Memorandum

CRIPA Investigation

MR-LA-002-001

AEP:RF:RJF
DJ 168-32-64

Subject	Date
Recommendation to Investigate Hammond Developmental Center Hammond, Louisiana	October 16, 1996

To Deval L. Patrick
Assistant Attorney General
Civil Rights Division

From AEP by RF
Arthur E. Peabody, Jr.
Chief
Special Litigation Section

INTRODUCTION

We recommend that the Department initiate an investigation into the conditions of confinement at the Hammond Developmental Center ("Hammond") in Hammond, Louisiana, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Hammond is the second largest state-operated institution for individuals with developmental disabilities in Louisiana, serving about 400 clients.

In a rare turn of events, legal counsel for Louisiana contacted us to alert us of deficient conditions at Hammond. This call, as well as other information we have obtained, indicates that residents of Hammond are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. Alleged unconstitutional conditions and practices include abuse and neglect and excessive use of physical and chemical restraints in lieu of adequate behavioral treatment. These deficiencies subject residents at Hammond to unreasonable risks to their personal safety and violate their constitutional rights.1/ In addition, the State is allegedly failing to evaluate Hammond residents for community placement and is therefore failing to provide services to Hammond

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1/ Residents of state-operated facilities for individuals with developmental disabilities and mental retardation have a fundamental Fourteenth Amendment due process right to reasonable safety and training. Youngberg v. Romeo, 457 U.S. 307 (1982). Such training must be sufficient to protect each resident's liberty interests and permit each resident an opportunity to function as independently as his or her individual handicapping conditions permit. See, e.g., Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir.), cert. denied, 498 U.S. 951 (1990); United States v. Tennessee, No. 92-2062, slip op. at 12 (W.D. Tenn. Feb. 17, 1994); Halderman v. Pennhurst State Sch. & Hosp., 154 F.R.D. 594 (E.D. Pa. 1994). See also 42 C.F.R. § 483.440.

residents in the least separate, most integrated setting as required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq.

We learned about unconstitutional and unlawful conditions at Hammond as a result of the contacts we made as part of our ongoing CRIPA investigation of the Pinecrest Developmental Center in Pineville, Louisiana. Pinecrest is the largest such facility in the State. Our investigation of Pinecrest uncovered unconstitutional and unlawful conditions including incidents of abuse and neglect, lack of adequate medical, psychiatric and nursing care, and failure to provide adequate programming. We are currently involved in consent decree negotiations with State officials to remedy these violations. If an investigation of Hammond is approved, we plan on conducting an expedited investigation and, if our findings warrant, we would include appropriate remedial actions for Hammond in an omnibus consent decree that addresses conditions at both Pinecrest and Hammond.

POSSIBLE VIOLATIONS

I. The State Admits Abuse, Neglect and Deficient Conditions and Practices at Hammond

Because of the good relationship we have established with opposing counsel in the Pinecrest matter, on October 10, 1996, we received an unsolicited call from Frank Perez, the Deputy General Counsel for the Louisiana Department of Health and Hospitals ("DHH"), who informed us that Hammond had just been placed on a twenty-four day "fast-track" for decertification in the Medicaid program. Perez indicated that he was calling us at the express request of Charles Castille, the General Counsel for DHH, who wanted us to be informed of this disturbing development right away. Perez explained that a few days earlier this month, Louisiana officials conducted a special surprise investigation of Hammond after having received allegations of abuse and neglect at the facility from an employee at Hammond. Perez informed us that the survey uncovered suspected client abuse and neglect and inappropriate use of restraints.

Specifically, the State surveyors discovered that a number of residents had been threatened and abused by staff with a towel named "Josephine."2/ It appears that staff had used the towel to choke the residents.3/ Upon questioning, three Hammond clients

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2/ Department of Health and Human Services, Health Care Financing Administration, Statement of Deficiencies, Hammond Developmental Center, Oct. 4, 1996, at 2-3.

3/ Id. at 3.

responded in an angry and frightened manner to the name "Josephine," and one pointed to a scarred, darkly discolored area on his right shin and stated that "Josie" did it.4/

The surveyors also found that the facility failed to provide clients with appropriate behavior modification treatment prior to using restraints: "the facility failed to assure that the client's record documents that the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective."5/ Specifically, the surveyors found that mechanical restraints were used for behavioral episodes where there was no evidence in the individual's program plan that these behaviors were being addressed with behavior management plans.6/ The facility also failed to obtain the proper consent for the use of physical or mechanical restraints on these individuals.7/

The surveyors further found that:

* the facility failed to provide the minimum ratio of direct care staff to clients;

* the facility failed to notify in a timely fashion appropriate authorities about suspected client abuse;

* there was an unacceptably high number of incidents of unknown origin at Hammond; and

* staff members, who had been suspected of client abuse, remained at the facility, and often continued to interact inappropriately with the clients.8/

Perez indicated that Louisiana officials intended to re-tour the facility again this week. He indicated that seven employees have already been suspended and that he expects major management changes at the facility. Recent newspaper accounts confirm that seven Hammond employees have been suspended amidst allegations

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4/ Id.

5/ Id. at 8.

6/ Id. at 8-9.

7/ Id. at 2.

8/ Id. at 3-7.

that they physically abused four adult clients under their care.9/

The fact that the opposing counsel from Louisiana called to inform us of these developments is powerful evidence that deficient conditions currently exist at Hammond that rise to a level warranting further investigation by the Department. However, we have compiled other information from a variety of sources, including parents and family members, that also strongly suggests that an investigation is called for at this time.

II. Family Members of Hammond Clients Detail Abuse, Neglect and Undue Restraint of Residents

a. Vince L.

A number of Hammond family members have furnished us with corroborating information about conditions and practices affecting their own children and relatives who live at Hammond. For example, Mrs. Geraldine Young recently forwarded to us a copy of a letter she had written to the Hammond Administrator which detailed that her profoundly retarded 26-year-old nephew, Vince L., has been beaten on the head, hit in the eye, bitten, and scratched on the neck while residing at Hammond.10/ She enclosed a copy of a formal Hammond investigation that confirmed that a bite to Vince's right shoulder by another client was due to neglect and was the result of "poor judgment" on the part of Hammond staff in allowing a more aggressive resident to attack Vince.11/ Even with this admission of neglect, Mrs. Young indicated to us that she believes the Hammond investigation is cursory and incomplete because it did not remedy the underlying problem.12/ Mrs. Young enclosed disturbing photographs of Vince with knots, bumps, bruises, and scars all over his body, and also attached a scribbled note that said "Please help us!"

Just this year, Vince has suffered from persistent episodes of agitation, and "out of control" behaviors that have often led

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9/ Workers Suspended in Abuse Probe; Four Cases Involve Disabled Clients, The New Orleans Times-Picayune, Oct. 11, 1996, at A3.

10/ Letter from Geraldine Young to Leonard J. McCaffery, Jr., Administrator, Hammond Developmental Center, July 18, 1996, at 1.

11/ Memorandum and Case Determination from Leonard J. McCaffery, Jr., Administrator, Hammond Developmental Center, to Geraldine Young, June 26, 1996, at 2.

12/ Telephone interview with Geraldine Young, July 2, 1996.

to his being placed in restraints.13/ Hammond documents reveal that "Vince frequently runs off or has to be physically controlled by staff; the episodes are very severe and represent a significant danger to himself and others."14/ During a two month period alone this year, Vince suffered from fourteen episodes of physical aggression, attempted to elope from the facility sixteen times, stole food five times, engaged in inappropriate sexual behavior and sexually aggressive behavior, and destroyed property.15/

b. Paula K.

Rose Anne Kliebert, mother of Paula Ann, a 23-year-old Hammond resident, told us that Paula suffers from severe aggressive behavior for which she does not receive any real programming, but is instead overmedicated with psychotropic medication.16/ Mrs. Kliebert and her husband recently wrote us that "[o]ur child is not getting the quality of care she needs and is not being protected from harm."17/ The Klieberts added that "[o]ur child has been restrained excessively ... and has sustained injuries requiring stitches as a result ... [o]ur child has not had an effective behavior program ... [c]onsultants' recommendations have not been implemented relating to a behavioral program ... [c]hemical restraints and psychotropic medications have been utilized in lieu of an effective behavioral program."18/ The Klieberts have also written to the Hammond Administrator expressing their concerns: "Paula was placed in restraints [at Hammond] and sustained a head injury requiring stitches due to the fact she was restrained in an unsafe manner. She was restrained in a bed with a bookcase headboard and during her resistance of the restraints cut her head."19/

13/ Hammond Client Record for Vince L., Service Areas and Service Objectives, June 15, 1996, at 1, 2.

14/ Id. at 1.

15/ Id. at 3.

16/ Telephone interview with Rose Anne Kliebert, June 3, 1996.

17/ Letter from Rose Anne and Paul Kliebert to Richard Farano, June 15, 1996, at 1.

18/ Id.

19/ Letter from Rose Anne Kliebert to Leonard J. McCaffery, Jr., Administrator, Hammond Developmental Center, Dec. 12, 1995, at 1.

Hammond documents clearly reveal that the facility has routinely placed Paula in mechanical restraints for hours at a time each day.20/ In a period of one day alone, Paula was restrained five times for a total of nine hours and forty-five minutes.21/ The following day she was restrained twice for a total of eight and a half hours, with only one fifteen minute break between sessions of restraint.22/ Paula's restraint logs from June through December 1995 reveal thirteen separate incidents of restraint for four hours or more in one day.23/

A May 1996 psychological evaluation of Paula, conducted at Hammond, revealed that "Paula exhibits aggressive and disruptive behavior that has resulted in multiple incidents of mechanical restraint over the past year ... [i]f Paula is not calm after two minutes of the hold, she is then placed in mechanical restraints ... Paula's maladaptive behavior in addition to the physical effort required to restrain her has resulted in numerous staff injuries as well as injury to Paula."24/ The evaluation also clearly indicates that Hammond has placed Paula in emergency chemical restraints simply because staff members have failed to adequately and appropriately treat her maladaptive behaviors.25/

Mrs. Kliebert indicated that she has repeatedly lobbied the Hammond Administrator to obtain more and better services to help her daughter, but that his response always is that he does not have the resources to implement what is needed.26/

c. Tammy H.

William and Sandra Holtman, parents of Tammy, informed us that they had recently removed their daughter from Hammond

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20/ Letters from Shirley M. Brumfield, MSW, BCSW, Social Worker Supervisor at Hammond, to Mr. and Mrs. Kliebert, Jan. 8, 1996, Dec. 7, 1995, Nov. 28, 1995, Sept. 12, 1995, and June 29, 1995.

21/ Letter from Brumfield to the Klieberts, June 29, 1995, at 1.

22/ Id.

23/ Letters from Brumfield to the Klieberts, June 1995 - Jan. 1996.

24/ Psychological Evaluation of Paula K., Hammond Developmental Center, May 16, 1996, at 1.

25/ Id.

26/ Telephone interview with Rose Anne Kliebert, June 3, 1996.

because of their concerns for her physical safety. Mrs. Holtman told us that she and her husband began to feel like they were accomplices in harming their daughter by leaving her in the institution for so long.27/ Mrs. Holtman told us that Hammond programs are not being fully implemented, and that generally, Hammond is "doing a half-assed job" and setting itself up for failure.28/ She said all the psychologists at Hammond are "poor," and that the staff members are "abusive."29/ She said that the Hammond Administrator knows that abuse and neglect are occurring at Hammond, but that he continues to do nothing about it.30/ Mrs. Holtman said he lies all the time, telling parents what he thinks they want to hear. As a result, she said the residents are "caught in the middle."31/

The Holtmans wrote us a compelling letter alleging abuse and neglect at Hammond.32/ The Holtmans indicated that Hammond staff failed to implement Tammy's Individual Program Plan and that as a result, they were forced to watch their daughter regress.33/ Mrs. Holtman tried to work for change by serving on the Hammond Human Rights Committee, but as she stated, "I was in shock the first few meetings and since then I have moved through a covey of emotions coming to my current state of anger at the situations the residents of [Hammond] are in. Anger at the seeming helplessness of the Administration at [Hammond] to correct the inadequacies and deliberate actions that violate the

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27/ Telephone interview with Sandra Holtman, July 19, 1996. The information furnished by the Holtmans is particularly significant, because Mr. Holtman was initially reluctant to come forward with any information. The positive relationship we established with Mr. Holtman during the Pinecrest investigation helped de-escalate tensions, calm his unfounded fears and incredibly, turned him into an ally who is now furnishing us with information that would enable us to investigate Hammond.

28/ Telephone interview with Sandra Holtman, July 19, 1996.

29/ Id.

30/ Id.

31/ Id.

32/ Letter from William H. and Sandra L. Holtman to Richard Farano, June 18, 1996, at 1.

33/ Id.

civil and human rights of the individuals who live at Hammond."34/

Mrs. Holtman added that "[w]e have tried working through the 'proper channels' to make necessary changes, but the slight changes these time consuming efforts make will never change the whole picture to make [Hammond] a place where the individuals who live there are free of abuse and neglect on a daily basis. Our endeavors alone will never change the apathy that exists among many of the professional and direct care staff and administration towards the lack of residents' needs being met."35/ Mrs. Holtman indicated that the corrective actions taken at Hammond in response to her many allegations of abuse and neglect are "ineffective and meaningless."36/

Mrs. Holtman explained that other issues such as improper cleaning of clothes and hair, haphazard regulation of heat and cold, ignoring unsanitary conditions, "set the foundation for greater abuse and neglect by direct care staff."37/ She added that the Hammond administration "allows" staff to treat the residents in a "demeaning manner."38/ Mrs. Holtman also indicated that she suspects the staff caused many of the "major" unexplained bruises her daughter suffered while at Hammond.39/ She has personally witnessed staff speaking to residents in an abusive manner.40/

The Holtmans attached a number of Hammond documents that confirm some of their fears. One document acknowledges that Hammond staff had neglected to supervise the residents properly,

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34/ Id. at 2.

35/ Id.

36/ Id.

37/ Id. at 4.

38/ Id.

39/ Id. at 4 ("[t]he major bruises she began having were large indicating an impact other than bumping into something and in areas unusual for her to have bruises ... we would inquire [of the Hammond staff] how the bruise happened and no one knew").

40/ Id.

and another admits that staff had neglected to properly document behaviors in a resident's chart.41/

d. Other Hammond Clients

The Holtmans, along with the family members of five other Hammond clients, wrote a letter to the Hammond Administrator to express their "concerns regarding the physical safety, the emotional well-being, the human dignity and the civil rights of our children/siblings while they are in residence at Hammond."42/ The family members also indicated that "certain chronic events have caused us to conclude that [Hammond] policies and procedures designed to protect our interests are at best inadequate."43/ The family members also stressed that they resented the "contemptuous attitude of indifference to the mistreatment of [Hammond] residents by some staff ... [w]e cannot and will not tolerate the exposure of our 'defenseless loved ones' to individuals who exhibit such an attitude and who react to non-compliant behavior outbursts with abusive actions."44/ The family members continued: "We strongly believe that the apathy by some staff toward the abuse/neglect of clients is deep-rooted and is partially the result of lenient disciplinary policies ... employees who are known to be abusers have been allowed to continue to work directly with clients who can neither defend themselves from physical and verbal abuse nor report the abuse/neglect to the appropriate authorities."45/

III. Hammond-Commissioned Safety Review Reveals Deficiencies

A May 1996 safety and environmental report commissioned by Hammond indicates, among other things, that:

* many of the incidents involving the clients on the units, including those involving abuse and neglect, are not reported;

41/ Memorandum and Case Determination from Leonard J. McCaffery, Jr., Administrator, Hammond Developmental Center, to Bill Holtman, Oct. 20, 1995, at 2; Memorandum and Case Determination from McCaffery to Sandra Holtman, Nov. 3, 1994, at 2.

42/ Letter from Hammond parents to Leonard J. McCaffery, Jr., Administrator, Hammond Developmental Center, Oct. 27, 1995, at 1.

43/ Id.

44/ Id.

45/ Id.

* there are still a large number of "unexplained" injuries at Hammond;

* over two dozen different clients were recorded as having been placed in mechanical restraints;

* the frequency in the use of restraints on a number of clients is quite large; and

* the Hammond direct care staff members speak casually about the common and chronic use of restraints.46/

IV. The State of Louisiana Fails to Provide Hammond Residents with Services in the Least Separate, Most Integrated Setting

In most cases, the facility is failing to appropriately assess whether or not the individual Hammond residents are currently situated in the most integrated setting appropriate to meet their individualized needs. Even where professionals have determined that a Hammond resident would benefit from placement in a less restrictive setting, the State is failing to implement these professional determinations. As a result, many Hammond residents who are suitable for community placement continue to be isolated from the rest of society. The State's failure to assess Hammond residents and to implement professional judgments about community placements raises issues about potential ADA and Section 504 violations.

CONCLUSION

Based upon the Medicaid decertification of Hammond which is currently in progress, the concern about deficiencies conveyed to us by legal counsel for Louisiana, and information provided by parents of Hammond residents, we recommend immediate initiation of a CRIPA investigation of Hammond. The information gathered thus far indicates that the inadequate conditions at Hammond deprive residents of their constitutional and statutory rights. Funds are available to conduct this investigation.

Approved: lk for DLP 12/18/96

Disapproved: _____

Comments:

46/ Report on incident management, abuse, neglect and investigatory practices at the Hammond Developmental Center, Antone Aboud, Ph.D., Labor Relations Alternatives, Inc., May 6, 1996, at 6-9.