Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2013

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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 Division engages in negotiation and conciliation efforts and provides technical assistance to help jurisdictions correct deficient conditions. If these efforts fail, the Division may file a lawsuit to correct the violations of rights.

The Division takes very seriously its responsibility to protect the rights of individuals residing in institutions. Over the last year, the Division has achieved important successes throughout all areas of its CRIPA authority. For instance, the Division opened a new investigation targeted to maximize impact on the issue of sexual abuse of female prisoners. The Division issued letters describing the findings of investigations that broke new ground on cutting-edge issues in its civil rights enforcement. The Division has vigorously enforced settlements to ensure that the rights of the individuals protected by those decrees are vindicated.

The Division 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 2013, the Division filed four complaints and entered into five settlement agreements. The Division also initiated a CRIPA investigation of a prison and issued two findings letters outlining findings of significant constitutional and federal statutory violations at two facilities.[1] At the end of Fiscal Year 2013, the Division had active CRIPA matters and cases involving 93 facilities in 25 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 minimums for such institutions. See attached statements.

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

A. Resolution of Investigations

1. Maple Lawn Nursing Home, Missouri

In March 2013, the Division and Marion County, Missouri, reached a settlement agreement to correct unlawful conditions at the Maple Lawn Nursing Home and to assist

[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.

residents of this facility in moving to integrated settings with appropriate supports, when they were able and willing to do so. In January 2011, the Division had issued findings that the Maple Lawn Nursing Home failed to provide services to individuals in the most integrated setting appropriate to their needs and to prevent unconstitutional harms or minimize risk of harms. The settlement agreement will require the jurisdiction to implement preadmission diversion practices, discharge and transition planning, adequate and appropriate medical care, and procedures to protect residents from harm. The agreement is monitored by a court monitor who issues compliance reports.

2. Robertson County Detention Facility, Tennessee

In April 2013, the Division reached a settlement agreement with Robertson County, Tennessee, to transform care for prisoners suffering from mental illness at the Robertson County Detention Center. In August 2011, the Division had issued findings that the Detention Center failed to provide mental health care to prisoners, placing prisoners at a substantial and unreasonable risk of serious harm. The settlement agreement will require the County to provide proper treatment to prisoners who have mental illness or are at risk of suicide, including treatment necessary to successfully reenter the community. An independent consultant will monitor compliance with the agreement and issue public compliance reports.

3. Miami-Dade County Jail, Florida

In May 2013, the Division and Miami-Dade County, Florida, reached a settlement agreement to remedy unconstitutional conditions for prisoners at the Miami-Dade County Jail. In August 2011, the Division had issued findings that Miami-Dade County Jail failed to provide prisoners with adequate mental health care and suicide prevention, protection from physical harm, and sanitary and safe conditions. The settlement agreement requires the Jail to implement

practices to protect prisoners from unnecessary or excessive force by staff and other inmates. The agreement also requires the Jail to provide prisoners with a process to express grievances and a safe environment. The Jail must implement self auditing measures to address prisoners' constitutional rights and develop and implement policies and procedures to ensure compliance with the agreement. A monitor will evaluate compliance with the agreement and provide technical assistance to the County as requested.

4. Piedmont Regional Jail Authority, Virginia

In September 2013, the Division and the Piedmont Regional Jail Authority reached a settlement agreement to remedy unconstitutional conditions at the Jail. In September 2012, the Division had issued findings that the Piedmont Regional Jail Authority violated the constitutional rights of prisoners. The settlement agreement requires the Jail to provide prisoners with adequate medical and mental health care, including chronic care. The agreement also requires the Jail to implement a reporting system to identify deficiencies in care in a timely manner and implement other measures to facilitate prisoners' access to adequate health care. The agreement is evaluated by a monitor, who issues public compliance reports and provides technical assistance to the Jail.

5. St. Tammany Parish Jail, Louisiana

In August 2013, the Division and St. Tammany Parish, Louisiana, signed a Memorandum of Agreement to remedy unconstitutional conditions at the Jail. In July 2012, the Division found that the Jail failed to provide prisoners with adequate mental health care and suicide prevention. The agreement requires improved screening and assessment, adequate and timely mental health treatment, enhanced staff training, and data collection. The agreement also builds upon improvements made by the Parish during the Division's investigation--most notably the removal

of small booking cages that were used for the confinement of suicidal prisoners, and the construction of a specialized housing unit to manage and monitor prisoners suffering from mental health crises. Compliance with the agreement will be assessed by an independent auditor, who will periodically inspect the Jail, issue written reports of compliance, and provide technical assistance as needed.

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 2013, the Division monitored 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
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	United States v. Texas, A-09-CA-490	E.D. Tex. 2009

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		
Georgia Regional Hospital in Atlanta, Georgia Regional Hospital in Savannah, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital and East Central Georgia Regional Hospital. (These facilities also serve people with mental illness.)	United States v. Georgia, 1-09-CV-0119 United States v. Georgia 01-10-CV-0249	N.D. Ga. 2009 N.D. Ga. 2010

B. Facilities for persons with mental illness:

Facility or Facilities	Case or Agreement	Court/Date
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; Central State Hospital; Southwest State Hospital; West Central Georgia Regional Hospital; and East Central Georgia Regional Hospital. (These facilities also serve people with developmental disabilities.)	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
Maple Lawn Nursing Home	United States v, Marion County Nursing Home District, 2:13-CV-00026	E.D. Mo. 2013

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
Circleville Juvenile Correctional Facility; Indian River Juvenile Correctional Facility; Cuyahoga Hills Juvenile Correctional Facility; and Scioto Juvenile Correctional Facility	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	United States v. Columbus Consolidated City/County Government, Georgia, 4-99-CV-132	M.D. Ga. 1999
Los Angeles Mens Central Jail, California	2002 Settlement Agreement	N/A
Dallas County Jail	2012 Settlement Agreement (converted from consent decree	N/A

	in United States v. Dallas County, Texas, 307 CV 1559-N)	
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
Oahu Community Correctional Center	United States v. Hawaii, CV-08-00585	D. Haw. 2008
Sebastian County Detention Center, Arkansas	2008 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
Robertson County Jail	United States v, Robertson County, 3:13-CV-00392	M.D. Tenn. 2013
Miami-Dade County Detention	United States v. Miami-Dade County, 1:13-CV-21570	S.D. Fla. 2013
St. Tammany Parish Jail	2013 Settlement Agreement	N/A
Piedmont Regional Jail Authority, Virginia	United States v. Piedmont Regional Jail Authority, 3:13-CV-646	E.D. Va. 2013

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
Taycheedah Correctional Institution, Wisconsin	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 2013, the Division terminated one CRIPA case. In May 2013, the Division and the State of Wisconsin jointly moved to dismiss United States v. Doyle, 08-C-753 (E.D. Wis. 2008) regarding conditions at Taycheedah Correctional Institution. Following an investigation of the prison, the Division issued its findings in 2006. The Division found that the prison failed to provide inmates with adequate psychiatric treatment and mental health care. Thereafter, in 2008, the parties entered into a memorandum of agreement to improve the care at the prison. The agreement provided for: measures to improve mental health care, crisis services and psychiatric treatment of inmates; the implementation of a compliance and quality assurance program; and a jointly selected consultant to provide technical assistance and biannual reporting of the steps taken by the State to comply with the agreement. During the Fiscal Year, the jurisdiction fulfilled the terms of the settlement agreement, and the parties moved for dismissal of the lawsuit. The Court dismissed the lawsuit on May 14, 2013.

VI. New CRIPA Investigations

The Division initiated one CRIPA investigation during Fiscal Year 2013, of Julia Tutwiler Prison for Women in Alabama. The investigation addresses allegations that prisoners are subjected to sexual abuse by prison staff in violation of their constitutional rights; allegations that the prison fails to report and prevent sexual abuse; and allegations that the prison fails to provide adequate mental health and medical care to victims of sexual abuse.

VII. Findings Letters

During the Fiscal Year, the Division issued two findings letters, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b, regarding two facilities. On May 22, 2013, the Division issued a findings letter regarding conditions at the Escambia County Jail in Florida. This jail houses nearly 1,300 prisoners. The Division investigated conditions at the jail related to sufficient

security levels, sanitation and environment, and the adequacy of medical and mental health care for prisoners. The Division found that, although conditions were improved through the implementation of new reforms, the jail consistently violated the constitutional rights of the prisoners. In particular, the Division found that staffing shortages led to unconstitutional inadequacies in mental health care and risks of harm to prisoners. The Division also found that the jail discriminated against prisoners based on race by implementing a policy and practice that segregated certain housing for only African-American prisoners.

On May 31, 2013, the Division issued a findings letter regarding the State Correctional Facility at Cresson in Pennsylvania. The Division began this investigation in December 2011 and investigated conditions at the prison regarding the use of solitary confinement on prisoners with serious mental illness and intellectual disabilities. The Division found that the prison routinely locked prisoners with serious mental illness in their cells for 22 to 23 hours a day. The Division also found that the prison subjects these prisoners to harsh and punitive conditions, including excessive use of force, and denies them basic necessities. The Division concluded that the prison's use of solitary confinement caused serious harms to prisoners, including mental decompensation, clinical depression, psychosis, self-mutilation, and suicide. In addition, the Division found that the prison relied on solitary confinement to warehouse its prisoners with serious mental illness because of deficiencies in its mental health program. During the Fiscal Year, the Division expanded this investigation into all of the prisons in the Pennsylvania Department of Corrections.

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 subject residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a).

VIII. Investigation Closures

In Fiscal Year 2013, the Division closed its investigation of William F. Green State Veteran's Home in Alabama, after the facility fully complied with the memorandum of understanding, resulting in improved health care, protecting residents from harm, and policies and procedures to ensure that residents and potential residents are served in the most integrated settings appropriate to their needs. The Division also ended its investigation of Worcester County Jail in Massachusetts following a change in facility leadership and the introduction of reforms there responsive to the issues raised in the Division's Findings Letter. Additionally, the Division closed its investigation of Delaware Correctional Center after the State achieved substantial compliance with a memorandum of agreement and implemented reforms in medical care, mental health care, and suicide prevention.

The Division ended its investigation of Dougherty County Jail after the jurisdiction made improvements to conditions with regards to staffing, infrastructural issues, grievances, use of force, and environmental health and safety at the Jail. The Division closed its investigation of the Alexander, Arkadelphia, and Booneville Human Development Centers in Arkansas after an adverse decision in a related matter brought by the Division.

Lastly, the Division ended its investigation of Clyde E. Choate Developmental Center after the State significantly expanded its commitment to community-based services. The Division will continue to monitor the State's efforts.

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 when 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. Often, after 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. In addition, during the course (and at the conclusion) of investigatory tours, the Division's expert consultants often meet with officials from the subject jurisdiction and provide helpful information 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 has 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 2013, 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 6,423 CRIPA-related citizen complaint letters and numerous CRIPA-related

citizen complaint telephone calls during the Fiscal Year. In addition, the Division responded to 603 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic and serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and to 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 jurisdictions operate facilities in a manner consistent with their obligations to provide 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. The Division also began expanding its juvenile practice into new areas. Using its authority under a section of the Violent Crime Control and Law Enforcement Act of 1994, the Department has investigated the conduct of police in arresting children for school-based offenses, and has examined whether entities involved in the administration of juvenile justice— including police, juvenile courts, and juvenile probation systems—comply with children's procedural due process rights, with the constitutional guarantee of Equal Protection, and with federal laws prohibiting racial discrimination. The Department has made findings of civil rights violations regarding the administration of juvenile justice in two jurisdictions. In one of these matters, in Shelby County, Tennessee, the Department and the jurisdiction entered into a settlement and are working cooperatively to

resolve concerns. The second matter, *United States v. City of Meridian, et al., (S.D. Miss*) is currently in litigation.

In addition, in a settlement involving the Los Angeles City juvenile justice camps, the Division looked beyond institutional conditions by expanding a long-standing conditions agreement to incorporate youths' access to community-based alternatives to detention.

XI. Conclusion

In Fiscal Year 2014 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. To that end, the Division does not enter into agreements that terminate on a pre-set date but only enters into agreements that terminate when the jurisdiction has engaged in necessary reforms.

VA | U.S. Department of Veterans Affairs

Office of the General Counsel
Washington DC 20420

MAR - 4 2014

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,

for Tammy L. Kennedy

Will A. Gunn
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 1019, *Nondiscrimination in Federally-Conducted and Federally-Assisted (External) Programs* (May 23, 2013).

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, *VHA Patient Advocacy Program,* 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).

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director *Washington, DC 20534*

February 28, 2014

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

FROM: Sara M. Revell, Assistant Director
Program Review Division, BOP

SUBJECT: Response for the Attorney General's Report to Congress for FY 2013 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997

The Bureau of Prisons appreciates the opportunity to report our actions during FY 2013 as related to the Attorney General's Report to Congress for FY 2013 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), the Prison Rape Elimination Act (PREA) of 2003 (Public Law 108-79; September 4, 2003), and 28 CFR Part 115, National Standards To Prevent, Detect, and Respond to Prison Rape; Final Rule, dated June 20, 2012. 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, and a zero tolerance

toward all forms of sexual activity, including sexual abuse and sexual harassment.

ACA standards have been incorporated into the Bureau's national policy, as well as the program review guidelines. Currently, 115 of the Bureau's 119 institutions and the Bureau's Headquarters are accredited by the Commission on Accreditation for Corrections. Additionally, the agency's two training centers, Staff Training Academy and Management and Specialty Training Center, will be attending their ACA panel hearings in August 2014 to be accredited. The newly activated facilities in Berlin, New Hampshire, and Aliceville, Alabama, are preparing for their initial accreditations. MCC San Diego and FDC Miami lost accreditation; however, MCC San Diego has re-applied and is scheduled for accreditation in FY 2014. 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. Particular attention is given 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 2013, there were 532 separate program reviews conducted by organizationally independent Bureau examiners which included a review of ACA standards. This number is higher than FY 2012, partially because of the newly activated facilities.

PREA audits for federal institutions began on August 20, 2013, with 5 institutions being audited for FY 2013. Also, at least 1/3 of the Bureau's federal institutions will be audited each year for the first three-years with the Central Office being audited annually to determine compliance with each PREA standard.

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 77 sites are accredited by The Joint Commission.

If you require additional information, please contact Joseph Pecoraio in my office at (202)307-0281.