Memorandum

AEP:VH:PSL:pmw
DJ 168-49-7

Subject
Recommendation to Investigate Los Lunas Hospital and Training School, Los Lunas, New Mexico

Date
JAN 13 1987

To
Wm. Bradford Reynolds
Assistant Attorney General
Civil Rights Division

From
Arthur E. Peabody, Jr.
Chief
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Introduction

Pursuant to the Civil Rights of Institutionalized Persons Act, (CRIPA) 42 U.S.C. §1997-1997j, we recommend initiation of an investigation into conditions of confinement at the Los Lunas Hospital and Training School in Los Lunas, New Mexico. The information which we have compiled indicates a pattern or practice of egregious or flagrant conditions which violate the constitutional rights of the persons residing at Los Lunas. These practices include inadequate medical care, misuse of medications, abuse of residents, neglect of residents, improper food services, inadequate numbers of qualified staff, substandard physical conditions and the denial of minimally adequate training required by Youngberg v. Romeo, 457 U.S. 307 (1982). These practices continue at Los Lunas despite the fact that the Health Care Financing Administration certified Los Lunas in October, 1986. 1/ However, certification came after the institution failed to meet HCFA standards following two prior inspections. 2/

Background 3/

The Los Lunas State Hospital was established in 1925 by the New Mexico State Legislature to care for "mental defectives" and received its first patient in 1929. In 1955 the legislature

1/ Albuquerque Journal, Oct. 30, 1986 at A3. Although HCFA certification might be considered prima facie evidence of a facility's adequacy, certification does not conclusively determine whether a facility meets all constitutional standards. See, Woe v. Cuomo, 729 F.2d 96 (2nd Cir. 1984), cert. denied, 105 S. Ct. 339 (1984).

2/ Albuquerque Journal, Oct. 30, 1986 at A3.

3/ Id. All the information in the Background section comes from this source.

expanded the scope of the hospital's responsibilities by adding a training school for "trainable mental defectives." In the same session, the hospital was also opened to those who were bedridden and needed 24-hour supervision and care. Currently, the facility serves approximately 350 severely mentally retarded and physically handicapped patients. The hospital has about 650 employees.

Sources of Information

We have obtained our information from various sources including an Executive Summary of a Task Force Report compiled by the New Mexico Health and Environment Department (HED), the Albuquerque Office of Protection and Advocacy (P and A), a series of local newspaper articles, telephone interviews with a former Protection and Advocacy attorney, Betsy Church, a former Los Lunas Special Education Director, Paul Wirth and a professor at the University of New Mexico in Albuquerque, Ruth Luckasson. Various other local attorneys were also contacted.

Factual Allegations

The information we obtained indicates that numerous deficiencies exist throughout the Los Lunas Hospital and Training School. Recently, Los Lunas was the defendant in a New Mexico state court lawsuit brought by local attorneys on behalf of 45 residents of one cottage at the facility in which two deaths and one rape occurred in September, 1986. On October 29, 1986 a New Mexico District Court Judge, following three days of closed-door testimony, ruled that Los Lunas has failed to properly care for its residents. 4/ Valencia County District Court Judge Tibo Chavez ruled Los Lunas has failed "to provide the level of medical care required by law and some patients have been abused and neglected." 5/ Following the ruling Judge Chavez forbade any of the attorneys or Los Lunas staff members involved to reveal specifics about the testimony. 6/

The hearing which produced the ruling followed a series of incidents, including the rape and death of a 19-year-old female resident in September. 7/ Hospital administrators, members of

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4/ Id. at p. 1.

5/ Id.

6/ October 30, 1986 telephone conversation with P and A attorney Ann Harvey.

7/ Albuquerque Journal, Oct. 30, 1986 at p. 1.

the medical staff, at least five other hospital employees and parents of residents of Los Lunas testified at the hearing. 8/ Judge Chavez ordered increased security at the hospital, independent medical examinations for residents to screen for abuse and required Los Lunas staff to notify a resident's attorney of any abuse reports. 9/ Despite the fact that Judge Chavez's order appears to be in the best interest of Los Lunas residents, HED is bitterly opposing entry of the order. Following the hearing, HED asked the New Mexico Supreme Court for a Writ of Prohibition, challenging the District Court's jurisdiction to enter the order. On December 10, 1986 the Supreme Court denied HED's request. 10/

The next day, December 11, 1986, HED filed notice with the state appellate court that it will formally appeal the Chavez ruling. 11/ While the appeal process continues, HED refuses to proceed with medical tests to determine whether residents have sufffered any mental, physical or sexual abuse. 12/ Local attorneys expect the appeal process to take over a year, 13/ during which time the Chavez order is automatically stayed and Los Lunas residents will be subjected to continuing deprivations of their constitutional rights.

Thus, the fact that a New Mexico state court judge has sought to alter certain procedures at Los Lunas should not preclude a CRIPA investigation for several reasons. First, the Chavez order is limited in its scope. The order does nothing to address problems of inadequate medical care, misuse of medication, improper food services, inadequate numbers of qualified staff, substandard physical conditions, and the denial of Youngberg training. 14/ Second, the order pertains to only 45 Los Lunas residents, all of whom reside at the same cottage. The order does not pertain to the majority of Los Lunas patients. Over

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8/ Id.

9/ Harvey interview.

10/ Albuquerque Journal, Dec. 11, 1986 at p. 1.

11/ Albuquerque Journal, Dec. 12, 1986.

12/ Id.

13/ Id.

14/ See infra pps. 4-10 and accompanying notes.

300 residents are excluded from the protection offered by the Chavez order. Third, as noted earlier, the appeal process is expected to take over a year and there is, of course, no guarantee that the Chavez order will survive appeal. Fourth, the state has shown its animosity toward instituting any of the reforms covered in the Chavez order by opposing entry of the order and refusing to proceed on its own with matters suggested by the Chavez order, such as the independent medical examinations to screen for abuse. Finally, our sources have stated that there is some question as to whether the court order would be fully and effectively implemented and whether there would be sufficient local resources available to be continually seeking enforcement of the Chavez order. 15/

The abuse, neglect and lack of proper medical care cited by Judge Chavez as well as the existance of other conditions at Los Lunas, including the lack of minimally adequate training required by Youngberg, deprive Los Lunas residents of their constitutional rights under the Due Process Clause of the Fourteenth Amendment. 16/

I. Abuse

Los Lunas residents are being subjected to physical and sexual abuse from staff and fellow residents. Judge Chavez, in his October 29, 1986 ruling said, "I have found that Mark Delgado, the director of the institution, has instituted reforms which will correct deficiencies. Not withstanding the tightening of the procedures, I also found there has been abuse and neglect of certain residents." 17/

15/ Telephone interviews conducted with Betsy Church, December 2, 1986 and Ruth Luckasson, December 15, 1986.

16/ See, Youngberg v. Romeo, 457 U.S. 307 (1982). Youngberg held the Fourteenth Amendment's liberty interest protects the right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints and such minimally adequate training as reasonably may be required by these interests.

17/ Albuquerque Journal, Oct. 30, 1986 at p. 1.

Judge Chavez's ruling came on the heels of two deaths at the hospital. As noted earlier, a 19-year-old female resident died September 26, 1986. She had been raped two days earlier and died as a result of internal wounds. 18/ A 27-year-old male patient died at the facility the same day the woman died, September 26, 1986, when he choked to death. 19/ The New Mexico State Police, the Valencia County District Attorney's Office and the New Mexico Health and Environment Department are investigating the deaths, but no charges have yet been filed. 20/

There have been six other deaths at the hospital before those in September and three of those deaths occurred at the same cottage (Bashein) as did the September deaths. 21/ One other patient at the cottage received head wounds and three others received puncture wounds in August and early September. 22/

Ms. Luckasson described Los Lunas as a "terrible, vindictive place." 23/ Many Los Lunas patients who require a blended diet are often fed simply ground-up garbage by the kitchen staff. 24/ Staff will feed patients "by filling their mouths with mush, throwing a towel over their faces and holding their heads back." 25/ The tremendous danger such a feeding procedure possesses to medically fragile or immobile patients who experience difficulty in chewing and swallowing is obvious. This feeding procedure is medically unacceptable for the type of patients residing at Los Lunas.

18/ Id. at A3.

19/ Id.

20/ Albuquerque Journal, Oct. 30, 1986 and Harvey interview.

21/ Id.

22/ Id.

23/ Luckasson interviews.

24/ Id.

25/ Id.

Los Lunas residents are also denied prompt and appropriate medical care due to the callousness of staff physicians. In one instance, a patient had slipped and fallen, knocking out several of his front teeth. The patient was taken to the staff doctor who said the patient "doesn't need those teeth. Anyway, mentally retarded people don't feel anything." 26/ The patient went unattended all day and, at the evening meal was fed hot cereal, causing the patient to begin screaming in pain. A university student working part-time at the hospital eventually took the patient in the student's own car to a local doctor. 27/

The September rape and death of the 19-year-old woman drew a good deal of local media attention. However, many more rapes take place at the facility than ever draw notice. 28/ The attitude of the staff is to "look the other way" when it comes to client-on-client rape or homosexual rape. 29/

Ms. Church told a Section attorney that Los Lunas residents are "definitely being abused." 30/ She said one resident, George Chavez, who is afflicted with Parkinson's Disease, has been "abused and beaten" by the staff in the year he has been there. 31/ Another instance involved the parents of one resident who became concerned that their child was being overmedicated and possibly sexually abused. The boy had been transferred to Los Lunas from a boys' home where he was being sexually abused. For a time the boy's behavioral problems abated but resurfaced later indicating a recurrence of abuse. The boy developed patterns of rectal bleeding, indicating he was again being sexually abused. 32/

26/ Id.

27/ Id.

28/ Id.

29/ Id.

30/ Church interview.

31/ Id.

32/ Id.

Not only are Los Lunas residents being physically and sexually abused but patients are often simply neglected by staff. One summer day several non-ambulatory patients were discovered sitting on the concrete outside one of the cottages. Besides being on the hot concrete, the patients were "covered with flies." 33/

II. Staffing

Los Lunas has an inadequate number of trained and qualified staff to provide the proper levels of care and services to hospital residents. The HED Task Force noted staffing shortages in several areas of the institution. 34/ The Report's Executive Summary states the shortage "was determined to be especially acute in the direct care areas where the turnover rate is very high, salaries are low, absenteeism is high, and there is an excessive amount of overtime work and double shifting." 35/ The Summary also notes staff shortages in Psychological Services, in the Housekeeping and Dietary Departments and cites "[s]evere problems of recruitment and retention in professional specialities such as Physical Therapy. 36/ The Task Force also determined staff training at all levels to be of inadequate quality and quantity. 37/

Ms. Church described Los Lunas as having an "incredible staff shortage." 38/ This shortage results in a variety of dangerous conditions to patient health and well-being. Staff will often feed patients too quickly in order to feed all

33/ Luckasson interview.

34/ The Los Lunas Task Force was appointed during the first week of October, 1984 by former HED Secretary Joseph Goldberg. The nine-member Task Force issued its Report December 12, 1984. The Special Litigation Section received a copy of the Report from an attorney at the Albuquerque Protection and Advocacy Office.

35/ Id.

36/ Id.

37/ Id.

38/ Church interview.

patients within a given time, thus exposing medically fragile patients to the unacceptable risks involved in not having sufficient time to intake and digest food. 39/

The lack of training for staff at Los Lunas also leads to an overuse of undue bodily restraints which is caused primarily by the lack of a qualified staff. The staff is also insufficient to provide basic care. For example, there is a "severe lack" of physical therapists at the facility. 40/ Bed-ridden patients will often develop painful contractures and will lose use of limbs because "there is no one to train the staff in what to do with bed-ridden patients." 41/ As a probable result of an under-trained staff, two mentally retarded men were mistakenly served oven cleaner instead of fruit juice in October, 1985. 42/

The lack of staff numbers has also created unsanitary conditions at the facility. Los Lunas has been described as a facility where the "whole place reaks of urine and patients are frequently lying around in dirty diapers." 43/ Thus, the lack of adequately trained staff poses an ongoing and continuous danger to the health and safety of Los Lunas residents.

III. Medications

Patients at Los Lunas are improperly and overly medicated. The approach to medication is a "shotgun method." 44/ Ms. Church stated that staff will "try a little of this and a little of that; some Valium, some Thorazine." 45/ Thus, there is a substantial question whether medication is being prescribed and monitored consistent with the exercise of professional judgment.

39/ Id.

40/ Id.

41/ Id.

42/ United Press Internal, October 8, 1985. Southwest Regional News Briefs. An Albuquerque private attorney, Lynn Eby, represents the two patients fed the oven cleaner and expects to bring a suit on their behalf in the near future.

43/ Church interview.

44/ Id.

45/ Id.

The heavy use of drugs at Los Lunas is in lieu of training and is done strictly "for the convenience of the staff. What you have is basically a bunch of drugged people sleeping all day." 46/ Numerous parents have approached the Protection and Advocacy Office concerned about the effects drugs were having on their children. Cases of Tardive Dyskinesia, the result of an over-use of psychotropic drugs, also exist at the facility. 47/

The medication review procedure is also abused at Los Lunas. Staff physicians are supposed to review patient medication every 30 days. However, these reviews often amount only to a nurse rewriting an order and a doctor initialing the order or the nurse forging the doctor's initials. 48/

IV. Training

Los Lunas residents are not provided sufficient training to protect their Youngberg established rights to the minimal training necessary to ensure a reasonably safe environment and freedom from undue bodily restraint. Mr. Luckasson told Section personnel that there was no programming to deal with the behavioral or emotional problems of the mentally retarded. 49/ For example, there is nothing done to assist residents with problems such as sleep disorders and thus a patient's health will deteriorate. 50/ Ms. Church stated that there was "absolutely no training going on." 51/ Paul Wirth, a former director of education at Los Lunas, agreed with our other sources that the lack of training for the residents directly contributed to the use of undue bodily restraints and created conditions posing undue risks to the physical safety of residents. 52/

46/ Id.

47/ Id.

48/ Church interview and Luckasson interview.

49/ Luckasson interview.

50/ Id.

51/ Church interview.

52/ Telephone interview with Paul Wirth conducted December 3, 1986. Mr. Wirth resigned from Los Lunas in July, 1985. He has worked there for three and one-half years prior to his resignation.

Wirth stated that, during his tenure, the most training any Los Lunas resident received was during the daytime hours of the facility's 190-day school year for those residents under 21 years of age. 53/ However, nothing is done for any resident after school hours. 54/ There are no programs and no activities for the residents after school hours. 55/ Compounding these problems is again the lack of adequately trained staff and the lack of any coordinated efforts between teachers and direct care staff. 56/

Thus, the lack of training afforded Los Lunas residents violates their rights established in Youngberg by not providing the minimal training necessary to ensure a reasonably safe environment and freedom from undue bodily restraints.

Conclusion

Conditions at Los Lunas Hospital and Training Center subject residents to deprivations which violate their Constitutional rights under Youngberg. We believe that the facts stated above show a facility which poses a substantial risk to the safety of its residents, and justifies an investigation of the facility. Therefore, we recommend that an investigation of Los Lunas be instituted under our CRIPA authority.

Accordingly, we have attached for your signature the appropriate letters notifying state and federal officials of our intented investigation.

Approved: JBR 1-14-87

Disapproved: _____

Comments: We should begin an investigation, but the existance of state proceedings suggests some degree of recognition of the problem. We should, therefore, confine our attention to areas not the subject of the state court proceedings and should lean, to the fullest extent possible, on local enforcement efforts. JBR

53/ Id.

54/ Id.

55/ Id.

56/ Id.