTO program. The MCMJ did not have written procedures governing the selection of FTOs, to ensure that FTOs are exemplary officers and demonstrate an interest, knowledge, and ability to train new officers in MCMJ

²³ The MCMJ reports that, following our tours, it developed an unusual occurrence form and an use-of-force form, which are centrally filed and reviewed. We have been unable to verify this information.

²⁴ The MCMJ reported that, following our tours, it had modified the sanction process. Reportedly, MCMJ no longer conducts informal discipline unless the inmate signs a written waiver of the hearing. We have been unable to verify this claim.

²⁵ We understand the MCMJ has since offered some in-service training and plans to offer pre-service and additional in-service training.

policies and procedures. The FTO program also did not describe the knowledge, skills, and abilities that trainees must demonstrate and simply listed the topics to be covered, such as "Cell Inspections" and "Sick Call/Sick Slip." Similarly, MCMJ did not document the performance of the trainees in these topics and FTOs simply noted the date the topic was covered with the trainee.

Other corrections officers did receive pre-service training, but the curricula we reviewed indicated the training provided was inadequate. The MCMJ training materials revealed that not nearly enough training was devoted to critical jail functions. For example, the training on the use of restraints and transporting prisoners was last revised in 1991, and did not adequately address the procedures for applying restraints. Moreover, the training was apparently a lecture format, with no practical component.

Staff reported, and our review corroborated, that MCMJ did not have adequate numbers of corrections staff. The MCMJ corrections staff worked a large amount of overtime. For example, it spent \$1.5 million on overtime for corrections staff in 2002. Yet the Jail still lacked sufficient staff to operate the facility. The staff vacancy rate in 2003 was reportedly 28 percent. The heavy use of overtime also raised concerns about officer fatigue, which can increase the risk of harm to inmates and staff.

The MCMJ also provided inadequate access to exercise, which is a significant mechanism corrections facilities use to decrease inmate aggression. The MCMJ had no indoor exercise facilities and, by its own admission, made limited use of its outdoor exercise yard. The MCMJ did provide some very limited outdoor recreation, and so did not violate the Constitution, but the very limited recreational opportunities raised tensions and thereby fostered inmate-on-inmate violence. Appropriately structured and supervised exercise provides an important outlet for inmate aggression, and thus, is an important inmate management tool. Furthermore, regularly scheduled exercise provides a privilege that staff can take away from an inmate for sustained rule violations. However, MCMJ's outdoor yard was utilized on only 45 days in 2002. Although MCMJ apparently has improved access somewhat since that time, it was still significantly limited at the time of our tour.

E. Safety and Sanitation

Although conditions at the Barracks were significantly better than at the Jail at the time of our tour in 2003, safety and sanitation conditions at both the Jail and the Barracks posed a significant risk of disease and injury to inmates and staff. We identified deficiencies in the areas of insect and rodent control, physical plant, fire safety, and general sanitation and safety. Similar to the security administration deficiencies discussed above, the safety and sanitation failures were exacerbated by the crowded conditions at the Jail. In 2007, we provided the County and the Sheriff a written report prepared by our expert corrections safety and sanitation consultant outlining our concerns.

1. Insect and Rodent Infestation

We found that there was a significant insect and rodent infestation at the Jail. We observed rodent droppings and a live rat in the kitchen during the height of lunch preparation. Insects and rodents in the kitchen area can spread food-borne illnesses, such as by carrying salmonella bacteria.²⁶ We also saw ants and unidentified black bugs throughout the Jail. Insects can spread disease and, given the general sanitation problems, insect bites can become infected. As discussed in section III.A.3, we noted an outbreak of a skin infection at MCMJ.

2. Physical Plant

Following our tours in 2003, MCMJ took a number of steps to reduce the inmate population and reported that, as of December 3, 2003, the inmate census had been reduced to 1,006 inmates; 817 in the Jail, and 189 in the Barracks. Unfortunately, this trend did not continue, and the Jail presently remains dangerously overcrowded. Since the start of our investigation, we have received many allegations of inmates being forced to sleep on the floor of their cells due to overcrowded conditions; some inmates sleeping just inches from toilets and sinks, including an inmate that was allegedly non-ambulatory.

At the time of our tour, there were a number of plumbing problems at the Jail, although we did not identify such problems

²⁶ We understand that following our tours, MCMJ has instituted periodic pest control visits covering the entire facility. We have been unable to verify this assertion.

at the Barracks. We observed inoperable showers and toilets throughout the Jail facility. For example, we observed numerous leaking toilets, including in cells with inmates sleeping on the floor near the leaks. In addition, we measured hot water temperatures above 120 degrees, which create a scalding threat to both inmates and staff. For example, the shower water temperature in one of the female units measured 130 degrees, which can cause burns in less than 30 seconds. These water temperatures allow inmates to harm themselves, accidentally or intentionally, and provide a weapon for inmates who want to harm others.

3. Fire Safety

We identified several deficiencies in MCMJ fire suppression and evacuation systems and procedures. For example, there were no sprinkler heads over the ovens in the kitchen or behind the dryers in the Jail, two places where fires are likely to originate.²⁷ We also identified deficiencies in evacuation systems and practices. For example, one fire door took over two minutes to open and another could not be opened by staff. Additionally, MCMJ has inadequate procedures to evacuate the facilities in the event of an emergency. We also noted several exit lights that were not working, impeding evacuation in the event of a fire.

4. General Sanitation and Safety

Many of the showers contained mildew and mold. Moreover, the laundry facilities do not adequately sanitize the clothing, which increases the risk of transmitting infectious diseases, such as skin infections.²⁸ In addition, the sink in the laundry room did not have a vacuum breaker to prevent back-flow from contaminating the potable water system.

Chemical safety was also inadequate at MCMJ. For example, we observed a container in the medical clinic marked "bleach"

²⁷ We note that MCMJ retained a new sprinkler-maintenance contractor shortly before our first tour, who was reportedly working to correct these problems. The MCMJ reported that, following our tours, it has worked with the Fire Marshal to identify and correct fire safety problems and conducted fire safety training.

²⁸ We understand that since our tours, MCMJ has acquired new washing machines.

that actually contained an ammonia-based chemical. Such mislabeling poses a significant risk of harm to inmates and staff because it may lead to accidental mixing of chlorine and ammonia-based chemicals, which releases highly toxic chlorine gas. In addition, inmate workers in the laundry were using corrosive chemicals without protective equipment such as goggles to prevent injury.²⁹

IV. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, MCMJ should implement, at a minimum, the following measures:

A. Medical Care

1. Revise intake procedures and the Jail Receiving Screening form to screen incoming inmates adequately. Ensure that a qualified medical professional reviews all screening on a timely basis.
2. Develop and implement a policy to ensure that a qualified medical professional completes a timely health appraisal of each inmate.
3. Develop and implement chronic disease policies and procedures that adequately identify inmates with chronic diseases and ensure adequate and timely monitoring of, and follow-up care for, inmates with chronic diseases.
4. Develop and implement adequate policies and procedures regarding the identification and treatment of contagious diseases such as tuberculosis and syphilis.
5. Develop and implement procedures to assure timely and appropriate access to medical care through sick call.
6. Develop and implement protocols specifying the appropriate response[s] to common acute symptoms.
7. Develop and implement policies and procedures that ensure timely and appropriate delivery of prescription medications.

²⁹ The MCMJ reports that, following our tours, it has taken various measures to address chemical safety issues.

8. Continue working with the Department of Health to prevent, diagnose, and treat the outbreak of skin infections. Develop and implement policies and procedures to address the likely causes of the outbreak and to treat infections.
9. Provide sufficient staffing to ensure that inmates' serious medical needs are met.

B. Mental Health Care

1. Revise intake procedures and forms to screen adequately incoming inmates for mental health issues. Ensure that a qualified mental health professional reviews all screening on a timely basis.
2. Ensure that staff conducting intake screening are trained adequately.
3. Develop and implement procedures to ensure inmates with mental health needs receive timely assessment by a qualified mental health professional.
4. Develop and implement policies and procedures to ensure timely and adequate responses to inmate requests for mental health care.
5. Ensure adequate on-site psychiatry coverage, and ensure adequate on-site supervision of mental health staff.
6. Develop and implement policies and procedures that ensure adequate monitoring and follow-up treatment of inmates with mental illness.
7. Develop and implement adequate suicide screening policies and procedures.
8. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.

C. Use of Restraints

1. Develop and implement a policy regarding the application of restraints that requires immediate prior written approval, if practicable, of the use of restraints for medical purposes by a qualified medical professional or immediate prior written supervisory approval, if practicable, for uses of restraints for security purposes, other than the use of

routine restraints for transporting inmates, such as handcuffing.

2. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.

D. Security, Supervision, and Protection From Harm

1. Develop and implement an objective, behavior-based classification system that separates inmates in housing units by classification levels.
2. Develop and implement written procedures for conducting and documenting security inspections and inmate welfare checks, including specific criteria for such evaluations and a systematic procedure for correcting any deficiencies identified.
3. Provide adequate corrections officer staffing and supervision to ensure inmate safety.
4. Develop and implement appropriate training for corrections staff addressing security administration and providing for proficiency testing.
5. Develop and implement policies governing the conduct of shakedowns that increase the frequency and identify the scope of shakedowns in order to minimize inmates' access to dangerous contraband.
6. Develop and implement policies requiring adequate documentation and investigation of significant events, including use of force by staff and instances of inmate-on-inmate assault.

E. Safety and Sanitation

1. Ensure regular and periodic cleaning and maintenance of all housing areas, including toilets and showers. Ensure regular and periodic insect and rodent control measures are performed.

2. Ensure proper operation of all fire detection and suppression systems. Develop and implement adequate evacuation procedures, including emergency door inspections.
3. Adjust the hot water in all housing areas to safe temperatures.
4. Develop and implement proper chemical safety measures.

V. CONCLUSION

We note again in conclusion the extraordinary and unexpected step taken by the County and Sheriff to cease all communications with the Department of Justice regarding this investigation, and the negative inferences we drew regarding the present status of the conditions at MCMJ in light of this action. Nevertheless, we once again invite the County and Sheriff to discuss with us the remedial recommendations we presented in this letter, with the goal of remedying the identified constitutional violations without resort to litigation.

In the event we are unable to reach a resolution regarding the above identified constitutional violations, we are obligated to advise you that the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, 49 days after receipt of this letter, to correct identified deficiencies or otherwise protect the rights of the inmates incarcerated at MCMJ. 42 U.S.C. § 1997b(a)(1). If you have any questions regarding this letter, please contact Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

cc: Lawrence M. Wettermark, Esq.
Attorney for the Mobile County Commission

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U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D. C. 20530*

The Honorable Carlos A. Gimenez
Mayor, Miami-Dade County
Stephen P. Clark Center
111 Northwest First Street, 29th Floor
Miami, FL 33128

AUG 24 2011

Re: Investigation of the Miami-Dade County Jail

Dear Mayor Gimenez:

The Department of Justice's Civil Rights Division has concluded its investigation of conditions at the corrections facilities operated by the Miami-Dade County Corrections and Rehabilitation Department ("MDCR"). This letter provides MDCR with our findings.

On April 2, 2008, we notified officials of Miami-Dade County ("County") of our intent to investigate the MDCR corrections facilities pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of prisoners in adult detention and corrections facilities. CRIPA requires that we advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b.

I. SUMMARY OF FINDINGS AND CONCLUSIONS

We conclude that there is a pattern and practice of constitutional violations in the correctional facilities operated by MDCR, and as a result of the unconstitutional operation of the Jail, prisoners suffer grievous harm, including death. As described more fully below, our specific findings include:

- MDCR is deliberately indifferent to the suicide risks and serious mental health needs of its prisoners. At least eight prisoners have committed suicide since 2007, and thousands of prisoners have suffered from inadequate mental health crisis services.
- MDCR fails to provide adequate acute care, chronic care, outpatient treatment, and

discharge services to prisoners with mental illness. Instead, MDCR inappropriately relies on medication management that fails to consistently incorporate diagnoses or treatment plans, even for prisoners with the most serious mental illnesses.

- MDCR is deliberately indifferent to the serious medical needs of prisoners including access to care for acute medical needs, management of chronic health problems, and record keeping and quality assurance. Prisoners wait weeks and even months to receive consultations for care from HIV, cardiology, and neurology specialists.
- MDCR fails to provide adequate intake screening, initial health assessments and acute care for newly incarcerated prisoners. Since 2008, at least five prisoners have died from MDCR's failure to identify and treat prisoners withdrawing from drugs or alcohol.
- MDCR is engaged in a pattern or practice of using excessive force against prisoners. MDCR corrections officers openly engage in abusive and retaliatory conduct, which frequently causes injuries to prisoners.
- MDCR is deliberately indifferent to the serious risk of harm to prisoners posed by fellow prisoners. Corrections officers fail to supervise prisoners, particularly prisoners known to be violent, resulting in ongoing harm and serious risk of harm. There is significant evidence to be concerned that the Jail fails to take reasonable steps to protect prisoners from sexual assault.
- The conditions of confinement within the Jail expose prisoners to an unreasonable risk of harm from inadequate fire and life safety systems and environmental health and sanitation deficiencies, including unreasonable risk of infection from overcrowding and inadequate laundry, housekeeping, and pest control.

II. INVESTIGATION

On June 9-13, 2008, June 16-20, 2008, and April 7-8, 2009, we inspected the facility together with consultants in the fields of corrections, custodial medical and mental health care, suicide prevention, and environmental health and sanitation. We interviewed administrative and corrections staff, medical and mental health care providers, prisoners, and members of the Miami-Dade community. Our investigation also included the review of policies and procedures, incident reports, grievances, medical records, and use of force records and investigations, including documents provided by the County subsequent to our on-site visits. In keeping with our pledge of transparency and providing technical assistance where appropriate, our consultants conveyed their preliminary impressions and concerns to County officials and the MDCR command staff at the conclusion of our tours.

We are grateful to MDCR Director Timothy P. Ryan and his entire staff for the assistance and cooperation extended to us. We found the MDCR officials helpful and professional throughout the course of the investigation. MDCR provided us with access to records and personnel, and responded to our requests, before, during, and after our on-site visits, in a transparent and forthcoming manner. We also appreciate MDCR's receptiveness to our consultants' on-site recommendations.

III. BACKGROUND

The corrections facilities operated by MDCR (collectively “Miami-Dade County Jail” or “the Jail”) hold an average of 7,000 prisoners in a complex of buildings spread out across the county, making it the nation’s eighth largest jail. The Jail has six corrections facilities: the Pre-Trial Detention Center (“PTDC”); the Women’s Detention Center (“WDC”); the Training and Treatment Center (“Stockade”); the Turner Guilford Knight Correctional Center (“TGK”); and the Metro West Detention Center (“MWDC”). Additionally, MDCR operates a boot camp program, with a housing facility adjacent to TGK (“Boot Camp”).

The prisoners incarcerated in the Jail are awaiting trial or serving sentences of less than one year. Two of the five facilities, PTDC and TGK, are booking facilities. These two facilities process and house all classifications of prisoners. PTDC, the County’s main jail building located across the street from the County Courthouse, has approximately 1,700 beds for male prisoners, and TGK has 1,300 beds for male, female, and juvenile prisoners. WDC has 375 beds and only houses female prisoners. The Stockade, the oldest MDCR facility, has approximately 1,200 beds for adult males. The largest of the five facilities is the MWDC, which is located approximately 16 miles west of PTDC and downtown Miami, and has approximately 3,000 beds for male prisoners of all classifications.

Health care, including mental health care, is provided to prisoners on-site by Correctional Health Services (“CHS”), a division of the Jackson Health System of Miami-Dade County (a community healthcare system consisting of Jackson Memorial Hospital, primary care centers, health clinics, and rehabilitation, nursing, and mental health facilities). Additionally, the Jackson Memorial Hospital, the largest of the medical centers operated by the Jackson Health System, maintains a specialized unit known as “Ward D” to provide emergency hospital care to MDCR prisoners in a secure environment staffed by MDCR corrections officers. Each month, CHS staff members see several thousand prisoner-patients, several hundred of whom require physician-level care, and approximately 75 prisoners who need inpatient care at Ward D. Moreover, of the approximately 7,000 MDCR prisoners, on average 1,000 suffer from mental illness, making the Jail one of the largest psychiatric facilities in Florida.

IV. FINDINGS

A. **MDCR PROVIDES CONSTITUTIONALLY INADEQUATE MEDICAL AND MENTAL HEALTH CARE.**

Jail prisoners have a constitutional right to be protected from harm, Farmer v. Brennan, 511 U.S. 825, 832 (1994), and serious risk of harm, Helling v. McKinney, 509 U.S. 25, 33-35 (1993). Whether that harm takes the form of illness, injury, or inhumane conditions, jailors cannot display “deliberate indifference” to a prisoner’s serious needs. Wilson v. Seiter, 501 U.S. 294, 302-303 (1991) (citing Estelle v. Gamble, 429 U.S. 97, 104-106 (1976)). MDCR is deliberately indifferent to the risk of suicide and the serious medical and mental health needs of prisoners. As illustrated below, the constitutional deprivations uncovered by our investigation are not the result of isolated incidents or the misconduct of a few MDCR staff members. Instead,

MDCR's deliberate indifference to protecting the Jail's prisoners from harm is a systemic failure.

1. MDCR is deliberately indifferent to prisoners' suicide risks and serious mental health needs.

Our investigation revealed that MDCR is deliberately indifferent to the suicide risks and serious mental health needs of prisoners who present symptoms of suicidal behavior or serious mental illness. See Campbell v. Sikes, 169 F.3d 1353, 1362 (11th Cir. 1999) (noting that a failure to provide proper medical care, includes a psychiatrist providing grossly inadequate medical care); Steele v. Shah, 87 F.3d 1266, 1269 (11th Cir. 1996) (same); Harris v. Thigpen, 941 F.2d 1495, 1505 (11th Cir. 1991) (noting that "this court has acknowledged that the deliberate indifference standard also applies to inmates' psychiatric or mental health needs."). Furthermore, jail officials have a constitutional obligation to act when there is a strong likelihood that a prisoner will engage in self-injurious behavior, including suicide. See Snow ex rel. Snow v. City of Citronelle, Ala., 420 F.3d 1262, 1268-69 (11th Cir. 2005) (noting defendants are deliberately indifferent if there is a strong likelihood that an inmate would commit suicide). In jail suicide cases alleging constitutional violations, "the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." Cook ex rel. Tessier v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting Cagle v. Sutherland, 334 F.3d 980, 986 (11th Cir. 2003)). Deliberate indifference is demonstrated by: "(1) subjective knowledge of a risk of serious harm; (2) disregard of... that risk; (3) by conduct that is more than mere negligence." Cook, 402 F.3d at 1115 (quoting Cagle at 986).

We observed systemic failures to address serious risks of prisoner suicide and to treat prisoners' serious mental health needs. Thousands of prisoners with serious mental illness have suffered in the Jail in recent years without adequate care. Instead, medication management is the only treatment available, and it is plagued with errors. The Jail does not provide adequate mental health crisis services, including access to: beds in a health care setting for short-term treatment and acute care (an inpatient level of care); chronic care and/or a special needs unit for prisoners who cannot function in the general population; outpatient treatment for prisoners in the general population; or services for prisoners in need of further treatment at the time of transfer to another institution or discharge to the community.

a. MDCR is deliberately indifferent to prisoners who pose a significant risk of suicide and self-harm.

Eight Miami-Dade County prisoners, including one in March 2011, committed suicide in the past four years, illustrating the harm resulting from MDCR's failure to take reasonable preventative measures.

- The Death of A.N.¹ On March 26, 2011, at approximately 9:45 p.m., A.N., a 24-year-old male, committed suicide by asphyxiation with a bed sheet tied around his neck. A.N. was booked on August 3, 2010. At various times during his incarceration at MDCR, he was evaluated by mental health providers as suicidal.

¹ To protect the identity of prisoners, we use coded initials throughout this letter.

A.N. was housed in the general psychiatric unit. On February 4, 2011, less than one month prior to his death, A.N. was evaluated as suicidal and placed in the suicide precaution housing unit. He was subsequently returned to the general psychiatric unit, where he reportedly committed suicide on March 26, 2011.

- *The Death of A.G.*: On September 16, 2010, at approximately 6:30 p.m., A.G., a 33-year-old male was found by a correctional officer hanging in his cell. A.G. was booked on September 10, 2010. The next day, the Jail transported him to the emergency room, noting him to be combative and psychotic. A.G. returned later that day, was seen by a mental health provider, and subsequently cleared for general population in medium level custody on September 14, 2010. There, A.G. reportedly committed suicide on September 16, 2010 by affixing a sheet to an upper corner portion of the cell and asphyxiating himself.
- *The Death of A.H.*: On February 11, 2010, A.H., a 40-year-old female was found by a corrections officer hanging by a bed sheet. A.H. was booked into the Women's Detention Center on February 9, 2010. She was reportedly seen by a mental health care provider and cleared for general population. Subsequently, A.H. was sent to administrative segregation under medical observation. There, A.H. reportedly committed suicide on February 11, 2010 by affixing a sheet to a vent and asphyxiating herself.
- *The Death of A.I.*: On May 20, 2009, at approximately 4:45 a.m., A.I., a 34-year-old male, was found by a correctional officer hanging from a ceiling light fixture by a bed sheet. A.I. was subsequently transported to the hospital and pronounced dead. A.I. was housed in administrative segregation for most of his confinement due to the high profile nature of his charges.
- *The Death of A.J.*: On April 18, 2007, A.J., a 50-year-old male, entered PTDC. The booking and intake screening process identified the prisoner in need of kidney dialysis. Accordingly, this prisoner was housed in a health clinic cell at PTDC. At approximately 12:30 a.m. on August 15, 2007, a corrections officer found A.J. hanging from the cell bars by a bed sheet. The prisoner was transported to the hospital, where he survived until life-support equipment was disconnected eight days later.
- *The Death of A.K.*: On July 9, 2007, A.K., a 32-year-old male, entered PTDC. This prisoner was housed in administrative segregation due to the high profile nature of his charges. Less than one month later, on August 5, 2007, a corrections officer found A.K. hanging from the cell bars by a bed sheet. The prisoner was pronounced dead by the Miami-Dade County Fire Rescue Department upon their arrival.
- *The Death of A.L.*: On April 26, 2007, A.L., a 23-year-old male, entered PTDC. The prisoner was transferred to MWDC and housed in administrative segregation due to the high profile nature of his charges. On May 27, 2007, a corrections officer found this prisoner hanging from a ceiling grate by a bed sheet. The

prisoner was pronounced dead by the Miami-Dade County Fire Rescue Department upon their arrival.

- The Death of A.M.: On August 5, 2006, A.M., a 41-year-old male, entered PTDC. The prisoner was housed in a multiple-occupancy classification cell at PTDC. The following day, August 6, 2006, other prisoners discovered this prisoner hanging from the cell bars by a shoelace. The other prisoners yelled for assistance. A corrections officer arrived but did not have appropriate tools to cut down the prisoner, so he gave a prisoner his personal keys to try to cut him down. Although MDCR policy requires responding corrections officers to initiate cardiopulmonary resuscitation ("CPR"), the prisoner was not administered CPR until nursing staff arrived six minutes later. MDCR's investigation of this suicide revealed that A.M. had expressed suicidal ideation several months earlier and had a history of at least one suicide attempt, neither of which was elicited by MDCR's screening process.

1) Suicide Risk and Mental Health Screening

Incoming prisoners' serious psychiatric needs, including suicidal ideation, go unidentified and unaddressed due to MDCR's deficient intake screening process. Deliberate indifference to a prisoner's serious medical needs violates the Eighth Amendment. See Mann v. Taser Int'l, Inc., 588 F.3d 1291, 1307 (11th Cir. 2009) ("...Serious medical need is determined by whether a delay in treating the need worsens the condition."); Farrow v. West, 320 F.3d 1235, 1243 (11th Cir. 2003) (noting a serious medical need is one that is diagnosed by a physician as requiring treatment or obvious to a lay person, as needing medical care); see also Madrid v. Gomez, 889 F.Supp. 1146, 1256-1257 (N.D. Cal. 1995) ("While a functioning sick call system can be effective for physical illnesses, there must be a 'systemic program for screening and evaluating inmates in order to identify those who require mental health treatment.'").

We found the Jail's suicide risk and mental health intake screening to be deficient in several key respects. Significantly, the intake form does not require the intake officer to ask the prisoner if he or she is currently suicidal or has a history of suicidal behavior. Nor does it require the intake officer to solicit input from the transporting officer upon a prisoner's admission to the Jail. The form also does not indicate how many questions must be answered affirmatively in order for the corrections officer to make a referral. In addition to the defects in the form, the screenings are conducted in a large open room in full view and hearing range of other staff and prisoners. The likelihood of obtaining accurate mental health information is seriously compromised by the lack of privacy. Once the intake form is complete, it is placed in the prisoner's booking jacket, rather than being forwarded to staff conducting the second round of screening.

The Jail's second round of intake screening, conducted by either a social worker or a nurse, also omits important inquiries, including whether the prisoner is currently suicidal, had a recent significant loss and/or suicide by family members or close friends. CHS nursing staff who screen and refer prisoners for mental health services also informed us that they do not review the intake screening form completed by the intake corrections officer, thus negating the entire

purpose of the screening by the intake corrections officer.²

The efficacy of the second round of screening is also compromised by CHS's failure to retrieve charts or other documentation of prior mental health treatment or suicide attempts from previous incarcerations. Further, social workers at the Jail do not have access to the Jackson Health System computerized records from treatment at Jackson Memorial Hospital, which would provide valuable information about previous mental health treatment and suicide attempts. Communication among medical, mental health, corrections, and transport staff is important because certain signs exhibited by suicidal prisoners can foretell a possible suicide. Staff may be able to prevent a suicide by communicating and acting upon these signs.

There also is a failure to consistently provide screening information to medical and mental health staff via placement of screening forms in the chart, and there is no formal communication between intake screening and classification staff. Without formal communication between screening and classification staff, prisoners with mental illness or at risk of suicide can be placed in housing units that are counter-therapeutic and potentially dangerous, based on the vulnerability of these prisoners. *See Estelle*, 429 U.S. at 104-05 (prison officials have an obligation to take action or to inform competent authorities once the officials have knowledge of a prisoner's need for medical or psychiatric care).

We observed that certain PTDC housing units appear inherently inappropriate and potentially dangerous for mentally ill or suicidal prisoners because of the types of prisoners housed on the floor (e.g., violent maximum security prisoners), the chaotic atmosphere, the design of the cells (e.g., traditional steel cell bars surrounding the cell), and poor officer visibility into the cells.

2) **Suicide Risk and Mental Health Assessment, Treatment, and Observation**

MDCR fails to properly observe and assess suicidal prisoners. The mental health staff fails to take adequate precautions to ensure that prisoners who have been identified as at risk of suicide are protected. They fail to write orders that specify how closely corrections staff should observe the prisoner and fail to reassess the prisoner daily.

The Jail's observation of suicidal prisoners is deficient in both policy and practice. MDCR's policy fails to clearly describe the types of behavior that should result in a prisoner being placed on observation for suicide. The policy also does not clearly delineate between the types of observation that may be implemented. Instead, MDCR policy has a single observation status: "[I]ine staff will maintain direct continuous observation of suicidal prisoners and document checks at intervals not to exceed every 15 minutes." Although it requires

² Prior to our April 2009 site visit, this screening was done by a licensed practical nurse ("LPN"), who was not trained in identification of mental illness or suicide risk, a common theme that we highlighted during our June 2008 site visit. By the time of our April 2009 site visit, MDCR had started assigning a social worker to complete this screening during ordinary business hours. While this assignment is an improvement, untrained LPNs still conduct the screening after ordinary business hours.

documentation at 15-minute intervals, it appears to require constant observation. In practice, suicidal prisoners are not constantly observed. This is particularly dangerous for the female suicidal prisoners at WDC who are housed in cells that have protrusions that can be used for hanging.

The Jail's clinical assessment of suicidal prisoners also is inadequate. A psychiatrist and social worker share an office, conducting simultaneous interviews with the office door open while other staff enter and exit. Progress notes we reviewed did not document suicide risk assessments or justification for any particular level of observation.³ In fact, the only indication in a prisoner's chart that the prisoner was on suicide watch was a notation that the prisoner shall "remain on 9-C-1." Such a notation does not constitute a suicide risk assessment. Instead, mental health staff must document the prisoner's current behavior and justify the particular level of observation that is ordered. Furthermore, the Jail does not require development of treatment plans for suicidal prisoners.

The deficiencies of this assessment process are exacerbated by the deficiencies in mental health rounds. Daily psychiatric rounds of the most seriously mentally ill prisoners, housed on the ninth floor of PTDC, are conducted cell-side, in full view and hearing of the other prisoners. These rounds are conducted quickly, often without psychiatric review of prisoners' charts. Although CHS improved its psychiatric rounds by making prisoner charts available to psychiatrists during rounds, our observation revealed that the psychiatrists rarely consult them.

Complicating these deficient assessment, treatment, and observation practices, we observed that prisoner medical charts did not consistently contain a mental health diagnosis for prisoners receiving psychotropic medications. Basic clinical processes require development of a diagnosis in order to treat the mental illness.

For example: A.B. had an initial psychosocial assessment on December 31, 2007. Although A.B.'s chart did not reflect a mental health diagnosis, A.B. continued to receive psychotropic medications for at least six months. Similarly, A.C.'s chart stated that he was receiving psychotropic medications. A.C.'s chart also noted that he was "known" to the mental health team, yet there was no diagnosis. CHS staff informed us that the failure to diagnose has been an ongoing problem.

Although MDCR's Suicide Prevention policy requires that medical staff determine the permitted activities and possessions for prisoners on suicide watch, CHS clinicians informed us that, contrary to policy, the practice is for corrections staff to make these decisions. This practice is inappropriate. For example, MDCR's practice is to require each prisoner placed on the 9-C wing to wear only a safety smock without any underwear, regardless of the specific reason for

³ We note that TGK does have a standard operating procedure providing that mental health staff conduct assessments of prisoners placed in segregation in a safety cell after 24 hours, 5 days, 30 days, 6 months, and every 6 months thereafter. While we commend MDCR for implementing this procedure and attempting to address the potential for decompensation of a prisoner's mental health status in segregation, it appears from documentation that, in practice, mental health staff merely "see" the prisoners on these intervals without conducting assessments.

the prisoner's assignment to the unit. MDCR and CHS need to have a clinical justification for limiting the property and clothing issued to prisoners. If a prisoner is issued only a safety smock and no underwear, it should be because this is clinically indicated, not because that is the usual practice. Corrections officers should not be making these decisions.

3) Medication Administration

MDCR's procedures for administering psychotropic medications are dangerous. We observed nurses administer psychotropic medications on PTDC's 9-C wing during our April 2009 site visit. The procedure is for one nurse and one corrections officer to walk from cell to cell in the unit with a cart containing drawers of alphabetically arranged paper medication records and medication bottles. Upon arrival at each cell, the corrections officer calls out the prisoner's name. Each cell houses multiple prisoners; however, no process was employed to verify the identity of the prisoner to whom the psychotropic medications were given.

The medication administration procedure lacked appropriate controls. After the corrections officer attempted to identify the prisoner, the nurse flipped through the paper records to try to determine if the prisoner was prescribed medications. She would then pour the medications in a cup for the prisoner. We observed the nurse repeatedly pouring medications back and forth between the medication bottle and the cup, with only an eye account of the actual number of pills to be included. The nurse also had to cut the pills in half on multiple occasions with an ineffective pill cutter that caused fragments of the medications to fall onto the cart, resulting in inaccurate medication dosing.

We observed several prisoners tell the nurse that she was giving them the wrong medication, or dosage, or at the wrong time frame. Six prisoners received no medications, even though these prisoners apparently required an intensive level of mental health services, as they continued to be housed on PTDC's 9-C wing after psychiatric rounds had taken place. For each of these prisoners, the nurse flagged the medication administration record ("MAR") with the reported intent to later return and review the medical record for verification. We concluded that the Jail's medication administration is chaotic, inefficient, and fraught with risk of errors that can cause serious harm to prisoners.

4) Suicide Prevention Training

The Jail fails to provide adequate suicide prevention training to all corrections, medical, and mental health staff. Successful suicide prevention is a collaborative process among all staff; however, training is particularly critical for corrections officers because they are often the only staff who are available 24 hours per day and who have regular contact with prisoners. Pre-service and annual training requirements should be clearly set forth in the relevant policy and should include sufficient topics to ensure that staff are able to recognize the verbal and behavioral signs that indicate a suicide risk, know what to do when a risk is suspected, and understand how to respond when there is a suicide attempt (generally achieved through mock drills).

The eight-hour training program initiated in April 2007 is not mandatory for MDCR staff. Our review of suicide prevention training records as of May 22, 2008, revealed that only

approximately 10% of MDCR's over 2,000 corrections officers had received it. None of CHS's nursing staff had been trained in suicide prevention, even though intake nurses are charged with identifying suicide risk. CHS mental health staff also did not receive any suicide prevention training until May 2008, when a facility psychiatrist provided social workers with a one-hour workshop consisting of seven Power Point slides. Notably, MDCR's suicide prevention policy does not address suicide prevention training requirements.

Even if the Jail's policy appropriately required that all corrections, medical and mental health staff receive adequate initial and annual suicide prevention training, current training staff resources at the Jail are woefully inadequate to complete even just the initial training on a timely basis. As was the case in April 2007 with the inception of MDCR's training, a single training officer is responsible for training all MDCR staff. According to this staff person, it will take approximately six years to complete initial suicide prevention training for all corrections officers, mental health care staff, and nursing staff at the current pace of training and training staff levels. The Jail is unable to adequately train staff with a single training officer. Moreover, training performed by a sole corrections officer omits important instructional input from mental health and medical staff.

MDCR's corrections officers also lack sufficient training in emergency intervention. According to MDCR policy, all corrections officers are required to be certified in first aid, CPR, and the use of an automated external defibrillator ("AED"). Although training records were not available during our June 2008 site visit, MDCR officials informed us that only approximately 75% of corrections officers have actually received the emergency intervention training that is required by policy. The impact of MDCR's failure to follow its own policy of training all corrections officers in emergency intervention is evident in MDCR's inadequate emergency responses to suicides.

b. MDCR's segregated housing units for prisoners with serious mental illness and suicidal behaviors are inhumane and unconstitutional.

1) The physical conditions are dangerous.

Prison officials have a duty under the Eighth Amendment to ensure "reasonable safety," a standard that incorporates due regard for prison officials' "unenviable task of keeping dangerous men in safe custody under humane conditions." *Farmer*, 511 U.S. at 845 (quoting *Helling*, 509 U.S. at 33). A prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement if he knows that prisoners face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it. *Farmer*, 511 U.S. at 847 n.9. In addition, elements of the conditions of confinement may establish an Eighth Amendment violation "in combination" even if each would not do so alone if "they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth, or exercise—for example, a low cell temperature at night combined with a failure to issue blankets." *Wilson v. Seiter*, 501 U.S. at 304.

The Jail houses male prisoners with serious mental illness and suicidal behaviors on PTDC's segregated ninth floor, 9-C wing. Prisoners on the 9-C wing are locked in their cells nearly 24 hours a day and do not receive recreation, telephone calls, or visitation, unless they are

in one of the five step-down cells on the wing.⁴ Rather than being therapeutic, the 9-C wing is chaotic, crowded, foul-smelling, depressing, and unacceptable for housing prisoners who are mentally ill or suicidal.⁵ It has 19 single-bunk cells for prisoners who are acutely mentally ill or suicidal, and the cells are frequently double or even triple bunked. In fact, we calculated the rate of overcrowding during one day of our visit, June 10, 2008, to be 62%—greatly exacerbating the already abysmal conditions on the wing. When these single-person cells house more than one prisoner, as they often do, the second or third prisoner must sleep on the bare floor because there is no additional mattress or bedding. The floors are often very cold, as the poor circulation of the wing's air-conditioning traps the cold air in the cells causing the temperature in the cells to drop as much as 20 degrees below room temperature. During our June 2008 site visit, we also observed that, for some of the 9-C wing prisoners who do have a bed, the bedding in some of the cells (e.g., cells 16 and 19) was so old and worn that it could no longer be adequately sanitized and should have been replaced.

Female prisoners who are identified as suicidal are housed in five cells on the 3-C wing of the WDC. The five cells used for suicidal prisoners at WDC are dangerous because they have many protrusions, including ventilation grates, exposed pipes in the toilet areas, and holes in restraint beds, all of which are potential anchor points for self-asphyxiation. Moreover, there are several blind spots in these cells, preventing officers from being able to minimize the risk of a suicide by closely observing the prisoner. In sum, the WDC suicide watch cells provide ample opportunity for the exact outcome that they should be designed to prevent.

Because MDCR staff and prisoners are aware of the horrid conditions on the 9-C wing, staff will threaten, punish, and retaliate against prisoners by transferring them (or threatening to transfer them) to the 9-C wing. For example, we reviewed an incident report from March 14, 2008, in which a prisoner was kicking his cell door, asking to see a doctor. After the Jail sent a nurse to see the prisoner, the prisoner continued to kick his door, demanding to see a doctor. The nurse ordered that the prisoner be placed on suicide precautions and, when the prisoner refused to be handcuffed for transport to the ninth floor, officers sprayed him with oleoresin capsicum agent ("OC spray") and escorted him to the 9-C wing. We could not find any documentation in this prisoner's file that indicated this prisoner presented a risk of suicide or had acute mental illness. We spoke with many prisoners who consistently reported being threatened with transfer to the 9-C wing.

The conditions of the PTDC ninth floor mental health unit are not new to MDCR and County officials. Over the past several years, print and television news media, as well as a non-

⁴ At the time of our April 2009 tour, no recreation officer was yet available to provide recreation to the prisoners on the 9-C wing, though a recreation officer was reportedly going to be hired.

⁵ The foul odor of the cells, and to a slightly lesser extent, the rest of the wing, is caused in part by the practice of not providing showers for the more acutely mentally ill or suicidal prisoners. We observed a garden hose attached to the wall on the 9-C wing which, although not in use during our visit, reportedly has been used to periodically spray prisoners in lieu of showers.

fiction book, have reported on the deplorable conditions of the ninth floor. Also chronicling the ongoing inhumane conditions on the ninth floor, a Miami-Dade County grand jury toured the 9-C wing in 2004 and again in 2008, concluding that “[n]ot much has changed The setting was not appropriate for treatment then. It is not appropriate now.”⁶ In February 2009, local state legislators toured the 9-C wing and called it “inhumane a God-awful place.”⁷

2) MDCR fails to provide adequate mental health services or other programming appropriate to the needs of prisoners confined to mental health units.

Despite the fact that MDCR categorizes the 9-C wing as its housing unit for prisoners who are acutely mentally ill or suicidal, no mental health programming is available to the prisoners confined there. Grossly incompetent or inadequate care can constitute deliberate indifference to the prisoner’s needs. *Waldrop v. Evans*, 871 F.2d 1030, 1033 (11th Cir. 1989) (quoting *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986)). Any individual contact with clinical staff is done cell-side, where clinicians attempt to assess the prisoners’ suicidality and mental status by talking to them through the food-tray slot in full view and hearing a range of the other prisoners in the cell and on the wing.

MDCR also does not consistently document a clear rationale explaining why prisoners are housed on the 9-C wing, rather than a less restrictive setting. For example, we reviewed documentation in W.W.’s medical chart indicating that, between April 23 and May 26, 2008, W.W. said he was “alright, ready to be transferred,” was “alert, calm, and cooperative,” and was “awake, alert, [and had] good eye contact.” Yet W.W. remained on the 9-C wing for the entire month despite clinical notations indicating that the 9-C wing was not appropriate for W.W. Other prisoner charts we reviewed contained no rationale for transferring a prisoner from other mental health units to the 9-C wing. For example, X.X. was housed on the 9-C wing during the week of our April 2009 site visit. Yet there was no documentation in his chart supporting the Jail’s decision to move X.X. from the 9-B wing—a unit for prisoners with less acute mental illness—to the 9-C wing.

c. MDCR’s discipline process fails to account for behaviors that are the product of a mental illness.

Another critical shortcoming of MDCR’s mental health services is MDCR’s failure to ensure disciplinary penalties are not imposed on prisoners with mental illness for conduct that is symptomatic of their mental illness. See *Thomas v. Bryant*, 614 F.3d 1288, 1307-17 (11th Cir. 2010) (holding that repeated chemical sprayings of a mentally ill prisoner constituted cruel and unusual punishment when facility did not evaluate whether the prisoner’s conduct was symptomatic of mental illness). Although corrections staff indicated that disciplinary measures

⁶ Final Report of the Miami-Dade County Grand Jury, Fall Term 2007, at 27 (Fla. Cir. Ct. August 11, 2008).

⁷ Carol Marbin Miller, *Mentally Ill in Jail in a New Crisis*, Miami Herald, February 20, 2009, at B1.

are “rarely used” for mentally ill prisoners, our review of records of disciplinary proceedings against mentally ill prisoners revealed that they were routinely subject to discipline for their symptomatic behavior. There is no formal system at the Jail for CHS mental health staff to advise or consult with corrections staff that conduct disciplinary hearings and assign punishment for disciplinary violations. Corrections staff who perform these functions agreed that mental health staff should be formally involved in disciplinary decisions regarding mentally ill prisoners.

2. MDCR is deliberately indifferent to the serious medical needs of prisoners.

A corrections official’s “deliberate indifference” to a prisoner’s serious medical needs is a violation of the Eighth and Fourteenth Amendments. Estelle, 429 U.S. at 104; Farrow v. West, 320 F.3d 1235, 1243-46 (11th Cir. 2003); Steele, 87 F.3d at 1259. Jail officials act with deliberate indifference when a prisoner needs serious medical care and the officials knowingly fail or refuse to provide that care. Farrow, 320 F.3d at 1246. The Constitution is violated if a prison official “knows of and disregards an excessive risk to inmate health or safety.” Farmer, 511 U.S. at 837. Providing only cursory care in such a situation amounts to deliberate indifference. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999). Conditions violate the Constitution if they pose an unreasonable risk of serious damage to a prisoner’s current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling, 509 U.S. at 33-36; Chandler v. Crosby 379 F.3d 1278, 1289 (11th Cir. 2004).

MDCR fails to identify and treat prisoners in the Jail who present obvious symptoms of serious illness and injury. When MDCR does identify prisoners in need of medical treatment, the treatment provided is often insufficient, placing the prisoners’ health and safety at risk. Prisoners are needlessly suffering and, in some cases dying, due to deliberate indifference. Below we highlight five major areas of deficiencies: correctional medical care intake screening and initial health assessments; access to care for acute medical needs; management of chronic health problems; record keeping; and quality assurance.

a. MDCR fails to identify timely the acute and chronic care needs of prisoners booked into the Jail.

MDCR’s failure to identify the acute and chronic care needs of prisoners entering the jail is clearest with respect to those prisoners who are withdrawing from drugs and alcohol. As a result, prisoners do not receive necessary care, which in turn, can lead to tragic results, as the following examples demonstrate:

- The Death of E.E.: On July 19, 2008, E.E. was processed into the Jail and received an intake screening at approximately 1:00 a.m. on July 20. Twelve hours later, E.E. was pronounced dead. The intake screening, completed by a licensed practical nurse (“LPN”), indicated no medical problems or history of drug or alcohol use, and E.E.’s behavior was noted as appropriate. At 5:30 a.m., however, E.E. suffered a seizure. Although an ambulance was called, neither MDCR nor CHS staff authorized E.E.’s transfer to the hospital. A nurse conducted a medical assessment following the seizure and noted E.E.’s blood

pressure to be 203/139.⁸ Despite this high reading, there is no mention of the elevated blood pressure in the comments to the assessment in the prisoner's medical chart. Additionally, there was no mention of the prisoner being disoriented. This is noteworthy because a social worker also evaluated E.E. and documented that E.E. appeared lethargic and disoriented. At 9:30 a.m., MDCR staff transported E.E. to the PTDC ninth floor mental health unit for a mental health evaluation and treatment. CHS staff did not, however, order treatment for E.E.'s seizure, monitor his blood pressure or other vital signs, or conduct further clinical evaluation. Approximately three hours later, staff reported finding E.E. unresponsive and transferred him to the hospital, where he was pronounced dead.⁹

- *The Death of B.B.*: B.B. died on May 22, 2008, the same day he entered the Jail. B.B. had a history of drug withdrawal. Staff reported finding B.B. unresponsive in his cell, and started CPR. Staff did not, however, use an automated external defibrillator ("AED").¹⁰ In facilities as large as MDCR, an AED should be available for an emergency situation when a prisoner is without both a pulse and respirations. More important, despite B.B.'s known history of drug withdrawal, MDCR did not provide an appropriate level of observation and monitoring of B.B.'s condition.
- *The Death of A.A.*: A.A. was admitted to the Jail on April 9, 2008, and died the following day. A.A. had a history of serious medical problems, including congestive heart failure, hypertension, and heart attack. At the time of his intake, A.A. was withdrawing from alcohol, and CHS staff placed him on a detoxification program. However, a detoxification form was not completed, and a physician did not sign the health assessment (indicating that a physician did not review the nurse's assessment findings). At 8:00 a.m. on April 9, A.A.'s blood pressure was 199/102, and by 10:00 a.m. it was 218/121. Given A.A.'s medical history and severely elevated blood pressure, A.A. should have been immediately treated by a physician.
- *The Death of C.C.*: On March 6, 2008, MDCR officials processed C.C. into the Jail with a slightly elevated pulse of 111. C.C. died the next day. A physician did not sign C.C.'s health assessment on March 6 (indicating that a physician did not review the nurse's assessment findings), and although a nurse referred C.C. to a physician due to the abnormal pulse, there is no documentation of nursing staff conducting follow-up vital sign monitoring. On the next day, March 7, staff

⁸ A normal blood pressure reading is 130/80.

⁹ This letter discusses prisoner deaths but the cause of death is not explained. MDCR does not maintain autopsy reports, and prisoner deaths are not formally reviewed. Therefore, the causes of death in the examples provided have not been formally determined.

¹⁰ An AED is an electronic device designed to deliver an electric shock to a victim of sudden cardiac arrest in order to restore heart rhythms to their normal pace.

found C.C. unresponsive, but did not use an AED as should be expected under the circumstances.

- *The Death of D.D.*: MDCR officials processed D.D. into the Jail on November 6, 2007. D.D. died on November 8, 2007. During the intake screening and initial assessment, CHS staff identified an infection in D.D.'s chest wall, as well as symptoms of drug withdrawal. CHS staff ordered monitoring of vital signs and a follow-up appointment with the physician on November 8. There is, however, no documentation of vital signs monitoring, and the follow-up appointment did not occur. Instead, on November 8, CHS staff reported finding D.D. unresponsive and transferred him to the hospital, where he died.

These prisoner deaths demonstrate that initial screening and health assessments are woefully inadequate. Obvious medical signs and symptoms, such as E.E.'s seizure and disorientation, are often missed by MDCR and CHS staff. Known issues like D.D.'s chest wall infection, or the elevated blood pressures of E.E. and A.A., or the history of drug and alcohol use by B.B., D.D., and A.A., are not sufficiently addressed.

Screenings and health assessments must be timely and thorough, and completed by competent professionals with the necessary training to identify signs that pose risks to prisoners' health. Just as important, correctional facilities must have quality assurance systems in place to ensure accountability for errors that lead to grievous harm. See Helling, 509 U.S. at 35; see also Chandler, 379 F.3d at 1289. MDCR is deliberately indifferent when it routinely provides only cursory care (or no care at all), when the need for more serious medical treatment is obvious at the time of the incident, and then made plain by the resulting harm. Farmer, 511 U.S. at 837.

b. MDCR fails to act on known medical problems discovered through its "sick-call" process.

MDCR prisoners can request medical treatment through sick-call. Despite its knowledge of sick-call complaints, the Jail fails to take timely and necessary action. This failure to act is unconstitutional deliberate indifference to prisoners' serious medical needs. Estelle, 429 U.S. at 104.

CHS nursing staff triage sick-call complaints during routine medication administration. These brief cell-side interactions do not allow for adequate assessment or medication administration. Prisoners are denied privacy, as the assessment is done with other prisoners standing in line for medication, well within hearing distance.

Nurses do not employ protocols or assessment forms during the sick-call triage. We observed nurses routinely failing to take and record vital signs. Vital signs should be a part of every medical clinical encounter and must be recorded in the medical record. In addition to these concerns, we found evidence that prisoners had to make several sick-call requests before a nurse would initially evaluate them, and then prisoners would endure extensive delays before seeing a physician after a nurse's referral.

Through CHS's sick-call process, CHS is made aware of prisoners' serious medical needs. Yet, CHS repeatedly fails to provide the necessary level of care. This situation amounts

to deliberate indifference resulting in grievous harm, as the following examples demonstrate:

- *The Death of F.F.:* F.F., a 48-year-old male with hypertension, died on January 5, 2008, two months after being admitted to the Jail. On January 2, 2008, F.F. complained to a CHS nurse of chest and gas pain. A complaint of gas pain must be evaluated carefully and fully in a prisoner with hypertension due to the risk for heart disease, as gas can mimic heart disease symptoms. The following day, a physician ordered tests to rule out heart disease. F.F. was supposed to see the physician again the next day, but did not, for reasons unknown. Instead, he was seen by a nurse who administered an antacid. No nursing protocols were used during the exam. The content of both nurse exams exceeded the scope of the nurses' qualifications. On January 5, 2008, F.F. was brought to the medical clinic unresponsive.
- *The Death of G.G.:* G.G. died on October 23, 2007. The day before his death, a CHS nurse evaluated G.G. for complaints of shortness of breath. The nurse's exam was inadequate and incomplete. During the exam, no vital signs were taken, no lung exam was completed, and G.G. was only given medication for a cold. The following day, G.G. made the same complaint and was taken to the hospital, where he died.

F.F.'s chest pain and G.G.'s shortness of breath were serious medical symptoms brought to the attention of MDCR and CHS staff. Disregarding the excessive risks to the prisoners' health and safety, MDCR failed to provide an appropriate level of care.

c. MDCR fails to provide adequate care to prisoners with serious chronic medical needs.

The Jail is deliberately indifferent to prisoners' serious medical needs when it fails to identify or adequately treat a prisoner's serious chronic illness. Lancaster v. Monroe County, Ala., 116 F.3d 1419, 1425 (11th Cir. 1997) (noting that an official acts with deliberate indifference when he knows that an inmate is in serious need of medical care, but he fails or refuses to obtain medical treatment for the inmate). See also Hill v. Dekalb Regional Youth Detention Ctr., 40 F.3d 1176, 1186 (11th Cir. 1994) ("Knowledge of the need for medical care and intentional refusal to provide that care constitute deliberate indifference.").

The systemic nature of MDCR's deliberate indifference is evidenced by the Jail's failure to operate a functional chronic care program. Prisoners who suffer from chronic medical illnesses must be regularly monitored by qualified medical professionals to prevent the progression of their illnesses. Monitoring should occur on a regular basis to ensure that symptoms are under control and that medications are appropriate. Morbidity and mortality rates of prisoners with chronic illnesses can be reduced with regular monitoring.

The Jail does not track prisoners with chronic illness nor monitor their conditions. Chronic care programs in correctional settings are critical to avoid placing prisoners with serious medical needs at excessive risk. The requirements of chronic care are addressed in guidelines

developed by the National Commission on Correctional Health Care (“NCCHC”).¹¹ While the Jail claimed to be following the NCCHC guidelines, our review of prisoner charts revealed that no chronic care program exists. For example, we found prisoners with HIV without any medication. We also found prisoners with diabetes and hypertension who were without expected tests in order to assess the status of their kidneys, cholesterol level, or heart functions. And, prisoners with histories of seizures were not monitored closely to determine the level of their seizure medication, which is necessary, as incorrect dosages above necessary levels can cause serious side-effects, such as brain and heart damage.

In addition, a critical component of a chronic care program is appropriate and timely referrals to medical specialists. MDCR acknowledged delays in consultations for specialty services such as cardiology, neurology, and HIV-related services. The Ancata court stated that “deliberate indifference to serious medical needs is shown when prison officials have prevented a prisoner from receiving recommended treatment or when a prisoner is denied access to medical personnel capable of evaluating the need for treatment.” Ancata, 769 F.2d at 704 (citing Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980)).

Our review of medical charts and interviews with CHS staff revealed that HIV-positive prisoners may wait up to six weeks for a specialist referral, and that other chronic conditions can take even longer. For example:

- HIV Consult: S.S. had an HIV-related referral ordered four weeks prior to our tour, but no response or report had been given about an appointment date.
- Neurology Consult: O.O. had a neurology consult ordered five months prior to our tour, but no response or report was present in the medical record.
- Cardiology Consults: P.P. had a cardiology consult ordered nearly five months prior to our tour, but no response or report was present in the medical record. R.R. had problems with chest pains and had a cardiology consult ordered six weeks prior to our tour, but no response or report was present in the medical record.
- Gynecology Consult: Q.Q. had a history of cervical cancer, and had a gynecology consult ordered seven weeks prior to our tour, but no response or report was present in the medical record.

There is no tracking system for outstanding consultation referrals. It is necessary to track this information, as prisoners with chronic conditions require a higher level of medical care than is often available on-site, making them more vulnerable to harm. This deficiency constitutes deliberate indifference. Ancata, 769 F.2d at 704.

¹¹ It should be noted that in 2008, NCCHC elevated the requirement of a chronic care program from “important” to “essential,” emphasizing the necessity of a functional chronic care program.

d. **MDCR's poor record keeping practices contribute to the pattern or practice of deliberate indifference to provide adequate medical services.**

MDCR fails to keep complete, accurate, readily accessible, and systematically organized medical records. A complete and adequate medical records system is critical to ensure that medical staff members are able to provide care. Inaccurate or incomplete record keeping places prisoners at excessive risk of serious harm.

The documentation of medical information for MDCR prisoners is done in part through a paper-based system, and in part through an electronic system maintained by the Jackson Health System. The CHS physicians have access to the electronic system to check laboratory data and consultation reports, but the CHS physicians cannot enter data into the system. Instead, CHS maintains a paper chart at the Jail. The current system requires physicians to use both the paper charts and the electronic system to access complete medical information about a prisoner. Moreover, other CHS health care staff, including nurses, do not have access to the electronic system at all; thus, laboratory data in the electronic system is not readily available to CHS non-physician medical staff.

Medical charts often contain an incomplete medical history; fail to document specialist appointments; do not include the medical staff member's name and title attached to notes; and are illegible. Moreover, the Jail's medical records fail to consistently record vital signs during clinical encounters. As noted above, vital signs should be part of every clinical encounter and must be recorded in the medical record.

In addition and contrary to MDCR policy, many charts do not contain the nursing intake screening or the booking officer screening. Thus, medical and mental health staff members do not have information from a prisoner's previous incarceration and often do not have information from the intake screening for the prisoner's current incarceration. Even when the current nursing intake screening is on file, MDCR relies on self-reporting by the prisoner without the benefit of review of prior treatment at the Jail.

B. **MDCR IS ENGAGED IN A PATTERN OR PRACTICE OF USING EXCESSIVE FORCE AGAINST PRISONERS.**

The Eighth Amendment protection from cruel and unusual punishment forbids the use of excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1, 5-7 (1992); Skritch v. Thornton, 280 F.3d 1295, 1300-01 (11th Cir. 2002). As the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to a prisoner of a jail incarcerated prior to trial as it would to a convicted prisoner, City of Revere, 463 U.S. at 244, jail officials will violate the Constitution if they use excessive force on jail prisoners. MDCR correctional officers routinely use excessive force against Jail prisoners in violation of the Constitution.

The use of force by a corrections officer violates the Constitution when it is not applied “in a good-faith effort to maintain or restore discipline,” but instead is administered “maliciously and sadistically to cause harm.” Hudson, 503 U.S. at 6-7; Campbell v. Sikes, 169 F.3d at 1374; Harris v. Chapman, 97 F.3d 499, 505 (11th Cir. 1996). Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; (4) any efforts made to temper the severity of a forceful response; and (5) the extent of the prisoner’s injury. Hudson, 503 U.S. at 7-8; Campbell, 169 F.3d at 1375; Harris, 97 F.3d at 505.

Our investigation included an intensive examination of MDCR use of force policies, training, and incident reports. We also conducted many staff and prisoner interviews on this issue. In some cases, our findings of excessive or inappropriate uses of force are in accord with the conclusions from MDCR’s own Internal Affairs Unit investigations.

MDCR corrections officers openly engage in abusive and retaliatory conduct, which frequently results in injuries to prisoners. In particular, there is a disturbing and distinct trend of MDCR corrections officers reacting to low level aggression from prisoners (e.g., abusive language or passive resistance to an order) by slapping or punching the prisoner in the head and verbally provoking the prisoner to physically respond. MDCR corrections officers often do not attempt any de-escalation techniques to combat low level aggression before engaging the prisoner in such an inappropriate manner.

Further, MDCR corrections officers frequently employ OC spray under circumstances that do not require such a level of force. Disturbingly, during our interviews with MDCR corrections officers, most officers could not articulate when the use of OC spray was appropriate. Only a few officers were able to competently discuss MDCR policy and explain the use of OC spray as a last resort before using physical force to restrain a resistive, violent, or combative prisoner. When asked, most officers were unfamiliar with the policy or guessed at responses, offering incomplete answers such as “when the prisoner doesn’t listen to you.” Well-trained corrections officers should be able to articulate clearly and without hesitation the level of prisoner resistance necessitating the deployment of OC spray—or any other use of force—as an appropriate response to restore and maintain order.

The following examples, some derived from MDCR’s own internal documents and investigations, illustrate the pattern or practice of using excessive force:

- Prolonged Fist Fight: On August 27, 2007, nine MDCR corrections officers, including a Field Training Officer, allowed prisoner A.N. and an officer to engage in a prolonged fist fight at the MWDC. None of the officers involved filed a use of force report. MDCR investigators discovered a video of the fight while investigating a separate incident. The video shows A.N. instigating a fight with an officer, and the officer responding by spraying A.N. with OC spray. A second officer kept other prisoners at arm’s length while the prisoner and the officer then engaged in a fist fight. Over a matter of minutes, up to nine other officers responded but failed to intervene in the fight.

- *Physical Assault:* On August 23, 2007, prisoner A.O. rendered a sworn statement to MDCR investigators alleging that a MDCR corporal in MWDC physically assaulted him by slapping him in the face several times, punching him in the right side of his face and his right eye, pushing him to the ground and kicking his face and body. A.O. reported that other corrections officers were present during the assault. A.O. explained that as the assault took place, he attempted to run toward the view of the security cameras, but was dragged back out of view by the officers. A second attempt to run toward the camera view was successful. The corporal caught A.O. at the elevators, however, and choked him and punched him in the side of the face. After reviewing the videotape, which also showed the officer pushing A.O.'s face to the floor while A.O. was restrained in handcuffs, MDCR's Internal Affairs Unit sustained the allegations in part, giving credit only to the acts caught on video, despite A.O.'s injuries corroborating the prisoner's full account. Internal Affairs further noted that several corrections officers, including a supervisor, either failed to report the incident accurately, or did not report the incident at all.
- *Instigating Fights:* In a May 2007 incident at PTDC, prisoner A.P. claimed that a corrections officer ordered him out of his cell and placed him in a visiting booth because the prisoner made derogatory comments about MDCR staff. While in the visiting booth, A.P. claims that an officer asked him if he wanted to fight one of the other officers. A.P. claims he told the officer he did not want to fight. Although the prisoner received a laceration above his eye, no use of force incident report was filed.
- *Striking Restrained Prisoners:* We requested to view videotapes from randomly selected shifts at the different facilities. One of the videotapes from PTDC's ninth floor mental health unit showed a prisoner being dragged to a chair by several MDCR corrections officers and then handcuffed to a table. After being restrained in handcuffs, the video shows an officer punching the side of the prisoner's face. Moments later, another officer arrived to photograph the prisoner's face. It does not appear, however, that any use of force report was filed in regard to this incident.

Interviews with juvenile prisoners housed in the TGK facility revealed a particularly violent atmosphere, often involving the corrections officers directly or indirectly. For example:

- *Violence Against Juveniles:* A videotape of the juvenile unit in May 2008 shows two officers casually engaged in conversation with a prisoner, when one of the officers—unprovoked by any physical movement by the prisoner—grabbed the prisoner and threw him onto a table, and then to the floor. The prisoner struggled to protect himself, while the other officer looked on without taking any action. The prisoner was then escorted to the front of the unit and left locked between two security doors in the hallway leading into the unit.

Contributing to this pattern or practice, use of force reporting in the Jail is frequently inaccurate or incomplete, and in incidents involving multiple officers, not all officers are

submitting individual reports. For example, according to MDCR records, there were 272 use of force incidents in a six-month period from October 2007 through March 2008. Most of the incidents involved physical force or the use of OC spray.¹² MDCR's Internal Affairs Unit, however, independently reported over 1,000 use of force incidents just involving OC spray in 2007. This level of discrepancy in use of force reporting generally, and incidents involving OC spray specifically, indicates a serious issue of under-reporting use of force incidents by MDCR officers.

C. MDCR IS DELIBERATELY INDIFFERENT TO SERIOUS RISKS TO PRISONER SAFETY POSED BY PRISONER VIOLENCE.

Prisoners have a constitutional right to be protected from harm. Farmer, 511 U.S. at 832. Corrections officials have a specific duty "to protect prisoners from violence at the hands of other prisoners." Id. at 833 (internal quotation marks and citations omitted). MDCR is violating that constitutional right through its deliberate indifference to the prisoner violence within the Jail. According to MDCR's own reporting of prisoner-on-prisoner assaults, the Jail is experiencing well over a hundred incidents every month.¹³ In fact, in a six-month period just prior to our tour, the Jail reported over 300 incidents of prisoner-on-prisoner assaults just in the MWDC facility. In that same six-month period, the Jail reported nearly 250 such incidents in the PTDC facility, and approximately 125 such instances in the Stockade facility.

Not every injury suffered by a prisoner at the hands of another prisoner will violate the Eighth and Fourteenth Amendments to the Constitution. The prisoner invoking the right must demonstrate that, (1) he or she was "incarcerated under conditions posing a substantial risk of serious harm," and (2) corrections officials were "deliberately indifferent" to the risk. Id. at 834. Accordingly, Jail officials must take reasonable steps to protect prisoners from physical violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy prisoners' basic needs, such as their need for safety. A corrections official's failure to supervise prisoners, particularly prisoners known to be violent, may result in unconstitutional conditions of confinement where assaults between prisoners occur due to the lack of supervision. Cottone v. Jenne, 326 F.3d 1352, 1359-60 (11th Cir. 2003) (noting that a lack of monitoring and supervision of known violent inmates, which led to inmate-on-inmate violence, constituted impermissible unconstitutional conduct).

There is a dangerous lack of meaningful supervision in the housing units, particularly the dormitory settings housing maximum security prisoners in PTDC and the Stockade. The

¹² We found that many use of force incidents in the Jail involved the use of OC spray. At the time of our tour, MDCR did not have a uniform system in place throughout the facilities to measure (by weight) OC spray canisters following deployment by a corrections officer (or on an otherwise regular basis) to ensure that the reported use was consistent with the contents of the container.

¹³ Nationwide, prisoner-on-prisoner assaults are under-reported, as prisoners often fear retaliation from other prisoners as a consequence of reporting such assaults. This trend of under-reporting suggests that the problem within MDCR facilities is even greater than the statistics noted in this letter would indicate.

problems with providing adequate supervision to the units in PTDC and the Stockade stem largely from the antiquated design of these facilities. For example, there are no officers stationed inside the majority of the dormitory housing units in PTDC and the Stockade. Therefore, in order for MDCR corrections officers to view the maximum security prisoners housed in most PTDC units, the officers must either enter the unit or walk along a narrow catwalk that runs behind the unit. The catwalk in PTDC is not designed for patrol and does not provide access into the unit should the officer observe an incident that calls for immediate response. MDCR corrections officers patrol the units regularly, but prisoners are aware of the patrol schedule and know when they are, and are not, being directly supervised. A similar situation exists in the Stockade. Most units in the Stockade, including those housing maximum security prisoners, are dormitory settings without a corrections officer present in the unit. Instead, officers patrol outside the several units. Due to the structure of the units in the Stockade, however, officers patrolling outside the units cannot effectively observe the prisoners without actually entering the units to conduct direct observation. As a result, during the time the officer is inside a particular unit conducting direct observation, the remaining units are unsupervised.

Supervision problems also persist in the two units housing male juveniles in TGK. The male juvenile prisoners (those prisoners under the age of 18 years, but being criminally charged as adults under Florida state law) are housed on the second floor of TGK. The juvenile housing units are not equipped to adequately separate the juveniles according to their classification status, resulting in juveniles of mixed security levels being housed in the same unit. The units are often overcrowded, exacerbating security concerns by increasing the number of mixed classification prisoners housed in close proximity, and decreasing the ratio of officers to prisoners. While corrections officers are posted inside the unit, there are blind spots throughout the unit that pose a danger to officers and prisoners when only a single officer is stationed within the unit.

Juvenile prisoners selected as "trustees" are often involved in the incidents of violence. Trustees assist in the jail operations by cleaning the unit and delivering food trays and hygiene supplies. The Trustee program is dangerous and contributes to unconstitutional conditions. First, Trustees reportedly withhold food and hygiene supplies from other prisoners creating a high risk of conflict. Second, we observed trustees being allowed free movement through the unit, including secure areas, when not working, even in nighttime hours. Surveillance videotapes revealed juvenile prisoners often walking behind the control panel that electronically locks and unlocks the individual cell doors. Reportedly, the prisoners on videotape were "trustees" and would do this to retrieve cleaning or hygiene supplies, such as toilet paper. Regardless of the reason, it is extremely dangerous to allow prisoners to have this type of access to the unit's control panel. Third, trustees are reportedly selected based on their ability to physically control the other juvenile prisoners. Juvenile prisoners reported that trustees are often asked by the corrections officers to physically discipline other prisoners.

We interviewed many of the juvenile prisoners, most of whom said they did not feel safe in the unit. Most of the juvenile prisoners we interviewed spoke about the practice of "taxing," an unauthorized and undocumented method of discipline in which corrections officers will lock down a juvenile prisoner in his cell for rule violations and force another prisoner (or prisoners) to inflict physical punishment on the locked-down prisoner. The juveniles reported that a "tax" also can result in extended lockdowns, sometimes lasting up to three days.

In addition, there is evidence that the Jail fails to take reasonable measures to protect prisoners from sexual assault. The August 2010 national survey on sexual victimization in jails and prisons conducted by the Department of Justice's Bureau of Justice Statistics found a high prevalence of sexual victimization at the Miami-Dade County PTDC.¹⁴ In this report, the Miami-Dade County PTDC ranks among one of the worst jails in the country with a high rate of prisoner-on-prisoner rape and sexual abuses in the facility. The national rate for jails is 1.5% and the PTDC had an alarming rate of 5.5%.¹⁵ The Office of Justice Programs of the Department of Justice notified MDCR that it is required to appear for a Prison Rape Elimination Act hearing in Washington, DC on September 15-16, 2011.¹⁶ We intend to monitor the results of the hearing and any related matters of sexual victimization at MDCR.

D. DANGEROUS AND UNSANITARY CONDITIONS EXPOSE PRISONERS UNWILLINGLY TO AN UNREASONABLE RISK OF HARM.

The Eighth Amendment guarantees that prisoners will not be "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). As the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to a prisoner of a jail incarcerated prior to trial, as it would to a convicted prisoner, City of Revere, 463 U.S. at 244, MDCR jail officials may not deprive prisoners of the minimal civilized measures of life's necessities. Accordingly, MDCR officials must provide, among other necessities, "reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (i.e., hot and cold water, light, heat, plumbing)." Chandler v. Baird, 926 F.2d 1057, 1065 (11th Cir. 1991) (citations omitted). Conditions violate the Constitution when they pose an unreasonable risk of serious damage to a prisoner's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling, 509 U.S. at 33-35; Crosby, 379 F.3d at 1289.

The Miami-Dade County Jail is failing to ensure that sanitation and environmental health conditions are consistent with constitutional standards. Simply stated, conditions within the Jail are unsuitable for detention housing, posing unreasonable risks of serious harm to prisoners' health and safety. In particular, our investigation revealed deficiencies in the following areas: (1) fire and life safety; (2) housekeeping; (3) hygiene and infection control; and (4) chemical control.

1. The inadequate fire and life safety systems of the Jail pose an unreasonable risk of harm to prisoners.

MDCR fails to ensure adequate fire and life safety systems throughout the Jail, particularly in PTDC. We observed numerous deficiencies during our tour that endanger the life and safety of prisoners and staff. In the event of a fire, there are several areas of the Jail where

¹⁴ U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-2009, <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2202> (August 2010).

¹⁵ *Id.*

¹⁶ Prison Rape Elimination Act of 2003, P.L. 108-79.

the sprinkler system would not activate or function properly because sprinkler heads were painted over or otherwise damaged. The lack of an operational sprinkler system greatly increases the risk of injury and death in a fire. For example: In PTDC East Wing Cell 2, all six sprinkler heads were non-functional because they had been recently painted over. In PTDC East Wing Cell 1, none of the sprinklers were operable because of paint coverings, parts missing, or cloth ropes tied to them. On PTDC's third, fifth, and seventh floors, sprinkler heads were covered with paint, or found to be inoperable for other reasons.

More fires occur in the laundry area of jails than in any other part of corrections facilities, and in PTDC, we observed a clothes dryer with no lint filter, resulting in a heavy lint accumulation behind the machine. In TGK, we observed a clothes dryer with a detached vent hose, blowing lint out behind and under the machine. Dryer lint is highly flammable and can cause a fire to spread rapidly.

In the event of a serious fire that requires an evacuation of prisoners from the facility, it is critical that the evacuation is conducted quickly, before toxic fumes begin to develop at the fire site. Therefore, in a jail setting, staff should be able to quickly access emergency keys that will unlock all doors along an evacuation route, including the final exit door to the outside of the building. Keys must be marked so as to be identifiable by sight and touch. However, within the Jail:

- *Inadequate Emergency Evacuation Key:* In WDC, we observed a corrections officer having difficulty locating the correct key to open the locked box containing the emergency evacuation key. When the officer did produce the key, it was not marked for identification by sight and touch.
- *Inadequate Emergency Evacuation Routes:* In PTDC, the evacuation route leads prisoners to the small enclosed recreation yard, but there is no access to the outside of the recreation yard away from the facility. Instead, an officer must unlock the recreation yard from the outside during an evacuation. This procedure creates an unacceptable risk of injury and death to prisoners and staff. In addition, several of the exit signs in PTDC were not properly marked and labeled.

When MDCR corrections officers working in control booths were asked about fire safety equipment such as the self-contained breathing apparatus ("SCBA"), on at least two occasions, the officers could not demonstrate how to properly determine air pressure in the SCBA, even though such tasks are required at the beginning and end of each shift by policy, and are supposed to be documented in log books. Our observations reveal that training is inadequate; log book documentation is of questionable veracity; and the officers are endangering prisoners (and themselves) by their lack of knowledge.

2. The sanitation within the Jail is not reasonably adequate to provide minimal civilized standards of life's necessities.

The level of cleanliness at the Jail is poor. While some facilities, such as WDC, are generally clean, other facilities are deplorable. During our site visit, the medical clinic area in MWDC was dangerously dirty. Bags of biohazardous materials and trash were stored in

hallways unsecured and unattended. The isolation cells in the clinic were filthy. One cell contained a bloody sheet that had not been removed from the bed. The floor behind the bed in the unit had a heavy accumulation of dirt, paper, and other debris. The other cell in the clinic contained a toilet that obviously had been continually used for some time despite a flushing malfunction.

PTDC, a nearly 50-year-old facility with structural deficiencies, such as cracked concrete and rusting metal, is difficult, if not impossible, to adequately clean. This is a serious issue because such surfaces collect dirt, dust, and debris which lead to bacterial growth, particularly in shower areas. Similarly, the age and condition of the Stockade make it difficult, if not impossible, to adequately clean. The construction of the Stockade includes concrete surfaces that cannot be adequately cleaned by normal cleaning methods, and the window openings are sealed with metal grating too small for normal cleaning equipment. As a result, dirt and grime build up on these sills and are carried into the unit on air currents. The Stockade units are said to be cleaned twice a year with a pressure washer, but the condition of the units we observed suggests that the power washing is ineffective or too infrequent.

In addition, the Stockade is infested with ants and rodents. Poor housekeeping contributes to the presence of these pests, which increases the risk of harm to the prisoners' health. We observed signs of insects and rodents throughout the facilities, including a heavy infestation of drain flies in shower and floor drains, particularly in TGK. Floor drains and shower drains throughout the facility had heavy accumulations of debris and organic matter, which serve as a food source and breeding site for drain flies. Outbreaks of adult flies have been associated with bronchial asthma in susceptible individuals. Their presence is a sign of inadequate housekeeping and sanitation.

TGK housekeeping also falls below constitutional standards. The TGK medical clinic was in need of immediate cleaning. We observed an ice machine in TGK with mold growth in the ice bin and an unapproved ice scoop made from a plastic jug lying on the ice. Molds and bacteria can thrive in the cold temperatures of an ice machine; therefore such machines should be emptied and cleaned regularly to prevent illness to those prisoners and staff consuming the ice.

In addition, improper storage, labeling, and use of cleaning chemicals in a corrections facility can lead to injuries to prisoners (as well as staff). During our tour, we observed unsafe and insecure storage of cleaning chemicals and spray bottles. Additionally, bulk containers were mislabeled or not labeled at all.

3. Hygiene and infection control are inadequate in the Jail, subjecting prisoners to an unreasonable risk of harm.

Communicable diseases may spread in areas where there is close skin-to-skin contact and where personal hygiene is compromised. Overcrowding in corrections facilities will compromise personal hygiene efforts due to the limited numbers of facility showers and sinks, and overburdened services such as laundry, maintenance, and food preparation. We observed overcrowding and the associated problems of personal hygiene.

- *MWDC Overcrowding:* MWDC, the newest of the five MDCR facilities, has a working capacity for 2,234 prisoners. MWDC was averaging approximately 2,700 prisoners at the time of our tour on June 9-13, 2008. The exact population on the day we toured MWDC was 2,691 prisoners. On that day, one entire unit was closed for shower repairs, further exacerbating the crowding issue.
- *PTDC Overcrowding:* In PTDC's 9-C wing, the mental health unit was overpopulated by 62% during our tour on June 9-13, 2008.

In addition to overcrowding, improper attention to personal hygiene and biohazards are a major cause of the spread of diseases and infections in health care settings. We observed several medical exam rooms with no hand washing sinks or hand sanitizer dispensers on the wall. In addition:

- *Nonfunctional Negative Pressure Rooms:* The TKG medical unit contains six negative pressure rooms used for prisoners with serious respiratory diseases, such as tuberculosis. The negative air pressure in such rooms prevents aerosolized pathogens from escaping the patient's room into the hallway and other areas. Only one room was occupied, and when we tested the air pressure, it contained positive air pressure.
- *Unsecure Sharps:* In various medical clinics throughout the Jail, we observed containers for needles and other sharp objects ("sharps containers") not securely mounted or protected. In many cases, the containers are kept on the floor under desks or tables where they could be easily knocked over.

Further, proper maintenance of mattresses plays an important role in preventing the spread of diseases and infections in a corrections setting. Mattresses that are damaged or worn beyond their ability to be properly disinfected should be discarded. We observed dozens of mattresses in use or waiting to be issued to prisoners that should have been discarded.

Similar to the inadequate mattress maintenance, MDCR laundry procedures fail to protect prisoners from the risk of contagious diseases and infections. The laundry operation of the Jail consists of several laundry areas at each facility. There are no uniform policies, however, and the procedures, machines, chemicals, and schedules differ in each MDCR facility. Some MDCR facilities are employing domestic grade washers and dryers that not suitable for institutional use.

We observed that blankets were not washed for months at a time, and that most prisoner uniforms were washed once a week at best, but many prisoners went longer without clean clothing. This practice is unhygienic and can contribute to the spread of disease. Moreover, as a result of these laundering practices, prisoners at the Jail resort to washing their clothes in sinks and showers and hang the clothes on lines to dry. Such clothes lines create security and fire risks within correctional settings.

V. REMEDIAL MEASURES

As stated above, MDCR is deliberately indifferent to the constitutional deficiencies of its facilities and is engaging in the use of excessive force against Jail prisoners. We believe that the deficiencies discussed in this letter are directly tied to current operational standards which grossly fall below what is required by generally accepted correctional standards. The following remedial measures should be immediately implemented by MDCR to correct the constitutional deprivations outlined above. The remedial measures below are consistent with generally accepted correctional standards. We believe that adopting the following measures will remedy the constitutional deficiencies found in medical care, mental health care, prisoner violence, sanitation and environmental health, and the use of excessive force.

A. MENTAL HEALTH CARE AND SUICIDE PREVENTION

1. Suicide Prevention

Generally accepted professional standards of correctional mental health care mandate the development of a suicide prevention policy, including evaluation by a psychiatrist and development of a management plan. These standards require eight critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of observation/assessment, intervention, reporting, and follow-up/morbidity-mortality review.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Require corrections intake screening to include a specific inquiry from transporting officer regarding whether the incoming prisoner's behavior indicates that he/she is at risk of suicide.
- Cease denial of property and privileges to acutely mentally ill and suicidal prisoners unless clinically indicated.
- Ensure that adequate pre-service and annual in-service suicide prevention training is mandatory for all corrections officers, medical, and mental health staff. Ensure an adequate number of corrections, medical, and mental health staff to conduct multidisciplinary pre-service and annual in-service suicide prevention training and a system of prioritization for attendance in training classes.
- Provide a curriculum for pre-service and annual in-service suicide prevention training that includes an array of topics and mock drills, sufficient for staff to be adequately trained to identify and manage suicide risk.
- Ensure that decisions regarding clothing, bedding, and other property given to suicidal prisoners are made by clinical staff on a case-by-case basis.
- Ensure that each suicidal prisoner has a bed and does not have to sleep on the

floor.

- Provide quality private suicide risk assessments of suicidal prisoners on a daily basis.
- Ensure that staff does not retaliate against prisoners by sending them to suicide watch cells. Ensure that prisoners placed in suicide watch cells are appropriately placed there based on sound suicide risk assessments.
- Clarify MDCR's policy regarding levels of observation of suicidal prisoners (e.g., constant observation, 15-minute intervals checks, etc.) and ensure that corrections officers implement documented appropriate levels of observation.
- Implement treatment plans for suicidal prisoners that identify signs, symptoms, and preventive measures for suicide risk.
- Require adequate emergency intervention training for all staff that regularly interact with prisoners. Enforce a policy requiring corrections officers to initiate CPR if they are the first responders to suicide attempts.
- Ensure that cutdown tools are readily available to staff who may be first responders to suicide attempts.
- Conduct adequate multidisciplinary morbidity-mortality reviews of all suicides and serious suicide attempts (i.e., suicide attempts requiring hospitalization). A preliminary review should occur within 30 days of the incident, and a comprehensive review should occur within 30 days of the completion of a coroner's report.

2. Mental Health Care Treatment

Mental health treatment should comport with constitutional requirements and generally accepted standards of care to aid in classification, identification of emergent mental health care needs, provision of continuous care, and management of medication. An adequate correctional mental health system will commonly include the following: crisis intervention program, acute care program, chronic care program/special needs unit, outpatient treatment services, consultation services, discharge/transfer planning, therapy services, and dedicated rounds by mental health professionals.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Revise intake procedures and forms to adequately screen incoming prisoners for mental health issues and ensure timely access to mental health professionals when the prisoner is presenting symptoms requiring such care.
- Incorporate mental health screening results into prisoners' files and implement a

formal communication process between intake and classification staff.

- Ensure that all staff conducting intake screening are trained adequately, including regarding identification and assessment of suicide risk, and are given appropriate tasks and guidance.
- Ensure that intake screening is conducted in a setting that provides the privacy consistent with correctional security and which includes specific inquiry regarding whether an incoming prisoner is currently suicidal or has a history of suicidal behavior.
- Ensure that medical and mental health staff conducting screening incorporate the corrections screening information into their screening process.
- Ensure that all reasonable efforts are made to obtain a prisoner's prior mental health records and that this information, along with all MDCR screenings, is incorporated into prisoners' charts.
- Develop and implement policies and procedures to ensure prisoners with serious mental health needs receive timely treatment as clinically appropriate, in a clinically appropriate setting.
- Ensure crisis services and acute care in an appropriate therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling.
- Ensure that mental health staff conduct documented in-person assessments of prisoners prior to placement in a special management unit (segregation) and on regular intervals thereafter as is clinically appropriate.
- Ensure an inpatient level of care that is available to all prisoners who need it, including regular, consistent therapy and counseling.
- Provide adequate on-site psychiatry coverage and psychiatry support staff in order to timely address prisoners' serious mental health needs.
- Ensure that psychiatrists provide documented diagnoses of prisoners.
- Implement an adequate scheduling system to ensure that mental health professionals see mentally ill prisoners as clinically appropriate, regardless of whether the prisoner is prescribed psychotropic medications.
- Ensure that adequate psychotherapeutic medication administration is provided.
- Ensure that mental health care staff are able to access prisoner medical records that are up-to-date, accurate, and that contain all clinically appropriate information.

- Implement policies and procedures requiring that mental health staff review mentally ill prisoners' disciplinary charges to ensure that MDCR does not impose a significant disciplinary penalty on mentally ill prisoners for conduct that is symptomatic of the prisoner's mental illness.
- Ensure that MDCR's quality assurance program is adequately maintained to identify and correct deficiencies with the mental health care system.
- Provide outpatient treatment, including regular, consistent therapy and counseling, to general population prisoners who are on the mental health caseload.
- Provide discharge/transfer planning, including services for prisoners in need of further treatment at the time of transfer to another institution or discharge to the community. These services should include the following:
 - a) arranging an appointment with mental health agencies for all prisoners with serious mental illness;
 - b) providing referrals for prisoners with a variety of mental health problems;
 - c) notifying reception centers at state prisons when mentally ill prisoners are going to arrive; and
 - d) arranging with local pharmacies to have prisoners' prescriptions renewed.

3. Mental Health Care Housing Units

Generally accepted professional standards of correctional mental health care require that correctional facilities provide correctional mental health systems that allow prisoners to leave their cells for recreation, telephone calls, and visitation, unless prisoners are restricted by a physician's written orders.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Provide for appropriate housing for mental health care, including a chronic care and/or special needs unit for prisoners who cannot function in the general population.
- Provide an appropriate housing unit for suicidal prisoners, and allow those prisoners to leave their cells for recreation, showers, and mental health treatment as clinically appropriate.
- Remove suicide hazards from all areas housing suicidal prisoners or place all

suicidal prisoners on constant observation.

B. MEDICAL CARE

MDCR should not deny, significantly delay, or intentionally interfere with medical treatment to prisoners. To the contrary, MDCR should provide adequate medical care to prisoners in need of serious medical attention.

1. Acute Care

Generally accepted correctional medical standards require that incoming prisoners be screened by staff trained to identify and triage serious medical needs, including drug or alcohol withdrawal, communicable diseases, serious acute or chronic illnesses, mental illness, and potential suicide risks. In particular, screening for symptoms of drug or alcohol withdrawal must begin at the initial intake or booking process.

In addition to the initial intake screening, the initial health assessment of a prisoner is an important aspect of corrections health care. Adequate and timely health assessments are necessary for the appropriate treatment of those prisoners who present either acute or chronic needs during intake screening. Generally accepted correctional medical standards require that an initial health assessment be conducted within fourteen (14) days of admission, or sooner when medically necessary. Initial health assessments also provide a secondary screening process for the identification of serious medical needs, should the intake screening procedure fail to do so.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that adequate intake screening and health assessments are provided.
- Ensure that intake screening is conducted as soon as possible, no later than 24 hours after prisoners enter the Jail.
- Ensure that prisoners are not transferred from the intake area until an intake screening is completed.
- Ensure that trained medical care providers review on a daily basis the medical screening information of those prisoners whose screening indicates a need for medical care, to provide prisoners timely access to a physician as is clinically appropriate when presenting symptoms requiring medical care, with the physician assessment occurring no later than 14 days after intake.
- Ensure that prisoners' acute and chronic health needs are identified in order to provide adequate medical care.
- Ensure that appropriate drug or alcohol withdrawal screening is conducted for all prisoners immediately upon entering the Jail, and prisoners presenting symptoms of drug or alcohol withdrawal are immediately evaluated by trained medical care

professionals.

- Ensure that appropriate detoxification monitoring is conducted in an appropriate infirmary setting on prisoners identified as withdrawing from drugs or alcohol.

2. Access to Care

Generally accepted correctional medical standards require that facilities like those operated by MDCR maintain a system to track prisoner requests for medical care, to evaluate whether prisoners are medically assessed in response to their requests, and to identify those prisoners still in need of medical care after the request is made. Moreover, corrections facilities must provide appropriate policies and procedures to guide nursing staff on how to conduct sick-call assessments, and when to refer requests to higher levels of care.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that the medical request process for prisoners provides prisoners with adequate access to medical care. This process should include logging, tracking, and timely responses by medical staff as clinically appropriate.
- Ensure that trained medical professionals review medical requests on a daily basis.
- Ensure that medical/sick call requests are appropriately triaged based upon the seriousness of the medical issue.
- Provide timely medical appointments and follow-up medical treatment.
- Ensure that prisoners receive treatment that adequately addresses their serious medical needs.
- Ensure that prisoners receive acute care in a timely and appropriate manner.

3. Chronic Care

Generally accepted standards of correctional medical care require that medical staff identify detainees with chronic conditions such as diabetes, tuberculosis, and heart disease and provide timely treatment for such conditions. Jails should have an assessment process to adequately identify detainees with serious chronic medical conditions. Prisoners who suffer from chronic medical illnesses must be regularly monitored by medical professionals to prevent the progression of their illnesses.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Develop a chronic care program. This program should include the following:

- a) a process that will identify prisoners who should be enrolled in a chronic care program;
 - b) a roster of prisoners enrolled in the program;
 - c) a schedule of medical visits for each prisoner enrolled in the program;
 - d) a system for determining which diagnostic tests will be required for each chronic condition; and
 - e) record-keeping which includes documentation of laboratory tests and medical orders.
- Ensure that prisoners receive thorough assessments for, and monitoring of, their chronic illnesses.
 - Ensure that standard diagnostic tools are employed to administer the appropriate preventative care in a timely manner.
 - Adopt and implement appropriate clinical guidelines for chronic diseases such as HIV, hypertension, diabetes, and policies and procedures on, inter alia, timeliness of access to medical care, continuity of medication, infection control, medicine dispensing, intoxication/detoxification, record-keeping, disease prevention, and special needs.
 - Ensure that the medical staff is adequately trained to identify prisoners in need of immediate or chronic care, and provide timely treatment or referrals for such prisoners.
 - Ensure that prisoners with chronic conditions are routinely seen by a physician as clinically appropriate, to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

4. Medical Record Keeping

A critical component in providing adequate medical care is a complete, accurate, readily accessible, and systematically organized medical records system. In a correctional setting, inaccurate or incomplete record keeping places prisoners at risk of serious harm.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that medical records are adequate to assist in providing medical care and managing the medical care needs of prisoners. Medical records must be complete, accurate, legible, readily accessible, and systematically organized.

- Ensure that all clinical encounters and reviews of prisoners are documented in the prisoners' records.
- Ensure that specialty consultations are timely and that any resulting reports are forwarded to medical staff. Specialist recommendations should be implemented in a timely manner or, where deemed inappropriate, a physician should properly document why such recommendations were not followed.

5. Quality Assurance

Correctional facilities benefit from having an adequate quality assurance process. Quality assurance is a basic component of clinical practice that is consistent with generally accepted correctional medical standards.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Develop and implement an adequate mortality review system.
- Ensure that the Jail's quality assurance system is adequate to identify and correct serious deficiencies with the medical system.

C. USE OF EXCESSIVE FORCE

Force used should not be disproportionate to the threat posed by the prisoner. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Our investigation identified a pattern and practice of excessive force employed by MDCR corrections officers against prisoners. In a correctional facility, an effective way to remedy a pattern or practice of use of excessive force is to address the deficiencies in the areas of policies and procedures, training, and accountability. Improvement in these areas will have the most impact on MDCR in reducing uses of excessive force.

1. Policies and Procedures

Adequate policies and procedures regarding the appropriate use of force are essential to ensuring that prisoners are not unnecessarily injured by corrections officers and corrections officers are not unnecessarily injured engaging with prisoners. The policies should be comprehensive, clear, up-to-date, and reflect current generally accepted correctional standards. We found that while MDCR's use of force policy is generally adequate as written, most officers were unfamiliar with the policy. Well-trained corrections officers should be able to articulate clearly and without hesitation the level of prisoner resistance necessary for any use of force, as an appropriate response to restore and maintain order.

To this end, MDCR should implement the following policy measures to correct the constitutional deprivations:

- Expressly prohibit the use of force as a response to verbal insults or prisoner threats.
- Expressly prohibit the use of force as a response to prisoners' failure to follow instructions where there is no immediate threat to the safety of the institution, prisoners, or staff, unless corrections officers have attempted a hierarchy of documented nonphysical alternatives.
- Expressly prohibit the use of force as punishment.
- Expressly prohibit the use of punching and slapping to the head, absent exigent circumstances.
- Develop and implement policies and procedures for the effective and accurate maintenance, inventory and assignment of OC spray and other security equipment.

2. Training

Use of force training is an essential tool for a corrections facility to ensure that officers are employing force in a manner consistent with generally accepted correctional standards, and not engaging in excessive force. Generally accepted correctional standards require that corrections officers receive annual refresher use of force training courses.

To this end, MDCR should implement the following training measures to correct the constitutional deprivations:

- Develop an effective and comprehensive training program in the appropriate use of force.
- Ensure that annual refresher training is provided to all MDCR officers.
- Ensure that staff receive adequate competency-based training in MDCR use of force policies and procedures.
- Ensure that staff receive adequate competency-based training in use of force and defensive tactics.
- Ensure that MDCR Internal Affairs management and staff receive adequate competency-based training in conducting investigations of allegations of excessive force.

3. Accountability

Generally accepted corrections standards require a process of reporting, administrative review, and investigation of each use of force. This process facilitates the determination of several critical questions, including: (1) whether criminal activity has occurred; (2) whether facility procedures have been followed; (3) whether remedial training is necessary; (4) whether review or change in policies is required; and (5) whether the incident is part of a larger trend. We found that MDCR is underreporting incidents and producing use of force reports that are frequently inaccurate or incomplete.

To this end, MDCR should implement the following accountability measures to correct the constitutional deprivations:

- Ensure that staff adequately and promptly (within 24 hours) report all uses of force.
- Ensure that management review of incident reports, use of force reports, and prisoner grievances alleging excessive or inappropriate uses of force includes a timely review of medical records of prisoner injuries as reported by medical professionals.
- Ensure that incident reports, use of force reports and prisoner grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.
- Develop and implement an adequate system of tracking and reviewing use of force incidents by MDCR officers. The system should be capable of identifying patterns and trends that can be addressed through training, administrative, or disciplinary measures.

D. PRISONER VIOLENCE

Jail officials must take reasonable steps to protect prisoners from physical violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy prisoners' basic needs, such as their need for safety.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that corrections officer staffing and supervision levels are appropriate to adequately supervise prisoners.
- Ensure frequent, irregularly timed, and documented security rounds by corrections officers inside each housing unit.
- Ensure that staff adequately and promptly report incidents involving prisoner violence.

- Develop a process to track all serious incidents that captures all relevant information, including: location, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
- Increase video surveillance in critical housing areas and adjust staffing patterns to provide additional direct supervision of housing units.
- Develop and implement appropriate training for corrections staff addressing security administration and providing for proficiency training.
- Develop a plan to reduce and prevent overcrowding, most immediately the triple-bunking of prisoners in cells designed for two prisoners.
- Develop and implement policies and procedures for an appropriate, objective classification system that separates prisoners in housing units by classification levels in order to protect prisoners from unreasonable risk of harm.

E. FIRE SAFETY AND ENVIRONMENTAL HEALTH

Generally accepted correctional standards require adequate sanitation and environmental health conditions, such as proper fire safety systems, sanitation, and hygienic materials and utilities. In order to cure its pattern or practice of inadequate sanitation and environmental conditions, the Jail should ensure that the facilities' conditions do not pose serious risks to prisoners' health and safety. To that end, MDCR should implement the following measures to correct the constitutional deprivations:

1. Fire Safety

- Ensure that all facilities have adequate fire and life safety equipment that is properly maintained and inspected.
- Implement competency-based testing for staff regarding fire/emergency procedures. Train and drill staff in use of fire safety equipment.
- Ensure that emergency keys are appropriately marked and consistently stored in a quickly accessible location.
- Ensure that fire alarms and sprinkler systems are installed and adequately maintained in all housing areas.
- Develop and implement policies and procedures for the control of chemicals in the facility, and supervision of prisoners who have access to these chemicals.

2. Sanitation

- Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.
- Ensure prompt and proper maintenance of shower, toilet, and sink units.
- Ensure that medical areas are adequately cleaned and maintained, including negative pressure rooms. Ensure that hand washing stations in medical areas are fully equipped, operational, and accessible.
- Ensure proper ventilation and airflow in all cells and housing units.
- Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.
- Secure all sharp medical tools.
- Destroy any mattress that cannot be sanitized sufficiently to kill any possible bacteria. Inspect and replace as often as needed all frayed and cracked mattresses.
- Ensure adequate pest control, including sufficient staffing for routine and follow-up pest control services.

3. Hygiene

- Ensure that laundry procedures protect prisoners from exposure to contagious disease, bodily fluids, and pathogens. Develop and implement a policy for handling, washing, and drying of laundry. Train staff and educate prisoners regarding laundry sanitation policies.

* * * * *

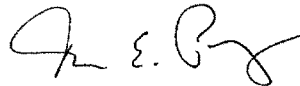
Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. As a matter of courtesy, we will not post this letter to the website until five calendar days from the date of this letter. We will also provide a copy of this letter to any individual or entity upon request.

We hope to continue working with the County officials in an amicable and cooperative fashion to resolve our outstanding concerns regarding the Miami-Dade County Jail. Since we toured, MDCR has reported that the Jail has adopted a number of improvements, many of which appear to be designed to address issues raised at the conclusion of our site visits. We appreciate the Jail's proactive efforts. Nonetheless, the deficiencies we identified are serious and systemic, and we anticipate that a court-enforceable agreement will be necessary to remedy them.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve all matters by working cooperatively with you and are confident that we will be able to do so in this case. The attorneys assigned to this investigation will be contacting the County's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please contact Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: R.A. Cuevas, Jr.
County Attorney
Miami-Dade County

Robert Duvall
Assistant County Attorney
Miami-Dade County

The Honorable Joe A. Martinez
Chair, Board of County Commissioners
Miami-Dade County

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Legal Advisor, Corrections and Rehabilitation Department
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The Honorable Wifredo A. Ferrer
United States Attorney
Southern District of Florida



U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D.C. 20530*

APR - 7 2011

The Honorable Michael A. Delaney
Attorney General
State of New Hampshire
Department of Justice
33 Capitol Street
Concord, NH 03301

Re: United States' Investigation of the New Hampshire Mental Health System
Pursuant to the Americans with Disabilities Act

Dear Attorney General Delaney:

We write to report the findings of the Civil Rights Division's investigation of the State of New Hampshire's mental health system, which offers services to persons with mental illness at the New Hampshire Hospital ("NHH") in Concord, NH, the Glencliff Home ("Glencliff") in Benton, NH, and other settings across the state. During our investigation, we assessed the State's compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134 (Part A), and its implementing regulations at 28 C.F.R. pt. 35, as interpreted in Olmstead v. L.C., 527 U.S. 581 (1999), requiring that individuals with disabilities, including mental illness, receive supports and services in the most integrated setting appropriate to their needs. The Department has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C § 12133; 28 C.F.R. §§ 35.170-174, 190(e). In our investigation, we did not assess or reach any conclusions about the quality of the care and services offered at NHH or Glencliff.

Consistent with legal requirements set forth in the ADA and its implementing regulations and in Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1, we write to provide you notice of the State's failure to comply with important aspects of the ADA and of the steps New Hampshire needs to take to meet its obligations under the law. By implementing the remedies set forth in this letter, the State will correct identified ADA deficiencies, fulfill its commitment to individuals with disabilities, and better protect the public fisc.

I. SUMMARY OF FINDINGS AND CONCLUSIONS

We have concluded that the State of New Hampshire fails to provide services to qualified individuals with mental illness in the most integrated setting appropriate to their needs, in violation of the ADA. This has led to the needless and prolonged institutionalization of individuals with disabilities who could be served in more integrated settings in the community with adequate services and supports. Systemic failures in the State's system place qualified individuals with disabilities at risk of unnecessary institutionalization now and going forward.

Our findings here, in large measure, are consistent with the State's own conclusions and admissions about deficiencies, weaknesses, and unmet needs in the New Hampshire mental health system. We have made a point to include these State conclusions and admissions in this letter, and we adopt them as part of our findings. Our specific findings include:

- The State acknowledges, and we agree, that its mental health system is “broken,” “failing,” and that it is in “crisis.”
- The State acknowledges, and we agree, that there are serious “unmet needs” and “weaknesses” in the State's mental health system that contribute to negative outcomes for persons with mental illness, such as the day-to-day harm associated with improperly and/or under-treated mental health conditions, needless visits to local hospital emergency departments, needless admissions to institutional settings like NHH and Glencliff, and the serious incidents that prompt involvement with law enforcement, the correctional system, and the court system.
- In spite of a challenging fiscal environment, the State has continued to fund costly institutional care at NHH and Glencliff, even though less expensive and more therapeutic alternatives could be developed in community settings.
- Community capacity in New Hampshire has declined in recent years and this has led to unnecessary institutionalization, prolonged institutionalization, a heightened risk of institutionalization, and a greater likelihood that some will end up in even less desirable settings not designed to provide mental health care, such as the state corrections system and the county jails.
- The number of inpatient and residential acute/crisis bed alternatives to NHH and Glencliff has diminished dramatically in recent years.
- There is a lack of safe, affordable, and stable community housing, including supported housing, for persons with mental illness in New Hampshire, which can lead to greater levels of impairment, more difficulty in accessing needed services and supports, a loss of stability, and a greater risk of hospitalization and/or institutionalization.
- High admission and readmission numbers to NHH reveal that there are inadequacies in the State's mental health system that are forcing persons with mental illness to obtain mental health services in an institutional setting.

- Many individuals admitted to NHH and Glencliff, especially those with intensive physical and/or mental health needs, remain there longer than necessary simply because community-based alternatives with adequate and appropriate services and supports are not available in sufficient supply in the community.
- The State's failure to develop sufficient community services is a barrier to the discharge of individuals from NHH and Glencliff who could be served in more integrated community settings with adequate and appropriate services and supports. The State already provides the types of services and supports these individuals would need to live successfully in the community, but the State does not offer these needed services and supports in sufficient supply.
- Individuals with developmental disabilities have remained institutionalized in the State's mental health system because of a lack of community alternatives with proper supports.
- Even though the State recognizes, and has seen first-hand, the benefits of Assertive Community Treatment ("ACT") in terms of promoting positive outcomes among persons with mental illness, the State has no ACT program in at least half of its ten regions statewide, leaving thousands of persons in need without the ability to even access ACT. Not only does the State recognize that ACT can produce positive outcomes, it acknowledges that ACT is cost-effective, especially for frequently-hospitalized individuals.
- The State fails to provide adequate and appropriate employment opportunities, including supported employment, to persons with mental illness in integrated community settings.

Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration with appropriate services and supports will permit the State to support people with disabilities, including mental illness, in settings appropriate to their needs in a more cost effective manner.

II. INVESTIGATION

On November 19, 2010, we notified you that we were opening an investigation of the State's mental health system pursuant to Title II of the ADA. On January 10, 2011, we participated in a meeting at NHH with various State officials and counsel, and then participated in an onsite tour of the facility. The next day, we participated in a similar meeting and tour at Glencliff. On January 21, 2011, as a follow-up to our onsite visits, we sent you a written request for documents and information. As agreed, several weeks later, you provided us with a written response to our request. On January 27, 2011, we also participated in a meeting with various advocacy groups and the State with regard to the adequacy of the services and supports provided to persons with mental illness in the State's mental health system.

Before proceeding to the detailed substance of the letter, we would first like to thank the State for the assistance and cooperation extended to us thus far, and to acknowledge the courtesy

and professionalism of all of the State officials and counsel involved in this matter to date. We appreciate that the State facilitated the walk-through tours of NHH and Glencliff, and that the State provided us with helpful documents and information both onsite during our January visit and in late February in response to our written request. We hope to continue our collaborative and productive relationship. We are certainly encouraged by our interactions thus far with State leadership, and hope that going forward, there is a desire to work toward an amicable resolution of this matter.

III. BACKGROUND

The New Hampshire Department of Health and Human Services (“DHHS”) is responsible for establishing, maintaining, and coordinating a comprehensive and effective service system for persons with mental illness in the state. The Department provides direct services to persons with mental illness primarily at two residential facilities: NHH, an acute psychiatric hospital; and Glencliff, a long-term care nursing facility.

NHH is a 202-bed facility, and it had a census of 175 on the day we visited in mid-January; the NHH average daily census in FY 2010 was 167. NHH is the only state-operated psychiatric hospital in New Hampshire.¹

Glencliff is a 114-bed facility and it had a full census on the day we visited in mid-January; the Glencliff average daily census in FY 2010 was 111. Glencliff is located in a woody, isolated area, far from the nearest town, which makes it difficult for family members and other visitors to see their loved ones. The State informed us that Glencliff provides a specialized level of nursing home care for individuals with serious mental illness or developmental disabilities. Admission to Glencliff is subject to State long-term care approval and to Pre-Admission Screening and Annual Resident Review (“PASARR”) approval.

In addition, the DHHS Division of Community-Based Care Services (“DCBCS”) and its Bureau of Behavioral Health (“BBH”), which is the New Hampshire State Mental Health Authority, oversees community-based services for persons with mental illness by contracting

¹ As of last year, the Philbrook Center for children is now located on a wing of the main NHH building. In addition, on the greater NHH campus, there is also a Transitional Housing Service (“THS”) program, comprised of six houses with a total of about 49 beds, currently serving approximately 45 persons. The State informed us that the THS is technically not a component of NHH, although it is a part of DHHS. According to the State, the THS provides an intermediary step between NHH and less restrictive community placement for individuals who it claims are not ready to fully transition to more independent living. In his 2011 budget address, the Governor announced plans to privatize the THS units and to replace them with community-based housing that will help integrate people back into their homes and lives. The Governor also announced that the State intended to close another unit at NHH, but he did not provide any further details about the unit closure or the THS privatization plan.

with ten regional Community Mental Health Centers (“CMHCs”) located throughout the state.² Each CMHC is supposed to be a full-service entity, offering a variety of programs and services in community settings, including: evaluation and assessment; emergency and crisis services; individual, family, and group therapy; medication monitoring; psychiatric evaluations; case management; symptom management services; and family support. While BBH leaves direct service delivery to each CMHC, BBH maintains oversight of the community system by conducting various types of reviews and requiring financial and performance reporting. In addition, BBH approves community service programs for each CMHC, provides staff training, and details what services are to be provided, how clinical records are to be maintained, and other aspects of CMHC operations.

The State informed us that in FY 2010, there were 51,305 persons served in the State’s community mental health system; within this total figure, there were 19,577 persons designated as part of the State’s “priority population” -- as either being an adult with “serious” or “severe mental illness” or a child or adolescent with “serious emotional disturbance.”

As we discuss in greater detail below, the average cost of institutionalizing a person at NHH is approximately \$287,000.00 per year. The average cost of institutionalizing a person at Glenciff is about \$124,000.00 per year. By contrast, the cost of serving a person in the community is roughly \$44,000.00 per year. Given this, New Hampshire can serve about six persons in the community for each person in NHH.

Per State policy, the State’s mental health service system is to provide “adequate and humane care to severely mentally disabled persons in the least restrictive environment,” and is to be directed toward “eliminating the need for services and promoting individuals’ independence.” RSA 135-C:1, II.

IV. FINDINGS AND CONCLUSIONS

We conclude that New Hampshire fails to provide services to qualified individuals with disabilities, including mental illness, in the most integrated setting appropriate to their needs as required by the ADA.

Community capacity in New Hampshire has declined in recent years and this has led to unnecessary institutionalization, prolonged institutionalization, and a heightened risk of institutionalization for persons with mental illness who could be served with more independence and dignity, at a fraction of the cost, in more integrated settings in the community with adequate protections, services, and supports. People in the community, for example, are now often forced to seek services in the NHH institution simply because community resources are deficient -- providing improper service or under-treatment of their mental health conditions. Many individuals recycle through NHH because community capacity in the State’s system is just not

² The State’s BBH also contracts with: eight private, not-for-profit Peer Support Agencies that provide peer-to-peer support by people with mental illness at more than a dozen different sites; one Community Mental Health Provider that mainly provides community housing and other residential supports; and one family mutual support organization.

adequate. Individuals at Glencliff are relegated to prolonged stays at the nursing facility because discharge and transition planning and implementation efforts there are insufficient, and because housing and other critical supports and services are unavailable or in too limited supply in the community. At both NHH and Glencliff, individuals with more complex physical and/or mental health conditions typically must remain institutionalized longer than necessary simply because more intensive protections, services, and supports are not sufficiently available in the State's community mental health system.

The State's failure to develop sufficient community services is a barrier to the discharge of individuals from NHH and Glencliff who could be served in more integrated community settings with adequate and appropriate services and supports. The State already provides the types of services and supports these individuals would need to live successfully in the community, but just not in sufficient supply. In general, therefore, systemic failures in the State's system subject qualified individuals with disabilities, including those in the community, to undue and prolonged institutionalization and place them at risk of unnecessary institutionalization now and going forward. All of this violates the ADA.

A. The ADA Prohibits Discrimination on the Basis of Disability through Improper Segregation of Qualified Individuals with a Disability in Institutional Settings that Do Not Enable Them to Interact with Non-Disabled Peers to the Fullest Extent Possible

Congress declared that the simple purpose behind enacting the ADA was to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities. 42 U.S.C. § 12101(b)(1).³ Congress took action because it found that "society has tended to isolate and segregate individuals with disabilities," that this is a form of discrimination against individuals with disabilities, and that this continues to be a "serious and pervasive problem." 42 U.S.C. § 12101(a)(2).⁴ Specifically, Congress found that discrimination against individuals with disabilities often exists in such critical areas as

³ Congress found that people with disabilities, as a group, occupy "an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally." 42 U.S.C. § 12101(a)(6). Congress explained that "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society." 42 U.S.C. § 12101(a)(7).

⁴ Nearly 20 years before enacting the ADA, Congress recognized that society historically had discriminated against people with disabilities by unnecessarily segregating them from their family and community, and in response, enacted Section 504 of the Rehabilitation Act of 1973, which forbids any program receiving federal aid from discriminating against an individual by reason of a handicap. Our findings and conclusions in this letter also implicate the State's compliance with Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 *et seq.*

institutionalization, housing, public accommodations, health services, access to public services, and employment. 42 U.S.C. § 12101(a)(3).

Congress declared that “the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous.” 42 U.S.C. § 12101(a)(9). In enacting the ADA, Congress emphasized that “the Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.” 42 U.S.C. § 12101(a)(8). Congress’ basic intent was to invoke the “sweep of congressional authority” to address the major areas of discrimination faced day-to-day by people with disabilities. 42 U.S.C. § 12101(b)(4).

Title II of the ADA⁵ prohibits discrimination on the basis of disability by public entities. This would encompass the State of New Hampshire, its agencies, and its mental health system, given that a “public entity” includes any State or local government, as well as any department, agency, or other instrumentality of a State or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. 42 U.S.C. § 12131(1); 28 C.F.R. § 35.102(a); 28 C.F.R. § 35.130(b).

In Title II, Congress established a straightforward prohibition on discrimination: “no qualified individual with a disability⁶ shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. The ADA’s implementing regulations mandate that a “public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). See also 28 C.F.R. § 41.51(d) (“[r]ecipients [of federal financial assistance] shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons”). The “most integrated setting appropriate to the needs of qualified individuals with disabilities” means “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”

⁵ In the ADA, Congress set forth prohibitions against discrimination in employment (Title I, 42 U.S.C. §§12111-12117), public services furnished by governmental entities (Title II, 42 U.S.C. §§ 12131-12165), and public accommodations and services provided by private entities (Title III, 42 U.S.C. §§ 12181-12189). Title II is the relevant subchapter with regard to the instant investigation of the State’s mental health system.

⁶ Like those persons served in the State’s mental health system here, a “qualified individual with a disability” is “an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 42 U.S.C. § 12131(2).

28 C.F.R. pt. 35 app. A. at 572 (July 1, 2010) (Preamble to Regulation on Nondiscrimination on the Basis of Disability in State and Local Government Services (July 26, 1991)).

The ADA's implementing regulations stress that "[i]ntegration is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second-class status." Id. at 570. The overarching intent behind the selection of the various forms of discrimination delineated in the regulations is to forbid practices that exclude and unnecessarily segregate. See also id. at 569 ("Taken together, these provisions are intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. Consistent with these standards, public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a class of individuals with disabilities can or cannot do.")

In construing the ADA's anti-discrimination provision, the Supreme Court held that "[u]njustified isolation ... is properly regarded as discrimination based on disability." Olmstead, 527 U.S. at 597. The Court recognized that unjustified institutional isolation of persons with disabilities is a form of discrimination because the institutional placement of persons who can handle and benefit from community settings "perpetuates unwarranted assumptions that persons so isolated are incapable or untrustworthy of participating in community life" and because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 600-01.

The Court described the dissimilar treatment persons with disabilities must endure just to obtain needed services: "In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." Id. at 601.

A violation of the ADA's integration mandate is made out if the institutionalized individual is "qualified" for community placement – that is, he or she can "handle or benefit from community settings," and the affected individual does not oppose community placement. Id. at 601-03. Indeed, the Court stressed that states "are required" to provide community-based treatment for qualified persons who do not oppose placement in a more integrated setting unless the State can establish an affirmative defense. Id. at 607.⁷

⁷ Olmstead, therefore, makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and to enable persons with disabilities to participate in all aspects of community life. This is consistent with guidance from the President. See, e.g., Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").

Both NHH and Glenclyff are segregated, institutional settings.⁸ Contrary to the requirements of the ADA and its implementing regulations, neither is a setting that enables individuals with disabilities to “interact with non-disabled persons to the fullest extent possible.” Instead, individuals housed at the two facilities live isolated lives, largely cut off from the rest of society. Most spend their entire day, every day, in an institutional setting. Individuals housed at these institutions are offered very limited opportunities day-to-day for community integration or meaningful employment, and, as a result, have few opportunities to interact with their non-disabled peers in community settings outside the institution. Moreover, both facilities limit individual autonomy and provide limitations on choice even while onsite.

B. The State Has Acknowledged Unmet Needs and Weaknesses in Its Mental Health System

In recent years, the State has been candid and open about the many limitations, shortcomings, and deficiencies in its mental health system. All of the State’s admissions lend support to our conclusion that the State is failing to provide services to persons with mental illness in the most integrated setting as required by the ADA.

Just last year, the State submitted its 2011 application to the federal government⁹ in its attempt to secure block grant funding for its mental health system, where the State admitted that there are “unmet needs” within the State’s mental health system, and admitted that there are “key issues that are weakening the system.” New Hampshire Unif. Application 2011, State Plan, Community Mental Health Services Block Grant (hereinafter “State Application”), Aug. 31, 2010 at 58, 60. The State reported that the “most emergent unmet needs” include the need to increase the availability of community residential supports through formal supported housing

⁸ An institutional setting is a segregated environment because individuals living in such a facility are separated from the community and walled off from the mainstream of society, isolated and apart from the natural community where all of us live, work, and engage in life’s many activities. Individuals living in an institution are deprived of many of the personal freedoms that citizens in the community enjoy. Institutionalized persons typically live a regimented life tied to the needs of the institution, characterized by lack of privacy and few choices. Institutionalization also stigmatizes individuals and prevents them from building lives in the community, forming personal relationships, and obtaining employment. Community-based programs, on the other hand, are integrated services both because they are physically located in the mainstream of society and because they provide opportunities for people with disabilities to interact with non-disabled persons in all facets of life.

⁹ Within the federal government, the Substance Abuse & Mental Health Services Administration (“SAMHSA”), Center for Mental Health Services, provides grant funds to establish or expand an organized community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances and adults with serious mental illness. States are required to submit an application for each fiscal year the State is seeking funds.

programs, specialized housing, and new crisis support beds; increase capacity for community-based inpatient psychiatric care; and develop additional Assertive Community Treatment (“ACT”) teams. State Application at 60, 62.

The State reported that these unmet needs and key issues were previously identified in the August 2008 document, “Addressing the Critical Mental Health Needs of NH’s Citizens,” commonly referred to as the “Ten-Year Plan.” State Application at 58, 60. We discuss the Ten-Year Plan in greater depth below. The State, in part, was the author of this plan,¹⁰ and through its 2011 block grant application, reinforced that the findings, conclusions, and recommended action steps in the Ten-Year Plan have continuing relevance today.¹¹ As a result, the State’s Ten-Year Plan is not an aspirational document or an historical remnant of a past time, but is instead a current roadmap for steps the State believes it needs to implement in order to meet the outstanding needs of persons with mental illness in New Hampshire.

In addition to the block grant application and the Ten-Year Plan, in April 2009, the State produced a follow-up report to its Ten-Year Plan that contained additional admissions about problems in the State’s mental health system. This report was the product of five “listening sessions” across the state that produced hours of testimony and discussion and “scores of accounts” about the problematic state of mental health services in New Hampshire. Addressing the Critical Mental Health Needs of NH’s Citizens, A Strategy for Restoration, Report of the Listening Sessions (hereinafter “State Report”), April 2009, at 3.

Overall, the State admitted that the findings in its Ten-Year Plan were “stark and painted a picture of a system in crisis.” State Report at 1. DHHS Commissioner Nicholas A. Toumpas concluded: “NH’s mental health care system is failing, and the consequence of these failures is being realized across the community. The impacts of the broken system are seen in the stress it is putting on local law enforcement, hospital emergency rooms, the court system and county jails, and, most importantly, in the harm under-treated mental health conditions cause NH citizens and their families.” *Id.*; see also *id.* at 4 (in summarizing the account of one community member during a listening session, the State characterized its mental health system as “broken”).

The State reported that its State-sponsored listening sessions brought forth “very moving testimony that demonstrated the need for a long-term commitment to improve and restore the system and to help people who are not receiving the care that they need.” *Id.* at 2. The State

¹⁰ The State’s DHHS published the Ten-Year Plan in collaboration with the New Hampshire Hospital Bureau of Behavioral Health and the Community Behavioral Health Association.

¹¹ Indeed, in its 2011 block grant application, the State adopted anew the recommendations contained in the Ten-Year Plan as the “key elements designed to address the unmet needs” of the State’s mental health system. State Application at 62; see also *id.* at 60 (the State reported that its current “primary strategy” to reduce unmet needs is through the Ten-Year Plan, which centers on areas targeted for system, policy, and fiscal reform). Moreover, in his very recent 2011 budget address, the Governor expressly referenced the Ten-Year Plan as the blueprint for the State’s efforts to develop and implement “fundamental changes” to the State’s mental health system going forward.

reported that there were stories about people who had been “pushed aside by the system, and who have been denied access to basic services such as mental health screening, preventive care, and the level and type of care, in the correct setting, that would have meant a successful outcome for them and their families.” Id. The State concluded that the personal stories “illustrated the need to restore New Hampshire’s mental health system.” Id.

The State reported that the “recurring themes” of its many listening sessions included “the lack of resources or appropriate resources in the correct places; the need for improved communication and coordination between systems with a focus on individuals’ and families’ needs; and earlier intervention and access to appropriate treatment so that individuals don’t end up in acute care, incarcerated, or homeless because of treatable mental health conditions, to name just a few. There was a call for long-term solutions.” Id. at 3.

In its Ten-Year Plan, the State outlined a series of recommendations that were to be implemented over the course of the subsequent ten years. Specifically, these recommendations included the need to: increase supported community housing; to develop and maintain a community housing subsidy bridge program linked with clinical services; to increase the number of community residential beds; to increase the number of community beds for persons in short-term crisis, for persons with co-occurring mental illness and substance abuse problems, and for persons with serious mental illness who have histories of violence or criminal involvement; to increase capacity for community-based inpatient psychiatric care; to develop additional ACT teams in the community; and to facilitate discharge of persons with developmental disabilities at NHH. State Ten-Year Plan at 9-15.

In September of 2010, at about the two-year anniversary of the State’s publication of its Ten-Year Plan, the New Hampshire Community Behavioral Health Association (“CBHA”), provided a short report on whether or not the State had accomplished what had been set forth in the plan. The CBHA noted some progress in a handful of areas, but concluded that little or no action had been taken in other important areas. For example, inconsistent with the State’s plan, the CBHA concluded that: admissions to NHH had increased 104 percent over the previous ten years; the five ACT teams recommended in the plan were not added in FY 2009 or FY 2010, putting additional demand on NHH for inpatient care; none of the target items for persons with developmental disabilities were achieved; CMHCs had closed 44 community beds in the previous two years; there had not been appropriations for the addition of 132 community beds; no additional DRF beds had been added; and a taskforce had not been convened to expand voluntary inpatient psychiatric care throughout the state. CBHA, New Hampshire Ten-Year Mental Health Plan Progress, Two Years Out, Sept. 24, 2010, at 2-3.

C. The State Has Continued to Invest in Expensive, Segregated Institutional Services While Denying Resources to the Community System

In spite of a challenging fiscal environment, the State has continued to fund costly institutional care at NHH and Glencliff, even though less expensive and more therapeutic alternatives could be developed in integrated community settings. This misplaced emphasis on institutional care reinforces the conclusion that the State is violating the ADA with regard to services provided to qualified persons with a disability.

The State informed us that its failure to implement recommendations from its Ten-Year Plan and other needed remedial measures is due, in part, to budget cuts and general fiscal constraints. These fiscal limitations have contributed to the State's failure to minimize the risk of institutionalization for qualified individuals with a disability pursuant to the ADA. For example, the State acknowledged that budget adjustments from deficits have caused staff reductions throughout DHHS, the closure of certain facilities and programs, and the potential reduction in certain services with an unknown specific impact on adult mental health services. Id. at 41.

In its 2011 block grant application, under the heading "A Stressed System," State Commissioner Toumpas admitted that millions of dollars in budget cuts to his Department in recent years have had an impact: "Given that the amount ... was so large, (and) ... coming on top of previous reductions, we could not avoid cutting into some of our direct services. Although every attempt was made to minimize the impact on clients, we simply cannot make reductions of this size and magnitude without there being consequences for the families and individuals we serve and for the staff who provide those services." Id. at 58.

The State acknowledged that the immediate and long-term impact of the State's budget crisis will "undoubtedly affect the State's approaches to achieving its vision" in transforming its mental health system. Id. at 67. The State admitted that the "demonstrated needs of the public far exceed the capacity of the state to meet those needs with limited and reduced public funds." Id. at 60. For example, the State reported that in New Hampshire, there is a "growing segment of the public that is clearly in high need of more accessible, available, and affordable mental health services." Id. The State reported that more individuals with mental health needs are presenting themselves to the CMHCs and that the intensity of care required is rising, at the same time that rates are being reduced, caseloads are increasing, and the number of emergency care beds is diminishing. Id. at 41.¹²

All of this is likely producing negative outcomes among inadequately or improperly served groups of persons with mental illness in the State's system. For example, the State acknowledged that in the year prior to the submission of its 2011 block grant application, there had been a 25 percent increase in the number of people taking their own lives and that the lack of sufficient staff-intensive monitoring outside the context of an in-patient stay at NHH could have played a role. Id. at 41.

All this is occurring while cuts are imposed on some important community programs. For example, the State reported that, during the 2009-2010 legislative session, spending on community behavioral health was reduced by approximately one million dollars. State Application at 44. More recently, proposed cuts to the state budget for the next biennium would, among other things, eliminate community case manager positions, eliminate community day

¹² The Ten-Year Plan earlier had identified recommended services that were "never implemented, the erosion of mental health services over the last fifteen years and a growing state population with related rising demands for mental health care." State Ten-Year Plan at 3.

programs, and change eligibility requirements for Medicaid, making thousands of persons with disabilities ineligible for the program. This would directly affect persons with severe mental illness and could contribute to poor individual outcomes and additional pressures on emergency departments and law enforcement.

We note that there is a substantial difference in the cost of providing care in institutional and community settings, which breaks down as follows:

1. NHH

The State informed us that total expenditures for NHH operations have risen in each of the last five years. Indeed, it cost nearly ten million dollars more to run NHH in FY 2010 than it did in FY 2006.

The per diem cost to serve a person with mental illness in an acute setting like NHH was \$788.00/day in FY 2010.¹³ Projected out for a full year, this amounts to about \$287,000.00 per NHH person per year. In 2009, Commissioner Toumpas admitted that “[w]e’re spending money for mental illness but we are not doing it effectively ... It costs \$275,000 to keep someone in NH Hospital and they are there because we don’t have the resources in the community.” State Report at 8. Importantly, services at NHH are primarily funded with State-only dollars without Federal matching funds, in contrast to community services where there is often a significant Federal matching contribution.

2. Glencliff

As with NHH, in recent years the State has continued to increase the flow of limited state funds to support institutional care and services at Glencliff. State general fund expenditures for Glencliff have steadily increased over the years, rising about two million dollars from FY 2006-2010, to a FY 2010 total of about \$12.5 million.

The per diem rate at Glencliff, \$340.71 per person, is less than that at NHH, but, as we set forth below, still much more than that for services in the community. Projected out for a full year, this amounts to about \$124,000.00 per person at Glencliff.

3. Community

The institutional NHH and Glencliff cost figures contrast markedly with the much lower per diem figures for persons with mental illness living in the community. Since July 1, 2009, the current community residence rate in New Hampshire has been \$120.00/day. This projects out to an approximate annual cost of \$43,800.00 – an amount which is about \$243,000.00 per person per year lower than the annual cost of residing at NHH and about \$80,000.00 per person per year

¹³ This per diem figure is slightly higher than the amount set in FY 2006 (\$756.00/day) and much higher than the amount set in FY 2007, which was \$671.00/day.

lower than the annual cost of care at Glencliff. So, for example, New Hampshire can serve roughly six people in the community for each person it serves at NHH.¹⁴

According to State estimates, the community cost of serving even high-risk individuals with complex needs is less expensive in New Hampshire than serving them in an acute care setting like NHH or a nursing home setting like Glencliff. For example, in its Ten-Year Plan, the State recommended a rate increase to \$170.00/day for community beds serving those with serious mental illness and complex medical conditions, and for community beds serving persons with serious mental illness and substance abuse; and a rate increase to \$260.00/day for community beds for persons with serious mental illness who have a history of violence or criminal involvement. State Ten-Year Plan at 10-11.¹⁵ Even the highest rate of \$260.00/day projects out to only about \$95,000.00 per person per year – still \$190,000.00 per person per year less than the current per diem rate at NHH; the lower \$170.00/day rate would cost about \$225,000.00 less per person per year compared to NHH.

D. The State Has Failed to Develop Adequate Capacity in Integrated Community Settings to Minimize the Risk of Institutionalization for Qualified Persons with a Disability

The State has admitted repeatedly that community capacity within New Hampshire has declined and/or failed to meet the needs of individuals with mental illness. This has led to unnecessary institutionalization and a further deepening of the daily risk of institutionalization for persons in need of mental health services, in violation of the ADA's integration mandate.

In its 2009 listening sessions report, the State concluded that, in recent years, “[a]s community capacity to serve more people declined, access to critical services became more difficult to get. More individuals found themselves in a system that could no longer meet their needs, some ending up in settings not designed to provide mental health care, such as the state corrections system and county jails.” State Report at 17.

In its Ten-Year Plan, the State acknowledged that a number of factors have “eroded the current and future capacity of New Hampshire’s system of care” for persons with mental illness. State Ten-Year Plan at 4. For example, the State reported that funding for Medicaid services, the

¹⁴ This is not a neat comparison though, as we understand that the per diem figures for NHH and Glencliff include room and board, while the community figures do not. However, even adding a generous amount for room and board (assume \$1,500.00/month) would only increase the community per diem cost by about \$50.00/day, for a total of \$170.00/day -- still far less than the \$788.00/day at NHH. On the other hand, none of these figures reflect the increase in federal reimbursement through the Medicaid program that would be available to the State through community waiver and other funding programs; with institutional mental health care, like that provided at NHH, federal Medicaid matching funds are largely unavailable.

¹⁵ We understand that these recommended rates were never approved. The State informed us that the last community rate increase occurred on July 1, 2009, from a per diem of \$107.00/day to the current \$120.00/day.

primary insurance for people with serious and persistent mental illness, has been restricted in New Hampshire as costs have increased. *Id.* at 5. The State concluded that the end result of this is less capacity to build additional community service options for a growing population that has more challenging needs. *Id.* The State reported that this will likely have a direct, negative effect on outcomes, as research demonstrates, for example, that “decreasing appropriate outpatient services may contribute to disengagement from treatment, and an increase in symptoms and ability to do everyday tasks like caring for oneself or working, which results in increased frequency of visits to expensive emergency departments and often the need for hospitalizations.” *Id.* Indeed, the State reported that “care in the middle and at the higher intensity end of the spectrum of treatment, including intensive outpatient care, residential care, and inpatient care, is not easily available to many individuals with severe mental illness, resulting in an overburden on [NHH] and poor outcomes for individuals who are unable to access sufficient treatment choices to remain in the community or to be discharged from the hospital when ready.” *Id.* at 4.

I. Acute/Crisis Beds

The State reported that inpatient and residential alternatives to NHH have diminished over the previous 15 years in a number of specific ways. *Id.* at 5. In its 2011 block grant application, the State acknowledged that the number of inpatient psychiatric beds available has dropped from a total of 814 beds in 1990 to 496 beds in 2008, and that more psychiatry units have closed and additional inpatient beds have been lost since then. State Application at 101. The State recognized that there is a “paucity” of hospital-based psychiatric care in rural areas of New Hampshire and that this has put a “significant strain” on the local hospitals. *Id.* at 166.¹⁶ The State characterized the situation as a “crisis,” and, according to the New Hampshire Hospital Association, reported that:

- there were 236 voluntary inpatient beds in 1990, but only 186 such beds in 2008;¹⁷
- over the previous eight years, the number of community Designated Receiving Facility (“DRF”) beds had “decreased dramatically” from 101 to 8 DRF beds (at just one hospital);¹⁸ and

¹⁶ The State acknowledged that it is a challenge for persons with mental illness in rural areas of the state to access needed mental health care and services: “Small rural hospitals do not have all the resources to treat mental illnesses, forcing patients to be stabilized then transported elsewhere for care.” State Application at 100.

¹⁷ More recent State documents reveal that as of FY 2009 (the most current figures available), this number has been reduced even further to 169 voluntary beds.

¹⁸ The State acknowledged that, because DRF care is now only available at one hospital, the State is lacking regional capacity for inpatient voluntary and involuntary care. State Ten-Year Plan at 12.

- over the previous eight years, the number of Acute Psychiatric Residential Treatment Program (“APRTP”) beds had decreased from 52 to 16 APRTP beds (now only located at the Cypress Center in Manchester as part of the CMHC there).

State Ten-Year Plan at 5, 11.

By the end of the current fiscal year, the State’s Ten-Year Plan called for the creation of 12 new crisis beds, 10 new community beds for persons with co-occurring disorders, six new community beds for high-risk individuals, and 12-16 new DRF beds. Although the State informed us that it has requested additional funding for crisis/acute beds and services, it could provide no assurance that these requests will be approved. As a result, we are left with the current numbers which reveal that since FY 2008 (the time of the creation of the Ten-Year Plan), acute/crisis bed capacity in the community has dropped by at least 22 beds.

2. *Community Housing*

In addition, pursuant to the terms of its Ten-Year Plan, by the end of the current fiscal year the State was to have created 52 additional residential group home beds in the community. However, the State informed us that in the last five years, it had created a total of only 17 new supported housing beds at two locations, while closing 56 beds. Therefore, instead of adding to the community residential bed capacity in New Hampshire, the State has reduced community residential beds by 39.¹⁹

In its Ten-Year Plan, the State admitted that “lack of safe, affordable and stable [community] housing is an increasing problem for individuals with serious mental illness in New Hampshire.” *Id.* at 6. Indeed, during the State-sponsored listening sessions, a top official from BHH concluded that “we have some people at NH Hospital because they can’t find housing.” State Report at 6. The State has admitted that sufficient formal supported housing is not available to most persons with mental illness in New Hampshire and that home-based community services need to be “further developed to meet the current need.” State Ten-Year Plan at 8.

The State has recognized that the lack of supported housing increases the risk of institutionalization. The State has declared that, for the individual struggling with the daily challenges of a serious mental illness, a lack of housing “leads to greater levels of impairment, more difficulty in accessing services and supports, and a loss of stability which leads to subsequent hospitalizations.” *Id.*

The State had concluded that housing for individuals with mental illness in their communities largely “evaporated” as rental costs increased, so the State’s BBH created a housing

¹⁹ We note that group homes are not likely the most integrated setting appropriate for many NHH and Glencliff residents. Nevertheless, they are more integrated settings than those institutions.

transition program with bridge funding to cover reimbursement gaps. State Report at 17.²⁰ One of the goals of this program is to show that a housing subsidy bridge program is a more clinically-effective (and cost-effective) model than institutional care. *Id.*; State Application at 97. The State informed us that this program was designed to increase access to safe, affordable housing for adults with serious mental illness, especially those who are homeless or at risk of homelessness. The State reported that 37 individuals enrolled in the first 12 months of the bridge subsidy program, with half coming from NHH.

E. Admissions/Readmissions Data Reveals Undue State Reliance on Institutional Services for Qualified Persons with a Disability

1. NHH

Because of the State's lack of community services, people with mental illness are forced to obtain mental health services in an institutional setting, in violation of the ADA. Admissions to NHH are high. The State reported that there were a total of 2,380 admissions to NHH in FY 2010, and that there has been a steady increase in NHH admissions in each of the last five fiscal years. The high and increasing number of admissions each year reflects the need for enhanced community mental health services to address mental health concerns, especially when an individual goes into crisis. Indeed, individuals are typically admitted to NHH directly from local hospital emergency departments because they are in crisis.

The State acknowledged: "What was once a nationally recognized model of care ... began to decline in recent years. Admissions to NH Hospital doubled during a 15-year time period and the census of the hospital increased by 50%. The state lost over 100 psychiatric inpatient beds in local community hospitals, resulting in more admissions and demand for services at a facility that was already at maximum capacity." State Report at 13, 16-17.

The high number of institutional admissions typically reveals that individuals' needs are not being met in the community, often because of a lack of capacity. This is consistent with the State's own conclusions in recent years. Indeed, in its Ten-Year Plan, the State reported that the "primary finding" of its taskforce was that many individuals have been admitted to NHH because they have "not been able to access sufficient [community] services in a timely manner (a "front-door problem") and remain there, unable to be discharged, because of a lack of viable community based alternatives (a "back-door problem")." State Ten-Year Plan at 6.

The State's readmissions data reinforce this conclusion. The State informed us that scores of persons are admitted to and discharged from NHH multiple times each year, in search of effective treatment for their mental illness. The State informed us that its overall NHH readmission rate of about 33 percent is higher than the comparable national average of about

²⁰ The State informed us that, thus far, much of the funding for this initiative has come from federal stimulus funds. Although this federal funding stream is ending, the State informed us that it expects to be able to continue the program going forward.

20 percent.²¹ Readmissions to NHH within 180 days of discharge represent about one-third of the annual admissions. In FY 2008, 230 persons were readmitted to NHH a total of about 700 times; all 230 persons had a minimum of two readmissions and at least one person was readmitted to NHH 25 times. The State estimated that about one-third of those readmitted that year had four or more readmissions to NHH. Thus, certain critical supports and services necessary to keep persons stable and healthy in the community and away from institutional care are often not present in the State's mental health system. These deficiencies cause unnecessary institutionalization and create an undue risk of institutionalization that violate the ADA.

In its 2011 block grant application, the State acknowledged that adult 30-day and 180-day readmission numbers to NHH have worsened in recent years; for example, the number of adult NHH readmissions within 180 days of discharge increased about 73 percent from FY 2008 to FY 2009. State Application at 119, 120. The State cited a number of factors as causing an increase in readmissions to NHH: limited housing and community supports post-discharge combined with the increased need for inpatient psychiatric beds as the number of inpatient beds has been decreasing. *Id.* The State recognized that the lack of adequate, safe, stable, and affordable housing is likely to be detrimental to supporting resiliency and recovery for individuals with serious mental illness. *Id.* at 132. Certainly, repeated institutionalization makes it difficult for persons with mental illness to maintain apartments, jobs, and relationships in the community.

2. Glencliff

The admissions data for Glencliff stand in stark contrast to that for NHH. The State reports that in 2010, there were only 15 admissions to Glencliff. The average number of admissions to Glencliff from 2006 through 2010 was about 17 per year. While we were onsite, Glencliff officials informed us that about 60-70 percent of Glencliff admissions now come from NHH, and that this is an improvement from prior years where the percentage was about 85 percent. The State also informed us that there is a waitlist of about two dozen people who are seeking admission to Glencliff.

Glencliff readmission numbers are small; the State reported that no individual discharged from Glencliff has returned to the facility since April of 2008. The State informed us that, since 2000, a total of seven persons discharged from Glencliff later returned -- two individuals returned in 2008; two individuals returned in 2007; and three individuals returned in 2004.

Nonetheless, as referenced earlier, the acknowledged lack of capacity in the State's community system to serve persons with mental illness and/or developmental disabilities, especially those with complex health care needs, places increased emphasis on providing needed services to these individuals in an institutional setting like Glencliff. Naturally, community capacity limits would tend to create undue institutional pressure and impact on the State's PASRR process, which is supposed to keep persons with mental illness and/or developmental disabilities out of institutional nursing home settings whenever possible. Sometimes, capacity

²¹ The NHH readmission figure includes individuals who had been released from the facility on a conditional discharge who then did not receive adequate services and supports in the community, thus necessitating re-institutionalization.

limits even prompt nursing home admissions of younger individuals. Indeed, the State's admissions data for Glencliff reveal that in recent years, it is tending to admit individuals who do not fall within traditional "frail elderly" parameters. For example, in 2009 and 2010, Glencliff admitted 37 persons, and about two-thirds of these individuals were 64 years old or younger, including 21 persons in their 40s or 50s. Glencliff is not exclusively admitting younger individuals, though; it admitted eight persons age 70 or older in 2009 and 2010.

F. Data on Length of Stay in State Institutions Reveals Unnecessary and Prolonged Institutionalization of Qualified Persons with a Disability

1. NHH

The State informed us that the majority of individuals admitted to NHH are discharged within 30 days of admission.²² Nonetheless, the State has acknowledged that, once admitted to NHH, almost a third of the individuals remain "longer than necessary." State Ten-Year Plan at 6. The State recognized that the doubling of admissions to NHH and the more than 50 percent increase in the NHH census occurred because "a number of individuals have stayed longer at [NHH] ... as community-based options for intensive treatment have declined." *Id.* at 4.

The State informed us that in FY 2010, for those who were in residence for less than a year, the average length of stay at NHH was 71 days. For those in residence for more than a year though, the average length of stay was 1,383 days, or more than three-and-a-half years.

The State informed us that there are 31 persons who have remained at NHH for over one year, and of these, 17 individuals have been held for longer than two years. A number of these individuals have been involved in serious incidents, including those that involve law enforcement; a small sub-group has been determined at some point to be "not guilty by reason of insanity." Many individuals have complex mental health issues. In its Ten-Year Plan, the State explained that individuals such as these have lived at NHH for "prolonged periods of time" because adequate community housing and treatment alternatives are "not available." State Ten-Year Plan at 6. The State explained that the "scarcity of high intensity community resources, including supervised residences and intensive community treatment" is one of several "barriers to discharge." *Id.*

The State also admitted that about half of the persons with developmental disabilities at NHH remained there "longer than required" to provide acute evaluation and stabilization of their presenting psychiatric symptoms. *Id.* at 14. The State informed us that at least four of the individuals who have resided at NHH for more than a year have a developmental disability and that three of these individuals have been institutionalized at NHH for over seven years each. In its Ten-Year Plan, the State acknowledged that half of the individuals at NHH with developmental disabilities were "unable to be discharged due to a lack of residential placement or insufficient specialized community services." *Id.* The State reported that the majority of

²² The 30-day metric is important, as around this time, an institutionalized person is at greater risk of losing community housing and other supports while away from a community home.

these persons experience behavioral disturbances that require a high level of structure and support that it claimed is currently only available at NHH; but the State admitted that these individuals could be served in the community with appropriate services. Id.

2. *Glencliff*

Once again, the situation at Glencliff is decidedly different from that at NHH. Whereas a large number of individuals regularly enter and leave NHH, individuals who enter Glencliff typically stay for prolonged periods, without much prospect for discharge to the community. This implicates State compliance with the ADA.

For some time at Glencliff, the overall average length of stay per person has been over five years; this is true both for individuals currently at Glencliff and for those who have been discharged or died. Some individuals have lived at Glencliff for decades; the State informed us that as of the end of last year, there were about a half-dozen individuals who have lived at Glencliff for over 20 years (with a total of 15 who have lived there for over ten years).

Some of these individuals at Glencliff have been involved in serious incidents over the years and many have complex physical and mental health concerns. However, in general, other than age in some cases, it does not appear that the individuals at Glencliff present any novel or different set of disabilities than their peers at NHH -- all of whom are at least nominally in the active, State-endorsed pipeline towards placement in a more integrated community setting. Given this, it is unclear then why similar placement efforts are not, and have not been, underway for the individuals at Glencliff. Certainly, maintaining individuals with mental disabilities unnecessarily in institutional settings violates the ADA, and is inconsistent with the State's own mandates, which require service in the least restrictive environment in the community. See RSA 135-C:1, II (the State's service system is to provide "adequate and humane care to severely mentally disabled persons in the least restrictive environment," and is to be directed toward "eliminating the need for services and promoting individuals' independence"); State Application at 37 (the objective of all programs in the State's system is the "reintegration of all persons into the community); Id. at 47 (State shall promote "respect, recovery, and full inclusion").

The State is maintaining two distinct and very different practices with regard to discharge planning and placement at the two facilities. The State informed us that at NHH, "[a]t the time of admission, there is a focus on developing a discharge plan for return back to the community, in collaboration with the individual, his/her family and the local community mental health center." But, at Glencliff, there appears to be virtually no immediate focus on discharge planning. Instead, the State takes a passive approach, generally not pursuing discharge and placement efforts unless and until a particular individual affirmatively asks for them. During our onsite visit, we learned that there was no meaningful discussion of community placement in any individual's regular Plan of Care meetings at Glencliff if the person does not expressly request it. As a result, team-driven placement plans are typically not developed or implemented for all but a handful of individuals at Glencliff each year. At best, it appears that there may only be a summary reference to placement status or interest in an individual's chart in the Plan of Care document, the Minimum Data Set ("MDS") data, and/or in the Social Services Progress Note section. In any event, this discharge planning is inadequate and a violation of the ADA.

The Glencliff placement data reinforces this conclusion. The State reported that no individual housed at Glencliff was discharged to a community residence in all of 2010, and that only one person was placed in the community in 2009. The only person discharged from Glencliff in 2008 was placed in NHH, perhaps an even more segregated and institutional setting than Glencliff.

The State reported that in the past ten years, from 2001-2010, a total of only eight individuals from Glencliff were placed in what the State designated as a community setting, and one of these individuals returned within two months of placement. This averages to less than one community placement per year from Glencliff. During this same ten-year period, the State reports that 11 individuals housed at Glencliff were placed in NHH or some other facility; all three of the people placed in an "other" facility though, eventually returned to Glencliff.

We find it troubling that in recent years, far more individuals housed at Glencliff have died each year than have been placed into community settings. For example, in 2009, one person was placed in the community from Glencliff, but 16 individuals died.

G. Some Placements from NHH May Not Be to the Most Integrated Setting

Although many individuals are placed in private residences or households in the community, we are concerned that part of the State's community system relies heavily on congregate housing resembling institutions. The State reported that it currently utilizes about two dozen community group homes with an average census of about 11 persons per site; one unlicensed home in Manchester serves 23 persons at one location. The large census size of such group residences typically renders them more institutional, less therapeutic, and, as a result, often unable to meet the needs of many persons with serious mental illness.

It is also of concern that about ten percent of the individuals discharged from NHH in FY 2010 were sent to homeless shelters, jail or other correctional facilities, or other residential or institutional settings. Indeed, in FY 2010, there were 687 persons served in the State's mental health system who were homeless or in a shelter. Consistent with the State's conclusions referenced above, without community housing, individuals with mental illness who are discharged to, or are at times living in, a homeless shelter are at increased risk of institutionalization going forward.

H. The State Has Developed Inadequate Assertive Community Treatment Team Resources to Prevent Unnecessary Risk of Institutionalization for Qualified Persons with a Disability

The State seems to recognize that in order to build needed capacity in the community so as to reduce the risk of institutionalization and to generally improve individual outcomes, it needs to expand its Assertive Community Treatment ("ACT") program.

ACT is a team-based model of providing comprehensive, intensive, and flexible treatment, services, and supports to individuals with mental illness, when and where they need

them – in their homes, at work, and in other community settings – 24 hours a day, seven days a week. ACT teams combine treatment, rehabilitation, and support services from professionals in a variety of disciplines, including but not limited to, psychiatry, nursing, substance abuse, and vocational rehabilitation. ACT is often intended for persons with severe mental illness who are at an elevated risk of inpatient hospitalization. Often these persons have high rates of co-occurring substance-related disorders, health care issues, and social risks such as poverty and homelessness. When ACT teams operate with high fidelity to established evidence-based practice models, they can reduce the risk of institutionalization and improve the quality of life for persons with mental illness, especially those with severe mental illness.²³ The Dartmouth ACT Scale, for example, is a widely-recognized tool for measuring the fidelity of ACT teams.

As part of its statewide evidence-based practice initiative, New Hampshire has begun to develop ACT teams to provide more proactive services and supports to persons with mental illness who live in the community. In its Ten-Year Plan, the State reported that ACT has been shown to be effective at helping individuals with serious mental illness manage their illnesses while living independently in the community: ACT reduces homelessness among those with serious mental illness, and ACT reduces hospital use and enhances the ability to maintain employment among persons with frequent hospitalizations. State Ten-Year Plan at 13. In its 2011 block grant application, the State again made this point, reporting that ACT teams in New Hampshire have made a positive “impact on the quality of life” for some individuals with mental illness with increased or high-volume hospitalizations, those who have experienced homelessness, or have had a high number of legal and police involvement incidents. State Application at 89-90.

Through FY 2010, the State informed us that it had created six ACT teams – three adult teams in the Northern region, one adult team each in the Nashua region and the Manchester region, and one children’s team in the Riverbend region (Concord). The State has taken steps to add an adult team in Riverbend and an adult team in the Center for Life Management (“CLM”) region (Derry). Even with these two new teams, that would still leave no ACT team in five regions – half of the ten total regions throughout the state. This is important, as we understand that ACT teams from one region do not provide services and supports to persons in need in other regions, even if they are geographically nearby. As a result, many thousands of persons with mental illness in New Hampshire do not even have the ability to access ACT team services, a foundational bedrock support upon which the State is looking to reform its community-based service system.

The need to provide more proactive ACT team services to persons with mental illness in the community is a pressing issue, given the worsening readmission numbers at NHH and the increased use of inpatient psychiatric beds at NHH. Moreover, the State informed us that the

²³ In its Ten-Year Plan, the State concluded that “[w]hen delivered with good fidelity to the model,” ACT has been demonstrated to reduce psychiatric hospitalization rates for individuals with severe mental illness and to improve other outcomes. State Ten-Year Plan at 13. In its 2011 block grant application, the State re-emphasized that evidence-based practices are “known to be effective, when practiced with fidelity to the model.” State Application at 121.

number of individuals receiving emergency services from CMHC Emergency Service Teams has increased over 16 percent from FY 2006-2010, totaling more than 10,000 individuals served in an emergency in FY 2010 alone.

In its Ten-Year Plan, the State called for the creation of five additional ACT teams by the end of the current fiscal year. Given that there were four ACT teams in FY 2008 (at the time of the creation of the Ten-Year Plan), that means that there should be nine ACT teams by the end of June 2011. With only six ACT teams, however, the State is far from its plan.

During our onsite visit, the State informed us that ACT teams in New Hampshire generally include, among other professionals, two Master's-level clinicians, a designated psychiatrist, and some nursing support. However, it is not clear that the New Hampshire ACT teams are currently operating with full fidelity to the ACT model. For example, the number of psychiatry hours appears to be somewhat limited in the New Hampshire ACT teams that are already operating. For example, the State informed us that the Riverbend children's team only has access to 0.15 Full-Time Equivalent ("FTE") of psychiatry, the Nashua adult team has access to 0.20 FTE of psychiatry, and the three Northern adult teams each only have access to between 0.07-0.20 FTE of psychiatry. The number of nursing hours are similarly limited, for example, never amounting to a full FTE at any of the ACT teams in Riverbend or Northern.

In spite of some important limitations, the State reported to us that as a result of its ACT initiatives, it had achieved very positive outcomes for individuals served thus far, including reduced admissions to institutions like NHH, and reduced visits to local hospital emergency rooms. For example, the State reported a 78 percent reduction in hospitalizations after its Riverbend children's ACT team began operations. The State also reported that in the first year of ACT in the Northern region, the annual bed day utilization dropped in half, from over 6,000 bed days per year to about 3,000 bed days per year. With regard to the Nashua region, the State informed us that, comparing the one-year period prior to ACT with the one-year period after ACT, the number of hospitalizations dropped from 37 to 22, and more dramatically, the number of inpatient days dropped from 1,454 days to 245 days – a notable 83 percent reduction.

Not only does the State recognize that ACT can promote positive outcomes for persons with mental illness, the State has also reported that ACT is fiscally prudent: when considering the overall cost of services, ACT is "cost-effective" for frequently hospitalized individuals, as one month of care at NHH costs a bit more than the cost for an entire year of ACT. State Ten-Year Plan at 14. Moreover, during our onsite visit, the State informed us that almost half of the cost of an ACT team is borne by the federal government through the Medicaid program. By comparison, the State reported that in FY 2010, Medicaid paid for less than five percent of total expenditures at NHH.

I. The State Fails to Provide Adequate Integrated Employment Opportunities for Qualified Persons with a Disability

The State is not currently meeting the needs of persons with mental illness who need adequate and appropriate employment opportunities in integrated community settings. These opportunities can arise in a variety of contexts, but typically involve employment in the private

sector in the open market. The State reported that only 21.5 percent of adults in the mental health system are competitively employed to some extent. State Application at 130. The State reported that only 7.8 percent of adults with severe mental illness received supported employment services in FY 2009. *Id.* at 123.

The State provided us with its recent State Health Authority Yardstick (“SHAY”) evaluation for supported employment in the state. NH SHAY Evaluation, Update on Recommendations, January 2011. The State informed us that it has addressed all of the recommended areas from this evaluation. However, the evaluation document primarily focused on process elements such as improving training efforts and written policies and regulations. There was nothing in the document that referenced increases in the number of persons with mental illness actually working in competitive and/or supported employment across the state. The positive momentum that may have been generated through this SHAY evaluation will only have meaning if outcomes have been achieved in that more persons are actively engaged in employment activities in integrated community settings.

V. RECOMMENDED REMEDIAL MEASURES

To remedy its failure to serve individuals with mental illness in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulations, the State should promptly implement the minimum remedial measures set forth below:

- The State should develop and implement a plan to address the already identified “unmet needs” and “weaknesses” in the State’s mental health system that contribute to negative outcomes for persons with mental illness, such as the day-to-day harm associated with improperly and/or under-treated mental health conditions, needless visits to local hospital emergency departments, needless admissions to institutional settings like NHH and Glencliff, and the serious incidents that prompt involvement with law enforcement, the correctional system, and the court system. The State should develop and implement effective measures from its Ten-Year Plan that support this goal.
- The State should provide a sufficiently rich mix of supports and services for persons with disabilities, including mental illness, so as to support positive individual outcomes such as to minimize or eliminate the harm associated with improperly or under-treated mental illness, to minimize or eliminate institutionalization and the undue risk of institutionalization, to minimize or eliminate emergency room/hospital visits/admissions, and to minimize or eliminate serious incidents involving law enforcement, local jails and correctional facilities, and the court system. The State should develop and implement effective measures from its Ten-Year Plan that support this goal.
- The State should expand less expensive and more therapeutic community placements, with adequate and appropriate services and supports, as an effective alternative to the costly and less therapeutic institutional care offered at NHH and Glencliff.

- The State should expand community capacity throughout the state so as to minimize or eliminate unnecessary institutionalization, prolonged institutionalization, and a heightened risk of institutionalization, and to reduce the risk that some qualified persons with a disability will end up in undesirable settings not designed to provide mental health care, such as the state corrections system and the county jails.
- The State should expand the number of inpatient and residential acute/crisis bed alternatives to NHH and Glencliff that have diminished in recent years.
- The State should expand safe, affordable, and stable community housing, including supported housing, for persons with mental illness in New Hampshire, so as to prevent greater levels of impairment, more difficulty in accessing needed services and supports, a loss of stability, and a greater risk of hospitalization and/or institutionalization. To this end, the State should increase the availability of community residential supports through formal supported housing programs, specialized housing with high-intensity community resources (especially for those with complex physical and/or mental health conditions that have led to serious incidents and/or past involvement with law enforcement), an adequate housing subsidy bridge program, and new short-term acute/crisis support beds, to meet the needs of persons with disabilities, including mental illness, in its mental health system in the most integrated community setting. Supported housing should provide individuals with their own leased apartments or home, where they can live alone or with a roommate of their choosing. The housing is to be permanent (e.g., not time-limited) and is not to be contingent upon participation in treatment. The supported housing provided by the State should be scattered-site, meaning in an apartment building or housing complex in which no more than ten percent of the units are occupied by individuals with a disability. Group homes should not constitute supported housing. The State should ensure that individuals in supported housing have access to a comprehensive array of services and supports necessary to ensure successful tenancy and to support the person's recovery and engagement in community life, including through ACT services.
- The State should ensure that any and all remedial plans cover and impact all individuals who are in or at risk of entering NHH, Glencliff, or other restrictive institutional settings.
- The State should create sufficient ACT teams to ensure that the needs of persons with disabilities, including mental illness, in the community are met and that undue risks of institutionalization are minimized or eliminated. The State should ensure that the ACT services deliver comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work and operate with fidelity to effective ACT models. At a minimum, there should be adequate ACT team services in each of the ten state regions. The ACT services should be provided through a multi-disciplinary team with services that are individualized and customized, and address the constantly changing needs of the individual over time. ACT teams should have the full array of staff on each team that are necessary to provide the following services: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live

successfully in the community. ACT teams should provide crisis services, including helping individuals increase their ability to recognize and deal with situations that may otherwise result in hospitalization, increase and improve their network of community and natural supports, and increase and improve their use of those supports for crisis prevention. ACT teams should provide services to promote the successful retention of housing, including peer support and services designed to improve daily living skills, socialization, and illness self-management. ACT teams that serve individuals with co-occurring substance abuse disorders should provide substance abuse treatment and referral services to those individuals. Such ACT teams should include on their staff a clinician with substance abuse expertise. ACT services should be available 24 hours per day, seven days per week. Finally, the number of individuals served by an ACT team should be no more than ten individuals per ACT team member.

- The State should provide adequate integrated vocational services to qualified individuals with a disability through supported employment programs, the access to which should be facilitated by ACT teams. Supported employment services should assist individuals in finding competitive and other employment in an integrated setting based on the individual's strengths and interests. Supported employment programs should assist individuals in identifying vocational interests and applying for jobs and should provide services to support the individual's successful employment, including social skills training, job coaching, benefits counseling, and transportation. Supported employment services are to be integrated with the individual's mental health treatment. Enrollment in congregate day programs does not constitute supported employment.
- The State should expand upon the current community structure so as to create an effective statewide crisis system. The State should enhance crisis stabilization programs operated by community providers so that they provide psychiatric stabilization and detoxification services as an alternative to psychiatric hospitalization. The State should provide crisis apartments in the community to serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.
- The State should develop and implement criteria to assess the adequacy of the individualized supports and services provided to persons by CMHCs to see whether their efforts are: reducing repeated admissions to institutional settings; increasing the stability of community residences; increasing housing services to individuals who have serious mental illness and who are homeless; retaining employment and/or schooling; increasing supported housing; and increasing supported employment.
- The State should develop and implement a plan to promptly discharge all persons with a developmental disability at NHH and Glenclyff to an integrated community setting that meets their individualized needs, including their need for habilitation, health care, and, where applicable, mental health care.

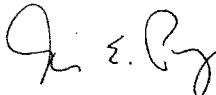
VI. CONCLUSION

Please be aware that this is a public document. Although we have already had some preliminary discussions about needed remedial steps, we now hope to engage the State in a more in-depth dialogue about remedies in the context of structured negotiations. Ultimately, we hope to be able to reach agreement with the State on a written, enforceable, voluntary compliance agreement that would set forth the remedial actions to be taken within a stated period of time to address each outstanding area. Such a disciplined remedial structure would provide all interested parties with the greatest assurance that discrimination will not recur.

If the State declines to enter into voluntary compliance negotiations or if our negotiations are unsuccessful, the United States may then need to take appropriate action, including initiating a lawsuit, to obtain redress for outstanding concerns associated with the State's compliance with the ADA. Nonetheless, as referenced above, we are encouraged by our interactions thus far with State leadership, and hope there is a desire to work with the United States toward an amicable resolution here.

Thank you again for your ongoing cooperation in this matter. We will contact you soon to discuss the issues referenced in this letter and to set a date and time to meet in person to discuss a remedial framework in which to address any outstanding individual and systemic concerns. If you have any questions, please feel free to contact Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393, or Richard Farano, the lead attorney assigned to this matter, at richard.farano@usdoj.gov, and/or (202) 307-3116.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: Anne M. Edwards
Associate Attorney General
Chief of Civil Litigation
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State of New Hampshire

Michael K. Brown
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Department of Justice
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John P. Kacavas
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District of New Hampshire

John Farley
Assistant United States Attorney
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U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530*

January 15, 2009

The Honorable Sonny Perdue
Office of the Governor
203 State Capital
Atlanta, Georgia 30334

Re: CRIPA Investigation of the Northwest Georgia Regional
Hospital in Rome

Dear Governor Perdue:

I am writing to provide the Civil Rights Division's second report of findings regarding our investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness or developmental disabilities who are treated in public institutions. The findings discussed in this letter apply particularly to the Northwest Georgia Regional Hospital in Rome, Georgia ("NWGRH" or "Facility"). Our first report, dated May 30, 2008, concerned the Georgia Regional Hospital in Atlanta ("GRHA").¹

On April 18, 2007, we notified you that we were initiating an investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to CRIPA. The State agreed that the Department's inspection of four of the State's hospitals would stand as representative of all seven hospitals in the system. We began our on-site inspections with a visit to GRHA on September 17 through 21, 2007. The visit to NWGRH was on October 29 through November 2, 2007, and the visit to the Georgia Regional Hospital at Savannah occurred on December 17 through 21, 2007. The visit to Central State Hospital in

¹ We note that many, if not all, of the findings we make regarding NWGRH are representative of conditions encountered at the two other hospitals we have inspected to date, the Georgia Regional Hospitals at Atlanta and Savannah.

Milledgeville was postponed, and we have not yet been able to find a mutually agreeable date for that visit. According to our agreement with the State, these four hospitals would be representative of the remaining State Psychiatric Hospitals, including Southwestern State Hospital, East Central Regional Hospital, and West Central Regional Hospital.

We conducted our on-site review with the assistance of expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, and discharge planning and community placement. While on-site, we interviewed administrative staff, mental health care providers, and patients, and examined the physical plant conditions throughout most, but not all, of the Facility.² In addition to our on-site inspection of NWGRH, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and grave concerns about NWGRH to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation

² As we noted in our May 30 letter, the State, asserting that CRIPA does not afford jurisdiction over admissions, intake, and "short-term outpatient" units, refused us access to such units at each of the hospitals we have visited thus far. The State's position is incorrect. See, e.g., 42 C.F.R. § 483.20 (2006) (describing the State's duty to provide physician orders for immediate care at the time of admission and to perform comprehensive assessments within fourteen days of admission). By law, our investigation must proceed regardless of whether officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigations. See H.R. Conf. Rep. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. As we informed the State's attorneys, the State's decision to deny us access to these areas permits us to draw negative inferences about conditions and practices in those units. See id. While we did not need to draw negative inferences in making the findings described in this letter, we reiterate that we are authorized to do so if the State continues to deny us access to these areas in the future.

pertaining to NWGRH, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at NWGRH violate the constitutional and statutory rights of its patients. In particular, we find that NWGRH: (1) fails to adequately protect its patients from harm; (2) fails to provide appropriate mental health treatment; (3) fails to use seclusion and restraints appropriately; (4) fails to provide adequate medical care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XVIII and Title XIX of the Social Security Act, 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid); Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d); Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; see also Olmstead v. L.C., 527 U.S. 581 (1999).

As we noted when we wrote concerning GRHA, the majority of the findings we have made have also been made by other agencies in the past. See, e.g., Peter Buckley, M.D., and Nan Lewis, M.P.H., Medical College of Georgia, Audit Summary - Northwest Georgia Regional Hospital - Rome, September 26, 2007 (describing deficits in protection from harm, mental health treatment, nursing staffing, risk management, and performance improvement); United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Survey of Northwest Georgia Regional Hospital at Rome, March 3, 2004 ("CMS Survey") (describing failure to meet federal regulatory standards in protection from harm, individualized mental health treatment, use of seclusion and restraints, and nursing services). Throughout this letter, we have included specific references to past findings by these entities, where appropriate. We found that these same conditions remain unabated, despite NWGRH's notice of the deficiencies.

Nearly a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities violates the law. Olmstead, 527 U.S. at 587. Olmstead involved two women with developmental disabilities and mental illness who were inappropriately confined at another of the State's Psychiatric Hospitals, GRHA. Id. at 593, 597. The Supreme Court held that states are required to provide mental health treatment to persons in the most integrated, appropriate settings. See id. at 596-97. In the wake of the Olmstead

decision, Georgia commissioned numerous studies of deficiencies in its community mental health care system, including: a February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); a January 2005 Study of the CSB Service Delivery System (Phase II); and a May 2005 Georgia Mental Health System Gap Analysis. As stated in the Phase II Study by the State's Department of Audits and Accounts, these studies "point to accountability, oversight, management, and quality of care issues." The finding that Georgia's high hospitalization and readmission rates compared to national averages persist, and are "evidence of a lack of community based services," was reiterated in the June 2, 2008 Governor's Mental Health Service Delivery Commission's Progress Report. Despite the mandate by the Supreme Court and the subsequent clear analysis and recommendations in Georgia's own reports, as indicated herein, our review of discharge planning at NWGRH finds that Georgia still frequently fails to ensure that patients receive appropriate and sufficient services to enable them to live in the most integrated setting consistent with their needs, as required by federal law.

I. BACKGROUND

Northwest Georgia Regional Hospital in Rome, Georgia serves residents of the 23 counties of northwest Georgia who have mental illness, substance abuse issues, and developmental disabilities. At the time of our visit, NWGRH had approximately 280 patients. Inpatient units included acute and long-term adult psychiatric units, forensic units, and units for persons with developmental disabilities.³ Approximately 100 patients reside on the developmental service units ("DSU"), which are the units for persons with developmental disabilities, approximately 70 patients reside on the forensic units, and the remainder reside on the adult mental health units. The Facility is located on a large campus that includes a number of additional programs not included in this review.

II. LEGAL STANDARDS

The Fourteenth Amendment due process clause requires state mental health care facilities to provide patients with "adequate food, shelter, clothing, and medical care," along with conditions

³ We note that, as with GRHA, the combination of populations at NWGRH is unusual for a psychiatric hospital. Each population and the combination of these populations present unique health, safety, and treatment concerns.

of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training, including treatment, as may be reasonable in light of their constitutionally-based liberty interests. Youngberg, 457 U.S. at 315, 319, 322.

In order to secure these liberty interests, individualized treatment must be provided to give patients "a reasonable opportunity to be cured or to improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975); D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997) (holding that the constitutional right to psychiatric care and treatment is triggered by the State's physical confinement of an individual with mental illness; the court noted the holding of Fifth Circuit cases, including Donaldson, which are binding upon the Eleventh Circuit if decided before September 30, 1981); see also Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

Treatment is not adequate if it "is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." Youngberg, 457 U.S. at 323. Patients have a due process right to have all major decisions regarding their treatment be made in accordance with the judgment of qualified professionals acting within professional standards. Griffith v. Ledbetter, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989).

In addition, patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16. States are also compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, it is not acceptable to rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188.

It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Id. at 1189. Seclusion and restraint should only be used as a last resort. Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980). Further, professional judgment should be exercised on a case-by-case basis regarding the most appropriate

setting in which individual patients should be placed. See, e.g., Thomas S., 902 F.2d at 254-55.

Additionally, patients in a psychiatric hospital have certain rights protected by federal statutory law. Specifically, the State must provide services and activities to patients at NWGRH that are consistent with Title XVIII and Title XIX of the Social Security Act and their implementing regulations. See 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid). Furthermore, the State must take reasonable steps to ensure that patients with limited English proficiency and sensory deficiencies are provided with meaningful access to programs and services. See Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; 45 C.F.R. § 80.3; Americans with Disabilities Act, 42 U.S.C. §§ 12132-12134.

Furthermore, Georgia must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); see Olmstead, 527 U.S. at 607 (holding that states are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities).

III. FINDINGS

Significant and wide-ranging deficiencies exist in NWGRH's provision of care. Certain conditions and services at NWGRH substantially depart from generally accepted professional standards and violate the constitutional and federal statutory rights of patients who reside there. In particular, we find that NWGRH: (1) fails to ensure the reasonable safety of its patients; (2) fails to provide adequate mental health treatment; (3) engages in the inappropriate use of seclusion and restraints;

(4) fails to provide adequate medical care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. Many of these deficiencies stem from a system that does not have clear, specific standards of care or an adequate number of trained supervisory, professional, and direct care staff.

A. NWGRH Does Not Adequately Protect Patients From Harm

Patients at NWGRH have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. NWGRH fails to provide a living environment that complies with this constitutional mandate. Specifically, patients at NWGRH are subject to self-injurious behaviors that are not responded to appropriately, particularly suicide attempts, and to frequent patient assaults that often result in serious harm. The Facility's ability to address this harm is hampered by inadequate incident and risk management, including deficient investigative practices.

1. Incidents at NWGRH Are Serious and Recurring

Our review of the incidents at NWGRH revealed that they are serious, recurring, and frequently result in grave harm. We highlight two areas where the problems are particularly acute: suicide ideation and attempts and patient aggression.

a. Suicidal Ideation and Attempts Are Not Addressed Appropriately

A significant number of patients are admitted to NWGRH for stabilization and protection because of suicidal ideation or attempts. We found a troubling number of incidents in which NWGRH failed to recognize signs of suicide risk and failed to take appropriate action. The following incidents illustrate the grave harm that has resulted from these failures:

- M.U.⁴ was transferred to NWGRH as an emergency involuntary admission on March 31, 2006, having refused to take her medications at a community-based residential services provider. Her admitting diagnosis was paranoid schizophrenia, and she also reportedly had a history of

⁴ To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

auditory and visual hallucinations. Documentation from her admission indicates that she denied present hallucinations, but she also stated that she believed she was under investigation. The admitting documentation also indicates that she refused to answer whether she was suicidal. Nevertheless, NWGRH placed her on routine observation. She was moved to a unit that evening. The next day, during room checks, M.U. was withdrawn, and NWGRH staff found her sitting on the floor of her room, rocking back and forth. That evening, when the unit was taken outside, M.U. climbed a tree and attempted to hang herself with her shoelaces. When that was unsuccessful, she dove head first out of the tree and died on impact.

- S.T. was admitted to NWGRH in October 2006, and he was noted to have a history of self-mutilation and suicide attempts. On October 19, 2006, just two weeks after his admission, S.T. went into a bathroom without any staff present after a staff member had given him a razor for shaving. S.T. removed the blade from the razor and slit his throat from ear to ear, resulting in four deep lacerations. Notably, although S.P. was placed on one-to-one observation following the incident, he was not reassessed for his emotional stability or risk of harm, and no treatment or behavioral interventions were made or modified.

Our review also revealed a number of incidents in which NWGRH failed to take appropriate corrective actions after the risk of suicide became evident. These examples illustrate a failure to intervene adequately to prevent future incidents:

- M.P. has lived on the DSU since 2004 and has a history of depression. On May 4, 2007, a staff member asked M.P. about an injury on his head, and M.P. alleged that he had been pushed into the wall by another staff member, striking his head. NWGRH initiated an investigation, which concluded that the allegation could not be substantiated. During interviews conducted pursuant to the investigation, however, three staff members reported that M.P. had threatened to kill himself earlier that day and was hitting his head against the wall in the dining room and his bedroom. None of the three staff members reported the suicide threats or self-injurious behaviors before the investigation. Moreover, even though the investigation recommended that the staff be retrained on reporting of suicidal threats and self-injurious behaviors, no referral was made to M.P.'s interdisciplinary team to reassess his current suicide risk

and to implement changes in his treatment and behavior plans.

- On June 16, 2007, D.I. attempted to strangle herself and was rushed to the emergency room. We found no evidence that this suicide attempt was reported or reviewed as required by NWGRH and State policies and generally accepted professional standards. Nor could we find any evidence that an investigation was conducted of the incident or that any corrective actions were taken.

b. Patient Aggression Is Not Controlled

Patient aggression is not adequately controlled at NWGRH. We found numerous instances in which patient-on-patient assaults resulted in serious injury to the victim, including fractures, lacerations, and head wounds, as the following examples indicate:

- A patient attacked K.Z. on September 25, 2007, and K.Z. suffered a laceration on his forehead that required sutures to close. On September 5, 2007, just 20 days earlier, a patient attacked K.Z., resulting in a cut above K.Z.'s right eye that also required sutures.
- In another assault in September 2007, a patient attacked A.W., fracturing his nose.
- On August 31, 2007, M.E. fractured his finger during a fight with another patient.
- Also on August 31, 2007, S.K. needed sutures to repair his left eyelid after an assault by another patient.
- Similarly, on August 23, 2007, E.Y. required sutures to close a cut on his left eyelid due to an assault. Five months earlier, on April 9, 2007, a patient attacked E.Y., and he sustained cuts to his face that required sutures.
- On July 3, 2007, a patient attacked K.I., resulting in cuts and bruises on K.I.'s scalp and left eyebrow and hearing loss in his left ear.
- When being assaulted by another patient on May 3, 2007, P.L. suffered a cut to the back of his head that needed sutures.
- On April 29, 2007, a patient assaulted K.R., and K.R. needed sutures to close the cut on his lip.

- A patient pushed K.H. to the floor on March 10, 2007, and K.H. hit his head, necessitating stitches to close the wound.
- On October 28, 2006, a patient hit C.D., fracturing his jawbone bilaterally.
- L.F. needed sutures to close a large wound to his scalp following an assault by another patient on October 1, 2006.

These examples also demonstrate the disturbing patterns we found in the patient-on-patient assaults, including repeat victims and units where patient aggression is particularly uncontrolled. E.Y. was attacked in both April and August 2007, resulting in significant lacerations, and K.Z. was attacked twice in September 2007, suffering similar injuries. Moreover, the two attacks on K.Z. both occurred on Unit 410, the same unit on which A.W. was assaulted, also in the month of September 2007. The repeated and significant level of violence on the units suggests a fundamental failure to address the root causes of patients' aggression and demonstrates a failure to intervene adequately to prevent future incidents.

2. NWGRH Provides Inadequate Incident and Risk Management

To protect its patients in accordance with generally accepted professional standards, NWGRH should have in place an incident and risk management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. NWGRH's policies and procedures indicate that NWGRH has developed incident and risk management protocols, including incident reporting protocols, that are consistent with generally accepted professional standards. Unfortunately, these protocols are not consistently implemented at NWGRH, and the actual incident and risk management system substantially departs from generally accepted professional standards. Specifically, NWGRH fails to report incidents in a consistent and timely fashion. Moreover, NWGRH fails to identify risks and to implement corrective actions, and performs inadequate investigations. As a result, patients are routinely exposed to actual and potential harm, as indicated previously.

a. Incident Reporting Is Incomplete and Untimely

The first necessary step to address harm like that at NWGRH is to ensure complete, accurate, and timely incident reporting. If incidents are not reported properly, NWGRH's ability to respond to harm or the potential for harm on both individual and systemic bases is significantly diminished. Our review found that incidents are frequently not reported in a timely manner and, in some instances, are never reported. These deficiencies expose NWGRH patients to harm, as the following examples demonstrate:

- D.J.'s attempted suicide, discussed above, was not reported or reviewed as required by NWGRH and State policies. As a result, no investigation was initiated and no corrective actions were implemented, increasing the likelihood that such an incident could recur.
- On September 9, 2007, a staff member noticed a large bruise on U.M.'s shoulder but did not report it, in violation of policy. Later that day, a second staff member noticed the bruise but did not report it, also violating policy. On the morning of September 10, 2007, a third staff member noticed the bruise but did not report it, violating reporting policies yet again. It was not until early in the afternoon of September 10, 2007, that a staff member noticed the bruise and reported it as required by policy. U.M. was diagnosed with a fractured left clavicle, and the investigation into the cause of the fracture revealed the three staff members' failure to report their observations.
- Our review of witness statements and progress notes dated August 10, 2007, revealed that O.N. had assaulted other patients every day for a week, but NWGRH's aggregate incident report data erroneously indicated that O.N. had not had an incident of aggression since May 14, 2007.
- On July 11, 2007, T.C. was allegedly unnecessarily and improperly restrained on the admissions unit. NWGRH did not report this incident to the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases ("MHDDAD") for five days, contrary to State policy.

- K.D., a patient with developmental disabilities, has a history of silent aspiration, dysphagia,⁵ and "handmouthing," where she places her hands in her mouth as a soothing mechanism. At approximately 4:30 p.m. on April 14, 2007, K.D. began exhibiting signs that she was choking. These signs continued and became so severe that at 6:00 p.m., the physician ordered increased supervision, vital sign measurements every two hours, and restricted her diet to ice chips. It was not until shortly after 8:00 p.m., however, when K.D. began to cough and gag repeatedly, that a staff member reported to the nurse that at approximately 4:00 p.m., when K.D. was moved from her bed to her wheelchair, a few broken hair barrettes were observed on her sheets. K.D. was immediately sent to a local hospital for observation, and was readmitted to the local hospital twice over the following two days for aspiration pneumonia. X-rays revealed a metallic object in her gastric area, and at least two broken barrettes were removed during surgery. The failure to immediately report the broken barrettes on K.D.'s bed is troubling, especially given the level of harm suffered. More troubling, however, is that this incident was never reported as the ingestion of inedible objects, known as "pica," and was thus not included in the Facility's aggregate data on pica incidents. Moreover, a safety plan addressing this risk was not completed until June 2007, nearly two months after the incident took place.
- U.N. is a patient with a significant history of choking, aspiration, and pica. On February 10, 2007, a NWGRH staff member left U.N. unattended during breakfast. When the staff member returned, she noted that U.N. had food on his face, but the paper cup holding the food was missing. At 9 a.m., a nurse attempted to give U.N. his medications, but he repeatedly spit them out. When the nurse inquired whether U.N. had eaten his breakfast, the staff reported that he had not eaten well and spilled his tray. It was not until the nurse asked to see U.N.'s tray and inquired about the cup that the staff member reported that the cup was missing. U.N. was placed on close observation, and was eventually sent to the local hospital. After returning briefly to NWGRH, U.N. began vomiting and was returned to the hospital. NWGRH and the local hospital both concluded that U.N.'s symptoms were due to the ingestion of the cup.

⁵ Dysphagia is the medical term for difficulty in swallowing.

The failure to report the missing cup immediately, given U.N.'s history of pica, placed him at significant risk of harm.

Without reliable and timely data regarding incidents and injuries, NWGRH is incapable of responding appropriately to prevent future harm. Moreover, NWGRH has repeatedly been put on notice of its failure to report incidents, and to report incidents in a timely manner, by the State itself. The State's own investigative findings and corrective action recommendations, made by MHDDAD, consistently note these failures, and yet they persist:

- On March 21, 2007, the State recommended that a staff member receive additional training on the reporting of incidents, and also receive counseling regarding her fears of retaliation if she reported incidents.
- On March 28, 2007, the State required NWGRH to submit a Plan of Correction describing the steps NWGRH would take to ensure that incidents are reported in a timely manner.
- On May 7, 2007, the State required NWGRH to submit a Corrective Action Plan describing the steps NWGRH would take to retrain staff members on reporting of critical incidents, and particularly allegations of abuse.
- On May 16, 2007, the State reported that an allegation of abuse was not reported promptly in violation of procedure. Because this allegation was not timely reported, procedures for immediately removing staff from client contact while an investigation was conducted were not followed.
- On May 31, 2007, the State reported that NWGRH staff failed to report a suicide threat.
- In an August 13, 2007, report, the State observed that allegations of physical abuse were not reported, and that when they were reported, it was not in a timely manner. According to the report: "This is a repeat recommendation to NWGRH. This issue was most recently noted as a concern by this investigator in a report dated June 22, 2007."

NWGRH's failure to report incidents and injuries in a consistent and timely manner, especially after it has been notified of this failure repeatedly by the State, substantially departs from generally accepted professional standards.

b. Risk of Harm Is Not Identified and Sufficient Preventive Actions Are Not Taken

Incident management focuses on the collection and aggregation of data that are meaningful to protect an individual from harm, while risk management focuses on identifying actual or potential harm from that data and taking timely action to prevent the harm from occurring or recurring. Generally accepted professional standards dictate that a facility's risk management program: (1) identify actual or potential risks of harm based on historical data, diagnoses, and co-occurring conditions; (2) develop timely and appropriate interventions designed to reduce or eliminate the risks of harm; and (3) monitor the efficacy of the interventions and modify them as necessary in response to further data. NWGRH's risk management program fails to meet these standards.

As an initial matter, NWGRH fails to identify actual or potential risks of harm through analysis of historical data. For example, more than half of NWGRH's patients identified as having pica behaviors in 2007 reside on one unit. In 2007, these six patients ingested batteries, buttons, paper clips, crayons, and cleaning fluid. These patients have been treated at the local hospital on at least four occasions after ingesting an inedible object. Despite the potential for harm, during our visit to this unit we observed that numerous objects, including objects similar to those ingested, were easily accessible to the patients. Most troubling, we observed one patient at risk for pica attempting to obtain an item that easily could have been swallowed.

NWGRH also fails to implement appropriate interventions and corrective actions in a timely manner, as demonstrated by the following examples:

- On August 3, 2007, S.Q. eloped from his unit and was later discovered outside another building on campus. His interdisciplinary team was assigned to address this issue, but no corrective action had been taken by the time of our tour on October 29, 2007, nearly three months later.
- On July 23, 2007, F.L. fell when a staff member attempted to transfer him to a wheelchair. We found no record that the staff member had been trained on proper transfer techniques as of October 29, 2007.
- On July 6, 2007, S.L. fell during a transfer from his wheelchair to the bathing trolley, but corrective actions

were not completed until September 11, 2007, more than two months later.

- On June 25, 2007, K.K. eloped from the same unit that S.Q. eloped from later in the summer. The unit leader was required to address the failures in supervision that permitted K.K. to elope and to ensure that all staff understood their supervisory responsibilities. These corrective actions were not recorded as complete until August 10, 2007, a week after K.K. eloped again, and a week after S.Q.'s elopement from the same unit.

The failure to identify patients at risk of harm and to complete corrective action plans in a timely manner jeopardizes NWGRH's ability to protect patients from harm, and is a substantial departure from generally accepted professional standards.

c. Investigative Practices Are Inadequate

Generally accepted professional standards dictate that facilities like NWGRH investigate serious incidents such as alleged abuse and neglect, serious injury, attempted suicide, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures. The investigative report should set forth the evidence considered, including all interviews conducted and documents reviewed, and it should clearly state the conclusions reached and the reasons for those conclusions.

The investigative process at NWGRH substantially departs from these standards. We found instances in which serious incidents and injuries, including attempted suicide, were not investigated at all. In addition, we also found instances in which critical evidence was not collected or considered, significantly diminishing the quality of the investigations. Failing to collect and consider significant relevant information is a substantial departure from generally accepted professional standards in performing investigations. The following investigations each illustrate these failures:

- As previously discussed, U.M. suffered a fractured clavicle on September 9, 2007. The investigative report into this incident does not include critical relevant information. In particular, it does not include any account of the events

that may have led to this injury. Moreover, there is no evidence that the investigator questioned U.M. about his injury or how it occurred. Ultimately, the report never determines what caused U.M.'s fractured clavicle.

- After M.U.'s suicide, discussed previously, NWGRH undertook a Root Cause Analysis ("RCA") to determine whether any measures could have been taken to prevent it. The RCA concluded that all policies and procedures had been followed, and staffing ratios were sufficient. The RCA bases this conclusion, in part, on its finding that neither the admitting hospital nor M.U. herself clearly indicated her suicidal ideation. The RCA does not appear to consider, however, that M.U. was admitted under the code for "Dangerous to Self Due to Mental Illness," and that this was the reason for her involuntary admission to the hospital and NWGRH. This status suggests that significant precautions should have been, but were not, taken.
- On February 2, 2007, N.L. alleged that she was struck by a staff member. There is no evidence in the investigative report, however, indicating that N.L. was examined by a nurse or other medical professional to determine whether she had an injury consistent with her allegation. Without considering this potentially critical evidence, the report instead concludes that the allegation could not be substantiated based on the staff member's denial and the supporting statement of another staff member.

Our review of the investigation into N.L.'s abuse allegation also revealed other troubling practices that substantially depart from generally accepted professional standards, and these practices unfortunately characterized other investigations we reviewed at NWGRH as well. First, the investigative process was not initiated in a timely manner. Although the alleged abuse occurred on February 2, 2007, the investigation did not commence until February 15, 2007, nearly two weeks later. The failure to investigate promptly impairs the collection and preservation of evidence and delays the implementation of corrective action that may prevent future harm. Second, the investigation included certain inconsistencies that raise doubts about its accuracy and thoroughness. The investigative report is dated February 21, 2007, but it includes a staff interview that is stated as having occurred on March 1, 2007. It is troubling that an apparently relevant staff interview may not have been conducted until after the report's conclusions were already reached.

B. Mental Health Care Is Inadequate

NWGRH patients have a constitutional right to receive adequate mental health treatment. Donaldson, 493 F.2d at 520. The mental health services at NWGRH, however, substantially depart from generally accepted professional standards. Psychiatric practices are marked by inadequate assessments and diagnoses, which in turn, lead to inadequate treatment planning and delivery of inadequate treatments and interventions. Contrary to generally accepted professional standards, treatment planning is not person-centered, individualized, or integrated across disciplines. Psychology services, physical, nutritional and speech therapy, and behavioral management services are particularly deficient. Medication practices and emergency services are inadequate. Each of these failures affects the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Many of these deficiencies directly threaten patients' physical health and well being as well. Moreover, as was also the case at GRHA, NWGRH's failure to treat a patient's mental health needs while hospitalized has frequently led to failed discharges and to repeated hospitalizations.

In accordance with generally accepted professional standards, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. Treatment plans should define the goals of treatment, the interventions to be used in achieving these goals, and the manner in which staff are to coordinate treatment. The treatment plans should also detail an integrated plan designed to promote the patient's stabilization and/or rehabilitation so that the patient may return to the community. Taken together, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are critical to a hospital's ongoing efforts at quality improvement.

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the

treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

NWGRH treatment planning substantially departs from these standards. From initial diagnosis and assessment to the development of skills and functioning necessary for recovery and community reintegration, NWGRH's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; and patients are at increased risk of relapses and repeat hospitalizations. Further, patients' options for discharge are significantly limited, resulting in unnecessarily prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

1. Psychiatric Assessments and Diagnoses Are Inadequate

Mental health treatment begins at the time of admission. An admissions work-up is an integral part of the course of hospitalization; it establishes the initial diagnosis and begins the course of treatment for patients as they begin their hospital stay. We noted many deficiencies in the initial assessments we reviewed. Assessments were often not timely or thorough. Fatal harm can result from a failed assessment: M.U., discussed previously, received no suicide risk assessment before being given access to a courtyard area where she killed herself.

An effective treatment plan begins with a diagnosis that is clinically justified. If mental health professionals do not correctly identify a patient's psychiatric condition before developing a treatment plan, the treatment interventions will not be aligned with the patient's needs. Thorough assessments are necessary to identify presenting problems and strengths and needs of the patient, and to identify potential risks from aggressive or self-injurious behavior, potential victimization, substance abuse, or certain medical conditions. Adequate assessments are essential to the development of a person-centered plan that can direct rehabilitation, treatment, and care while the patient resides in the hospital, and to formulate an adequate discharge and transition plan for the patient's return to the community. Psychiatry, medicine, nursing, psychology, and social work should

each contribute to the assessment in accord with generally accepted professional standards.

At a minimum, an initial assessment should include: (1) an adequate review of presenting symptoms and the patient's mental status; (2) a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the patient and others. As more information becomes available, the assessment must be updated to include: (1) a history of the presenting symptoms from the patient based on the patient's level of functioning and from collateral sources, as available; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's biopsychosocial functioning; (4) a review and critical examination of diagnostic conclusions made in the past in light of new information; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

In many cases, initial assessments at NWGRH are incomplete. The majority of records reviewed at NWGRH lack assessments of social, vocational, functional, educational, and independent living skills. They also uniformly fail to assess history of community living and prior placements. These inadequacies are especially troubling for patients with a history of failed discharges and frequent re-admissions. Each of these deficiencies in assessment creates a serious impediment to the treatment team's ability to identify the services and supports a patient may need while in the Facility and upon discharge. An example of inadequate assessments includes:

- E.G., who has a diagnosis of schizoaffective disorder and mild mental retardation, resided at NWGRH from April through August 2007. Eighteen previous placements in different foster homes were disrupted by her aggressive behaviors. NWGRH did not perform a functional assessment to identify possible reasons for these behaviors or to develop a behavioral plan. E.G. received 31 PRN⁶ medications during this admission, with one only two days before her discharge, and continued to have incidents of aggression and property destruction. Her treatment plan was not adjusted to address

⁶ PRN, or pro re nata, medications are dispensed on an "as needed" basis.

her aggressive behavior. Thus, one of the primary problems presented at admission - E.G.'s aggressive and maladaptive behavior - was not assessed, not treated, and appeared not to be resolved at discharge.

NWGRH patients are routinely given tentative and unspecified diagnoses (including "rule out" and "not otherwise specified" ("NOS") diagnoses) as a result of these flawed assessments. We found virtually no evidence of further assessments or observations to finalize the diagnoses. Because different psychiatric conditions can have similar signs and symptoms, it is important for mental health professionals to address NOS diagnoses to ensure that a patient's treatment is appropriate for his or her actual mental health needs. At NWGRH, however, NOS diagnoses persist for months and over multiple admissions, with no sign of further diagnostic testing or refinement. The prevalent use of the "NOS" diagnosis reflects an inadequate diagnostic evaluation process and contributes to the lack of specificity in treatment plans. For example:

- N.Y. has had numerous diagnoses over the course of 16 admissions, and his stays are characterized by frequent agitation and clinical instability. There is no evidence that the Facility conducted psychological testing to clarify his diagnosis and, thus, target treatments more effectively.
- K.R. has a diagnosis of psychosis NOS, and her treatment has not changed significantly over the course of more than 50 admissions.

NWGRH's failures in the preliminary stages of assessment and diagnosis, as well as its failure to reassess patients to refine diagnoses, substantially depart from generally accepted professional standards. Patients receive or are at risk of receiving treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses. The result is that the actual mental illness is often unaddressed, placing patients at risk of prolonged institutionalization and/or repeated admissions to the Facility.

2. Treatment Planning Is Inadequate

a. Treatment Plans Are Not Individualized or Patient Centered and Do Not Address Patients' Needs

Treatment plans, which at NWGRH are called Individual Recovery Plans ("IRP") or Individual Habilitation Plans ("IHP"), are, for the most part, inadequate and fall far short of

generally accepted professional standards. They are frequently minimalist, generic, and reflect neither the true scope of patients' needs nor an integrated, coherent plan for treatment. Surveys by the Centers for Medicare and Medicaid Services documented incomplete assessments that result in incomplete and generic treatment interventions. See e.g., March 3, 2004 CMS Survey (treatment plans for 11 of 11 patients lacked comprehensive and individualized interventions). When the treatment team fails to identify or address all of a patient's presenting concerns, that patient is deprived of treatment for those concerns, and frequently subject to a longer period of institutionalization or to a repeat admission when those conditions or behaviors become barriers to successful community integration. Even worse, treatment plans at NWGRH often reflect contradictory plans of care. Treatment plans do not reflect interdisciplinary planning and corroboration, and contradictory assessments from different disciplines are neither addressed nor reconciled. Examples of deficient IRPs include:

- K.J. was re-admitted in July of 2007, one month after his last discharge. His diagnoses included depressive disorder and cocaine dependence. He received no treatment for substance abuse while in the Facility, and no referral to substance abuse services in the community. He was homeless at the time of this admission, and was discharged to a hotel.
- T.C., on her 44th admission to NWGRH, had been at the Facility for six weeks at the time of our visit. She had not participated in any active treatment, and had not been referred for a behavioral assessment, yet received PRN medications for disruptive behavior 13 times in a month.
- M.L. has a diagnosis of depressive disorder and anxiety disorder and was receiving two psychotropic medications, Buspar and Lexapro, presumably to address these disorders, yet his behavioral support plan ("BSP") does not address any behaviors or symptoms associated with depression or anxiety.
- F.C.'s communication assessment notes that he is considered "nonverbal," yet his behavior plan suggests that he "request social attention by speaking to others."
- K.I.'s annual communication assessment recommended no formal communication training; at the same time, his behavioral assessment found that his challenging behaviors served to elicit attention and gain access to desired activities, which are maladaptive means of communicating.

As discussed supra, Section III.B.1, inadequate assessments that fail to discern the reasons for multiple re-admissions, and treatment plans that fail to address relevant clinical presentations in a specific, individualized, strengths-based, and recovery-oriented manner have resulted in repeated failures of treatment at NWGRH and the subsequent failure to succeed in the community. Multiple re-admissions are extraordinarily costly to patients and the system. Frequent relapses may cause a progressive worsening of a patient's mental illness and make the patient more intractable to treatment. Multiple re-admissions are also costly to the system of care, resulting in multiple assessments, care plans, and other treatments, where one adequate provision of these services would have sufficed.

Treatment plans at NWGRH often provide no clear alternatives if the initial, vague interventions prove ineffective, leaving staff with few alternatives to restraint, seclusion, and PRN medications to address challenging behaviors. We typically found generic treatment objectives for patients with psychotic diagnoses and substance abuse diagnoses. The recurrence of near-identical goals and objectives for so many patients makes evident the non-individualized nature of NWGRH's treatment plans.

NWGRH does not provide sufficient treatment programming to patients, as noted by the State's own audit, which found "a fair amount of patient inactivity and sleeping on the units." NWGRH also fails to intervene when patients do not participate in even the limited number of treatment groups available. For example:

- F.O. attended none of the 35 groups scheduled in one week; his treatment team took no notice.
- B.T. attended no activities according to his QMRP quarterly review, although he was credited with 100% attendance and engagement levels, contradictory findings that apparently were not challenged by his treatment team.
- T.C., noted above, did not participate in active treatment for the first six weeks of her current admission, which was her 44th.

The lack of meaningful treatment and habilitation services for patients on the DSU, where the majority of the patients may need behavioral supports, is particularly problematic. A sense of staff complacency pervades the DSU, where patients' limited skills or challenging behaviors seemingly are accepted by staff as unchangeable, and is reflected in the inadequate treatment

plans and interventions for the patients of these units. For example:

- N.C.'s person-centered planning meeting was held without her, even though N.C. is described as a "very effective communicator via verbal productions" with excellent receptive language skills. The record also shows no participation by any family member, advocate, guardian, or direct care staff who knows N.C.
- None of T.M.'s training goals are related to the choices identified in her ISP, which is not surprising, given that neither T.M. nor any direct care staff participated in her person-centered planning meeting.
- K.I.'s plan includes only two training goals: one, within two years to be able to point to his pill and state its purpose; and two, within three years to fill out a mock check. The expectation of such slow and limited progress indicates unreasonably low expectations for K.I. Moreover, this plan ignores K.I.'s clear need for communication training to provide appropriate ways to express his preferences. His behavioral assessment hypothesizes that his challenging behaviors are associated with attempts to access preferred activities, that is, to communicate what he'd like to do.

The State's own audit also noted a concern with low hours of active treatment and patient interaction on the DSU. NWGRH's failure to provide adequate treatment to DSU patients is exacerbated by clinically outdated and unsupportable opinions about patients with developmental disabilities. For example, G.L.'s diagnoses include "behavior problems secondary to mental retardation." To conclude that challenging behaviors are an inherent and unchangeable part of the condition of mental retardation is a gross deviation from generally accepted professional standards, and suggests a lack of training and competency regarding current practices. Because of this commonly-held view at NWGRH, these behaviors are not addressed, patients are deprived of effective treatment, and these behaviors become a justification for continued institutionalization. This is an egregious violation of these patients' rights.

b. Failure to Address Repeated Admissions

High rates of re-admission at the Georgia Regional Hospitals are well documented. Audits commissioned by the Governor, including the 2005 Georgia Mental Health Gap Analysis study,

concluded that a 30-day readmission rate 55 percent greater than the national average contributed to overburdening the State's Psychiatric Hospitals. These conditions persist.

The work of admitting patients and providing the crisis stabilization necessary for new admissions leaves an already overburdened system with fewer staff resources to provide treatment planning, interventions, and supervision for patients. Moreover, frequent re-admissions are extremely detrimental to these individual patients, disrupting their recoveries and their lives in the community. Frequent relapses and re-admissions may progressively worsen a patient's serious and persistent mental illness and make patients more intractable to treatment. Thus, generally accepted professional standards demand that treatment teams routinely examine and address issues that cause patients to be admitted repeatedly to the hospital. However, in multiple cases of repeated admissions, we saw no evidence that the treatment team examined or addressed the factors that led to re-admission and altered the patient's treatment from a previous stay at the hospital. For example:

- K.T. was admitted for the fourth time on October 27, 2007, and was discharged, still grossly psychotic, two days later. His previous admission was just a month earlier, when he was discharged after just three days to a homeless shelter. At the time of that third admission, his team expressed the "hope" of identifying permanent housing such as a group home. But he was nonetheless discharged to a shelter without the supports of a group home, an unsuitable discharge that led to his fourth admission.
- K.J., discussed above, was also re-admitted within one month of his prior discharge. Despite diagnoses of depressive disorder and cocaine dependence, he received no treatment for substance abuse while institutionalized, and no referral to substance abuse services in the community.
- T.C., on her 44th admission to NWGRH, had not participated in any active treatment, and had not been referred for a behavioral assessment six weeks into her current hospitalization, despite frequent episodes of disruptive behavior and resulting restraint and administration of PRN medications.
- N.Y. was hospitalized for the 7th time in 2007 alone, yet his files contained no clinical information from prior hospitalizations to guide the team in understanding the

course of his illness and possible reasons for his repeated admissions.

c. Treatment for Substance Abuse Is Inadequate

There is a stark lack of treatment for patients with co-occurring diagnoses of substance abuse. It was evident in a significant number of records that this issue was one of the most serious impediments to community placement and part of the reason for frequent re-admissions to the hospital. In addition to lack of treatment in the Facility, we did not find a single referral for community substance abuse treatment in the discharge plans we reviewed for patients with a substance abuse problem. Among the more egregious examples were:

- N.T., with diagnoses of schizoaffective disorder and opiate dependence, reported using heroin for the past nine months. She was discharged following her 19th admission to the home of a family friend.
- K.U., with diagnoses of psychotic disorder, mood disorder, alcohol dependence, cocaine dependence, opiate abuse, and alcohol withdrawal, reported that he lived in an environment that was "drug infested." He was nonetheless discharged after ten days with no connection to substance abuse treatment.

The lack of substance abuse programming and its deleterious effects on patients at NWGRH is well known to hospital and State administrators. CMS cited NWGRH on February 7, 2007, for failing to provide adequate discharge planning in the case of a patient discharged with a bus ticket, a boxed lunch, and the address of an out-of-state shelter, but no provision for follow-up psychiatric care or substance abuse programming. We found numerous instances of similarly deficient discharge planning in our visit more than eight months later. In a pattern that echoes the failure of accountability throughout this system, the Facility's Chief of Social Work was unfamiliar with the plan of correction submitted to CMS that promised monthly audits of discharge plans overseen by the Chief of Social Work.

3. Behavioral Management Services Are Inadequate

a. Behavioral Services Are Not Timely

Behavioral support plans ("BSPs") at NWGRH are largely nonexistent, and those that exist are largely inadequate and not well integrated into overall treatment. Many patients who were

repeatedly subject to seclusion, restraint, and/or administration of PRN medications - measures that should be reserved for emergency crisis intervention - have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Routinely, even when a treatment team makes a recommendation for a BSP, these plans are not developed and implemented in a timely manner. Examples of failure to provide, or of inordinate delay in providing behavior management services include:

- N.Y., on his 7th admission in 2007, was subject to repeated PRNs and restraint, but had no behavior supports consistently in place.
- K.Q., whose challenging behaviors include rectal digging, aggression, and agitated movement (which his treatment team characterizes as "buck dancing"), waited nine months from referral to approval of a BSP.
- O.N., whose challenging behaviors include self-injury and physical and verbal aggression, showed marked increases in problematic behaviors in May, June, and August 2007, while his BSP remained "under development." The BSP had not been implemented by the time of our tour in late October.
- T.C. received multiple PRN medications and restraints due to agitation and aggression over a six-week period, but attended no active treatment and received no counseling; at the time of our tour, she had not been referred for an individual behavioral intervention.
- Q.M.'s treatment notes indicate that she does not understand her treatment and is confused and disorganized. She had received frequent PRNs during her year-long hospitalization, yet the hospital had not provided her with a functional assessment or behavioral treatment plan. We saw no evidence that her treatment plan had been adjusted despite her poor response to the current plan.
- D.D. was administered emergency medications at least nine times during the four months he waited for NWGRH to develop a BSP.
- A behavior specialist prepared a BSP for G.L. in May 2006, but it was not approved and implemented for more than five months. During this wait, G.L. continued to harm himself frequently.

- K.C. was admitted in January 2007, in part, because of unmanageable behaviors at home. While at the Facility, he continued to engage in self-injurious behaviors and physical aggression, behaviors that were noted by his treatment team in its monthly reviews. Despite continued maladaptive behaviors, and significant spikes in these behaviors in May and August, no behavior support plan was developed for more than nine months.

b. Behavioral Plans Are Not Modified Appropriately

For those few patients with behavioral management plans, treatment teams routinely fail to revise those plans, notwithstanding evidence of continuing or escalating problem behaviors. For example:

- G.L., whose BSP was delayed for more than five months in 2006, continued to engage in self-injurious behavior frequently in during the first quarter of 2007. Nonetheless, his QMRP Quarterly review for that quarter recommended "[n]o changes at this time." His substantially increased aggression and episodes of taking others' food in the following quarter drew the same response from his team: "Continues current programing . . . [N]o changes at this time."
- K.Y. showed an onset of physical aggression and increased verbal aggression in the first two quarters of 2006, yet his BSP was not revised; his current BSP states that he "has displayed neither maladaptive behaviors nor depressive or psychotic symptoms since his admission . . .," an assertion clearly inconsistent with this record.

NWGRH has too few skilled psychologists and behavioral specialists on staff to develop and monitor adequate behavior management plans for the many patients whose behaviors suggest a compelling need for such plans. At the time of our visit, the Chief of Psychology's caseload included 110 patients on the mental health units, plus 105 patients on the DSU. Generally accepted professional standards would require at least five more psychologists to service these units. Two forensic psychologists were responsible for 67 forensic patients and all necessary court evaluations. A total of six behavior specialists were also assigned to the units. Generally accepted professional standards require the work of the behavior specialists to be supervised by a doctoral-level psychologist - adding to the psychologists' already-impossible workload.

c. Behavioral Plans Substantially Depart From Generally Accepted Professional Standards

The few behavioral assessments in place at NWGRH substantially depart from generally accepted professional standards. In some cases, patients with behavior plans had no functional assessments of the problematic behaviors to support the behavior plan. In others, the functional analysis was deficient in one or more significant ways: many failed to hypothesize the function of the challenging behavior; did not consider antecedent, environmental, or health factors that influence a behavior; did not contain sufficient baseline data; failed to identify target or replacement behaviors; and suggested inappropriate and even dangerous replacement behaviors. These inadequacies in behavioral assessments undermine all subsequent behavioral treatment planning. Examples include:

- L.Q.'s BSP suggests that, as a replacement behavior for his aggression, L.Q. should stand up, move around, and "feel[] around the walls" as an indication that he wishes to go for a walk. L.Q. is legally blind. The suggested replacement behavior to "feel[] around the walls" is demeaning and deviates grossly from generally accepted professional standards.
- L.Q.'s BSP also suggests that rectal digging may be an appropriate self-stimulatory behavior to engage in when he is in a private place. Encouraging as a replacement behavior an activity that can easily lead to injury or illness evidences questionable clinical judgment.
- BSPs for Y.B., K.C., and G.L. include the planned use of manual holds or restraints, a gross departure from generally accepted professional standards.

NWGRH fails also to collect sufficient behavioral data on which to base treatment decisions, and staff told us that no data at all are collected on replacement behaviors. Generally accepted professional standards require a mental health professional to analyze objective data concerning symptoms or behavior, and not merely anecdotal information. The lack of accurate behavioral data hinders accurate evaluation of the progress, or lack of progress, made by patients. Accordingly, actions by treatment teams are often based on inaccurate and limited data, leaving teams at risk of making decisions that are not clinically indicated. Examples include:

- D.I. has a behavior plan to reduce his intrusiveness, and his prior treatment plan included a communication goal to "verbally express wants, needs, and feelings with intelligibility." His new plan discontinues the communication goal without addressing whether he had made any progress. Improved communication skills could help reduce maladaptive, intrusive behaviors, and the team's decision to drop that goal does not appear to be based on objective data.
- O.N.'s BSP cites baseline data from a previous admission in 2005-06, and includes no data from his current admission, even though he had been at the Facility for at least four months in 2007.
- The replacement behaviors on F.C.'s BSP are identical in 2005 and 2007, although there are no data to determine whether he has made any progress in acquiring replacement behaviors. The data on his target behaviors, however varies widely, suggesting that whether or not he acquired replacement behaviors, they were not serving the purpose of reducing maladaptive target behaviors.

Behavioral data in individual charts is not current, and appears typically to be updated only annually. The failure to implement timely behavioral supports, to evaluate and revise behavior plans as clinically indicated, and to collect objective data with which to support clinical decisions are all egregious departures from generally accepted professional standards.

C. Seclusion and Restraints Are Used Inappropriately

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, the State may not subject patients of NWGRH to seclusion and restraint "except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training." Id. at 324. Generally accepted professional standards require that seclusion and restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. NWGRH's

use of seclusion and restraints, including medication used as a chemical restraint, substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of seclusion and restraint, and the fact that these measures restrict patients' rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like NWGRH reduce their use of seclusion/restraint by addressing behavior problems with less intrusive and restrictive strategies. We found that, while NWGRH has reduced the use of physical restraint and seclusion - which is commendable - the use of chemical restraint remains high, and when physical restraint and seclusion are used, the time periods that patients are subject to them is excessive.

Throughout the Facility, staff effort is focused primarily on controlling patients rather than treating them and replacing their maladaptive behaviors. On the adult mental health units, for example, only two of the 110 patients had behavior plans, despite many instances of challenging behaviors. Untrained staff lack the skills necessary to handle the large number of highly challenged patients who are dangerous to themselves or others or who have specialized needs. Not surprisingly, we found that in these difficult circumstances, staff resort to seclusion, restraint, and, secondarily, PRN medication, in lieu of appropriate treatment. Restrictive interventions clearly are used in place of active treatment, as punishment, and for the convenience of staff at NWGRH, contrary to generally accepted professional standards.

Use of antipsychotic medications for behavior control is chemical restraint. We found numerous instances where medications are being used as a form of behavior control, rather than as form of treatment for symptoms of psychosis. In many of these instances, the patient had no behavioral treatment plan, or the existing behavior plan was not utilized sufficiently. For example, N.Y. has been given multiple PRN medications for behavior control, including Ativan, Zyprexa, Thorazine, Geodon, and Haldol. N.Y. did not have a behavioral treatment plan in place when he was given any of these medications. The use of medications as chemical restraint, especially when there is no behavioral treatment plan in place, is a substantial departure from generally accepted professional standards. Moreover, the use of medications for these purposes has a significant potential for harm because of the side effects linked to exposure to antipsychotic medications, including irreversible motor

disorders, such as tardive dyskinesia, and the inability to control levels of glucose and lipids in the blood.

Furthermore, in a significant departure from generally accepted professional standards, NWGRH does not ensure that seclusion and restraints, including manual holds and PRNs, are used only as a last resort and not in the place of active treatment, as punishment, or as a convenience for staff. In some BSPs, such as those of Y.B., K.C., and G.L., restraints are written right into the program.

Our review also noted that, while the use of physical restraints and seclusion at NWGRH is relatively low compared to the other State Psychiatric Hospitals we visited, the duration of the restraint or seclusion is often extended. The following uses of mechanical restraint illustrate their extended use at NWGRH:

- On September 14, 2007, L.C. was mechanically restrained for four hours; the day before, L.C. was also mechanically restrained for four hours. On September 11, 2007, just two days previous, L.C. was mechanically restrained for eight hours, while the day before she was mechanically restrained for nearly three and a half hours;
- On September 13, 2007, N.G. was mechanically restrained for nearly three hours;
- K.R. was mechanically restrained for three and a half hours on August 25, 2007; he had previously been restrained for the same length of time on April 28, 2007;
- On May 13, 2007, E.G. was mechanically restrained for over two and a half hours; she had previously been restrained for three hours and 15 minutes on April 17, 2007;
- T.I. was mechanically restrained on April 28, 2007, for four hours;
- On April 15, 2007, B.M. was mechanically restrained for nearly seven and a half hours; and
- On April 4, 2007, O.D. was mechanically restrained for nearly ten hours.

As with mechanical restraints, use of seclusion at NWGRH, when used, is often extended:

- On September 10, 2007, L.C. was held in seclusion for four hours; as noted above, over the next four days L.C. also spent nearly 20 hours in mechanical restraints;
- On July 4, 2007, K.N. was held in seclusion for seven hours and 45 minutes; and
- On June 30, 2007, S.N. was held in seclusion for seven hours.

The extended use of mechanical restraints and seclusion at NWGRH suggests that they are not being terminated as soon as the person is no longer a danger to himself or others. The failure to terminate the use of mechanical restraints or seclusion when the person is no longer a danger is a substantial departure from generally accepted professional standards.

In addition, contrary to generally accepted practices, we found insufficient review of restrictive programs by the Facility's human rights committee, and inappropriate exclusion from treatment as a punishment for problem behaviors. Examples include:

- S.K. was restricted from day treatment for one week because he tried to kiss a staff member.
- U.W. was restricted from day programs because he brought cigarettes back to the unit.
- B.R.'s behavior contract includes "24 hour social isolation" and "24 hours media restriction" that do not appear to have been approved by the human rights committee.

D. Medical Care Is Inadequate

Although NWGRH patients are entitled to receive adequate health care, see Youngberg, 457 U.S. at 315, the Facility's basic medical care and nursing services substantially depart from generally accepted professional standards. NWGRH, like GRHA, fails to provide basic medical care and has inadequate clinical oversight, pharmacological practices, medication administration, infection control, physical and nutritional management, emergency preparedness, and staffing. Our findings regarding medical care echo many of those previously made in the State's own survey by the Medical College of Georgia.

1. Inadequate Clinical Oversight

The major role of clinical oversight in any institution is to ensure that generally accepted professional standards of practice and accountability are maintained. These standards require that nursing departments have a nursing and medical quality assurance program. Such a program provides internal monitoring for a nursing department and permits a facility to identify its problematic areas and correct them. A regular review of provided services also allows the nursing department to ensure that the services it purports to provide are those that it actually provides.

A quality assurance program for nursing consists of a number of monitoring instruments that measure the quality of care and services that are provided by the nursing department. These data are then regularly reviewed, analyzed, tracked, and trended. For areas that yield a low level of compliance, a plan of correction should be developed and implemented to increase the compliance rates for areas that are found to be deficient. Monitoring permits nursing management and facility administration to be aware and responsive to the needs of a department. It also assists nursing management in determining what types of interventions are needed when problem areas are identified and in tracking outcomes after interventions have been initiated.

NWGRH's nursing department does not have a program that monitors, tracks, identifies trends, and recognizes when a particular system is in need of corrective action. The data provided in response to our request for all nursing monitoring data, which was sparse, was not able to be interpreted in any meaningful way. Predictably, then, NWGRH's nursing services have several problematic areas that have not been identified by nursing leadership and, as a result, poor nursing practices have not been addressed.

Interviews with nursing management and staff confirmed that monitoring, if it is done at all, is done informally and inconsistently. Indeed, the lack of monitoring is disturbing given that the Medical College of Georgia survey identified problems with NWGRH's nursing care, but no actions have been taken to address these problems.

2. Failure to Provide Basic Medical Care

Effective medical services depend on timely, thorough assessments and monitoring. Generally accepted professional standards require nursing assessments to be designed to collect

specific, individual data to assist the team and the patient with case formulation, diagnosis, and treatment planning. The nursing assessments we reviewed at NWGRH did not meet these standards. At best, the nursing assessments were superficial and had little to no clinical relevance. Based on our review, NWGRH does not have a system in place ensuring that nursing assessments and documentation are adequate, complete, and accurate. For example, upon her admission, E.Y. was noted to be at risk for falls. The nurse's note indicates that, on the same day as her admission, E.Y. fell in her room and complained of leg pain. The following day she fell twice, and a nurse noted she had a knot on the back of her head. Her assessments following the falls, to the extent they were performed, do not indicate whether any vitals signs were taken, which leg was injured, or whether a neurological check was conducted. E.Y. had numerous other falls that lacked adequate nursing assessments - she fell a total of six times in one month without any proactive interventions except being placed in a bed with side rails. E.Y. experienced a dramatic change in her mental status following one fall: she became drowsy, her speech became slurred and disconnected, and she required hospitalization for a procedure to relieve pressure on her brain. In short, E.Y. was not appropriately assessed by nursing to determine her status after each fall. E.Y.'s treatment plan indicates that physical therapy could have been consulted for her risk of falls, but no such consult was initiated. The failure of basic nursing care and lack of interventions to address her risk of falls resulted in significant harm to E.Y.

The nursing assessments for O.G. were similarly incomplete. O.G. was sent to the emergency room for dehydration, malnourishment, and medical instability. But the nursing notes stated only that he was sent to the emergency room for evaluation - no symptoms or vital signs were recorded. The note upon his return to NWGRH included orders to encourage oral intake; no further assessment of his status was included in his record. D.J. was also transported to an emergency room without an adequate nursing assessment. In her case, the nurse's note indicated that D.J. had symptoms suggesting a possible stroke or infarction.⁷ But there is no indication of when these symptoms began, and no vital signs were taken or neurological checks conducted before D.J.'s transportation to the emergency room. The nursing assessment, as with the cases described above, was incomplete and unacceptable.

⁷ Infarction is a condition in which tissue dies because its blood supply is blocked.

We also reviewed numerous assessments lacking information required for basic medical care. For example, the psychiatric nursing assessment for K.H. presented only a generic picture of his condition at admission. The only written description of him noted that he was "agitated" and that he was "cooperative at times" and "uncooperative at times." While the nurse indicated that he had Hepatitis C and tachycardia,⁸ his problem list did not include either of these issues. The psychiatric nursing assessment for another patient, D.O., was incomplete. Although the nurse noted that the patient had stomach surgery resulting from a gunshot wound to the abdomen, the only related documentation was vague: "some bowel and kidney complications." D.O. was taken to the hospital for severe diarrhea and nausea several days after this incomplete assessment. Similarly, while the nursing assessment for M.N. indicated that she had hypertension, cellulitis, and a urinary tract infection, it failed to indicate that she was significantly obese. Such an omission places her at medical risk and is also a factor in selection of an appropriate psychotropic medicine. The omission extended to treatment: M.N.'s treatment plan did not address her obesity in any way. Thus, the nursing assessments at NWGRH are inadequate; they do not facilitate sound clinical judgments in planning appropriate interventions and place the patients residing there at significant risk for harm.

The health care plans at NWGRH are similarly inadequate. The purpose of a health care plan is to guide therapeutic interventions systematically, document progress, and achieve the expected individual outcomes. These plans should be individualized and should identify priorities for care and interventions that are consistent with current generally accepted professional standards. The numerous plans we reviewed all had essentially identical goals, objectives, and recommendations, reflecting a lack of individualization and no identification of priorities in a given patient's care. The listed interventions provided no guidance regarding treatment modalities, and the plans failed to include proactive interventions addressing risk factors.

We reviewed a sample of health care plans for NWGRH patients identified as at risk for aspiration. None of the health care plans included aspiration as a health risk. Proactive interventions, such as obtaining lung sounds and oxygen saturation to determine changes in health status, were absent in

⁸ Tachycardia is the medical term for a rapid heart rate, usually defined as over 100 beats per minute.

the health care plans for these at-risk patients. Instead, the health care plans we reviewed included the generic statement "monitor and maintain good physical health over the next 12 months." The harm caused by non-individualized treatment can be seen in the following examples:

- E.D. was sent to the hospital because of coffee ground emesis,⁹ respiratory congestion, and possible pneumonia. E.D. is also at risk for aspiration. But his health care plan did not include these health issues or related interventions to assist staff in providing care.
- D.H. was diagnosed with the infectious disease methicillin-resistant staph ("MRSA") and is also at high risk for aspiration due to gastro-esophageal reflux disease. His health care plan did not include either of these major health issues nor did it include regular assessment of his health status. The generic quality of his health care plan provides no guidance to staff.
- T.H. has been identified as at high risk for aspiration. His health care plan did not include this risk and therefore does not provide for interventions to prevent aspiration or assess any potential status change. T.H. has been sent to the hospital three times in three months for episodes of difficulty breathing, rhonchi,¹⁰ lethargy, and pneumonia. Despite repeated hospital visits, his health care plan requires no proactive assessments or interventions.
- N.N. has similarly been identified as at high risk for aspiration and has no health care plan that addresses this risk. She too has endured repeated trips to the hospital for episodes of dehydration, fever, lethargy, and possible aspiration pneumonia.
- K.D. has been sent to the hospital twice for aspiration pneumonia and choking; her health care plan did not include aspiration as a risk.
- D.M. was sent to the hospital four times in two weeks: the first time for fever, cough, and respiratory distress, the second time for respiratory distress and symptoms of

⁹ Coffee ground emesis is the medical term for vomit that contains blood.

¹⁰ A coarse rattling sound usually caused by the accumulation of mucus or other material in a bronchial tube.

pneumonia, and the third and fourth times for pneumonia. Her health care plan did not include her risk for aspiration or any preventative interventions.

- R.H. was sent to the hospital for shortness of breath, cough, and pneumonia, but R.H.'s health care plan did not include her risk for aspiration or any preventative interventions.

Health care plans at NWGRH are alarmingly inadequate. They provide no clinical template for health care and fail to identify and address significant health issues so that positive outcomes may be achieved. Many patients suffered acute health issues; their health care plans failed to address these issues, and were not modified to prevent recurrences. The health care plans at NWGRH depart substantially from generally accepted professional standards, resulting in harm to patients.

3. Pharmacology Practices are Inadequate

Medication practices at NWGRH substantially depart from generally accepted professional standards in several critical respects. Contrary to accepted practice, pharmacological treatments are frequently the only interventions used to manage symptoms and behaviors, as discussed in Section III.C, supra. Many patients receive psychotropic medication - or multiple medications - for the purpose of sedation or to manage behavior, without underlying behavioral support plans. N.Y. and E.G., discussed previously, are two egregious examples of patients who received multiple medications for disruptive behavior without any behavioral support plans in place.

We also found medication prescription practices that are inconsistent with generally accepted professional standards. Polypharmacy, the practice of prescribing multiple medications to address the same indications, is widespread, and many records lack appropriate justification for this practice. For example, K.U., K.R., and K.N. were each receiving five such medications without sufficient clinical justification. Moreover, a number of medications were prescribed (and in some instances, not prescribed) in a manner inconsistent with generally accepted professional standards. For example, we observed orders for the emergency administration of Depakote and serotonin-specific re-uptake inhibitors, although these medications take weeks to be effective, and are thus inconsistent with emergency dosing. These practices substantially depart from generally accepted professional standards in pharmacology.

4. Inadequate Medication Administration

Generally accepted professional standards dictate that medications be administered according to nursing procedures that ensure that the correct patient receives the prescribed dosage of the prescribed medication by the prescribed route at the prescribed time. Moreover, generally accepted professional standards require that nursing staff properly complete Medication Administration Records ("MARs"). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently, which could result in serious harm.

Our review of the MARs revealed numerous instances in which NWGRH administered medicine in manner that deviates substantially from generally accepted professional standards. Specifically, we found MARs that had blanks and MARs that were signed before medication was actually administered or signed in bulk after all medication had been administered. We also found missing signatures in the Narcotics Logs, where the on-coming and off-going nurses are to sign after the narcotics are counted together. Because narcotics have powerful and potentially addictive effects and are often classified as controlled substances, NWGRH's failure to account properly for their administration is deeply troubling. Also troubling is the failure of the nursing staff to understand their duty to report the errors indicated above as medication variances. These errors, and the failure of nurses to record them as variances, indicate both a gross underreporting of medication variations at NWGRH and a serious lack of supervision of medication administration.

5. Inadequate Infection Control

Generally accepted professional standards require adequate infection control. The components of an adequate infection control program fall into two general categories: surveillance and reporting; and control and prevention.

Surveillance and reporting include data collection on infections acquired in the community before admission to NWGRH and on infections acquired while residing at the Facility. These data can be used to establish baseline infection rates for different units to determine problem areas or areas where

in-service education could lower infection rates. This information can also be used to identify outbreaks of infections rapidly so that concentrated efforts can be initiated to prevent the spread of the infection.

In addition, Facility personnel should be monitored and data analyzed for possible exposure to, or as the source of, communicable and infectious diseases. The environment itself must be monitored as a source of potential infection hazards, especially during outbreaks of infection. Further, the Facility must report all communicable diseases to the appropriate health authorities in the State.

Control and prevention activities are of equal importance in an infection control program. In general, developing policies and procedures, staff training, patient educational programs regarding communicable diseases, and regular committee review of infection control activities are components of a infection control program that complies with generally accepted professional standards.

NWGRH's infection control program fails to meet these standards. NWGRH focuses on data collection at the expense of adequate treatment of patients with infectious diseases. The Infection Control Nurse has virtually no connection with the unit staff actually caring for patients with infectious diseases; the Infection Control Nurse does not review, and plays no role in developing, health care plans for these patients. Unsurprisingly, we found numerous patients with infectious diseases who had no provision in their respective health care plans for interventions related to their infectious diseases:

- One patient, E.E., was noted to have heavy growth of MRSA. Her medical record did not, however, reflect any treatment plan addressing either the care of the lesion or the need to take precautions related to it. The record did include a nurse's note that a call had been placed to the Infection Control Nurse to discuss MRSA compliance, but the documentation indicated that there was no answer. We found no other documentation indicating that the infection control program played any role in ensuring that E.E. received proper treatment or that other patients in her unit were protected.
- The admission notes for K.H. indicated that he had Hepatitis C, but his medical record included no treatment plan for this issue. As a result, K.H. was not provided with any type of education regarding transmission of the

disease or needed life-style changes that may have led to a long-term positive outcome. Further, we found no indication that the infection control program had any involvement with his case.

- Echoing the case of K.H., we found seven patients residing in the same unit and included in the infection control list as having Hepatitis B. None of their health care plans mention Hepatitis B, nor did we find any indication that the infection control program was involved in their cases.

NWGRH's infection control data collection efforts have no accompanying analysis regarding possible unit-level transmission of infectious disease. Moreover, NWGRH has not performed an analysis to demonstrate the efficacy, or lack thereof, of the activities and interventions of the infection control program. Our review found no data addressing employee health issues or patients who refuse tuberculin skin tests or immunizations. Further, there is no system in place ensuring that infection control data collected throughout the Facility is reliable, and data reliability from the units is problematic. The unreliability of infection data and the limited use to which it is put demonstrates that the infection control program at NWGRH is inadequate. Consequently, patients are at a high risk for harm.

6. Inadequate Physical and Nutritional Management

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of patients who are at risk for aspiration/choking and the assignment of an appropriate risk level; the identification of patients' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; the development and implementation of a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; the provision of competency-based training to all staff assisting these patients regarding individualized dysphagia plans; the development of a method to monitor, track, and document clinically objective data, including triggers, lung sounds, oxygen saturations, and vital signs, to determine if treatment interventions are effective or in need of modification; the development of a mechanism for reporting triggers that generate an immediate response from a physical nutritional management team ("PNMT") to re-evaluate the plan and its implementation; development of an overall monitoring system

conducted by members of the PNMT to ensure that plans are being consistently implemented and that this monitoring is most intense for those with the highest level of risk; and assurance that this system is effective so that it may be transferred into the community.

NWGRH patients residing at the DSU who are at risk for aspiration are not provided adequate assessments, interventions, proactive monitoring of symptoms, and regular treatment plan monitoring, which places them at significant risk for harm. NWGRH does not provide these patients with physical and nutritional management care consistent with generally accepted professional standards.

None of NWGRH's various disciplines, including nursing, physical therapy, occupational therapy, speech pathology, and dietary management, have the requisite specialized training or expertise in treating patients with physical and nutritional management needs. NWGRH fails to identify patients who have physical or nutritional management issues adequately, and the draft policies NWGRH has developed in this area fall far short of addressing the individualized needs of persons at risk for aspiration.

NWGRH's failures in training its staff and in identifying patients having physical and nutritional management issues includes patients facing serious risks of harm from aspiration and choking. In our review, we found no written criteria that adequately identified patients at risk for aspiration and choking. When asked, staff members were unable to articulate how to identify patients at risk for aspiration. Even for those patients who had been identified as at risk, NWGRH did not assess the degree of risk. Patients with recurrent episodes of aspiration pneumonia would, for example, normally be considered at the highest level of risk, but NWGRH made no such designation. As a result, NWGRH does not focus its most intensive, proactive treatments and interventions on the patients who need them. Indeed, there is little difference in the clinical care and treatment plans for patients who had no designated risk of aspiration and for patients who had a significant risk of aspiration.

For example, NWGRH designated four patients living on one unit as being at risk for aspiration. Our review of the alternative positioning for all of these patients showed that each patient had the same three generic alternative positions. None had clinical assessments indicating that these positions were evaluated as safe. Nor did we find follow-up assessments

indicating that these positions were safe. The alternative positions for these patients may therefore actually increase their risk for aspiration; we found no clinical data indicating otherwise. This lack of safety assessments extended to other high-risk activities, including oral care, bathing, dental appointments, and during sleep.

The mealtime plans we reviewed also lacked information to guide staff in feeding patients designated as at risk for aspiration. Mealtime plans for tube-fed patients – a group at the highest risk for aspiration – contained no special instructions for positioning during feeding or how long after the feeding the patient should remain in a specific upright position. Moreover, staff assigned to assist patients with meals and other activities did not receive competency-based training on carrying out the requirements of mealtime plans or treatment plans. The widespread absence of information guiding the treatment of at-risk patients is therefore compounded by the absence of any system to ensure that staff are competent in adequately executing treatment and mealtime instructions.

We observed numerous instances of inadequate staff assistance during mealtimes. Staff did not follow any procedure in keeping patients upright after meals. Our mealtime observations also showed that patients in wheelchairs were not in correct body alignment, thereby increasing their risk of aspiration. We observed a number of these patients coughing and gagging throughout their meals. Staff members stated that such coughing and gagging was a regular occurrence, and further indicated that they respond by feeding the patients slowly. This is not what we observed. Instead, we observed staff members responding to coughing and gagging by encouraging more food and fluids, a practice which increases the risk of aspiration. Furthermore, staff members did not respond to episodes of coughing or gagging by calling a nurse for assessment before continuing a meal. Nor did staff document these episodes of coughing and gagging – known triggers or symptoms of aspiration – in the patients' charts.

The failure to document episodes of coughing and gagging at mealtimes is symptomatic of NWGRH's deficiencies regarding aspiration risk. NWGRH does not identify individualized symptoms of aspiration or triggers to be monitored for patients who are at risk for aspiration. Consequently, no clinical data exists that would permit the PNMT team to evaluate the effectiveness of its interventions, except an actual episode of pneumonia, aspiration pneumonia, or respiratory distress. Without clinical data gathering that would enable early intervention to prevent an

episode of aspiration or aspiration pneumonia, NWGRH operates reactively, resulting in harm.

We observed such reactive treatment in the case of N.T., who displayed chronic symptoms of aspiration that were inadequately addressed. N.T. had been on a pureed diet with liquids thickened to a honey consistency for over a year. Interviews with staff indicated that N.T. had significant difficulties in swallowing, and would cough, hold food in his mouth, and refuse food during mealtimes. His record contained only a bare statement that his swallowing function had declined, but no monitoring appears to have been conducted. N.T. eventually developed unstable vital signs and was sent to the community hospital, where he was diagnosed with aspiration pneumonia. Upon his return to NWGRH, all of his previous treatment plans were reinstated without review. NWGRH ultimately determined that the diet it had provided to N.T. for at least a year had been causing him to aspirate. He now receives nothing by mouth and is given all nourishment through a tube.

The example of N.T. also shows that NWGRH does not initiate 24-hour dysphagia treatment plans even when an acute event, such as aspiration pneumonia, occurs. Such a plan should contain specific and individualized instructions and proactive interventions to address all activities during a patient's 24-hour day. But staff perception of N.T., as a result of their lack of training and expertise in dysphagia, is that he is no longer at risk of aspiration because he now has a tube. But N.T. does, in fact, remain at high risk for aspiration, a fact only partially reflected in the speech therapist's note that N.T. "could remain at risk for aspiration." N.T. continues to be at significant risk for harm.

N.T. is not the only patient at risk for harm due to the lack of safe, appropriate, and adequate interventions. Our review yielded a number of other examples:

- Y.O. has issues with weight loss and has had episodes of vomiting, difficulty in swallowing, coughing, and elevated temperatures. He has had several tests showing that he has a significant swallowing disorder and that he aspirates, but there has been no systematic tracking of his triggers for aspiration. He has not been given a treatment plan or intervention that adequately address his dysphagia and aspiration. Y.O. is therefore at risk for harm.
- N.N., a patient at risk for aspiration, was repeatedly sent to the emergency room for dehydration, fever, lethargy, and

pneumonia. Staff members indicated that she coughs frequently during mealtime. Nevertheless, NWGRH does not regularly collect data indicating when she began to experience triggers or how often they occurred, nor were lung sounds and oxygen saturation levels regularly taken to note changes in her status. Without this data, NWGRH is not adequately monitoring her aspiration risk.

- D.M. is also at risk for aspiration. She has had repeated visits to the emergency room for fever, cough, respiratory distress, bronchitis, and pneumonia. NWGRH has failed to institute proactive interventions and a systematic review of her condition, despite her repeated visits to the emergency room.

The lack of effective response by NWGRH, even to repeated acute instances of illness, is demonstrated in three other patients at risk for aspiration that we reviewed, each of whom made repeated trips to the emergency room. K.D. was sent to the emergency room three times - twice on the same day - for choking, turning blue, and pneumonia. E.N. was sent four times with multiple seizures, medication toxicity due to dehydration, lethargy, and aspiration pneumonia. And T.H. was sent to the emergency room three times for difficulty breathing, rhonchi, and pneumonia.

These examples demonstrate that there is no system in place at NWGRH to ensure that patients at risk for aspiration are provided with safe, appropriate, and adequate treatment interventions. Patients with dysphagia who have experienced recurrent respiratory distress, pneumonia, or aspiration pneumonia are not comprehensively reevaluated to assess the appropriateness of the current treatment plan and to modify interventions when necessary. The failure to reassess these patients and to provide proactive interventions is a gross departure from generally accepted professional standards. These deficiencies have resulted in harm and continue to place patients with physical and nutritional issues at serious risk of harm.

7. Emergency Preparedness Is Inadequate

In accordance with generally accepted professional standards, all staff should be well-trained in emergency preparedness, aware of emergency materials and where they are located, and conduct sufficient practice codes to be able to perform adequately when confronted with an actual emergency. Appropriate emergency medical response also includes physical plant readiness.

NWGRH practices and procedures regarding emergency preparedness substantially depart from generally accepted professional standards. This deviation is well-illustrated by the medical emergency drills we reviewed, a significant number of which were failed drills. In several of the drills, there was an absence of leadership, as the first-arriving nurse did not take charge of the code. One drill continued for 14 minutes without a physician arriving, and the nursing manager was unable to find the site of the drill. These drills also featured a variety of improper practices, including improper use of the Automated External Defibrillator ("AED"), incorrect positioning of the victim, and an inability to perform CPR correctly. Indeed, a review of documentation for current staff members showed that 197 employees had not been certified in CPR, while 146 held expired CPR certifications. NWGRH has no system in place to ensure that staff are properly trained and updated in CPR. Perhaps more egregiously, the nurse executive indicated that he was unaware that there were significant issues regarding drills. These repeated errors and lack of training place patients at the Facility at significant risk for harm.

These serious deficits in training exist throughout NWGRH's emergency preparedness programs. For example, we observed nurses who did not know how to turn on oxygen tanks, despite emergency preparedness documentation indicating that they were completing this task daily. In one instance, we observed a nurse struggle to turn a tank on, ask another nurse for assistance, and, after several failed joint attempts, successfully turn the tank on only to discover that it was empty. The monitoring sheet for the oxygen tank, however, indicated that it was full. We found numerous other instances where oxygen tanks had not been checked appropriately, according to NWGRH's own documentation. This pattern of unacceptable nursing practice was prevalent throughout the Facility.

Nor were nurses trained appropriately in testing suction machines or AED. Suction machine testing done by nurses was superficial, essentially demonstrating only that the suction machines could turn on rather than actually perform their intended function. Documentation indicated, however, that the suction machines were tested daily to ensure functionality. Nurses were unaware of when AED batteries should be changed to ensure functionality, and we did not find a single AED with documentation showing the installation date for its battery. Failures with respect to testing emergency equipment and documenting such testing extended to supervision by Nurse Managers. The managers did not observe staff checking emergency

equipment, nor did they review the emergency equipment logs for accuracy.

Poor preparedness and training in handling emergency code drills has significant ramifications for NWGRH's response to actual emergency codes. Moreover, errors in that response are not likely to be corrected by NWGRH's emergency code review process. Our review of actual codes showed the review process to be both incomplete and superficial. These reviews lacked important information related to the conduct of the code and, further, made no recommendations to improve conduct of future emergency codes. For example, in two separate codes, NWGRH's official review indicated that the AED showed that no shock was necessary. But records from the code itself indicated that the AED had not actually been applied; application of the AED is necessary for the AED to show that no shock was necessary. The absence of any critical review of these emergency codes permits the deficient practices outlined above to continue. As such, NWGRH departs from generally accepted standards of practice both in the substance of its emergency preparedness and in its procedures for reviewing that preparedness.

8. Inadequate Staffing and Nursing Services

The deficiencies in medical and nursing care identified above are exacerbated by chronic staffing shortages. Generally accepted professional standards require facilities like NWGRH to have staff sufficient to provide nursing services that, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization.

The current nurse executive at NWGRH admitted that recruitment and retention has been a major issue for the nursing department. He reported that NWGRH needed to fill 68 Registered Nurse vacancies and 46 Licensed Practical Nurse vacancies. Further, according to the nurse executive, the nursing department was struggling to maintain minimum staffing ratios. Nevertheless, the nurse executive was unable to produce any meaningful data about which shifts and units had fallen below minimum staff ratios or departmental turnover rates. Shortages have also resulted in many units having inadequate nurse management. Despite the nurse executive's evident awareness of the nursing shortage, we found no indication that a system had been established to review the effect of the shortage on clinical outcomes.

Moreover, the State's own 2007 survey by the Medical College of Georgia noted the nursing staff shortage and its potential effect on the services provided to patients at the NWGRH. NWGRH's corrective action plan promised that staffing problems would be addressed, but the nursing executive was unable to articulate the safeguards that had been implemented to ensure safe practices during the current staffing shortage. Our review showed that a number of shifts at NWGRH fall below minimum staffing levels each week. The nursing executive reported that NWGRH was in the process of working on revising the policy for minimum staffing ratios, but he was unable to describe the model, or to produce any data or criteria, used in determining what would constitute adequate staffing levels.

NWGRH's failure to provide adequate nursing staff, along with the deficits in care and treatment that necessarily result from the critical and ongoing shortages at NWGRH, is a substantial departure from generally accepted professional standards.

E. Services to Populations with Specialized Needs Are Inadequate

1. Services to Patients with Limited English Proficiency Are Insufficient

Pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., and its implementing regulations, NWGRH is required to take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency ("LEP"). See 45 C.F.R. Part 80 (Department of Health and Human Services regulations). Georgia's Mental Health Gap Analysis in May 2005 identified glaring deficiencies in mental health services available to persons with hearing impairments or limited English proficiency. Although the State has adopted a Limited English Proficiency and Sensory Impaired Client Services Manual, we saw little evidence that the policies outlined in the Manual were followed. Examples include G.R., whose record indicates that he was unable to receive adequate treatment and services because of his limited English language ability. U.M. also has extremely limited English language ability, which made it impossible for him to assist in the investigation of his unexplained injury - a broken clavicle. The language barrier thus was a barrier to his participation in treatment and to efforts to protect him from future harm. The records of two acutely psychotic patients, J.P. and O.G., state that they "refused" interpretation services, but do not evidence any attempt by the Facility to address these refusals, which

effectively denied these patients psychiatric care. NWGRH's failure to ensure that meaningful access to necessary services is being provided to persons with LEP violates federal law.

2. Services to Patients with Sensory Impairment Are Insufficient

Title II of the Americans with Disabilities Act prohibits discrimination against persons with disabilities in the provision of benefits and services. Patients with vision and hearing impairments receive inadequate services at NWGRH. For example, at the time of our visit, there was no vision specialist on staff, no Braille instruction, and no orientation or mobility instruction for patients who are legally blind. To the contrary, staff told us that the treatment team had been reluctant to provide P.C. with a cane typically used by persons with limited sight for fear that he would use it as a weapon. The treatment plan for, another patient, P.P., who is legally blind, encourages him to "feel around the walls" as the preferred method of communicating that he would like to go for a walk. R.D., who has a hearing impairment, has been at the Facility for nearly two years. At the time of our visit, her treatment team was starting to pursue hearing aides for her; reportedly she had destroyed some in the past. Although the audiologist recommended using sign language, no staff member on her unit can sign. These examples evidence a profound lack of attention to the needs of patients with hearing and vision loss. They also suggest that the State has taken no effective action to remedy deficiencies in services to persons with sensory impairments, although these deficiencies were clearly identified in the State's own Mental Health Gap Analysis in 2005. These deficiencies violate federal law.

F. Inadequate Discharge Planning and Placement in the Most Integrated Setting

Federal law requires that NWGRH actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patients' needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a patient's stay, NWGRH should: (1) identify, through professional assessments, the factors that likely will foster viable discharge for the patient; and (2) use these factors to drive treatment planning and intervention. Without clear and purposeful identification of such factors, patients will be denied rehabilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The NWGRH discharge planning process substantially departs from generally accepted professional standards. Furthermore, NWGRH fails to meet the discharge planning principles stated in its own policies. The State's own audits of the "State of Georgia Behavioral Health System," prepared for the Governor in 2004 and 2005, identified egregious, systemic deficits in the coordination of care between NWGRH and the community. Based on our review of recent discharges from NWGRH, these same deficits persist. Specifically, we find that: (1) discharge plans are based on incomplete and inadequate assessments; (2) discharge planning services are not provided in accordance with NWGRH policies, although those policies are consistent with generally accepted professional standards; (3) inadequate coordination of care leads routinely to inappropriate discharges; and (4) discharge plans fail to address repeated readmissions.

1. Discharge Plans Are Based on Inadequate Assessments

Deficits in discharge planning begin with assessments upon admission. Complete and accurate assessments are essential to develop a treatment plan that can direct rehabilitation while in a facility and to form the basis for a viable discharge plan. In addition to the deficits in assessments discussed previously in this letter, the majority of charts we reviewed were missing assessments of social, vocational, functional, educational, self-care, and independent-living skills, particularly for those patients with short lengths of stay. The absence of information on critical aspects of functioning is a serious impediment to identifying the services and supports needed for these patients to transition successfully to community living. NWGRH fails to take advantage of available information regarding previous admissions, successful and unsuccessful treatments, and skills that needed to be developed to live successfully in the community. These failures greatly contribute to the high rate of recidivism at NWGRH.

As described previously, treatment teams at NWGRH routinely fail to adjust treatment plans even when objective signs show that the current plan is ineffective. Thus, patients do not receive supports and services to address problematic symptoms and behaviors that often disrupt community placements. The case of E.G., discussed previously, is one example. Her aggressive behaviors had disrupted 18 prior foster home placements, and the behaviors continued throughout her stay at NWGRH, requiring PRN medications 31 times, including just two days before her discharge. Despite this, there was no change in her treatment to address aggressive behavior.

2. Discharge Planning Services Are Not Provided in Accordance with NWGRH Policy

We found that, although NWGRH has a number of policies and procedures that articulate an adequate discharge planning and coordination of care process, in practice, these policies and procedures are not implemented. For example, NWGRH's policy for discharge of patients to personal care homes, which are among the most frequent placements, require adequate discharge planning to ensure that the home is suitable to the individual's needs. The procedures require the treatment team meeting to include a liaison from the Community Service Board ("CSB"), to develop a list of any specialized care recommendations, and facilitate a leave of absence pending discharge to the home in order to facilitate adjustment to the new home. We saw only one case in which the Facility's discharge policies had been followed, for A.N. In every other discharge that we reviewed there was noncompliance: no contact with the CSB, no specialized care recommendations, and no placement of patients on extended leave to the new home pending discharge. This noncompliance is particularly troubling because many patients discharged from NWGRH have major impairments in multiple areas of functioning, and would typically require substantially more supervision and oversight than a personal care home can usually provide.

NWGRH policy also notes that shorter lengths of stay may not permit contacts with outpatient providers before the day of discharge. In those cases, the case manager is supposed to contact the provider on the day of discharge and make aftercare arrangements, document these on the discharge letter, and fax it to the provider. We did not find a single aftercare plan complying with NWGRH policy in any of the discharge records we reviewed. For patients discharged to homeless shelters, the case manager is supposed to call and verify that the shelter is still receiving clients. We spoke with administrators of Must Ministries, a homeless shelter in Marietta, Georgia, who confirmed that, in their experience, NWGRH's practice does not follow this policy. Discharged patients typically arrive at the shelter without an advance phone call, and the shelter is not able to provide the level of care needed by individuals with serious mental illness or substance abuse disorders. These failures violate NWGRH policies and are a substantial departure from generally accepted professional standards.

3. Inadequate Coordination of Care Routinely Leads to Inappropriate Discharges

Contrary to generally accepted professional standards, NWGRH fails to provide adequate coordination and continuity of care, and this failure routinely leads to inappropriate discharges. The failure to appropriately coordinate continuing care results in numerous negative outcomes, including placements in inappropriate locations, re-admissions to the Facility, and unnecessary delays in community placement.

NWGRH declined to provide for our review aggregate information on the discharge location of all recently discharged patients. Nonetheless, during our review of individuals' records, we noted multiple examples of patients discharged to inappropriate locations, including patients with a history of repeat admissions discharged to homeless shelters without appropriate support:

- L.L. was discharged from her 18th admission to a Salvation Army homeless shelter, with no contact from the local Community Service Board.
- K.N. was discharged following his third admission with a bus ticket, five days of medication, and the address of a rescue mission shelter in a different state.
- K.T. was discharged from his third and fourth admissions to a homeless shelter.

Homeless shelters are not equipped to provide the level of care required for a patient being discharged from a psychiatric hospital, many of whom have severe and persistent mental illness.¹¹ NWGRH's own documents note that NWGRH's professionals are aware that shelters do not have sufficient structure or supervision for persons with mental illness. Patients discharged to homeless shelters are likely to return to the hospital and repeat the cycle of inadequate discharge multiple times. Research indicates that the best chance for a successful recovery outcome is achieved when the person receives adequate care during the first episode of the psychiatric illness and that the opportunities for successful recovery diminish on each future episode. NWGRH's failure to provide adequate coordination and

¹¹ Indeed, as we noted in the findings letter regarding GRHA, the Supreme Court, in Olmstead, stated that homeless shelters were inappropriate discharge locations. Olmstead v. L.C., 527 U.S. 581, 605 (1999).

continuity of care, routinely resulting in inappropriate discharges, is a substantial departure from generally accepted professional standards.

4. Discharge Plans Fail to Address Repeated Readmissions

In addition to many discharges to inappropriate locations without sufficient supports, we noted approximately 240 patients who were discharged and re-admitted to the hospital within the first nine months of 2007. Dozens of these patients had lifetime histories of more than 20 re-admissions. That so many patients go through the cycle of admission and discharge multiple times indicates significant flaws in the discharge planning process.

NWGRH is not adequately addressing the significant barriers to successful discharge that many patients face. NWGRH social workers identified housing as a primary barrier to community placement. The Chief of Social Work denied that sufficient substance abuse treatment was a placement barrier for those patients with substance abuse history, but in our review of discharge plans, we saw no referrals for this essential service. The State's own findings in the 2005 Georgia Mental Health Gap Analysis also discussed the dearth of sufficient Assertive Community Treatment teams, which serve as a vital link between the hospital and the community for participants. Assertive Community Treatment programs offer an array of services customized to individual needs, delivered by a community-based team of mental health practitioners, and available 24 hours per day. Our review of discharges from NWGRH suggests that this glaring gap in provision of services, and in particular for patients with a history of repeated admissions, is as great today as it was three years ago.

In most cases, neither formal or informal supports have been developed and prepared for use by patients transitioning from NWGRH. There is little indication that the Facility has attempted to locate, develop, or advocate for needed supports or services that NWGRH professionals acknowledge are needed to ensure successful transitions to community living. NWGRH's failure to address repeat admissions and barriers to successful placement deviates substantially from generally accepted professional standards.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at

NWGRH, the State of Georgia should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

The Georgia Psychiatric Hospitals shall provide their patients with a safe and humane environment and protect them from harm. At a minimum, the Georgia Psychiatric Hospitals shall:

1. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards. The Georgia Psychiatric Hospitals shall:
 - a. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury; patient aggression; abuse and neglect; contraband; and suicide ideation or attempts;
 - b. Require all staff to complete competency-based training in the revised reporting requirements;
 - c. Create or revise, as appropriate, and implement thresholds for indicators of events, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide ideation or attempts, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level; whenever such thresholds are reached, this will be documented in the patient medical record, with explanations given for changing/not changing the patient's current treatment regimen;
 - d. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide ideation or attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that investigation of such incidents that are comprehensive, include

consideration of staff's adherence to programmatic requirements, and are performed by independent investigators;

- e. Require all staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings;
 - f. Monitor the performance of staff charged with investigative responsibilities and provide administrative and technical support and training as needed to ensure the thorough, competent, and timely completion of investigations of serious incidents;
 - g. Ensure that corrective action plans are developed and implemented in a timely manner;
 - h. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from patient aggression and abuse and neglect allegations, to ensure that such incidents are properly investigated and appropriate corrective actions are identified and implemented in response to problematic trends; and
 - i. Create or revise, as appropriate, and implement policies and procedures regarding the creation, preservation, and organization of all records relating to the care and/or treatment of patients, including measures to address improper removal, destruction, and/or falsification of any record.
2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards. At a minimum, such a system shall:
- a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by the Georgia Psychiatric Hospitals, as well as the outcomes being achieved by patients;

- b. Analyze the information collected in order to identify strengths and weaknesses within the current system; and
- c. Identify and monitor the implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

B. Mental Health Care

1. Assessments and Diagnoses

The Georgia Psychiatric Hospitals shall ensure that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, the Georgia Psychiatric Hospitals shall:

- a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments; and ensure that assessments include a plan of care that outlines specific strategies, with rationales, including adjustment of medication regimens and initiation of specific treatment interventions.
- b. Ensure that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of all patients requiring restrictive interventions.
- c. Develop diagnostic practices, consistent with generally accepted professional standards, for reliably reaching the most accurate psychiatric diagnoses.
- d. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, maladaptive behaviors and substance abuse problems.
- e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's

history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.

- f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.
- g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.
- h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries, and require each clinical discipline's peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action.

2. Treatment Planning

The Georgia Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, the Georgia Psychiatric Hospitals shall:

- a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.
- b. Ensure that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include:

- (1) Review by psychiatrists of all proposed behavioral plans to determine that they are compatible with the psychiatric formulations of the case;
 - (2) Regular exchange of objective data between the psychiatrist and the psychologist and use of this data to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies;
 - (3) Integration of psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap; and
 - (4) Documentation in the patient's record of the rationale for treatment.
- c. Ensure that treatment plans address repeated admissions and adjust the plans accordingly to examine and address the factors that led to re-admission.
- d. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.
- e. Ensure that treatment plans are consistently assessed for their efficacy and reviewed and revised when appropriate.
- f. Provide adequate and appropriate mental health services, including adequate psychological services, behavioral management, and active treatment, in accordance with generally accepted professional standards.
- g. Provide psychologists with sufficient education and training to ensure:
- (1) competence in performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors;

- (2) the development and implementation of clear thresholds for behaviors or events that trigger referral for a behavioral assessment;
 - (3) timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record;
 - (4) the development and implementation of protocols for collecting objective data on target and replacement behaviors; and
 - (5) assessments of each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.
- h. Re-assess all patients at the Facility to identify those who would benefit from speech and communication therapy and provide sufficient qualified and trained staff to provide services to all patients who would benefit from this service.
- i. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs, goals, and interventions, as well as discharge criteria.
- j. Ensure that the medical director timely reviews high-risk situations, such as patients requiring repeated use of seclusion and restraints.
- k. Develop and implement policies to ensure that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, and physical, cognitive and/or sensory impairments are evaluated, treated, and monitored in accordance with generally accepted professional standards.

- l. Develop and implement policies for patients exhibiting suicidal ideation, including for patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.
- m. Develop a system to ensure that staff receive competency-based training on individualized plans, including behavioral support plans and interventions, and document this training.
- n. Ensure that restrictive interventions receive appropriate review by a Human Rights Committee, or its equivalent, to guarantee any restriction of rights are necessary, appropriate, and of limited duration.
- o. Ensure that all psychotropic medications are:
 - (1) administered as prescribed;
 - (2) tailored to each patient's individual symptoms;
 - (3) monitored for efficacy and potential side-effects against clearly-identified target variables and time frames;
 - (4) modified based on clinical rationales; and
 - (5) properly documented.
- p. Institute systematic monitoring mechanisms regarding medication use throughout the Facility. In this regard, the Georgia Psychiatric Hospitals shall:
 - (1) Develop, implement, and continually update a complete set of medication guidelines in accordance with generally accepted professional standards that address the indications, contraindications, screening procedures, dose requirements, and expected individual outcomes for all psychiatric medications in the formulary; and

- (2) Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, a documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely, critical review of the patient's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

C. Seclusion and Restraints

The Georgia Psychiatric Hospitals shall ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances i.e., when a patient poses an imminent risk of injury to himself or a third party - any device or procedure that restricts, limits, or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, the Georgia Psychiatric Hospitals shall:

1. Eliminate the use of planned (i.e., PRN) seclusion and planned restraint.
2. Ensure that restraints and seclusion:
 - a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;
 - b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;
 - c. Are not used as part of a behavioral intervention;
 - d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and
 - e. Are used in a reliably documented manner.

3. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:
 - a. The range of restrictive alternatives available to staff and a clear definition of each; and
 - b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.
4. Ensure that if seclusion and/or restraint are initiated, the patient is regularly monitored in accordance with generally accepted professional standards and assessed within an appropriate period of time, and that an appropriately trained staff member makes and documents a determination of the need for continued seclusion and/or restraint.
5. Ensure that a physician's order for seclusion and/or restraint includes:
 - a. The specific behaviors requiring the procedure;
 - b. The maximum duration of the order; and
 - c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.
6. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.
7. Ensure that at least every thirty minutes, patients in seclusion and/or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.
8. Ensure that immediately following a patient being placed in seclusion and/or restraint, the patient's treatment team reviews the incident within one business day, and the attending physician documents the review and the reasons for or against change in the patient's

current pharmacological, behavioral, or psychosocial treatment.

9. Comply with the requirements of 42 C.F.R. § 483.360(f) regarding assessments by a physician or licensed medical professional of any resident placed in seclusion and/or restraints.
10. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

D. Medical and Nursing Care

The Georgia Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards. Such services should result in patients of the Georgia Psychiatric Hospitals receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, the Georgia Psychiatric Hospitals shall:

1. Ensure adequate clinical oversight to ensure that generally accepted professional standards are maintained.
2. Ensure that patients are provided adequate medical care in accordance with generally accepted professional standards.
3. Ensure sufficient nursing staff to provide nursing care and services in accordance with generally accepted professional standards.
4. Ensure that, before nursing staff work directly with patients, they have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.
5. Ensure that nursing staff accurately and routinely monitor, document, and report patients' symptoms and target variables in a manner that enables treatment

teams to assess the patient's status and to modify, as appropriate, the treatment plan.

6. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.
7. Ensure that nursing staff are appropriately supervised to ensure that they administer, monitor, and record the administration of medications and any errors according to generally accepted professional standards.
8. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.
9. Ensure that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.
10. Ensure that each patient's treatment plan identifies:
 - a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;
 - b. The related symptoms and target variables to be monitored by nursing and other unit staff; and
 - c. The frequency by which staff need to monitor such symptoms.
11. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, the Georgia Psychiatric Hospitals shall:
 - a. Actively collect data with regard to infections and communicable diseases;
 - b. Analyze these data for trends;
 - c. Initiate inquiries regarding problematic trends;

- d. Identify necessary corrective action;
 - e. Monitor to ensure that appropriate remedies are achieved;
 - f. Integrate this information into the quality assurance review of the Georgia Psychiatric Hospitals; and
 - g. Ensure that nursing staff implement the infection control program.
- 12. Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing.
 - 13. Ensure that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.
 - 14. Provide adequate, appropriate, and timely rehabilitation therapy services and appropriate adaptive equipment to each individual in need of such services or equipment, consistent with generally accepted professional standards.
 - 15. Establish an effective medical emergency preparedness program, including appropriate staff training; ensure staff familiarity with emergency supplies, their operation, maintenance and location; conduct sufficient practice drills to ensure adequate performance when confronted with an actual emergency.
- E. Services to Populations with Specialized Needs
- 1. Provide adequate services to patients with limited English proficiency or sensory deficiencies, consistent with the requirements of the State's Limited English Proficiency and Sensory Impaired Client Services Manual and federal law.

F. Discharge Planning

The State shall ensure that patients receive services in the most integrated, appropriate setting that is consistent with their needs and legal status and actively pursue the appropriate discharge of patients. More particularly, the Georgia Psychiatric Hospitals shall:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:
 - a. The individual patient's symptoms of mental illness, psychiatric distress, or cognitive impairment;
 - b. Any other barriers preventing that specific patient from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and
 - c. The patient's strengths, preferences, and personal goals.
2. Ensure that the patient is an active participant in the placement process.
3. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.
4. Provide the patient adequate assistance in transitioning to the new setting.
5. Ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.
6. Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services, including:
 - a. Develop a system of follow-up with community placements to determine if discharged patients are

receiving the care that was prescribed for them at discharge; and

- b. Hire sufficient staff to implement these minimum remedial measures with respect to discharge planning.
7. The State shall ensure that it provides community-based treatment for persons with disabilities consistent with federal law.

V. CONCLUSION

We appreciate the cooperation we received from the Georgia Department of Mental Health Developmental Disabilities and Addictive Diseases, and the State's Attorney General's Office during our visit to NWGRH. We also wish to thank the administration and staff at NWGRH for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tour. Further, we wish to especially thank the hospital's staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at these facilities. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

As discussed in our letters of June 27, 2008, and November 20, 2008, we will forward our expert consultants' reports under separate cover once we are confident that you intend to use the reports to address the deficiencies outlined in our findings letters. These reports are not public documents. Although our expert consultants' reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that State chooses to cooperate with us so we may provide them to you in the near future, and that you will give

this information careful consideration and use it to assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We remain amenable to expeditiously resolving this matter by working cooperatively with you. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Thurbert E. Baker
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Office of the Attorney General Of Georgia

B.J. Walker
Commissioner
Georgia Department of Human Resources

Gwendolyn Skinner
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August 14, 2009

The Honorable David A. Paterson
Governor of New York
State Capitol
Albany, New York 12224

Re: Investigation of the Lansing Residential Center, Louis Gossett, Jr.
Residential Center, Tryon Residential Center, and Tryon Girls Center

Dear Governor Paterson:

I write to report the findings of the Civil Rights Division's investigation of conditions at four Office of Children and Family Services ("OCFS") facilities: Lansing Residential Center ("Lansing"), Louis Gossett, Jr. Residential Center ("Gossett"), Tryon Residential Center ("Tryon Boys"), and Tryon Girls Residential Center ("Tryon Girls"). On December 14, 2007, we notified you of our intent to conduct an investigation of the juvenile facilities pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). We informed you that our investigation would focus on whether youth were adequately protected from harm, and would specifically address allegations of sexual misconduct and unreasonable use of restraints. At the conclusion of our first set of tours, we notified you that we would be expanding the scope of our investigation to include mental health care at each of the four facilities.

On June 2-5, June 30-July 3, November 12-14, and November 24-26, 2008, we conducted on-site inspections of the facilities. On our first set of tours, we were accompanied by expert consultants in protection from harm and use of force, and on our second set we were accompanied by expert consultants in mental health care. Before, during, and after our tours, we reviewed an extensive number of documents including policies and procedures, incident reports, medical and psychology records, unit logs, and training materials. Additionally, we interviewed administrators, professionals, staff, and youth. We observed the youth in a variety of settings, including on their living units, while dining, in classrooms, and during recreation. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we conducted exit conferences upon the conclusion of

each set of tours, during which our expert consultants conveyed their initial impressions and concerns.

We thank the staff from OCFS and each of the facilities for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation and appreciate their receptiveness to our consultants' on-site recommendations. Attorneys and staff assisted our investigation by providing us with unfettered access to records and personnel, and responding to all of our requests in a transparent and forthcoming manner. We have every reason to believe that OCFS and facility administrators are committed to remedying deficiencies at the facilities.

Consistent with our statutory obligation under CRIPA, we set forth below the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described below, we conclude that the conditions at Lansing, Gossett, Tryon Boys, and Tryon Girls violate constitutional standards in the areas of protection from harm and mental health care.

In the course of our investigation, we also reviewed allegations of custodial sexual misconduct. We find no current systemic constitutional deficiencies in this area. In the wake of custodial sexual misconduct charges at the facilities, OCFS has taken multiple steps, including but not limited to installing video cameras, increased staff accountability, and additional training for staff in order to safeguard youth at the facilities. We commend OCFS for the steps it has taken and encourage it to continue its work to minimize such risks and ensure youth safety.

I. BACKGROUND

A. Description of the Facilities

OCFS operates 31 residential juvenile justice facilities throughout New York State. Residential facilities house court-placed youths according to three different security designations: secure (most restrictive), limited-secure, and non-secure (least restrictive). Our investigation focused on the following four facilities.

1. Louis Gossett, Jr. Residential Center

Gossett is a limited-secure facility for male youth located outside of Ithaca, New York. All services are centralized in one large building, including youth housing, programming (e.g., school, dining, medical services, recreation), and administration. There are ten housing units with fifteen beds per unit. Each youth is assigned to an individual room on the perimeter of a large dayroom. Each

housing unit has a large unit office where staff often meet with youth. Housing units are assigned according to education level, except one unit which houses youth in the Community Reintegration Program. This program is for youth who were placed previously in the State's residential facilities, but then re-offended and were re-committed. During our June tour of Gossett, the census was 128 youths. During the November tour, the census was 131 youths.

2. Lansing Residential Center

Lansing is a residential facility for female youth located adjacent to Gossett. In January 2008, Lansing's security designation changed from limited-secure to non-secure. The campus consists of nine distinct buildings, three of which were utilized for housing at the time of our tours. The main, older multi-level building contains housing for less than 20 youth and includes a school, counseling offices, the cafeteria, and other services. There is also a newer, multi-structure area with cottage-style housing units and a school building. The housing units in this area have capacity for 16-17 youths each. Each housing unit is organized according to educational level. The rated capacity for the facility is 50 youths. During our June tour, Lansing housed 41 youths, and in November there were 36 youths.

3. Tryon Residential Center

Tryon Boys is a limited-secure residential facility for male youth located outside of Johnstown, New York. Tryon Boys is a large campus with multiple buildings, including seven housing units in four cottage-style buildings and separate buildings for dining, school, medical services, and other services. There are two specialized housing units, Elmwood 2 and Briarwood 2. Elmwood 2 is designated as housing for youth in the substance abuse treatment program. Briarwood 2 houses youth in the mental health treatment program. Notably, Tryon Boys also serves as a "hub" for youth in OCFS custody who are being transported between detention and residential centers. At times, youth being transported spend the night at Tryon Boys with the general population.

The facility has a capacity of 180 youths, but during our tours, the facility was far below that capacity. During the June/July tour, the total population was 103 youths. By the November tour, the total population had been decreased to 26 youth in order for the staff to attend training.

4. Tryon Girls Residential Center

Tryon Girls is located adjacent to Tryon Boys and, like Tryon Boys, consists of multiple buildings and primarily cottage-style housing units. The campus includes several different security levels and programmatic housing: one secure

unit with 16 beds, one unit for youths in the Community Reintegration Program with 16 beds, several general limited-secure units with 16 beds each, and one mental health unit with nine beds. During our June/July tour, there were 54 youths. During the November tour, there were 50 youths.

B. Legal Background

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights and the federal statutory rights of juveniles in juvenile justice facilities. 42 U.S.C. § 1997. Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority with responsibility for the incarceration of juveniles to engage in a pattern or practice of conduct that deprives incarcerated juveniles of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to file a civil action to eliminate the pattern or practice.

The Due Process clause of the Fourteenth Amendment to the U.S. Constitution governs the standards for conditions of confinement of juvenile offenders who have not been convicted of a crime. Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987); Jones v. Blanas, 393 F.3d 918, 931 (9th Cir. 2004). Confinement of youth in conditions that amount to punishment, or in conditions that represent a substantial departure from generally accepted professional standards, violates the Due Process clause. Youngberg v. Romeo, 457 U.S. 307 (1982); Bell v. Wolfish, 441 U.S. 520 (1979); Society for Good Will to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239, 1245-46 (2d Cir. 1982)(extending Youngberg reasoning to children who are the responsibility of the state). The Fourteenth Amendment prohibits imposing on incarcerated persons who have not been convicted of crimes conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. at 539-540.

Youths in the custody of the State have a constitutional right to be free from physical abuse by staff and assaults inflicted by other youths. Youngberg, 457 U.S. at 315-16 (“personal security constitutes a ‘historic liberty interest’ protected substantively by the Due Process Clause”). Juveniles also have the right to be free from excessive use of force by staff and unreasonable bodily restraints. Youngberg, 457 U.S. at 315-16; Rodriguez v. Phillips, 66 F.3d 470, 477 (2d Cir. 1995)(holding that Fourteenth Amendment ensures freedom from excessive use of force in non-arrestee, non-prisoner context); Alexander S. v. Boyd, 876 F. Supp. 773, 786 (D.S.C. 1995) (in absence of genuine risk of serious bodily harm to another, use of a form of tear gas on youth detainees merely “to enforce an order” violates Due Process).

Confined juveniles also must receive adequate medical treatment, including adequate mental health treatment and suicide prevention measures. See Youngberg, 457 U.S. at 323-24 & n.30; Martarella v. Kelley, 349 F. Supp. 575, 598 (S.D.N.Y. 1972) (holding that juvenile facilities operated by the State of New York were obligated to provide adequate treatment to youths in custody).

II. FINDINGS

A. Failure to Protect Youth From Harm

Youth at OCFS facilities have a right to be free from unnecessary restraint and the use of excessive force. Youngberg, 457 U.S. at 315-16. Our investigation revealed that: 1) staff resort quickly to a high degree of force that is disproportionate to the level of the youth's infraction; and 2) the technique employed to restrain a youth results in an excessive number of injuries. We also found that investigations into uses of force and restraints were inadequate and that, in many instances, OCFS failed to hold staff accountable for gross violations of OCFS policy on the use of force and restraints.

1. Use of Excessive Force and Inappropriate Restraints

Staff at the four facilities consistently used a high degree of force to gain control in nearly every type of situation. OCFS' policy on physical restraints appropriately limits "the use of physical restraint to exceptional circumstances when all other pro-active, non-physical behavior management techniques have been tried and failed." OCFS Use of Physical Restraint Policy, 3247.13, sec. I. Moreover, the policy provides that "when the use of physical restraint is necessary, staff shall employ only the minimum amount of physical control necessary to stabilize the youth/situation." Id. In practice, however, staff at the facilities routinely used uncontrolled, unsafe applications of force, departing both from generally accepted standards and OCFS policy. Anything from sneaking an extra cookie to initiating a fistfight may result in a full prone restraint with handcuffs.¹ This one-size-fits-all control approach has not surprisingly led to an alarming number of serious injuries to youth, including concussions, broken or knocked-out teeth, and spiral fractures.

¹ A full restraint or full prone restraint is one of the OCFS-approved restraint techniques which staff explained and demonstrated for us during our tours. A full restraint involves staff ultimately placing the youth face down on the ground with his or her arms behind the back. The youth is frequently handcuffed by staff while in this position. By policy, the youth may not be handcuffed longer than thirty minutes.

a. Use of Excessive Force

Our investigation revealed that staff use excessive force to control youth's behavior. Staff at the four facilities have been trained to initiate the same response in any given situation regardless of the level of the youth's resistance to following directions. Further, the practices that staff use tended to escalate, rather than de-escalate, minor behavior problems into serious incidents. At Gossett, the practice is known as "pin pushing." By policy, this practice would not appear to be problematic; however, in application, it leads to a deviation from OCFS Use of Force Policy and excessive uses of force.

In general, "pin pushing" refers to staff pushing the button on their radios any time youth exhibit resistance to following directions. When staff push the pin, it triggers a response team that rushes to the location of the incident and is supposed to de-escalate the situation. In actuality, in many of the incidents we reviewed and observed during our tour, the team's actions actually intensified the tension to the point where a restraint was employed. As a result, a behavior such as pouring sugar into a glass of orange juice is just as likely to result in a restraint as initiating a fist-fight.

Staff are instructed to push the pin – thereby deploying a response team to the location – at even the slightest sign of resistance by a youth. For instance, Gossett's policy on "pin pushing" is set out in a memorandum to staff, which states as follows:

This memo is to serve as a reminder and a warning² of the guidelines set forth, from both the Facility Director and Facility Policy.

- If you "think," "feel," or "suspect" that you may have to use physical force - PUSH THE PIN.
- If a resident is physically or verbally aggressive - PUSH THE PIN.
- If a resident says "no" or demonstrates defiance in any manner - PUSH THE PIN.

Memorandum, dated December 18, 2007.

² Use of the word "warning" seems to imply that staff will be punished for their failure to push the pin.

The procedure at Tryon Boys is slightly different insofar as staff use a very basic code system comprised of two codes: a Code Red, which signals a security emergency, and a Code White, which signals an emergency escort. Other than that, there appears to be no attempt to tailor the response to the particular situation.

Given its effect, and coupled with the liberal number of circumstances in which staff are instructed to push the pin, this procedure conflicts with OCFS policy limiting use of force to “exceptional circumstances.” For example:

- Following a discussion with a YDA³ on the unit, a youth went to his room, visibly upset, and slammed the door. The YDA pushed the pin and the response team arrived. They ordered the youth to come out of his room, and when he refused, the staff entered his room and used force to remove him. The youth sustained multiple head injuries, abrasions to both of his elbows, and suffered a nosebleed after staff forcibly removed him from his room.
- In another incident, a youth “stormed off” and slammed his door after an argument with a YDA over not being allowed to participate in a basketball game. The YDA pushed the pin and the response team arrived. The response team entered the youth’s room, forcibly removed him, and restrained him. The youth sustained injuries to his left and right cheeks, his chin, and his neck.
- In yet another incident, the youth refused to get dressed until he was given the opportunity to shower. Staff pushed the pin and the response team arrived. The response team entered the youth’s room and placed him in a full restraint. The youth was released and allowed to stand up, at which point he stepped toward a YDA and was again placed in a full restraint. As a result, the youth sustained an abrasion to his right temple.

OCFS’ restraint policy prohibits staff from entering a youth’s room to confront negative behavior except to prevent the youth from physically harming himself/herself; however, there was no evidence or claims by staff in any of the above three incidents that suggested that these youth were threatening or engaging in self-harm.

³ Youth Division Aide, known as a YDA for short, is a first-line custody staff position.

- Staff pushed the pin when a youth refused to stop laughing loudly in the cafeteria after staff warned him several times to stop. Once the response team arrived, the youth was restrained, handcuffed, and removed from the cafeteria. The youth sustained a lip laceration, injuries to both wrists and elbows, and a bruise to his right upper arm.
- In another incident, staff ordered a youth to get up from the table where he was sitting and stand next to him. The youth complied, but in so doing, reportedly glared at the staff and “invaded [their] space.” The staff used force to place the youth in a sitting restraint.⁴ Reportedly, the youth had fractured his collarbone at a prior placement, and it was re-injured during this incident.

The above examples illustrate that staff consistently respond to what appear to be, at least initially, minor incidents with a high degree of force. Interviews with staff revealed that they do not believe that they have options to respond to youth’s behaviors. For example, according to both staff and youth, a common behavior that frequently results in a “pin push” is when a youth is “refusing to move.” Reportedly, this includes a youth’s refusal to get out of bed in the morning. When we asked a number of staff if there were any tactics, other than an escort, that they could use to address a situation where a youth refused to move, we consistently received responses such as: “I don’t know,” “nothing,” or “just sit there and wait.” In fact, staff informed us that recent measures to reduce restraints have put staff’s safety at risk since their “hands are tied” and they are forced to just step aside when youth are defiant. While we trust that this is not OCFS’ intent, this perception among staff is clearly problematic. The impact of resorting to the same failed method in confronting youth’s behaviors is evidenced by the number of youth who have been restrained multiple times in a short time period, particularly those whose behaviors could be a result of mental health problems. For example:

- One youth was restrained 11 times between January 3 and May 30, 2008. This youth was assigned to the mental health unit and has a habit of engaging in self-mutilating behavior when distressed. In eight of the 11 restraint incidents, she sustained injuries such as abrasions, shoulder/arm bruising, and swollen lips. Our review revealed that staff fail to engage in verbal strategies and too often employ a high degree of force to control her behavior.

⁴ A sitting or seated restraint is another OCFS-approved restraint technique. Basically, a sitting restraint involves staff securing the youth’s arms while seated on the floor with his or her legs in front of the body and the staff behind the youth.

- Another youth was restrained 13 times between January 3 and June 17, 2008. This youth had a history of arguing/fighting with her peers. One of the incidents, in which she was fully restrained for failing to follow staff's instruction to put her hands behind her back, resulted in bruises and abrasions to both of her arms. The restraint was precipitated by a YDA who, according to a YC,⁵ entered the youth's room and started removing photographs from her wall. A second YC reported that the YDA "initiated a restraint that was too hasty," yet no immediate corrective action was taken. At the time of our tour, this incident had been referred for investigation and the outcome was still pending.
- Another youth was restrained eight times between April 24 and June 25, 2008. This youth was assigned to a mental health unit and has a history of engaging in self-mutilation and suicidal gestures. In nearly every one of the eight incidents, the youth was engaging in behaviors such as head banging, putting paper clips in her mouth, tying a string around her neck, etc.; behaviors that, due to her mental illness, were beyond her control. Each of those incidents resulted in a full prone restraint, which is essentially punishment for exhibiting symptoms of her illness. Our experts (both in protection from harm and mental health) agreed that behavioral interventions would be more appropriate in these types of situations.

b. Inappropriate Restraints

Our investigation revealed that restraints are used frequently and result in a high number of injuries. For instance, in 2007 at Lansing, the total number of restraints was 698, an average of 58 restraints per month. One hundred and twenty-three Lansing residents were injured as a result of restraints that year. These injuries included bruises, concussions, knocked out teeth, and fractures. Some of the injuries suffered by girls at Lansing have been quite severe. For example, in the first three and a half months of 2008, one youth suffered a left shoulder separation and a hairline fracture to her left arm from one incident, and another resident suffered a shoulder displacement in one incident and a spiral fracture to her left arm in another.

⁵ A Youth Counselor, known as a YC for short, is a custody staff member who supervises a unit. The level of authority is designated by a "I" or a "II" following the YC title.

The number and severity of injuries resulting from restraints is made worse by poorly executed or intentionally harmful restraints. Many youth, particularly at the Tryon facilities, explained to us that a typical, unauthorized restraint technique is for staff to “hook and trip”; in other words, staff restrain a youth’s arms behind his or her back, then trip the youth’s legs so they fall to the floor face first. This clearly incorrect method of restraining youth may account for some of the bruising to the chin, forehead, and cheeks and broken teeth described in incident reports. In addition, youth also frequently reported to us that staff often restrain a youth’s arms behind his or her back, then pull forcefully up on the youth’s arms, resulting in severe pain and discomfort in the shoulders and arms.

Even when staff are following approved practices, restraints can be dangerous. In particular, the use of prone restraints is controversial and has been banned by many facilities nationwide due to the high risk of serious injury or death.⁶ In spite of the known risk of prone restraints, staff at the facilities are trained to use prone restraints. The danger of prone restraints is that if the individual’s airway is constricted, he or she is unable to express physical distress. Further, the restrained individual’s struggle for air may be misconstrued by staff as resistance, resulting in increased force on the restrained individual. Indeed, in November 2006, a 15-year-old resident at Tryon Boys died following a prone restraint. The youth allegedly pushed a staff member and was then pinned face-down on the floor and handcuffed by two staff. The youth stopped breathing only minutes later, and then died at a nearby hospital. His death was ruled a homicide by the medical examiner. Despite this tragic death, a dangerous combination of high rates of prone restraints and a low standard for initiating a restraint remains at the facilities.

Our expert reviewed a number of videos of incidents at Tryon Boys that were available during the tour. The videos we viewed showed staff applying force in ways that were both excessive and inappropriately executed. In one example, the force used was particularly dangerous:

- While staff were attending to a youth (“Y1”) who was engaging in self-mutilation in his room, a second youth (“Y2”) bolted from his room and headed down the hallway. Staff immediately used force to subdue Y2. None of the available staff took any actions to clear the other youths from the hallway or to secure the doorway of Y1. A third youth

⁶ The New York Department of Corrections and New York Office of Mental Health have already banned the use of prone restraints in adult correctional and mental health facilities. Dan Higgins, “Prone Restraint” Allowed at Youth Facilities, Albany Times Union, Nov. 22, 2006.

("Y3") came from his room and began kicking Y2, who was being restrained by staff on the floor and was unable to defend himself. Surprisingly, staff took no action to secure Y3. Y1 then exited his room. He was immediately placed in a choke hold by a YDA and taken to the ground. Additional staff began to arrive during the next five minutes, including the facility director, to assist in restraining Y2, yet no one assisted the YDA who was restraining Y1 in a choke hold nor told him to stop a clearly inappropriate restraint technique.

2. Failure to Adequately Investigate Use of Force Incidents

Incident reviews and investigations are necessary to ensure that staff are following OCFS policy and that youth are protected from abuse. These investigations are essential to identify staff in need of training and/or discipline, as well as to clear staff who have been wrongfully accused. Poor investigations prevent facility administrators from spotting trends and taking the appropriate measures to correct them when necessary. The investigation process must have reasonable integrity, preserve all physical evidence (e.g., videotape footage, documentation and photographs of injuries, clothing, etc.), obtain statements from all youth and staff involved in the incident and those who witnessed the incident, and utilize other sources of information to corroborate or refute the allegation (e.g., logbooks, other sources of facility documentation).

Many of the investigations our expert reviewed were inadequate, both by agency and generally accepted professional standards. For example, some investigations were superficial and failed to include relevant evidence or any attempt to reconcile conflicting evidence. Some investigations were not conducted by detached investigators, which calls their reliability into question. The following examples illustrate the types of breakdowns in the incident review system that our expert observed during his review:

- An investigation was initiated upon a youth's allegations that a YDA used excessive force and threatened him. During the incident in question, the youth destroyed property in his room and was forcibly removed to the unit office by a YDA and a YCII. Once in the office, the YDA and YCII placed the youth in a prone restraint, reportedly due to the youth's "struggling." Later, the youth complained to his counselor that after the situation resolved and the YCII left the office, the YDA placed his forearm against his neck and threatened that "next time I am going to hurt you real bad." A YCI completed the investigation into the incident and concluded that the youth's allegations were unfounded. There were numerous flaws in this investigation, which include: i) the documents do not describe the justification for the use of force that occurred in the unit office; ii) the investigator did not

interview the YCII who was involved in the incident; iii) the YCII involved in the incident signed off on the investigation as the Facility Investigation Coordinator; and iv) a YCI was investigating a YCII, his superior.

- In the course of a restraint, a youth sustained a spiral arm fracture, prompting an investigation. The incident began when the youth went to his room and slammed the door. Staff pushed the pin and a response team arrived. The youth was taken to the unit office and counseled. He returned to his room where he began “rapping” and was instructed by a YDA to sit in a chair in his doorway. The acting Case Manager then ordered staff to: “Hook him up and escort him to the office.” This resulted in a full take-down restraint, during which the youth sustained the spiral arm fracture. This investigation was essentially never reviewed, because it was signed off on by the same person who investigated the incident. In addition, the investigator failed to explain how, despite his identification of a number of “errors in judgment,” he could “conclude” that, “It is not necessarily a conclusion that his lack of procedure contributed to the injury.”
- Another investigation was initiated by a youth’s allegation that a YDA grabbed him and threw him into a gym divider (temporary wall) when he refused to run in place. Despite statements by another YDA and another youth that the YDA grabbed the youth by the shirt and escorted him to the gym hallway, the investigator concluded that no unnecessary force was used because there was no evidence that the YDA threw the youth into a wall. Serious flaws in this investigation include the investigator’s failure to address the violation of OCFS’s policy against using “touch controls” when directing a youth, and the investigator’s failure to reconcile the YDA’s statement that he never touched the youth with evidence to the contrary.
- In another alleged incident, a youth reported that, during a restraint, staff pulled her to the ground by her hair. The investigation included a written statement from another YDA who witnessed the incident that a hair pull tactic was employed. The subject of the investigation had an extensive disciplinary history, including use of force violations. The investigator concluded that, although the YDA acted precipitously, there “was not enough evidence to prove misconduct.” Notwithstanding the use of an unauthorized tactic, the YDA’s disciplinary history, and evidence that the YDA failed to wait for assistance, the investigator merely recommended a counseling memo.

- An investigation was prompted when a youth, who wore purple laces to indicate that her medical status required that she only be restrained in a sitting position, was reportedly subjected to a full prone restraint. According to the incident report, the YDA responded to a call for all available staff to report to a housing unit due to an incident, and upon arrival found three youths yelling and screaming and “assumed they were fighting.” The YDA placed the youth with purple laces into a full restraint, then placed her in a sitting restraint and applied handcuffs when he realized that she had purple laces. Photographs and the clinic report documented that she sustained bruising and swelling to her cheek, arm, and shoulder. This incident was reviewed, but no follow-up was recommended despite the injuries and the use of a full prone restraint on a youth with medical restrictions. Indeed, no inquiry was made related to whether the force was even necessary.

3. Failure to Take Corrective Action Against Staff

Equally as important as an adequate system for reviewing incidents is prompt corrective action in response to staff misconduct. Contrary to generally accepted professional standards, administrators in the facilities take no action, impose actions that are inconsistent with the seriousness of the violation, or fail to impose action in a timely manner. The following incidents illustrate the various breakdowns:

- Facility investigators concluded that a YDA used excessive force on a youth that resulted in two broken teeth, lacerations, bruises, and welts after she was left in a restraint for 3-4 minutes. Reportedly, the YDA had to be told by another YDA to stop the restraint after the youth began bleeding from her mouth. An administrative review of this incident was conducted on December 3, 2007, however we were unable to find whether this employee was ever disciplined. Six months later there was no indication of disciplinary action or retraining.
- A youth alleged that a YDA called him a “pussy” and threw him to the ground, causing a laceration to his chin that required sutures. The allegations were sustained and the YDA was recommended for termination. The YDA had three prior use of force violations on his record, one of which included fracturing a youth’s shoulder. The facility recommended termination, however the union achieved the following settlement: Letter of Reprimand, fine of \$800 to be taken in ten increments, and suspension of two weeks to be held in abeyance to be taken upon repetition of the same or similar acts within one year.

- Facility investigators investigated an incident involving a youth who was restrained for threatening to urinate on the floor. She sustained a concussion, vomited, urinated, and defecated when she was forcibly taken to the floor by a male staff who reportedly weighed in excess of 300 pounds. Inconceivably, the facility investigator concluded that the force was not excessive. However, the investigator also found that “this restraint could have been avoided had [the YDA] waited for assistance to come to his unit” and sustained a finding of Inappropriate Custodial Conduct. When our expert inquired as to the disposition of this case, we were provided a memorandum from the Facility Director to the Director of Labor Relations recommending that a “Counseling Memorandum be placed in [the YDA’s] personal history file.” However, we were then advised that this recommendation was a newly-discovered “clerical mistake” and the Facility Director had really intended to request that disciplinary action be taken against the staff.
- A youth alleged that she was restrained for taking a cookie without permission during evening snack time. The investigator concluded that the YDA who “hooked up” the youth, did so unnecessarily, and noted that the YDA had “several disciplines relating to inappropriate handling of residents.” One year later, sanctions were imposed pursuant to a settlement that included a “Letter of Reprimand” and a “fine of 3 days pay to be taken in the form of accruals.” One year is far too long a delay to arrive at a disposition on an incident involving a staff member who had been disciplined previously for misconduct and who had youth contact during this time.
- Another investigation resulted in a finding that a YDA inappropriately entered a youth’s room and used unnecessary force. After the incident, the youth complained of a swollen jaw and an injured wrist. The investigation noted that this YDA had a “lengthy institutional abuse history that includes six other indicated reports regarding four separate incidents from November 2004 through April 2006,” however, six months later this YDA remained employed at the facility.
- A youth alleged that a YDA dragged her from her bed and restrained her, causing her to sustain lacerations, bruises, and welts. The investigation found that the YDA used unnecessary force and fabricated evidence during the course of the investigation. The investigation was completed on August 14, 2007 and administratively reviewed on February 8, 2008, almost six months later. Four months after that, the YDA remained employed at the facility.

B. Failure to Provide Adequate Mental Health Care and Treatment

The State has an obligation to provide adequate mental health treatment to confined juveniles. See Youngberg, 457 U.S. at 323-24 & n.30. We find that the mental health care at Lansing, Gossett, Tryon Boys, and Tryon Girls substantially departs from generally accepted professional standards. Specifically, we find that: 1) inadequate behavioral management has led to an over-reliance on restraints and other forms of punishment to control youth's behaviors; 2) evaluation and diagnoses are inadequate; 3) the facility follows poor medication administration; 4) treatment planning is inadequate; and 5) substance abuse treatment is insufficient.

1. Failure To Provide Adequate Behavioral Management

Generally accepted professional standards require that juvenile justice facilities establish individualized behavior management programs to address the problematic behavior of youths with mental illness. Behavior management programs should include plans and strategies to address mental health crises and reduce their potential for recurrence. Staff employed at juvenile justice facilities should be trained in crisis intervention and de-escalation techniques, and should utilize the least restrictive measures necessary when a youth with mental illness acts out. Physical restraints should be used as an infrequent last resort.

Our investigation revealed that, while some attempts had been made to establish individual behavior management plans for youth with mental illness, the facilities failed to address problematic behavior and mental health crises with the least restrictive measures. Restraints were the standard for controlling behavior at all four facilities, and youths with mental illness were restrained more often than other youth. This was particularly acute at the two Tryon facilities. At Tryon Boys, youth with mental illness, who represented 50% of the population, were involved in 82% of the restraint episodes. At Tryon Girls, youth with mental illness, who represented 48% of the population, were involved in 60% of the restraint episodes.

During our tours, we reviewed records and directly observed youth with serious mental health problems that neither clinicians nor staff knew how to address. The harm resulting from the failure to provide adequate behavioral management is clearly illustrated by the case of the following youth:

- We discovered during our tour that this youth had been placed on a living unit by herself since August 2008 (approximately three months). Apparently in fear for the safety of others, and with no tools to address the youth's extremely challenging behavior, staff had virtually abandoned this youth. Her records and interviews with staff describe

complex behavioral problems and symptoms of a very serious mental illness which the facility was unable to address.

The youth was aggressive and assaultive, went through periods where she did not attend to her basic hygiene (including urinating and defecating on the floor of her room), refused to participate in activities, and refused medication. She had been taken to the emergency room on several occasions for forced injections and had been incarcerated in the local jail after injuring a staff person.

At the time of our November tour, this youth's mental health treatment (as well as her education) were effectively on hold. She never left her housing unit because she did not want to, and would only allow certain YDAs to work with her. She refused to attend school, refused to speak with her assigned counselor, and refused to take her psychotropic medication. She simply remained in the living unit in her pajamas. Her mental health treatment providers expressed concern for the youth's welfare but were clearly very frustrated by the lack of tools to address her complex behavioral problems. Although the problems with the youth had been ongoing, and she had lived in her own cottage for three months, the facility was at a loss for how to address her problems. She had been restrained by staff 15 times in the course of a little more than three months.

Another case involving a different youth further illustrates staff's ineffective efforts to address self-injurious behavior:

- According to staff, the youth had experienced a negative phone call with his family, and thereafter began rubbing raw a scratch on his finger. He was moved from his housing unit to the medical infirmary. The incident occurred in the evening, when mental health staff were no longer at the facility. Custody staff tried to convince him to stop hurting his finger, but the youth simply stared back at them mute and without expression. Staff attempted to stop his self-injurious behavior by standing over him, directing him to stop, asking why he was hurting himself, holding his hand up away from his body, and applying bandages. These actions were ineffective, and ultimately he was placed in handcuffs and shackles and transported to a local emergency room for an evaluation.

Youth who engage in self-injurious behavior are typically experiencing emotional pain for which they do not have appropriate coping skills. Most professionals would recommend that during this type of crisis, staff sit quietly with

the youth and empathize with his or her emotional pain (provided that the youth is not seriously injuring him or herself). It is impossible to teach new strategies to replace maladaptive coping strategies during the crisis. Later, staff should work with the youth in treatment to teach healthy coping strategies and to address specific issues which lead to crises. The crisis management plan for the youth should include efforts to reduce the potential for reoccurrence, through psychiatric treatment, treatment planning, behavioral modification, and environmental changes.

2. Failure to Properly Evaluate and Diagnose Mental Health Problems

Professional standards for the care of youth in juvenile justice facilities require that youth be evaluated by a psychiatrist for mental health problems, that those evaluations include specific information, and that the psychiatrist and other mental health treatment providers work with the youth based on agreed-upon diagnoses.

The psychiatric evaluation should include a review of: current mental status; the history of the present illness; psychiatric history; medical history; family history; current medications and response to them; history of treatment with medications and response; medication allergies; social history; substance abuse history; interviews of parents or guardians; and a review of prior mental health records. Psychiatric evaluations serve as the foundation for determining a youth's diagnosis and what type of treatment is appropriate, including whether psychotropic medication should be used. The evaluation should document how symptoms meet diagnostic criteria for any specific diagnosis, and should include an explanation and justification for the given diagnosis.

The majority of psychiatric evaluations at the four facilities did not come close to meeting the criteria described above. The evaluations typically lacked basic, necessary information, including justification for the diagnosis and evidence of prior record review. As a consequence, the treatment of youth with serious mental illness was based on poor information and was generally ineffective. The harm resulting from the failure to adequately assess a youth's psychiatric status is illustrated by the following example:

- A youth was diagnosed with Oppositional Defiant Disorder and a possible mood disorder based on the initial psychiatric evaluation at the facility. However, the evaluation failed to document what symptoms indicated the diagnoses, and there was no evidence that staff had reviewed evaluations from the youth's prior placements. If facility staff had reviewed prior evaluations of the youth, they would

have learned crucial details which may have guided an effective treatment program. The prior evaluations detailed a history of significant trauma, including severe parental abuse and neglect. Two prior placements diagnosed him with Posttraumatic Stress Disorder (“PTSD”).

During his commitment at the facility, the youth experienced difficulties, including several physical restraints due to his aggression “after conflict with staff.” It is likely that his aggression following conflicts with adults is triggered by his history of trauma, which none of the facility’s health providers nor treatment team were addressing.

The failure at Gossett, Lansing, Tryon Boys, and Tryon Girls to conduct proper psychiatric evaluations is compounded by the fact that youth frequently are assigned several different diagnoses at the same facility. It was not uncommon to find that the psychiatrist, other mental health treatment providers, and a youth’s treatment plan each assigned a different diagnosis to the same youth. It is difficult, if not impossible, to develop a cohesive treatment strategy when the treatment providers do not even agree on the youth’s problems. To further complicate matters, youth at Gossett, Lansing, and Tryon Boys had been evaluated at a reception center prior to their transfer, which then added a fourth diagnosis to the equation.⁷

Failing to properly evaluate and diagnose mental health problems results in ineffective treatment and harm to youth. For example:

- One 16-year-old resident was given one diagnosis by the psychiatrist, and a different diagnosis by her counselor. There was no explanation of how her symptoms met the criteria for either diagnosis, and her treatment seemed ineffective in addressing her issues. The evaluation from the reception center discussed the youth’s history of physical abuse, exposure to domestic violence, and childhood sexual abuse. She was diagnosed at the reception center with Bipolar Disorder, PTSD, and Conduct Disorder.

⁷ The same psychiatrist who completes the intake assessment for female youth at the reception center provides the ongoing treatment of many of the youth who are placed at Tryon Girls. As a result, the youth’s diagnosis from the reception center and the psychiatrist’s diagnosis at Tryon Girls were generally consistent. However, the same problems with different diagnoses from the psychiatrist, the mental health treatment provider, and the treatment plan exist at Tryon Girls.

Upon arrival at Lansing in August 2008, there was a cursory intake psychiatric evaluation. The evaluation noted that the youth had a history of family violence, hospitalizations resulting from aggression or suicidality, nightmares, flashbacks, panic attacks, and possible dissociation. She was diagnosed with Conduct Disorder, without any discussion of how her symptoms met the diagnostic criteria. In September 2008, an unsigned mental health assessment in the youth's records reported that she demonstrated high agitation and labile affect,⁸ and diagnosed her with a mood disorder. During this time, she was prescribed – without justification – a psychotropic medication not indicated for the treatment of Conduct Disorder or a mood disorder.

Counseling notes from this time period state that the youth had experienced flashbacks due to past parental abuse, and that when she was restrained by staff, this would escalate into an assault on the staff. The counselor noted that the youth has “a problem with close contact when angry” and needs “quiet time to calm down appropriately.” However, this astute observation was not addressed in the youth's treatment plan, and staff continued to frequently restrain her – 16 times in less than two months.

3. Inappropriate Medication Practices

If psychotropic medications are used, generally accepted professional standards require that youth be properly assessed and that medications be prescribed based on identified target symptoms and a known benefit to treat those symptoms, based on a valid diagnosis and understanding of the root causes of the illness. The psychiatrist should provide ongoing management and monitoring of the youth's symptoms and the effectiveness of the medication. Medication changes should follow documented monitoring of the effects of previous medication choices and reasons for abandoning a previous medication regimen. Because many psychotropic medications may cause harmful side effects, careful monitoring through laboratory tests is often necessary.

a. Prescription and monitoring of medications

Each psychotropic medication prescribed should treat specific target symptoms exhibited by a youth, insofar as these symptoms relate to a specific psychiatric diagnosis. The effect of medication on the target symptoms should be

⁸ “Labile affect” refers to rapid shifts of outward emotional expression, such as changing quickly from laughing to crying.

carefully monitored, and adjusted, if needed, if the target symptoms do not improve. Without an individual and symptom-specific rationale for the use of psychotropic medications, medication may be inappropriately used for sedation, especially where multiple medications are used.

Across the four facilities, there was a pervasive lack of documentation of either the target symptoms for the medications or monitoring of the effectiveness (or lack thereof) of medication on those target symptoms.

- One 15-year-old youth was on six psychotropic medications at the time of our tour. We were unable to determine from his records either his agreed-upon psychiatric diagnoses or the target symptoms for the six medications. The youth was diagnosed by the facility's psychiatrist with Oppositional Defiant Disorder, but there was little documentation of review of symptoms other than the word "sleep" with a check mark beside it, and notes stating: "[N]o psychosis/mania. Mood OK, affect fine . . . does not appear depressed/anxious." His diagnoses on the treatment plan were listed as Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder ("ADHD"), Bipolar Disorder, parent/child relational problem, and cannabis abuse. These diagnoses were not reflected in the psychiatric progress notes.

In addition to the lack of documented rationale for the various diagnoses of the youth and the prescription of multiple psychotropic medications, the apparent ineffectiveness of his treatment went unaddressed. He continued to exhibit challenging behavior, including losing his temper and defiance. He was restrained on six occasions in the span of three months. In one incident, the youth began shouting and banging on the door of his room. He was physically moved from his room and ultimately placed in a full prone restraint, then restrained with handcuffs for 20 minutes. In another incident, the youth was placed in a full prone restraint for refusing to follow the rules during recreation, and was placed in isolation. During isolation, he repeatedly banged his head on the wall. As a result of the restraint, he suffered facial abrasions and pain to his shoulders. There were no changes in the youth's medications following these incidents.

b. Monitoring for side effects

Psychotropic medications may cause adverse, and sometimes serious, side effects. Therefore, generally accepted professional standards require routine monitoring for potential side effects, including abnormal involuntary movement

monitoring; routine laboratory examinations, including medication levels and electrocardiograms; vital sign monitoring; and weight monitoring.

Our review of the four facilities' psychotropic medication practices showed substantial departures from generally accepted professional standards. Our expert consultant did not find any charts where youth were being monitored for abnormal involuntary movement. In interviews, the psychiatrists confirmed that they did not routinely monitor for involuntary movements but one agreed that "it would probably be a good idea." In addition, there are no system-wide protocols specifying which medications require which laboratory examinations. Where laboratory examinations were conducted, they omitted critical information. For example:

- One youth was prescribed multiple psychotropic medications. The laboratory examinations appropriately included testing of blood sugar and liver function, but omitted a complete blood count and medication level. (One of the drugs prescribed to the youth can cause a decrease in platelets, among other serious side effects.) In subsequent psychiatric progress notes, there was no evidence that the results of the requested tests were ever reviewed by the psychiatrist. The failure to test for serious side effects and the failure to review the results of the tests placed this youth at serious risk of harm.

c. Medication refusal documentation at Tryon Boys

Once a youth assents to treatment with psychotropic medication and other informed consent requirements are met, the medication should be administered according to the agreed-upon regimen by trained medical staff qualified to dispense medications. If a youth refuses medication, standards of care require that the youth state the refusal to the medical staff responsible for dispensing the medication, and that the youth should sign a refusal document stating why he or she is refusing. A youth's refusal should be communicated to mental health staff, including the treating psychiatrist, so they can discuss the risks of non-adherence with the youth as well as discuss any other concerns, such as unpleasant side effects.

At Tryon Boys, documentation showed a disproportionately high rate of medication "no shows" without a notification by the youth to medical staff, signed refusal form, or follow-up by mental health staff. For example:

- One youth who was prescribed three psychotropic medications was a "no show" for medications on 13 occasions between November 1 and 19, 2008. Non-compliance with these medications could result in serious side effects. Specifically, rapid reduction of one of the medications can result in seizures, and a rapid reduction of another of

the prescribed medications can cause a severe increase in blood pressure. Moreover, the youth's psychiatric symptoms and problematic behavior appeared to be escalating even before the extended period of medication non-compliance in November, and then worsened, resulting in staff restraining him with increasing frequency. Despite these clear signs of problems with the youth's mental health and behavior, nothing in the psychiatric progress notes addresses either medication non-adherence or the restraint episodes.

Notably, the medication administration records of youth who refused medication indicated that medical staff "encouraged" custody staff to bring youth for medications, but when a youth failed to appear, it was custody staff – not the youth – who told medical staff. While youth have the right to refuse medication, allowing youth to simply decline medication verbally to custody staff impedes access to care. It inhibits medical staff from getting the information they need to determine why the youth is refusing medication, and to discuss with the youth whether non-adherence to treatment is the best choice. In addition, it opens the door to custody staff making decisions about taking youth to receive medications based on convenience or perceived understaffing.

d. Informed consent

Informed consent is necessary prior to the prescription of psychotropic medication for any patient, but it is particularly critical in child and adolescent treatment. There are few psychotropic medications approved by the U.S. Food and Drug Administration for the treatment of youth, and a paucity of controlled studies addressing the efficacy and safety of the use of psychotropic medication in this population.

According to generally accepted professional standards, the following information should be provided to the youth and to his or her parents or guardians by an individual with prescriptive authority: (1) the purpose/benefit of the treatment; (2) a description of the treatment process; (3) an explanation of the risks of the treatment; (4) a statement of alternative treatments, including treatment without medication; and (5) a statement of the unknown risks of the medications.

Informed consent procedures at the four facilities substantially depart from generally accepted professional standards. We found that, in practice, staff members calling the parent/guardian to obtain informed consent typically did not have prescriptive authority, and therefore were not able to discuss the medication with the parent/guardian. Consent obtained in this manner is not "informed." Each facility's informed consent process relied on professionals without prescribing authority to contact the parent/guardian for verbal consent.

Policy Number LGC 3243.14 in the Gossett Facility Operations Manual defines “mental health clinician” to include a social worker, psychiatric/community mental health nurse, psychologist or psychiatrist. Further, the policy provides that:

At no time during this process is the clinician expected to enter into an independent discussion with the parent/guardian as to the risk and benefits of the prescribed medication(s). If the parent/guardian wishes to discuss the risks/benefits of medications, arrangements must be made for the parent/guardian to have the opportunity to speak with the prescribing physician . . . no longer than two weeks from the time requested.

4. Inadequate Treatment Planning

In order for youth to receive adequate mental health treatment, they must be provided adequate treatment plans that guide their care. All of a youth’s mental health treatment providers, including the psychiatrist, should agree on the youth’s diagnosis, identify what problems need to be addressed and what may be causing those problems, and develop goals with the youth on how to work on those problems. The treatment plan should be written in language which the youth understands. The youth, psychiatrist, other mental health treatment providers, and other facility staff, such as teachers and custody staff, who know the youth should all be included as members of the treatment team. In addition, the treatment team should revise the plan, including the youth’s diagnosis, as the youth progresses and the team learns more about the youth. If the treatment plan is not helping, then it should be revised.

The treatment plans at all four facilities substantially departed from these standards. Many youths had complex mental health needs documented in their records, but the treatment plans were superficial, generalized, and in jargon which the youths did not understand. For example:

- One 16-year-old youth’s mental health history and risk factors (which were described in detail in the evaluation from a reception center) include psychiatric hospitalization, a history of deaths of family members and friends, significant social skill deficits, low cognitive functioning, low academic level, daily drug use, depression, and hopelessness. He was diagnosed at the reception center with ADHD, PTSD, Conduct Disorder, a mood disorder, a learning disorder, borderline intellectual functioning, and drug abuse. Clinicians would generally recommend that a youth exhibiting such symptoms of PTSD and learning disabilities must be helped to: (1) understand his trauma as the source of his anger and recover from this trauma, and (2) understand his cognitive impairments and how to compensate for

them so that they do not adversely affect his emotions, relationships with peers, and ability to follow directions. However, the treatment plan goals were vague, simplistic, and did not address the youth's underlying problems in any meaningful way. His mental health goals included "cooperat[ing] with psychiatric evaluation and medication for ADHD and anger dysregulation" and "regulat[ing] emotions on unit, display increased cooperation with staff and refrain from aggression toward peers."

The composition of the treatment team is a fundamental element of treatment planning. However, the treatment teams generally lacked critical members, most often the youth and the psychiatrist. One psychiatrist described his role as "an outsider" and expressed frustration because, "I have to beg, borrow, and steal information."

Treatment planning at the four facilities is further hindered by a maze of uncoordinated plans and goals for the youth (in addition to the treatment plan itself). On the living units, each youth has a binder called a Youth Development Log ("YDL") which contains a variety of materials, including the Resident Behavior Assessment ("RBA") and, sometimes, the Behavior Improvement Plan ("BIP"). The RBA contains "focus items" which are intended to be behavioral interventions, and also includes items that youth's staff mentors are required to rate the youth on weekly. A second binder includes, among other items, the mental health treatment plan and the psychiatrist's notes. The school has its own records, including the Individualized Education Plan.⁹ If a youth is involved in substance abuse treatment, it appears that the plans related to substance abuse are separate. These plans each operate without reference to the others.

Our investigation found that the RBA seemed to take precedence over treatment planning. The RBA is a boilerplate form that requires staff to choose which statements reflect the youth's behavior, such as "Models and promotes the use of non-violent alternatives for resolving conflicts," and "Regularly lies to avoid punishment or blame." The main focus of the RBA appears to be behavior control. In observing four different treatment team meetings during our tours, the focus in each meeting was on the RBA, with little or no acknowledgment of the treatment plan.

⁹ The Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 *et seq.*, requires the development of Individual Education Plans ("IEP") for qualifying youths with disabilities. The IEP should include information about a youth's disabilities, including mental illness.

In addition, generally accepted professional standards require treatment planning to be a coordinated and dynamic process. Treatment plan goals should be revised as necessary based on the youth's behavior and accomplishments, any changes in the working psychiatric diagnosis, and any other developments, such as new information provided by the youth about drug use, abuse history, or other issues. However, treatment planning is so fragmented that staff fail to communicate crucial details about youth's behaviors and symptoms to other staff. For example:

- A youth told us that he feels persecuted and ostracized at the facility due to his medical and mental health problems. In addition to his psychiatric illness, this youth suffers from a serious urological problem. In October 2008, he was seen at the clinic for vomiting and other symptoms, which he mistakenly believed were caused by pregnancy. The exam notes state that the youth may be delusional. Despite this significant incident, it appears that the youth's belief that he was pregnant and the possibility that he was delusional was not communicated to the treating psychiatrist. It is unknown whether this was addressed in the youth's individual therapy. (Because the youth's assigned counselor is employed by the State Office of Mental Health, rather than OCFS, the individual therapy notes are filed separately from OCFS documents, further hindering the goal of integrated treatment planning.) A cohesive, comprehensive treatment plan for this youth would be invaluable not only to the treatment team, but also to other staff who attempt to address his behavioral and mental health challenges on a daily basis. Instead of productive interventions, custody staff had resorted to restraining him.
- Another youth's assessment documented her depression and anger. Before being placed in the facility, she had been the victim of a serious sexual assault, had been placed in a psychiatric hospital, and had been suspended from school for fighting. The facility psychiatrist recommended that the youth receive psychotherapy in order to address her past trauma. Her single, simplistic treatment goal was: "Youth will identify one way that her behavior has consequences for her and for others" and listed the same treatment modalities as for any other youth at the facility. Several days after her treatment plan was completed, the youth attempted to hang herself with a shoelace. In a suicide risk evaluation following this incident, the youth asserted that "as long as she is feeling this bad, she will try to kill herself." Despite these signs of serious mental distress, her treatment plan remained unchanged following the suicide attempt.

Many youth at the four facilities had well-documented trauma that was left untreated and unaddressed in treatment planning. We found that in attempting to control youth behavior through commands and the threat of restraints, staff unintentionally triggered traumatized youth, who reacted with escalating anxiety, angry outbursts, or aggression. Traumatized youth interpreted staff's action as attempts to victimize them. To address the unique needs of traumatized youths, treatment planning consistent with the standard of care would include developing multi-disciplinary interventions so that staff do not escalate youth's reactions or further traumatize them, and so that the youths learn to use coping skills. Failing to help these youths with past trauma means that they will probably continue to be reactive and aggressive upon their return to the community. In the short-term, failing to treat their trauma often results in staff unwittingly triggering this aggression. At these facilities, this aggression is controlled by restraining youth. For example:

- One 17-year-old youth was being treated for PTSD. She has a history of sexual abuse, and experiences flashbacks, anxiety, hypervigilance, and affective instability as part of her mental illness. Her simplistic treatment plan goals include reducing aggression, reducing anxiety, and developing coping skills. There is no reference to the likely connection between her traumatic experiences and reactivity nor an individualized strategy to help her develop appropriate coping skills. Similarly, the focus of unit staff is on her aggression and her IEP describes her as "disruptive, argumentative and aggressive ... rude, disrespectful, loud, obnoxious" and notes that she is easily distracted, requires one-on-one assistance, has a short memory span and trouble following verbal and written direction. Unsurprisingly, the failure to address her past trauma and its effect on her reactivity and anxiety or her learning problems has harmed this youth. In the five months since she had arrived at the facility, she had been restrained approximately two times each month.

5. Insufficient programming to address youth's substance abuse issues

Generally accepted professional standards require that juvenile justice facilities address the substance abuse needs of youth in their custody. OCFS staff stated that the youth in the New York system with the highest risk level for substance abuse disorders are placed in specific facilities with substance abuse treatment programs. Tryon Boys is one such facility.

Our review of youth records found that most youth were not identified as having substance abuse problems. It is unlikely that the vast majority of youth at

these four facilities do not have substance abuse or dependence problems. Typically, drug use is a factor in the actions which lead to youth's detainment in juvenile justice facilities. Moreover, our record review found youths whose histories specifically indicated drug use issues who were not being treated for substance abuse problems. For example:

- One youth has a self-reported history of daily marijuana use, and indicated that her father also has a substance abuse history. She was diagnosed in the initial facility psychiatric evaluation with Cannabis Abuse (among other diagnoses). She was not, however, referred for any substance abuse treatment.
- Another youth self-reported that she used marijuana daily and frequently used alcohol. The reception center's assessment gave her preliminary diagnoses of Cannabis Dependence (in remission due to placement in a controlled environment) and Alcohol Abuse. But the facility's assessments included no mention of a substance abuse or dependence diagnosis or her history of drug use.

In addition, there appears to be an artificial separation between youth's mental health diagnoses and substance abuse disorders; youths with both problems were typically diagnosed either with a mental health diagnosis or a substance abuse problem, but not both. There is high co-morbidity between mental illness and substance abuse, and to treat one and ignore the other effectively treats neither issue. The high rate of substance abuse by traumatized youth is well-documented. This is often a maladaptive coping mechanism, in which the substances are used to soothe and numb feelings and memories associated with the trauma. Thus, excluding treatment of trauma from substance abuse treatment in such cases is problematic.

- For example, one 17-year-old resident's initial psychiatric diagnosis at the facility was PTSD. He was later moved into a different housing unit for substance abuse treatment, and his diagnosis changed to alcohol abuse, cannabis dependence, depressive disorder, and conduct disorder. Treatment for the trauma of PTSD was inexplicably dropped.

The failure of the facilities to address the substance abuse needs of youth deviates substantially from the standard of care.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of the youth confined at Gossett, Lansing, Tryon Boys, and Tryon Girls, OCFS should implement, at a minimum, the following measures:

A. Protection of Youth From Harm

1. Ensure that youth are adequately protected from excessive use of force by staff.
2. Ensure that youth are not subjected to undue restraints, that restraints are used only when a youth presents a clear danger to him/herself or others, and that restraints are never used to punish youth.
3. Ensure that the use of physical restraint is limited to exceptional circumstances when all other pro-active, non-physical behavior management techniques have been tried and failed, and that in the limited circumstances when physical restraint is necessary, staff shall employ only the minimum amount of physical control necessary to stabilize the situation. Revoke all memorandums or directives to "push the pin" when youth shows any sign of resistance, including the December 18, 2007 Gossett memorandum. Ensure that staff understand that such guidance is no longer in effect.
4. Review the use of physical restraint techniques, including the use of face-down restraints, to determine whether the practices should be eliminated or modified in order to conform to generally accepted professional standards. If face-down restraints continue to be used, develop procedures which require that trained staff shall monitor youths in restraints for signs of physical distress and ensure that restrained youths are able to speak. Ensure that staff are adequately trained in physical restraint techniques, procedures to monitor the safety and health of youths while restrained, and first aid and CPR. Ensure that only those staff whose training is current in the above procedures are authorized to utilize physical restraints.
5. Provide adequate training and supervision to staff in all areas necessary for the safe and effective performance of job duties, including training in child abuse reporting; in the safe and appropriate use of force and physical restraint; in the use of force continuum; and in crisis intervention and de-escalation techniques.

Routinely provide refresher training as required by generally accepted professional standards.

6. Ensure that all allegations of child abuse and mistreatment are promptly referred to the appropriate authorities.
7. Ensure that serious incidents, allegations of abuse, and allegations of staff misconduct are adequately and timely investigated by neutral investigators with no involvement or interest in the underlying event. Ensure that staff who are the subject of an allegation of abuse be removed from direct youth supervision pending the outcome of the referral or investigation.
8. Ensure that facility administrators take prompt and appropriate corrective measures in response to staff misconduct.

B. Mental Health Care

1. Provide adequate mental health and rehabilitative treatment.
2. Ensure that there is an adequate, appropriate, and effective behavior management system in place, and that the system is regularly reviewed and modified in accordance with evidence-based principles.
3. Train all staff, including custody staff, on appropriate strategies to address youth's mental health crises, including crises resulting in self-injurious behaviors. Develop policies and procedures for contacting mental health treatment providers outside of regular working hours in the event of a youth's mental health crisis.
4. Ensure that psychiatric evaluations comply with generally accepted professional standards, including review of youth's prior records and identification of how the youth's symptoms meet diagnostic criteria for the diagnosis.
5. Ensure that the mental health treatment providers, including the psychiatrists, develop a uniform working diagnosis for each youth.
6. Ensure that prescription of psychotropic medications is tied to specific target symptoms, and that youth records reflect the rationale for prescription of every medication, the target symptoms intended to be treated by the medication, and monitoring of the effectiveness of the medication on the target symptoms.

7. Ensure that the following information is provided to youth and to his or her parents or guardians by an individual with prescriptive authority: (1) the purpose/benefit of the treatment; (2) a description of the treatment process; (3) an explanation of the risks of the treatment; (4) a statement of alternative treatments, including non-treatment with medication; and (5) a statement of the unknown risks of the medications.
8. Develop and implement system-wide protocols for routine monitoring, including laboratory examinations and side effect monitoring, for each psychotropic medication prescribed. Ensure that monitoring is completed in accordance with generally accepted professional standards, and that results are adequately reviewed by each youth's psychiatrist.
9. Ensure that youth's refusals of psychotropic medication is communicated to medical staff directly by the youth, that the youth signs a refusal form, and that the youth's refusal of medication is communicated to his or her mental health treatment providers.
10. Revise system-wide policy and procedure for obtaining informed consent for psychotropic medications in accordance with generally accepted professional standards.
11. Develop and maintain adequate formal treatment planning in accordance with generally accepted professional standards. Ensure that treatment planning focuses on the youth's treatment plan, not collateral documents such as the "Resident Behavior Assessment." If a youth has a history of trauma, ensure that treatment planning recognizes and addresses youth's history of trauma and its impact.
12. Ensure that treatment teams include the youth and the youth's psychiatrist in addition to other appropriate staff.
13. Ensure that all youth who have problems with substance abuse or dependence are provided adequate treatment for those problems.
14. Ensure that youth whose serious mental health needs cannot be met at the facilities are promptly transferred to appropriate settings that meet their needs.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until 10 calendar days from the date of this letter.

The collaborative approach the parties have taken thus far has been productive. We hope to continue working with OCFS in an amicable and cooperative fashion to resolve our outstanding concerns. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical, technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you.

Accordingly, the lawyers assigned to this matter will be contacting the attorneys for OCFS to discuss next steps in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Loretta King

Loretta King
Acting Assistant Attorney General

cc: The Honorable Andrew M. Cuomo
Attorney General
State of New York

Gladys Carrión, Esquire
Commissioner
Office of Children and Family Services

Karen Walker Bryce
Deputy Commissioner and General Counsel
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Annette Larrier
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U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D.C. 20530*

SEP 11 2009

Marlin N. Gusman
Orleans Parish Criminal Sheriff
2800 Gravier Street
New Orleans, LA 70119

Re: Orleans Parish Prison System
New Orleans, Louisiana

Dear Sheriff Gusman:

I am writing to report the findings of the Civil Rights Division's investigation of conditions of confinement at the Orleans Parish Prison ("OPP"). On February 12, 2008, we notified you of our intent to conduct an investigation of conditions at OPP pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On June 23-27, 2008, August 18-20, 2008, and November 17-20, 2008, we conducted on-site inspections at OPP with expert consultants in corrections, use of force, custodial medical and mental health care, and sanitation.¹ We interviewed administrative staff, security staff, medical and mental health staff, facilities management staff, training staff, and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, use of force reports, investigative reports, inmate grievances, disciplinary reports, unit logs, orientation materials, medical records, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary impressions to OPP officials and legal counsel for the Sheriff's Office at the close of each of our site visits.

¹ Our corrections expert was the only expert who accompanied us on the August on-site visit, and our medical health care expert was the only expert who accompanied us on the November on-site visit.

We remain sensitive to the fact that OPP is still recovering from the devastating effects of Hurricane Katrina and commend the Sheriff and his staff for their extraordinary efforts to structurally rebuild the facilities. We also note the tremendous strides and improvements that the Sheriff and his staff have made in light of the scope and depth of destruction caused by Hurricane Katrina.

We commend the OPP staff for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation with our investigation and appreciate the receptiveness to our consultants' on-site recommendations. Accordingly, we have every reason to believe that the Sheriff, his office, and the City are committed to remedying all known deficiencies at OPP. We hope to be able to work cooperatively to such a resolution.

Prior to our investigation, many media reports, allegations, and even rumors circulated regarding conditions at the Jail following the Hurricane. Our review of documents, investigative files, and interviews of staff and inmates has been to ascertain if the Constitution has been violated in a systemic manner. Again, commendably, we recognize the Sheriff's efforts in safely and efficiently evacuating the inmates and his efforts to secure the necessary funding to rebuild.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at OPP violate the constitutional rights of inmates. In particular, we find that inmates confined at OPP are not adequately protected from harm, including physical harm from excessive use of force by staff and inmate-on-inmate violence. In addition, we find that inmates do not receive adequate mental health care, including proper suicide prevention. While OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in medication management. OPP inmates also face serious risks posed by inadequate environmental and sanitation conditions.

I. BACKGROUND

Located in downtown New Orleans, OPP is one of the largest correctional facilities in Louisiana. Despite its name, OPP operates like a county jail (Louisiana's parishes are equivalent to other states' counties). Like most county jails, OPP houses a large number of pre-trial detainees and inmates serving short misdemeanor sentences. Currently, OPP is able to accommodate 2,545 inmates and serves as overflow for the Louisiana Department of Corrections and the federal prison system.

Prior to its loss of physical plant space, due to damages sustained in Hurricane Katrina, OPP's capacity was 8,000 and the facility housed an average of 6,500 inmates daily. Again, it currently can house 2,545 inmates. OPP currently operates six of the original 12 jail buildings and is staffed by approximately 450 security officers. At the time of our visits, OPP housed inmates in the House of Detention ("HOD"), South White Street, Templeman V, Conchetta,

eight windowless tents constructed with FEMA financial assistance (“The Tents”), and the Broad Street work-release facility.

Recently, the Orleans Law Enforcement District (“LED”) was statutorily created to provide financing to the Criminal Sheriff’s Office. Further the LED is authorized to issue bonds for equipping and furnishing facilities for the Criminal Sheriff and for agencies where there is a use or benefit to the LED and the Sheriff. Of the \$63,225,000 in bonds issued for the LED, \$40,890,000 have been designated to the Sheriff for the jail and other facilities, which should impact the constructing, improving, renovating, and repairing of various facilities at OPP.

In making our findings, we acknowledge that there have been ongoing improvements at OPP during the course of our investigation. The damaged Intake Processing Center (“IPC”) was demolished and a new IPC opened in June 2008. In addition, we are aware that the 80-year-old original Orleans Parish Prison Jail re-opened in February 2009. The refurbished jail is designed to hold more than 800 inmates. We understand that the Sheriff plans to occupy the jail with inmates currently housed in temporary facilities or facilities in need of work. Despite these commendable improvements, we believe there are serious constitutional deficiencies at OPP, as will be discussed in detail below.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. In defining the scope of jail inmates’ Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates’ safety and provide “humane conditions” of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (finding that a municipality assumed a constitutional obligation under the Fourteenth Amendment to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir. 1996) (en banc), rev’d on other grounds, 135 F.3d 320, 324 (5th Cir. 1998) (“[T]he State owes a duty to both [detainees and convicted prisoners] that effectively confers upon them a set of constitutional rights that fall under the Court’s rubric of ‘basic human needs.’”). The Fifth Circuit has held that the protection of pretrial detainees’ rights under the due process clause of the Fourteenth Amendment is “at least as great as the Eighth Amendment protections available to a convicted prisoner.” Id. (quoting City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983)).

A jurisdiction’s constitutional obligation to provide adequate medical care to inmates includes the duty to provide adequate psychological and psychiatric mental health care. Farmer, 511 U.S. at 832; Gates v. Cook, 376 F.3d 323, 332 (5th Cir. 2004) (finding that “mental health needs are no less serious than physical needs”); Woodall v. Foti, 648 F.2d 268, 272 (5th Cir.

1981) (finding that an inmate stated a claim of deliberate indifference where prison officials refused to treat him and knew that he had been diagnosed as a pedophile and as a manic depressive with suicidal tendencies). Consequently, a prison's failure to take any steps to save a suicidal detainee from self harm may constitute a constitutional violation. Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1187 (5th Cir. 1986).

The standard for adequate mental health care follows the standard for medical care, requiring a showing of both the subjective and objective components of "deliberate indifference." Gates v. Cook, 376 F.3d at 333. The jail officer's subjective knowledge must be determined by the finder of fact through circumstantial evidence or the obviousness of the risk. Id. The Fifth Circuit emphasized "that the essential test is one of medical necessity and not one simply of desirability." Woodall v. Foti, 648 F.2d 268, 272 (5th Cir. 1981). In determining the adequacy of mental health care, the Court makes a holistic assessment of the prisoner's conditions of confinement. Gates v. Cook, 376 F.3d at 343 (acknowledging that "the isolation and idleness of Death Row combined with the squalor, poor hygiene, temperature, and noise of extremely psychotic prisoners create an environment 'toxic' to the prisoners' mental health.").

The Eighth and Fourteenth Amendments forbid prison officials from using excessive physical force against inmates and pre-trial detainees. See Hudson v. McMillian, 503 U.S. 1 (1992), Farmer, 511 U.S. at 832; see also United States v. Walsh, 194 F.3d 37, 48 (2d Cir. 1999) ("the right of pre-trial detainees to be free from excessive force amounting to punishment is protected by the Due Process Clause of the Fourteenth Amendment.") (citing Bell, 441 U.S. at 535 [citations omitted] [emphases in the original]). The Fifth Circuit has held that this is true even when the use of force does not result in significant injury. Gomez v. Chandler, 163 F.3d 921, 924 (5th Cir. 1999) (concluding that there is no categorical requirement for an Eighth Amendment excessive force claim to be supported by a prisoner's significant, serious, or more than minor physical injury).

The standard for measuring the appropriateness of the force used is "whether force was applied in a good-faith effort to maintain or restore discipline or maliciously and sadistically for the very purpose of causing harm." Hudson, 503 U.S. at 6 (quoting Johnson v. Glick, 481 F.2d 1028, 1033 (2d Cir. 1973)). In determining whether force was used in good faith or in excess, courts examine a variety of factors, including:

"[T]he need for the application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response."

Id. at 7-8.

Prison officials have a duty, under the Eighth Amendment, to protect prisoners from violence at the hands of other inmates. Farmer, 511 U.S. at 832-833; Longoria v. Texas, 473 F.3d 586, 592 (5th Cir. 2006). The standard for adequate protection from inmate violence is the

same as the standard for medical and mental health care, laid out in Farmer and discussed above, requiring a showing of “deliberate indifference.” Id. at 837-839. The Fifth Circuit has determined that prison officials can be held liable for their failure to protect an inmate if they are deliberately indifferent to a risk of serious harm posed by another inmate’s violent acts. Cantu v. Jones, 293 F.3d 839, 843-844 (5th Cir. 2002) (affirming verdict against prison-guard defendants found to have manifested the requisite deliberate indifference when they left the door to inmate’s cell open, allowing him to escape and assault another inmate).

Prison officials must minimize inmate exposure to unhygienic conditions. Palmer v. Johnson, 193 F.3d 346, 352-353 (5th Cir. 1999) (finding that deprivation of toilet privileges for 17 hours forcing prisoners to urinate and defecate in a confined area with 48 other inmates constituted cruel and unusual punishment); Gates, 376 F.3d at 338 (holding that filthy cell conditions constituted an Eighth Amendment violation). Prisoners must be protected from both present and continuing exposure to harm caused by unsafe conditions, including mingling with inmates with contagious diseases. Helling v. McKinney, 509 U.S. 25, 33-34 (1993) (asserting that the Eighth Amendment protects against sufficiently imminent dangers as well as current unnecessary and wanton inflictions of pain and suffering).

The Fifth Circuit has held that both objective and subjective components are needed to establish an Eighth Amendment violation caused by unhygienic conditions. Harper v. Showers, 174 F.3d 716, 720 (5th Cir. 1999). First, there must be an objective showing of conditions “so serious as to deprive prisoners of the minimal measure of life’s necessities.” Id. (quoting Woods v. Edwards, 51 F.3d 577, 581 (5th Cir. 1995)). Second, there must be a subjective showing that the prison official was deliberately indifferent to such serious conditions. Id.

III. FINDINGS

We find that OPP fails to adequately protect inmates from harm and serious risk of harm from staff and other inmates; fails to provide inmates with adequate mental health care; fails to provide adequate suicide prevention; fails to provide adequate medication management; fails to provide safe and sanitary environmental conditions; and fails to provide adequate fire safety precautions.

A. INADEQUATE PROTECTION FROM HARM

Corrections officials must take reasonable steps to guarantee inmates’ safety and provide “humane conditions” of confinement. Farmer, 511 U.S. at 832. Providing humane conditions requires that a corrections system must satisfy inmates’ basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

To reasonably ensure safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. Officials must also take reasonable steps to protect

inmates from violence at the hands of staff and other inmates. In addition, officials must provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. Finally, a jail has an obligation to protect vulnerable inmates from harm, such as those who are at risk from other inmates. For the reasons set forth below, OPP fails to meet constitutional standards in all of these regards.

1. Unnecessary and Inappropriate Uses of Force

Although the violence present in a correctional setting necessarily permits the appropriate use of force, the Constitution forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted correctional practices provide that appropriate uses of force in a given circumstance should include a continuum of interventions, and that the amount of force used should not be disproportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Our investigation included an intensive examination of documents provided by OPP concerning the incidents listed below and various others occurring between January 2007 and August 2008. We also conducted a great many staff and inmate interviews. In many cases, our findings of inappropriate or excessive uses of force are in accord with OPP's own conclusions.

We believe that there is a pattern and practice of unnecessary and inappropriate uses of force by OPP correctional officers. Indeed, we found several examples where OPP officers openly engaged in abusive and retaliatory conduct, which resulted in serious injuries to inmates. According to our expert, in some instances, the officers' conduct was so flagrant it clearly constituted calculated abuse.

The following examples, derived from OPP's own internal documents, reflect disturbing evidence of officers openly engaging in retaliatory and abusive conduct:

- In July 2008, A.A. and B.B. were ordered into an empty holding cell on the OPP receiving docks.² Once in the cell, an officer entered the cell and began hitting and repeatedly beating both inmates. A.A. was beaten in the face, chest, and stomach. After knocking A.A. to the ground, the officer continued to beat and drag A.A. on the floor before finally choking and threatening to kill him. The officer then began beating B.B. in the arm, chest, and stomach area. After beating B.B., the officer placed his fist against B.B.'s jaw and stated, "I should break your

² To protect inmates' privacy, we have used initials other than their own.

f----- jaw.” Notably, this incident lasted for more than 10 minutes while several other officers observed the beatings without intervening or reporting the abuse. It was later determined that the officer beat the inmates because he believed that one of the inmates had robbed him several weeks earlier on the street. Defense attorneys for both A.A. and B.B. filed a formal complaint. OPP’s Special Operations Division (“SOD”) sustained allegations of abuse and recommended that the officer be suspended. After the officer’s initial suspension, the Sheriff terminated the officer involved in the battery along with the four other officers who observed the beatings.

- In September 2007, C.C. was beaten in the Tents. While lying on his bunk smoking a cigarette, an officer ordered C.C. to go outside to the security area. Once in the security area, the officer then ordered C.C. to “tie his shoes” (a code we learned at OPP is an invitation to fight). At which point, C.C. refused to fight the officer. The officer then slapped C.C. in the face, knocked him to the ground, and continued to punch him several times in his back. The officer then took C.C. into a bathroom and continued to beat him. According to OPP reports, this incident was witnessed by another officer, yet the incident was never reported. C.C.’s grandfather filed a complaint on his behalf. OPP’s Internal Affairs Division (“IAD”) reviewed the incident and found that an assault did occur, but only charged the officer with untruthfulness (for not reporting that he pushed C.C. to the ground several times) and failure to keep the commanding officer informed (for not reporting C.C.’s alleged smoking violation). The Sheriff placed the officer on 90 days probation as a result of this incident.
- In August 2007, D.D. was beaten by an officer in HOD. According to OPP reports, D.D. was transferred to HOD after he exposed himself to a female officer. An HOD sergeant reported the incident to the female officer’s boyfriend, an OPP corrections officer. The sergeant gave the boyfriend/officer the “green light” to physically abuse the inmate. The officer went into D.D.’s cell and began repeatedly punching and kicking him. The officer knocked D.D. to the floor then he dragged D.D. out of the cell and continued to beat him on the tier. The officer finally stopped beating him after D.D. started bleeding under his eye. D.D. sustained bruising under both eyes and bruising to his body. This assault, witnessed by at least one other officer, was unreported. D.D.’s injuries were eventually observed by an uninvolved officer, who made a report of them. OPP’s SOD sustained allegations of abuse. The officer involved in the beating, the sergeant, and the officer witness were all suspended for 14 days.
- In August 2007, E.E. was beaten by two officers in his cell. While lying asleep in his bed, two officers entered E.E.’s cell and beat him for nearly 10 minutes, before leaving the cell. E.E. sustained two black eyes and bruises on his upper, middle, and lower back. Several inmates witnessed the beating. The officers failed to

document the incident. Again, it was only after an uninvolved officer observed E.E.'s injuries that any report was made. When questioned by SOD investigators on why they failed to notify the Watch Commander of the incident with E.E., one of the involved officers replied, "the rank (referring to supervisors) does not like to be bothered." OPP's SOD sustained allegations of abuse and recommended that both officers be suspended for 14 days.

In April 2007, F.F. was severely beaten by two officers in IPC. While in IPC, two officers placed F.F. in an empty cell and began beating him in his face and head area. Even after F.F. requested medical attention, the officers returned to the cell and continued to beat and kick him in his face and head area. F.F. received serious trauma to his head and face. This incident was not reported by either OPP officer. As soon as he was released from OPP, F.F. was taken to the emergency room where he was treated for injuries sustained as a result of the beating. F.F.'s brother reported the injuries to OPP's Internal Affairs Division ("IAD").³ After its internal investigation, IAD sustained the allegations of abuse against both officers involved. Despite IAD's findings, it was not until our expert consultant made repeated inquiries related to the beating and the outcome that the Sheriff's office took disciplinary action (the officers were terminated).

a. Inadequate Policies and Procedures

Adequate policies and procedures regarding the appropriate use of force are essential to ensuring that inmates are not abused by security staff. The policies should be comprehensive, clear, up-to-date, and reflect currently acceptable practices. OPP's policies and procedures are lacking in all respects.

OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, however, the policy fails to define what constitutes a use of force. Without a definition, staff are left to their own subjective interpretations, which results in inconsistent use and reporting on the use of force. Furthermore, the policy does not provide guidance on levels of resistance versus levels of response - e.g., passive resistance versus active aggression and empty hands controls versus impact strikes. In addition, the policy fails to identify approved self-defense tactics, approved less lethal weaponry, and fails to list general prohibitions - e.g., to punish, to retaliate, or to restrict respiration. Moreover, the policy does not contain any requirement to employ verbal strategies when appropriate and fails to require video of anticipated or calculated force. Further troubling on a systemic level, the current use of force policy does not require or have an established criteria for administrative review of investigations.

³ This incident was reported by F.F.'s brother, an Orleans Parish Sheriff's Office Lieutenant.

b. Inadequate Use of Force Reporting

Although OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, we found that the policy is not consistently followed. In our review of hundreds of use of force incident reports, it was clear that officers routinely fail to adequately document incidents. In many instances, use of force reports prepared by officers lacked sufficient detail necessary to determine what type of force was used and whether the force used was justified. Also, we reviewed several reports which mention several officers, but that contain only one officer-filed report. This is a stark contrast from what the reporting policy requires. Compounding the reporting problem, we found that OPP does not have a standardized-use of force form or format, resulting in a system in which the reporting officer has wide discretion in determining what details to include in the report. As a result, administrative review is limited and officer conduct is not effectively evaluated. We found that OPP's deficient reporting practices likely accounted for the dearth of incidents referred to IAD for investigation.

OPP's deficient reporting practices are best illustrated by the examples noted below:

- In the July 2008 incident involving A.A. and B.B., there is no indication that the incident occurred, no indication of the inmates' injuries, and no indication that any officer reported the incident;
- In the August 2007 case of E.E., there is no indication of any injury in the OPP reports, no witness statements gathered, and no indication that the officers reported the incident; and
- In the August 2007 case of D.D., there is no indication of any injuries D.D. sustained, no indication that any officers reported the incident, and no indication that any statements were taken.

These incidents were not reported, indicating either a recognition of officer wrongdoing or a failure to recognize and report officer conduct believed to be within policy. In all of the above-mentioned examples, the incidents were not reviewed until a third party reported the officers' conduct. An effective reporting system would provide more detailed use of force and incident reports and ensure sufficient supervisory and administrative review.

c. Inadequate Management Review of Use of Force

The principal purpose of administrative review and investigation of each use of force is to ensure that no criminal activity has occurred, that facility procedures have been followed, that no remedial training is necessary, and that no review or change in policies is required. OPP's current use of force policy does not include a provision for administrative review. Therefore, there is an apparent gap in the review process where officer misconduct is not captured and

reviewed. Incidents that typically should be referred to IAD and SOD for further review are not forwarded. This lapse of review does not comport with generally accepted correctional standards.

On the rare occasion where we found that an incident was referred for management review, it was apparent that reviewers were not adequately trained to review officer conduct and the reviewers operated without any criteria for determining whether the level of force used was appropriate. Again, appropriate referrals to IAD or SOD were not made. Moreover, we spoke to various OPP officials about self-initiated reviews and we were unable to determine what division, if any, was qualified or assigned the duty to review use of force incident reports other than IAD. We find this system inadequate.

d. Lack of Investigative Policies and Procedures

Generally accepted correctional practices require clear and comprehensive policies and procedures governing the investigation of staff use of force and misconduct. Adequate policies and procedures include, at a minimum, screening of all use of force and incident reports, specific criteria for initiating investigations based upon the report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file. OPP's investigatory practices fail to comport with these generally accepted correctional standards.

OPP does not have an IAD standard operations manual for use of force investigations. In fact, the only guidance that investigators have is a two-page draft memo (dated January 3, 2007) that offers vague descriptions of procedure, which include: "[i]f a complaint appears to be worthy of an investigation it is assigned to one of the IAD investigators." The memo fails to offer any guidance as to what constitutes a "worthy" complaint and fails to require IAD to gather essential documentation from use of force and incident reports. Virtually all of the investigations that we reviewed contained significant investigatory flaws. The deficiencies in OPP's practice is reflected in the following examples:

- An IAD case file we reviewed indicates that in March 2007, an officer observed another officer deliver a series of multiple closed fist strikes to G.G. in a holding cell. The eyewitness officer observed the assaulting officer strike G.G. in the face, knocking him to the floor. While on the floor, the officer continued to strike G.G. even though the eyewitness officer yelled at the assaulting officer to "stop." The eyewitness officer filed a report with IAD the next day detailing her observations. The investigator concluded that only necessary force was used. The investigator, however, failed to interview or attempt to interview G.G., failed to locate and question additional witnesses, failed to collect incident reports, and failed to determine if the officer filed a contemporaneous report. The investigator

based his findings on the absence of injury and G.G. not seeking medical treatment.

- Another, IAD case file indicates that in January 2007, an inmate was beaten by several officers in IPC. The investigation only contained the inmate's statement and an undated memo from one of the officers involved. The officer acknowledged during the investigation that he and three other officers had to "restrain" the inmate. The officer also states they escorted the inmate to "medical with no injuries found." The IAD investigation failed to contain any incident reports or interviews with the other officers, failed to contain medical reports, and failed to determine if this was an unreported use of force.

2. Inadequate Classification System

An adequate classification system is a fundamental management tool to aid in providing a reasonably safe environment in a correctional institution. The primary goal of a classification system is to determine the degree of supervision required to control each inmate and to maintain the safety and security of the institution and the community. The classification system at OPP contributes to its deficiencies in safety and security. Generally accepted correctional practices for classification systems utilize a variety of objective, behavior-based factors to determine the appropriate level of custody. Factors considered include: severity of offense, prior convictions, prior incarcerations, and personal characteristics such as age, residence, and employment. Typically, inmates are divided into high, medium, and low security classifications, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted practices, OPP relies on an antiquated charge-based classification scheme that uses the amount of an inmate's bond as the primary classification factor for general population inmates (aside from the obvious separation factors such as male or female). For example, inmates with bonds of \$100,000 and over were housed in the HOD; federal inmates and bonds of \$100,000 and less were housed in Templeman V; bonds of \$75,000 and over were housed in the Tents; all females were housed at South White Street; and all work-release inmates were housed at Broad Street.

The current classification system does not consider an inmate's prior convictions, prior assaultive behavior, or true potential for violence. Even after inmates are classified, we learned from various OPP officials that housing assignments were predicated on space availability. As a result, we found instances where inmates with differing classification levels were assigned to ten-person cells at HOD. Under this system, there is very little to safeguard against housing predatory inmates with vulnerable inmates. Not surprisingly, we found a disturbingly high number of assaultive incidents in the multiple-occupancy cells at HOD.

Although we identified incidents throughout the facility, we are particularly concerned with the seriousness and frequency of incidents in the HOD and the Tents. We reviewed the

emergency route tracking log for July thru August 2008, which documents the referrals from OPP to the emergency room, and found a litany of serious injuries normally associated with assaultive behaviors including: blunt head trauma, facial fractures, jaw fractures, stab wounds, lip lacerations, and eye socket fractures. The majority of these injuries resulted from inmate-on-inmate assaults.

3. Inmate-on-Inmate Assaults

The high incidence of inmate-on-inmate violence at the HOD and the Tents demonstrates OPP's inability to keep its inmates reasonably safe. The following examples, derived from our review of OPP's own incident reports, illustrate our concerns:

- In August 2008, an 18-year-old inmate housed in a ten-person cell with 10-13 other inmates, all of whom were older, was attacked and beaten. At least four inmates assaulted him before officers arrived. The inmate sustained a fractured jaw and loosened teeth from the beating. The inmate had to be transferred to the medical floor as a result of the injuries he sustained.
- In June 2008, a 50-year-old inmate, who was recently arrested for public intoxication, was housed in a cell with 15-17 other inmates in the HOD. While in the cell, he was jumped by three inmates and sustained an eye injury and a head wound that required sutures.
- In June 2008, an inmate who was recently charged with a misdemeanor domestic violence offense was beaten in the Tents by another inmate. The inmate sustained a broken jaw and had to be taken to the emergency room for medical care.
- In May 2008, an inmate charged with aggravated rape was attacked by multiple inmates in a stairwell between the third and fourth floors of the HOD. The inmate was later moved to protective custody.
- In April 2008, another sex offender housed in HOD was beaten by several inmates after they learned of his offense. The inmate sustained two black eyes and injuries to his forehead and temple. After the beating, the inmate was moved to protective custody.
- In April 2008, an inmate was attacked by another inmate with a knife in the Tents because of an argument over the television. We learned from a tier representative (inmate trustee) that the inmate with the knife was a "known trouble maker" and had a history of assaultive behavior at the facility.
- In April 2008, an inmate was seriously injured after a fight over cigarettes. An officer observed the injured inmate washing blood from his face. The inmate was

immediately taken to the emergency room where he was treated for a fractured nose and injuries to his jaw, head, and back.

- In March 2008, an inmate suffered injuries to his eye, shoulder, elbow, and knee after multiple inmates jumped and beat him in a bathroom in the Tents.
- In February 2008, while in the Tents, an inmate was beaten by another inmate. We learned through OPP documents that the same two inmates were involved in a prior altercation in which one inmate was stabbed. It was only after the second incident that OPP placed the inmates in separate tents.
- In May 2007, a sex offender housed in the HOD in a 10- person cell was attacked and beaten by several other inmates and sustained a stab wound to his eye and a fractured jaw.

The frequency and serious nature of injuries sustained by OPP inmates represent a systemic level of violence that poses a serious risk of harm to both inmates and correctional staff at the jail.

4. Inadequate Staffing and Inmate Supervision

Staffing levels at OPP are inadequate to protect inmates from harm. Correctional facilities must protect inmates from harm by providing adequate staff supervision. Because of the jail's size and the physical configuration of its most densely populated facility (HOD), we found instances where officers failed to conduct scheduled rounds and were required to supervise an entire floor because of staff shortages. We also noted instances at other jail facilities (The Tents) where officers were required to supervise an entire pod (more than 80 inmates) during shifts. In both examples, it appears that OPP failed to adequately staff the buildings with this highest frequency and nature of injuries by inmates.

Exacerbating the staffing shortages, we found that OPP operates its facility without a staffing plan or analysis to establish the minimum number of security staff needed to safely manage OPP's population. Generally accepted professional standards provide that a staffing plan or analysis is vital in determining supervision posts, the span of control for each post, and what posts are essential to adequately staff OPP. Although we found staffing shortages throughout the facility, we are particularly concerned with the staffing levels at the HOD and the Tents - the two facilities where we found unacceptably high levels of serious inmate-on-inmate violence

We reviewed HOD's monthly squad status report for June 2008 and found that the total number of security staffing assigned to HOD for the month was 68 officers. During this same period, the average daily population was 868. In our expert's opinion, this 1:13 officer-to-inmate ratio per month is clearly deficient for the largest facility in OPP. We also found several instances during January 2007 and June 2008 where the HOD average daily population was 900

and only 12 officers were on shift, a 1:75 officer-to-inmate ratio. On these occasions, the majority of the multiple occupancy cells housed more than 10 inmates and four of the eight floors had only one officer responsible for over 140 inmates. We found several instances where staff failed to conduct daily rounds in the HOD and one officer had to monitor and supervise an entire floor for extended periods. During our review, we found the most densely populated facility (HOD) at OPP also was the most understaffed, which likely explains the high incidence of violence.

Similarly, we found deficient staffing levels at the Tents, the second largest facility in OPP. This facility comprises eight separate tent-like structures with metal framing and a polyester membrane covering. Each housing unit, known as a "pod," has a bed capacity for 88 inmates (44 double bunk beds). Each pod is equipped with an elevated officer station situated mid-way between the 44 beds. During our review of the June 2008 monthly squad staffing report, we found the total security staff was 33 officers, while the average daily population was 528. Again, we found several instances during February 2007 thru May 2008 where the inmate average daily population was more than 580 and the facility only had seven officers on shift, allowing only one officer to each pod during the shift. This deficient staffing places both inmates and staff at risk.

C. INADEQUATE MENTAL HEALTH AND MEDICAL CARE

1. Mental Health Care

OPP fails to provide inmates with adequate mental health care that complies with constitutional standards. Specifically, we found the following deficiencies: (a) inadequate suicide prevention; (b) inadequate intake and referral process; (c) inadequate staffing; (d) inadequate assessment and treatment; and (e) inadequate quality assurance review.

a. Inadequate Suicide Prevention

Suicide prevention practices at OPP are grossly inadequate. Generally accepted professional standards of correctional mental health care mandate the development of suicide prevention measures, including evaluation by a psychiatrist and development of a management plan. While OPP's suicide prevention policy requires that all inmates with suicidal ideation be directly observed by staff immediately and at all times, our investigation revealed practices inconsistent with generally accepted standards and OPP's own policy.

OPP inmates with suicidal ideation are transferred to HOD-10 and placed in five-point restraints before they are evaluated by a psychiatrist. The practice of initiating restraints, the most restrictive of suicide precautions, without medical or mental health review is inconsistent with generally accepted professional standards. Furthermore, we found that restraints are used as the first response to inmates with suicidal ideation and are seemingly used in a punitive fashion.

Moreover, we found that OPP fails to protect inmates from harm while in restraints. The following examples are illustrative:

- On January 6, 2009, H.H., a 43-year-old woman, stopped breathing while in restraints at OPP. H.H. was sent to HOD-10 hours after intake because she was considered hostile and suicidal. While in HOD-10, H.H. was placed in five-point restraints even after she repeatedly complained of asthma and breathing distress. H.H. did not receive physician or psychiatric care to determine if medication was appropriate or if placing an asthmatic individual in a five-point restraint was acceptable. Although she was under direct observation, H.H. was reportedly seen attempting to get out of the restraints. As OPP staff intervened and placed her in the restraints, H.H.'s body went limp. OPP medical staff responded to assess her condition. She was sent to the emergency room, where she was later pronounced dead.
- In June 2008, I.I. was placed in five-point restraints for more than 24 hours after he reported suicidal ideation. I.I. had a history of mental illness and taking psychotropic medications. Even though OPP staff received medical orders prescribing a nine hour time-frame for restraints, OPP placed him in restraints for over 24 hours without appropriate observation. OPP did not follow its own suicidal ideation policy, failed to provide I.I. with one-to-one observation, and went beyond the medical orders for restraint usage.
- On March 27, 2008, J.J. was placed in five-point restraints for more than 35 hours after he reported suicide ideation. The restraints were intermittently maintained by three consecutive orders from March 27, 2008 at 11:20 a.m. to March 29, 2008 at 5:00 a.m. Records showed that J.J. was neither agitated nor disruptive and OPP did not follow its own suicidal ideation policy and provide J.J. with one-to-one observation. We found that J.J.'s care and treatment was inconsistent with generally accepted professional standards of care and, indeed, inhumane.

Compounding the risks inherent in these practices, OPP has neither a restraint chair nor a safe cell. Inmates are restrained to metal beds affixed to a cell wall. The positioning of the bed prohibits 360 degree access to the inmate and, ironically, is itself a suicide hazard as even restrained individuals can strangle themselves by affixing clothing or sheets to this type of bed.

b. Inadequate Intake and Referral Process for Inmates with Mental Illness

OPP fails to properly identify inmates with mental illness through adequate intake screening and referral. The identification and follow-up of known mental illness should be a key focus of intake screening. In addition, mental health screening information should be incorporated into an inmate's medical record. This ensures the prompt continuation of necessary

medication for all inmates with chronic mental health conditions. Persons with potentially serious chronic mental illness (i.e., active psychosis, suicidal) should be referred from screening for prompt mental health evaluation and examination by a psychiatrist. We found the systems for intake and referral at OPP to vary markedly from generally accepted correctional mental health standards.

The average percentage of inmates receiving mental health services in city jails ranges from 18 to 30 percent. OPP's staff reported that 150 inmates were on the mental health caseload, approximately 6% of OPP's total inmate population, indicative of the failure to adequately identify and refer inmates with mental illness. This indicator was confirmed by our expert consultants' review of OPP medical records and inmate interviews which indicated that the numbers of OPP inmates referred for mental health services should be significantly higher.

We found OPP's intake and referral services inadequate and delayed. As a result, an alarmingly high number of inmates with mental health issues, including past mental health treatment, history of suicidal behavior or attempts, and/or being on psychotropic medications fail to consistently be referred to mental health service providers. In addition, we found that OPP does not have a formal referral process. As a result, inmates are not seen, as a matter of practice, on an emergent (immediate), urgent (within 24 hours), or routine basis (within five days) by the psychiatrist. Therefore, inmates who either received mental health services prior to incarceration or present with significant mental health concerns, typically have substantial delays before being referred to a mental health provider. Inmates who are not timely referred remain untreated and have suffered from a worsening of their symptoms, including suicidal and homicidal ideation. The deficient intake and referral process is illustrated in the following examples:

- In April 2008, during intake, K.K. reported that he attempted suicide five times in the last nine months. Even with this self-report, OPP staff failed to note his prior history and failed to refer K.K. to a psychiatrist. Due to this failure, K.K. was not assessed for six weeks. When he was finally assessed, he was diagnosed with Chronic Schizophrenia and was on a hunger strike. OPP's failure to properly note his mental health status and history at intake, contributed to his delayed treatment and degenerative mental health state.
- In May 2007, L.L., a 57-year-old man, was sent to general population, even though he suffered from a brain disease affecting his mental capabilities. While in general population, L.L. showed signs of memory loss but did not receive any mental health care or services. Five months after intake, L.L. was finally seen by mental health staff and diagnosed with probable dementia. OPP's deficient intake process failed to give L.L. adequate care and agitated his mental condition.

c. Inadequate Staffing

We found that OPP fails to employ sufficient mental health staff to ensure that inmates receive adequate services. The HOD-10 unit, which serves as the House of Detention crisis unit for all mental health inmates, has only one full-time psychiatrist and one part-time psychiatrist. HOD-10 also has four licensed practical nurses, supervised by one registered nurse. During our site visits, we noted that there were no licensed drug counselors or social workers on staff. We found inadequate mental health staffing resulting in delays in inmates being assessed and treated.

In the South White Street Facility, we found that female inmates were not receiving necessary and adequate mental health care because of inadequate staffing. Even though some of these inmates received previous community mental health treatment, psychotropic medications, or been placed on suicide watch, they received deficient mental health care. Without adequate mental health staffing, including social workers and drug counselors, many of these women will not receive needed mental health services, such as: group or individual therapy, substance or physical abuse counseling, and other services to address their underlying mental disorders. The following examples are illustrative of OPP's failure to provide adequate mental health care because of inadequate staffing:

- On May 20, 2008, M.M. was screened and sent to the segregation unit of the women's facility. Despite reporting that she had been taking psychotropic medication for depression and anxiety, the psychiatrist did not evaluate her for three weeks. Like other inmates in OPP, M.M. was given her medication via the "Keep on Person" program. This program allows inmates to keep medications in their possession and self-administer these medications. Inmates are not given appropriate instruction on use of the medications, nor are they adequately monitored. M.M. reported that no one monitored her medication and that she took it when she thought she needed it.
- On April 6, 2008, N.N. reported at intake that she had a history of depression and that she had been taking antidepressants before incarceration. The psychiatrist ordered an antidepressant via telephone but did not assess N.N. until over a month after the initial medication order. During the psychiatric assessment, N.N.'s antidepressant dosage was increased. In our expert's opinion, the psychiatrist should have interviewed and assessed N.N. in person before prescribing the initial medication. Further, N.N.'s second visit with the psychiatrist was more than two months after her initial assessment. This is insufficient since she received an increased dose of antidepressants during the psychiatric assessment.

d. Inadequate Assessment and Treatment

OPP fails to appropriately and timely assess and treat inmates with mental illnesses. Our investigation revealed a lack of attention to past mental health information and a failure to

provide timely psychiatric assessment and treatment. These failures are inconsistent with generally accepted professional standards and have resulted in mental health deterioration and unnecessary suffering. The following examples are illustrative of OPP's failure to adequately assess and treat mental health inmates resulting in mental health deterioration and unnecessary suffering:

- On December 14, 2007, O.O. was screened with a history of heroin use and past psychiatric treatment. It took more than four months before he received a psychiatric assessment. When O.O. was finally assessed, he was suffering from heroin dependence, cocaine and alcohol abuse, and symptoms of seasonal affective disorder. He received treatment four months after intake.
- On August 29, 2007, P.P., a 43-year-old man, hung himself with a telephone handset cord in OPP's HOD-4 unit. P.P. was referred to a psychiatrist at OPP, but was never assessed. P.P. complained of insomnia and informed OPP that he had been on psychotropic medications. His complaints were not addressed by a psychiatrist and he committed suicide at OPP by hanging himself 22 days after the psychiatric referral. While P.P.'s suicide does not appear foreseeable, the delay of 22 days is unacceptable even for a non-emergency referral within the correctional system.
- On August 17, 2006, Q.Q. was sent to the psychiatric unit after complaints of homicidal ideation. It took OPP staff more than seven and a half months before Q.Q. received an initial psychiatric assessment. When he finally began treatment on March 3, 2007, he had a number of mental health illnesses and disorders. OPP should provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care. The delay in Q.Q.'s initial psychiatric assessment is unacceptable.

Exacerbating the problem with assessment and treatment, we found that OPP lacks multi-disciplinary treatment teams where other staff, with the exception of the nurses on HOD-10, participate in the care of inmates. Effective mental health treatment of inmates often involves services provided by a multi-disciplinary treatment team that includes psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, drug counselors, and correctional officers. Under OPP's procedures, the psychiatrist writes a plan as part of the initial psychiatric evaluation, and discussions are later held with a nurse. By not having social workers as part of the treatment team, for example, inmates do not receive the benefit of group therapy. And, without the input of correctional officers, who experience daily contact with inmates, the mental health service providers will not have the benefit of the correctional officers' ongoing observations.

e. Inadequate Quality Assurance Review

Generally accepted correctional mental health standards call for adequate quality assurance review. Such review is necessary to examine the effectiveness of the mental health care delivered and to implement corrective action so that the quality of care is improved.

We found that OPP fails to engage in consistent, effective quality assurance review in order to monitor and assess the quality of mental health offered at the facility. During our site visits, we found that despite the existence of OPP's Medical Quality Improvement Committee, there is no formalized review and evaluation process for mental health services. It is essential that a consistent and effective quality assurance process exists to track and trend mental health

related deficiencies at the facility. OPP fails to conduct formal quality reviews of (1) effectiveness of the intake and referral process; (2) management of psychotropic medications; (3) suicide prevention including assessment of suicide risk; (4) review and tracking of suicide attempts; (5) monitoring of inmates on suicide observation; (6) treatment planning and treatment interventions for inmates in the mental health program; (7) appropriate use of restraints and monitoring of inmates in restraints; (8) discharge planning for the effective management and continuity of care for inmates released from custody; and (9) review and audits of medical records for quality and appropriateness of documentation of services provided.

2. Medical Care

Jail officials are responsible for providing adequate medical care to inmates. Our investigation revealed that medical care provided at OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in OPP's medication management.

a. Inadequate Medication Management

Generally accepted correctional medical standards require that facilities administer medication and maintain adequate medication records to meet the medical needs of the inmates and to prevent medication errors and other risks of harm. We found that OPP's practices were inconsistent with generally accepted professional standards of care.

In particular, OPP's "Keep on Person" ("KOP") medications program is deficient. The KOP program allows inmates to keep medications in their possession and self-administer these medications. Both general population and mental health inmates are provided small, unmarked envelopes with four days of medications twice per week. This distribution process is deficient because it fails to consistently provide inmates with adequate instruction on how to take the medications, fails to monitor inmates' medication intake, and fails to give the name of the prescribed medications. This lack of basic information and supervision in the KOP program fails

to protect inmates from improper use and harm. The following examples in which inmates obtained dangerous quantities of medication and overdosed are illustrative of this concern:

- On August 21, 2008, R.R. overdosed on his medication. He was rushed to the emergency room after OPP staff discovered that R.R. had ingested six antidepressant and four antipsychotic pills. We found that OPP failed to monitor R.R.'s medication intake, and did not provide him with adequate instruction regarding his medication, including informing him of the harm in ingesting high amounts. When asked about overdosing on his medication, R.R. stated he missed his earlier doses, so decided to take all of his pills at one time to "catch-up."
- On January 20, 2008, S.S. was neither screened as a mental health patient nor prescribed an antipsychotic, yet he was rushed to the emergency room after he ingested a dangerous amount of antipsychotic medication. Even though S.S. survived, we found that OPP staff was unaware of the dosage S.S. ingested, or how S.S. had obtained the medication.
- On January 8, 2007, T.T. overdosed on 40 to 50 doses of psychotropic medication. T.T. was rushed to the emergency room after OPP discovered that she swallowed large quantities of medication. We found that OPP staff failed to monitor T.T. and failed to provide adequate medication management.

In addition, we found many instances where OPP failed to maintain documentation contemporaneously with medication administration. Contemporaneous documentation of medication is the practice of maintaining records at the same time that medication is administered to inmates to ensure that errors do not occur. It provides a more accurate accounting of the time, date, and type of medication received.

We also found that OPP's system for obtaining informed consent for medications substantially departed from generally accepted standards. During intake, inmates are required to sign a form that gives blanket consent for medications. This practice is not an informed consent because OPP is not also providing inmates with sufficient information about the medication and necessary treatment throughout an inmate's incarceration. Once a diagnosis is made and an inmate is prescribed medication, there is responsibility on the part of the medical staff to address an inmate's treatment at appropriate intervals during incarceration. Furthermore such blanket inmate consent can deter the medical staff from appropriately monitoring chronic or life-saving medications.

D. INADEQUATE ENVIRONMENTAL HEALTH and SANITATION

Although several areas in the OPP have undergone recent renovations, OPP has serious environmental health and sanitation problems.

1. Inadequate Pest Control

OPP has a visible pest problem. Although mice and cockroaches are nocturnal by nature, we observed both during our daytime visit, indicating there is a widespread presence. We also found other evidence of their presence in several of the buildings housing inmates, as well as in the food warehouse. Additionally, inmates complained about rodents and roaches in the facilities, and several work orders noted the presence of rodents in cells. Despite the obvious extent of these infestations, OPP was unable to produce a list of services or chemicals used for pest control. When asked about how often OPP sprayed or treated for pests, staff gave inconsistent responses, ranging from weekly to every three months.

2. Physical Plant and Housekeeping

With the challenges OPP faced after Hurricane Katrina, it is not surprising that the maintenance of the facilities presents an ongoing struggle. We are well aware that Hurricane Katrina rendered parts of OPP inhabitable and left others severely flood damaged. In a correctional setting where inmates and staff depend on maintenance staff for water, heat, lighting, and ventilation, however, these issues must be addressed in a timely manner in order to reduce the risks of illness and injury to inmates and staff.

We found that areas of OPP that housed inmates remain in a state of disrepair. The correctional staff generate work orders to the Facilities Department, which tracks the completed tasks. During our site visit, we observed hundreds of maintenance and repair needs, including approximately 60 broken or non-operational toilets, sinks, and drains in the HOD alone. We also observed a high number of broken, missing, or hazardous tiling, vents, and flooring in need of repair or replacement. Broken tiling and flooring is significant because these materials can be fashioned into weapons. We observed The work orders from 2007 and 2008 confirmed the problems we observed, including those of numerous work orders for broken toilets, sinks, and showers, as well as for water leaks.

Ventilation in many parts of OPP is extremely poor. Air quality measurements within HOD indicated that the temperature exceeded 85 degrees for many of the cells. We observed ventilation fans covered with visible layers of dust and debris, which can contain toxic chemicals, rodent waste and insect parts. The thick layer of dust and debris obstructs proper ventilation and the circulation of these substances in the air increases the risk of transmitting and contracting airborne diseases to both inmates and staff.

During our visits, we also observed obvious electrical hazards throughout the facilities. Electrical panels were not locked in the kitchen or in the rooms adjacent to housing areas. The panels often were located in rooms scattered with litter. Many of the panels needed repair, and other panel door covers were missing altogether. These conditions pose a safety hazard to inmates and staff.

In addition, OPP does not properly store and control chemicals, cleaning agents, and other hazardous materials. Although several chemicals were stored in the appropriately labeled boxes, these chemicals were never opened or used. Our consultant noted other unlabeled chemicals stored in cells and other housing areas throughout the facilities. These chemicals are harmful if used in wrong concentrations or on the wrong surfaces. Furthermore, many inmates had unsupervised access to these chemicals, which if used improperly could cause serious harm or be used as a weapon.

While the lighting in common areas at OPP is adequate, inmates had covered many lighting fixtures with paper, cardboard and other materials in 30 percent of the individual cells. The covering of light fixtures not only presents a fire and health hazard, but also compromises the security of those housed in the cells, especially in light of the problems with supervision and inmate violence at OPP.

Finally, the conditions in the OPP housing areas are generally unsanitary. Dirt, dust, and debris covered many parts of the facilities, including the floor, windows, and corners. The shower and toilet areas had problems with mold. In HOD, the floor drains in these areas had no covers, and the shower vents were blocked with paper and other debris. The amount of refuse led our expert to recommend that all units in HOD "should be cleaned thoroughly."

3. Food Service

Food service practices at OPP place inmates at risk of harm. Approximately 7,200 meals are prepared in the food service area daily. Although a new kitchen had opened just days prior to our May 2008 tour, we observed improperly stored food, unattended cleaning materials and chemicals on the floor, and insects in the food preparation area. Furthermore, the kitchen had litter on the floors, and all kitchen employees did not have access to hand-washing facilities.

Food delivery at OPP is also inadequate. The facility delivers food to the housing areas by placing food in insulated containers for delivery. Generally accepted professional standards require that hot food be served at 140 degrees. Although when originally put in the insulated transportation containers, the food temperature measured well in excess of 140 degrees, it took as long as *four hours* for food prepared in the kitchen to reach some of the housing units. For those housing units, food temperatures were well below 140 degrees when served. In some cases we measured the temperature at 88 degrees for some hot food. The range of temperature between 41 degrees and 140 degrees is typically called the food danger zone. Bacteria that causes food-borne illness multiply and grow at this temperature range.

Once the food arrives at the housing units, handling and service did not comport with generally accepted professional standards. As in many other correctional facilities, OPP relies primarily on inmates to serve food. During meal times, inmate workers placed food containers on dirty tables and did not wash their hands before serving food. We also observed instances where gloves were inconsistently used. For example, we observed a food handler at the facility

using his bare hands to serve noodles on the individual plates. These practices are unsanitary, can result in cross contamination, and greatly increase the risk of food-borne disease.

4. **Fire Safety**

While it appears that OPP has taken steps to protect inmates and staff in the event of fire or an emergency, they remain at serious risk of harm because of certain deficiencies in emergency preparedness in terms of accessibility of fire equipment and consistency of conducting fire drills.

OPP has an adequate number of fire extinguishers, and emergency exit procedures were posted in each facility. Fire extinguishers were inspected regularly, but often were housed in locked compartments. When asked to locate fire extinguishers, some staff took an inordinate amount of time to find the keys to unlock the compartments. In the new kitchen and intake areas, it took the staff an unacceptable length of time to locate any of the three available fire extinguishers and find a key to unlock the compartment containing the fire extinguisher.

Although OPP appears to perform fire drills, they are not conducted in a manner consistent with generally accepted correctional standards, which require monthly fire drills. Monthly drills should rotate so that they are conducted quarterly on each shift. Drills should be conducted at differing times and under differing conditions, such as using different egress routes to confirm that officers have the necessary keys and know how to use them. Records of each drill should be maintained for at least one year. While staff reported that OPP conducts monthly fire drills, it remained impossible to discern when these drills actually occurred because OPP did not document any of these drills. Some inmates claimed that the drills occurred weekly, others stated that drills took place every two months.

IV. REMEDIAL MEASURES

In order to address the identified deficiencies and protect the constitutional rights of inmates confined at OPP, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice:

A. **Protection from Harm**

1. Use of Force
 - a. Develop and maintain comprehensive and contemporary policies and procedures regarding permissible use of force.
 - (1) Prohibit the use of force as a response to verbal insults or inmate threats.

- (2) Prohibit the use of force as a response to inmates' failure to follow instructions where there is no immediate threat to the safety of the institution, inmates, or staff, unless OPP has attempted a hierarchy of nonphysical alternatives which are documented.
 - (3) Prohibit the use of force as punishment.
- b. Establish effective oversight of the use of force.
- (1) Develop and implement a policy to ensure that staff adequately and promptly report all uses of force.
 - (2) Ensure prompt management review of use of force reports. The review should include:
 - i. case-by-case review of individual incidents of use of force; and
 - ii. systemic review in order to identify patterns of incidents.
 - (3) Ensure that incident reports, use of force reports and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.
 - (4) Develop and maintain comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.
 - (5) Develop and implement a process to track all incidents of use of force that at a minimum includes the following information: the inmate(s) name, housing assignment, date and type of incident, injuries (if applicable), if medical care is provided, primary and secondary staff directly involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
- c. Develop an effective and comprehensive training program in the appropriate use of force.
- (1) Ensure that staff receive adequate competency-based training in OPP's use of force policies and procedures.

- (2) Ensure that staff receive adequate competency-based training in use of force and defensive tactics.
 - (3) Ensure that SOD and IAD management and staff receive adequate competency-based training in conducting investigations of use of force allegations.
2. Safety and Supervision
- a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates.
 - b. Ensure that inmate work and housing areas are adequately supervised whenever inmates are present.
 - c. Ensure frequent, irregularly timed, and documented security rounds by correctional officers inside each housing unit.
 - d. Ensure that staff adequately and promptly report incidents.
 - e. Develop a process to track all serious incidents that captures all relevant information, including: location of incident, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
 - f. Establish a procedure to ensure that inmates do not possess or have access to contraband. Conduct regular inspections of cells and common areas of the housing units for contraband.
 - g. Conduct regular inspections of cells and common areas of the housing units to identify and prevent rule violations by inmates.
 - h. Review, and revise as applicable, all security policies and Standard Operating Procedures ("SOPs") on an annual basis.
 - i. Review, and revise as applicable, all security post orders regularly.
 - j. To the extent possible, taking into account the different security levels and different physical layouts in the various divisions, standardize security policies, procedures, staffing reports, and post analysis reports across the divisions.

- k. Provide correctional officers transferred from one division to another formal training on division-specific post orders.
 - l. Implement specialized training for officers assigned to special management units, which include disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be regularly assigned to these units for stability purposes.
3. Classification
- a. Develop and implement an objective classification system that separates inmates in housing units by classification levels.
 - b. Update facility communication practices to provide officers involved in the classification process with current information as to cell availability on each division.
 - c. Update the classification system to include information on each inmate's history.
 - d. Provide competency-based training and access to all supervisors on the full capabilities of the OPP classification and inmate tracking system (or any replacement system).

B. Mental Health Care

- 1. Use of Restraints
 - a. Develop and implement a policy for the use of restraints that is consistent with generally accepted professional standards, including the requirement of written approval by a qualified medical or mental health professional prior to the use of restraints.
 - b. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.
 - c. Ensure that restraints are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

2. Suicide Prevention
 - a. Develop policies and procedures to ensure appropriate management of suicidal inmates and the establishment of a suicide prevention program.
 - b. Ensure that OPP suicide prevention policies include an operational description of the requirements for both pre-service and annual in-service training.
 - c. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff who work directly with inmates have demonstrated competence in identifying and managing suicidal inmates.
 - d. Ensure that any staff who are exempt from suicide prevention training have limited inmate contact.
 - e. Ensure that intake staff are sufficiently experienced and qualified to identify inmates that pose a risk for suicide, and conduct appropriate follow-up evaluations by mental health professionals of new inmates within 14 days of intake.
 - f. Screen all inmates upon intake, including questioning to assess current and past suicide risk.
 - g. Document inmate suicide attempts at OPP in the inmate's correctional record in the classification system, in order to ensure that intake staff will be aware of past suicide attempts if an inmate with a history of suicide attempts is admitted to OPP again in the future.
 - h. Ensure that inmates on suicide precautions receive adequate mental status examinations by a mental health clinician.
 - i. Ensure that suicidal inmates are housed in an area that is safe for them with appropriate supervision and observation by staff.
 - j. Ensure that 15- and 30-minute checks of inmates under observation for risk of suicide are timely performed and appropriately documented.
 - k. Provide different levels of supervision of inmates based on the presenting risk factors for suicide.

- l. Ensure that inmates placed on suicide watch are assessed adequately, monitored appropriately to ensure their health and safety, and released from suicide watch as their clinical condition indicates according to generally accepted standards of care.
 - m. Ensure a component of administrative review is implemented following a suicide or a suicide attempt to identify what could have been done to prevent the suicide.
3. Intake and Referral
 - a. Develop and implement an appropriate intake screening instrument that identifies mental health needs, and ensures timely access to a mental health professional when presenting symptoms require such care.
 - b. Ensure that inmates with potentially serious chronic mental health illness are referred for prompt mental health evaluations and examinations by a psychiatrist.
 - c. Ensure that OPP's intake evaluation process includes a mental health screening that is incorporated into an inmate's medical record.
4. Staffing
 - a. Provide staffing adequate for inmates' serious mental health needs.
 - b. Provide adequate on-site psychiatry coverage, including ensuring that psychiatrists see inmates in a timely manner.
5. Assessment and Treatment
 - a. Develop and implement policies and procedures for appropriate assessments of inmates with serious mental illness.
 - b. Provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care.
 - c. Ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses and problems. Provide therapy services where necessary for inmates with serious mental health needs.

- d. Ensure that mental health evaluations done as part of the disciplinary process include recommendations based on the inmate's mental health status.
 - e. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.
 - d. Ensure that psychotropic medications are reviewed by a psychiatrist on a regular, timely basis and inmates are properly monitored.
6. Quality Assurance and Review
- a. Develop and implement a quality assurance program to assist OPP in identifying and correcting serious deficiencies within the mental health system, prioritizing its efforts at reform, and developing appropriate remedies.

C. Medical Care

1. Medication Administration
- a. Ensure that treatment and administration of medication to inmates is implemented in accordance with generally accepted professional standards of care.
 - b. Ensure that administration of medication is accurate and adequately documented. Develop policies and procedures for the accurate administration of medication and maintenance of medication records. Provide a systematic review of the use of medication to ensure that each inmate's prescribed regimen continues to be appropriate and effective for his condition.
 - c. Develop and implement an appropriate medication administration protocol that provides adequate direction on how to take medications, describes the name of prescribed medications, and identifies how inmates are monitored.

D. Sanitation and Environmental Conditions

1. Sanitation and Maintenance of Facilities
- a. Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and

supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.

- b. Ensure adequate pest control, including sufficient staffing for routine and follow-up pest control services.
 - c. Ensure proper ventilation and airflow in all cells and housing units.
 - d. Ensure adequate lighting in all housing units and prompt replacement and repair of malfunctioning lighting fixtures.
 - e. Ensure prompt and proper maintenance of shower, toilet, and sink units.
 - f. Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.
 - g. Use cleaning chemicals that sufficiently destroy the pathogens and organisms in biohazard spills.
2. Environmental Control
- a. Repair electrical panels; develop and implement a system for maintenance and repair of electrical panels, devices, and exposed electrical wires.
3. Food Service
- a. Provide training for kitchen workers in the areas of food safety, proper food handling, and proper hygiene to reduce the risk of food contamination and food-borne illnesses.
 - b. Ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are properly cleaned and sanitized.
 - c. Ensure that foods are served and maintained at proper temperatures.

E. Fire and Life Safety

- 1. Ensure that all facilities have adequate fire and life safety equipment which is properly maintained and inspected.
- 2. Implement competency based testing for staff regarding fire/emergency procedures.

3. Develop and implement adequate policies and procedures regarding fire prevention including emergency planning and drills.
4. Ensure that emergency keys are appropriately marked, available, and consistently stored in a quickly accessible location.
5. Inventory and store all flammable, toxic, and caustic materials in a well ventilated, but locked, compartment.
6. Ensure that emergency drills are conducted on a regular basis.

* * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the City in an amicable and cooperative fashion to resolve our outstanding concerns regarding OPP. Assuming there is a continuing spirit of cooperation from the City, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail.

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If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,



Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable C. Ray Nagin
Mayor
The City of New Orleans

T. Allen Usry, Esq.
Counsel for the Sheriff's Office

Penya M. Moses-Fields, Esq.
City Attorney
The City of New Orleans

The Honorable Jim Letten
United States Attorney
Eastern District of Louisiana



U.S. Department of Justice

Civil Rights Division

*Office of the Assistant Attorney General**Washington, D.C. 20530*

AUG 26 2011

VIA E-MAIL AND U.S. MAIL

Howard R. Bradley
County Mayor
501 S. Main Street
Courthouse, Room 108
Springfield, TN 37172

Re: Investigation of Robertson County Detention Facility

Dear Mayor Bradley:

We write to report the findings of the Civil Rights Division's investigation of conditions at the Robertson County Detention Center ("RCDF" or "Jail"), conducted pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"). The Civil Rights Division commenced its investigation at the request of the United States Attorney's Office for the Middle District of Tennessee, after that office received complaints from prisoners regarding RCDF's provision of nutrition and medical care. During our investigation, we assessed RCDF's compliance with the Constitution, which requires the Jail to provide detainees with humane conditions of confinement, including adequate medical and mental health care, food, clothing, and shelter.

While we found RCDF's practices with respect to nutrition, medical care, and environmental health and safety adequate or minimally adequate to comply with the Constitution, we found a pattern or practice of constitutional violations in RCDF's provision of mental health care. Specifically, RCDF's mental health practices place prisoners at a substantial and unreasonable risk of serious harm. In the other areas we investigated, we have serious concerns that do not yet rise to the level of constitutional violations, including numerous medical practices that could result in constitutional violations if left unremedied. By implementing the remedies set forth below, the County will fulfill its duty to uphold the Constitution and protect the health and safety of those in its custody.

In making these findings, we note that RCDF has been cooperative throughout our investigation and receptive to our preliminary findings and initial recommendations. We are thus

confident that RCDF will take appropriate measures to remedy the deficiencies we detail in this letter, and look forward to working cooperatively with RCDF as it does so.

I. Summary of Findings and Conclusions

We have concluded that Robertson County (“the County”) fails to provide mental health care to prisoners at RCDF in violation of the Fourteenth Amendment to the Constitution. Addressing these deficiencies should be RCDF’s highest priority, as we believe that these lapses, if not corrected, have a strong likelihood of resulting in unnecessary injury and/or loss of life. Our specific findings of practices that do not comport with the requirements of the Constitution include:

- RCDF fails to protect prisoners from harm by permitting Licensed Practical Nurses (“LPNs”) – individuals with little or no mental health training – to independently manage suicide precautions. The Constitution requires the Jail to provide prisoners with mental health needs with access to medical personnel who are qualified to diagnose and treat mental illness.
- RCDF fails to provide prisoners with serious mental illnesses with timely and competent mental health care. Specifically, (a) prisoners with chronic mental illnesses who are not capable of requesting mental health care are effectively denied treatment; (b) prisoners who request mental health care experience delays that violate constitutional standards; and (c) nurses are responsible for providing mental health care beyond their training and qualifications.

While we do not find a current violation of the Constitution, we find that certain medical practices at RCDF may pose unreasonable risks to prisoners’ safety and health and, if left unremedied, may violate the Constitution. Additionally, we find that while the Jail’s nutrition and sanitation meet minimum constitutional requirements, certain of RCDF’s practices in these areas are deficient or cause us concern.

II. Investigation

On July 13, 2010, we notified you that we were opening an investigation of conditions at RCDF pursuant to CRIPA. Based on the allegations and information we received from the United States Attorney’s Office, the initial focus of our investigation was the nutritional adequacy of the diet provided to RCDF prisoners. In 2009, Chief Judge Todd Campbell conducted a six-day evidentiary hearing to assess a prisoner’s claim that he had lost significant weight during his confinement at RCDF. *United States v. Williams*, No. 3:09-00090 (M.D. Tenn. 2009). During the course of the hearing, numerous RCDF inmates testified that they had also lost substantial amounts of weight while at the Jail.

On October 12-15, 2010, we conducted an onsite inspection of the Jail to assess RCDF’s provision of nutrition, medical care, and environmental health and safety. Expert consultants in all three of these areas accompanied us. We toured the facility, observed facility processes, interviewed staff and prisoners, and reviewed an array of documents, including policies and

procedures. Following our onsite inspection, we requested additional documents related to suicide prevention measures and mental health care at RCDF, including prisoners' mental health records, suicide precaution logs, and policies and procedures. An expert consultant in the area of correctional mental health care conducted an offsite review of these documents. Consistent with our pledge of transparency, and to provide technical assistance where appropriate, we conveyed our preliminary determinations regarding nutrition and diet, medical care, and environmental health and safety to RCDF administrators and staff during exit presentations at the close of our onsite visit.

We are confident that the new leadership at RCDF will take appropriate measures to address the deficiencies we detail in this letter. Sheriff Bill Holt and the entire RCDF staff have been helpful and professional throughout the course of our investigation. RCDF has provided us with access to prisoner records and personnel, and responded to our requests, before, during, and after our onsite visit, in a transparent and forthcoming manner. We also appreciate RCDF's receptiveness to our consultants' onsite and post-tour recommendations, and note that at every opportunity, the Sheriff and RCDF's administration have expressed their commitment to working with the United States to provide prisoners with reasonably safe and humane conditions of confinement, as required by the Constitution. We expect we will continue to work with RCDF in a cooperative manner as the Jail addresses the issues we have identified both previously and in this letter.

III. Background

RCDF is located in Springfield, Tennessee, approximately thirty miles north of Nashville. The Robertson County Sheriff's Office, headed by Sheriff Bill Holt, operates the Jail. After serving as Chief Deputy, Sheriff Holt was elected Sheriff in August 2010.

RCDF houses pre-trial federal and state detainees and sentenced state prisoners. At the time of our tour, the Jail housed 280 prisoners in a building that RCDF opened in July 2009. The Jail was in the process of renovating the former jail, originally constructed in 1997. Once renovations to that facility are complete, RCDF will have the capacity to house over 600 prisoners.

RCDF contracts with private companies to provide food and medical services to the Jail. ABL Management, Inc. ("ABL"), a food provider, manages the Jail's food services and Southern Health Providers, Inc. ("SHP"), a medical services provider, supplies onsite medical and mental health care to prisoners.

IV. Findings and Conclusions

We conclude that RCDF fails to provide prisoners with constitutionally adequate mental health care and have serious concerns about medical care, nutrition, and environmental health. These findings are detailed below.

A. Legal Standards Governing Our Investigatory Conclusions

The Eighth Amendment affords convicted prisoners protection from cruel and unusual punishment. U.S. Const. amend. VIII. While the constitutional rights of convicted prisoners and pre-trial prisoners are guaranteed by the Fourteenth Amendment, the Supreme Court has consistently held that pre-trial prisoners “retain at least those constitutional rights . . . enjoyed by convicted prisoners [under the Eighth Amendment].” *Bell v. Wolfish*, 441 U.S. 520, 545 (1979); *Danese v. Asman*, 875 F.2d 1239, 1243 (6th Cir. 1989). The Eighth Amendment requires prison officials to “provide humane conditions of confinement.” *Spencer v. Bouchard*, 449 F.3d 721, 727-28 (6th Cir. 2006) (quoting *Farmer v. Brennan*, 511 U.S. 825, 832 (1994)). Specifically, prison officials “must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must ‘take reasonable measures to guarantee the safety of the inmates.’” *Id.*

The Constitution protects prisoners not only against ongoing harms, but also against the risk of future harm. *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (“That the Eighth Amendment protects against future harm to inmates is not a novel proposition It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.”). Conditions posing a substantial risk of serious harm to prisoners therefore violate the Constitution, even if no prisoner has suffered actual harm at the time the violation is found. *See Farmer*, 511 U.S. at 845-47; *Helling*, 509 U.S. at 35 (finding that risk of future harm to prisoner’s health stated a cause of action under the Eighth Amendment); *Blackmore v. Kalamazoo Cnty.*, 390 F.3d 890, 899 (6th Cir. 2004) (noting that the Constitution “does not require actual harm to be suffered”). The Supreme Court has clearly stated that “a remedy for unsafe conditions need not await a tragic event.” *Helling*, 509 U.S. at 33.

B. RCDF Provides Constitutionally Inadequate Mental Health Care

Corrections officials violate the constitutional rights of prisoners if they are deliberately indifferent to their serious medical needs, including prisoners’ psychological needs. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Horn v. Madison Cnty. Fiscal Ct.*, 22 F.3d 653, 660 (6th Cir. 1994). Corrections officials act with deliberate indifference if they “(1) subjectively kn[ow] of a risk to the inmate’s health, (2) dr[aw] the inference that a substantial risk of harm to the inmate exist[s], and (3) consciously disregard[] that risk.” *Jones v. Muskegon Cnty.*, 625 F.3d 935, 941 (6th Cir. 2010). In essence, prison officials act with deliberate indifference by “denying or delaying access to medical care’ for a serious medical need.” *Phillips v. Roane Cnty., Tenn.*, 534 F.3d 531, 539 (6th Cir. 2008) (quoting *Estelle*, 429 U.S. at 104-05). Our investigation revealed that RCDF’s mental health care system fails to meet constitutional standards. By permitting unqualified personnel to manage suicide precautions for prisoners at risk of engaging in self-harm without supervision and failing to provide prisoners with serious mental illnesses with competent and timely mental health care, RCDF fails to provide constitutionally adequate mental health care.

1. *RCDF violates constitutional standards by permitting LPNs to manage suicide precautions.*

Prisoners have an “established right to medical attention once . . . prisoner[s’] suicidal tendencies are known” to prison officials. *Comstock v. McCary*, 273 F.3d 693, 711 (6th Cir. 2002). Medical attention provided solely by nurses who are not qualified and trained to treat prisoners’ psychiatric needs is not sufficient to meet constitutional standards. Rather, prisoners with psychiatric needs have a right to “reasonable access to medical personnel *qualified to diagnose and treat*” mental illness. *Inmates of Allegheny Cnty. Jail v. Pierce*, 612 F.2d 754, 762 (3d Cir. 1979) (emphasis added). RCDF violates this basic tenet by permitting its LPNs – individuals with little or no mental health training – to both place prisoners on and remove them from suicide watch.¹

The Sixth Circuit has recognized that prison officials may violate the Constitution by removing prisoners from suicide watch without first making a “reasoned assessment or evaluation of the patient’s suicide risk.” *Comstock*, 273 F.3d at 710-11 (finding constitutional violation where psychologist removed prisoner from suicide watch based on an “evaluation [that] was unreasonable and constituted deliberate indifference to the risk that [the prisoner] would harm himself when presented with the opportunity.”). Presently, RCDF’s sole physician is the only RCDF staff person qualified based on his training to conduct such a reasoned assessment. He is only onsite two hours each week and there is no psychiatrist on staff.² Despite his limited time onsite, the physician acts as the Medical Director and is responsible for overseeing RCDF’s entire clinical operation and for providing direct patient care for prisoners with medical or mental health care needs. To compensate for the lack of onsite physician time, the nursing staff provide clinical care that exceeds their licensure and training. RCDF’s policies recognize that LPNs are not qualified or trained to independently make a reasoned assessment or evaluation of a prisoner’s suicide risk. *See, e.g.*, SHP Chronic Care Protocol (protocol emphatically warns “Remember, only the Medical Team Administrator, Psych Nurse or Psychiatrist can remove a prisoner from Suicide Observation.”)³

RCDF’s use of LPNs to make determinations regarding suicide precautions deviates from minimum constitutional requirements, RCDF’s own policies, medical community practice, and the recommended guidelines of the National Committee for Correctional Health Care (“NCCHC”), and ultimately places prisoners at risk of serious harm. *See Ramos v. Lamm*, 639 F.2d 559, 576 (10th Cir. 1980) (finding that prison officials failed to provide constitutionally adequate medical care where non-physician medical staff were “being used as ‘physician substitutes’ and . . . being

¹ There are two types of licensed nurses, LPNs and registered nurses, or RNs. Registered nurses have a more advanced degree and more training than LPNs. LPNs are supervised by registered nurses to carry out some clinical functions. A registered nurse can develop a nursing diagnosis, but not a medical diagnosis.

² SHP policies reflect the need for a psychiatric provider at RCDF. For example, the Chronic Care Protocols state that after the medical staff and psychiatric nurse screen an inmate, “a referral may be made to see the Psychiatrist.”

³ The SHP Chronic Care Protocol alternately refers to the “Psych Nurse” as the “Psych RN.” The current psychiatric nurse is a registered nurse.

forced to make decisions and perform services for which they are neither trained nor qualified.”). The following example demonstrates RCDF’s constitutionally infirm practice of removing prisoners from suicide watch without providing a reasoned and comprehensive evaluation of their suicide risk by a trained mental health professional:

- On October 10, 2010, RCDF staff placed Prisoner A on suicide watch and started him on an antidepressant. There was no progress note in his record documenting the rationale for placing him on suicide watch or ordering the antidepressant. Two days later, an LPN removed him from suicide watch. Neither the psychiatric RN nor the physician conducted a mental health assessment of Prisoner A before the LPN removed him from suicide watch. Nevertheless, the LPN ordered that Prisoner A be placed on razor restriction and prohibited him from having sheets in his cell, indicating that the nurse believed that Prisoner A was still at risk of engaging in self-harm.

Our review also revealed numerous instances where RCDF nurses removed prisoners from suicide watch after prisoners signed contracts essentially promising not to harm themselves. For someone with suicidal ideation or who is actively suicidal, these “contracts for safety” have little protective validity, yet RCDF is using them in place of an evaluation by a qualified mental health practitioner. The following examples illustrate this practice:

- On September 16, 2010, RCDF staff placed Prisoner B in isolation.⁴ According to a nurse’s notes, Prisoner B was removed from isolation after signing a contract promising not to engage in self-harm. This occurred although the psychiatric RN had specifically noted that Prisoner B should not be permitted to contract for safety.
- Prisoner C was placed on suicide watch on August 29, 2010, due to suicidal ideation. The next day, an LPN removed Prisoner C from suicide watch after she signed a contract. The psychiatric nurse saw Prisoner C for the first time ten days later.
- On April 28, 2010, RCDF staff placed Prisoner D on suicide observation after he used a pencil to engage in self-injurious behavior. Two days later, RCDF staff removed Prisoner D from observation after he signed a contract promising not to engage in self-harm. RCDF did not conduct a formal mental health assessment of Prisoner D before removing him from observation.

This practice falls below constitutional standards. *See Comstock*, 273 F.3d at 710-11 (psychologist placed prisoner at risk of harm by removing him from suicide watch based on an evaluation that “left him no way to corroborate [the prisoner’s] self-serving statement that he was feeling better”); *see also Farmer*, 511 U.S. at 843 n. 8 (A prison official may “not escape

⁴ In order to do so, RCDF staff removed another inmate with a mental health condition from isolation, indicating problems with crowding in the cells designated for mental health observation.

liability if the evidence show[s] that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist.”).

The physician and psychiatric nurse have little or no involvement in the management of suicide precautions. During the first day of our onsite tour, we were told that there were not any prisoners on suicide watch. However, we observed two prisoners in suicide smocks (commonly called “turtle suits”). These two prisoners were in isolation cells and had all of their clothes removed except for the soft upper body cloth suit. Neither the medical staff, including the physician, nor the psychiatric nurse was able to provide information regarding the status of these two prisoners.

Our review of prisoners’ records confirmed our onsite observations that prisoners on suicide watch are not adequately supervised or monitored. Prisoners on suicide watch often had no clear documentation in their chart outlining when and why they were placed on a suicide watch, or when they were removed. Suicide precaution logs revealed that these forms often appeared to be completed in advance, indicating that RCDF staff did not conduct intermittent checks. Moreover, we discovered numerous cases where either more than fifteen minutes elapsed between checks or checks were not staggered. RCDF’s failure to adequately monitor and supervise prisoners on suicide watch contravenes RCDF’s own policy and the constitutional requirement that, at a minimum, correctional mental health programs must include “a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies.” *Ruiz v. Estelle*, 403 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff’d in part and rev’d in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982); *see* SHP Suicide Prevention Policy (requiring staggered checks every 10-15 minutes); *see also* Lindsay M. Hayes, *Guide to Developing and Revising Suicide Prevention Protocols Within Jails and Prisons*, Nat’l Ctr. on Insts. & Alternatives 5 (2011) (recommending that a prisoner who is actively suicidal should be observed “on a continuous, uninterrupted basis,” and a prisoner who is “not actively suicidal, but expresses suicidal ideation . . . and/or has a recent prior history of self-destructive behavior” should be observed “at staggered intervals not to exceed every 10 minutes (e.g., 5, 10, 7 minutes)).”

Finally, RCDF uses seclusion and restraint inappropriately and without necessary safeguards when responding to the risk of suicide. Specifically, RCDF nurses and custody staff use the restraint chair as a form of “suicide watch” without an order from the physician. The records we reviewed demonstrated that RCDF staff place prisoners in the restraint chair, confine them to the chair for hours at a time, and then remove them, without ever providing the prisoner with a face-to-face evaluation by the physician. The following examples illustrate this practice:

- Prisoner E entered RCDF on September 11, 2010, with a dual diagnosis of mental illness and substance abuse. Custody and nursing staff placed Prisoner E in restraints and subsequently placed him on suicide watch. The psychiatric nurse did not evaluate Prisoner E until after he had been on suicide watch for 48 hours and had been at the Jail for more than two weeks. Even then, she did not conduct a comprehensive mental health evaluation or develop an adequate treatment plan.

- On May 15, 2010, Prisoner F entered RCDF. Based on his previous admission to RCDF, it was clear that Prisoner F had a history of suicidal ideation. The day of his admission, RCDF staff placed him in the restraint chair without a physician's order or a face-to-face evaluation. According to his chart, on May 28, 2010, custody staff observed Prisoner F consume a handful of pills. As a result of this suicide attempt, staff transferred Prisoner F to a hospital critical care unit. The psychiatric nurse did not see Prisoner F until a week after his return from the hospital. Prisoner F never received follow-up care by the physician.

RCDF does not maintain complete records regarding the use of seclusion or the restraint chair. Moreover, RCDF does not have a medical or mental health policy specific to the use of involuntary psychotropic medication or restraints. The use of restraint and seclusion are safety interventions only and do not constitute a valid form of mental health treatment. The use of restraint and seclusion may lead to the worsening of a mentally ill individual's symptoms and carries the risk of physical injury.⁵

2. *RCDF violates the Constitution by failing to provide seriously mentally ill prisoners timely and competent mental health care.*

In order to meet the minimum required by the Constitution, a correctional mental health care program must include "the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders." *Ruiz*, 403 F. Supp. at 1339. Moreover, this treatment must be provided in a timely manner. *See Phillips*, 534 F.3d at 539 (prison officials violate constitutional standards by "denying or delaying" prisoner's access to treatment for a serious medical need); *Blackmore*, 390 F.3d at 900 (noting that a "delay alone in providing medical care creates a substantial risk of serious harm"). RCDF fails to provide prisoners identified as seriously mentally ill or suicidal with timely and competent mental health care. Specifically, prisoners with chronic mental illnesses who are not capable of requesting mental health care are effectively denied treatment, prisoners who request mental health care experience unreasonable delays, and nurses are responsible for providing mental health care beyond their training and qualifications.

- a. RCDF does not provide prisoners with chronic mental illnesses with adequate mental health care and treatment.

Despite the existence of a policy entitled "Chronic Care Protocols: Diagnosed Mentally Ill Patients," RCDF does not have an established system for providing chronic care to psychiatric

⁵ See, e.g., Nat'l Ass'n of State Mental Health Program Dirs. ("NASMHPD"), *NASMHPD's Position Statement on Seclusion and Restraint*, at 1 (July 15, 2007), http://www.nasmhpd.org/position_statement.cfm. NASMHPD is an organization made up of directors of state public mental health systems. According to NASMHPD, "seclusion and restraint are safety interventions of last resort and are not treatment interventions." *Id.* NASMHPD's Position Statement emphasizes that "[t]he use of seclusion and restraint creates significant risks for all individuals involved . . . includ[ing] serious injury or death . . ." *Id.*

patients. Mental health services at RCDF are primarily provided at the request of the prisoners.⁶ As a result, prisoners who are too ill to write a request for an appointment are, in effect, denied constitutionally adequate mental health care. See *Casey v. Lewis*, 834 F. Supp. 1477, 1550 (D. Ariz. 1993) (finding prison officials deliberately indifferent where “severely mentally ill inmates cannot make their needs known to mental health staff.”); see also *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982) (Jail officials must provide prisoners with a mechanism “to make their medical problems known to the medical staff.”). This practice places seriously mentally ill prisoners at considerable risk of harm, including decompensation.

We did not review a single record that contained an appropriate treatment plan. The following example demonstrates the constitutionally inadequate mental health care RCDF provides to prisoners with severe and chronic mental illnesses:

- Prisoner G entered the Jail on July 21, 2010, with a history of severe mental illness and prior suicide attempts. Despite these risk factors, intake staff never referred Prisoner G to mental health services. Prisoner G did not receive mental health care until August 11, 2011, after he engaged in self-harm by inserting a foreign object into his urinary and digestive tracts. Even then, he was not referred to the physician. Instead, he was seen in an intermittent fashion by the psychiatric nurse, who conducted visits cell-side, preventing confidential communications. This is the only form of mental health treatment RCDF provided to Prisoner G.

Indeed, instead of providing seriously mentally ill prisoners with chronic care, RCDF essentially relies on “therapeutic lockdown,” in which a detainee is isolated in his or her cell and denied any staff interaction, including contact with mental health staff. This use of long-term seclusion is contrary to generally accepted professional standards of mental health care and the Constitution. While the psychiatric nurse provides these prisoners with minimal medication management, RCDF provides no other treatment modalities. In order to provide constitutionally adequate mental health care, “the prescription of [psychotropic] drugs cannot supplant the necessity of psychiatric counseling.” *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); see also *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995) (a constitutionally adequate mental health care system includes, at a minimum, “a treatment program that involves more than segregation and close supervision of mentally ill prisoners”).

- b. RCDF does not respond to requests for mental health care in a timely manner.

RCDF’s mental health care system fails to provide timely treatment in violation of the Constitution. See *LeMarbe v. Wisneski*, 266 F.3d 429, 439 (6th Cir. 2001) (“[A] deliberately indifferent delay in giving or obtaining treatment may also amount to a violation under the Eighth Amendment.”). Even those prisoners who are able to request mental health services must wait significant periods of time before seeing the psychiatric nurse. The psychiatric nurse works at the facility one day per week for six to eight hours and essentially acts as the sole provider of mental

⁶ SHP policy expressly permits this practice. See Chronic Care Protocols (“At all times, Inmates must complete and submit a sick call request form to see the Psych RN or Psychiatrist.”).

health care to RCDF prisoners. Our review revealed that, on average, it takes approximately two to three weeks for the psychiatric nurse to respond to a prisoner referral. Delays of two weeks or more for mental health care effectively deny prisoners access to medical care in violation of the Constitution. See *Ramos*, 639 F.2d at 578 (staff shortages leading to prisoners being placed on waitlist of two to five weeks constitutes effective denial of mental health care and demonstrates deliberate indifference). Shorter delays also deny prisoners access to medical care when the need is urgent. See, e.g., *Fitzke v. Shappell*, 468 F.2d 1072, 1076-77 (6th Cir. 1972) (delay of 12-17 hours in receiving treatment where circumstances indicated prompt need for medical attention stated a cause of action for denial of medical care). The following examples demonstrate RCDF's delays in providing mental health care:

- Prisoner C was placed on suicide watch on August 29, 2010, due to suicidal ideation. On August 30, 2010, a nurse removed Prisoner C from suicide watch after she signed a contract. The psychiatric nurse saw Prisoner C for the first time ten days later, on September 9, 2010. On November 3, 2010, Prisoner C again requested to see the psychiatric nurse. Despite Prisoner C's depression and suicidal ideation, the psychiatric nurse did not respond to her request for more than two weeks.
- Upon his admission in July 2010, Prisoner H reported his history of mental illness and treatment with Seroquel. Outside records documented that Prisoner H had, in fact, been receiving this medication prior to his arrival at RCDF. Despite his request to receive this medication, RCDF staff did not provide Prisoner H with Seroquel until two months after his admission.
- Prisoner I had a known history of mental illness and suicidal ideation. Specifically, Prisoner I cut her arms with a razor blade while on suicide observation at RCDF. Prisoner I had also attempted suicide prior to her incarceration by stabbing herself in the stomach. An RCDF nurse noted in Prisoner I's record that "it is felt by staff that [Prisoner I] is trying to end her own life due to the serious charges she faces." On April 8, 2010, Prisoner I submitted a request for mental health care. Despite her risk factors, the psychiatric nurse did not see Prisoner I until nearly one week after her request for mental health services.
- Prisoner J entered RCDF on March 6, 2010. Ten days later, Prisoner J was placed on suicide watch due to suicidal ideation, auditory hallucinations, and engaging in self-harm. Prisoner J filed multiple sick call requests in order to be seen for adjustment of his psychotropic medication. On average, the psychiatric nurse took about three weeks to respond to his requests. During these delays, he was placed in restraints and subject to uses of force by custody staff.

RCDF's practice of permitting two to three weeks – or more – to elapse between a prisoner's request for mental health care and the provision of care does not meet constitutional standards.

- c. RCDF permits nurses to provide mental health care beyond their training and qualifications.

RCDF's practice of permitting nurses who are not trained and qualified to provide mental health care to manage psychotropic medications and treat prisoners with serious mental health needs violates the Constitution and generally accepted practices. *See, e.g., Inmates of Allegheny Cnty. Jail*, 612 F.2d at 762; *Balla*, 595 F. Supp. at 1577 (finding that "minimally adequate psychiatric care" includes adequate coverage by a psychiatrist to "provide treatment to those inmates capable of deriving benefit").

The "appropriate supervision and periodic evaluation" of prisoners on psychotropic medications is "constitutional minima . . . specific to mental health care." *Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995). RCDF prisoners are being treated with anti-psychotics and major mood stabilizers. Yet, the physician does not consistently evaluate prisoners on psychotropic medications, nor does he review the prescribed psychotropic medications to ensure their appropriateness and to prevent negative interactions with other medications.⁷ Instead, the psychiatric nurse essentially prescribes and manages medications for patients with mental health conditions, responsibilities that are beyond the scope of a nurse's training. The following examples demonstrate RCDF's practice of permitting staff to provide mental health care beyond their licensure and training:

- Prisoner K entered the Jail on September 7, 2010, with a history of mental illness. The psychiatric nurse saw Prisoner K two weeks after he requested an appointment. Prisoner K reported to the nurse that, prior to arriving at RCDF, he was prescribed Cymbalta, a drug commonly used to treat depression. The psychiatric nurse independently gave Prisoner K permission to take Cymbalta if his family was able to provide the medication. The psychiatric nurse never referred Prisoner K to the physician for an evaluation or an alternative drug. Moreover, the prisoner's family should not be responsible for his medical or mental health care while in the custody of the Jail.
- Prisoner L entered RCDF on July 30, 2010, with a history of anxiety and treatment with psychotropic medication. RCDF intake staff did not refer Prisoner L to a qualified mental health professional within 14 days of arrival as required by the standard of care. Instead, an LPN managed his treatment with preformatted treatment protocols and telephone orders.
- On May 15, 2010, Prisoner F entered RCDF. The psychiatric nurse mismanaged the doses of Prisoner F's psychotropic medications, causing Prisoner F to be overly sedated and lethargic. Prisoner F never received follow-up care by the physician.

⁷ Certain medications, including Depakote and Lithium, require monitoring by diagnostic blood tests to ensure that the medications are not causing harm to the patient.

The physician is the only RCDF medical professional who is equipped by his training and licensure to manage and treat patients with a medical and/or mental health diagnosis. In order to ensure that prisoners receive constitutionally adequate mental health care, RCDF must ensure that a physician is available to train nursing staff and to provide oversight. RCDF must increase its mental health staffing to meet the needs of its population and limit the psychiatric nurse's and LPNs' job responsibilities to those services they are trained and licensed to perform.

C. RCDF's Medical Care Is Deficient and Creates a Risk of a Constitutional Violation

RCDF provides prisoners with medical care minimally adequate to comply with the Constitution. We did not identify a pattern or practice of incidents in which prisoners suffered harm due to RCDF's medical practices, or in which RCDF's medical practices placed prisoners at an unreasonable risk of harm. Nonetheless, we identified numerous practices in the area of medical care that could result in constitutional violations if left unremedied. The Constitution protects a prisoner's "right not to have his serious medical needs disregarded by his doctors." *LeMarbe*, 266 F.3d at 440. Prison officials knowingly disregard, or act with deliberate indifference to this right by "'denying or delaying access to medical care' for a serious medical need." *Phillips*, 534 F.3d at 539 (quoting *Estelle*, 429 U.S. at 104-05). Officials also violate the Constitution when they are deliberately indifferent to "an unreasonable risk of serious damage to . . . [a prisoner's] future health." *Helling*, 509 U.S. at 35.

Our review revealed that RCDF's medical practices place prisoners at risk of receiving delayed or deficient medical care. Specifically, RCDF permits unqualified staff to conduct health assessments, provides poor medication management, and lacks a chronic care program. In addition, RCDF should improve its management of infectious diseases. Although we did not identify any instances of serious harm from these systemic deficiencies during our review, these deficiencies could place prisoners at risk of harm, and, if left unremedied, may result in constitutional violations.

As discussed in our assessment of mental health care, many of these lapses are directly related to RCDF's inadequate medical staffing. Due to the inadequate physician support at RCDF, nurses practice and provide medical care beyond their training and licensure. Specifically, nurses make decisions regarding which drugs should be prescribed and conduct health assessments with little or no oversight. Moreover, nurses are permitted to use "medical protocols" to prescribe medications. The use of inappropriate health staff for the management and evaluation of serious medical conditions could place the prisoners at risk for both unnecessary morbidity and mortality.

Specific deficiencies we observed included the following:

- LPNs conduct comprehensive medical assessments of prisoners, a function LPNs are not licensed or qualified to perform.
- RCDF dispenses medications to prisoners without any supporting medication orders or progress notes. Dispensing medications without a progress note,

physician order, or other documentation is dangerous and can have a lethal outcome for the patient.

- RCDF's medication verification procedures result in unnecessary and unreasonable delay in providing medication to prisoners.
- RCDF lacks a defined system to track or manage prisoners with chronic medical conditions.
- RCDF does not have a procedure in place to test prisoners annually for tuberculosis and does not track Methicillin-resistant *Staphylococcus aureus*⁸ or any other infectious disease information.

If left unremedied, RCDF's provision of medical care by unqualified staff may result in a denial of care and violate the Constitution.

D. RCDF Provides Prisoners with Adequate Nutrition

We found that RCDF provides prisoners with constitutionally adequate nutrition. All prisoners must receive adequate food and water. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Helling*, 509 U.S. at 31-32. To be adequate, the food provided must be sufficient to maintain normal health. *Cunningham v. Jones*, 567 F.2d 653, 660 (6th Cir. 1977). For prisoners to maintain normal health, the food they receive must contain both adequate nutrients and calories. *See, e.g., Hutto v. Finney*, 437 U.S. 678, 683, 686-87 (1978) (discussing caloric intake); *Phelps v. Kapnolas*, 308 F.3d 180, 187 (2d Cir. 2002) (diet must be nutritionally adequate).

On December 22, 2010, we provided RCDF with our preliminary findings regarding the nutritional adequacy of the meals that the Jail provides. In that letter, we stated that we had found information to support prisoners' claims that, in 2008 and part of 2009, they were not receiving enough food, likely due to the actions of a former food service contract employee. While we conclude here that RCDF has resolved its issues related to the provision of adequate nutrition, we note that this incident underscores how important it is for the Jail to supervise kitchen operations, and more broadly, the operations of all of its contractors.

Although our review indicates that RCDF's menu is constitutionally adequate, we have some concerns regarding RCDF's food preparation, portioning, and service practices that can

⁸ MRSA is a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death. A MRSA infection is sometimes confused by detainees and medical staff for a spider or insect bite, causing delays in treatment while the infection worsens or spreads. MRSA is resistant to common antibiotics, such as methicillin, oxacillin, penicillin, and amoxicillin. MRSA is usually spread by direct physical contact, but may also spread through indirect contact, by touching objects such as towels, sheets, wound dressings, and clothes. MRSA can be difficult to treat and can develop into life-threatening blood or bone infections. *See generally* Ctrs. for Disease Control & Prevention, Methicillin-resistant *Staphylococcus Aureus* (MRSA) Infections, <http://www.cdc.gov/mrsa/index.html> (last updated Apr. 8, 2011).

impact the adequacy of nutrition provided to prisoners. We discuss these practices and some recommended actions below. As a general proposition, however, RCDF should consider developing a standing committee devoted to food and food related issues in order to identify issues and implement corrective actions where needed. This committee should be comprised of RCDF administrative staff, first line jail supervisors, correctional officers, kitchen employees, and medical representatives, and include a mechanism for prisoner feedback.

Additionally, in order to avoid any issues before they develop, RCDF should take a more active role managing its food service operation. While a contractor provides RCDF's food service, the Sheriff and RCDF are ultimately responsible for the food service operation. In particular, RCDF should regularly review key documents and observe kitchen operations. Such oversight will ensure that RCDF's food contractor meets its contractual obligations and provides safe and nutritious meals as required by the Constitution.

1. *RCDF's menu provides nutritionally adequate meals.*

RCDF appears to provide nutritionally adequate meals. RCDF should ensure, however, that a qualified dietician approves its menus in advance. RCDF utilizes a four-week cycle menu, ostensibly approved by a dietician on staff with RCDF's food contractor. At the time of our tour, the menu had been changed several months prior to our visit, yet the kitchen staff did not have an updated, dietician-approved menu reflecting the changes. Additionally, RCDF staff informed us that a new menu was scheduled to go into effect in the month following our tour. To prevent the reoccurrence of the concerns that initially prompted our investigation, it is vital that a qualified, credentialed dietician reviews all menus prior to their implementation so that the Jail is assured that the menu it serves is calorically and nutritionally adequate. This is especially important at RCDF, where no commissary is available to prisoners, as RCDF's kitchen provides prisoners' only source of nutrition.

Following our visit to the Jail, RCDF provided us with a copy of RCDF's revised, dietician-approved menu (hereinafter the "October 2010 menu"), and a nutritional analysis of that menu. Based on our expert dietician's review, the October 2010 menu – currently in effect at RCDF – should provide prisoners with adequate nutrients and calories to maintain normal health, assuming it is implemented as written.

Specifically, the nutritional analysis for the October 2010 menu indicates that RCDF served an average of 2,900 calories/day per prisoner during the menu's four-week cycle. Daily caloric needs are predicted by an individual's Estimated Energy Requirement ("EER"), which varies by age, gender, weight, height, and level of physical activity. Our expert dietician evaluated the EER for two reference individuals, a male and a female between the ages of 19-30, who engage in low levels of physical activity, as representative of the energy needs of a majority of RCDF prisoners. Based on these reference individuals, the October 2010 menu is adequate to meet the maintenance energy needs of the majority of prisoners at RCDF. The October 2010 menu also meets the major nutrient requirements for men and women aged 19 to 70 and pregnant women.

2. *RCDF's food preparation, portioning, and service practices impact nutritional adequacy.*

In addition to a nutritionally sufficient menu, nutritional adequacy requires RCDF to prepare and portion meals in a manner consistent with the menu's requirements, and to provide every prisoner with his or her prescribed diet. Overall, our investigation indicated that RCDF prisoners were receiving adequate nutrition in accordance with the Jail's menu and the Constitution. We observed, however, several practices that could impact the level of nutrition each prisoner actually receives.

As we stated in our December 22, 2010 letter, to reduce the need for any variances from standardized recipes, the food contractor should provide, and the kitchen staff should follow, standardized recipes scaled to the number of meals needed. These recipes should be updated when RCDF's population changes significantly, or when suppliers or ingredients change. Facilities commonly either maintain copies of recipes scaled to their particular needs or use computer software to generate recipes adjusted to the needed number of meals. These tools reduce reliance on quick estimates, and increase the accuracy of the nutritional analysis of the menu in use. Finally, kitchen staff should record the recipe number used on the daily food production schedule to ensure compliance with the menu, and the food contractor's regional supervisor and food service director should monitor both the adequacy of the documentation and the cooking for compliance with the standardized recipes.

Additionally, for prisoners to receive the benefits of RCDF's menu, the Jail must provide each prisoner with the correct tray at every meal. To ensure that RCDF is doing so, the Jail should develop and implement a policy and procedure to ensure that correctional officers consistently document receipt of meal trays. Each officer responsible for distributing meals should confirm a prisoner's identity by checking his or her wrist identification band before handing the food tray to the prisoner, and then document the fact that the prisoner received his or her meal. This documentation should include any meal refusals.

E. Environmental Health and Safety at RCDF Comport with Constitutional Standards

We found that the environmental conditions at RCDF did not violate the Constitution. In certain areas, however, RCDF's practices fall below national standards. The Eighth Amendment guarantees that prisoners will not be "deprive[d] of the minimal civilized measure of life's necessities." *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981). As the Due Process Clause of the Fourteenth Amendment affords at least the same protections to a pre-trial detainee in a jail, RCDF must be sure that it does not deprive prisoners of the minimal civilized measures of life's necessities. Accordingly, RCDF must provide essential sanitation and meet prisoners' basic hygiene needs. *Flanory v. Bonn*, 604 F.3d 249, 253-55 (6th Cir. 2010). Conditions violate the Constitution when they pose an unreasonable risk of serious harm to a prisoner's current or future health, and where the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. *Helling*, 509 U.S. at 33-36; *Flanory*, 604 F.3d at 255 (citing *Helling*).

At the time of our tour, RCDF was undergoing extensive remodeling of its facility following the construction of a new addition that had been open for approximately one year. As a result, the facility is clean and in generally excellent condition. Nonetheless, RCDF must remain attentive to issues of food safety, chemical control, pest control, fire safety, and other issues of cleanliness and sanitation, all of which may pose unnecessary risks to prisoner health and safety without the implementation of effective programs and services. We identified many of our concerns and provided guidance as to how to address them during our tour, and so discuss these issues only briefly here.

Specific deficiencies we observed included the following:

- RCDF staff lack control over many kitchen tools and implements that could be used as weapons.
- RCDF's food service manager and staff lack basic food safety training.
- RCDF kitchen sanitation is inadequate in certain areas.
- RCDF fails to screen food service employees and inmate staff for communicable diseases that could be transmitted by foods.
- RCDF has no documented program or process for maintaining and controlling the chemicals used throughout the facility. These unsecured chemicals can be used as weapons or, if ingested, may pose a suicide risk.
- RCDF lacks a written emergency plan including evacuation routes and secure areas for prisoners to be housed in the event of an emergency.
- RCDF lacks control over items in the medical clinic, including medical sharps and biohazard waste, that may pose a risk to prisoners and staff.

V. Summary of Remedial Measures

To remedy its failure to provide constitutionally adequate mental health care to RCDF prisoners, the County should promptly implement the minimum remedial measures set forth below. Specifically, RCDF should:

- Gain access to a qualified provider or contract psychiatrist(s) at least every two weeks;
- Modify the psychiatric nurse's job description and job responsibilities to prohibit her from independently prescribing medications and practicing medicine;
- Require the medical director, or any contract psychiatrist RCDF hires, to supervise the psychiatric nurse on a regular basis;

- Ensure that appropriate mental health assessments are conducted within 24 hours of a prisoner's arrival at RCDF, or sooner if clinically appropriate for prisoners identified as potentially suicidal (and ensure that those prisoners identified as potentially suicidal are on constant watch until they receive their mental health assessment);
- Develop more defined referral parameters to ensure that prisoners with mental health needs are referred to the physician. Intake staff and nurses must be provided with clear guidance regarding which prisoners should be referred to the physician and how quickly that referral should take place. These guidelines should require an immediate referral for emergent issues, a referral within 24 hours when an expedited evaluation is necessary, and a referral within 72 hours for a routine evaluation;
- Ensure that LPNs are not permitted to remove prisoners from suicide watch;
- Ensure that there is no ambiguity regarding the status of a prisoner who is on suicide watch. Qualified medical staff should determine the appropriate level of care and/or housing based on the clinical status of the prisoner and additional information provided by the security staff. Prisoners on suicide watch should be evaluated daily and the medical staff must be aware of all prisoners on a watch;
- Enhance communication between custody and medical staff and implement policies and procedures that provide for the timely treatment and regular monitoring of prisoners on suicide watch;
- Develop and implement written policies for the use of restraints on prisoners with mental illness, requiring written approval by a qualified mental health professional prior to use of restraints, monitoring, and documentation;
- Ensure that all custody and medical staff are trained on the policies and procedures governing appropriate use of restraints on prisoners with mental illness;
- Ensure that prisoners who request mental health care through the sick call system for urgent needs are seen by a qualified mental health professional within 24 to 72 hours;
- Require the RCDF physician to conduct a screening evaluation and comprehensive evaluation of all prisoners taking psychotropic medications within 30 days of their arrival at the Jail. The physician should monitor these prisoners periodically to ensure they are stable, that the medications are working effectively, and that the medications are not causing unwanted toxic or metabolic side effects;

- Develop procedures to ensure that prisoners who are prescribed psychotropic medications that require blood tests are closely monitored;
- Develop a system to conduct qualitative reviews of adverse events performed from a mental health perspective;
- Document all medications, including psychotropic medications, ordered for prisoners on the medication order form. Progress notes should support the order to dispense the medication; and
- Institute a chronic care program to address the needs of prisoners with serious mental illnesses. Prisoners with chronic mental illness should be placed on a chronic mental health list for follow-up as clinically appropriate every 30, 60, or 90 days without having to request follow-up. Basic services must include, at a minimum:
 1. Identification and referral of inmates with mental health needs;
 2. Crisis intervention services;
 3. Psychotropic medication management, when indicated;
 4. Individual counseling, group counseling, psychosocial/ psycho-educational programs; and
 5. Treatment documentation and follow-up.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding conditions at RCDF. Since our onsite visit, RCDF has reported that the Jail has taken various steps to address many of the concerns we raised at our exit presentation at the close of that visit. We appreciate the Jail's proactive efforts, and are confident that the Jail will be able to resolve all the matters we raised.

CRIPA obligates us to advise you that, in the event we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct the constitutional deficiencies we have identified in this letter 49 days after the appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting you to discuss this matter in further detail.

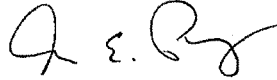
Please note that this letter is a public document. It will be posted on the Civil Rights Division's website. As a matter of courtesy, we will not post this letter to the website until five business days from the date of this letter. We will also provide a copy of this letter to any individual or entity upon request.

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Should you have any questions or concerns regarding this letter, please feel free to contact Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. E. Perez', written in a cursive style.

Thomas E. Perez
Assistant Attorney General

Enclosures

cc: Sheriff Bill Holt
Robertson County

Captain Tony Crawford
Jail Administrator
Robertson County Detention Facility

Clyde W. Richert III
County Attorney

The Honorable Jerry E. Martin
United States Attorney
Middle District of Tennessee

U.S. Marshal Denny W. King
U.S. Marshals Service
Middle District of Tennessee



U.S. Department of Justice
Civil Rights Division

*Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530*

October 7, 2009

The Honorable Martin O'Malley
Office of the Governor
100 State Circle
Annapolis, Maryland 21401

Re: Investigation of the Rosewood Center, Owings Mills, Maryland

Dear Governor O'Malley:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Rosewood Center ("Rosewood"), in Owings Mills, Maryland. On July 11, 2008, we notified you of our intent to conduct an investigation of Rosewood pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of persons with developmental disabilities who are served in public institutions.

On October 6-9, 2008, we conducted an on-site review of care and treatment at Rosewood with expert consultants in various disciplines. During our visit, we interviewed Rosewood administrators, professionals, staff, and consultants, and visited residents in their residences, at activity areas, and during meals. Before, during, and after our site visit, we reviewed a wide variety of relevant State and facility documents, including policies and procedures, incident reports and investigations, and medical and other records relating to the care and treatment of Rosewood residents. In keeping with our pledge of transparency and to provide technical assistance, where appropriate, we conveyed our preliminary findings to State counsel and to certain State and facility administrators and staff during exit briefings at the close of our on-site visit.

We would like to express our appreciation to Rosewood administrators, professionals, and staff and to the State officials who participated in our visit for their assistance, cooperation, professionalism, and courtesy throughout our investigation. At the time of our visit, Rosewood had the benefit of a competent and

caring Facility Director and management team that were expending considerable effort to make changes at Rosewood, some of which we discuss in this letter, and we thank them for their efforts and for their assistance during our tour. We hope to continue to work with the State and Rosewood officials in the same cooperative manner going forward.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). We have concluded that certain conditions and practices at Rosewood violated the constitutional and federal statutory rights of its residents. In particular, we find that the State fails to provide Rosewood's former residents with adequate transition planning and placement in the most integrated setting, and that Rosewood failed to provide its residents with adequate protection from harm; behavioral, habilitation, and communication services; and health care, including infection control and physical and nutritional management. See Olmstead v. L.C., 527 U.S. 581 (1999); Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, 12132 *et seq.*; and 28 C.F.R. § 35.130(d). These failures are likely to have lingering effects, including placement into inappropriate settings, which must be ameliorated and remedied. Thomas S. v. Flaherty, 902 F.2d 250, 254-55 (4th Cir. 1990).

At the outset, we wish to highlight the context in which our investigation took place. On January 15, 2008, Maryland Governor Martin O'Malley announced that the State intended to close Rosewood by June 30, 2009. Shortly before the Governor's announcement, DDA recommended in November 2007 that 153 of the 166 residents then residing at Rosewood be moved to community settings that meet the safety, health, and habilitation needs of each individual. At the time of our visit in October 2008, Rosewood had just embarked on the process of transitioning residents to other placements, with 128 individuals continuing to reside at Rosewood. On June 3, 2009, the State informed us that Rosewood has now moved all of its residents to other placements and is no longer providing services to persons with developmental disabilities.

Because of the closure, a significant concern that underlies many of the findings we set forth in this letter is particularly troubling: Rosewood's assessments of its residents were critically deficient. Across disciplines, we found that assessments were inaccurate, incomplete, and untimely. The medical, psychiatric, nutritional, behavioral, habilitation, vocational, and communication assessments provided by Rosewood substantially depart from generally accepted professional standards. The harm from the inadequacies of the assessments is

multi-faceted. While in the facility, the inadequate assessments exposed the individuals to physical harm, to regression in treatment of their disabilities, and to unnecessarily prolonged institutionalization. A greater concern in the present context, however, is that the lack of adequate assessments has undermined Rosewood's ability to determine the strengths and needs of its residents so that they can be safely placed in the most integrated setting appropriate to their needs. Similarly, the physical harm, regression in treatment, and prolonged institutionalization may have lingering effects for the individuals' current placement. Indeed, the conditions we found at Rosewood – including inadequate protection from harm; inadequate behavioral, habilitation, and communication services; and inadequate health care, including infection control and physical and nutritional management – all have undermined the care and treatment that Rosewood's residents received while in the facility and may jeopardize their current safety, well-being, and ability to flourish in less-restrictive settings.

Moreover, we have grave concerns regarding the inadequacies in the State's and Rosewood's discharge planning and transition process, especially given the deficiencies we found in Rosewood's assessments. While at Rosewood, we requested copies of the monitoring reports that are periodically performed as to individuals who have recently been discharged. This information is crucial to effective discharge planning, as it affords Rosewood and the State the opportunity to identify problems in the transition process and to implement corrective actions. During our tour, we were given copies of a limited number of these monitoring reports to review. However, the State has refused to provide us with the copies of the additional reports we requested at the end of our tour, on grounds that these documents are not in Rosewood's possession, albeit, apparently, they are in the State's possession. The State's refusal to release these documents is disturbing. As a threshold matter, Rosewood's placement consultant specifically noted that he had reviewed copies of the monitoring reports we requested. Second, this information is essential to effective discharge planning. If Rosewood did not have this information, it is a substantial departure from generally accepted professional standards in discharge planning. Finally, the State appears to be selectively cooperative in providing the United States with information central to the safety and well-being of Rosewood's residents, all of whom the State has placed elsewhere. In any event, as discussed in more detail in Section II.A, the few monitoring reports Rosewood provided to us during our tour revealed critical deficits in the transition process, including failures to conduct assessments and provide services in a timely manner for individuals now in community placements. Because many of Rosewood's former residents who have recently been placed in the community are medically and behaviorally fragile, these deficits expose these individuals to significant risk of harm.

Accordingly, in this letter we describe not only the failures we found in the State's and Rosewood's discharge planning and transition process, but also those failures in the provision of services we found to have existed while Rosewood remained open, including inadequate protection from harm, behavioral, habilitation, and communication services, and health care, as all of these deficiencies are likely to have ongoing effects that the State must take adequate measures to ameliorate.

I. BACKGROUND

Rosewood was one of four residential centers operated by the Maryland Developmental Disabilities Administration ("DDA"). Located in Owings Mills, Maryland, which is approximately 20 miles outside of Baltimore, Maryland, Rosewood was licensed as a 257-bed intermediate care facility for individuals with mental retardation ("ICF/MR"). Additionally, Rosewood operated a forensic unit for individuals with developmental disabilities who have been involved in criminal proceedings.

II. FINDINGS

A. **The Process Through Which the State Has Placed Rosewood's Residents Out of the Facility and Is Overseeing Their Transition from the Facility Substantially Departs from Generally Accepted Professional Standards and Exposes Them to Significant Risk of Harm.**

We have significant concerns that the discharge process, which we understand was recently completed, may have exposed many of Rosewood's residents to grievous harm. According to the "Rosewood Progress Summary" dated October 8, 2008, which has been used by Rosewood's discharge planning team, at least 101 individuals at Rosewood had no placement target date, only nine months before all the individuals were placed. Given that only approximately 25 to 30 residents were placed from November 2007 to October 2008, Rosewood appears to have placed individuals into the community at an unprecedented rate to meet this schedule. Moreover, as discussed below, we found that, across disciplines, Rosewood's assessments were seriously deficient, and that the process put into place by the State to monitor individuals' well-being after they have been placed is significantly flawed. Furthermore, according to Rosewood's placement consultant, many of these individuals were awaiting housing renovations that take several months to complete. The delays in obtaining suitable housing arrangements, and the other deficiencies outlined above, raise grave concerns about whether individuals were rapidly placed into circumstances that expose them to harm. The

failure to meet individuals' needs in a timely manner jeopardizes their health and safety, with potentially tragic consequences.

Federal law requires that Rosewood have actively pursued the timely discharge of each resident to the most integrated, appropriate setting that is consistent with the resident's needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a resident's stay, Rosewood should have: (1) identified, through professional assessments, the factors that likely would foster a safe and successful transition to the most integrated setting appropriate for the resident's needs; and (2) used these factors to drive treatment planning, habilitation, and intervention. Without clear and purposeful identification of such factors, residents would be denied habilitation and other services and supports that would help them function successfully in the most integrated setting appropriate for their needs.

The Rosewood discharge planning and transition process has substantially deviated from generally accepted professional standards. As an initial matter, it is troubling that, in November 2007, Rosewood and the Maryland Developmental Disabilities Administration determined that the community was the most integrated setting for 92 percent of the individuals residing at Rosewood. The fact that the average length of institutionalization for residents at Rosewood is 30 years, and that some residents for whom community placement is planned have been institutionalized for more than 50 years, strongly suggests that Rosewood has not been actively pursuing the timely discharge of residents into the most integrated setting appropriate to their needs for many years.

More immediately, the State's and Rosewood's discharge planning and transition process has not adequately addressed the needs of the individuals who have recently been placed into other settings, exposing these individuals to significant risk of harm. As discussed in Sections II.C and II.D, below, Rosewood's medical, psychiatric, nutritional, behavioral, habilitation, vocational, and communication assessments were inadequate, undermining Rosewood's ability to determine the strengths and needs of individuals so they are placed in a safe and appropriate setting. These assessments, when performed, were often significantly outdated. For example, A.A.¹ has been diagnosed with multiple psychiatric disorders, for which he receives multiple psychotropic medications. His most recent psychiatric evaluation, and the one that was sent to prospective community providers, was dated February 5, 2001 – more than seven years before the date of

¹ To protect residents' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with resident names.

our tour. Tellingly, Rosewood's placement consultant reported that community providers have complained that "new" behaviors and needs emerge after placement that they were not made aware of when accepting the individual into their program, suggesting that the information they were provided regarding the individual's needs was inadequate.

Furthermore, the discharge planning process that the State and Rosewood instituted has not resulted in a comprehensive picture of an individual's strengths and needs and has not identified essential information regarding the individual's health, psychiatric, and behavioral needs to effect a safe and meaningful transition. As noted, Rosewood's assessments across disciplines were inadequate, yielding an incomplete or inaccurate picture of the individual for community providers. Rosewood's and the State's discharge planning process has not identified these deficiencies in assessments, nor has the process required assessments to be updated before they were sent to providers or prior to discharge.

Similarly, the discharge planning process has not generated sufficient information about an individual in developing the discharge plan. Rosewood laudably instituted, as part of its discharge planning process, the Essential Lifestyle Plan ("ELP") method. We commend Rosewood on including this method in its discharge planning process, particularly for its focus on the individual's personal preferences in the transition to a more integrated setting. Nevertheless, we observed several of the ELP meetings during our tour and reviewed ELP plans for individuals whose ELP meeting has already been held, including meetings and plans for B.B., C.C., D.D., and E.E. Although these meetings produced information about the individuals' preferences and desires, critical information about the individuals' needs was not discussed or included. Essential services, such as medical care, dental care, behavioral supports, communication supports, and vocational skills, were not addressed, and providers of these services at Rosewood were not in attendance at ELP meetings. Historical information in these disciplines was also not included in the plans we reviewed, including the failure to include psychotropic medication history and descriptions of the individual's behavioral symptoms associated with the psychiatric diagnosis. The failure to account for such fundamental information in planning and providing for individuals' transition from the facility is a gross violation of generally accepted professional standards of care that reduces important placement decisions to guesswork, leaves providers ill-equipped to address the individuals' needs, and exposes individuals to a significant risk of harm.

Rosewood's and the State's discharge planning process also contains inadequate follow-up activities after the individual has been placed into the community, and the information that has been gathered reveals that services often were not in place at time of discharge or performed as required by the placement

plan. According to policy, site reviews of the community placement are supposed to be conducted after 30, 60, 90, and 180 days and memorialized in a monitoring report. However, these site reviews lack a standard format to assess quality indicators and ensure that the placement is appropriate and the placement plan is being followed. Without a structured and consistent monitoring approach, it is not possible to identify problematic trends reliably so that systemic remedial actions can be instituted.

Further, as discussed previously, if it is true that community monitoring reports have not been in Rosewood's possession, this indicates a serious deficiency in Rosewood's and the State's discharge planning process. Information regarding the effectiveness of the placement and the discharge planning process, including the adequacy of the assessments and the discharge plan, is essential to correcting problems in the process and maintaining adequate discharge planning.

Our review of the small number of periodic monitoring reports Rosewood did provide revealed troubling lapses in services for the individuals who have been discharged. For example, according to A.A.'s 90-day monitoring report, his nursing assessment has still not been completed three months after his placement, he has not had an ophthalmology appointment as recommended by Rosewood, and he missed his dental appointment. F.F. was discharged on March 21, 2008, but his 60-day monitoring visit was not performed until June 23, 2008, more than 90 days after his discharge. His 60-day monitoring visit found that his individual service plan for his residential and day programs was missing information. On July 24, 2008, F.F. was given a new service coordinator: his fifth coordinator in the four months since he had been discharged. G.G., who was at Rosewood for 51 years, was discharged on January 14, 2008, without appropriate community-based day services in place. According to the monitoring reports, appropriate day services had not been arranged by August 13, 2008, seven months after her placement. The monitoring reports for G.G. also revealed that there had been four case manager changes since she left Rosewood, her "waiver paperwork" – presumably related to her funding – was not completed for months after her placement, and her "30-day" individual service plan meeting was not held until 65 days after her placement. These monitoring reports disclose a discharge process that is uncoordinated and lacking in resources, exposing these individuals to lapses in care and services that could result in significant harm.

Our interviews with Rosewood's facility director and placement consultant indicated that they were aware of deficiencies in the assessments and discharge planning provided at Rosewood. However, they also appeared to be aware of many of the deficiencies in the care provided at Rosewood and the corresponding potential for harm. It appeared that they believed that transition to outside placements, even without adequate assessments and discharge plans, was preferable to

continuing to house individuals at Rosewood because discharging them posed less risk of harm. We do not question this conclusion, but we have grave concerns that the shortcomings in assessments and discharge planning outlined above will result in tragedy, especially for person who are medically and behaviorally fragile, and must be addressed.

B. Rosewood Did Not Protect Individuals From Harm in Accordance with Constitutional Standards.

The Supreme Court has recognized that persons with developmental disabilities who reside in state-operated institutions have a “constitutionally protected liberty interest in safety.” Youngberg, 457 U.S. at 318. Therefore, as the Court explained, the state “has the unquestioned duty to provide reasonable safety for all residents” within the institution. Id. at 324. Rosewood failed to provide a living environment that complied with this constitutional mandate. Individuals residing at Rosewood were subject to frequent injuries that often resulted in serious harm, to unchecked self-injurious behavior, and to neglect. Rosewood’s ability to address this harm was hampered by inadequate incident, risk, and quality management systems, including deficient investigative practices. Moreover, Rosewood’s use of restraints and restrictive interventions substantially departed from generally accepted professional standards. This harm undermined the other care and treatment provided at Rosewood and may have prolonged the time periods that individuals were institutionalized in violation of Olmstead. In short, Rosewood’s failure to protect its residents from harm violated their constitutional rights, and these violations may have lingering effects that must be addressed by the State in their current placements.

1. Inadequate Incident and Risk Management

In accordance with Youngberg and generally accepted professional standards, Rosewood should have had in place an incident and risk management system that was designed to prevent incidents of harm to residents and that ensured appropriate corrective action when such incidents did occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. Rosewood’s incident and risk management system fell significantly short of these standards. Although we found that Rosewood improved its incident reporting process during the months

before our tour,² Rosewood performed inadequate investigations and failed to identify risks and to implement corrective actions. Moreover, Rosewood's incident management process did not have adequate oversight by qualified staff members. As a result, residents living at Rosewood were routinely exposed to actual and potential harm that may have lingering effects on these individuals in their current placements.

a. Inadequate Investigative Practices

To comply with Youngberg's guarantee of reasonable safety, facilities like Rosewood must investigate serious incidents such as alleged abuse and neglect, serious injury, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures.

The investigative process at Rosewood significantly departed from these standards. Investigation reports often lacked written statements from key witnesses and other staffing information relevant to the incident. Moreover, most investigation reports failed to include a complete or thoughtful analysis of the information gathered. Even when Rosewood investigators conducted interviews of witnesses, summaries were rarely recorded or maintained.

One indication of poor investigative practices is a high number of injuries for which a cause cannot be determined. At Rosewood, almost twenty percent of injuries reported and investigated from August 2007 to October 2008 were "of unknown origin." The high percentage of injuries arising from unknown causes strongly suggests a failure to conduct thorough investigations. These are not merely minor injuries for which the origin is unknown: H.H. suffered a fractured clavicle on February 7, 2008, and Rosewood was unable to identify a possible cause.

² Despite improvements in incident reporting shortly before Rosewood's closure, we nevertheless noted a few incidents that were unreported that raise concern. For example, in June 2007 Rosewood had x-rays performed on one individual to determine if he had swallowed any foreign objects. The x-ray revealed that the individual had several fractured ribs, but this injury was not reported or investigated. In May 2008, the same individual, who requires a special diet and supervision due to repeated eating difficulties, had a gagging episode that was recorded in the nursing notes but was not reported as an incident and was not investigated. While we commend Rosewood's efforts to improve the incident reporting process, these reporting failures are troubling.

Despite the severity of the injury, Rosewood's investigation report failed to include written statements by witnesses, summaries or other evidence that witness interviews were conducted, or any analysis of available information. In light of the injury's unknown origin, Rosewood's failure to include these elements in the investigation is particularly troubling. The failure to perform an adequate investigation of this injury is a substantial departure from generally accepted professional standards. Moreover, as discussed in more detail in the next section, the incompleteness of this investigation is particularly troubling in light of the pattern of shoulder and arm injuries at Rosewood occurring from December 2007 to April 2008.

Another example of Rosewood's inadequate investigatory practices is the May 2008 investigation and mortality review of I.I. In early April, I.I. suffered from severe constipation. Rosewood staff attempted various interventions with no success. On April 4, 2008, a staff member ordered the administration of magnesium citrate, a laxative, to be carried out during the "next shift." Although the magnesium citrate was unsuccessful, I.I. was not transferred to Northwest Hospital Center until April 6, 2008, two days after the unsuccessful use of magnesium citrate. At Northwest Hospital Center, he exhibited symptoms of increased abdominal distention and decreased respiration. Shortly thereafter, I.I. was diagnosed with obstipation (severe constipation), a swallowing disorder, and aspiration pneumonia. After spending time in both Northwest and Rosewood's hospice care, I.I. died on May 5, 2008. His death certificate listed his cause of death as "atherosclerotic heart disease," a condition ostensibly unrelated to his reason for hospitalization.

Nevertheless, Rosewood's internal investigation into I.I.'s death substantially departed from generally accepted professional standards. The investigation failed to analyze several factors that could have contributed to I.I.'s death, including factors suggesting that I.I. did not receive adequate care and clinical services while at Rosewood. The investigator failed to explore whether I.I.'s bowel management regimen was adhered to by Rosewood staff in the days preceding his hospitalization. Similarly, the investigator did not evaluate the timeliness of Rosewood's decision to transfer I.I. in light of the fact that attempted interventions were unsuccessful in relieving his severe constipation. Moreover, the investigation did not evaluate Rosewood's decision to hold the administration of magnesium citrate until the following shift. There is also no evidence that Rosewood identified I.I.'s swallowing disorder before he was admitted to the hospital, and there was no analysis of whether this failure was excusable. Additionally, the investigation and mortality review did not include the results of a comprehensive medical record review for I.I. Critically, the investigation and mortality review failed to consider whether the care and services I.I. received at Rosewood, or the lack thereof, contributed to his death in any way.

Rosewood's failure to investigate incidents adequately, particularly incidents of this magnitude, significantly departed from generally accepted professional standards. Without adequate investigation, Rosewood was unable to identify the factors that led to the incident and take corrective action, thus exposing residents then residing at Rosewood to a continued risk of harm. Moreover, for many of Rosewood's residents, the harm that they suffered or were exposed to during their residence at Rosewood impaired the other care and treatment they received and may have lingering effects in their current placements.

b. Failure to Identify Risk of Harm and to Take Sufficient Preventive Actions

Rosewood's risk management systems failed to identify risk of harm adequately based on the incident data collected, and, even when risk of harm was identified, Rosewood failed to take sufficient and timely action to prevent the harm from occurring or recurring. Generally accepted professional standards dictate that a facility's risk management program: (1) identify actual or potential risks of harm based on historical data, diagnoses, and co-occurring conditions; (2) develop timely and appropriate interventions designed to reduce or eliminate the risks of harm; and (3) monitor the efficacy of the interventions and modify them as necessary in response to further data. Rosewood substantially departed from each of these standards, resulting in violations of the constitutional rights of Rosewood's former residents.

Our review found evident trends in Rosewood's existing incident data. Nevertheless, Rosewood failed to identify, analyze, or correct such continuing patterns of incidents and injuries. We found numerous examples of significant incidents or escalating patterns of incidents that remained unaddressed. For example:

- From August 2007 to July 2008, J.J. suffered 17 injuries, although he was on one-to-one supervision, 24 hours a day, for that entire period. There is no evidence that Rosewood examined the effectiveness of J.J.'s staff supervision or otherwise made recommendations to reduce the number of injuries to this individual.
- From August 2007 to July 2008, K.K. suffered 29 injuries. There is no evidence that Rosewood identified or analyzed this pattern of injury. Moreover, Rosewood's Standing Committee, which is responsible for reviewing incidents and investigations, made no recommendation to facility staff to reduce the number of injuries to K.K.

- As previously discussed, Rosewood has a high number of injuries of unknown origin: almost twenty percent of all reported injuries between August 2007 and October 2008. This high rate suggests a failure to recognize a trend in injuries of unknown origin and respond appropriately. While it suggests a failure to perform adequate investigations as discussed above, it also suggests that individuals are not receiving a level of supervision sufficient to protect them from harm, whether inflicted by themselves or other residents. There is no evidence that Rosewood identified or in any way addressed this troubling pattern of injuries.
- From December 2007 to April 2008, three residents suffered fractured clavicles, including H.H.'s fractured clavicle discussed previously, and one resident suffered a compound fracture of her arm. Even though two of the residents lived in the same housing unit, Rosewood took no action to identify or investigate this pattern of shoulder and arm injuries or to take any corrective measure that would reduce the risk of similar harm to residents. All four injuries were deemed to be of unknown origin by Rosewood without further analysis or investigation.

The failure to identify actual or potential risks to residents and respond with appropriate interventions is a significant departure from generally accepted professional standards. Even when risks were identified, however, Rosewood inadequately addressed those known risks and failed to monitor interventions to determine whether they were effective. For example:

- On September 30, 2008, L.L. choked on a dinner roll while on an outing to a restaurant. Rosewood had previously identified that L.L. requires a ground diet, verbal prompts, and supervision to monitor his rate of eating. Nevertheless, following this incident Rosewood made no recommendation for counseling, retraining, or disciplinary action for the staff involved, or any other corrective action. Four days later, L.L. was admitted to the hospital with a diagnosis of possible aspiration pneumonia. Rosewood did not investigate whether there was a link between the choking incident and the aspiration pneumonia or make any recommendation for follow-up action. The failure to investigate the possible relationship between the choking incident and the aspiration pneumonia, to recommend reevaluation of L.L.'s mealtime supervision, and to implement corrective action, left L.L. at risk for a repeat choking incident or another case of aspiration pneumonia.
- In January 2008, M.M. reported to staff that he was sexually assaulted by another resident. M.M. was on one-to-one supervision at the time of the alleged assault. Rosewood investigated and determined that sexual activity did occur, but concluded that it was consensual. The investigation also

indicated that M.M. was not properly supervised at the time the incident occurred, but Rosewood made no recommendation for counseling, retraining, or disciplinary action for the staff members assigned to M.M.

N.N. experienced at least three choking incidents from April 2007 to May 2008. After the first choking episode, Rosewood performed a swallowing assessment and designed a meal plan requiring close supervision during meals, with a staff member prompting him not to eat too quickly. The investigation into this incident found that staffing during the incident was "two below legal," but the report made no recommendation regarding staffing. Despite the formulation of the meal plan, N.N. continued to experience choking incidents. We observed N.N. several times during our tour, and we found that Rosewood staff continued to fail to implement his eating guidelines. During none of our observations did a staff member prompt him to eat less quickly, despite his rapid consumption of food. Additionally, we observed other instances in which he was not closely supervised during eating.

As shown above, Rosewood consistently failed to analyze patterns and trends in incidents and injuries. Even when staff members identified the potential for harm or a recurring pattern of harm, Rosewood often failed to make recommendations to reduce the potential for harm and to implement corrective actions. When made, recommendations for corrective action were often insufficient to address the problems of supervision, care, and treatment identified by the investigation. Where corrective actions were implemented, such as the meal plan for N.N., Rosewood did not monitor their implementation sufficiently to determine whether the corrective action was effective to address the potential for harm. These failures not only resulted in harm, they also jeopardized the other care and treatment provided at Rosewood, resulting in long-term harm to these individuals that violates their constitutional rights under Youngberg and their statutory rights under Olmstead.

c. Inadequate Quality Management

To meet Youngberg's standards, a facility like Rosewood must develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of corrective actions taken in response to problems that are discovered. Quality management activities should include regular observations throughout the facility, as well as interviews with staff members, residents, and their families concerning the adequacy of services provided. Any committee,

system, or process for monitoring should be objective and be overseen by qualified staff members.

Rosewood's quality management systems substantially departed from generally accepted professional standards. First, the Rosewood Standing Committee, designed to oversee quality, incident, and risk management, routinely failed to identify inadequacies in these systems and thus failed to reduce the risk of harm to residents. Documentation of Standing Committee meetings demonstrates that review of incidents, investigations, and corrective actions was cursory. Review of the Standing Committee minutes revealed that from January 10, 2008 to August 7, 2008, every incident report the committee reviewed was marked "Approved." The minutes do not indicate that the Committee evaluated or discussed the quality of any investigations or corrective actions. The minutes for the January 10, 2008, meeting, which lasted an hour and fifteen minutes, indicate that the Standing Committee reviewed seventeen incidents, including one death, and nine instances of restrictive behavior management intervention. Thus, according to Rosewood's own minutes, the Standing Committee spent an average of less than three minutes on each incident or intervention. At another meeting held February 14, 2008, the minutes indicate that the Standing Committee performed 108 reviews of: annual health care service plans, which include restrictive interventions for medical appointments; behavior intervention plans, including restrictive interventions such as the use of physical restraints and one-to-one supervision; and incident reports, including a death, allegations of abuse, and various injuries. The minutes indicate that each item was approved, and they do not indicate that any questions were raised about any item. The Standing Committee chairperson indicated that meetings typically last between one and two hours, suggesting that, even if the February 14, 2008, meeting lasted two hours, the committee spent an average of barely a minute on each item. In short, the review and oversight performed by Rosewood's Standing Committee substantially departed from generally accepted professional standards and violated the constitutional rights of Rosewood's former residents.

Additionally, the composition of the Standing Committee substantially departed from generally accepted professional standards. During our investigation, the chairperson of the Standing Committee served as both committee chair and lead investigator of serious injuries and deaths suffered by Rosewood residents. The chairperson's dual function presented a conflict of interest, as committee members were charged with reviewing the quality of the chairperson's investigations. Moreover, the Standing Committee did not have as regular members a registered nurse, physician, or staff member with expertise in behavior management. The lack of input from qualified staff was detrimental to an effective review by the Standing Committee, because many reported incidents at Rosewood were the result of resident maladaptive behavior.

Second, Rosewood's Quality Assurance Department failed to ensure that the facility protected resident health and safety and provides quality services. Rosewood's Quality Assurance Department consisted of a Director, a Compliance Officer, a nurse, a part-time investigator, and support staff. According to the Director, the only regular internal quality assurance activity, other than the incident management described above, was an ongoing audit of program and medical records conducted by the Quality Assurance nurse. The Director confirmed that the Quality Assurance Department did not track or trend key indicators of harm to residents, nor did it conduct periodic reviews of the environment or observations of residents to determine if resident program plans were being implemented, and there were no regular interviews with staff to determine the adequacy of their training or understanding of resident treatment plans.

Moreover, the audits performed by the Quality Assurance nurse were inadequate. Her review of program and medical records merely evaluated whether record-keeping procedures were followed and did not undertake any qualitative review of the services provided. For example, while the Quality Assurance nurse ensured that certain documents were in the record, that they were signed, and that nursing assessments were conducted in a timely manner, she did not review whether the assessments were adequate or whether needed interventions were identified and implemented. Furthermore, even when problems were identified, there was no process in place to ensure that they were rectified.

Because of these deficiencies in Rosewood's Standing Committee and Quality Assurance Department, Rosewood's quality management systems substantially departed from generally accepted professional standards and exposed residents living at Rosewood to a significant risk of harm that may have lingering effects on these individuals' care, treatment, and well-being.

2. Inappropriate Restraint Usage

Constitutional standards require that, in an institution like Rosewood, restraints only be used when imminent risk of harm to oneself or others is present. Moreover, Rosewood must have effective procedures in place to safeguard individuals for whom a proposed behavior management program includes a restraint or other restrictive intervention. These procedures must include the receipt of written informed consent and review by the Standing Committee. The committee review should consider whether less restrictive measures to change the resident's maladaptive behavior have been attempted and failed; whether the intervention proposed is the least restrictive intervention likely to be effective; and whether the behavior management plan includes an active treatment component to reduce or eliminate relying upon the restrictive technique. Our review of

Rosewood's records indicated that Rosewood's restraint practices substantially departed from generally accepted professional standards.

As an initial matter, we were unable to discern the overall rate of use of restraints at Rosewood because the facility's reporting of the use of restraints, including the type of restraint and whether any injury occurred, was unreliable. The reports on restraint use that Rosewood provided to us indicated that from August 2007 to September 2008, Rosewood staff used restraints in 15 instances on five residents. Our review of a sample of individuals' records, however, indicated that the actual use of restraints was higher than reported by Rosewood, including the use of restraints for medical and dental procedures as discussed in more detail below. Furthermore, the use of restraints that Rosewood did report suggested the use of practices that substantially depart from generally accepted professional standards. For example, on October 19, 2007, a Rosewood staff member placed a resident in a prone restraint, a highly dangerous technique that exposes the restrained individual to significant risk of harm, including death.

Rosewood routinely used restraints for medical and dental procedures without evidence that less restrictive measures were attempted and failed. Behavior support plans ("BSPs") for these individuals did not include any interventions to reduce or eliminate the need for the restraint, such as a desensitization plan. For example, Rosewood authorized the use of a manual hold on N.N. to undergo medical procedures, and his active treatment program did not reflect any intervention to reduce reliance upon this restraint. O.O. and P.P. were both restrained on a papoose board for dental procedures, but there was no documented evidence that less restrictive measures were attempted. Although the use of restraints for dental procedures appeared to have declined during our investigation, the failure to ensure that appropriate safeguards were taken before restrictive interventions were used was a substantial departure from generally accepted professional standards.

Moreover, Rosewood's Standing Committee did not conduct substantive reviews of all BSPs that include restrictive interventions. For example, as discussed previously, the minutes from the February 14, 2008, meeting indicate that the Standing Committee reviewed 108 annual health care service plans. Each plan describes various interventions needed for residents to cooperate with medical appointments, including the use of seatbelt wheelchair restraints, the use of helmets, and the assignment of residents to locked buildings. The Committee minutes denote each restrictive intervention as "approved," yet do not reflect any discussion weighing the effectiveness or restrictiveness of each intervention. Moreover, because Committee meetings typically last one to two hours, it is highly unlikely that any substantive discussion of the appropriateness of the interventions occurred.

Separately, Rosewood's system for obtaining informed consent for restrictive behavior management programs was inadequate. At Rosewood, written consent to use restrictive interventions was not consistently informed. Although Rosewood's consent form included a standardized paragraph stating that the benefits of the proposed intervention outweigh the risks involved, the form did not consistently include information specific to the particular intervention proposed. Moreover, side effects information was rarely included on medication consent forms.

Rosewood's failure to review and oversee appropriately the use of restraints and restrictive interventions was a substantial departure from generally accepted professional standards and violated the restrained individuals' constitutional rights. Moreover, the unjustified and unlawful use of restrictive interventions, particularly the ongoing use of restraints for medical and dental procedures without any attempts to reduce reliance on the restraint, is likely to have lingering negative effects on them.

C. Rosewood's Behavioral, Habilitation, and Communication Services Substantially Departed From Generally Accepted Professional Standards and Exposed Its Residents to Significant Risk of Harm.

Rosewood's residents are entitled to "the minimally adequate training required by the Constitution . . . as may be reasonable in light of [the residents'] liberty interests in safety and freedom from unreasonable restraints." Youngberg, 457 U.S. at 322. A central purpose of this training is to enable the movement of individuals into the most integrated setting appropriate to their needs as required by Olmstead, 527 U.S. at 607. These standards require that appropriate psychological interventions, such as behavior programs and habilitation plans,³ be used to address significant behavior problems and assist residents to live in more integrated settings. Rosewood's behavioral, habilitation, and communication services were critically deficient, in part because Rosewood provided inadequate assessments in each of these areas. Adequate assessments are the essential underpinning to the provision of adequate services; without an accurate and comprehensive understanding of the needs and strengths of the individual who is being treated, the treatments themselves cannot be adequate. The failures in these services have resulted in ongoing harm to individuals who have resided at Rosewood, and the State must remedy the lingering effects of this harm.

³ Habilitation includes, but is not limited to, individualized training, education, and skill acquisition programs developed and implemented by interdisciplinary teams to promote the growth, development, and independence of individuals.

1. Ineffective Behavior Programs

Challenging, even harmful (“maladaptive”) behaviors frequently can be an issue for persons with developmental disabilities, and are often one of the reasons an individual is placed in an institutional setting. The harm from such behaviors can be severe, even fatal. Examples include punching, slapping, scratching oneself or others, intentionally destroying property, or pica.⁴ The causes of these behaviors often reflect the primary characteristic of developmental disability – difficulty learning, in this case, learning effective and healthy ways to meet one’s needs and wants.

Numerous individuals at Rosewood exhibited challenging behaviors that Rosewood did not adequately address, resulting in repeated instances of harm to those individuals. H.H. exhibited a behavior in which he struck his head against walls with such force that he injured his head and caused damage to the wall. In the building in which H.H. lived, the walls were lined with indentations at the height of his head, demonstrating the repeated nature of this behavior. In 2007 and 2008, H.H. suffered multiple injuries due to self-injurious behaviors, including fractures, facial bruising, and head lacerations requiring sutures to close. Many of these injuries were not observed by staff, but often the cause of the injury is reported as due to a “history of running into walls.” Several other individuals, including Q.Q. and R.R., have long histories of repeated self-injurious and/or aggressive behaviors, such as hitting their own heads, biting arms, and attacking others, resulting in injury. The failure to address these behaviors adequately likely results in ongoing harm to these individuals and impair their progress in treatment and habilitation. Rosewood’s failure to provide adequate behavior programs before these individuals were discharged suggests that these individuals may still be receiving inadequate treatment and may have been placed into settings that are unnecessarily restrictive or that are inadequate to meet the individuals’ needs.

Other individuals, such as I.I. and J.J., suffered similar injuries within a short period of time, suggesting a failure to understand the cause of the first injury and implement a behavior intervention to address it. Within three weeks in March 2008, I.I. removed two of his own teeth. On February 20, 2008, J.J. became upset, bit himself on the right forearm, and hit his head against the wall. Four months later, on June 28, 2008, J.J. became upset, bit his forearm until it bled, and hit himself in the eye. We found no evidence that Rosewood revised these individuals’ BSPs in response to the initial incident. Rosewood’s failure to respond

⁴ Pica is a condition in which a person ingests or attempts to ingest nonfood substances such as clay, chalk, hair, or glue.

appropriately to the initial harm placed these individuals at continued risk of harm, a risk that, for J.J. and I.I., materialized into actual harm.

Additionally, we found that Rosewood substantially departed from generally accepted professional standards concerning the use of psychotropic medication for individuals with intellectual disabilities, suggesting that psychotropic medications were used in place of adequate behavior programs. Our review found a pattern of continuing individuals on high dosages of antipsychotic agents despite the lack of any empirical evidence that the medication had been helpful. At the time of our review, 58 of the 128 individuals at Rosewood received psychotropic medications, and 42 of these individuals received multiple psychotropic medications. However, our review found that the psychiatrist generally did not use behavioral information, such as frequency or intensity of target behaviors, to evaluate the efficacy of the psychotropic medication, and there was a lack of coordination between psychiatric and behavioral services. Continuation of high dosages of psychotropic medication that is not justified by empirical, clinical evidence often has long-term negative effects, such as tardive dyskinesia, that may continue in the individuals' new placements and must be ameliorated.

Remarkably, according to the records provided to us by Rosewood, it appears that less than one-half (27 out of 58) of the individuals who received psychotropic medications had ever had a psychiatric evaluation. The failure to provide a psychiatric evaluation for persons receiving psychotropic medications is an egregious departure from generally accepted professional standards. Furthermore, this practice indicates that psychotropic medications were being used in place of behavioral supports.⁵ Compounding this problem was the considerable variance in the quality of the psychiatric evaluations that have been performed, as well as the lack of current evaluations. For example, according to the records Rosewood provided, some individuals had not had a comprehensive psychiatric evaluation in many years: S.S.'s most recent evaluation was on September 24, 1992; T.T.'s most recent evaluation was on February 8, 1993; U.U.'s most recent evaluation was on January 8, 1997; and V.V.'s most recent evaluation was on November 13, 1998. The lack of current evaluations, combined with the lack of coordination between psychiatric and behavioral services, strongly suggests that psychotropic medications were being improperly used as a means of chemical restraint to control behavior, in lieu of therapeutic behavioral interventions. Moreover, not all individuals at Rosewood who received psychotropic medications had a behavior support plan in

⁵ If Rosewood's records were wrong, and the remaining 31 individuals did receive a psychiatric evaluation, Rosewood's failure to track this information accurately would also have been a substantial departure from generally accepted professional standards that exposed these individuals to harm.

place: Rosewood reported that 58 individuals were on psychotropic medications, but only 54 individuals had a behavior support plan. Therefore, at least four individuals did not have a behavior support plan despite being on psychotropic medications.

In addition, the behavioral interventions that Rosewood did develop substantially departed from generally accepted professional standards. Generally accepted professional standards of practice provide that behavioral interventions should be: (1) based upon adequate assessments of the causes and “function” (i.e., purpose) of the behavior; (2) be based on the individual’s strengths; (3) be implemented as written; and (4) be monitored and evaluated adequately. Ineffective behavioral interventions increase the likelihood that residents engage in maladaptive behaviors, subjecting them to unnecessarily restrictive interventions and treatments. Rosewood’s behavioral interventions were often not effective. In particular, they often were not based on adequate assessments and often were not monitored, evaluated, and revised adequately.

a. Behavioral Assessments Substantially Departed From Generally Accepted Professional Standards

Without a thorough assessment of the function of an individual’s maladaptive behavior, including clearly identified, appropriate replacement behaviors, behavioral interventions will not be successful in modifying the maladaptive behavior. In this regard, a functional assessment identifies the particular positive or negative factors that prompt or maintain a challenging behavior for a given individual. By understanding the precursors and, separately, the purposes or “functions,” of challenging behaviors, professionals can attempt to reduce or eliminate these factors’ influence, and thus reduce or eliminate the challenging behaviors. Without such informed understanding of the cause of behaviors, attempted treatments are arbitrary and ineffective.

Rosewood’s functional assessments were not adequate for this purpose. The functional assessments that we reviewed all contained significant omissions, including:

- Demographic information, including the individual’s social history and treatment experiences;
- Assessment tools used to determine the function of behavior;
- Antecedent, behavior, and consequence (“ABC”) data, with analysis;
- Information from the interdisciplinary team;

- Information from direct care staff interviews;
- Structured direct observation data, performed over time and across settings;
- Preference and reinforcement assessments;
- Medical information, particularly about health problems that influence behavior;
- Mental health information, including DSM-IV⁶ diagnoses and a description of the clinical and behavioral manifestations associated with each diagnosis;
- A summary of the assessment; and
- Recommended treatments and interventions for developing new skills and replacement behaviors.

The failure to include these elements in the functional assessment of individuals at Rosewood was a substantial departure from generally accepted professional standards. More specifically, without this information, the behavior assessment cannot adequately provide a comprehensive understanding of the individual or effectively guide selection of replacement behaviors or intervention procedures, and the resulting BSP will typically fail to address the individual's maladaptive behaviors. The failure to provide an adequate BSP that addresses these behaviors impairs individuals' ability to move successfully to, and succeed in, less restrictive settings.

Relatedly, we found that the conclusions formed in the assessments were generic, rather than specific to the individual. For example, many of the assessments we reviewed hypothesized that the function of the individual's maladaptive behavior was to "avoid/escape nonpreferred activity and attempt to communicate/express feelings." While this hypothesis may have been generally accurate, it was insufficient to guide selection of replacement behaviors or intervention procedures.

Furthermore, maladaptive behavior is frequently a form of communication for persons with developmental disabilities who lack the tools to communicate more conventionally. Consequently, although a complete functional assessment should address communication, a separate, reliable communication assessment should be

⁶ DSM-IV refers to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

routinely used to identify the role of communication in an individual's maladaptive behaviors and, separately, as discussed below regarding habilitation, to identify appropriate learning objectives and interventions. Relatedly, another common cause of maladaptive behavior is pain. Failure to respond to pain in a timely manner leads to avoidable suffering and is recognized as contributing to increases in maladaptive behaviors. As discussed in more detail below, Rosewood's communication assessments and services were insufficient to meet the needs of the numerous individuals at Rosewood who suffer from speech and language difficulties. The failure to provide adequate communication services undermined Rosewood's ability to provide adequate behavioral services and to transition its residents successfully into less restrictive settings.

b. Inappropriate, Insufficient, or Non-Existent Behavioral Interventions

To meet constitutional standards, effective behavioral interventions should target the function of the maladaptive behavior to the maximum extent possible and be built on replacing the maladaptive behavior with a healthy alternative behavior that serves the same function. To a lesser extent, behavioral interventions may include modifying the environmental causes of the maladaptive behavior. Although effective behavioral interventions typically include a means of redirecting an individual from a maladaptive behavior, this is distinct from seeking only to control or suppress the maladaptive behavior.

Behavioral interventions at Rosewood substantially departed from generally accepted professional standards in important respects. Rosewood's interventions and replacement behaviors, when included, were often generic and did not include information about the individual's personal preferences, skills, and abilities that could be used to build a lifestyle of positive behaviors that would replace the maladaptive behaviors. Replacement behaviors and strategies to reinforce those behaviors were often not related to the function of the maladaptive behavior, and were not designed to promote independence so that the individual could move into the community successfully. Where psychotropic medication was used to address maladaptive behaviors, the rationale for the use of the psychotropic medication did not address the relationship between the psychiatric diagnosis and the behaviors exhibited.

Moreover, we found multiple examples of individuals who had been identified as having significant maladaptive behaviors but who nevertheless were not receiving structured behavioral interventions to address these behaviors. For instance, as previously discussed, although 54 individuals at Rosewood had a BSP, 58 individuals received psychotropic medications, suggesting that at least four individuals with significant maladaptive behaviors did not receive behavioral

support services and did not even have a BSP in place to address their challenging behaviors. Furthermore, our review found that seven individuals had BSPs for pica, but we found that at least two additional individuals had exhibited pica behavior but did not have a BSP addressing it. Specifically, M.M. reported on February 18, 2008, that he swallowed four staples, and on June 13, 2008, staff found W.W. with foam from a cushion in her mouth. Neither individual had a BSP addressing pica. We also found that at least 16 individuals at Rosewood needed specialized behavioral services to address maladaptive sexual behavior. Eleven of these individuals were in sexual behavior support groups, and six were receiving therapy, but reportedly due to cost controls, Rosewood planned to discontinue the therapy. Many of these individuals were recommended for community placement, including at least two individuals, X.X. and Y.Y., who allegedly sexually assaulted minors before their admission to Rosewood. The failure to address these individuals' maladaptive behaviors significantly impairs these individuals' ability to live successfully in less restrictive settings.

c. Implementation of Behavioral Treatment Was Not Documented or Observed

Consistent and correct implementation of appropriate behavioral interventions is essential. As discussed above, however, Rosewood did not consistently or correctly implement behavior interventions required by the residents' BSPs. This may have been due, in part, to Rosewood's failure to institute a reliable system to verify staff members' ability to implement the requirements of the BSP. We could not find any evidence of a system to verify staff members' ability to implement BSPs, including such training as a "behavior drill." In a behavior drill, maladaptive behaviors are described by professional staff, and the competency of the direct care staff to implement the BSP is measured by their ability to respond appropriately. Further, we could not find any evidence that professional staff performed routine observations of individuals with BSPs to ensure that staff members were implementing the BSP correctly. This is a significant deficiency; without relative certainty that plans are being implemented as designed, it is impossible to determine whether a behavioral plan is effective.

During our tour, we observed several individuals engaging in behavior for which they have a BSP, but staff did not intervene as required by the BSP. For example, during a visit to Mandel Cottage on October 8, 2008, we observed Z.Z., H.H., and N.N. slapping their heads repeatedly, but staff failed to intervene as required by their BSPs. The failure to intervene as required by the BSP is a substantial departure from generally accepted professional standards and exposes these individuals to harm. Indeed, the multiple injuries suffered by H.H. that were reportedly unobserved by Rosewood staff members, despite the measures required by his BSP, demonstrate that harm actually occurred. Furthermore, the failure to

provide effective behavioral treatment compromises these individuals' ability to transition successfully to less restrictive settings and undermines the other treatment these individuals received while at Rosewood.

d. Monitoring and Evaluation of Behavioral Programs Was Inadequate

Constitutional standards require that facilities monitor residents who have behavior programs to assess the residents' progress and the program's efficacy. Without the necessary monitoring and evaluation, residents are in danger of being subjected to inadequate and unnecessarily restrictive treatment, to avoidable injuries related to untreated behaviors, and to unnecessarily prolonged institutionalization.

As indicated in the previous section, Rosewood did not assess, for clinical purposes, critical aspects of behavioral services at the facility, such as the development and update of functional assessments and staff implementation of programs. Further, as noted above, Rosewood relied extensively on psychotropic medications as a primary form of behavioral intervention, although Rosewood was seeking to reduce the use of psychotropics. Rosewood did not ensure, however, that psychiatric evaluations were conducted and routinely updated, or that data on target behaviors were routinely provided to the prescribing psychiatrist. As for traditional behavioral interventions, although Rosewood gathered some data to assess the interventions' efficacy, the facility lacked a standard, clinically justified method to gather data and confirm its accuracy. Additionally, the presence and absence of replacement behaviors that mitigate or prevent the maladaptive behavior's occurrence were not tracked. In short, Rosewood lacked a means to ensure that appropriate data were accurately and consistently reported.

Moreover, the BSPs we reviewed failed to provide adequate strategies for measuring the effectiveness of the plan. The outcomes emphasized by Rosewood to measure effectiveness focused on reducing the frequency of problem behaviors but failed to address improving skills or increasing independence adequately, jeopardizing the transition of Rosewood's residents into more integrated settings where these skills and independence are essential. Although all the BSPs we reviewed referred to collecting data regarding the occurrence of problem behaviors, none of the BSPs addressed the methods used to promote positive replacement behaviors. Teams did not monitor data regarding the individual's use of such behaviors, and Rosewood did not collect data tracking the delivery of positive reinforcement strategies.

e. Quality Assurance and Oversight of Behavioral Support Services Were Insufficient

Further, the safeguard of professional review and monitoring of behavioral services, as of our tour, was not taking place at Rosewood. These responsibilities generally fall on an adequate peer review process (an assessment of a practitioner's work by other professionals in the field to foster compliance with the generally accepted professional standards of the discipline) and a functioning behavior management review committee ("BMRC"). Neither of these important safeguards was functioning at Rosewood. Before implementation, BSPs were not reviewed by professionals with expertise in applied behavior analysis and the development and implementation of behavior supports, including, in particular, the use of positive behavior support strategies. Moreover, we found that the BMRC was not appropriately evaluating the content and quality of the behavior programs. Specifically, the BMRC did not ensure that BSPs included: (1) data that were reliable and supported the proposed interventions and replacement behaviors; (2) data-driven treatment that matched the function of the problem behavior; (3) clear implementation instructions; (4) clear and reliable means to assess the BSP's efficacy; and (5) restraints and right restrictions that were the least restrictive means necessary to protect the individual and others from harm. The BMRC's failure to provide critical and substantive review of behavior support plans permitted behavior programs to continue when these programs were ineffective, inefficient, and inconsistent. This failure to provide effective oversight impaired the ability of Rosewood's residents to progress in their treatment and hindered their ability to be transferred successfully to more integrated settings.

Additionally, as discussed in Sections II.B.1.c and II.B.2, above, Rosewood's Standing Committee approved, without modification, every plan submitted to it during the time of our review. Although these plans included restraints and restrictive interventions, there is no evidence that the Standing Committee, which was charged with reviewing incidents, investigations, allegations of abuse and neglect, and the use of restrictive behavior management techniques, provided any substantive review or discussion of these restrictions before approving them. The failure to provide adequate quality assurance and oversight of behavioral support services is a substantial departure from generally accepted professional standards, the effects of which may still linger in individuals' current placements.

2. Habilitation Programs Did Not Meet Generally Accepted Professional Standards

Persons with developmental disabilities are to receive adequate habilitation training and related vocational and day program services and supports so that they may acquire new skills, grow and develop, and enhance their independence, all of

which equip the individual to live successfully in more integrated settings. Federal regulations require that:

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a). Rosewood's habilitation programs did not meet these requirements and were inconsistent with generally accepted professional standards. The failure to provide adequate habilitation programs violates the mandates set forth in Olmstead, 527 U.S. at 607, and, following Rosewood's closure, may have led to placement in inappropriately restrictive settings.

As an initial matter, and as indicated above, Rosewood did not conduct comprehensive functional assessments of its residents on a regular basis. The assessments we reviewed were not current at the time of the annual individual service plan meeting, nor were they current when provided to prospective community placement providers or at time of discharge. The failure to perform current assessments, especially as of the time of discharge, and to provide these assessments to prospective community placement providers strongly suggests that individuals may have been placed into settings that are inappropriate to their needs and may be more restrictive than necessary. When assessments were performed, they lacked sufficient detail and did not include a comparative analysis to the previous period of review, making it impossible to gauge whether the individual was progressing in the habilitation program while at Rosewood.

Moreover, the assessment results we reviewed were not integrated into a meaningful plan that was individualized to the preferences, skills, and needs of the resident, and functional and relevant objectives that lead toward independence and success in less restrictive settings were not being targeted. Similarly, the goals, objectives, and strategies included in habilitation plans were not behaviorally stated or measurable, again inhibiting Rosewood's ability to gauge whether the individual was progressing. The training schedules included in the plans were not individualized or implemented as developed and did not reflect the individual's preferred activities as identified in the person-centered planning process. Although Rosewood instituted a new treatment mall, the new programs were not individualized to the residents' needs and strengths. The majority of the training activities at Rosewood appeared to be nonfunctional, occupying individuals' time

but not addressing critical, functional objectives. Specifically, the training objectives at Rosewood did not appear to support the individual's independent functioning, to improve the individual's quality of life, or to facilitate a smoother and more immediate transition to the most integrated setting appropriate for the individual's needs. Relatedly, we found that only 10 of the 128 individuals at Rosewood at the time of our tour attended day programs off of the Rosewood campus, despite the State's plan to transition nearly all of these individuals to community settings. The following illustrate these findings:

- We observed A.B. and A.C., who are 48 and 56 years old, respectively, engaged in sorting shapes into a cube. It is unclear how this activity serves any functional purpose for these individuals.
- We observed A.D. engaged in sorting silverware into a silverware tray during his day program. After he completed sorting the silverware, the staff member emptied the tray and instructed him to do it again. While this activity could be functional in the proper context, the manner in which it was carried out had little therapeutic value.
- We observed staff coloring line drawings while the residents at the table sat idle, with little or no interaction from staff.
- We observed A.E., A.F., and A.G. seated in wheelchairs or lying on mat tables and positioned in front of a mirror. According to staff, the individuals had been placed in this manner for about 30 minutes so they could "look at themselves."

These activities offer little aid to these individuals in acquiring skills that support independent functioning and facilitate transition to the most integrated setting appropriate for their needs. The failure to provide meaningful habilitation activities on a consistent basis is a substantial departure from generally accepted professional standards. More specifically, Rosewood's failure to provide adequate active instruction and treatment denied individuals the opportunity to increase their independence and likely made it more difficult for them to transition to the most integrated setting appropriate for their needs. Indeed, this failure jeopardizes the success of these residents' recent movement to community placements, and the State must take steps to remedy any lingering effects of this inadequate treatment.

Additionally, individuals at Rosewood were typically not provided with alternative active treatment when they were unable to attend their normal day program due to health concerns. While some of these interruptions were relatively brief, others, such as those for A.H., A.I., and A.J., lasted from one week to five weeks. These lengthy interruptions were a significant delay in Rosewood's delivery

of habilitation services and could have led to regression or loss of functional abilities. They also strongly indicate that Rosewood did not provide individualized habilitation services as required by generally accepted professional standards. The failure to provide adequate habilitation services is particularly troubling in light of Rosewood's closure, as habilitation services are essential to preparing individuals for a more integrated environment.

Similarly, we found that the vocational aspect of Rosewood's training and habilitation services was inadequate. Rosewood lacked policies regarding the provision of vocational services, including policies regarding vocational assessments, development of individual job profiles and career plans, and development of employment opportunities. As a result, Rosewood did not provide comprehensive assessments that evaluated residents' vocational needs, interests, and aptitudes. Rosewood also did not perform a systematic assessment of work options in the anticipated community placement setting, so vocational plans, when made, were completed without regard to actual work opportunities.

Further, individuals' vocational needs and skills, including their employment histories and work experiences, were generally not integrated into the individual's support plan or into his or her discharge plan. We found several individuals who have worked during their time at Rosewood, but for whom the facility had made no plans for employment upon discharge from the facility. F.F.'s work experience included contract production mailings and janitorial work, but he had no employment plan when he was discharged on March 21, 2008, beyond the limited opportunities offered by his day program. E.E., who recently completed his GED, worked while at Rosewood, but had no community-based employment plan in place in October 2008, although he was scheduled to be discharged imminently.

In addition, we found that vocational opportunities at Rosewood were generally limited to options dependent on Rosewood operations and were not individualized to the residents' skills and abilities. For example, A.K. worked on the moving crew at Rosewood, and the plan in October 2008 was for him to continue to work at Rosewood after he had been moved to a community placement, as no community employment plans had been made for him at that time. Similarly, A.L. is a former Rosewood resident who has lived in the community for some time, but continued to work at Rosewood after his placement. It is unclear where or whether A.K. and A.L. will work now that Rosewood has closed.

Generally accepted professional standards suggest that the focus of treatment in a facility should address the barriers that prevent individuals from living successfully in community settings. An important part of habilitation is learning and using skills in the environment in which those skills are useful. The appropriate environment is one of the most powerful motivators for skill

acquisition, and this often will be in a community setting. In fact, generally accepted professional standards of care increasingly emphasize use of community settings for skills acquisition. Rosewood's lack of active instruction, treatment, and training in a community setting, coupled with the absence of vocational opportunities in discharge plans, greatly hindered success in this area. Rosewood's failure to provide adequate habilitation and training programs, including vocational services, is a substantial departure from generally accepted professional standards. This failure is particularly troubling given Rosewood's closure, as these programs are important elements in the successful transition into community placements. Rosewood's failure to provide adequate services in these areas jeopardizes its former residents' success in community settings and must be remedied if the State is to comply with the requirements of Youngberg and Olmstead.

3. Communication Services Were Not Adequate

If communication skills deteriorate or are not developed, individuals are more likely to be unable to convey basic needs and concerns, are more likely to engage in maladaptive behavior as a form of communication, and are more likely to be at risk of bodily injury, unnecessary psychotropic medications, and psychological harm from having no means to express needs and wants. Lack of communication skills will also make it more difficult for staff to recognize and diagnose health issues, such as pain, and will hinder an individual's ability to move to the most integrated setting appropriate for his or her needs as required by Olmstead. Rosewood failed to provide its residents with adequate and appropriate communication services and, at the time of our visit, lacked the resources to address this deficiency. This failure impaired Rosewood's ability to prepare its residents for transition into community settings during the recent closure in violation of these individuals' rights.

More specifically, Rosewood's speech and communication services were grossly insufficient to meet the needs of its residents. At the time of our visit, we found that nearly 80 percent of Rosewood residents had difficulty communicating, but according to Rosewood's records, only 13 individuals received communication programs. Rosewood's failure to provide adequate communication services was evident in the high frequency of maladaptive behaviors that have a communicative function. As noted previously, H.H. caused himself repeated injuries from hitting his head on the wall. Our expert found that this repeated self-injurious behavior was likely related to his inability to communicate in socially appropriate ways. Likewise, A.M. did not use typical communication methods. She was described as non-verbal, and had long history of pica, including ingestion of hair. We observed A.M. sitting in the dining room and waiting for her food for 26 minutes while other residents were served and eating. A.M. became increasingly agitated and attempted to scavenge objects from the floor. A staff member intervened and

returned A.M. to her chair, but A.M. began pulling at her own hair and placing it in her mouth. A staff member intervened occasionally, but A.M. succeeded in placing hair in her mouth on several occasions. The longstanding nature of H.H.'s and A.M.'s behavioral difficulties suggests a failure to identify the communication needs of these individuals and provide them with safe and acceptable methods of communication. Without appropriate communication training and services, individuals such as H.H. and A.M. were at significant risk of harm. This risk of harm likely continues in these individuals' current placements, as Rosewood did not recognize the risk and thus failed to communicate it to these individuals' current providers.

Rosewood's failure to provide adequate communication services began with inadequate assessments. At Rosewood, there was a clear absence of communication assessment strategies to identify communication needs and appropriate communication supports to improve communication and functional status. Similarly, Rosewood did not perform formal assistive technology or alternative augmentative communication assessments because there was a lack of equipment to provide those services. We did not observe any communication devices in use at Rosewood during our tour, although according to Rosewood records, at least two individuals, A.N. and A.O., had alternative augmentative communication devices. We observed A.O. several times during our tour, both in his residence and during meals, and a communication device was not accessible to him during these observations. Because of Rosewood's failure to provide adequate communication assessments, these individuals may still be without adequate communication services in their current placements, as their communication needs would not have been included in their discharge plan.

Furthermore, there was a significant lack of coordination between communication and behavior specialists in the development of habilitation, training, and behavioral interventions, whether or not a communication difficulty had been specifically identified. We found that communication specialists were generally not consulted regarding maladaptive behaviors or the development and implementation of plans for replacement behaviors in the BSP process. Likewise, there was a substantial deficit of speech and communication services in developing individual service plans. Communication specialists generally were not identified in the plan as the person responsible for developing a communication program when the maladaptive behavior has a communicative intent.

Similarly, we also noted that the facility served a significant number of individuals with hearing impairments. According to the Speech and Language Director, however, Rosewood did not have any data regarding the number of individuals with hearing impairments or total hearing loss. Furthermore, Rosewood did not provide treatment that was designed by trained professionals to

address the specialized needs of individuals with hearing loss. Where Rosewood does provide communication assistance to individuals with hearing loss, the program is often inappropriate or not implemented correctly. For example, A.P. had worn hearing aids in the past to address his hearing loss, but, at the time of our visit, refused to wear them. Rosewood did not implement any program interventions to address this refusal, such as desensitization training. Another individual, Q.Q., is deaf and, according to his individual service plan, had a full-time interpreter to accommodate his hearing loss. Rosewood only had one full-time interpreter, however, and during our observations of Q.Q., the interpreter was working with other residents and was not accessible to Q.Q. Rosewood's failure to provide adequate services to those with hearing impairments denies these individuals their voice, limited their ability to express preferences and choices, and deprived them of an opportunity to participate in their treatment. The failure to provide adequate services to those with hearing impairments may well continue in the individuals' current placements because, in most instances, Rosewood did not recognize its failure to provide these services and thus would not have indicated a need for them in the individuals' discharge plans.

D. Rosewood's Medical and Nursing Care Substantially Departed from Generally Accepted Professional Standards and Exposed Its Residents to Significant Risk of Harm.

The Supreme Court has determined that institutionalized persons with developmental disabilities are entitled to adequate medical care, Youngberg, 457 U.S. at 324. Indeed, adequate medical care is one of the "essentials of care that the State must provide." Id.

Rosewood did not provide adequate medical and nursing care. Both Rosewood's general approach to medical care and its execution of the specifics of such care were significantly flawed. In its approach, Rosewood was essentially reactive in the care it provided; the facility typically responded to health problems when those problems were brought to its attention, usually through health conditions reaching acute status. Adequate medical services are, in contrast, proactive. Such proactive services involve medical professionals accurately identifying at-risk individuals, performing regular assessments, and providing coordinated treatment before the onset of serious medical issues. Such proactive, rather than reactive, medical services are particularly necessary at a facility like Rosewood, where residents often had complex medical issues and frequently could not articulate their health status or communicate medical problems. The failure to provide proactive care that treats health conditions before they become acute can, in many instances, result in the degradation of a person's health condition and make the individual more susceptible to adverse conditions in the future, such as infection or aspiration pneumonia. The lingering effects of these deficiencies may persist

after the individual's placement into the community and must be monitored closely to prevent further harm.

Rosewood's reactive approach often resulted in the delaying in, or absence of, necessary medical and nursing services. Further, the services Rosewood did provide were flawed. More particularly, Rosewood had inadequate nursing services, including inadequate assessments, nursing care plans, and quality assurance. In addition, Rosewood's infection control and physical and nutritional management services also departed from generally accepted professional standards and exposed residents to significant risk of harm. This risk of harm likely continues in the individuals' current community placements, because the inadequate assessments and care plans they received inhibited the ability to provide appropriate supports and services upon discharge.

1. Rosewood's Nursing Assessments and Nursing Care Plans Departed from Generally Accepted Professional Standards of Care

As noted above, a preliminary stage in providing appropriate medical care for this population is the screening of individuals to determine their health care needs and risk status. However, Rosewood often did not correctly identify which of its residents were at high-risk for a variety of significant medical issues common to the population it serves. Rosewood's lists of high-risk individuals often omitted residents that the facility's own medical records showed should be included, a phenomenon we discuss below in detail. Consequently, Rosewood did not fulfill the first requirement of adequate medical care. We have grave concerns that many of these individuals who are high-risk for certain conditions continue to be exposed to significant harm because their medical needs and risk status were not communicated to the providers in their current placement.

Furthermore, when high-risk individuals were correctly identified, the nursing assessments and nursing care plans for these individuals failed to meet generally accepted professional standards. These standards require nursing assessments to be designed to collect specific, individual data to assist the team and the individual with case formulation, diagnosis, and treatment planning. However, the nursing assessments we reviewed were replete with omissions; information that generally accepted professional standards require assessments to produce was often missing. Without adequate assessments, proactive care cannot be provided, whether at Rosewood or in the community.

Similar deficits existed in nursing care plans. Nursing care plans should contain nursing diagnoses, measurable outcomes, and, most crucially, additions to and deletions from the care plan as the particular health needs of an individual change. None of the nursing care plans we reviewed met these standards. As a

result, nursing care plans did not contain adequate interventions, and these inadequate interventions may continue in the individuals' current placement. Furthermore, nursing care plans did not provide the means to evaluate their effectiveness, and Rosewood lacked other mechanisms to evaluate its nursing interventions. Consequently, there was no systematic way in which Rosewood could determine whether the interventions its nurses made were appropriate for a given individual. As a result of these deficiencies, individuals at Rosewood were subject to interventions that were unsupported and unconnected to their specific needs.

The care of two individuals illustrates these problems:

- A.F., a resident with a history of hospitalizations related to gastrostomy tube ("g-tube") complications, had a standing order for an abdominal binder to protect the integrity of the tube. Nevertheless, our review of her nursing records from January through June of 2008 revealed only sporadic documentation regarding use of an abdominal binder to protect the gastrostomy tube. The failure to use the abdominal binder, or to document its use

correctly, is particularly troubling because A.F. was hospitalized again in February 2008 due to g-tube complications. The failure to ensure that the abdominal binder was used likely contributed to this negative outcome.

- Generally accepted professional standards require that nursing assessments of respiratory changes include, at a minimum, lung sounds and respiratory rate. However, our review found these assessments to be generally lacking. In the case of one individual, L.L., the absence of an appropriate respiratory assessment may have contributed to a negative outcome: L.L. was hospitalized in October 2008 due to a worsening respiratory condition that an adequate assessment might have prevented. Our review of L.L.'s nursing notes revealed that nurses had recorded that he sounded congested for 12 days before his hospitalization, but the notes did not demonstrate that appropriate nursing assessments were completed.

The deficiencies in the care of these two individuals may have compromised their health on an ongoing basis and may require close monitoring to prevent recurrence or other complications.

Moreover, Rosewood's failures regarding nursing screening, assessments, and interventions can be concretely seen in its response to a number of conditions for which its residents were at high risk, such as bowel impaction and obstruction, aspiration pneumonia, compromised skin integrity, and bone fractures. Inaccuracies and gaps in Rosewood's data collection made analysis of its treatment

of these conditions difficult, but we nevertheless found numerous instances in which Rosewood's care substantially departed from generally accepted professional standards.

a. Care for Individuals at Risk of Bowel Impaction and Obstruction Substantially Departed from Generally Accepted Professional Standards

Individuals with developmental disabilities are often at risk of bowel impaction and obstruction because of physical inactivity due to their physical limitations, medication regimen, inability to communicate their needs, or a combination of these factors. Nevertheless, bowel impaction and obstruction are typically preventable conditions, but they can result in significant physical harm and even death if adequate care is not provided. Although Rosewood provided us with a list identifying eight individuals at high risk of bowel impaction and obstruction, our review found that another nine individuals met the high-risk criteria because they previously were either treated for, or admitted to the hospital with, fecal impactions. For example, at the time of our review, A.Q. was not on Rosewood's high-risk list, although A.Q. had been admitted to an acute care hospital on May 17, 2008, four months before our review, and was discharged with a diagnosis of bowel obstruction. These individuals may well continue to be at risk in their current placements because their risk of bowel obstruction was not communicated to their current provider.

In addition to failing to identify high-risk individuals adequately, Rosewood did not adequately assess the conditions of those it identified. Generally accepted professional standards for interventions in cases of constipation require nurses to make a variety of assessments, including bowel elimination patterns, bowel sounds, abdominal distention, and dietary and fluid intake, so that they may intervene appropriately.

We found a number of individuals for whom appropriate interventions are significantly hampered because these assessments were not performed consistent with generally accepted professional standards. In the case of abdominal distention, a cardinal sign of bowel obstruction, nursing assessments should include abdominal girth measurements and monitoring of elimination patterns. However, Rosewood did not adequately perform such assessments. For example, the records for two individuals, A.R. and I.I., who have histories of chronic constipation and documented abdominal distentions, did not contain adequate nursing assessments. As a result, these individuals experienced recurring bowel issues that required acute care hospitalization. In the case of I.I., discussed previously in Section II.B.1.a, nursing staff was notified that he had not had a bowel movement for three days. Rosewood staff attempted several interventions, all of which were

unsuccessful. Despite the ineffectiveness of its interventions, Rosewood failed to promptly move I.I. to the hospital. Upon his eventual arrival at the hospital, I.I. was found to have severe constipation, a swallowing disorder, and aspiration pneumonia.

Similarly, A.S., A.F., A.T., and H.H. had each been previously diagnosed with constipation, but their nursing care plans failed to address this condition. Consequently, there could be no expectation that the potentially life-threatening condition they suffered from would receive treatment until it had an acute manifestation, at which point the individuals had already suffered significant harm and be in danger of greater harm.

The absence of adequate assessments, comprehensive nursing care plans, and accompanying interventions placed these individuals at risk of harm from bowel impaction and obstruction. Accordingly, Rosewood substantially departed from generally accepted professional standards of nursing assessment and intervention regarding these conditions. These individuals may continue to be at increased risk of harm in their current placements because of the inadequate care they received for bowel obstruction during their residence at Rosewood, and they likely require increased monitoring to ensure they do not suffer further complications.

b. Care for Individuals at Risk of Aspiration Pneumonia Substantially Departed from Generally Accepted Professional Standards

Similarly, Rosewood did not assess individuals at risk of aspiration pneumonia consistent with constitutional standards. Aspiration pneumonia is a generally preventable condition that is caused by the presence of foreign materials, such as food or vomit, in the lungs. The contributing factors to aspiration pneumonia, including impaired ability to swallow or maintain posture, the use of gastrostomy tubes for nutrition, and gastroesophageal reflux, place many of the individuals at Rosewood at high risk. Notably, as of the time of our tour, there had been three deaths at Rosewood resulting from pneumonia in the past year.

As with bowel impaction and obstruction, Rosewood's list of high-risk individuals for aspiration pneumonia was incomplete. The list lacked at least three individuals, A.U., C.C., and L.L., who had all been hospitalized within the past year for pneumonia. These individuals likely continue to be at risk of harm, because their aspiration pneumonia risk would not have been communicated to their current placement providers.

The number of individuals residing at Rosewood who experienced acute hospital admissions for aspiration pneumonia was particularly disturbing. From March 2008 to July 2008, a five-month period, ten individuals were hospitalized for aspiration pneumonia collectively fourteen times. Six of the ten individuals hospitalized for aspiration pneumonia putatively received 24-hour nursing care in the clinic. Constant nursing care should not typically result in acute care hospitalizations for aspiration pneumonia, and strongly suggests that the care these six individuals received at Rosewood substantially departed from generally accepted professional standards.

More egregiously, A.R. was hospitalized four times in a five-month period in 2008 for aspiration pneumonia and three times the previous year. However, no comprehensive post-hospitalization review was performed and no recommendations or alterations to A.R.'s care plan were identified after any hospitalization. Rosewood's failure to recognize the increasing danger to A.R. and respond appropriately placed this individual at significantly heightened risk for continued aspiration pneumonia and death.

Similarly, the nurses' notes for L.L., an individual discussed previously, state that he sounded congested for 12 consecutive days prior to his hospitalization for aspiration pneumonia. Despite the observations in the nurses' notes, nothing in his record indicates that an assessment or intervention was performed. This delay placed L.L. at significant risk of harm.

Another individual, N.N., had repeated choking and gagging episodes. X-rays taken in June 2007 revealed multiple rib fractures in various stages of healing, likely related to the repeated use of the Heimlich maneuver. Nevertheless, on several occasions, Rosewood assessed N.N. and determined that he did not have a swallowing disorder. The repeated nature of N.N.'s choking and gagging episodes strongly suggests that Rosewood's determination that he did not have a swallowing disorder was incorrect. Further, as described in more detail below, our observations of N.N. revealed that staff members were not implementing his eating guidelines, thereby exposing N.N. to risk of further choking episodes.

The pervasive absence of adequate nursing assessments and interventions for individuals such as A.R., L.L., and N.N. placed them at significant risk of harm. Because of the inadequate assessments and interventions they received, this risk may continue in their current placements, as their risk would not have been adequately communicated to their current placement providers. Moreover, the ongoing failure to treat these conditions has likely compromised these individuals' health, an effect that may linger in their current placement and likely requires ongoing monitoring and treatment.

c. Care for Individuals With Skin Integrity Problems Substantially Departed from Generally Accepted Professional Standards

Rosewood's nursing care plans, assessments and interventions for individuals who have skin integrity issues, such as pressure ulcers, also did not meet constitutional standards. Alterations in skin integrity can cause serious harm, including death. Rosewood's identification of individuals experiencing this risk was again inadequate: the high-risk list that the facility provided us did not identify which individuals required additional nursing monitoring based on their increased level of risk due to impaired mobility, impaired nutritional status, incontinence, and/or impaired cognitive ability, all conditions that increase the risk of skin-integrity problems. Similarly, nursing care plans did not consistently identify skin-integrity risks for non-ambulatory residents. Because this inadequate information was likely communicated to the individuals' current placement providers, these individuals may continue to be at significant risk of harm.

Generally accepted professional standards require targeted nursing interventions for individuals with skin integrity issues, including repositioning every two hours and monitoring to ensure adequate nutrition and hydration. However, this information was absent from the facility's nursing care plans. One individual, A.R., was treated for a lesion or wound on his right lateral ankle for several months. However, wound care did not appear on his current nursing care plan, nor was it identified on the 45-day nursing assessment that we reviewed. The failure to include wound care in the assessment and plan casts significant doubt on the accuracy of nursing documents at the facility. Moreover, this failure placed A.R. at risk of harm; without accurate nursing assessments and plans, he could have received lapses in care, or received care that was counterproductive to his wound care, by staff members who were unaware of his condition. These risks may continue in his current placement if, as is likely given the deficits in his assessments and nursing care plan, his wound care needs were not adequately communicated to his current placement providers.

With respect to repositioning, we observed an individual, A.V., lying on a mat table with both of her feet bandaged. Staff reported that A.V. had "wounds" from skin breakdown. A.V.'s injury suggests that she was not adequately repositioned, an intervention necessary for individuals who are not able to reposition themselves. The failure to intervene appropriately exposed A.V., and others like her, to an ongoing risk of harm while at Rosewood, and these conditions may persist in the individuals' current placement if the need for repositioning was not communicated.

d. Care for Individuals At Risk for Fractures Substantially Departed from Generally Accepted Professional Standards

Individuals with developmental disabilities are also at high risk for fractures from falls due to early onset osteoporosis, side effects of medications, impaired cognitive function, impaired mobility, or non-ambulatory status. As with the conditions discussed above, Rosewood did not conform to constitutional standards for nursing assessment or intervention in the nursing services it provided to individuals at high risk for fractures from falls.

Generally accepted professional standards of nursing care for these individuals require risk assessment and review of medications, functional and sensory status, and physical environment, as well as referral to physical therapy. Generally accepted professional standards for nursing interventions for such individuals require the identification of safety precautions necessary for activities of daily living, as well as specific placement in therapeutic positioning that promotes weight bearing.

Rosewood substantially departed from these standards. For example, A.P. was diagnosed with osteoporosis, unsteady gait, and seizure disorder. His nursing care plan, however, did not adequately address his unsteady gait; it simply called for monitoring for injuries from falls, a purely reactive approach that was of little benefit to A.P. Worse, A.P. suffered from a total of nine falls in 12 months, but there was no indication that he had been evaluated after these incidents. Thus, Rosewood did not adhere to even the minimal, reactive nursing care plan that it had in place for A.P. Accordingly, A.P. was at continuing risk of harm due to inadequate nursing services while at Rosewood. Similarly, the nursing care plans for two non-ambulatory individuals with osteoporosis, A.F. and A.T., did not address any of the interventions necessary to prevent fractures. These at-risk individuals were thereby placed at an increased risk of harm by Rosewood's failure to respond appropriately to their unique needs, and this risk may continue in their current placements because of the deficits in their nursing care plans.

Rosewood housed a population in which fractures from falls were a known and regular risk. Further, hip fractures are a leading cause of death in older, medically fragile individuals in any population. Rosewood's failure to identify the risks faced by individuals in its care and to implement preventative strategies to reduce the occurrence of falls was a substantial departure from generally accepted professional standards, violated these individuals' constitutional rights, and placed them at significant and continuing risk of harm.

Rosewood's inadequate response to the common conditions described above demonstrates a distinct and disturbing pattern in the medical and nursing care that the facility provided. Rosewood regularly failed to identify the members of its population who are at high risk for a variety of medical issues, and where it did identify those individuals, it failed to assess and treat them adequately. As such, Rosewood's medical and nursing care typically reacted to health issues if and when they became so serious that they could not escape notice. Rosewood therefore failed to conform to generally accepted professional standards in nursing care and, consequently, placed those it served at significant risk of harm. Moreover, these individuals may continue to be at risk, because the failures in their assessments and nursing care plans suggests that inaccurate and incomplete information about their health risks was provided to their current placement providers.

2. Rosewood's Nursing Quality Assurance Substantially Departed from Generally Accepted Professional Standards

Generally accepted professional standards for a nursing quality assurance program require a number of monitoring instruments that measure the quality and effectiveness of nursing care and services. An effective quality assurance program should allow the facility to identify problematic areas in nursing care and develop and implement corrective action plans accordingly.

Rosewood's nursing quality assurance program substantially departed from these standards. The data we reviewed at Rosewood did not reflect a quality assurance program capable of improving care: data collected for quality assurance were not complete and were not utilized appropriately. For instance, the forms used for nursing quality assurance contained significant omissions, resulting in a failure to collect information that is essential to assess the quality of nursing services. Even more troubling was Rosewood's failure to use the information the quality assurance program did gather. Specifically, the quality assurance nurse collected some data regarding nursing services. However, this information, and any analysis of it that may have been performed, was not regularly shared with the nursing department. As a result, to the limited extent that the quality assurance program identified areas needing correction, this information was not used by the nursing department to correct inadequacies in the provision of care.

Moreover, as previously discussed, Rosewood's repeated failure to identify as high-risk even those individuals whose records indicated that they were at such risk further evidences inadequacies in Rosewood's quality assurance program. Beyond the examples discussed in Section II.D.1, we found numerous other areas in which Rosewood failed to identify individuals who are at high risk. Rosewood's list of individuals having significant physical health risks or behavioral health risks omitted three residents who received gastronomy tube feedings and require 24-hour

positioning. The list also omitted two residents with seizure disorders who required thickened liquids. Rosewood's list of residents who were hospitalized for medical emergencies was similarly incomplete. The list failed to comprehensively identify the circumstances of the hospitalization and did not identify all the hospitalizations for each individual. As previously discussed, Rosewood's failure to identify individuals who are at risk strongly suggests that inaccurate and incomplete information was given to these individuals' current placement providers, placing these individuals at ongoing risk of harm in their current settings.

The inadequacies of Rosewood's quality assurance program were also demonstrated by the failure to document medication administration errors correctly. In Rosewood's internal ten-month list of medication errors, only three errors were identified, an implausibly low number for a facility of Rosewood's size that suggests the facility suffers from a major under-reporting problem regarding medication errors. Our review confirmed that Rosewood's medication administration error reporting did not comply with generally accepted professional standards. As an initial matter, Rosewood appeared to be utilizing an incorrect definition of a medication administration error. At the time of our visit, the nursing department examined the medical administration records at the change of shift meeting and, if a blank was found, signed the records at that time. In fact, each of these blanks should have been recorded as an administration error. Reconciling medication administration records after the fact, as Rosewood did, is a substantial departure from generally accepted professional standards. Our review found still other medication errors, including errors for A.W., A.X., and A.V., not reflected in the facility's own report. The medication error for A.V. was particularly egregious, as it led to an acute hospitalization, and she may continue to suffer from its effects.

Nursing quality assurance programs depend on comprehensive data to evaluate the quality and effectiveness of nursing care. When that data are incomplete, the quality assurance program is unable to assess the provision of nursing services reliably and to initiate necessary corrections and improvement. As discussed above, Rosewood's nursing care data were incomplete and unreliable. Further, we found no corrective action taken as a result of issues the quality assurance program identified. These significant departures from generally accepted professional standards placed residents of Rosewood at considerable risk of harm, a risk that may continue in these individuals' current placements because of the inaccuracy of the information given to their current providers.

3. Rosewood's Infection Control Program Substantially Departed from Generally Accepted Professional Standards

Constitutional standards require that an adequate infection control program be in place at facilities such as Rosewood. An effective infection control program

requires the ability to identify and report instances of infectious disease and the ability to control and prevent infectious disease. Data collected in the course of carrying out the former function should be used to establish baseline infection rates and can be used to identify infection outbreaks. These data and the accompany analysis should be put to use in developing policies and procedures and in conducting staff training and resident educational programs to aid in controlling and preventing infection.

Although Rosewood took the positive step of establishing an infection control nurse position, our review of the infection control program found that it substantially departed from generally accepted professional standards. First, Rosewood's infection control data and documentation suffered from the same lack of reliability that pervades the facility's medical documentation. Infections identified in nurses' notes were absent from nursing care plans and, therefore, were not adequately monitored or tracked to determine if the infection had spread. Without accurate reporting and collection of data on infections, effective infection control is impossible. More pertinently for present purposes, however, the inaccuracies in Rosewood's infection data suggest that current placement providers may not have been adequately informed about the potentially heightened infection risks posed by the population that Rosewood was transitioning into the community, inhibiting the providers' ability to assess and care for these individuals and potentially placing other individuals at risk of infection.

Moreover, Rosewood did not use the information it collected on infections to control the outbreak of infections in a manner consistent with generally accepted professional standards. The minutes of the infection control meetings showed that Rosewood's infection control program did not address the substantive issues of infection control, including the analysis of data to control the spread of infections and prevent future infections. The minutes indicate that Rosewood's infection control program was only engaged in the most basic of infection control practices, such as assuring that staff were adhering to universal precautionary procedures. While the meeting minutes show that lists of residents suffering from infectious diseases were discussed, there is no evidence of any analysis regarding unit transmission, trends of infection, or any other analysis related to the cause of infection or controlling infection. This was true even when residents in the same unit had the same infectious disease. The minutes for one meeting note a spike in pneumonia and cellulitis, but include a correction plan limited to discussing adjustments to the residential heating systems with the maintenance department. No root cause analysis or other meaningful data analysis appears to have been performed in any instance identified in the facility's infection control records that were provided to us. Thus, even in the circumstances where Rosewood adequately identified individuals with an infectious disease, it did not engage in the substantive steps necessary for providing effective infection control. Rosewood's

infection control program therefore departed substantially from generally accepted professional standards and exposed residents at Rosewood to harm. The failure to control the outbreak of infections adequately may have led to the unnecessary spread of infection, the effects of which may continue to compromise the health of those individuals who were infected.

4. Rosewood's Physical and Nutritional Management Substantially Departed from Generally Accepted Professional Standards

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of residents who are at risk for aspiration, choking, and dysphagia⁷ and the assignment of an appropriate risk level; the identification of residents' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; the development and implementation of a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; and the provision of competency-based training to all staff assisting these residents regarding individualized physical and nutritional management plans.

Rosewood's provision of physical and nutritional management substantially departed from generally accepted professional standards. As described in Section II.D.1.b, above, we found critical deficits in nursing assessments, plans, and interventions for individuals at high risk of aspiration pneumonia. Further, Rosewood did not meet generally accepted professional standards relating to safe positioning. We observed fourteen individuals receiving 20-hours-per-day continuous tube feeding, an unusually high number. More importantly, the positioning for many of these individuals resulted in them being poorly supported and, accordingly, in poor alignment, whether in their hospital beds, in recliners, or on positioning-mat tables supported by pillows and bean-bags. These apparatuses generally do not provide the stabilization needed to maintain postural alignment and, worse, increase the risks of aspiration and gastroesophageal reflux while also reducing the ability to breathe and digest food safely and effectively. Indeed, some of the primary supports that Rosewood used, such as bean-bags, recliners, and

⁷ "Dysphagia" refers to difficulty in swallowing, a condition that confers health risks on populations like those at Rosewood: it may result in aspiration into the airway and respiratory compromise, it may confer nutritional risks culminating in malnutrition because of insufficient intake of food and fluids, and it predisposes to choking, which has its own associated morbidity and mortality risks.

pillows, are known to increase the risk of harm from aspiration. These supports also increase the risk that deformities will become worse because they do not provide proper support. Thus, Rosewood's positioning, rather than being therapeutic, increased the risk of harm that its residents faced. The effects of this inadequate positioning likely continue in these individuals' current community placements, as many of the effects are long-term, including such conditions as increased deformities and increased susceptibility to aspiration and aspiration pneumonia.

Rosewood's inadequate physical therapy interventions may be seen in the example of four individuals, A.Y., U.U., A.Z., and A.G., whom we observed with inadequate seating systems. Disturbingly, the Rosewood physical therapist stated that the seating systems, although new and state-of-the-art, had been designed for comfort and not proper positioning; the seating systems therefore simply conformed to the established pattern of deformity for the individuals using them. As a result, the seating systems utilized at Rosewood did not appear to be used to prevent the further progression of known deformities; as noted above, they appeared to be generally used for comfort rather than care. Rosewood therefore placed individuals at increased risk of harm through inadequate support systems, a risk that likely continues in the residents' current placement, because the seating systems likely went with the residents when discharged.

Rosewood also substantially departed from generally accepted professional standards with respect to risks associated with food consumption. During mealtimes we observed, staff were frequently unfamiliar with the individuals they were serving. Mealtime cards, designed to inform staff as to a particular resident's eating needs, were often unavailable and, in other instances, staff members were unable to locate them or were unaware of their existence. Nursing was not an active participant in mealtimes, either in monitoring residents with known swallowing issues or in assisting staff with mealtime activities. Our observations revealed a general lack of attentiveness: one resident, B.A., coughed throughout the mealtime and another, B.C., spent the meal with his chest harness strap draped across his shoulder and the side of his face, but there were no interventions in either case. Similarly, N.N., an individual described above, was supposed to receive close supervision during meals, including interventions to encourage him to eat more slowly. However, Rosewood failed to implement these guidelines during the mealtime we observed. Further, staff members supervising N.N. while he was eating a snack during a morning break in his day program were unaware that N.N. was at risk of choking and aspiration. Failure to adhere to meal plans and supervise N.N. placed him at significant risk of harm. Moreover, the hospitalizations for aspiration pneumonia described in Section II.D.1.b, above, strongly suggest that inadequate nutritional management, including poor supervision at mealtimes, occurred. The health effects of the harm suffered due to

this failure to supervise individuals adequately may be long-term, and we have concerns that these individuals may continue to be exposed to harm if their need for supervision was not adequately communicated to their current providers.

In summary, Rosewood substantially departed from generally accepted professional standards of medical and nursing care. As discussed above, the medical and nursing care that Rosewood provided did not focus on preventing or mitigating health problems before the problems reached acute status. Instead, Rosewood addressed health problems when they reached the acute stage, a reactive approach that placed residents at Rosewood at a significant risk of harm. Compounding this reactive approach to care was the facility's failure to adequately monitor, and respond to changes in, an individual's health status, and to monitor and address facility-wide health-related indicators. Rosewood's failure to provide adequate care jeopardized its residents' health, and the lingering effects of these failures may persist after their placement into the community. Moreover, the critical deficits in assessments, nursing care plans, and data collection suggests that inaccurate and incomplete data was provided to their current placement providers, placing these individuals at an ongoing risk of harm.

III. MINIMUM REMEDIAL MEASURES

To remedy the identified deficiencies in the care provided to Rosewood's former residents during their time at the facility, as well as the identified deficiencies in the process through which the State has placed Rosewood's residents out of the facility and is overseeing their transition to other settings, and to protect the constitutional and statutory rights of former Rosewood residents, the State should promptly implement, at a minimum, the remedial measures set forth below:

A. Transition and Placement in the Most Integrated Setting

1. Principal Requirement: In accordance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, and implementing regulation 28 C.F.R. § 35.130(d), the State should ensure that each former Rosewood resident is served in the most integrated setting appropriate to meet each person's individualized needs and should remedy any inappropriate community placements. To this end, the State should provide individuals transitioning from Rosewood with adequate and appropriate protections, supports, and services, consistent with each person's individualized needs, in the most integrated setting in which they can be reasonably accommodated, and where the individual does not object.

2. Appropriateness of Placement:

- a. The State should perform and maintain current, complete, and accurate interdisciplinary assessments of each individual to determine whether the individual is in the most integrated setting appropriate to the individual's needs. The State should ensure that those performing these assessments are demonstrably competent to do so and have adequate information regarding options for placements, programs, and other supports and services.
- b. If it is determined that a more integrated setting than the individual's current placement would appropriately meet the individual's needs and the individual does not oppose that placement, the State should promptly develop and implement a transition and community support plan that specifies actions necessary to ensure safe, successful transition to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames.
- c. Subject to the conditions of court confinement, all individuals can be served in integrated community settings when adequate protections, supports, and other necessary resources are identified as available by service coordination. The State should ensure that this is clearly set forth in each individual's written interdisciplinary team recommendation contained within each individual's transition and community support plan, or equivalent, as a means to protect against needless reinstitutionalization.

3. Individual Involvement and Choice:

- a. In determining whether individuals are placed appropriately, each individual should be involved in the team evaluation, decision-making, and planning process to the maximum extent practicable, using whatever communication method he or she prefers.
- b. To foster each individual's self-determination and independence, the State should use person-centered planning principles at every stage of the process. This should facilitate the identification of the individual's specific interests, goals, likes

and dislikes, abilities and strengths, as well as deficits and support needs.

- c. Each individual should be given the opportunity to express a choice regarding his or her placement. The State should provide individuals with choice counseling to help each individual make an informed choice; the State should provide enhanced counseling to those individuals who lived at Rosewood for many years.
- d. If the current placement is determined to be inappropriate and the individual opposes movement toward a more integrated setting, the State should document the steps taken to ensure that any individual objection is an informed one. The State should set forth and implement individualized strategies to address concerns and objections to placement in the more integrated setting.
- e. Throughout the process, the State should regularly educate individuals about the various community options open to them. Any written materials or presentations should be easy for individuals to understand.
- f. If the current placement is determined to be inappropriate, the State should provide each individual with several viable placement alternatives to consider whenever possible. The State should provide field trips to these viable alternative placements and facilitate overnight stays at certain of the placements, where appropriate.
- g. Where family members and/or guardians have reservations about the individual's current placement or movement to a more integrated setting, the State should provide ongoing educational opportunities to such family members and/or guardians with regard to placement and programming alternatives and options. These educational opportunities should include information about how the individual may have viable options other than living with the family members and/or guardians. The State should identify and address the concerns of family members and/or guardians with regard to community placement. The State should encourage family members and/or guardians to participate, whenever possible, in individuals' on-site, community home field trips.

4. Transition and Community Support Plans:
 - a. The State should develop or revise, as appropriate, a written transition and community support plan specifying the particular protections, supports, and services that each individual needs to live in the community safely and successfully.
 - b. Each transition and community support plan should be developed or revised using person-centered planning principles. Each transition and community support plan should specify with particularity the individualized protections, supports, and services needed to meet the needs and preferences of the individual in the most integrated setting appropriate to their needs, whether that be their current placement or another yet to be determined, including the scope, frequency, and duration of the individualized protections, supports, and services. Each transition and community support plan should include all individually-necessary protections, supports, and services, including but not limited to: housing and residential services; transportation; staffing; health care and other professional services; specialty health care services; therapy services; psychological, behavioral, and psychiatric services; communication and mobility supports; programming, vocational, and employment supports; and assistance with activities of daily living. Each plan should include specific details about which particular community providers, including residential, health care, and program providers, can furnish needed protections, services, and supports.
 - c. In developing and/or revising and implementing these plans, the State should avoid placing individuals into nursing homes or other institutional settings whenever possible. Nursing homes are often not well-suited to provide needed habilitation to persons with developmental disabilities. The State should develop and implement a systemic plan to develop integrated community alternatives to nursing homes for all individuals with unique or more intense and complex health care needs.
 - d. If it is determined that the individual is not currently in the most integrated setting appropriate to their needs, the transition and community support plan should identify the date movement to the most integrated setting can occur, as well as timeframes for completion of needed steps to effect the

transition. The transition and community support plan should include the name of the person or entity responsible for: commencing transition planning; identifying providers and other protections, supports, and services; connecting the individual with providers; and assisting in transition activities as necessary. The responsible person or entity should be experienced and capable of performing these functions.

- e. Each transition and community support plan should be developed sufficiently prior to movement to another placement so as to enable the careful development and implementation of needed actions to occur before, during, and after the transition. This should include identifying and overcoming, whenever possible, any barriers to transition. The State should work closely with pertinent community agencies so that the protections, supports, and services that the individual needs are developed and in place at the alternate site prior to the individual's movement to the other placement.
- f. The State should update the transition and community support plans as needed throughout the planning and transition process based on new information and/or developments.
- g. In developing or revising the transition and community support plans, the State should attempt to locate community alternatives in regions based upon the presence of persons significant to the individual, including parents, siblings, other relatives, or close friends, where such efforts are consistent with the individual's desires.
- h. If it is determined that the individual is not currently in the most integrated setting appropriate to their needs, the State should provide as many individual on-site and overnight visits to various proposed residential placement sites in the community as are appropriate and needed to ensure that the placement ultimately selected is, and will be, adequate and appropriate to meet the needs of each individual. The State should modify the transition and community support plans, as needed, based on these community visits.
- i. In developing or revising the transition and community support plans, the State should include a schedule for monitoring visits to the new residence to assess whether the ongoing needs of the

individual are being met. Each plan should specify more regular visits in the days and weeks after any initial placement.

5. Implementation of Transition and Community Support Plans: The State should implement, in an expeditious manner, the newly developed or revised transition and community support plans that can be reasonably accommodated, by transferring each individual to an adequate and appropriate alternative community setting pursuant to the details set forth in each transition and community support plan, or by providing those supports and services determined to be necessary in the revised transition and community support plan.
6. Developing and Expanding Community Capacity:
 - a. The State should take effective steps to support and expand service and provider capacity in the community so as to better serve individuals placed and to be placed in the community. This should include, but not be limited to, developing community capacity with regard to: housing and residential services; health care and other professional services; specialty health care services; therapy services; communication and mobility supports; and psychological, behavioral, and psychiatric services.
 - b. The State should develop and implement a plan with effective steps to expand and improve expert health care and expert psychological, behavioral, and mental health services in the community for community residents with complex health care needs, and/or behavior problems and/or mental illness. The intent of the plan should be to better meet individuals' health care, behavioral, and mental health needs in the community, avoid crises marked by the escalation of health care and/or behavior problems, and to minimize or eliminate failed or troubled community placements due to poorly addressed individual behaviors and, thus, minimize or eliminate re-institutionalization.
 - c. To assist in this process, the State should develop and implement a plan to utilize and/or expand the State's existing information systems to better meet the needs of persons with developmental disabilities. The plan should address how to provide more immediate and better access to records and expert professionals, transmit lab results and radiological reports

between health care and other professionals, better track quality of care, improve communication with local hospitals and specialists, and generally provide better proactive care and treatment through a more seamless continuum of care to enhance individual outcomes.

7. Monitoring of Community Placements and Quality Assurance Measures:

- a. The State should develop and implement a system, including service coordination services, to effectively monitor community-based placements and programs to ensure that they are developed in accordance with the individualized transition and community support plans set forth above, and that the individuals placed are provided with the protections, services, and supports they need. These and other monitoring and oversight mechanisms should serve to help protect individuals from abuse, neglect, and mistreatment in their community residential and other programs. The State's oversight should include regular inspections of community residential and program sites; regular face-to-face meetings with individuals and staff; and in-depth reviews of treatment records, incident/injury data, key-indicator performance data, and other provider records.
- b. Former Rosewood residents who have been placed in the community should be served by an adequate number of service coordinators to meet individuals' needs. The State's service coordination program should provide for various levels of follow-up and intervention, including more intensive service coordination for those individuals with more complex needs. All service coordinators should receive appropriate and adequate supervision and competency-based training.
- c. The State should provide prompt and effective support and intervention services to individuals who present adjustment problems related to the transition process such that each individual may stay in his or her community residence when appropriate, or be placed in a different, adequate, and appropriate community setting as soon as possible. These services may include, but not be limited to: providing heightened and enhanced service coordination to the individual/home; providing professional consultation, expert

assistance, training, or other technical assistance to the individual/home; providing short-term supplemental staffing and/or other assistance at the home as long as the problem exists; and developing and implementing other community residential alternative solutions for the individual.

- d. The State should maintain individuals in the most integrated community setting appropriate for their needs. Any admission or re-admission to a State institution should be considered short-term. If a individual is re-admitted to a State institution, the State should document the basis for the re-admission and then conduct a prompt assessment to identify and resolve any factors necessitating the re-admission.
- e. The State should regularly collect, aggregate, and analyze data related to transition and placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated and appropriate setting. Such problems or barriers may include, but not be limited to insufficient or inadequate: housing, community resources, health care, behavior management and services, and meaningful day activities including supported employment. The State should review this information on a regular basis and develop and implement prompt and effective strategies to overcome the problems and barriers identified.
- f. The State should regularly review various community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State should develop and implement effective strategies to any gaps or weaknesses or issues identified.

B. Amelioration of Improper Treatment

1. Principal Requirement: The State should ameliorate any lingering effects of the improper treatment provided at Rosewood, by ensuring that former residents receive compensatory services in the most integrated setting appropriate to their individual needs.

2. Behavioral, Habilitation, and Communication Services:
 - a. Provide training, including behavioral and habilitative services, consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. These services should be developed by qualified professionals consistent with accepted professional standards to reduce or eliminate risks to personal safety, to reduce or eliminate unreasonable use of bodily restraints, to prevent regression, and to facilitate the growth, development, and independence of every individual. To this end, the State should take the following steps:
 - i. Provide individuals who have behavior problems with an adequate functional assessment so as to determine the appropriate treatments and interventions for each person. Ensure that this assessment is interdisciplinary and incorporates medical and other unaddressed conditions that may contribute to a individual's behavior;
 - ii. Develop and implement comprehensive, individualized behavior programs for the individuals who need them. Ensure that the appropriate staff in the individuals' current placement know how to implement the behavior programs and ensure that they are implemented consistently and effectively. Ensure that appropriate behavioral data and notes with regard to the individual's progress on the programs is recorded by the current placement provider;
 - iii. Ensure that current placement providers monitor adequately the individuals' progress on the programs and revise the programs when necessary to ensure that individuals' behavioral needs are being met, and that ongoing training for staff is provided whenever a revision is required;
 - iv. Ensure that each individual who is receiving psychotropic medications has first been thoroughly evaluated and diagnosed according to generally accepted professional standards. Ensure that each individual diagnosed with mental illness is provided with a comprehensive psychiatric assessment, a DSM-IV diagnosis, appropriate

psychiatric treatment including appropriate medication at the minimum effective dose that fits the diagnosis, and regular and ongoing monitoring of psychiatric treatments to ensure that they are meeting the needs of each person. Ensure that psychiatrist(s) provide new assessments and/or revisions to any aspect of the treatment regimen whenever appropriate. Ensure that reliable behavioral and other data are provided to psychiatrists in making their assessments. Ensure that psychiatric services are implemented in close collaboration with psychologists and others, when warranted, to provide coordinated behavioral care;

- v. Ensure that all individuals receive meaningful habilitation daily in their current placement, including but not limited to individualized training, education, and skill acquisition programs developed and implemented to promote the growth, development, and independence of each individual, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue restraint. Ensure that there is a comprehensive, interdisciplinary habilitative plan for each individual for the provision of such training, services and supports, formulated by a qualified interdisciplinary team that identifies individuals' strengths, needs, preferences, and interests. Ensure that the plans address the individuals' needs, preferences, and interests in an integrated fashion that utilizes the individuals' existing strengths. Ensure that staff in the current placement are trained in how to implement the written plans and that the plans are implemented properly; and
- vi. Provide an assessment of all individuals and develop and implement plans based on these assessments to ensure that individuals are receiving vocational and/or day programming services in the most integrated setting appropriate to meet their needs. Ensure that there is sufficient staffing and transportation to enable individuals to work in an appropriate setting or to attend appropriate programming or activities when necessary.

- b. Provide communication services consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. To this end, the State should take these steps:
 - i. Assess or reassess all individuals discharged from Rosewood to identify those who would benefit from speech and communication therapy and ensure that adequate and appropriate services are provided to all individuals who would benefit from this service; and
 - ii. Ensure that speech and language services are developed and implemented in collaboration with psychologists and other services to provide coordinated care.

- 3. Health Care:
 - a. Provide medical care and nursing services consistent with generally accepted professional standards to individuals who received inadequate services while at Rosewood. To this end, the State should take these steps:
 - i. Ensure that each individual is provided with proactive, coordinated, and collaborative health care and therapy planning and treatment based on his or her individualized needs in their current placement;
 - ii. Assess or reassess all individuals discharged from Rosewood to identify, diagnose, and treat health problems in a timely manner, including health conditions such as infection, bowel impaction and obstruction, aspiration and aspiration pneumonia, skin care, and fractures ;
 - iii. Ensure that all individuals with a health problem are treated in a timely manner. To that end, ensure that individuals' current nursing care plans include individualized proactive interventions so that individuals who are at "high risk" are identified, monitored consistent with their risk status, and treated according to generally accepted professional standards;
 - iv. Ensure that all individuals who are at risk for aspiration or dysphagia are provided with an effective physical and

nutritional management program, but not limited to the development and implementation of assessments, risk assessments, interventions for mealtimes and other activities involving swallowing, and monitoring to ensure that interventions are effective. Ensure that staff at these individuals' current placements with responsibilities for individuals at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.

IV. CONCLUSION

We appreciate the cooperation we received from the Maryland Developmental Disabilities Administration and the State's Attorney General's Office. We also wish to thank the administration and staff at Rosewood for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tours. Further, we wish especially to thank those individual hospital staff members who made daily efforts to provide appropriate care and treatment, and who improved the lives of residents at Rosewood. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. These reports are not public documents. Although our expert consultants' reports are their work – and do not necessarily represent the official conclusions of the Department of Justice – their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to

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do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Douglas F. Gansler
Attorney General for the State of Maryland

John M. Colmers, Secretary
Maryland Department of Health and Mental Hygiene

Michael S. Chapman, Executive Director
Maryland Developmental Disabilities Administration

Robert M. Day, Facility Director
Rosewood Center

Rod J. Rosenstein
United States Attorney
District of Maryland



U.S. Department of Justice
Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
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January 18, 2011

BY FIRST CLASS MAIL

The Honorable Michel Claudet
President, Terrebonne Parish
8026 Main Street, Suite 700
Houma, LA 70360

Re: Terrebonne Parish Juvenile Detention Center, Houma, Louisiana

Dear Mr. Claudet:

I write to report the findings of the Civil Rights Division's investigation of conditions at the Terrebonne Parish Juvenile Detention Center ("Terrebonne" or "the Facility"). On November 19, 2009, we notified Parish officials of our intent to conduct an investigation of Terrebonne pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). Section 14141 gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions.

Summary of Findings

The youth confined to Terrebonne are subjected to conditions that place them at serious risk of avoidable harm in violation of their rights protected by the Constitution of the United States. During our investigation, we received a significant number of credible reports of sexual and physical misconduct by staff members on youth within their custody. The allegations exposed wide-spread and systemic abuses and revealed a lack of accountability and controls that would have prevented harm to the young people confined there.

Allegations of sexual misconduct have led to criminal charges against seven staff members. Our findings are not limited to the conduct charged in the criminal cases, but include numerous additional accounts. These incidents are compounded by a lack of systems in place to identify and correct misconduct.

In addition to sexual misconduct, there is a pervasive atmosphere of excessive force and violence. We found:

- Physical restraints, including handcuffing and a restraint chair, are routinely used when verbal or non-physical methods would have been adequate;
- The inappropriate and dangerous use of chemical agents;
- Excessive use of isolation as punishment or for control;
- Suicidal behavior six times the national average and an inadequate suicide prevention program; and
- High levels of fighting and assaults between youth.

These conditions are the result of, and allowed to continue to exist because generally accepted juvenile justice standards are not followed. We found that staff did not receive minimally adequate training, and that existing policies and procedures are inadequate to ensure that minimally necessary force is used to control youth; that chemicals are used safely; or that youth are protected from sexual or physical abuse. In addition, we found that the facility lacks adequate staff and that the staffing pattern places youth at risk of harm because of fatigue, reduced accountability, overreliance on seclusion, and inadequate supervision.

Significantly, we found limited mechanisms to provide accountability. During our inspections we uncovered staff members who lied about performing room checks. This information would not have been discovered but for our efforts. In addition, we found that child abuse allegations are not reported to state officials as required by law; the facility fails to collect data that would permit managers to identify and address problems; there is inadequate supervision of line staff; and no meaningful quality assurance program exists.

The failure to meet generally accepted juvenile justice standards in the face of severe problems in the facility violates the Fourteenth Amendment's mandate that youth in state custody be protected from harm. In this letter we provide additional recommendations that are minimally necessary to bring the facility into compliance with the Constitution.

Investigation

On March 22-25, 2010, we conducted on-site inspections at Terrebonne with expert consultants in juvenile justice administration and protection from harm. We interviewed Facility management personnel, direct care and administrative staff, and youth. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigative reports, grievances from youth, staff personnel files, unit logs, orientation materials, staff training materials, and school records. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to Terrebonne and Terrebonne Parish officials at the close of our on-site visits. We followed up with a letter to the Parish on April 22, 2010 outlining some of our most pressing concerns.¹

¹ In our letter, we expressed serious concern that overnight rooms checks were not being consistently performed, and that staff routinely appeared to be falsifying room check documentation. In addition, we expressed concern that overnight shift staff were not being adequately supervised and were not being held accountable for complying with Terrebonne policies and procedures.

We commend the staff at Terrebonne for their helpful and professional conduct throughout the course of the investigation. We received full cooperation with our investigation and appreciate the Parish's receptiveness to our consultants' on-site recommendations. Also, we appreciate comments made by Ralph Mitchell, the Director of the Terrebonne Parish Department of Public Safety, indicating that he had become aware of some of the problems we identified, and had begun formulating remedies to address some of our most serious concerns.

In addition, we appreciate the thorough cooperation provided by Facility Director Jason Hutchinson. Director Hutchinson brings a number of strengths to the role of facility superintendent -- he is a bright, caring, dedicated, and committed person who has brought about several innovations in education and programming that affirm his commitment to the best interest of detained youth. He is appropriately educated, holding a bachelor's degree in psychology and a master's degree in special education. Director Hutchinson has experience working with troubled youth in the public schools and educational programming for adults in jail. The Director was highly receptive to our observations and has reported to us that he has implemented a number of remedial measures in response to our April 22, 2010 letter. In particular, on May 20, 2010 we were advised by counsel for the Parish that the Director has taken steps to ensure that overnight room checks are performed in a timely manner, and that overnight shift staff are now subject to periodic surprise visits by external law enforcement personnel.

We now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described more fully below, we conclude that certain conditions at Terrebonne violate the constitutional rights of the youth.

I. BACKGROUND

Terrebonne is a secure juvenile detention facility opened on September 1, 1998 and located in Houma, Louisiana. The Facility's mission is to "provide short-term care in the secured custody of juveniles who are accused, adjudicated pending court action, awaiting transfer to another facility, and who cannot be served in an open setting."² Terrebonne also served as one of three regional placement centers in Louisiana for adjudicated female youth pursuant to a per diem contract between Terrebonne Parish and the State. In May 2009, however, the State removed its contracted population from the Facility, and only the detention and pending placement populations remain.

One of the published goals of Terrebonne is to house "the juveniles in a safe and humane environment, maintaining the level of security necessary to prevent escape and assure that the juveniles live free of fear from assault or intimidation by staff or other juveniles." Terrebonne has a capacity to hold 60 juveniles, including 40 males and 20 females. On February 1, 2010, the Facility housed a total population of 40 youth, and during the period of review, remained below

² http://www.tpcg.org/view.php?f=juvenile_detention.

operational capacity. Between its 1998 opening and July 31, 2007 (the most recent period for which published figures are available), the Facility has processed over 7,000 youth.³

II. LEGAL STANDARDS

Section 14141 authorizes the Department of Justice to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights of youth in juvenile justice institutions. 42 U.S.C. § 14141. Youth detained at Terrebonne are protected by the Fourteenth Amendment and have a substantive due process right to reasonably safe conditions of confinement and freedom from unreasonable bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 316 (1982) (“If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily detained - who may not be punished at all - in unsafe conditions.”). The Fourteenth Amendment, rather than the Eighth Amendment applies because the youth are held for detention or rehabilitation, not punishment.⁴ The purpose of the Louisiana youth delinquency statute is to “accord due process to each child who is accused of having committed a delinquent act... and to secure for him care as nearly as possible equivalent to that which the parents should have given him.”⁵

To determine whether the Fourteenth Amendment was violated, a balancing test must be applied: “It is necessary to balance ‘the liberty of the individual’ and ‘the demands of an organized society.’” Youngberg at 320 citing Poe v. Ullman, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting). The Youngberg Court went on to hold that “If there is to be any uniformity in protecting these interests, this balancing cannot be left to the unguided discretion of a judge or jury.” Id. at 321. Instead, the Court held that there was a constitutional violation if the detaining official substantially departed from generally accepted professional standards, and that departure endangers youth in their care. See id. at 314.

As a general matter, the Supreme Court has held that corrections officials must take reasonable steps to guarantee detainees’ safety and provide “humane conditions” of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (holding that a municipality assumed a constitutional obligation to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir.) (en banc) (recognizing a duty to provide detainees with basic human needs including protection from harm). In addition, an official’s failure to maintain adequate policies, procedures, and

³ Id.

⁴ In Ingraham v. Wright, the Supreme Court rejected application of the Eighth Amendment deliberative indifference standard in a non-criminal context. 430 U.S. 651, 669 n.37 (1977) (“Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions.”). In addition, the Court held that the Due Process Clause of the Fourteenth Amendment was the proper constitutional gauge to determine the rights of adults detained by a state, but not yet convicted of any crime. Bell v. Wolfish, 441 U.S. 520 (1979). See also, Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996). At a minimum, youth should be accorded the same constitutional protections.

⁵ La. Child. Code Ann. art. 801 (2010).

practices for the prevention of suicides may violate a detainee's due process rights. Silva v. Donley County, 32 F.3d 566, 1994 WL 442404, *5-7 (5th Cir. 1994) (unpublished) (holding sheriff's failure to establish suicide detection and prevention training for jail personnel, condoning de facto policy of sporadic cell checks, and absence of a policy for observing "at-risk" detainees may rise to deliberate indifference to known risk of suicide in detention settings).

Additionally, juvenile detainees have a constitutional right to be free from sexual assault and forced sexual contact by correctional staff. See, e.g., Spencer v. Doe, 139 F.3d 107, 112 (2d Cir. 1998) (noting that juvenile detainee had the right to be protected from sexual molestation under the Fourteenth Amendment); Ware v. Jackson County, 150 F.3d 873, 884-85 (8th Cir. 1998) (sexual assault of adult inmate may violate Eighth Amendment); Barney v. Pulsipher, 143 F.3d 1299, 1310 (10th Cir. 1998) (forced oral sex and sexual assault of adult prisoners are "sufficiently serious to constitute a violation under the Eighth Amendment"). Sexual assaults by staff, including rape, coerced sodomy, or touching of female prisoners' breasts and genitalia, are simply not part of the penalty that juvenile detainees pay for their offenses against society. See Farmer v. Brennan, at 834.

Confined youth have a constitutional right of freedom from unreasonable bodily restraints. Youngberg v. Romeo, at 320. The routine improper use of an isolation unit in a state facility can constitute cruel and unusual punishment. Morgan v. Sproat, 432 F. Supp 1130 (S.D. Miss. 1977). In Morgan, youth were placed on the highly restrictive unit for a variety of disciplinary offenses, including some as minor as "being disrespectful to staff members, stealing, and behaving inadequately...". Id. at 1129. The average length of confinement on the unit was 11 days. After considering extensive expert testimony in other cases, the court severely restricted the conditions under which the facility could place youth in such a unit:

The defendants will therefore be enjoined from using the isolation unit as an isolation unit, except under the following limited conditions which are necessary to insure that placement therein will not do any emotional or psychological harm to the students: students may not be placed in the isolation unit except where there is substantial evidence that they constitute an immediate threat to the physical well-being of themselves or others; confinement may not exceed 24 hours and must be approved within one hour of the confinement by the Superintendent, one of the Assistant Superintendents, the Chief Counselor or a staff psychologist; students in the isolation unit must be visited at least once every three hours during the day by the Chief Counselor, the students' own counselor or a licensed psychologist; the cells in the isolation unit must be provided with transparent windows, lights, mattresses, blankets, sheets, pillows, small tables for reading, chairs, soap and towels; unless a contrary program is indicated in an individual case by a licensed psychologist, students placed in the isolation unit must be permitted to sleep a reasonable time during the day, to have reading materials, to send and receive mail, and to have visitors; the students must receive daily at least an hour's physical exercise outside of the isolation unit or in the gym; and they must be allowed to eat their meals outside of their cells. Id. at 1140.

Finally, conditions of confinement claims may be based not only upon existing physical harm to youth, but also on conditions that threaten to cause future harm. Helling v. McKinney,

509 U.S. 25 (1993) (stating "it would be odd to deny relief to detainees who plainly proved an unsafe, life-threatening condition in their facility on the ground that nothing yet had happened to them."). In Helling, the court recognized various circuit courts holding that "a detainee need not wait until he is actually assaulted before obtaining relief" and that the Constitution "protects against sufficiently imminent dangers..." Id., at 33-35 (internal citations omitted). See also, Herman v. Holiday, 238 F.3d 660 (5th Cir. 2001) (recognizing Helling standard); Hoeing v. Collins, 95 F.3d 53 (5th Cir. 1996) (unpublished); Gates v. Collier, 501 F.2d 1291, 1308-10 (5th Cir. 1974) (holding that failure to provide adequate systems to protect inmates against future harm including physical assaults and abuse constituted cruel and unusual punishment).

III. FINDINGS

We find that Terrebonne fails to adequately protect youth in its care from harm and serious threat of harm by staff, other youth and from self-harm.

A. The Facility fails to adequately protect youth from harm by detention staff.

In 2009, direct care staff members (including two supervisors) were indicted or charged with a total of 21 counts of custodial sexual misconduct or related crimes involving female youth under their supervision. These crimes include molestation, indecent behavior, criminal malfeasance, and obstruction of justice. While the charged staff members have not yet been adjudicated in a criminal court,⁶ Parish and Facility officials have not disputed the substance of the charges, and have taken some corrective action to prevent a recurrence of the conduct alleged. The charged staff members have all been removed or have resigned from their posts. A summary of the most serious charges follow.

On June 24, 2009, a Louisiana grand jury returned an eight-count indictment against Supervisor 1⁷, a male Terrebonne correctional supervisor in charge of the night shift, alleging that Supervisor 1 engaged in unlawful lewd behavior and sexual conduct with four detained female youth, ages 15 or 16, between April 29, 2008 and April 28, 2009.

Three weeks later, on July 13, 2009, the grand jury returned a four-count indictment against Staff 1, a male Terrebonne correctional officer, alleging that Staff 1 engaged in unlawful lewd behavior and sexual conduct with two detained female youth, ages 15 and 16.

⁶ Four of the accused staff are scheduled for trial in February 2011, with the remaining staff trial dates to occur sometime afterwards.

⁷ Because individuals who have been charged but not yet adjudicated in a criminal court are presumed innocent, we are not using the names of the accused staff.

In addition to the grand jury indictments against Supervisor 1 and Staff 1, the Terrebonne Parish District Attorney brought charges directly (bypassing the grand jury system) against four additional Terrebonne staff related to custodial sexual misconduct at the Facility.⁸

* * *

Whether or not each of the charged staff are ultimately adjudicated guilty in a criminal court, we examined whether there are adequate systems and structures in place at Terrebonne to minimize the risk of future harm to youth. Helling, 509 U.S. at 33-35. We find, among other things, that youth are not adequately protected from harm by staff. Specifically, we find that staff are not adequately supervised; that use of force policies, procedures, and practices are inadequate; that there are inadequate numbers of direct care staff to ensure the safety of youth; that there are inadequate systems for reporting allegations of child abuse; and that the Facility fails to provide appropriate training on the prevention of custodial sexual misconduct. In each of these areas, we find that Terrebonne substantially departs from generally accepted professional standards in juvenile detention in a manner that endangers youth, and thus violates the youths' constitutional rights to reasonably safe conditions of confinement and freedom from unreasonable bodily restraint. Youngberg, 457 U.S. at 324.⁹

1. Staff Accountability

Since February 2009, a total of 15 incidents of staff misconduct were investigated at the facility level. The 15 incidents were all investigated and staff were held accountable for their failure to follow required procedures. Staff received letters from the Director that discussed the procedures violated and why they were important to the effort to protect youth from harm and suggested appropriate ways of handling the situation, should it arise again in the future.

While these examples represent efforts on the part of Facility administrators and supervisors to enforce some Facility procedures and hold staff accountable for their failures to follow certain Facility procedures, during the week of our visit, we became aware of several other instances in which staff routinely violate policy and procedure and yet were not held

⁸ These charges alleged, among other things, that Staff 2 engaged in unlawful custodial sexual misconduct with a female youth, age 14-15, over a ten month period ending in March 2009; and that Supervisor 2 engaged in unlawful custodial sexual misconduct with a female youth, age 15-16, over a six month period ending in March 2009. Both Staff 2 and Supervisor 2 are male.

⁹ Even applying the more lenient adult corrections deliberate indifference standard, we find that Parish officials disregarded known substantial risks of serious harm to youth at the Facility, and thus acted with deliberate indifference to those risks in violation of youths' constitutional rights. See Helling, 509 U.S. at 33-35. For example, at least as early as June 2009, officials were aware of serious criminal allegations regarding custodial sexual misconduct at the Facility, but had not taken necessary remedial steps to eliminate this known danger. Similarly, at least as early as October 2009, officials were aware of the high rate of suicidal behavior at the Facility, but had not taken necessary remedial steps to ameliorate this known risk.

accountable for their behavior. While certain supervisors may have been aware of the staffs' failures in these areas, no formal investigation or documentation regarding employee discipline was provided. As discussed throughout this letter, this lack of staff accountability has led to a blatant disregard for the performance of job functions essential to keeping youth reasonably safe in a juvenile detention facility. Youngberg, 457 U.S. at 324. See also, Gates, 501 F.2d at 1308-10 (holding failure to adequately supervise inmates unconstitutional). These situations included:

- Failing to make 15-minute confinement checks (violates Policy #17.2 "Minor Violations and Their Resolutions," "During room restriction staff contact will be made every 15 minutes"). Several examples were noted during our videotape verification of Room Confinement Check Sheets.
- Failing to notify the Facility's social worker of all youth placed on suicide precautions (violates Policy #8.5 "Mental Health Care Program," "Suicide watch... shall be on a continuous basis until evaluation can be performed by a clinician"). We discovered two situations in March 2010 where two youths were placed on suicide precautions and the social worker was not notified.
- Failing to stay on post on the 3rd shift or otherwise leaving a housing unit unsupervised (violates Policy #15.4 "Shift Assignments" "To ensure proper supervision... juvenile caseworker positions should be located in or immediately adjacent to juvenile living areas"). Several youth and staff reported to us that direct care staff members on the 3rd shift congregate in the common area during the youths' sleeping hours, leaving the housing units unattended. Further, an incident report from March 11, 2010 revealed that a staff member assigned to monitor a housing unit left the dorm, and one of the youth attempted suicide by strangulation. Staff members were alerted to the situation by one of the other youth housed on the unit.
- During interviews, several staff indicated a blatant disregard for policy. One second shift employee believed it was unnecessary to conduct routine room checks of youth during the night. Another staff admitted to sleeping during the night shift. One second shift supervisor indicated that when staff appear to be sleeping, the supervisor is merely "telling them to walk around in order to wake them up" without instituting any disciplinary action.

Each of these situations represents staff misconduct and failure to follow policy and procedure that could result in serious harm to youth (by youth, by staff, or self-inflicted). While the Director had taken action against staff members who violated the Use of Force policy and other types of misconduct, the other issues appeared not to have been addressed in any substantive manner. Each of the issues — 15-minute confinement checks, suicide precautions, and youth supervision — should be part of routine oversight by the Facility's supervisors. This does not appear to be occurring with either the regularity or the keen eye required to ascertain whether staff are following policy consistently.

2. Use of Force and Isolation

The duty to protect youth from harm includes efforts to prevent youth from harming each other (i.e., fighting) and also efforts to ensure that, when staff must intervene physically, they do so using means that do not unnecessarily subject youth to pain or injury. Youngberg, 457 U.S. at 324. Attaining either of these objectives requires a facility to have detailed policies and procedures guiding the use of force that are in line with contemporary standards.

In many cases, youth-on-youth violence and other out-of-control behavior can be prevented with proper behavior management techniques and sound verbal de-escalation skills. Failing this, staff has a duty to reduce the harm that can occur by intervening with tempered, well-timed, well-executed physical restraint. Conditions of confinement at the Facility are unconstitutional because youth are being harmed or are at risk of harm, Terrebonne's policies and procedures substantially depart from generally accepted standards of care, and actual practices suggest that staff do not regularly follow these inadequate policies. Youngberg, 457 U.S. at 324.

a. Policy and Training

The Facility's Policy #15.3 "Use of Force" emphasizes using non-physical means to control the situation and, failing that, using only the minimum amount of force necessary to gain control. While this is a solid beginning, the policy lacks several key elements.

Terrebonne's policy does not provide specific training requirements for the use of force, stating only that "staff will be trained in approved methods." Currently there are no approved methods, indicating that the policy itself is largely aspirational. All staff reported that they had never been trained on specific restraint techniques and were forced to rely on their own judgment or training received in other settings (e.g., military or adult correctional facilities). Not only does this make enforcing Terrebonne's policy difficult, as there are no sanctioned techniques and therefore no techniques that are specifically prohibited, it also leaves staff with very few tools for safely and effectively responding to youth's aggression or out-of-control behavior. As a result, youth have been injured and the risk to both youth and staff safety is significant.

Further, knowledge about the safe use of chemical agents (oleo capsicum or "OC") was minimal among staff. Some staff were able to recount only basic facts about the use of OC (e.g., to deploy the spray in very short bursts; how to hold the canister), while others could not recall any specific information from the OC training they received. In addition, none of the staff interviewed were well-versed in proper OC decontamination procedures.

b. Improper and Unnecessary Use of Physical Restraint

Conditions of confinement at Terrebonne are unconstitutional because staff members use force that is either unnecessary or poorly executed. Generally accepted professional standards in a juvenile detention facility require that only appropriate levels of force are used, and only when a youth's behavior poses an imminent risk of harm to himself or others, or only when necessary to restore essential institutional security. See Youngberg, 457 U.S. at 324; Hudson v. McMillian, 503 U.S. at 6-9 (1992); Gomez v. Chandler, 163 F.3d 921 (5th Cir. 1999). Examples of the inappropriate or unnecessary use of force at Terrebonne include the following:

- On March 5, 2010, a youth went into the bathroom on the housing unit without permission. The youth complied with the staff's directive to come out of the bathroom, but balked at the staff's insistence that he be placed in isolation for this minor rule violation. When staff responded to the call for assistance to transport the youth to the isolation unit, the youth then became aggressive, resulting in a physical restraint, a botched mechanical restraint (staff could not remove the handcuffs), the use of OC spray, and two staff injuries. Given that the youth complied with the initial directive to leave the bathroom and (at that point) posed no threat to other youth or staff, the entire restraint and ensuing injuries could have been avoided.
- On March 4, 2010, a youth reportedly cursed at staff and then went to his bunk. Staff reported that he "took him out of bed" to transport him to the isolation unit for this minor rule violation. Video footage of this incident showed a single male staff person lifting a youth (who was simply lying on his bed, not threatening staff or other youth) off his bed and struggling with him as he carried him off the housing unit. Neither the written incident report nor the video footage suggested any reason why this youth's behavior could not have been handled on the unit, without physical intervention. The restraint was both unnecessary and very poorly executed. The staff member involved received a verbal warning for his involvement in this incident.
- On March 7, 2010, a youth approached another youth in the housing unit and began to punch him in the head and body. Two staff members pulled the two youth apart from behind. One staff member pulled one of the youth to another area of the unit, but did not secure him in any way (e.g., using an escort technique or other method to control the youth's movement until he was calm). That youth broke away, ran across the dorm and jumped over a table, and began to assault the other youth again. The staff members' physical intervention was so poorly executed that it provided an opportunity for another assault to occur.

c. Unnecessary Use of Chemical Agents and Restraint Chair

In determining whether a physical intervention may be unconstitutional, it is "proper to evaluate the need for application of force, the relationship between that need and the amount of force used, the threat 'reasonably perceived by the responsible officials,' and 'any efforts made to temper the severity of a forceful response.'" Hudson v. McMillian, 503 U.S. 1, 6-9 (1992). Conditions of confinement at Terrebonne violate youths' constitutional rights because the use of severe interventions at the Facility, such as chemical agents and restraint devices, are often not needed, when no threatening behavior is apparent, and before reasonable efforts to temper the precipitating behavior have been attempted.

Terrebonne policy permits the use of both OC spray and the restraint chair only in extraordinary circumstances. After these items are deployed, generally accepted professional standards dictate that nursing staff must assess the youth to determine whether any injuries or complications arise as a result of their use. Nonetheless, we identified a number of examples where staff used these types of force on youth who were not particularly threatening, and sometimes even compliant, or where nursing staff were not consulted after their use, both

violations of youths' constitutional rights. Hudson v. McMillian, 503 U.S. 1; Youngberg, 457 U.S. at 324. Examples include:

- On March 14, 2010, a female youth was booked into the Facility. The youth indicated that she did not want to take a shower but was very calm during this refusal, walking slowly with her arms wrapped around her torso. Staff tried to persuade her for a couple minutes, and then wheeled the restraint chair over to her. The youth became very distressed as the staff forced her into the chair, crying and thrashing her head about as the staff strapped her in. She remained in the restraint chair for 20 minutes. Although the Director of the Facility initially stated that this was a "good example of the use of the restraint chair," when questioned during the viewing of the videotape, he agreed that the youth did not pose a threat to herself or anyone else at the time. The videotape clearly shows that the restraint chair caused distress and was completely unnecessary in the circumstance in which it was used.
- On September 1, 2009, a male youth is seen on videotape hitting his head on a table one time. Staff walked over to him and engaged the youth in a short discussion. The youth got up from the table and walked to the unit door, on his own and without any threatening gestures or body language. As the restraint chair was brought toward him (it is unclear in the documentation why staff felt the restraint chair was necessary), the youth's behavior escalated and he began to resist staff's efforts to put him in the chair. The chair itself was off camera, and the restraint chair documentation indicates only that the youth was still in the chair at the first 15-minute check. The exact time of release is not noted. This is another example of a fully compliant youth who was placed in a mechanical restraint device that caused the youth significant distress. If used at all, the restraint chair should be reserved only for out-of-control youth who pose an immediate danger to themselves or others.
- On January 9, 2010, an incident report describes a youth refusing to comply with a directive to proceed to the isolation unit. The youth was seated at a table at the time. Staff did not attempt physical restraint nor did staff call for assistance. Given the youth's history of threatening staff verbally, the staff "thought the safest way for everyone would be to pepper spray the youth." The first burst of spray hit the youth on the side of the face and the youth "retreated," only to be hit with a second burst of spray on the neck. After being sprayed twice, the youth then became assaultive toward staff. Not only was OC spray used as a "first" rather than a "last resort," but it was used on a youth who was merely non-compliant and not physically threatening or aggressive toward staff. This youth did not receive medical attention following the use of OC spray as "no medical personnel were present." Staff was given a written warning and additional training for this incident, although the failure to provide prompt medical attention was not addressed.
- On February 2, 2010, a youth who assaulted another youth and became physically assaultive toward staff was sprayed with OC spray. The Chemical Agent Form indicates "No medical attention was needed." Failure to provide medical attention after such exposure to OC is a blatant departure from generally accepted professional standards.

These examples illustrate that Terrebonne's policy and practices around these issues are inadequate in terms of their ability to assure that staff use these tools only when necessary, or that youth receive medical attention following their use. Rather than protecting youth from harm, staff may in fact cause harm with their uncontrolled, poor execution and lack of medical attention following the incident.

d. Use of Excessive or Unnecessary Isolation

Terrebonne violates youths' constitutional rights by subjecting them to harmful and unnecessary restraint in isolation rooms. In addition, the amount of youth isolation at Terrebonne is excessive and disproportionate to the underlying disciplinary offense committed by the youth. Isolation in juvenile facilities should only be used when the youth poses an imminent danger to staff or other youth, or when less severe interventions have failed.¹⁰ Morgan v. Sproat, 432 F. Supp. at 1132. Youth at Terrebonne are denied many of these basic protections.

Youth at the Facility are isolated at rates significantly higher than nationally reported field averages. Specifically, the number of room confinements and the average number of hours spent in isolation are approximately twice the Performance-based Standards ("PbS")¹¹ national field average ("NFA"), and the maximum time youth spend in confinement is approximately four times the PbS NFA.¹²

¹⁰ Examples of less severe interventions may include, among other things, a loss of certain privileges, a reduction in behavior management levels, or a restriction from participating in an optional activity.

¹¹ Performance-based Standards for Youth Correction and Detention Facilities is a self-improvement and accountability system used in 31 states and the District of Columbia to better the quality of life for youths in custody. PbS gives agencies the tools to collect data, analyze the results to design improvements, implement change, and measure effectiveness with subsequent data collections from within the facility and against other participating facilities. See <http://www.pbstandards.org>.

¹² We note that, while the PbS national field average is neither a representative nor a random sample, it is the best available database for external comparisons related to the occurrence of critical behaviors.

Table 1. Estimated TPJDC Rates of Specific Incidents for October 2009 as Compared with PbS Field Averages from the October 2009 National Data Collection period

Incident Category	Total Number	Terrebonne Rate	PbS National Field Average
Suicidal Behavior	9	0.627	0.119
Battery and Fighting	6	0.418	0.350
Pepper Spray	3	0.209	0.105
Isolations	76	5.299	2.84
Avg. Isolation Hours – Max.	3240	42.63	11.44
Avg. Isolation Hours – Med.	1620	21.32	11.44

While isolation in certain circumstances may clearly be warranted, use of isolation at the Facility is sometimes unnecessary. The following examples reflect the common practice at Terrebonne:

- On February 27, 2010, a female youth received an incident report for writing notes to male residents and for becoming rude and argumentative when presented with the infraction. According to the Facility records, she received 35 hours of isolation or room confinement for behaviors that could have been handled with a time out or some type of program restriction.
- On February 27, 2010, another youth received 31 hours of isolation for refusal to stop talking during sleeping hours in the boys' dorm. Again, this is an example where isolation is used although no lesser interventions had been attempted and no security threat was present.

Use of isolation for mere rule enforcement is unnecessary and inappropriate. In addition, the duration of such sanctions is far in excess of acceptable practice for such minor violations, and violates youths' constitutional rights.

3. Staffing

Some of the above described problems appear to have resulted from inadequate staffing. For example, this serious deficiency in staffing places youth at risk of harm because of staff fatigue, reduced accountability, overreliance on seclusion, and inadequate youth supervision. Terrebonne claims to maintain a 1:8 staffing ratio during waking hours.¹³ However, we found

¹³ Generally accepted professional standards in a juvenile detention center require a direct supervision ratio of a minimum of 1:8 during waking hours, and a minimum of 1:16 during sleeping hours. More staff-rich ratios may be required depending on the unique features and characteristics of the facility and youth.

that, typically, the direct supervision ratios are much lower and fall far below generally accepted professional standards. This deficiency contributes to violations of youths' constitutional rights to reasonably safe conditions of confinement. Youngberg, 457 U.S. at 324.

Terrebonne uses an unusual staff schedule. Four discreet teams of staff exist, and each team works a designated 12-hour shift on designated days, a 4-3 rotation with some built-in overtime. In other words, there are two different teams that cover the first shift (6:00 a.m. – 6:00 p.m.) and two different teams that cover the second shift (6:00 p.m. – 6:00 a.m.). Within each team, there is a shift supervisor and an assistant shift supervisor in addition to a standard rotation of post assignments, even though there are no official post designations. Staff rotate through various unofficial posts at three-hour intervals, which results in only one staff member assigned to the direct and continuous supervision of a living unit for a three-hour period of time while the additional staff perform other support duties in the "general vicinity." These "general vicinity" staff do not provide direct and continuous supervision but are available on short notice to supply back-up and support to the single staff member assigned to direct and continuous supervision. These "general vicinity" staff are counted into the staffing ratio by the Facility. This process represents a miscalculation of the ratio and a misrepresentation of the level of supervision.

4. Child Abuse Reporting

Generally accepted professional standards and Louisiana State Law require any caretaker who knows or suspects that an incident of alleged child abuse¹⁴ has occurred must immediately initiate or cause to be initiated a report to the local law enforcement or social services agency.¹⁵ This is so, whether or not the responsible individual believes the allegations to be credible. In other words, self-screening of abuse allegations undermines the important safeguard principles the standards are designed to maintain.

Because Terrebonne's Child Abuse Reporting policy provides the Director with latitude in determining the veracity of allegations prior to reporting to law enforcement and child welfare, youths' constitutional rights are violated. See Youngberg, 457 U.S. at 324. The policy states that the Director "shall promptly determine the facts surrounding the incident." In a small number of cases, this latitude has resulted in the Director's review and investigation of incidents of mistreatment alleged via the grievance system, when these allegations should also have been reported to law enforcement and child welfare. Failing to report allegations of abuse to an appropriate external agency is contrary to accepted professional standards (see PREA IN-2) and

¹⁴ Under Louisiana law, "child abuse" includes, among other things, "[t]he infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon a child... which seriously endanger the physical, mental, or emotional health and safety of a child...". La. Child. Code Ann. art. 603(1) (2010).

¹⁵ See La. Child. Code Ann. art. 610 (2010). In addition, proposed Prison Rape Elimination Commission Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities ("PREA") require that "investigations of abuse are prompt, thorough, objective and conducted by individuals who have specialized training in abuse involving young victims." PREA IN-2 (emphasis added).

is also a violation of State law. Allegations that were not reported to law enforcement are summarized below:

- On December 28, 2009, a youth alleged that staff “slung him across the dorm... slammed him into the wall... dragged him by his handcuffs and threw him into the door.” The Director conducted an administrative investigation concluding that the staff had not violated Facility policies.
- On March 8, 2010, a youth alleged that he witnessed one staff choking another youth and another staff dragging a third youth to the isolation unit. While the reporting youth withdrew his complaint, the Director continued to administratively investigate the incident, finding the allegations to be unsubstantiated.
- During our interviews, a youth told us about an incident that occurred the day before in which he was reportedly “choked” by staff during a restraint. The youth had visible scratches on his neck. When we brought this incident to the attention of the Director, he indicated that he was already aware of it and had sent the accused staff home pending the outcome of an administrative investigation.

The Facility Director should have reported each of these occurrences to the law enforcement and child welfare agencies so that they could make an independent determination about whether the facts in each case warranted an investigation. The three investigatory bodies serve different purposes: 1) law enforcement determines whether a criminal violation occurred; 2) child welfare determines whether abuse or neglect occurred according to child welfare standards; and 3) the Facility determines whether policies and procedures were violated. Each of these entities must be informed of all allegations of abuse to ensure that all three inquiries are pursued. The Facility Director should never screen out an allegation or otherwise determine that it should not be reported to law enforcement and child welfare, no matter the findings of the administrative investigation. This is because law enforcement and social services agencies have specialized training in investigations of this type, where many internal facility investigators do not. Failure to make the reports improperly removes the oversight of external agencies from their shared duty to protect youth from harm.

5. Training on Prevention of Sexual Misconduct

While training on certain subjects at Terrebonne is adequate, one serious omission is staff training regarding custodial sexual misconduct. In the year since the discovery of allegations of serious and pervasive sexual misconduct at the Facility, Terrebonne has failed to develop a curriculum and mandate that all staff receive training in the prevention of this insidious danger. Given the apparent history of problems at the Facility, this omission is a substantial departure from generally accepted professional standards and in violation of the law. Youngberg, 457 U.S. at 324.

B. The Facility fails to adequately protect youth from self harm.

In addition to failing to protect youth from harm by staff, Terrebonne fails to adequately protect youth from self harm, and therefore violates youths' constitutional rights. Youngberg,

457 U.S. 307; Silva, 32 F.3d 566. Generally, youth in juvenile justice systems are at increased risk of suicide, but available statistics for the Facility reveal that youth confined at Terrebonne may be even more prone to engage in self harming behavior. For example, in October 2009, the rate of suicidal behavior at the Facility was more than five times the National Field Average. See Table 1.

Shockingly, we found that room checks for youth being held in isolation were routinely missed, and that staff often falsified the documentation of required room checks. Because youth held in isolation are known to be at heightened risk of suicide, this practice subjects youth at the Facility to serious risk of harm in violation of youths' constitutional rights. Helling, 509 U.S. at 25; Silva, 32 F.3d at 566. See also, Lewis v. Parish of Terrebonne, 894 F.2d 142 (5th Cir. 1990) (stating "one need not find a 'goose case' to imbue a warden at a jail with a constitutional duty to protect a prisoner prone to suicide from self destruction."). Also, we identified significant deficiencies in each of the core components of an adequate suicide prevention program. Taken together, these deficiencies place youth at serious risk of future harm. In each of these areas, we find that Terrebonne substantially departs from generally accepted professional standards in juvenile detention, and thus violate the youths' constitutional right to reasonably safe conditions of confinement. See Youngberg, 457 U.S. at 324. Each of the core components and the Facility's deficiencies in each area are described below.

1. Supervision

We reviewed the incident reports and observation forms for 17 youth placed on suicide precautions between September 2009 and March 2010. The observation forms, called "Confinement Check Forms," nearly always indicate that staff checked the safety and welfare of youth at exact 15-minute intervals. Not only is this level of precision impossible to achieve, it is counter to the best interest of the youth. The generally accepted practice is for youth on close observation to be checked at random (unpredictable) intervals, not to exceed 15 minutes. Further, we attempted to verify the data presented on the observation forms using videotaped footage of the overnight shifts on the isolation unit. In February 2010, large proportions of safety and welfare checks were determined to have been fraudulently recorded (i.e., the staff indicated a check was conducted on the observation form, but the videotaped footage revealed they did not actually do so). The following examples are illustrative of this extremely dangerous failure:

- A male detainee received a 48-hour confinement from February 21 through February 22, 2010. On the evening of February 21, the time under review ran from 2215 hours through 0530 hours or 7 hours and 15 minutes. This equates to 30 room checks. The log contains 30 entries by the staff, including the staff member's initials and the numerical behavior identifier, indicating that 30 room checks were made. However, the video shows only 11 room checks were actually performed.
- On the following evening the same detainee was confined from 2200 hours through 05:30 hours or 7.5 hours. This equates to 31 room checks. The log shows 26 entries by the staff members, including the staff member's initials and the numerical behavior identifier, thereby acknowledging that five room checks were missed. But the video shows only 19 room checks. Additionally, the 48-hour confinement extended over a

Monday and Tuesday, but there is no documentation that the detainee received any schooling or recreation.

- A detainee received a 32-hour room confinement beginning on February 27, 2010. For the evening of February 27, the time under review was from 2200 hours to 0530 hours or 7.5 hours. This equates to 31 room checks. Thirty-one room checks were entered on the form, including the staff member's initials and the numerical behavior identifier; but the video shows that only eight were made.
- On the following evening the same detainee was under review from 2200 hours through 0545 hours or 7 hours and 45 minutes. This equates to 32 room checks. Thirty-two room checks appear on the log, including the staff member's initials and the numerical behavior identifier; but the video shows again that only eight room checks were made.
- A female detainee received a 35-hour room confinement beginning on February 27, 2010. On the evening of February 27, the time under review ran from 2200 hours through 0600 hours this equates to 33 room checks. Thirty-three room checks are indicated on the log, including the staff member's initials and the numerical behavior identifier; but the video shows that only four room checks were made.

This pattern of overnight supervision creates a severe risk of harm to youth in the facility. The dangerousness of this situation cannot be overemphasized. Anytime a youth is locked in a room alone, the risk of self-harm increases. The combination of a youth assessed at higher risk of self-harm, isolation, and staff negligence in performing safety checks is a serious risk to youth safety.¹⁶

Additionally, Terrebonne has a single level of suicide precautions — "close observation" where youth are to be monitored at 15 minute intervals. Youth who are actively suicidal, either threatening or engaging in suicidal behavior, are routinely transported to the local emergency room for an evaluation and possible admission to a psychiatric hospital. Both documentation and reports from staff indicated that these high-risk youth are indeed transferred to the hospital for evaluation. However, generally accepted professional standards require that, pending transfer, these youth should be placed under constant observation by a dedicated staff member with no other responsibilities at the time (i.e., one-on-one supervision). This does not occur at Terrebonne, in violation of youths' constitutional rights to reasonably safe conditions. Youngberg, 457 U.S. at 324. Instead, youth awaiting transfer are only monitored at the 15-minute intervals prescribed for youth at much lower-risk of self-harm. This is an extremely dangerous practice given the youth's demonstrated active suicidal behavior.

¹⁶ As indicated previously, Parish Counsel forwarded us a list of measures the Facility has purportedly taken to ensure that, among other things, room checks are being performed as required by policy. A number of these reported measures should assist the Facility in monitoring staff in performing these duties, including plans to purchase an electronic tour guard system, and the periodic verification of overnight room checks with Facility digital video reviews. While these proactive measures are commendable, we are not in a position to confirm the adequacy of implementation of this corrective action.

2. Training

Adequate suicide prevention training standards require initial training for new staff that includes the instruction in environmental risk factors for suicide, individually predisposing factors, high-risk periods for incarcerated youth, warning signs and symptoms, the facility's suicide prevention procedures, liability issues, and a discussion of recent suicide attempts at the facility. In addition, the program should include a two-hour annual refresher training with a review of risk factors, warning signs and symptoms, and policy changes. All staff should also be trained in the use of emergency equipment (e.g., the rescue tool).

In late 2009, the Facility developed a training curriculum for suicide prevention. The curriculum content appears adequate. However, rather than the prescribed eight-hour training, the training session was only five hours of actual instruction time. Of the 52 direct care staff at the Facility, documentation indicated that 83% participated in the training. Several staff reported that training in this area was not considered to be mandatory and that staff who did not attend were not held accountable. Make-up sessions for those staff who did not attend had not been scheduled, nor had provisions been made for teachers and other non-direct care staff to attend the training. While most of the staff believed the Facility owned a rescue tool, none of the staff knew where it was or had been trained in how to use it. These inadequacies in the training for direct care and other Facility staff (e.g., teachers) is particularly concerning because most of a youth's self-harm behavior will happen in their presence, rather than in the presence of mental health staff who may have greater expertise in this area.

3. Intake Screening

Terrebonne's intake screening questionnaire asks only if the youth currently feels like hurting himself or herself. This single question is inadequate to the task of identifying youth at elevated risk of self-harm and is not aligned with contemporary standards. The screening should also include questions about past suicidal behavior, prior mental health treatment, recent significant losses, family/friend's history of suicide, and whether the youth demonstrated any risk of suicide during his or her previous stays at the Facility. Further, at Terrebonne, intake staff sometimes waits for the Facility's social worker to become available so that she can perform the screening, which is contrary to the standard endorsing immediate screening upon admission. Finally, the intake screening should be conducted by an individual who is trained to ask these questions competently. We learned that the Facility had just recently begun training intake staff on appropriate youth screening.

4. Communication

The strength of a facility's suicide prevention program rests on the quality of communication between direct care staff and mental health staff (who must be engaged in treatment to mitigate the youth's risk of self-harm). Communication between the direct care staff and mental health staff at Terrebonne is fragmented, at best. While a list of youth on suicide precautions is created each day, it is not broadly distributed and some of the direct care staff interviewed indicated that they were often unaware of which youth were on precautions. Further, we learned that twice during March 2010, youth were placed on suicide precautions by direct care staff and the social worker was not notified. We were informed that the direct care

staffs' experience with the previous social worker, who was unresponsive to most staff requests, led them to rely on the direct care supervisors for most decisions regarding mental health. Reportedly, this has been a difficult cycle to interrupt. Finally, there is no mechanism for the mental health staff to communicate with direct care staff regarding the source of potentially suicidal youth's stress, the specific risks posed, or coping mechanisms or activities that may help to mitigate the youth's risk of harm. Given that youth spend most of their time with direct care staff at the Facility, effective communication is vital if there is to be a coherent strategy for supporting youth during a time of crisis. Overall, the mechanisms for communication between direct care and mental health care staff at the Facility do not conform to contemporary standards of care.

5. Assessment

A youth's risk of self-harm is not static — it will increase and decrease depending on a range of influences (e.g., contact with family, outcomes in court, environmental stressors, treatment by mental health care staff, interaction with peers and direct care staff, etc.). Accordingly, the youth's need for precautions needs to be assessed frequently so that the level of supervision can be adjusted as necessary. Rather than using a structured assessment process on a daily basis, the social worker did not have a set schedule for follow-up with youth on suicide precautions. This was confirmed in our review of the mental health care files of five youth who had been on suicide precautions in early 2010. While detailed progress notes were kept on all contacts with youth, these contacts were not at the frequency (i.e., daily) prescribed by contemporary standards.

In large part, the lack of a clear and consistent procedure for on-going assessment of suicide risk can be attributed to the fragmentation of the mental health service delivery system at the Facility. The Facility's lead social worker, another part-time social worker, a counselor, and a variety of community-based counselors all provide mental health care services to Terrebonne youth. While the number of available counselors is encouraging, the fact that they do not communicate regularly, share information on clients, or have access to each other's progress notes means that the service delivery system is disjointed and a strong potential exists for a youth's mental health needs to fall through the cracks.

6. Housing

In early January 2010, the Facility began to maintain youth on suicide precautions in the general population, reassigning their bunks to ensure the best camera angle possible. But, youth on suicide precautions at the Facility are sometimes placed in isolation on the Delta dorm, in the individual cells on the housing units, or in the cells adjacent to the medical unit. While these assignments may be convenient for the staff who are responsible for supervising the youth, isolating youth at risk of self-harm can increase their sense of alienation and detachment from programming, and thus may actually increase their risk of self-harm rather than reduce it. When legitimate security concerns permit, facilities should house youth on suicide precautions in the general population, where their access to programming is more certain and they are able to maximize their interactions with staff and peers, which is likely to reduce the risk of self-harm. Several staff explained that the decision to house youth at risk of self-harm in the isolation unit was because of the availability of video surveillance. While video surveillance can be a good

supplement to staff supervision (but should never replace it), the extent to which staff actually monitor the video feed is questionable whether the youth is in the dorm or an isolation cell. Several of the isolation rooms are literally covered in graffiti made with writing implements or etched into the paint with sharp objects. In addition to the obvious concern about youth's access to sharp objects, the time required to complete the graffiti suggests that staff may not be monitoring the youth's behavior in the isolation rooms with any regularity.

More regularly housing youth on suicide precautions in the general population will be difficult to execute properly given the Facility's current staffing pattern. A single staff person is often responsible for supervising up to 20 youth on a housing unit. Without an improved ratio of staff to youth, maintaining youth at risk of self-harm on the housing units is impractical, if not dangerous.

7. Lethality Reviews

Following a serious suicide attempt¹⁷ or a completed suicide, generally accepted professional standards require facilities to convene a multidisciplinary team to review the circumstances surrounding the incident to identify the conditions that gave rise to it. The discussion should include a review of the circumstances, facility procedures relevant to the incident, training issues, mental health services received by the youth, and recommendations for changes to Facility policy and procedure that could reduce the likelihood of a similar incident in the future. It is particularly concerning that, at Terrebonne, no such review process exists.

* * *

Overall, Terrebonne's suicide prevention practices are far outside of contemporary standards for adequately protecting youth from self-harm. The fragmentation between and among direct care and mental health care staff, the failure to maintain close supervision of youth with demonstrated risks of self-harm, the failure to conduct required room checks for youth at heightened risk of self-harm (i.e., isolated youth), and the lack of any process to review the circumstances surrounding incidents of self-harm, despite their recent uptick, creates a very dangerous situation for the Facility, its staff, and the youth in its care, in violation of youths' constitutional rights. Youngberg, 457 U.S. at 307; Silva, 32 F.3d at 566.

C. The Facility fails to provide an appropriate housing classification system.

There are significant occurrences of youth violence at Terrebonne. For example, the most recent comparative statistics indicate that youth-on-youth assaults are approximately 20% higher than the National Field Average. See Table 1. Terrebonne lacks certain fundamental safeguards to adequately protect youth from harm by other youth. This violates youths' constitution rights to reasonably safe conditions of confinement. Youngberg, 457 U.S. 307. See also, Farmer v. Brennan, 511 U.S. at 825. Specifically, one key strategy for protecting youth from harm is to identify those at highest risk of causing harm to other youth and supervising

¹⁷ We identified two incidents in February 2010 where youth engaged in serious suicide attempts and/or were considered to be at such heightened risk of suicide that protective hospitalization was required.

them intensively to mitigate this risk. Accurately identifying high-risk youth requires an objective process that is consistently implemented at admission. Once identified, high-risk youth must be supervised more closely and supported with other behavior management techniques to either limit their access to potential victims or to help them to develop the skills they need to control their aggression. Adequate standards of care require a structured classification process to guide housing and programming decisions. Terrebonne's lack of an adequate housing classification system substantially departs from generally accepted professional standards in juvenile detention, and thus violates the youths' constitutional right to reasonably safe conditions of confinement. Youngberg, 457 U.S. 307

Terrebonne's policy requires each youth to be "classified according to age, sex, delinquent orientation, level of risk and program needs" and that youth with special needs must receive "special consideration." However, the policy provides no procedures, tools or instruments toward this end. Once the youth is classified, the policy offers no guidance as to what a classification to a certain category would mean in terms of the youths' housing or supervision. Again, this policy appears to be aspirational but has no bearing on the actual practices at the Facility. The Facility Director and various supervisors indicated that they currently make efforts to place more aggressive male youth in a housing unit separate from less aggressive males, but these determinations were entirely subjective and based on either recollections from a youths' previous admissions or his behavior during the current incarceration. Bed assignments are made at the discretion of unit supervisors. Aside from grouping more aggressive youth together, no additional staffing or programming enhancements were in place to address the heightened risk.

While both the policy and the current effort to segregate more violent youth from less violent youth indicate the Facility is aware of the need for strategic housing decisions, the procedures for classifying youth are well outside contemporary standards of care. As noted above, the Facility's policy implies a structured classification process, but it is entirely subjective, unsupported by procedures and tools to assess youths' risk, silent on the process for making subsequent unit and bed assignments, and lacks enhancements to supervision and programming to mitigate the risks posed by highly aggressive youth. As a result, the classification process at the Facility is ineffective to the task of protecting youth from harm.

D. The Facility fails to adequately report incidents and collect key data.

The purpose of a facility incident reporting process is to have a full and complete record of what occurs in the facility so that administrators can identify the various conditions that create the opportunity for incidents to occur, can monitor staff responses, can identify training needs, and can develop prevention strategies that could make each type of incident less likely to occur in the future. The overall process for incident reporting at Terrebonne is far below generally accepted practices creating risks of undetected or unidentified harm, in violation of youths' constitutional rights. See Youngberg, 457 U.S. at 307; Helling, 509 U.S. at 25. An adequate incident reporting and data collection system should be implemented at Terrebonne to ensure that remedial measures are appropriately implemented and sustainable.

Terrebonne does not have a stand-alone incident reporting policy; rather, procedures for reporting incidents are embedded within a much broader policy. While the section of the policy

pertaining to incident reporting includes a comprehensive list of the types of incidents that must be reported, it provides no guidance on the required content of the reports or any procedures for administrative review.

If incident reports are to be useful in the effort of preventing institutional misconduct and protecting youth from harm, they must also provide a complete account of the event. Only when these details are known can the underlying causes of youths' misbehavior be addressed. Further, improving the quality of staff responses to misconduct requires an understanding of the precise way in which staff handled the incident. We reviewed approximately 150 incident reports generated at the Facility in early 2010. Key omissions across these reports include: 1) the number of youth and staff present at the time of the incident, and the location of individuals present; 2) activity that occurred just prior to the incident; 3) a thorough description of the incident; 4) specificity as to how staff responded and intervened; and 5) witness statements from all staff and youth present.

Perhaps as a result of these inadequacies in the content of the incident reports, aggregate data on the types of incidents occurring at the Facility are difficult to reconcile with the incident reports themselves. Incidents may be variously marked as "horseplay," "pushing," "battery," or "fighting" but the distinctions in the written narratives are unclear. Terrebonne's leadership discussed the difficulty experienced in responding to our document request because many of the incident reports were either mislabeled or did not clearly specify the type of incident that occurred.

E. The Facility fails to provide adequate quality assurance systems.

Terrebonne does not currently have any structured process for quality assurance. In fact, Facility leadership indicated that the assimilation of documents in preparation for our visit marked the first time that Facility staff had begun to look at the patterns that exist across the various documents needed to illustrate the Facility's practices. While individual incidents and situations are reviewed by the Facility's management team on a daily basis, the historical lack of oversight of the program, its various components and how they intersect and, at times, interfere with each other have contributed to an environment that does not adequately protect youth from harm from other youth, staff, or themselves. An adequate quality assurance program should be implemented at Terrebonne to ensure that remedial measures are appropriately implemented and sustainable.

* * *

The Parish should expeditiously implement the following remedial measures to correct the constitutional deprivations outlined above. The remedial measures below are consistent with generally accepted juvenile corrections standards.

IV. REMEDIAL MEASURES**A. Protection from Harm by Staff**

1. Adopt a zero-tolerance policy for abuse of youths by staff and other youths, including sexual abuse.
2. Review all incident reports at least three times per week to determine whether staff may be violating policies, procedures, and rules, and document the review.
3. Review all youth grievances at least three times per week to determine whether staff may be violating policies, procedures, and rules, and document the review.
4. Conduct routine and unpredictable audits of video recordings and surprise in-person visits to the Facility during the overnight shift and on weekends to determine whether staff may be violating policies, procedures and rules.
5. Promptly investigate any incident where staff are suspected of possible violations of policies, procedures, or rules.
6. Impose and document appropriate counseling, reprimands, training, or sanctions on staff found to have violated policies, procedures, or rules.
7. Develop and implement an age-appropriate use of force curriculum (including, among other things, de-escalation techniques and an appropriate continuum of interventions short of physical force).
8. Provide a minimum of eight hours of competency-based training for all staff on the approved use of force curriculum (including use of physical force, physical restraints, mechanical restraints, any fixed-restraints, and any chemical agents), provide new employee training, and provide two hours of annual refresher training.
9. Prohibit the use of fixed-restraints and chemical agents, except in extraordinary circumstances (e.g., when less severe interventions are unsuccessful or unavailable).
10. Adopt an adequate continuum of disciplinary sanctions, restricting the use of isolation to situations where a youth poses an imminent threat to themselves or others, or when less severe disciplinary measures have proven ineffective.
11. Prohibit the use of disciplinary isolation longer than 72 hours, except in extraordinary circumstances and with the express authorization of the Facility Director. Thorough documented justification shall be maintained for any use of isolation longer than 72 hours.

12. Ensure that direct care staffing ratios are maintained at a minimum of 1:8 during waking hours and 1:16 during sleeping hours, and that staff are in the same room as the youth, awake, and alert.
13. Ensure that all youth allegations or staff reports of child abuse are referred to the appropriate external agency immediately, and no later than the end of the employee's shift.
14. Provide a minimum of two hours of competency-based training for all staff on the identification and prevention of custodial sexual misconduct or other sexual misconduct, and provide new employee and annual refresher training.

B. Protection for Self-Harm

1. Provide a minimum of eight hours of competency-based suicide prevention training for all staff which includes: the environmental risk factors; individually predisposing factors; high-risk periods; warning signs and symptoms, the Facility's suicide prevention procedures; liability issues; a discussion of recent suicide attempts at the Facility; the use of a rescue tool. This should be part of new employee training, and there shall be four hours of annual refresher training. Staff shall be certified in CPR and first aid.
2. Revise the intake screening questionnaire to include, among other things, whether the youth feels like hurting himself or herself, any past suicidal behavior (in a facility or otherwise), any prior mental health care treatment, any recent significant losses, family or friends' history of suicide.
3. Require direct care staff to immediately notify mental health care staff any time a youth is placed on suicide precautions.
4. Notify all direct care staff on a daily basis of all youth on suicide watch precautions.
5. Provide a mechanism where mental health care staff provide critical information about youth on suicide precautions to direct care staff regarding known sources of stress to potentially suicidal youth, the specific risks posed, or coping mechanisms or activities that may help to mitigate the risk of harm.

6. Ensure that youth on suicide precautions are re-assessed at least three times per week by the mental health care staff to determine whether the level of supervision should be raised or lowered.
7. Ensure that all mental health care staff within the Facility have access to critical information for youth on suicide precaution (e.g., progress notes from all treating clinicians).
8. Prohibit the routine use of isolation rooms for youth on suicide precautions. Ensure that isolation rooms are only used when legitimate security concerns exist and are documented.
9. Ensure that youth who have been identified with a high risk of suicide (e.g., selected for transfer to a hospital) receive one-on-one supervision by a direct care staff with no other duties until the youth is transferred out of the Facility.
10. Ensure that the safety and welfare of all youth in isolation is verified by staff at unpredictable intervals not to exceed 15 minutes, and that each check is accurately documented.
11. Ensure that all serious suicide attempts are reviewed by a multidisciplinary team to review all relevant facts and circumstances surrounding the incident, and implement any appropriate remedial action.

C. Housing Classification

1. Adopt and implement an adequate objective housing classification instrument and system that determines a youths' risk of engaging in serious institutional misconduct (e.g., assaultive behavior). The scored factors should include, among other things, a youth's prior institutional misconduct. Administrative overrides of risk classification should not exceed 20%.
2. Ensure that youth are classified to an appropriate housing unit and bed within 24 hours of intake, and that high-risk youth are housed separately from low-risk youth.
3. Ensure that youth who commit serious institutional misconduct after their initial classification are reassessed within 72 hours.

D. Incident Reporting and Data Collection

Ensure that incident reports contain all material information including, at a minimum, a) the number of youth and staff present at the time of the incident, and the location of individuals present; b) activity that occurred just prior to the incident; c) a thorough description of the incident; d) specificity as to how staff

responded and intervened; and e) witness statements from all staff and youth present.

E. Quality Assurance

Develop and implement an effective quality assurance program to ensure that policies, procedures, and practices at the Facility are being followed, and whether policies require improvement or updating. The program should: a) create standards that reflect current facility policies; b) establish a process for auditing facility practices that includes document review, interviews with youth and staff, and observation of operational procedures and programs; c) draft a written report on the level of compliance with each quality assurance standard; and d) create corrective action plans to address the deficits noted by the quality assurance audits.

* * *

Please note that this letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post the letter on the Civil Rights Division's website until five calendar days from the date of this letter.

Thank you for your cooperation and assistance with this investigation. We hope that these recommendations will be received in the spirit of assisting in our mutual goal of ensuring the safety and security of youth in the Terrebonne Parish Juvenile Detention Center. We look forward to working with you to negotiate a resolution of the deficiencies described in this letter.

If you have any questions regarding this letter, please call Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section at (202) 514-6255.

Sincerely,

s/ Thomas E. Perez

Thomas E. Perez
Assistant Attorney General

cc: Courtney Alcock, Esquire
Counsel for Terrebonne Parish

Mr. Jason Hutchinson
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Terrebonne Parish Juvenile Detention Center

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November 19, 2009

The Honorable Andrew J. Spano
County Executive
938 Michaelian Office Building
148 Martine Avenue
White Plains, NY 10601

RE: CRIPA Investigation of the Westchester County Jail,
Valhalla, New York

Dear Mr. Spano:

We write to report the findings of the investigation of the Civil Rights Division and the United States Attorney's Office into conditions at the Westchester County Jail ("WCJ" or "the Jail"). On August 30, 2007, we notified you of our intent to conduct an investigation of WCJ pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of incarcerated persons.

On February 25-28, 2008, we conducted an on-site inspection at WCJ with expert consultants in corrections and custodial medical and mental health care. We interviewed Jail staff in administration, security, medical and mental health, facilities management, and training. We also interviewed inmates. Before, during, and after our visit, we reviewed an extensive number of videos and documents, including policies and procedures, orientation and staff training materials, and unit logs. We also reviewed numerous internally prepared Jail reports involving incidents, uses of force, investigations, and disciplinary matters. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to WCJ officials and legal counsel for Westchester County (the "County") at the close of our site visit.

We thank the staff at WCJ for their helpful and professional conduct throughout the course of the investigation. The County provided us with access to records and personnel, and responded to our requests, before, during, and after our on-site visit in a forthcoming manner. We also appreciate the County's

receptiveness to our consultants' on-site recommendations. Accordingly, we have every reason to believe that the County is committed to remedying all known deficiencies at WCJ.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. See 42 U.S.C. § 1997b. As described more fully below, we conclude that certain conditions at WCJ violate the constitutional rights of inmates. In particular, we find that inmates confined at WCJ are not adequately protected from harm, including physical harm from use of excessive by staff. In addition, we find that inmates do not receive adequate medical and mental health care.¹

As discussed in this letter, these conditions have resulted in serious harm to WCJ inmates. The number of serious incidents discussed herein indicates that WCJ is not adequately providing for the safety and well-being of the inmates.

I. BACKGROUND

The WCJ is located in Valhalla, New York, within Westchester County. The Jail comprises three divisions which house pre-trial detainees and sentenced inmates: the Jail Division,² the Penitentiary Division,³ and the Women's Unit.⁴ The Jail has an operating capacity of 1,693 beds, and employs approximately 900 uniformed and civilian employees. During our visit there were 1400 inmates detained at the Jail.

¹ This letter does not encompass any findings or conclusions with respect to whether WCJ has violated the provisions of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12131 et seq., and the Department of Justice's implementing regulation, 28 C.F.R. Part 35.

² The Jail Division houses pre-trial and sentenced inmates who have sentences of more than one year, but who are awaiting transfer to the New York State Department of Correctional Services ("NYSDCS").

³ The Penitentiary Division houses male inmates with sentences of less than one year.

⁴ The Women's Unit houses pre-trial and sentenced female inmates with sentences of less than one year, and female inmates who have been sentenced to prison terms exceeding one year but are awaiting transfer to the NYSDCS.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to seek injunctive relief to enforce the constitutional rights of inmates subject to a pattern or practice of unconstitutional conditions in jails and prisons. 42 U.S.C. § 1997a.

Prison administrators are constitutionally required “to take reasonable measures to guarantee the safety of inmates.” Hudson v. Palmer, 468 U.S. 517, 526 (1984). When a jurisdiction takes a person into custody and holds him against his will, the Supreme Court has held that the Constitution “imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.” County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (quoting DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)); see also Harris v. Westchester County Dept of Corr., No. 06 Civ. 2011 (RJS), 2008 WL 953616, at *6 (S.D.N.Y. Apr. 3, 2008).

A. Protection From Harm

The Eighth and Fourteenth Amendments protect inmates and pre-trial detainees from present, continuing, and future harm. See Hudson v. McMillian, 503 U.S. 1 (1992); Farmer v. Brennan, 511 U.S. 825, 832 (1994); see also United States v. Walsh, 194 F.3d 37, 48 (2d Cir. 1999) (“the right of pre-trial detainees to be free from excessive force amounting to punishment is protected by the Due Process Clause of the Fourteenth Amendment”) (citing Bell v. Wolfish, 441 U.S. 520, 535 (1979) (citations omitted)). While the constitutional rights of convicted prisoners and pre-trial inmates are guaranteed under different constitutional norms, courts have consistently held that pre-trial detainees “retain at least those constitutional rights . . . enjoyed by convicted prisoners [under the Eighth Amendment].” Bell, 441 U.S. 520 at 545; Benjamin v. Fraser, 343 F.3d 35, 50 (2d Cir. 2003) (“under the Due Process Clause, [pre-trial detainees] may not be punished in any manner – neither cruelly and unusually nor otherwise”); see also Cuoco v. Moritsugu, 222 F.3d 99, 106 (2d Cir. 2000) (noting that courts apply the “Eighth Amendment deliberate indifference test to pre-trial detainees bringing actions under the Due Process Clause of the Fourteenth Amendment”); Weyant v. Okst, 101 F.3d 845 (2d Cir. 1996).

The Eighth and Fourteenth Amendments forbid excessive physical force against inmates and pre-trial detainees. See Hudson, 503 U.S. 1; Farmer, 511 U.S. at 832; see also Walsh, 194 F.3d at 48; Brown v. Doe, 2 F.3d 1236, 1242 n.1 (2d Cir. 1993) (“After conviction, the Eighth Amendment ‘serves as the primary source of substantive protection . . . in cases . . . where the deliberate use of force is challenged as excessive and unjustified.’”) (citations omitted). Constitutional standards also apply even when the use of force does not result in significant injury.

See Walsh, 194 F.3d at 48. Allegations of excessive force are evaluated under two components: “(1) a subjective component which focuses on the defendant’s motive for his conduct; and (2) an objective component which focuses on the conduct’s effect.” Jeanty v. County of Orange, 379 F. Supp. 2d 533, 540 (S.D.N.Y. 2005) (citing Sims v. Artuz, 230 F.3d 14, 20 (2d Cir. 2000)).

Under the subjective component, courts examine whether the force applied was applied “maliciously and sadistically to cause harm” rather than “applied in a good-faith effort to maintain or restore discipline.” Jeanty, 379 F. Supp. 2d at 540 (quoting Hudson, 503 U.S. at 7, and citing Blyden v. Mancusi, 186 F.3d 252, 262-63 (2d Cir. 1999)) (internal quotation marks omitted). In determining whether excessive force was used, courts examine a variety of factors, including:

[T]he need for application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response.

Hudson, 503 U.S. at 7 (internal quotation marks and citation omitted); see also Jeanty, 379 F. Supp. 2d at 540 (citing Scott v. Coughlin, 344 F.3d 282, 291 (2d Cir. 2003)). Under the objective component, courts examine whether the force applied was “sufficiently serious by objective standards.” Id. (quoting Griffin v. Crippen, 193 F.3d 89, 91 (2d Cir. 1999)) (internal quotation marks omitted). Although the malicious and sadistic use of force by prison officials violate contemporary standards of decency, the Second Circuit has held that “not every push or shove . . . violates a prisoner’s constitutional rights.” Boddie v. Schnieder, 105 F.3d 857, 862 (2d Cir. 1997) (internal quotation marks omitted). However, “a showing of extreme injury is not required to bring an excessive force claim if the alleged conduct involved unnecessary and wanton infliction of pain.” Jeanty, 379 F. Supp. 2d at 540 (quoting Sims, 230 F.3d at 21-22 (quoting Hudson, 503 U.S. at 10)) (internal quotation marks omitted).

It is widely recognized that jail officials bear an affirmative duty to intercede on behalf of an inmate when the officer witnesses other officers using excessive force against the inmate. See Anderson v. Branen, 17 F.3d 552, 557 (2d Cir. 1994); Sims v. Griener, No. 00 Civ. 2524 (LAP), 2001 WL 1142189, at *5 (S.D.N.Y. Sept. 27, 2001); see also Allen v. City of New York, 480 F. Supp. 2d 689 (S.D.N.Y. 2007) (holding that a prisoner could proceed with claim that officers failed to intervene when a fellow officer subjected the inmate to excessive force). “The duty arises if the officer has a reasonable opportunity to intercede.” Jones v. Huff, 789 F. Supp. 526, 535 (N.D.N.Y. 1992) (citing O’Neill v. Krzeminski, 839 F.2d 9, 11-12 (2d Cir. 1988)).

The right to be protected from harm includes the right to be reasonably protected from constant threats of violence. See Farmer, 511 U.S. at 833. Prison officials have a duty to protect inmates from harm caused by other inmates and from excessive physical force by correctional staff. See id.; see also Ayers v. Coughlin, 780 F.2d 205, 209 (2d Cir. 1986). In determining whether conduct rises to the level of a constitutional violation, the Second Circuit requires that the “prison official have ‘knowledge that an inmate faces substantial risk of serious harm and disregard[ed] that risk by failing to take reasonable measures to abate the harm.’” Patrick v. Amicucci, No. 05 Civ. 5206 (GEL), 2007 WL 840124, at *5 (S.D.N.Y. Mar. 19, 2007) (quoting Hayes v. N.Y. City Dep’t of Corr., 84 F.3d 614, 620 (2d Cir. 1996)). The Second Circuit also requires that “an injured inmate . . . show not only that he was exposed to a substantial risk of serious harm but also that the defendant officials acted with deliberate indifference to his health or safety.” Patrick, 2007 WL 840124, at *3 (citing Farmer, 511 U.S. at 837). Liability arises where an official knew of and disregarded “an excessive risk to inmate health or safety [and is both] aware of facts from which the inference could be drawn that a substantial risk of harm exists, and he must also draw the inference.” Id. Prison officials have been found liable when “they are on notice of a substantial risk of serious harm to an inmate and fail to take reasonable steps to protect him [or her].” Id.; see also Hayes, 84 F.3d at 621 (reversing summary judgment on behalf of prison officials where genuine issues of material fact remained as to officials’ knowledge of the substantial risk of harm to inmate).

B. Medical Care

A prison official’s deliberate indifference to a prisoner’s serious medical needs violates the Eighth Amendment. See Estelle v. Gamble, 429 U.S. 97, 104 (1976); Hathaway v. Coughlin, 37 F.3d 63, 66 (2d Cir. 1994); Odom v. Kerns, No. 99 Civ. 10668 (KMK) (MHD), 2008 WL 2463890, at *6 (S.D.N.Y. June 18, 2008). Pre-trial detainees are protected against deliberate indifference to their serious medical needs under the Fourteenth Amendment. See Harris, 2008 WL 953616, at *6 (“Pretrial detainees’ claims concerning the alleged denial of adequate medical care also implicate the Due Process Clause The Second Circuit has found that an unconvicted detainee’s rights are at least as great as those of a convicted prisoner.”) (quoting Weyant v. Okst, 101 F.3d 845, 856 (2d Cir. 1996)). Thus, “the official custodian of a pretrial detainee may be found liable . . . if the official denied treatment needed to remedy a serious medical condition and did so because of his deliberate indifference to that need.” Id. (quoting Weyant, 101 F.3d at 856).

“Deliberate indifference” involves both an objective and a subjective component. The objective component is met if the deprivation is “sufficiently serious.” Farmer, 511 U.S. at 834. Prison officials may not refuse, unreasonably delay, or intentionally interfere with medical treatment for incarcerated

individuals. When an inmate complains about a delay in treatment, “it’s the particular risk of harm faced by a prisoner due to the challenged deprivation of care . . . that is relevant for Eighth Amendment purposes.” Smith v. Carpenter, 316 F.3d 178, 186 (2d Cir. 2003); see also Blaylock v. Borden, 547 F. Supp. 2d 305, 310-11 (S.D.N.Y. 2008).

Prison officials also may not provide an easier but less effective course of treatment nor may they offer only cursory medical care when the need for more serious treatment is obvious. See Estelle, 429 U.S. at 104-05. Failure to provide adequate medical care to address an inmate’s serious medical needs may constitute a constitutional violation. See Jones v. Westchester County Dep’t of Corr. Med. Dep’t, 557 F. Supp. 2d 408, 413-14 (S.D.N.Y. 2008).

A jail’s obligation to provide adequate medical care includes a duty to provide adequate mental health care. See Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989) (“We think it plain that from the legal standpoint psychiatric or mental health care is an integral part of medical care”); accord Atkins v. County of Orange, 372 F. Supp. 2d 377, 408 (S.D.N.Y. 2005) (“In the Second Circuit, it is equally clear that psychiatric or mental health care “is an integral part of medical care”) (citing Langley, 888 F.2d at 254), aff’d, 248 Fed. Appx. 232 (2d Cir. 2007). Where a jail’s “actual practice” towards treatment of mentally ill inmates is clearly inadequate, the facility may be held to be “on notice” at the time of an inmate’s incarceration that there is a substantial risk of deprivation of necessary care. Woodward v. Corr. Med. Servs. of Ill., Inc., 368 F.3d 917, 927 (7th Cir. 2004).

In addition, detainees have a right to be free of bodily restraints, such as shackles or a restraint chair, unless the facility demonstrates a legitimate penological or medical reason for the restraint. See, e.g., Washington v. Harper, 494 U.S. 210, 220-23, 236 (1990) (prison may forcibly administer anti-psychotic drugs if supported by legitimate penological or medical reasons, despite inmate’s liberty interest in avoiding forced medication); Doe v. Dyett, No. 84 Civ. 6251 (KMW), 1993 WL 378867, at *2-3 (S.D.N.Y. Sept. 24, 1993) (holding that forced administration of medicine to inmate “jeopardizing his own or the institution’s safety . . . does not amount to a due process violation”). Restraints imposed by correctional officers that are medically unjustifiable and have no adequate security rationale infringe on an inmate’s due process rights. See Smith v. Coughlin, 748 F.2d 783, 787 (2d Cir. 1984) (holding that restraints on inmates must be supported by “penological justification”).

III. FINDINGS

We found that WCJ has a pattern of failing to: (1) adequately protect inmates⁵ from harm and serious risk of harm from staff; and (2) provide inmates with adequate medical and mental health care. These deficiencies violate WCJ inmates' constitutional rights.

A. INADEQUATE PROTECTION FROM HARM

Although the violence present in any correctional setting necessarily permits an appropriate use of force, the Eighth Amendment forbids excessive physical force against prisoners. Hudson, 503 U.S. at 9. Corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement, including taking reasonable steps to protect inmates from physical abuse and use of excessive force. Farmer, 511 U.S. at 832-33. Providing humane conditions requires that a corrections system must satisfy inmates' basic needs, such as their need for safety. To ensure reasonably safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. Officials must also provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. As illustrated below, WCJ fails to provide constitutionally adequate protection from harm for its inmates.

1. Use of Excessive Force By WCJ Staff

We found evidence of a pattern and practice of use of excessive force by the Emergency Response Team ("ERT").⁶ Although an appropriate use of force in a correctional setting is permissible and often necessary to adequately ensure staff and inmate safety, the law forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson, 503 U.S. 1 at 7.

⁵ From here forward, both pre-trial detainees and convicted prisoners will be called "inmates."

⁶ The ERT is a team of correction officers and supervisors who respond to incidents such as inmate-on-inmate and inmate-on-staff assaults. Each ERT comprises several correctional officers protected in full riot gear and helmets, and falls under the command of the Emergency Services Unit ("ESU").

Generally accepted correctional practices provide that appropriate uses of force in a given circumstance should be proportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or employing passive escorts, should be used or considered prior to more serious and forceful interventions.

However, and as detailed below, our review of videotaped use of force incidents reflect a pattern and practice in which the ERT uses excessive force against inmates. In the videos we reviewed, ERT officers are seen shoving inmates aggressively into fixed objects when less injurious tactical holds could be safely employed. The officers are seen routinely applying needlessly painful escort techniques (bent wrist locks while apparently applying intense pressure). The officers are also seen routinely employing crowd control contaminants (MK-9 in a 16 ounce canister) when they are tactically contraindicated rather than utilizing an equally effective personal size canister (MK-4 in a three ounce canister).⁷ Also troubling is the fact that the ERT officers often seem to disregard some inmates' mental impairments in use of force incidents, which appears to greatly heighten the volatility of a given situation. Indeed, they utilize threatening and aggressive verbal strategies, which tend to escalate rather than de-escalate a potentially volatile situation.

In arriving at our findings, we reviewed hundreds of WCJ use of force incidents from 2006-2007, dozens of which were captured on videotape. This review revealed a failed administrative review process at WCJ and a pattern and practice of the ERT to engage in needlessly aggressive and injurious force against inmates. We are concerned both about the nature and severity of the force used by the ERT, and the paucity of the subsequent investigations, particularly where the evidence clearly indicates that supervisory review and/or investigations were warranted. The following are but some of the incidents that highlight these deficiencies.

- On January 11, 2007, AA, a 38-year-old female, refused orders to lock-in her cell.⁸ According to the sole ERT report written for this incident, ERT "attempted to take control of AA but she resisted. ERT then took control of her and placed her in restraints." The report indicates that AA was then escorted to a search area where she "became very combative," at which time [Oleoresin Capsicum] ("OC") spray was

⁷ During our tour of WCJ, we brought the problematic use of MK-9 canisters to the attention of WCJ management and understand that a memorandum directing the discontinuance of such tactic was issued.

⁸ To protect inmates' identities, we use fictitious initials throughout this letter.

administered.⁹ It appears that the report was reviewed by a sergeant directly involved in the incident. A video of this incident was recorded; we found no evidence that the video was ever reviewed by an independent supervisor.

In our review of the video of this incident, we found that not only did the report inaccurately characterize the force used against AA, but also that the force used was excessive. Our review of the video indicates that what the officer reported as “taking control” of AA was really the ERT officer driving AA’s head to a wall while other officers took her to the ground to apply handcuffs and leg restraints. We also observed that AA was escorted with a bent wrist tactic, which appeared to cause her substantial and unnecessary pain. Finally, we are concerned that AA was sprayed, at point blank range, in the face with OC spray from a MK-9 canister while she was lying prone and cuffed on the floor.¹⁰

- In another use of force report, also dated January 11, 2007, a WCJ officer described the incident as follows: “ERT entered the inmate receiving holding cell and attempted to restrain inmate [AB] who resisted ERT.”

Our review of the video of this incident showed that the ERT entered a holding cell where AB and several other inmates were housed, and ordered them to place their hands on the wall. The video shows that AB complied. The video then shows that an ERT officer ordered AB to his knees; while he was attempting to kneel, he was thrown into the wall, causing a wound to open over his eye. Inmate AB was then cuffed and escorted with a bent wrist technique to receive medical aid. We were troubled to see this use of excessive force used against a compliant inmate who did not appear to pose a threat to officers or himself. Indeed, the video does not suggest that the force used was justifiable or necessary to achieve a legitimate penological interest. This incident should have been reviewed and investigated by the Special Investigations Unit (“SIU”) to assess the appropriateness of the use of force used; we found no evidence that it was.¹¹

⁹ OC spray, commonly known as pepper spray, is a chemical agent that irritates the eyes and respiratory system of a target.

¹⁰ MK-9 canisters are often employed for crowd control situations, and pose a serious risk of unnecessary harm when used on a restrained individual at point blank range, as was done in this incident.

¹¹ The SIU is assigned the responsibility for investigating “any serious allegation regarding the inappropriate or unlawful use of physical force or deadly physical force by an employee.” See SOP II 07-02.

- During a February 14, 2008, strip search of AC, the ERT took him to the ground and sprayed him in the face with an MK-9 canister. The sole report filed for this incident alleged that AC “became combative,” and thus the MK-9 was used.

In our review of the video, it did not appear that AC was combative during the strip search. In fact, AC was compliant with the officers’ commands. We interviewed AC, and his recollection of the incident is consistent with our viewing of the video.

- On May 22, 2007, inmate AD was ordered to be placed on suicide watch from the booking area where he was housed. When AD refused orders to comply, the sole use of force report for this incident, written by an ERT sergeant, described the incident as follows: “necessary force was used and the inmate was placed in full restraints.”

Our review of the video of this incident shows the ERT rushing AD, knocking him against the wall and to the floor. We did not observe any indication that AD was combative. As a result, AD sustained a bloody nose and a lip laceration. We fail to see that this force was “necessary” as described in the report, especially in light of the fact that 8-10 officers responded to handle this incident. This incident should have been referred for investigation rather than addressed in a conclusory report that the force was necessary. We found no evidence that any supervisor conducted any form of review.

- Following a September 17, 2007, use of force incident with inmate AE, an ERT sergeant wrote a report in which he described AE as “violently resisting” the attempts of team members to cuff him necessitating a “one second burst of [OC] to halt his violent behavior.”

The video shows that AE was in a fully prone, face down position, and surrounded by the ERT when a MK-9 canister appears on camera and is discharged at point blank range in AE’s face. In an interview with AE, he claimed to have been struck with a closed fist while in the prone position. The tape also shows one of the ERT officers dragging AE along the floor by his handcuffs. Even a casual review of this video should have prompted some level of investigative inquiry because the video showed that unsafe and highly injurious tactics were used against AE by members of the ERT.

- On October 16, 2007, inmate AF was ordered to be placed on a suicide watch. The ERT sergeant who prepared the use of force report

conclusorily described AF as “combative” and in a “blind rage.” On the video tape, the sergeant repeatedly describes AF as “highly combative.” He claimed he used OC spray to “halt his rage.”

In our review of the 40-plus minute video of this incident we found the use of a chemical agent inappropriate, claims of resistance exaggerated, and ERT’s tactics unsafe and unprofessional. When the tape begins, AF, already restrained, is taken nude to a holding cell and placed in a painful escort position, at which time he cries out and is told to “shut up.” AF is then bent over causing him to have difficulty breathing; AF is visibly bleeding. AF is then taken to receive medical attention and thereafter escorted in a needlessly painful manner to the forensic unit where he is thrown on the bed of the cell. AF repeatedly asks for water and is again told to “shut up.” While lying face down in a prone position under the total control of ERT officers and lying still, he is told to stop resisting or chemical agents will be used. He is then thrown to the floor at which time the sergeant, utilizing a MK-9 canister, sprays AF with OC spray at point blank range.

Next, the ERT exits and secures the cell door. Inmate AF’s movements about the cell appear to be reactions to the OC spray. It is these reactions that the ERT sergeant describes as “extremely combative” behavior. The ERT re-enters the cell and places the subject in four-point restraints during which time officers apply their body weight in an unsafe manner on his legs and chest.¹² As nurses enter to treat AF, an officer can be heard to say “he ain’t getting nothing.” The following day a watch commander directed a memo to the warden recommending that the video of this incident be “. . . accessed and examined.” We found no evidence that such a review was ever conducted.

- On September 22, 2007, inmate AG, described as “nervous and paranoid” by WCJ staff, was strip searched although he “had to be constantly physically directed using soft hand techniques to complete the search.” After the strip search he was left unrestrained in the cell. According to the report, the ERT returned to move AG to booking for a suicide watch. He was ordered to “kneel down against the back wall of the cell in the compliance position.” He did not comply and OC spray was dispersed through the cuff port of the cell door.¹³ The door was

¹² Applying such weight on an individual poses significant risks of positional asphyxia. Positional asphyxia is known to restrict breathing, and in some cases, cause death.

¹³ A “cuff port” is a small opening on the front of a cell that has a secure flap through which a food tray may be passed or hands presented by a detainee for cuffing.

then opened and he immediately fell to the ground face down in a prone position and was once again restrained.

We conclude that WCJ unjustifiably used OC spray on AG. Inmate AG does not appear combative in the video, and appears disoriented. An officer on the video can be heard to say that AG has “trouble with commands.” Of particular concern, as the sergeant disperses the OC spray, a female voice can be heard to say “he’s got asthma.” A review of this video should have prompted an investigative inquiry on whether the use of OC spray was contraindicated both because of his mental state and the possibility that he had asthma.

- The reporting ERT captain in a June 18, 2007, use of force report summarized an incident with inmate AH as follows: “During the search, detainee was not complying with numerous orders. He refused to remove his clothing and he disobeyed orders to face the rear wall. He became combative and resistive. His actions necessitated him being restrained. Chemical agents were deployed in order to regain control and compliance.”

Our review of this incident is inconsistent with the captain’s report. First, AH, who has a history of psychiatric disorders, appears compliant with the series of specific orders he was given to remove his clothing. Second, as AH was ordered to remove his underwear, an officer immediately took him to the floor of the cell, where AH was sprayed with OC from a MK-9 canister. The video does not corroborate the ERT captain’s report that AH was combative. Of particular note, as AH is prone on the floor, the video shows that a sizeable pool of blood begins to grow from the open wound to his head he sustained during the use of force.¹⁴ Given the injuries AH sustained, and the questionable use of the MK-9, an investigation should have been conducted. We found no evidence that an investigation was conducted.

- On April 20, 2007, inmate AI refused to lock-in her cell, as ordered. The ERT responded. The reporting sergeant described the use of force incident as follows: AI “became combative and started kicking and cursing ERT” when they attempted to place her in restraints. Once in restraints she was escorted to the elevator at which time she “dropped to the floor and was non-responsive.” After exiting the elevator she

¹⁴ Notably, AH was unable to make his court-mandated appearance as he had to be taken to the hospital for treatment of the serious head wound.

was taken to a medical station where “she was evaluated medically and psychologically . . . During the evaluation inmate [AI] attempted to spit on staff. Because of her actions, a spit hood was placed on her.”

Our review of the 23-plus minute video of this incident reveals discrepancies between the sergeant’s report and the video. First, the video does not support the sergeant’s claim that AI was “combative” and “kicking” during the initial restraint. AI in fact is shown cooperating with officers but was asking to speak with a supervisor. As AI is placed on the elevator, she is thrust against the elevator walls with officers pressing against her as she cries out in pain, claiming officers hit her head. She drops to the floor and is suddenly quiet. As AI is removed from the elevator, she again asks to speak to a sergeant. As the officers pick her up and begin to escort her with a bent wrist hold she cries out in pain saying “you are hurting my wrist.” Once AI arrives at the medical station, officers place her hands in a painful position over the back of a chair. AI again cries out in pain, and requests that medical personnel examine her wrist. The video provides no evidence that medical personnel examined her wrists.¹⁵ This incident should have been thoroughly investigated, especially given the graphic evidence that can be seen throughout the course of the video. We found no evidence that a supervisor was called to the scene or that an investigation was conducted.

2. Inadequate Review of Use of Force Incidents

We found that WCJ inadequately reviews use of force incidents to prevent a pattern of use of excessive force against inmates. As a result, staff who subject inmates to excessive force are not adequately identified, nor are appropriate remedial measures taken.

Our review of numerous use of force incidents indicated that WCJ’s Use of Force Standard Operating Procedures (“SOP”) concerning administrative review of use of force incidents was not followed. In an interview with the SIU Commander during our site inspection, he advised that his unit did not initiate any use of force investigations in 2007, nor were any use of force incidents referred to his unit for the year. Furthermore, in the course of our tour of the facility, we were unable to identify a supervisory official independent of the ERT who is responsible for

¹⁵ The video shows that AI consistently requested medical attention for the pain in her wrist. After leaving the medical area, AI is escorted to booking and continues to cry out in pain. After she is turned over to the female officers for the strip search she becomes compliant but continues to cry of pain from her wrist. After the strip search, the ERT re-enters the room and re-cuffs her for the short distance to the suicide watch cell while she cries out in pain.

reviewing incident videos. Instead of SIU or other independent review, we found that first line supervisors of the ERT routinely signed off on use of force reports without comment. Of particular concern, we found that supervisors frequently review their own actions when involved in use of force incidents.¹⁶ Failure to review uses of force effectively provides Jail Staff with unfettered use of force. As a result, WCJ is unable to adequately protect its inmates from harm.

Indeed, in 2007, only two investigations of use of force incidents were completed by jail security administrators. Neither of these investigations were initiated by WCJ officials. One investigation was conducted only after an inmate, DU, filed suit against WCJ. The second resulted from a referral from the Westchester County District Attorney's Office regarding allegations of an inmate, DV, concerning excessive force. We found no evidence that WCJ officials initiated investigations prior to the referrals. Further, we were concerned about the adequacy of these two investigations. One of the two investigations appears to be simply a cursory review of the detainee's complaint. The second investigation failed to address or investigate a questionable use of crowd control contaminant.¹⁷

3. Inadequate Use of Force Documentation

Effective measures to prevent excessive and inappropriate uses of force start with the adequate reporting of information, which permits the identification of potential problem cases and effective internal investigations. We find that WCJ fails to adequately document uses of force in its written reports, and thus fails to adequately protect inmates from harm. In light of discrepancies between the video we reviewed and the written reports noted above, we are concerned with the inadequate documentation on other uses of force where no videos were present.

We begin by noting that WCJ fails to maintain an adequate use of force reporting mechanism. Notably, WCJ's Use of Force SOP V 01-09 (April 25, 2002) does not contain a generally applicable reporting requirement for correction officers who use force on inmates or witness correction officers' use of force on inmates. Similar to the deficiencies we observed in the video, we were unable to identify a supervisory official outside of the ERT who is responsible for reviewing incident reports. As noted above, the commander of the SIU told us during our tour that his unit did not conduct any use of force investigations for 2007. Compounding these deficiencies, while the SIU receives copies of all special reports, they are reviewed for informational purposes only. The SIU does not have any guidelines or criteria

¹⁶ See Westchester County Document Submission.

¹⁷ The litigation file revealed that these two use of force incidents were not investigated prior to the commencement of litigation.

for reviewing use of force incidents, and WCJ does not contain a standardized use of force reporting form.

Many WCJ officers simply fail to document uses of force, or do so inadequately. Our review of all use of force incidents for 2007 indicate that WCJ officers routinely file incomplete, vague, or conclusory reports. As noted above, our review also indicates that in some instances exaggerated reports are filed as well. The following reports are so inadequate that they do not allow a substantive review of the incidents by senior officials, and may fail to disclose critical information. For example:

- Only one of the two officers involved in a November 22, 2007 incident filed a use of force report. The only detail provided in the sole report was: “while inmate [DD] was being stripped he turned in an aggressive manner, myself and C. O. had to apply restraints, inmate continued to resist, after given numerous orders.”
- On November 11, 2007, the ERT responded and used force to subdue DE, but only one member of the ERT filed a report in which the ERT’s actions were described. The force used, however, was inadequately described as follows: “when the restraints were removed from [DE], he became combative with ERT. ERT quickly subdued [DE] and applied restraints.”
- Only one member of the ERT who responded to restrain DF filed a report in which the force used was described. Again, the report was inadequate. The December 12, 2007, incident was inadequately documented as follows: “inmate became violent and ERT use necessary force to place the inmate in full restraints.”
- On November 23, 2007, the ERT responded and used force against DG, but only one member of the ERT filed a report in which force was described. The correction officer inadequately described the incident, and force used, as follows: “ERT proceeded with the search and [DG] became assaultive and combative. ERT regained custody of [DG] and he continued to deal with my orders with indifference. [DG]’s head began to shake and he appeared to be in some sort of medical distress.”
- Even though the ERT responded and used force against DH on October 13, 2007, only one member of the ERT filed a report, in which force was described as follows: “There he was being removed from handcuffs, and became unruly. ERT used necessary force to regain control and place the inmate in handcuffs and leg irons.”

- On January 2, 2007, an ERT responded and used force against DI in order to have the inmate remove his clothing. Only one member of the ERT filed a report. The forcible disrobing of DI is inadequately summarized in the report as follows: "I gave him an order to remove all of his clothing. [DI] did not comply with that order. I then ordered ERT officers to remove the clothing, necessary force was used to obtain [sic] this task."

Finally, we were concerned with the video recording techniques used by WCJ staff. In many of the videos we viewed, the usefulness of the tapes was limited because WCJ staff failed to focus the lens and properly position the filming officer to allow an adequate recording of the incident. In some videos, it appeared that the filming officer permitted WCJ staff to physically obstruct the line of sight of the recording.¹⁸ Further, WCJ operates without a written policy on the retention of use of force videotapes.

4. Detainee Grievances

WCJ fails to maintain an adequate detainee grievance system, further contributing to the problems of monitoring and investigation of use of force incidents. An inmate grievance system is a fundamental element of a functional jail system, intended to provide a mechanism for allowing inmates to raise conditions of confinement related concerns and issues to the administration. If viewed as credible by inmates, it can also serve as a source of intelligence to staff regarding potential security breaches as well as staff excessive force or other misconduct. The grievance system should be readily accessible to all inmates. Inmates should be able to file their grievances in a secure and confidential manner and without threat of reprisals. Staff responsible for answering inmate grievances should do so in a responsive and prompt manner. We found a number of serious concerns with the grievance process at WCJ.

Despite the pattern of force described above, the Facility Grievance Coordinator reported that no grievances have been filed by WCJ detainees for 2006 and 2007. This clearly indicates that any grievance system is not functional, thus depriving WCJ of a valuable source of information concerning use of force incidents.

¹⁸ The late Judge Charles L. Brieant, Jr., who presided over the criminal proceedings against former WCJ Corrections Officer Paul Cote, observed similar problems with the ERT videotapes, noting: "when the real action occurs, for some reason or another, the lens is either pointed at the floor or the ceiling." Transcript of Proceedings, dated April 20, 2006, United States v. Cote, No. 06 Cr. 121 (CLB) at 17.

At least a partial explanation for the lack of grievances alleging excessive force is the requirement that a detainee is provided a grievance form “only after exhausting the informal complaint process.” (See SOP V 02-07, Inmate Grievance Program). Requiring a detainee to pursue the matter informally compromises the review and investigative processes, especially in those instances in which unlawful actions may have occurred. Detainees who may have been subjected to unlawful force will at best be reluctant to seek resolution from those who may have witnessed or been involved in the very actions that would form the basis for the grievance.

5. Employee Disciplinary Sanctions for Use of Force Violations

WCJ fails to adequately discipline officers for using excessive force against inmates. To ensure reasonably safe conditions for inmates, correctional facilities must develop and maintain adequate systems to investigate staff misconduct, including alleged physical abuse by staff. Generally accepted correctional practices require clear and comprehensive policies and practices governing the investigation of staff use of force and misconduct. Adequate policies and practices include, at a minimum, screening of all Use of Force and Incident Reports, specific criteria for initiating investigations based upon the report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file. The investigation must also be and appear to be unbiased.

In our investigation, we found that WCJ fails to initiate disciplinary measures to correct officers who use excessive force. This may be due to lack of oversight and adequate reporting, or also because of deficiencies within WCJ policies. While WCJ officers are subject to a Code of Conduct (SOP II 20-02), the Code has not been revised since 1998. The Code does not contain provisions that prohibit physical abuse of inmates, and does not define excessive or unnecessary force. While the policy prohibits force to be used as punishment, the Code fails to provide proper guidance regarding employee sanctions when excessive force is used.

6. Inmate Classification

Although WCJ utilizes a charge-based classification scheme, *i.e.*, custody categories determined largely based on the detainee’s criminal charge, a review of the December 27, 2007 Housing Roster indicates that detainees of as many as three different housing categories are routinely co-mingled. For instance, 2-NE in the

New Jail houses inmates of three separate custody categories (AA, A, & B).¹⁹ Various levels of co-mingling of detainees by custody categories can be seen throughout the facility.

Generally accepted professional standards require that jails adequately classify and segregate inmates based on legitimate penological needs. The primary purpose of an inmate classification scheme is to provide separate housing for detainees based on differing levels of needs and security risks. The routine and indiscriminate mixing of custody categories is often associated with high levels of inmate-on-inmate violence; such high levels most often occur within institutional settings and crowded multiple occupancy housing (double/triple celling and predominance of dorm housing). WCJ operates below capacity with single celling and a 1:1.8 officer/inmate ratio. A review of all incident reports for 2007 and other data on inmate safety indicates that WCJ does not have high levels of inmate-on-inmate violence. However, these same incident reports do provide examples of serious assaults between and among detainees of different custody categories. While WCJ officials do routinely move to separate such offenders by housing and "keep separate" designations, WCJ officials should seriously consider implementing a more objective classification scheme that anticipates an increase in population, when single celling the entire population is no longer possible. Any abnormal rise in inmate-on-inmate violence involving predatory conduct by high custody offenders against low custody offenders, regardless of the current favorable conditions (a single celled population under capacity), will require a more objective scheme that provides for housing separation based on security risks.

7. Inmates in Protective Custody

WCJ provides separate housing for inmates requiring protective custody. These inmates are confined in a virtual lockdown setting (in-cell for over 22 hours a day). While these inmates may require separation from general population inmates, access to programs and services for such a population is still required. Unless their custody level dictates otherwise, such detainees should be permitted more than one hour out-of-cell per day; the current management of these Protective Custody detainees constitutes, for all practical purposes, punitive segregation housing.

¹⁹ WCJ uses five custody categories to classify its inmates. AAA is the highest level security classification. AA and A follow. Generally, AA and A classifications are assigned to inmates charged with crimes against persons. B is next highest. Generally, B is assigned to inmates charged with crimes against property. C is the lowest security level classification.

B. MEDICAL CARE DEFICIENCIES

Jail officials are responsible for providing adequate medical care to inmates. Moreover, a jail may not deny or intentionally interfere with medical treatment. A delay in providing medical treatment may be so significant that it amounts to a denial of treatment. Our investigation revealed that there are certain aspects of the medical care and treatment offered at WCJ to be commended, for example, the Jail's affiliation with the Westchester Medical Center,²⁰ use of Telemedicine and Digital Radiography,²¹ and Methadone treatment program. However, there are some areas where the medical care provided at WCJ falls below the constitutionally required standards of care. Specifically, we found the following deficiencies: inadequate infection control; inadequate access to dental care; and an inadequate medical grievance process.²²

1. Infection Control

WCJ fails to adequately treat, contain, and manage infectious disease. This failure is dangerous and places inmates, staff, and the community at unnecessary risk of serious health problems. The WCJ's management of *Methicillin resistant Staphylococcus aureus* ("MRSA")²³ deviates from generally accepted correctional

²⁰ As a result of this relationship, WCJ inmates have ready access to clinical specialists, providers, and nurses. The relationship also provides additional clinical services and academic resources to the health services in the jail.

²¹ Telemedicine and Digital Radiography is a technology where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations. These technologies can improve the quality of care and access to specialty services beyond the scope of what the Jail may be able to provide.

²² While at the facility we observed a newly admitted inmate being interviewed in an open area within sight and sound of other inmates and correctional staff. While this appeared to be an isolated incident, all attempts should be made to safely conduct health examinations with sight and sound privacy.

²³ MRSA is a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death. A MRSA infection is sometimes confused by detainees and medical staff as a spider or insect bite, causing treatment to be delayed while the infection has time to worsen or spread. See <http://www.aafp.org/fpr/20041100/10.html>. (Last visited May 21, 2009.) MRSA is resistant to common antibiotics, such as methicillin, oxacillin, penicillin, and amoxicillin. MRSA is almost always spread by direct physical contact. However,

medical standards. Inmates with infectious diseases at WCJ are not appropriately contained, treated, or managed. Indeed, MRSA infections typically occur more often in an environment of congregated living such as WCJ. It is important for medical staff to be aware of MRSA infections because MRSA is contagious and can lead to serious medical complications, including death. Improper treatment may prolong the condition and the period of contagion.

At the time of our on-site investigation, WCJ had reported no MRSA infections at its facility for several months. Given the propensity for MRSA to flourish in an environment such as WCJ, the lack of recorded cases is unsettling. Indeed, we identified several likely cases through inmate interviews and examination of inmate medical records. For example:

- Inmate MA was initially evaluated on August 28, 2007 for a “spider bite” infection that continued to worsen. AB was also examined on August 30th, September 5th, September 11th, and September 17th. He was prescribed Keflex,²⁴ but the condition developed into a localized cellulitis.²⁵ The chart does not indicate that MRSA was considered, and no cultures were performed.
- Inmate MB was initially evaluated on August 15, 2007 for a “spider bite” under his arm. He was seen again on September 11th, at which time he was prescribed Keflex. MB was subsequently seen on multiple occasions regarding the same “spider bite” on September 22nd, September 28th, October 23rd, and December 19th, without resolution. The chart does not indicate that MRSA was considered, and no cultures were performed.

spread may also occur through indirect contact by touching objects such as towels, sheets, wound dressings, and clothes. MRSA can be difficult to treat and can progress to life-threatening blood or bone infections. See MedicineNet.com, http://www.medicinenet.com/staph_infection/page2.htm. (last visited May 21, 2009.)

²⁴ Keflex is a cephalosporin antibiotic. It is commonly used to “treat infections caused by bacteria, including upper respiratory infections, ear infections, skin infections, and urinary tract infections.” See <http://www.drugs.com/keflex.html> (last visited May 21, 2009.)

²⁵ Cellulitis is a skin infection caused by bacteria that gets into the skin and spreads to deeper tissues. See MedicineNet.com, <http://www.medicinenet.com/cellulitis/article.htm>. (last visited May 21, 2009.)

- Inmate MC was evaluated for a “boil” under his arm on August 27, 2007, accompanied by a fever of 101 degrees Fahrenheit and cellulitis. He was prescribed Dicloxacillin.²⁶ The condition continued, and MC was seen again on September 2nd, 3rd, 4th, and 11th. He required an incision and drainage by a general surgeon, and the condition was finally resolved on September 27, 2007. MC developed another lesion on January 11, 2008, and was prescribed Keflex. The chart does not indicate that MRSA was considered, and no cultures were performed.
- Inmate MD was initially evaluated for a possible “insect bite” on October 21, 2007, and prescribed Keflex. By October 23rd, the condition had worsened to a localized cellulitis. On November 15th, MD was also treated for facial lesions. MD’s medication was switched from Keflex to Dicloxacillin; however, on November 19th, he was given more Keflex. The chart does not indicate that MRSA was considered, and no cultures were performed.
- Inmate ME was seen for a skin infection on November 20, 2007. He was prescribed a combination of sulfamethoxazole and trimethoprim (antibiotics commonly used to treat bacterial infections),²⁷ and the infection resolved without additional intervention. The rapid response of the infection to Bactrim, a non-penicillin antibiotic to which most MRSA is sensitive, suggests that this infection was MRSA.

The cases described above were likely MRSA infections, but a definitive diagnosis of MRSA cannot be made if cultures of a wound are not performed. However, if the condition fails to adequately respond to penicillin-derivative antibiotics (e.g., Keflex or Dicloxacillin) and appears clinically to be a typical MRSA infection (e.g., a “spider bite” or cellulitis), MRSA can be suspected. The above cases illustrate that the lack of reported MRSA cases at WCJ is likely due to the failure of WCJ staff to adequately identify the condition, rather than an absence of the infection among the prison population. WCJ’s medical staff’s failure to identify the commonly known signs associated with MRSA, and, at a minimum, to conduct a culture of the infection when topical treatments proved futile, demonstrates a

²⁶ Dicloxacillin is a penicillin antibiotic. It is commonly used to treat many infections caused by bacteria, including bronchitis, pneumonia, or staphylococcal infections. See <http://www.drugs.com/mtm/dicloxacillin.html> (last visited May 21, 2009.)

²⁷ See http://www.medicinenet.com/sulfamethoxazole_with_trimethoprim-oral/article.htm (last visited Jun. 4, 2009.)

failure of the medical staff to provide adequate medical care. There is little evidence in the health records of these inmates that WCJ medical staff considered MRSA as an etiology for these infections. Without surveillance of MRSA by culture or clinical suspicion, the facility is unable to monitor the effectiveness of prevention and control measures.

In failing to adequately treat, contain, and manage MRSA, WCJ has placed its inmates and staff and the community at unnecessary risk of serious health problems. Indeed, in May 2008, just four months after our on-site investigation, a MRSA outbreak was reported at WCJ, affecting two inmates and two correctional officers.²⁸

2. Dental Care

Dental care is an important component of overall inmate health care. Poor oral health has been linked to numerous systemic diseases. Generally accepted correctional standards require that prisons provide surface restorations, prophylaxis, and preventative care. Contrary to these standards, dental care at WCJ is not timely and does not include immediate access for painful or urgent conditions. Moreover, there is little documentation to indicate that WCJ inmates receive preventive care following one year in custody.

The wait time for inmates to receive dental services at WCJ is unacceptably long, especially for inmates complaining of pain. In the majority of records reviewed by our consultant, inmates requesting dental care were not seen by a dentist for four to six weeks. Among those complaining of pain, approximately one-half received a short course of pain medication while waiting for a dental appointment. Moreover, in the instances when an inmate actually saw a dentist, dental treatment was deferred to outside care. In several of the medical records reviewed, the term "follow-up outside" routinely appeared, despite chronic pain expressed by the inmate. In one extreme case, the dentist documented the patient's complaint as "I am suffering from serious pain and discomfort in my mouth because of the brackets and braces," and responded by writing "follow-up outside." This response is unacceptable. In the case of this inmate, he was still in custody six months after seeing the dentist. The inmate submitted a request to see the dentist, stating that he was experiencing "serious pain in [his] mouth." At that time the dentist indicated in the inmate's chart that the patient would be scheduled for treatment, but four months later, this still had not occurred.

²⁸ See Glenn Blain, Superbug Reported at Westchester Jail, The Journal News, May 24, 2008, at 13A.

3. Medical Grievance Process

Although WCJ has instituted a policy for submitting grievances, it is not consistently implemented or effectively publicized. According to the Grievance Mechanism, CHS-A-11, inmate complaints must be written on an inmate Grievance Form and submitted to WCJ staff. During our on-site visit, however, many of the corrections officers in WCJ's housing units did not have Grievance Forms available for inmates if requested. Further, when inmates and jail staff were asked where an inmate could get a form to file a grievance, both the inmates and jail staff provided inconsistent responses.

Because inmates have no alternative options for health care other than the services provided them at WCJ, it is important for inmates to have access to a medical grievance process. If an inmate perceives that his or her serious health needs are being unmet, the grievance process provides a mechanism to investigate the legitimacy of that concern. In order to be effective, however, a grievance policy must be made clear to prison staff and inmates. As noted above, WCJ staff and inmates are not aware of the procedures for filing a grievance, and inmates are unable to obtain grievance forms on their housing units. Without consistent access to grievance forms for inmates, the medical grievance process cannot operate as required.

C. INADEQUATE MENTAL HEALTH CARE

WCJ fails to provide inmates with adequate mental health care that complies with constitutional standards. While WCJ employs the services of a mental health director to oversee the mental health services provided at the facility and operates a certified forensic unit, deficiencies remain. In particular, deficiencies were found in the areas of forced medication and the treatment provided juvenile inmates.

1. Use of Force to Involuntarily Administer Medications

ERTs are routinely employed to restrain an inmate who refuses to voluntarily submit to medication prescribed by a WCJ physician. As noted above, each ERT is comprised of several correctional officers protected in full riot gear and helmets. See Section III.A.1, supra. In at least 33 incidents in 2007, ERTs were employed to physically restrain the inmates while a nurse administered the medication involuntarily. In several of these incidents, physical force was used, including the use of chemical agents. According to our consultant, the use of force and the application of mechanical restraints to administer involuntary medication is inappropriate and can be interpreted as forcing medication by intimidation. Our

consultant reviewed videos of eleven inmates who were extracted by ESU for involuntary administration of medication, some of whom were forcibly medicated on multiple occasions. For example:

- Forced medication was ordered for inmate PA. An ERT was summoned to PA's cell at the request of medical staff and asked PA to come forward to receive his injection. PA refused while lying on his bed reading papers. The ERT again ordered PA to come forward, informing him that they were authorized to use chemical agents if necessary. Again, PA did not comply, and continued to lie down and read. The ERT then rushed into PA's cell, restrained him while he was lying in his bed, and – even though PA had not been threatening, violent, or out of control – discharged pepper spray into his face. After the ERT had left, PA began to feel the effects of the chemical agent. The ERT then re-entered PA's cell and escorted him to a shower room for decontamination. Following a shower, PA was moved into a medication room, where he was stripped naked and injected by the nurse while under continuous restraint. The medical record contains no documentation of the circumstances preceding or following the incident, and no medical assessment was conducted following the application of force.
- Forced administration of medicine was ordered for inmate PB, who was reportedly acting erratically and aggressively toward staff. Summoned to assist in administering the medication, the ERT physically restrained PB on the ground, placing him in a "hog-tie" position. The ERT then lifted PB and moved him into a treatment room. Once in the room, PB was pushed against the wall, causing him to scrape his face. As the ERT officers tried to hoist and position him, PB slid passively toward the floor and hit his knee, which began to bleed. During the incident, PB cried out, "this hurts," and "I can't breathe," and moaned as he was tossed around by the team. Eventually, PB was escorted to an area for nurses to tend to his bleeding. The ERT officers reported that PB "gave himself some scrapes and scratches" and that he "scraped his knee when he assaulted the officer." However, the video indicates otherwise. PB appeared cooperative as the medical team provided care. Naked, shackled, and handcuffed, PB was then escorted aggressively down the hall, once again shouting that he was in pain. The manner in which PB was escorted appeared in the video to be very abrupt, rough, and painful. The medical record contains no details of the events surrounding this use of force.

- Inmate PC was placed into the Forensic Unit following admission to WCJ and assessed as having psychosis with possible risk to harm himself or others. The ERT was called by medical staff to assist with PC's forced medication order on two different days, and the use of OC spray was authorized by the psychiatrist on both occasions. On the first day, PC was resting on his bed in no distress when the ERT approached his door and asked him to lie face down and put his hands behind his head. After PC complied, the team rushed into his room and roughly stretched his arms and legs into a hog-tied position. The nurse administered the injection and departed. The team slowly released PC, and although he shouted in some pain, they left the room. The medical record did not comment on this event. The next day, the team was again asked to assist with administering medication. PC, who was sitting calmly on his bed, laid down as requested by ERT and put his hands behind his head. When the team entered the room, PC began to move, and the team aggressively wrestled him to the floor, where he was put into the hog-tie position and pulled across the floor by his legs. As PC was being pulled across the floor, his shirt pulled up and his bare abdomen scraped across the floor. PC was then hoisted by his legs and arms behind his back on the bed, and his legs and arms were tightly compressed so he could not move. The nurse then entered the room to administer injections to his buttocks. Although PC occasionally screamed of pain, and at one point uttered, "I can't breathe," the nurse did not react, and did not evaluate or discuss the tight position of the restraints by the ERT. The medical record does not include an assessment before or after the use of force.
- Inmate PD was in the Forensic Unit refusing to answer questions or cooperate with medical examinations. Almost two weeks after being in WCJ, the medical team authorized the use of force by the ERT so that PD would have a chest X-ray in order to screen for tuberculosis. A single note, written after the X-ray was taken, explained that an attempt was made to persuade PD to have the chest X-ray, but that he calmly declined. No prior notes documented any attempt to screen the patient for tuberculosis. The ERT ordered PD to lie face down on the bed, and he complied. PD was put into full mechanical restraints, shuffled down the hallway to the X-ray room, and underwent an X-ray.

The use of force and application of mechanical restraints in the above incidents were excessive and disproportionate to the threats presented. If therapeutic intervention was the reason for ordering that these inmates be involuntarily medicated, the manner of delivery was the antithesis of therapy and caused harm. Even in incidents where the ERT does not use force to restrain the

inmate, the process can still be interpreted as forcing medication by intimidation. There are more appropriate and less violent methods to administer involuntary medication to patients who need intervention, such as providing intensive counseling to inmates concerning the need for such medication. There is little evidence in the medical records that WCJ staff attempted such counseling prior to calling in ERT.

Moreover, the number of incidents where ERT is employed to assist with involuntary medications is high. The actual use of force, including the use of chemical agents, is aggressive and not therapeutic. Based on the videotapes reviewed by our consultant, none of the inmates discussed above presented an immediate or serious risk to themselves or others. In the case of PA, for example, there was no display of aggressive or threatening behavior by the inmate to justify the deployment of pepper spray. Similarly, in the case of PB, there was no display of aggressive or threatening behavior to justify the rough treatment.

In addition, WCJ staff have failed to adequately document occasions in which medication is forcibly administered. In every instance in which force is used to administer medication to an inmate, the medical record should clearly indicate the medical justification for involuntary medication, as well as the circumstances necessitating the use of force. Jail staff should also include a thorough assessment and documentation of the inmate's condition following the forced medication in the inmate's medical record, including incidents where only intimidation is used, to ensure that any injuries sustained during the involuntary administration are properly treated. Moreover, a thorough assessment and documentation of the inmate's condition will alert staff as to whether the medication has the desired effect on the inmate or whether there are any adverse side effects. In the above cases, involuntary medication was ordered, but our consultant was unable to determine the basis of these orders from a review of the incident notes, medical records or the videotape. In addition, as also noted above, the medical record did not appropriately document the inmate's condition or the circumstances surrounding the use of force.

2. Confinement Rounds

WCJ's Special Housing Unit ("SHU") is the disciplinary segregation unit for male inmates. Inmates housed in the SHU are isolated in individual cells with self-contained toileting and showering facilities. Because the cells are self-contained, the inmate is rarely brought out of his cell. Each inmate has access to a recreation area and is permitted one hour of recreation time, to be served alone. Our consultant found that while inmates housed in confinement areas received previously arranged or established mental health treatment, most inmates do not receive routine mental health evaluations.

Inmates confined in isolation or segregation have an increased risk of mental health deterioration. Generally accepted correctional practices suggest that regular psychological assessments by a qualified mental health professional are necessary to ensure the mental health of an inmate confined in such units beyond 30 days.²⁹ Many of the inmates are confined in the SHU for well over 30 days. Accordingly, qualified mental health professionals should make segregation rounds at least once a week to identify those inmates at risk of experiencing psychological deterioration. Although WCJ medical staff conducts and documents daily rounds in the SHU, this does not constitute an appropriate mental health assessment.

D. JUVENILES

WCJ houses both juveniles awaiting processing to determine transfer to a juvenile detention facility and juveniles adjudicated as adults. Under New York State law, minors as young as thirteen years old may be tried and convicted as adults.³⁰ Despite this legal categorization, minors who are adjudicated as adults are still developmentally, physically, and mentally adolescents. WCJ's treatment of juveniles raises serious constitutional concerns regarding the length of disciplinary sentences and the adequacy of the mental health care and suicide prevention for juveniles housed in the SHU. We are also concerned with the Jail's failure to adequately separate juveniles from adult inmates by sight and sound, in contradiction to generally accepted correctional standards, and the Jail's failure to seek parental consent for the administration of psychotropic medication.

1. Juveniles in the SHU

a. Length of Disciplinary Sentences

Based on our consultant's review of the inmate logs at the SHU, since December 2007, half of the admissions to the SHU were inmates ranging in age between 16 and 18 years old. A review of the disciplinary records for the five of the six minors in SHU on December 31, 2007, reveal that the average sanction imposed was in excess of 365 days, with the longest period of isolation, at the time of our on-site investigation, recorded at 510 days. One 16-year-old minor was given a sanction of 360 days for refusing to lock-in from the dayroom and allegedly taking a swing at an officer. While we acknowledge the seriousness of the disciplinary infraction, a one-year term of isolation/seclusion for a minor is an extremely severe sanction, especially when contrasted with an adult detainee in the SHU who was

²⁹ Standards for Adult Correctional Institutions, 4th Edition, 4-4255.

³⁰ New York Penal L. § 1.20(42) (2008); New York Crim. Proc. L. § 720.10(1)-(2).

given a 45-day sanction for assaulting another inmate. Just two months prior, this same adult inmate had assaulted and injured another inmate with a weapon. Another 16-year-old minor was given 510 days for assaulting a correctional officer. When he completes his SHU term for this disciplinary sanction he will be one month short of his 18th birthday. We also note that an 18-year-old was given an indefinite sentence in the SHU.

The severity of these sentences imposed on a juvenile population raises numerous constitutional issues. The length of these sentences create an “atypical and significant hardship,” requiring the application of due process in disciplinary proceedings. Sandin v. Conner, 515 U.S. 472, 484 (1995); Colon v. Howard, 215 F.3d 227 (2d Cir. 2000) (finding 305 days “atypical”). While sentences of this length may not pose disproportionality problems in an adult population,³¹ our consultants expressed serious concern about the imposition of such lengthy sentences on a juvenile population. Further, such sentences may inflict substantial psychological harm on such a population, particularly where, as detailed below in Section III.D.1.a, adequate controls are not in place to identify and remedy such harm.

b. Mental Health and Suicide Prevention

At WCJ, the excessive SHU sentences given to juveniles have contributed to the deteriorating mental health of those juveniles, as illustrated by the following examples. This is especially true given the lack of routine mental health care for SHU inmates. See Section III.C.2, *supra*. Inmates housed in the SHU do not receive routine mental health evaluations, unless previously arranged prior to admittance in the SHU. As a result, deterioration of mental health is either unnoticed or ignored. For example:

- Inmate SA is 16 years old. He was placed in the SHU on July 5, 2007, only five days after he entered the facility. SA received a sentence of 510 days in isolated confinement as a result of an altercation that caused injury to a correctional officer, which again took place within the first few days of his incarceration. After two months of being in

³¹ See, e.g., Dixon v. Goord, 224 F. Supp. 2d 739, 748 (S.D.N.Y. 2002) (inmate’s punishment of ten months in SHU after being found guilty of assaulting a prison officer was “penologically justified and not grossly disproportionate”) (citing Sostre v. McGinnis, 442 F.2d 178, 190-94, & n.28 (2d Cir. 1971) (serious offenses can justify lengthy disciplinary detention)).

the SHU, SA attempted to cut his wrists, although this did not result in a major injury. A mental health evaluation was performed and concluded that he had "poor impulse control."

- Inmate SB is 18 years old. At the time of our visit, SB was serving 240 days in the SHU. He was first admitted to the SHU for 30 days in 2007, and then readmitted on August 1, 2007, for 240 days. When SB first entered WCJ he had a negative psychiatric screen except for a history of Attention Deficit Hyperactivity Disorder, and it was determined at that time that no additional mental health intervention was required. However, twelve days after being admitted to the SHU for the second time, SB began to exhibit suicidal ideation. On August 12th, SB made a suicidal gesture of hanging, followed by a razor blade threat to harm himself on August 26th. SB's behavior was identified by mental health staff as "poor impulse control." SB has continued to be a behavioral and management challenge for the officers in the SHU.

WCJ lacks a process of identifying and recognizing special mental health needs for its juvenile population. There is little evidence to suggest that WCJ employs any special accommodation or therapeutic approach that recognizes the special needs of adolescents or juveniles regarding their behavior and development. For example:

- Inmate SB, described above, has not been frequently followed by mental health staff. In November 2007, SB was placed on Risperdal,³² an antipsychotic medication. A few weeks later, the medication was discontinued due to his non-compliance. A mental health treatment plan, drafted on November 27, 2007, indicated that a follow-up meeting was scheduled for February 27, 2008. There were no interval evaluations or mental health interventions. During this time, SB's behavior continued to deteriorate.
- Inmate SC is 18 years old. He was observed in a suicide prevention cell in the booking area. SC was brought into the suicide prevention cell from the general population juvenile housing area. He indicated that he was having trouble coping in the area with the other juveniles, although he was not specific as to why he was having trouble coping, and had several superficial self-inflicted abrasions. This was his third admission to the suicide prevention cell within a week. Each time he

³² Risperdal is commonly used to "treat schizophrenia and symptoms of bipolar disorder." See <http://www.drugs.com/risperdal.html>. (last visited May 21, 2009).

was observed in the suicide cell, mental health staff determined that SC no longer posed a suicide risk, and he was subsequently returned to the general juvenile area.

As these examples illustrate, WCJ is not providing adequate mental health treatment and suicide prevention for juveniles in its facility. The number of juveniles in the SHU, and the level of problems caused by those juveniles, are disproportionate to the number of juveniles housed at WCJ.

2. Sight and Sound Separation

Generally accepted correctional standards require the sight and sound separation of juveniles from adults. WCJ does not appropriately apply sight and sound separation when it comes to the separation of juveniles and adults. On one floor at WCJ dedicated to female inmates, female juveniles were housed in the back corner of a housing unit for adult females. Within this unit, the adult and juvenile females were separated by a metal mesh fence that did not prevent open visualization and communication. In addition, male juveniles confined to the SHU were within sound, and often sight, of adult males in the SHU. Separation of juvenile populations from adults is a requirement of correctional standards. The potential for harassment and verbal victimization, if not more, is possible if adult prisoners are not separated by sight and sound.

3. Consent to Treatment

Generally accepted correctional standards require that the consent of a parent, guardian, or legal custodian, be obtained in order to prescribe medications for chronic or mental health conditions for inmates under the age of 18. Our consultant, however, found that WCJ did not consistently maintain a consent form signed by a parent or guardian for each juvenile inmate. For example:

- Inmate VA is 16 years old. She was placed on psychotropic medications. No consent was found in her medical records.
- Inmate VB is also 16 years old. She was placed on psychotropic medications. While her medical records reflect a telephone discussion with a parent regarding her treatment, no formal consent form could be found.
- Inmate VC is also 16 years old. She was placed on psychotropic medications. However, unlike inmates VA and VB, inmate VC had an informed consent form signed by a parent consenting to treatment.

Persons under the age of 18 years require consent of a parent or guardian prior to the delivery of most health care services. This consent is not consistently being obtained at WCJ.

IV. REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of detainees, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice:

A. Protection from Harm

1. Use of Force

- a. Develop and maintain comprehensive policies and procedures, consistent with current legal standards, regarding permissible use of force. Such policies and procedures should specifically include, inter alia, the following:
 - (i) Definitions of force and excessive or unnecessary force.
 - (ii) Prohibition on the use of force as a response to verbal insults or inmate threats.
 - (iii) Prohibition on the use of force as a response to inmates' failure to follow instructions where there is no immediate threat to the safety of the institution, inmates, or staff, unless WCJ has attempted a hierarchy of nonphysical alternatives which are documented.
 - (iv) Prohibition on the use of force as punishment.
 - (v) Prohibition on the use of crowd control chemical agents on individual inmates and develop and maintain a policy and practice for the appropriate use of chemical agents.

- b. Establish effective oversight of the use of force.
- (i) Develop and implement a policy to ensure that staff adequately and promptly report all uses of force. Such policies and procedures should include, inter alia, provisions for the following:
 - (A) Development and implementation of a standardized use of force reporting form.
 - (B) Ensuring that all staff receive training in how to complete a use of force reporting form and to properly describe a use of force incident on such a form.
 - (C) Ensuring that all staff involved in or witnessing any use of force incident adequately and promptly report such use of force.
 - (ii) Develop and implement a policy and practice for management review of all use of force incidents.
 - (iii) Ensure that review of incident reports, use of force reports, videotapes recording use of force incidents, and inmate grievances involving or alleging use of force by ERT is performed by management without direct supervisory authority over ERT members or supervisors.
 - (iv) Ensure that incident reports, use of force reports, videotapes recording use of force incidents, and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria for misconduct, that it is referred for investigation.
 - (v) Ensure that management review of incident reports, use of force reports, videotapes recording use of force incidents, and inmate grievances alleging excessive or inappropriate uses of force

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includes a timely review of medical records of inmate injuries as reported by medical professionals.

- (vi) Develop and implement comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.
 - (vii) Develop and implement policies, procedures, and practices on the proper use of videotapes for recording of use of force incidents and storage and retention of such videotapes.
 - (viii) Develop and implement policies, procedures and practices for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.
 - (ix) Develop and implement a process to track all incidents of use of force that at a minimum includes the following information: the inmate(s) name, housing assignment, date and type of incident, injuries (if applicable), if medical care is provided, primary and secondary staff directly involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
- c. Develop an effective and comprehensive training program in the appropriate use of force.
- (i) Ensure that staff receive adequate competency-based training in WCJ's use of force policies and procedures.
 - (ii) Ensure that staff receive adequate competency-based training in use of force and defensive tactics.
 - (iii) Ensure that management and staff involved in use of force investigations receive adequate competency-based training in conducting investigations of use of force allegations.

2. Safety and Supervision

- a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates.
- b. Ensure that inmate work areas are adequately supervised whenever inmates are present.
- c. Ensure frequent and documented security rounds timed at varying intervals by correctional officers inside each housing unit.
- d. Develop and implement policies and procedures requiring all tools, utensils, equipment, flammable materials, etc. to be inventoried and locked down when not being used.
- e. Ensure that staff adequately and promptly report safety- or security-related incidents.
- f. Develop a process to track all serious incidents that captures all relevant information, including: location, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.
- g. Ensure that inmates placed in lock down status are provided with appropriate due process that has been developed and implemented in policies and procedures.
- h. Increase use of overhead recording security cameras throughout the common areas of the facility and ensure that the use of cameras are to supplement and not replace supervision.
- i. Review, and revise as applicable, all security policies and SOPs on an annual basis.
- j. Review, and revise as applicable, all security post orders regularly.

- k. Revise policies, SOPs, and post orders for all staffed posts to include instruction on use of deadly force and when and under what circumstances weapons should be used.
 - l. To the extent possible, taking into account the different security levels and different physical layouts in the various divisions, standardize security policies, procedures, staffing reports, and post analysis reports across the divisions.
 - m. Provide formal training on division-specific post orders each time a correctional officer is transferred from one division to another.
 - n. Implement specialized training for officers assigned to special management units, which include the SHU, disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be regularly assigned to these units for stability purposes.
3. Disciplinary Process
- a. Ensure that inmates are afforded due process for any disciplinary actions against them, including promptly receiving a disciplinary ticket, a written decision detailing the reasons for the decision and length of sentence, and a fair hearing.
 - b. Ensure that disciplinary hearings are conducted in a private setting.
 - c. Develop and implement a policy, procedure and practice to review sentences committing inmates to the SHU for longer than 30 days.
 - d. Develop and implement a policy, procedure and practice to ensure that juvenile offenders are not incarcerated in the SHU in a manner or at such length inconsistent with their age and developmental needs.

4. Classification
 - a. Develop and implement policies, procedures and practices for an objective classification system that separates inmates in housing units by classification levels.
 - b. Update facility communication practices to provide officers involved in the classification process with current information as to cell availability on each division.
5. Inmate Grievance Procedure
 - a. Develop and implement policies, procedures, and practices to ensure inmates have access to an adequate grievance process that ensures that grievances are processed and legitimate grievances addressed and remedied in a timely manner, responses are documented and communicated to inmates, inmates need not confront staff prior to filing grievances about them, and inmates may file grievances confidentially.
 - b. Ensure that grievance forms are available on all units and are available to inmates with Limited English Proficiency.
 - c. Ensure that inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, referred for investigation.
6. Access to Information
 - a. Ensure that newly admitted inmates receive information they need to comply with facility rules and regulations, be protected from harm, report misconduct, access medical and mental health care, and seek redress of grievances.
 - b. Ensure that inmates who are not literate are afforded the opportunity to have information on facility rules and services explained to them orally.

- c. Ensure that information on facility rules and services is available in Spanish.

7. Employee Discipline

- a. Ensure Employee Code of Conduct includes prohibition on use of excessive or unnecessary force.
- b. Update Standard Operating Procedure on Use of Force to include definition of excessive or unnecessary force and appropriate sanctions for use of such force.

B. Medical Care

1. Intake Screening

- a. Ensure that adequate intake screening and health assessments are provided.
- b. Develop and implement an appropriate medical intake screening instrument that identifies observable and non-observable medical needs, including infectious diseases, and ensure timely access to a physician when presenting symptoms require such care.

2. Treatment and Management of Communicable Disease

- a. Provide adequate treatment and management of communicable diseases, including MRSA.
- b. Ensure that inmates with communicable diseases are appropriately screened, isolated, and treated.
- c. Develop and implement an adequate MRSA control plan in accordance with generally accepted correctional standards of care. Such plan should provide guidelines for identification, treatment, and containment to prevent transmission of MRSA to staff or inmates.
- d. Develop and implement policies that adequately manage contagious skin infections. Develop a skin infection control plan to set expectations and provide a work plan for the prevention of transmission of skin infections,

including drug-resistant infections to staff and other inmates.

- e. Develop and implement adequate guidelines to ensure that inmates receive appropriate wound care.

3. **Dental Care**

- a. Ensure that inmates receive adequate dental care in accordance with generally accepted professional standards of care. Such care should be provided in a timely manner.
- b. Ensure that inmates complaining of pain are provided with interim pain relief until they can be seen for dental appointments.

4. **Access to Health Care**

- a. Ensure inmates have adequate access to health care.
- b. Ensure that the medical request process for inmates is adequate and provides inmates with adequate access to medical care. This process should include logging, tracking, and timely responses by medical staff.

5. **Medication Administration**

- a. Ensure that treatment and administration of medication to inmates is implemented in accordance with generally accepted professional standards of care.

C. Mental Health Care

1. **Timely and Appropriately Evaluate Inmates**

- a. Ensure WCJ properly identifies inmates with mental illness through adequate screening.

2. **Assessment and Treatment**

- a. Ensure that treatment plans adequately address inmates' serious mental health needs and that the plans

contain interventions specifically tailored to the inmates' diagnoses and problems.

- b. Ensure that mental health evaluations done as part of the disciplinary process include recommendations based on the inmate's mental health status.
3. Psychotherapeutic Medication Administration
- a. Ensure that ERTs are not used to administer involuntary medication unless the inmate is clearly uncontrolled and presenting an immediate risk to him/herself or others.
 - b. Ensure that, after each use of force employed in connection with involuntary administration of medicine, the medical record clearly documents the reasons for administering medication involuntarily, the use of force employed to administer medication, and the inmate's condition following the use of force.
4. Other Mental Health Issues
- a. Ensure that a psychiatrist or physician conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. Seclusion or restraint orders should include sufficient criteria for release.
 - b. Ensure that all staff (including correctional officers) who directly interact with inmates receive competency-based training on basic mental health information (e.g., diagnosis, specific problematic behaviors, psychiatric medication, additional areas of concern); recognition of signs and symptoms evidencing a response to trauma; and the appropriate use of force for inmates who suffer from mental illness.
 - c. Ensure that all inmates housed in isolated confinement areas, such as the SHU, receive weekly mental health screenings conducted by qualified mental health professionals.

- d. Ensure that administrative segregation and observation status are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

D. Juveniles

- 1. Isolation Confinement
 - a. Develop alternative disciplinary actions for juveniles violating institutional rules that result in appropriate time in isolation confinement.
 - b. Ensure that health care staff are involved in developing and implementing treatment plans for juveniles facing isolation confinement.
 - c. Ensure that juveniles held in the SHU have access to programs appropriate for juveniles.
- 2. Mental Health Care
 - a. Provide greater interaction with Jail Staff and more rehabilitative programming for juveniles, including those who have committed disciplinary infractions.
 - b. Ensure that juvenile inmates undergo mental health evaluations that address the special developmental needs of adolescents.
 - c. Ensure that juvenile inmates undergo mental health evaluations at regular intervals even if they are not receiving psychotropic medications.
- 3. Other Issues
 - a. Ensure that all juvenile inmates are provided housing that maintains sight and sound separation from adult inmates.
 - b. Establish a process for routinely obtaining signed consent forms from the parent or guardian of any juvenile receiving prescribed medications or health care

treatments unless otherwise permitted by state or local laws.

* * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding WCJ, and to develop specific policies and procedures that will implement the remedial measures discussed above. Assuming the County continues to cooperate, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. See 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting you to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195, or David Kennedy, of the United States Attorney's Office, at (212) 637-2733.

Sincerely,

Thomas E. Perez
Assistant Attorney General

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PREET BHARARA
UNITED STATES ATTORNEY
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cc: Joseph K. Spano
Commissioner of Correction
County of Westchester

cc: Charlene M. Indelicato
County Attorney
Office of the County Attorney

Attachment A



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

December 5, 2011

The Honorable Lamar S. Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter to the Attorney General dated September 8, 2011, regarding hiring practices of the Department's Civil Rights Division (the "Division"). In a separate letter, also dated today, we describe our production of documents responsive to your request on this subject.

We are pleased to report that the Division has taken unprecedented steps over the last three years to ensure that hiring of career employees is based on each individual's qualifications for the job, divorced from improper political considerations, plain and simple. The Division has instituted new policies founded on the fundamental principle that merit, not political affiliation or ideology, must guide hiring decisions for career positions. We believe that the issuance and implementation of these policies has addressed the well-documented politicization of career hiring that took place in the Division during the last Administration, and we are proud of the caliber of the Division's new employees.

In July 2008, the Department's Office of the Inspector General (OIG) and Office of Professional Responsibility (OPR) found that, during the previous Administration, the Division improperly used political or ideological affiliations in assessing applicants for career attorney positions in violation of both Departmental policy and federal law.¹ The July 2008 Report focused particular attention on the fact that between 2003 and 2006, Bradley Schlozman, who was a Deputy (DAAG), and later a Principal Deputy (PDAAG) and Acting Assistant Attorney General within the Division, considered political and ideological affiliations when hiring and taking other personnel actions relating to career attorneys, in violation of Department policy and federal law.² The report made recommendations on how the Division should reform its hiring process to ensure that such illegal and improper practices could not again occur.

¹ U.S. Department of Justice, Office of the Inspector General/Office of Professional Responsibility, "An Investigation of Allegations of Politicized Hiring and Other Improper Personnel Actions in the Civil Rights Division" (July 2, 2008) ("July 2008 Report").

² *Id.* at 64.

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In 2009, the Division not only implemented the OIG/OPR recommendations, but also took substantial additional steps to eliminate the likelihood that improper considerations could again play a role in the hiring process for career attorney positions. Until the improper conduct described above occurred, merit had been the touchstone of the hiring process for career professionals in the Civil Rights Division for decades – through both Republican and Democratic Administrations. Merit is once again the guiding principle of the Division’s hiring process and selection criteria. Determinations of merit, of course, include consideration of experience in the relevant field. For this reason, many of the Division’s hires have civil rights experience, which is directly relevant to the work they would be expected to do in the Civil Rights Division.

To fully respond to your letter, which is primarily based on blog postings written by former employees of the Division,³ and to clarify that the concerns expressed in your letter are entirely unfounded, we respond below to each of the above points in some detail. First, we describe the improper hiring practices that took place during the last Administration and prompted corrective action in this Administration. We then describe the policies put into place in this Administration, with respect to both to the hiring process and the criteria that are treated as permissible considerations in hiring career attorneys. Last, we address the unsubstantiated suggestion that consideration of job-related experience is serving as a proxy for hiring on the basis of political affiliation or ideology.

The discussion below responds to the questions 5-9 in your letter. Questions 1-4 request documents and other materials and are addressed in the accompanying letter addressing our response to your document request; all of the internal documents and memorandum referenced below are being provided to your office in response to your request for information.

I. Hiring Practices Between 2002-2008

The July 2008 OIG/OPR report found that beginning in 2002,⁴ the political appointees in the Office of the Assistant Attorney General for Civil Rights (“OAAG” or “front office”) revised the written policies governing the hiring process for experienced attorneys: the process was centralized, and primary responsibility for decision-making was shifted from the Section Chiefs – who are career employees – to the political appointees in the OAAG. Under those new written policies, the DAAGs or their front office designees reviewed the applications, determined which applicants should be interviewed, and then forwarded all of the applications to the Section Chiefs. The Section Chief then interviewed the applicants identified by the DAAGs, and, in some cases, was permitted to identify and interview other applicants for further consideration. The Section Chief then made a hiring recommendation to the DAAG; the DAAG in turn forwarded the Section Chief’s and the DAAG’s own recommendations to the AAG for approval. See Mem. from D. Greene to Section Chiefs re: New Attorney Hiring Process, Feb. 25, 2002,

³ One of these former employees, who left the Division in January 2006, worked in the Office of the Assistant Attorney General while the illegal hiring practices documented in the July 2008 Report took place. This individual declined to cooperate with the OPR/OIG investigation.

⁴ Prior to 2002, most non-manager experienced attorneys were interviewed and hired at the Section Chief level, subject to approval by the OAAG.

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which was issued at the direction of former AAG R. Boyd. In 2003, that process was modified further and Section Chiefs were permitted to review applications in the Human Resources office only; they were not provided copies of the application materials. See Mem. from former AAG R. Alexander Acosta to Section Chiefs re: Attorney Hiring Process, Dec. 1, 2003.

In addition to documenting the shift of control over the hiring process from career managers to political appointees, the July 2008 Report included a number of specific findings of improper consideration of political and ideological affiliations in hiring decisions. Specifically, the July 2008 Report found that Mr. Schlozman actively sought and hired candidates with conservative political or ideological affiliations who rarely had any civil rights background, rarely expressed any interest in civil rights enforcement, and had little or no relevant work experience. In some cases, newly hired attorneys would appear on a Section roster having been hired without any involvement by the Section Chief in the hiring process. In numerous e-mails, Mr. Schlozman expressly referenced the political or ideological affiliations of applicants.⁵ See July 2008 Report at 14-35.

The Report also included findings that, although the extent to which the Section Chiefs were involved in the hiring process varied among the Division's sections, the Section Chiefs of many sections were effectively excluded from the decision-making process for hiring career attorneys for their sections. Mr. Schlozman often conducted interviews himself; Section Chiefs were given little notice of interviews and discouraged from asking questions during interviews; Section Chiefs were denied access to information about the full pool of applicants; and the assessments and recommendations of Section Chiefs were ignored, as were their objections to the hiring of several attorneys on the grounds that the attorneys were unqualified or had been fired from other jobs. See July 2008 Report at 14-35.

We are concerned that your letter appears to minimize the gravity of the behavior documented in the July 2008 Report and elsewhere. The improper consideration of political or ideological affiliation in hiring and other personnel decisions in the Civil Rights Division during this time period was not, as your letter states, limited to the misconduct of a "single specific hiring manager," namely Mr. Schlozman. Although the July 2008 Report's findings focused on his misconduct, the Report further concluded that several other political appointees, including two AAGs and two Principal DAAGs, had knowledge or some indication of Mr. Schlozman's improper consideration of political and ideological affiliations and failed to take action to ensure that hiring decisions were consistent with federal law and Department policy. See July 2008 Report at 45-52. Moreover, we do not believe the Report supports the conclusion set out in your letter that, except for Mr. Schlozman's hires, there was a "republican-to-democrat hiring split

⁵ Specifically, the July 2008 Report included findings, based on direct evidence, that Mr. Schlozman favored applicants with conservative political or ideological affiliations, whom he referred to as "real Americans," "right-thinking Americans" or members of "the team," and disfavored applicants with civil rights or human rights experience whom he considered to be "liberal." It was documented that Mr. Schlozman wrote: "this has lib written all over it," "conservative?" and "Unfortunately I have an interview at 1 with some lefty who we'll never hire but I'm extending a courtesy interview as a favor." In an e-mail to an attorney hired by Mr. Schlozman who commented that his "office is even next to a Federalist Society member," Mr. Schlozman responded, "Just between you and me, we hired another member of 'the team' yesterday. And still another ideological comrade will be starting in one month. So we are making progress." See July 2008 OIG Report at 14-35.

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that was closer to 50-50.” Of the 13 hires (out of 112) during the period in question that were not attributed to Mr. Schlozman, four were identified as conservative, three as liberal, and six as unknown. In addition, improper hiring practices were not limited to the Civil Rights Division during this time period. See OIG/OPR Report, An Investigation of Allegations of Politicized Hiring by Monica Goodling and Other Staff in the Office of the Attorney General, July 28, 2008; OIG/OPR Report, An Investigation of Allegations of Politicized Hiring in the Department of Justice Honors Program and Summer Law Intern Program, June 24, 2008.

In the wake of substantial media attention to the politicization of the hiring process, in June 2007, then-Assistant Attorney General for Civil Rights Wan Kim issued a memorandum stating that personnel decisions within the Division were required to comport with applicable law and that “there will be no discrimination based on . . . political affiliation.” See Mem. from AAG W. Kim to Division Employees re: Guidance on Personnel Matters, June 29, 2007. Acting AAG Grace Chung Becker issued a similar memorandum in August 2008.

II. Hiring Practices Beginning in 2009

Based on the investigation summarized in the July 2008 Report, OIG and OPR recommended that the Division take a number of steps to “help ensure that such conduct does not occur in the future,” including providing regular training on merit system principles and prohibited personnel practices to supervisors and personnel with a role in hiring career employees; issuing periodic statements to all employees about what constitutes prohibited personnel practices; reaffirming that the Department, as an employer, is committed to compliance with all laws, regulations and policies; and providing information about how employees can report violations. See July 2008 Report at 64-65.

Beginning in 2009, the Civil Rights Division not only implemented the recommendations set forth in the July 2008 Report, but also took additional concrete actions, as set forth below, to insulate the hiring process from improper political considerations and to ensure that career staff, whatever the political or ideological perspectives of the governing Administration, are selected based on qualifications and without regard to political affiliation.

To help guide the formulation of these policies, in 2009, the Division convened a Working Group comprised of the career Section Chief or a career Deputy Chief from each of the Division’s sections, the Director of the Division’s Professional Development Office, the Division’s Human Resources Officer and the Division’s employment counsel. The Working Group was tasked with, among other things, reviewing the policies and practices for hiring experienced attorneys for career positions in the Division and recommending changes in those policies and practices, particularly in light of the findings and recommendations in the July 2008 Report. In September 2009, the Working Group submitted to the Acting AAG recommendations for written policies and processes governing the hiring of experienced attorneys and attorney promotions, which reflected the input of the Working Group and all Division Section Chiefs.

These recommendations were based in large part on the general recommendations of the July 2008 Report and the specific recommendations of this working group of career Division

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managers. Shortly after his confirmation and before the Division began a hiring cycle to fill more than 100 positions, Assistant Attorney General Thomas E. Perez acted on those recommendations and issued a series of written policies designed to restore credibility, transparency and fairness to the process used for hiring career attorneys.⁶ Each of these reforms is rooted in the recommendations made in the July 2008 Report.

These new written policies were posted publicly on the Division's website,⁷ and provide specific guidance to supervisors and employees involved in the hiring process about merit system principles and prohibited personnel practices. Integral to the new process, the Division each year issues a written policy statement to all employees reiterating the AAG's commitment to ensuring that all personnel decisions are consistent with applicable law and Department policies, including an express statement that consideration of political affiliation, and using ideological affiliation as a proxy for determining political affiliation, are strictly prohibited.⁸

The fundamental principle animating these new policies is that merit, not political affiliation or ideology, must guide hiring decisions for career positions. These written policies and guidance memoranda include the following core safeguards for hiring experienced, non-managerial, attorneys:⁹

- Shifting primary decision-making for hiring these attorneys back to the career Section Chiefs who supervise the day-to-day work of the sections, including creating a process whereby:

⁶ See, Mem. from AAG T. Perez to All CRT Employees re: Civil Rights Division Experienced Attorney Hiring Process, Dec. 3, 2009; Mem. from AAG T. Perez to CRT Managers, Supervisors and Staff Involved in the Hiring Process for Filling Career Positions re: Merit System Principles and Prohibited Personnel Practices, Dec. 10, 2009; Mem. from AAG T. Perez to All OAAG Attorneys, All Section Managers, All Experienced Attorney Hiring Committee Members and Human Resources re: Guidance for Civil Rights Division Managers Regarding Hiring for Career Experienced Attorneys, Jan. 20, 2010.

⁷ <http://www.justice.gov/crt/employment/> (last visited Oct. 31, 2011).

⁸ See, e.g., Mem. from Acting AAG L. King to All Division Employees re: Guidance on Personnel Matters, April 28, 2009; Mem. from AAG T. Perez to All Division Employees re: Interim Guidance on Equal Employment Opportunity, Merit System Principles and Prohibited Personnel Practices, July 13, 2010.

⁹ Because your letter focuses on the Division's non-manager experienced attorney hiring process, we have not gone into detail about the conclusions of the July 2008 Report that relate to the Honors Program or SLIP hiring process. However, because you have requested documents related to the hiring process for the Honors Program, in addition to producing those documents, we note that the Department and OARM, which oversees the Honors Program and SLIP hiring processes, made significant changes to those processes beginning in 2007, following complaints of politicization under the last Administration and based on the recommendations of the OIG and OPR in a June 2008 report. In addition to adhering to the OARM guidance, the Civil Rights Division issued further guidance for the specific procedures and time frames to be followed by the career Division employees serving on the Honors Program/SLIP Hiring Committee – including specific prohibition against consideration of political or ideological affiliations in making hiring decisions and requirements that members of the Division's Honors Program Hiring Committee attend mandatory training on, *inter alia*, merit system principles. Mem. from AAG T. Perez, 2010 Civil Rights Division Honors Program / Summer Law Intern Program Hiring Process, Aug. 17, 2010. AAG Perez's memorandum, as well as the materials from those training programs, are included with the documents provided to you with this response.

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- applications are reviewed and applicants selected for interview by Section-level Hiring Committees comprised of career attorneys and chaired by career Section Chiefs;
 - hiring recommendations are made to OAAG by career Section Chiefs with input from the Committee;
 - hiring recommendations must be made in writing and include a summary of how the recommended applicant's or applicant's education, work experience and references satisfy the qualifications for the position set forth in the vacancy announcement;
 - decisions by the Assistant Attorney General or his/her designee to reject the Section Chief's recommended applicant(s) must be made in writing.
- Requiring that all attorney vacancies be publicly advertised via section-specific vacancy announcements (i.e., generic, non-section specific "trial attorney" announcements will no longer be used); that all vacancies be posted on the Division's and the Department's websites, as well as on the Office of Personnel Management's website (www.usajobs.gov);¹⁰ and that vacancy announcements identify the specific qualifications/criteria for selection (e.g., substantive knowledge and expertise in the laws, rules and regulations applicable to the work of the section).
 - Affirmatively apprising every employee in the Division of job vacancies and inviting all employees to notify organizations of these openings.¹¹
 - Requiring that only applicants who apply through the normal application process in response to a particular vacancy announcement may be considered (i.e., unsolicited applications or applications sent directly to political appointees, career managers or anyone else may not be considered).
 - Identifying categories of skills and experience that should be included in vacancy announcements and considered in making hiring decisions, including but not limited to: academic achievement; interest in the enforcement of civil rights laws; substantive

¹⁰ Due to budgetary constraints and the Department's hiring freeze, some recent Division job openings have only been available to internal Division applicants. For this reason, some job announcements have been posted only on the Division's internal website.

¹¹ In addition, the Division's public website states: "Announcements are also distributed by the Office of Attorney Recruitment and Management and/or by the Division's Human Resources Office to a broad and diverse array of organizations, including but not limited to bar associations, law schools and professional organizations. Sections may also distribute announcements to additional organizations who may know of qualified candidates for a particular vacancy announcement. To expand our recruitment efforts, the Civil Rights Division is developing an outreach list of organizations to circulate Civil Rights Division-specific attorney job announcements. If you are, or know of, an organization that might be interested in receiving these announcements, please e-mail CRD_SpecProgVacancies@usdoj.gov," <http://www.justice.gov/ert/employment/> (last visited Oct. 31, 2011).

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knowledge and expertise in the laws, rules and regulations applicable to the work of the section; experience conducting investigations and developing cases for litigation; written and oral communication skills; oral advocacy skills; and negotiation skills.

- Identifying the criteria that may not be considered in making hiring decisions, including the following express prohibition against consideration of political affiliation:

The Civil Rights Division is an equal opportunity / reasonable accommodation employer. All hiring is based on merit; consistent with applicable federal law and Department of Justice policies, discrimination based on race, color, national origin, gender, age, political affiliation (including using ideological affiliation as a proxy for determining political affiliation), disability, marital status, sexual orientation, gender identity, status as a parent, membership or non-membership in an employee organization, or personal favoritism is strictly prohibited.¹²

- Providing information regarding the complaint procedures for reporting suspected violations of the non-discrimination policy or prohibited personnel practices (including potentially improper interview questions). That information includes the contact information for the Department's Equal Employment Opportunity Office and the Office of Special Counsel.

In addition, a key component of the revamped hiring process was the creation of a mandatory training program for all Division employees involved in the hiring process, including political appointees and career attorney managers. This program was created by the Division's Professional Development Office, with input from the Department's Office of Attorney Recruitment and Management (OARM) and the Division's Employment Counsel. To our knowledge, this is the first time that the Division has held mandatory training that specifically addresses issues related to the career attorney hiring process. The Division conducted seven sessions of that program between June 2009 and April 2010, and these trainings continue to be held periodically.

As reflected in the training materials that we are providing in response to your letter, the program specifically addresses merit system principles and prohibited personnel practices, including the prohibition against consideration of political or ideological affiliation in hiring. The training also includes specific discussion of the findings of the OIG/OPR reports – including reports documenting improper hiring practices elsewhere in the Department – and examples of the illegal hiring practices identified in those reports to make clear the types of information that may not be considered during the hiring process. Equal employment opportunity and merit system principles are also addressed in several other training programs the Division provides to its employees, including a Supervisor Training program and in the Equal Employment Opportunity segment of the Division's annual Professionalism Training program, which employees are required to attend.

¹² The January 20, 2010 guidance memorandum and the April 28, 2009 and July 13, 2010 Division policy statements specifically list all of the prohibited personnel practices.

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You asked what guidance has been given to employees involved in the hiring process with respect to hiring selection criteria (question 7). Those policies are described above. You also asked whether internet searches were performed on applicants to the Division (question 5). Because of the misuse of information culled from internet searches by political appointees in the prior Administration to determine the political or ideological affiliations of applicants, the Division has erred on the side of caution in addressing the use of internet searches in its guidance memorandum and in its mandatory hiring training.¹³ The policy instructs employees involved in the hiring process that they “may not conduct internet searches of applicants at any point during the hiring process.”¹⁴ Moreover, the prohibition against internet searches of applicants – and the reasons for that prohibition – are specifically discussed during the mandatory trainings for all employees involved in the hiring process. Employees are instructed that, pending further guidance from the Department, they may not conduct internet searches of applicants, including pulling articles applicants have written.¹⁵ Thus, while your letter states that internet searches of the Division’s hires would reveal their political or ideological affiliations, this policy precludes such searches and serves as an added precaution against the possibility that internet searches of applicants’ backgrounds will be misused to reveal their political or ideological affiliations.

Your letter, and the blog posts referenced in it, also suggest that all of the Civil Rights Division’s hires since 2009 are “liberal,” and that this means the Division screens applicants for ideology. Specifically, the blog posts posit that working at certain organizations, belonging to certain groups, participating in certain activities in law school, or even having a certain sexual orientation necessarily reflects a particular political or ideological affiliation. We dispute the allegation that this information serves – or was treated – as a valid proxy for assessing political affiliation. As would any responsible employer, the Division places a high value on an applicant’s relevant experience in the field, as well as demonstrated commitment to full and fair enforcement of civil rights laws, when making hiring decisions. The examples of prior employment cited in these blog posts – noting, for example, that numerous new hires for the Division had previously worked for civil rights organizations – reflect nothing more than that. It is no more surprising or inappropriate for the Civil Rights Division to select applicants with civil

¹³ This policy was created primarily in response to the OIG and OPR report finding the White House Liaison and Senior Counsel to the Attorney General during the prior Administration improperly considered political and ideological information garnered from searches of the political contribution and voter registration records of candidates for career positions, as well as internet searches of candidates for career positions using the following internet search string:

[First name of a candidate]! and pre/2 [last name of a candidate] w/7 bush or gore or republican! or democrat! or chagr! or accus! or criticiz! or blam! or defend! or iran contra or clinton or spotted owl or florida recount or sex! or controvers! or racis! or fraud! or investigat! or bankrupt! or layoff! or downsiz! or PNTR or NAFTA or outsourc! or indict! or enron or kerry or iraq or wmd! or arrest! or intox! or fired or sex! or racis! or intox! or slur! or arrest! or fired or controvers! or abortion! or gay! or homosexual! or gun! or firearm!

¹⁴ See OIG/OPR Report, An Investigation of Allegations of Politicized Hiring by Monica Goodling and Other Staff in the Office of the Attorney General, July 28, 2008, 99-103, 121.

¹⁵ See Mem. from AAG T. Perez to All OAAG Attorneys, All Section Managers, All Experienced Attorney Hiring Committee Members and Human Resources re: Guidance for Civil Rights Division Managers Regarding Hiring for Career Experienced Attorneys, Jan. 20, 2010.

¹⁶ See, e.g., Training Materials from Jan. 21, 2010 Hiring Training, which included a slide that reads: “Can you conduct internet searches about applicants? No, not at this time. Further guidance will follow.”

The Honorable Lamar S. Smith

Page 9

rights experience than it is, for example, for the Antitrust Division to hire attorneys with antitrust experience. Nor does this reflect a form of “disparate impact” discrimination, in response to question 9 in your letter. We also disagree with the premise that working for civil rights organizations necessarily correlates with a “liberal” ideology, as attorneys from across the ideological spectrum have historically worked for and supported the work of a variety of civil rights organizations. The party of Lincoln has a long history of support for civil rights; it would be incorrect to suggest that a person must be affiliated with only one political party to have worked in a civil rights organization.

Your letter asks whether there is a policy or guidance that suggests that experience representing defendants in civil rights cases should not be considered on par with experience having represented plaintiffs (question 8). The Division does not have a policy or a practice – official or unofficial – suggesting that one type of civil rights experience is less valuable than another kind. Indeed, such a policy would be counterproductive because the Division’s jurisdiction covers a wide range of federal civil rights statutes; its enforcement efforts are strengthened by the fact that its attorneys have a range of legal skills and experiences. The resumes of the Division’s attorney hires since 2009, which we are providing to you today, reflect a diverse array of legal experiences.

Experience, sound judgment, and a demonstrated commitment to full and fair enforcement of civil rights laws, not ideology, are key attributes that the Division looks for in its candidates. The Division has hired people from a variety of legal backgrounds because these critical skills can be found in many different settings. For instance, the Division has hired individuals from large and small law firms alike; lawyers with experience in civil rights organizations, as well as the Judge Advocate General (JAG) Corps; people with prosecution experience and criminal defense experience; lawyers with civil litigation backgrounds on both the plaintiff and defense sides; and people who have clerked or externed for judges appointed by every president since President Carter.¹⁶ The Division does not inquire into the ideological or political affiliation of these applicants, but inquires instead into whether they are the best qualified applicants for the position.

Moreover, as detailed in this letter and in our document production, the Division has issued a number of written policies to all employees involved in the hiring process setting forth the selection criteria that may or may not be considered in making hiring recommendations or selections. Those policies include job-related skills and experience, such as substantive knowledge and expertise in the laws, rules and regulations applicable to the work of the section; experience conducting investigations and developing cases for litigation; written and oral communication skills; oral advocacy skills; and negotiation skills. Those policies draw no distinction between skills and experience gained representing plaintiffs or defendants, and employees involved in the hiring process were not instructed – officially or unofficially – to make such a distinction.

¹⁶ As part of our production to you today, we are providing all of the resumes that were produced pursuant to the Freedom of Information Act request that formed the basis of the blog postings your letter cites. Although this information can be found in these resumes, much of it was not mentioned in the blog postings cited in your letter.

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Your letter also suggests that the Division's recruiting for career positions has been one-sided, citing an on-line report that Mr. Perez spoke to the American Constitution Society for Law and Policy and containing a partial quote of what he said. A review of a recording of the event shows that Mr. Perez's statement in full was: "We've restored the nonpartisan merit based transparent hiring process for all attorneys. Go to our website and you will see the hiring policy and I am going to be calling each and every one of you to recruit you because we've got 102 new positions in our budget and so we're going to be moving forward. That is something to clap about."¹⁷ As he did at this event, Mr. Perez has spoken at law schools and legal organizations all across the country to recruit for the Division and to ensure large pool of well-qualified applicants. In addition, the job announcements that were developed and sent out pursuant to the Division's new hiring policies were, at Mr. Perez's direction, widely disseminated without regard to the ideology or political affiliation of the recipients of the announcements.

Of course, the most effective way to judge the quality and qualifications of the Division's hires under its current leadership is by the quality of the Division's work. On October 21, we sent you a letter summarizing the impressive work of the Division over the last two and a half years. During this period, the Division's new hires, working alongside its longstanding and dedicated career staff, have made significant strides in restoring the Division's capacity to fulfill its critical mission.

Finally, you ask about the Division's efforts to close a budget gap. The Division was privileged to receive substantial new funding in Fiscal Year 2010, which it used to hire the career professionals whose hiring is the subject of your letter. The amounts appropriated during that period, however, were not annualized to cover the full costs of the authorized hiring; increased costs for items such as rent and equipment have further strained the Division's resources. In response, the Division, along with the rest of the Department, has taken prudent steps to reduce its expenditures, including by offering a buyout to long-term employees. The Division will continue to take steps to ensure responsible stewardship of its resources.

We hope that this information is helpful. Please do not hesitate to contact this office if we may provide additional assistance regarding this or any other matter.

Sincerely,

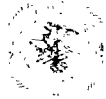


Ronald Weich
Assistant Attorney General

cc: The Honorable John Conyers, Jr.
Ranking Minority Member

¹⁷ See <http://www.c-spanarchives.org/program/290782-1> (last visited October 29, 2011).

Attachment B



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

March 2, 2012

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Senator Grassley:

This responds to your letter to the Attorney General dated December 20, 2011, concerning Department of Justice conference expenditures. We are fully cognizant of the importance of using scarce tax dollars wisely and the need to eliminate all wasteful and excessive spending. As described below, consistent with our broad efforts to generate savings and efficiencies, in the past year the Department has reduced its conference spending by 30 percent compared to FY 2010.

Conferences are a vital aspect of developing and maintaining a responsive and well-trained law enforcement workforce, and a well-coordinated federal, state, local, and tribal criminal justice system. The majority of our conferences are core operational training events for law enforcement personnel and prosecutors in fields such as money-laundering prevention, firearms training, DNA forensic examination, criminal discovery (such as *Brady* and *Giglio* discovery obligations), and the prevention of violent gang crime. These are valuable training opportunities for our agents, analysts, deputy marshals, prosecutors, and other criminal justice personnel at which they obtain tools and information that are fundamental to their performance. Our grant-making components also conduct critical information-sharing sessions with grantees in order to ensure effective use of grant dollars. Events approved recently include:

- Training for Cybersecurity Professionals;
- Training for Laboratory Evidence Technicians on Recovery of Human Remains;
- Advanced Counterintelligence Techniques;
- Jail Administration Training for Indian Country;
- Protecting Native Children Who Disclose Sexual Abuse;
- Fire Fighting for Correctional Institutions;
- Law Enforcement Operational Medical Program Training;

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- National Advisory Committee Meeting on Recommendations to DOJ and HHS on Interventions with Teens Who Witness Sexual Assault and Intimate Partner Violence;
- Telecommunications Exploitation Training;
- Weapons of Mass Destruction Preparedness and Response;
- Tripwire Analysis;
- Boot Camp for Prosecutors;
- Use of Less Lethal Technology;
- Child Fatality Investigations;
- Crime Scene Evidence Photography; and
- Basic Financial Investigations Training.

These training sessions and conferences support the core law enforcement mission of the Department. They are essential to our national security, law enforcement, and criminal justice missions. We will remain vigilant to ensure that conferences and training events are meeting the Department's needs and that our spending guidelines are enforced.

We respond below to the nine questions contained in your letter.

1. Why did the cost of conference expenditures at the Department nearly double between 2008 and 2010?

Response: There are two aspects to the increase in reported conference spending between 2008 and 2010: the first is the overall growth in the Department's budget in those years, and the second pertains to changes we made in our reporting methodology for conference expenditures of \$20,000 or more that the Department reports to Congress as required by the annual Appropriations Act (referenced to throughout this letter as "conference spending"). **It is important to note that the Department reduced conference spending by over 30 percent in FY 2011.**

First, the Department's budget increased by nearly 12 percent from FY 2008 to FY 2009, an increase of \$2.7 billion, not including supplemental appropriations. In FY 2010, the budget grew by an additional 8 percent. A portion of those additional resources were devoted to conferences and training, which accounts for part of the cost increase from 2008 to 2010.

Our "conference" reporting, as noted at the outset, **includes core operational training events for law enforcement staff, prosecutors, and grantees.** Our Department staff grew by nearly 6,000 positions from 2008 to 2010. Since our conference spending includes core training for our personnel, particularly entry-level personnel, it was not unexpected that as more resources were appropriated for critical law enforcement programs, the cost of associated training programs would increase commensurately.

Second, during the period from 2008 to 2010, the Department expanded and refined its conference reporting requirements. Conference spending is not a standard cost category in federal accounting systems. Instead, "conference" spending is actually a blend of travel, lodging, meal, registration, planning, instructor, and related contracting costs. In

The Honorable Charles E. Grassley
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April 2008, the Department issued more comprehensive policies on conferences. Due to the complexity of the requirements, some components could not implement the policy in its entirety in that year. The Inspector General’s report cited in your letter referenced this fact. Accordingly, FY 2008 is not an ideal year to use for baseline purposes since costs were underreported, and some FY 2008 costs were reported in FY 2009.

Nonetheless, the Department’s efforts to limit and monitor conference spending have yielded significant reductions. For FY 2011, the Department spent \$64.5 million on conferences, a reduction of \$27.1 million, or 30%, from FY 2010.

In Thousands	Fiscal Year			
	2008	2009	2010	2011
Total Conference Spending	\$ 47,894	\$ 73,370	\$ 91,561	\$ 64,502
Change from Prior Year		53%	25%	-30%

2. What “proactive steps” did you take beginning in 2009 to implement tighter internal controls to reduce just these sorts of activities?

Response: The Department has taken multiple steps to ensure that conference spending is proper and reasonable. These steps are proving successful as demonstrated by the \$28 million reduction referenced above. Importantly, because our conferences include core law enforcement training efforts, we have reduced the cost of our conferences rather than ending important training work. We are sensitive to the spending areas questioned in the last Inspector General report. We have reduced our spending on meals and refreshments. We look more closely at the use and cost of planning firms. We require cost comparisons when event sites are selected. We have worked to maintain essential training events, but at lower cost.

In April 2008, the Department issued a comprehensive Bulletin entitled “Conference Planning, Conference Cost Reporting, and Approval to Use Non-Federal Facilities” and issued further guidance on proper conference spending in June 2008. These policies set limits on conference food and beverage spending.

In May 2009, the Deputy Attorney General issued a memorandum to all heads of Department components instructing them to limit conference spending overall, select venues based on business need and minimizing travel and other costs, and provide meals infrequently and only when necessary. In addition, the memorandum explicitly instructs grant organizations that grant funding is not to be used for lavish food or refreshments.

In January 2011, the Attorney General instructed all components to limit travel, training, and conference spending to only essential needs. These restrictions were reinforced by the Deputy Attorney General in October and November 2011, including direction to use video conferencing where feasible.

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Our grant-making components have also taken steps to ensure that conference events comply with spending limitations. We have developed and implemented protocols to ensure that conference cost estimates have greater transparency and scrutiny during the planning phase, and we are providing additional training to Department staff and award recipients alike. In FY 2011, the grant organizations placed special conditions on cooperative agreements to ensure that food and beverage costs are consistent with guidelines established by the Department and used for federally planned conferences. In addition, all three grant components have already implemented or will soon implement a number of other steps to address concerns, such as revising their Financial Guides, amending their grant guidelines, and revising their grant monitoring plans. Please see our answer to Question 8 for additional actions taken.

- a. Did any of these proactive steps involve dollar caps on individual conference expenditures?

Response: Yes. The Justice Management Division's (JMD) Policies and Procedures Bulletin referenced above established thresholds for expenditures on meals and refreshments.

- b. Were any particular types of conference expenditures prohibited?

Response: In May 2009, the Deputy Attorney General issued a memorandum to all heads of Department components that prohibited the use of funds for lavish food or refreshments. The Deputy Attorney General later prohibited refreshments altogether except where participants cannot obtain them on their own without greatly disrupting the conference schedule, reduced the limit to half of the existing limit, and prohibited conference planners except when critically necessary. In October 2011, the Deputy Attorney General issued a memorandum to all heads of Department components that prohibited the purchase of trinkets, i.e., superfluous conference supplies such as portfolios and the like.

3. How much did the Department budget for conferences in 2011?

Response: The Department does not have a budget line item specifically for conferences. Conferences include a wide variety of training and other necessary events, and as explained above, conferences *per se* are not a standard federal budgeting or accounting category, so we do not budget separately for conferences. However, in accordance with then-OMB Director Jacob Lew's September 21, 2011, memorandum "Eliminating Excess Conference Spending and Promoting Efficiency in Government," the Department will continue to limit conference spending to only those events that are critical to the mission of the Department.

- a. Who was the highest ranking official at DOJ that approved the budget for conference expenditures?

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Response: As noted above, the Department does not have a specific budget line item for conferences. Prior to September 27, 2011, conferences were approved by the appropriate component approving official, consistent with the Department's order on funds control.

As required by OMB's directive, on September 27, 2011, the Deputy Attorney General declared that Department-sponsored conferences must be approved by the Attorney General or himself, through the Assistant Attorney General for Administration. On November 22, 2011, the Deputy Attorney General delegated to the Assistant Attorney General for Administration/Chief Financial Officer of the Department the authority to approve conferences under \$250,000. Component heads and their principal deputies may approve conference expenses up to \$20,000.

- b. Were you consulted on the specific budget for conference expenditures prior to approval?

Response: Please see our answer to Question 3(c), below.

- c. Was the Deputy Attorney General consulted on the specific budget for conference expenditures prior to approval?

Response: As noted above, the Department does not approve a single amount each year for conferences – our training and conference events support essential national security, law enforcement, and criminal justice system needs within the broad programmatic budgets that are appropriated to us. The Deputy Attorney General and Attorney General approve overall funding levels for Department components, but specific programmatic budgets are appropriately the purview of the components under the Department's funds control order.

4. How much of that money has been spent to date in 2011?

Response: Based on the reporting requirements contained in *Conference Planning, Conference Cost Reporting, and Approval to Use Non-Federal Facilities*, conference spending totaled \$64,486,549 in fiscal year 2011. This represents a 30 percent decrease from FY 2010 spending.

5. How much has the Department budgeted for conferences in 2012?

Response: As explained above, while conferences are not a separate budget category, the Department continues to operate under the spending restrictions established by the Attorney General and Deputy Attorney General in 2011. This includes limiting conference expenditures to only those that are essential; using videoconferencing where feasible; and limiting meals, refreshments, planning, and other costs.

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- a. Who was the highest ranking official at DOJ that approved the budget for conference expenditures?

Response: Please see our answer to Question 3.

- b. Were you consulted on the specific budget for conference expenditures prior to approval?

Response: Please see our answer to Question 3.

- c. Was the Deputy Attorney General consulted on the specific budget for conference expenditures prior to approval?

Response: Please see our answer to Question 3(c).

6. What procedures are in place to review budget line items that increase significantly? For example, is there any procedure in place to flag accounts that increase by more than 50% year over year? If not, why not?

Response: The Department regularly reviews all budget line item increases before submitting the President's Budget and annual spending plans to Congress. Line items that increase significantly are scrutinized closely to determine the necessity of the increase and the impact it will have on the Department's mission. In addition, each component reports its financial and performance information quarterly to the Justice Management Division's Budget Staff. These reports provide useful information about each component's spending in the current fiscal year and alert Department leadership to any concerns about the financial solvency, staffing, or performance related issues so that appropriate action can be taken.

7. Have you asked the Inspector General to determine the reason for the dramatic rise in costs? If not, please explain why not.

Response: No. As explained in Answer 1, the significant budget increases the Department received for its critical missions in FY 2009 and FY 2010 resulted in the growth of the Department's overall staff and its activities. Associated training and conference spending also increased, but at roughly one percent of our overall increase. In light of these factors, we do not perceive the need for an Inspector General review. However, we report our conference spending to the Inspector General on a quarterly basis.

8. Provide a copy of all correspondence and memoranda instructing DOJ personnel to take "proactive steps" to "implement tighter internal controls to reduce" conference expenditures.

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Response: The following documents (copies of which are enclosed) have been issued related to conference expenditures:

- April 29, 2008 – Justice Management Division Finance Staff issued Policy and Procedures Bulletin 08-08 *Conference Planning, Conference Cost Reporting, and Approval to Use Non-Federal Facilities*.
- May 8, 2008 – The Assistant Director of the Procurement Policy and Review Group issued a memorandum to procurement chiefs to inform them that P&P 08-08 and FMM 08-07 had been issued.
- June 5, 2008 – The Assistant Attorney General for Administration issued a memorandum to component heads to inform them that P&P 08-08 had been issued and to highlight key points.
- May 4, 2009 – The Deputy Attorney General issued a memorandum to component heads on “Conference and Premium Class Travel Expenditures.” The memo highlights key points of the P&P 08-08.
- January 21, 2011 – The Attorney General issued a memorandum to component heads on “Temporary Freeze of Hiring and Non-Essential Spending” which required components to limit conference spending to essential needs only.
- September 27, 2011 - The Deputy Attorney General issued a memorandum to component heads on "Conference Approval Requirements" which required DAG approval for all conferences in accordance with the P&P 08-08 definition.
- September 29, 2011 – The Assistant Attorney General for Administration issued a memorandum to component heads on "Conference Approval Requirement."
- September 29, 2011 – The Assistant Attorney General for Administration issued a memorandum to JMD Deputy Assistants Attorney General and Staff Directors on "Conference, Food, and Related Spending Approval Requirement." {Attachment 8}
- October 5, 2011 – The Deputy Attorney General issued a memorandum to heads of Department components on "Continued Restrictions on Non-Essential Spending" that extended the Attorney General's January 21, 2011, requirement for components to limit conference spending to essential needs only and limited refreshments to once a day.
- October 21, 2011 – Assistant Attorney General for Administration issued a memorandum to heads of department Components on "Conference Approval Requirements."
- October 24, 2011 – Email from the Deputy Assistant Attorney General/Controller “*Reminder/Action: Day Forward Conference and Events Approval Requirements*,” attached revised formats for submitting conferences for approval and reiterated the procedures in place until a revised Financial Management Policies and Procedures Bulletin is issued.
- November 22, 2011 - Deputy Attorney General issued a memorandum to Heads of Department Components “*Further Delegation for Approval of Conferences*.”

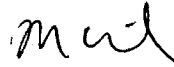
The Honorable Charles E. Grassley
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9. Provide a copy of all documents and communications provided to Mr. Lew that form the basis of his statement in the Sept. 21, 2011, memorandum that DOJ has taken "proactive steps to implement tighter internal controls to reduce" conference expenditures.

Response: Copies of those documents listed in the response to Question 8 that were issued prior to September 21, 2011, were provided to the Office of Management and Budget.

We hope that his information is helpful. Please do not hesitate to contact this office if we may provide additional assistance regarding this or any other matter.

Sincerely,



Ronald Weich
Assistant Attorney General

Enclosures

cc: The Honorable Patrick Leahy
Chairman



FINANCIAL MANAGEMENT
POLICIES AND PROCEDURES BULLETIN

No. 08-08


April 2008

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

APR 29 2008

JMD Senior Staff

Bureau Chief Financial Officers

FROM: 
Melinda B. Morgan
Director
Finance Staff
Justice Management Division

SUBJECT: Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

1. **PURPOSE.** This policy provides guidance to components when planning and reporting on conferences. This policy also lays out the requirement for components to seek approval prior to using a non-federal facility for a predominantly internal training or conference meeting.

2. **BACKGROUND.** In the summer of 2005, a subcommittee of the U.S. Senate Committee on Homeland Security and Governmental Affairs launched a government-wide inquiry into conference spending. The inquiry found that since fiscal year (FY) 2000, federal agencies spent at least \$1.4 billion on conferences and did not consistently or transparently track funds spent on conferences and related travel. In September 2007, the Department of Justice's (Department) Inspector General (IG) released a report highlighting the high costs and inconsistent or nonexistent reporting procedures of 10 conferences conducted by the Department in FY 2006. The IG Report recommended that the Department develop and implement consistent conference

planning and reporting procedures. The procedures contained in this policy are consistent with the recommendations contained in the IG Report. Additionally, Section 218 of the Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161), requires the Attorney General to submit quarterly reports to the IG regarding the costs and contracting procedures for each conference held by the Department for which the cost to the government was more than \$20,000. Therefore, each component is required to submit to the Justice Management Division a quarterly report regarding the conferences it funds.

Finally, section 1173 of Public Law 109-162, the Violence Against Women and Department of Justice Reauthorization Act of 2005, states that unless authorized in writing by the Attorney General, the Department (and each entity within it) shall use for any predominantly internal training or conference meeting only a facility that does not require a payment to a private entity for the use of the facility. The Act also requires the Attorney General to prepare an annual report to the Chairmen and ranking minority members of the Committees on the Judiciary of the Senate and of the House of Representatives that details each training and conference meeting that required specific authorization. The report must include an explanation of why the facility was chosen and a breakdown of any expenses incurred in excess of what would have been the cost of conducting the training or conference meeting at a facility that did not require such authorization. The Attorney General has delegated his responsibilities under this provision to the Assistant Attorney General for Administration (AAG/A).

3. DIRECTIVES AND SOURCES REFERENCED.

- 5 U.S.C. §4101(6), Definitions, Non-Government Facility
- 31 U.S.C. §3302, Custodians of Money ("Miscellaneous Receipts Act")
- 31 U.S.C. §6305, Using Cooperative Agreements
- Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161)
- The Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162)
- Federal Travel Regulation (FTR), 41 C.F.R. §300-3.1 and §301-74
- Department of Justice, Office of the Inspector General, "Department of Justice Conference Expenditures," Audit Report 07-42, September 2007 ("IG Report")
- Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 C.F.R. part 70)
- Federal Acquisition Regulation (FAR), Volume 1, Part 10
- Office of Management and Budget (OMB) Cost Principles Circular A-122, 2 C.F.R. 230
- Office of Justice Programs Financial Guide
- Financial Management Memorandum 08-07, Implementation Guide for Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

4. DIRECTIVES RESCINDED.

- Financial Management Policies and Procedures Bulletin 06-12, Use of Non-federal Conference and Training Facilities
- Financial Management Policies and Procedures Bulletin 00-19, Refreshments at Conferences

5. DEFINITIONS.

- a. Conference. The FTR defines "conference," in part, as a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. A conference is typically a prearranged event with designated participants and/or registration, a published substantive agenda, and scheduled speakers or discussion panels on a particular topic.

This Bulletin applies to any conference planned and held by components themselves, and conferences funded by a component but conducted by an outside entity through the use of a contract or a cooperative agreement. **For a conference conducted through the use of a cooperative agreement, only §§9 and 10(b) of this guidance are applicable.** With respect to conferences funded by more than one agency, this Bulletin applies if the Department provides more funding than any other agency. When reporting on such conferences, a component should only account for the funding provided by the Department.

The following types of activities are excluded from the definition of "conference" for the purposes of the §10(a) reporting requirement *only*. (Examples for each of the following types of activities that are excluded can be found in Attachment A.)

- 1) Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers;
 - 2) Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy;
 - 3) Undercover activities and training conducted in accordance with the Attorney General's guidelines; or
 - 4) Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is *not* excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.
- b. Predominantly internal training or conference meeting. A predominantly internal training or conference meeting is one that is held by the Department and where the majority (more than 50%) of the attendees are Department employees. As above, "training or conference meeting" is defined broadly to include a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. The above list of activities (§5(a)(1)-(4)) that are excluded from the conference reporting requirements of §10(a) are *not* excluded from this

definition. For the purposes of this bulletin, "predominantly internal training or conference meetings" will be referred to as "predominantly internal events."

- c. Federal facility. Federal facility means property owned, leased, or substantially controlled by the federal Government or the Government of the District of Columbia.
- d. Non-federal facility. Non-federal facility is any facility that is not a federal facility. For further clarification see the definition of "non-Government facility" in 5 U.S.C. §4101(6).
- e. Conference or Event planner. A conference or event planner is a contractor hired by a component to perform the logistical planning necessary to hold a conference. "Logistical planning" may include: interacting with caterers, recommending venues, developing programs, advertising, setting the stage and audio/visual (a/v) equipment, securing hotel rooms, and other non-programmatic functions.

6. CONFERENCE PLANNING.

- a. Conference Justification. The decision to host any event, whether it be a conference or predominantly internal event, or to send employees to attend an event, requires fiscal prudence and is subject to the availability of funds from individual component appropriations. Components must document a written justification for each conference that includes a programmatic reason to hold the event and an approval from an appropriate sponsoring agency official.
- b. Planning Requirements. When planning a conference, components are required to follow Part 301-74 of Title 41 of the Code of Federal Regulations, entitled "Conference Planning." These regulations, in part, require that components:
 - 1) Minimize all conference costs, including administrative costs, conference attendees' travel costs, and conference attendees' time costs;
 - 2) Maximize the use of Government-owned or Government provided conference facilities as much as possible; and
 - 3) Identify opportunities to reduce costs in selecting a particular conference location and facility (e.g., through the availability of lower rates during the off-season at a site with seasonal rates). 41 C.F.R. §301-74.1.
- c. Use of External Conference Planners. Minimizing conference costs must be a critical consideration in a component's decision whether to plan a conference with internal Department staff or to enter into a contract with an external conference planner. The use of an external conference planner should be used only when necessary and conference planning costs should always be kept to a minimum.

- d. Large and/or Expensive Conferences. The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- e. Charging Conference Fees. A component cannot charge fees to conference attendees to cover its costs unless the component has very specific statutory authority to do so. See 31 U.S.C. §3302. However, if the component uses a private contractor (such as an external event planner, hotel, or other third party) to facilitate the conference or provide goods and services to the attendees, the contractor may charge fees. It is important that the fees charged by the contractor cover *only* the goods and/or services provided to the attendees by the contractor (or subcontractor(s)) and do not cover or defray costs that are the responsibility of the component. For example, if a contractor such as a hotel is providing attendees with lodging, meals and refreshments for a conference, the hotel may charge attendees directly for the costs of those items. The contractor must deal directly with the attendees to collect the fees; the component must not be involved in any such collection.
- f. Selecting a Location. An event location is comprised of two variables: the city and the facility in which the event takes place. To ensure that the government obtains the best conference location for the best value, conference planners must compare multiple facilities in multiple cities, unless an overriding operational reason is documented to hold the conference in a specific city. Adequate cost comparisons should compare and document the availability of lodging rooms at per diem rates, the convenience of the conference location, availability of meeting space, equipment and supplies, and the commuting or travel distance of attendees.

To ensure that components maximize the use of federal facilities and minimize total costs to the Department, conference planners shall first consider all federal facilities in the locations identified via city-level cost comparison analysis. A list of some federal facilities is available on the Non-federal Facility Request Center web site:

<http://10.173.2.12/jmd/fs/nfrc/index.htm>. If a federal facility meets the component's needs at a reasonable price, there is no requirement that non-federal facilities be considered. The component may consider non-federal facilities if:

- 1) federal facilities are not available or do not meet the component's requirements (e.g., size of the meeting room, necessary technological equipment, sufficient lodging at the facility or in the proximity of the facility); or
- 2) the component believes that a non-federal facility can be procured at a lower cost taking into account all costs described in this section.

If a federal facility cannot meet the component's needs at a reasonable price, the conference planner must conduct and make available market research to determine the facility that best meets the needs of the conference as set forth in the Federal Acquisition Regulation (FAR), Volume 1, Part 10. In order for this market research to be effective, the components must communicate the same sufficiently detailed requirements to all potential facilities. During

the market research, components must not make any commitments to any of the facilities. The market research must determine the cost of the event with respect to each of the three (or more) facilities, broken down as follows. Costs related to attendees (e.g., travel, lodging, per diem) must include costs of all attendees whose expenses are being covered by the component; therefore, include Department employees as well as non-Department attendees (e.g., facilitators, guest speakers) whose expenses are being covered by the component.

- 1) conference and meeting space, including rooms for break-out sessions;
- 2) audio visual services;
- 3) other equipment costs (e.g., computer fees, telephone fees);
- 4) printing and distribution;
- 5) meals provided by the Department;
- 6) refreshments provided by the Department;
- 7) meals and incidental expenses for attendees (M&IE portion of per diem);
- 8) lodging costs;
- 9) transportation to/from conference location (e.g., common carrier, POV);
- 10) local transportation (e.g., rental car, POV) at event location;
- 11) conference planners;
- 12) conference facilitators;
- 13) any other costs associated with the conference.

Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. See §8(b). Special approval is also required to hold such an event in certain locations. §8(b)(3).

7. MEALS AND REFRESHMENTS.

a. When permissible to provide.

- 1) *Federal Government Employees.* Meals and/or refreshments¹ may be paid for by the Department and provided to federal Government employees at conferences or training sessions where *all three* of the following are true:
 - a) the meals and refreshments are incidental to the conference or training;
 - b) attendance at the meals and when refreshments are served is important for the host agency to ensure attendees' full participation in essential discussions, lectures, or speeches concerning the purpose of the conference or training; AND
 - c) the meals and refreshments are part of a conference or training that includes not just the meals and refreshments and discussions, speeches, lectures, or other business that

¹ Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

may take place when the meals and refreshments are served, but also includes substantial functions occurring separately from when the food is served.

While as a general rule the Department does not pay for meals and/or refreshments for employees at their duty stations, if a conference or training meets the above criteria, meals and refreshments may be served to employees who are not on travel. With respect to Department employees who are on travel, they must deduct from their per diem the amount for each meal provided by the Department.

- 2) *Non-Federal Government Attendees.* The Department can only pay for the meals and/or refreshments² of non-federal attendees at conferences IF ONE of the following applies:
 - a) The component has specific statutory authority permitting it (e.g., 42 U.S.C. §3788(f) for programs covered by the Omnibus Crime Control and Safe Streets Act; 42 U.S.C.A. §3771 and *note*);
 - b) The non-federal attendees qualify as individuals serving the Department pursuant to 5 U.S.C. §5703;³ OR
 - c) The expenses can be considered official reception and representation expenses (28 U.S.C. §530C(b)(1)(D), and are counted towards the Department's Representation Fund limitations (*see* DOJ Order 2110.31B).
- 3) *Charging Non-Federal Attendees.* As discussed in §6(e), a private contractor (such as an external event planner, hotel, or other third party) can charge fees to non-federal attendees to cover the costs of such goods and services as meals and/or refreshments. The contractor must deal directly with the attendees to collect the fees for the meals and/or refreshments; the component must not be involved in any such collection.
- b. Minimizing costs of meals and refreshments. Components (as well as contractors hired as conference or event planners) must adhere to the following cost thresholds, described further in Attachment B, for the costs of the meals and refreshments provided at the conference.
 - 1) *Refreshments.* Refreshments include light food and drink served at breaks, such as coffee, tea, milk, juice, soft drinks, donuts, bagels, fruit, pretzels, cookies, chips, or muffins. The cost of these items, plus any hotel service costs, cannot exceed 23% of the locality M&IE

² Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

³ Non-federal attendees who are provided any travel, lodging or meals and/or refreshments by the Department pursuant to 5 U.S.C. §5703 must be issued invitational travel orders. These are required even when a non-federal attendee is "local" to the conference and is only being provided meals and/or refreshments.

rate per person per day. For example, if the M&IE rate for a particular location is \$54.00 per person per day, then the total refreshments costs cannot exceed \$12.42 (\$54.00 x 23%) per person per day.

- 2) *Meals.* The cost of any meal provided, plus any hotel service costs, cannot exceed 150% of the locality M&IE rate per meal. For example, if dinner will be provided in a locality with a \$49.00/day M&IE rate, the dinner rate in the locality is \$24.00 per dinner. Therefore, the cost of the dinner provided at the conference cannot exceed \$36.00 (\$24.00 x 150%) per person. All Department employees attending the conference must ensure that the provided meal is deducted from their claimed M&IE; in this example the employee would deduct \$24.00 from claimed M&IE for the provided dinner.
- 3) Component Heads must request approval from the AAG/A to provide refreshments or meal costs that exceed these thresholds. *See* §8(d).

8. SPECIAL APPROVALS.

a. Use of Non-Federal Facilities for Predominantly Internal Events.

- 1) Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. Such requests must be submitted by no lower than the management official responsible for approving the conference in the component and must be sent to the Director, Finance Staff, using the Conference Reporting and Non-federal Facility Request Center web site, <http://10.173.2.12/ind/fs/nfrc/index.htm>. Any request for approval of a non-federal facility must include the following:
 - a) Statement of the purpose of the training or conference meeting;
 - b) Number of attendees and their organizations and duty stations (components must also indicate which, if any, of the attendees who are not Departmental employees will have their expenses paid for by the component);
 - c) Frequency of the training or conference meeting and the date of the last such event, if applicable;
 - d) Dates of the training or conference meeting;
 - e) Location of the training or conference meeting (city/state) and reason(s) for choosing the location;
 - f) Reason why a location where a federal facility is located was not considered, if applicable;
 - g) List of federal and non-federal facilities considered;
 - h) Estimated costs of using each of the federal and non-federal facilities considered.

- including all costs listed in §6(f) as determined by the market research, itemized and broken out by category;
- i) Reasons why the federal facilities did not meet the meeting's requirements, if applicable (refer to §6(f));
 - j) Justification for the use of a non-federal facility; and
 - k) Gift acceptance approval, if required.
- 2) Approval for Certain Locations. Any request to hold a predominantly internal event in a non-federal facility in the following locations must be submitted by the Component Head, and this responsibility cannot be redelegated.
- a) Any location outside the continental United States (including Hawaii and Alaska);
 - b) Any location known for gambling (e.g., Las Vegas, Nevada; Reno, Nevada; Atlantic City, New Jersey);
 - c) Any location considered a tourist attraction or common vacation location (e.g., Disney World and Orlando, Florida; Niagara Falls, New York; Lake Tahoe); or
 - d) Any resort facility or resort location (e.g., Hilton Head, South Carolina; Sonoma Valley, California).
- b. Large and/or Expensive conferences. The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- c. Meals and Refreshments Exceeding Thresholds. Component Heads must request approval from the AAG/A to provide meals and/or refreshments that exceed the cost thresholds described in §7(b). Component Heads must submit a memorandum to the AAG/A through JMD Finance Staff acknowledging that the proposed meals and refreshments exceed these thresholds and explaining why this is deemed necessary. This responsibility cannot be redelegated. When the conference at issue also requires a request to use a non-federal facility, this memorandum must be submitted with the non-federal facility request form. For all other events, the memorandum must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.

9. CONFERENCES HELD BY COOPERATIVE AGREEMENT RECIPIENTS

- a. When to Use Cooperative Agreement. A cooperative agreement may not be chosen in order to avoid the statutory and regulatory requirements associated with the use of a contract. The decision to use a cooperative agreement, as opposed to a contract or grant, should be made in consultation with the component's legal counsel, applying the standards set forth in 31 U.S.C. §6305, which, in general, authorizes the use of a cooperative agreement where the conference would carry out a public purpose of support or stimulation of outside entities, and substantial involvement by the Department is expected. Although the standards in §6305 must govern

the choice of vehicle, in determining if a conference **would** carry out such a public purpose (as opposed to merely providing a direct benefit to the Department or its employees), a significant factor is whether the primary beneficiaries of the conference are outside the federal Government.

b. Cost Principles that Apply to Non-Profit Cooperative Agreement Recipients.

- 1) Directives. Non-Profit cooperative agreement recipients must comply with the Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 CFR Part 70), OMB Cost Principles Circular A-122, 2 C.F.R. 230, and, if applicable, the Office of Justice Programs Financial Guide, or any other component-specific guidance. According to A-122: "Costs of meetings and conferences, the primary purpose of which is the dissemination of technical information, are allowable. This includes costs of meals, transportation, rental of facilities, speakers' fees, and other items incidental to such meetings or conferences."
- 2) Reasonable Standard. The amount spent on conference costs is governed by the general principle that the costs be "reasonable," which is further defined in OMB Circular A-122, Attachment A, paragraph 3. Furthermore, cooperative agreement recipients must comply with the travel guidelines at OMB Circular A-122, Attachment B, paragraph 51, and the OJP Financial Guide (if applicable), which require that if a recipient does not have a written travel policy, the recipient must abide by the rates and amounts established by the General Services Administration (GSA) in the Federal Travel Regulations, 41 C.F.R. ch. 301.⁴

c. Required Special Condition For New Awards. All cooperative agreements that include holding a conference as a recipient responsibility must include the following special condition:

"Within 45 days after the end of any conference, meeting, retreat, seminar, symposium, training activity, or similar event funded under this award, and the total cost of which exceeds \$20,000 in award funds, the recipient must provide the program manager with the following information and itemized costs:

- 1) name of event;
- 2) event dates;
- 3) location of event;
- 4) number of federal attendees;
- 5) number of non-federal attendees;

⁴ GSA's regulations and per diem rates may be found at www.gsa.gov

- 6) costs of event space, including rooms for break-out sessions;
- 7) costs of audio visual services;
- 8) other equipment costs (e.g., computer fees, telephone fees);
- 9) costs of printing and distribution;
- 10) costs of meals provided during the event;
- 11) costs of refreshments provided during the event;
- 12) costs of event planner;
- 13) costs of event facilitators; and
- 14) any other direct costs associated with the event.

The recipient must also itemize and report any of the following attendee (including participants, presenters, speakers) costs that are paid or reimbursed with cooperative agreement funds:

- 1) meals and incidental expenses (M&IE portion of per diem);
- 2) lodging;
- 3) transportation to/from event location (e.g., common carrier, privately owned vehicle (POV)); and
- 4) local transportation (e.g., rental car, POV) at event location.

Note that if any item is paid for with registration fees, or any other non-award funding, then that portion of the expense does not need to be reported."

- d. Information Gathered From Former or Existing Cooperative Agreement Recipients. Components are required to gather the specific information listed in section (c) from any cooperative agreement recipient that held a conference between October 1, 2007 and the present, and from any cooperative agreement recipient that holds a conference under the terms of an existing cooperative agreement.
- e. Review and Reporting. Each sponsoring component must review the itemized costs and clarify any of the reported information with the cooperative agreement recipient, as necessary. The component must also itemize all of the transportation costs, M&IE, per diem, and lodging costs *paid by the component itself* to send either its component employees or employees of another DOJ component to the event. The DOJ employee travel costs paid by the component should be added to each itemized category as well as the overall cost of the event. Within 45 calendar days following the close of each fiscal quarter, the component shall submit a report on each conference costing more than \$20,000 held by its cooperative agreement recipients, as described in §10(b).

10. REPORTING.

- a. Quarterly Reporting of Conference Costs. The Attorney General is required to submit quarterly reports to the IG regarding the costs and contracting procedures relating to each conference held by the Department for which the total cost of the conference was more than \$20,000. To facilitate this process, each office holding a conference as defined by §5(a) and costing more than \$20,000, is required to submit the following information to the appropriate office within its component:

- 1) a description of the purpose of each conference, the number of participants attending the conference, and how many were federal government employees;
- 2) a detailed list of all costs categorized in §6(f), and any issues encountered in determining the costs related to that conference; and
- 3) a description of the contracting procedures with respect to each contract relating to that conference, including:
 - a) whether contracts were awarded on a competitive basis for that conference; and
 - b) a discussion of any cost comparison conducted by the Department in evaluating potential contractors for that conference.

No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a) during that quarter must submit a report, signed by the Component Head, which includes the above information for each such conference. The template at Attachment B should be used to compile the information and submit this report. The component must also submit any special approvals required by §8 with this report. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.

- b. Quarterly Reporting on Cooperative Agreement Conferences. No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a), through the use of a cooperative agreement as described in §9 and costing more than \$20,000, shall report on the event using the template at Attachment B. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.
- c. Quarterly Reporting on Use of Non-Federal Facilities for Predominantly Internal Events. Within 45 calendar days following the close of each fiscal quarter, every component that has held a predominantly internal event at a non-federal facility must submit a report, signed by the Component Head, to Conferences.and.Non-federal.Center@usdoj.gov. The template at Attachment B should be used to compile the information and submit this report. The report must highlight and explain any increases in costs above those submitted with the original request for approval. All market research data and cost analysis/actual cost information must remain on file with the component.

11. QUESTIONS. Questions regarding these requirements may be directed to Lori Arnold, Assistant Director, Financial Management Policies and Requirements Group, Finance Staff, on (202) 616-5216, or Melinda Jones, of her staff, on (202) 353-2527.

Attachments

Activities Not Reported as Conferences under §10 (a)**Activity Type 1:**

Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers.

Activity
Meeting of attorneys to discuss a pending case
Meeting of DOJ agents to discuss strategy in an ongoing hostage situation

Activity Type 2:

Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy.

Activity Type 3:

Undercover activities and training conducted in accordance with the Attorney General's guidelines.

Activity Type 4:

Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is not excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.

Activity
Quarterly Firearms Certification

Activities Reported as Conferences under §10 (a) if over \$20,000

Activity	Description
OCDETF Financial Investigations Seminar	Mandated seminar to learn financial investigative techniques of criminal enterprise
Computer Analysis and Response Team Moot Court	Attendees meet to gain exposure to cross examination from attorneys on cases they have investigated
OIG Investigations Managers Conference	Meeting of Senior Managers from within the Investigations Division
Immigration Judge Training	Immigration judges from across the U.S. gain training and participate in policy discussions
Operational Medic Program	Attendees are trained in order to comply with National Registry of Emergency Technicians' national standards

Quarterly Report on Conference Costs

Attachment B

Component: _____ Telephone: _____

Point of Contact: _____ Email: _____

Conferences/Events						
Conference Title:	Non-Federal Facility	Conference over \$20,000	Non-Federal Facility	Conference over \$20,000	Non-Federal Facility	Conference over \$20,000
Event Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference Date (Start & End)						
Facility Name						
City and State						
Number of Federal Attendees						
Number of non-Federal Attendees						
Total Number of Attendees						
Purpose of the Conference:						
Conference Costs:						
Conference/Meeting Space (incl. Break out Room Cost)		\$0.00		\$0.00		\$0.00
AV Equipment & Services		\$0.00		\$0.00		\$0.00
Other Equipment Costs		\$0.00		\$0.00		\$0.00
Printing and Distribution		\$0.00		\$0.00		\$0.00
Gov't Provided Meals		\$0.00		\$0.00		\$0.00
Refreshments		\$0.00		\$0.00		\$0.00
MBIE		\$0.00		\$0.00		\$0.00
Lodging		\$0.00		\$0.00		\$0.00
Transportation		\$0.00		\$0.00		\$0.00
Local Transportation		\$0.00		\$0.00		\$0.00
Conference Planner		\$0.00		\$0.00		\$0.00
Conference Facilitator		\$0.00		\$0.00		\$0.00
Other Costs		\$0.00		\$0.00		\$0.00
Total Conference Cost		\$0.00		\$0.00		\$0.00
Average Cost per Attendee		\$0.00		\$0.00		\$0.00
Describe any issues encountered in determining the costs related to the conference:						
Description of contracting procedures:						
For Events in Non-Federal Facilities Only						
Total Original Cost Estimate		\$0.00		\$0.00		\$0.00
Variance (Actual vs. Estimated)		\$0.00		\$0.00		\$0.00
Variance Justification:						

¹ Attach additional pages to explain methodology if you are unable to capture costs as described in Policy XX or if any costs appear to be out of the ordinary.

² Attach additional pages to explain contracting procedures.

³ Use Attachment C to provide a justification narrative for all events in which the actual cost exceeds the estimate, the justification needs to be itemized.

Non-federal Facility Event Variance Justification

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference Costs	Estimated Cost	Reported Cost	Variance	Justification ¹
Conference/Meeting Space	\$0.00	\$0.00	\$0.00	
AV Equipment & Services	\$0.00	\$0.00	\$0.00	
Other Equipment Costs	\$0.00	\$0.00	\$0.00	
Printing and Distribution	\$0.00	\$0.00	\$0.00	
Gov't Provided Meals	\$0.00	\$0.00	\$0.00	
Refreshments	\$0.00	\$0.00	\$0.00	
M&IE	\$0.00	\$0.00	\$0.00	
Lodging	\$0.00	\$0.00	\$0.00	
Transportation	\$0.00	\$0.00	\$0.00	
Local Transportation	\$0.00	\$0.00	\$0.00	
Conference Planner	\$0.00	\$0.00	\$0.00	
Conference Facilitator	\$0.00	\$0.00	\$0.00	
Other Costs	\$0.00	\$0.00	\$0.00	
Total Conference Cost	\$0.00	\$0.00	\$0.00	

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference Costs	Estimated Cost	Reported Cost	Variance	Justification ¹
Conference/Meeting Space	\$0.00	\$0.00	\$0.00	
AV Equipment & Services	\$0.00	\$0.00	\$0.00	
Other Equipment Costs	\$0.00	\$0.00	\$0.00	
Printing and Distribution	\$0.00	\$0.00	\$0.00	
Gov't Provided Meals	\$0.00	\$0.00	\$0.00	
Refreshments	\$0.00	\$0.00	\$0.00	
M&IE	\$0.00	\$0.00	\$0.00	
Lodging	\$0.00	\$0.00	\$0.00	
Transportation	\$0.00	\$0.00	\$0.00	
Local Transportation	\$0.00	\$0.00	\$0.00	
Conference Planner	\$0.00	\$0.00	\$0.00	
Conference Facilitator	\$0.00	\$0.00	\$0.00	
Other Costs	\$0.00	\$0.00	\$0.00	
Total Conference Cost	\$0.00	\$0.00	\$0.00	

¹Attach additional pages to describe justification

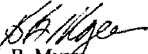


U.S. Department of Justice
Justice Management Division
Management and Planning Staff

Washington, D.C. 20530

May 8, 2008

MEMORANDUM FOR BUREAU PROCUREMENT CHIEFS

FROM: 
H. B. Myers
Assistant Director
Procurement Policy and Review Group

SUBJECT: DOJ Procurement Guidance Document (PGD) 08-07
Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

This procurement Guidance Document contains revised policies and procedures pertaining to Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities. The use of non-federal conference and training facilities. Procurement Guidance Document 06-05 is hereby cancelled.

Background. In the summer of 2005, a subcommittee of the U.S. Senate Committee on Homeland Security and Governmental Affairs launched a government-wide inquiry into conference spending. The inquiry found that since fiscal year (FY) 2000, federal agencies spent at least \$1.4 billion on conferences and did not consistently or transparently track funds spent on conferences and related travel. In September 2007, the Department of Justice's (Department) Inspector General (IG) releases a report highlighting the high costs and inconsistent or nonexistent reporting procedures of 10 conferences conducted by the Department in FY 2006. The IG report recommended that the Department develop and implement consistent conference planning and reporting procedures. The procedures contained in this policy are consistent with the recommendations contained in the IG Report. Additionally, Section 218 of the Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161), requires the Attorney General to submit quarterly reports to the IG regarding the costs and contracting procedures for each conference held by the Department for which the cost to the government was more than \$20,000. Therefore, each component is required to submit to the Justice Management Division a quarterly report regarding the conference it funds.

Section 1173 of Public Law 109-162, the Violence Against Women and Department of Justice Reauthorization Act of 2005 (The Act), states that unless authorized in writing by the Attorney General, the Department of Justice (and each entity within it) shall use for any predominantly internal training or conference meeting only a facility that does not require a payment to a private

entity for the use of the facility. The Act also requires the Attorney General to prepare an annual report to the Chairmen and ranking minority members of the Committees on the Judiciary of the Senate and of the House of Representatives that details each training and conference meeting that required specific authorization. The report must include an explanation of why the facility was chosen, and a breakdown of any expenditures incurred in excess of what would have been the cost of conducting the training or conference meeting at a facility that did not require such authorization. The Attorney General has delegated his responsibilities under this provision to the Assistant Attorney General for Administration.

Procedures. Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities, dated April 29, 2008, provides the implementation regulations to comply with statutory and other requirements. Financial Management Memorandum 08-07, dated April 29, 2008, is an implementation guide for Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities. A copy both documents are attached for your information and guidance. Following are highlights of the program and a note on meals and refreshments:

- Consolidated Policy – The Conference Planning and Reporting has been combined with the Approvals to Use Non-federal Facilities Policy. Policy & Procedures Bulletin 06-12 has been rescinded.
- Conference Definition (Section 5a) – The conference definition is broad and includes the training activities. Exclusions are defined.
- Selecting a Location (Section 6f) – A location is comprised of both the city and the facility in which the conference will be held.
- Calculating Conference Costs (Section 6f) – Components are required to be able to report actual cost for 13 cost categories.
- Provided Meals and Refreshments (Section 7a) – Meals and refreshments may not be provided at government expense unless certain criteria is met.
- Minimizing costs of Meals and Refreshments (Section 7b) – Meals and refreshments must fall within established thresholds.
- Large Conferences (Section 8c) – The Component Procurement Chief must review and approve all conferences that exceed \$500,000 or 500 attendees.
- Conferences held by Cooperative Agreement (Section 9) – Different planning and reporting (Section 10b) requirements are explained.
- Quarterly Reporting of Conference Costs (Section 10a) – Pursuant to Section 218 of the Consolidated Appropriations Act, Component Heads are required to report on all conferences exceeding \$20,000.

- **Reporting Deadline** (Sections 10a, b, and c) – Reports are due 45 calendar days after the end of each fiscal quarter.
- **Reporting on Events Held in Non-federal Facilities** (Section 10c) – Component Heads are required to prepare a consolidated quarterly report of all events held in a non-federal facility rather than report after each event.
- **New Email Inbox** – All non-federal facility requests and reports and conference reports must be sent to the new address entitled Conferences.and.Non-federal.Center@usdoj.gov. The previous email address, Non-fed.Facility.Request.Center@usdoj.gov, has been deactivated.
- It is understood that some components want to provide meals and refreshments to non-federal attendees and object to the requirement that they may be provided only under certain conditions. The Office of Legal Counsel recently reviewed their opinion in light of these concerns yet concluded there is no basis for overturning their original conclusion.
- Please direct questions to Lori Arnold, Assistant Director, Financial Management Policies and Requirements Group, Finance Staff, on (202)616-5216 or Melinda Jones, of her staff, on (202)353-2527.

These requirements are effective April 29, 2008. Please make this information immediately available to the appropriate people in your organization and add this document to your collection of DOJ Procurement Guidance Documents.

Attachments:

- Financial Management Policies and Procedures Bulletin 08-08: Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities
- Financial Management Memorandum 08-07: Implementation Guidance for Financial Management Policies and Procedures Bulletin 08-08 Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities



U.S. Department of Justice
Justice Management Division
Finance Staff

Washington, D.C. 20530


APR 29 2008

FINANCIAL MANAGEMENT MEMORANDUM 08-07

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

JMD Senior Management Staff

Bureau Chief Financial Officers

FROM: 
Melinda B. Morgan
Director

SUBJECT: Implementation Guide for Financial Management Policies and Procedures
Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals
to Use Non-federal Facilities

This is to provide implementation guidance for Financial Management Policies and Procedures Bulletin (P&P) 08-08 on Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities.

Quarterly Reporting on Conference Costs

As described in §10(a) and (b), components must report quarterly costs on all covered conferences. The requirement is effective October 1, 2007; therefore, reports on conferences held during the first two quarters of Fiscal Year (FY) 2008 are to be submitted by the Component Head by June 13, 2008, in the reporting format set forth by P&P 08-08. Effective thereafter, reporting is due no later than 45 calendar days after the close of each fiscal quarter.

Reporting on Use of Non-Federal Facilities for Predominately Internal Events

Components are no longer required to submit individual reports for each event held at a non-federal facility. As described in §10(c), each Component Head is required to submit a single quarterly report in the reporting format set forth by P&P 08-08. The first quarterly report for the period ending June 30, 2008, is due no later than August 15, 2008. In this report, you must report any events not previously reported.

In addition to the new reporting requirements, the following must be considered when planning a conference or event:

- Avoid locations and accommodations that give the appearance of being lavish or are resort destinations. Component Heads are required to submit written justification if the facility gives the appearance of being lavish or is a resort location. This cannot be re-delegated.

- Ensure the selected lodging location is within per diem.
- Ensure the costs of meals and refreshments are within the prescribed limits.
- Ensure meals provided by the government are deducted from Meals and Incidentals Expenses (M&IE) claimed by all Department attendees (by meal).
- Ensure that multiple facilities in multiple cities are compared when considering conference locations.
- Ensure proper requests are submitted for approval to Justice Management Division (JMD) at least 45 days before your approval is required.
- Ensure that reporting of costs for all Non-federal Facility events and Conferences are submitted by Component Heads no later than 45 days following the close of each fiscal quarter.

If you have any questions, please contact Lori Arnold on (202) 616-5216, or Melinda Jones, of my staff, on (202) 353-2527.



FINANCIAL MANAGEMENT
POLICIES AND PROCEDURES BULLETIN

No. 08-08

April 2008

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

JMD Senior Staff

Bureau Chief Financial Officers

APR 29 2008

FROM: *Melinda B. Morgan*
Melinda B. Morgan
Director
Finance Staff
Justice Management Division

SUBJECT: Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

1. **PURPOSE.** This policy provides guidance to components when planning and reporting on conferences. This policy also lays out the requirement for components to seek approval prior to using a non-federal facility for a predominantly internal training or conference meeting.

2. **BACKGROUND.** In the summer of 2005, a subcommittee of the U.S. Senate Committee on Homeland Security and Governmental Affairs launched a government-wide inquiry into conference spending. The inquiry found that since fiscal year (FY) 2000, federal agencies spent at least \$1.4 billion on conferences and did not consistently or transparently track funds spent on conferences and related travel. In September 2007, the Department of Justice's (Department) Inspector General (IG) released a report highlighting the high costs and inconsistent or nonexistent reporting procedures of 10 conferences conducted by the Department in FY 2006. The IG Report recommended that the Department develop and implement consistent conference

planning and reporting procedures. The procedures contained in this policy are consistent with the recommendations contained in the IG Report. Additionally, Section 218 of the Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161), requires the Attorney General to submit quarterly reports to the IG regarding the costs and contracting procedures for each conference held by the Department for which the cost to the government was more than \$20,000. Therefore, each component is required to submit to the Justice Management Division a quarterly report regarding the conferences it funds.

Finally, section 1173 of Public Law 109-162, the Violence Against Women and Department of Justice Reauthorization Act of 2005, states that unless authorized in writing by the Attorney General, the Department (and each entity within it) shall use for any predominantly internal training or conference meeting only a facility that does not require a payment to a private entity for the use of the facility. The Act also requires the Attorney General to prepare an annual report to the Chairmen and ranking minority members of the Committees on the Judiciary of the Senate and of the House of Representatives that details each training and conference meeting that required specific authorization. The report must include an explanation of why the facility was chosen and a breakdown of any expenses incurred in excess of what would have been the cost of conducting the training or conference meeting at a facility that did not require such authorization. The Attorney General has delegated his responsibilities under this provision to the Assistant Attorney General for Administration (AAG/A).

3. DIRECTIVES AND SOURCES REFERENCED.

- 5 U.S.C. §4101(6), Definitions, Non-Government Facility
- 31 U.S.C. §3302, Custodians of Money ("Miscellaneous Receipts Act")
- 31 U.S.C. §6305, Using Cooperative Agreements
- Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161)
- The Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162)
- Federal Travel Regulation (FTR), 41 C.F.R. §300-3.1 and §301-74
- Department of Justice, Office of the Inspector General, "Department of Justice Conference Expenditures," Audit Report 07-42, September 2007 ("IG Report")
- Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 C.F.R. part 70)
- Federal Acquisition Regulation (FAR), Volume 1, Part 10
- Office of Management and Budget (OMB) Cost Principles Circular A-122, 2 C.F.R. 230
- Office of Justice Programs Financial Guide
- Financial Management Memorandum 08-07, Implementation Guide for Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

4. DIRECTIVES RESCINDED.

- Financial Management Policies and Procedures Bulletin 06-12, Use of Non-federal Conference and Training Facilities
- Financial Management Policies and Procedures Bulletin 00-19, Refreshments at Conferences

5. DEFINITIONS

- a. Conference. The FTR defines "conference," in part, as a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. A conference is typically a prearranged event with designated participants and/or registration, a published substantive agenda, and scheduled speakers or discussion panels on a particular topic.

This Bulletin applies to any conference planned and held by components themselves, and conferences funded by a component but conducted by an outside entity through the use of a contract or a cooperative agreement. For a conference conducted through the use of a cooperative agreement, *only* §§9 and 10(b) of this guidance are applicable. With respect to conferences funded by more than one agency, this Bulletin applies if the Department provides more funding than any other agency. When reporting on such conferences, a component should only account for the funding provided by the Department.

The following types of activities are excluded from the definition of "conference" for the purposes of the §10(a) reporting requirement *only*. (Examples for each of the following types of activities that are excluded can be found in Attachment A.)

- 1) Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers;
 - 2) Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy;
 - 3) Undercover activities and training conducted in accordance with the Attorney General's guidelines; or
 - 4) Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is *not* excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.
- b. Predominantly internal training or conference meeting. A predominantly internal training or conference meeting is one that is held by the Department and where the majority (more than 50%) of the attendees are Department employees. As above, "training or conference meeting" is defined broadly to include a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. The above list of activities (§5(a)(1)-(4)) that are excluded from the conference reporting requirements of §10(a) are *not* excluded from this

definition. For the purposes of this bulletin, "predominantly internal training or conference meetings" will be referred to as "predominantly internal events."

- c. Federal facility. Federal facility means property owned, leased, or substantially controlled by the federal Government or the Government of the District of Columbia.
- d. Non-federal facility. Non-federal facility is any facility that is not a federal facility. For further clarification see the definition of "non-Government facility" in 5 U.S.C. §4101(6).
- e. Conference or Event planner. A conference or event planner is a contractor hired by a component to perform the logistical planning necessary to hold a conference. "Logistical planning" may include: interacting with caterers, recommending venues, developing programs, advertising, setting the stage and audio/visual (a/v) equipment, securing hotel rooms, and other non-programmatic functions.

6. CONFERENCE PLANNING.

- a. Conference Justification. The decision to host any event, whether it be a conference or predominantly internal event, or to send employees to attend an event, requires fiscal prudence and is subject to the availability of funds from individual component appropriations. Components must document a written justification for each conference that includes a programmatic reason to hold the event and an approval from an appropriate sponsoring agency official.
- b. Planning Requirements. When planning a conference, components are required to follow Part 301-74 of Title 41 of the Code of Federal Regulations, entitled "Conference Planning." These regulations, in part, require that components:
 - 1) Minimize all conference costs, including administrative costs, conference attendees' travel costs, and conference attendees' time costs;
 - 2) Maximize the use of Government-owned or Government provided conference facilities as much as possible; and
 - 3) Identify opportunities to reduce costs in selecting a particular conference location and facility (e.g., through the availability of lower rates during the off-season at a site with seasonal rates). 41 C.F.R. §301-74.1.
- c. Use of External Conference Planners. Minimizing conference costs must be a critical consideration in a component's decision whether to plan a conference with internal Department staff or to enter into a contract with an external conference planner. The use of an external conference planner should be used only when necessary and conference planning costs should always be kept to a minimum.

- d. Large and/or Expensive Conferences. The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- e. Charging Conference Fees. A component cannot charge fees to conference attendees to cover its costs unless the component has very specific statutory authority to do so. See 31 U.S.C. §3302. However, if the component uses a private contractor (such as an external event planner, hotel, or other third party) to facilitate the conference or provide goods and services to the attendees, the contractor may charge fees. It is important that the fees charged by the contractor cover *only* the goods and/or services provided to the attendees by the contractor (or subcontractor(s)) and do not cover or defray costs that are the responsibility of the component. For example, if a contractor such as a hotel is providing attendees with lodging, meals and refreshments for a conference, the hotel may charge attendees directly for the costs of those items. The contractor must deal directly with the attendees to collect the fees; the component must not be involved in any such collection.
- f. Selecting a Location. An event location is comprised of two variables: the city and the facility in which the event takes place. To ensure that the government obtains the best conference location for the best value, conference planners must compare multiple facilities in multiple cities, unless an overriding operational reason is documented to hold the conference in a specific city. Adequate cost comparisons should compare and document the availability of lodging rooms at per diem rates, the convenience of the conference location, availability of meeting space, equipment and supplies, and the commuting or travel distance of attendees.

To ensure that components maximize the use of federal facilities and minimize total costs to the Department, conference planners shall first consider all federal facilities in the locations identified via city-level cost comparison analysis. A list of some federal facilities is available on the Non-federal Facility Request Center web site: <http://10.173.2.12/jmd/fs/nfrc/index.htm>. If a federal facility meets the component's needs at a reasonable price, there is no requirement that non-federal facilities be considered. The component may consider non-federal facilities if:

- 1) federal facilities are not available or do not meet the component's requirements (e.g., size of the meeting room, necessary technological equipment, sufficient lodging at the facility or in the proximity of the facility); or
- 2) the component believes that a non-federal facility can be procured at a lower cost taking into account all costs described in this section.

If a federal facility cannot meet the component's needs at a reasonable price, the conference planner must conduct and make available market research to determine the facility that best meets the needs of the conference as set forth in the Federal Acquisition Regulation (FAR), Volume 1, Part 10. In order for this market research to be effective, the components must communicate the same sufficiently detailed requirements to all potential facilities. During

the market research, components must not make any commitments to any of the facilities. The market research must determine the cost of the event with respect to each of the three (or more) facilities, broken down as follows. Costs related to attendees (e.g., travel, lodging, per diem) must include costs of all attendees whose expenses are being covered by the component; therefore, include Department employees as well as non-Department attendees (e.g., facilitators, guest speakers) whose expenses are being covered by the component.

- 1) conference and meeting space, including rooms for break-out sessions;
- 2) audio visual services;
- 3) other equipment costs (e.g., computer fees, telephone fees);
- 4) printing and distribution;
- 5) meals provided by the Department;
- 6) refreshments provided by the Department;
- 7) meals and incidental expenses for attendees (M&IE portion of per diem);
- 8) lodging costs;
- 9) transportation to/from conference location (e.g., common carrier, POV);
- 10) local transportation (e.g., rental car, POV) at event location;
- 11) conference planners;
- 12) conference facilitators;
- 13) any other costs associated with the conference.

Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. See §8(b). Special approval is also required to hold such an event in certain locations. §8(b)(3).

7. MEALS AND REFRESHMENTS.

a. When permissible to provide.

- 1) *Federal Government Employees.* Meals and/or refreshments¹ may be paid for by the Department and provided to federal Government employees at conferences or training sessions where *all three* of the following are true:
 - a) the meals and refreshments are incidental to the conference or training;
 - b) attendance at the meals and when refreshments are served is important for the host agency to ensure attendees' full participation in essential discussions, lectures, or speeches concerning the purpose of the conference or training; AND
 - c) the meals and refreshments are part of a conference or training that includes not just the meals and refreshments and discussions, speeches, lectures, or other business that

¹ Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

may take place when the meals and refreshments are served, but also includes substantial functions occurring separately from when the food is served.

While as a general rule the Department does not pay for meals and/or refreshments for employees at their duty stations, if a conference or training meets the above criteria, meals and refreshments may be served to employees who are not on travel. With respect to Department employees who are on travel, they must deduct from their per diem the amount for each meal provided by the Department.

- 2) *Non-Federal Government Attendees.* The Department can only pay for the meals and/or refreshments² of non-federal attendees at conferences IF ONE of the following applies:
 - a) The component has specific statutory authority permitting it (e.g., 42 U.S.C. §3788(f) for programs covered by the Omnibus Crime Control and Safe Streets Act; 42 U.S.C.A. §3771 and *note*);
 - b) The non-federal attendees qualify as individuals serving the Department pursuant to 5 U.S.C. §5703;³ OR
 - c) The expenses can be considered official reception and representation expenses (28 U.S.C. §530C(b)(1)(D)), and are counted towards the Department's Representation Fund limitations (*see* DOJ Order 2110.31B).
- 3) *Charging Non-Federal Attendees.* As discussed in §6(c), a private contractor (such as an external event planner, hotel, or other third party) can charge fees to non-federal attendees to cover the costs of such goods and services as meals and/or refreshments. The contractor must deal directly with the attendees to collect the fees for the meals and/or refreshments; the component must not be involved in any such collection.
- b. Minimizing costs of meals and refreshments. Components (as well as contractors hired as conference or event planners) must adhere to the following cost thresholds, described further in Attachment B, for the costs of the meals and refreshments provided at the conference.
 - 1) *Refreshments.* Refreshments include light food and drink served at breaks, such as coffee, tea, milk, juice, soft drinks, donuts, bagels, fruit, pretzels, cookies, chips, or muffins. The cost of these items, plus any hotel service costs, cannot exceed 23% of the locality M&IE

² Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

³ Non-federal attendees who are provided any travel, lodging or meals and/or refreshments by the Department pursuant to 5 U.S.C. §5703 must be issued invitational travel orders. These are required even when a non-federal attendee is "local" to the conference and is only being provided meals and/or refreshments.

rate per person per day. For example, if the M&IE rate for a particular location is \$54.00 per person per day, then the total refreshments costs cannot exceed \$12.42 (\$54.00 x 23%) per person per day.

- 2) *Meals.* The cost of any meal provided, plus any hotel service costs, cannot exceed 150% of the locality M&IE rate per meal. For example, if dinner will be provided in a locality with a \$49.00/day M&IE rate, the dinner rate in the locality is \$24.00 per dinner. Therefore, the cost of the dinner provided at the conference cannot exceed \$36.00 (\$24.00 x 150%) per person. All Department employees attending the conference must ensure that the provided meal is deducted from their claimed M&IE; in this example the employee would deduct \$24.00 from claimed M&IE for the provided dinner.
- 3) Component Heads must request approval from the AAG/A to provide refreshments or meal costs that exceed these thresholds. See §8(d).

8. SPECIAL APPROVALS.

a. Use of Non-Federal Facilities for Predominantly Internal Events.

- 1) Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. Such requests must be submitted by no lower than the management official responsible for approving the conference in the component and must be sent to the Director, Finance Staff, using the Conference Reporting and Non-federal Facility Request Center web site, <http://10.173.2.12/jmd/fs/nfrc/index.htm>. Any request for approval of a non-federal facility must include the following:
 - a) Statement of the purpose of the training or conference meeting;
 - b) Number of attendees and their organizations and duty stations (components must also indicate which, if any, of the attendees who are not Departmental employees will have their expenses paid for by the component);
 - c) Frequency of the training or conference meeting and the date of the last such event, if applicable;
 - d) Dates of the training or conference meeting;
 - e) Location of the training or conference meeting (city/state) and reason(s) for choosing the location;
 - f) Reason why a location where a federal facility is located was not considered, if applicable;
 - g) List of federal and non-federal facilities considered;
 - h) Estimated costs of using each of the federal and non-federal facilities considered,

including all costs listed in §6(f) as determined by the market research, itemized and broken out by category;

- i) Reasons why the federal facilities did not meet the meeting's requirements, if applicable (refer to §6(f));
 - j) Justification for the use of a non-federal facility; and
 - k) Gift acceptance approval, if required.
- 2) Approval for Certain Locations. Any request to hold a predominantly internal event in a non-federal facility in the following locations must be submitted by the Component Head, and this responsibility cannot be redelegated.
- a) Any location outside the continental United States (including Hawaii and Alaska);
 - b) Any location known for gambling (e.g., Las Vegas, Nevada; Reno, Nevada; Atlantic City, New Jersey);
 - c) Any location considered a tourist attraction or common vacation location (e.g., Disney World and Orlando, Florida; Niagara Falls, New York; Lake Tahoe); or
 - d) Any resort facility or resort location (e.g., Hilton Head, South Carolina; Sonoma Valley, California).
- b. Large and/or Expensive conferences. The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- c. Meals and Refreshments Exceeding Thresholds. Component Heads must request approval from the AAG/A to provide meals and/or refreshments that exceed the cost thresholds described in §7(b). Component Heads must submit a memorandum to the AAG/A through JMD Finance Staff acknowledging that the proposed meals and refreshments exceed these thresholds and explaining why this is deemed necessary. This responsibility cannot be redelegated. When the conference at issue also requires a request to use a non-federal facility, this memorandum must be submitted with the non-federal facility request form. For all other events, the memorandum must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.
9. CONFERENCES HELD BY COOPERATIVE AGREEMENT RECIPIENTS
- a. When to Use Cooperative Agreement. A cooperative agreement may not be chosen in order to avoid the statutory and regulatory requirements associated with the use of a contract. The decision to use a cooperative agreement, as opposed to a contract or grant, should be made in consultation with the component's legal counsel, applying the standards set forth in 31 U.S.C. §6305, which, in general, authorizes the use of a cooperative agreement where the conference would carry out a public purpose of support or stimulation of outside entities, and substantial involvement by the Department is expected. Although the standards in §6305 must govern

the choice of vehicle, in determining if a conference would carry out such a public purpose (as opposed to merely providing a direct benefit to the Department or its employees), a significant factor is whether the primary beneficiaries of the conference are outside the federal Government.

b. Cost Principles that Apply to Non-Profit Cooperative Agreement Recipients.

- 1) Directives. Non-Profit cooperative agreement recipients must comply with the Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 CFR Part 70), OMB Cost Principles Circular A-122, 2 C.F.R. 230, and, if applicable, the Office of Justice Programs Financial Guide, or any other component-specific guidance. According to A-122: "Costs of meetings and conferences, the primary purpose of which is the dissemination of technical information, are allowable. This includes costs of meals, transportation, rental of facilities, speakers' fees, and other items incidental to such meetings or conferences."
- 2) Reasonable Standard. The amount spent on conference costs is governed by the general principle that the costs be "reasonable," which is further defined in OMB Circular A-122, Attachment A, paragraph 3. Furthermore, cooperative agreement recipients must comply with the travel guidelines at OMB Circular A-122, Attachment B, paragraph 51, and the OJP Financial Guide (if applicable), which require that if a recipient does not have a written travel policy, the recipient must abide by the rates and amounts established by the General Services Administration (GSA) in the Federal Travel Regulations, 41 C.F.R. ch. 301.⁴

c. Required Special Condition For New Awards. All cooperative agreements that include holding a conference as a recipient responsibility must include the following special condition:

"Within 45 days after the end of any conference, meeting, retreat, seminar, symposium, training activity, or similar event funded under this award, and the total cost of which exceeds \$20,000 in award funds, the recipient must provide the program manager with the following information and itemized costs:

- 1) name of event;
- 2) event dates;
- 3) location of event;
- 4) number of federal attendees;
- 5) number of non-federal attendees;

⁴ GSA's regulations and per diem rates may be found at www.gsa.gov

- 6) costs of event space, including rooms for break-out sessions;
- 7) costs of audio visual services;
- 8) other equipment costs (e.g., computer fees, telephone fees);
- 9) costs of printing and distribution;
- 10) costs of meals provided during the event;
- 11) costs of refreshments provided during the event;
- 12) costs of event planner;
- 13) costs of event facilitators; and
- 14) any other direct costs associated with the event.

The recipient must also itemize and report any of the following attendee (including participants, presenters, speakers) costs that are paid or reimbursed with cooperative agreement funds:

- 1) meals and incidental expenses (M&IE portion of per diem);
- 2) lodging;
- 3) transportation to/from event location (e.g., common carrier, privately owned vehicle (POV)); and
- 4) local transportation (e.g., rental car, POV) at event location.

Note that if any item is paid for with registration fees, or any other non-award funding, then that portion of the expense does not need to be reported."

- d. Information Gathered From Former or Existing Cooperative Agreement Recipients. Components are required to gather the specific information listed in section (c) from any cooperative agreement recipient that held a conference between October 1, 2007 and the present, and from any cooperative agreement recipient that holds a conference under the terms of an existing cooperative agreement.
- e. Review and Reporting. Each sponsoring component must review the itemized costs and clarify any of the reported information with the cooperative agreement recipient, as necessary. The component must also itemize all of the transportation costs, M&IE, per diem, and lodging costs *paid by the component itself* to send either its component employees or employees of another DOJ component to the event. The DOJ employee travel costs paid by the component should be added to each itemized category as well as the overall cost of the event. Within 45 calendar days following the close of each fiscal quarter, the component shall submit a report on each conference costing more than \$20,000 held by its cooperative agreement recipients, as described in §10(b).

10. REPORTING.

a. Quarterly Reporting of Conference Costs. The Attorney General is required to submit quarterly reports to the IG regarding the costs and contracting procedures relating to each conference held by the Department for which the total cost of the conference was more than \$20,000. To facilitate this process, each office holding a conference as defined by §5(a) and costing more than \$20,000, is required to submit the following information to the appropriate office within its component:

- 1) a description of the purpose of each conference, the number of participants attending the conference, and how many were federal government employees;
- 2) a detailed list of all costs categorized in §6(f), and any issues encountered in determining the costs related to that conference; and
- 3) a description of the contracting procedures with respect to each contract relating to that conference, including:
 - a) whether contracts were awarded on a competitive basis for that conference; and
 - b) a discussion of any cost comparison conducted by the Department in evaluating potential contractors for that conference.

No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a) during that quarter must submit a report, signed by the Component Head, which includes the above information for each such conference. The template at Attachment B should be used to compile the information and submit this report. The component must also submit any special approvals required by §8 with this report. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.

b. Quarterly Reporting on Cooperative Agreement Conferences. No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a), through the use of a cooperative agreement as described in §9 and costing more than \$20,000, shall report on the event using the template at Attachment B. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.

c. Quarterly Reporting on Use of Non-Federal Facilities for Predominantly Internal Events. Within 45 calendar days following the close of each fiscal quarter, every component that has held a predominantly internal event at a non-federal facility must submit a report, signed by the Component Head, to Conferences.and.Non-federal.Center@usdoj.gov. The template at Attachment B should be used to compile the information and submit this report. The report must highlight and explain any increases in costs above those submitted with the original request for approval. All market research data and cost analysis/actual cost information must remain on file with the component.

11. QUESTIONS. Questions regarding these requirements may be directed to Lori Arnold, Assistant Director, Financial Management Policies and Requirements Group, Finance Staff, on (202) 616-5216, or Melinda Jones, of her staff, on (202) 353-2527.

Attachments

Activities Not Reported as Conferences under §10 (a)

Activity Type 1:

Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers.

Activity
Meeting of attorneys to discuss a pending case
Meeting of DOJ agents to discuss strategy in an ongoing hostage situation

Activity Type 2:

Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy.

Activity Type 3:

Undercover activities and training conducted in accordance with the Attorney General's guidelines.

Activity Type 4:

Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is not excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.

Activity
Quarterly Firearms Certification

Activities Reported as Conferences under §10 (a) If over \$20,000

Activity	Description
OCDETF Financial Investigations Seminar	Mandated seminar to learn financial investigative techniques of criminal enterprise
Computer Analysis and Response Team Moot Court	Attendees meet to gain exposure to cross examination from attorneys on cases they have investigated
OIG Investigations Managers Conference	Meeting of Senior Managers from within the Investigations Division
Immigration Judge Training	Immigration judges from across the U.S. gain training and participate in policy discussions
Operational Medic Program	Attendees are trained in order to comply with National Registry of Emergency Technicians' national standards

Quarterly Report on Conference Costs

Attachment B

Component: _____ Telephone: _____

Point of Contact: _____ Email: _____

Conference Title:	Non-Federal Facility		Conference over \$20,000		Non-Federal Facility		Conference over \$20,000	
Event Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference Date (Start & End)								
Facility Name								
City and State								
Number of Federal Attendees								
Number of non-Federal Attendees								
Total Number of Attendees								

Purpose of Conference	Non-Federal Facility	Conference over \$20,000	Non-Federal Facility	Conference over \$20,000
Conference Costs:				
Conference/Meeting Space (incl. Break out Room Cost)		\$0.00	\$0.00	\$0.00
AV Equipment & Services		\$0.00	\$0.00	\$0.00
Other Equipment Costs		\$0.00	\$0.00	\$0.00
Printing and Distribution		\$0.00	\$0.00	\$0.00
Gov't Provided Meals		\$0.00	\$0.00	\$0.00
Refreshments		\$0.00	\$0.00	\$0.00
M&IE		\$0.00	\$0.00	\$0.00
Lodging		\$0.00	\$0.00	\$0.00
Transportation		\$0.00	\$0.00	\$0.00
Local Transportation		\$0.00	\$0.00	\$0.00
Conference Planner		\$0.00	\$0.00	\$0.00
Conference Facilitator		\$0.00	\$0.00	\$0.00
Other Costs		\$0.00	\$0.00	\$0.00
Total Conference Cost		\$0.00	\$0.00	\$0.00
Average Cost per Attendee		\$0.00	\$0.00	\$0.00

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For Events in Non-Federal Facilities Only			
Total Original Cost Estimate	\$0.00	\$0.00	\$0.00
Variance (Actual vs. Estimated)	\$0.00	\$0.00	\$0.00

¹ Attach additional pages to explain methodology if you are unable to capture costs as described in Policy XX or if any costs appear to be out of the ordinary.
² Attach additional pages to explain contracting procedures.
³ Use Attachment C to provide a justification narrative for all events in which the actual cost exceeds the estimate, the justification needs to be itemized.

Non-federal Facility Event Variance Justification

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference Costs	Estimated Cost	Reported Cost	Variance	Justification
Conference/Meeting Space	\$0.00	\$0.00	\$0.00	
AV Equipment & Services	\$0.00	\$0.00	\$0.00	
Other Equipment Costs	\$0.00	\$0.00	\$0.00	
Printing and Distribution	\$0.00	\$0.00	\$0.00	
Gov't Provided Meals	\$0.00	\$0.00	\$0.00	
Refreshments	\$0.00	\$0.00	\$0.00	
M&IE	\$0.00	\$0.00	\$0.00	
Lodging	\$0.00	\$0.00	\$0.00	
Transportation	\$0.00	\$0.00	\$0.00	
Local Transportation	\$0.00	\$0.00	\$0.00	
Conference Planner	\$0.00	\$0.00	\$0.00	
Conference Facilitator	\$0.00	\$0.00	\$0.00	
Other Costs	\$0.00	\$0.00	\$0.00	
Total Conference Cost	\$0.00	\$0.00	\$0.00	

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference Costs	Estimated Cost	Reported Cost	Variance	Justification
Conference/Meeting Space	\$0.00	\$0.00	\$0.00	
AV Equipment & Services	\$0.00	\$0.00	\$0.00	
Other Equipment Costs	\$0.00	\$0.00	\$0.00	
Printing and Distribution	\$0.00	\$0.00	\$0.00	
Gov't Provided Meals	\$0.00	\$0.00	\$0.00	
Refreshments	\$0.00	\$0.00	\$0.00	
M&IE	\$0.00	\$0.00	\$0.00	
Lodging	\$0.00	\$0.00	\$0.00	
Transportation	\$0.00	\$0.00	\$0.00	
Local Transportation	\$0.00	\$0.00	\$0.00	
Conference Planner	\$0.00	\$0.00	\$0.00	
Conference Facilitator	\$0.00	\$0.00	\$0.00	
Other Costs	\$0.00	\$0.00	\$0.00	
Total Conference Cost	\$0.00	\$0.00	\$0.00	

¹Attach additional pages to describe justification



U.S. Department of Justice

JUN -5 2008

Washington, D.C. 20530

MEMORANDUM FOR COMPONENT HEADS

FROM:

Lee J. Lofthus
Assistant Attorney General
for Administration

SUBJECT:

Conference Planning, Conference Cost Reporting, and Approvals to Use
Non-federal Facilities

Attached is Financial Management Policies and Procedures Bulletin (P&P) 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities, which covers the new conference planning and reporting requirements. The prior Bulletin, Use of Non-federal Conference and Training Facilities, 06-12, has been rescinded and is combined with this policy. The attached Executive Summary explains the new requirements contained in this policy. The two primary goals of the new policy are to keep conference costs to a minimum and to ensure we can fulfill the statutory reporting requirements to Congress. In addition, I want to remind you of some considerations to help ensure your approval requests and reports are processed smoothly.

- Avoid locations and accommodations that give the appearance of being lavish or are resort destinations. Component Heads are required to submit written justification if the facility gives the appearance of being lavish or is a resort location. This cannot be re-delegated.
- **Ensure the selected lodging location is within per diem.**
- Ensure the costs of meals and refreshments are within the prescribed limits.
- Ensure meals provided by the government are deducted from Meals and Incidentals Expenses (M&IE) claimed by all Department of Justice attendees (by meal).
- Ensure that multiple facilities in multiple cities are compared when considering conference locations.
- Ensure proper requests are submitted to the Justice Management Division in time to allow for appropriate review prior to your contract commitment.
- Ensure that reporting of costs for all Non-federal Facility events and Conferences are submitted by Component Heads no later than 45 days following the close of each fiscal quarter.

If you have questions, please let me know or your staff may contact Lori J. Arnold, Assistant Director, Financial Management Policies and Requirements Group, on (202) 616-5216.

Attachments

**Conference Planning, Conference Cost Reporting, and Approvals to Use
Non-federal Facilities Policy Executive Summary**

- Consolidated Policy – The Conference Planning and Reporting has been combined with the Approvals to Use Non-federal Facilities Policy. Policy & Procedures Bulletin 06-12 has been rescinded.
- Conference Definition (Section 5a) – The conference definition is broad and includes the training activities. Exclusions are defined.
- Selecting a Location (Section 6f) – A location is comprised of both the city and the facility in which the conference will be held.
- Calculating Conference Costs (Section 6f) – Components are required to be able to report actual cost for 13 cost categories.
- Provided Meals and Refreshments (Section 7a) – Meals and refreshments may not be provided at government expense unless certain criteria is met.
- Minimizing costs of Meals and Refreshments (Section 7b) – Meals and refreshments must fall within established thresholds.
- Large Conferences (Section 8c) – The Component Procurement Chief must review and approve all conferences that exceed \$500,000 or 500 attendees.
- Conferences held by Cooperative Agreement (Section 9) – Different planning and reporting (Section 10b) requirements are explained.
- Quarterly Reporting of Conference Costs (Section 10a) – Pursuant to Section 218 of the Consolidated Appropriations Act, Component Heads are required to report on all conferences exceeding \$20,000.
- Reporting Deadline (Sections 10a, b, and c) – Reports are due 45 calendar days after the end of each fiscal quarter.
- Reporting on Events Held in Non-federal Facilities (Section 10c) – Component Heads are required to prepare a consolidated quarterly report of all events held in a non-federal facility rather than report after each event.
- New Email Inbox – All non-federal facility requests and reports and conference reports must be sent to the new address entitled Conferences.and.Non-federal.Center@usdoj.gov. The previous email address, Non-fed.Facility.Request.Center@usdoj.gov, has been deactivated.

We understand that some components want to provide meals and refreshments to non-federal attendees and object to the requirement that they may be provided only under certain conditions. The Office of Legal Counsel recently reviewed their opinion in light of these concerns yet concluded there is no basis for overturning their original conclusion.



**FINANCIAL MANAGEMENT
POLICIES AND PROCEDURES BULLETIN**

No. 08-08

April 2008

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

JMD Senior Staff

Bureau Chief Financial Officers

FROM: Melinda B. Morgan
Director
Finance Staff
Justice Management Division

SUBJECT: Conference Planning, Conference Cost Reporting, and Approvals to Use Non-Federal Facilities

1. **PURPOSE.** This policy provides guidance to components when planning and reporting on conferences. This policy also lays out the requirement for components to seek approval prior to using a non-federal facility for a predominantly internal training or conference meeting.

2. **BACKGROUND.** In the summer of 2005, a subcommittee of the U.S. Senate Committee on Homeland Security and Governmental Affairs launched a government-wide inquiry into conference spending. The inquiry found that since fiscal year (FY) 2000, federal agencies spent at least \$1.4 billion on conferences and did not consistently or transparently track funds spent on conferences and related travel. In September 2007, the Department of Justice's (Department) Inspector General (IG) released a report highlighting the high costs and inconsistent or nonexistent reporting procedures of 10 conferences conducted by the Department in FY 2006. The IG Report recommended that the Department develop and implement consistent conference

planning and reporting procedures. The procedures contained in this policy are consistent with the recommendations contained in the IG Report. Additionally, Section 218 of the Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161), requires the Attorney General to submit quarterly reports to the IG regarding the costs and contracting procedures for each conference held by the Department for which the cost to the government was more than \$20,000. Therefore, each component is required to submit to the Justice Management Division a quarterly report regarding the conferences it funds.

Finally, section 1173 of Public Law 109-162, the Violence Against Women and Department of Justice Reauthorization Act of 2005, states that unless authorized in writing by the Attorney General, the Department (and each entity within it) shall use for any predominantly internal training or conference meeting only a facility that does not require a payment to a private entity for the use of the facility. The Act also requires the Attorney General to prepare an annual report to the Chairmen and ranking minority members of the Committees on the Judiciary of the Senate and of the House of Representatives that details each training and conference meeting that required specific authorization. The report must include an explanation of why the facility was chosen and a breakdown of any expenses incurred in excess of what would have been the cost of conducting the training or conference meeting at a facility that did not require such authorization. The Attorney General has delegated his responsibilities under this provision to the Assistant Attorney General for Administration (AAG/A).

3. DIRECTIVES AND SOURCES REFERENCED.

- 5 U.S.C. §4101(6), Definitions, Non-Government Facility
- 31 U.S.C. §3302, Custodians of Money ("Miscellaneous Receipts Act")
- 31 U.S.C. §6305, Using Cooperative Agreements
- Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161)
- The Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162)
- Federal Travel Regulation (FTR), 41 C.F.R. §300-3.1 and §301-74
- Department of Justice, Office of the Inspector General, "Department of Justice Conference Expenditures," Audit Report 07-42, September 2007 ("IG Report")
- Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 C.F.R. part 70)
- Federal Acquisition Regulation (FAR), Volume 1, Part 10
- Office of Management and Budget (OMB) Cost Principles Circular A-122, 2 C.F.R. 230
- Office of Justice Programs Financial Guide
- Financial Management Memorandum 08-07, Implementation Guide for Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities

4. DIRECTIVES RESCINDED.

- Financial Management Policies and Procedures Bulletin 06-12, Use of Non-federal Conference and Training Facilities
- Financial Management Policies and Procedures Bulletin 00-19, Refreshments at Conferences

5. DEFINITIONS.

- a. Conference. The FTR defines "conference," in part, as a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. A conference is typically a prearranged event with designated participants and/or registration, a published substantive agenda, and scheduled speakers or discussion panels on a particular topic.

This Bulletin applies to any conference planned and held by components themselves, and conferences funded by a component but conducted by an outside entity through the use of a contract or a cooperative agreement. **For a conference conducted through the use of a cooperative agreement, only §§9 and 10(b) of this guidance are applicable.** With respect to conferences funded by more than one agency, this Bulletin applies if the Department provides more funding than any other agency. When reporting on such conferences, a component should only account for the funding provided by the Department.

The following types of activities are excluded from the definition of "conference" for the purposes of the §10(a) reporting requirement *only*. (Examples for each of the following types of activities that are excluded can be found in Attachment A.)

- 1) Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers;
 - 2) Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy;
 - 3) Undercover activities and training conducted in accordance with the Attorney General's guidelines; or
 - 4) Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is *not* excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.
- b. Predominantly internal training or conference meeting. A predominantly internal training or conference meeting is one that is held by the Department and where the majority (more than 50%) of the attendees are Department employees. As above, "training or conference meeting" is defined broadly to include a meeting, retreat, seminar, symposium, event or training activity. 41 C.F.R. §300-3.1. The above list of activities (§5(a)(1)-(4)) that are excluded from the conference reporting requirements of §10(a) are *not* excluded from this

definition. For the purposes of this bulletin, "predominantly internal training or conference meetings" will be referred to as "predominantly internal events."

- c. Federal facility. Federal facility means property owned, leased, or substantially controlled by the federal Government or the Government of the District of Columbia.
- d. Non-federal facility. Non-federal facility is any facility that is not a federal facility. For further clarification see the definition of "non-Government facility" in 5 U.S.C. §4101(6).
- e. Conference or Event planner. A conference or event planner is a contractor hired by a component to perform the logistical planning necessary to hold a conference. "Logistical planning" may include: interacting with caterers, recommending venues, developing programs, advertising, setting the stage and audio/visual (a/v) equipment, securing hotel rooms, and other non-programmatic functions.

6. CONFERENCE PLANNING.

- a. Conference Justification. The decision to host any event, whether it be a conference or predominantly internal event, or to send employees to attend an event, requires fiscal prudence and is subject to the availability of funds from individual component appropriations. Components must document a written justification for each conference that includes a programmatic reason to hold the event and an approval from an appropriate sponsoring agency official.
- b. Planning Requirements. When planning a conference, components are required to follow Part 301-74 of Title 41 of the Code of Federal Regulations, entitled "Conference Planning." These regulations, in part, require that components:
 - 1) Minimize all conference costs, including administrative costs, conference attendees' travel costs, and conference attendees' time costs;
 - 2) Maximize the use of Government-owned or Government provided conference facilities as much as possible; and
 - 3) Identify opportunities to reduce costs in selecting a particular conference location and facility (e.g., through the availability of lower rates during the off-season at a site with seasonal rates). 41 C.F.R. §301-74.1.
- c. Use of External Conference Planners. Minimizing conference costs must be a critical consideration in a component's decision whether to plan a conference with internal Department staff or to enter into a contract with an external conference planner. The use of an external conference planner should be used only when necessary and conference planning costs should always be kept to a minimum.

- d. Large and/or Expensive Conferences. The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- e. Charging Conference Fees. A component cannot charge fees to conference attendees to cover its costs unless the component has very specific statutory authority to do so. *See* 31 U.S.C. §3302. However, if the component uses a private contractor (such as an external event planner, hotel, or other third party) to facilitate the conference or provide goods and services to the attendees, the contractor may charge fees. It is important that the fees charged by the contractor cover *only* the goods and/or services provided to the attendees by the contractor (or subcontractor(s)) and do not cover or defray costs that are the responsibility of the component. For example, if a contractor such as a hotel is providing attendees with lodging, meals and refreshments for a conference, the hotel may charge attendees directly for the costs of those items. The contractor must deal directly with the attendees to collect the fees; the component must not be involved in any such collection.
- f. Selecting a Location. An event location is comprised of two variables: the city and the facility in which the event takes place. To ensure that the government obtains the best conference location for the best value, conference planners must compare multiple facilities in multiple cities, unless an overriding operational reason is documented to hold the conference in a specific city. Adequate cost comparisons should compare and document the availability of lodging rooms at per diem rates, the convenience of the conference location, availability of meeting space, equipment and supplies, and the commuting or travel distance of attendees.

To ensure that components maximize the use of federal facilities and minimize total costs to the Department, conference planners shall first consider all federal facilities in the locations identified via city-level cost comparison analysis. A list of some federal facilities is available on the Non-federal Facility Request Center web site:

<http://10.173.2.12/jmd/fs/nfrc/index.htm>. If a federal facility meets the component's needs at a reasonable price, there is no requirement that non-federal facilities be considered. The component may consider non-federal facilities if:

- 1) federal facilities are not available or do not meet the component's requirements (e.g., size of the meeting room, necessary technological equipment, sufficient lodging at the facility or in the proximity of the facility); or
- 2) the component believes that a non-federal facility can be procured at a lower cost taking into account all costs described in this section.

If a federal facility cannot meet the component's needs at a reasonable price, the conference planner must conduct and make available market research to determine the facility that best meets the needs of the conference as set forth in the Federal Acquisition Regulation (FAR), Volume 1, Part 10. In order for this market research to be effective, the components must communicate the same sufficiently detailed requirements to all potential facilities. During

the market research, components must not make any commitments to any of the facilities. The market research must determine the cost of the event with respect to each of the three (or more) facilities, broken down as follows. Costs related to attendees (e.g., travel, lodging, per diem) must include costs of all attendees whose expenses are being covered by the component; therefore, include Department employees as well as non-Department attendees (e.g., facilitators, guest speakers) whose expenses are being covered by the component.

- 1) conference and meeting space, including rooms for break-out sessions;
- 2) audio visual services;
- 3) other equipment costs (e.g., computer fees, telephone fees);
- 4) printing and distribution;
- 5) meals provided by the Department;
- 6) refreshments provided by the Department;
- 7) meals and incidental expenses for attendees (M&IE portion of per diem);
- 8) lodging costs;
- 9) transportation to/from conference location (e.g., common carrier, POV);
- 10) local transportation (e.g., rental car, POV) at event location;
- 11) conference planners;
- 12) conference facilitators;
- 13) any other costs associated with the conference.

Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. See §8(b). Special approval is also required to hold such an event in certain locations. §8(b)(3).

7. MEALS AND REFRESHMENTS.

a. When permissible to provide.

- 1) *Federal Government Employees.* Meals and/or refreshments¹ may be paid for by the Department and provided to federal Government employees at conferences or training sessions where *all three* of the following are true:
 - a) the meals and refreshments are incidental to the conference or training;
 - b) attendance at the meals and when refreshments are served is important for the host agency to ensure attendees' full participation in essential discussions, lectures, or speeches concerning the purpose of the conference or training; AND
 - c) the meals and refreshments are part of a conference or training that includes not just the meals and refreshments and discussions, speeches, lectures, or other business that

¹ Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

may take place when the meals and refreshments are served, but also includes substantial functions occurring separately from when the food is served.

While as a general rule the Department does not pay for meals and/or refreshments for employees at their duty stations, if a conference or training meets the above criteria, meals and refreshments may be served to employees who are not on travel. With respect to Department employees who are on travel, they must deduct from their per diem the amount for each meal provided by the Department.

- 2) *Non-Federal Government Attendees*. The Department can only pay for the meals and/or refreshments² of non-federal attendees at conferences IF ONE of the following applies:
 - a) The component has specific statutory authority permitting it (*e.g.*, 42 U.S.C. §3788(f) for programs covered by the Omnibus Crime Control and Safe Streets Act; 42 U.S.C.A. §3771 and *note*);
 - b) The non-federal attendees qualify as individuals serving the Department pursuant to 5 U.S.C. §5703;³ OR
 - c) The expenses can be considered official reception and representation expenses (28 U.S.C. §530C(b)(1)(D)), and are counted towards the Department's Representation Fund limitations (*see* DOJ Order 2110.31B).
 - 3) *Charging Non-Federal Attendees*. As discussed in §6(e), a private contractor (such as an external event planner, hotel, or other third party) can charge fees to non-federal attendees to cover the costs of such goods and services as meals and/or refreshments. The contractor must deal directly with the attendees to collect the fees for the meals and/or refreshments; the component must not be involved in any such collection.
- b. Minimizing costs of meals and refreshments. Components (as well as contractors hired as conference or event planners) must adhere to the following cost thresholds, described further in Attachment B, for the costs of the meals and refreshments provided at the conference.
- 1) *Refreshments*. Refreshments include light food and drink served at breaks, such as coffee, tea, milk, juice, soft drinks, donuts, bagels, fruit, pretzels, cookies, chips, or muffins. The cost of these items, plus any hotel service costs, cannot exceed 23% of the locality M&IE

² Note that the rules are the same regardless of whether the component is providing a meal or merely refreshments.

³ Non-federal attendees who are provided any travel, lodging or meals and/or refreshments by the Department pursuant to 5 U.S.C. §5703 must be issued invitational travel orders. These are required even when a non-federal attendee is "local" to the conference and is only being provided meals and/or refreshments.

rate per person per day. For example, if the M&IE rate for a particular location is \$54.00 per person per day, then the total refreshments costs cannot exceed \$12.42 (\$54.00 x 23%) per person per day.

- 2) *Meals.* The cost of any meal provided, plus any hotel service costs, cannot exceed 150% of the locality M&IE rate per meal. For example, if dinner will be provided in a locality with a \$49.00/day M&IE rate, the dinner rate in the locality is \$24.00 per dinner. Therefore, the cost of the dinner provided at the conference cannot exceed \$36.00 (\$24.00 x 150%) per person. All Department employees attending the conference must ensure that the provided meal is deducted from their claimed M&IE; in this example the employee would deduct \$24.00 from claimed M&IE for the provided dinner.
- 3) Component Heads must request approval from the AAG/A to provide refreshments or meal costs that exceed these thresholds. See §8(d).

8. SPECIAL APPROVALS.

a. Use of Non-Federal Facilities for Predominantly Internal Events.

- 1) Any component wishing to hold a predominantly internal event at a non-federal facility that requires payment to that facility for the event (including any payment for meals, lodging, or other expenses related to the event) must obtain approval from the AAG/A before entering into a contract with such facility. Such requests must be submitted by no lower than the management official responsible for approving the conference in the component and must be sent to the Director, Finance Staff, using the Conference Reporting and Non-federal Facility Request Center web site, <http://10.173.2.12/jmd/fs/nfrc/index.htm>. Any request for approval of a non-federal facility must include the following:
 - a) Statement of the purpose of the training or conference meeting;
 - b) Number of attendees and their organizations and duty stations (components must also indicate which, if any, of the attendees who are not Departmental employees will have their expenses paid for by the component);
 - c) Frequency of the training or conference meeting and the date of the last such event, if applicable;
 - d) Dates of the training or conference meeting;
 - e) Location of the training or conference meeting (city/state) and reason(s) for choosing the location;
 - f) Reason why a location where a federal facility is located was not considered, if applicable;
 - g) List of federal and non-federal facilities considered;
 - h) Estimated costs of using each of the federal and non-federal facilities considered,

- including all costs listed in §6(f) as determined by the market research, itemized and broken out by category;
- i) Reasons why the federal facilities did not meet the meeting's requirements, if applicable (refer to §6(f));
 - j) Justification for the use of a non-federal facility; and
 - k) Gift acceptance approval, if required.
- 2) **Approval for Certain Locations.** Any request to hold a predominantly internal event in a non-federal facility in the following locations must be submitted by the Component Head, and this responsibility cannot be redelegated.
- a) Any location outside the continental United States (including Hawaii and Alaska);
 - b) Any location known for gambling (e.g., Las Vegas, Nevada; Reno, Nevada; Atlantic City, New Jersey);
 - c) Any location considered a tourist attraction or common vacation location (e.g., Disney World and Orlando, Florida; Niagara Falls, New York; Lake Tahoe); or
 - d) Any resort facility or resort location (e.g., Hilton Head, South Carolina; Sonoma Valley, California).
- b. **Large and/or Expensive conferences.** The appropriate Component Procurement Chief must review and approve all conferences exceeding \$500,000, or that will have over 500 attendees. Such approval must be in writing and submitted with the report required in §10(a).
- c. **Meals and Refreshments Exceeding Thresholds.** Component Heads must request approval from the AAG/A to provide meals and/or refreshments that exceed the cost thresholds described in §7(b). Component Heads must submit a memorandum to the AAG/A through JMD Finance Staff acknowledging that the proposed meals and refreshments exceed these thresholds and explaining why this is deemed necessary. This responsibility cannot be redelegated. When the conference at issue also requires a request to use a non-federal facility, this memorandum must be submitted with the non-federal facility request form. For all other events, the memorandum must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.
9. **CONFERENCES HELD BY COOPERATIVE AGREEMENT RECIPIENTS**
- a. **When to Use Cooperative Agreement.** A cooperative agreement may not be chosen in order to avoid the statutory and regulatory requirements associated with the use of a contract. The decision to use a cooperative agreement, as opposed to a contract or grant, should be made in consultation with the component's legal counsel, applying the standards set forth in 31 U.S.C. §6305, which, in general, authorizes the use of a cooperative agreement where the conference would carry out a public purpose of support or stimulation of outside entities, and substantial involvement by the Department is expected. Although the standards in §6305 must govern

the choice of vehicle, in determining if a conference **would** carry out such a public purpose (as opposed to merely providing a direct benefit to the Department or its employees), a significant factor is whether the primary beneficiaries of the conference are outside the federal Government.

b. Cost Principles that Apply to Non-Profit Cooperative Agreement Recipients.

- 1) Directives. Non-Profit cooperative agreement recipients must comply with the Uniform Administrative Requirements for Grants and Cooperative Agreements with Non-Profit Organizations (28 CFR Part 70), OMB Cost Principles Circular A-122, 2 C.F.R. 230, and, if applicable, the Office of Justice Programs Financial Guide, or any other component-specific guidance. According to A-122: "Costs of meetings and conferences, the primary purpose of which is the dissemination of technical information, are allowable. This includes costs of meals, transportation, rental of facilities, speakers' fees, and other items incidental to such meetings or conferences."
- 2) Reasonable Standard. The amount spent on conference costs is governed by the general principle that the costs be "reasonable," which is further defined in OMB Circular A-122, Attachment A, paragraph 3. Furthermore, cooperative agreement recipients must comply with the travel guidelines at OMB Circular A-122, Attachment B, paragraph 51, and the OJP Financial Guide (if applicable), which require that if a recipient does not have a written travel policy, the recipient must abide by the rates and amounts established by the General Services Administration (GSA) in the Federal Travel Regulations, 41 C.F.R. ch. 301.⁴

c. Required Special Condition For New Awards. All cooperative agreements that include holding a conference as a recipient responsibility must include the following special condition:

"Within 45 days after the end of any conference, meeting, retreat, seminar, symposium, training activity, or similar event funded under this award, and the total cost of which exceeds \$20,000 in award funds, the recipient must provide the program manager with the following information and itemized costs:

- 1) name of event;
- 2) event dates;
- 3) location of event;
- 4) number of federal attendees;
- 5) number of non-federal attendees;

⁴ GSA's regulations and per diem rates may be found at www.gsa.gov

- 6) costs of event space, including rooms for break-out sessions;
- 7) costs of audio visual services;
- 8) other equipment costs (e.g., computer fees, telephone fees);
- 9) costs of printing and distribution;
- 10) costs of meals provided during the event;
- 11) costs of refreshments provided during the event;
- 12) costs of event planner;
- 13) costs of event facilitators; and
- 14) any other direct costs associated with the event.

The recipient must also itemize and report any of the following attendee (including participants, presenters, speakers) costs that are paid or reimbursed with cooperative agreement funds:

- 1) meals and incidental expenses (M&IE portion of per diem);
- 2) lodging;
- 3) transportation to/from event location (e.g., common carrier, privately owned vehicle (POV)); and
- 4) local transportation (e.g., rental car, POV) at event location.

Note that if any item is paid for with registration fees, or any other non-award funding, then that portion of the expense does not need to be reported."

- d. Information Gathered From Former or Existing Cooperative Agreement Recipients. Components are required to gather the specific information listed in section (c) from any cooperative agreement recipient that held a conference between October 1, 2007 and the present, and from any cooperative agreement recipient that holds a conference under the terms of an existing cooperative agreement.
- e. Review and Reporting. Each sponsoring component must review the itemized costs and clarify any of the reported information with the cooperative agreement recipient, as necessary. The component must also itemize all of the transportation costs, M&IE, per diem, and lodging costs *paid by the component itself* to send either its component employees or employees of another DOJ component to the event. The DOJ employee travel costs paid by the component should be added to each itemized category as well as the overall cost of the event. Within 45 calendar days following the close of each fiscal quarter, the component shall submit a report on each conference costing more than \$20,000 held by its cooperative agreement recipients, as described in §10(b).

10. REPORTING.

- a. Quarterly Reporting of Conference Costs. The Attorney General is required to submit quarterly reports to the IG regarding the costs and contracting procedures relating to each conference held by the Department for which the total cost of the conference was more than \$20,000. To facilitate this process, each office holding a conference as defined by §5(a) and costing more than \$20,000, is required to submit the following information to the appropriate office within its component:
- 1) a description of the purpose of each conference, the number of participants attending the conference, and how many were federal government employees;
 - 2) a detailed list of all costs categorized in §6(f), and any issues encountered in determining the costs related to that conference; and
 - 3) a description of the contracting procedures with respect to each contract relating to that conference, including:
 - a) whether contracts were awarded on a competitive basis for that conference; and
 - b) a discussion of any cost comparison conducted by the Department in evaluating potential contractors for that conference.

No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a) during that quarter must submit a report, signed by the Component Head, which includes the above information for each such conference. The template at Attachment B should be used to compile the information and submit this report. The component must also submit any special approvals required by §8 with this report. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.

- b. Quarterly Reporting on Cooperative Agreement Conferences. No later than 45 calendar days following the close of each fiscal quarter, every component that has held a conference as defined by §5(a), through the use of a cooperative agreement as described in §9 and costing more than \$20,000, shall report on the event using the template at Attachment B. The report must be submitted to Conferences.and.Non-federal.Center@usdoj.gov.
- c. Quarterly Reporting on Use of Non-Federal Facilities for Predominantly Internal Events. Within 45 calendar days following the close of each fiscal quarter, every component that has held a predominantly internal event at a non-federal facility must submit a report, signed by the Component Head, to Conferences.and.Non-federal.Center@usdoj.gov. The template at Attachment B should be used to compile the information and submit this report. The report must highlight and explain any increases in costs above those submitted with the original request for approval. All market research data and cost analysis/actual cost information must remain on file with the component.

11. QUESTIONS. Questions regarding these requirements may be directed to Lori Arnold, Assistant Director, Financial Management Policies and Requirements Group, Finance Staff, on (202) 616-5216, or Melinda Jones, of her staff, on (202) 353-2527.

Attachments

Activities Not Reported as Conferences under §10 (a)**Activity Type 1:**

Law enforcement planning, staging, surveillance, undercover, or other meetings related to a law enforcement operation, and meetings to coordinate the Department's investigative, intelligence and/or prosecutorial efforts in connection with a pending case, specific criminal activity or a threat against the United States, including those that occur at law enforcement or security operational centers.

Activity
Meeting of attorneys to discuss a pending case
Meeting of DOJ agents to discuss strategy in an ongoing hostage situation

Activity Type 2:

Training courses taught at federal training centers, such as the National Advocacy Center, the Federal Law Enforcement Training Center, the Federal Bureau of Investigation National Academy, and the Drug Enforcement Administration Training Academy.

Activity Type 3:

Undercover activities and training conducted in accordance with the Attorney General's guidelines.

Activity Type 4:

Testing where the primary purpose of the event is to evaluate an applicant's qualifications to perform certain duties necessary to perform his or her job. In order for an event involving testing to be excluded from the reporting requirement, the majority of the event must be devoted to the administration and taking of the test. An event is not excluded from the reporting requirement if a test is incidental to the training course and is given upon its completion to determine satisfactory participation.

Activity
Quarterly Firearms Certification

Activities Reported as Conferences under §10 (a) if over \$20,000

Activity	Description
OCDETF Financial Investigations Seminar	Mandated seminar to learn financial investigative techniques of criminal enterprise
Computer Analysis and Response Team Moot Court	Attendees meet to gain exposure to cross examination from attorneys on cases they have investigated
OIG Investigations Managers Conference	Meeting of Senior Managers from within the Investigations Division
Immigration Judge Training	Immigration judges from across the U.S. gain training and participate in policy discussions
Operational Medic Program	Attendees are trained in order to comply with National Registry of Emergency Technicians' national standards

Quarterly Report on Conference Costs

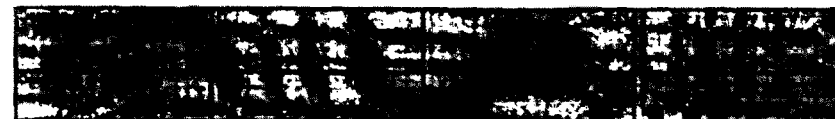
Attachment B

Component: _____ Telephone: _____

Point of Contact: _____ Email: _____

Conference Information						
Conference Title:	Non-Federal Facility		Conference over \$20,000		Non-Federal Facility	
Event Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference Date (Start & End)						
Facility Name						
City and State						
Number of Federal Attendees						
Number of non-Federal Attendees						
Total Number of Attendees						

Conference Costs			
Conference/Meeting Space (incl. Break out Room Cost)	\$0.00	\$0.00	\$0.00
A/V Equipment & Services	\$0.00	\$0.00	\$0.00
Other Equipment Costs	\$0.00	\$0.00	\$0.00
Printing and Distribution	\$0.00	\$0.00	\$0.00
Gov't Provided Meals	\$0.00	\$0.00	\$0.00
Refreshments	\$0.00	\$0.00	\$0.00
M&IE	\$0.00	\$0.00	\$0.00
Lodging	\$0.00	\$0.00	\$0.00
Transportation	\$0.00	\$0.00	\$0.00
Local Transportation	\$0.00	\$0.00	\$0.00
Conference Planner	\$0.00	\$0.00	\$0.00
Conference Facilitator	\$0.00	\$0.00	\$0.00
Other Costs	\$0.00	\$0.00	\$0.00
Total Conference Cost	\$0.00	\$0.00	\$0.00
Average Cost per Attendee	\$0.00	\$0.00	\$0.00



For Events in Non-federal Facilities Only			
Total Original Cost Estimate	\$0.00	\$0.00	\$0.00
Variance (Actual vs. Estimated)	\$0.00	\$0.00	\$0.00

¹ Attach additional pages to explain methodology if you are unable to capture costs as described in Policy X01 or if any costs appear to be out of the ordinary.

² Attach additional pages to explain contracting procedures.

³ Use Attachment C to provide a justification narrative for all events in which the actual cost exceeds the estimate, the justification needs to be itemized.

Non-federal Facility Event Variance Justification

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference/Meeting Space	\$0.00	\$0.00	\$0.00
AV Equipment & Services	\$0.00	\$0.00	\$0.00
Other Equipment Costs	\$0.00	\$0.00	\$0.00
Printing and Distribution	\$0.00	\$0.00	\$0.00
Gov't Provided Meals	\$0.00	\$0.00	\$0.00
Refreshments	\$0.00	\$0.00	\$0.00
MAIE	\$0.00	\$0.00	\$0.00
Lodging	\$0.00	\$0.00	\$0.00
Transportation	\$0.00	\$0.00	\$0.00
Local Transportation	\$0.00	\$0.00	\$0.00
Conference Planner	\$0.00	\$0.00	\$0.00
Conference Facilitator	\$0.00	\$0.00	\$0.00
Other Costs	\$0.00	\$0.00	\$0.00
Total Conference Cost	\$0.00	\$0.00	\$0.00

Conference Title: _____
 Conference Date: _____
 City and State: _____

Conference/Meeting Space	\$0.00	\$0.00	\$0.00
AV Equipment & Services	\$0.00	\$0.00	\$0.00
Other Equipment Costs	\$0.00	\$0.00	\$0.00
Printing and Distribution	\$0.00	\$0.00	\$0.00
Gov't Provided Meals	\$0.00	\$0.00	\$0.00
Refreshments	\$0.00	\$0.00	\$0.00
MAIE	\$0.00	\$0.00	\$0.00
Lodging	\$0.00	\$0.00	\$0.00
Transportation	\$0.00	\$0.00	\$0.00
Local Transportation	\$0.00	\$0.00	\$0.00
Conference Planner	\$0.00	\$0.00	\$0.00
Conference Facilitator	\$0.00	\$0.00	\$0.00
Other Costs	\$0.00	\$0.00	\$0.00
Total Conference Cost	\$0.00	\$0.00	\$0.00

¹ Attach additional pages to describe justification



U.S. Department of Justice

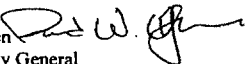
Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

May 4, 2009

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: David W. Ogden 
Deputy Attorney General

SUBJECT: Conference and Premium Class Travel Expenditures

As the Department of Justice works to accomplish its vital mission on a daily basis, we must also make certain we do so with a focus on accountability and transparency to the American taxpayers. As Department leadership, we must ensure that our financial resources are utilized in the most advantageous and responsible manner. I am writing to highlight two areas of significant fiscal importance that receive significant attention from the Department's Office of the Inspector General, Congressional oversight offices, and the Governmental Accountability Office. Component Heads must ensure that adequate internal controls exist in these areas and authorizing officials are focused on their individual responsibilities.

Conferences: The Department spent over \$47 million on conferences and training events in fiscal year 2008. Section 218 of the Department of Justice Appropriations Act, 2008 (Title II, Division B, Public Law 110-161), requires the Attorney General to submit quarterly reports to the Inspector General regarding the costs and contracting procedures for each conference held by the Department for which the cost to the government exceeds \$20,000. Justice Management Division (JMD) Financial Management Policies and Procedures Bulletin (P&P) 08-08, *Conference Planning, Conference Cost Reporting, and Approvals to Use Non-federal Facilities* includes guidance for keeping conference costs to a minimum and avoiding potentially extravagant locations, along with ensuring the Department can fulfill the statutory reporting requirements. Important aspects of that policy that must be followed include:

- Conference locations are to be selected based on business need and minimization of travel and other costs.
- Locations and accommodations should not be selected based on their lavish or resort qualities. Component Heads are required to submit a written justification in advance if a proposed facility gives the appearance of being lavish or is a resort location. The Component Head approval cannot be re-delegated.

Memorandum for Heads of Department Components
Subject: Conference and Premium Class Travel Expenditures

Page 2

- Components must restrict the number of people traveling to conferences to the minimum necessary to accomplish the official purpose.
- Ensure the selected lodging location is within per diem rates.
- Meals should be provided on an infrequent basis and only as a working meal when necessary to accomplish the purpose of the event. Refreshments should be kept to an absolute minimum. Grant making organizations should instruct grant recipients that Department grant funding is not be used for lavish food, refreshments, or entertainment purposes.
- Ensure that travelers are aware of their responsibility to reduce per diem when meals are provided at the conference.
- Ensure that reporting of costs for all non-federal facility events and conferences are submitted by Component Heads no later than 45 days following the close of each fiscal quarter.

Premium Class Travel: The Federal Travel Regulations (FTR) require travel be accomplished by the means most advantageous to the government. For airfare, that means using government contract coach fares unless certain circumstances make it absolutely necessary to use higher cost premium class fares. In response to January 2008 guidance from the Office of Management and Budget, the JMD issued P&P 08-07, *Use of Premium Class Travel Accommodations*. Important aspects of the policy include:

- Premium class travel includes both business and first class accommodations.
- Premium class travel must be authorized by the Component Head or Principal Deputy.
- Premium class travel must be authorized on a case by case basis with an acceptable justification as stated in the FTR. The justification must be documented on the travel authorization.
- Business class travel justified on the basis of the 14-hour rule must demonstrate mission criteria and why coach travel, with or without a rest stop or rest period en route, cannot accomplish the official purpose for the travel. The 14-hour rule may not be used as a justification for first class travel

In closing, I want to emphasize the need to maximize our financial resources, ensure we are prudent in our spending, and avoid the fact or appearance of extravagant spending, especially during these challenging financial times.



Office of the Attorney General
Washington, D.C. 20530

January 21, 2011

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS
AND UNITED STATES ATTORNEYS

FROM:  THE ATTORNEY GENERAL

SUBJECT: Temporary Freeze of Hiring and Non-Essential Spending

The Department is currently operating under a Continuing Resolution (CR) through March 4, 2011, with funding under the CR limited to last fiscal year's budget level. While we do not yet know what action will be taken to fund the Department for the remainder of the year, there is a realistic prospect that we will have to operate the entire year at last year's levels despite the higher cost of our staffing and operations this year. Accordingly, I am ordering a Department-wide temporary freeze on hiring. I am also ordering reductions to non-personnel spending.

The actions I am taking, including the general freeze on hiring, are designed to keep the Department operating effectively within constrained funding levels. They will also help us avoid more severe measures such as employee furloughs. I am fully aware of the difficult situation this creates for your operations and that many important activities will be curtailed. Nonetheless, we must take these actions to maintain our essential public safety responsibilities and meet our responsibility to ensure our financial solvency and accountability.

Temporary Hiring Freeze

Effective immediately, I am directing a temporary freeze on all new hiring in all DOJ Components. The following conditions will apply:

1. Written commitments formally issued by your component's servicing human resources office on or before the date of this memorandum will be honored.
2. Hiring for agents, deputy U.S. Marshals, intelligence analysts, and correctional officers is frozen, but essential backfills in these position categories, not to exceed current staffing levels or available funding, are authorized to maintain public safety and national security protections. Current staffing levels are defined as positions filled as of the pay period ending January 1, 2011.
3. Attorney General Honors Program (HP) and Summer Legal Intern Program (SLIP) commitments already built into this current budget cycle will be honored.
4. Hiring in the Working Capital Fund is frozen. Hiring in non-appropriated (e.g., fee-based) accounts is permitted subject to funding availability. Hiring with funding from reimbursable resources is subject to the same freeze restrictions as hiring with direct funding.

5. Career ladder promotions are not subject to the freeze.
6. Position changes within a component are not subject to the freeze since internal hires without backfill do not increase overall staffing levels, but any such changes must be within a component's available funding.
7. Conversion of personnel in career trainee/intern programs into permanent appointments (e.g., conversion of Federal Career Intern participants, Presidential Management Fellows) are allowed.
8. Other personnel actions that are not impacted by the freeze include non-competitive temporary promotions not to exceed 120 days, within grade increases, payroll corrections, retirements, voluntary early retirements, voluntary separation incentive payments, and disciplinary/adverse actions.

There may be hiring circumstances affected by external entities, e.g., the Merit Systems Protection Board, the Equal Employment Opportunity Commission, etc. Similarly, there may be hiring actions resulting from formal Reemployment Priority List actions. Consult the Justice Management Division (JMD) Human Resources Staff for guidance in these special circumstances.

I will consider a very limited number of exemptions from the freeze for individual positions, in extraordinary circumstances and on a case-by-case basis. Requests must include the position description and a justification regarding the critical need to fill the position, impact on mission if left unfilled, and why current staff levels are not sufficient to fulfill the duties during the hiring freeze. The request should also include confirmation that your component has available funding for the hire. Please submit exemption requests to the JMD Deputy Assistant Attorney General/Controller.

Non-Personnel Expenses

Also effective immediately and continuing through the remainder of FY 2011, components should suspend all non-essential travel, training, and conferences. The number of Department attendees at all conferences must be minimized. Component expenditures across the board – e.g., vehicles, employee permanent change-of-station moves, information technology (IT) projects, equipment, supplies, contracts – should be held to essential needs. Given the difficult funding environment, your reductions to non-personnel expenditures will help ensure you have the necessary funds for staff and essential operations.

Components are to manage their operations within apportioned budget authority. Component full year operating plans should be formulated in a manner that avoids any reliance on staff furloughs in order to maintain solvency.

We anticipate revisiting the freeze and the other measures discussed above once we have a better understanding of our full year funding situation; however, all restrictions described herein will remain in effect until further notice. For questions regarding these subjects, please contact Lee Lofthus, Assistant Attorney General for Administration, on 202-514-3101.



U. S. Department of Justice


Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

September 27, 2011

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: James M. Cole 
Deputy Attorney General

SUBJECT: Conference Approval Requirement

In accordance with the Office of Management and Budget's Memorandum M-11-35, dated September 21, 2011, "Eliminating Excess Conference Spending and Promoting Efficiency in Government," (attached) effective immediately and until further notice, approval of agency conference-related activities and expenses must be cleared at the Deputy Secretary (or equivalent level). As such, all requests to hold Department-sponsored conferences must be approved by the Attorney General or me, through the Assistant Attorney General for Administration. The format for your requests will be provided to you under separate cover by the Justice Management Division. Please expect the reporting requirements for all planned Department-sponsored conferences to be more inclusive, covering the conferences to be held in federal facilities as well as non-federal facilities, and requiring a full detailed description of all the anticipated costs associated with each event.

As directed by the President, we are also conducting a thorough review of the policies and controls associated with conference-related activities and expenses. Your cooperation in this review and input into policies is requested.

Again, effective immediately, no conference can take place until submitted to me and approval obtained, including conferences for which prior commitments and/or contracts have been made. Please be assured that these are necessary steps to strengthen the Department's internal controls and ensure that the Department continues to identify priority areas for reducing waste and promoting greater efficiency.

Attachment



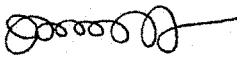
EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

September 21, 2011

M-11-35

MEMORANDUM TO THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: Jacob J. Lew
Director 

SUBJECT: Eliminating Excess Conference Spending and Promoting Efficiency in Government

From the start of this Administration, it has been a priority of the President to make sure that the Government operates with the utmost efficiency and eliminates unnecessary or wasteful spending. Now more than ever, as families across the country are tightening their belts, we cannot afford duplicative programs, out-dated and inefficient processes, or wasteful spending decisions. As responsible stewards of taxpayer dollars, we must seize every opportunity to improve Government performance and management so that we save money and deliver a higher quality of service to the American people.

To that end, the Administration has taken a series of steps since taking office. These range from cracking down on improper payments, to ending or reforming costly information technology projects, to reducing the number of no-bid contracts, to eliminating scores of unnecessary programs. Recently, the Administration launched the Campaign to Cut Waste, an intensified effort to identify areas across the Government where waste or excess may exist, and to take immediate steps to address them. We also are working with agencies to develop and share new efficiencies and reforms that will drive down costs and improve the way Government operates.

That is what we did under the Recovery Act, where the Vice President and OMB worked hand-in-hand with the heads of executive departments and agencies to make sure that programs were implemented quickly, efficiently, and, most importantly, responsibly. And that is what we must be committed to doing across the Government. As the President stated in his June 13, 2011, Executive Order on "Delivering an Efficient, Effective and Accountable Government" which launched the Campaign to Cut Waste, "The American people must be able to trust that their Government is doing everything in its power to stop wasteful practices and earn a high return on every tax dollar that is spent."

Last week, the Vice President convened the heads of executive departments and agencies to discuss the Campaign to Cut Waste. At that meeting, the Vice President asked department and agency heads to undertake a thorough review of wasteful and inefficient spending and report back on measures that we can – and should – halt, as well as new practices that can improve Government performance and management. In particular, the Vice President asked agency heads to focus on ways to get better prices for the goods and services that we buy, eliminate duplicative or

unnecessary publications, streamline the Government's automotive fleet, and curb unnecessary travel and related expenses.

Yesterday, the Office of Inspector General at the Department of Justice issued a report that underscores the importance of acting on this charge immediately and forcefully. The report noted that excessive funds have been spent on a variety of purchases at 10 different law enforcement conferences.

It is important to note that many of the instances described in the report date back to 2004. And beginning in 2009, the Department of Justice under Attorney General Holder's leadership, took proactive steps to implement tighter internal controls to reduce just these sorts of activities. Yet, the IG report provides a reminder of how important it is that agencies undertake all due diligence to protect taxpayer resources from unnecessary expenditures. Indeed, through the President's SAVE Award, many Federal employees have questioned the utility and frequency of conferences and other meetings especially in light of advances in video conferencing technology. Therefore, the President has directed me to instruct all agencies and departments to conduct a thorough review of the policies and controls associated with conference-related activities and expenses. Until such time as the Deputy Secretary (or equivalent) can certify that the appropriate policies and controls are in place to mitigate the risk of inappropriate spending practices with regard to conferences, approval of conference-related activities and expenses shall be cleared through the Deputy Secretary (or equivalent).

As directed in the President's Executive Order, the Vice President will reconvene the heads of departments and agencies in December to discuss further progress under the Campaign to Cut Waste. In advance of this meeting, agencies must report to OMB on the results of their review of conference-related activities and expenses. These results will be compiled for the Vice President to review and will be a subject of discussion at the meeting. Further, each department and agency shall also be prepared to discuss with the Vice President progress on the other aforementioned priority areas for reducing waste and promoting greater efficiency.

The Campaign to Cut Waste is a necessary and essential effort to secure the confidence of the American people that their taxpayer dollars are being used wisely. Information requested under this memorandum shall be provided by agencies to Danny Werfel, OMB Controller, by November 1, 2011. Please contact Debra Bond (dbond@omb.eop.gov), OMB Deputy Controller, if you have any questions about or need any assistance with this guidance.




U. S. Department of Justice

SEP 29 2011

Washington, D.C. 20530

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: Lee J. Lofthus 
 Assistant Attorney General
 for Administration

SUBJECT: Conference Approval Requirement

This is a follow-up to the memorandum from the Deputy Attorney General (DAG), "Conference Approval Requirement," dated September 27, 2011, advising you that effective immediately and until further notice, approval of conference-related activities and expenses for Department-sponsored conferences (including conferences to be held at federal facilities) must be submitted through my office and approved by the Attorney General (AG) or the DAG. All such requests must comply with the process and guidelines described below and must include: a summary cost memorandum (format attached) from the Component Head or Principal Deputy, or, if so delegated by you, from your Chief Financial Officer or Executive Officer on your behalf; and the attached "Department of Justice Conference Request Form" ("form"). The memorandum and form must be sent via email to Conferences.and.Non-federal.Center@usdoj.gov.

Approval is required for any conference, as defined in JMD Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Nonfederal Facilities (P&P 08-08), paragraph 5(a). <http://dojnet.doj.gov/jmd/fs/policies/policies/200808.pdf>. **Note, however, that all conferences falling within this definition must receive approval, regardless of cost.** (Note the \$20,000 threshold referenced in P&P 08-08 will continue to apply with respect to P&P 08-08's other reporting requirements.) Those activities that are excluded from the reporting requirement in paragraph 5(a) of P&P 08-08 (such as law enforcement staging and planning activities) are also excluded from this approval requirement. Consistent with the definition in P&P 08-08 paragraph 5(a), the approval requirement applies to any conferences planned and held by components themselves, as well as conferences funded by a component but conducted by an outside entity through the use of a contract or a cooperative agreement. (Conferences funded by a grant are *not* covered by this approval requirement.) Please note that additional information may be forthcoming from the Office of Management and Budget, which may require modifications to this guidance.

Conference Approval Process and Guidelines*Conferences Being Held Between Now and October 4th*

The JMD Finance Staff has issued separate guidance to the Chief Financial Officers and Executive Officers with respect to conferences being held between now and October 4th.

Conferences to be Held After October 4th for Which a Contract Has Been Executed

With respect to conferences that are scheduled to take place after October 4, 2011, if a contract already has been executed (whether by your component or a cooperative agreement recipient), and the conference occurs in October, your component must complete the attached form and provide it to the JMD Finance Staff by Monday, October 3, 2011. For conferences occurring after October, submit the request as soon as possible but not later than October 17, 2011. Based on the review of the request, JMD may require additional information, including a copy of the contract supporting the event.

Future Conferences for Which a Contract Has Not Been Executed

For future events where a contract has not yet been finalized, submit your request 30 calendar days prior to the expected date of contract award (whether by your component or a cooperative agreement recipient). For events planned for dates already within the 30 day lead-time, submit the attached form to the JMD Finance Staff as soon as possible. Please combine requests within your component and submit one consolidated request each week (events already within the 30 day lead-time period should be submitted separately and as soon as possible). You will receive a response to your request within two weeks of receipt. Components must continue to report quarterly conference expenditures as required by P&P 08-08.

Events must not proceed, or contracts awarded, until approval has been given. If you have any questions, please let me know or have your staff contact Chris Alvarez, Deputy Director or Lori Fears, Assistant Director of the JMD Finance Staff on (202) 616-5234 or (202) 616-5216, respectively.

Attachments

cc: OBD Executive Officers
Bureau Chief Financial Officers
Justice Management Division Senior Staff

MEMORANDUM FOR LEE J. LOFTHUS
 ASSISTANT ATTORNEY GENERAL
 FOR ADMINISTRATION

THRU: Melinda Morgan
 Director, Finance Staff

FROM: Component Head

SUBJECT: Conference Approval Request

This memorandum is to request approval by Deputy Attorney General (DAG) for the following conferences, which meet the requirements of JMD Financial Management Policies and Procedures Bulletin 08-08, Conference Planning, Conference Cost Reporting, and Approvals to Use Nonfederal Facilities:

Title of the Conference:	Name of Conference
Date of Conference (Start & End):	XX/XX/20XX to XX/XX/20XX
Facility Name:	Name
Facility Type (federal or nonfederal):	federal or nonfederal
City and State:	Any Town, Any State
Number of Federal Attendees:	XXX
Number of non-Federal Attendees:	XXX
Total Number of Attendees:	XXX
Conference Planner:	\$XX,XXX.XX
Total Conference Cost:	\$XX,XXX.XX
Pct of Total that is Travel & Per Diem:	XX%

Title of the Conference:	Name of Conference
Date of Conference (Start & End):	XX/XX/20XX to XX/XX/20XX
Facility Name:	Name
Facility Type (federal or nonfederal):	federal or nonfederal
City and State:	Any Town, Any State
Number of Federal Attendees:	XXX
Number of non-Federal Attendees:	XXX
Total Number of Attendees:	XXX
Total Conference Cost:	\$XX,XXX.XX
Pct of Total that is Travel & Per Diem:	XX%

DAG APPROVAL: _____

DAG DISAPPROVAL: _____

DAG OTHER: _____

Component Name: _____
 Submission Date: _____

General Conference Information:	1	2	3	4
Title of the Conference				
Purpose/Justification of Conference				
Cooperative Agreement (Yes / No)				
Date(s) of Conference				
Facility Name				
Facility Type (Federal or non-Federal)				
Other Facility Names Consider				
City and State				
Number of DOJ Federal Attendees	-	-	-	-
Number of Other Federal Attendees	-	-	-	-
Number of non-Federal Attendees	-	-	-	-
Total Number of Attendees	-	-	-	-
Conference Costs:				
Conference/Meeting Space	\$ -	\$ -	\$ -	\$ -
AV Equipment & Services	-	-	-	-
Printing and Distribution	-	-	-	-
Gov't Provided Meals*				
Breakfast	-	-	-	-
Lunch	-	-	-	-
Dinner	-	-	-	-
Refreshments*	-	-	-	-
M&IE	-	-	-	-
Lodging	-	-	-	-
Transportation	-	-	-	-
Local Transportation	-	-	-	-
Conference Planner	-	-	-	-
Conference Facilitator	-	-	-	-
Other Costs**	-	-	-	-
Total Conference Cost:	\$ -	\$ -	\$ -	\$ -

GSA Meals and Incidental Expenses (M&IE)

<http://www.gsa.gov/portal/category/21287>

Meals

Breakfast

GSA M&IE - Breakfast	\$	-	\$	-	\$	-	\$
JMD 150%							
Number of Attendees							
Number of Days Breakfast Provided							
Total JMD Breakfast Threshold	\$	-	\$	-	\$	-	\$

Lunch:

GSA M&IE - Lunch	\$	-	\$	-	\$	-	\$
JMD 150%							
Number of Attendees							
Number of Days Lunch Provided							
Total JMD Lunch Threshold	\$	-	\$	-	\$	-	\$

Dinner:

GSA M&IE - Dinner	\$	-	\$	-	\$	-	\$
JMD 150%							
Number of Attendees							
Number of Days Dinner Provided							
Total JMD Dinner Threshold	\$	-	\$	-	\$	-	\$

Refreshments:

GSA M&IE Total	\$	-	\$	-	\$	-	\$
JMD 23% Threshold							
Number of Attendees							
Number of Days Refreshments Provided							
Total JMD Refreshment Threshold	\$	-	\$	-	\$	-	\$



U. S. Department of Justice

SEP 29 2011

Washington, D.C. 20530

MEMORANDUM TO DEPUTY ASSISTANT ATTORNEYS GENERAL
JUSTICE MANAGEMENT DIVISION

JUSTICE MANAGEMENT DIVISION SENIOR STAFF

FROM:

Lee J. Loftus
Assistant Attorney General
for Administration

Subject:

Conference, Food, and Related Spending

One of the Justice Management Division's (JMD) primary responsibilities is ensuring the effective use of the Department's funds. This is no less true for our use of the funds allocated to our Division. Effective October 1, 2011, and until further notice, all JMD spending on JMD-sponsored conferences, meals, refreshments, and related expenditures require the written approval of the Assistant Attorney General for Administration. This restriction supersedes any existing delegations to the contrary.

If your office plans a conference, meeting, or training event, the expectation is that the event will be held in a federal facility or held by video conference where feasible. It is also expected that other costs will be held to a minimum, including the avoidance of meals, refreshments, logo-training materials (e.g. logo portfolios, etc.). Your request with full cost breakout must be submitted for written approval. You may refer to my memorandum to Heads of Department Components dated September 29, 2011, for the specific conference approval requirements.

Other spending that requires written approval by the AAG/A is any expenditure on meals or refreshments in any circumstance (including awards events), and any spending on any trinket (as defined in P&P 11-04, Restrictions on Using Department of Justice Funds to Purchase Trinkets, August 12, 2011) purchased by a JMD office for JMD-use or dissemination, regardless of funding source or use. I do not anticipate such requests since items of this nature are seldom "essential" to accomplishing our work, and it is my intention that our funds be used to accomplish the fundamental priority of JMD – the support of the Department and the forty-plus other components that carry out the DOJ mission.

The restrictions in this memo apply regardless of funding source.



U. S. Department of Justice


Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

October 5, 2011

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: James M. Cole 
Deputy Attorney General

SUBJECT: Continued Restrictions on Non-Essential Spending

On January 21, 2011, the Attorney General announced a Department-wide hiring freeze and also directed that components suspend all non-essential travel, training, and conferences for the duration of FY 2011. He also directed that other expenditures across the board be held to only essential needs. This memorandum announces that the restrictions from FY 2011 will continue for FY 2012, including limiting expenditures to essential needs.

Consistent with this guidance, components must limit travel, training, conferences, and conference attendance to that which is essential to accomplishing our core mission requirements. For conferences, use video conferencing where feasible. Use event planners only in exceptional circumstances, when they are critically necessary. Keep other costs to a minimum as well, including working meals. Do not purchase refreshments unless the location does not allow for attendees to obtain refreshments on their own, or when doing so would greatly disrupt the conference schedule. If you provide refreshments, you must not serve them more than once a day and you must adhere to the dollar limits established in Justice Management Division Policy & Procedures Bulletin 08-08. Suspend purchases of all trinkets, including logo-supplies, logo-portfolios, "message-related" items, clothing, etc., until further notice (this applies to conference-related purchases and those that are not associated with a conference). Finally, limit other spending, such as information technology projects, vehicle replacement, employee permanent change-of-station moves, equipment, supplies, and contracts, only to essential needs.

In the coming weeks my office will be looking at additional areas in which the Department can achieve savings, particularly through better economies of scale in our bulk purchasing across components and more effective delivery of enterprise/commodity IT services. We look forward to working with you in these areas, and we welcome your ideas for further savings opportunities.

Memorandum for Heads of Department Components
Subject: Continued Restrictions on Non-Essential Spending

Page 2

The restrictions in this memorandum apply regardless of funding source, but they do not apply to the use of Representation Funds. Refer to DOJ Order 2110.31B for guidelines on the use of Representation Funds.

Thank you for ensuring that our scarce resources in FY 2012 are devoted to fulfilling our extraordinary mission responsibilities and supporting our skilled and dedicated staff.



U.S. Department of Justice

Washington, D.C. 20530

OCT 21 2011

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: Lee J. Lofthus
 Assistant Attorney General
 for Administration

SUBJECT: Conference Approval Requirements

This is a follow-up to my September 29, 2011, memorandum on *Conference Approval Requirement* and the Deputy Attorney General Memorandums issued September 27, 2011, *Conference Approval Requirement* and October 5, 2011, *Continued Restrictions on Nonessential Spending*.

The Deputy Attorney General (DAG) has delegated to me the authority to approve all Department-sponsored conferences and events (including those held by cooperative agreement recipients) where the cost to the Department is less than \$250,000; when the cost to the Department for these conferences or events are \$250,000 or more, they must be approved by the Attorney General (AG) or DAG, thru the Controller and me. Please note that regardless of the approval amounts indicated above, these approvals must be received in advance, or the event cannot proceed. The September 29th memo requested you to submit all planned events by October 17th; therefore, no after-the-fact approvals are foreseen.

Components must limit travel, training, conferences, and conference attendance (including non-DOJ-sponsored events) to that which is essential to accomplishing the Department's core mission requirements, i.e., conferences must be for core mission purposes. The following reminders and new requirements apply. Prior to transmittal to the Department for Approval, **Component heads must certify (in writing) that the events and participation in these events is mission critical** (also discussed below).

1. The Justice Management Division's (JMD) Financial Management Policies & Procedures (P&P) Bulletin No. 08-08, entitled "Conference Planning, Conference Cost Reporting, and Approvals to use Non-federal Facilities," dated April 2008, is in effect with the following revisions from recent policy memos from Department leadership:

- Video conferencing must be used where feasible.

- Use event planners only in exceptional circumstances, when they are critically necessary.
 - Keep other costs to a minimum, including government-provided meals.
 - Do not purchase refreshments unless the location does not allow for attendees to obtain refreshments on their own, or when doing so would greatly disrupt the conference schedule. In addition, you are only authorized to provide refreshments once a day.
 - Suspend purchases of all trinkets (this applies to conference-related purchases and those that are not associated with a conference).
2. Component Heads **must** certify in writing that each conference or conference-related event is compliant with all of the Departmental guidelines and controls on conferences and restrictions on non-essential spending and the conference and is essential to accomplishing the Department's core mission requirements. This certification must be approved by the Component Head or principal deputy/equivalent **only** (or, for FBI, the Associate Deputy Director), without further delegation. Please be mindful that this is an internal control and it is an auditable part of the process. See Attachment 1 for a list of Departmental requirements and controls. You must include this certification with your transmittal to the Department.
 3. Quarterly reporting requirements for all Department-sponsored conferences will be more inclusive, covering more detailed cost data. The data capture is intended to incorporate all of the known requirements as of today.
 4. The DAG or AAG/A approval is **not required for events and conferences which are held at no additional cost to the government** (excluding government salaries, benefits, local mileage reimbursements and similar costs); However, please be advised that you will still be required to report this information on a quarterly basis via email to Conferences.and.Non-Federal.Center@usdoj.gov. This level of reporting and other reporting requirements are evolving. Until our FY2012 Appropriation is enacted, you must be prepared to report this type of information and other levels of detail, even if prior approvals by the Department are not required.

OTHER CLARIFICATIONS / PROCESS CHANGES:

The JMD Finance Staff is currently in the process revising the current JMD P&P 08-08 to include all recent policy requirements issued via memorandum and to strengthen controls over conference expenditures. A draft will be shared with all components for comment prior to issuance. You should note, however, that the DAG has requested that we issue the new policy by December 1st so this process will be expedited.

Until the revised P&P is formally issued the following **interim measures are in place for conference approval and reporting.**

1. Requests for approval must be in the revised format provided by JMD (Attachment 2). The data from the revised format will be used to help streamline the conference request and approval process. NOTE: There is no longer a separate process for approval to use non-federal facilities.
2. The requests must be transmitted by the Component's Chief Financial Officer or Executive Officer to the Office of the Controller, via email to: Jolene.Lauria-Sullens@usdoj.gov, with cc to Maureen.Lyons@usdoj.gov. This cannot be delegated to a lower level of the organization and the transmittal to the Controller is not in lieu of Component Head certification (noted above). These are separate controls in the process, and both Component Head certification and CFO/Executive Officer review and transmittal must be followed, not one or the other. Where a component has multiple districts or field offices, these requests must come through the central office to DOJ.
3. Format for the email request is also attached (Attachment 3). If the request for approval is time sensitive, the email message must be flagged for appropriate handling. It is not necessary to create or repeat summary information from Attachment 2.
4. Please note the revised format (Attachment 2) is subject to change depending on final appropriations requirements. The Department is in the process of detailing and collecting requirements to develop a more automated workflow (e.g. a SharePoint type solution). Note these interim changes to the required data for requests:
 - The request must contain a written purpose and justification for the conference in.
 - A lump sum amount entitled "Other Costs" is not acceptable. Other costs must be itemized so that a total accounting for items purchased is visible. This will cut down on the need to follow-up with components on the break-out of "other" costs.
 - If a conference planner or facilitator is used, justification that the cost is beneficial to the government must be included in the request for conference approval
 - If meals (breakfast, lunch, dinner) are provided, a description of the meals must be included in the request for conference approval.
 - **If refreshments are provided (limited to once per day), the amount paid for refreshments is limited to one half of the current threshold established by P&P 08-08 (e.g. M&IE Rate x 23% x 50%). A description of refreshments must be included in the request for conference approval. NOTE this change. The refreshment amounts in P&P 08-08 were developed prior to the DAG's limitation of once a day. This is one example of a change that will be included in the revised P&P.**
5. If the information submitted approval does not meet the Department's stated requirements (above), the **entire submission will be returned** to the Component for revisions. The Components are required to resubmit via the Chief Financial Officer/Executive Officer when all of the policy compliance issues are resolve.

To be clear, if during JMD's review JMD Finance, or others have general questions of clarification, we will not return the package. But, for example, "other costs" are not

itemized or any required explanation is not in the transmittal, the entire package will be returned. We will not hold the package until pieces and parts show up. This will allow for the Department to focus on those requests that follow the guidelines and not overburden our review and approval process with constantly updating and reconciling submissions.

We will make every effort to turn these around as quickly as practicable; however, in return, given the volume of requests requiring approval we cannot spend our time on incomplete submissions.

6. The AAG/A or DAG approval is not required for training in federal training facilities, such as the National Advocacy Center (NAC) and the Federal Law Enforcement Training Center (FLETC).

I appreciate all of the efforts of you and your staff to comply with these requirements. We expect to update these procedures in the near future as additional controls and/or delegations are developed. I cannot understate that this is an evolving process and these memos and procedures are our auditable controls. This is a high risk control environment and therefore your Component's high-level involvement and attention is required.

If you have any questions on these interim policies and procedures, please contact Jolene Lauria Sullens, Deputy Assistant Attorney General/Controller on (202) 514-1843.

Attachments

cc: DOJ Controller
Director, JMD Finance Staff
Director, JMD Budget Staff
OBD Executive/Admin Officers
Bureau Chief Financial Officers

Department Conference Guidelines and Controls

1. Deputy Attorney General memorandum of October 5, 2011, entitled "Continued Restrictions on Non-Essential Spending;"
2. Deputy Attorney General memorandum of September 27, 2011, entitled "Conference Approval Requirement;"
3. Assistant Attorney General of Administration memorandum of September 29, 2011, entitled "Conference Approval Requirement;"
4. Justice Management Division (JMD) Financial Management Policies and Procedures Bulletin (P&P) 08-08 entitled "Conference Planning, conference cost Reporting, and Approvals to use Non-federal Facilities," dated April 8, 2008;
5. JMD Financial Management Memorandum 07-08 "Implementation Guide" for P&P 08-08, dated April 29, 2008; and
6. Federal Travel Regulation, 41 C.F.R. §301-3.1 and §301-74.
7. Attachment 2: Revised Conference & Event Approval Request Form. Submit one form per event.
8. Attachment 3: Format for email message transmitting the files for Conference & Event Approval Request Form.

Format for Email Transmittal of Conference & Event Approval Request Form

From: Component CFO or Component Executive Officer

To: Jolene.Lauria-Sullens@usdoj.gov

Cc: Maureen.Lyons@usdoj.gov

Subj: Conference & Events Approval Form

Attached are approval forms for [Insert Number] conferences planned by [Name of Component] for the time period of [Date of first event – to – Date of last event]. Also attached is a certification from [Name of Component Head] that these events are essential to accomplishing the Department's core mission requirements.

These are being submitted for approval by the Assistant Attorney General for Administration (AAG/A) [replace with Deputy Attorney General for events costing \$250,000 or more] in compliance with AAG/A's memorandum of October XX, 2011. This transmittal certifies that these events are in accordance with applicable policies, procedures, and sound financial management principles.

[If applicable, indicate date urgency or other urgent items]

[Insert separate files – Attachment 2 – for each request and your Component Head's certification]

Attachment 1

DRAFT – CONFERENCE & EVENTS APPROVAL FORM	
Name of Requestor	
Component Name	
Submission Date	
Title of the Conference	
Start Date	
End Date	
Location: Country	
Location: City	
Location: State	
Total Number of Attendees	
Total Cost	

General Conference Information:	
Purpose / Justification of Conference	
Conference Type	
Funding Appropriation Symbol	
Facility Name (Specific)	
Facility Type (Federal/Non-federal)	
Cooperative Agreement (Yes / No)	
Number of DOJ Federal Attendees	
Number of Other Federal Attendees	
Number of Non-federal Attendees	
Total Number of Attendees	0

(Non-federal facilities require additional information, below)

Conference Costs	Total Cost	% of Total Cost
Conference/Meeting Space		
AV/ Equipment & Services		
Printing and Distribution		
Gov't Provided Meals *		
Breakfast		
Lunch		
Dinner		
Refreshments *		
M&IE		
Lodging		
Transportation		
Local Transportation		
Conference Planner*		
Conference Facilitator/Trainer		
Other Costs: (Items Below)	\$0	
Total Conference Cost	\$0	

M&IE Threshold Amounts:

M&IE Total for City:	http://www.osa.gov/portal/category/21297		
	Total Number Of Meals	Per Person Threshold	Total JMD Threshold
Breakfast			
Lunch			
Dinner			
Refreshments			

Name of Requestor	
Component Name	
Submission Date	
Justification Required:	
Gov't Provided Meals:	
Refreshments	
Conference Planner	

Justification for selecting non-federal Facility:

Reason for Non-Use

Selection Process: Indicate the facilities considered

Facility	Federal or Non-federal	Total Est. Cost	Reason for non-use

Estimated Attendee Information

Attendee Duty Station	Attendee Organization	Number of Attendees	Non-DOJ Employees



U. S. Department of Justice

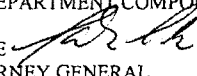
Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

November 22, 2011

MEMORANDUM FOR HEADS OF DEPARTMENT COMPONENTS

FROM: JAMES M. COLE 
DEPUTY ATTORNEY GENERAL

SUBJECT: Further Delegation for Approval of Conferences

In my memorandum dated October 17, 2011, entitled "Delegation for Approval of Conferences," I delegated to the Assistant Attorney General for Administration (AAG/A) the authority to approve all Department-sponsored conferences (including those held by cooperative agreement recipients) where the cost of the conference to the Department is less than \$250,000. I am now delegating to the Heads of Department Components the authority to approve certain Department-sponsored conferences (including those held by cooperative agreement recipients) without preapproval by the AAG/A or the Deputy Attorney General.

Effective immediately, Component Heads may approve conferences that meet the following three criteria:

- (1) The total estimated cost of the conference to the Department is \$20,000 or less;
- (2) The conference is being held without the use of a conference or event planner as defined in the Justice Management Division (JMD) Policies & Procedures Bulletin 08-08, "Conference Planning, Conference Cost Reporting, and Approvals to Use Non-Federal Facilities" (P&P 08-08) §5.e.; AND
- (3) The conference is being held in federal space or, if non-federal space is used the conference location was selected through documented competitive bids; and, if the conference is predominantly internal, the guidelines in P&P 08-08 were followed.

Once the Component Head determines that a conference meets the above three criteria, the Component Head must review the relevant information and make the following determinations before approving the conference:

- The conference purpose is essential to accomplishing the Department's core missions and cannot be fulfilled through the use of video conferencing or a webinar;
- The individuals planning the conference have exercised fiscal prudence to ensure that conference costs are limited and that government funds are not being expended for items or activities that do not support the Department's core missions;

- To the extent meals are provided, they are being provided only when necessary to accomplishing official business and are within P&P 08-08, § 7 guidelines (note that conferences run by cooperative agreement recipients must now also comply with the meal and refreshment guidelines in P&P 08-08 and below).
- Refreshments, other than meals, are not provided at government expense or, if they are, the Component Head determines that: (a) the location does not allow for attendees to obtain refreshments on their own, or doing so would greatly disrupt the conference schedule; (b) refreshments are being provided no more than once per day; and (c) the amount paid for the refreshments is minimal and limited to one half of the current threshold established by P&P 08-08, §7.b.1;
- The combined cost for meeting rooms, breakout rooms, and audio visual support must be arranged via competitive bid, be reasonable given the number of attendees, and cannot exceed the average of \$15 per attendee per day; and
- The conference is not being held in resort or similar locations defined in P&P 08-08, §8.a.2(b)-(d).

Component Heads may delegate this conference approval authority to their Principal Deputies (or, in the case of the Federal Bureau of Investigation, the Associate Deputy). This authority may not be delegated further except with respect to the following types of conferences: a) webinars for which there are no costs for travel, event planning, meals, refreshments, hotel rooms, meeting rooms and the total cost of the webinar event is less than \$1,000, b) conferences which are held at no cost to the government (excluding costs for government salaries, benefits, local mileage reimbursements and similar costs), and c) meetings that have no formal or published agenda, scheduled speakers, or discussion panels, that involve less than 30 people, local travel only, and that incur no costs for meeting rooms or refreshments at the government's expense.

If the Component Head cannot make the above-referenced determinations, the Component Head must disapprove the conference, or, in extraordinary cases, submit the request for AAG/A approval. The Component Head may consult with JMD during the review process. All conferences with costs that are greater than \$20,000 or that utilize an event planner must be submitted to AAG/A for review and approval. Be prepared to cancel events for which the request for approval is submitted less than five business days before event's start date.

All Component Head-approved conferences and events must be reported quarterly to JMD via the standard conference reporting process required by P&P 08-08. Please be reminded that all requests for the use of non-federal facilities for any predominately internal conferences, require prior approval by the AAG/A. All Component Head-approved conferences and events are subject to post-approval review and audit by JMD. At a minimum, JMD will audit a sample of all Component Head approved events.

The restrictions in my memorandum to Component Heads on October 5, 2011 entitled "Continued Restrictions on Non-Essential Spending" as well as the restrictions in the AAG/A memorandum to Component Heads on October 21, 2011 entitled "Conference Approval Requirements" remain in effect.

From: Lauria-Sullens, Jolene (JMD)
Sent: Monday, October 24, 2011 2:27 PM
To: Exec/Admin Officers OBDs; Bureau Chief Financial Officers; Bureau Accounting Officers; Budget Officers Group
Cc: Lyons, Maureen (JMD)
Subject: REMINDER/ACTION: DAY FORWARD Conference and events approval requirements
Importance: High

Friday you received e-mail notification of updated policies and process with regard to Conference and conference related events. Also, these materials were reviewed at the Executive Officers meeting.

These new procedures are DAY FORWARD and are INTERIM procedures until a revised Financial Management Policies and Procedures is issued.

I am re-sending Attachment 2 and Attachment 3 that incorporate SMALL minor changes/edits to both the data sheet and the e-mail transmittal format. For example, a column was added to the data sheet that will indicate the final approved amount if expenses were removed or re-priced from the original request; and, the template for the transmittal e-mail was edited slightly for specific dates of control memos.

PLEASE REMEMBER to send individual spreadsheets for each event so we can assign a unique identifier for tracking. You may send multiple spreadsheets in one file. Also, you must attach your component head's written certification of the events you are transmitting. The component head's certification can be delegated to the principal deputy or the officially designated acting official, but no lower than those levels indicated in the AAGA Memo dated October 21st.

PLEASE REMEMBER to forward your e-mail with the appropriate SUBJECT HEADING: Conference and Events Approval Form.

PLEASE REMEMBER if your event is exigent (it is planned for the same week you are requesting approval) that must be indicated the time sensitivity in your e-mail transmittal so we can address it appropriately.

1000

PLEASE REMEMBER: if your request is not complete per the instructions it will be returned for re-submittal. Due to the volume of requests, we can not keep a log of incomplete submissions.

Finally, we will be pulling together a working group to develop a more automated process that is seamless from the requestor to final approval. We plan to distribute a revised policy and procedures bulletin or comment in the next few weeks.

Thank you again for your patience. ANY questions on these procedures, please direct them to the Office of the Controller, myself or Maureen Lyons (202-514-1843)



Revised Format for Conference ...



email template
event approval ...

Ms. Jolene A. Lauria Sullens
Deputy Assistant Attorney General/Controller
United States Department of Justice

"If you wish for Peace, work for Justice"

conference expenditures were allowed to increase nearly 90% in two years under the Obama Administration.

In a September 21, 2011, memorandum to the heads of executive departments and agencies, Mr. Lew wrote: “[B]eginning in 2009, the Department of Justice under Attorney General Holder’s leadership took proactive steps to implement tighter internal controls to reduce just these sorts of activities.”⁶ However, as the numbers above indicate, the massive and unexplained increase in conference spending in just the first two years of the administration occurred during this same timeframe that Mr. Lew alleges you took steps to implement tighter budget controls. A 90% increase in conference expenditures during times of fiscal belt-tightening is hardly a laudable achievement. American taxpayers deserve an explanation for this dramatic increase. Accordingly, I ask that you provide answers to the following questions:

- 1) Why did the cost of conference expenditures at the Department nearly double between 2008 and 2010?
- 2) What “proactive steps” did you take beginning in 2009 to implement tighter internal controls to reduce just these sorts of activities?
 - a. Did any of these proactive steps involve dollar caps on individual conference expenditures?
 - b. Were any particular types of conference expenditures prohibited?
- 3) How much did the Department budget for conferences in 2011?
 - a. Who was the highest ranking official at DOJ that approved the budget for conference expenditures?
 - b. Were you consulted on the specific budget for conference expenditures prior to approval?
 - c. Was the Deputy Attorney General consulted on the specific budget for conference expenditures prior to approval?
- 4) How much of that money has been spent to date in 2011?
- 5) How much has the Department budgeted for conferences in 2012?
 - a. Who was the highest ranking official at DOJ that approved the budget for conference expenditures?
 - b. Were you consulted on the specific budget for conference expenditures prior to approval?
 - c. Was the Deputy Attorney General consulted on the specific budget for conference expenditures prior to approval?

⁶ Memorandum from OMB Director Jacob Lew to the Heads of Executive Departments and Agencies, “Eliminating Excess Conference Spending and Promoting Efficiency in Government,” September 21, 2011.

The Honorable Eric H. Holder, Jr.
December 20, 2011
Page 3

- 6) What procedures are in place to review budget line items that increase significantly? For example, is there any procedure in place to flag accounts that increase by more than 50% year over year? If not, why not?
- 7) Have you asked the Inspector General to determine the reason for the dramatic rise in costs? If not, please explain why not.
- 8) Provide a copy of all correspondence and memoranda instructing DOJ personnel to take "proactive steps" to "implement tighter internal controls to reduce" conference expenditures.
- 9) Provide a copy of all documents and communications provided to Mr. Lew that form the basis of his statement in the Sept. 21, 2011, memorandum that DOJ has taken "proactive steps to implement tighter internal controls to reduce" conference expenditures.

I look forward to receiving your complete response. Thank you in advance for ensuring that it arrives no later than January 5, 2011. Should you have any questions regarding this letter, please contact Tristan Leavitt of my staff at (202) 224-5225.

Sincerely,



Charles E. Grassley
Ranking Member

Attachment C



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

November 30, 2011

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Senator Grassley:

This responds to your letter dated November 14, 2011, in which you express concern about delays in resolving FBI whistleblower reprisal cases. The Department shares your concerns and has recently implemented several changes to improve the effective and efficient adjudication of FBI whistleblower cases.

The time required for the Department's final resolution of an FBI whistleblower case is dependent upon a number of factors, including: the complexity of the legal and factual issues presented; the time for and extent of discovery; the time for the parties' respective briefs on the issues; the number and procedural posture of other such cases pending at one time; and whether the parties proceed to a hearing before the Director of the Office of Attorney Recruitment and Management (OARM), where the parties have the opportunity to call and cross-examine witnesses. In some instances, delay results from stay requests and requests for extension of the deadlines for discovery and submissions of briefs made by the parties. For example, in one of the cases you cite, a party asked for a stay to pursue a concurrent Title VII case. To allow the complainant/employee claiming retaliation the fairest opportunity to pursue redress, the Department has been very willing to grant such requests.

This is not to suggest that such requests are the sole or even most significant cause for delay. The legal requirements and various stages of review in adjudication of an FBI whistleblower case also affect case processing time. Before a complainant may file a request for corrective action with OARM, the complainant must first file a complaint of reprisal with either the Department's Office of Professional Responsibility (OPR) or Office of the Inspector General (OIG). The complainant may then file with OARM, but only within certain time requirements, *i.e.*, either within 60 calendar days of receipt of notification from the Conducting Office¹ that it is terminating its investigation, or any time after 120 calendar days from the date the complainant first filed the complaint of reprisal with the Conducting Office if the complainant has not been notified by the Conducting Office that it will seek corrective action. To enforce corrective action, the matter must be brought to OARM (*See* 28 C.F.R. § 27.3-27.4).

¹The term "Conducting Office" refers to whichever of OIG or OPR examines the initial complaint.

The Honorable Charles E. Grassley
Page 2

After filing with OARM, the complainant must establish jurisdiction over the claim by making a nonfrivolous allegation that the complainant made a protected disclosure that was a contributing factor in the FBI's decision to take, or fail to take (or threaten to take or fail to take), a personnel action. An employee who establishes jurisdiction, must then prove the merits of the allegations by preponderant evidence. If the employee meets that burden, OARM may order corrective action as appropriate and authorized by the regulations, unless the FBI proves by clear and convincing evidence that it would have taken the same personnel action in the absence of the employee's protected disclosure. As these are adversarial proceedings, the parties at each stage require time to present motions and written and/or oral arguments, and to conduct discovery. The parties have the opportunity to seek review of any final determination by the Deputy Attorney General.

As noted above, the Department has recently implemented several changes to significantly shorten the adjudication of FBI whistleblower cases. OARM has adopted a number of procedural guidelines modeled after those utilized by the administrative judges of the U.S. Merit Systems Protection Board to substantially reduce case processing time. A copy of OARM's case processing directive, effective October 14, 2011, is attached and can also be found on OARM's FBI whistleblower website at: <http://www.justice.gov/oarm/wb/whistleblowers.htm>.

The Department has also devoted additional resources to this task. While the current number of cases on OARM's docket is relatively small, the number of cases pending at one time fluctuates and can be heavily impacted by cases in which complex and novel factual and legal issues are presented, and where discovery is extensive and contentious. To expedite the resolution of pending cases, the Department has funded an attorney detail position to augment the staff conducting case reviews. A senior-level official from the U.S. Merit Systems Protection Board with extensive experience has filled the position. The Department will continue to closely monitor these changes to assess their impact on the process, and will make further adjustments as needed.

We hope this information is helpful. Please do not hesitate to contact this office if we may provide additional assistance regarding this or any other matter.

Sincerely,



Ronald Weich
Assistant Attorney General

cc: The Honorable Patrick Leahy
Chairman

**OFFICE OF ATTORNEY RECRUITMENT AND MANAGEMENT
PROCEDURES FOR FBI WHISTLEBLOWER REPRISAL CLAIMS
BROUGHT PURSUANT TO 28 C.F.R. PART 27**

1. **PURPOSE:** This directive establishes Office of Attorney Recruitment and Management (OARM) policies and procedures for processing whistleblower reprisal cases brought under 28 C.F.R. part 27 by former or current employees of, or applicants for employment with, the Federal Bureau of Investigation (FBI). This directive is OARM policy and shall be applied accordingly. Exceptions and/or modifications to this policy may be made at the discretion of the Director or Assistant Director of OARM.
2. **SCOPE:** This directive applies to:
 - A. OARM in its delegated authority to adjudicate whistleblower reprisal cases brought under 28 C.F.R. part 27, by current and former employees of, or applicants for employment with, the FBI; and
 - B. The parties to a whistleblower reprisal case before OARM (Complainant or Complainant's designated representative, if any, and the FBI).
3. **AUTHORITIES:**
 - A. 5 U.S.C. § 2303
 - B. 28 C.F.R. part 27
4. **DEFINITIONS:**
 - A. Appeal: When a party (Complainant or the FBI) files a request for review by the Deputy Attorney General of the Director of OARM's Final Determination or Corrective Action Order, pursuant to 28 C.F.R. § 27.5.
 - B. Classified Information: Official information or material that requires protection in the interest of national security and is classified for such purpose by an appropriate classification authority in accordance with the provisions of Executive Order 12958, Classified National Security Information.
 - C. Clear and Convincing Evidence: The measure or degree of proof that produces in the mind of the trier of fact a firm belief as to the allegations sought to be established; it is a higher standard than preponderant evidence.
 - D. Complainant: A former or current employee of, or applicant for employment with, the FBI who has filed a request for corrective action with OARM.

- E. Conducting Office: The office that conducts the investigation into a complainant's reprisal allegations, either the Department of Justice's Office of the Inspector General (OIG) or Office of Professional Responsibility (OPR).
- F. Corrective Action: Generally, the placement of a complainant, as nearly as possible, in the position the complainant would have been in had the whistleblower reprisal not occurred. Corrective action may include: reimbursement for attorneys fees, reasonable costs, medical costs incurred and travel expenses; back pay and related benefits; and any other reasonable and foreseeable consequential damages. Compensatory damages for emotional distress, *i.e.*, pain and suffering, are not included.
- G. Investigating Office: The office that receives the report of an alleged reprisal, either OIG or OPR. Once received, the office that received the report of reprisal consults with the other Investigating Office to determine which office is more suited, under the circumstances, to conduct an investigation into the allegation (*i.e.*, to serve as the Conducting Office).
- H. Mediation: Mediation is an informal process in which a neutral third party, the mediator, assists the opposing parties in reaching a voluntary, negotiated resolution of a complaint. Mediation is different from other forms of dispute resolution in that the parties participate voluntarily, and the mediator has no authority to make a decision.
- I. Nonfrivolous Allegation: An allegation of fact which, if proven, could establish a prima facie case that OARM has jurisdiction over the matter at issue.
- J. Personnel Action: A personnel action means an appointment, a promotion; an adverse action or other disciplinary action; a detail, transfer, or reassignment; a reinstatement; a restoration; a reemployment; a performance evaluation; a decision concerning pay, benefits, or awards, or concerning education or training if the education or training may reasonably be expected to lead to an appointment, promotion, performance evaluation, or other action described within 5 U.S.C. § 2302(a)(2); a decision to order psychiatric testing or examination; and any other significant change in duties, responsibilities, or working conditions.
- K. Preponderant Evidence: The degree of relevant evidence that a reasonable person, considering the record as a whole, would need to find that a contested fact is more likely true than untrue.
- L. Protected Disclosure: A disclosure of information to specified individuals or offices listed under 28 C.F.R. § 27.1(a) which Complainant reasonably believes

evidences a violation of any law rule or regulation; mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health or safety.

- M. Request for Corrective Action (RCA): A request by Complainant that the Director of OARM order the FBI to remedy or "correct" the consequences of the FBI's alleged unlawful reprisal.

5. **BURDENS OF PROOF:**

- A. Jurisdiction: In order to establish OARM's jurisdiction over his RCA, Complainant must:
1. Show that he exhausted his administrative remedies with the Conducting Office (by first filing a complaint of reprisal with either OIG or OPR); and
 2. Make a nonfrivolous allegation that he made a protected disclosure that was a contributing factor in the FBI's decision to take or fail to take, or threaten to take or fail to take, a personnel action against him.
- B. Timeliness: Complainant must show that his RCA was timely filed with OARM. Complainant's RCA must be received by OARM either:
1. Within 60 calendar days of receipt of notification of termination of an investigation by the Conducting Office; or
 2. At any time after 120 calendar days from the date Complainant first notified an Investigating Office of an alleged reprisal if Complainant has not been notified by the Conducting Office that it will seek corrective action.
- C. Merits: If Complainant shows that OARM has jurisdiction over his RCA, Complainant must then prove the merits of his case by preponderant evidence. If Complainant meets this burden, then the Director of OARM will order corrective relief that is deemed appropriate and authorized by 28 C.F.R. § 27.4(f), unless the FBI proves by clear and convincing evidence that it would have taken the same personnel action(s) against Complainant in the absence of his protected disclosure(s).

The case law of the U.S. Merit Systems Protection Board and the U.S. Court of Appeals for the Federal Circuit, although not binding on OARM, is instructive and looked to for guidance.

6. **PROCEDURES:** The procedures set forth herein apply to FBI whistleblower reprisal cases brought under 28 C.F.R. part 27:

A. **Filing of Pleadings:** All pleadings filed with OARM must meet the following requirements:

1. **Page Limit:** Pleadings must not exceed 25 pages (not to include any attachments). OARM may grant a motion for leave to exceed the 25-page limit for good cause shown.
2. **Paper Size:** Pleadings and attachments must be filed on 8½ inch by 11-inch paper, except for good cause shown. All electronic submissions must be formatted so that they will print on 8½ by 11-inch paper.
3. **Date of Filing:** All pleadings must be filed by the date set by the applicable regulations, 28 C.F.R. part 27, or OARM. The date of filing is the date on which the submission is postmarked, faxed, or emailed (if submitted electronically). Extensions of filing dates will be granted only if requested in writing and if good cause is shown.
4. **Service:** All pleadings filed with OARM must be served upon the opposing party and/or designated representative, if any.
5. **Certificate of Service:** All pleadings filed with OARM must be accompanied by a certificate of service stating the:
 - a. Method of service (e.g., by mail, facsimile, or email);
 - b. Date of service; and
 - c. Name and address of the individual(s) served.

OARM may reject a submission that does not have a certificate of service.

6. **Organization:**

- a. **Hardcopy:** When a pleading submitted by postal mail or facsimile includes three or more documentary attachments, the attachments should be "tabbed." A "tab" is a dividing page, a portion of which extends beyond the normal 8½ inch width of paper, and which contains a description or label. Pages in a pleading should be sequentially numbered or Bates stamped, and the attachments

should be preceded by a table of contents describing each attachment and indicating the page on which it starts.

- b. Electronic: Electronic tables of contents take the place of physical "Tabs" in pleadings filed by traditional/hardcopy means. When an electronic pleading contains three or more electronic supporting documents, each attachment must be identified in the accompanying table of contents and designated with a brief descriptive label (e.g., "Exh. 4b, Decision Notice"). Each pleading should be assembled into a single PDF document, to include all electronic attachments, and will contain sequential page numbers. Pleadings are subject to a 10 megabyte size limit. If what would otherwise be a single pleading must be broken into multiple pleadings because of size limit, each should contain the same descriptive title, together with a "Part" designation in parentheses (e.g., Brief on the Merits of Complainant's RCA (Part A), Brief on the Merits of Complainant's RCA (Part B), etc.).
7. Classified Information: The parties shall not file any classified information with OARM. In the event such information becomes relevant to proceedings before OARM, appropriate arrangements for the protection, transmission, and handling of such materials must be in compliance with FBI and other applicable requirements regarding classified materials.

B. Motions:

1. Form: All motions, except those made during a prehearing conference or a hearing, must be in writing. All motions must include a statement of the reasons supporting them. Written motions must be filed with OARM and served upon the other party. A party filing a motion for extension of time, a motion for postponement of a hearing, or any other procedural motion must first contact the other party to determine whether there is any objection to the motion, and must state in the motion whether the other party has an objection.
2. Objection: Unless OARM provides otherwise, any objection to a written motion must be filed within 10 days of the date of service of the motion.
3. Motions for Extension of Time: Motions for extension of time will be granted only on a showing of good cause. **OARM, in its discretion, may grant or deny motions for extensions of time to file pleadings without providing any opportunity to respond to the motions.**

C. Discovery:

1. Scope: Discovery covers any non-privileged matter that is relevant to the issues involved in the request for corrective action, including the existence, description, nature, custody, condition, and location of documents or other tangible things, and the identity and location of persons with knowledge of relevant facts. Relevant information includes information that appears reasonably calculated to lead to the discovery of admissible evidence.
2. Methods: Parties may use one or more of the methods provided under the Federal Rules of Civil Procedure. These methods include written interrogatories to parties, depositions, requests for production of documents or things for inspection or copying, and requests for admission. The Federal Rules of Civil Procedure may be used as a general guide for discovery practice in proceedings before OARM. Those rules, however, are instructive rather than controlling.
3. Initial Disclosures: Without awaiting a discovery request, and within 10 days of the date of OARM's jurisdictional Opinion and Order, each party must provide the following information to the other:
 - a. The FBI must provide:
 - (i) A copy of, or a description by category or location of all documents in the possession, custody, or control of the FBI that the FBI may use in support of its claims or defenses; and
 - (ii) The name and position title and, if known, the contact information of each individual likely to have discoverable information that the FBI may use in support of its claims or defenses, identifying the subjects of such information.
 - b. Complainant must provide:
 - (i) A copy of, or a description by category or location of all documents in the possession, custody, or control of Complainant that Complainant may use in support of his claims or defenses, and
 - (ii) The name and position title and, if known, the contact information of each individual likely to have discoverable

information that Complainant may use in support of his claims or defenses, identifying the subjects of such information.

These disclosures must be based on the information reasonably available to the parties at the time they are made. A party is not excused from making its disclosures because it challenges the sufficiency of the other party's disclosures, or because the other party has not made its disclosures. **They must be served on the other party, but not on OARM.** If they are served on OARM, they will be rejected and returned to the party.

4. **Initial Requests for Discovery:** An initial request for discovery must be served on the other party within 25 calendar days of OARM's jurisdictional Opinion and Order.
5. **Responses to Initial Discovery Requests:** Responses to initial discovery requests must be served no later than 20 calendar days after the date of service of the other party's discovery request or OARM order. Any discovery requests following the initial request must be served within 10 calendar days of the date of service of the prior response, unless the parties are otherwise directed. Unless the parties file a motion to compel, **no discovery requests or responses are to be served on OARM.** If they are, they will be rejected and returned to the parties. OARM expects the parties to assist in the expeditious processing of the case by honoring requests for relevant documents and producing material witnesses without additional OARM intervention.
6. **Motions to Compel Discovery:** If a party fails or refuses to respond in full to a discovery request, the requesting party may file a motion to compel discovery. The requesting party must file the motion with OARM, and must serve a copy of the motion on the other party from whom the discovery was sought. The parties must attempt to resolve a discovery dispute before filing a motion to compel with OARM. Thus, the moving party shall discuss the anticipated motion with the opposing party either in person or by telephone and the parties must make a good faith effort to resolve the dispute and narrow the areas of disagreement. The motion to compel shall include:
 - a. A copy of the original request for discovery, showing that the information sought is relevant and material; and
 - b. A copy of the response to the request (including the objections to discovery), or, where appropriate, a statement that no response has

been received, along with an affidavit or sworn statement supporting the statement; and

- c. A statement that the parties have discussed the anticipated motion and have made a good faith effort to resolve the discovery dispute and narrow the areas of disagreement.

Any motion for an order to compel discovery must be filed with OARM within 10 calendar days of the date of service of objections, or, if no response is received, within 10 calendar days after the time limit for response has expired. Any pleading in opposition to a motion to compel discovery must be filed with OARM within 10 calendar days of the date of service of the motion.

7. Limits on the Number of Discovery Requests:

- a. Absent prior approval by OARM, interrogatories served by parties upon another party may not exceed 25 in number, including all discrete subparts.
- b. Absent prior approval by OARM, each party may not take more than 10 depositions.
- c. Requests to exceed the aforementioned limitations may be granted at the discretion of OARM.
- d. OARM may also limit the frequency or extent of use of the discovery methods in the event OARM finds that:
 - (i) The discovery sought is cumulative or duplicative, or is obtainable from some other source that is more convenient, less burdensome, or less expensive;
 - (ii) The party seeking discovery has had sufficient opportunity by discovery in the action to obtain the information sought; or
 - (iii) The burden or expense of the proposed discovery outweighs its likely benefit.

8. Time for Discovery: Discovery must be completed within the time OARM designates.

- D. Case Suspension Procedures: In some situations, the parties may conclude that they need more time than is routinely provided for discovery or settlement discussions. If so, the parties may request that OARM suspend the case for 30 days, as follows:
1. *Joint requests*: The parties may submit a joint request for additional time to pursue discovery or settlement. Upon receipt of such request, an order suspending processing of the case for a period up to 30 days may be issued at the discretion of OARM.
 2. *Unilateral requests*: In lieu of participating in a joint request, either party may submit a unilateral request for additional time to pursue discovery. Unilateral requests for additional time of up to 30 days may be granted for good cause shown at the discretion of OARM.
- No case may be suspended for more than a total of 30 days under these procedures.** Should the parties contact OARM during the period of suspension for assistance relative to discovery, and if OARM's involvement is likely to be extensive, OARM will notify the parties that it will be necessary to take the case off suspension and return it to standard processing.
- E. Dismissal Without Prejudice to Refiling: A case may not be suspended for more than 30 days. However, the case may be dismissed without prejudice to refile for good cause shown (*e.g.*, where the parties agree that additional time for settlement discussions or discovery is necessary, Complainant needs time to retain counsel, etc.). Dismissal without prejudice is a procedural option that is committed to the sound discretion of OARM. Generally, the parties will be given 90 days to refile a case dismissed without prejudice. In the event the parties need additional time, the parties shall provide OARM with a written case status update and establish good cause for the time requested.
- F. Hearings: Complainant does not have an automatic right to a hearing. A hearing may be held at the discretion of OARM where Complainant has presented a cognizable legal claim supported by sufficient evidence of a triable issue of fact. Hearings before OARM shall be closed to the public. Generally, the parties, the witnesses, and the Director/Assistant Director of OARM shall attend hearings in person. However, OARM, in its discretion, may hold the hearing in whole or in part by telephone, video-conference, or in-person at OARM's hearing/conference room (or designated alternate hearing site). Among the factors OARM will consider in deciding whether to hold a hearing in whole or in part by video-conference or telephone are:

1. The distance that Complainant and/or Complainant's representative must travel to access video conferencing equipment;
2. A comparison of the total costs of holding an in-person, video, or telephonic hearing;
3. The distance the parties and their witnesses would have to travel to appear in person; and
4. Whether appearance by video-conference or telephone of Complainant and his or her witnesses would unduly prejudice Complainant.

Either party may file a motion for postponement of the hearing. The motion must be made in writing and must either be accompanied by an affidavit or sworn statement. The affidavit or sworn statement must describe the reasons for the request. OARM will grant the request for a continuance of the hearing only upon a showing of good cause.

G. Closing the Record:

1. When a Hearing is Held: When there is a hearing, the record ordinarily will close at the conclusion of the hearing. When OARM allows the parties to submit argument, briefs, or documents previously identified for introduction into evidence, however, the record will remain open for as much time as OARM grants for that purpose.
2. Decision Based on the Written Record: If no hearing is held, the record will close on the date OARM sets as the final date for the receipt or filing of submissions of the parties.
3. When the Record Closes: Once the record closes, no additional evidence or argument will be accepted unless the party submitting it shows that the evidence was not readily available before the record closed. OARM will include in the record, however, any supplemental citations received from the parties or approved corrections of the transcript, if one has been prepared.

7. **EFFECTIVE DATE AND IMPLEMENTATION:** This policy is effective immediately

upon signature of the Director and Assistant Director of OARM.

Louis DeFalaise

Louis DeFalaise, Director
Office of Attorney Recruitment and Management

10/12/11

Date

Hilary Smith

Hilary Smith, Assistant Director
Office of Attorney Recruitment and Management

10/14/11

Date

1017

Attachment D



United States Department of Justice
Justice Management Division

Charge Card Management Plan

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1. Introduction

As required by OMB Circular A-123, Appendix B – Improving the Management of Government Charge Card Programs, this plan outlines the policies and procedures within the Department of Justice that are critical to the management of the charge card program, in order to ensure that:

- a system of internal controls is followed, and;
- the potential for fraud, misuse, and delinquency is mitigated.

This plan is also intended to maximize the opportunities for increased savings offered by the use of government commercial cards.

This document is intended to be a living document and will be updated as changes occur within the Department's charge card program.

2. Personnel Management

2.1 Key management officials

This section provides a list of the key program management officials associated with the charge card program within the Department, along with their title and responsibilities. The key officials for each program are listed in the tables below.

Purchase Card Program		
Name	Title	Responsibilities
Michael Jordan	Purchase card Level 1 A/OPC, Contracting Officer's Technical Representative (COTR), Management and Planning Staff (MPS), Justice Management Division (JMD)	Oversees the agency's purchase card program
Cleopatra Allen	Assistant Director, Procurement Policy and Review Group, MPS, JMD	Provides policy leadership in strategic planning, acquisition and procurement management

Travel Card Program		
Name	Title	Responsibilities
Kevin Derouin/Florence Wilcots	Travel card Level 1 A/OPC, Finance Staff, JMD	Oversees the agency's travel card program
Lori Arnold	Assistant Director, Finance Staff, JMD	Provides policy leadership in strategic planning, budgeting and financial management

Fleet Card Program		
Name	Title	Responsibilities
Phillip Duncan	Fleet card Level 1 A/OPC, Facilities and Administrative Services Staff (FASS), JMD	Oversees the agency's fleet card program
Randy Wilson	Assistant Director, FAAS, JMD	Provides policy leadership in strategic planning, budgeting and property management

2.2 Process for appointing cardholders and AOs

This section outlines the Department's policies and procedures, by program, for appointing cardholders and Approving Officials (AOs).

Purchase card program

Individuals are appointed as purchase cardholders based on

- a thorough review of the requesting organization's mission;
- procurement activity; and
- the number of cardholders available to support that activity.

Applications to obtain a purchase card are submitted to the bureau's Level II or greater Agency Program Coordinator (APC) in the headquarters procurement office. If approved, the applicant is issued a formal limited delegation of procurement authority. This delegation sets forth the limits of the cardholder's authority and provides the cardholder with identity of their APC and/or AO. It also informs the cardholder that their transactions are subject to review by AOs, APCs and other authorized individuals. As part of the appointment process, cardholders are provided with appropriate Department and Bureau guidelines and instructions for supporting purchase card transactions and use of JPMorgan Chase's (JPMC) Electronic Access System (EAS) PaymentNet. Through PaymentNet, the National APC or authorized official can perform the necessary processing and provide for the issuance of a government purchase card through JPMC after the employee has satisfied the approval and training requirements.

AOs are appointed at a sufficient level commensurate with their duties to ensure that they are able to effectively monitor the cardholder performance. When appointing AOs bureaus must consider the span of control to ensure that the number of cardholders and the charge card volume is at an appropriate level for effective oversight. AOs are appointed in writing and similar to cardholders; receive copies of Departmental and Bureau regulations and guidelines, including "do not buy lists". Cardholders and AOs are also provided documentation outlining their duties and responsibilities. Training and instructions for using PaymentNet to monitor cardholder activity are also provided to AOs.

Travel card program

Individual travel charge cards are issued to all employees regardless if they travel on official government business. An employee is anyone for whom there is a SF-50, Personnel Action, or an SF-61, Appointment Affidavit, on file within the Department. To apply for a travel charge card, employees are required to complete the mandatory sections of the JPMC Cardholder Application form and sign the cardholder agreement form acknowledging their understanding of the terms of the travel card agreement and their agreement to be bound by them. The National APC can submit the request through PaymentNet or fax the signed application to JPMC for eventual issuance of the card.

Fleet card program

With the exception of the Office of the Inspector General (OIG), fleet cards are assigned to a vehicle and not to a person. In this way, the card is assigned generically so that when personnel changes occur, a new fleet credit card does not need to be reissued.

When a new vehicle is assigned to an office or individual, a fleet card is created for that vehicle, or in the case of the OIG, to an individual. An exception to this would be at Bureau of Prisons (BOP) institutions that have fueling on site and do not have a need for a fleet card assigned to each vehicle. At those institutions, five fleet cards are generically assigned on an as-needed basis for staff travel and use outside of the prison. The OIG has a fleet card program manager that is notified when an employee needs a card. The manager either assigns a new card or obtains information on an existing card that is then reissued to a different or new employee.

In most instances, AOs are a headquarters level fleet manager or an administrative officer. AOs are responsible for maintaining vehicle information such as mileage and fuel use. AOs are located in field or regional offices supporting a group of employees and the vehicles that are required to support the functions of the office. Usually one AO is assigned at each site.

The ratio of cardholders to AOs varies from bureau to bureau. The U.S. Marshals Service has xxx AOs/APCs for 5,283 fleet cards. BOP has an AO at each site location or institution. The

OIG has xx AOs/APCs for 145 fleet cards.

2.3 Procedures at employment termination or transfer

This section outlines the procedures implemented by the Department when an employee terminates employment within the Department or transfers to a different bureau or transfers within the same bureau.

Purchase card program

Purchase cardholders who terminate their employment with the Department are required to notify the appropriate official in their bureau (i.e., Approving Official, Cost Center Manager, Funds Control Officer, etc.) and surrender their cards for destruction. Those officials with the authority to cancel cards directly will do so and then notify the bureau APC. The APC will notify JPMC to close the account. AOs, Cost Center Managers or Funds Control Officers are responsible for ensuring cardholder's balances are cleared prior to separation. APCs are responsible for reviewing the Cardholder Profile data in PaymentNet, to ensure that cards have been cancelled and that no new transactions have been placed on the card. Purchase card holders who transfer within the Department or its components are required to surrender their cards for destruction and are issued new cards at their new duty station as appropriate.

Travel card program

When an employee terminates employment with the Department, the APC must close the account via the PaymentNet, or by notifying JPMC via telephone, e-mail, or fax. The cardholder is required to destroy the card personally, or forward the card, cut in two, to the APC. The APC is responsible each month for reviewing the Cardholder Profile or through account queries via PaymentNet to determine if the JPMC has satisfied the request to cancel a card. For the coming year, the Department is planning to explore the possibility of incorporating the cancellation/destruction of the travel card into the Official Departing Employee Process as an added control measure.

Employees may only transfer to a new hierarchy within a Department component. Employees transferring within the Offices, Boards, and Division can have their account transferred by notifying the National APC. If an employee transfers to another component, the employee's former APC must cancel the account and the new APC must request an account with the new component. If the "departing" office APC fails to submit the transfer, the National APC can perform this activity and should do so. The APC is responsible for reviewing Cardholder Profile data in PaymentNet, each month to determine if JPMC has satisfied the request to transfer the account.

Fleet card program

Retrieving fleet cards that are assigned to a vehicle is unnecessary when a cardholder terminates employment with the Department. For those few individuals (OIG) directly assigned a fleet card, when they terminate employment their fleet card is required to be returned as part of his/her accountable property. That card can then be reassigned or closed at the discretion of the APC or manager.

3. Training

3.1 General

This section summarizes the Department's general training requirements relevant for all charge card program participants.

Charge card participants are required to complete training appropriate to their duties prior to appointment as cardholders, AOs or APCs. Refresher training for charge card participants must be completed within three years of appointment, or date of last refresher training. Charge card participants are issued a certificate of training upon completion of required training. Components conducting in-house training are required to document and maintain records of training attendance and completion in their respective offices. Training for charge card participants must be in accordance with the requirements of OMB Circular A-123, Appendix B. Charge card participants are provided:

- copies of Departmental regulations;
- bureau specific guidelines, including "do not buy lists";
- instructions governing their specific duties and responsibilities;
- lists of documentation required to support purchase card acquisitions; and
- instructions for using JPMC's EAS training (current and revised).

Training modules are also updated as a result of regulatory or programmatic changes or as a result of reviews or audits of cardholder activity.

In addition, numerous additional training opportunities are available throughout the year such as formal APC training courses, webinars, and GSA conferences. JPMC personnel also provide periodic and ad hoc training on an individual or group basis. Guidance from GSA and OMB is routinely distributed to users for review or action.

All charge card participants are required to submit copies of their certificates of training to the appropriate APC.

Those activities with integrated card programs are required to train their cardholders in the appropriate business line(s) available to them.

3.2 Purchase card program

This section outlines the Department's training requirements for purchase card program participants.

Cardholders

Cardholders are required to be trained in the appropriate use of purchase cards prior to receiving an appointment. The training is tailored by the Department's individual bureaus and ranges from: completion of the GSA on-line training and the Department's ethics training; viewing bureau developed training disseminated on a CD or through other electronic medium; or, attending bureau developed intensive one day training sessions for program participants. Cardholders with delegated purchase card authority over the micro-purchase threshold receive additional training and must be warranted contracting officers.

At a minimum, cardholders are required to complete the GSA on-line purchase card training which covers a variety of topics, including:

- cardholder's responsibilities;
- appropriate uses of the card;
- mandatory sources, such as Ability One organizations;
- environmental considerations, such as the Resource Conservation and Recovery Act and energy efficient products;
- prohibited acquisitions;
- Section 508 compliance; and,
- penalties for inappropriate card usage.

Components that have developed in-house training for cardholders may continue to utilize those training tools as long as the materials are in compliance with Appendix B.

Certificates of completed training are maintained by cardholders and must be available for review during periodic audits of their purchase card activities. Copies of training certificates are submitted to the appropriate APC.

Approving Official (AO)

AOs are required to receive training prior to appointment. Training will consist of completing the GSA on-line training for cardholders or bureau developed AO training and ethics training. Certificates of training are required to be kept by AOs. Certificates of completed training are maintained by AOs and must be available for review during periodic audits of purchase card activities. Copies of training certificates are submitted to the appropriate APC.

Agency Program Coordinators (APC)

APCs are senior procurement personnel with an extensive background in acquisitions and advanced computer skills. They are responsible for communicating significant program events and data to bureau and the Department's management. APCs receive training from the on-line GSA training course. APCs are encouraged to obtain a copy of the GSA publication *Blueprint For Success: Purchase Charge Card Oversight*. JPMC has developed an APC Guide and also offers training in charge card management practices and the use of PaymentNet. Training includes understanding the roles and responsibilities of program participants. It also includes using the PaymentNet for program management and monitoring through the use of reports and risk management techniques.

Components that have developed in-house training for APCs may continue to utilize those training tools as long as the materials are in compliance with Appendix B. Copies of APC's training certificates are submitted to the National APC. The Department and JPMC also hold quarterly meetings with the National APCs to discuss program changes and address concerns. The Department encourages National APCs to continuously educate the local APCs by frequently emailing updates on program changes as well as changes or updates to Departmental policies and procedures. In addition, the Department is in the process of developing procurement guidance in the use of Federal Strategic Sourcing Initiatives (FSSI) Blanket Purchase Agreements for Office Supplies. These 15 BPAs offer substantial discounts to purchase card users when purchasing routine office supplies.

3.3 Travel card program

This section outlines the Department's training requirements for travel card program participants.

Cardholders

The Department encourages components to conduct continuous, rather than periodic, year round training for all cardholders. The training will make the cardholders aware of their individual responsibilities under the travel charge card programs, and any consequences for violation.

At a minimum, the Department requires cardholders to complete GSA's web-based training for cardholders. Refresher training should occur every 3 years. Upon successful completion of that training, employees must submit a certificate of training to the APC. Components that have developed in-house training for cardholders may continue to utilize those training tools as long as the materials are in compliance with Appendix B.

The Department has also developed educational materials such as travel charge card policies and guides for cardholders which are readily accessible on the Department's Intranet. In addition, cardholders are frequently issued GSA's publication "Helpful Hints for Travel Card Use" as a training tool.

Agency Program Coordinators (APC)

The Department recognizes the importance of APCs and the diverse role they play in managing the Department's travel card program. Travel APCs have advanced computer skills and an extensive background in managing travel programs. They are responsible for communicating significant program events and data to component management.

At a minimum, the Department requires APCs to complete GSA's web-based training prior to appointment. Upon successful completion of that training, APCs must produce and maintain the certificate of training on file. Refresher training must be taken at least every 3 years. Components that have developed in-house training for APCs may continue to utilize those training tools as long as the materials are in compliance with Appendix B.

JPMC has developed an APC reference guide to assist the APCs in performing their role. The guide addresses critical areas of PaymentNet such as account setup and maintenance, disputes, and reports. JPMC also holds quarterly meetings with the National APCs to discuss program changes and address concerns.

The Department encourages National APCs to continuously educate the local APCs by frequently emailing updates on program changes as well as Federal Travel Regulations and Departmental policies and procedures. In addition, APCs are encouraged to utilize the GSA SmartPay® publication, "A Guide for Managing Your GSA SmartPay® Travel Charge Card Program" for helpful hints, best practices and suggestions for managing their travel program.

3.4 Fleet card program

This section outlines the Department's training for fleet card program participants.

There is no formal training at the Department level in place for the specific use of fleet cards. In general, guidelines for using any government credit card (purchase, travel) also apply to the fleet card. More detailed training in this area is at the component level. The training provided for the other business lines applies to fleet for those activities with integrated cards. The fleet cards are limited in their use since they are coded electronically to only be used for fuel and maintenance. If the product being purchased or service performed on the vehicle is not a Merchant Category Code (MCC) for fuel or maintenance, the transaction will not be authorized. The fleet cards generally have a dollar limit per transaction (usually \$50-\$100) which prevents abuse.

The OIG does provide guidelines with the issuance of each new fleet card. An introduction to the fleet card program and use of the fleet card is incorporated in the new agent orientation PowerPoint presentation created by the administrative section of the Investigations Division, OIG.

Fleet APCs have an extensive background in fleet management and advanced computer skills. They are responsible for communicating significant program events to bureau and the Department's management.

3.5 Record keeping

This section summarizes the Department's procedures for documentation and record retention.

Purchase card program.

Program participants receive certificates upon successful completion of training. Certificates of training are maintained by the individual program participants and must be available for review during periodic audits of their activities. Copies of training certificates are submitted to the appropriate APC.

Components conducting in-house training are required to document and maintain records of training attendance and completion in their respective office.

Travel card program

At a minimum, the Department requires cardholders and APCs to obtain the certificate of training produced by GSA upon completion of their web-based travel cardholder and APC training. APCs are responsible for maintaining training certificates for cardholders under their respective account. Current certificates of training are kept by program participants as long as they continue to perform charge card activities.

Components conducting in-house training are required to document and maintain records of training attendance and completion in their respective office.

3.6 Ensuring effectiveness of training requirements

This section outlines the Department's procedures for ensuring that training policies and procedures remain current and effective.

Purchase card program.

The effectiveness of training for program participants is evaluated by National APCs through the use of PaymentNet Net to periodically review cardholder transactions and on site audits of cardholder activities. The Department's OIG evaluates the effectiveness of cardholder training through the use of data mining techniques. Transactions are reviewed on a quarterly basis or more frequently if necessary. On site audits of cardholder activities are conducted on a rotating basis. Training materials, policies and procedures are updated as the program requirements changes and as patterns of inappropriate activity revealed through reports generated by the Department's OIG. APCs use of PaymentNet, or by on-site audits.

Travel card program.

The Department determines the effectiveness of its training requirements based on the percentage of cardholder delinquency and misuse. The Department requires National APCs to perform an annual review of their overall training process and training materials to ensure its accuracy and effectiveness. The Department's training materials, policies and procedures are updated as a result of program monitoring and program requirement changes.

4. Risk Management

4.1 General

The Department and JPMC have instituted a new procedure designed to alert purchase, travel and fleet cardholders of suspicious activity on their accounts. When JPMC notices suspicious activity on an account, the cardholder is called and an email is sent to the APC. If the cardholder cannot be reached, a security flag is placed on the account and it is temporarily suspended. The block is removed when the cardholder contacts the JPMC Security Department and requests removal.

The Department routinely transmits to JPMC a Current Employee Department-wide file which JPMC compares against JPMC's Department Travel Cardholder file for discrepancies or inaccuracies. For those individuals within the Travel Cardholder file that do not have a corresponding employee on the Current Employee file, the travel card coordinator is notified immediately and resolution at the travel coordinator level occurs as soon as possible.

A similar process is repeated every month for those employees who have separated from the Department. Information on separated employees is routinely compared by DOJ and JPMC to ensure accuracy.

This process will ensure that there are not any cards open for former employees.

4.2 Creditworthiness policies and procedures

This section summarizes the Department's policies and procedures regarding creditworthiness and performing credit checks.

Purchase Card Program

Not Applicable

Travel Card Program

Per the Master Contract with GSA, credit scores and creditworthiness determinations can be performed on each new travel card applicant. JPMC has agreed to provide us with credit scores at no cost. JPMC will keep all credit scores together with applications tendered by the Department. ATF performs its own creditworthiness determinations using Equifax; ATF performs this before processing an application. All scores are kept with the applications and are confidential. The Department is developing Department-wide policy.

Fleet Card Program

Not Applicable

4.3 Controls, practices, and procedures related to Centrally Billed Account (CBA) delinquencies

This section outlines the Department's risk management procedures in regard to CBA delinquencies.

The Department is working with JPMC to manage CBA delinquencies. We have requested that JPMC flag CBAs that are in danger of becoming delinquent sufficiently in advance so that

corrective measures can be instituted to prevent potential delinquencies from becoming actual delinquencies. To ensure timely, accurate and appropriate payments of CBAs, several Department components have implemented a monthly direct payment system with JPMC. Components that do not participate in a monthly direct payment system must process CBA invoices in compliance with the Prompt Pay Act.

Departmental components receive Aging reports from JPMC on a monthly basis. These reports indicate debt by monthly measurement (1-30 past due days, 31-60 past due days, 61-90 past due days, 91-120 past due days, etc.) Component APCs are required to review and monitor the Aging data on a monthly basis and advise their National APC of CBA accounts approaching pre-suspension, suspension, pre-cancellation, or cancellation.

4.4 Controls, practices, and procedures related to Individually Billed Account (IBA) delinquencies

This section outlines the Department's risk management procedures in regard to IBA delinquencies.

The Department monitors monthly reports from JPMC, GSA's Chief Financial Officer's (CFO) reports and reports generated by APCs from PaymentNet. Those reports are used to monitor and prevent delinquencies. Delinquent cardholders are contacted by the local APC by e-mail or verbally if a delinquency persists. The initiation and severity of disciplinary action depends on the size of the amount and length of time of the delinquency.

Available through PaymentNet, the Department monitors the pre-suspension/pre-cancellation report on IBA accounts from JPMC on a monthly basis. These reports indicate debt by monthly measurement (1-30 past due days, 31-60 past due days, 61-90 past due days, 91-120 past due days, etc.). Delinquent accounts in the 31-60 past due days range are in "pre-suspension status." Delinquent accounts in the 61-90 days range are in "suspension" status. Delinquent accounts in the 91-120 past due days range are in "cancellation" status. If necessary, JPMC will notify APCs the names of cardholders who are delinquent on the 45th past due day after the close of the previous billing cycle.

The Department's Travel Card Program Guide requires the travel card coordinator to inform the appropriate supervisory or management official, in writing, of the following: pending suspensions (accounts 45 past due days); suspensions (accounts 61 past due days); pending cancellations (accounts 110 past due days); and, cancellations (accounts 120 past due days).

4.5 Controls, practices, and procedures related to charge card misuse and abuse

This section outlines the Department's risk management procedures in regard to charge card misuse and abuse.

Specific risks associated with charge card programs are inappropriate use, misuse, waste, fraud and abuse. The Department employs a multi-tiered approach to managing these risks that includes managing these risks at all levels of participation by employees in its charge card programs.

The Department's cardholders are trained in the proper use of Government charge cards. Training ensures that cardholders are aware of the penalties for inappropriate use, misuse, abuse and fraud involving charge cards. AOs are trained in the proper exercise of their responsibilities especially the importance of reviewing cardholder transactions.

The Department requires that AO's have a maximum of seven cardholders reporting to them, or that AOs review 300 or fewer transactions during any one billing cycle, to ensure effective review of cardholder transactions.

APCs use PaymentNet to continually monitor cardholder activities, program performance and to mitigate the risks associated with charge card programs.

The OIG receives downloads of cardholder activities for all business lines directly from JPMC and uses Audit Control Language (ACL), a proprietary software language, to review cardholder transactions. The Department's OIG has developed, tested and validated several data mining reports over the past years that it uses to detect possible charge card misuse. Through PaymentNet, reports of declined transactions are available, and subsequently reviewed for emerging patterns. Exception reports are also used by the IG and are particularly helpful in reviewing and monitoring cardholder activities. Local coordinators also review online reports available in PaymentNet. While the OIG is not considered a part of the DOJ internal control process, at present this review by the OIG provides valuable assistance to the Department in ensuring that the charge cards are properly used by its employees.

The Department will continue to utilize the PaymentNet system which allows the components to access real-time data on its cardholders' purchase card activity and to quickly identify and respond to issues of fraud, misuse, or abuse. As the capabilities of the PaymentNet system are enhanced, our ability to manage our card programs will increase. In addition, infrequently used cards or accounts are placed in "inactive" status to decrease the risk of misuse.

In addition, the Department has recently made available an additional data mining tool – MasterCard's Electronic Management System (EMS) through its relationship with JPMC and the GSA SP2 contract. Restricted to national level APCs and Department oversight officials, EMS will help leverage the Department's ability to more effectively oversee the program. While training of DOJ staff has only been conducted in the last few months, EMS shows promise. However, to fully utilize the capabilities of EMS, expertise will need to be gained by its users in the coming months before it reaches its full capability.

While EMS offers an available option for the future, APCs currently use a multi-tiered approach through the use of standard and ad hoc reports available to them from PaymentNet to monitor transactions. If inappropriate use of the charge card is discovered, there is a range of disciplinary actions available from employee counseling and retraining, reducing cardholder's authority, canceling cards and, if necessary, prosecution of cardholders for fraudulent activity.

4.6 Appropriate authorization controls establishment

This section summarizes the Department's authorization controls.

Purchase card program.

The Department places authorization controls on the use of cards as a risk management tool. These controls vary among Departmental components. The general purchasing trends of an office are reviewed to determine the need for additional cards and serve as a guide in establishing single purchase and cycle limit restrictions. Automated Teller Machine (ATM) privileges are blocked for purchase cards, as are travel related MCCs. MCC blocking for purchase transaction include:

- 4411 – Cruise Lines;
- 5861 – Furriers and Fur Shops;
- 5813 – Bars, Cocktail Lounges, Discotheques, etc.;
- 5921 – Package Stores, Beer, Wine, Liquor;

- 5944 – Clock, Jewelry, Watch, and Silverware Stores;
- 7273 – Dating and Escort Services;
- 7276 – Tax Preparation Service, and;
- 7297 – Massage Parlors

These controls greatly reduce the risks associated with abuse or misuse.

Travel card program.

The Department utilizes a number of authorization controls within the travel charge card program. However, the controls vary among components within the Department. These controls include, but are not limited to:

- setting card spending limits;
- setting limits on the employees to whom cards will be issued;
- setting or blocking ATM privileges;
- deactivating cards when cardholders are not on travel; and,
- blocking selected MCCs.

All of these controls greatly reduce the risks associated with abuse or misuse

4.7 Ensuring effectiveness of risk management controls

This section outlines the Department's procedures for ensuring that risk management policies and procedures remain current and effective.

The Department continuously reviews the effectiveness of its risk management strategies and policies for all business lines. Reviewing risk management strategies and policies is the responsibility of AOs, when reviewing cardholder statements, APCs, when running reports and conducting on-site reviews of cardholder activities, and the OIG through its in depth data mining of cardholder transactions.

Risk management controls are updated as a result of: legislation; increased incidents of questionable transactions highlighted through our monitoring of cardholder activities; increases in the number of cases of questionable activities reported to the OIG; and, in response to OIG recommendations resulting from audits or monitoring the Department's charge card program.

The best practices that the Department employs in managing its risk are: thorough training of cardholders and AOs in their obligations and responsibilities; limiting the number of cardholders reporting to an AO, or the number of transactions that they review during any one cycle; APCs review of cardholder activities and spending patterns through the use of PaymentNet standard and ad hoc reports; APCs periodic on-site reviews and audits of cardholder activities; the OIG's use of data mining techniques and audits of cardholder transactions; and, working with JPMC to detect suspicious activity on cardholder accounts. Additionally, the use of the MasterCard EMS data mining software will allow users to further leverage the Department's ability to monitor transactions activities.

5. Strategic Sourcing

5.1 Strategic sourcing implementation

This section summarizes the Department's policies and practices related to strategic sourcing.

The Department has implemented a strategic sourcing plan that consists of a review of accounts payable data, including purchase card data, to determine our major trading partners and the commodities that we obtain from them. Commodities have been identified and the opportunities for strategic sourcing of those commodities are currently being studied. We are collecting data on our acquisitions of the selected commodities and gathering information from the vendors that supply those items to us.

We have partnered with JPMC, our commercial card provider, and MasterCard Worldwide. JPMC has offered the services of their Expansion Services to assist in implementing strategic sourcing. Expansion Services is an entity within JPMC that is dedicated to assisting their customers in expanding commercial card opportunities available to them. MasterCard Worldwide is working with JPMC to improve the quality of data available for analysis. The Department is also reviewing selected commodity classes to determine if we could benefit from a strategic sourcing approach to acquiring those commodities.

The Department is continuing the process of analyzing its spending data to determine the nature of available strategic sourcing opportunities. In light of increased emphasis on providing procurement savings to the Department, its various components are engaged in an ongoing examination of its acquisition programs, including the charge card program.

5.2 Promoting effectiveness of strategic sourcing policies

This section outlines the Department's procedures for promoting strategic sourcing policies and procedures.

As strategic sourcing initiatives are put into place, training will be provided to our cardholders and acquisitions personnel throughout the Department. Cardholders and acquisitions personnel will be made aware of discount agreements and methods available to use those agreements. The Department will use the exception reporting capability in PaymentNet to monitor employee use of our discount agreements.

Use of Department wide or bureau wide discount agreements will be mandatory except under unusual circumstances. In the case of multiple awards, acquisitions from vendors will be rotated. Changes in pricing under agency contracts will be communicated to cardholders through APCs and to appropriate component acquisitions personnel. The Department is currently developing policy for the utilization of GSA's Federal Strategic Sourcing Initiative's (FSSI) Blanket Purchase Agreements (BPAs) for the purchase of office supplies. These 15 BPAs will offer users discounted rates of 5% - 20% from normal prices. The discounted rates will be offered immediately for those users utilizing the purchase card.

5.3 Ensuring effectiveness of strategic sourcing policies

This section outlines the Department's procedures for ensuring that strategic sourcing policies and procedures remain current and effective.

When the discount agreements are in place, acquisitions data from selected commodities will be collected from PaymentNet, and from MasterCard EMS once it is operational and in use. Information will be gathered on acquisitions from the vendors that supply those items to us. That

information will be reviewed to ensure compliance with strategic sourcing policies and to ensure the Department is getting the best value for its acquisition dollars.

Refunds and Tax Recovery

6.1 Refund management

This section outlines the Department's policies and procedures to promote and ensure the effectiveness of refund management controls.

It is the Department's policy to maximize its charge card refunds by increasing opportunities to expand the charge card program and reduce the payment cycle time. Bureaus are encouraged to streamline their programs and processes to allow greater expansion of those programs. The department has continued to negotiate more favorable refund terms with JPMC over the life of the Master Task Order. The Department has consistently improved its program to allow it to meet successive incentive targets that increase refunds.

Refunds are allocated based on component's spending and speed of payment. Components have reviewed their billing and payment practices to maximize available incentives. This includes consolidating and reducing the number of billing accounts as well as increasing the payment frequency. The Chief AO (CAO) is responsible for reviewing the refund management policies. The CAO and APCs jointly review the refund agreement. The charge card program business practices and refund calculations are periodically reviewed to ensure that charge card refunds are maximized.

6.2 Tax recovery

This section outlines the Department's policies and procedures to promote and ensure the effectiveness of tax recovery.

The Department's policy is to minimize the payment of taxes by its cardholders. Cardholders are to provide notice to vendors that the Department's transactions are exempt from the payment of state and local taxes, unless mandated by State or local jurisdictions. Cardholders are encouraged to contact merchants upon discovery of assessed sales tax. When contacting merchants, cardholders should remind them of the Department's tax exempt status and request that merchants refund any taxes. We promote tax exemption and recovery through cardholder training and the review of invoices. Purchase, travel and fleet cards are clearly marked as being official U.S. Government cards, while purchase cards are embossed with the Department's tax number. The Department is exploring options for placing the Department's tax number on travel cards as they become subject to reissuance or are new.

Further guidance on the use of travel cards and its tax ramifications can be found on the Department's Intranet site along with links to appropriate state and local tax documents for those jurisdictions that allow federal tax exemption. The Assistant Attorney General for Administration also issued further guidance in March 2010 informing DOJ employees of their responsibilities in this area and instructing them to challenge vendors in obtaining tax exemption whenever possible. The guidance also indicated that if travelers pay State or local lodging taxes and should have been exempt, then the traveler must not be reimbursed. The Department's CFO is responsible for annually reviewing tax recovery policies.

Additionally, GSA, as part of the SmartPay II Program and its contract with the banks, is directing JPMC and the other banks to develop plans for tax recovery programs for their federal customers. The Department is fully supportive of that effort and has voiced repeatedly its interest in implementing such a program. JPMC has recently partnered with Deloitte LLP, a leading international accounting and consulting firm, to provide tax recovery assistance to them in pursuit of this initiative. The initial step for JPMC/Deloitte is to develop a viable tax recovery plan to provide these unique services. This critical first step is slated for completion in the 1st Quarter 2011. Once the plan is submitted and approved by GSA, pilots will be conducted with 1 to 3

agencies – one of which is the Department of Justice. Those pilots are tentatively slated for implementation in the 1st - 3rd Quarters of 2011. While that plan is pending for the travel and purchase programs, JPMC/MasterCard has already instituted a "net billing" procedure in the fleet program to ensure that the Department is billed for fleet related products and services exclusive of State and local taxes.

7. Reporting

7.1 Reports

This section outlines the various charge card reports that the Department utilizes for monitoring delinquency, misuse, performance metrics, and other transactions and program management issues.

The Department uses reports available to it from several sources to monitor its charge card activities. APCs use PaymentNet as the primary vehicle to continually monitor cardholder activities, program performance and to mitigate the risks associated with charge card programs. Approving Official/Span of Control available through PaymentNet are run to ensure that AO to cardholder ratios are maintained and that the number of transactions being reviewed during a cycle is appropriate. Transaction Detail Reports are used to monitor cardholder activities to prevent inappropriate, wasteful, abusive or fraudulent use and also to monitor the effectiveness of training programs. Transaction Activity by MCC Type, Declined Transaction Reports and Merchant Activity Reports are used to monitor cardholder's spending patterns and to highlight potential patterns of questionable card usage. In addition, APCs monitor exception reports of cardholder activity which can be custom designed in PaymentNet. Reports are generated monthly and also at random to detect possible misuse as soon as possible. Reports are tailored to specific component requirements and may be scheduled to run automatically. APCs are responsible for reviewing the Cardholder Profile Report to ensure that cards have been cancelled and that no new transactions have been placed on the card when an employee separates from the service. PaymentNet reports such as the Account Management Report, Cardholder Status with Hierarchy and Closed Date are reviewed each month to ensure that the Bank has satisfied requests to cancel cards.

APCs use PaymentNet, to run reports to review cardholder statements, cardholder profiles and hierarchy, status of state and local tax recovery, merchant activity, MCC activity, and many other facets of charge card activity, on an as needed basis. JPMC, through Payment Net, also provides ad hoc reports such as declined transactions, delinquency and convenience check usage. Monthly GSA CFO Reports and Aging Reports, through Payment Net such as the 45 Day, Charge Off, Delinquency with Current Balance, suspend/cancellation are also monitored to monitor charge card activities on CBA and IBA and accounts. Additionally, standard and ad hoc reports available from MasterCard's Enhanced Merchant Reporting (EMR) are used by APCs as an additional means of monitoring charge card activities. EMR may also be used to generate 1099 reports.

Additionally, the OIG receives data feeds of individual transactions from JPMC. The OIG has developed and validated an extensive number of reports which are run against the JPMC data to monitor charge card activities for incidents of waste, fraud and abuse.

As user expertise develops, the recently implemented MasterCard Expert Monitoring System (EMS) data mining tool will offer a range of reports designed and implemented by the user. It will allow users to create custom reports either not available through PaymentNet or requiring JPMC creation. EMS access and training has been given (or made available) to National APCs, IG staff, and selected Department oversight personnel where expertise can be developed and data mining can occur in the next few months.

8. Section 508 of the Rehabilitation Act

8.1 Section 508 Compliance

This section summarizes the Department's policies and practices related to ensuring that products procured comply with Section 508 of the Rehabilitation Act.

The Department ensures that the acquisition of electronic, information technology and telecommunications equipment complies with the requirements of Section 508 of the Rehabilitation Act P.L. 105-220, as amended, by providing training to its contracting officers and purchase card holders. Reviews of purchase card activities ensure that those requirements are being met by purchase card holders. The Department has a direct link to Section 508 information at <http://www.usdoj.gov/crt/508/508home.html> from the Department's web site to provide information about Section 508. Procurement Guidance Document 05-02 was issued on February 2, 2005, to remind acquisition personnel that Section 508 requirements would apply to micro-purchases after April 1, 2005.

Purchase approval decisions concerning Section 508 are made on micro-purchase checklists.

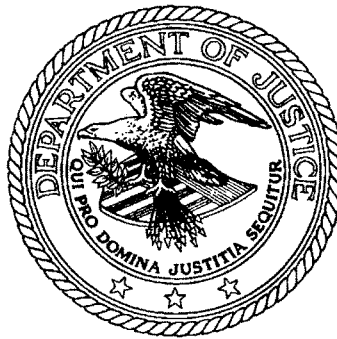
9. Environmental Requirements

9.1 Environmental quality of products procured with purchase cards

This section summarizes the Department's policies and practices related to the environmental quality of products procured with purchase cards.

The Department ensures that its cardholders acquire products compliant with the RCRA, FSRIA, EPA Act, and EO 13101, 13123, 13221 and 13148 through training and reviews of cardholder activities. The web site at <http://www.usdoj.gov/ind/pe/envproc.htm> provides links to assist cardholders in complying with environmental requirements. As better data concerning environment quality products becomes available from JPMC and MasterCard the monitoring of purchase card acquisitions will be improved.

Travel Charge Card Program Guide



Offices, Boards, and Divisions
U.S. Department of Justice

1039



U.S. Department of Justice
Justice Management Division
Finance Staff

Washington, D.C. 20530

MEMORANDUM

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

JMD Senior Management Staff

FROM: Lee Lofthus, Director /s/ July 2, 2001
Finance Staff
Justice Management Division

SUBJECT: Travel Charge Card Program Guides

Attached are two Travel Charge Card Program Guides: 1) Travel Charge Card Guide and 2) Travel Charge Card Reference Guide for Cardholders. These two guides replace the guides by the same names which were issued on January 19, 2001. After consultation with the Personnel Staff and the Office of the Inspector General, minor changes were made to the sections in both guides which pertain to disciplinary action for abuse/misuse of the card.

The Travel Charge Card Guide contains information for supervisory and management officials and designated travel card coordinators. The other guide is directed to the individual travel cardholder. Both are a synopsis of Federal statutes, official travel regulations, and Department of Justice policies.

Please call Diane Kelly of my staff on (202) 616-5504 if there are any questions on the information presented in these Guides.

Attachments

cc: Bureau Finance Officers

**THE OBD GOVERNMENT TRAVEL CHARGE CARD PROGRAM
POLICY, PROCEDURES, AND ENROLLMENT GUIDE**

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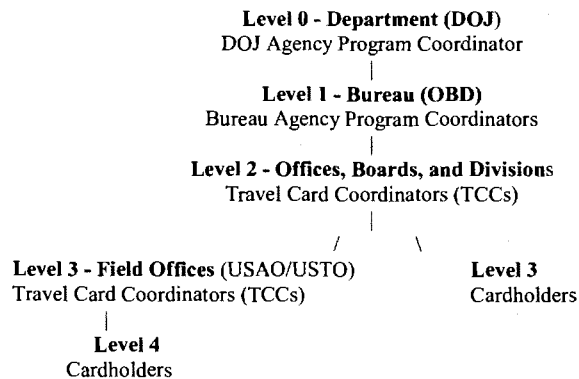
OBD APPLICATION FORM A
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**THE GOVERNMENT TRAVEL CHARGE CARD PROGRAM
POLICY, PROCEDURES, AND ENROLLMENT GUIDE**

SECTION I. TRAVEL CARD PROGRAM OVERVIEW

The Government Travel Charge Card (Travel Card) Program was created by the General Services Administration (GSA) as a travel and transportation payment and expense control system. It includes employee travel charge cards, automated teller machine (ATM) services, and Government Transportation Accounts (GTAs) for use by Government employees traveling on official business. Bank One (hereinafter, the Contractor) is currently under contract to the GSA and the Department of Justice to provide these services.

The travel charge card program management is structured as follows:



Individual Travel Cards

An individual travel card is to be issued to any employee who expects to travel. (An employee is anyone for which there is a SF-50, Personnel Action, or an SF-61, Appointment Affidavit, on file within the Department. Contractors are not employees, and should not be given cards.) There is no credit check performed by the Contractor prior to issuance of a card.

The travel card must be used for all official travel expenses: common carrier transportation tickets, lodging, rental cars, and other expenses, to the extent the card is accepted. The card must also be used for cash advances through the ATM program. The travel card program minimizes the need for cash, is the most efficient method available for purchase and payment of business travel expenses, and maximizes the benefits to the Department under the charge card contract.

The intentional use of the travel card for purchases, other than official, is strictly prohibited and will subject employee to disciplinary action.

Travel-Related and Miscellaneous Expenses

In addition to travel and transportation charges, the travel card may be used for authorized "travel-related expenses." Travel-related expenses means any expense allowable under Federal Travel Regulations (FTR) or OBD travel policy. Examples provided in the FTR include: charges for necessary typing or stenographic purposes, rental of typewriters, clerical assistance, services of guides, interpreters, packers, drivers of vehicles, storage of property used on official business and other miscellaneous expenditures not enumerated, when necessarily incurred by the traveler in connection with the transaction of official business.

Miscellaneous and travel-related expenses must be approved in advance by the appropriate official. Examples of other travel-related expenses include, but are not limited to, supplies or parts such as minor purchases of computer technology, and expenses associated with prisoner transportation; e.g., meals.

In unusual cases, if employees are unable to secure advance approval for unanticipated travel-related or miscellaneous expenses, those expenses may be approved when employees voucher for their travel expenses. Employees are advised, however, that when expenses are incurred which have not been previously authorized, the employee assumes the risk of financial liability if the expenses are partially or fully disapproved.

Employees should not use their travel card to charge expenses for others (e.g., reserving a room for a co-worker or witness). Employees who do so are solely responsible for any liability which may occur if the transactions are not properly settled.

Liability for Charges Made with the Individual Travel Card

The Government is not directly liable for any charges made using the individual travel card. The Department will reimburse employees in a timely manner for authorized and allowable travel expenses, and the employee must pay the Contractor in full within 25 days from the statement closing date. Employees are responsible for full payment of all charges made using the card regardless of the amount reimbursed. Because the Government travel card is not a "credit" card, there is no interest assessed on unpaid balances. There is, however, a late fee of \$25 on any account which has been canceled due to delinquency exceeding 120 days.

1. **Disputed Charges.** Any travel card expense item which an employee is refusing to pay, for any reason, should be reported to the Contractor by the employee as soon as possible. Employees may make billing inquiries and report disputes 24 hours a day, seven days a week, by calling 1-888-297-0781 from within the United States or by calling collect at (847) 488-0781 from international locations. The Contractor will confirm all disputes in writing, within three working days. Once an item is identified as an "open or disputed" item, the account receives a notation and the item is assigned a date in which all research by the Contractor must be completed (typically 60 days). Until that date, the account is given a

pending credit in the amount of the dispute. Amounts which have been disputed with the Contractor will not be considered delinquent.

If, within two billing cycles, the Contractor has not had a satisfactory response from the establishment in regards to the disputed amount, the charge will be reversed to the establishment and the credit made permanent. However, if the establishment supplies the Contractor with documentation showing the charge was valid, the pending credit will be rebilled and payment of the amount is due within 25 days.

Employees are responsible for resolving re-billed disputes directly with the establishments in question if still dissatisfied.

2. Airline Ticket Refunds. A charge for a canceled or returned unused portion of a transportation ticket must be disputed with the Contractor in order to have it temporarily removed until the merchant issues a credit. If credit is not received for a canceled or unused portion of a ticket within two billing cycles, the employee should contact the Travel Management Center (TMC) or the airline, as appropriate, to determine the status of the request for refund. If no satisfaction is received from the TMC or airline, employees should contact their TCC for assistance. (Note: when returning tickets or portions of tickets to the TMC, the employee should always request a receipt. Tickets should not be returned through interoffice distribution systems and, if mailed, should be sent registered mail. An unused ticket or portion of a ticket is equivalent to cash.)
3. Lost Ticket Applications. In the case of a lost ticket, employees must file a Lost Ticket Application (LTA) with the airline, which may be done through the TMC, and provide a copy of the LTA to the Contractor when disputing the charge. The Contractor will issue a pending credit until the airline issues a refund, which generally takes up to six months. Because the airlines charge a minimum fee to process LTAs, that amount will be deducted by the airline from the refund. Since the entire amount of the ticket was disputed and temporarily credited, this fee, at time of refund will result in a debit to the cardholder's account. The cardholder is liable for this remaining charge. The LTA processing charge may be reimbursed by the Department under appropriate circumstances as determined by the proper officials within the organization.

Cash Advances

The ATM Cash Advance feature allows travelers to use their cards to obtain cash advances to pay for official expenses that cannot be charged using the card. Employee card ATM cash advances shall be used in lieu of government issued cash advances. Government issued cash advances shall not be used unless a determination has been made by the appropriate official (i.e., within the Financial Organization, or Executive or Administrative Officer or

equivalent, subject to approval of the Financial Officer heading each Component) that ATM advances will not meet mission-related needs of the traveler. Under the current contract, there is a flat \$2 fee per withdrawal, regardless of the amount of the withdrawal. There may also be a network access fee charged by the ATM network. Both the \$2 withdrawal fee and the network access fee are reimbursable. (See P&P Bulletin 99-8, Travel Advances, dated December 9, 1998.)

Government Transportation Accounts (GTA)

“Office” GTA accounts may be established to pay for official transportation charges for new employees and for invitational travelers. GTA accounts are established by the OBD APC, and then managed and operated by the OBD. The TCC is also responsible for reconciling and submitting the monthly invoices to an approving official for payment. GTA accounts may not be used for lodging or miscellaneous charges without prior approval of the OBD APC.

GTA accounts may not be used to purchase GSA City-Pair contract fares for Cost Reimbursable Contractors (CRCs), employees of contractors, or grantees whose grants include their travel expenses.

Benefits Derived from Use of the Travel Card and GTA

Any benefits derived from use of the travel card, including frequent flyer miles awarded for the card's use for airfare, hotel, rental cars or other travel-related expenses, belong to the Government, and must be used for official travel. In accordance with the Attorney General's memorandum of July 2, 1993, to Heads of Components, any benefits are to be used for free or reduced official travel costs, and are not for premium class upgrades. See also, the memorandum of September 15, 1995, to Heads of Components, from the Assistant Attorney General for Administration (and Financial Management Policies and Procedures Bulletin 96-01, October 17, 1995) on Gainsharing.

The OBD receives a quarterly rebate from the Contractor based upon the charging volume of the individual travel card and the centrally billed accounts. The OBD rebate is deposited to a central account within JMD and used to pay OBD transportation transaction fees charged by the DOJ nation-wide Travel Management Center.

SECTION II. MANAGEMENT OVERSIGHT RESPONSIBILITIES

Responsibilities of the TCC

The TCC is responsible for the day-to-day management of the program, including the review of oversight reports provided by the Contractor. However, if reports indicate possible misuse or abuse of the card or chronic delinquent payments on the part of an employee, the TCC is required to notify the appropriate supervisory or management official (e.g., cardholder's

immediate supervisor, section chief or equivalent, administrative officer, etc.).

The TCC is not responsible for resolving questionable transactions or overdue accounts with the employee; that is the responsibility of supervisory or management officials.

The TCC shall inform the appropriate supervisory or management official, in writing (e-mail is acceptable) of the following: questionable ATM or charge card transactions; pending suspensions (account is 45 days past due); suspensions (account is 60 days past due); pending cancellations (account is 110 days past due), and cancellations (account is 120 days past due).

Responsibilities of the Supervisory and Management Officials

Supervisory and Management Officials are expected to work closely with their employees and the TCC to ensure that the travel card is used solely for official business-related expenses while in travel status, and that debts to the Contractor are paid promptly.

They should instruct their employees that misuse or abuse of the travel charge card, or a consistently delinquent payment history, may be cause for reconsideration or possible revocation of employee security clearances, and that various disciplinary actions will be considered, up to and including removal for misconduct.

Intentional misuse of the travel card, regardless of the dollar amount, must be reported to the Office of the Inspector General (OIG) via e-mail by the supervisor or the TCC. Inappropriate charges exceeding \$1000, intentional or not, must also be reported to the IG. The IG address is: oighotline.oighotline@usdoj.gov. The OIG will record the matter and review the particulars of the misuse before deciding how to proceed. Delinquency of more than 180 days will be reported to the OIG by the bank.

Disciplinary Action for Abuse/Misuse of Card

The TCC shall provide written notification of questionable transactions to the employee's supervisor. The supervisor shall promptly meet with the employee to discuss the questionable transactions. If the transactions are in accordance with established policy regarding use of the Card and ATM Program, supervisor shall notify the APC accordingly, in writing, and the matter will be considered to be resolved.

If the transactions were not in accordance with established policies, the supervisor shall take appropriate action. It is the responsibility of the employee's supervisor to make a determination, based upon the facts presented by the TCC and the employee, as to whether or not the employee's travel charge card should be canceled based upon the improper transaction(s). Misuse of the Card is a violation of the agreement with the Contractor and is in violation of Departmental policy. Any offense, whether intentional or not, resulting in charges in excess of \$1,000, must be reported to the OIG within 48 hours of learning about the offense. If misuse

results in total charges under \$1,000, the supervisor may offer the employee the chance to repay the debt, and

- a. take no further action; or
- b. take disciplinary action commensurate with the seriousness of the misuse or abuse of the card.

The supervisor is responsible for notifying the TCC of the action to be taken as to the status of the card. The TCC will then notify the Contractor, if necessary. The TCC is authorized to provide the Contractor with the forwarding address of transferred or separated employees who depart with an outstanding balance.

If an employee account is canceled due to non-payment, that information may be provided by the Contractor to a regional credit bureau. The employee will receive notice from one of those credit bureaus to pay in full within 45 days or be reported to a National Credit Bureau. In addition, the employee will be charged a \$25 late fee by the Contractor. If the account is referred to an attorney for collection, the cardholder will be responsible for the attorney's fees, if any, not to exceed one third of recovered amount plus actual court costs except where prohibited by law.

Travel After Card Suspension/Cancellation

If an employee is required to travel while card privileges are suspended or canceled, the appropriate supervisory or management official will have to determine whether or not transportation expenses shall be charged to an office central account (GTA). This is the only alternative to purchasing transportation tickets, as the use of personal cards or cash is prohibited by the FTR. If travel is authorized after a card is canceled, the employee is expected to pay all lodging and incidental expenses out-of-pocket, and file for reimbursement. Travel advances shall not be provided to employees who lost travel card charge privileges due to misuse or non-payment of charge card bills. Supervisors and managers are expected to inform employees that suspension or cancellation of charge card privileges impairs the ability of employees to travel on Government business in the most efficient manner, may reflect unfavorably in performance evaluations, or be cause for discipline.

Because the use of the GTA account expends additional government resources, use of an office's GTA account for an employee whose card has been suspended or canceled due to nonpayment should be considered as a last resort. Employees whose cards have been suspended or canceled must be counseled to pay the Contractor in full or otherwise resolve the matter to ensure that their credit rating is sufficient for reinstatement of the Travel Card. No card will be issued to the employee by the Contractor if the credit check is unfavorable.

SECTION III. OTHER TCC RESPONSIBILITIES

The day-to-day management of the program consists of completing charge card applications, receiving and monitoring reports; contacting appropriate persons in the event of misuse/abuse of the card by a cardholder; assisting cardholders as necessary; acting as liaison between the Component/Office and the OBD APC; and maintaining accounts. Each TCC must have an assigned alternate capable of assuming these responsibilities in their absence.

Each TCC is assigned a unique hierarchy number by the OBD APC. Each individual card under the TCC is generated under a specific hierarchy number at setup, on the card application. The hierarchy dictates how reports are distributed, and how the Contractor rebate from travel card use will be disseminated.

Completing the Application

The Contractor's application form (Appendix A) is split into seven parts. The TCC completes Sections I, II, IV, V and VI. Section III is to be completed by the applicant. Because much of the information is standardized, a "master" form should be created for each hierarchy to save time and decrease the potential for error.

1. **Billing Address.** OBD employees are required to receive their statements at their home address, unless there are extraordinary circumstances which prohibit it. Card delivery to an office mail room is considered insecure.
2. **Social Security Number (Mandatory).** No application will be processed by the Contractor without an SSN. If an applicant absolutely refuses to submit his SSN, the TCC must enter 999-99-9999. (Note: the applicant should be informed that refusal to complete the SSN will prohibit the employee from participating in the OBD program which allows the Bank to be paid directly from the reimbursement voucher.) Employees who are not on the DOJ payroll (Special Assistants, Deputized Agents, etc.) must also use leading nines (first five digits of the SSN) in the SSN field to distinguish them from NFC- paid employees. They may use the last four number of their SSN if they wish to participate in the automated call system utilized by the Contractor.
3. **Confirmation of Receipt of Cardholder Agreement (Mandatory).** The Cardholder Agreement (Appendix B) is a separate form from the application. Each applicant should be provided with a copy of the Agreement at the time they are handed an application. The employee's signature on the application (Section III) attests to the fact that they have read the Agreement.
4. **Hierarchy Level (Mandatory).** Every application requires a Level 2 number, offices within some of the OBDs will also require Level 3 and possibly Level 4 numbers. All litigating divisions are Level 2; field offices of the U.S. Attorneys and U.S. Trustees are Level 3, with a roll-up to a Level 2 (their Headquarters'

- offices).
5. Cardholder Controls. The OBD APC set the cardholder control limits for all OBD cardholders as follows: Dollars per Cycle: \$15,000; Dollars per Day: N/A; Dollars per Transaction: N/A; Transactions per Cycle: N/A; Transactions per Day: N/A; ATM Limit: \$300 per day NTE \$300 weekly.

Each TCC may alter their cardholder controls as appropriate, either en masse or by individual cardholder. To alter en masse, the TCC would be required to establish the limits for each line item mentioned in Section V and send a written request to the Contractor, asking that all cards under their hierarchy be set at those limits. To alter the limits by individual cardholder, the TCC would complete Section V on a "Change" form or new application form and submit it to the Contractor. Monthly limit changes are effective immediately upon verbal request made to the Contractor.

If required, these limits can be altered to fit a particular situation and then be returned to the original limits. For instance, if an employee is traveling overseas and requires a larger ATM withdrawal, the TCC could alter the ATM limit on a "Change" form, notify the Contractor by telephone of the urgency of the request, and then fax the form to the Contractor. ATM limit changes are effective after midnight of the day the verbal request is made of the Contractor.

Processing the Application

Once the application has been approved and signed by an authorized primary or alternate TCC, it is to be faxed to the Contractor at 1 888-297-0785. Routine processing takes approximately 14 calendar days from the faxing of the application to the card delivery. In the case of an emergency, a card can be delivered within three business days. For expedited service, the application should be faxed with a note requesting expedited treatment, the date the card is required, and where the card can be delivered by overnight mail. (Expedited cards are generally mailed to the attention of the TCC for distribution.) The TCC should alert Customer Service of the impending fax.

The applicant will receive a card at the address supplied in Section III of the application. The Customer Service number is provided to each cardholder on the back of the card. The new cardholder must activate the card prior to use. A sticker on the card provides the activation telephone number and instructions.

The cardholder will receive a separate notice from the Contractor of the ATM Personal Identification Number (PIN). Cardholders who forget or lose the PIN, or who wish to customize the PIN, should call the Contractor on the toll-free Customer Service.

Account Maintenance

The Coordinator shall submit all account maintenance requests to the Contractor in writing. Either a brief memorandum on DOJ letterhead or a maintenance form provided by the

Contractor may be used. Either medium must contain the signature of an authorized TCC. Maintenance requests may be fax to 1 888-297-0785.

1. Transfer. Card transfers to a new hierarchy number can only be accomplished within a Component (e.g., within the OBD, within DEA, within BOP, etc.) In a transfer between Components, the card must be canceled and a card requested by the new Component. This is to allow each Component to issue a card with its own design.

It is the responsibility of the coordinator in the employee's "departing" office to complete the "Change" form requesting a transfer to a new office. (Contact the OBD APC for the new Hierarchy Number.) However, if the "departing" TCC fails to submit a change form requesting the transfer, the "receiving" office can and should do so.

2. Cancellation. The TCC must submit a delete form to the Contractor. The cardholder may destroy the card personally, or forward the card, cut in two, to the TCC. A card should never be forwarded in one piece through the mail or interoffice distribution. The TCC shall review the Account Management Report, TBR 830, each month to determine if the Contractor has satisfied the request to cancel a card. See Appendix D for a sample of an OBD delete form.
3. Reinstatement. An account which was canceled due to delinquency may be reinstated at the Contractor's discretion. The account must be paid in full, including any late charges, to even be considered for reinstatement. The cardholder's TCC must send a written request for reinstatement to the OBD APC.. The request shall include the name and account number of the cardholder, and a statement to the effect that the cardholder's account has been reviewed by the TCC and it has been confirmed that all past debts have been paid.

No employee should depart an office without either a cancellation or transfer form being completed by the Coordinator.

Original applications and maintenance requests shall be maintained by the TCC in an alpha file for the duration of the contract. The TCC does not need to maintain the Cardholder Agreement.

The Contractor provides specialized Customer Service Representatives to work directly with the TCCs. Customer Service may be reached at 1 888-297-0783, 24 hours a day, seven days a week. The TCC shall always identify him or herself as a Department of Justice primary or alternate TCC and cite their hierarchy number.

Access to account information, and the ability to set up new card accounts, is strictly limited to authorized primary and alternate program coordinators. The original list of

“authorized” TCCs and alternate TCCs was submitted to the Contractor by the OBD APC. Any changes to the list, including address and telephone number changes, must be submitted to the OBD APC by email. The OBD APC will pass on the requested change to the Contractor.

Reports

The Contractor supplies an array of reports for program management. The following reports are mandatory to each Coordinator: TBR 830, Account Management Report; TBR 340, Account Aging Analysis; TBR 400, Account Cycle Report, TBR 360, Account Suspension and Cancellation, and TBR 361, Account Pre-suspension/Cancellation. These reports should be reviewed by the TCC within three days of receipt. The reports enable the TCC to monitor charge activity and to identify potential problems, e.g., questionable charges, delinquent payments, pending card renewals, etc. The TCC may work directly with the Contractor to receive or establish additional reports.

The TCC should contact the Contractor for further details about questionable charges, and suspect charges should be referred to the appropriate supervisory or management official (e.g., cardholder's immediate supervisor, section chief or equivalent, administrative officer, etc.), for review and response (see Section II, above).

Many of the reports may be destroyed each month when the latest, matching report is received. However, it is recommended that portions of reports that may show card abuse or a history of delinquent payments be retained for one year.

Assisting the Cardholder

While the cardholder is liable for payment of all charges within 25 days of the statement closing date whether or not reimbursed by the Government, the TCC may intervene between the cardholder and the contractor to request an extension when lack of reimbursement is the fault of the Government. However, the Contractor is under no contractual obligation to extend a cardholder's period to pay.

APPENDIX A

**Travel (Individual Bill)
Cardholder Account Form**

**OBD
APPLICATION FORMS**

Section I: Card Type

Travel Card Integrated Card

If NEW, check one of the following: Standard Generic Quasi-generic
 Request PIN Other

New Change (Only complete fields to be changed)
 Duplicate

Cardholder Account # _____

CPP: Access Non-Authorized
 Mandatory Non-Mandatory

Section II: Agency/Organization Information

Agency/Organization Name: DOI Agency/Organization Address: _____

Section III: Cardholder Information

Cardholder Name _____ (24 Characters) Verification # (SSN) _____

Name Line 2 US DEPARTMENT OF JUSTICE (24 Characters)

Address Line 1 _____ (35 Characters)

Address Line 2 _____ (35 Characters)

City _____ (25 Characters) State _____ Country _____ Zip Code _____

(Cardholder: by signing this form you evidence your acceptance of the terms and conditions of the Cardholder Agreement attached hereto and made part hereof)

Work Phone: (____) _____

Signature _____ Date _____ Internet Address _____ Fax No (____) _____

Section IV: Reporting Hierarchy Levels (Required Information)

Reporting Hierarchy Level Numbers	Level 2	Level 3	Level 4 N/A	Level 5 N/A

Section V: Cardholder Controls (Required unless specified)

Dollars per Cycle \$ _____

Dollars per Day: \$ _____

Dollars per Transaction: \$ _____

Transactions per Cycle: _____ ATM Limit: \$500 / \$1000
 (Daily) (Weekly)

Transactions per Day: _____

Section VI: Cardholder Approvals

Approved By: _____, APC Signature: _____ Date: _____
 (Please Print)

Internet Address: _____ Tele: () _____ Fax: () _____

Section VII: Bank Use Only

Account Number _____

Signature Verified: _____ Date: _____ Initials: _____ Mgt: _____

USAO SAMPLE***Travel (Individual Bill)*****USAO SAMPLE
Cardholder Account Form**

Section I: Card Type

Travel Card Integrated Card

New If NEW, check one of the following: Standard Generic Quasi-generic

Change (Only complete fields to be changed) Request PIN Other

Delete/Close

Cardholder Account # _____

CPP: Access Non- Authorized

Mandatory Non-Mandatory

Section II: Agency/Organization Information

Agency/Organization Name: DOJ Agency/Organization Address: _____

Section III: Cardholder Information

Cardholder Name _____ (24 Characters) Verification # (SSN) _____

Name Line 2 US DEPARTMENT OF JUSTICE (24 Characters)

Address Line 1 _____ (35 Characters)

Address Line 2 _____ (35 Characters)

City _____ (25 Characters) State _____ Country _____ Zip Code _____

(Cardholder: by signing this form you evidence your acceptance of the terms and conditions of the Cardholder Agreement attached hereto and made part hereof)

Signature _____ Date _____ Internet Address _____ Fax No. (_____) _____

Section IV: Reporting Hierarchy Levels (Required Information)

Reporting Hierarchy Level Numbers	Level 2	Level 3	Level 4	Level 5
	21300	313	N/A	N/A

Section V: Cardholder Controls (Required unless specified)

Dollars per Cycle: \$ _____

Dollars per Day: \$ _____

Dollars per Transaction: \$ _____

Transactions per Cycle: _____ ATM Limit: \$500 / \$1000

Transactions per Day: _____ (Daily) (Weekly)

Section VI: Cardholder Approvals

Approved By: _____ APC Signature: _____ Date: _____

(Please Print) Tel: _____ Fax: _____

Section VII: Bank Use Only

Account Number _____

Signature Verified: _____ Date: _____ Initials: _____ Mgt: _____

USTO SAMPLE***Travel (Individual Bill)*****USTO SAMPLE
Cardholder Account Form**

Section I: Card Type

Travel Card Integrated Card

If NEW, check one of the following: Standard Generic Quasi-generic

Change (Only complete fields to be changed) Request PIN Other

Delete/Close

Cardholder Account # _____

CPP: Access Non-Authorized

Mandatory Non-Mandatory

Section II: Agency/Organization Information

Agency/Organization Name: DOJ Agency/Organization Address: _____

Section III: Cardholder Information

Cardholder Name _____ (24 Characters) Verification # (SSN) _____

Name Line 2 US DEPARTMENT OF JUSTICE (24 Characters)

Address Line 1 _____ (35 Characters)

Address Line 2 _____ (35 Characters)

City _____ (25 Characters) State _____ Country _____ Zip Code _____

(Cardholder: by signing this form you evidence your acceptance of the terms and conditions of the Cardholder Agreement attached hereto and made part hereof)

Work Phone: (____) _____

Signature _____ Date _____ Internet Address _____ Fax No. (____) _____

Section IV: Reporting Hierarchy Levels (Required Information)

Reporting Hierarchy Level Numbers	Level 2	Level 3	Level 4	Level 5
	22600	326	N/A	N/A

Section V: Cardholder Controls (Required unless specified)

Dollars per Cycle: \$ _____

Dollars per Day: \$ _____

Dollars per Transaction: \$ _____

Transactions per Cycle: _____ ATM Limit: \$500 / \$1000

Transactions per Day: _____ (Daily) (Weekly)

Section VI: Cardholder Approvals

Approved By: _____, APC Signature: _____ Date: _____

(Please Print)

Internet Address _____ Tele: _____ Fax: _____

Section VII: Bank Use Only

Account Number _____

Signature Verified: _____ Date: _____ Initials: _____ Mgt: _____

APPENDIX B**CARDHOLDER AGREEMENT**

Bank One GSA SMARTPAY CARD

INDIVIDUALLY BILLED CARDHOLDER AGREEMENT

IMPORTANT: BEFORE YOU SIGN OR USE THE GOVERNMENT CARD OR SIGN THIS AGREEMENT, READ THE AGREEMENT THOROUGHLY. PLEASE RETAIN THIS AGREEMENT FOR YOUR RECORDS.

The following is the agreement between us and you covering your Bank One GSA SmartPay Card (herein referred to as the "Card") and your card account with us. BY ACTIVATING, SIGNING OR USING THE CARD AND/OR ACCOUNT AND/OR SIGNING THIS AGREEMENT, YOU WILL BE BOUND BY THE TERMS AND CONDITIONS OF THIS AGREEMENT. IF YOU DO NOT AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT, CUT THE CARD IN HALF AND RETURN THE PIECES TO US.

1) Definitions - The words "you" or "your" mean the Agency/Organization employee whose name appears on the Card. The words, "we", "our" and "us" refer to The First National Bank of Chicago (First Chicago). The words "Agency/Organization" mean the United States federal agency, bureau, division, office or other organizational entity participating in the program that has requested/authorized us to open an account for you. The word "Program" means the Card program established pursuant to the GSA Contract. The word "Card" means the Card issued to you by us under the Program. The word "Account" means the Account and the Account Number established by us in connection with the Card. The words "GSA Contract" refer to the General Services Administration contract no. GS-23F-98003.

2) Promise to Pay - All amounts charged to the Account including purchases, cash advances and fees will be called "Charges." You promise to pay for all Charges made by you or anyone you allow to use the Account until paid in full. Official travel and travel-related expenses charged to the Card will be reimbursed by the Agency/Organization under the Agency's/Organization's expense reimbursement procedures applicable to you. You also agree to report your expenses promptly to the Agency/Organization in accordance with its expense reimbursement procedures. You are responsible for making payment to us. You are responsible for all Charges made with the Card even if you let someone else use the Card. You must retrieve the Card from that person to avoid further liability.

3) Use of Card - You agree to use the Card only for official travel and travel-related expenses away from your official station/duty station in accordance with your Agency/Organization policy. You agree not to use the Card for personal, family or household purposes. Charging privileges on the Card are provided to you by us pursuant to the GSA Contract and the task order of your Agency/Organization. No other person is permitted to use the Card issued to you for Charges or for any other reason. Charging privileges will be withdrawn upon (i) request by GSA or Agency/Organization; (ii) termination of your employment with your Agency/Organization; (iii) termination or expiration of the GSA Contract; (iv) termination or the expiration of Agency/Organization task order; or (v) Cards being reported lost or stolen or suspicion of fraud.

4) Billing Statements - You will receive a billing statement periodically (normally monthly). Your payment is due at our offices on or before the Payment Due Date shown on your billing statement. Payment for all undisputed Charges is due upon receipt of your billing statement.

5) Payments - You must pay the undisputed portion of the new balance in full each month. Payments must be made in U.S. currency, in electronic form or with a money order payable in U.S. dollars, or with a draft or a check drawn on a bank in the U.S. and payable in U.S. dollars. If we decide to accept a payment made in some other form, payment will not be credited to your Account until your payment is converted into one of the forms just mentioned. We may accept late payments, partial payments or checks and money orders marked "payment in full" or with other restrictive endorsements without losing any rights under this Agreement or under the law.

6) Travelers Checks - Your Agency/Organization may approve your Account for travelers check purchases. This will enable you to make purchases of travelers checks using your Card.

7) ATM - Your Agency/Organization may approve your Account for cash access privileges. This will enable you to obtain cash from automated teller machines ("ATMs") operated by a bank or other institutions. If you are approved for cash

Account you agree to cooperate with us during our investigation, which will include your completion of a Dispute Form. Should you need a replacement

access privileges, you will receive a personal identification number ("PIN"). You agree to take all reasonable precautions to prevent any other person from learning your PIN or using your Card to make unauthorized transactions. You agree that if you voluntarily give the Card and your PIN to someone else for any reason, you are authorizing all transactions made by that person.

8) Charges - You agree to pay the following Charges unless your Agency/Organization has negotiated a lower rate or fee, in which case, you will pay the lower amount.

- D. Late fee - If your Account has been canceled, \$25.00 for any payment not received within 120 calendar days past the closing date on the statement of account in which the charge first appeared.
- E. Cash Advance Fee - The cash advance fee is \$2.00 for each cash advance transaction. In some cases, a surcharge may be imposed by ATM operators.
- F. Travelers Check Fee - The travelers check fee is \$2.50 for each travelers check order purchased with the Card.
- G. Return Check Fee - If your check is not honored, or if we must return it to you because it cannot be processed, then we will charge a Returned Check Fee of \$25.00.
- H. Delinquency and Collection Fee - If we refer your Account to an attorney for collection you will be responsible for attorney's fees, if any, not to exceed one third of recovered amount plus actual court costs except where prohibited by law.

9) Disclosure of Account Information - In addition to the routine uses under the Privacy Act, you authorize us to (i) provide information about your Account to our service providers administering your Account under the GSA Contract; and (ii) disclose all necessary Account information to an outside attorney, collection agency or credit bureau if we refer all or part of the Account for collection in accordance with the GSA Contract and your Agency/Organization's task order. You understand that past due Accounts will be reported to your Agency/Organization. By signing this agreement, you are providing your prior written consent to the disclosure of Account information as provided in this Section 9.

10) Suspension - We can suspend your Account and prohibit further Charges if i) payment for any undisputed principal amount is not received within 61 calendar days from the closing date on the statement in which the unpaid charge first appeared, or within the Agency/Organization time frame specified in the task order, unless otherwise directed by the Agency/Organization, or ii) the Agency/Organization or GSA requests the suspension. Bank One will reinstate your suspended Account upon full payment of the amount due unless otherwise directed by the Agency/Organization.

11) Cancellation - We can cancel your Account and prohibit further Charges if (i) your employment with your Agency/Organization is terminated regardless of the reason; ii) the GSA Contract and/or Agency/Organization task order expires or is terminated; iii) your Agency/Organization or GSA requests it; iv) the Account has been used for other than authorized purposes and cancellation is approved by your Agency/Organization; v) your Account has been suspended two times during a 12 month period for non-payment of undisputed principal amounts and is past due again (for purpose of this section 11, subsection v), "past due" means payment is not received within 45 calendar days from the closing date on the statement of Account in which the Charge first appeared; and vi) the Account is 126 calendar days past due from the closing date on the statement of Account in which the unpaid Charge first appeared, or within the Agency/Organization time frame specified in the task order, unless otherwise directed by the Agency/Organization. We may reinstate a canceled Account upon full payment of the amount due and any late fee assessed. You can cancel your Account at any time by writing to us at First Chicago, 2500 Westfield Drive, B-3, Elgin, IL 60123.

12) Lost or Stolen Card - You agree to notify us immediately if the Card is lost or stolen or if you suspect it is being used without your permission. The toll-free domestic telephone number is 1 (888) 297-0782 and the international number for collect calls is 1 (847) 488-4442. If there is any unauthorized use of your Card or

PRIVACY ACT NOTICE:

In accordance with the Privacy Act (5 U.S.C. 552a), the following notice is

card, please call the same telephone number listed in section 12 for lost and stolen Cards.

13) Change of Terms - We may, with the written consent of GSA and your Agency/Organization, change the terms of this Agreement upon 30-day written notice to you. Changes in any such notice may apply to new transactions and to your Account balance on the date the change becomes effective. If you do not agree to a change in terms of this agreement, you must notify us prior to the effective date of the change, cut the card in half, and return the pieces to us.

14) Foreign Exchange - Charges made in a foreign currency will be converted into U.S. Dollars using a favorable interbank rate, or where required by law, an official rate. The rate shall be the rate in existence at the time the transaction is processed.

15) Disclaimer of Liability - In no event shall we be liable to you for any consequential, special, indirect or punitive damages of any nature.

16) Assignment - We can assign your Account and any of our rights under this Agreement without your consent or notice to you.

17) Notices - All notices required to be given by us in connection with your Account shall be deemed to have been delivered on the earlier of the day on which the notice is actually received by the party to which addressed or three days after the notice has been deposited in the United States mail, postage prepaid.

18) Severability - If any provision in this Agreement is held to be inoperative, unenforceable or invalid, that provision shall be inoperative, unenforceable or invalid without affecting the remaining provisions.

19) Collection/Telephone Monitoring - You agree that if you do not pay your Account, Bank One or our collection agent may call you regarding the collection of your Account. You understand that the calls could be automatically dialed and a recorded message may be played. You agree such calls will not be "unsolicited" calls for purposes of local, state or federal law. You agree that we may monitor telephone calls between you and us to ensure the quality of the customer service we provide.

20) GOVERNING LAW - THIS AGREEMENT AND YOUR ACCOUNT ARE SUBJECT TO THE GSA CONTRACT AND SHALL BE GOVERNED BY FEDERAL LAWS AND THE LAW OF ILLINOIS.

provided: The information requested on the card application form is collected pursuant to Executive Order 9397 and chapter 57, title 5, United States Code, for the purposes of recording travel expenses incurred by the employee/member and to claim entitlements and allowances prescribed in applicable federal travel regulations. The purpose of the collection of this information is to provide Government agencies necessary information on the GSA Contract which provides travelers with Cards for official travel and related expenses, attendant operational and control support, and management information reports for expense control. Routine uses which may be made of the collected information and other account information in the system of records entitled "Travel Charge Card Program GSA/GOVT-3" are as follows: (1) transfers to appropriate Federal, State, local, or foreign agencies when relevant to civil, criminal, administrative, or regulatory investigations, (2) pursuant to a request of another Federal agency in connection with hiring, retention, issuing a security clearance, reporting an employee investigation, clarifying a job, letter or contract or issuing a license, grant, or other benefit, (3) to a Member of Congress or to a Congressional Staff Member in response to an inquiry of the Congressional Office made at the request of the individual about whom the record is maintained, (4) to officials of labor organizations when necessary to their duties of exclusive representation, (5) to a Federal agency for accumulating reporting data and monitoring the system, (6) GSA contract travel agents assigned to agencies for billing of travel expenses, (7) listing, reports, and records to GSA by the contractor to conduct audits of carrier charges to the Government, and (8) any other use specified by GSA in the system of records entitled "Travel Charge Card Program GSA/GOVT-3," as published in the Federal Register periodically by GSA. The information requested is not mandatory. Failure to provide the information will nullify the application, and a Card will not be issued to the employee/member.

APPENDIX C

CHANGE FORM

**Travel (Individual Bill)
Cardholder Account Form**

Section I: Card Type

Travel Card Integrated Card

If NEW, check one of the following: Standard Generic Quasi-generic

Change (Only complete fields to be changed) Request PIN Other

New

Cardholder Account # _____

CPP: Access Non-Authorized
 Mandatory Non-Mandatory

Section II: Agency/Organization Information

Agency/Organization Name: DOJ Agency/Organization Address: _____

Section III: Cardholder Information

Cardholder Name _____ (24 Characters) Verification # (SSN) _____

Name Line 2 US DEPARTMENT OF JUSTICE (24 Characters)

Address Line 1 _____ (35 Characters)

Address Line 2 _____ (35 Characters)

City _____ (25 Characters) State _____ Country _____ Zip Code _____

(Cardholder: by signing this form you evidence your acceptance of the terms and conditions of the Cardholder Agreement attached hereto and made part hereof)

Signature _____ Date _____ Internet Address _____ Fax No. (_____) - _____

Section IV: Reporting Hierarchy Levels (Required Information)

Reporting Hierarchy Level Numbers	Level 2	Level 3	Level 4 N/A	Level 5 N/A

Section V: Cardholder Controls (Required unless specified)

Dollars per Cycle: \$ _____

Dollars per Day: \$ _____

Dollars per Transaction: \$ _____

Transactions per Cycle: _____ ATM Limit: \$500 / \$1000

Transactions per Day: _____ (Daily) (Weekly)

Section VI: Cardholder Approvals

Approved By: _____, APC Signature: _____ Date: _____
(Please Print) Tele: _____ Fax: _____

Section VII: Bank Use Only

Account Number _____

Signature Verified: _____ Date: _____ Initials: _____ Mgt: _____

APPENDIX D

DELETE CANCEL FORM

**Travel (Individual Bill)
Cardholder Account Form**

Section I: Card Type

Travel Card Integrated Card

If NEW, check one of the following: Standard Generic Quasi-generic

Change (Only complete fields to be changed) Request PIN Other

Delete/Close

Cardholder Account # _____

CPP: Access Non-Authorized
 Mandatory Non-Mandatory

Section II: Agency/Organization Information

Agency/Organization Name: DOJ Agency/Organization Address: _____

Section III: Cardholder Information

Cardholder Name _____ (24 Characters) Verification # (SSN) _____

Name Line 2 US DEPARTMENT OF JUSTICE (24 Characters)

Address Line 1 _____ (35 Characters)

Address Line 2 _____ (35 Characters)

City _____ (25 Characters) State _____ Country _____ Zip Code _____

(Cardholder: by signing this form you evidence your acceptance of the terms and conditions of the Cardholder Agreement attached hereto and made part hereof)

Signature _____ Date _____ Internet Address _____ Fax No. (____) _____

Section IV: Reporting Hierarchy Levels (Required Information)

Reporting Hierarchy Level Numbers	Level 2	Level 3	Level 4 N/A	Level 5 N/A
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Section V: Cardholder Controls (Required unless specified)

Dollars per Cycle: \$ _____

Dollars per Day: \$ _____

Dollars per Transaction: \$ _____

Transactions per Cycle: _____ ATM Limit: \$500 / \$1000
(Daily) (Weekly)

Transactions per Day: _____

Section VI: Cardholder Approvals

Approved By: _____, APC Signature: _____ Date: _____
(Please Print)

Internet Address: _____ Tele: _____ Fax: _____

Account Number _____

Signature Verified: _____ Date: _____ Initials: _____ Mgt: _____

Section VII: Bank Use Only

Travel Charge Card

Reference Guide for Cardholders



Offices, Boards, and Divisions
U.S. Department of Justice

1060



U.S. Department of Justice
Justice Management Division
Finance Staff

Washington, D.C. 20530

MEMORANDUM

TO: Executive/Administrative Officers
Offices, Boards, and Divisions

JMD Senior Management Staff

FROM: Lee Lofthus, Director /s/ July 2, 2001
Finance Staff
Justice Management Division

SUBJECT: Travel Charge Card Program Guides

Attached are two Travel Charge Card Program Guides: 1) Travel Charge Card Guide and 2) Travel Charge Card Reference Guide for Cardholders. These two guides replace the guides by the same names which were issued on January 19, 2001. After consultation with the Personnel Staff and the Office of the Inspector General, minor changes were made to the sections in both guides which pertain to disciplinary action for abuse/misuse of the card.

The Travel Charge Card Guide contains information for supervisory and management officials and designated travel card coordinators. The other guide is directed to the individual travel cardholder. Both are a synopsis of Federal statutes, official travel regulations, and Department of Justice policies.

Please call Diane Kelly of my staff on (202) 616-5504 if there are any questions on the information presented in these Guides.

Attachments

cc: Bureau Finance Officers

TRAVEL CHARGE CARD REFERENCE GUIDE FOR CARDHOLDERS**The Travel Card Program**

The Government Travel Charge Card (Travel Card) Program was created by the General Services Administration (GSA) as a travel and transportation payment and expense control system. It includes employee travel charge cards and automated teller machine (ATM) services. Bank One (hereinafter, the Contractor) is currently under contract to the GSA and the Department of Justice to provide these services.

Travel Card Eligibility

Anyone who is employed by the Department of Justice and travels, or is reasonably expected to travel, should have an official travel card.

The card is issued by the Fiscal/Administrative Section of the Component for which a person works. The Component Travel Card Coordinator may require a request from a supervisor prior to processing an application.

The Department requires that a personal address be used as the cardholder's billing address. Before completing the application, the applicant should be provided a Travel Card Agreement, which explains the terms and conditions of the official travel card. This should be read carefully, especially the terms on liability. The applicant's signature on the application form represents that the applicant has read and accepted the terms of the Agreement.

The official travel card is not a credit card in the true sense. There is no credit check for first time applicants. Conversely, the account cannot be used as a credit reference by the cardholder. As long as an account is in good standing, it does not appear on National Credit Bureau reports. All charges must be paid in full, each month, upon receipt of the statement. The card may only be used for official travel related expenses. **The intentional use of the travel card for purchases, other than official, will subject an employee to disciplinary action.**

Proper Use of the Travel Card

The travel card is for all official travel-related expenses. This includes:

- Air, rail, and bus tickets
- Taxis and other forms of ground transportation
- Meals
- Lodging

The card may also be used for authorized miscellaneous expenses related to travel, such as: charges for necessary typing or stenographic purposes, clerical assistance, services of guides, interpreters, packers, drivers of vehicles, storage of property used on official business, etc.

The ATM feature of the card allows the traveler to obtain cash to pay for official expenses that cannot be charged using the card. ATM cash advances are in lieu of the Government-issued cash advance.

Miscellaneous and travel-related expenses must be approved in advance by the appropriate official. In unusual cases, if an employee is unable to secure advance approval for unanticipated travel-related or miscellaneous expenses, those expenses may be approved when the employee vouchers for his travel expenses. Employees are advised, however, that when expenses are incurred which have not been previously authorized, the employee assumes the risk of financial liability if the expenses are partially or fully disapproved.

An employee should not use his or her travel card to charge expenses for others (e.g., reserving a room for a co-worker or witness) because the employee can only claim his or her own expenses. An employee who does incur charges on behalf of another is solely responsible for any liability which may occur if the transactions are not properly settled.

The travel card should not be used at an employee's permanent duty station except to purchase tickets or withdraw funds from an ATM (no more than three days prior to travel). The card is not to be used to pay for local taxis, tolls to and from the permanent duty station, etc.

Liability

The cardholder is liable for all valid charges to the account. The Department of Justice is not directly liable for any charges made using the individual travel card. An employee is required to voucher for reimbursement within five days of the end of travel and the Department is responsible for reimbursing the employee in a timely manner so that the employee can pay the Contractor in full upon receipt of the monthly travel card statement.

Failure to pay the travel card company in full and on time can lead to suspension and cancellation of the travel card. A cardholder whose card is canceled due to delinquency will be reported to a national credit bureau. Additionally, an employee whose account has been canceled has no means to pay for future official travel, which may have a negative impact on job performance.

Cash Advances (ATM)

The ATM limit on the travel card is \$300 per day and \$300 per week. However, different ATMs may further limit withdrawal amounts.

The traveler is authorized to withdraw up to \$40 per day times the number of days on travel or, if authorized, 80% of the total of M&IE and "Other" from the Travel Authorization.

Each withdrawal, regardless of the amount, has a flat fee of \$2, which is reimbursable. Each ATM network may also charge a small fee, which is also reimbursable. The traveler should be aware that some ATM networks, especially in resort areas, may charge a fee in excess of \$3. These ATMs should be avoided. The Department will only reimburse access fees up to \$5 per transaction. (See DOJ Financial Management Policy and Procedure Bulletin 99.08.)

Funds should not be withdrawn more than three days prior to departure, nor after return to the official duty station.

Reimbursement

The Federal Travel Regulations require that a claim for reimbursement of travel expenses be filed within five days of the end of the trip. The Department is required to quickly process the claim. If an employee has not received reimbursement within 15 days of submitting the voucher, he should contact his approving official to ensure that it was approved and forwarded for further processing. If so, then the employee should contact his Fiscal or Administrative Unit to inquire as to its status at that location.

When claiming ATM withdrawals, only the withdrawal fee of \$2 and any network access fee should appear on the voucher, not the dollar amount withdrawn.

Billing and Payment

Each cardholder will receive a monthly statement within ten days of the closing of the OBD billing cycle, which is the 23rd of the month.

Any charge made within the billing cycle should appear on the statement. A traveler should not request an airline ticket be issued sooner than two days prior to departure to avoid having the charge billed to the travel account too soon. (This does not prohibit the traveler from making reservations well in advance.)

The cardholder should review the statement immediately upon receipt. Any unrecognized charges, or a charge for a canceled airline ticket, should be disputed with the travel card company at once. Disputing is an easy process: contact Customer Service at 1-888-297-0781.

The dispute process removes the charge(s) from the account for up to 60 days. That should be enough time for the airline to credit the account for a canceled ticket. In the case of an unrecognized charge, it gives the Contractor time to research the debit and either provide the cardholder with proof that the charge is indeed valid or, in the case of a truly invalid charge, reverse it to the merchant.

Charges in dispute are not considered delinquent. Charges not formerly disputed, and not paid, are considered delinquent and can lead to suspension or cancellation.

All undisputed charges should be paid no later than 25 days upon receipt of the statement. Payment received after this time-frame is considered delinquent. The contract with Bank One allows it to suspend card privileges at 60 days past due. Accounts will be canceled at 120 days past due.

A cardholder's request to be reinstated must be made through his Travel Card Coordinator (TCC), and only after the account has been paid in full, including any late fee that has been assessed. (A late fee of \$25 is assessed against the account 120 days past the closing date on the statement of account in which the charge first appeared.) If the cardholder's office/division concurs with the reinstatement request, it will forward it to the Agency Program Coordinator, who makes the official request to the Contractor.

Reinstatement of a canceled account is at the discretion of the Contractor alone, and requires a full credit review by the company. An employee with a poor payment history typically is not approved for reinstatement or, if reinstated, is given a very low credit limit and canceled immediately if delinquency recurs. An employee who fails the credit check is typically not reinstated.

Monitoring of Charges and Payment

The travel cardholder should be aware that monthly reports are provided to the TCC of each OBD which details each charge or cash withdrawal made by cardholders. The TCC is also advised when a cardholder is delinquent.

The TCC is required to notify a cardholder's supervisor if misuse or abuse of an account is suspected or when payment is 45 days past due. The supervisor or TCC is required to report to the Office of Inspector General, any intentional misuse of the travel card, regardless of the dollar amount, and must report any charge of \$1000 or more that is inappropriate, intentional or not. The OIG will record the matter and review the particulars of the misuse before deciding how to proceed. Delinquency beyond 180 days will be reported to the OIG by the bank.

Misuse or abuse of the travel card, or a consistently delinquent payment history, may be cause for reconsideration or possible revocation of an employee's security clearance. Additionally, sanctions against the employee, ranging from reprimand to removal, may be considered.

Account Maintenance

The cardholder is responsible for contacting the Contractor's Customer Service at 1-888-297-0781 to report a change in billing address or phone number. The cardholder should contact the Travel Card Coordinator for his unit if transferring within the OBD or the Department, or if leaving the Department. The TCC is authorized to provide the Contractor with the forwarding address of transferred or separated employees who depart with an outstanding balance.

An employee may keep the same travel card if transferring within the OBDs (this includes offices of the U.S. Attorney and U.S. Trustee), but should be sure to notify the TCC of the impending transfer so that the internal reporting structure of the account can be transferred to the new office. Because each Bureau has its own card design, cards are not transferrable between Bureaus of the Department. If transferring to another Bureau, the cardholder should contact the Contractor's Customer Service and request the account be canceled, and then the card should be cut in half and returned to the TCC for "in-house" cancellation. Canceling the card personally ensures the account cannot be used in case the destroyed card falls into the wrong hands. A new card can be issued at the new duty station if required.

Travel Card Assistance

Questions relating to the travel card account should be addressed to the card company's Customer Service, at 1-888-297-0781. Representatives are available to assist cardholders twenty-four hours a day, seven days a week. They can be helpful if the account is being declined by a merchant, when there is a question about a charge or a credit, or if the cardholder is having payment difficulties.

Questions relating to making a claim for reimbursement, status of a claim, or the acceptable use of the card, should be directed to the Travel Card Coordinator for the cardholder's office or Division. Each Division has a TCC, usually located in the Fiscal/Administrative Section for the Division. Each Office of the U.S. Attorney and U.S. Trustee has its own TCC, typically the Administrative or Budget Officer.

If a cardholder is unable to obtain information from their immediate TCC, they may contact Diane Kelly, the Agency Program Coordinator at (202) 616-5504.



U.S. General Services Administration

Helpful Hints for Travel Card Use



The GSA SmartPay® 2 Travel Charge Card

The Travel and Transportation Reform Act of 1998 (Public Law 105-264) mandates federal government cardholders to use the contractor-issued travel charge card for official government travel expenses and to receive cash advances.

Having this card provides your agency/organization with numerous benefits. With these benefits come certain responsibilities for you. This booklet is intended as a quick reference for "Dos and Don'ts" to using your travel charge card. It also provides helpful information about your card.

Cardholder Responsibilities: DOs

In addition to your agency's travel policy, you should comply with the following guidelines:

DO use your government travel charge card to pay for official travel expenses.

DO obtain travel advances for official travel through an ATM if authorized by your agency.

DO track your expenses and keep receipts while on travel so you have accurate information for filing your travel claim.

DO file your travel claim within five days after you complete your trip or every 30 days if you are on continuous travel.

DO submit payment in full for each monthly bill.

DO follow your bank's dispute process for charges which are incorrect.

DO contact your bank's customer service number if you have questions about your monthly bill.

DO be aware that misuse of the travel charge card could result in disciplinary actions by your agency.

DO be aware that failure to pay your bill in a timely manner can result in suspension or cancellation of your card.

DO return your travel charge card to your Agency/Organization Program Coordinator (A/OPC) to be destroyed if you leave your agency or retire.

DO immediately report your lost or stolen card to your A/OPC and the card-issuing bank.

DO destroy any lost or stolen cards that are recovered.

DO be aware of identity theft schemes attempting to gain access to financial information.

Cardholder Responsibilities: DON'Ts

DON'T use your travel charge card for personal use.

DON'T obtain travel advances through the ATM which exceed your expected out of pocket expenditures for a trip.

DON'T obtain travel advances through the ATM unless you are on travel or will be on travel shortly.

DON'T allow your monthly bill to become overdue because this could result in suspension or cancellation of your card.

DON'T wait for receipt of your monthly billing statement to file your travel claim.

DON'T forget that the card is issued in your name and liability for payment is your responsibility.

DON'T write your personal identification number (PIN) on your card or carry your PIN in your wallet.

Paying Your Travel Charge Card Bill

Make payment for all undisputed charges on your travel charge card bill **in full** by the statement billing due date, which is 25 to 30 days after the closing date on the billing statement. The due date is printed on the bill.

Failure to pay your monthly bill in a timely manner will result in the loss of your charging privileges. If your card is suspended, you will be unable to use it until your bank receives payment. If your card is cancelled due to non-payment, your delinquency may be reported to credit bureaus, be referred to collection agencies, or lead to other collection actions and you may not be eligible to receive a new card account.

Reporting a Lost or Stolen Card

Immediately report your lost or stolen travel charge card to:

- Your card-issuing bank;
- Your A/OPC; and
- Your supervisor.

You will be responsible for those charges made **before** the travel charge card was reported lost or stolen. The bank will mail you a new card within one business day from the time theft or loss was reported. The bank assigns a new number to the replacement card.

Resources

Online Training

Visit our website at www.gsa.gov/gsmartpay for online GSA SmartPay® 2 travel cardholder training, *Charting the Course*, to receive detailed training on the use of the card.

Once you complete the training module, take the online quiz. A passing score on the quiz will enable you to print out a Certificate of Training Completion.

Resources

Bank Contacts

To receive information about your card-issuing bank, visit the bank online or call its customer service number:

Citibank:

www.citimanager.com

(800) 790-7206 (within the United States)

(904) 954-7850 (outside the United States)

JPMorgan Chase Bank:

www.jpmmorganchase.com/smartpay

(888) 297-0781 (within the United States)

(847) 488-4441 (outside the United States)

Resources

Bank Contacts

U.S. Bank:

www.usbank.com/gov

(888) 994-6722 (within the
United States)

(701) 461-2232 (outside the
United States)

For additional information on the GSA
SmartPay® 2 charge card program,
visit www.gsa.gov/gsmartpay.

Contact Your Program Coordinator

Write the name, phone number,
and e-mail address of your
Agency/Organization Program
Coordinator (A/OPC) here:

Contact your A/OPC if you have any
questions regarding your travel
charge card.

How to reach us

For additional information,
visit our Web site:

www.gsa.gov/gsasmartpay

Attachment E



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

FEB 24 2012

The Honorable Jeff Sessions
United States Senate
Washington, D.C. 20510

Dear Senator Sessions:

This responds to your letter dated January 31, 2012, requesting responses to questions pertaining to Justice Elena Kagan and the health care legislation that is currently the subject of litigation before the Supreme Court.

During the past year, the Justice Department has responded to several requests from House Judiciary Committee Chairman Lamar Smith for documents and other information relating to Justice Kagan's activities while she served as Solicitor General, with particular reference to the Patient Protection and Affordable Care Act. The Department has disclosed documents relating to that topic in response to requests pursuant to the Freedom of Information Act; we have offered copies of those documents to the House Judiciary Committee and would be pleased to provide them to you as well if you wish. Beyond that, we have explained to Chairman Smith that we have serious separation of powers concerns about a congressional inquiry regarding this matter. Enclosed are copies of our letters to Chairman Smith on this subject.

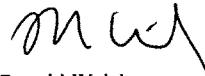
As we told Chairman Smith, we believe that the rigorous confirmation process was the appropriate forum to explore any concerns about the nominee's role in the legislative process relating to this statute and, in fact, then-Solicitor General Kagan responded to questions about this matter during the Senate Judiciary Committee confirmation proceedings. Moreover, there is an established legal process for parties to pending litigation to raise their concerns about possible conflicts of interest that may bear on a Justice's decision to recuse. Under these circumstances, we have respectfully declined to respond to further congressional inquiries into the pre-confirmation activities of a sitting Justice of the Supreme Court, which we believe pose an unacceptable risk of inappropriate encroachment on the judicial branch. For these same reasons, we must respectfully decline your request for information about this matter.

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The Honorable Jeff Sessions
Page Two

Please do not hesitate to contact this office if we may provide assistance on any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'R Weich', written in a cursive style.

Ronald Weich
Assistant Attorney General

Enclosures



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

October 27, 2011

The Honorable Lamar Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This responds to your letter to the Attorney General, dated July 6, 2011, on behalf of 49 Members of Congress who wrote to you requesting that you seek documents and other information about activities of Supreme Court Associate Justice Elena Kagan while she served as the Solicitor General of the United States.

As noted in the letter you received from your colleagues, the Department has disclosed records relating to the Patient Protection and Affordable Care Act (PPACA) in response to three Freedom of Information Act (FOIA) requests, two of which were consolidated in *Media Research Center v. Department of Justice* (D.C.D.C.). The U.S. District Court for the District of Columbia recently granted the government's motion for summary judgment in that case. The documents disclosed by the government in the case include records from the Office of the Solicitor General. If you are not already in possession of these documents, we would be pleased to provide them to you upon request. We are not aware of any information in the documents that "raise(s) questions" about then Solicitor General Kagan's statements in the confirmation process.

We have grave concerns about the prospect of a congressional investigation into the pre-confirmation activities of a sitting Supreme Court Justice. The Senate confirmation process is a rigorous, in-depth inquiry into the background and activities of nominees, particularly for the Supreme Court. As you note, then-Solicitor General Kagan answered questions about the topics described in your letter during the course of her confirmation. We are unaware of any precedent for Congress to conduct a post-confirmation investigation regarding the pre-confirmation activities of a sitting Justice, and we would regard such a course of action as an unseemly encroachment on the judicial branch of government.

Moreover, any questions about participation in cases by sitting Justices are more properly addressed in the context of specific litigation, where the parties have an opportunity to seek recusal if they choose to do so. In that regard, we note that many of the Members who signed the letter to you have signed amicus briefs challenging the constitutionality of the legislation.

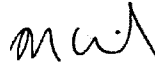
1082

The Honorable Lamar Smith
Page 2

For these reasons, we respectfully decline to produce the documents and access to individuals requested in your letter. We would be pleased to discuss this further with Committee staff if that would be helpful.

Please do not hesitate to contact this office if we may provide additional assistance regarding this or any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'RW', written in a cursive style.

Ronald Weich
Assistant Attorney General

cc: The Honorable John Conyers, Jr.
Ranking Member



U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

November 10, 2011

The Honorable Lamar S. Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This responds to your letter dated October 28, 2011, which followed up on our previous correspondence regarding your July 6, 2011 request on behalf of 49 Members of Congress who wrote to you asking that you seek documents and other information about activities of Supreme Court Associate Justice Elena Kagan while she served as the Solicitor General of the United States. We regret that you are dissatisfied with our response of October 27, 2011.

We have carefully reconsidered your request, but we must again respectfully decline to comply with your requests because of the significant concerns articulated in our October 27 letter, in addition to the confidentiality interests implicated by your request. While we appreciate the Committee's oversight role regarding Department activities, the practical impact of this particular request would be to probe whether a Supreme Court Justice should participate in a case pending before the Court. As we previously stated, we are concerned that such an inquiry would pose an unacceptable risk of inappropriate encroachment upon the judicial branch and we believe that any questions regarding participation by a Justice in a pending case should be addressed in the context of the case itself.

In any event, based upon the record searches we have conducted in response to Freedom of Information Act (FOIA) requests, we are not aware of any information that raises questions about then-Solicitor General Kagan's statements during the confirmation process regarding the topic framed in your July 6 letter. As you know, the Department previously released documents under the FOIA relating to this matter, and we have enclosed here additional documents that were released yesterday, none of which changes our view. The materials withheld under FOIA implicate substantial Executive Branch confidentiality interests relating to internal deliberations.

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The Honorable Lamar S. Smith
Page 2

While we must respectfully disagree with you on this matter, we would be pleased to confer with you about it further if that would be helpful.

Sincerely,

A handwritten signature in black ink, appearing to read 'R Weich', written in a cursive style.

Ronald Weich
Assistant Attorney General

cc: The Honorable John Conyers, Jr.
Ranking Member



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

December 6, 2011

The Honorable Lamar S. Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This responds to your letter of November 22, 2011, which followed up on our previous correspondence regarding your July 6, 2011 requests on behalf of other Members who asked you to seek documents and other information about activities of Supreme Court Associate Justice Elena Kagan while she served as Solicitor General of the United States. In your letter, you also concurred with the November 18, 2011 request made by Senators McConnell, Kyl, Grassley, and Lee.

We believe that the questions you have raised are premised upon a selective reading of documents that the Department has already released in response to Freedom of Information Act (FOIA) requests. In fact, those documents are consistent with then-Solicitor General Kagan's statements on this issue during the confirmation process. In addition, federal law provides a process for recusal determinations in the context of litigation.

We have serious separation-of-powers concerns regarding a congressional inquiry that aims to circumvent this existing legal process by inquiring into the pre-confirmation activities of a sitting Supreme Court Justice. That is especially so in connection with a pending case in which many Members of Congress submitted amicus briefs in the lower courts. We are unaware of any precedent for the Department to participate in such an inquiry, which poses an unacceptable risk of inappropriate encroachment upon the judicial branch.

For the foregoing reasons, we regret that we cannot be of further assistance in this matter. Please do not hesitate to contact this office if we may provide assistance regarding any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Weich".

Ronald Weich
Assistant Attorney General



U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

January 6, 2012

The Honorable Lamar S. Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This responds to your letter of December 13, 2011, which followed up on our previous correspondence regarding your July 6, 2011 requests for documents and interviews you believe relevant to the issue of whether Supreme Court Associate Justice Elena Kagan should recuse herself from pending litigation challenging the Patient Protection and Affordable Care Act (PPACA).

As we have stated in our prior letters, we have serious separation-of-powers concerns regarding this congressional inquiry, which would circumvent the existing legal process for recusal determinations in pending Supreme Court litigation by inquiring into the pre-confirmation activities of a sitting Supreme Court Justice. We have previously informed you that we are unwilling to participate in the inquiry because it poses an unacceptable risk of inappropriate encroachment upon the judicial branch. We adhere to that position.

Your recent letters have made it clear that the Committee's inquiry is also based on a purpose that falls outside the scope of Congress's oversight authority. The Department has long recognized, as it stated in an opinion issued during the Reagan Administration, that "Congress may conduct investigations in order to obtain facts pertinent to possible legislation and in order to evaluate the effectiveness of current laws." *Scope of Congressional Oversight and Investigative Power with Respect to the Executive Branch*, 9 Op. O.L.C. 60, 61 (1985). And in numerous decisions, the Supreme Court has held that an oversight request must be for a legislative purpose, *i.e.*, to "obtain information in aid of the legislative function." *McGrain v. Daugherty*, 273 U.S. 135, 176 (1927). *See also, e.g., Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 504 n.15 (1975); *Watkins v. United States*, 354 U.S. 178, 187 (1957) (Congress's

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oversight activities must “be related to, and in furtherance of, a legitimate task of the Congress”).

The Committee has shown over the course of its four letters to the Department on this matter that its inquiry regarding Justice Kagan does not seek facts in aid of Congress’s legitimate legislative function, but instead seeks documents and information in order to influence a case pending in the Supreme Court. Your most recent letter, dated December 13, observed that “[t]he health care law being considered by the Court presents questions of singular constitutional importance. Given such, the public has a right to know the extent of Justice Kagan’s involvement with this legislation as well as any previously stated legal opinions about the legislation while she served as Solicitor General.” That letter was of a piece with your prior letters. For example, although your letter of November 22 asserted that your requests have been “pursuant to the Judiciary Committee’s oversight authority over the Department of Justice and the Office of the Solicitor General,” the very next sentence of the letter clearly stated the non-legislative purpose of the inquiry: “The results of that oversight would have a bearing on whether Justice Kagan had a possible conflict of interest that might preclude her from participating in litigation in the Supreme Court challenging the constitutionality of PPACA due to her involvement with this legislation while she was serving as the United States Solicitor General.” Similarly, your initial letter of July 6 stated that the request was prompted by “questions . . . about whether Justice Kagan’s prior work on [PPACA] while serving as Solicitor General should disqualify her from hearing challenges to its constitutionality.”

Seeking information for the purpose of affecting pending judicial matters is plainly not a permissible objective of congressional oversight. Such a non-legislative purpose for a congressional inquiry was rejected by the Supreme Court in *Sinclair v. United States*, 279 U.S. 263, 295 (1929), where it stated that “Congress is without authority to compel disclosures for the purpose of aiding the prosecution of pending suits.” *See also Barenblatt v. United States*, 360 U.S. 109, 112 (1927) (“lacking the judicial power given to the Judiciary, Congress cannot inquire into matters that are exclusively the concern of the Judiciary”); *Kilburn v. Thompson*, 103 U.S. 168, 192 (1881) (“The matter was still pending in a court, and what right had the Congress of the United States to interfere with a suit pending in a court of competent jurisdiction?”). This is not a situation in which Congress’s effort to obtain information for a legitimate legislative purpose would have the incidental effect of revealing information useful in pending litigation. *Cf. Sinclair*, 279 U.S. at 295. Rather, as the Committee’s letters show, the Committee’s only purpose is to influence the pending litigation challenging the constitutionality of PPACA.

Furthermore, the fact that this request was made “[o]n the[] behalf” of Members of Congress who have submitted amicus briefs in the lower courts in support of the challenge to PPACA now pending in the Supreme Court reinforces our conclusion that the purpose of the request is to influence the outcome of the litigation by affecting the recusal decision of Justice Kagan. Indeed, over two-thirds of the Members upon whose behalf you pursue this inquiry have joined in submitting an amicus brief to the Supreme Court on this pending matter.

In short, we do not believe that this inquiry is within Congress’s oversight authority because the Committee’s purpose of obtaining information in order to affect whether Justice Kagan should recuse herself concerns a matter within the province of the Supreme Court, not Congress. Accordingly, as we have previously stated, we regret that we cannot be of further

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assistance in this matter. Please do not hesitate to contact this office if we may provide assistance regarding any other matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'mwl', written in a cursive style.

Ronald Weich
Assistant Attorney General

cc: The Honorable John Conyers, Jr.
Ranking Minority Member

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U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

JUN 06 2012

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed please find responses to questions for the record arising from the appearance of Attorney General Eric Holder before the Committee on November 8, 2011.

We hope that this information is of assistance to the Committee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

A handwritten signature in black ink, appearing to read "Judith C. Appelbaum".

Judith C. Appelbaum
Acting Assistant Attorney General

Enclosure

cc: The Honorable Charles Grassley
Ranking Member

**Questions for the Record
Attorney General Eric H. Holder, Jr.
Committee on the Judiciary
United States Senate
November 8, 2011**

QUESTIONS POSED BY SENATOR WHITEHOUSE

1. **Too many Americans have lost their homes as a result of mortgage servicers using robo-signing and other unfair and illegal foreclosure practices. News reports have indicated that the Justice Department, federal regulators, and several state Attorneys General are negotiating a global settlement with large mortgage servicers related to those illegal foreclosure practices.**
 - A. **Will you provide me an update on the Department's investigations into illegal foreclosure practices?**

Response:

While we cannot discuss ongoing pending investigations, we can tell you that on February 9, 2012 the Department announced that a settlement in negotiations with the nation's top five mortgage servicers. This agreement is the product of extensive investigations conducted by a variety of federal agencies and state attorneys general, including those carried out by the U.S. Trustees Program on bankruptcy claims, by the Department of Housing and Urban Development Office of the Inspector General on claims made to the Federal Housing Administration, and various U.S. Attorney's Offices. State and federal agencies entered into information-sharing agreements and shared evidence concerning servicing abuses.

As a result, this landmark agreement holds the banks accountable for "robo-signing" (the practice of submitting foreclosure documents that were not properly reviewed or notarized) and other mortgage servicing abuses through substantial financial payments and extensive consumer relief. The settlement, the largest joint federal-state settlement ever obtained, will require a commitment from the nation's five largest mortgage servicers – Bank of America Corporation, JPMorgan Chase & Co., Wells Fargo & Company, Citigroup Inc. and Ally Financial Inc. (formerly GMAC) – of at least \$25 billion. They will pay billions of dollars to the states and the federal government and, importantly, commit billions more to consumers.

The banks will be required to spend \$20 billion on various forms of financial relief for homeowners. That relief includes reducing the principal on many of the banks' loans to allow homeowners to keep their homes. They will also refinance loans for "underwater" borrowers who have been unable to refinance due to negative equity. The settlement also requires the mortgage servicers to implement unprecedented changes in how they service mortgage loans, handle foreclosures, and ensure the accuracy of information provided in federal bankruptcy

court. The new servicing standards will prevent foreclosure abuses of the past and will create dozens of new consumer protections.

The banks will be subject to a federal court order enforceable by a federal judge. In addition, a special independent monitor will have the authority to oversee the banks and monitor their compliance. Federal agencies and state attorneys general can enforce compliance if there are violations.

- B. Will you work to ensure that any settlement with the servicers would fully hold the banks and servicers accountable for their wrongful conduct; make sure that those home-owners in Rhode Island and elsewhere who were wronged receive full and fair compensation; make certain that banks discontinue illegal foreclosures; and ensure that banks are not given immunity against investigations and criminal and civil liability for a broader set of conduct, including the securitization and lending practices that contributed to the financial crisis?**

Response:

While the settlement agreement resolves certain civil claims based on mortgage loan servicing activities, it preserves a wide variety of other potential claims. For example, it does not preclude state and federal authorities from pursuing criminal enforcement actions, and does not prevent any claims by any individual borrowers who wish to bring their own lawsuits. Thus, the settlement does not grant blanket immunity for potential wrongdoing related to illegal mortgage and foreclosure practices. In addition, on January 27, 2012, the Department of Justice along with several federal and state partners announced the creation of a joint federal-state Residential Mortgage Backed Securities (RMBS) Working Group to investigate wrongdoing in this market under the auspices of the President's Financial Fraud Enforcement Task Force. Similar to the criminal and individual claims described above, the claims that will be the focus of this Group's work are not precluded by the settlement. The RMBS Working Group will concentrate on the investigation of fraud in the packaging and sale of RMBS offerings – essentially securitizers – as distinct from mortgage-servicing procedures.

2. **In recent years, a number of individuals alleging that they have been harmed by illegal or wrongful government actions have been unable to obtain redress in the courts because government lawyers have invoked the state secrets privilege. The privilege plays an important role in protecting information that could harm national security if it were disclosed. But that protection should not come at the expense of investigating and ensuring accountability for government wrongdoing. You issued a memorandum in September 2009 (“Policies and Procedures Governing Invocation of the State Secrets Privilege”), which provides that a case will be referred to the relevant Inspector General’s office if there are credible allegations of government misconduct and the case is not able to be litigated because of the state secrets privilege.**

A. Have any such cases been referred to an Inspector General, or any other form of independent review?

Response:

As your question recognizes, the state secrets privilege does play an important role in protecting information that could harm the national security if disclosed. As the Attorney General made clear, however, the Department of Justice will not defend an invocation of the privilege in order to (i) conceal violations of the law, inefficiency, or administrative error; (ii) prevent embarrassment to a person, organization, or agency of the United States government; (iii) restrain competition; or (iv) prevent or delay the release of information which would not reasonably be expected to cause significant harm to national security. If the Attorney General concludes that it would be proper to defend invocation of the privilege in a particular case, and that invocation of the privilege would preclude adjudication of particular claims, but the case raises credible allegations of government wrongdoing, the Department will refer those allegations to the Inspector General (IG) of the appropriate department or agency for further investigation, and will provide prompt notice of the referral to the head of the appropriate department or agency.

The Department's policy is not to disclose the existence of pending IG investigations. Consistent with that policy, we could not provide the number of cases, if any, that may have been referred to an IG pursuant to the Department policy on state secrets privilege. However, to the extent IG investigations are undertaken, the Government has typically released public versions of final IG reports.

B. What safeguards exist to ensure that such referrals will be made in appropriate circumstances?

Response:

Consistent with the policies and procedures governing invocation of the state secrets privilege issued on September 23, 2009, the Department refers allegations of government wrongdoing to an Inspector General where, in the Attorney General's judgment, the case raises credible allegations of government wrongdoing.

3. **Last month, the SEC reached a settlement with Pipeline Trading Systems and two of its executives for violations of federal securities laws. According to the Settlement Order, the Commission found that Pipeline operated a private stock-trading platform, or "dark pool," but did not disclose to its customers that the majority of shares traded on this platform were bought or sold by its own wholly owned subsidiary. Many investors use "dark pools" to avoid moving the price of a stock merely by placing an order to buy or sell it. Because traditional trading venues, such as stock exchanges, typically post information about available orders, when information about a large order becomes known by other market participants, an opportunistic firm using sophisticated algorithms can trade in front of that order to**

the detriment of the firm that placed it. According to the SEC Settlement Order, Pipeline gave its own subsidiary its customers' order and trade data, and superior electronic access to its trading platform, which allowed the subsidiary to act in a predatory fashion. The subsidiary was able to anticipate market movements, trading in front of Pipeline's customers' orders – to the benefit of Pipeline and the possible detriment of its customers.

The SEC has indicated that approximately 30 percent of the trading volume in U.S.-listed equities is now executed in dark pools and similar venues. As the Pipeline case demonstrates, the rise of trading in dark pools creates new opportunities for perpetrating securities frauds, and may place ordinary investors at a significant disadvantage.

- A. With that in mind, has the Department coordinated with the SEC to investigate possible criminal securities fraud in dark pools and similar alternate trading venues?**

Response:

Through the dedicated leadership of the co-chairs and members of the Securities and Commodities Fraud Working Group of the President's Financial Fraud Enforcement Task Force, the Department of Justice is in constant communication with the Securities and Exchange Commission (SEC) and other law enforcement and regulatory agencies about new and emerging trends in fraud schemes throughout the country. We will continue to be vigilant in investigating and prosecuting financial fraud where we see it, including in dark pools and similar alternate trading venues.

- B. Does the Department need additional tools or resources to deter and punish high-frequency trading conduct that is intended to manipulate markets or that takes advantage of inside information?**

Response:

The Department is prepared to investigate any matter involving dark pool or other high frequency manipulative trading that the SEC or the Commodity Futures Trading Commission refers to the Department. Such cases often require significant attorney and agent resources, and also require the assistance of sophisticated analysts to investigate numerous trades, sophisticated trading activity, and brokerage account activity. Consistent with the President's Budget, we will work closely with Congress regarding any additional tools or resources that could be used to hold security fraudsters accountable.

- 4. As you know, I believe that the Margolis decision memorandum on the OPR Report about attorney misconduct in the Office of Legal Counsel (OLC) during the previous Administration misconstrued the duty of candor to which OLC attorneys should be held. Because the protections of adversarial**

advocacy and judicial review are not available to OLC, the duty of candor for OLC attorneys should be higher than – or at least equal to – the duty of candor that attorneys owe to a court under the Rules of Professional Conduct (RPC).

I was pleased to hear from you, in response to a previous question for the record, that “[a]s standard practice” OLC strives to provide a balanced presentation of arguments, including relevant precedents, that “well exceeds the minimum standards” in the RPC. A rule adopting this practice would clarify the responsibilities of OLC attorneys. To that end, has the Department adopted a binding policy or rule reflecting that OLC attorneys should meet the standards you have described? Absent a different rule, is not the “Margolis policy” the effective rule?

Response:

As the question indicates, attorneys in the Office of Legal Counsel (OLC) are subject to the governing rules of professional responsibility; but OLC has also published a memorandum dated July 16, 2010, identifying and describing in detail the “best practices” that govern the work of attorneys providing legal advice on behalf of the Office (available at <http://www.justice.gov/olc/pdf/olc-legal-advice-opinions.pdf>) (“OLC Best Practices Memo”). That memorandum sets forth the “guiding principles” of the Office which require that OLC “provide advice based on its best understanding of what the law requires” and specifically state that, “in rendering legal advice, OLC seeks to provide an accurate and honest appraisal of applicable law, even if that appraisal will constrain the Administration’s or an agency’s pursuit of desired practices or policy objectives.” See OLC Best Practices Memo at 1. Moreover, the memorandum makes clear that “regardless of the Office’s ultimate legal conclusions, it should strive to ensure that it candidly and fairly addresses the full range of relevant legal sources and significant arguments on all sides of a question,” *id.* at 2, and that opinions prepared by the Office should provide “a balanced presentation of arguments on each side of an issue,” *id.* at 4. The memorandum also lays out the rigorous process that the Office follows in reaching its legal conclusions. OLC relies on the guiding principles set forth in the July 16, 2010 memorandum, and the Department endorses the memorandum.

QUESTIONS POSED BY SENATOR KLOBUCHAR

5. **The Senate recently approved an amendment, which I supported, to prohibit gun-walking operations, but that provision is not yet law. Will you commit to prohibiting the Department of Justice and its subsidiary agencies from using the gun-walking tactics employed in Operation Fast and Furious?**

Response:

The Attorney General has already prohibited the Department of Justice and its component agencies from using the inappropriate tactics employed in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez and Medrano. In early March 2011, the Attorney General instructed the Deputy Attorney General to issue a directive making clear that such tactics should not be used again. In a letter to Chairman Leahy and other members dated January 27, 2012, Deputy Attorney General James M. Cole outlined reforms adopted by the Department, including ATF, to ensure that such inappropriate tactics are not employed in future investigations.

6. **Based on what has occurred with Fast and Furious, do you think any changes are needed in the approval process for proposed operations and tactics at ATF or at the Department of Justice generally? Is this an issue you plan to review?**

Response:

Operation Fast and Furious and the similar operations in the prior Administration like Wide Receiver, Hernandez and Medrano, demonstrated the need to strengthen ATF and Department policies and procedures to ensure that the inappropriate tactics used in those investigations are not used again. To that end, ATF, which since August 30, 2011 has been under the leadership of Acting Director B. Todd Jones, has clarified its firearms transfer policy, implemented a new monitored case program, and revised its policies regarding the use of confidential informants and undercover operations. These reforms, as well as others, are described more fully in Deputy Attorney General James M. Cole's January 27, 2012 letter to Chairman Leahy and other members.

QUESTIONS POSED BY SENATOR FRANKEN

7. **Last November, the Equal Employment Opportunity Commission (EEOC) issued a report in which it concluded that Bureau of Prisons (BOP) employees “have an unusually heightened fear of retaliation.” See United States Equal Employment Opportunity Commission Final Program Evaluation Report: Federal Bureau of Prisons at p. 3 (Nov. 24, 2010). The EEOC found that the “vast majority of BOP non-supervisory employees interviewed reported an atmosphere of overall retaliation by management” and that BOP employees often “do not report discrimination, harassment, and retaliation because they believe they involuntarily will be transferred.” Id. at pp. 12, 16. The EEOC also found that BOP’s equal employment opportunity program “has several deficiencies that might adversely affect its employees’ perception of it.” Id. at pp. 3-4.**

What is BOP doing to address the problems outlined in the EEOC report? In answering this question, please specify (a) whether BOP has made any changes to its equal employment opportunity program, and, if so, please provide the current status of those changes; (b) whether and to what extent BOP has engaged with union representatives about issues of retaliation, harassment, and discrimination; and (c) whether and to what extent BOP has provided guidance or training to its supervisory employees in response to the EEOC report.

Response:

We are committed to equal employment opportunity and to ensuring a workplace free of discrimination and retaliation. The Bureau of Prisons (Bureau) has taken many significant steps to modify its Equal Employment Opportunity (EEO) program and implement the recommendations in the Equal Employment Opportunity Commission (EEOC) report.

- A. On October 21, 2010, the EEO Office was moved from the Office of General Counsel to the Program Review Division (PRD), which is the independent audit arm of the Bureau of Prisons (BOP). In addition, the PRD Assistant Director was designated as the EEO Director, reporting directly to the Bureau Director.

The BOP hired 13 additional full time EEO counselors. Now, with the exception of the staff located in the Bureau facilities in Puerto Rico and Hawaii (due to their locations, these two facilities are serviced by BOP staff who serve as EEO Counselors in addition to their full-time BOP assignment), all facilities are serviced by full time EEO counselors (18 in total).

- B. The BOP EEO Officer, who has day-to-day supervision of the EEO Office and its functions, has met with the union to discuss issues of retaliation, harassment, and discrimination. BOP EEO management and union representatives have worked jointly to draft an anti-harassment policy that is almost complete. This workgroup is also collaborating to update the EEO complaints processing policy.

- C. Since the report, the BOP EEO Officer has provided live training on two occasions to all BOP wardens. The first training focused on retaliation and the second on more general EEO issues. In addition, the EEO Officer provided video-conference training to all Bureau supervisors on two occasions. The first training focused on the EEO process generally, and the second focused on the full-time EEO Counselor program and confidentiality within the EEO process. All supervisors were also required to review an online training on retaliation developed by the EEO Officer.

All BOP staff received EEO training, to include training on the mediation process, during the agency's mandatory 2011 Annual Training. Finally, the BOP has been in compliance with the No FEAR Act of 2002 training requirements for all staff since its implementation.

8. **The media recently reported that the FBI will soon roll out a "facial recognition" identification service in four states: Michigan, Washington, Florida, and North Carolina. This service will allow federal and state law enforcement officers to identify a suspect on the street by taking his or her picture and running it past a federal database of faces. Since then, civil liberties advocates from the Electronic Frontier Foundation to the Cato Institute cautioned that this database would allow the uploading of photos of innocent people that had never been convicted of a crime.**
- A. **What legal or procedural restrictions are there on the type or source of photos that can be submitted?**

Response:

The FBI's Next Generation Identification (NGI) program is in the early stages, with preparations currently underway to deploy the Interstate Photo System Facial Recognition Pilot (hereafter Pilot). State participation in the Pilot has not yet been established. We anticipate that full facial recognition services may be deployed in 2014.

The Pilot Repository will contain only photos provided by authorized criminal justice agencies for criminal justice purposes and associated with fingerprints from a criminal arrest or booking. Participating agencies will be required to comply with appropriate quality assurance procedures to ensure that only complete, accurate, and valid information is maintained in the Pilot Repository. Photos will be searched against those in the Repository only when the photos are obtained from authorized criminal justice agencies, only for criminal justice purposes, and only when consistent with parameters established in a memorandum of understanding (MOU) with criminal justice agencies. These parameters will address purpose, authority, scope, disclosure, use, and security. The information derived from Pilot searches will be used only as investigative leads and will not be considered positive identifications.

B. Will the FBI allow the photos of citizens who have never been convicted of a crime to be included in its facial recognition database?

Response:

As noted above, the Pilot Repository will contain only facial images associated with fingerprints from a criminal arrest or booking.

The FBI's collection and retention of identifying information is governed by statute: 28 U.S.C. § 534(a) requires that the "Attorney General shall - (1) acquire, collect, classify, and preserve identification, criminal identification, crime, and other records." As interpreted by federal case law, the word "shall" not only provides authorization, it also provides imperative direction, requiring that identification materials and records be acquired and preserved. (*United States v. Rosen*, 343 F. Supp. 804, 806 (S.D.N.Y. 1972). "[E]ven in the situation where a person has been acquitted of charges against him, the arrest records and other materials of identification . . . may be retained *unless*: (1) there is a statute that directs return of such arrest records; (2) the arrest was unlawful; or (3) the record of the arrest is the 'fruit' of an illegal seizure." (*Rosen* at 808 (emphasis in original).) The retention of identification records has been addressed by the federal courts in other contexts, including in a 1976 case in which the court found that the maintenance and dissemination of arrest records of persons never convicted of a criminal charge arising from the conduct for which they were arrested does not violate constitutional due process protections or the constitutional right to privacy. (See *Hammons v. Scott*, 423 F. Supp. 625, 628 (N.D. Cal. 1976).)

C. Will private citizens be able to correct any inaccurate information in the FBI's database?

Response:

The FBI is primarily the custodian of criminal history information submitted by federal, state, and local criminal justice agencies. To assist in ensuring the integrity of information housed in the Pilot Repository, the FBI will require that retainable photo data be accompanied by fingerprints to verify the individual's identity, unless the MOU between the FBI and the contributor memorializes that identification will be confirmed by the state agency. Authorized criminal justice agencies may amend, modify, or delete their photo information should errors or court-ordered expungements require it.

As with all identification information, the subject of photo information may obtain a copy of the record by submitting a written request to the FBI (see the Guide for Obtaining Your FBI Identification Record on www.fbi.gov). If, after reviewing the identification record, the subject believes that it is incorrect or incomplete and wishes to change, correct, or update the record, the subject should apply directly to the agency that contributed the challenged information. If the subject of a record submits the challenge directly to the FBI, we will forward the challenge to the contributing agency, asking that agency to verify or correct the challenged entry. Upon receipt of an official communication directly from the contributing agency, the FBI will make any necessary changes to the record.

- D. Can photos be submitted that are obtained from commercial social networking sites or similar sites?**

Response:

As noted above, the Pilot Repository will contain only photos provided by authorized criminal justice agencies for criminal justice purposes and associated with fingerprints from a criminal arrest or booking. Only photos obtained from authorized criminal justice agencies will be searched against those in the Repository. Authorized criminal justice agencies may submit photos obtained from commercial social networking sites so they may be searched against the Pilot Repository for criminal justice purposes.

- E. What entities (local, state, national, international) can add photos to the database?**

Response:

As noted above, the Pilot Repository will contain only photos provided by authorized criminal justice agencies for criminal justice purposes and associated with fingerprints from a criminal arrest or booking.

- F. What entities (local, state, national, international) can search the database?**

Response:

Search of the Pilot Repository will be restricted to authorized criminal justice agencies for criminal justice purposes.

- G. What safeguards are in place to prevent authorized users from searching outside of the authorized scope of use?**

Response:

Searches of the Pilot Repository will be subject to the same security and privacy protocols that apply to searches of other FBI information systems and are articulated in established FBI Security Policy. The dissemination of any information obtained from these systems is also restricted; this information will be treated as "law enforcement sensitive" and protected from unauthorized disclosure in accordance with the Privacy Act of 1974 and the "Disclosure and Use of Information" section of the MOU. 28 U.S.C. § 534 and 28 C.F.R. §§ 20.33 and 50.12 require that disseminated records be used only for authorized purposes and provide that a user's access will be subject to cancellation if shared information is further shared improperly.

- H. What other protections will the FBI take to safeguard civil liberties?**

Response:

NGI program managers have worked closely with privacy and civil liberties attorneys in the FBI's Office of the General Counsel (OGC), as well as with Department of Justice (DOJ) attorneys, and have briefed privacy advocacy groups regarding the privacy and civil liberties considerations and planned safeguards. These considerations have been addressed in the FBI Security Policy. In addition, an Interstate Photo System Privacy Impact Assessment (PIA) has been completed and approved. A Privacy Threshold Analysis will be conducted to update the PIA as part of the ordinary process and in support of the full facial recognition service.

To ensure full implementation of the security policies and to prevent the misuse of data, all federal, state, and local users are subject to periodic audits conducted by both an FBI Audit Unit and appropriate state auditors. Access to an FBI information system may be terminated or restricted in response to improper access, use, or dissemination of the system's records.

9. **Under the Debbie Smith Act (DSA), Congress has appropriated to NIJ more than \$700 million for use in eliminating rape kit backlogs. However, only a fraction of those funds actually have been spent on direct backlog reduction. Please (a) provide data on the percentage of DSA funds that have been used for direct support to crime laboratories and law enforcement agencies to reduce rape kit backlogs; (b) provide data on the percentage of DSA funds that have been used for other purposes, identifying what those purposes are; and (c) explain why NIJ believes that its existing funding breakdown is appropriate in light of persistently large rape kit backlogs.**

Response:

NIJ's principal forensics-related appropriations in Fiscal Year 2012, under the Department of Justice Appropriations Act, 2012 provides "\$117,000,000 for a DNA analysis and capacity enhancement program and for other local, State, and Federal forensic activities, including the purposes authorized under section 2 of the DNA Analysis Backlog Elimination Act of 2000 (the Debbie Smith DNA Backlog Grant Program)." Previous years' appropriations (referred to hereafter as the "DNA and other forensics" appropriation) have had similar language.

In Fiscal Year (FY) 2011, NIJ awarded \$88.7 million – over 70% of all funds received by NIJ from the FY 2011 "DNA and other forensics" appropriation – directly to states and units of local government under the FY 2011 DNA Backlog Reduction Program. One of the major purposes of that program was to cover costs of laboratory analysis of forensic DNA casework samples, a category that includes samples from rape kits or other sexual assault evidence.

Remaining funds from the FY 2011 "DNA and other forensics" appropriations were used to support basic and applied research to find faster and more efficient methods for analyzing DNA and other forensic evidence; assist with solving cold cases with DNA; perform social

science research (e.g., to identify best practices for addressing untested sexual assault kits); and provide training and technical assistance in the areas of DNA and other forensic sciences.

Although the FY 2012 appropriation for DNA and other forensics is lower than in FY 2011, NIJ will continue to use a similarly high-percentage of that appropriation exclusively for the FY 2012 DNA Backlog Reduction Program. As in FY 2011, funds awarded under the FY 2012 DNA Backlog Reduction Program will be available, among other things, to cover costs of laboratory analysis of forensic DNA casework samples, a category that includes samples from rape kits or other sexual assault evidence. While making funds available to state and local crime laboratories for analysis of forensic DNA casework samples is a top priority, NIJ also believes that other DNA- and forensics-related programs and activities are important in reaching the same goal of reducing backlogs, albeit indirectly, by enhancing capacity within crime laboratories, training personnel, solving “cold” cases, and developing modern methods to analyze evidence.

- 10. The National Institute of Justice (NIJ) defines a backlogged rape kit as one that has not been tested 30 days after it was submitted to a laboratory. This definition excludes rape kits held in police storage facilities. Why does NIJ define backlogs in this manner, and what is being done to account for and reduce the backlog of rape kits in law enforcement custody?**

Response:

The NIJ definition of backlogs is designed as a measure of timeliness specifically for forensic evidence that has been submitted to a crime laboratory for analysis. It does not include forensic evidence that has not been submitted to a crime laboratory for testing.

NIJ refers to evidence in law enforcement custody that has not been submitted to a crime laboratory as untested evidence. Untested sexual assault kits (SAK), previously referred to as rape kits, can be stored in a number of places: police department evidence rooms, crime labs, hospitals, clinics, rape-crisis centers. It is unknown how many unanalyzed SAKs there are nationwide. There are many reasons for this, but one of the primary reasons is that tracking and counting SAKs is an antiquated process in many U.S. jurisdictions. A recent NIJ study found that 43 percent of the nation’s law enforcement agencies do not have a computerized system for tracking forensic evidence, either in their inventory or after it is sent to the crime lab.

There may be legitimate reasons that SAKs are not sent to a lab. Not all evidence collected in an alleged sexual assault is going to be probative. In cases where consent is an issue (the suspect admits sexual contact, but maintains it was consensual), detectives may consider that the SAK does not add any important information to the investigation. Also, evidence may not be sent to a lab for analysis if charges against the alleged perpetrator have been dropped or the suspect has pled guilty.

NIJ has invested funds in a comprehensive study of the outcomes of the testing of over 10,000 previously untested SAKs in Los Angeles and is assisting the New Orleans Police Department in dealing with their untested SAK issues. NIJ is currently studying the SAK

backlogs and untested sexual assault evidence that has not been sent to a crime lab for testing in Detroit, Michigan and Houston, Texas. The purpose of this project is to help the nation move beyond the DNA backlog crisis management of the moment — to the adoption of systematic practices, procedures, and protocols that will prevent the accumulation of untested SAKs in police departments from ever happening again.

11. **The Department has issued almost double the number of National Security Letters (NSLs) involving different U.S. persons in 2010 as it did in 2008 or 2009. In your November 2, 2011 response to a question for the record regarding NSLs, you explained that “[t]o the extent these numbers may indicate an upward trend, we are unable to explain the increase because we do not collect statistics or other information that would enable us to discern the reason for the increase.” This is unacceptable, especially given the previous Inspector General reports that have demonstrated widespread and systematic abuse of NSLs. Please explain how the Department exercises oversight over the issuance of NSLs, and what steps the Department plans to implement to better track how and why these NSLs are issued.**

Response:

An increase, even a significant one, in the number of National Security Letters (NSLs) is not necessarily a sign of NSL misuse or abuse, as opposed to effective and productive intelligence gathering to protect the nation. The FBI has in place robust rules, policies, procedures, and training to ensure that NSL issuance and use are appropriate. In addition, the FBI and DOJ exert significant oversight of NSLs.

As indicated in the Department’s response to Questions for the Record arising from the May 4, 2011, Senate Judiciary Committee hearing regarding “Oversight of the U.S. Department of Justice,” changes in the numbers of NSLs issued from year to year may be based on the types of threats being investigated or the locations of the threats (in the United States versus outside the United States). These variables affect the way we gather information and what information we need to address the threat. For example, if more threats involving U.S. persons arise because known U.S. persons become radicalized, the FBI will investigate those threats. Such investigations may include issuing NSLs to help determine whether a U.S. person poses a terrorism threat.

The question indicates that DOJ’s Inspector General (IG) reported “widespread and systematic abuse” of NSLs. The conduct addressed in the IG’s March 2007 report entitled, “A Review of the Federal Bureau of Investigation’s Use of National Security Letters” occurred between 2003 and 2005 and, although serious, was not pervasive. Importantly, the IG found that FBI agents had not intentionally sought to misuse NSLs, but that the errors were the product of a lack of adequate guidance and oversight. Both issues were immediately addressed and are continually assessed by both the FBI and DOJ. Indeed, in its March 2008 review of the FBI’s use of NSLs, the IG found that the FBI and DOJ had made significant progress in implementing its recommendations and in adopting other corrective actions to address problems in the use of NSLs.

As has been briefed to Congress, mandatory use of the FBI's automated NSL creation system, mandatory legal review of each NSL, and clear and widely distributed policy guidance regarding NSL usage have prevented most of the errors identified in the 2007 IG report. In addition, audits and reviews of FBI NSL usage by DOJ's National Security Division, the FBI's Inspection Division, and the FBI's OGC have shown that the errors identified in the 2007 IG report have been reduced dramatically. These results demonstrate that the policies, procedures, training, and oversight mechanisms that are in place are working effectively to reduce the risk that this tool is being misused or abused, and to ensure that NSLs are issued in accordance with the law.

12. **The GAO recently published a report on suspension and debarment programs in the federal government. GAO found that the Department of Justice had relatively few suspensions and debarments, and it recommended several steps DOJ should take to improve its suspension and debarment program. Please indicate the status of the Department's efforts to implement these recommendations. In addition to the steps recommended by GAO, will the Department take steps to improve and promote inter-agency communication and case referrals, especially when the Department is investigating a government contractor in a civil or criminal matter and has relevant information as to the responsibility of that contractor?**

Response:

In its report, *Suspension and Debarment: Some Agency Programs Need Greater Attention and Governmentwide Oversight Could be Improved*, GAO-12-270T (Oct. 6, 2011) (Report), the Government Accountability Office (GAO) recommended that agencies conform their suspension and debarment programs to those programs at agencies that engage in a large number of suspensions and debarments. GAO issued three recommendations to various agencies, including the Departments of Justice, Commerce, Health and Human Services, and Treasury. Specifically, the report recommended that agencies: (1) promote the case referral process; (2) assign dedicated full-time staff to its suspension and debarment program; and (3) develop and implement additional policies and procedures to supplement the guidance contained in the Federal Acquisition Regulation (FAR), 48 C.F.R. Subpart 9.4. The recommendations are based on GAO's review of the "shared traits" of the four agencies with the largest total number of suspension and debarment cases for Fiscal Years 2006 to 2010, as identified in the General Service Administration's (GSA) Excluded Parties List System (EPLS). The Report neither addresses in detail the policies and practices of the other federal agencies, nor considers certain factors that may impact the number of suspension and debarment cases, including, for example, the total number of contractors and grantees conducting business with an agency, or the types of products or services being acquired by an agency. Importantly, GAO recognized that, because each agency's fundamental mission and organizational structure is unique, each agency must determine for itself whether, and to what extent, it can benefit from conforming its suspension and debarment programs to those agencies' programs.

As the Department informed GAO in its July 20, 2011, response to the draft Report, DOJ concurs with much of the Report's findings and conclusions, and in particular with the Report's emphasis on the need for agencies to devote sufficient attention to suspension and debarment to ensure that the government conducts business only with responsible parties. DOJ also agrees that suspension and debarment are powerful administrative tools available to federal agencies and, when used appropriately, help protect the government's interests. DOJ fully and actively supports the use of suspension and debarment.

In order to ensure that DOJ continues to protect the integrity of federal programs by conducting business with responsible parties, the Department has implemented a number of measures consistent with the recommendations of GAO, as well as those contained in the recent report of DOJ's Office of the Inspector General (OIG), *Audit of Administrative Suspension, Debarment, and Other Internal Remedies Within the Department of Justice*, Audit Report 12-01 (Oct. 2011). Among these measures, the Attorney General recently issued a memorandum to all U.S. Attorneys, Assistant U.S. Attorneys, DOJ litigating divisions and Trial Attorneys, and the Director of the Federal Bureau of Investigation, titled *Coordination of Parallel Criminal, Civil, and Administrative Proceedings* (Jan. 30, 2012) (Memorandum), promoting the case referral process, including suspension and debarment. The Memorandum reiterates that DOJ has placed a high priority on combating white-collar crime, including fighting against fraud, waste, and abuse, whether in connection with healthcare, procurement, or other financial fraud. The Memorandum also reiterates DOJ's longstanding policy that criminal prosecutors, civil trial counsel, and investigators timely communicate, coordinate, and cooperate with one another and with agency attorneys inside and outside DOJ to the fullest extent appropriate and permissible whenever an alleged offense or violation of federal law gives rise to the potential for parallel (whether simultaneous or successive) criminal, civil, regulatory, and/or administrative proceedings. The Memorandum also emphasizes the need for litigating and investigating activities to have in place policies and procedures for early coordination of parallel proceedings, and the need for these policies and procedures to stress effective, timely, and regular communication between criminal, civil, and agency attorneys. The Memorandum underscores that, at every point throughout the process -- from case intake and investigation to final case resolution -- DOJ attorneys and investigators need to assess the potential impact of any action on potential criminal, civil, regulatory, and administrative proceedings to the extent possible and permissible. The Memorandum also directs DOJ's Office of Legal Education, in consultation with the United States Attorney's Offices, the Civil Division, the Criminal Division, and other DOJ litigating divisions, to facilitate the provision of instruction and training materials on parallel proceedings, including suspension and debarment.

Additionally, DOJ's Senior Procurement Executive (SPE) recently issued a Procurement Guidance Document (PGD), PGD 12-08 (Feb. 1, 2012), directed to all Bureau Procurement Chiefs (BPCs) and contracting officers, emphasizing the FAR and Justice Acquisition Regulation (JAR) requirement that DOJ solicit offers from, award contracts to, and consent to subcontracts with responsible contractors only. The PGD reiterates the importance of the FAR requirement that contracting officers review the EPLS both after opening bids or receipt of proposals and immediately prior to contract award to ensure that no award is made, option exercised, or order issued to a contractor listed on the EPLS. The PGD also reminds contracting officers that agencies may not solicit offers from, award contracts and orders to, or consent to subcontracts

with a contractor suspended, proposed for debarment, or debarred, unless the head of the agency (or his or her delegate) determines in writing that there is a compelling reason to do so. The PGD also directs contracting officers to consider termination of any existing contract or order with a contractor if, during performance of the contract or order, the contracting officer learns that the contractor is suspended, proposed for debarment, or debarred. The PGD explains that, in accordance with the procedures in the FAR and the JAR, prior to making a decision to terminate an existing contract or order, the contracting activity should consult with both the program office and the activity's legal counsel.

DOJ also has implemented an electronic suspension and debarment case tracking system. The system is accessible to those persons within DOJ with responsibility for the suspension and debarment program, including the suspending and debarring official (SDO), the SDO's legal counsel, and those responsible for entering information into the EPLS. The system will help ensure that suspension and debarment case referrals are acted upon in a timely manner, thereby providing an additional level of protection for DOJ and other Executive Branch agencies from conducting business with persons and organizations who have demonstrated fraudulent behavior or a pattern of poor performance. The system also will help ensure that persons and organizations referred for suspension and debarment are provided due process.

DOJ also participates in the activities of the Interagency Suspension and Debarment Committee (ISDC) -- a government-wide organization created to monitor and coordinate suspension and debarment activities. DOJ participates with the ISDC on an on-going basis regarding, among other things, the facilitation of lead agency coordination of prospective suspension and debarment cases and the development of a unified Federal policy as it relates to suspension and debarment. On February 8, 2012 an Assistant Director within the Civil Division's Commercial Litigation Branch (Fraud Section), provided a presentation to the ISDC, discussing DOJ's longstanding policy outlined in the Attorney General's January 30, 2012 Memorandum, emphasizing DOJ's commitment to engaging in effective, early, and regular communication during the investigation and litigation processes with agency attorneys, to ensure that the Government makes use of all available remedies in its fight against fraud, waste and abuse, including administrative remedies such as suspension and debarment.

DOJ considered carefully GAO's view that some agencies will benefit from the implementation of additional policies and procedures, but has concluded that additional policies and procedures are not necessary at this time. As explained in DOJ's letter to GAO, DOJ already relies upon a number of policies, procedures, and guidelines in its suspension and debarment program, including the FAR, JAR, OMB's guidelines related to non-procurement suspension and debarment, and DOJ's regulations related to non-procurement suspension and debarment at 2 C.F.R. § 2867. The JAR specifically outlines DOJ's internal processes when a possible cause for suspension or debarment arises, including directing the contracting activity to actively seek review by the activity's legal counsel and the BPC. Additionally, the Attorney General's Memorandum, as well as the United States Attorney's Manual (USAM) and the Environmental Crimes Manual (ECM), inform litigating and investigating activities of DOJ's longstanding policy requiring coordination of criminal, civil, and administrative actions -- including emphasizing the need for timely and effective communication with agencies' suspension and debarment authorities. Likewise, DOJ does not believe that it is either necessary

or practical at this time to assign dedicated full-time staff to its suspension and debarment program.

DOJ believes that the measures described above, coupled with those measures already in place -- including close cooperation with the OIG -- will improve DOJ's suspension and debarment program and demonstrate, both within and outside the agency, that DOJ is serious about holding entities with which it does business accountable. DOJ also believes that these measures will help ensure that DOJ continues to protect the integrity of Federal programs by conducting business with responsible parties only.

- 13. As you said in your testimony, the recently disclosed anti-Muslim statements in FBI training materials are inconsistent with the views of the Department of Justice and the FBI and have set back your substantial outreach efforts with Muslim and other minority communities around the country. These communities can and should be important partners in our counterterrorism efforts. The Department is undertaking a comprehensive review of its counterterrorism training and reference materials. What will the Department do beyond removing existing problematic statements in training materials to ensure that the FBI's efforts to communicate and work with Muslim and other minority communities around the country are not undermined by such bias in the future?**

Response:

Since September 2011, when several articles were published regarding the FBI's counterterrorism training materials, senior FBI officials have held more than 100 meetings with community advocates and leaders from the Muslim, Arab, Sikh, South Asian, and interfaith communities to discuss these training materials. These meetings have been held at FBI Headquarters and all 56 FBI field offices to discuss the training issue, explain how these events came to pass, and identify the corrective actions being taken moving forward. These efforts continue. As recently as February 8, 2012 FBI Director Mueller met with many of these groups to continue this dialogue. Among other things, they discussed in detail the FBI's review of its training materials, which was conducted by a team of 25 FBI inspectors with training and assistance provided by a five-person team of subject matter experts (SMEs). The SME team included both FBI and non-FBI personnel with academic backgrounds in Islamic studies and Arab history from prestigious institutions.

The review has included approximately 160,000 pages of counterterrorism training materials, more than 4,500 presentations, and more than 1,000 minutes of video.

The materials were measured against the following requirements:

- Training must be consistent with both Constitutional principles and the FBI's core values. (The FBI's core values are available on its website, www.fbi.gov, and include respect for the dignity of all those we protect, compassion, and fairness.)
- Training must be tailored, focused, and supported with appropriate course materials.

- Training must be properly reviewed and trainers must know their subject areas.
- Training must facilitate further learning and professional development.

The review team authored concrete enterprise-wide guidelines regarding training related to counterterrorism and countering violent extremism, to be used both to evaluate current training and as the basis of future curriculum development. While the vast majority of the reviewed training materials met these high standards, some did not. Fewer than one percent of the documents were determined to have factual or other problems and were removed from FBI training curricula. The review revealed that the problems with the FBI's training materials were related to the absence of a centralized process to ensure that all training is reviewed, validated, standardized, and mapped to appropriate learning objectives. Moving forward, all training materials produced or used by the FBI will be subject to such a process.

QUESTIONS POSED BY SENATOR GRASSLEY

Memos to Attorney General

14. In your October 7, 2011, letter to Congress, you wrote: "On a weekly basis, my office typically receives over a hundred pages of so-called 'weekly reports' that, while addressed to me, actually are provided to and reviewed by members of my staff and the staff of the Office of the Deputy Attorney General. The weekly reports contain short summaries of matters that the agencies deem of interest that week."

In 2010, who in the Attorney General's office was responsible for reading memos to the Attorney General's office from Assistant Attorney General Lanny Brewer?

Response:

Responsibility for reading memos to the Office of the Attorney General from the heads of Department components typically depends on the subject matter of the memos and the make-up of the Attorney General's staff at any particular time. We understand that the Committee has had the opportunity to interview current and former members of the staff of the Office of the Attorney General about responsibilities within that office in 2010.

- A. Was this same individual responsible for handling the entire portfolio of the Criminal Division within the Office of the Attorney General?

Response:

Please see response to question 14, above.

- B. In 2010, who in the Attorney General's office was responsible for reading memos to the Attorney General's office from National Drug Intelligence Center Director Michael Walther?

Response:

Please see response to question 14, above.

- C. In 2010, who in the Attorney General's office was responsible for reading memos to the Attorney General's office from ATF Acting Director Kenneth Melson?

Response:

Please see response to question 14, above.

D. At any time during 2010, did Monty Wilkinson have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson, either in Wilkinson's role as Counselor to the Attorney General or as Deputy Chief of Staff and Counselor?

Response:

Please see response to question 14, above.

E. At any time during 2010, did then-Deputy Chief of Staff and Counselor James Garland have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson?

Response:

Please see response to question 14, above.

F. At any time during 2010, did Monty Wilkinson have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson, either in Wilkinson's role as Counselor to the Attorney General or as Deputy Chief of Staff and Counselor?

Response:

Please see response to question 14, above.

G. At any time during 2010, did then-Counselor to the Attorney General Molly Moran have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson?

Response:

Please see response to question 14, above.

H. At any time during 2010, did then-Counselor to the Attorney General John Bies have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson?

Response:

Please see response to question 14, above.

- I. **At any time during 2010, did Counsel Aaron Lewis have responsibility for reading memos to the Attorney General's office from Assistant Attorney General Breuer, Director Walther, or Acting Director Melson?**

Response:

Please see response to question 14, above.

Communication Between Wilkinson and Burke

15. **On December 14, 2010, your Deputy Chief of Staff Monty Wilkinson emailed U.S. Attorney Dennis Burke asking if he was available for a call that day. At 2 am the next morning of December 15, 2010, Burke said that he would call that day to explain in detail what was clearly a reference to Operation Fast and Furious.**

You said in response to a question about this at the hearing:

The conversations that they had were about a variety of things. I've looked at the emails. Now the possibility of me coming out to at some point talk about being engaged in a press conference, other matters, but there was no discussion between them of the tactics that are of concern with regard to Fast and Furious and as a result of that, Mr. Wilkinson did not share information with me about his contacts with former U.S. Attorney Burke.

- A. **Did that phone call between Wilkinson and Burke take place on December 15, 2010?**

Response:

The Attorney General has no personal knowledge of whether a call between Mr. Wilkinson and Mr. Burke took place on December 15, 2010. As the Department has previously explained, the e-mail you have paraphrased does not refer to Operation Fast and Furious by name and does not discuss the inappropriate tactics that were used in that operation. Moreover, the Department has advised the Committee that neither Mr. Wilkinson nor Mr. Burke has any recollection of speaking with the Attorney General about Operation Fast and Furious in December 2010, and the Attorney General similarly has no recollection of speaking with either of them about it. *See Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa at 3 (Oct. 31, 2011); Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa at 2 (Jun. 27, 2012).*

- B. **If the phone call did take place, what specific topics were discussed?**

Response:

Please see response to question 15(A), above.

- C. When did Mr. Wilkinson learn of the connection between an ATF operation and the guns recovered at the Terry murder scene? How did [he] learn about it?**

Response:

The Attorney General has no personal knowledge of when or how Mr. Wilkinson learned of the connection between an ATF operation and the guns recovered at the scene of Agent Terry's tragic murder. The Department has produced to Congress an e-mail on this subject from then-U.S. Attorney Dennis Burke to Mr. Wilkinson, and the Committee has had the opportunity to interview Mr. Wilkinson and question him about this e-mail.

- D. What other emails exist between Mr. Wilkinson and U.S. Attorney Dennis Burke on the issue of your participation in a press conference? Please provide copies of these emails to the Committee.**

Response:

The Department has produced to Congress e-mails between Mr. Wilkinson and Mr. Burke relating to Mr. Burke's interest in having the Attorney General participate in the January 2011 press conference announcing the Fast and Furious indictments. As the Department has previously explained, the Attorney General did not attend the press conference announcing the Fast and Furious indictments, and neither Mr. Wilkinson nor Mr. Burke has a recollection of speaking to the Attorney General about whether he would attend. The Attorney General similarly does not have a recollection of discussing the subject with either Mr. Wilkinson or Mr. Burke. See *Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa at 3 (Oct. 31, 2011)*; *Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa at 2 (Jan. 27, 2012)*.

- E. Did you see these emails contemporaneously, or did you review them later (either as part of the investigation into Fast and Furious or in preparation for the oversight hearing)?**

Response:

The Attorney General does not recall seeing the e-mails referenced in the responses to questions 15(C) or 15(D) at or near the time they were sent. The Attorney General does not recall when he first saw those e-mails, but it would have been well after the allegations of inappropriate tactics in Operation Fast and Furious were made public.

- F. Why did you ultimately opt not to participate in such a press conference?**

Response:

The Attorney General does not recall being consulted about participating in the January 2011 press conference announcing the indictments in Operation Fast and Furious.

ATF's Denial of Gun Walking Allegations

16. You said in the hearing that you “received things as late as March of 2011 from people at ATF, who assured [you] that gun walking did not occur.”

A. What “things” did you receive?

Response:

In the period after allegations of inappropriate tactics in Operation Fast and Furious were made public, the leadership of ATF provided assurances to the Department that the allegations were untrue. Notwithstanding these assurances, in February 2011, the Attorney General requested that the Department’s Office of the Inspector General conduct a review and, in early March 2011, the Attorney General instructed the Deputy Attorney General to issue a directive that the tactics used in Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez and Medrano, should not be used.

B. Who at ATF made these representations to you?

Response:

Please see response to question 16(A), above.

C. Do you consider these documents to be responsive to the House Oversight and Government Reform Committee subpoena of October 12, 2011?

Response:

The Department has made clear that materials responsive to the House Oversight and Government Reform Committee’s October 11, 2011 subpoena have been provided consistent with the Department’s practices in this area across Administrations of both political parties. *See Letter from Deputy Attorney General James M. Cole to Hon. Darrell E. Issa (May 15, 2012).*

1. If so, please identify when the Department is planning on producing these documents pursuant to the House Oversight and Government Reform Committee subpoena.

Response:

Please see response to question 16(C), above.

2. If not, please produce these documents to this Committee.

Response:

Please see response to question 16(C), above.

Refusal to Allow Witnesses to Testify

17. **We have tried to schedule transcribed interviews with 12 Justice Department witnesses. The only one you have made available is the now-former U.S. Attorney Dennis Burke. Your department is refusing to schedule the other 11. For 3 of the witnesses, your staff cited the so-called "line attorney policy" as the reason for your refusal.**

A. Why is the Department refusing to schedule the other 8 witnesses?

Response:

The Department's position regarding witness interviews was set forth in a letter to Chairman Issa and Senator Grassley dated December 6, 2011. As the letter explains in greater detail, Administrations of both political parties have agreed that it is the Department's supervisory personnel, not line employees, who make policy decisions that are properly the subject of Congressional review, and therefore those supervisory personnel should be the ones to explain their decisions if called upon to do so. Requiring line attorneys to respond to congressional inquiries threatens to chill the objective exercise of their prosecutorial discretion and creates the impermissible appearance of political influence on prosecutorial decisions. Furthermore, in an ongoing criminal investigation such as this, testimony by line attorneys could significantly complicate the government's ability to bring dangerous individuals to justice.

Consistent with Department policy, since our December 6, 2011 letter was sent, the Committee has requested to interview, and has interviewed, Gary Grindler, the former Acting Deputy Attorney General and now the Attorney General's Chief of Staff; Monty Wilkinson, the Attorney General's former Deputy Chief of Staff; Jason Weinstein, Deputy Assistant Attorney General for the Criminal Division; and Edward Siskel, former Associate Deputy Attorney General.

- B. It looks like a game of delay to get past the December 8th hearing in the House. Will you commit to setting dates for the other 8 witnesses by the end of this week and cooperating with staff on the order and timing—yes or no? And, if not, why not?**

Response:

Please see response to question 17(A), above.

- C. The line attorney on the anthrax investigation appeared recently on *PBS Frontline*. How is it appropriate to grant full access to a line attorney for the press while you're denying a Congressional request?**

Response:

The attorney you reference is an Executive Assistant United States Attorney who was made available for press inquiries to discuss public aspects about the long closed anthrax investigation. That is very different from making a line attorney available for a congressional interview, particularly with respect to open investigations and prosecutions.

- D. The line attorney policy is merely an arbitrary policy. It is not a legal privilege, so if the House subpoenas their testimony, it will not be a defense. Why is the Department so determined to prevent their testimony that you are willing to push the envelope and force these witnesses into a choice between contempt of Congress and following orders?**

Response:

Please see response to question 17(A), above.

- E. Congress has prohibited the use of appropriated funds to pay the salary of anyone who tries to prevent federal employees from communicating with Congress. How can you refuse to schedule an interview with someone willing to speak to us without violating that provision of the law?**

Response:

The Executive Branch's interpretation of the statutory provisions to which you refer is set forth in a May 21, 2004 opinion of Assistant Attorney General Jack L. Goldsmith, III. *See Authority of Agency Officials to Prohibit employees from Providing Information to Congress* (May 21, 2004), available at <http://www.justice.gov/olc/crsmemoresponse.htm>. That opinion fully supports the Department's position in this matter.

Additional Gun Recoveries

- 18. In the DOJ's August 31, 2011 response to previous QFR's, it stated "ATF is aware of only one instance where a firearm associated with Operation Fast and Furious was...recovered in connection with a crime of violence in the United States." The weapons recovered in the death of Agent Terry were excluded from this calculation.**
- A. Since the time of that letter, have there been any other instances of firearms associated with Operation Fast and Furious being recovered within the United States in connection to a crime of violence?**

Response:

ATF has advised the Department that, as of May 1, 2012, it is not aware of additional instances in which a firearm associated with Operation Fast and Furious was traced and coded as recovered in connection with a crime of violence in the United States.

1. **If so, how many additional guns have been recovered? How many crimes have these guns been connected to? How many violent crimes, as designated in FBI crime statistics, have these guns been connected to?**

Response:

Please see response to question 18(A), above.

U.S.-Sourced Guns

19. **You said in your statement, “[O]f the nearly 94,000 guns that have been recovered and traced in Mexico in recent years, over 64,000 were sourced to the United States.”**

- A. **What definition of “sourced” does this statement rely on?**

Response:

A firearm sourced to the United States is one that was determined through the firearms tracing process to have been manufactured by or imported into the United States by a federally licensed firearms dealer.

- B. **If “sourced” were instead defined as “traceable to an identifiable U.S. gun store,” how would the figure of 64,000 change?**

Response:

ATF cannot reliably trace a firearm “to an identifiable U.S. gun store” because, under ATF’s regulatory structure, several different types of federal firearms licensees (FFLs) may possess the same type of license, making it impossible in the tracing process to distinguish between a retailer—commonly thought of as a “gun store”—and a wholesaler.

- C. **Of the guns submitted by Mexico for tracing in 2009 and 2010, respectively, how many are traceable to an identifiable U.S. gun store?**

Response:

Please see responses to questions 19(A) and (B), above.

Long Gun Reporting

20. On July 12, 2011, Chairman Issa and I sent you a letter regarding the Department's decision to require Federal Firearms Licensees (FFLs) on the Southwest border to report multiple sales of long guns. That letter provides multiple examples of officials looking for ways to use Fast and Furious to justify the long-gun reporting requirement. In addition to emails between senior ATF officials contemplating using Operation Fast and Furious to push for a reporting requirement, we have now learned that your then-acting Deputy Attorney General and current Chief of Staff Gary Grindler was briefed on the subject on March 12, 2010. During that briefing, his handwritten notes indicate that the topic of long gun reporting was discussed within the context of Operation Fast and Furious.

A. Why has the Department failed to respond to my July 12, 2011, letter?

Response:

The Department has responded to your letter. *See Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa and Senator Charles E. Grassley (Dec. 13, 2011).*

B. As Chairman Issa and I asked in that letter, is there any other evidence suggesting that ATF or DOJ officials discussed how Operation Fast and Furious could be used to justify additional regulatory authorities for the ATF? If so, please provide such evidence to the Committee.

Response:

The Department's response to your letter attached documents reflecting ATF's concerns regarding multiple sales of long guns. As you know, earlier this year a federal district judge upheld ATF's authority to require federal firearms licensees in the four Southwest Border states to report multiple sales of certain long guns.

1. Are there any such indications prior to the March 12, 2010, briefing?

Response:

Please see response to question 20(B), above.

a. Rather than collecting additional information on law-abiding gun owners, what steps have you taken to ensure that the ATF is better able to act on the information it already possesses to interdict the flow of firearms to criminals?

Response:

ATF has clarified its firearms transfer policy, implemented a new monitored case program, and revised its policies regarding the use of confidential informants and undercover operations. These reforms, as well as others, are described more fully in Deputy Attorney General James M. Cole's January 27, 2012 letter to Chairman Leahy and other members. In addition, as the Attorney General has previously testified, and as ATF witnesses appearing before the House Committee on Oversight and Government Reform have testified, ATF's ability to stem the illegal flow of weapons to Mexico would be enhanced if Congress provided additional tools necessary for ATF to carry out its mission more effectively. These tools include additional funding so that ATF can increase the number of agents along the Southwest Border; confirmation of the President's nominee to be Director of ATF; and enactment of a federal firearms trafficking statute with more stringent penalties for straw purchasers.

21. Fraud Cases**Questions:**

- A. Please provide an annual breakdown of the number of health care fraud cases initiated Department-wide from 2001 to the present, including the number of cases to date in 2011.**

Response:

Department of Justice attorneys in the Civil and Criminal Divisions and the United States Attorney's Offices, working with the FBI and the HHS-OIG and other investigative partners, investigate and prosecute numerous health care fraud matters every year. Although the Department does not use the terminology "cases initiated," we report below on cases in which criminal charges were filed in court. It is not unusual for more than one defendant to be charged in a criminal case so the number of individuals who were charged with criminal offenses may be higher.

In addition, we report below on civil cases which were filed in court by the United States or qui tam relators which were settled or resolved by a court judgment, as well as matters which were initiated by the Department but were resolved by a settlement without any court filing. These matters are listed in the fiscal year in which they were finally resolved (*e.g.*, a case including multiple settlements over several years is listed only in the fiscal year of the final settlement).

	Criminal Cases Filed	Civil Cases (Settlement or Court Judgment)
FY 2001:	445	259
FY 2002:	361	237
FY 2003:	362	298
FY 2004:	395	215

FY 2005:	382	187
FY 2006:	355	187
FY 2007:	434	208
FY 2008:	502	254
FY 2009:	481	225
FY 2010:	488	263
FY 2011:	489	242

B. Please provide an annual breakdown of the revenue generated from any health care fraud cases Department-wide from 2001 to the present, including the revenue to date in 2011.

Response:

Revenue generated from health care fraud cases is recorded in the Department's Consolidated Debt Collection System (CDCS). The "Collections" reported below are actual moneys paid to the Government pursuant to litigation and enforced collection by the Department as reported in CDCS. It does not include civil or administrative penalties imposed and collected by other agencies such as HHS. The collections are reported according to the year in which they were collected which may differ from the year the settlement agreement was reached or the court judgment was imposed.

CDCS is the Department of Justice's Department-wide financial litigation and collection system. It supports the collection efforts of the US Attorney's Offices, the Department's Litigating Divisions, and Private Counsel under contract with the Department to litigate and collect on behalf of the United States. The CDCS was fully deployed at the beginning of Fiscal Year (FY) 2008 in all judicial districts across the country and its territories. Prior to FY 2008, there was no centralized DOJ collection system and each component within the Department maintained its own system. Although each component may have recorded information differently prior to FY 2008 depending on its own requirements, historical data was collected from these systems and entered into CDCS and is reported below.

Collections in Health Care Fraud Cases

FY 2001	\$519 M
FY 2002	\$1.5 B
FY 2003	\$900 M
FY 2004	\$ 1.4 B
FY 2005	\$ 786 M
FY 2006	\$ 1.7 B
FY 2007	\$1.6 B
FY 2008	\$1.1 B
FY 2009	\$2.2 B
FY 2010	\$3.2 B
FY 2011	\$ 2.9 B

- C. Please provide an annual breakdown of the number of mortgage fraud cases initiated Department-wide from 2001 to the present, including the number of cases to date in 2011.**

Response:

Department of Justice attorneys in the Civil and Criminal Divisions and the United States Attorney's Offices, working with the FBI and other investigative partners, investigate and prosecute numerous mortgage fraud matters every year. Although the Department does not use the terminology "cases initiated," we report below on cases in which criminal charges were filed in court. It is not unusual for more than one defendant to be charged in a criminal case so the number of individuals who were charged with criminal offenses may be higher. The Department's case management systems did not differentiate mortgage fraud cases from other types of fraud cases prior to 2008, so the report below reflects data from 2008 through 2011 only. In addition, the Department is unable to provide a reliable number of civil mortgage fraud cases because the case management system used by the United States Attorney's Offices does not track civil mortgage fraud cases.

Criminal Mortgage Fraud Cases Filed

FY 2008	88
FY 2009	248
FY 2010	656
FY 2011	523

- D. Please provide an annual breakdown of the revenue generated from any mortgage fraud cases Department-wide from 2001 to the present, including the revenue to date in 2011.**

Response:

Revenue generated from mortgage fraud cases is recorded in the Department's Consolidated Debt Collection System (CDCS), which is used by all Department components involved in the federal debt collection process. Mortgage fraud collections were not tracked apart from other types of fraud causes until fiscal year 2009.

The "Collections" reported below are actual moneys paid to the Government pursuant to litigation and enforced collection by the Department as reported in CDCS. It does not include civil or administrative penalties imposed and collected by other agencies. The collections are reported according to the year in which they were collected which may differ from the year the settlement agreement was reached or the court judgment was imposed.

Collections in Mortgage Fraud Cases

FY 2009	\$1.2 M
FY 2010	\$2 M

FY 2011 \$7.1 M

- E. Please provide an annual breakdown of the number of procurement fraud cases initiated Department-wide from 2001 to the present, including the number of cases to date in 2011.**

Response:

Department of Justice attorneys in the Civil and Criminal Divisions and the United States Attorney's Offices, working with the FBI and other investigative partners, investigate and prosecute numerous procurement fraud (PF) matters every year. Although the Department does not use the terminology "cases initiated," we report below on cases in which criminal charges were filed in court. It is not unusual for more than one defendant to be charged in a criminal case, so the number of individuals who were charged with criminal offenses may be higher.

In addition, we report below on civil cases, which were filed in court by the United States or qui tam relators, which were settled or resolved by a court judgment, as well as matters which were initiated by the Department but were resolved by a settlement without any court filing. These matters are listed in the fiscal year in which they were finally resolved (e.g., a case including multiple settlements over several years is listed only in the fiscal year of the final settlement).

	Criminal PF Cases Filed	Civil PF Cases (Settlement or Court Judgment)
FY 2001	131	21
FY 2002	116	22
FY 2003	113	25
FY 2004	104	19
FY 2005	85	22
FY 2006	103	22
FY 2007	108	27
FY 2008	105	29
FY 2009	100	18
FY 2010	109	26
FY 2011	121	25

- F. Please provide an annual breakdown of the revenue generated from any procurement fraud cases Department-wide from 2001 to the present, including the revenue to date in 2011.**

Response:

Revenue generated from procurement fraud cases is recorded in the Department's Consolidated Debt Collection System (CDCS). The "Collections" reported below are actual moneys paid to the Government pursuant to litigation and enforced collection by the Department as reported in CDCS. It does not include civil or administrative penalties imposed and collected

by other agencies. The collections are reported according to the year in which they were collected which may differ from the year the settlement agreement was reached or the court judgment was imposed.

CDCS is the Department of Justice's Department-wide financial litigation and collection system. It supports the collection efforts of the US Attorney's Offices, the Department's Litigating Divisions, and Private Counsel under contract with the Department to litigate and collect on behalf of the United States. The CDCS was fully deployed at the beginning of Fiscal Year (FY) 2008 in all judicial districts across the country and its territories. Prior to FY 2008, there was no centralized DOJ collection system and each component within the Department maintained its own system. Although each component may have recorded information differently prior to FY 2008 depending on its own requirements, historical data was collected from these systems and entered into CDCS and is reported below.

Collections in Procurement Fraud Cases

FY 2001	\$ 19M
FY 2002	\$ 33 M
FY 2003	\$ 51M
FY 2004	\$ 27 M
FY 2005	\$ 13 M
FY 2006	\$ 603 M
FY 2007	\$ 24 M
FY 2008	\$ 87 M
FY 2009	\$53 M
FY 2010	\$ 29 M
FY 2011	\$ 57M

22. Housing Testing Program in the Civil Rights Division's Housing and Civil Enforcement Section

Questions:

- A. What criteria must an individual meet in order to be a tester in the Housing Testing Program?**

Response:

The Fair Housing Testing Program accepts recruit forms from all non-attorney Department of Justice employees who are interested in assisting with fair housing and other civil rights investigations by serving as testers in these investigations. Interested employees are invited to attend a three-hour tester training session once prior approval has been obtained from their supervisors. The tester training sessions are led by Test Coordinators who work for the Fair Housing Testing Program. Each prospective tester completes a Tester Application Form and is interviewed individually by a Test Coordinator. Department employees who are selected to

participate as testers must also complete a “practice” test as part of their training. Once trained, Department employees are selected to assist in a testing investigation based on whether they have the specific characteristics relevant to the investigation. In addition, selection is always contingent upon receiving prior approval from a supervisor releasing the employee from his or her regular duties for the time required to participate in a testing investigation.

When the Department uses a local contractor to facilitate a testing investigation, all testers recruited by the contractor must attend a three-hour tester training session led by Test Coordinators who work for the Fair Housing Testing Program. Each prospective contract tester completes a Tester Application Form and is interviewed individually by a Test Coordinator. Prospective contract testers who are selected to participate as testers must also complete a “practice” test as part of their training. Once trained, contract testers are selected to participate in a testing investigation based on whether they possess the specific characteristics relevant to the investigation.

- B. At what level within the Housing and Civil Enforcement Section must individuals be approved in order to become testers for the Housing Testing Program?**

Response:

Test Coordinators who work for the Fair Housing Testing Program approve all DOJ and contract testers.

- C. What is the process for individuals becoming approved to be testers for the Housing Testing Program?**

Response:

Please see responses to questions 22(A) and (B), above.

- D. At what level within the Housing and Civil Enforcement Section must contractors be approved for the Housing Testing Program?**

Response:

The Director of the Fair Housing Testing Program identifies potential contractors if and when a contractor is needed to facilitate a testing investigation. The Deputy Chief who oversees the Fair Housing Testing Program and the Section Chief both must give their approval before the Director of the Fair Housing Testing Program may send a potential contractor a Statement of Work, describing the work to be performed. If the Director of the Fair Housing Testing Program sends a Statement of Work to a potential contractor and receives an appropriate proposal in return, the Director of the Fair Housing Testing Program submits the Statement of Work and Proposal to the Civil Rights Division’s Comptroller for consideration and approval.

- E. What is the process for contractors being approved for the Housing Testing Program?**

Response:

Please see response to question 22(D), above.

- F. What safeguards exist to ensure that travel in the Housing Testing Program is limited to the dates on which testing is conducted?**

Response:

The Fair Housing Testing Program has protocols in place to ensure that travel related to the Testing Program is limited to what is needed to accomplish the work required in each investigative trip. The Director of the Fair Housing Testing Program reviews and the Deputy Chief who oversees the Fair Housing Testing Program approves all travel authorizations for Test Coordinators and Testers. Following travel, the Director of the Fair Housing Testing Program reviews the Test Coordinator and Tester travel vouchers to ensure that they are consistent with what was authorized.

- G. What was the contractor budget for the Housing Testing Program for fiscal years 2010 and 2011?**

Response:

The Fair Housing Testing Program operates within the Housing and Civil Enforcement Section and does not have a separate budget. The Civil Rights Division, however, is able to capture all contractor costs associated with the program. The amounts listed below represent actual contractor expenditures.

FY 2010- \$98,196
FY 2011- \$89,103

- H. What is the proposed contractor budget for the Housing Testing Program for fiscal year 2012?**

Response:

The Fair Housing Testing Program operates within the Housing and Civil Enforcement Section and does not have a separate budget. The Civil Rights Division, however, is able to capture all contractor costs associated with the program. In FY 12, the program projects spending \$70,000; however no contracts have been received as of yet, except those that carry over from FY 2011.

- I. For each fiscal year from 2005 to 2011, what was the overall budget of the Housing Testing Program, including the travel budget for Department employees?

Response:

The Fair Housing Testing Program operates within the Housing and Civil Enforcement Section and does not have a separate budget. As such, the amounts listed below represent actual expenditures related to the program. The Civil Rights Division is able to capture all non-personnel costs associated with the program. These amounts include costs related to travel, contractors, and equipment as well as items such as voicemail, printing, and supplies. The Division, however, does not capture or track its personnel costs down to the level of detail for a specific program within a Section. Therefore, the Division is not able to provide personnel costs.

FY 2005 – \$275,964
 FY 2006 – \$315,844
 FY 2007 – \$445,333
 FY 2008 – \$442,335
 FY 2009 – \$423,598
 FY 2010 – \$387,375
 FY2011 – \$340,889

- J. For each fiscal year from 2005 to 2010, what were the actual overall expenditures in the Housing Testing Program, including the expenditures by Department employees?

Response:

Please see responses to question 22(I), above.

23. Misuse of Department Funds

Questions:

- A. When OIG finds Department employees guilty of using official funds for personal purposes, is there any internal mechanism for recovering those funds from the employee if the U.S. Attorney declines to prosecute the case?

Response:

Yes, it is the Department's policy to recoup money where it has determined that the use of funds was improper.

B. Are employees typically required to repay taxpayer funds when the OIG finds them guilty of using official funds for personal purposes?

Response:

The Department does not tolerate misuse of official funds. It is Department policy to recoup money where it has determined that the use of funds was improper.

Politicized Hiring in the Civil Rights Division

24. In response to my letter regarding reports of politicized hiring within the Department of Justice Civil Rights Division, your Assistant Attorney General responded that “[t]he examples of prior employment cited in these blog posts and your letter noting, for example, that numerous new hires for the Civil Rights Division had previously worked for civil rights organizations - reflect nothing more than that,” and further dismisses any claim that Civil Rights Division uses the affiliation of candidates with liberal organizations to determine their political party and hire them on that basis. However, you yourself have been reported as having said to a convention of the American Constitution Society (ACS), prior to taking office, “we are going to be looking for people who share our values” and a “substantial number of those people” would probably be “members of the ACS.” Assistant Attorney General Perez took this a step further, saying, “I am going to be calling each and every one of you to recruit you, because we’ve got 102 new positions in our budget”

A. Beginning January 1, 2009, has the Civil Rights Division hired a single person affiliated with institutions that might be considered conservative? If so, please identify the number of individuals and the name of the institution each was affiliated with.

Response:

As described in the Department’s September 8, 2009, letter to you, the Department has taken significant steps to ensure that hiring of career employees is based on each individual’s qualifications for the job, divorced from political considerations. The Division has instituted new policies that are founded on the fundamental principle that merit, not political affiliation or ideology, must guide hiring decisions for career positions.

The Division’s merit-based hiring policy expressly precludes consideration of ideology or political affiliation in hiring. As would any responsible employer, the Division places a high value on an individual’s relevant experience in the field, as well as a demonstrated commitment to full and fair enforcement of civil rights laws when making hiring decisions. To that end, the Division has hired people from a variety of legal backgrounds – from large and small law firms; lawyers with experience working at civil rights organizations as well as the Judge Advocate General (JAG) Corps; individuals who have worked as prosecutors and others who have worked

as criminal defense lawyers; and lawyers who have clerked or externed for judges appointed by every president since President Carter.

Because the Division does not inquire about the ideological or political affiliation of these applicants, but inquires instead into whether they are the best-qualified applicants for the position, we are not in a position to answer your question about our employees' political or ideological affiliations. Not only do the Division's policies prohibit consideration of an individual's organizational affiliations in hiring, but the Division also does not know the organizational affiliations of candidates beyond what is disclosed by the candidates themselves, for example, on their resumes, because the Division's current policy expressly prohibits conducting any internet searches on applicants' backgrounds. For additional information on the Division's hiring process, please see the attached letter to Chairman Smith, dated December 5, 2011. (See attachment A.)

B. Beginning January 1, 2009, how many individuals affiliated with institutions widely considered as liberal or progressive has the Civil Rights Division hired?

Response:

Please see the answer and attachment provided in response to question 24(A), above. The Division's revised hiring process expressly rejects the kind of assessment that underlies this question.

C. Beginning January 1, 2009, how many individuals affiliated specifically with ACS has the Civil Rights Division hired?

Response:

Please see the answer and attachment provided in response to question 24(A), above.

D. Beginning January 1, 2009, how many individuals who made contributions to the election campaign of President Obama has the Civil Rights Division hired?

Response:

Please see the answer and attachment provided in response to Question 24(A), above, and the attached letter to Chairman Smith. It is against the Division's policies to obtain or consider such information as a part of the hiring process described in the above response and in detail in the attached letter.

E. If politicized hiring has not been occurring, how does the Department account for the fact that every single one of the new attorneys hired in the Civil Rights Division in the first two years of this Administration has had liberal or progressive credentials?

Response:

The Department respectfully disagrees with the premise of this question. Please see response to question 24(A), above, and the attached letter to Chairman Smith.

F. According to the New York Times, 60 percent of the Civil Rights Division's hires in the first two years of this Administration had ideological credentials, more than double the proportion in the Bush Administration, during which the New York Times indicated the number was under 25 percent. Are the New York Times' numbers accurate? If not, please provide accurate numbers.

Response:

With respect to the current Administration, please see the answer to Question 24(A), above, and the attached letter to Chairman Smith. With respect to the previous Administration, a report from OIG and OPR entitled "An Investigation of Allegations of Politicized Hiring and Other Improper Personnel Actions in the Civil Rights Division," (July 2, 2008) (Released Publicly January 13, 2009) (OIG/OPR Report), found that between 2003 and 2006, Bradley Schlozman, who was a Deputy and later a Principal Deputy and Acting Assistant Attorney General within the Civil Rights Division, considered political and ideological affiliations in making personnel decisions, in violation of Department policy and federal law. The report noted that several other political appointees had knowledge or some indication of Mr. Schlozman's improper consideration of political and ideological affiliations and failed to take action to ensure that hiring decisions were consistent with federal law and Department policy. Of the 13 hires (out of 112) during the period in question that were not attributed to Mr. Schlozman, four were identified in the OIG/OPR report as conservative, three as liberal, and six as unknown.

G. How do these numbers not indicate the presence of a double standard given the criticism leveled at the Bush administration's Civil Rights Division?

Response:

Please see responses to questions 24(A)-(F), above.

H. What steps are currently being taken by the Department to attract an ideologically diverse applicant pool to the Civil Rights Division?

Response:

The Civil Rights Division has taken a number of steps during Assistant Attorney General Perez's tenure to ensure a broad-based, qualified applicant pool. The Division now requires that all attorney vacancies: 1) be publicly advertised on the websites of the Office of Personnel Management (www.usajobs.gov), the Department of Justice, and the Division. The Division also now affirmatively appraises all Division employees of job vacancies and invites all

employees to notify organizations of these openings. In addition, the Division's public website invites interested organizations to receive vacancy announcements, stating:

Announcements are also distributed by the Office of Attorney Recruitment and Management and/or by the Division's Human Resources Office to a broad and diverse array of organizations, including but not limited to bar associations, law schools and professional organizations. Sections may also distribute announcements to additional organizations who may know of qualified candidates for a particular vacancy announcement. To expand our recruitment efforts, the Civil Rights Division is developing an outreach list of organizations to receive Civil Rights Division-specific attorney job announcements. Organizations that might be interested in receiving these announcements may e-mail CRT.SpecProgVacancies@usdoj.gov.

<http://www.justice.gov/crt/employment/>.

Assistant Attorney General Perez and other Department officials have visited and addressed law schools and legal organizations across the country to recruit for the Division and to ensure a large pool of well-qualified applicants. In addition, the job announcements that were developed and sent out pursuant to the Division's new hiring policies were, at Mr. Perez's direction, widely disseminated without regard to the ideology or political affiliation of the recipients of the announcements.

Conference Expenditures

25. The Department's inspector recently issued a report on the tremendous increase in expenditures for conferences that has occurred at the Department on your watch, from \$47.8 million in 2008 to \$91.5 million in taxpayer dollars in 2010, the most recent available year. This is nearly a doubling of conference expenditures in the past two years. This level of growth is astonishing given our nation's current fiscal crisis and the \$14 trillion national debt.

A. Why have conference expenditures at the Department doubled in the last two years?

Response:

This question is addressed in our March 2, 2012 response to your letter to the Attorney General dated December 20, 2011. (See attachment B.)

B. How can you explain this increase in conference expenditures given the tremendous budget crisis the government is now facing?

Response:

Please see our March 2, 2012 response to your letter to the Attorney General dated December 20, 2011.

C. How much money did the Department spend on conferences in FY2011?

Response:

In our March 2, 2012 response to your letter to the Attorney General dated December 20, 2011, based upon information available at the time, we had determined that the Department had spent \$64.5 million on conferences in FY 2011, which would have been a reduction of \$27.1 million or 30%, from FY 2010. Updated information reflects that we reduced spending by \$26 million from FY 2010 to FY 2011, a reduction of 29%.

D. How much money does the Department anticipate spending on conferences for FY2012?

Response:

Please see our March 2, 2012 response to your letter to the Attorney General dated December 20, 2011.

E. What are you doing to reduce these expenditures?

Response:

Please see our March 2, 2012 response to your letter to the Attorney General dated December 20, 2011.

F. In FY 2008 Department of Justice conference expenditures were nearly \$48 million. It appears the FBI alone spent nearly \$47 million on conferences in FY2010. Why has the FBI increased conference expenditures to a level equal to that of the entire Department in FY 2008?

Response:

Under the applicable federal regulations (41 C.F.R. § 300-3.1 and 5 C.F.R. § 410.404), conferences include training activities designed to improve individual and/or organizational performance. Conferences are a vital aspect of developing and maintaining a responsive and well-trained law enforcement workforce, and a well-coordinated federal, state, local, and tribal criminal justice system. The majority of the FBI's "conferences" are operational training events for our law enforcement staff – essential training such as money laundering prevention, firearms qualification, DNA forensic examination, defensive tactics, surveillance, narcotics investigation, telecommunication exploitation, and other training designed to improve operational performance. This type of conference-related expenditure is critical to the FBI's mission.

Lawsuits Against States with Pro-Enforcement Laws

26. Your department has filed suit against the states of Arizona, Alabama and South Carolina for their immigration enforcement laws. It's reported that your department is considering challenges against Utah, Indiana and Georgia. Meanwhile, some cities and local jurisdictions are enacting policies and practices that expressly prohibit law enforcement from cooperating with the federal government when it comes to undocumented immigrants. Cook County, Illinois, for example, is ignoring ICE requests to hold individuals, letting criminals back into society and posing a threat to public safety.

A. Would you agree that Cook County's policy to ignore federal immigration detainees is a threat to national security?

Response:

Under the Immigration and Nationality Act and its implementing regulations, the Department of Homeland Security is responsible for determining how and under what circumstances it will use detainees as part of its immigration enforcement regime. It is in the best position to determine whether Cook County's policy regarding detainees conflicts with existing law and its practice with respect to detainees in Cook County or elsewhere.

B. What steps has your Department taken to encourage Cook County to reverse its ordinance? If none – will you get involved?

Response:

Please see response to Question 26 (A), above. The Department of Justice is aware of ongoing communications between DHS and Cook County regarding detainees. The Department of Justice is not directly involved in those communications.

C. Would you instruct your Department to withhold funding for localities, like Cook County, who defy immigration law and willfully not cooperate with the federal government when it comes to immigration enforcement?

Response:

We cannot speculate about what action, if any, we would take in this particular context. As we have noted elsewhere, however, it is imperative that state and local governments cooperate with the federal government with respect to immigration enforcement. The state laws that we have challenged are clearly preempted by federal law.

Costs of Litigation Against States

27. According to a Quinnipiac poll released yesterday, 61 percent of American's support Arizona's immigration law that your Department is asking the courts to nullify, and 59 percent of Americans want an Arizona-style law in their own state. I believe those numbers are an indictment of this administration's refusal to enforce our immigration laws. Nevertheless, on October 31st, the Justice Department announced that it plans to sue the State of South Carolina to enjoin its immigration law.

A. How much has the Department spent in litigating against the State of Arizona?

Response:

The Department has spent roughly \$385,020 in litigation against the State of Arizona. The U.S. Attorney's Office for the District of Arizona participated in this litigation with the other components of the Department; however, the U.S. Attorney's Offices do not record the costs of litigating individual cases.

B. How much has the Department spent in litigating against the State of Alabama?

Response:

The Department has spent roughly \$159,000 in litigation against the State of Alabama. The U.S. Attorney's Office for the Northern District of Alabama participated in this litigation; however, the U.S. Attorney's Offices do not record the costs of litigating individual cases.

C. How much has the Department spent in litigating against the State of South Carolina?

Response:

The Department has spent roughly \$34,357 in litigation against the State of South Carolina. The U.S. Attorney's Office for the District of South Carolina participated in this litigation; however, the U.S. Attorney's Offices do not record the costs of litigating individual cases.

Ensuring Schools Educate Undocumented Students

28. Very recently, the Civil Rights Division sent a letter to Alabama school districts about their obligation to give equal access to public education to children who are

here illegally. The letter to Alabama Superintendents requested names of all students, including those who had unexplained absences and those who were "English Language Learners."

A. Is your Department targeting Alabama because they have a stricter state law that deals with illegal immigrants? Were there reports of wrongdoing?

Response:

The Civil Rights Division has the obligation to enforce laws that prohibit discrimination against public school students on the basis of, among other things, race, color, and national origin, *see* 42 U.S.C. § 2000c-6 (Title IV), and that require school districts to take appropriate action to overcome the language barriers of English Language Learner (ELL) students. *See* 20 U.S.C § 1703 (Equal Educational Opportunities Act). As the Division's October 31, 2011 letter to Alabama school districts noted, we have received information raising concerns that H.B. 56 may be preventing or discouraging students from participating in public education programs based on their or their parents' race, national origin, or actual or perceived immigration status. The Division contacted school districts and requested information based on those concerns and in furtherance of the Division's obligation to investigate potential violations of Federal civil rights laws.

B. What does your Department plan to do with the names and the data provided by the Alabama schools, if they choose to comply with your request?

Response:

We cannot comment on an open and ongoing investigation. The Department requested the information to assist in determining what further action, if any, is warranted under the civil rights laws we enforce. Where violations are found, the Department will act vigorously to enforce Federal statutory and constitutional law guaranteeing all students equal access to public education.

The Department will maintain the confidentiality of any private student information received. The United States is authorized to receive documents containing private student information pursuant to the federal law enforcement exception to the privacy requirements in Family Educational Rights and Privacy Act (FERPA). *See* 20 U.S.C. § 1232g (b)(1)(C)(ii).

C. Will you commit to making sure school districts that don't comply with your request are not punished or singled out?

Response:

The Department does not punitively single out school districts. The Department will continue to act vigorously and appropriately in carrying out its obligation to investigate potential violations of Federal civil rights law.

Memo Issued by Office of Legal Counsel Regarding Anwar al-Awlaqi

29. **Eliminating a terrorist threat certainly helps to ensure the safety of the American people. Engaging those threats on the battlefield is a byproduct of our continued war on terrorism. However, I want to confirm that when we encounter an American terrorist overseas, we have the legal authority to conduct operations that specifically target American citizens even when they are engaged in terrorist activity. I understand there is an obvious balance between fighting the war on terrorism and protecting the Constitutional rights of American citizens. Therefore, I want to understand the legal rationale behind the Department of Justice's opinion that essentially authorized the U.S. military to target an American citizen.**

I recently wrote to you regarding Anwar al-Awlaqi, an American born citizen, a senior leader, recruiter, and motivator with the Islamist militant group al-Qaeda. I asked for a copy of the secret memorandum issued by Department's Office of Legal Counsel (OLC) that allegedly authorized the operation which resulted in the death of Anwar al-Awlaqi. I also offered to make appropriate arrangements if the memo was classified.

Will you commit today to providing me and this committee a copy of the OLC Memo that addressed the operation targeting Anwar al-Awlaqi? If not, why not?

Response:

The Department, when responding to requests on this topic, has not addressed the question whether there is an Office of Legal Counsel opinion in this area. The Department understands the Committee's interest in the legal issues, and will, to the extent possible, work with the Committee to assist in the process of answering questions that its members have in an appropriate setting.

Transfer of a Terrorist into the U.S.

30. **Ali Mussa DaqDuq is an enemy combatant captured overseas. He has played a prominent role in terrorist activities against the United States as a senior Hezbollah commander. Suffice it to say, bringing him to the United States to stand before an Article III court defies common sense. This individual does not deserve the rights afforded to American citizens. The American people do not want you bringing in terrorists, who will then potentially be released into American society if they're not convicted. And you of course cannot guarantee a guilty verdict or lifetime sentence. Thus, if ever someone deserved to be tried before a military commission, it would be this terrorist. Furthermore, delaying this decision could result in DaqDuq's release to Iraq which could have grave consequences as he could simply walk free and resume his terrorist activities against the United States.**

On May 16, 2011, I – along with 5 other Senators - wrote to you and expressed my concerns with bringing DaqDuq to the United States. The response sent back by your office was essentially a non-answer. The letter merely stated that you “remain committed to using all available tools to fight terrorism, including prosecution in military commissions or Article III courts, as appropriate.”

A. The fact is, if you won't consider Guantanamo Bay, then you're really not considering all available tools, are you?

Response:

Ali Mussa Daqduq is no longer in U.S. custody and is currently being held by the Government of Iraq. The Iraqis have an ongoing investigation into Daqduq's criminal activities committed on Iraqi soil. The United States has delivered an extradition request to the Government of Iraq, which is making its way through the Iraqi legal process.

The President has determined that it is in the national security interests of the United States to close the detention facility at Guantanamo Bay. This position, which has been supported by our military leadership and many in both political parties, is based on the judgment that maintaining the Guantanamo Bay facility and sending additional detainees to it would undermine international counterterrorism cooperation and continue to be used by extremists to justify terrorist acts.

B. Do you believe enemy combatants captured overseas should be afforded the same rights as American citizens? If so, do you believe that extends to granting them asylum if they're found not guilty in an Article III court proceeding?

Response:

The legal protections that must be afforded to captured terrorists vary depending on the authority under which they are held and where they are held. For example, those held as detainees under the law of war at Guantanamo Bay have the right to petition for habeas corpus, and the U.S. Government must prove that such individuals are part of or substantially supporting al Qaeda, the Taliban or associated forces. The courts have developed evidentiary and other procedural rules for habeas proceedings involving Guantanamo Bay detainees that afford the detainees certain legal protections. Such individuals must also be released when hostilities end, unless the United States decides to prosecute them for war crimes or other crimes triable by military commission. Those tried by military commission must be afforded the legal protections established by Congress in the Military Commissions Act of 2009, including, among other protections, the right to counsel; the presumption of innocence; the right against self-incrimination; the right to present evidence, cross-examine the government's witnesses and compel the attendance of witnesses in their defense; the right to exculpatory evidence; the right to suppression of evidence that is not probative or that will result in unfair prejudice; protection against double jeopardy; and the right to an appeal. Those tried in federal court must be afforded

similar rights, many of which are secured by the Constitution in that context, but there are some rules, such as the requirement for a unanimous jury verdict and the rules for admission of custodial statements of the accused, that are different.

Since 2001, we have successfully prosecuted hundreds of individuals in terrorism-related cases in our federal courts, including many who were first apprehended overseas. Many of the convictions have resulted in long sentences, including life sentences for the most serious cases. Those convicted are held safely and securely in our federal prisons. In the event an alien terrorism defendant were brought to the United States to stand trial and were acquitted, the Department of Homeland Security would detain him and begin the process of removing him from the country. Non-citizens brought to the United States for trial are paroled into the country solely for that purpose. When that purpose no longer exists, their authority to remain in the United States ends as well.

FBI Whistleblowers

31. **As you are well aware, I am a long-standing advocate for whistleblower rights. Whistleblowers point out fraud, waste, and abuse when no one else will, and they do so while risking their professional careers. Retaliation against whistleblowers should never be tolerated.**

Agent Jane Turner was a career FBI agent with an outstanding record for conducting investigations involving missing and exploited children. She filed a whistleblower complaint with the Department's Office of the Inspector General (OIG), in 2002 when she discovered that FBI agents removed items from Ground Zero following the terrorist attacks of 9/11.

Robert Kobus is a 30 year non-agent employee of the FBI who disclosed time and attendance fraud by FBI agents. The OIG also conducted an investigation into his allegations and substantiated that he was retaliated against for protected whistleblowing. The FBI management not only demoted Mr. Kobus to a non-supervisory position, but they even moved him to a cubicle on the vacant 24th floor of the FBI's office building.

Agent Turner and Mr. Kobus have cumulatively seen their investigations take 13 years to complete. Unfortunately, a final judgment has not been issued for either case. These excessive delays indicate that the process of adjudicating whistleblower claims at the Department of Justice is broken.

- A. In your opinion, what is an appropriate amount of time to conduct a whistleblower complaint investigation?**

Response:

Under the FBI whistleblower regulations, the investigating office is required to determine within 240 days whether there are reasonable grounds to believe that there has been or will be a reprisal for a protected disclosure, unless the complainant agrees to an extension. It is difficult to specify a generally appropriate time to conduct an investigation because particular investigations vary greatly in their degrees of difficulty and complexity, and the extent to which the investigating entity encounters cooperation or obstacles.

- B. Would you agree that 9 years is an excessive amount of time to conduct such an investigation? What about 4 years?**

Response:

See response to 31(A), above. The Department is unaware of any investigation that by itself took the amount of time cited. However, an investigation is only the first step in the whistleblower process. Seeking corrective action for a reprisal then requires filing with the adjudicative office. These are adversarial proceedings, and varying circumstances and complexities of a case can affect the time for final resolution of a matter.

- C. Is 9 years an excessive amount of time to determine if a whistleblower has suffered reprisal as a result of their allegations? What about 4 years?**

Response:

It depends on the facts and circumstances of each individual case.

- D. Could you explain why it has taken 9 years to resolve Agent Turner's whistleblower complaint?**

Response:

The case processing time for a particular FBI whistleblower case is dependent upon a number of factors, including: the complexity of the legal and factual issues presented; the time for and extent of discovery, as well as the time for the parties' respective briefs on the issues; the number and procedural posture of cases pending on the docket at one time; whether the parties proceed to a hearing before the Director of the Office of Attorney Recruitment and Management (OARM), where the parties have the opportunity to call and cross-examine witnesses; and the time required for the Department to prepare and issue written decisions.

Another important factor causing delay occurs when an employee/complainant seeks to stay proceedings in a whistleblower matter pending resolution of claims concurrently filed in alternate legal or administrative forums (e.g., Title VII and EEO claims). Extensions of deadlines for discovery and submissions of pleadings by the parties also add time to the process.

Recognizing the importance of whistleblower claims, the Department has tried to give every procedural leeway to employee/complainants to vindicate their rights. At the same time, we recognize the importance of timely resolution of such claims. Therefore, the Department recently adopted a number of changes designed to decrease case processing time. These changes are described in F below.

- E. Can you explain why Mr. Kobus' case has now languished in bureaucratic red tape for approximately 4 years?**

Response:

Please see response to 31(D), above.

- F. Will you commit to reviewing the aforementioned matters and ensure that the Office of Attorney Recruitment and Management (OARM) and the Deputy Attorney General conduct their respective reviews of whistleblower complaints in a more transparent and expeditious manner?**

Response:

As indicated in the Department's response to your November 14, 2011 letter to the Attorney General (see attachment C) the Department has recently implemented several changes to improve the effective and efficient adjudication of FBI whistleblower cases. In addition to procedural changes designed to shorten resolution time, the Department has added a detailee to the adjudicating office who has extensive whistleblower adjudication experience. The Department will closely monitor the effect of these changes and is committed to making every effort to improve the efficiency of the Department's adjudication of FBI whistleblower cases.

Office of Legal Policy

- 32. The last time that you appeared before the Committee, I asked you questions concerning the operation of the Office of Legal Policy (OLP). I do not consider your answers to my previous questions to be responsive. I hope that you will be more responsive on this occasion.**
- A. Despite a Department-wide freeze, OLP sought an exemption, and it received your permission to hire an additional four attorneys. These staffing levels are not appropriate in light of underutilized attorneys under the prior authorization levels.**
- 1. Please provide a copy of the materials that OLP submitted to the Justice Management Division (JMD) in support of its exemption request.**

Response:

OLP sought an exemption from the hiring freeze, pursuant to established procedures, in light of its significant responsibilities and workload, combined with the fact that it had five vacancies among its relatively small number of attorney positions.

As the Department informed you in its letter of September 8, 2011, though we were pleased to provide you with a full list of case-by-case exception requests and decision outcomes, we are unable to provide the internal documents relating to those matters. The Department has certain confidentiality interests in the underlying documents because they set forth advice and recommendations to the Deputy Attorney General and, in some instances, implicate the confidentiality interests of employees.

2. **Please provide a copy of materials surrounding JMD's review and approval of OLP's request.**

Response:

Please see the response to 32(A)(1), above.

3. **Please provide a copy of materials surrounding the Office of the Attorney General's review and approval of OLP's request.**

Response:

Please see response to 32(A)(1), above.

- B. **The Assistant Attorney General for OLP, Mr. Schroeder, while a nominee for that position, insisted on the appointment of a particular appointee, who to the knowledge of the career employees, produced no work. He did not come to work two days per week at a time when OLP had no policy concerning telecommuting. In the entire month of December, 2009, this employee did not spend a single day at his OLP office. The OLP career attorneys allowed him to do so if he complied with various requirements that documented the work he produced. He did not do so. After one year of producing no work at OLP, this employee left the Department of Justice for a position in private life, whereupon AAG Schroeder sought to provide this individual with a consulting contract.**

1. **Has anyone at the Department of Justice undertaken any investigation into these facts?**

Response:

The preface to the question is not factually accurate. The employee in question performed valuable work during his time at the Office of Legal Policy, including judicial nominations vetting work and assignments involving policy issues related to international law

and affairs. The employee performed that work regularly and pursuant to accepted office procedures. Accordingly, an investigation has not been initiated.

2. If so, what were the findings of the investigation?

Response:

Please see response to 32(B)(1), above.

3. Was any follow up undertaken? If so, what actions were recommended and carried out?

Response:

Please see response to 32(B)(1), above.

4. Do you believe that an OIG or OPR investigation is warranted into these facts?

Response:

For the reasons given in response to question 32(B)(1), above, the Department has not initiated an investigation.

33. Travel Card Use in the Department

Questions:

A. Does the Department have any written policies on the issuance and/or use of travel cards? If so, please provide copies of such written policies.

Response:

The Department has the following written policies on the issuance and use of the travel cards; these documents have been submitted for the record (see attachment D).

1. Department of Justice Charge Card Management Plan
2. Department of Justice Travel Charge Card Program Guide
3. Department of Justice Travel Charge Card Reference Guide for Cardholders
4. GSA Travel Card Training at <https://smartpav.gsa.gov/cardholders/training>
5. GSA Travel Card Holder Helpful Hints

B. What is the criteria used in issuing Department travel cards to employees?

Response:

Any employee of the Department who is required to perform official travel may be issued a travel card if approved by the appropriate authorizing official.

- C. Please provide a breakdown by Division of the number of Department travel cards currently possessed by Main Justice employees (i.e. not including agency components).**

Response:

The number of travel cards issued in the Offices, Boards, and Divisions is 18,146.

This number excludes the following Department components: Federal Bureau of Investigation; Drug Enforcement Administration; United States Marshals Service; Bureau of Alcohol, Tobacco, Firearms and Explosives; Office of Justice Programs; Bureau of Prisons; and Federal Prison Industries. Overall, however, the Department has approximately 90,000 travel cardholders

- D. What is the Department's official disciplinary policy for individuals found to have misused government travel cards?**

Response:

The Department holds employees accountable if they are found to have misused their government travel card. Intentional misuse of the travel card, regardless of the dollar amount, must be reported to the Office of the Inspector General. A management official is responsible for determining the appropriate disciplinary action to take with sanctions for misuse ranging from reprimand to removal.

- E. If a copy of this disciplinary policy regularly provided to Department employees? Please provide a copy of such policy as issued to Department employees.**

Response:

Employees are made aware of the policies regarding proper use of the travel card and possible disciplinary action through the policies listed in 33(A) above.

- F. Does the Department generally control merchant codes to prevent travel cards from being used at certain categories of merchants?**

Response:

The Department restricts the use of certain merchant category codes to ensure the government-issued travel cards can be used only with merchants whose business is related to

travel (e.g., gas stations, airlines, restaurants). If an employee attempts to use the travel card at a clothing store, for example, the merchant would decline the travel card and the purchase would not occur. The appropriate discipline is determined based on an analysis of the factors set forth in *Douglas v. Veterans Administration*, 5 M.S.P.R. 280 (1981).

G. Does the Department deactivate travel cards when employees are not on official travel?

Response:

Each component of the Department may deactivate travel cards when employees are not on official travel at its discretion. The Department does not mandate this. The Department has approximately 90,000 travel cardholders and the administrative cost of activating and deactivating cards each time a person travels would be prohibitive for the value.

Civil Rights of Institutionalized Persons

34. **The Attorney General is obligated to provide written notice under the Civil Rights of Institutionalized Persons Act before proceeding with litigation to enforce the law's provisions.**

Please provide a copy of all letters that you have written to state or local officials concerning conditions at jails, prisons, other correctional facilities, or pretrial detention facilities pursuant to your obligation under 42 U.S.C. 1997B(a) since January 20, 2009, and continuing through the date that your response to this question is provided to me.

Response:

A CD containing notice letters issued since January 20, 2009, is attached.

Olympic Games Security

35. **The Olympic Games will soon take place in London. As usual, the United States will participate, by sending athletes. We all recognize an event of this magnitude will draw spectators as well. Media reports indicate that the United States is concerned that inadequate security is being provided at these Games. In fact, reports indicate that the U.S. is "preparing to send up to 1,000 of its agents, including 500 from the FBI, to provide protection for America's contestants and diplomats." At the same time, reports include statements from British officials and anti-terrorism officials raising concerns that the U.S. is meddling, being overly demanding, and adding unnecessary friction and pressure on the London Organizing Committee.**

- A. Have you spoken with anyone about the possibility of sending federal agents to the London Olympic Games? If so, please state how recently, with whom, and the content of the conversations.**

Response:

The U.S. Department of State (DOS) is the lead agency for U.S. Government (USG) support to international special events. The DOS-sponsored International Security Event Group (ISEG), chaired by the DOS Diplomatic Security Service (DSS), meets monthly to address USG support to foreign governments during international events, and the discussions of the London Olympic Games have included the FBI's role in, for example, responding to incidents over which the U.S. exercises extraterritorial jurisdiction. The possibility of such an incident is increased by the anticipated U.S. presence during the London Olympics, which will be extensive, including U.S. athletes, spectators, corporate sponsors, press, and dignitaries. Because of this possibility, one or more Department of Justice attorneys will staff the Joint Operations Center to ensure that U.S. authorities have immediate access to an experienced counterterrorism prosecutor in the event of an act of terrorism involving American citizens or interests. In support of both the country DOJ attaché and the FBI legal attaché, DOJ has sent at least one such attorney to each Olympic Games for at least the past decade.

The FBI enjoys a strong relationship with its law enforcement and intelligence community counterparts in the United Kingdom (UK), and in other countries, as part of a coordinated international effort to proactively address global terrorist threats. Various FBI programs and their British counterparts are regularly coordinated through collaborative research, intelligence and information exchanges, and exercises that integrate tactics, techniques, and practices to jointly address these global threats. Providing FBI resources in support of the 2012 London Olympics is a logical extension of the FBI's continued collaboration with its UK counterparts and speaks to the high quality of this key international relationship.

In May 2009 and November 2010, the FBI traveled to London with other members of the ISEG to provide to Olympic planners briefings on the ISEG and background on individual USG agency roles, responsibilities, and capabilities. In September 2011, the FBI deployed an FBI Olympic Facilitator (FBI-OF) to London. The FBI-OF is responsible for conducting liaison with the DOS Senior Olympic Security Coordinator, relevant USG law enforcement agencies, and host nation Olympic planners. The FBI-OF is also tasked with developing and coordinating the FBI's crisis management and operational plans and will remain on-site through the conclusion of the Games. The FBI-OF has discussed FBI support to the Olympic Games with his UK planning counterparts, including London's Metropolitan Police Department and others. In addition to the FBI-OF, in October 2011, FBI working-level planners met with UK Olympic planners in London on several occasions to address financial and logistical matters regarding Olympic support.

There have also been several executive-level meetings with UK representatives that involved discussions related to the 2012 London Games. These meetings include the following:

- In October 2010, two Assistant Commissioners from London's Metropolitan Police Department traveled to Washington, D.C., to provide briefings on Olympic planning to the

ISEG, the Assistant Directors (ADs) of the FBI's International Operations Division and Critical Incident Response Group (CIRG), and others.

- During September 13-16, 2011, the AD of the FBI's CIRG met in London with executives of the Metropolitan Police regarding preparations for the Olympics Games.
- On September 15, 2011, the FBI Director met with the UK Home Secretary at FBI Headquarters to discuss numerous topics, including potential FBI support for the London Games.
- On September 20 and October 6, 2011, UK law enforcement executives met in Washington, D.C., with FBI Executive Assistant Directors (EADs) and ADs to discuss potential FBI support to the London Games.
- During the week of November 7, 2011, the EAD of the FBI's National Security Branch traveled to London, where he discussed the London Olympics with UK officials.
- During November 14-17, 2011, UK executives involved in Olympic planning (including two Assistant Commissioners from the Metropolitan Police and the Director of Olympic Security, Olympic Security Directorate, Home Office) met in Washington, D.C., to update the ISEG on preparations for the London Olympic Games. Various meetings during this period included the EAD of the FBI's Criminal, Cyber, Response and Services Branch, the Acting AD of the FBI's Counterterrorism Division, and the AD of the FBI's CIRG.
- On February 16, 2012, the FBI Director toured London's Olympic Park and met with the President of the UK Association of Chief Police Officers, the Commissioner of the Metropolitan Police Service (MPS), an MPS Assistant Commissioner who is the National Olympic Coordinator, and the UK Home Secretary regarding Park security, counterterrorism measures, and staffing.

B. Is the U.S. sending federal agents for security purposes to the London Olympic Games? If so, please provide the details, such as how many, from what agencies, their expected work schedule, how long they will be needed before and after the games in that country, etc.

Response:

Although recent media reports have indicated that the FBI will be sending 500 federal agents to the London Olympics to provide protection and/or security for the event, these reports are erroneous. The FBI will not provide security, nor will it provide protection for U.S. Olympic athletes or diplomats. The FBI will also not provide the reported 500 agents, though the exact number has not yet been established and will not be provided in an open forum for security reasons when it is established.

For the operational period of the Olympic Games (July 18 through August 13, 2012), the FBI will support USG Olympic operations by staffing the USG Joint Operations Center at the

U.S. Embassy in London. Drawn from various technical and investigative disciplines, these FBI personnel will be available in the event of a critical incident, including in support of investigative or intelligence efforts related to acts of terrorism or other criminal acts directed at U.S. citizens.

C. Please define the “security” that agents would be providing.

Response:

As noted above, FBI personnel assigned to the London Olympic Games will provide neither security nor protection for this event.

DOS has “lead agency” status for USG support to the London Olympic Games. FBI personnel will act as planners, liaison personnel, subject matter experts, and advisors to FBI executives, DOS, the U.S. Embassy in London, and the host government, should they request such support.

D. Please describe the circumstances surrounding the event that requires, or would require, the U.S. to send federal agents to provide protection at the London Olympic Games?

Response:

The FBI will not provide “protection” during the London Olympic Games. If the President or other U.S. dignitaries attend the Games, questions regarding their protection would best be directed to the U.S. Secret Service and the DOS DSS.

The FBI’s deployment to the UK for the Olympic Games will be in support of DOS and with the concurrence of the British Government. In the event of a critical incident, any FBI response will be in support of those entities and at their request.

E. Please provide an estimate of the cost associated with sending 500 federal agents to London to provide security, including salaries, per diem costs, travel expenses, new gear or equipment, etc.

Response:

As noted above, the FBI will not be sending 500 agents to London for the Olympic Games and any agents who are present will not be there to provide security.

Currently, the total costs associated with FBI support for USG Olympic operations at the London Games and incurred over Fiscal Years (FY) 2010, 2011, and 2012 are estimated at \$1,883,700. This includes travel, per diem, and costs associated with the USG interagency deployment to the games such as space rental and the build out of office space. Salaries are not included because the FBI would incur salary costs regardless of our provision of support to the Olympics.

- F. If money is spent to send federal agents to provide security at the London Olympic Games, then which budget will absorb the cost? How much is this cost in relation to the agencies overall budget?**

Response:

The FBI does not receive funding specifically to support major special events, domestically or internationally. The FBI's support for the USG's involvement in the Olympics is funded through the FBI's CIRG budget. Because the planning cycle for each Olympic Games ranges from two to six years, the cost of the FBI's support cannot be tied to one fiscal year. Costs to support USG Olympic operations at the London Olympic Games will be incurred in FYs 2010, 2011, and 2012. The FBI's overall budgets for those years were \$7,658,622,000 in FY 2010, \$7,818,953,000 in FY 2011, and \$8,036,991,000 in FY 2012.

- G. Has the U.S. ever sent federal agents for security purposes to an Olympic Games in the past? If so, please describe the situation, which Games it was, how many agents were sent, and the total cost.**

Response:

In addition to the support routinely provided by the FBI to Olympic Games that take place in the United States, the FBI has deployed personnel in a liaison capacity to every Olympic Games occurring outside the United States beginning with the 1988 Summer Olympic Games in Seoul, Republic of Korea. The degrees of support and costs have varied widely and have depended on several factors, including the nature and number of any threats associated with the games, the degree of USG interagency participation, whether we have received requests for support from the host government, and the capabilities of the host government. Costs have also varied depending on the host nation's economy, lodging prices as influenced by hotel availability, and the currency exchange rate at the time the costs were incurred.

The estimated costs of FBI support to the most recent Olympic Games are approximately \$1,382,900 for the 2008 Summer Olympic Games in Beijing, China, and \$1,181,700 for the 2010 Winter Olympic Games in Vancouver, British Columbia, Canada. These costs include travel, per diem, and costs associated with the USG interagency deployment to the games such as space rental and the build out of office space. Costs associated with the Vancouver Games also include the cost of support to Olympic activities in the State of Washington, which were declared a Special Events Assessment Rating Level I domestic special event by the Department of Homeland Security. Salaries are not included in the estimated costs because the FBI would incur salary costs regardless of our provision of support to the Olympics.

With one unique exception, the FBI has not provided agents for "security" purposes for any Olympic Games. Although we cannot identify the event in this forum for security reasons, the exception occurred when, in addition to FBI personnel deployed to the Games in other capacities, the FBI augmented the DSS security efforts by pre-staging ten FBI Agents at the venue where all U.S. Olympic athletes were in-processed and conducted their daily training

routines in preparation for their events. In this extremely unusual situation, the decision to deploy FBI Agents in this "security" capacity was based on the threat posture at the time and was made with the concurrence of the host government. The estimated cost for this contingent was \$52,900.

- H. **If federal agents are sent to provide protection at an Olympic Games, do you believe this sets a precedent that must be followed for future Olympic Games? What about other international sporting competitions, such as the Pan American Games?**

Response:

As indicated in the response to subpart D, above, the FBI does not provide "protection" at Olympic Games. The FBI does, though, participate in the USG decision-making process regarding the provision of support to international special events. Events considered for ISEG support are not restricted to "sporting events," but may also include such events as international summits, World's Fairs, and industrial/trade fairs. Even when other ISEG members have decided to support a given event, this does not obligate the FBI to participate. The decisions to provide FBI support to international special events are made on a case-by-case basis, taking into consideration the nature and number of any threats associated with the event, the degree of USG interagency participation, whether we have received requests for support from the host government, and the capabilities of the host government.

Based on these considerations, the FBI participated in the USG interagency support for the Pan Am Games in both Rio de Janeiro, Brazil, in 2007 and Guadalajara, Mexico, in 2011, as well as for the 2010 World Cup in Pretoria, South Africa. Planning is currently underway to provide support for the 2014 Winter Olympics in Sochi, Russia, the 2014 World Cup in several Brazilian cities, and the 2016 Summer Olympics in Rio de Janeiro, Brazil.

36. Muslim Chaplains

Questions:

- A. **At the present time, what entity is responsible for accrediting Muslim chaplains that serve in the Bureau of Prisons?**

Response:

All Chaplains in the Bureau are accredited in the same manner to avoid discrimination based upon race, religion, creed or ethnicity. The Bureau Central Staffing Unit (CSU) in Grand Prairie, Texas, ensures each chaplaincy applicant meets all the required standards set forth in Program Statement 3939.07, Chaplains Employment, Responsibilities, and Endorsements. Applications for Chaplain vacancies must be submitted through www.usajobs.gov. After the CSU has collected all essential applicant information, the files are sent to the Bureau's Central Office (headquarters) Religious Services Branch in Washington, D.C. for final review.

Our current Muslim chaplains are endorsed by their mosques or national organizations. The Religious Services Branch has designated a subject matter expert for the Islamic faith. Subject matter experts are responsible for verifying appropriateness of applicants, educational credentials, endorsement organizations, and ministry experience.

Foreign Corrupt Practices Act Guidance

37. Assistant Attorney General Lanny Breuer recently announced in a public speech that the Department is preparing, “detailed new guidance on the [Foreign Corrupt Practice Act’s] criminal and civil enforcement provisions” to be released next year. At a hearing on the FCPA hack in November 2010, many Senators expressed their concerns with the Department’s enforcement of the statute. Specifically, members raised concerns with the fact that the law includes broad language that is not well defined, and that a lack of clear guidance from the Department in the form of advisory opinions has created an air of uncertainty in how U.S. corporations do business abroad. I welcome this call for new guidance to help ensure that businesses that want to do the right thing, know what the right thing is in the eyes of the Justice Department.

A. When will the guidance be published?

Response:

For more than a decade, the Department has made available to the public the Lay Person’s Guide to the Foreign Corrupt Practices Act (FCPA). The Department is currently working to update that Guide. It is anticipated that the new Guide will include the following topics, among others:

1. U.S. interagency and international cooperation in global anti-corruption efforts;
2. The civil and criminal provisions of the FCPA, including the criminal intent requirement, the definitions of a “foreign official” and facilitation payments, and issues such as conspiracy law and aiding and abetting in the FCPA context;
3. FCPA penalties, sentencing and enforcement, including examples of civil and criminal penalties, different types of negotiated resolutions (plea agreements, deferred prosecution agreements and non-prosecution agreements), and the guiding principles of FCPA enforcement, such as the *Principles of Federal Prosecution* and the *Principles of Federal Prosecution of Business Organizations*; and
4. Corporate compliance programs, including discussion of successor liability and due diligence, and guidance regarding the benefits of effective compliance programs.

We believe the new Guide will provide a more comprehensive and user-friendly reference source for business managers, compliance officers and practitioners.

The exact form of the Guide is still being considered. It is being drafted in the first instance by the Fraud Section, which, pursuant to the U.S. Attorney’s Manual (USAM 9-47.110),

has principal criminal enforcement authority for the FCPA, one benefit of which is uniform FCPA enforcement nationally. The Guide is being – and will be – reviewed by and/or discussed with officials in government agencies outside the Department, including the SEC. That process is currently underway.

With respect to input from interested outside parties, the Department is already in communication with outside groups regarding many of the issues that the Guide will address. For example, in coordination with the Commerce Department and the SEC, the Department met with numerous interested parties, such as business groups from a variety of industries, including small, medium and large enterprises. During these meetings, the Department discussed, among other things, the FCPA's definition of foreign official and facilitation payments, the benefits of self-disclosure, successor liability, and compliance programs and their importance in FCPA matters. The Department will continue to meet with interested parties.

- B. What form will the guidance take and what steps will be taken to ensure that it is implemented nationally and uniformly? Will the guidance be incorporated into the U.S. Attorneys' Manual?**

Response:

Please see response to QFR 37(A), above.

- C. Does the Department intend to solicit the views of interested outside parties as it prepares the guidance, particularly the regulated business community? If so, how?**

Response:

Please see response to QFR 37(A), above.

- D. Who at the Department will be primarily responsible for drafting the guidance?**

Response:

Please see response to QFR 37(A), above.

- E. What will be the Securities and Exchange Commission's (SEC) role in formulating the guidance? Will the SEC be bound by the guidance? Will the Department enter into a Memorandum of Understanding with the SEC regarding the guidance?**

Response:

Please see response to QFR 37(A), above.

- F. **AAG Breuer's remarks indicate that the guidance addresses the FCPA's "enforcement provisions." Will the guidance offer only the Department's interpretation of the Act's enforcement provisions or will the guidance set forth the Department's enforcement policies?**

Response:

Please see response to QFR 37(A), above.

1. **Will the guidance include the Department's interpretations of ambiguous statutory terms such as "foreign official" and "government instrumentality"?**

Response:

Please see response to QFR 37(A), above.

2. **Will the guidance clarify when a company may be held liable for the actions of an independent subsidiary?**

Response:

Please see response to QFR 37(A), above.

3. **Will the guidance clarify the extent to which one company may be held liable the pre-acquisition or pre-merger conduct of another?**

Response:

Please see response to QFR 37(A), above.

4. **Will the guidance include an enforcement safe harbor for gifts and hospitality of a de minimis value provided to foreign officials?**

Response:

Please see response to QFR 37(A), above.

- G. **Other Department guidelines, including the Corporate Charging Guidelines, indicate that they may not be relied up on by defendants and do not limit the Department's litigation prerogatives. Will the same be true of the forthcoming FCPA guidance, or will defendants be able to rely upon this guidance in litigation?**

Response:

Please see response to QFR 37(A), above.

Christine Varney

38. **On July 6, 2011, representatives of Cravath, Swaine & Moore LLP confirmed that Assistant Attorney General for Antitrust Christine Varney would be joining their firm, which only has offices in New York City and London. Just three months later, on October 4, 2011, the Department submitted to Congress a plan for reorganization of the Antitrust Division. The plan would close various field offices and increase the amount of antitrust work in the New York City field office.**

A. When did the Department begin formulating plans to reorganize the Antitrust Division?

Response:

In February 2011, the Deputy Attorney General issued a memorandum to Department component heads to seek operational and programmatic efficiencies, to realign functions in various offices, to lower lease costs by consolidating office space, and to seek ways to more effectively utilize the Department's resources. In addition to the Antitrust Division's response to this call, several Department components, including the U.S. Attorneys, the U.S. Trustees, and the Federal Bureau of Investigation, have proposed consolidations of field office and sub-regional office space, of which Congress has also been notified. The Department made the realignment submission to Congress in October, after former Assistant Attorney General Christine Varney had left the Division.

B. Were these changes to the structure of the Antitrust Division being considered while Ms. Varney was negotiating an employment contract with Cravath, Swaine & Moore LLP?

Response:

The Division's realignment was in response to the Department's call for cost-cutting measures in February 2011, and the Department's decision to realign the Antitrust Division field offices was made in October, after former Assistant Attorney General Christine Varney's departure from the Division on August 4, 2011.

QUESTIONS POSED BY SENATOR HATCH

39. **With respect to intellectual property theft, I am concerned that countries like China are trying to gain a competitive advantage over the United States by stealing our software. In 2010 alone, it is estimated that the commercial value of software piracy worldwide was nearly \$60 billion – with China accounting for approximately \$8 billion of this number.**

It is my understanding that the Department of Justice is actively engaged with Chinese officials to combat software piracy in China.

- A. What challenges do DOJ officials encounter in their intellectual property infringement investigations in China?**

Response:

Although many Department of Justice's intellectual property ("IP") investigations have some nexus to China, the Department itself does not conduct investigations in China. Rather, the Department has prioritized developing critical and strong relationships with Chinese law enforcement to work with them in cases with a connection to China.

For example, since 2006, the Department's Criminal Division and the Chinese Ministry of Public Security ("MPS") have co-chaired the Intellectual Property Criminal Enforcement Working Group ("IPCEWG") of the U.S.-China Joint Liaison Group for Law Enforcement Cooperation ("JLG"), which has resulted in an open dialogue on intellectual property enforcement, the sharing of information on selected investigations, and a number of successful joint intellectual property operations. The IPCEWG last met in October of 2011. The meeting resulted in an agreement to continue to increase cooperation and information sharing in cases involving intellectual property crime with a connection to China.

However, even with the emphasis the Department has placed on strengthening its law enforcement relationships and cooperative efforts, the Department still faces a range of challenges in cases related to China. For instance, the sheer volume of counterfeit and pirated products imported into the United States from China presents a daunting hurdle. Customs and Border Protection ("CBP") estimates that 61% of its seizures of infringing goods originated from China in 2010. In addition to the sheer volume, traffickers in counterfeit products originating from China often seek to avoid detection by using multiple transshipment points as a means to disguise the true origin of the counterfeit goods. For example, they may ship their illegal cargo through multiple ports in different continents before the goods arrive in lucrative markets in the U.S., Europe, and elsewhere. This use of transshipment points increases the complexity of detecting the actual source of the goods.

Through the Department's Intellectual Property Task Force, the Department has identified four enforcement priorities for IP investigations and prosecutions, including offenses that involve (1) health and safety, (2) links to organized criminal networks, (3) large scale

commercial counterfeiting and online commercial piracy, and (4) trade secret theft or economic espionage. Similarly, the IPCEWG focuses on selected priority investigations for joint cooperation and effort. The Department's enforcement efforts in China would be further enhanced by the deployment of an experienced prosecutor to the region to focus on intellectual property and related issues as part of the Department's ICHIP program (discussed in response to Question 40, below), for which the President's FY 2013 budget provides funding.

B. How do these challenges compare to other developing countries?

Response:

Many of the challenges the Department faces regarding China apply to other countries as well. There are the general challenges for any international effort, including language barriers, time differences, diplomatic considerations, and the time and expense of travel. Additionally, legal and procedural hurdles exist relating to the sharing of case information and evidence across borders and to addressing inconsistent laws and enforcement priorities across countries.

In addition, the method described above of using transshipment points to mask the true origin of counterfeit goods is not unique to China or to developing countries generally. Traffickers in counterfeit products from a variety of countries may ship their illicit goods through multiple countries en route to entry into the United States or other markets. Moreover, the availability of broadband Internet access and inexpensive computers allows criminals to cheaply and widely distribute software, movie, or music from and to almost anywhere in the world. The Internet also permits trade secret thieves to engage in corporate espionage in another country from the comfort of their own offices or homes. These advances in technology, broader Internet access, and improvements in manufacturing, transportation, and shipping present a range of challenges in transnational IP criminal enforcement.

The Department confronts a variety of additional hurdles in working with developing countries to combat IP crime. For example, some countries may lack adequate resources or training on basic IP enforcement or technology issues. In other countries, there may be a lack of political will or priority on criminal IP enforcement. In still others, there may be a lack of cooperation between the agencies responsible for enforcing IP laws. Finally, many countries where counterfeiting and piracy are especially prevalent also face high levels of public corruption. Trafficking in counterfeit goods can be a very profitable enterprise; and, because convictions for IP offenses often result in low penalties, authorities in some countries may perceive IP crime as, at most, a minor infraction. In turn, IP criminals, by offering substantial financial rewards with little accompanying risks, often succeed in bribing police and public officials.

C. In addition to your Intellectual Property Law Enforcement Coordinators, what other initiatives has the DOJ undertaken to shutdown foreign entities that are stealing U.S. intellectual property?

Response:

In addition to the efforts of the Department's IP Law Enforcement Coordinator ("IPLEC") program and the IPCEWG explained above, the Department works with a multitude of other countries to address the myriad of issues arising in international IP enforcement. International outreach and training exist as critical components of such an effort because they enhance international cooperation and strengthen our law enforcement relationships with our foreign counterparts. Outreach is accomplished by direct work on specific cases; through extensive cooperation with the State Department and other U.S. agencies to provide targeted training and capacity building; through engagement in multi-lateral bodies such as the Asia-Pacific Economic Cooperation and the Justice Department-led IP Crimes Enforcement Network ("IPCEN") in Asia; and with international law enforcement groups such as the World Customs Organization and INTERPOL.

Over the past five years, Department attorneys have provided training and education on intellectual enforcement to over 10,000 prosecutors, police, judicial officers, and other government officials from over 100 countries. Examples of recent successful programs include several border enforcement trainings in Mexico, South Africa and Nigeria, and a pilot program in Ghana to set up an interagency enforcement task force. These international training programs have resulted in positive, measurable results, including seizures of large quantities of counterfeit pharmaceuticals and consumer products and millions of dollars in pirated computer software and counterfeit hardware, much of it intended for distribution in the United States. Improved coordination with foreign law enforcement has led to the successful prosecution of criminal organizations that distribute these items and, in some instances, has helped to shut down the factories and computer servers in foreign jurisdictions from which the counterfeit and pirated goods originated.

40. **We all know that resources are tight during these difficult budgetary times, but what can we in Congress do to help you increase your enforcement efforts to curb intellectual property theft?**

Response:

The President's FY 2013 Budget increases funding for international investigation and deterrence of intellectual property crime by \$5 million, which brings the Department's investment to nearly \$40 million annually to combat online piracy and otherwise protect our nation's intellectual capital and maintain our competitive edge in developing American ideas and technologies to better compete in the global marketplace.

In March 2011, the Office of the Intellectual Property Enforcement Coordinator transmitted to Congress a white paper identifying a number of recommended changes to federal laws and regulations designed to improve the U.S. Government's ability to address developing challenges in combating IP crime. Among the recommendations were a number of important criminal law proposals, including increasing penalties associated with certain types of intellectual property crimes, creating a felony offense for streaming copyrighted works, and

obtaining wiretap authority for criminal copyright and trademark offenses. Congress has introduced legislation addressing many of these issues. The Department looks forward to working with Congress as it continues to consider some of these proposals.

A key component of the Department's international enforcement efforts has been the Department's Intellectual Property Law Enforcement Coordinator ("IPLEC") program, first established in 2006, through a partnership between the Office of Overseas Prosecutorial Development ("OPDAT") and the Computer Crime and Intellectual Property Section ("CCIPS"). Through this program, the Department has deployed experienced prosecutors to U.S. embassies in regions particularly critical to IP enforcement. The President's FY 2013 budget includes additional funding to continue and to expand this program, now known as the International Computer Hacking and Intellectual Property ("ICHIP") program, to deploy experienced prosecutors in other regions critical to IP enforcement, and to better integrate them with the Department's existing network of experienced IP prosecutors (known as CHIP attorneys) in United States Attorney's Offices throughout the United States.

QUESTIONS POSED BY SENATOR KYLImmigration Detainers**Background information:**

In recent months, the Justice Department has sued the states of Arizona, Alabama, and South Carolina over new laws that, for the most part, prescribe enforcement policies for illegal aliens who have committed crimes in these states. The department, it is also believed, is considering similar lawsuits against Utah, Indiana, and Georgia.

On the other hand, the Justice Department has remained largely silent about the policies some jurisdictions (such as Cook County, Illinois) have enacted that prohibit or hinder compliance with federally directed detainers for these same types of individuals.

In recent press articles, Cook County cites comments from a federal judge who recently issued an injunction against a new state law in neighboring Indiana (*Buquer v. City of Indianapolis*, No. 1:11-cv-708-SEB-MJD, 2011 WL 2532935 (S.D. Ind. June 24, 2011)) as its justification for refusing to hold already locally detained individuals – individuals who were requested by DHS officials — for the customary 48 hours prior to their release to federal immigration officials. The judge’s comments are below:

“A detainer is not a criminal warrant, but rather a voluntary request that the law enforcement agency ‘advise [DHS], prior to release of the alien, in order for [DHS] to arrange to assume custody.’ *Id.* § 287.7(a).”

There are several problems with this. First, the statement cited by Cook County is actually not at the heart of the *Buquer* decision, and the context in which it was made is not readily applicable to the county’s decision. In *Buquer*, the court dealt with a state statute that permitted state law enforcement to *arrest* a person for whom a detainer had been issued by DHS or ICE. The Cook County situation is different, as the county is refusing to enforce the detainers for illegal aliens who are already in prison. Thus, while Indiana is authorizing officers to make arrests based on detainers, Cook County is refusing to even hold prisoners for the customary 48-hour federally directed detainer period.

Moreover, it also seems that the ruling issued by the judge in *Buquer* is simply erroneous. The judge notes that ICE detainers are a “voluntary request.” However, this statement directly contradicts federal regulation, which quite clearly does not identify detainers issued by DHS as “voluntary requests,” as the judge in *Buquer* ruled. The pertinent federal regulation reads in part:

“Upon a determination by the Department to issue a detainer for an alien not otherwise detained by a criminal justice agency, such agency shall maintain custody

of the alien for a period not to exceed 48 hours . . . in order to permit assumption of custody by the Department.” 8 CFR 287.7(d) (emphasis added).

It would seem, then, that Cook County's reliance on the recent injunction is flawed for two reasons: (1) the two situations are not analogous – one deals with granting arrest authority, while the other deals with detaining those already in jail or prison for 48 hours at the request of immigration officials; and (2) the statement made by the judge in *Buquer* seems to directly contradict federal regulation.

41. **What is your position on ordinances that allow localities to ignore detainers issued by federal immigration enforcement entities?**

Response:

Under the Immigration and Nationality Act and its implementing regulations, the Department of Homeland Security is responsible for determining how and under what circumstances it will use detainers as part of its immigration enforcement regime. It is in the best position to determine whether an ordinance regarding detainers conflicts with existing law and its practice with respect to detainers.

42. **Why is your department using its resources to sue states that have passed laws that, for the most part, deal with individuals who have committed crimes and also are illegally in the U.S., while you simultaneously remain almost entirely silent on the circumvention of federal detainers issued by federal immigration officials that we all know is occurring?**

Response:

We do not accept the premise of your question. The Department is suing states that have passed laws that conflict with federal law and the federal government's preeminent role in immigration matters, that create a patchwork of state immigration schemes that interfere with federal law and federal law enforcement objectives, and that burden lawfully present immigrants and United States citizens. As for detainers, please see our response to Question 41.

43. **Some of the localities say that they cannot detain individuals for 48 hours because they do not have the money to continue to hold them. Programs such as the State Criminal Alien Program (SCAAP), additional ICE personnel, adequate federal detection trustee (through the Justice Department) funding, and adequate U.S. Marshals Service funding would help in this regard. Have you spoken to DHS Secretary Janet Napolitano about these issues facing counties? If so, what is your plan to provide additional resources?**

Response:

We are in regular contact with DHS about how to allocate resources to maximize law enforcement objectives.

44. **Regarding Operation Streamline, which is tangentially related to this issue, I have asked you numerous times to take the lead with Secretary Napolitano to double or triple the number of Streamline cases heard in the Tucson area. Yet, despite my staff being told by Customs and Border Protection officials that Streamline is one of the most cost-effective ways to reduce repeat illegal crossings at the border, you haven't pushed for adequate funding for this program. Why is it that you and Secretary Napolitano won't take the lead to double or triple the number of prosecutions in Tucson (through Operation Streamline)?**

Response:

The Department of Justice supports the Operation Streamline program. However, the Department's ability to prosecute those individuals apprehended by CBP agents in areas where Operation Streamline and similar efforts have been implemented is limited by the current capacity of the criminal justice infrastructure in those areas.

The Department continues to focus its resources on its felony prosecutions. For example, in FY 2011, the District of Arizona increased its felony prosecutions of border-related offenses by filing an additional 1,681 new cases from FY 2010 for a total of 7,033 felony cases filed. In fact, the District of Arizona had the second-highest number of felony case filings in the nation.

Currently, the Tucson sector has a daily limit of 70 Operation Streamline misdemeanor defendants. This is due in very large part to courtroom and cellblock capacity. Significant expansion of capacity would be needed if Operation Streamline were to double or triple the number of misdemeanor defendants processed per day.

45. **Do you believe DoJ has all of the resources it needs to fulfill its responsibilities related to illegal immigration and border security? If not, where would you apply additional resources?**

Response:

The Department of Justice is very appreciative of Congress' efforts to fund and bolster border security efforts along the Southwest Border over the last five years. The Department would like to convey our gratitude to Congress for funding the President's request to dedicate law enforcement and prosecutor resources in the 2010 Emergency Border Security Supplemental Appropriations Act.

The President's 2013 Budget request includes a total program increase of \$1,963,000 to expand the highly successful Legal Orientation Program of the Executive Office for Immigration

Review (EOIR). The program educates detained aliens about EOIR immigration proceedings, allowing them to make more informed decisions earlier in the adjudication process, thereby increasing efficiencies for both EOIR courts and DHS detention programs. The request will add six additional sites to the 26 currently operating, 24 of which are in detention settings, and responds to increasing demand, as well as the expansion goals articulated by DHS, the Administration, and many Members of Congress.

EOIR could benefit from additional funding for full-time employees, including immigration judges and the necessary support staff. Prior to the FY 2011 targeted hiring freeze, EOIR was engaged in a critical hiring effort, strongly supported by the Department, the Administration and Congress. The imposition of the 2011 hiring freeze has resulted in EOIR struggling to maintain its corps of immigration judges and associated staff, as EOIR's caseload continues to rise to record levels.

Crime Victims' Rights Act

46. **On June 6, 2011, I sent you a letter asking why you were taking out of context remarks that I made during the legislative process that led to approval of the Crime Victims' Rights Act. I explained quite clearly to you that the intention of Congress was to give rights to crime victims *throughout* the criminal justice process, even before the technical filing of criminal charges.**

In a response sent almost five months later (November 3, 2011), Assistant Attorney General Ron Weich wrote that the Department has concluded that the CVRA is "best read" as applying only *after* the formal filing of criminal charges, an opinion at odds with the intent of the CVRA's authors. The Department has failed to convince any appellate or district court to agree with its position in a published opinion. To the contrary, the Fifth Circuit and District Courts in the Eastern District of New York, Southern District of Texas, Eastern District of Virginia, Northern District of Indiana, and Southern District of Florida have all published opinions rejecting the Department's position and agreeing with me that Congress extended rights to victims in the investigative phase of a criminal prosecution.

In light of this legal authority, how can the Department continue to persist in the view that the CVRA is "best read" to deprive victims of rights before the technical filing of criminal charges?

Response:

The Department of Justice is firmly committed to respecting the rights of crime victims during all phases of the criminal justice process, from the time they are first identified during a law enforcement investigation, up through and including the resolution of any federal charges that might be brought. The nature and extent of those rights are described in a number of federal statutes, including the Victim's Rights and Restitution Act (VRA) and the Crime Victims Rights Act (CVRA).

The manner in which department personnel are expected to interact with crime victims is addressed in the Attorney General's Guidelines for Victim and Witness Assistance (the AG Guidelines). The AG Guidelines were completely revised in 2011, and training on the revised guidelines (which took effect on October 1, 2011) has been ongoing for months. The AG Guidelines are extensive, and make two points very clearly. First, all department personnel are expected to treat crime victims with dignity, respect, and fairness at all times, whether required by a statute or not. In that vein, the guidelines encourage department employees to provide services and assistance to crime victims above and beyond those required by the VVRA and CVRA. Second, however, CVRA rights attach when criminal proceedings are initiated by complaint, information, or indictment.

This latter position was adopted only after due deliberation. In fact, as part of the guidelines revision process, the department's Office of Legal Counsel (OLC) was asked to consider the question of when CVRA rights attach. OLC issued its formal opinion on December 17, 2010, which opinion is available at <http://www.justice.gov/olc/2010/availability-crime-victims-rights.pdf>. OLC concluded that the CVRA is "best read as providing that the rights identified in [the CVRA] are guaranteed from the time that criminal proceedings are initiated . . ." In reaching its conclusion, OLC was aware of and considered both the full legislative history of the CVRA and the extant judicial decisions which addressed this question, both published and unpublished. Some of those judicial decisions agreed with OLC, some did not, but OLC's opinion is binding upon the Executive Branch.

47. **As you know, the circuits are split about whether the Crime Victims' Rights Act gives crime victims the right to the same kinds of ordinary appellate protections that other litigants receive. Four circuits have taken what is in my view the correct view on this issue — that Congress intended to extend to crime victims the same kinds of appellate protections other litigants receive. Four circuits have, however, disagreed. In view of this clear division of opinion on an extremely important question of implementing the CVRA, it would clearly seem to be appropriate for the U.S. Supreme Court to resolve the circuit split. But the Justice Department has opposed Supreme Court review, contending that "the disagreement among the courts of appeals is also of little practical importance."**

How can the Justice Department claim to be working to protect the rights of crime victims while at the same time telling the Supreme Court that whether crime victims are able to obtain appellate protection of their rights is "of little practical importance"?

Response:

The Department remains firmly committed to ensuring that the Crime Victims' Rights Act of 2004 (CVRA) is implemented and administered in a manner that fully protects and respects the rights of crime victims. Among the rights provided by the Act is the right of a crime victim, who is not a party to a criminal case, to seek judicial review, in their own name, of a district court order denying them their statutory rights by filing a "petition ... for a writ of

mandamus.” 18 U.S.C. § 3771(d)(3). By its terms, the statute thus authorizes victims to seek one specific form of judicial review – mandamus review – while reserving to the government alone the prerogative to seek a different form of review – appellate review. See 18 U.S.C. § 3771(d)(4) (“In any appeal in a criminal case, the Government may assert as error the district court’s denial of any crime victim’s right in the proceeding to which the appeal relates.”). In post-CVRA litigation, some victims’ rights advocates have argued that, even though the statute explicitly authorizes victims to seek “mandamus” review, the courts of appeals should review a victim’s CVRA petition for a writ of mandamus as if it were an ordinary appeal and should therefore not apply the standards that courts traditionally apply in reviewing extraordinary petitions for writs of mandamus. Some courts of appeals have agreed with victims and applied ordinary appellate standards of review, while other courts of appeals have determined that the statutory term “mandamus” carries with it an intent to have courts apply traditional mandamus standards of review.

Recently, one crime victim presented this disagreement to the Supreme Court, and the government, in its filing, asserted that the Court should not grant review in that particular case to resolve the disagreement because there was no reason to believe that, in any of the CVRA mandamus cases before the courts of appeals, the result would have been different had the lower courts applied the ordinary standards of appellate review urged by the victim. See *In re: Fisher*, No. 10-1518, cert. denied, 2011 WL 5902485 (Nov. 28, 2011). The Department routinely files briefs advising the Supreme Court that a particular case does not merit the Court’s review where the resolution of the question would not alter the result, and our invocation of that principle in this case reflects that precept. That position should not be understood to evince a departure from our strong commitment to protecting victim’s rights.

QUESTIONS POSED BY SENATOR SESSIONS

48. At the hearing, you were asked whether the Department of Justice planned to comply with the House Judiciary Committee's letter asking for any documents related to Justice Kagan's involvement in the health care legislation and related litigation during her tenure as Solicitor General. You testified that you were not aware of the request, but that you recalled instances in which your staff would "physically, literally move [then-Solicitor General Kagan] out of the room whenever a conversation came up about the health care reform legislation." However, during her confirmation hearing, Justice Kagan herself testified that she "attended at least one meeting where the existence of the litigation [in *State of Florida v. U.S. Dep't of Health and Human Services*] was briefly mentioned." In addition, emails that the Department of Justice was compelled to release in response to lawsuits under the Freedom of Information Act the day after your appearance before the Judiciary Committee and earlier this year seem to contradict your purported lack of cognizance of the House Judiciary Committee's request and your assertion that at all times in this matter Solicitor General Kagan was excluded from discussions and/or deliberations regarding these matters. I am deeply disturbed by these developments and believe that the Justice Department should have provided these documents to the Senate Judiciary Committee during Justice Kagan's confirmation hearing. The Department's failure to provide this information to Congress and to comply with FOIA requests, as well as your apparent inattention to these matters, is unacceptable. I have set forth the substance of the aforementioned emails below. Please review them and provide answers to the questions that follow.

According to an email dated October 13, 2009 – well before March 5, 2010, the date Justice Kagan stated that she was aware she was being considered as a potential Supreme Court nominee – her top Deputy, Neal Katyal, informed her "we got [Senator Olympia] Snowe on health care."

According to a January 8, 2010 email chain – two weeks after the Senate passed the health care legislation – Brian Hauck, senior counsel to Associate Attorney General Tom Perrelli, emailed General Kagan's principal deputy, Neal Katyal, to tell him that Perrelli wanted "to put together a group to get thinking about how to defend against the inevitable challenges to the health care proposals that are pending." Katyal instantly replied: "Absolutely right on. Let's crush them. I'll speak to [Solicitor General] Elena [Kagan] and designate someone." At 10:57 a.m., Katyal forwarded Hauck's email to General Kagan and said: "I am happy to do this if you are ok with it," to which General Kagan responded four minutes later: "You should do it." Approximately two hours later that day, Katyal emailed again to Hauck informing him of General Kagan's determinations: "Brian, Elena would definitely like OSG [Office of the Solicitor General] to be involved in this set of issues. I will handle this myself, along with an Assistant from my office [REDACTED] and will bring in Elena as needed."

A March 16, 2010 email from General Kagan asks then-Acting Assistant Attorney General for the Office of Legal Counsel David Barron whether he has seen former Judge Michael McConnell's "piece in the wsj," referring to a March 15th op-ed in the *Wall Street Journal* in which Judge McConnell discussed House Democrats' proposal to circumvent a potential Senate filibuster of the health care bill. Barron responds: "YES – HE IS GETTING THIS GOING."

In a March 18, 2010 email, Katyal wrote to Perrelli and copied General Kagan, discussing in detail a draft complaint by the Landmark Legal Foundation and strategy regarding the potential litigation:

"Tom, I was just looking at the draft complaint by Landmark Legal Foundation. It is clearly written to be filed when the House approves the reconciliation bill and before the President signs it. See paras 15-17. [http://www.landmarklegal.org/uploads/Landmark%20Complaint%20\(00013086-2\).pdf](http://www.landmarklegal.org/uploads/Landmark%20Complaint%20(00013086-2).pdf)

Also para 27 says the action is being brought before it is signed by President so that no expectations of regularity can be asserted, etc. As such, we could be in court very soon.

In light of this, for what it is worth, my advice (I haven't discussed this with Elena, but am cc'ing her here) would be that we start assembling a response, [REDACTION] so that we have it ready to go. They obviously have their piece ready to go, and I think it'd be great if we are ahead of the ball game here."

Then, on March 21, 2010 – the date the House of Representatives passed the Patient Protection and Affordable Care Act – General Kagan wrote to Justice Department adviser Laurence Tribe regarding the health care legislation: "I hear they have the votes, Larry!! Simply amazing." The subject line of that email chain, which was initiated by Tribe, states "fingers and toes crossed today!" in an apparent reference to the vote. Tribe responded: "So health care is basically done! Remarkable. And with the Stupak group accepting the magic of what amounts to a signing statement on steroids!" – an apparent reference to the group of House Democrat congressmen who had indicated they would not vote for the legislation if it permitted federal funds for abortions and later acquiesced when the President agreed to sign an executive order preventing federal funding for abortions.

At 6:11 p.m. that same day, General Kagan had an email exchange with her deputy, Neal Katyal. This email chain – titled "Health care litigation meeting" – was initiated when Associate Attorney General Tom Perrelli emailed a group of Justice Department lawyers, including Katyal, notifying them that there was going to be a meeting the next day to plan for the litigation expected to challenge the health care legislation. At 6:18 p.m., Katyal forwarded this email chain to General Kagan, stating: "This is the first I've heard of this. I think you should go, no? I will,

regardless, but feel like this is litigation of singular importance.” At 6:19 p.m., General Kagan replied: “What’s your phone number?”

- A. Are you aware of any instances during Justice Kagan’s tenure as Solicitor General of the United States in which she was present in any meeting or conversation in which the Patient Protection and Affordable Care Act and/or litigation related thereto was discussed?

Response:

Please see the attached letter sent to Senator Sessions on February 24, 2012. (See attachment E.)

- B. Are you aware of any instances during Justice Kagan’s tenure as Solicitor General of the United States in which she was asked for her opinion or otherwise consulted, in her capacity as Solicitor General or otherwise, regarding the Patient Protection and Affordable Care Act and/or litigation related thereto?

Response:

Please see the response to 48(A), above.

- C. Are you aware of any instances during Justice Kagan’s tenure as Solicitor General of the United States in which she offered any views or comments in her capacity as Solicitor General or otherwise regarding the Patient Protection and Affordable Care Act and/or litigation related thereto?

Response:

Please see the response to 48(A), above.

- D. Are you aware of any instances during Justice Kagan’s tenure as Solicitor General of the United States in which she reviewed any documents in her capacity as Solicitor General or otherwise related to the Patient Protection and Affordable Care Act and/or litigation related thereto?

Response:

Please see the response to 48(A), above.

- E. Are you aware of any instances during Justice Kagan’s tenure as Solicitor General of the United States in which information related to the Patient Protection and Affordable Care Act and/or litigation related thereto was relayed or provided to her?

Response:

Please see the response to 48(A), above.

- F. When did your staff begin “removing” Solicitor General Kagan from meetings on this matter? On what basis did you take this action? In what other matters was such action taken?**

Response:

Please see the response to 48(A), above.

- G. As noted above, in a January 8, 2010 email, Deputy Solicitor General Neal Katyal wrote that “Elena would definitely like OSG to be involved in this set of issues.” Katyal later wrote that he wanted the Solicitor General’s office to be “heavily involved even in the dct [district court].” Are you aware of any conversation or meeting in which Justice Kagan approved the involvement of the Solicitor General’s office as described in this email, i.e., “in the [district court],” or the basis on which she justified that involvement?**

Response:

Please see the response to 48(A), above.

- H. Did you ever have a conversation with Justice Kagan regarding her recusal from matters before the Supreme Court related to the Patient Protection and Affordable Care Act? If so, please describe the circumstances and substance of those conversations.**

Response:

Please see the response to 48(A), above.

- 49. As you know, Assistant Attorney General for the Civil Rights Division Tom Perez – who has not appeared as counsel in your Department’s lawsuit against Alabama with respect to H.B. 56 – has sent letters to the superintendent of every school district in Alabama demanding information related to the pending litigation without setting forth any legal authority that would compel its production. Although Mr. Perez referred to Title IV of the Civil Rights Act of 1964, 42 U.S.C. § 2000c-6, and the Equal Educational Opportunities Act, 20 U.S.C § 1703, neither of those statutes gives the Attorney General the authority to compel the requested information unless the Department of Justice has received written complaints, determined that the complaints are meritorious, and determined that the complainants are unable to bring a suit on their own. If all of those conditions are satisfied, then the Department of Justice may initiate a civil action on behalf of the complainants and**

presumably seek the requested information through the discovery process. Please provide the legal basis upon which this request was made.

Response:

On October 31, 2011, the Civil Rights Division sent information requests to 39 school districts in Alabama, or about one-third of the total school districts in the state. The legal basis for these requests was the Department's express authority to investigate and enforce Title IV of the Civil Rights Act of 1964, 42 U.S.C. § 2000c-6, and the Equal Educational Opportunities Act, 20 U.S.C § 1703. We requested that Alabama school districts provide student enrollment, attendance, and withdrawal data to assist us as we review of compliance with those statutes.

As you have noted, Title IV of the Civil Rights Act requires that certain conditions are met before I may authorize initiating suit. At this time, the Department has not filed an action under Title IV, and so no certification under Title IV has been made or is required. Accordingly, the October 31 information request to school districts expressly noted that the Civil Rights Division's pending inquiry was "preliminary in nature."

50. **It is my understanding that the Office of the Attorney General of Alabama has requested that the Justice Department share any information regarding any alleged complaints with respect to H.B. 56, as the State of Alabama is determined to see that school children are protected from any alleged unlawful activity. Please provide my office and the Office of the Attorney General of Alabama with copies of any written complaints received with respect to the alleged discrimination against school children in Alabama. If the Department has received complaints through the hotline that it set up, please provide a description of those complaints to my office and to the Office of the Attorney General of Alabama.**

Response:

As you know, the Department cannot disclose information from confidential law enforcement files pertaining to an open and ongoing investigation. As we noted in our November 4, 2011 letter to the Attorney General of Alabama, the complaints we have reviewed may implicate non-discrimination statutes related to education that the Department has express authority to investigate and enforce.

51. **In his November 1, 2011 letter to the Alabama school superintendents, Assistant Attorney General Perez expressed the Department of Justice's concern "that the requirements of Alabama's H.B. 56 may chill or discourage student participation in, or lead to the exclusion of school-age children from, public education programs based on their or their parents' race, national origin, or actual or perceived immigration status." Meanwhile, the Superintendent of the Alabama Department of Education has made "clear that no child will be denied an education based on unlawful status or on a failure to provide the requested documentation." Is it the**

Department of Justice’s position that, in addition to prohibiting a state from “deny[ing] a discrete group of innocent children the free public education that it offers to other children residing within its borders . . . [absent] a showing that it furthers some substantial state interest,”¹ the Equal Protection Clause further prohibits states from implementing policies that might have a “chilling effect” on the enrollment of children of illegal aliens? Please explain your answer.

Response:

As the Supreme Court stated in *Plyler v. Doe*, “denial of education to some isolated group of children poses an affront to one of the goals of the *Equal Protection Clause*: the abolition of governmental barriers presenting unreasonable obstacles to advancement on the basis of individual merit.” 457 U.S. 202, 221-222 (1982) (emphasis in original). In addition to the protections the Court set forth in *Plyler*, the Department also enforces or coordinates the enforcement of multiple statutes that protect students’ equal rights to access educational opportunities and prohibit discrimination in public education. Title IV of the Civil Rights Act of 1964, 42 U.S.C. § 2000c-6, prohibits discrimination in public schools on the basis of race, color, and national origin. Title VI prohibits discrimination on these same bases by recipients of Federal financial assistance, and Title VI’s implementing regulations, 28 C.F.R. § 42.104(b)(2) and 24 C.F.R. § 100.3(b)(2), prohibit schools from adopting or using criteria or methods which have the effect of discriminating on these bases. Accordingly, under Federal law, states cannot adopt policies or practices that prevent, discourage, or lead to the exclusion of students from public education based on their or their parents’ actual or perceived immigration status. Policies that have a chilling effect on enrollment may impermissibly prevent students from accessing the educational opportunities to which they have equal rights.

52. According to 8 U.S.C. § 1373, U.S. Immigration and Customs Enforcement is required to respond to inquiries by state and local law enforcement officers about the immigration status of detained individuals. However, Secretary Napolitano has stated that the Department of Homeland Security will not cooperate with the State of Alabama in this regard, but will cooperate with the Department of Justice in its effort to enjoin state laws such as Alabama’s H.B. 56.

A. Have you advised DHS and/or ICE that there is a clear congressional directive to cooperate with state and local law enforcement officers seeking information about immigration status?

Response:

In its litigation against Alabama’s H.B. 56, the federal government did not state that it would not respond to inquiries under 8 U.S.C. § 1373; rather, the federal government argued that a mandatory state verification scheme of the type enacted in H.B. 56 would hinder the Department of Homeland Security’s ability to effectively respond to various high priority immigration verification and enforcement matters. For further details on this issue, we refer you to the brief filed by the Department in *United States v. Alabama*, N.D. Ala., No. 11-J-2746,

¹ *Plyler v. Doe*, 457 U.S. 202, 230 (1982).

available at <http://www.justice.gov/opa/documents/motion-preliminary-injunction.pdf>, as well as the Department of Homeland Security's "Guidance on State and Local Governments' Assistance in Immigration Enforcement and Related Matters," available at <http://www.dhs.gov/files/resources/guidance-state-local-assistance-immigration-enforcement.shtm>.

- B. Why is the executive branch unwilling to respond to inquiries from local authorities when they have arrested someone who appears to be unlawfully present in the U.S.?**

Response:

The federal government is willing to respond to such inquiries, and this question should be directed to the U.S. Department of Homeland Security.

- 53. Please provide the amounts expended by the Department in its litigation against (a) the State of Arizona; (b) the State of Alabama; and (c) the State of South Carolina.**

Response:

The Department has spent roughly (a) \$385,020 in litigation against the State of Arizona; (b) \$159,000 in litigation against the State of Alabama; and (c) \$34,357 in litigation against the State of South Carolina. The U.S. Attorney's Offices for the District of Arizona, the Northern District of Alabama, and the District of South Carolina participated in this litigation with the other components of the Department, however, the U.S. Attorney's Offices do not record the costs of litigating individual cases.

- 54. According to 8 U.S.C. § 1373(a), Notwithstanding any other provision of Federal, State, or local law, a Federal, State, or local government entity or official may not prohibit, or in any way restrict, any government entity or official from sending to, or receiving from, the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual.**
- a. Cook County, Illinois, recently passed an ordinance prohibiting local law enforcement from cooperating with ICE detainers, ostensibly in direct violation of this statute. Does the Department plan to take any action against Cook County, Illinois? If not, why?**

Response:

As we have stated previously, under the Immigration and Nationality Act and its implementing regulations, the Department of Homeland Security is responsible for determining how and under what circumstances it will use detainers as part of its immigration enforcement

regime. It is in the best position to determine whether Cook County's policy regarding detainees conflicts with existing law and its practice with respect to detainees in Cook County.

- b. Does the Department plan to take any action against other jurisdictions, such as Santa Clara and San Francisco counties in California and Washington, D.C., which have a *de facto* policy of refusing to comply with federal immigration law enforcement? If not, why?**

Response:

Please see the response to Question 54(A), above. We cannot speculate as to any action we might or might not take against any jurisdiction.

- 55. Congress has passed several laws that require states to play an important role in enforcing federal immigration laws, including statutes that require states to provide information about persons they come across that are unlawfully present in the U.S. In addition, Congress has expressly required federal agencies to cooperate with the states and provide information about immigration status in response to their inquiries.**

- a. Is it the Department's position that, notwithstanding those Congressional directives, local law enforcement officials do not have the authority to verify a person's immigration status once that person is lawfully stopped or arrested?**

Response:

The Department's position has been that state laws that mandate that local law enforcement officials verify a person's immigration status conflict with federal law, because they prevent local law enforcement officers from tailoring their assistance to federal enforcement priorities – priorities which Congress has tasked DHS with establishing. Such laws, particularly when considered in the aggregate, will divert federal attention away from truly exigent circumstances, including high priority criminal aliens who may otherwise be released; and interfere with other objectives of the immigration system.

- b. Is it the Department's position that federal executive agency policy alone can preempt valid state laws? If so, what happens when that policy is contrary to federal statutes?**

Response:

The Department's position is not that federal agency policy preempts state immigration schemes. Rather, it is our position that federal law preempts these schemes. As the Supreme Court has long recognized, immigration is such "a field where flexibility and the adaptation of the congressional policy to infinitely variable conditions constitute the essence of the program."

Knauff v. Shaughnessy, 338 U.S. 537, 543 (1950). Thus, where a state attempts to remove or undermine the Executive's ability to exercise congressionally delegated authority, the state law cannot stand.

- c. **You testified that “the Department has challenged immigration related laws in several states that directly conflict with the enforcement of federal immigration policies.” How does Alabama’s H.B. 56 “directly conflict with the enforcement of federal immigration policies”?**

Response:

Alabama’s H.B. 56 was designed to affect virtually every aspect of an unauthorized alien’s daily life, including housing, transportation, school, and the ability to enter into contracts for even basic human necessities. Because Alabama’s H.B. 56 involved several immigration provisions that are invalid for a number of distinct reasons, I refer you to the brief filed by the Department in *United States v. Alabama*, N.D. Ala., No. 11-J-2746, available at <http://www.justice.gov/opa/documents/motion-preliminary-injunction.pdf>, which details how each of the challenged provisions conflicts with federal immigration law.

56. **On November 1st, Assistant Attorney General for the Criminal Division, Lanny Breuer, testified before this Committee that although he and/or his top deputies approved several ATF wiretap applications for Operation Fast and Furious, Main Justice has “only one” role in reviewing wiretap applications: “to ensure that there is legal sufficiency to make an application” to intercept communications – to ensure that the government’s petition to the federal judge is, in his words, a “credible request.” He further testified that it is the job of the district offices actually carrying out the investigation “to determine that the tactics that are used are appropriate” and that Main Justice has to rely on those prosecutors in the field and not second-guess them.**

In response to questions about Mr. Breuer’s testimony, you stated: “I don’t have any information that indicates that those wiretap applications had anything in them that talked about the tactics that have made this such a bone of contention” You added, “I’d be surprised if the tactics themselves about gun walking were actually contained in those applications.”

- A. Can the Department of Justice certify to a court that a wiretap application has what Mr. Breuer called “legal sufficiency” if Main Justice has not evaluated the tactics being used in the underlying operation?**

Response:

Sections 2510 *et seq.* of Title 18 of the U.S. Code (“Title III”) set forth the findings a court must make before authorizing a wiretap. These findings include whether there is probable cause for the requested intercept and whether necessity for it exists. Following a process that has

been in place at the Department for decades, the Department's Office of Enforcement Operations (OEO) reviews wiretap applications submitted by an Assistant United States Attorney or other federal prosecutor to ensure that the application complies with the statutory requirements set forth in Title III. OEO then prepares an analysis of whether the application satisfies both Title III's legal requirements and Department policy. Once OEO's analysis is complete, a packet containing OEO's analysis and the wiretap application is sent to a Deputy Assistant Attorney General (DAAG) in the Criminal Division for his or her review. If the reviewing DAAG is satisfied that the application meets the necessary legal requirements, then he or she will authorize the prosecutor to seek court approval for the wiretap.

B. 18 U.S.C. § 2510 et seq. expressly direct that before a wiretap may be authorized, the application must set forth "a full and complete statement as to whether or not other investigative procedures have been tried and failed or why they reasonably appear to be unlikely to succeed if tried or to be too dangerous." Can the Department of Justice certify to a court that alternative investigative techniques have been tried and failed if Main Justice does not review the alternative investigative techniques before submitting the application to the court?

Response:

Please see the response to question 56(A), above.

C. How can Department of Justice perform their role to ensure that there is legal sufficiency for a wiretap if, as you testified, there was no "information that indicates that those wiretap applications had anything in them that talked about the tactics that have made this such a bone of contention"?

Response:

Please see the response to question 56(A), above.

D. Even if Deputy Assistant Attorneys General are provided with a "summary" memorandum from the Electronic Surveillance Unit, the affidavits submitted in support of wiretap applications are very detailed and must set forth the "facts of the investigation that establish the basis for those probable cause and other statements required by Title III to be included in the application." Investigative techniques such as "gun-walking" tactics are precisely the type of facts called for in these affidavits. ATF Assistant Special Agent in Charge George Thomas Gillett told Committee staff that "while the Department of Justice wouldn't authorize the day-to-day surveillance operations of an investigative criminal enforcement group for ATF on the street level, it would, or should at least, be aware those investigative techniques were employed, had been used, and were a foundation of the Title III affidavit being sent up for approval at the highest levels of the Department of Justice."

1. **Who in the Department of Justice is responsible for reviewing affidavits in support of wiretap applications to ensure that all other investigative tactics have either failed or are impracticable?**

Response:

Please see the response to question 56(A), above.

2. **Were any of those officials made aware of the gun-walking tactics employed in Operation Fast & Furious or any similar investigations? If so, who were they?**

Response:

The Department understands that the Committee has obtained testimony from the former leaders of both ATF and the U.S. Attorney's Office in Arizona that they were unaware of the inappropriate tactics used in Operation Fast and Furious until allegations about those tactics became public. As a result, prior to that time, they did not advise Department officials in Washington of those tactics. Other operations, like Wide Receiver and Hernandez in the prior Administration, used similar tactics and the Department has produced documents to the Committee that identify those who received information about the tactics used in those matters.

57. **Senator Grassley asked why you would risk contempt of Congress by refusing to acknowledge who in the Department of Justice reviewed and prepared drafts of the Department's February 4th letter assuring Congress that "ATF makes every effort to interdict weapons that have been purchased illegally and prevent their transport into Mexico." You responded that you would "act in a manner that's consistent with the history and tradition of the department." Is there a Department of Justice policy "consistent with the history and tradition of the department" that would prohibit the Attorney General from responding to Congressional inquiries concerning the identities of Department of Justice officials who participated in preparing a materially false letter in response to a Congressional inquiry? Please explain your answer.**

Response:

Last year the Department took the extraordinary step of providing the Committee with 1,364 pages of highly deliberative material that shows how inaccurate information came to be included in the Department's February 4, 2011 letter. The production of these documents represented an exception to the position to which Administrations of both political parties have adhered regarding such deliberative material. The documents provided reflect the identities of those who participated in the drafting of the Department's letter.

58. **In a December 2010 letter to the Senate Majority and Minority Leaders, you wrote to express your opposition to Congress' decision to prohibit the use of funds to transfer detainees from GITMO to the United States for any purpose because "[i]n order to protect the American people as effectively as possible, we must be in a position to use every lawful instrument of national power to ensure that terrorists are brought to justice and can no longer threaten American lives."**

A. Do you support or oppose President Obama's issuance of executive orders to end the CIA's detention program and to terminate the CIA's use of enhanced interrogation techniques?

Response:

The Department supports President Obama's issuance of Executive Order 13491. President Obama issued Executive Order 13491, Ensuring Lawful Interrogations, in order to improve the effectiveness of human intelligence-gathering; to promote the safe, lawful, and humane treatment of individuals in United States custody and of United States personnel who are detained in armed conflicts; and to ensure compliance with the treaty obligations of the United States, including the Geneva Conventions, and domestic law.

With respect to interrogation practices, the Executive Order directed that a Task Force study and evaluate "whether the interrogation practices and techniques in Army Field Manual 2-22.3, when employed by departments and agencies outside the military, provide an appropriate means of acquiring the intelligence necessary to protect the Nation, and, if warranted, to recommend any additional or different guidance for other departments or agencies." A Task Force was assembled consisting of representatives from the relevant national security agencies, including representatives of the relevant components of the Intelligence Community responsible for interrogating terrorist detainees.

After extensively consulting with representatives of the Armed Forces, the relevant agencies in the Intelligence Community, and some of the nation's most experienced and skilled interrogators, the Task Force concluded that the Army Field Manual provides appropriate guidance on interrogation for military interrogators and that no additional or different guidance was necessary for other agencies. These conclusions rested on the Task Force's unanimous assessment, including that of the Intelligence Community, that the practices and techniques identified by the Army Field Manual or currently used by law enforcement provide adequate and effective means of conducting interrogations.

B. Do you support or oppose President Obama's decision to halt all proceedings before military commissions?

Response:

The halt on military commission proceedings has been rescinded, and I agree that military commissions, as reformed by the Military Commissions Act of 2009 and other reforms, be allowed to resume. It is essential that the government have the ability to use both military

commissions and federal courts as tools to keep this country safe. As you know, in November 2009, after consulting with the Secretary of Defense, the Attorney General referred a number of cases of detainees held at Guantanamo Bay for prosecution in military commissions.

Both systems – federal courts and our reformed military commissions – can be effective tools to disrupt terrorist plots and activities, gather intelligence through cooperation by the accused, and incapacitate terrorists through prosecution and conviction. When determining which system to use to prosecute any particular individual, we remain relentlessly practical - focusing exclusively on which option will produce a result that best serves our national security interests in the unique facts and circumstances of that case.

C. Do you support or oppose the closure of GITMO without conducting any study concerning what to do with the detainees once the facility is closed?

Response:

The President remains committed to closing the detention facility at Guantanamo Bay and to maintaining a lawful, sustainable, and principled regime for the handling of detainees, regardless of the place of detention, consistent with the full range of U.S. national security interests. The Department supports that policy.

59. **After President Obama ordered the halt of all proceedings before military commissions on his second full day in office, the chief military judge at GITMO, Army Colonel James Pohl, denied the administration's request to delay the arraignment of Abd al-Rahim al-Nashiri, who is accused of masterminding the attack on the USS Cole in October 2000. Judge Pohl said that he found the administration's arguments "unpersuasive," that delaying the case "[did] not serve the interest[s] of justice," and that "the public interest in a speedy trial [would] be harmed by the delay in the arraignment." Since the judge refused to delay the case, the administration withdrew the charges without prejudice, further delaying justice for the families of the 17 Naval officers killed in the attack on the USS Cole. As of President Obama's March 7, 2011 order, proceedings before the military commissions at GITMO have resumed, and the arraignment of Abd al-Rahim al-Nashiri finally took place on November 9th. Do you believe that the procedures and policies in place for al-Nashiri's trial before a military commission at GITMO meet constitutional standards?**

Response:

Yes. The Administration, working on a bipartisan basis with members of Congress, has successfully enacted key reforms to the military commission process in the Military Commissions Act of 2009. These reforms included a ban on the use of statements obtained as a result of cruel, inhuman, or degrading treatment, and a better system for handling classified information, among others. As a result of these reforms, the Department believes the military commissions can deliver fair trials and just verdicts and will meet constitutional standards.

60. In a speech in June of this year, you said that when it comes to the decision whether to try terrorists before military commissions or in federal courts, “politics has no place – no place – in the impartial and effective administration of justice.” But in a speech before the European Parliament in September, you reaffirmed your commitment to closing GITMO “as quickly as possible, recognizing that we will face substantial pressure.” And you testified before this Committee on November 8th that “the administration[’s] policy is to try to close Guantanamo[;] it would be an appropriate thing to do for a whole variety of reasons.”
- A. If politics has no place in determining whether to try terrorists before military commissions or in civilian courts, why is it acceptable to bow to what you perceive as the “substantial pressure” from the international community to close GITMO?

Response:

Please see response to question 30(A), above.

- B. You testified that “the men and women [at GITMO] conduct themselves in an appropriate way and that prisoners are treated in a humane fashion;” you agreed that every detainee at Guantanamo Bay has the opportunity to file a *habeas* petition in federal court to test the legality of his detention; you acknowledged that many such cases are now ongoing; and you conceded that any conviction by military commission is automatically appealed to an Article III court. Aside from international and domestic politics, which you insist have no place in deciding where and how to try terrorist suspects, what other reasons are there to close GITMO?

Response:

Please see response to question 30(A), above.

61. Do you stand by the administration’s commitment to close GITMO even though we know that according to the Director of National Intelligence, as of September 2011 over a quarter of former GITMO detainees — 161 out of nearly 600 — are either confirmed or are suspected to have returned to the battlefield?

Response:

Please see Response to question 30(a), above. We will continue to work to close the detention facility at Guantanamo Bay because that will ultimately make the Nation safer. We take any incidence of recidivism extremely seriously and that is why all of this Administration’s transfer decisions have been based upon comprehensive reviews of intelligence and threat

information. No detainee has been transferred during this Administration absent a court order unless there was unanimous consent by all agencies on the Guantanamo Task Force, based on both an assessment of the detainee's threat level and assessment of the recipient government's ability to mitigate that threat. Since August 2009, no detainee has been transferred without Congress having been given 15 days' advance notice, and no objections have been received. To date, the recidivism rate of the detainees this Administration has transferred is much lower than that of detainees transferred by the prior administration. It is also important to note that nearly half of confirmed or suspected recidivists have been neutralized by being either captured or killed. In sum, we are working across the government and with partner governments to minimize risk and keep the American people safe.

- 62. On March 26, 2010, Assistant Attorney General Ron Weich provided to the Senate Judiciary Committee a chart of international terrorism and terrorism-related prosecutions since September 11, 2001, as maintained by the Counterterrorism Section of the National Security Division. Mr. Weich stated that the chart is "regularly updated on a rolling basis by career federal prosecutors." Please provide to the Committee the most recently updated chart.**

Response:

An updated chart reflecting public convictions through December 31, 2011 will be provided to the Committee as soon as it is available.

- 63. It is my understanding that the Voting Section of the Civil Rights Division was alerted in October 2010 about non-citizens registered to vote as well as duplicate voter registrations in Harris County, Texas.**

- A. What actions did the Voting Section take as a result of this report?**

Response:

Because these alleged violations of the federal criminal laws fall within the jurisdiction of the Public Integrity Section of the Criminal Division of the Department of Justice, these allegations were referred to the Public Integrity Section.

- B. Did the Voting Section initiate an investigation? If not, why?**

Response:

Because these alleged violations of the federal criminal laws fall within the jurisdiction of the Public Integrity Section of the Criminal Division of the Department of Justice, these allegations were referred to the Public Integrity Section.

64. **A recent report by the U.S. Election Assistance Commission showed that several states have more registered voters than citizens recorded in the most recent census and that other states, like Colorado, have noncitizens registered to vote. Christopher Coates, former Chief of the Voting Section, testified before the U.S. Commission on Civil Rights on September 24, 2011 that the U.S. Election Assistance Commission reported in 2009 that eight states were severely out of compliance with Section 8 of the Motor Voter Act.**

A. What actions have you taken to ensure that these states come into compliance with the Motor Voter Act?

Response:

The Department of Justice has initiated investigations of a number of states to determine whether they are in compliance with the requirements of Section 8 of the NVRA. The Department continues to review NVRA compliance around the country, including consideration of the Election Assistance Commission's nationwide NVRA data issued this year. Last year, for the first time ever, the Department published on its website a document providing comprehensive guidance to state and local officials and the public concerning implementation of all of the requirements the NVRA. The feedback that the Department has received has indicated that many have found this guidance to be helpful.

B. How many Section 8 cases has the Voting Section brought under the Motor Voter Act since 2009?

Response:

While the Department of Justice has initiated a number of new investigations under Section 8 of the NVRA since 2009, it has not brought any new cases under Section 8 since 2009.

65. **Coates also testified that that Loretta King, the former Assistant Deputy Attorney General of the Civil Rights Division, expressed to Coates that she was opposed to race neutral enforcement of the Voting Rights Act. Coates further testified that this view has been adopted by the administration.**

A. Are you opposed to race neutral enforcement of the Voting Rights Act?

Response:

The Department of Justice is committed to vigorous enforcement of all federal civil rights laws it is charged with enforcing, including the Voting Rights Act, and will pursue civil rights violations regardless of the race of either the victims or the perpetrators.

B. Section 2 of the Voting Rights Act states, "No voting qualification or prerequisite to voting or standard, practice, or procedure shall be imposed or

1177

applied by any State or political subdivision in a manner which results in a denial or abridgement of the right of any citizen of the United States to vote on account of race or color..." Do you agree that this section applies to all U.S. citizens?

Response:

Yes.

QUESTIONS POSED BY SENATOR CORNYN

66. **The National Trails System Act allows inactive railways to be converted into public recreational trails. The Department of Justice is currently grappling with thousands of takings claims related to the conversion of privately held railroad corridors, including cases affecting South Carolina landowners.**

A. Please provide a general update on the status of these takings cases, the number of pending cases, and the progress in resolving them.

Response:

The Department presently is defending approximately 60 Fifth Amendment takings cases involving the National Trails System Act ("Trails Act"). Virtually all of these cases are pending in the United States Court of Federal Claims, with a few pending in some federal district courts. The cases seek just compensation for the alleged taking by the United States of easements from landowners along railroad corridors located throughout the United States. Railroad corridors in approximately 30 states presently are being litigated, requiring the application of statutory and court-issued law for each state. The cases vary in size, with the smallest involving a single plaintiff and the largest involving approximately 2500 claims. Approximately half of the cases have been certified by the courts as opt-in class actions, which adds procedural complexity. The cases involve resolution of questions about the meaning and scope of a wide variety of 19th Century property transfers through written deeds, direct condemnations, federal land grants, and adverse possession.

The pending cases are in different stages of proceedings, with some only recently filed and others at various stages of resolution. Depending on the nature of plaintiffs' property interests and the applicable state law, various legal issues may require resolution by the court. Where appropriate, the Department of Justice seeks to resolve issues through negotiation with the opposing party, including the determination of compensation.

B. Please describe what policies or practices the Department of Justice has implemented since the 2002 hearing in which Assistant Attorney General Sansonetti testified that the Department would work to more promptly and cost-effectively resolve this litigation.²

Response:

In his 2002 testimony, Assistant Attorney General Sansonetti emphasized the Department's efforts in resolving Trails Act takings cases promptly and cost-effectively, including through the use of Alternative Dispute Resolution (ADR) techniques. ADR – particularly in the form of direct negotiation between the parties – has proven successful in many

² See *Litigation and its Effects on the Rails-to-Trails Program: Hearing Before the Subcomm. on Commercial and Administrative Law of the H. Comm. on the Judiciary*, 107th Cong. 2 (2002) (Statement of Thomas L. Sansonetti, Asst. Att'y General, Environment and Natural Resources Division, U.S. Dept. of Justice).

of our Trails Act cases. Although it can take many different forms, ADR in these cases often includes streamlining techniques to reduce the burden of title analysis, including categorization of conveyances into groups of similar instruments and the use of stipulations on those categories that are to be evaluated by well-settled state law. Streamlining techniques also are applied to reduce appraisal costs and expedite valuation determinations, including the grouping of properties based on current use and physical location and the use of representative-parcel valuations to achieve global monetary settlements. This latter process has proven especially effective once the court has resolved certain threshold issues that can significantly influence an appraiser's determination of a property's value. Approximately 40 Trails Act cases have been fully resolved since 2002, and dozens more have been significantly advanced during that time-period.

AAG Sansonetti also testified that ADR "is not a panacea. For ADR to be successful, both sides . . . must want to make it work. And also, the parties must have sufficient information about the factual and legal merits of their claims to be able to appropriately evaluate them." This latter point cannot be overstated. The federal courts have emphasized that liability determinations in Trails Act cases requires an examination of each conveyance document against the law of the state where the property is located. This analysis has resulted in the dismissal of claims by hundreds of plaintiffs who, after careful review by the court, were found to not own the property interests they contended was taken. In other instances, claims were dismissed when courts determined that interim trail use and railbanking were within the scope of the easements conveyed to the railroad. While this process is often burdensome, it cannot be circumvented without it resulting in the improper payment of millions of dollars to countless individuals who have suffered no harm under the law.

C. What additional policies or practices will the Department of Justice adopt to more fairly, promptly, and cost effectively resolve pending and future National Trails System Act takings claims?

Response:

The Department endeavors to resolve these cases fairly, promptly, and cost effectively, as the very large number of pending Trails Act cases places a substantial burden on the limited resources of the Department. As to currently pending cases, longstanding Department policy prohibits me from discussing the specifics of matters in litigation. Future cases will benefit from precedent established through resolution of the current cases, which should help to facilitate a narrowing of issues by the courts. Among the issues that we will seek to resolve is the proper means of determining attorneys' fees to be awarded to plaintiffs' counsel. These class-action attorneys frequently seek payment by the United States of attorneys' fees that significantly exceed the amount of compensation awarded to their clients, thus complicating the Department's ability to settle cases or bring court-resolved cases to a prompt conclusion.

67. Houston-based firearms dealer Carter's Country has publicly alleged that, between 2006 and 2010, ATF agents repeatedly directed their store clerks to go through with the sale of firearms to suspicious purchasers who may have been working on behalf

of Mexican drug cartels. The Attorney for Carter's Country has publicly confirmed that, in many instances, ATF did not show up to interdict the weapons that they directed store clerks to transfer to suspected drug cartel straw purchasers.

Additionally, congressional investigations have revealed that one of the weapons used in the February 15, 2011 murder of one of my constituents—U.S. ICE agent Jaime Zapata— was purchased by Otilio Osorio, a firearms trafficker that ATF may have had under surveillance at least 23 days prior to the date on which he was allowed to purchase this murder weapon. Our investigations have also revealed that, on November 10, 2010, Mr. Osorio and two co-conspirators illegally transferred 40 weapons with obliterated serial numbers to an ATF informant as part of an investigation of the Los Zetas drug cartel.

This evidence raises serious concerns that ATF may have used “gun-walking” tactics in Texas under your watch. On August 11, 2011, I sent you a letter asking that you promptly disclose the details of any past or present Texas-based “gun-walking” program operated by your department. As of the date these questions were sent to you, your department has failed to provide an answer to my letter.

- A. Can you assure my constituents that ATF has not used “gun-walking” tactics in Texas under your watch?

Response:

Following the public revelation of inappropriate tactics used in Fast and Furious, the Department endeavored to identify ATF operations in which similar tactics were used. The Department thereafter notified the Committee of the additional operations it had identified, including some that occurred during the prior Administration. As we have noted, after the Attorney General learned of the inappropriate tactics used in Operation Fast and Furious, he instructed the Deputy Attorney General to issue a directive that those tactics not be used anywhere in the country, including in Texas.

- B. Why did your department fail to arrest Otilio Osorio and his two co-conspirators immediately after they illegally transferred 40 weapons with obliterated serial numbers to an ATF informant?

Response:

The investigation and prosecution of those responsible for Special Agent Zapata’s murder are ongoing. For that reason, and because disclosure could compromise these efforts, the Department is not in a position to provide additional information at this time.

- C. Was the weapon purchased by Otilio Osorio and subsequently used to murder agent Zapata trafficked to Mexico after November 8, 2010—the date on which ATF could have arrested Mr. Osorio for illegally transferring 40 weapons with an obliterated serial number to an ATF informant?

Response:

Please see the response to question 67(B), above.

- D. Can you assure the family of Agent Zapata that your department had no reason to believe that Otilio Osorio was involved in weapons trafficking either on or prior to October 10, 2010—the date on which he purchased one of the weapons used to murder agent Zapata?**

Response:

Department officials have been in direct contact with Special Agent Zapata's family about this matter.

- E. If you are unwilling to answer my questions, when can I expect a response to my August 11 letter that asked you to promptly disclose the details of any past or present Texas-based "gun-walking" program operated by the ATF?**

Response:

Please see the response to question 67(A), above.

- 68. According to data published by the U.S. Attorney's Office for the District of Arizona, Operation Fast and Furious has had significant spillover effects in the State of Texas. See: http://www.justice.gov/usao/az/press_releases/2011/Fast_Furious_Map_ATF.pdf. For instance, at least 119 firearms "walked" by your department as a part of Operation Fast and Furious have been recovered in my home state.**
- a. Please give an account of every Operation Fast and Furious firearm recovery in the State of Texas, including: (1) a description of the weapon; (2) the name of the purchaser of the weapon, if known; (3) the name of the person who possessed the weapon at the time of the recovery; (4) the purchase date of the weapon; (5) the particular purchase location of the weapon; (6) the particular recovery location of the weapon; (7) the name of the law enforcement agency that recovered the weapon; and (8) a description of the circumstances that led to the recovery of the weapon.**

Response:

Documents provided to the Committee have contained information about firearms associated with Operation Fast and Furious that were recovered in the State of Texas.

- b. **If you are unwilling to give an account of every Operation Fast and Furious firearm recovery in the State of Texas, as requested above, then please provide some detail about the 57 Operation Fast and Furious weapons that have been recovered in San Antonio.**

Response:

The 57 weapons referenced in the website link above pertain to firearms that ATF believes were purchased by individuals who have been indicted in connection with Operation Fast and Furious. Since the prosecution of those individuals remains pending, we are not in a position to disclose additional information about those weapons at this time.

69. **Beginning as early as July 5, 2010, your office received a series of at least 14 memos addressed to you that discussed the details of "Operation Fast and Furious." In a July 5th memo addressed to you, National Drug Intelligence Center Director Michael Walther wrote that:**

"From July 6 through July 9, the National Drug Intelligence Center Document and Media Exploitation Team at the Phoenix Organized Crime Drug Enforcement Task Force (OCTDETF) Strike Force will support the Bureau of Alcohol, Tobacco, Firearms, and Explosives' Phoenix Field Division with its investigation of Manuel Celis-Acosta as part of OCTETF Operation Fast and Furious. This investigation, initiated in September 2009 in conjunction with the Drug Enforcement Administration, Immigration and Customs Enforcement, and the Phoenix Police Department, involves a Phoenix-based firearms trafficking ring headed by Manual Celis-Acosta. Celis-Acosta and [redacted] straw purchasers are responsible for the purchase of 1,500 firearms that were then supplied to Mexican drug trafficking cartels. They also have direct ties to the Sinaloa Cartel which is suspected of providing \$1 million for the purchase of firearms in the greater Phoenix area."

Additionally, in a November 1st, 2010 memo addressed to you, entitled "SIGNIFICANT UPCOMING EVENTS," Assistant Attorney General Lanny Breuer, one of your chief deputies, wrote that:

"On October 27, the organized Crime and Gang Section (OCGS) indicted eight individuals under seal relating to the trafficking of 228 firearms to Mexico. The sealing will likely last until another investigation, Phoenix-based "Operation Fast and Furious," is ready for takedown."

These memos deal with highly controversial and sensitive subject matter, namely the trafficking of firearms that were supplied to Mexican drug cartels. Taken at face value, these memos raise concerns that should have reasonably been further

investigated by the chief law enforcement officer of the United States. I would like to ask you a series of questions about these memos.

- A. **At the Senate Judiciary Committee oversight hearing on November 8, you unequivocally told me that you had not ever “received” these memos. Can you assure me that these memos were never placed on your desk or in your constructive possession?**

Response:

As the Attorney General testified, these weekly reports, which contain brief, high-level summaries of a number of matters, were provided to members of his staff and the information about which you have asked was not brought to his attention. These brief summaries did not say anything about the inappropriate tactics used in Operation Fast and Furious; as a result, it is not surprising that the Attorney General’s staff did not bring the weekly reports to his attention.

- B. **At the Senate Judiciary Committee oversight hearing on November 8, in reference to these memos, you told me that: “there was no need for them [your staff] to bring to my attention the reports.”**
1. **Do you still believe that there is no need for your staff to bring to your attention a memo that details the transfer of “1,500 firearms” to straw purchasers who then “supplied” these firearms to “Mexican drug trafficking cartels”—especially where nearly identical language was written to your personal attention on at least six separate occasions?**

Response:

Please see the response to question 69(A), above.

2. **Shouldn’t our nation’s chief law enforcement officer have notice of an operation involving some of the sensitive and controversial considerations detailed in these memos?**

Response:

Please see the response to question 69(A), above.

- C. **Do you think it was acceptable for you to not be given the November 1, 2010 memo that discussed “the trafficking of 228 firearms to Mexico”—especially where the memo was personally addressed to you, from your chief deputy, and written under the heading of “SIGNIFICANT RECENT EVENTS?”**
1. **Wouldn’t all of this, on its face, suggest to a reasonable person that the memo was relatively important?**

Response:

Please see the response to Question 69(A). In addition, we note that the November 1, 2010, memorandum – and the reference to 228 firearms – concerned the second indictment obtained by the Criminal Division’s Gang Unit in *Operation Wide Receiver*, which, as you know, was investigated by ATF during the prior Administration.

2. **Wouldn’t it also suggest that the nation’s chief law enforcement officer should be at least somewhat familiar with the details of the investigation described in the memo?**

Response:

Please see the responses to questions 69(A) and 69(C)(1), above.

- D. **Has anyone been held accountable for failing to bring to your attention any of the memos addressed to you that discussed Operation Fast and Furious before you have testified that you became aware of that program?**

Response:

Please see the response to question 69, above.

- E. **Do you believe that anyone should be held accountable for failing to bring these memos to your attention?**

Response:

Please see the response to question 69(A), above.

70. **On January 30, 2011 Senator Grassley handed you two letters outlining his questions and concerns regarding Operation Fast and Furious. At the November 8, 2011 Senate Judiciary Committee oversight hearing, you responded to my question about this letter by saying that “I did” investigate the allegations contained in the letter after receiving it. On February 4, 2011, however, [Assistant] Attorney General Ron Weich sent a letter to Senator Grassley stating that “the allegation described in your January 27 letter—that ATF ‘sanctioned’ or otherwise knowingly allowed the sale of assault weapons to a straw purchaser who then transported them to Mexico—is false.” We have now learned that Assistant Attorney General Lanny Breuer had knowledge of ATF “gun-walking” tactics as early as April 2010.**

- A. **When you “investigated” the allegations in Senator Grassley’s January 30, 2011 letter, did you consult with Assistant Attorney General Lanny Breuer?**

Response:

Last year the Department took the extraordinary step of providing the Committee with 1,364 pages of highly deliberative material that shows how inaccurate information came to be included in the Department's February 4, 2011 letter. The production of these documents represented an exception to the position to which Administrations of both political parties have adhered regarding such deliberative material. The documents provided reflect the identities of those who participated in the drafting of the Department's letter.

- B. If not, given the extremely serious allegations in Senator Grassley's letter, why did you fail to consult with your chief deputy who is directly charged with oversight of the ATF?**

Response:

Please see the response to question 70(A), above. In addition, we note that Assistant Attorney General Breuer is the head of the Department's Criminal Division; his duties do not include "oversight of the ATF."

- C. Why did you fail to share the information contained in Senator Grassley's January 30, 2011 letter with [Assistant] Attorney General Ron Weich, and instead allow him to submit a letter to Congress containing materially false information?**

Response:

Please see the response to question 70(A), above.

- D. Did Assistant Attorney General Breuer view [Assistant] Attorney General Weich's February 4, 2011 letter prior to its submission to Senator Grassley?**

Response:

Assistant Attorney General Breuer answered this question during his appearance before the Committee on November 1, 2011 and in his responses to questions for the record arising from that appearance.

- 1. If so, why did Assistant Attorney General Breuer fail to correct the letter?**

Response:

Please see the response to question 70(D), above.

- 2. If not, given the serious nature of the allegations involved, why did [Assistant] Attorney General Weich fail to consult with the Assistant**

Attorney General—the Department of Justice official directly charged with oversight of the ATF?

Response:

Please see the responses to questions 70(A) and 70(B), above.

- E. Do you think it is ever excusable for the Department of Justice to send a letter containing false or inaccurate information to Congress where you and/or one of your chief deputies has knowledge or reason to believe that the information contained in the letter is false or inaccurate?**

Response:

The Department takes seriously its obligation to provide Congress with accurate information. After it became clear that the Department's February 4, 2011 letter to Senator Grassley contained inaccurate information, the Department appropriately withdrew that letter. Further, the Department provided the Committee with 1,364 pages of highly deliberative material in order to accommodate the Committee's interest in understanding how the inaccurate information came to be included in the February 4, 2011 letter. This extraordinary accommodation represented an exception to the Department's longstanding position across Administrations of both political parties with respect to deliberative material generated in the course of responding to congressional oversight. Finally, as detailed in a letter to the Committee from Deputy Attorney General Cole dated January 27, 2012, the Department has taken additional steps to ensure that Congress receives accurate information in response to its requests.

- F. If not, has anyone been held accountable for the February 4th, 2011 letter from Deputy Attorney General Ron Weich to Senator Grassley which contained false information?**

Response:

Please see the response to question 70(E), above.

- 71. In your testimony before the House Judiciary Committee on May 3, 2011, you told Representative Issa that you were not sure of the exact date you learned about Operation Fast and Furious, but that it was "probably. . .over the last few weeks." We now know that this statement was false. During my questions at the November 8, 2011 Senate Judiciary Committee oversight hearing, you told me that a better way to have expressed the date on which you learned about Operation Fast and Furious would have been "over the last couple of months." However, at that same hearing, you also admitted that you were familiar with the contents of two letters that Senator Grassley personally handed to you on January 30, 2011 outlining his questions and concerns regarding Operation Fast and Furious.**

- a. It seems to me that more than a “couple of months” separate January 30, 2011 from May 3, 2011, when you told the House Judiciary Committee that you had learned about Operation Fast and Furious “over the last few weeks.” Please take this opportunity to clarify your statements and estimate the exact date on which you learned about Operation Fast and Furious.

Response:

As the Attorney General has testified previously, his first recollection of Operation Fast and Furious dates to early 2011, when the allegations of inappropriate tactics used in that operation became public.

72. In your testimony before the Senate Judiciary Committee at your confirmation hearing in January 2009, you said “we will carry out our constitutional duties within the framework set forth by the Founders, and with the humility to recognize that congressional oversight and judicial review are necessary; they are beneficial attributes of our system and of our Government.” During my questions, I asked you if “you would work with us to open up the government, to make it more transparent and accountable.” In response to my question, you said “yes, exactly right.” Similarly, during Senator Grassley’s questions at that same hearing you pledged “to be responsive to all congressional requests for information and provide this information to Congress in a timely manner.”

Your conduct throughout the congressional investigation into ATF “gun-walking” schemes has, however, spectacularly failed to meet the standard of transparency that you promised, under oath, to uphold during your confirmation proceedings. As a point of reference, this investigation would not have existed but for ATF whistleblowers coming to Congress and asking us to investigate. To this day, your department’s failure to comply with congressional requests forces us to rely on whistleblowers to answer our questions. For example, it took your department nearly three months to acknowledge and expressly refuse to answer a letter I sent to you on August 11, 2011 asking that you promptly disclose the details of any past or present Texas-based “gun-walking” program.

- A. Do you believe this is a legitimate congressional investigation?

Response:

Congress has raised legitimate questions about the inappropriate tactics used in Operation Fast and Furious. The Department has worked diligently to provide answers to those questions and to questions about similar operations in the prior Administration such as Wide Receiver, Hernandez, and Medrano. The Department has responded to more than three dozen letters from Members of Congress; facilitated numerous witness interviews; and provided to Congress over 7,000 pages of documents, including virtually unprecedented access to 1,364 pages of highly deliberative material showing how inaccurate information came to be included in the

Department's February 4, 2011 letter. The Department is committed to working with Congress to address the public safety and national security crisis along the Southwest Border.

B. Why did we have to rely on whistleblowers to begin this investigation?

Response:

As the Attorney General has said, he was unaware of the allegations of inappropriate tactics in Operation Fast and Furious until they were made public in early 2011.

C. Have you commended the whistleblowers who risked their careers to come forth and expose the ill-advised "gun-walking" tactics used by ATF under your watch?

Response:

In the Attorney General's opening remarks before this Committee, he said that "we have a responsibility to act" to stop the flow of illegal guns to Mexico, and we "can start by listening to the agents, the very agents who serve on the front lines of the battle and who testified here in Congress." As the Attorney General noted, "[n]ot only did they bring the inappropriate and misguided tactics of Operation Fast and Furious to light[,] [t]hey also sounded the alarm to Congress that they need our help. ATF agents who testified before a House committee [last] summer explained that the agency's ability to stem the flow of guns from the United States into Mexico suffers from a lack of effective enforcement tools."

The Attorney General likewise commended these ATF agents during his testimony before the House Judiciary Committee in December 2011.

D. Why does your department continue to withhold documents and witnesses so that we have to rely on whistleblowers to answer our questions?

Response:

As the Department has made clear, materials responsive to the House Oversight and Government Reform Committee's October 11, 2011 subpoena, and witnesses requested by the Committee for transcribed interviews, have been made available to the Committee consistent with the Department's practices in this area across Administrations of both political parties. *See Letter from Deputy Attorney General James M. Cole to Hon. Darrell E. Issa at 4 (Feb. 1, 2012); Letter from Assistant Attorney General Ronald Weich to Hon. Darrell E. Issa (Dec. 6, 2011).*

E. Will you assure the members of this committee that our future requests for information will be promptly and fully complied with?

Response:

Please see the response to question 72(D), above.

73. **Mexico is currently embroiled in a fight for its life against international drug cartels. Additionally, on October 31, 2011, news reports confirmed that some cartel-related violence spilled over into the United States in Hidalgo, Texas. In 2008 the United States entered into a security cooperation agreement, known as the Merida Initiative, in order to combat the threats of drug trafficking and transnational organized crime. However, at least 195 firearms “walked” by your department as a part of Operation Fast and Furious have been recovered at crime scenes in Mexico—many of which were committed by the agents of drug cartels.**

A. Have you spoken with Mexican officials about the tragic consequences of your Department’s “gun-walking” operations?

Response:

The details of conversations between the Attorney General and his counterparts in the Mexican government are not appropriate for public discussion. However, the cooperative relationship between the Justice Department and the Mexican government in combating drug cartels has been – and continues to be – unprecedented. The collaboration between the two countries has included the extradition of large numbers of defendants from Mexico to the United States; the sharing of intelligence between U.S. and Mexican law enforcement; our work with vetted law enforcement units in Mexico; and the creation of joint task forces with our Mexican partners.

B. If so, please detail all communications you have had with Mexican official’s regarding your Department’s “gun-walking” operations.

Response:

Please see the response to question 73(A), above.

C. As of the date on which these questions were sent to you, there are still have more than 1,000 unrecovered weapons from Operation Fast and Furious, most of which are likely in Mexico. What are you doing each and every day to ensure that these weapons are recovered before they end up at crime scenes?

Response:

The details of ongoing law enforcement investigations are not appropriate for public discussion. However, as the Attorney General said in his opening statement before this Committee on November 8, 2011, Operation Fast and Furious was flawed in its concept and flawed in its execution. He acknowledged that the effects of these mistakes will be felt for years to come as guns that were lost during this operation continue to show up at crime scenes both here and in Mexico.

D. Do you believe that your department's tactics have caused irreparable damage to the United States' relationship with Mexico?

Response:

The Department's cooperation with the Mexican government in combating drug cartels has been – and continues to be – unprecedented. The collaboration between the two countries has included the extradition of large numbers of defendants from Mexico to the United States; the sharing of intelligence between U.S. and Mexican law enforcement; our work with vetted law enforcement units in Mexico; and the creation of joint task forces with our Mexican partners. That said, the inappropriate tactics employed in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez, and Medrano, should never have been used. That is why, in February 2011, the Attorney General requested that the Department's Office of the Inspector General conduct a review; and why, in early March 2011, the Attorney General instructed the Deputy Attorney General to issue a directive making clear that such tactics should not be used.

74. **As you know, on October 18, 2011, I offered an amendment to the CJS appropriations bill that would cut off all funding for the Department of Justice to conduct "gun-walking" programs similar to Operation Fast and Furious. That amendment passed the Senate with unanimous, bipartisan support.**

A. Do you personally support this amendment?

Response:

This amendment is consistent with Department policy and is therefore unnecessary, but the Department does not object to its adoption.

B. What do you say to the 99 members of the United States Senate who could not trust you to end the ill-advised practice of "gun-walking" on your own?

Response:

Any suggestion that the Attorney General did not act swiftly to end the use of these inappropriate tactics after learning of them is wrong. Shortly after the allegations of inappropriate tactics in Operation Fast and Furious were made public, the Attorney General took decisive action to ensure that the tactics employed in Operation Fast and Furious and in operations in the prior Administration like Wide Receiver, Hernandez, and Medrano, were not used again. The Attorney General asked the Department's Office of the Inspector General to conduct a review and he instructed the Deputy Attorney General to issue a directive making clear that such tactics should not be used.

- C. Can you assure the American people that “gun-walking” programs like Operation Fast and Furious are not currently being administered by your department, and that they will never again occur under your watch?**

Response:

The Attorney General has made clear that the inappropriate tactics used in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez, and Medrano are inconsistent with Department policy and he instructed the Deputy Attorney General to issue a directive that these tactics should not be used.

- D. What specific steps have you taken to ensure that “gun-walking” programs like Operation Fast and Furious are not currently being administered by your department, and that they will never again occur under your watch?**

Response:

In a letter to Chairman Leahy and other members dated January 27, 2012, Deputy Attorney General James Cole described the reforms the Department has instituted to ensure that the inappropriate tactics used in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez, and Medrano are not used again. The Attorney General also requested a review of these issues by the Department’s Office of the Inspector General and instructed the Deputy Attorney General to issue a directive indicating that these tactics should not be used.

- 75. Throughout your career, you have supported strict gun control regulations—including long-gun registration requirements and bans on certain automatic weapons. Additionally, in 2007, you signed on to an amicus brief in the *Heller* case which argued that the right to bear arms was not an individual right. On November 1, 2010, Assistant Attorney General Lanny Breuer told National Public Radio: “if any good can come of this horrific, terrible tragedy [Operation Fast and Furious], it should be that America has a serious and real conversation about our gun laws today.”**

- A. Do you agree with Assistant Attorney General Breuer’s statement, even though Operation Fast and Furious involved federally-licensed firearms dealers who affirmatively raised red flags about the weapons purchases in question—and were nonetheless directed by ATF to go through with the sale of these weapons? It seems to me that Operation Fast and Furious has actually shown us that legitimate American firearms dealers are very careful about the persons to whom they sell weapons.**

Response:

Operation Fast and Furious was a fundamentally flawed operation that employed inappropriate tactics. The same whistleblowers who alerted Congress to the inappropriate tactics used in Fast and Furious have also called on Congress to give ATF more effective tools to combat gun trafficking and improve public safety.

B. Do you agree that the most important conversation that the American people should be having as a result of Operation Fast and Furious is how we will ensure that your Department never again engages in the practice of “gun-walking?”

Response:

The Department has a responsibility to ensure that the inappropriate tactics used in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez, and Medrano, are not used again. At the same time, Congress must provide law enforcement with the tools needed to prevent the acquisition of weapons by people who are not permitted to possess them, as well as the trafficking of those weapons across our border with Mexico.

C. What do you say to the multiple firearms dealers who assisted the ATF in Operation Fast and Furious under the express understanding that the weapons involved would be interdicted by your Department prior to the termination of direct surveillance?

Response:

The Department is grateful for the cooperation that FFLs provide to law enforcement every day to ensure that weapons are kept out of the hands of those not legally entitled to possess them. As the Attorney General has said repeatedly, the tactics used in Operation Fast and Furious and in similar operations in the prior Administration like Wide Receiver, Hernandez, and Medrano, were inappropriate and should not be used again.

76. In your November 8, 2011 testimony to the Senate Judiciary Committee, you referred to Operation Fast and Furious as a “local law enforcement operation.” During my questions at that hearing, you re-characterized this testimony—referring to Operation Fast and Furious as “a federal law enforcement operation. . . that was of local concern.”

Given the international ramifications of Operation Fast and Furious, coupled with the distinctly national concern of drug cartel violence, do you stand by your characterization of Operation Fast and Furious as an operation of “local concern?”

Response:

Operation Fast and Furious was an investigation conducted by ATF's Phoenix Field Division. The Attorney General's comments were intended to reflect that fact.

77. International parental child abductions represent a growing threat to American children. Even more troubling, virtually none of the kidnapped children who are taken to non-Hague Treaty signatory countries are returned to their lawful homes in the United States.

A. What measures could the Department of Justice take to aid the enforcement of family court orders intended to prevent the abduction of a child whose custody is properly under the jurisdiction of a US court?

Response:

There are a host of measures law enforcement can take to prevent international parental child abductions. The Department of Justice's Office of Juvenile Justice and Delinquency Prevention has published "A Family Resource Guide on International Parental Kidnapping," last updated in 2007 and available at <https://www.ncjrs.gov/pdffiles1/ojdp/215476.pdf>, that sets out how families and enforcement officials can marshal an effective response to this problem, including preventing abductions from happening in the first place. It offers descriptions and realistic assessments of available civil and criminal remedies, explains applicable laws, identifies private and public resources, and much more. It specifically includes chapters on preventing international parental kidnapping and stopping an abduction in progress. These chapters describe the mechanism for enforcing court orders intended to prevent international parental kidnapping as well as assistance that Department components, primarily the FBI, can provide in such cases. Parents who are concerned that their children may be abducted may contact the FBI's Crimes Against Children coordinator in their local FBI office to request such assistance.

B. What measures could the Department of Justice take to investigate international child abductors and their accomplices, and to aid Department of State officials and the families of the children to obtain their safe and timely return?

Response:

The Department of Justice, as well as our law enforcement partners at the state and local levels, have a variety of tools at their disposal to investigate international child abductors and their accomplices. Appropriate investigative steps in international parental kidnapping cases, however, vary widely depending on the particular facts and circumstances of each case. The FBI must take into account a variety of factors in determining how aggressively to pursue, and what steps to take in pursuing, a criminal investigation in an international parental kidnapping case, including the available options for return of the child and the steps other investigators, prosecutors, the Department of State, and the left-behind parent are taking to obtain the return of

the abducted child. Typically, the State Department's Office of Children's Issues will first explore issues relating to the nature of any existing custody order, the laws of the country to which the child was taken, whether that country is a Hague signatory or not, and the availability of local counsel, with family members and/or local law enforcement, with the primary goal of obtaining the return of the child. The FBI and federal prosecutors will then explore whether criminal charges in a particular case might be appropriate, and will do so in a manner that does not interfere with any attempts to obtain the child's return. Typically, the criminal process would not be pursued if the circumstances indicate it would jeopardize an active Hague Convention civil process seeking the return of the child.

C. What is the Department of Justice response protocol for children who are abducted to non-Hague Treaty signatory countries?

Response:

The Department's response to international parental kidnapping cases involving a non-Hague country depends very much on the facts and circumstances of each case. In some cases, the facts support pursuing criminal charges against the abducting parent despite the reality that it will be difficult or impossible to obtain the extradition of the abducting parent. The FBI may, for example, engage INTERPOL Washington to obtain international lookout/advisory notices to assist law enforcement authorities in INTERPOL's member countries in finding abducting parents and abducted children if they travel internationally. This can result in a child being returned to the left-behind parent. Additionally, INTERPOL Washington works with state and local law enforcement to issue notices for abducted children to limit the ability of the taking parent to travel undetected between Hague and non-Hague Treaty countries. In all cases, though, including those involving non-Hague Treaty countries, the Department first refers left-behind parents to the State Department's Office of Children's Issues, which provides initial advice on how to respond immediately – including through diplomatic channels – to best improve the chances to recover the child (see http://travel.state.gov/abduction/abduction_580).

D. Would your department be willing to provide a report on the recent successes and failures in returning domestically abducted children to their lawful home, and the recent successes and failures in returning internationally abducted children to their lawful home— including a discussion of arrests, prosecutions, and convictions for international child abduction?

Response:

The Department of Justice maintains data on federal investigations and prosecutions of international parental kidnapping cases. According to the Executive Office for United States Attorneys, the number of international parental kidnapping cases (18 U.S.C. § 1204) filed each year since FY 2007 is as follows: FY 2007 – 19; FY 2008 – 16; FY 2009 – 19; FY 2010 – 13; and FY 2011 – 13. FBI records indicate that children were located in the following numbers of cases for this period: FY 2007 – 18; FY 2008 – 5; FY 2009 – 5; FY 2010 – 10; and FY 2011 – 7. (We realize that the numbers of children located are lower than the numbers of prosecutions.

The International Parental Kidnapping statute concerns the prosecution of the abductor (parent), not the return of the child. Although every attempt is made during FBI investigations to locate and recover the child victim, some abductors are prosecuted without the return of the child.) These numbers do not include comprehensive information on children abducted internationally who are returned to their homes. Likewise, we do not maintain data on domestic parental abduction cases. The State Department's Office of Children's Issues or the National Center for Missing & Exploited Children may be able to provide you with additional information about on whether other sources of such data exist.

E. How can the Department of Justice aid the Department of State in charging and prosecuting travel document frauds committed during the course of international child abductions?

Response:

If the evidence in an international parental kidnapping case supported a charge for travel document fraud, the Department of Justice could charge that offense. In some cases, charging a travel document fraud case could provide better avenues for extradition, as our extradition treaties with many countries require dual criminality of the offense (meaning that the extraditable conduct must be a crime in both countries), and dual criminality may be more likely to exist with a travel document fraud charge than an international parental kidnapping charge. Additionally, a travel document fraud charge provides a good basis to request that INTERPOL Washington generate an international lookout/advisory notice, which can help locate the abducting parent and the abducted child if they travel internationally. If the Department charges a travel document fraud case, it can convey the charging document and arrest warrant to the State Department, which may in turn, pursuant to its regulations, explore whether a U.S. passport of the person charged (in this instance, the abducting parent) could be revoked. Revocation of a U.S. passport may assist in securing the return of the abducting parent with the child to the United States.

F. Could United States family court orders be used to prevent international child abductions by making them accessible and available to Department of Homeland Security officials at airports?

Response:

The Department of Justice defers to the Department of Homeland Security on this matter.

QUESTIONS POSED BY SENATOR LEE

78. On October 28, 2011, the Chairman of the House Judiciary Committee, Representative Lamar Smith, sent you a letter reiterating a prior request, on behalf of 49 members of Congress, that the Department produce certain documents and make available certain witnesses related to work Supreme Court Justice Elena Kagan may have been involved in with respect to the legal defense of the Patient Protection and Affordable Care Act ("PPACA"). (See attached letters from Rep. Smith). At the Oversight Hearing, I asked whether the Department intended to comply with that request. You stated that you were not familiar with the request. In light of the information in the attached letters, does the Department now intend to comply with this request?

Response:

Please see the response to 48(A), above.

79. With respect to Justice Kagan's involvement in discussions related to PPACA, you stated that then-Solicitor General Kagan was physically moved out of the room whenever a conversation came up about that legislation.

- A. PPACA was signed into law on March 23, 2010. Justice Kagan was nominated to the Supreme Court on May 10, 2010. For discussions regarding PPACA that occurred before and after its enactment, but before then-Solicitor General Kagan was nominated to the Supreme Court, why did you feel the need to remove her from the room?

Response:

Please see the response to 48(A), above.

- B. Was then-Solicitor General Kagan removed from the room for all discussions and meetings related to PPACA?

Response:

Please see the response to 48(A), above.

- C. For which discussions or meetings was then-Solicitor General Kagan not removed from the room?

Response:

Please see the response to 48(A), above.

D. I understand that you have not previously asserted or identified any legal privilege with respect to the requested documents and witnesses. In light of that fact, as well the care you assert was taken with respect to then-Solicitor General Kagan's involvement in discussions regarding PPACA, why would the Department not comply with Representative Smith's request?

Response:

Please see the response to 48(A), above.

80. To obtain authorization to conduct a wiretap, Federal law requires that an application be submitted to the Department of Justice for review and approval before that application is submitted to a court of competent jurisdiction for an order authorizing the interception. At the Oversight Hearing, I asked you about statements made by the Assistant Attorney General for the Criminal Division, Lanny Breuer, at a November 1, 2011 hearing before the Senate Judiciary Committee. With respect to the Department's role in reviewing and approving wiretap applications, Mr. Breuer stated: "The role of the reviewers and the role of the deputy in reviewing Title III applications is only one: it is to ensure there is legal sufficiency to make an application to go up on a wire and legal sufficiency to petition a federal judge somewhere in the United States that we believe it is a credible request."

A. Do you agree that the Justice Department's only duty in reviewing and approving an application for a wiretap is to "ensure there is legal sufficiency" and that it is "a credible request"?

Response:

Please see the response to question 56(A), above.

B. What is the Justice Department's proper role in reviewing such applications?

Response:

Please see the response to question 56(A), above.

C. Mr. Breuer has been the Assistant Attorney General for the Criminal Division since April 20, 2009. If you disagree with his statements regarding the role of the Department with respect to wiretap applications, what steps will you take to remedy problems created by the deficient review of wiretap applications that may have resulted from the inadequate policy implemented

by Mr. Br[e]uer? What policies will you put in place to ensure that the proper standard is implemented going forward?

Response:

Please see the responses to question 56(A), above.

81. As part of Operation Fast & Furious, the Department of Justice reviewed several wiretap applications. At the Oversight Hearing, you stated that Mr. Br[e]uer's deputies, who report directly to him, would have reviewed these applications. I asked why, after reviewing these applications, Mr. Br[e]uer's deputies did not notify him of the problematic tactics being used. You responded that you did not know the contents of the wiretap applications and therefore could not conclude that the deputies would have been put on notice of the problematic tactics.

A. Did the wiretap applications submitted as part of Operation Fast & Furious provide any information that would have led a reasonable person to conclude that gun-walking was occurring?

Response:

The wiretap applications submitted in connection with Operation Fast and Furious are sealed pursuant to court order and the contents of those materials are statutorily prohibited from disclosure. For those reasons, and because disclosure of information contained in such applications would adversely affect ongoing prosecutions, it would be inappropriate to respond to this question.

B. What are the dates of the wiretap applications that provided notice of gun-walking?

Response:

Please see the response to question 81(A), above.

82. The federal wiretap statutes provide that a wiretap application must set forth "a full and complete statement as to whether or not other investigative procedures have been tried and failed or why they reasonably appear to be unlikely to succeed if tried or to be too dangerous." 18 U.S.C. § 2518(1)(c).

A. If the wiretap applications did not provide a full and complete statement as to the investigative procedures that had been tried, why were these applications approved by the Department of Justice for submission to a court?

Response:

Please see the response to question 81(A), above.

- B. If the wiretap applications did provide a full and complete statement as the investigative procedures that had been tried, did that statement provide information on the tactics used in Operation Fast & Furious?**

Response:

Please see the response to question 81(A), above.

- C. If your answer to question 5(b) is that the applications did not provide information on the tactics used, how is it possible to provide “a full and complete statement as to whether or not other investigative procedures have been tried and failed or why they reasonably appear to be unlikely to succeed if tried or to be too dangerous” without providing any information on a chief, and highly controversial, tactic being used as part of the operation?**

Response:

Please see the response to question 81(A), above.

- D. If your answer to question 5(b) is that the applications did not provide information on the tactics used, doesn't the absence of any mention in the wiretap applications of a chief, and highly controversial, tactic raise serious questions about the procedures being used to submit and approve wiretap applications? What will your Department do to ensure that the wiretap application process is brought into accordance with the letter and spirit of the wiretap statutes?**

Response:

Please see the response to question 81(A), above.

QUESTIONS POSED BY SENATOR COBURN

83. **Shortly after your confirmation, you made a series of speeches stating the Justice Department should make changes to the criminal justice system that are “smart on crime.” As a result, in the spring of 2009, you formed a Sentencing and Corrections Working Group within the Department to review federal sentencing and incarceration policies.**

In December 2010, Assistant Attorney General for the Criminal Division, Lanny Breuer, wrote a progress report for that working group. You referenced this in your response to Senator Schumer’s question on this topic in written questions following your last appearance before this committee. I read with interest your response, as well as Mr. Breuer’s report.

I agree that there is much to be done at the federal level to address issues affecting the federal Bureau of Prisons (BOP), its employees and inmates, but it must be done in a fiscally responsible manner.

- A. I recognize that there are certain congressional policies that weigh into the cost of the federal prison system; however, I cannot believe there are absolutely no other types of cost-savings to be achieved in the BOP that do not compromise the safety of BOP employees and inmates. Other than policy-related matters, are there any programs, offices, or expenditures at the BOP you believe could be consolidated or eliminated to reduce the burgeoning \$6 billion BOP budget without compromising the obvious need for the safety of prison personnel and inmates?**

If so, what do you recommend? If not, then can I assume the BOP does not waste a single penny in its yearly operations?

Response:

I have worked closely with all Department of Justice (Department) agencies and components to identify programs, offices, and expenditures where costs could be cut without sacrificing public safety. I have pressed BOP to be especially diligent. Beginning in June of 2011, we have been working with BOP leadership to identify any additional program and policy changes that would yield cost savings. Based on this ongoing work, BOP is making all reasonable operational changes to reduce costs that can be made without sacrificing the safety and security of BOP staff, federal inmates, and the public.

As the federal inmate population is projected to continue to increase, BOP requires sufficient resources to keep pace in providing the safe and secure housing of inmates, as well as the safety of BOP staff. Nevertheless, BOP has made great strides in past years in streamlining and consolidating functions and operations. BOP has co-located institutions; de-layered management positions; closed four stand-alone minimum-security prisons; and consolidated

procurement, sentence computation, inmate designation, human resources, and other administrative functions. At the same time, the agency has managed more inmates with relatively fewer staff, as compared to the size of the inmate population, primarily by taking advantage of improved security technologies and improved architectural designs in our newer facilities, and by enhancing population management and inmate supervision strategies. Overall, BOP has streamlined operations, improved program efficiencies, and implemented inmate management tools to function efficiently and economically even as its workload increases every year.

In FY 2011, the BOP inmate population increased by 7,541 net new inmates to a total population of 217,768 and system-wide crowding was at 39 percent over-rated capacity, with 55 percent and 51 percent at high and medium security institutions respectively. Even with changes to the U.S. Sentencing Guidelines, which were made applicable retroactively, providing some crack cocaine offenders sentence reductions, BOP projects an additional 11,500 inmates by the end of FY 2013. While some of these inmates will be housed in contract facilities, crowding and inmate to staff ratios are likely to increase.

The FY 2013 President's Budget request includes program increases for BOP totaling \$81.4 million. These additional resources will help ensure the continued secure incarceration of the growing federal inmate population. Increases include \$55.5 million to begin activation of two prisons, the high-security U.S. Penitentiary in Yazoo City, MS (1,216 beds), and the medium-security FCI facility in Hazelton, WV (1,280 beds). Construction of these facilities will be completed in the fall of 2012. The request also includes \$25.8 million to procure 1,000 new contract beds. The new contract beds and the activations of newly constructed prisons will provide additional capacity to help mitigate the impacts of the growing Federal prison population.

As a result of our additional work on this issue, the President's FY 2013 Budget Request also proposes offsets of \$58 million for:

- **Good Conduct Time Proposed Legislation Change (\$41 million)**: The Administration has proposed legislation to amend Federal inmate good conduct time credit to provide inmates incentives that encourage positive behavior. The proposed legislation would continue to provide inmates with incentives for good behavior as well as participation in programming that is proven to reduce the likelihood of recidivism. The proposed sentencing reforms include (1) an increase in the amount of credit an inmate can earn for good behavior, and (2) a new sentence reduction credit, which inmates can earn for participation in education and vocational programming proven to reduce recidivism. These proposals if enacted before FY 2013 could result in significant cost avoidance, potentially up to \$41 million in FY 2013, by slowing the rate of the federal inmate prison population growth.
- **Compassionate Release Program (\$3.2 million)**: Under current law, BOP may exercise its authority to pursue a reduction in sentence through the sentencing court for inmates who are terminally ill or otherwise eligible for early release due to "extraordinary or compelling circumstances." Criteria for release under these circumstances are

established both in law and administratively determined policy. By reexamining current practice, the BOP could pursue a reduction in sentence for more inmates in FY 2013.

- **Information Technology Savings (\$2.8 million):** As part of its effort to increase IT management efficiency and comply with OMB's direction to reform IT management activities, the Department is implementing a cost-saving initiative as well as IT transformation projects. This offset represents savings that will be generated through greater inter-component collaboration in IT contracting. Funds will be redirected to support the Department's Cyber-security and IT transformation efforts as well as other high priority requests.
- **Realign Regional Office and Administrative Operations (\$11 million):** BOP intends to continue its efforts to streamline its business process by reducing or realigning its regional office operations. The BOP is undergoing a review to determine how to best consolidate its regional functions and/or locations and non-institution based staff for this realignment.

B. Also, following the last hearing, Senator Schumer asked you whether the Department had implemented any of the working group's recommendations, but your response was not clear to me on exactly what had or had not been implemented as a result of the working group's efforts. Could you please detail, based on each of the 6 teams within the working group, what recommendations were made, which of those have been implemented, and explain the reasoning behind each?

Response:

The Department created the Sentencing and Corrections Working Group to undertake a thorough review of federal sentencing and corrections policies, with an eye toward possible reform. The Working Group examined, among other issues, the structure of federal sentencing, prisoner reentry and alternatives to incarceration, internal Department sentencing policies, federal cocaine sentencing policy, other racial and ethnic disparities in sentencing, and the federal death penalty protocol. The Working Group issue teams assigned to each of these areas examined available research and data surrounding each team's issues and developed reform options. The issue teams did not make formal recommendations, but provided analysis on each option for reform. These reform options were later considered across the Department and a variety of reform steps were taken.

For example, while Congress and the Department had been working on reentry issues and improving reentry at the state and federal level long before the Working Group was begun, the Working Group efforts revealed that at the federal level, much more could be done. The passage of the Second Chance Act was an important step and helped to shape prisoner reentry as a national priority. The Working Group concluded, though, that offender reentry strategies had the potential to reduce crime substantially and to control criminal justice costs. Focusing on those reentry programs and practices that have the potential not only to reduce the recidivism rate but

also to improve public safety and reduce total criminal justice spending, the Working Group developed options for reform.

As a result, on October 8, 2010, the Department launched Project Reentry, which is an internal DOJ working group chaired by the Deputy Attorney General. Project Reentry focuses federal resources on increasing public safety and maximizing the efficient use of public safety dollars to reduce reoffending of released offenders. Modeled on Project Safe Neighborhoods, Project Reentry has three major components: (a) coordination and planning; (b) data generation and evidence analysis; and (c) policy change. Project Reentry efforts include:

- Seeking legislation to ensure that the full 54 days of sentence credit authorized for federal inmate good conduct is available for each year of the sentence imposed upon the inmate;
- Seeking legislative expansion of sentence credit – currently provided only for successful completion of the Residential Drug Abuse Program (RDAP) – to participation in other recidivism-reducing programs such as Federal Prison Industries, vocational training, and adult education. Despite the fact that many of the Bureau of Prisons’ major inmate programs have been shown to reduce recidivism, currently only RDAP offers inmates the opportunity to earn a sentence reduction; research suggests that sentence reduction opportunities via recidivism-reducing programs is a cost-effective way of increasing public safety. To ensure that truth-in-sentencing principles are not eroded, we will also insist that regardless of any changes to good conduct time and credits for participating in recidivism-reducing programs, there remains a requirement that offenders serve at least two-thirds of any imposed sentence;
- Supporting ongoing efforts by federal courts around the country to experiment with reentry courts and other mechanisms to improve prisoner reentry. In this regard, the Department has developed and issued a comprehensive U.S. Attorney toolkit focused on reentry for nationwide distribution;
- The Reentry Council adopting a mission statement and goals that the federal departments and agencies represented on the Council are working to implement; and
- DOJ staff meeting with staff from the Administrative Office of the U.S. Courts and the U.S. Sentencing Commission to improve coordination on reentry-related issues.

With respect to coordination, the Department has convened an interagency Reentry Council to improve coordination among the myriad federal departments and subcomponents focused on state, local, tribal, and federal reentry issues. This Council tracks developing reentry-related research and legislation and helps to ensure that resources devoted to reentry are used wisely and efficiently.

The Sentencing and Corrections Working Group took on many other issues beyond prisoner reentry. You can find a full summary of these issues and the progress of the Working Group in a recent article authored by Assistant Attorney General Lanny Breuer in the Federal

Sentencing Reporter, "The Attorney General's Sentencing and Corrections Working Group: A Progress Report," *Federal Sentencing Reporter*, Vol. 23, No. 2, pp.110-114.

The reform efforts already implemented include:

- The passage of the Fair Sentencing Act to reform federal cocaine sentencing policy (the reasoning behind this reform included ensuring just punishment for all offenders, eliminating unwarranted sentencing disparities, and promoting greater trust and confidence in the federal criminal justice system);
- A new internal Department of Justice charging and sentencing policy (the reasoning for the new policy is explained in the memorandum creating the policy, which can be found at: http://www.fd.org/pdf_lib/holdermemo.pdf);
- A new policy on the structure of federal sentencing and mandatory minimum sentencing statutes, which was discussed in detail in testimony by U.S. Attorney Sally Q. Yates before the U.S. Sentencing Commission and which can be found at: http://www.ussc.gov/Legislative_and_Public_Affairs/Public_Hearings_and_Meetings/20100527/Testimony_Yates_DOJ.pdf;
- Changes to the federal death penalty protocol to improve the effectiveness of the Department's death penalty review process (the changes are detailed in a memorandum from the Attorney General that also lays out the reasoning behind the changes and which can be found at: <http://www.justice.gov/oip/docs/death-penalty-protocol.pdf>); and
- The creation of a review team to ensure that unwarranted racial and ethnic disparities are identified and addressed.

The Department has also been working with the U.S. Sentencing Commission to review and revise the federal sentencing guidelines to strengthen law enforcement in several key areas, including child pornography, fraud, and gun trafficking.

84. **The GAO recently issued a report to Congress entitled "Asbestos Injury Compensation: The Role and Administration of Asbestos Trusts, GAO-11-819. In that report, it noted the lack of transparency in the operation of 524(g) trusts, including that most (65%) of the 524(g) trusts will not release information on exposure history because their internal operating guidelines prohibit such disclosure. The current lack of transparency and oversight has promoted a system where claimants could file inconsistent claims among the numerous trusts (there are over 50 separate trusts with more to come). In fact, the RAND Corporation recently observed that 524(g) trusts do not "link payments across trusts to the same individual." In other words, a single asbestos claimant could secure compensation from each of the numerous existing trusts with no centralized scrutiny as to whether that claimant is making consistent claims and/or whether that claimant is recovering twice for the same injury.**

The Department of Justice oversees the Executive Office for U.S. Trustees. What steps can and will the Department of Justice take to ensure that claims data, including exposure history, is available to stakeholders in the bankruptcy system as well as to the tort system to prevent the sort of fraud uncovered in some court decisions³?

Response:

In nearly all asbestos bankruptcy cases, asbestos personal injury claims are administered, evaluated, and paid through trusts created by the debtor's plan of reorganization. While specific arrangements vary from case to case, in most instances the trusts operate according to the terms of a trust agreement (TA) and a set of trust distribution procedures (TDP), which are negotiated by the various constituencies in the bankruptcy case. Both the TA and the TDP are submitted to creditors and the bankruptcy court for approval in conjunction with confirmation of the debtor's reorganization plan.

Although the United States Bankruptcy Code requires that the debtor implement a claims trust in order to resolve unknown asbestos claims, *see* 11 U.S.C. § 524(g)(2)(B), it grants the proponent of the bankruptcy plan broad flexibility in determining how the trust will operate. 11 U.S.C. § 524(g)(2)(B)(ii)(V). As a result, TA and TDP provisions regarding trust oversight, disclosure, and anti-fraud measures are not dictated by statute, but rather are contractual terms negotiated between the plan proponent (usually the debtor) and the beneficiaries of the proposed trust, and which are approved by the court as part of plan confirmation.

United States Trustees do not generally have the legal authority to compel parties to include specific provisions in reorganization plans, TAs, or TDPs. United States Trustees are not authorized to propose reorganization plans, *see* 11 U.S.C. § 307, and the Bankruptcy Code provides few substantive requirements on how 524(g) trusts must operate. As a result, so long as the plan has been properly solicited, approved by a vote of creditors, and otherwise complies with the Bankruptcy Code, the United States Trustee's practical ability to challenge particular provisions of a proposed 524(g) trust is limited.

Further, as discussed in the GAO Report, the United States Trustee does not have any statutory authority to oversee the operations of debtors after they have exited bankruptcy, and the bankruptcy court itself maintains only a limited jurisdiction over the case once the plan has been confirmed and consummated. *See* U.S. Gov't Accountability Office, GAO-11-819, *Asbestos Injury Compensation: The Role and Administration of Asbestos Trusts*, at 15 (2011). Finally, asbestos TAs and TDPs historically have not assigned any continuing oversight role to the United States Trustee after confirmation, and it is unclear whether the United States Trustee would have the statutory authorization to accept such a role even if such a provision were included.

³ *See, e.g., Kanunian v. Lorillard Tobacco Company*, No. CV 442750 (Ohio Cuyahoga County Com. Pl. Jan. 18, 2007).

SUBMISSIONS FOR THE RECORD

**Firearms Trace Data from the Department of Justice
12/1/2006 – 9/30/2011**

Every day, thousands of guns are smuggled across the US border into Mexico; in the past 5 years, **of the 94,000 guns that have been recovered AND traced in Mexico, over 64,000 are from the U.S.** This number does not even account for the thousands of guns that are never recovered by Mexican law enforcement or traced.

Listed below are the total numbers and percentages for firearms recovered and traced in Mexico indicating those firearms manufactured in the United States, imported into the United States, foreign made with an unknown importer and unknown country of origin and unknown importer. The information is based on the time period of December 1, 2006 through September 30, 2011. The information is based on queries of the Firearms Tracing System (FTS) on October 25th, 2011.

Time Period	12/1/2006 - 9/30/2011		
	# of Traces	%	Total %
Manufactured in the United States	48,307	51.5	68.3
Imported into the United States	15,805	16.8	
Total	64,112		
Foreign Made - Unknown Importer	11,028	11.7	31.7
Unknown Country of Origin - Unknown Importer	18,755	20.0	
Total	29,783		
Total Number of Traces	93,895	100	
Duplicate Firearm Traces	22,501		
Total with Duplicate Traces	116,396		

Statement by Senator Charles E. Grassley
November 8, 2011

Thank you, Mr. Chairman, for holding this important oversight hearing. If our time were not so limited, I would have liked to ask about the Department's conference budget, the broken system of reviewing FBI whistleblower cases, the Department's attempt to use the tragic failure in Fast and Furious as a pretext to call for new, stricter gun laws, and many other important topics. However, oversight on Operation Fast and Furious has been my focus since the last time Attorney General Holder appeared before the Committee.

Just over nine months ago Attorney General Holder sat in my office. After discussing a number of items with him, I handed him two letters I had written to the Acting Director of the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), Kenneth Melson.¹ A member of my staff briefly outlined the allegations contained therein that had come to us from an ATF whistleblower.

My letters mentioned: (1) the death of Border Patrol Agent Brian Terry, (2) the allegation that ATF had sanctioned the sale of hundreds of assault weapons to straw buyers, (3) the allegation that two of those weapons had been found at the scene of Agent Terry's death, and (4) the allegation that the whistleblowers who provided this information were already facing retaliation.²

Just four days later, I received a response back from the Justice Department.³ That response explicitly stated that the whistleblower allegations were "false" and that "ATF makes every effort to interdict weapons that have been purchased illegally and prevent their transportation to Mexico."⁴ In the nine months since then, mounting evidence has put the lie to those claims. We have learned that instead of making every effort to interdict, ATF actually allowed the transfer of firearms in several operations, in hopes of making bigger cases.⁵ Agents who objected to the practice called it "walking guns."⁶ In addition to documentary evidence contradicting the Department's denials, six ATF agents testified powerfully at two House Oversight Committee hearings about gunwalking in Operation Fast and Furious.

Assistant Attorney General Lanny Breuer admitted one week ago in this room that the Department's letter to me in February was absolutely false.⁷ Think about that for a second. It's bad enough that the head of the Criminal Division admits that the Department's letter to me was false. It gets worse, though. He admitted that he knew all along that it was false. Although he could not recall whether he helped edit it, he knew it was false because he was aware of a previous gunwalking operation called Wide Receiver. Yet he remained silent for nine months as

¹ Letters from Senator Charles E. Grassley to Kenneth Melson, Acting Director of the ATF (Jan. 27, 2011, and Jan. 31, 2011).

² *Id.*

³ Letter from Ronald Weich, Asst. Att'y Gen, U.S. Dept. of Justice, to Senator Charles E. Grassley (Feb. 4, 2011).

⁴ *Id.*

⁵ Email from George Gillett to David Voth, Oct. 05, 2010, HOCR DOJ 001349-001352 (Attachment 1).

⁶ Joint Staff Report, The Department of Justice's Operation Fast and Furious: Accounts of ATF Agents, at p. 19 (June 14, 2011).

⁷ *Combating International Organized Crime: Hearing Before the Subcomm. on Crime and Terrorism of the S. Comm. on the Judiciary*, 112th Cong. (2011) (statement of Lanny Breuer, Asst. Att'y Gen.).

the public controversy over gunwalking grew. He was aware that Congress had been misled and yet made no effort to correct the Department's official denial. I am eager to hear whether the Attorney General thinks that is acceptable and what he intends to do about it.

Much has been said recently about guns being walked in Operation Wide Receiver "during the Bush era." It doesn't matter to me when it happened, we need to get to the bottom of it. According to the Justice Department, Bush-era prosecutors refused to bring the case.⁸ However, under Mr. Breuer's leadership headquarters revived it despite the gunwalking issues.⁹ Reviving the case may have provided the green light to the Phoenix Field Division to repeat the gunwalking strategy in Operation Fast and Furious on a much bigger scale.

It seems likely that the same ATF managers responsible for overseeing Wide Receiver might have interpreted the administration's willingness to prosecute such cases as an approval of gunwalking as an acceptable tactic. If that was not the case, then it was Mr. Breuer's responsibility to clearly communicate that gunwalking was not acceptable and to institute oversight and safeguards to ensure that it did not happen again. He did not do that.

In fact, it is clear from documents produced by the Justice Department that in early 2010, the ATF, Main Justice, and the U.S. Attorney's Office in Arizona considered Wide Receiver and Fast and Furious to be a set of related cases.¹⁰ Yet Mr. Breuer claims that he saw the flaws in one but not the other.¹¹

As Mr. Breuer's deputy was learning about the Wide Receiver in March 2010, he asked: "[D]id ATF allow the guns to walk, or did ATF learn about the volume of guns after the FFL began cooperating?"¹² That was the right question, at the right time, about the wrong case. It was too late to stop gunwalking in Wide Receiver. However, Fast and Furious was still very active. By that time, 1,228 weapons had been purchased by the straw buyers in Fast and Furious, and hundreds had been recovered in Mexico. Gun dealers were giving ATF real time notice each time the straws bought another batch of guns. As one of the ATF agents testified before the House Committee, "This wasn't a who done it."¹³ Yet the criminals were allowed to keep breaking the law, all in the hopes of catching bigger fish.

In March 2010, the Attorney General's current chief of staff, then the No. 2 individual in the Department as the Deputy Attorney General, received a personal briefing on Fast and Furious.¹⁴ The briefing included a presentation detailing the numbers of firearms each straw buyer had purchased up to that point, including 313 by one and 241 by another.¹⁵ The presentation

⁸ Letter from Ronald Weich, Asst. Att'y Gen., Department of Justice, to Senator Patrick J Leahy (Oct. 31, 2011).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Combating International Organized Crime: Hearing Before the Subcomm. on Crime and Terrorism of the S. Comm. on the Judiciary*, 112th Cong. (2011).

¹² Email from Jason Weinstein to Kevin Carwile, Mar. 16 2010, HOCR DOJ 003438 (Attachment 2).

¹³ *Operation Fast and Furious: The Other Side of the Border: Hearing before the H. Comm. on Oversight and Government Reform*, 112th Cong. 128-129 (2011) (statement of Carlos Canino, ATF Acting Attache to Mexico).

¹⁴ ATF Monthly Meeting with the Acting Deputy Attorney General, HOCR DOJ 002817-002823 (Mar. 12, 2010) (Attachment 3).

¹⁵ *Id.*

explained that those two straw buyers had spent almost \$214,000 and \$140,000, respectively, on the weapons.¹⁶ A copy of the Deputy Attorney General's presentation includes his handwritten notations. One said, "all cash," which is a typical red flag of straw buying.¹⁷

The Deputy Attorney General also wrote such detail in his notes as "followed to 3 stash houses."¹⁸ Yet the presentation also clearly included a map that he labeled "seizures in Mexico."¹⁹ Didn't he stop to question how these weapons were going from being under surveillance at stash houses in the U.S. to being recovered in Mexico? Didn't he ask why search warrants or other techniques could not have been used to seize the weapons and prevent them from being trafficked to Mexico? Or was the strategy of "allowing the transfer of firearms to continue to take place" explained to him?²⁰

That's how it was described in other briefing papers prepared by ATF, and one of the emails transmitting that paper said it was "likely to go to the DAG [Deputy Attorney General]."²¹ The ATF strategy was clearly documented. Agents were even forbidden to stop and question the straw buyers for fear that it would scare them off and stop further straw buying at the cooperating gun dealers.

In the same time period the Deputy Attorney General received such a detailed briefing, the Justice Department's Criminal Division in Washington, D.C. assigned a prosecutor to Fast and Furious as the result of a direct request from ATF Director Melson to Mr. Breuer.²² Simultaneously, Mr. Breuer's deputies and the Justice Department Office of Enforcement Operations reviewed and approved detailed wiretap applications for Fast and Furious. Mr. Breuer and his deputies were quick to recognize gunwalking in a Bush-era case and ask all the right questions. Yet, tell-tale information was right under their very noses that the same field division was doing it again, and Mr. Breuer claims he didn't make the connection.²³

Mr. Breuer admitted before this Committee last week that that very same deputy who informed him of gunwalking in Wide Receiver also approved at least one of the wiretap applications in Operation Fast and Furious.²⁴ As Mr. Breuer himself said, "The Congress made clear in law that wiretaps on telephones are an extraordinarily intrusive technique."²⁵ Thus, wiretap applications are extremely detailed documents. In order to justify tapping the phone of a private citizen, the law requires that law enforcement agencies show that they have tried everything else first. Agencies have to explain the techniques they have tried or considered in order to explain to the court why a wiretap is the only way to get the evidence needed for prosecution. The Justice Department is supposed to review those claims to make sure they are legally sufficient.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Email from George Gillett to David Voth, Oct. 05, 2010 (Attachment 1).

²¹ *Id.*

²² Email from Kenneth Melson to Lanny Breuer, Dec. 04, 2009, HOCR DOJ 2730 (Attachment 4).

²³ *Combating International Organized Crime: Hearing Before the Subcomm. on Crime and Terrorism of the S. Comm. on the Judiciary*, 112th Cong. (2011).

²⁴ *Id.*

²⁵ *Id.*

But the very same facts that would show the need to obtain the wiretap would also show that the Justice Department knew these individuals were trafficking weapons. Indeed, the goal of the wiretap was to identify other co-conspirators. That's all well and good, but they should have stopped the flow of guns in the meantime. Anyone reviewing the affidavits would likely know that was not happening.

The Justice Department has now produced 10 memos about Operation Fast and Furious received by the Attorney General from March to November 2010, including two he did not reference in his October 7, 2011, letter to Congress.²⁶ Additionally, the Office of National Drug Control Policy recently produced another three memos addressed to the Attorney General on the issue, bringing the count to 13.²⁷ These additional three memos were also not included in the Attorney General's October 7 letter. The memos describe the government's knowledge that straw buyers were responsible for the purchase of over a thousand firearms and that the guns were being supplied to Mexican drug trafficking cartels. The Attorney General has said that since he does not have time to read the memos he receives, these memos were read by his staff instead.²⁸ I look forward to hearing today who on his staff did read them, who was responsible for overseeing the case, and why it was deemed unworthy of his attention.

I am also interested to hear when the Attorney General learned of the connection between Operation Fast and Furious and the weapons found at the scene of Border Patrol Agent Brian Terry's death. The Attorney General's then-Deputy Chief of Staff Monty Wilkinson, spoke with U.S. Attorney Dennis Burke about Operation Fast and Furious the very day that Border Patrol Agent Brian Terry died.²⁹ Did he learn of the connection between Fast and Furious and Agent Terry's death and bring it to the Attorney General's attention? Then-Acting Deputy Attorney General Gary Grindler found out within 48 hours of Agent Terry's death of the connection to Fast and Furious.³⁰ Just two weeks after that, the Attorney General announced that Mr. Grindler would be his new Chief of Staff. Did Mr. Grindler bring the connection between Fast and Furious and Agent Terry's death to the Attorney General's attention?

One month ago Attorney General Holder finally acknowledged that Operation Fast and Furious was flawed.³¹ Yet he said on September 7 of this year:

[T]he notion that somehow or other that this thing reaches into the upper levels of the Justice Department is something that at this point I don't think is supported by

²⁶ Memorandum to the Attorney General from Kenneth Melson, HOCR DOJ 003270-003271 (Mar. 01, 2010); Weekly Report to the Attorney General from Lanny Breuer, HOCR DOJ 003263 (Oct. 25, 2010) (Attachment 5).

²⁷ Weekly Memoranda to the Attorney General from NDIC, ONDCP F&F 000134-000137, 000183-000187, 000205-000208 (Attachment 6).

²⁸ Letter from Attorney General Eric Holder to Chairman Issa, et al. (Oct. 7, 2011).

²⁹ Email from Monty Wilkinson to Dennis Burke, HOCR USAO 003073-003074 (Dec. 14, 2010) (Attachment 7).

³⁰ Email from Brad Smith to Gary Grindler, HOCR DOJ 002875-2881 (Dec. 17, 2010) (Attachment 8).

³¹ Letter from Attorney General Eric Holder to Chairman Issa, et al. (Oct. 7, 2011).

the facts. And I think as we examine and as all the facts are in fact revealed, we'll see that is not the case.³²

I look forward to closely examining this claim with Mr. Holder today.

I would also add that those who seek to use this tragedy to call for new gun control should note that many of the individuals involved in *Fast and Furious* should have been indicted and arrested nearly a year before they were. While trafficking in firearms is a real problem in Mexico, blaming our Second Amendment freedoms in the U.S. isn't accurate and won't fix anything.

Countless stories have documented the weak controls of U.S.-made weapons in Central American nations which has been a source for firearms in Mexico. Other sources, such as weapons that walk off Mexico military bases, pose a problem too.

So, to say that guns in Mexico are "sourced" to the U.S. just because they were made here is misleading.³³ It doesn't mean that they were ever sold in a retail gun store in the U.S. The faulty statistics include U.S. weapons sold to the military in Mexico, weapons that were transferred into Mexico years ago, guns from *Fast and Furious*, and many other sources.

More accurate statistics breaking down what is really known about the sources of guns in Mexico would help, and I urge the Attorney General to provide these more detailed breakdowns. As we learn more about the utter failure to enforce our existing gun laws in *Fast and Furious*, I'm eager to hear from Attorney General Holder who he plans to hold accountable. I also want to know how he plans to prevent another tragedy like this in the future.

Let me be clear. The bottom line is that it doesn't matter how many laws we pass if those responsible for enforcing them refuse to do their duty—as was the case in *Fast and Furious*.

³² Carrie Johnson, *Holder Takes Heat Over 'Fast And Furious' Scandal*, NPR (Oct. 6, 2011) available at <http://www.npr.org/2011/10/06/141124685/holder-takes-heat-over-fast-and-furious-scandal>.

³³ Letter from Senator Charles E. Grassley to Acting Director Kenneth Melson (June 16, 2011) (Attachment 9).

1212

Attachment 1

From: Gillett, George T. Jr.
Sent: Tuesday, October 05, 2010 3:36 PM
To: Voth, David J.
Subject: FW: Document1
Attachments: briefing paper II (3).docx; Doc1.docx

Can you put it in a BP format for me?

From: Newell, William D.
Sent: Tuesday, October 05, 2010 12:11 PM
To: Gillett, George T. Jr.
Subject: Re: Document1

Have him put into a BP format, will most likely go to DAG.
Bill Newell
Special Agent in Charge
ATF Phoenix Field Division (AZ and NM)
Cell: [REDACTED]

NOTICE: This electronic transmission is confidential and intended only for the person(s) to whom it is addressed. If you have received this transmission in error, please notify the sender by return e-mail and destroy this message in its entirety (including all attachments).

From: Gillett, George T. Jr.
To: Newell, William D.
Sent: Tue Oct 05 14:50:12 2010
Subject: Fw: Document1

I have not reviewed but don't want to stand in the way of progress.

George T. Gillett
ASAC, Phoenix Field Division
Cell: [REDACTED]

NOTICE: This electronic transmission is confidential and intended only for the person(s) to whom it is addressed. If you have received this transmission in error, please notify the sender by return e-mail and destroy this message in its entirety (including all attachments).

From: Voth, David J.
To: Gillett, George T. Jr.
Sent: Tue Oct 05 14:46:43 2010
Subject: Document1
Here it is...


Phoenix Field Division
Phoenix Group VII (SWB Group)
Briefing Paper on: 785115-10 [REDACTED]

Background

1. This investigation has currently identified more than 20 individual connected straw purchasers. More suspects are being identified as the scope of the investigation expands. The straw-purchase suspects currently identified are associated with one another [REDACTED].
[REDACTED] To date (September 2009 – present) this group has purchased in excess of 650 firearms (mainly AK-47 variants) for which they have paid cash totaling more than \$350,000.00.
2. To date there have been five (5) notable seizure events connected with this group, and approximately 53 firearms originally purchased by this group have been recovered. Three of these seizures have been in the Country of Mexico, one recovery in Douglas, AZ, and one recovery in Nogales, AZ. The U.S. recoveries were both believed to be destined for Mexico.
3. The seizures referenced above were not from any member of the targeted group of straw purchasers identified in this investigation. Rather, they were from Hispanic individuals (both male and female) whose association with our target group is currently unknown.
[REDACTED] Two such transactions were observed to take place at auto shops/auto auctions.
4. At one of the Mexico seizures there were 45 firearms recovered in addition to 500 kilograms of cocaine, 85 pounds of methamphetamine, and over \$2,000,000.00 in U.S. currency. Of the 45 firearms recovered, 14 of those firearms (all AK-47 variants) were originally purchased by this target group. Our investigation has not produced any indication of drug trafficking or financial resources consistent with the seizures listed above.

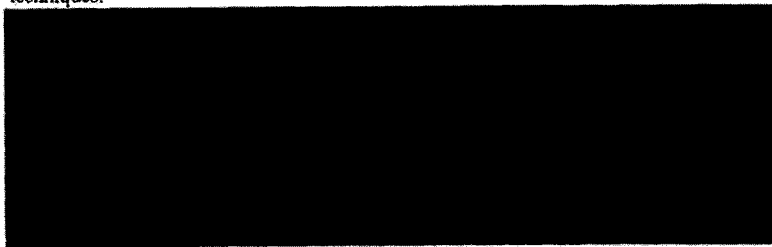
5. [REDACTED]

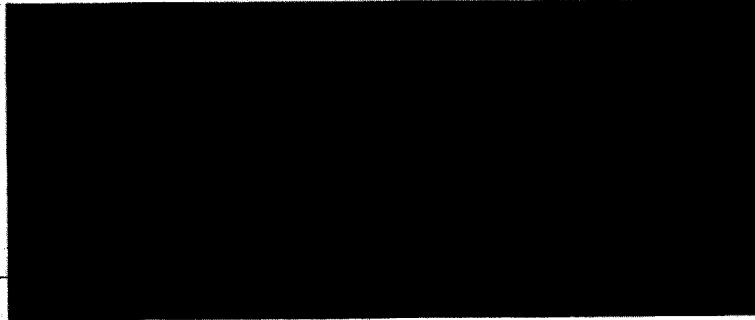
6. [REDACTED]

7. There have been three (3) recorded telephone calls since January 4, 2010, between the most prolific suspected straw-purchaser and the Federally Licensed Firearms Dealer (Lone Wolf Trading Company). These conversations have been to schedule a future purchase of AK-47 variant rifles. The anticipated purchase is approximately forty (40) rifles.
8. On January 5, 2010, ASAC Gillett, GS Voth, and case agent SA MacAllister met with AUSA Emory Hurley, who is the lead, federal prosecutor on this matter. Investigative and prosecution strategies were discussed and a determination was made that there was minimal evidence at this time to support any type of prosecution; therefore, additional firearms purchases should be monitored and additional evidence continued to be gathered. This investigation was briefed to United States Attorney Dennis Burke, who concurs with the assessment of his line prosecutors and fully supports the continuation of this investigation.
9. 
and the weapon(s) will be interdicted prior to their crossing of the Mexican border.
10. A joint strategy/de-confliction meeting is planned for Friday, January 15, 2010, with representatives from ICE, DEA, and ATF. This investigation, as well as other ongoing investigations, will be briefed to all present.

Investigative Techniques Used to Date

11. To date in this investigation we have utilized numerous proactive, advanced investigative techniques:





Strategy

12. This investigation is currently being conducted in conjunction with the Phoenix DEA OCDETF strike force. ATF Phoenix VII is the lead investigating enforcement group. A formal OCDETF proposal is completed and will be presented on January 26, 2009, in furtherance of this investigation. It is unknown at this time what connection exists between these straw-purchasers and the drug trafficking organizations (DTOs) of Mexico.
13. Currently our strategy is to allow the transfer of firearms to continue to take place in order to further the investigation and allow for the identification of additional coconspirators who would continue to operate and illegally traffic firearms to Mexican DTOs which are perpetrating armed violence along the Southwest Border. This all in compliance with ATF 3310.4(b) 148(a)(2).
14. The ultimate goal is [REDACTED] to identify and prosecute all co-conspirators of the DTO to include the 20 identified straw purchasers, the facilitators of the distribution cell centered here in Phoenix, the transportation cells taking firearms South, and ultimately to develop and provide prosecutable information to our Mexican law enforcement counterparts for actions.

1216

Attachment 2

RC-1

From: Weinstein, Jason
Sent: Tuesday, March 16, 2010 11:04 AM
To: Carwile, Kevin
Subject: RE: talking points

I'm looking forward to reading the pros memo on Wide Receiver but am curious -- did ATF allow the guns to walk, or did ATF learn about the volume of guns after the FFL began cooperating?

From: Carwile, Kevin
Sent: Tuesday, March 16, 2010 10:47 AM
To: Weinstein, Jason
Subject: talking points

Here is a quick page of talking points. You did not describe the intended audience. The two operations are pre-indictment so the info on these matters would need to be kept internal. See attached.

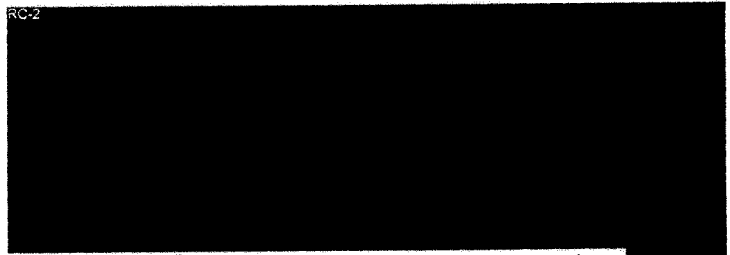
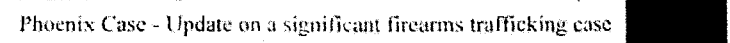

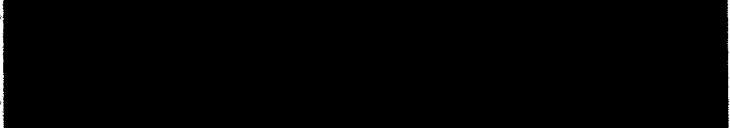
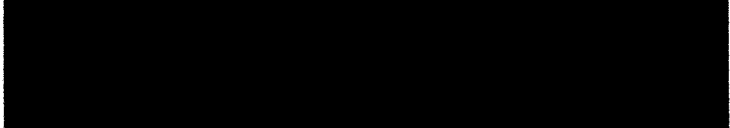

P. Kevin Carwile
Chief, Gang Unit
Criminal Division
U.S. Department of Justice

HOCR WR 003438

Attachment 3

ATF Monthly Meeting
with the Acting Deputy Attorney General
Friday, March 12, 2010

AGENDA

- 1. 
- 2. 
- 3. 
- 4. Phoenix Case - Update on a significant firearms trafficking case
- 5. 
- 6. 
- 7. 

ATF Monthly Meeting

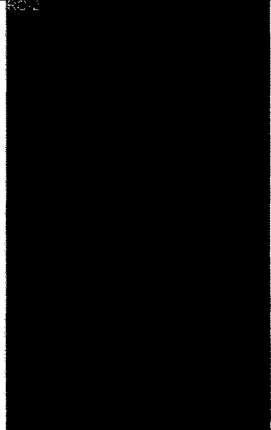
3/12/10



3. Operation The Fast
 & Various
Chapters
 long visits - multiple
 calls & issues

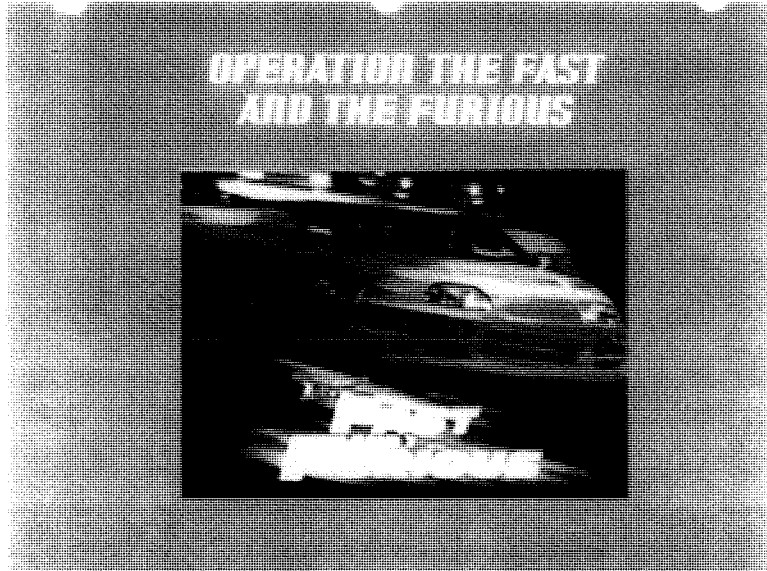
~~Process~~

seizure in Mexico
 take to produce
 to see in
 look to cartel



1000 ATF STRIKE FORCE
 Primary - Phoenix WAO

①



Note: This paper has been withheld from this report page disclosure because they contain sensitive investigative details and information about targets/subjects.



HQGR DOJ002823

1224

Attachment 4

From: Melson, Kenneth E.
Sent: Friday, December 04, 2009 12:26 PM
To: Back, Michelle A.
Subject: FW: Weapons seizures in Mexico

Would you set up a meeting with Mr. Breuer, Billy, Mark, and Sam should go too. Thanks.

From: Breuer, Lanny A. **RC-1**
Sent: Friday, December 04, 2009 10:18 AM
To: Melson, Kenneth E.
Cc: Siskel, Edward N. (ODAG) (SMO); Hoover, William J.; Weinstein, Jason; Rosen, Paul; Raman, Mythili; Fagell, Steven
Subject: RE: Weapons seizures in Mexico

Ken,

We think this is a terrific idea and a great way to approach the investigations of these seizures. Our Gang Unit will be assigning an attorney to help you coordinate this effort. Please let us know who will be the POC at ATF on this, and we'll have the Gang Unit folks reach out to that person. I would love to see you to discuss this further and other issues of common interest. I hope you are well.

Best,

Lanny

From: Melson, Kenneth E. **RC-1**
Sent: Thursday, December 03, 2009 5:46 PM
To: Breuer, Lanny A.
Cc: Siskel, Edward N. (ODAG) (SMO); Hoover, William J.
Subject: Weapons seizures in Mexico

Lanny: We have decided to take a little different approach with regard to seizures of multiple weapons in Mexico. Assuming the guns are traced, instead of working each trace almost independently of the other traces from the seizure, I want to coordinate and monitor the work on all of them collectively as if the seizure was one case. Using the traces as intelligence, and compiling the information from each trace investigation, we can connect the purchases, identify the traffickers and use more serious charges against them. The intelligence analysis and linking of trace data and investigation results will be done at HQ out of our intelligence directorate. I would like to see if you have any interest in assigning a criminal division attorney to work with that group to develop multi-division/district cases and perhaps go to the district with the best venue to indict the case. The level of activity will depend on the number of Mexican seizures, and whether they will trace the guns, or allow us to do it. We do seem to be making progress with our Mexican partners. We are currently working on a case with SSP which might lead us to the first joint arrest in Mexico of a person connect to US arms trafficking. We should meet again just to catch up on where we are in our gun trafficking issues and we could talk about the above idea as well. Let me know what you think. Thanks. Ken.

HOGRAF - 002730

Attachment 5

U.S. Department of Justice

Criminal Division

Assistant Attorney General

Washington, D.C. 20530

MEMORANDUM

TO: The Attorney General
The Acting Deputy Attorney General

FROM: Lanny A. Breuer
Assistant Attorney General

DATE: Week of October 25, 2010

RE: Weekly Report

I. SIGNIFICANT UPCOMING EVENTS

A. Litigation

1. *Indictments/Investigations*

- *Tucson Gun Trafficking* (D. Ariz.): On October 27, the Organized Crime and Gang Section (OCGS) plans to indict eight individuals under seal relating to the trafficking of hundreds of firearms to Mexico. The sealing will likely last until another investigation, Phoenix-based "Operation Fast and Furious," is ready for takedown.

• RC-2


2. *Guilty Pleas*

• RC-2


~~LAW ENFORCEMENT SENSITIVE~~

~~SENSITIVE GRAND JURY MATERIAL
RESTRICTED BY FED. R. CRIM. P. 6(e)
HOCR DOJ 003263~~

1226

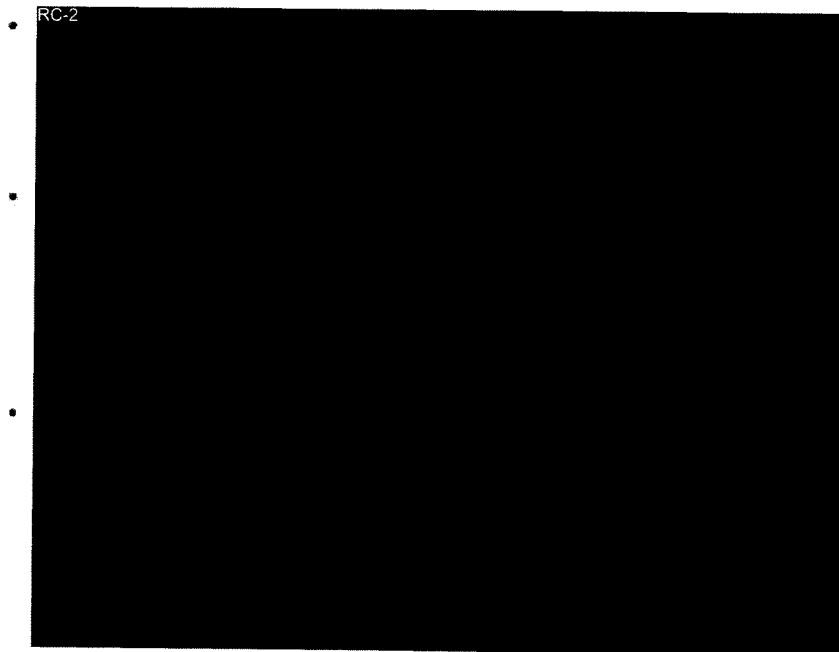
MEMORANDUM FOR THE ATTORNEY GENERAL

THROUGH THE DEPUTY ATTORNEY GENERAL

FROM: Kenneth E. Melson
Deputy Director, Bureau of Alcohol, Tobacco, Firearms
and Explosives

SUBJECT: Weekly Report for March 1-5, 2010

EXPECTED LEGISLATIVE OR POLICY DEVELOPMENTS:

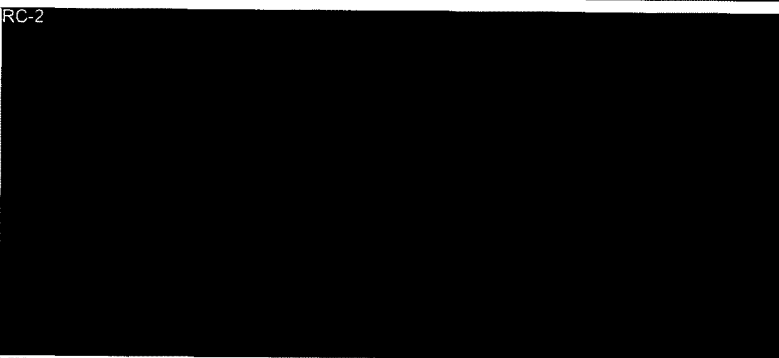


HGR DOJ 003270

RC-2




• RC-2



- ***Bureau of Alcohol, Tobacco, Firearms and Explosives Seizes 41 Firearms En Route to Mexico – Phoenix, Arizona:***
On February 22, 2010, the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) reported on the investigation of a firearm trafficking organization operating in Phoenix. ATF agents obtained a court order authorizing the installation of a GPS tracking device inside the polymer stock of an AK-47 type firearm. The firearm was provided by ATF agents to a cooperating Federal firearms licensee (FFL), who sold it to a target of this investigation. ATF agents tracked the firearm from Phoenix to a location in Tucson and then south across the Tohono O'odham Reservation. Agents contacted the U.S. Border Patrol as there is not an established port of entry, wall, or fence on the reservation since it straddles the U.S.-Mexican border. Border Patrol agents made a vehicle stop and recovered 41 firearms. Both women in the vehicle stated they intended to take the firearms into Mexico.

• RC-2



1228

Attachment 6

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U.S. Department of Justice

National Drug Intelligence Center

Office of the Director

DATE: June 28, 2010

MEMORANDUM TO THE ATTORNEY GENERAL

THROUGH THE ACTING DEPUTY ATTORNEY GENERAL

FROM: Michael F. Walther
Director
National Drug Intelligence Center

SUBJECT: WEEKLY REPORT FOR JUNE 28 THROUGH JULY 2, 2010

The National Drug Intelligence Center weekly report for June 28 through July 2 is as follows:

Next Week



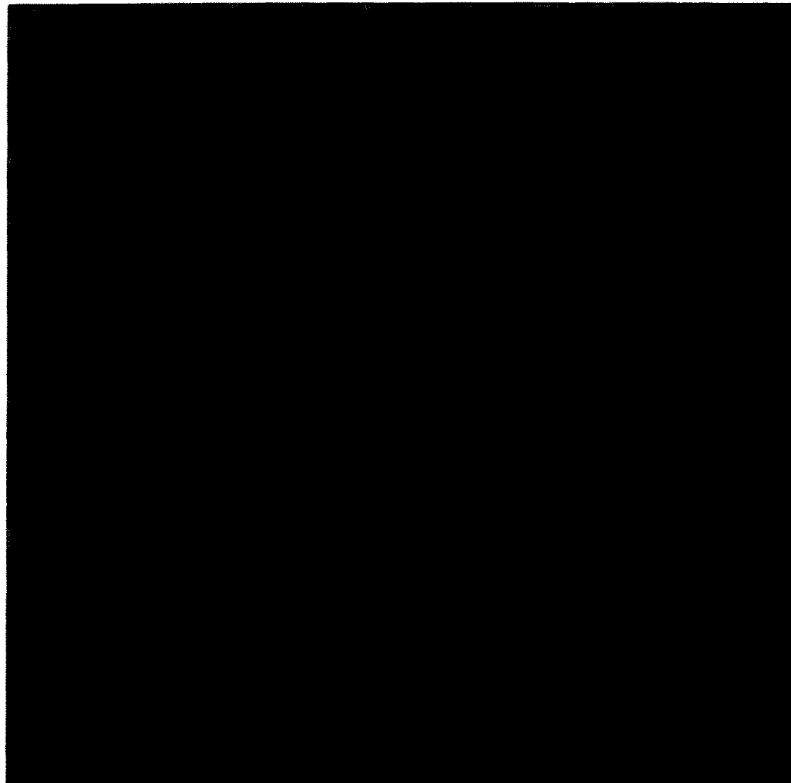
1 of 10

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

ONDCP F&F 000134

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated June 28, 2010
Subject: Weekly Report from June 28 through July 2, 2010



- ***(LOU-LES) Document and Media Exploitation Support to the Organized Crime Drug Enforcement Task Force:***

From July 6 through July 9, the National Drug Intelligence Center Document and Media Exploitation Team at the Phoenix Organized Crime Drug Enforcement Task Force (OCDETF) Strike Force will support the Bureau of Alcohol, Tobacco, Firearms, and Explosives' Phoenix Field Division with its investigation of Manuel Celis-Acosta as part of OCDETF Operation Fast and the Furious. This investigation, initiated in September 2009 in conjunction with the Drug Enforcement Administration, Immigration and Customs Enforcement, and the Phoenix Police Department, involves a Phoenix-based firearms trafficking ring headed by Manuel

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ONDCP F&F 000135

1230

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated June 28, 2010
Subject: Weekly Report from June 28 through July 2, 2010

Celis-Acosta. Celis-Acosta and [REDACTED] straw purchasers are responsible for the purchase of 1,500 firearms that were then supplied to Mexican drug trafficking cartels. They also have direct ties to the Sinaloa Cartel which is suspected of providing \$1 million for the purchase of firearms in the greater Phoenix area.

[REDACTED]

This Week

[REDACTED]

4 of 10

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ONDCP F&F 000136

1231

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated June 28, 2010
Subject: Weekly Report from June 28 through July 2, 2010

Intelligence Studies

Intelligence Study	Requesting Agency	Publication Date
[REDACTED]		
National Marijuana Threat Assessment 2010	Office of National Drug Control Policy	June 2010
[REDACTED]		
West Central Region Gangs in Indian Country Threat Assessment	Office of National Drug Control Policy	July 2010
[REDACTED]		

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U.S. Department of Justice

National Drug Intelligence Center

Office of the Director

DATE: January 31, 2011

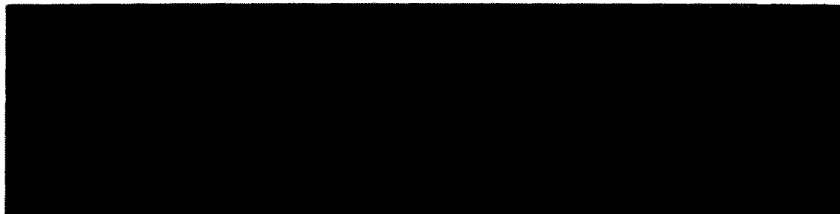
MEMORANDUM TO THE ATTORNEY GENERAL

THROUGH THE DEPUTY ATTORNEY GENERAL

FROM: Michael F. Walther
Director
National Drug Intelligence Center

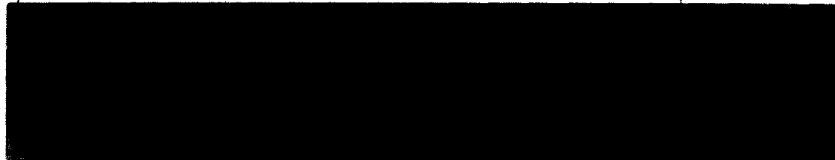
SUBJECT: NATIONAL DRUG INTELLIGENCE CENTER REPORT FOR
JANUARY 31 THROUGH FEBRUARY 4, 2011

STRATEGIC INTELLIGENCE



Pending Intelligence Publications

Intelligence Publication	Requesting Agency	Publication Date
Domestic Cannabis Cultivation Threat Assessment 2010	ONDCP	February
West Central Region Gangs in Indian Country Threat Assessment	ONDCP	February



1 of 4

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ONDCP F&F 000205

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated January 31, 2011
 Subject: Weekly Report from January 31 through February 4, 2011

Intelligence Publication	Requesting Agency	Publication Date
Southwest Border Drug Seizure Statistics Report September 2010	ONDCP	February
Cocaine Availability in U.S. Drug Markets January through June 2010	ONDCP	March
Economic Impact of Illicit Drug Use on American Society	ONDCP	March
Pacific Region Gangs in Indian Country Threat Assessment	ONDCP	March
National Drug Threat Assessment 2011	ONDCP	March
Great Lakes Region Gangs in Indian Country Threat Assessment	ONDCP	March
Southwest Region Gangs in Indian Country Threat Assessment	ONDCP	March
Southwest Border Drug Seizure Statistics Report October 2010	ONDCP	March
Southwest Border Drug Seizure Statistics Report November 2010	ONDCP	March
OCDETF Northern Border Drug Threat Assessment	OCDETF	May

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Memorandum to the Attorney General from Michael F. Walther dated January 31, 2011
Subject: Weekly Report from January 31 through February 4, 2011

DOCUMENT AND MEDIA EXPLOITATION

Missions

Activity	Requesting Agency	Dates
-----------------	--------------------------	--------------



Investigation:	OCDETF Operation FAST AND THE FURIOUS	ATF, Phoenix, Arizona	Jan 31 – Feb 11
-----------------------	---------------------------------------	-----------------------	-----------------

Region: Phoenix, Douglas, and Nogales, Arizona;

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Memorandum to the Attorney General from Michael F. Walther dated January 31, 2011
Subject: Weekly Report from January 31 through February 4, 2011

Activity	Requesting Agency	Dates
and El Paso, Texas		
Targets: Manuel CELIA-ACOSTA		
Drugs/Crime: Straw purchase of firearms for SINALOA CARTEL		
Participants: ATF		



4 of 4

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ONDCP F&F 000208

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U.S. Department of Justice

National Drug Intelligence Center

Office of the Director

DATE: August 2, 2010

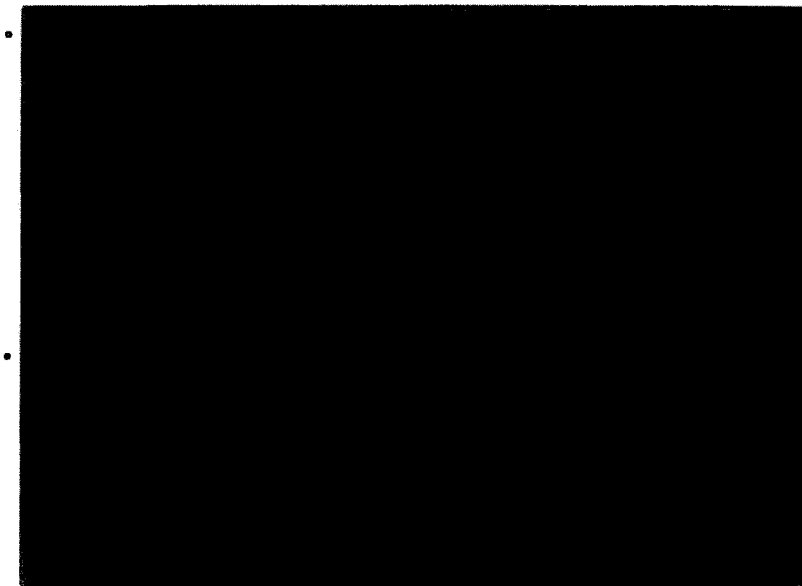
MEMORANDUM TO THE ATTORNEY GENERAL
THROUGH THE ACTING DEPUTY ATTORNEY GENERAL

FROM: Michael F. Walther
Director
National Drug Intelligence Center

SUBJECT: WEEKLY REPORT FOR AUGUST 2 THROUGH AUGUST 6, 2010

The National Drug Intelligence Center weekly report for August 2 through August 6 is as follows:

Next Week



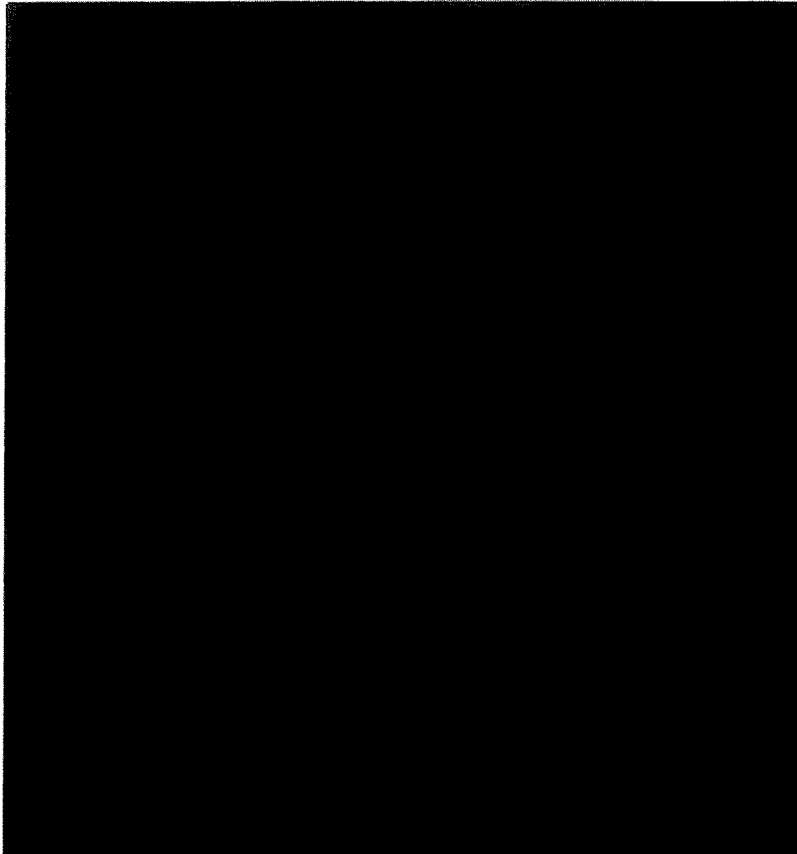
1 of 9

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ONDCP F&F 000183

LIMITED OFFICIAL USE – LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated August 2, 2010
Subject: Weekly Report from August 2 through August 6, 2010



(LOU-LES) Document and Media Exploitation Support to the Organized Crime Drug Enforcement Task Force:

From August 2 through August 6, the National Drug Intelligence Center Document and Media Exploitation Team at the Phoenix Organized Crime Drug Enforcement Task Force (OCDETF Strike Force) will support the Bureau of Alcohol, Tobacco, Firearms, and Explosives' Phoenix Field Division with its investigation of Manuel Celis-Acosta as part of OCDETF Operation

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ONDCP F&F 000164

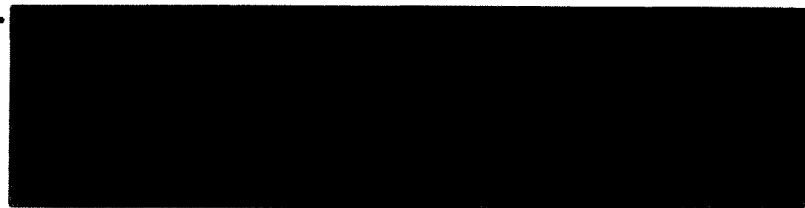
LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated August 2, 2010
Subject: Weekly Report from August 2 through August 6, 2010

Fast and the Furious. This investigation, initiated in September 2009 in conjunction with the Drug Enforcement Administration, Immigration and Customs Enforcement, and the Phoenix Police Department, involves a Phoenix-based firearms trafficking ring headed by Manuel Celis-Acosta. Celis-Acosta and [REDACTED] straw purchasers are responsible for the purchase of 1,500 firearms that were then supplied to Mexican drug trafficking cartels. They also have direct ties to the Sinaloa Cartel which is suspected of providing \$1 million for the purchase of firearms in the greater Phoenix area.



Last Week



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ONDOP F&F 000185

LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated August 2, 2010
Subject: Weekly Report from August 2 through August 6, 2010



- ***(LOU-LES) Document and Media Exploitation Support to the Organized Crime Drug Enforcement Task Force:***
From July 26 through July 30, the National Drug Intelligence Center Document and Media Exploitation Team at the Phoenix Organized Crime Drug Enforcement Task Force (OCDETF) Strike Force supported the Bureau of Alcohol, Tobacco, Firearms, and Explosives' Phoenix Field Division with its investigation of Manuel Celis-Acosta as part of OCDETF Operation Fast and the Furious. This investigation, initiated in September 2009 in conjunction with the Drug Enforcement Administration, Immigration and Customs Enforcement, and the Phoenix Police Department, involves a Phoenix-based firearms trafficking ring headed by Manuel Celis-Acosta. Celis-Acosta and [REDACTED] straw purchasers are responsible for the purchase of 1,500 firearms that were then supplied to Mexican drug trafficking cartels. They also have direct ties to the Sinaloa Cartel which is suspected of providing \$1 million for the purchase of firearms in the greater Phoenix area.

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ONDCP F&F 000186

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LIMITED OFFICIAL USE - LAW ENFORCEMENT SENSITIVE

Memorandum to the Attorney General from Michael F. Walther dated August 2, 2010
Subject: Weekly Report from August 2 through August 6, 2010



Intelligence Studies

Intelligence Study	Requesting Agency	Publication Date
National Marijuana Threat Assessment 2010	Office of National Drug Control Policy	August 2010
West Central Region Gangs in Indian Country Threat Assessment	Office of National Drug Control Policy	August 2010

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ONDCP F&F 000187

Attachment 7

RC-1

m: Morrissey, Mike (USAAZ)
t: Wednesday, December 15, 2010 3:15 PM
to: Cunningham, Patrick (USAAZ); Burke, Dennis (USAAZ); Scheel, Ann (USAAZ)
cc: Tarango, Manuel (USAAZ)
Subject: RE: Fast and Furious: You available for a call today?

I'd like to make Jan 19 the "set in stone" date for an indictment, so that this comes to pass and we can make definite plans for searches and arrests. I agree with Pat that we should have a back up date but I do not want to use it. Mike

-----Original Message-----

From: Cunningham, Patrick (USAAZ)
Sent: Wednesday, December 15, 2010 1:05 PM
To: Burke, Dennis (USAAZ); Scheel, Ann (USAAZ)
Cc: Morrissey, Mike (USAAZ); Tarango, Manuel (USAAZ)
Subject: Fast and Furious: You available for a call today?

After speaking to Morrissey and Emory, here are some possible dates for Fast and Furious:

Indictment of about 20 defendants on January 19, a Wednesday, to include Conspiracy to falsely purchase weapons (straw purchasing) and to sell firearms without a license, unlawful export of weapons to Mexico which requires Pelak's (sp?) approval in Washington, and money laundering. IRS is doing the money laundering investigation.

January 26, a Wednesday--reserve GJ date if we are not ready on Jan 19

January 27, three search warrants, some civil seizure warrants, arrests of the 20 defendants, and Press Event that day after the take down.

See you about 3pm. PJC

-----Original Message-----

From: Burke, Dennis (USAAZ)
Sent: Wednesday, December 15, 2010 12:15 AM
To: Cunningham, Patrick (USAAZ); Scheel, Ann (USAAZ)
Subject: FW: You available for a call today?

----- Original Message -----

From: Burke, Dennis (USAAZ)
Sent: Wednesday, December 15, 2010 02:14 AM
To: Wilkinson, Monty (OAG) (SMO)
Subject: Re: You available for a call today?

Sorry for going dark on you. I was at Navajo and Hopi all day and coverage was weak at best. I did get your vm. We have a major gun trafficking case connected to Mexico we are taking down in January. 20+ defendants. Will call today to explain in detail.

From: Wilkinson, Monty (OAG) (SMO)
Sent: Tuesday, December 14, 2010 11:18 AM
To: Burke, Dennis (USAAZ)
Subject: You available for a call today?

HOCR USAO 003073

Attachment 8

From: Smith, Brad (ODAG) <RC-1 [REDACTED]>
Sent: Friday, December 17, 2010 11:58 AM
To: Grindler, Gary (ODAG) <RC-1 [REDACTED]>; Monaco, Lisa (ODAG) <RC-1 [REDACTED]>; Luck, Stacey (ODAG) <RC-1 [REDACTED]>
Cc: Michalic, Mark (ODAG) <RC-1 [REDACTED]>; Johnston, Deborah A. (ODAG) <RC-1 [REDACTED]>
Subject: ATF Update
Attach: RC-2 [REDACTED], December Fast and Furious BP for SAC (2) (2).docx; December Fast and Furious BP Supplemental December 16 2010.docx

<< .>> G<< .>> u<< .>> r<< .>> y,

Mark and I just wanted to pass along a few quick ATF-related updates we received from Billy Hoover. We do not believe anything requires immediate action from our office, but we wanted to make sure you were aware of the issues.

RC-2 [REDACTED]

Second, you may recall that a CBP border agent was killed on Tuesday in a firefight in Arizona involving along the Mexican border. Two of the weapons recovered from the scene (AK-47 variants) have been linked to Jaime Avila Jr., a "straw firearms purchaser" that ATF and USAO for Arizona have been investigating since November 2009 as part of its larger "Fast and Furious" operation. (It is not clear if the shots that killed the CBP agent came from the weapons linked to Avila.) ATF agents, assisted by ICE, USMS, and Phoenix police, arrested Avila on Wednesday for falsification of ATF forms, and in a subsequent interview, he admitted to serving as a straw purchaser. The attached background papers, which ATF prepared, provide additional details on the case, if you are interested.

RC-2 [REDACTED]

Thanks.

Brad

1243

Sensitive But Unclassified – For Official Use Only

Briefing Paper

Phoenix Field Division

Phoenix Group VII (OCDETF Strike Force/Gunrunner)

ATF Investigation 785115-10-0004

Operation: Fast & Furious, OCDETF No. SW-AZP-0496

Case Background

The Phoenix Group VII Field Office is leading an investigation entitled "Operation Fast & Furious" in conjunction with Immigration and Customs Enforcement (ICE), Drug Enforcement Administration (DEA), Internal Revenue Service (IRS) and the Phoenix Police Department (PPD). This operation was approved as an OCDETF case by the Southwest Region as SW-AZP-0496.

Since October 2009, ATF and the other partners listed above have been investigating a firearm trafficking organization that is being funded by the Sinaloa drug trafficking organization (DTO), a narcotics trafficking organization well known for violent criminal activity in Mexico. This organization is also involved in trafficking firearms to Mexico, and smuggling cocaine and marijuana into southern Arizona to be distributed throughout the United States. The OCDETF investigation of this organization is addressing violations of Federal Laws to include Firearms, Narcotics, Money Laundering, and Conspiracy Laws.

Agents believe that the Phoenix-based firearm trafficking group is actively purchasing firearms through "straw" purchasers using narcotics proceeds. From October 2009 to October 2010 agents have documented that this organization spent approximately 1.25 million dollars in cash at various Phoenix area Federal Firearms Licensees to acquire in excess of 1,900 firearms. The firearms are then being trafficked into Mexico using false compartments in various vehicles through various international Ports of Entry in Arizona and Texas.

RC 3

[REDACTED] and many other investigative techniques to further the investigation. Through these investigative techniques agents have been able to identify a large number of additional co-conspirators and disrupt the illegal activities of this firearms trafficking organization by seizing numerous firearms and narcotics. To date, over three hundred firearms and over fifty pounds of marijuana have been recovered by agents in addition to the numerous firearms and narcotic seizures in Mexico related to this investigation.

Sensitive But Unclassified – For Official Use Only

HOCR DOJ 002876

Sensitive But Unclassified - For Official Use Only

Over the past several weeks agents, in conjunction with the investigative partners and the United States Attorney's Office (USAO) have been preparing for the indictment of [REDACTED] individuals in this investigation. Agents initially anticipated a first wave of indictments on December 7, 2010. However, in light of additional evidence obtained in support of this investigation and investigative efforts on the part of IRS the first wave of approximately 20 indictments have been pushed back another 30 days. The reasons for this include the very proactive stance the IRS has taken during the past several weeks. [REDACTED]

[REDACTED] In addition the USAO has agreed to approve the inclusion of five Federal search warrants. The additional preparation for the search warrants and [REDACTED] coupled with available Grand Jury time, has pushed the indictment date to the week of January 10, 2011.

On December 3rd SAC Newell and ASAC Needles met with USA Burke, Chief of Criminal Cunningham and the lead AUSA for this case and discussed all these matters.

It should be further noted that firearms purchasing and trafficking activity by this organization has subsided significantly since early October of this year. This is due to several factors not the least of which are the many proactive measures taken by the agents assigned to Phoenix Group VII. It should also be noted that throughout the course of the investigation numerous seizures were made by other State, local and Federal law enforcement agencies at the direction of Phoenix Group VII in order to ensure the seized firearms did not reach their intended destination but also to ensure the leadership of this firearms trafficking organization was not "tipped off" to the proactive measures taken while the larger conspiracy case was being prepared for the USAO.

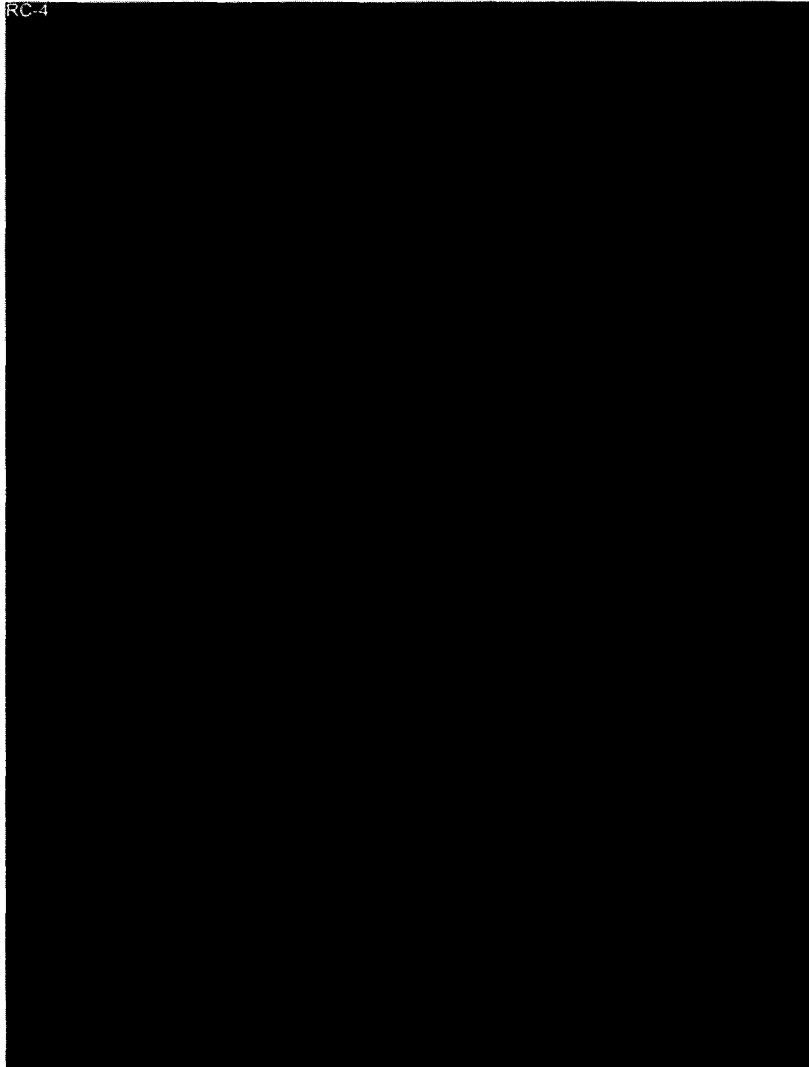
2
Sensitive But Unclassified - For Official Use Only

HOGH DOJ 002877

1245

Sensitive But Unclassified – For Official Use Only

List of Defendants Referred to USAO for Prosecution:



³
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HOCR DOJ 002878

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Proposed Charges:

1. Title 18, United States Code, Section 554, Smuggling Goods from the United States.
2. Title 18, United States Code, Section 922(a)(1), Dealing in Firearms without a License;
3. Title 18, United States Code, Section 922(a)(5), Transferring Firearms to a Non-Resident of the State;
4. Title 18, United States Code, Section 922(a)(6) Making a False Statement in Connection with the Acquisition of a Firearm;
5. Title 18, United States Code, Section 924(a)(1)(A) Making a False Statement in Connection with the Acquisition of a Firearm;
6. Title 18, United States Code, Section 924(n), Interstate/International Firearms Trafficking;
7. Title 18, United States Code, Sections 924(c) and 924(o), Use of a Firearm in Furtherance of a Drug Trafficking Offense/Conspiracy to Use a Firearm in Furtherance of a Drug Trafficking Offense.
8. Title 18, United States Code, Section 1343, Wire Fraud;
9. Title 18, United States Code, Section 1956, Money Laundering;
10. Title 18, United States Code, Section 371, Conspiracy to Commit any Offense Against the United States;
11. Title 21, United States Code, Sections 841 and 846, Possession/Conspiracy to Possess a Controlled Substance with Intent to Distribute;
12. Title 21, United States Code, Sections 960 and 963, Import/Conspiracy to Import a Controlled Substance;
13. Title 22, United States Code, Section 2778, Attempt/Export Munitions without a License;
14. Title 31, United States Code, Section 5324, Structuring Transactions to Evade Reporting Requirements; and
15. Title 31, United States Code, Section 5332, Bulk Cash Smuggling;

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1247

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Briefing Paper

Phoenix Field Division

Phoenix Group VII (OCDETF Strike Force/Gunner)

ATF Investigation 785115-10-0004

Operation: Fast & Furious, OCDETF No. SW-AZP-0496

Supplemental

On December 15/16, 2010, after the shooting death of U.S. Border Patrol Agent Brian Terry near Rio Rico, Arizona (approx 25 miles north of Nogales) Southern Arizona law enforcement officers/agents responded and conducted a search of the area. This search resulted in the arrest of four individuals. One of them, Manuel Osorio Arellances DOB: 8-4-76, was shot in the exchange of gunfire ^{RC-5} [REDACTED]

In addition and during the search of the area two RomArm/Cugir, Model GP WASR 10, 7.62x39mm AK-47 rifles, serial numbers 1983AH3977 and 1971CZ3775 were recovered near the scene of the shooting. An Urgent firearms trace requested by ATF agents on-scene determined that these firearms were in ATF's National Tracing Center's Suspect Gun Database due to their association to an ATF led OCDETF investigation out the Phoenix OCDETF Strike Force. This investigation, entitled "Fast and Furious", due to the very quick manner in which a complex firearms trafficking organization acquired several hundred firearms was initiated in October 2009 and is being conducted in conjunction with ICE/HSI, IRS, DEA and the Phoenix Police Department.

Due to the "hit" in the Suspect Gun Database the Phoenix Field Division's Field Intelligence Group was notified and confirmed that the two recovered firearms were part of a sale of three Romarm/Cugir AK-47 variant rifles purchased by Jaime AVILA Jr. on January 16, 2010 from Lone Wolf Trading Company in Glendale, Arizona. Jaime Avila Jr. is one of [REDACTED] straw firearms purchasers identified in the "Fast and Furious" investigation and recommended by ATF for prosecution to the U.S. Attorney's Office in Phoenix, Arizona.

Jaime Avila Jr. is known to have purchased a total of 52 firearms beginning in late November 2009 and ending in mid-June 2010. He had purchased 13 firearms by the time he purchased the three AK-47 variant rifles on January 16, 2010, two of which were recovered near Rio Rico, Arizona on December 16th. The 52 firearms purchased by Jaime Avila Jr. included 17 AK-47 variant rifles, 11 Fabrique National "FN57" 5.7x28mm pistols, 10 9mm pistols, 5 .45 and .40 caliber pistols, 2 Barrett .50 caliber rifles and several other assorted firearms.

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On December 15, 2010, ATF agents, assisted by ICE, the USMS and the Phoenix Police Department located Jaime Avila Jr. and subsequently interviewed and arrested him on charges stemming from his falsifying ATF F 4473s by using a false address during his purchase of four (4) firearms on June 12, 2010, and another four (4) firearms on June 15, 2010. During his interview, Jaime Avila Jr. admitted to ATF agents that he straw purchased these firearms for an unidentified Hispanic male as well as admitted he had used an address of a residence he had not resided in for several years. This was confirmed by interviewing the current residents of the address he used along with verification via utility systems queries.

Jaime Avila Jr was held overnight and ATF agents have prepared a Federal criminal complaint for him based on violations of Federal firearms laws specifically of Title 18, United State Code, Sections 924(a)(1)(A)

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HOCR DOJ 002881

Attachment 9

United States Senate

WASHINGTON, DC 20510

June 16, 2011

Via Electronic Transmission

Kenneth Melson
Acting Director
Bureau of Alcohol, Tobacco, Firearms, & Explosives
U.S. Department of Justice
99 New York Avenue, NE
Washington, DC 20226

Dear Acting Director Melson:

I write today in response to a June 10, 2011, article in *The Wall Street Journal* titled, "Mexican Guns Tied to U.S.," which cites a letter you sent to Senator Diane Feinstein, the Chairman of the Senate Caucus on International Narcotics Control ("Caucus"). As the Co-Chairman of the Caucus, and Ranking Member of the Senate Committee on the Judiciary ("Committee"), I have been investigating serious allegations raised by whistleblowers within the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) that agents knowingly allowed weapons to be sold to straw purchasers who then transferred those weapons to Mexican Drug Trafficking Organizations ("DTOs"). These allegations were the subject of two Congressional hearings this week and the timing of the release of this information raises questions about why the ATF would choose to release this information publicly now. Further, after reviewing the data presented in the article, I have questions about why ATF provided some select information, but not a more detailed analysis that would help Congress, and the American people, better understand the causes and sources of illegal firearms in Mexico.

Federal law prohibits the ATF from releasing firearm trace data or multiple handgun sales reports, but it does not prohibit the release of aggregate statistical data on illegal gun trafficking. However, I am concerned that the selective release of certain statistical data without further clarification and categorization may inaccurately reflect the scope and source of the problem of firearms in Mexico and the DTO violence. For example, the article states that ATF traced firearms in Mexico that were submitted for tracing by the Government of Mexico ("GOM") 21,313 firearms in 2009 and 7,971 firearms in 2010. The article further adds that of the firearms traced, 14,213 in 2009 were manufactured in the U.S. or imported to the U.S. from other countries. The article adds that 6,291 firearms in 2010 were either manufactured in the U.S. or imported from other countries. Taken together, these numbers provided the basis for the general estimate that 70% of firearms provided to the ATF from the GOM were traced back to the U.S.

The implication the article makes is that these firearms must come directly from U.S. manufacturers or U.S. Federal Firearms Licensees ("FFLs") selling guns to DTO members who smuggle the guns over the Southwest border. Unfortunately, this information paints a grossly inaccurate picture of the situation.

First and foremost, it is worth noting that the firearms data discussed in the article is based upon only the firearms that were submitted by the GOM to ATF for tracing. According to a May 6, 2009, article written by the Associated Press, over 305,424 confiscated weapons are locked in vaults in Mexico.¹ The weapons submitted for tracing represent only a small percentage of the number of weapons found to be part of the DTO related crime in Mexico. Further, there has been significant evidence in the media recently regarding the proliferation of weapons in Mexico smuggled out of Central America. For example, at a recent hearing before the Caucus on Central American security cooperation we heard testimony from witnesses that corrupt officers with access to unsecured arsenals in Guatemala and Honduras were an important source of weapons. In one recent media report, they discussed how over 1,100 fragmentation grenades, M-60 machine guns, and over a dozen grenade launchers were recovered in Guatemala at an alleged safe house of the Zetas DTO. That same article added that the Zetas had stolen over 500 weapons from a Guatemalan military base between 2007 and 2008.

Additional evidence regarding the source of weapons in Mexico is contained in an unclassified cable from the U.S. Department of State ("DOS") dated July 2, 2010, obtained by my office and attached to this letter. The cable, titled, "Mexico Weapons Trafficking – The Blame Game" seeks to dispel rumors about the source of weapons trafficked to Mexico. The unclassified cable includes sections such as: "Myth: An Iron Highway of Weapons Flows from the U.S.," "Myth: The DTOs Are Mostly Responsible," "Myth: Mexico Aggressively Investigating Weapons Confiscated," "Myth: Mexico Methodically Registers and Tracks Weapons," and "Myth: The GOM Justice System is Tough on Violators of Gun Laws." While this cable is very candid about the true problem of weapons smuggling inside Mexico, the cover emails forwarding this cable suggest that the ATF and officials associated with the ATF disagreed.

In fact, one email written by Special Agent in Charge William Newell states, "I could go on and on but once our 'Fast and Furious' case breaks it will change this." Unfortunately, it now appears that Special Agent in Charge Newell's prediction was correct, but instead of an "Iron Highway" operating on its own, it was ATF who fueled the flow of weapons through its "Fast and Furious" investigation which knowingly sanctioned the sale of nearly 2,000 firearms to straw purchasers.

I understand that agents working on tracing weapons in Mexico back to the U.S. routinely instruct GOM authorities to only submit weapons for tracing that have a likelihood of tracing back to the U.S. The purpose of this policy is to direct resources to tracing firearms that may have a U.S. nexus, instead of simply wasting resources on tracing firearms that will not trigger a U.S. source. So, based upon this background information, it is not surprising that reviewing a sample of weapons that is purposefully directed to increase the likelihood of U.S. generated weapons would in fact skew toward the direction of making it look like U.S. gun dealers provide more weapons than they actually do. However, further discussion of the data that is presented in the article is warranted.

¹ E. Eduardo Castillo, *AP Impact: Mexico's Weapons Cache Stymies Tracing*, May 6, 2009, available at <http://www.brownsvilleherald.com/common/printer/view.php?db=brownsville&id=97742> (last visited June 13, 2011).

Looking specifically at the information provided by the ATF to Senator Feinstein and the *The Wall Street Journal* raises some questions when compared more detailed data provided to my office. ATF actually traced 26,813 firearms in 2009 and 9,443 in 2010. Further, that data indicates that of those firearms actually submitted for tracing, a vast majority of those firearms did not come from FFLs (either U.S. based or Mexican based). In fact, of the 26,813 weapons traced in 2009, only 5,800 actually traced back to U.S. or Mexican FFLs. Table 1 illustrates a more detailed breakdown of the firearms data for both 2009 and 2010. The most noteworthy portion of the information is that nearly 78% of firearms traced in 2009 and 66% of firearms traced in 2010 were assigned to a catchall category “No Final Sale Dealer” which means the firearms did not trace back to a United States FFL. This category of firearms includes firearms that have no nexus with U.S. commerce. It also includes firearms where the only nexus to U.S. commerce is that they were manufactured by U.S. companies. This means they are not sold by FFLs in the United States. Instead, they may be sold to foreign countries or militaries requiring approval of the State Department and Homeland Security. Additionally, this category includes firearms in the ATF’s Suspect Gun Database—a category which would include nearly 2,000 firearms as part of ATF’s Fast and Furious Investigation where the ATF knowingly authorized firearm sales to straw purchasers before the weapons were trafficked to Mexican DTOs.

Table 1: Firearms Tracing Information for 2009 and 2010

Year	Number of Firearms Submitted for Tracing by Government of Mexico	Number of Firearms Traced to Federal Firearm Licensees (FFLs)	Number of Firearms Assigned to “No Final Sale Dealer”
2009	26,813	5,800 (22%)	21,013 (78%)
2010	9,443	3,176 (34%)	6,267 (66%)

Because the numbers provided to my office indicate that the data provided to Senator Feinstein and *The Wall Street Journal* may not be entirely accurate and because further questions and breakdowns of that data are necessary for Congress to make an informed decision about the sources of weapons that are fueling the DTO related violence in Mexico, I ask that you provide responses to the following questions:

- (1) Of the 21,013 firearms in the “No Final Sale Dealer” category for 2009, how many of those firearms can be traced back to military sales to the GOM? How many can be traced to the military of Guatemala? How many can be traced to the military of Honduras? How many can be traced to the military of El Salvador? How many can be traced to other Central American and South American militaries? How many can be traced to other foreign militaries? How many are in that category because they were in the Suspect Gun Database?
- (2) Of the 6,267 firearms in the “No Final Sale Dealer” category for 2010, how many of those firearms can be traced back to military sale to the GOM? How many can be traced to the military of Guatemala? How many can be traced to the military of Honduras? How many can be traced to the military of El Salvador? How many can

be traced to other Central American and South American militaries? How many can be traced to other foreign militaries? How many are in that category because they were in the Suspect Gun Database?

- (3) How many of those weapons in the "No Final Sale Dealer" category for 2009 and 2010 were previously reported lost or stolen?
- (4) Has the ATF requested access to the 305,424 firearms held by the GOM military vault? How many of those firearms have been traced? How many of those firearms would trace back to the GOM and the Mexican military?
- (5) Data indicates that the top source dealer for illegal firearms traced in Mexico for 2009 was "Direccion General De Industria Milita" or the Directorate General of Military Industry in Mexico. They provided 120 firearms that were later traced back, likely after a crime. Why does this entity have a U.S. Federal Firearms License? Are sales to this and other foreign entities with U.S. FFL's included in the numbers the ATF provided as being a gun from a "U.S. Source". If so, why?
- (6) Why did the number of trace requests drop significantly from 2009 to 2010, but the percentage trace to U.S. FFLs go up? What is behind this trend?

Accordingly, as Co-Chairman of the Caucus and Ranking Member of the Committee, I request your prompt response to these important questions no later than June 23, 2011.

Sincerely,



Charles E. Grassley
Co-Chairman, Senate Caucus on International Narcotics Control
Ranking Member, Senate Committee on the Judiciary

Attachment

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Department of Justice

STATEMENT FOR THE RECORD OF

ERIC H. HOLDER, JR.
ATTORNEY GENERAL

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ENTITLED

"OVERSIGHT OF THE U.S. DEPARTMENT OF JUSTICE"

PRESENTED

NOVEMBER 8, 2011

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**Statement of
Eric H. Holder, Jr.
Attorney General
United States Department of Justice**

**Committee on the Judiciary
United States Senate**

**“Oversight of the U.S. Department of Justice”
November 8, 2011**

Chairman Leahy, Ranking Member Grassley, and distinguished members of the Committee. I appreciate the opportunity to appear before you today.

Over the last three years, I have been privileged to address this Committee on numerous occasions – and to partner with many of you – in advancing the goals and priorities that we share. I am extremely proud of the Department’s historic achievements over the last two years. Despite significant financial constraints, we have effectively confronted a range of national security threats and public safety challenges.

I’m especially pleased to report that our efforts to combat global terrorism have never been stronger. Since I last appeared before this Committee in May – just three days after the decade-long manhunt for Osama bin Laden came to a successful end – the Department has achieved several additional milestones. For example, last month, we secured a conviction against Umar Farouk Abdulmutallab for his role in the attempted bombing of an airplane traveling from Amsterdam to Detroit on Christmas Day 2009. We also worked closely with our domestic and international partners to thwart an attempted plot – allegedly involving elements of the Iranian government – to assassinate the Saudi Arabian Ambassador to the United States on American soil. We have also disrupted numerous alleged plots by homegrown violent extremists – including one targeting a military recruiting center in Washington State and another targeting

U.S. soldiers in Texas. Meanwhile, in one of the most complex counter-intelligence operations in history, we brought down a ring involving 10 Russian spies. And just last week, a federal jury in Manhattan convicted Viktor Bout, one of the world's most prolific arms dealers, for his efforts to sell millions of dollars-worth of weapons – including 800 surface-to-air-missiles and 30,000 AK-47s – for use in killing Americans.

On other fronts, the Department has made extraordinary progress in protecting civil rights, combating financial fraud, safeguarding our environment, and advancing our fight against violent crime. We have filed a record number of criminal civil rights cases. And, in the last fiscal year, our Civil Rights Division's Voting Section opened more investigations, participated in more cases, and resolved more matters than in any other similar time period in the last dozen years. This section is also immersed in reviewing over 4,500 submissions for review under Section 5, including redistricting plans and other proposed state and local election-law changes that would impact the access some Americans would have to the ballot box.

We've also worked to ensure that states do not institute an unconstitutional patchwork of immigration laws. In recent months, the Department has challenged immigration-related laws in several states that directly conflict with the enforcement of federal immigration policies. Not only would these laws divert critical law enforcement resources from the most serious public safety threats, they can lead to potentially discriminatory practices and undermine the vital trust between local jurisdictions and the communities they serve.

The Department also has focused its efforts on the fight against financial fraud over the last two years – by spearheading the interagency Financial Fraud Enforcement Task Force and successfully executing the largest financial and health-care fraud takedowns in history. In addition, we secured a conviction in the biggest bank fraud prosecution in a generation, taking

down a nearly \$3 billion fraud scheme. And, through our aggressive enforcement of the False Claims Act, a law significantly strengthened in recent years by this Committee, we've secured record-setting recoveries that have exceeded \$8 billion since January 2009.

I am proud of these – and our many other – achievements. And, I am committed to building on this progress. Although I hope to spend much of our time together discussing the work that's ongoing throughout the Department, I'd like to take a moment to address the public safety crisis of guns flowing across our border into Mexico – and the local law enforcement operation known as “Fast and Furious” that has brought renewed public attention to this shared national security threat.

I want to be clear: any instance of so-called “gun walking” is unacceptable. Regrettably, this tactic was used as part of Fast and Furious, which was launched to combat gun trafficking and violence on our Southwest Border. This operation was flawed in concept, as well as in execution. And, unfortunately, we will feel its effects for years to come as guns that were lost during this operation continue to show up at crimes scenes both here and in Mexico. This should never have happened. And it must never happen again.

To ensure that it will not, after learning about the allegations raised by ATF agents involved with Fast and Furious, I took action. I asked the Department's Inspector General to investigate the matter, and I ordered that a directive be sent to the Department's law enforcement agents and prosecutors stating that such tactics violate Department policy and will not be tolerated. More recently, the new leadership at ATF has implemented reforms to prevent such tactics from being used in the future, including stricter oversight procedures for all significant investigations.

Today, I would like to correct some of the inaccurate – and irresponsible – accusations surrounding Fast and Furious. Some of the overheated rhetoric might lead you to believe that this local, Arizona-based operation was somehow the cause of the epidemic of gun violence in Mexico. In fact, Fast and Furious was a flawed *response* to, not the *cause* of, the flow of illegal guns from the United States into Mexico.

As you all know, the trafficking of firearms across our Southwest Border has long been a serious problem – one that has contributed to approximately 40,000 deaths in the last five years. As Senator Feinstein highlighted just last week, of the nearly 94,000 guns that have been recovered and traced in Mexico in recent years, over 64,000 were sourced to the United States.

The mistakes of Operation Fast and Furious, serious though they were, should not deter or distract us from our critical mission to disrupt the dangerous flow of firearms along our Southwest Border. I have supported a number of aggressive, innovative steps to do so and our work has yielded significant successes. We've built crime-fighting capacity on both sides of the border by developing new procedures for using evidence gathered in Mexico to prosecute gun traffickers in U.S. courts; by training thousands of Mexican prosecutors and investigators; by successfully fighting to enhance sentencing guidelines for convicted traffickers and straw purchasers; and by pursuing coordinated, multi-district investigations of gun-trafficking rings.

This year alone, we have led successful investigations into the murders of U.S. citizens in Mexico, created new cartel-targeting prosecutorial units, and secured the extradition of 104 defendants wanted by U.S. law enforcement – including the former head of the Tijuana Cartel. This work has undoubtedly saved and improved lives in the United States as well as Mexico. I am personally committed to combating gun trafficking and reducing the alarming rate of violence along the Southwest Border by using effective – and appropriate – tools.

Like each of you, I want to know why and how firearms that should have been under surveillance could wind up in the hands of Mexican drug cartels. But beyond identifying where errors occurred and ensuring that they never occur again, we must be careful not to lose sight of the critical problem that this flawed investigation has highlighted: we are losing the battle to stop the flow of illegal guns to Mexico. That means we have a responsibility to act. And, we can start by listening to the agents who serve on the front lines of this battle. Not only did they bring the inappropriate and misguided tactics of Operation Fast and Furious to light, they also sounded the alarm to Congress that they need our help.

ATF agents who testified before a House committee this summer explained that the agency's ability to stem the flow of guns from the United States into Mexico suffers from a lack of effective enforcement tools. One critical first step should be for Congressional leaders to work with us to provide ATF with the resources and statutory tools it needs to be effective. Another would be for Congress to fully fund our request for teams of agents to fight gun trafficking. Unfortunately, earlier this year the House of Representatives actually voted to keep law enforcement in the dark when individuals purchase multiple semi-automatic rifles and shotguns in Southwest border gun shops. Providing law enforcement with the tools to detect and disrupt illegal gun trafficking is entirely consistent with the constitutional rights of law-abiding citizens and it is critical to addressing the public safety crisis on the Southwest border.

As someone who has seen the consequences of gun violence firsthand – and who has promised far too many grieving families that I would do everything in my power not only to seek justice on behalf of their loved ones, but also to prevent other families from experiencing similar tragedies – I am determined to ensure that our shared concerns about Operation Fast and Furious

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lead to more than headline-grabbing Washington “gotcha” games and cynical political point scoring.

We have serious problems to address – and sacred responsibilities to fulfill. We must not lose sight of what’s really at stake here: lives, futures, families, and communities. When it comes to protecting our fellow citizens – and stopping illegal gun trafficking across our Southwest Border – I hope we can engage in a responsible dialogue and work toward common solutions. And, I hope we can begin that discussion today.

I welcome any questions that you have for me.



The Attorney General

Washington, D.C.

October 7, 2011

The Honorable Darrell E. Issa
Chairman
Committee on Oversight
and Government Reform
U.S. House of Representatives
Washington, DC 20515

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Lamar S. Smith
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

The Honorable Elijah Cummings
Ranking Minority Member
Committee on Oversight
and Government Reform
U.S. House of Representatives
Washington, DC 20515

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable John Conyers, Jr.
Ranking Minority Member
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Messrs. Chairmen and Senator Grassley, Congressman Conyers, and
Congressman Cummings:

I have watched for some months now as the facts surrounding Operation Fast and Furious have been developed on the public record. I have not spoken at length on this subject out of deference to the review being conducted, at my request, by our Department's Inspector General. However, in the past few days, the public discourse concerning these issues has become so base and so harmful to interests that I hope we all share that I must now address these issues notwithstanding the Inspector General's ongoing review.

For example, I simply cannot sit idly by as a Majority Member of the House Committee on Oversight and Government Reform suggests, as happened this week, that law enforcement and government employees who devote their lives to protecting our citizens be considered "accessories to murder." Such irresponsible and inflammatory rhetoric must be repudiated in the strongest possible terms. Those who serve in the ranks of law enforcement are our Nation's heroes and deserve our Nation's thanks, not the disrespect that is being heaped on them by those who seek political advantage. I trust you feel similarly and I call on you to denounce these statements.

I also want to be very clear that protecting American citizens from the devastating effects of gun violence is among the most important responsibilities of the Department of Justice. Likewise, ensuring that weapons sold here do not flow south to Mexico is of paramount importance. We are committed to disrupting and dismantling the organizations that traffic weapons across our borders and I am proud to

The Honorable Darrell E. Issa, The Honorable Patrick J. Leahy,
The Honorable Lamar S. Smith, The Honorable Elijah Cummings,
The Honorable Charles E. Grassley, The Honorable John Conyers, Jr.
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stand with our brave law enforcement officers who fight every day to protect our citizens and those of Mexico from the effects of gun violence and illegal gun trafficking.

A. Fast and Furious was a Flawed Response to a Serious Problem on the Southwest Border

According to ATF, it took into evidence nationwide approximately 35,000 firearms in FY 2011. In FY 2010, the number was approximately 37,500. During that same period, ATF reports that it took into evidence nationwide over 5 million rounds of ammunition. Still, the Southwest Border remains the front line in the battle against illegal gun trafficking. ATF and our prosecutors struggle mightily to make cases against gun smugglers and do outstanding work on a daily basis in an effort to stop the flow of guns across our borders.

Notwithstanding the seriousness of the problem faced on the Southwest Border, there is no doubt that Operation Fast and Furious was fundamentally flawed. Regrettably, its effects will be felt for years to come as weapons that should have been interdicted but were not continue to show up at crime scenes in this country and in Mexico. This is both tragic and completely unacceptable. I want to be very clear that we must aim to disrupt and dismantle the dangerous cartels that operate south of our border. That said, in our pursuit of that goal we must take all steps possible to prevent guns from crossing our border and the desire to bring cartel leaders to justice does not and cannot justify losing track of dangerous weapons.

For that very reason, in 2011, after the controversy about this matter arose, I took decisive action to ensure that such operations are never again undertaken. First, I referred the matter to the Department's Inspector General for review so the facts underlying it could come out. Second, I instructed the Deputy Attorney General to reiterate to our prosecutors and law enforcement components that Department policy prohibits the design or conduct of undercover operations which include the uncontrolled crossing of guns across the border. In addition, new leadership is now in place both at ATF and in the United States Attorney's Office in Arizona. It has become clear that the flawed tactics employed in Fast and Furious were not limited to that operation and were actually employed in an investigation conducted during the prior Administration. Regardless, those tactics should never again be adopted in any investigation.

B. No Knowledge of Fast and Furious' Misguided Tactics

Much has been made in the past few days about my congressional testimony earlier this year regarding Fast and Furious. My testimony was truthful and accurate and I have been consistent on this point throughout. I have no recollection of knowing about Fast and Furious or of hearing its name prior to the public controversy about it. Prior to early 2011, I certainly never knew about the tactics employed in the operation and it is my understanding that the former United States Attorney for the District of Arizona and the former Acting Director and Deputy Director of ATF have told Congress that they, themselves, were unaware of the tactics employed. I understand that they have also told Congress that they never briefed me or other Department leadership on the misguided tactics that were used in Fast and Furious. Of course, that is not surprising for, as Chairman Issa made clear in an interview on CNN just this week, even the former Acting Director of ATF "has said he didn't know about" the tactics being used in the field by his agency.

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The Honorable Lamar S. Smith, The Honorable Elijah Cummings,
The Honorable Charles E. Grassley, The Honorable John Conyers, Jr.
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In the past few days, some have pointed to documents that we provided to Congress as evidence that I was familiar with Fast and Furious earlier than I have testified. That simply is not the case and those suggestions mischaracterize the process by which I receive information concerning the activities of the Department's many components. On a weekly basis, my office typically receives over a hundred pages of so-called "weekly reports" that, while addressed to me, actually are provided to and reviewed by members of my staff and the staff of the Office of the Deputy Attorney General. The weekly reports contain short summaries of matters that the agencies deem of interest that week. Sometimes, the summaries are simply a sentence-long and other times they consist of a paragraph. In some cases, the summaries are of policy-related issues or upcoming events. In other cases, the summaries are brief, high-level reviews of pending matters or investigations. It is important to look at the documents supposedly at issue here and, for that reason, I have attached them to this letter and am making them public in the form they previously were provided by us to Congress. Please note that none of these summaries say anything about the unacceptable tactics employed by ATF.

Attorneys in my office and in the Office of the Deputy Attorney General review these weekly reports and bring to my attention only those matters deemed to require my consideration or action; given the volume of material to which I must devote my attention, I do not and cannot read them cover-to-cover. Here, no issues concerning Fast and Furious were brought to my attention because the information presented in the reports did not suggest a problem. Rather, the entries suggest active law enforcement action being taken to combat a firearms-trafficking organization that was moving weapons to Mexico. For example, the ATF weekly report for July 19-23, 2010 briefly described the seizure in Phoenix of 73 firearms and 250 AK-47 drum magazines from a local business as part of Operation Fast and Furious, again with no mention of any unacceptable tactics.

If a component of the Department has concerns about a particular matter, there are established avenues for raising them with my office or that of the Deputy Attorney General and a weekly report is not one of them. As Attorney General, I am not and cannot be familiar with the operational details of any particular investigation being conducted in an ATF field office unless those details are brought to my attention. That did not happen with Fast and Furious until the public controversy arose in 2011.

Senator Grassley has suggested that I was aware of Operation Fast and Furious from letters he provided to me on or about January 31, 2011 that were addressed to the former Acting Director of ATF. However, those letters referred only to an ATF umbrella initiative on the Southwest Border that started under the prior Administration -- Project Gunrunner -- and not to Operation Fast and Furious.

To be sure, during 2010 I knew generally that ATF was conducting gun trafficking operations along the Southwest Border and elsewhere in the country since that is a core part of its mission given the large number of firearms flowing to Mexico each year from the United States. I also was aware of the existence of Project Gunrunner. More specifically, however, I now understand some senior officials within the Department were aware at the time that there was an operation called Fast and Furious although they were not advised of the unacceptable operational tactics being used in it. For example, I understand that we have provided to Congress materials from a March 2010 monthly meeting between the then-Acting Deputy Attorney General and senior ATF officials that included discussion of Fast and

The Honorable Darrell E. Issa, The Honorable Patrick J. Leahy,
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The Honorable Charles E. Grassley, The Honorable John Conyers, Jr.
Page Four

Furious. That meeting, of course, occurred shortly before Chairman Issa received his own briefing regarding Fast and Furious from some of the same ATF officials. I am aware that Chairman Issa has said that he was not briefed on the unacceptable details of Fast and Furious. Like Chairman Issa, the then-Acting Deputy Attorney General was not told of the unacceptable tactics employed in the operation in his regular monthly meetings with ATF to discuss its activities throughout the United States and abroad.

C. Congress Has Failed to Consider Whether Additional Tools Are Needed to Stem the Flow of Guns into Mexico

ATF witnesses testified before the House Committee on Oversight and Government Reform that the agency's ability to stem the flow of guns from the United States into Mexico is severely impaired by a lack of effective law enforcement tools. For example, a number of witnesses indicated that current penalties for illegal straw purchases are inadequate to deter such activity or to induce cooperation with law enforcement authorities after a violation is detected. Likewise, the lack of reporting requirements for multiple long gun purchases in a short period of time hindered law enforcement efforts to combat gun trafficking. Yet, the House of Representatives has voted to block a rule that requires such reporting on the Southwest Border.

As I have said, the fact that even a single gun was not interdicted in this operation and found its way to Mexico is unacceptable. Equally unacceptable, however, is the fact that too many in Congress are opposed to any discussion of fixing loopholes in our laws that facilitate the staggering flow of guns each year across our border to the south. I cannot help but note that at the same time that some members of Congress understandably criticize the Fast and Furious operation, they vehemently refuse to consider whether ATF has the resources and legal tools it needs to do its job -- tools that would be entirely consistent with the constitutional rights of law-abiding citizens.

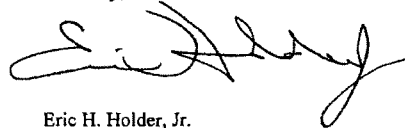
A telling moment in this regard came during one of the Fast and Furious hearings held by the House Committee on Oversight and Government Reform when Representative Maloney sought to question an ATF witness about potential reforms to our laws that would help stem the flow of illegal weapons. Representative Maloney was cut-off in mid-sentence by Chairman Issa, who then "cautioned" the witness that it would not be "valid testimony" to respond to such questions because the Committee was not interested in "proposed legislation and the like[.]" While failing to interdict weapons is an unacceptable tactic to stop the flow of illegal weapons, it seems clear that some in Congress are more interested in using this regrettable incident to score political points than in addressing the underlying problem. Even in the face of an unprecedented flow of guns across the border, too many in Congress still oppose every effort to reform our gun laws in ways that would make the United States and our Mexican neighbors safer.

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The Honorable Darrell E. Issa, The Honorable Patrick J. Leahy,
The Honorable Lamar S. Smith, The Honorable Elijah Cummings,
The Honorable Charles E. Grassley, The Honorable John Conyers, Jr.
Page Five

Until we move beyond the current political climate -- where real solutions take a back seat to both political posturing and making headlines on cable news programs, and is deemed more important than actually solving our country's difficult challenges -- nothing is going to change. I hope we can engage in a more responsible dialogue on this subject in the future. There is much we all need to do together to stop gun violence on both sides of the border and make our Nation safer.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric Holder", written in a cursive style.

Eric H. Holder, Jr.

Enclosures

**Statement Of Senator Patrick Leahy (D-Vt.),
Chairman, Senate Judiciary Committee,
Hearing On Oversight Of The Department Of Justice
November 8, 2011**

We welcome Attorney General Holder back before the Judiciary Committee as we continue our important focus on oversight.

When Attorney General Holder was here in May, details were just emerging about the successful military and intelligence operation that killed Osama bin Laden, providing a measure of justice and closure for Americans resulting from the horrific attacks during the first year of the Bush administration. That was not an isolated success; during the last couple of years, the Obama administration has successfully reinvigorated, retooled and refocused our national security efforts.

The Attorney General is a key member of that national security team. Under his leadership, the Justice Department last month foiled an assassination attempt in the United States of the Saudi Ambassador to the United States and prevented an act of terrorism on U.S. soil. Last week, four men in Georgia were arrested in a domestic terrorism plot, accused of planning to use guns, bombs, and the toxic poison ricin to kill Federal and state officials. Earlier this year, the Christmas Day bomber was convicted in Federal court, pleading guilty and facing a possible life sentence.

We must ensure that we do all we can to assist efforts to bring terrorists to justice by providing the administration with the full array of authorities and options we need in our counterterrorism efforts. In my view, a view that I know is shared by the Director of National Intelligence and the Attorney General, it is shortsighted for Congress to hamstring the Government's efforts. Between September 11, 2001, and the end of 2010, 438 suspects were successfully prosecuted by the Bush and Obama administrations on terrorism charges in Federal courts. Military commissions have resulted in only six convictions since September 11, five of which resulted from plea bargains.

The Attorney General and the administration must have all options available concerning terrorism cases, including the ability to prosecute terrorists in Federal criminal courts. As a former prosecutor, I have confidence in the abilities of our Federal counterterrorist enforcement agents, our prosecutors and our Federal justice system to bring terrorists to justice, as they have demonstrated time and again. There is an extraordinary record of accomplishment. We must continue to give the FBI and the men and women of the Justice Department the tools, flexibility and support they need to do their jobs.

The record over the last three years with respect to crime has also been outstanding. Despite the recession and economic challenges we are facing from Europe, natural disasters and shocks to the global economy, and despite the persistence of unacceptably high unemployment, the Justice Department, working with its state and local law enforcement partners, has done a good job heading off a surge in crime. Over the past three years, crime rates have fallen rather than rising as expected in hard times. On that front, too, the work of the dedicated men and women in law

enforcement, from the Justice Department to state and local officers, should be recognized and commended.

As we proceed, and we will each have questions today about matters that concern us and areas in which we hope to see improvement, the American people should not lose sight of the big picture and the job the Justice Department is doing to keep us safe and secure.

Let me now speak briefly about a few matters concerning open government. For five decades, the Freedom of Information Act (FOIA) has given life to the American value that in an open society, we must carefully balance the public's right to know and the Government's need to keep some information secret. Recently, I shared my concerns with the Attorney General – as did Senator Grassley – about a Justice Department proposal that would have allowed the Government to misrepresent whether certain sensitive law enforcement records exist in response to FOIA requests. I commend the Attorney General for being responsive to the concerns that a number of us raised about this proposal. His decision last week to promptly withdraw the proposal was the right thing to do and honors the President's commitment to openness and transparency in our Government.

I also appreciate how much more cooperative this Justice Department has been and how much more responsive it has been than had been the case during the previous administration. An exception, however, has been the failure to provide this Committee with the legal justification underlying drone strikes against an American citizen overseas. We know that justification exists; we know the administration carefully considered this matter. There is no reason, in my view, to withhold it from the American people's elected representatives.

This morning there will be more questions about the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) gun trafficking investigations along our southern border. Attorney General Holder has repeatedly reiterated and reinforced that longstanding Department of Justice policy prohibits the transfer of firearms to known criminals without the proper monitoring or controls by law enforcement. The Attorney General requested an investigation by the Office of Inspector General last February. The Department has made available to Congress more than 4000 pages of documents and a dozen witnesses for interviews as part of its continuing responsiveness to congressional inquiries. Administration officials have testified at 17 congressional hearings about these matters, including six held before this Committee.

I urge that, as they engage in important oversight, Senators remain mindful that these matters also involve ongoing and highly sensitive criminal investigations. We must respect the need for law enforcement and prosecutors to do their jobs to address the serious threat of violence posed by these brutal drug cartels. I do not think anyone wants to hamper the efforts of law enforcement agents against the Mexican cartels, including the ongoing criminal investigation and prosecution related to the tragic murder of Agent Brian Terry.

We are working with the Department of Justice on a series of important legislative initiatives, including reauthorizing the Second Chance Act, the Trafficking Victims Protection Act, the Civilian Extraterritorial Jurisdiction Act, reform of the Electronic Communications Privacy Act, and reauthorization of the Violence Against Women Act. These issues have in the past been the

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subject of bipartisan cooperation and consensus. I hope they can be, again. I would like to see us break through the partisan gridlock.

Later this week, the Committee will move forward on the Respect for Marriage Act, a bill I was proud to join in introducing with Senator Feinstein and others that will repeal DOMA (the Defense of Marriage Act), and restore the rights of all lawfully married couples. I thank Attorney General Holder for his support of our efforts to end the Federal Government's unequal treatment of lawful marriages. The time has come for the Federal Government to recognize that all married couples deserve the same legal protections.

I thank the men and women of the Department of Justice who work hard every day to keep us safe and uphold the rule of law. I thank Attorney General Holder for returning to the Committee and look forward his testimony.

#####

PATRICK J. LEAHY, VERMONT, CHAIRMAN

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United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

BRUCE A. CUNIN, *Chief Counsel and Staff Director*
KOLAN L. DAVIS, *Republican Chief Counsel and Staff Director*

March 10, 2011

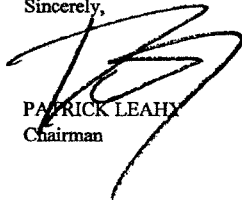
The Honorable Eric Holder Jr.
Attorney General
United States Department of Justice
950 Pennsylvania Ave, N.W.
Washington, DC 20001

Dear Attorney General Holder:

I forward to you the enclosed letter from the National Rifle Association requesting examination of the Bureau of Alcohol, Tobacco, and Firearms (ATF) activities related to "Project Gunrunner." I understand that Senator Grassley has been making inquiries, as well. He raised the matter today in an oversight hearing with Secretary Napolitano.

I write to ask whether components of the Department have reviewed this matter and the status of any such inquiries. I also inquire with respect to the operation and whether it remains ongoing.

Sincerely,



PATRICK LEAHY
Chairman

PATRICK J. LEAHY, VERMONT, CHAIRMAN

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United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

BRUCE A. COHEN, Chief Counsel and Staff Director
KOLAN L. DAVIS, Republican Chief Counsel and Staff Director

June 23, 2011

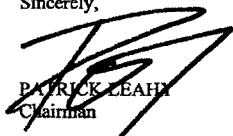
The Honorable Eric Holder Jr.
Attorney General of the United States
United States Department of Justice
950 Pennsylvania Ave, N.W.
Washington, D.C. 20001

Dear Attorney General Holder:

I write to request that copies of all documents delivered to the Chairmen and Ranking Members of the House Committee on Oversight and Government Reform and the House Committee on the Judiciary in connection with the Bureau of Alcohol, Tobacco, Firearms and Explosives' Project Gunrunner and Operation Fast and Furious be delivered to the Senate Committee on the Judiciary, to me as its Chairman and Senator Grassley as our Ranking Republican Member. I also request that any documents made available for inspection by the bipartisan staff of those two House Committees in this regard likewise be made available for inspection by the bipartisan staff of the Senate Committee on the Judiciary under the same terms and conditions as made available to the House Committees. Finally, I request that any witnesses made available for interviews by the staffs of the House Committees in this regard be made available for interviews by bipartisan staff of the Senate Committee on the Judiciary.

Since I have prepared this letter in an effort finally to allow the Senate to vote on the President's nominations of Jim Cole to be Deputy Attorney General, Lisa Monaco to be Assistant Attorney General for National Security and Virginia Seitz to be Assistant Attorney General for the Office of Legal Counsel, my request is not intended to become operative until after the Senate Majority Leader has proceeded to those nominations, the debates are concluded and the Senate has voted on each of them.

Sincerely,


PATRICK LEAHY
Chairman

cc: Honorable Charles E. Grassley
Ranking Republican Member

PATRICK J. LEAHY, VERMONT, CHAIRMAN

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United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

BRUCE A. COHEN, *Chief Counsel and Staff Director*
KOLAN L. DAVIS, *Republican Chief Counsel and Staff Director*

November 7, 2011

Cynthia A. Schnedar
Acting Inspector General
United States Department of Justice
950 Pennsylvania Ave, N.W.
Washington, DC 20001

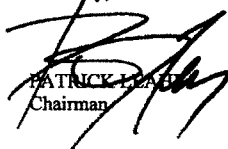
Dear Acting Inspector General Schnedar:

On April 18, the Department of Justice informed me that your office is investigating allegations that have been raised about the Bureau of Alcohol, Tobacco, Firearms and Explosives' (ATF) Operation Fast and Furious. I understand that your office initiated this review at the request of Attorney General Holder on February 28 and that it is ongoing.

Recent documents provided by the Department of Justice to Congress show that the ATF utilized similar investigative techniques years earlier. For instance, in connection with Operation Wide Receiver in 2006, hundreds of weapons apparently moved beyond the custody and control of the ATF and possibly into Mexico and Arizona. Recent documents also show that Attorney General Mukasey may have been briefed in 2007 on the ATF's operations on the southern border, including an indication that guns may have entered Mexico out of the control of law enforcement officials.

I am writing to ask whether your office's investigation includes a review of the tactics developed and used earlier in these prior ATF operations. I appreciate your efforts to conduct a thorough investigation in a manner that does not hamper the efforts of law enforcement agents to fight against violent drug cartels in Mexico. I hope that your investigation can also be concluded as quickly as possible.

Sincerely,


PATRICK J. LEAHY
Chairman



**NATIONAL
FRATERNAL ORDER OF POLICE®**

328 MASSACHUSETTS AVE., N.E.
WASHINGTON, DC 20002
PHONE 202-547-8198 • FAX 202-547-8190

CHUCK CANTERBURY
NATIONAL PRESIDENT

JAMES G. PASCO, JR.
EXECUTIVE DIRECTOR

2 November 2011

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman,

This is in response to your recent inquiry about the relationship between the Fraternal Order of Police and U.S. Attorney General Eric H. Holder, Jr.

As you know, the FOP supported the nomination of Mr. Holder in January 2009 after undertaking an exhaustive examination of Mr. Holder's record of public service. From his first twelve years in the U.S. Department of Justice in the Public Integrity Section, to his rulings from the bench of the Superior Court of the District of Columbia and his role as a prosecutor while serving as U.S. Attorney for the District of Columbia, to his role as Deputy Attorney General and Acting Attorney General of the United States, our review concluded that his positions and actions were consistent with the goals and objectives of the Fraternal Order of Police and the rank-and-file officers we proudly represent. We were the only law enforcement organization to testify in support of his nomination before the Judiciary Committee in 2009.

The FOP has unique insight into Mr. Holder's lengthy career in public service because we did not just work with him in his various policy-making roles at the Justice Department, but also in the courtroom, both as a judge and as U.S. Attorney. The leadership of the District of Columbia FOP Lodge and our members from the many different law enforcement agencies in the city reported that they found Judge Holder fair and U.S. Attorney Holder an able and aggressive prosecutor. These experiences have made him a more able U.S. Attorney General and we are happy to report that his commitment to law enforcement and the rank-and-file officer remains very strong.

We have been pleased to work with General Holder and other members of his leadership team on a wide variety of law enforcement issues, most recently and most importantly, on officer safety. This calendar year has seen a dangerous spike in the number of law enforcement officers killed in the line of duty. Early this year, General Holder reached out to the FOP in an effort to understand the reasons behind the increased death and to help improve the safety of officers in every region of the country.

— BUILDING ON A PROUD TRADITION —



11/08/2011 9:11AM

We are also pleased that we have been able to work with General Holder closely on the fiscal challenges that State and local law enforcement officers are facing as budgets are crunched and Federal assistance diminishes. He has been a true champion of the programs we care most about—the hiring program administered by the Office of Community Oriented Policing Services (COPS), the Edward Byrne Memorial Justice Assistance Grant (Byrne-JAG) program, the State Criminal Alien Assistance Program (SCAAP) and the Bulletproof Vest Partnership (BVP) grant program. With his able leadership, we hope to preserve these vital programs.

The FOP is very proud of the strong and positive working relationship that we have had with Eric Holder, not just for the two years in which he has served as the nation's "top cop," but through his long career of public service. As the brother of a retired law enforcement officer and one of the most dedicated and experienced law enforcement leaders, General Holder has been a true partner to the FOP and to our nation's rank-and-file officers. If I can be of any further assistance in this matter or share any additional details about our relationship with the Attorney General of the Department of Justice, please do not hesitate to contact me or Executive Director Jim Pasco in my Washington office.

Sincerely,


Chuck Canterbury
National President

cc: The Honorable Charles E. Grassley, Ranking Member, Committee on the Judiciary, United States Senate

The Salt Lake Tribune

Don't hamstring ATF

By mark shurtleff and terry goddard

Published: November 5, 2011 01:01AM

Updated: November 5, 2011 01:01AM

Congress and the media have understandably focused on the missteps of the U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives in the "Fast and Furious" sting operation that allowed suspected "straw buyers" to purchase weapons and transport them to Mexico in order to build cases against drug cartels.

However, the covert operation was terminated abruptly after its possible connection to the tragic death of Border Patrol Agent Brian Terry was revealed. Unfortunately, most of the recent criticism about the operation seems to be serving as a means to attack Attorney General Eric Holder and destroy the ATF, rather than to hold those behind Fast and Furious accountable.

The focus should be on the real public safety problem underlying this controversy: keeping arms from the Mexican drug cartels and protecting the security of the United States. However, many of the roadblocks faced by ATF and the Department of Justice are not being built by international criminals, but by Congress.

We are two Southwestern law enforcement officials, one a Republican and one a Democrat, and both gun owners who have faced border-related crimes on a daily basis over the past decade. We are very concerned about what is happening in Mexico, a critical U.S. ally which must be freed from the clutches of transnational criminal organizations.

We have worked closely with ATF and the Justice Department in our common fight against violent crime and appreciate that Holder has sought more resources for border law enforcement.

Gun sales along the border are exploding because it is illegal to privately possess most firearms in Mexico. Organized criminals are using high-power, military-grade weapons which pose a serious threat to the rule of law in Mexico. These weapons played a major role in the slaughter of 40,000 people there in the past five years. About 95 percent of weapons recovered from murders in Mexico were traced to the U.S. We warned that these weapons would be used against officials in our country.

Right now the ATF needs support to stop "straw buyers," those who are paid to make illegal gun purchases for gun traffickers or cartels. U.S. state attorneys general have been meeting and collaborating for years with Mexican state attorneys general on border security and have been cross-training law enforcement and



Al Hartmann | The Salt Lake Tribune Utah Attorney General Mark Shurtleff was in good spirit as he started his first chemo infusion treatment 9 a.m. Monday January 10th at the Jordan Valley Hospital Office of Utah Cancer Specialists. The port on the upper right side of his chest is where the chemo is delivered.

prosecutors. We have asked them to attack the flood of drugs and people being smuggled into the U.S. and they have pleaded with us to stem the flow of guns smuggled into Mexico. Mexican President Felipe Calderon gave this same urgent message to President Obama and Congress.

ATF has also been invaluable by providing evidence to state authorities. For example:

- Arizona arrested and incarcerated two individuals who were conspiring to smuggle powerful .50-caliber guns to Mexican cartels. These weapons, loaded with armor-piercing rounds, would threaten Mexican army armored personnel carriers or helicopters.

- An 11-month ATF investigation led state authorities to X-Caliber Guns, a Phoenix gun store which provided nearly 1,000 firearms seized at crime scenes in Mexico, including guns used to assassinate a top Sonora police official. Even though the straw buyers testified to getting paid anonymously and being coached by the store owner to falsify forms to purchase weapons, a judge ruled in favor of the defendant.

Congress adds to the problem by putting severe restrictions on ATF; limiting its jurisdiction, forbidding the release of illegal gun trafficking statistics and failing to adequately fund the agency. Holder's Oct. 7 letter to Congress correctly stated that "the agency's ability to stem the flow of guns from the United States into Mexico is severely impaired by a lack of effective law enforcement tools ... [and] current penalties for illegal straw purchases are inadequate to deter such activity or to induce cooperation with law enforcement authorities."

Dedicated ATF agents are soldiering on in the face of hostile fire. We should stop disparaging these men and women on the front lines during this time of stress and scrutiny. Our nation's commitment to help Mexico in the fight against the cartels is more critical today than ever. Division, doubt and brinkmanship only discourage our Mexican allies and embolden our mutual enemies.

It would be tragic if the furor over Fast and Furious causes our country to abandon Mexico to the cartels. The cartels are our enemy, not the ATF or Department of Justice. We need to provide the men and women fighting this critical battle with the tools they need.

Mark Shurtleff is Utah attorney general; Terry Goddard is former Arizona attorney general.

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U.S. Department of Justice

Office of the Inspector General

October 28, 2011

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

Dear Mr. Chairman and Senator Grassley:

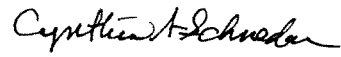
Enclosed is a revised version of the U.S. Department of Justice Office of the Inspector General's report, "Audit of the Department of Justice Conference Planning and Food and Beverage Costs," Audit Report 11-43 (October 2011). This revised report supersedes the original version of the report, published in September 2011.

This report examined event planning and food and beverage costs at 10 Department of Justice (Department) conferences between October 2007 and September 2009, including a discussion of costs for food and beverages purchased for an Executive Office for Immigration Review (EOIR) conference at the Capital Hilton in Washington, D.C. in August 2009. After publication of the report, we received additional documents and information concerning the food and beverage costs at the EOIR conference. After further review of the newly provided documentation and information, and after discussions with the Capital Hilton and the Department, we determined that our initial conclusions concerning the itemized costs of refreshments at the EOIR conference were incorrect. We therefore deleted references to any incorrect costs and revised the report based on these additional documents. We also included a preface explaining the circumstances of our revisions.

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Please contact me or Senior Counsel Jay Lerner at (202) 514-3435 if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Cynthia A. Schnedar". The signature is written in a cursive style with a large initial "C".

Cynthia A. Schnedar
Acting Inspector General

Enclosure



**AUDIT OF DEPARTMENT OF
JUSTICE CONFERENCE PLANNING
AND FOOD AND BEVERAGE COSTS**

U.S. Department of Justice
Office of the Inspector General
Audit Division

Audit Report 11-43
Originally Issued September 2011
Revised Version Issued October 2011



U.S. Department of Justice
Office of the Inspector General

Washington, D.C. 20530

Preface to the Revised Report

This revised report supersedes the original version of the Office of the Inspector General's (OIG) report, "Audit of Department of Justice Conference Planning and Food and Beverage Costs," Audit Report 11-43, published in September 2011. The original report, which examined event planning and food and beverage costs at 10 Department of Justice (the Department) conferences between October 2007 and September 2009, contained a discussion of costs for food and beverages purchased for an Executive Office for Immigration Review (EOIR) conference at the Capital Hilton in Washington, D.C., in August 2009. Among other things, the report concluded that the EOIR had spent \$4,200 for 250 muffins, or \$16 per muffin, a finding that brought significant negative publicity to the Department and the Capital Hilton.

After publication of the report, we received additional documents and information concerning the food and beverage costs at the EOIR conference. After further review of the newly provided documentation and information, and after discussions with the Capital Hilton and the Department, we determined that our initial conclusions concerning the itemized costs of refreshments at the EOIR conference were incorrect and that the Department did not pay \$16 per muffin. We have therefore revised the report based on these additional documents and deleted references to any incorrect costs. We regret the error in our original report.

Finally, we hope that our correction of the record for this 1 conference among the 10 conferences we reviewed does not detract from the more significant conclusion in our report: government conference expenditures must be managed carefully, and the Department can do more to ensure that taxpayer dollars are spent wisely and accounted for properly.

AUDIT OF DEPARTMENT OF JUSTICE CONFERENCE PLANNING AND FOOD AND BEVERAGE COSTS

EXECUTIVE SUMMARY

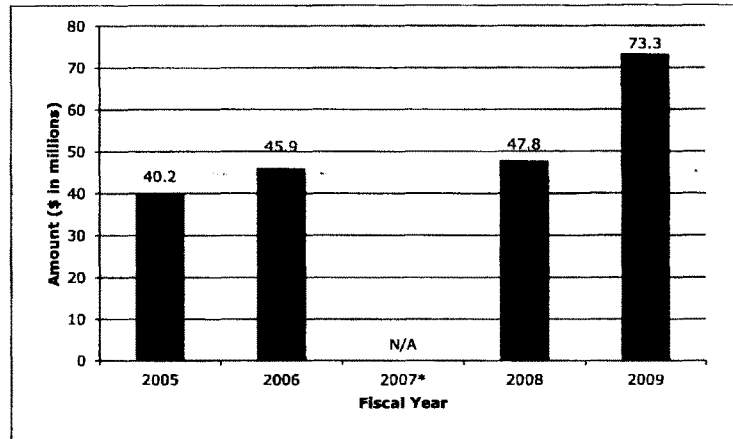
Department of Justice (DOJ) components host and participate in conferences to work with officials from other DOJ and federal entities, state and local law enforcement agencies, Native American and Alaskan Native tribes, and non-profit organizations. A DOJ Office of the Inspector General (OIG) audit issued in September 2007 examined expenditures for 10 major DOJ conferences held between October 2004 and September 2006.¹ The audit found that DOJ had few internal controls to limit the expense of conference planning and food and beverage costs at DOJ conferences. We identified several conference expenditures that were allowable but appeared to be extravagant. For example, one conference had a luncheon for 120 attendees that cost \$53 per person, and another conference had a \$60,000 reception that included platters of Swedish meatballs at a cost of nearly \$5 per meatball. The audit further found that DOJ components permitted event planners to charge a wide array of costs for logistical services, such as venue selection and hotel negotiations. We made 14 recommendations intended to help the Justice Management Division (JMD) and other DOJ components implement stronger oversight of conference expenditures. In response to these recommendations, JMD implemented guidelines in April 2008 that established DOJ-wide conference food and beverage spending limits based on meals and incidental expenses (M&IE) rates set by the General Services Administration (GSA).

Since 2008, DOJ appropriation acts have required that the Office of the Attorney General report conference costs quarterly.² For fiscal years (FY) 2008 and 2009, DOJ reported that it hosted or participated in 1,832 conferences. As shown in the exhibit below, the reports detailed that the conference activity over these 2 years cost a total of \$121 million.

¹ U.S. Department of Justice Office of the Inspector General, *Department of Justice Conference Expenditures*, Audit Report 07-42 (September 2007).

² The Attorney General must submit quarterly reports to the DOJ Inspector General regarding the costs and contracting procedures for each conference held by DOJ for which the cost to the government was more than \$20,000. Pub. L. No. 110-161 § 218 (2008) and Pub. L. No. 111-8 § 215 (2009). The Attorney General has delegated the responsibility to compile these reports to the Finance Staff of the Justice Management Division (JMD). Each component therefore submits to JMD a quarterly report of its respective conference costs.

**REPORTED DOJ CONFERENCE COSTS
FYs 2005 TO 2009**



Source: DOJ component conference expenditures reports. Conference cost reports for FYs 2005 and 2006 were completed at the request of the U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information and International Security. Conference cost reports for FYs 2008 and 2009 were issued through DOJ appropriation act requirements.

Note: DOJ did not compile conference expenditure reports for FY 2007 because there were no requests from Congress or legislative requirements to compile and report this information.

OIG Audit Approach

For this audit, the OIG reviewed a judgmental sample of 10 DOJ conferences that occurred between October 2007 and September 2009 to determine whether DOJ components properly accounted for and minimized costs of conference planning, meals, and refreshments. The 10 sampled conferences cost \$4.4 million, as detailed in the following exhibit.

For each of the 10 selected conferences, we assessed event planning and food and beverage costs to identify whether there were expenditures indicative of wasteful or extravagant spending.

Appendix I contains a more detailed description of our audit objective, scope, and methodology.

Results in Brief

DOJ spent over \$4.4 million on the 10 conferences reviewed by this audit. The audit focused on two major conference cost categories that our September 2007 report revealed as most potentially susceptible to wasteful spending – event planning services and food and beverages. For event planning services, DOJ spent \$600,000 (14 percent of costs) to hire training and technical assistance providers as external event planners for 5 of the 10 conferences reviewed.⁴ This was done without demonstrating that these firms offered the most cost effective logistical event planning services. Further, these event planners did not accurately track and report conference expenditures.

In addition, DOJ spent about \$490,000 (11 percent of costs) on food and beverages at the 10 conferences. All the conferences occurred at major hotels that applied service fees – usually around 20 percent – to the cost of already expensive menu items. Our assessment of food and beverage charges revealed that some DOJ components did not minimize conference costs as required by federal and DOJ guidelines. For example, one conference served Beef Wellington hors d'oeuvres that cost \$7.32 per serving. Coffee and tea at the events cost between \$0.62 and \$1.03 an ounce. At the \$1.03 per-ounce price, an 8-ounce cup of coffee would have cost \$8.24.⁵

⁴ Training and technical assistance providers are firms or personnel procured by DOJ awarding agencies to provide support and offer specialized assistance on specific grant initiatives.

⁵ Components and event planners reviewed procured beverages (coffee and tea) by the gallon and not by single serving size. Because there are 128 ounces in each gallon and conference attendees could have received different serving sizes of hot beverages, our audit applies the standard 8-ounce measurement for one cup as a single serving of beverages procured by the gallon but served individually.

In April 2008, JMD implemented new conference reporting and meal and refreshment cost limits for some DOJ conferences.⁶ These rules required that components hosting conferences minimize costs at every opportunity and made components responsible for tracking and reporting conference expenditures. The meal and refreshment limits generally prohibited components from spending more than 150 percent of the applicable GSA per diem rate for meals served at a DOJ conference.⁷ However, these limits specifically did not apply to conferences funded via cooperative agreements, which are a type of funding vehicle awarded by a DOJ component (particularly an awarding agency) when it expects to be substantially involved in the work performed.

Of the 10 conferences reviewed, 5 conferences were planned by training and technical assistance providers hired by two DOJ components: the Office of Justice Programs (OJP) and the Office on Violence Against Women (OVW).⁸ We found that OJP and the OVW did not collect salary and benefit cost data from their external event planners for these five conferences. As a result, the mandated DOJ conference cost reports did not include over \$556,000 – or 93 percent of the total estimated \$600,000 – spent on event planning services for these five events.

⁶ Appendix III presents the April 2008 JMD policy that established meal and refreshment cost limits for DOJ conferences.

⁷ The term “per diem” refers to the travel allowance provided to federal employees for meals and incidental expenses. GSA breaks down the daily per diem rate into allocations for breakfast, lunch, dinner, and incidentals. For example, when a federal traveler receives \$64 per day, GSA allocates \$12 for breakfast, \$18 for lunch, and \$31 for dinner, with the remaining \$3 for incidentals, such as gratuities. Under the JMD rules, the 150 percent threshold is applied to each of these individual meal allocations and includes applicable service charges.

⁸ The five other conferences were planned internally by full-time DOJ employees.



U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 18, 2011

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This responds to your letter to the Attorney General, dated March 9, 2011, which asked about the Department of Justice's review of allegations about the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) program known as Project Gunrunner, which is a broad initiative to address weapons trafficking along the Southwest Border generally.

We believe that the allegations referenced in your letter pertain specifically to Operation Fast and Furious, which is an ongoing criminal investigation of an extensive gun-trafficking enterprise. Fast and Furious is being undertaken as part of the broader Project Gunrunner initiative, and the purpose of the investigation is to dismantle a transnational organization believed to be responsible for trafficking weapons into Mexico, in part by prosecuting its leadership. The investigation is led by a dedicated team of prosecutors from the United States Attorney's Office in Arizona and ATF agents. To date, these efforts have resulted in an indictment charging 20 defendants with federal firearms offenses and the investigation is continuing. As we have advised Senator Grassley in response to his requests to us, we are not in a position to provide additional information about the investigation at this time, consistent with the Department's longstanding policy of not disclosing non-public information on ongoing criminal investigations.


On February 10, 2011, Department and ATF representatives conducted a briefing for Committee staff about Project Gunrunner. We noted in the briefing that stopping the flow of weapons across the border into Mexico is a challenging task given the resources of the cartels and the cartels' use of sophisticated trafficking organizations to move firearms across the border. These trafficking organizations typically involve the use of straw purchasers, who purchase the weapons not for themselves, but with the purpose of transferring them to others who then facilitate their movement across the border to the cartels. Among the challenges in investigating a trafficking organization is developing sufficient evidence to prove that particular firearm purchases are, in fact, unlawful straw purchases. It is, of course, legal for a non-prohibited person to purchase an unlimited number of firearms from a licensed gun dealer and then to sell or barter those firearms to another person.


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At the request of the Attorney General, the Acting Inspector General is investigating allegations that have been raised about Operation Fast and Furious. The Attorney General has also made it clear to the law enforcement agencies and prosecutors working along the Southwest Border that the Department should never knowingly permit firearms to cross the border. We note that the National Rifle Association (NRA) letter enclosed with your letter suggested that the Committee conduct oversight, including hearings, regarding ATF's activities relating to the Southwest Border. Given the ongoing criminal investigations in Arizona and the Inspector General's ongoing review of allegations regarding those investigations, we do not believe that such oversight, or hearings, would be helpful at this time. We also note that the Cochise County Sheriff's Office is leading a separate investigation of the shooting death of Robert Krentz in Arizona, which also was mentioned in the NRA letter.

We hope that this information is helpful. Please do not hesitate to contact this office if we may be of assistance in this or any other matter.

Sincerely,



 Ronald Weich
Assistant Attorney General

cc: The Honorable Charles Grassley
Ranking Minority Member



U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

October 31, 2011

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This responds further to your letter to the Attorney General, dated June 23, 2011, requesting that the Senate Judiciary Committee receive the same access to documents that the Department provides to the House Committee on Oversight and Government Reform related to the Bureau of Alcohol, Tobacco, Firearms, and Explosives' (ATF) Project Gunrunner.

Enclosed on CD please find 652 pages of documents that we produced to the House Oversight and Government Reform Committee on October 31, 2011. In response to Chairman Smith's request, we also will provide these documents to the House Judiciary Committee. These documents bear limited redactions to protect specific details about pending investigations, including text that would identify targets and sensitive techniques or disclose prosecutorial deliberations, plus limited information relating to line employees, such as their cellular phone numbers. We also have withheld text that implicates individual privacy interests, including information about individuals who have been investigated but not prosecuted. In addition, we have redacted text from multi-subject documents that is not responsive to your requests. In some substantial multi-subject documents, such as weekly reports, we have not included pages that contained text that was either not responsive or contained details of particular investigations other than Fast and Furious. The nature of specific redactions is indicated by a redaction code ("RC") set forth in the enclosed list.

We have also located an additional 47 pages of law-enforcement sensitive material that we are prepared to make available at the Department for review by Committee staff. There are limited redactions of text that would identify law-enforcement sensitive details and techniques as well as information implicating individual privacy interests. In response to Chairman Smith's request, the documents will also be made available for review at the Department by staff of the House Committee on the Judiciary.

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To assist the Committee in its oversight duties, we also appreciate the opportunity to provide you with relevant and necessary context for several of the documents in today's production.

Documents from the U.S. Attorney's Office for the District of Arizona

The documents stamped HOCR USAO 002960-61 reflect communications in January 2010 among then U.S. Attorney Dennis Burke and his staff regarding the Fast and Furious investigation. The communications to Mr. Burke recount a division between ATF's Phoenix Field Division and ATF Headquarters over how to proceed in the investigation. They also demonstrate that the U.S. Attorney's Office's view at that time was that there was insufficient evidence to charge any of the suspects, and thus the office adopted the approach preferred by ATF's Phoenix Field Division to pursue a longer-term investigation.

In assessing the January exchange, you may wish to refer to HOCR USAO 003026-27 and 003046-47. These are memoranda regarding the Fast and Furious matter that were prepared by the U.S. Attorney's Office in August 2010, which state that "[t]hus far the investigation has interdicted approximately 200 firearms, including two .50 caliber rifles. Investigating agents have pursued interdiction of the firearms transferred to the conspirators where possible. Agents have not purposely let guns 'walk.' Interdiction in some cases has been hampered by counter-surveillance used by the targets." An OCDETF-related memorandum written in October 2010 used the same language and added that "ATF has undertaken a very aggressive approach to seizing firearms tied to this conspiracy whenever a legal theory for seizure can be developed."

We are also producing documents relating to a March 2010 visit by the Attorney General to Arizona. The Attorney General's schedule during the brief trip was extremely busy. Among other meetings and events there, he attended a conference of U.S. Attorneys, a session with tribal leaders, and a mortgage fraud press conference. He also met with the Mexican Attorney General and visited the U.S. Attorney's Office for the District of Arizona and with a broad range of U.S. law enforcement personnel. In addition, he was scheduled for a ten-minute meeting with then U.S. Attorney Burke. In anticipation of that visit, officials in the Arizona U.S. Attorney's Office solicited and collected "[s]ignificant case summaries" regarding matters being handled in the office. One of the initial summaries prepared by the office in anticipation of the Attorney General's visit related to Operation Fast and Furious. However, a review of the Attorney General's briefing materials for that trip (HOCR HRNDZ 003245-48) demonstrates that the "significant case list" actually transmitted by prosecutors in Arizona to the Attorney General's Office did not include any reference to Fast and Furious. Indeed, the criminal cases that were listed had already been formally charged by the office. The Fast and Furious investigation had not yet resulted in charges.

Nor have we located any evidence suggesting that then U.S. Attorney Burke briefed the Attorney General on Fast and Furious either during their ten-minute meeting or at another time during the visit. According to Mr. Burke's private counsel, with whom we have conferred, Mr. Burke does not recall having briefed the Attorney General about Fast and Furious at any time. The Attorney General similarly has no recollection of having been briefed on the investigation.

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His staff member's notes from other meetings during the trip reflect general discussions about challenges on the Southwest border and the demand for firearms in Mexico but no mention of Fast and Furious, much less of any of the inappropriate operational tactics employed in that investigation.

Today's production also contains e-mail communications (HOCR USAO 003070, 3073-74, 3085-86, 3087) reflecting an interest on the part of the Arizona U.S. Attorney's Office in late December 2010 and early January 2011 in having first the Attorney General and then the Deputy Attorney General participate in the late-January press conference announcing the Fast and Furious indictments. As you know, neither the Attorney General nor the Deputy Attorney General attended that press conference. The staff member in the Attorney General's office with whom Mr. Burke raised the possibility has no recollection of speaking to the Attorney General about it, and we note that Mr. Burke's email to the staff member does not refer to Fast and Furious by name, let alone discuss any operational tactics. Moreover, according to Mr. Burke's counsel, Mr. Burke does not recall ever having discussed this matter with either the Attorney General or Deputy Attorney General.

Documents from Main Justice

With this letter, we are also producing additional weekly reports to the Office of the Attorney General that either relate to gun trafficking issues generally, or to Fast and Furious in language already included in reports made available to you in a prior production, or relate generally to developments in a separate investigation, Operation Wide Receiver. Many of those entries do not refer specifically to Fast and Furious by name and none of them contain references to any inappropriate investigative tactics. The Attorney General provided important context for weekly reports like those produced today in his October 7, 2011 letter to you and other members of Congress.

Documents from ATF

We are producing as well a January 2011 e-mail (HOCR ATF 003600-03) showing that, in response to an Office of the Attorney General request on January 7, 2011 for anticipated policy announcements and initiatives from each Department component, ATF submitted information about three items, including a short summary of the expected Fast and Furious indictments and press event to occur less than two weeks later. The information was requested so that the Office of the Attorney General could decide what items to include in a periodic report to the White House's Office of Cabinet Affairs. Although ATF submitted information about Fast and Furious, that information was not provided to the Office of Cabinet Affairs as part of the Department's policy update, because the information provided by ATF related to a specific case and not a policy initiative, as requested.

Documents Related to the Wide Receiver Matter

In addition, we are producing documents that reflect the involvement of the Gang Unit of the Justice Department's Criminal Division in a pair of gun trafficking cases referred to

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separately as "Wide Receiver 1" and "Wide Receiver 2." These cases originated in the Arizona U.S. Attorney's Office and were investigated by ATF in 2006 and 2007, prior to Operation Fast and Furious. These documents also reflect the Gang Unit's involvement in a third gun trafficking case that also originated out of the Arizona U.S. Attorney's Office, *United States v. Raul Flores Lopez, et al.* ("Flores"). The documents further reflect a Gang Unit prosecutor's attempts to become involved in several additional gun trafficking cases in Arizona, including the Fast and Furious case.

According to these documents, in the summer of 2009 the Gang Unit offered to assist several U.S. Attorneys' Offices along the Southwest Border in their efforts to combat gun trafficking to Mexico. Shortly thereafter, in response to the Gang Unit's offer, the Arizona U.S. Attorney's Office sought assistance on the Wide Receiver cases, which had been languishing in that Office's Tucson branch at least since ATF had completed its investigation and presented the case for prosecution close to two years earlier. The Arizona U.S. Attorney's Office had been involved in the underlying ATF investigation.

As of the fall of 2009, when the Gang Unit was asked to prosecute the Wide Receiver cases (HOCR WR 003371), none of the Wide Receiver defendants had been indicted notwithstanding that the case had long since been presented for prosecution. A prosecutor in the Gang Unit began to analyze the results of ATF's completed investigation and reached the conclusion that the Wide Receiver cases would likely need to involve two indictments against multiple defendants. In an early review of the case, the prosecutor wrote that "it appears that the biggest problem with the case is its [sic] old [and] should have been taken down last year AND a lot of guns seem to have gone to Mexico." HOCR WR 003383. Despite this, the prosecutor recommended to her supervisors that "we get our feet wet and take the case." *Id.* In the fall of 2009, she wrote a draft memorandum setting forth her preliminary analysis. HOCR WR 003391-93. She addressed this memorandum to Deputy Assistant Attorney General ("DAAG") Jason Weinstein but emailed it only to her immediate supervisors (HOCR WR 003390); we have found no indication that the draft memorandum was subsequently finalized or that it was sent to DAAG Weinstein. At the same time that the prosecutor assigned to the Wide Receiver cases was analyzing the completed Wide Receiver investigation, she was also preparing to try a death penalty case in Maryland against a member of the MS-13 gang who had ordered the murder of a juvenile. That trial began in January 2010 and concluded in March 2010.

While she was trying the MS-13 case, ATF headquarters asked the Gang Unit to assist with the Fast and Furious matter. In response to that request, on March 5, 2010, a different Gang Unit prosecutor attended a briefing on the case. Within two weeks, however, the Gang Unit prosecutor learned that the U.S. Attorney's Office in Arizona would be handling Fast and Furious by itself, and, consequently, he had no substantive involvement with the matter.

Following the conclusion of the MS-13 trial in Maryland, the Gang Unit prosecutor handling the Wide Receiver cases completed a prosecution memorandum for Wide Receiver 1. Upon reading that memorandum in April 2010, DAAG Weinstein became aware that in 2006 and 2007, as part of the Wide Receiver investigation, ATF had failed to interdict guns despite having the ability and legal authority to do so and that, as a result, guns had crossed the border into Mexico. HOCR WR 003442. According to an e-mail he sent in April 2010, DAAG

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Weinstein was “stunned” to learn these facts. Mr. Weinstein and others in the Gang Unit quickly alerted Assistant Attorney General Lanny Breuer, who directed Weinstein to meet with ATF senior leadership. HOCR WR 003442, 003451. On April 28, 2010, DAAG Weinstein met with two senior ATF officials to alert them that the Criminal Division was planning soon to indict the Wide Receiver cases, but that ATF’s 2006 and 2007 investigation had been problematic, both because ATF had failed to interdict a significant number of guns despite having the ability and legal authority to do so and some of those guns had crossed the border into Mexico, and because of certain allegations involving the ATF agent who had conducted the investigation. HOCR WR 003442, 003485. According to contemporaneous notes taken by a participant in the meeting, the fact that guns had “walk[ed]” in Wide Receiver was explicitly discussed with the ATF officials. HOCRWR 003478a.

The documents produced today reflect that the Gang Unit prosecutor was ready to indict the Wide Receiver cases and unseal them beginning in the spring of 2010, but that the Assistant U.S. Attorney in the U.S. Attorney’s Office in Arizona handling Fast and Furious believed that if the Wide Receiver indictments became public at that time they would negatively impact his case. The Assistant U.S. Attorney therefore requested that the indictments and/or the unsealing of the indictments in Wide Receiver be delayed. HOCR WR 003480, 003489. As a result of that request, Wide Receiver 1 was indicted under seal in May 2010, Wide Receiver 2 was indicted under seal in October 2010, and both cases were unsealed in November 2010. HOCR DOJ 003260, 63.

Over the course of the next several months, the Gang Unit prosecutor handling the Wide Receiver cases sought to become involved in other gun trafficking cases in Arizona. Thus, in approximately July 2010, she was asked to assist with several additional cases, including Fast and Furious. She was informed at that time, however, that the Assistant U.S. Attorney handling Fast and Furious was unlikely to need much help on the case until it was indicted; and, ultimately, she did not become closely involved with any of the cases that she had been asked to help on that summer. HOCR WR 003517, 003518, 003534. In September 2010, she expressed to her immediate supervisors her increasing “frustrat[ion]” with her lack of involvement on Arizona gun trafficking cases, noting that despite having been “ostensibly assigned” to Fast and Furious she had had “little to no involvement” with the case, and did not think there would be enough work for her in Arizona to keep her busy. HOCR WR 003517-19.

In October 2010, however, the Gang Unit prosecutor handling the Wide Receiver cases was asked to handle a separate straw purchaser case involving the seizure of 49 guns. That case, referred to as *Flores*, appeared to be tangentially related to Fast and Furious insofar as several of the suspects in *Flores* appeared to have purchased guns for suspects in Fast and Furious. HOCR WR 003521. The Gang Unit prosecutor agreed to handle the case, and, in January 2011, the *Flores* indictment was announced together with the Fast and Furious indictment.

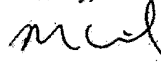
Today, the Gang Unit (now part of the Criminal Division’s Organized Crime and Gang Section) continues to prosecute Wide Receiver 2 and *Flores*. To date, in both Wide Receiver cases, six defendants have pleaded guilty, and two remain fugitives. In *Flores*, seven defendants have pleaded guilty, and one is scheduled to go on trial next month.

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The Honorable Patrick Leahy
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We hope this information is helpful and look forward to working with the Committee as this matter continues.

Sincerely,



Ronald Weich
Assistant Attorney General

Enclosures

cc: The Honorable Charles Grassley
Ranking Minority Member