U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

MAR 28 2012

The Honorable John Boehner
Speaker
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Pursuant to 42 U.S.C. § 1997f, we are pleased to transmit to Congress the enclosed report describing the Department's activities under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, during Fiscal Year 2011.

We hope this report is useful to you. 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

Enclosure

U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

MAR 28 2012

The Honorable Daniel K. Inouye
President Pro Tempore
United States Senate
Washington, D.C. 20510

Dear Mr. President:

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MAR 28 2012

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

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Sincerely,

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Assistant Attorney General

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MAR 28 2012

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Madam Leader:

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Sincerely,

Ronald Weich
Assistant Attorney General

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Washington, D.C. 20530

MAR 28 2012

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

Pursuant to 42 U.S.C. § 1997f, we are pleased to transmit to Congress the enclosed report describing the Department's activities under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, during Fiscal Year 2011.

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Enclosure

Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2011

Table of Contents

I. Introduction and Overview

Individuals confined in institutions are often among the most vulnerable in our society. Recognizing the need to protect the rights of those residing in public institutions, Congress in 1980 passed the Civil Rights of Institutionalized Persons Act (CRIPA). CRIPA gives the Attorney General the authority to investigate conditions at certain residential institutions operated by or on behalf of state and local governments—including facilities for individuals with psychiatric or developmental disabilities, nursing homes, juvenile justice facilities, and adult jails and prisons—to determine whether there are violations of the Constitution or federal law. CRIPA enforcement has been delegated to the Department of Justice's Civil Rights Division ("the Division"). CRIPA is enforced by the Division's Special Litigation Section ("the Section")

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

The Division takes very seriously its responsibility to protect the rights of individuals residing in institutions. Over the last year, the Section has achieved important successes throughout all areas of its CRIPA authority. The Section has opened new investigations that are targeted to maximize their impact on the issues and populations that fall within our statutory authority. The Division has issued letters describing the findings of our investigations that break new ground on cutting-edge problems in its civil rights enforcement. The Division has entered into landmark settlements that have significantly changed the civil rights landscape in its statutory areas and has vigorously enforced settlements to ensure that the rights of the individuals protected

by those decrees are vindicated. The Section has engaged in extensive outreach to stakeholders and the community to ensure that their concerns are reflected in its enforcement efforts. Finally, the Division has been involved in policy initiatives that implicate the work of the Section and advance the civil rights of those protected by CRIPA.

In Fiscal Year 2011, the Division filed two complaints, settled two contested litigations, entered into four consent decrees, and entered into one out-of-court settlement. The Division also initiated CRIPA investigations of 17 publicly-operated facilities and issued six findings letters outlining findings of significant constitutional and federal statutory violations at six facilities.[1] At the end of Fiscal Year 2011, the Division had active CRIPA matters and cases involving 163 facilities in 32 states, the District of Columbia, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands.

As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions that subject residents of publicly-operated institutions to grievous harm. 42 U.S.C. § 1997a (a). In addition to its enforcement efforts at state and local facilities, pursuant to Section f(5) of CRIPA, the Division provides information regarding the progress made in each federal institution (specifically from the Bureau of Prisons and the Department of Veterans Affairs) toward meeting existing promulgated standards or constitutionally guaranteed minima for such institutions. See attached statements.

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

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

A. Resolution of Investigations

1. Lake County, Indiana

In December 2010, the Division reached an agreement with Lake County, Indiana to correct unlawful conditions of confinement at the Lake County Jail in Crown Point, Indiana. The agreement was filed simultaneously with a CRIPA complaint in United States v. Lake County, IN (N.D. Ind.). An investigation of the Jail uncovered systemic deficiencies including a suicide rate that was more than five times the national average jail suicide rate that violated the constitutional rights of approximately 1,000 male and female inmates confined there. These violations included: failure to protect individuals from harm, particularly involving suicide risk; failure to identify and treat individuals' psychiatric disabilities; failure to provide adequate medical services, including administration of medications; failure to provide adequate fire safety; and failure to adequately maintain the physical plant of the facility, thereby endangering both staff and inmates. The agreement requires Lake County Jail officials to implement remedial measures to ensure that inmates are safe and protected from unreasonable risks to their health and safety, including improved assessment, treatment, and monitoring of inmates at risk of suicide, as well as increased medical, fire safety and sanitation services. The Division will monitor compliance in this case.

2. Delaware Mental Health

In July 2011, the Division reached a comprehensive agreement with Delaware officials that will transform Delaware's services for persons with psychiatric disabilities from an institution-based system to a community-based system. A CRIPA and ADA investigation of the Delaware Psychiatric Center in New Castle, Delaware, and other state services concluded that Delaware's mental health services system fails to provide services to individuals with serious

mental illness in the most integrated setting appropriate to their needs, as required by the ADA. These failures were needlessly prolonging institutionalization of many individuals who could be adequately served in community settings. The consent decree, filed under the ADA but also resolving the CRIPA investigation, was ordered by the court on July 15, 2011. It requires the State to develop integrated systems to support persons with serious and persistent mental illness. Over the next five years, Delaware will prevent unnecessary hospitalization by expanding and deepening its crisis intervention system, and providing intensive community supports, such as assertive community treatment and intensive case management. Delaware will offer scattered-site supported housing to persons in the agreement's target population who need housing support, and Delaware will offer individuals a variety of supports for daily living, including supported employment, rehabilitation services, and improved family and peer support systems. A court-appointed monitor will review and report on the State's compliance with the agreement.

3. William F. Green State Veterans' Home

In January 2011, the Division reached an agreement with Alabama officials to resolve findings of unconstitutional conditions at the William F. Green State Veterans' Home in Bay Minette, Alabama. An investigation found that numerous conditions and practices at the facility violated the constitutional and federal statutory rights of the residents. The investigation identified deficiencies regarding protection from harm, medical and nursing care, and nutrition and hydration practices. These collective deficiencies were all contributing to preventable injuries, illnesses, and even untimely deaths at the facility. Under the memorandum of understanding, the State agrees to provide adequate medical, functional, nursing, and psychological care to residents through improvements in staff training, infection control, appropriate use of psychotropic medications, improved nutrition and hydration practices,

increased rehabilitation and restorative care, development of prevention techniques regarding aspiration, pressure sores, and falls, and prevention of harm from peer assaults, neglect, and other mistreatment. The agreement also requires the State to evaluate individuals in the facility and assist in identifying appropriate supports to live in the community. The Division will monitor compliance with the agreement.

B. Contested Litigation

1. Georgia MH and DD

In November 2010, the court approved a landmark ADA settlement with Georgia to reform the State's mental health and developmental disability systems, following more than ten months of litigation to enforce the Section's January 2009 CRIPA Agreement with the State, as well as an additional lawsuit brought pursuant to the ADA, United States v. Georgia, (N.D. Ga. 2010). In January 2009, the Division entered into a CRIPA agreement to resolve both our CRIPA and ADA findings of unlawful conduct. The State then took the position that the 2009 CRIPA Agreement did not cover the ADA findings. This resistance to ADA reform prompted the Section's ADA lawsuit and eventual ADA settlement. The ADA settlement will provide comprehensive relief to more than 9000 individuals with mental illness in Georgia by increasing community based services, including crisis services, a range of case management (including ACT teams), supported housing, and services supporting meaningful daily life for individuals with mental illness. The Georgia ADA agreement also requires that the State expand its use of community-based services for more than 1150 individuals with intellectual disabilities, including Medicaid-funded community-based waivers, crisis services, and respite services. The settlement is court-enforceable and is monitored by an independent consultant. Since the settlement was entered, the Section has been vigorously enforcing its terms. The Independent Reviewer issued

the First Compliance Report in October 2011, finding that the State is in compliance with the majority of target outcomes for the first year of the ADA agreement and highlighting areas of needed improvement. The Section is separately monitoring the CRIPA settlement.

2. Erie County, New York

On September 30, 2009, the Division filed a complaint in United States v. Erie County, New York, 1:09-CV-000849 (W.D. N.Y. 2009), regarding conditions at the Erie County Holding Center, a pre-trial detention center in Buffalo, NY, and the Erie County Correctional Facility, a correctional facility in Alden, NY. The complaint alleged unconstitutional conditions at the facilities, including: staff-on-inmate violence, inmate-on-inmate violence, sexual misconduct between staff and inmates, sexual misconduct among inmates, inadequate systems to prevent suicide and self-injurious behavior, inadequate medical and mental health care, and serious deficiencies in environmental health and safety. In June 2010, the Division reached a Stipulated Agreement that addressed the County's inadequate system of suicide prevention and self-injurious behavior of holding center inmates, requiring Erie County and the Sheriff to implement detailed remedial measures to ensure that holding center inmates are protected from suicide hazards.

On August 25, 2011, the court signed a stipulated order of dismissal, pursuant to F.R.C.P. 41 (a)(2), regarding the remaining issues in the case, but retained jurisdiction to ensure the agreement's implementation. The agreement requires County officials to implement improved procedures regarding: safety and supervision of Erie County inmates; prevention, detection and investigation of sexual abuse; comprehensive procedures to reduce unnecessary use of force, including annual staff training and use of de-escalation techniques; improved medical and mental health services; and quality management practices to ensure compliance with the agreement.

Two independent Technical Compliance Consultants, selected by the parties and appointed by the court, will evaluate implementation of the Stipulated Agreement to determine compliance.

3. Conway Human Development Center, Arkansas

The Division filed a complaint on January 16, 2009 in United States v. Arkansas (E.D. Ark.), alleging violations of the constitutional and statutory rights of individuals with developmental disabilities at the Conway Human Development Center in Conway, Arkansas. During a lengthy trial in the fall of 2010, the Division presented evidence of violations under CRIPA, the ADA and the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400 et seq. On June 8, 2011, the court issued a final judgment dismissing the case with prejudice. The court found that the weight of the evidence did not support the Division's CRIPA and ADA claims and that, while many of the IDEA claims were meritorious, injunctive relief was unwarranted because the State's Department of Education is overseeing the facility's remedial efforts.

4. Terrell County Jail, Georgia

The Division sought a court finding of contempt in the litigation regarding Terrell County Jail (Georgia). The motion sought to extend the consent decree with a bright line termination provision because of the jurisdiction's non-compliance. After the close of FY 11, the motion was resolved by settlement that extended the decree.

5. Radar Juvenile Facility, Oklahoma

The Division also sought a finding of contempt in the litigation regarding the Rader Juvenile Facility (Oklahoma). The motion sought to extend a consent decree with a bright line termination provision because of the jurisdiction's non-compliance. The motion was denied, and the case was dismissed by the court pursuant to the bright line termination provision.

6. Golden Grove Correctional and Adult Detention Facility, Virgin Islands

The Division has been enforcing a CRIPA consent decree regarding this prison in the Virgin Island for 25 years. To address the persistent constitutional violations at the prison, the Division moved for the appointment of a receiver. The defendants responded by moving to dismiss the case under the Prison Litigation Reform Act ("PLRA"). Both motions are pending.

7. Cook County Jail, Illinois

As part of its enforcement of a 2010 CRIPA settlement, the Division helped persuade a three-judge panel to grant the County's request for a prisoner release order pursuant to the PLRA. This order will aid Cook County in keeping the jail population at a manageable level, thus helping to avoid crowded conditions that, as the Division's investigation showed, contribute to unconstitutional conditions of confinement.

III. Prison Litigation Reform Act

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

IV. Compliance Evaluations

During Fiscal Year 2011, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in numerous facilities throughout the United States. These facilities are:

A. Facilities for persons with developmental disabilities:

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

B. Facilities for persons with mental illness:

Facility or Facilities	Case or Agreement	Court/Date
Guam Adult Mental Health Unit	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Vermont State Hospital	United States v. Vermont, 2:06-CV-1431	D. Vt. 2005
Metropolitan State Hospital, Napa State Hospital, Atascadero State Hospital, and Patton State Hospital	United States v. California, 06-2667 GPS	M.D. Cal. 2006

St. Elizabeth's Hospital	United States v. District of Columbia, 1:07-CV-0089	D. D.C. 2007
Georgia Regional Hospital in Atlanta, Georgia Regional Hospital in Savannah, Northwest Georgia Regional Hospital, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital and East Central Georgia Regional Hospital.	United States v. Georgia, 1-09-CV-0119 United States v. Georgia 01-10-CV-0249	N.D. Ga. 2009 N.D. Ga. 2010
Connecticut Valley Hospital	United States v. Connecticut, 3:09-CV-00085	D. Conn. 2009
Kings County Hospital Center	United States v. Kings County, New York, CV-10-0060	E.D.N.Y. 2010
Delaware Psychiatric Center	United States v. Delaware, 1-11-CV-00591	D. Del. 2011

C. Nursing Homes:

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

D. Juvenile justice facilities:

Facility or Facilities	Case or Agreement	Court/Date
Bayamon Detention Center, Centro Tratamiento Social Bayamon, Centro Tratamiento Social Humacao, Centro Tratamiento Social Villalba, Centro Tratamiento Social Guayama, Guali Group Home, and Ponce Detention and Social Treatment Center for Girls	United States v. Commonwealth of Puerto Rico, 9 4-2080 CCC	D. P.R. 1994
Arkansas Juvenile Assessment and Treatment Center	United States v. Arkansas, 03CV00162	E.D. Ark. 2003
Oakley Training School	United States v. Mississippi, 3:03 CV 1354 BN	S.D. Miss. 2003

Hawaii Youth Correctional Facility	United States v. Hawaii, 1:06-CV-00073-SPK-L	D. Haw. 2006
L.E. Rader Center	United States v. Oklahoma, 06-CV-673-TCK FHM	E.D. Okla. 2006
Baltimore City Juvenile Justice Center	United States v. Maryland, 1:05-CV-01772	D. Md. 2007
Evins Regional Juvenile Center	United States v. Texas, 7:08-CV-00038	S.D. Tex. 2008
Marion County Superior Court Juvenile Detention Center	United States v. Marion County Superior Court, Indiana, 1:08-CV-0460-LJM-T	N.D. Ind. 2008
Circleville Juvenile Correctional Facility, Indian River Juvenile Correctional Facility, Cuyahoga Hills Juvenile Correctional Facility, Mohican Juvenile Correctional Facility, Ohio River Valley Juvenile Correctional Facility, Freedom Center, Scioto Juvenile Correctional Facility, and Marian Juvenile Detention Center	United States v. Ohio, C2 08 0475	S.D. Ohio 2008
Los Angeles County Juvenile Camps	2009 Settlement Agreement	N/A
Lansing Residential Center, Louis Gossett, Jr. Residential Center, Tryon Residential Center, and Tryon Girls Center	United States v. New York, 10-CV-858	N.D. N.Y. 2010

E. Jails:

Facility or Facilities	Case or Agreement	Court/Date
Hagatna Detention Center and Fibrebond Detention Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Harrison County Jail	United States v. Harrison County, Mississippi, 1:95 CV5-G-R	S.D. Miss. 1995
Sunflower County Jail	United States v. Sunflower County, Mississippi, 4:95 CV 122-B-O	S.D. Miss. 1995
Coffee County Jail, Georgia	1997 Settlement Agreement	N/A
Saipan Detention Facility, Tinia Detention Facility, and Rota Detention Facility	United States v. Commonwealth of the Northern Mariana Islands, CV 99-0017	D. N. Mar. I. 1999
Muscogee County Jail, GA	United States v. Columbus Consolidated City/County Government, Georgia, 4-99-CV-132	M.D. Ga. 1999

McCracken County Regional Jail	United States v. McCracken County, Kentucky, 5:01CV-17-J	W.D. Ky. 2001
Los Angeles Mens Central Jail, California	2002 Settlement Agreement	N/A
Dallas County Jail	United States v. Dallas County, Texas, 307 CV 1559-N	N.D. Tex. 2007
Terrell County Jail	United States v. Terrell County, Georgia, 04-cv-76	M.D. Ga. 2007
Baltimore City Detention Center, Maryland	2007 Agreement	N/A
Wilson County Jail, Tennessee	2008 Settlement Agreement	N/A
Oahu Community Correctional Center	United States v. Hawaii, CV-08-00585	D. Haw. 2008
King County Correctional Facility	United States v. King County, Washington, CV-9-0059	W.D. Wash. 2009
Sebastian County Detention Center, Arkansas	2009 Settlement Agreement	N/A
Grant County Detention Center, Kentucky	2009 Settlement Agreement	N/A
Oklahoma County Jail and Jail Annex, Oklahoma	2009 Settlement Agreement	N/A
Cook County Jail	United States v. Cook County, Illinois, 10-cv-2946	N.D. Ill. 2010
Lake County Jail	United States v. Lake County, Indiana, 2:10-CV-476	N.D. Ind. 2010

F. Prisons:

Facility or Facilities	Case or Agreement	Court/Date
Golden Grove Correctional and Adult Detention Facility	United States v. Territory of the Virgin Islands, 86-265	D. V.I. 1986
Saipan Prison Complex	United States v. Commonwealth of the Northern Mariana Islands, CV-99-0017	D. N. Mar. I. 1991
Guam Adult Correctional Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Delaware Correctional Center, Howard R. Young Correctional Institution, Sussex Correctional Institution, and Delores J. Baylor Women's Correctional Facility, Delaware	2007 Agreement	N/A
Taycheedah Correctional Institution	United States v. Doyle, 08-C-0753	E.D. Wis.2008
Erie County Detention Center and Holding Facility	United States v. Erie County, New York, 09-CV-0849	W.D. N.Y. 2009

V. Termination of CRIPA Cases

In Fiscal Year 2011, five CRIPA cases were terminated after jurisdictions successfully came into compliance with settlement agreements and court orders. For example, in December 2010, the court dismissed United States v. Vermont, 2:06-CV-1431 (D. Vt. 2005), the Division's CRIPA case involving conditions at the Vermont State Hospital in Waterbury, Vermont. The 2006 settlement required the State to address findings of unconstitutional conditions that included unconstitutional treatment planning; psychiatric and psychological care; suicide prevention; risk management; use of restraint and seclusion; discharge planning; and community integration. Vermont's successful reform effort addressed each of the identified deficiencies and achieved substantial compliance with federal law in all areas. The case was closed on December 17, 2010.

During the Fiscal Year, the Division successfully ended its oversight of United States v. Mississippi, 3:04-CV-933 (S.D. Miss. 2004) regarding Reginald P. White Nursing Home in Meridian, Mississippi. Following the 2002 investigation of conditions at the state-operated nursing home, the parties entered into a settlement agreement approved by the court in 2004. During two extensions to the bright line termination date, the facility implemented a host of remedial measures that addressed identified deficiencies, including inadequate nursing care; physician care; mental health services; staff training and oversight; and compliance with the integration provisions of the ADA. Even after the court approved the motion to dismiss on February 24, 2010, the parties agreed to exchange additional information on progress regarding restorative care and ADA compliance activities. Based on successful outcomes of that process, the case was closed on December 22, 2010.

Similarly, in United States v. South Carolina, 3:09-CV-98 (D. S.C. 2009) the State and the Division jointly moved to dismiss the Rule 41(b)(2) settlement agreement based on substantial

compliance with remedial measures to improve serious deficiencies, including inadequate medical, mental health, and nursing services; inadequate nutrition and hydration; inadequate pressure ulcer treatment and fall prevention; improper use of restraints; inadequate protection from harm; and violations of the integration provision of the ADA. During the life of the settlement, the State, among other things, hired qualified medical and mental health staff, improved pressure sore and fall prevention, improved psychiatric practices, reduced the use of improper restraints, improved documentation, and improved palliative and end-of-life care. The court approved the motion to dismiss and the case was closed on February 15, 2011.

The Division terminated oversight of the Hawaii Youth Correctional Facility in Kailua, Hawaii in United States v. Hawaii, 1:06-CV-00073 (D. Haw. 2006) following expiration of the Rule 41 (a)(2) settlement agreement and a subsequent disengagement agreement. A 2005 CRIPA investigation found that the facility violated youth rights under the Constitution and federal law with regard to protection from harm, including self-harm; staff abuse; failure to investigate abuse; excessive use of disciplinary isolation; exploitation of youth; an inadequate grievance system; inadequate access to medical and mental health care; and inadequate access to special education. Based on steps taken by the State to address identified deficiencies, the Division closed the case on May 11, 2011.

The Division closed United States v. Texas, 7:08-CV-00038 (S.D. Tex. 2008) regarding conditions at the Evins Regional Juvenile Center in Edinburg, Texas. A 2007 investigation found patterns and practices that violated the constitutional rights of the youth by failing to adequately protect them from youth-on-youth and staff-on-youth violence. Specifically, the Division found that inadequate staffing, programming, classification and a dysfunctional grievance system led to youth-on-youth violence and inadequate staffing and staff training led to staff-on-youth violence.

In May 2008, the court entered the Agreed Order that contained a May 2011 termination date. During that period, Texas implemented remedies to address protection from harm, staff training, and quality assurance. At a status conference in August 2011, the Division informed the court that the State was compliant in all areas, and the court acknowledged that no further action was needed in the case. The case was closed on September 22, 2011.

VI. New CRIPA Investigations

The Division initiated five CRIPA investigations during Fiscal Year 2011, involving the following facilities:

- Walnut Grove Youth Correctional Facility, Mississippi;
- Department of Mental Health, Mississippi, including:
  - Boswell Regional Center;
  - Ellisville State School;
  - Hudspeth Regional Center;
  - North Mississippi Regional Center;
  - South Mississippi Regional Center;
  - East Mississippi Regional Center;
  - Mississippi Adjustment Center;
  - Mississippi State Hospital;
  - South Mississippi State Hospital;
  - Central Mississippi Residential Center;
  - East Mississippi State Hospital;
  - North Mississippi State Hospital; and
  - Specialized Treatment Center;
- Piedmont Regional Jail, Virginia;
- Topeka Correctional Facility, Kansas; and
- St. Tammany Parish Jail, Louisiana.

VII. Findings Letters

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

- Delaware Psychiatric Center, Delaware;
- Maple Lawn Nursing Home, Missouri;
- Central Virginia Training Center, Virginia;
- Leflore County Juvenile Detention Center, Mississippi;
- Miami-Dade County Detention Center, Florida; and
- Robertson County Detention Center, Tennessee.

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

VIII. Investigation Closures

In Fiscal Year 2011, the Division closed its investigation of Rogers State Prison in Georgia, where it determined after thorough investigation that conditions were not unlawful. Although the Rogers investigation did not reveal a pattern or practice of conduct that violated prisoners' constitutional rights, there were areas of concern that were addressed in a March 2011 technical assistance letter. Because of Georgia's prompt remedial responses to the technical assistance the Division provided, the matter was closed.

The Division closed the investigation of Patrick County Jail in Virginia after the County addressed safety and security concerns identified in the investigation and dedicated resources to building a new jail facility.

The Division ended its 1998 investigation of the Laguna Honda Hospital and Rehabilitation Center, operated by the City of San Francisco, after the City effectuated far-reaching integration reforms to address *Olmstead* violations such that individuals who are elderly or disabled can receive necessary services at scattered-site locations in their home communities. The City also implemented improved health care and nursing and psychiatric services at the facility.

Similarly, the Division terminated the Rainier School investigation in Washington State, also opened in 1998, after the jurisdiction achieved substantial compliance with an agreed Exit Plan, and implemented systemic policies and procedures to minimize risks and ensure compliance with constitutional and federal statutory rights for persons with developmental disabilities at the facility.

The Division closed its investigation of the LaSalle County Nursing Home in Illinois after the County voluntarily improved incident investigation reviews and increased medical service hours. The Division terminated investigations of five Los Angeles County Juvenile Camps that were voluntarily shut down by County authorities at their administrative discretion during the investigation. Lastly, the Division closed the investigation of Rosewood Center in Maryland after the State closed the facility and placed residents in community-based settings.

IX. Technical Assistance

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Division advises responsible public officials of the availability of such aid

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

In addition, to ensure timely and efficient compliance with settlement agreements, the Division issued numerous post-tour compliance assessment letters (and in some cases, emergency letters identifying emergent conditions) to apprise jurisdictions of their compliance status. These letters routinely contain technical assistance and best practices recommendations.

X. Responsiveness to Allegations of Illegal Conditions

During Fiscal Year 2011, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live in the facilities, relatives of persons living in facilities, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The Division received about 7,100 CRIPA-related citizen complaint letters, over 1,000 more letters than it received in Fiscal Year 2010, and received more than 300 CRIPA-related telephone complaints during the Fiscal Year. In addition, the Division responded to 240 CRIPA-related

inquiries from Congress and the White House.

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

XI. CRIPA Subpoena Authority

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

XII. Conclusion

In Fiscal Year 2012 and beyond, the Division intends to continue aggressive investigation and enforcement under CRIPA, ensuring that settlements resulting from its enforcement efforts are strong enough to adequately address unlawful deficiencies. The Division will also continue to work with jurisdictions to craft agreements that focus on bringing them into compliance. Unlike the practice used frequently in the past, the Division does not enter into agreements that terminate on a pre-set date but only enters into agreements that ensure that the jurisdiction has engaged in necessary reforms.

U.S. Department of Justice

Federal Bureau of Prisons

Washington, DC 20534

October 24, 2011

MEMORANDUM FOR JUDY C. PRESTON, DEPUTY CHIEF
SPECIAL LITIGATION SECTION
CIVIL RIGHTS DIVISION, DOJ

FROM: H. J. Marberry, Assistant Director
Program Review Division, BOP

SUBJECT: Response for the Attorney General's Report to Congress for FY 2011 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997

The Bureau of Prisons appreciates the opportunity to report our actions during FY 2011 as related to the Attorney General's Report to Congress for FY 2011 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997.

The following is provided for insertion into the report:

FEDERAL BUREAU OF PRISONS

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

These standards have been incorporated into the Bureau's national policy, as well as program review guidelines. Currently, 116 Bureau institutions and the Bureau's Headquarters are accredited by the Commission on Accreditation for Corrections. The Bureau uses the ACA standards mentioned above for institution accreditation.

Accredited institutions are subject to interim audits by the Commission to monitor standards compliance, particularly in the vital areas of inmate rights, healthcare, security, safety, and sanitation. The standards are reviewed at least annually for continued compliance, by institutional staff, through the operational review process. In addition to operational reviews, program reviews are conducted at all federal prisons in each discipline at least once every 3 years to monitor policy compliance. In FY 2011, there were 431 separate program reviews conducted by organizationally independent Bureau examiners which included a review of ACA standards. This number is lower than FY 2010, partially because of the closure of some Unicor Factory operations.

The Bureau utilizes a medical classification system that identifies each inmate's medical and mental health needs, along with the forensic needs of the court. Additionally, the Bureau assigns inmates to facilities (identified as Care Levels 1 through 4) with appropriate in-house and community health care resources. All Care Level 2, 3, and 4 institutions are required to be accredited by The Joint Commission on Accreditation of Healthcare Organizations. Currently, all 102 sites are accredited by The Joint Commission.

If you require additional information, please contact Anthony Boyd in my office at (202)305-7301.

DEPARTMENT OF VETERANS AFFAIRS
General Counsel
Washington DC 20420

OCT 31 2011

In Reply Refer To:

Judy C. Preston, Deputy Chief
Special Litigation Section
Civil Rights Branch
U.S. Department of Justice
601 D Street, N.W.
Washington, D.C. 20004

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

Dear Ms. Preston:

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

Sincerely yours,

Thompson

Will A. Gunn
for General Counsel

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

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

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

VA further protects patients' civil rights through its program of hiring individuals to serve as Patient Advocates. The purpose of VA's Patient Advocacy Program is "to ensure that all veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner." VHA Handbook 1003.4, paragraph 3 (September 2, 2005). The Advocates assist patients in understanding their rights and represent them in the enforcement of those rights. VA also facilitates the representation of patients by external stakeholders, including, but not limited to, veterans service organizations and state protection and advocacy systems, which seek to represent patients in VA facilities. *Id.* at paragraph 8.

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

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

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