Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2004

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I. Introduction and Overview

The Attorney General has authority to investigate conditions in public residential facilities[1] and to take appropriate action if a pattern or practice of unlawful conditions deprives persons confined in the facilities of their constitutional or federal statutory rights, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §§ 1997- 1997j.[2] The Attorney General has delegated day-to-day responsibility for CRIPA activities to the Civil Rights Division and its Special Litigation Section.

Protecting the rights of institutionalized persons is a priority in the Department's civil rights law enforcement effort. According to the Assistant Attorney General of the Civil Rights Division, R. Alexander Acosta, "Safeguarding the rights of America's most defenseless citizens -- the elderly, children, victims of abuse, persons with mental illness or developmental disabilities -- is one of the Department's highest civil rights priorities. This Administration is firmly committed to vigorously enforcing CRIPA to protect the vulnerable and rooting out systemic conditions of physical abuse and injury."

The Division's commitment to the vigorous enforcement of CRIPA is evidenced by recent activities under that statute: since January 20, 2001, the Division has opened 46 CRIPA investigations, issued 34 findings letters, filed 13 cases, and obtained 38

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[1] Institutions covered by CRIPA include nursing homes, mental health facilities, facilities for persons with developmental disabilities, jails, prisons, and juvenile justice facilities.

[2] CRIPA does not cover the federal statutory rights of persons in jails and prisons.

substantial agreements.[3] For investigations alone, this figure represents more than a 30 percent increase over the 35 such investigations initiated over the preceding four years.

From May 1980, when CRIPA was enacted, through September 2004, the Division investigated conditions in 409 nursing homes, mental health facilities, facilities for persons with developmental disabilities, residential schools for children with disabilities, jails, prisons, and juvenile justice facilities. As a result of the Department's CRIPA enforcement, thousands of persons residing in public institutions across our country no longer live in dire, often life-threatening, conditions.

At the end of fiscal year 2004, the Division was active in CRIPA matters and cases involving over 164 facilities[4] in 34 states, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands.[5] The Division continued its investigations of 56 facilities, and monitored the implementation of consent decrees, settlement agreements, memoranda of understanding, and court orders involving 105 facilities.[6] During the fiscal year, the Division, accompanied by

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[3] These figures are for the four year period January 2001 through January 2005.

[4] This figure does not include the Division's monitoring of the District of Columbia community system for persons with mental retardation in Evans and United States v. Williams (D. D.C.), a pre-CRIPA suit.

[5] Fiscal year 2004 began on October 1, 2003, and ended on September 30, 2004. This report is submitted to Congress to supplement the Attorney General's report on Fiscal Year 2004 Department activities by providing additional details about CRIPA actions during the fiscal year pursuant to 42 U.S.C. § 1997f.

[6] In addition, the Division is monitoring compliance with court orders that cover persons who previously resided in institutions, but who currently reside in community based

(continued...)

expert consultants, conducted 121 tours of facilities to evaluate conditions and monitor compliance.

The Division filed six institutional lawsuits involving ten facilities while closing six cases during the fiscal year. In two other cases, four facilities were dismissed from the cases. The Division initiated 14 investigations and issued 11 findings letters regarding investigations of 17 facilities during the fiscal year.[7] In addition, during fiscal year 2004, the Division closed ten investigations of ten facilities. Two other facilities covered by CRIPA settlements were closed voluntarily by the State.[8]

In keeping with the statutory requirements of CRIPA and the Attorney General's initiative, the Division engaged in negotiations and conciliation efforts to resolve a number of CRIPA matters both before and after filing CRIPA cases. The Division maximized its impact and increased its efficiency by continuing to focus on multi-facility investigations and cases, obtaining widespread relief whenever possible. Lastly, the Division consulted with public officials and provided technical assistance to a substantial number of jurisdictions to assist in the correction of deficient conditions.

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[6] (...continued)
residential settings in Hawaii, Indiana, Pennsylvania, Puerto Rico, Tennessee, and Wisconsin.

[7] The agreements and findings letters are available on the Division's website at http://www.usdoj.gov/crt/split/index.html.

[8] The Georgia Department of Juvenile Justice closed two of its Youth Detention Facilities during the fiscal year.

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

A. Cases Filed

1. On December 18, 2003, the Division filed a complaint in United States v. Mississippi (S.D. Miss.) regarding conditions of confinement at the Oakley Training School in Raymond, Mississippi, and the Columbia Training School in Columbia, Mississippi. These facilities are state operated juvenile justice facilities. The complaint alleges that the State engages in unlawful patterns and practices at the facilities, including failure to: protect youth from harm, provide adequate medical, mental health care and rehabilitative treatment; and provide adequate education services. The Division is conducting discovery in preparation for trial which is scheduled to begin in February 2006.

In its June 2003 findings letter, the Division had found the following conditions at the two juvenile justice facilities: staff hog-tie youth and shackle youth to poles in public places. Girls are punished for their suicidal behavior by being stripped and placed naked, for extended periods of time, in a windowless, empty cell called the "dark room," with only a hole in the floor to use as a toilet. Girls are forced to eat their own vomit if they throw-up while exercising in the hot sun. Staff use excessive force with impunity. Upon re-commitment to the facilities, youth are taken to the intake area and punched and slapped by staff as punishment for re-commitment. Abusive staff members are not terminated. Vacancy rates in the facilities are 39 percent and 30 percent. The dental clinic at one of the facilities was full of mouse droppings, dead roaches, and cobwebs; medications in the cabinet had expired over ten years ago.

2. On January 12, 2004, the Division filed a complaint and consent decree in United States v. Louisiana (M.D. La.) regarding conditions at Pinecrest Developmental Center in Pinecrest, Louisiana and Hammond Developmental Center in Hammond, Louisiana. The action resolves the investigation into alleged pattern or practice violations at these facilities, the two largest state-owned and operated residential facilities in Louisiana serving persons with developmental disabilities. The Consent Decree requires the State to: improve practices to meet the basic care needs of the residents; provide adequate medical, dental, and psychiatric care; adequate nutritional and physical support; adequate nursing, psychological, and behavioral services; ensure that the residents are free from undue bodily restraint; and the consent decree also requires the State to provide treatment in the setting most appropriate to the resident's needs. Under the terms of the Decree, an Independent Expert will monitor the State's compliance with the agreement and issue public reports on compliance status over the next three years.

3. On February 17, 2004, the Division filed a complaint and a consent decree in United States v. Breathitt County, Kentucky (E.D. Ky.), a case regarding unconstitutional conditions at the Nim Henson Geriatric Center. The consent decree requires the County to provide adequate medical care and medication management; improve wound care; restrict the use of chemical restraints; provide adequate nutrition and restorative care; and institute more rigorous overview of incident management to ensure that the residents are adequately protected from harm. The consent decree also requires the County to provide treatment in the setting most appropriate to the resident's needs. The Division is monitoring compliance with the consent decree.

4. On June 7, 2004, the Division filed a complaint in United States v. Terrell County, Georgia (M.D. Ga.) alleging unconstitutional conditions in the Terrell County Jail in Dawson, Georgia. The complaint alleges that the County has failed to: protect inmates from serious harm; provide adequate medical and mental health care, nutrition and food service, and sanitary living conditions; provide adequate fire safety; and, provide adequate access to courts. Discovery is proceeding in the case.

5. On August 2, 2004, the Division filed a complaint together with a settlement agreement in United States v. State of New Jersey (D. N.J.) regarding conditions at New Lisbon Developmental Center, a residential facility for about 600 persons with developmental disabilities. The Agreement requires the State to provide: a reasonably safe living environment for all residents; adequate psychological and behavioral services; restrictions on the use of restraints; adequate medical, psychiatric, and habilitative care; and services to residents in the most integrated setting appropriate to their individual needs. A Compliance Monitor has been appointed to oversee implementation of the agreement over the next four years. The agreement will also be monitored by a team of experts who will issue biannual reports.

6. On September 15, 2004, the Division filed a complaint in United States v. State of Arizona (D. Ariz.) along with a settlement agreement concerning Adobe Mountain School and Black Canyon School in Phoenix, Arizona and Catalina Mountain School in Tucson, Arizona, three state juvenile justice facilities. The agreement requires the State to: develop and implement suicide prevention training for staff in order to provide safety for youth; provide an effective grievance system; develop and implement adequate abuse, incident and use of force management processes to

ensure that youth are protected from serious harm; provide sufficient numbers of adequately trained direct and supervisory staff to permit youth reasonable access to medical and mental health services and education; utilize an adequate disciplinary confinement system; provide adequate special education services; and provide adequate mental health care services. The Division, as well as an independent consultants committee, is monitoring implementation of the agreement and the State has already made substantial progress towards compliance

B. Settlements in Cases Filed in Prior Fiscal Years

1. On October 14, 2003,[9] the court in United States v. Territory of the Virgin Islands (D. V.I.) entered as an order the Stipulated Agreement regarding the Golden Grove Correctional and Adult Detention Facility. The Agreement requires the Territory to: revise and implement suicide prevention procedures; improve medical and mental health care; provide effective fire safety and sanitation; develop and distribute a comprehensive policy manual; and maintain tool security. The Division will continue to monitor compliance with the Stipulated Agreement.

2. On November 4, 2003, the court in United States v. Essex County, New Jersey (D. N. J.), entered an Amended Consent Decree regarding conditions at the Essex County Juvenile Detention Center in Newark, New Jersey. This agreement requires the County to implement a strategy to reduce juvenile fights and injuries, and reduce gang related violence amongst the youths. The agreement also requires:

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[9] Though the initial Stipulated Agreement in United States v. Territory of the Virgin Islands was originally filed September 25, 2003, the federal court requested that it be re-filed due to loss of the document. The Agreement was re-filed on October 10, 2003. The settlement was not counted in Fiscal Year 2003.

independent investigations of each alleged incident of staff abuse; improved staff training, and adequate and appropriate mental health care for every youth who requires mental health services. The Division will continue to monitor compliance with the new agreement.

3. On November 14, 2003, the Division entered into a settlement agreement with Simpson County, Mississippi to rectify conditions of confinement that allegedly violated the constitutional rights of inmates housed in the Simpson County Jail. The United States intervened in Rainer and the United States. v. Jones, (S.D. Miss.) regarding Simpson County Jail in 1995. The settlement agreement addresses the development of policies and procedures, fire safety, inmate classification, and suicide prevention. The Division is actively monitoring the agreement.

4. On December 31, 2003, the Division entered into an amended Settlement Agreement in United States v. Louisiana (M.D. La.) involving four juvenile justice correctional facilities. The amended agreement dismissed all of the United States' claims at two juvenile justice facilities, Bridge City and Swanson, as the State was in compliance with terms of prior settlement agreements and court orders. The 2003 Agreement also calls for provision of services for youth who require substance abuse and sexual offender treatment at the two remaining juvenile justice facilities. Independent Monitors will continue to review compliance with this agreement as well as the prior agreements in this case.

5. On December 31, 2003, the court entered an order regarding disbursement of Court Fine Monies in United States v. Tennessee (M.D. Tenn.) concerning the Arlington Developmental Center in Memphis, Tennessee. The

disbursement criteria are designed to support the development of an accessible, comprehensive, and cost-effective system of services and supports for class members in the community consistent with the Remedial Order and the court-ordered Community Plan.

6. See complaint filed in United States v. State of Arizona (D. Ariz.), discussed supra at p. 6.

C. Out of Court Settlements Addressing Deficiencies Identified by CRIPA Investigations

1. On February 26, 2004, the Division entered into a settlement agreement with the State of Nevada regarding conditions of confinement at the Nevada Youth Training Center in Elko, Nevada. The agreement requires the State to assure the safety of youth in its custody by: careful review of disciplinary procedures, adequate monitoring of incidents involving harm to youth at the facility, and limits on the use of force; providing adequate mental health care; expanded staff training; and implementation of an effective, reliable grievance process. The Division is continuing to monitor compliance with the agreement.

2. On June 16, 2004, the Division signed a settlement agreement with the Banks-Jackson-Commerce Nursing Home, in Commerce, Georgia, regarding the care and treatment of residents in the nursing home units of the Banks-Jackson-Commerce Medical Center and Nursing Home. The agreement requires the facility to assess residents' needs in a timely manner; develop effective preventive measures regarding resident falls and accidents; provide adequate medical and psychological services, including adequate hydration and aspiration prevention, and appropriate use of

psychotropic medications; provide ongoing activities that assist each resident in attaining and maintaining functional skills; and provide services in the most integrated setting appropriate to individual resident needs. The Division is continuing to monitor compliance with the agreement.

3. On July 16, 2004, the Division entered into a settlement agreement with Wicomico County, Maryland regarding the Wicomico County Detention Center in Salisbury, Maryland. The agreement requires Wicomico County to: ensure that inmates are appropriately screened for and provided necessary medical and mental health care; revise and augment its polices on the use of force to provide additional operational guidance to Detention Center staff; provide adequate supervision of inmates by adequately trained security staff; and improve sanitation and food services at the facility. The Division is continuing to monitor the County's compliance with the terms of the agreement.

4. On August 26, 2004, the Division entered into a settlement agreement with Los Angeles County, California and the Los Angeles County Office of Education (LACOE) regarding the conditions of confinement in three Los Angeles County Juvenile Halls: Central Juvenile Hall, Los Padrinos Juvenile Hall, and Barry J. Nidorf Juvenile Hall. The agreement requires the County to provide adequate: medical and mental health care, including suicide prevention; juvenile justice practices; education; and safety and sanitation at all three juvenile justice facilities. The agreement provides for a Monitor and Monitoring Team which will assess, review, and report independently on the County and LACOE's implementation of the agreement. The Division will carefully evaluate compliance as reported by the Monitor.

5. On August 27, 2004, the United States and the Arkansas Department of Corrections entered into a settlement agreement regarding the conditions of confinement at both McPherson (a female prison) and Grimes Correctional Units. The agreement requires the State to provide adequate: medical and mental health care; protection from harm; and life safety and sanitation at both facilities. The Division will continue to monitor this agreement.

III. Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626, which was enacted on April 26, 1996, covers prospective relief in prisons, jails, and juvenile justice facilities. The Division has defended the constitutionality of the PLRA and has incorporated the PLRA's requirements in the remedies it seeks regarding improvements in correctional facilities. For example, the settlement agreement filed in United States v. County of Essex on November 2003, is PLRA compliant in that it contains the requisite admission of liability and requires only the minimum remedial measures needed to correct constitutional violations in the areas of mental health, education and religious liberty.

IV. Compliance Evaluations

During fiscal year 2004, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in publicly operated facilities throughout the United States. These facilities are:

A. Facilities for persons with developmental disabilities: Southbury Training School (United States v. Connecticut (D. Conn.)); Embreeville Center (United States v. Pennsylvania (E.D. Pa.));[10] Arlington Developmental Center (United States v. Tennessee (W.D. Tenn.)); Clover Bottom Developmental Center, Greene Valley Developmental Center, and Harold Jordan Center (United States v. Tennessee (M.D. Tenn.)); Southern Wisconsin Developmental Center and Central Wisconsin Developmental Center (United States v. Wisconsin (W.D. Wis.)); Centro de Servicios Multiples de Camaseyes, and Centro de Servicios Multiples Rosario Bellber (United States v. Commonwealth of Puerto Rico (D. P. R.)); Ft. Wayne Developmental Center and Muscatatuck Developmental Center (United States v. Indiana (S.D. Ind.)); Pinecrest Developmental Center and Hammond Developmental Center (United States v. State of Louisiana (E.D., La.); New Lisbon Developmental Center (United States v. State of New Jersey (D. N.J.)); and Oakwood Communities, Kentucky (2004 Settlement Agreement).

B. Facilities for persons with mental illness: Hawaii State Hospital and children and adolescent residential services at Queens Medical Center and Kahi Mohala

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[10] Embreeville Center closed during fiscal year 1998 but, under the terms of the consent decree, the Division continued to monitor conditions in community placements of former Embreeville residents throughout fiscal year 2004 and until January 2005 when the case was dismissed by the district court.

Behavioral Treatment Center (United States v. Hawaii (D. Haw.)); Guam Adult Mental Health Unit (United States v. Territory of Guam (D. Guam)); Pilgrim Psychiatric Center (United States v. New York (E.D. N.Y.)); and Memphis Mental Health Institute (United States v. Tennessee (W.D. Tenn.)).

C. Nursing Homes: Bergen Regional Medical Center, (2002 Settlement Agreement); Nim Henson Geriatric Center (United States v. Breathitt County, Kentucky (E.D. Ky.)); and (Banks-Jackson-Commerce Medical Center (2004 Settlement).

D. Juvenile justice facilities: 29 juvenile justice facilities in Georgia (United States v. State of Georgia (N.D. Ga.)); Essex County Juvenile Detention Center (United States v. Essex County (D. N. J.)); 15 juvenile justice facilities in Puerto Rico (United States v. Commonwealth of Puerto Rico (D. P. R.)); Kagman Youth Facility (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)); Jetson Juvenile Correctional Facility and Swanson Juvenile Correctional Facility (United States v. Louisiana (M.D. La.)); Alexander Youth Services Center (United States v. Arkansas (E.D. Ark.)); Nevada Youth Training Center (2004 Settlement Agreement); Central Juvenile Hall, Los Padrinos Juvenile Hall, and Barry J. Nidorf Juvenile Hall, California (2004 Settlement Agreement); and Adobe Mountain School, Black Canyon School, and Catalina Mountain School (United States v. State of Arizona (D. Ariz.)).

E. Jails: Hagatna Detention Center and Fibrebond Detention Facility (United States v. Territory of Guam (D. Guam)); Harrison County Jail (United States v. Harrison County (S.D. Miss.)); Simpson County Jail (Rainier and United States v. Jones (S.D. Miss.)); Sunflower County Jail (United States v. Sunflower County (S.D. Miss.)); four jails in the Northern Mariana Islands (United States v. Commonwealth of the Northern

Mariana Islands (D. N. Mar. I.)); Muscogee County Jail (United States v. Columbus Consolidated City/County Government (M.D. Ga.)); Morgan County Jail and Sheriff's Department (United States v. Morgan County, Tennessee (E.D. Tenn.)); McCracken County Regional Jail (United States v. McCracken County, Kentucky (W.D. Ky.)); Nassau County Correctional Center (United States v. Nassau County, New York (E.D. N.Y.)); Shelby County Jail (United States v. Shelby County, Tennessee (W.D. Tenn.)); eight jails in Los Angeles County, California (2002 Settlement Agreement); and Wicomico County Jail, Maryland (2004 Settlement Agreement).

F. Prisons: Guam Adult Correctional Facility (United States v. Territory of Guam (D. Guam)); Montana State Prison (United States v. Montana (D. Mont.)); Golden Grove Correctional and Adult Detention Facility (United States v. Territory of the Virgin Islands (D. V.I.)); Saipan Prison Complex (United States v. Commonwealth of the Northern Mariana Islands (D. N. Mar. I.)); Wyoming State Penitentiary (United States v. State of Wyoming (D. Wyo.)); and McPherson Correctional Facility and Grimes Correctional Facility, Arkansas (2004 Settlement Agreement).

G. Other Facilities: New Mexico School for the Visually Handicapped (United States v. New Mexico (D. N. Mex.)).

V. Enforcement Activities

The Division took enforcement action in our CRIPA cases during the fiscal year where public officials failed to meet their legal obligations under consent decrees and other court orders.

On May 28, 2003, the Division filed a motion in United States v. Harrison County, Mississippi (S.D. Miss.) for an order to show cause why defendants should not be held in

contempt for failure to comply with the 1995 consent decree regarding the Harrison County Jail in Gulfport, Mississippi. The Division's motion seeks to enforce provisions in the consent decree regarding protection from harm for inmates. On March 23, 2004, the district court found the defendants in contempt and issued a Minute Entry Order directing that the defendants allocate funds and hire certain numbers of additional corrections staff to address the concerns raised in the Division's motion.

VI. Termination of CRIPA Consent Decrees and Partial Dismissals of Complaints

When jurisdictions comply with settlement agreements or court orders and correct unlawful conditions in the institution, the Division joins with defendants to dismiss the underlying action. During fiscal year 2004, the Division joined with defendants to seek dismissal of all claims regarding the children and adolescent programs at Queens Medical Center & Kahi Mohala Behavioral Health Hospital in United States v. Hawaii (D. Hi.); all claims regarding the Gila County Jail in United States v. Gila County, Arizona (D. Ariz.); all claims regarding the Tupelo City Jail in United States v. Tupelo City, Mississippi (N.D. Miss.); all claims regarding Tallulah and Bridge City juvenile justice facilities in United States v. State of Louisiana (M.D. La.); and all claims regarding the Forest City Jail in United States v. Forest City, Mississippi (S.D. Miss.).

During the fiscal year, Georgia voluntarily closed two youth detention centers, one in Pelham and one in Swainsboro, in United States v. State of Georgia (N.D. Ga.). In Johnson & United States v. Regier (M.D. Fla.), involving the G. Pierce Wood Memorial Hospital, the court dismissed the case.

VII. New CRIPA Investigations

The Division initiated 14[11] CRIPA investigations during fiscal year 2004. These new investigations involved the following facilities:

- Grant County Jail, Kentucky;
- Augusta State Medical Prison, Georgia;
- Napa State Hospital, California;
- Plainfield Juvenile Correctional Facility, Indiana;
- Logansport Juvenile Intake/Diagnostic Facility, Indiana;
- South Bend Juvenile Correctional Facility, Indiana;
- Charlotte Hall Nursing Home, Maryland;
- Baxter Manor Nursing Home, Arkansas;
- L.E. Rader Center, Oklahoma;
- Patton State Hospital, California;
- Lanterman Developmental Center, California;
- Vermont State Hospital; and
- Hawaii Youth Correctional Facility.

VIII. Findings Letters

During the fiscal year, the Division issued 11 written findings letters[12] regarding 17 facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42

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[11] One investigation while approved during the fiscal year, has not yet been made public.

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

U.S.C. § 1997b, including:

- Arkansas Correctional Units, Arkansas;

  McPherson Correctional Unit

  Grimes Correctional Unit

- Arizona Juvenile Facilities;

  Adobe Mountain School

  Black Canyon School

  Catalina Mountain School

- Metropolitan State Hospital, California;

  Adults Services and Facility-wide Protection from Harm

- North Carolina Mental Health Facilities;

  Broughton Hospital

  Cherry Hospital

  Dorothea Dix Hospital

  John Umstead Hospital

- Maryland Juvenile Justice Facilities;

  Cheltenham Youth Facility

  Charles H. Hickey, Jr. School

- Maxey Training School, Michigan;
- Conway Human Development Center, Arkansas;
- Nashville Metropolitan Bordeaux Hospital, Tennessee;
- Baxter Manor Nursing Home, Arkansas;
- A. Holly Patterson Geriatric Center, New York; and

- Laguna Honda Hospital, California regarding the State.[13]

In these investigations, the Division made significant findings of constitutional deficiencies. For example, in the Division's investigation of state juvenile justice facilities, the investigation revealed that facility staff beat, punch, and slam youth to the ground. Numerous staff at both facilities have been charged with criminal offenses for the assaults perpetrated against youth. Evidence shows that youth-on-youth violence occurs on an almost daily basis, at times resulting in injuries which require hospitalization. Youth at the facilities are denied adequate access to toilets, requiring youth, at times, to urinate out of windows and defecate in their bed sheets. The Justice Department also found systematically inadequate medical and mental health care, as well as inadequate special educational services.

In another juvenile training school, in a one year period, three boys committed suicide. In one suicide, staff lacked the appropriate tool to cut the noose from a victim's neck and also did not have oxygen in the tank they brought to help resuscitate him. Youth at the facility are sexually abused. Staff engage in sexual acts with boys. Youth are sexually assaulted and threatened with sexual assault by other youth, all without effective intervention from management. Youth are physically abused by staff, who hit youth and slam them to the ground. One staff member required youth under his supervision to crawl through a drainage ditch. Living conditions are unsanitary. Most rooms lack toilets. Boys are not released from their rooms to use the restroom as needed, requiring that they urinate and defecate in containers in their rooms.

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[13] We have a separate investigation of Laguna Honda regarding the City and County of San Francisco.

The Division also found that many residents with disabilities are unnecessarily segregated at one of the largest publicly-operated nursing homes in the country. Although the facility is county owned and operated, the Division found that the State is contributing to this segregation. The State routinely grants two-year extensions for Medicaid payments to be made to residents who have few, if any, skilled nursing needs. For example, one resident wants to move to the community, and his doctors say he can if he has appropriate housing supports. However, the State approved his continued stay at the nursing home for another two years. Another resident has been at the nursing home since 1991, after a traffic accident. He goes to work each day and uses public transportation. He needs supports to find housing and adjust to community living. The State, however, approved his stay at the nursing home for another two years. The State also is failing to place persons with developmental disabilities residing at the nursing home in integrated, community settings appropriate to meet their needs. For example, one resident goes four days a week to a day program. The State approved a two-year extension for her to remain at the nursing home. Another resident with developmental disabilities is only 35-years-old. She originally moved to the nursing home to be with her mother, who was living at the nursing home. The 35-year-old's doctors have not identified any reason why she cannot live in the community. The State, however, approved a two-year extension for her to remain in the nursing home.

In an investigation of a state operated mental health facility, the Division's investigation of the facility uncovered significant civil rights violations relating to deficiencies in care and services provided to patients (both adolescents and adults). The facility frequently uses older psychotropic medications, with serious side effects, to

sedate patients. One adolescent received 22 such psychotropic "as-needed" sedatives over a two-month period. One boy's record indicated that he had developed prominent breasts, a potential side effect of one of his medications, and that the facility had done nothing about it. Adult patients are routinely treated with psychotropic medication without an appropriate diagnosis. The facility does not conduct psychological testing in Spanish of patients whose primary language is Spanish.

IX. Investigation Closures

During the fiscal year, the Division closed investigations of ten facilities:

- Chesapeake City Jail, Virginia;
- Mitchell County Jail, Georgia;
- Lee County Jail, Mississippi;
- Claudette Box Nursing Facility, Alabama;
- Girls Boot Camp, South Dakota;
- Patrick Henry Brady Boot Camp, South Dakota;
- Custer Youth Correctional Center (Living Center), South Dakota;
- Quest Program, South Dakota;
- Landmark Learning Center, Florida; and
- Daviess County Detention Center, Kentucky.

X. New Freedom Initiative

The Division also enforces Title II of the Americans with Disabilities Act, 42 U.S.C. § 12131 et seq., and its implementing regulations 28 C.F.R.¶ 35.130(d), to ensure that public officials operating healthcare facilities are taking adequate steps to provide

services to residents in the most integrated setting appropriate to their needs. In June 2001, President George W. Bush announced the New Freedom Initiative which set as a high priority for this Administration efforts to remove barriers to community placement for persons with disabilities. The executive order, "Community-based Alternatives for Individuals with Disabilities,"[14] emphasized that unjustified isolation or segregation of qualified individuals with disabilities in institutions is a form of prohibited discrimination, and that the United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community. As part of the mandate to fully enforce Title II of the Americans with Disabilities Act, the Division took steps to secure increased access to residential, day, and vocational services where appropriate in fiscal year 2004 in the following facilities:

- Hammond and Pinecrest Developmental Centers, Louisiana;
- Arlington Developmental Center, Tennessee;
- Nim Henson Geriatric Center, Kentucky;
- Oakwood Communities, Kentucky;
- New Lisbon Developmental Center, New Jersey; and
- Banks-Jackson-Commerce Medical Center and Nursing Home, Georgia.

The Division is monitoring community placements or the community systems for persons with developmental disabilities in a number of states, including the District of Columbia (in a pre-CRIPA lawsuit), Indiana, Pennsylvania, Puerto Rico, Tennessee, and Wisconsin, and for persons with mental illness in Hawaii.

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[14] Exec. Order No. 13217, 66 Fed. Reg. 33155 (June 18, 2001).

XI. Technical Assistance

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

In fiscal year 2004, the Division provided numerous instances of technical assistance in the process of enforcing CRIPA. For example, as part of the Division's investigation of the Banks Jackson Commerce Medical Center and Nursing Home, the Division took an expert consultant in nursing to the facility to offer consultations on policies, practices, and procedures being implemented by the nursing facility. In our pre-CRIPA lawsuit involving the community system for persons with developmental disabilities in the District of Columbia, Evans and United States v. Williams (D.D.C.), we offered numerous instances of technical assistance in providing written guidance and comments on policies and procedures, as well as providing consultations on many

aspects of the system.

XII. Responsiveness to Allegations of Illegal Conditions

During fiscal year 2004, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live at the facilities and their relatives, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received well over 5,000 CRIPA-related citizen letters and hundreds of CRIPA-related telephone complaints during the fiscal year. In addition, the Division responded to over 220 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and nursing homes, the Division focused on allegations of abuse and neglect; adequacy of medical and mental health care; use of restraints and seclusion; and services to institutionalized persons in the most integrated setting appropriate to meet their needs as required by Title II of the Americans with Disabilities Act and its implementing regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d). With regard to juvenile justice facilities, the Division focused on allegations of abuse, adequacy of mental health and medical care, and provision of adequate rehabilitation and education, including special education services. In jails and prisons, the Division placed emphasis on allegations of abuse including sexual abuse, adequacy of medical care and psychiatric services, and grossly unsanitary and other unsafe conditions.

XIII. Juvenile Justice Activities

The welfare of our nation's youth confined in juvenile justice facilities has been a high priority for the Division. During Fiscal Year 2004 there were five investigations of juvenile justice facilities initiated, three findings letters issued, five settlement agreements approved, and two complaints filed (one simultaneously with a settlement agreement and the other complaint is being litigated). Overall, this Administration has authorized 14 investigations of juvenile justice facilities, issued eight findings letters, and obtained eight substantial agreements. For investigations alone, this represents more than double the six such investigations authorized in the preceding four years.

The conditions in juvenile justice facilities is documented in the Division's work: A findings letter in one jurisdiction disclosed frequent occurrences of sexual abuse at one male youth facility. In another state run juvenile justice facility two guards assaulted a youth, striking him numerous times. The juvenile was then left in his cell for over three hours before receiving any medical attention. The Division continues its strong stand in United States v. Mississippi (S.D. Miss.) regarding the conditions of confinement at Oakley Training School and Columbia Training School. Youth in these two facilities, both male and female, have been the victims of egregious abuse at the hands of their guards and staff. The Division will sharpen its focus even more on conditions of confinement in juvenile justice facilities in the new fiscal year, seeking to implement remedial measures to protect and habilitate confined youth.