U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

NOV 26 1991

REGISTERED MAIL
RETURN RECEIPT REQUESTED

Honorable Robert Casey
Governor
Commonwealth of Pennsylvania
Governor's Executive Office
Room 225
Main Capitol Building
Harrisburg, Pennsylvania 17120

Re: Notice of Findings Regarding Embreeville Center, 42 U.S.C. § 1997b

Dear Governor Casey:

I am writing in reference to this Department's investigation of the Embreeville Center ("Embreeville"), Coatesville, Pennsylvania, pursuant to authority granted by the Civil Rights of Institutionalized Persons Act ("the Act"), 42 U.S.C. §1997 et seq. As described below, our reevaluation of Embreeville conducted during a tour of April 4 and 5, 1991 and review of materials received subsequent to that tour disclosed that unconstitutional conditions persist at the facility.

In February 1990, we notified the Commonwealth of Pennsylvania that conditions at Embreeville violated the constitutional rights of mentally retarded and developmentally disabled persons who live there. Preliminary negotiations to address these conditions commenced. However, in November 1990, the Commonwealth advised us that it would not enter into a judicially enforceable agreement concerning facilities administered by the Office of Mental Retardation. That position precluded any further negotiations. Consequently, in order to ascertain whether the unconstitutional conditions cited in our February 9, 1990 findings letter had been remedied, we retoured Embreeville with two independent consultants, a physician and a psychologist. Regrettably, this tour disclosed that the following longstanding constitutional violations continue:

1. Training and behavioral programs at Embreeville do not reflect the exercise of judgment by a qualified professional. They are not individualized, do not address particular resident's needs, and many programs actually strengthen the dangerous behaviors they are designed to eliminate. The deficiencies in development and implementation of the training and behavioral programs are a consequence of inadequate numbers of adequately trained psychologists and direct care staff. (See February 9, 1990 letter at p. 2-3);

2. Embreeville staff overuse and misuse psychotropic medication to control the behavior of residents. Psychotropic medication is used for the convenience of staff and in lieu of training programs. This use constitutes undue chemical restraint. (See February 9, 1990 letter at p. 3); and

3. There is a critical shortage of nurses which compromises the medical care provided to Embreeville residents. (See February 9, 1990 letter at p. 4).

In addition, the April 1991 tour and our subsequent review of documents disclosed other areas in which residents of Embreeville are being subjected to unconstitutional conditions of confinement. We found that the following additional conditions subject Embreeville residents to undue risks of harm.

1. Embreeville residents receive inadequate medical care.

Medical care provided to Embreeville residents does not meet professional standards. Our medical consultant found inadequate recognition of medical emergencies and inadequate and delayed responses to such emergencies. At times, these failures have contributed to residents' deaths. For example, we found that there was a 13 minute delay from the time that a resident was noted to have suffered cardiac and respiratory arrest until the time that a physician was notified. That delay was followed by an additional 10 minute delay for the physician and paramedics to arrive. Our consultant concluded that these delays contributed to the resident's untimely death.

Embreeville's one part-time psychiatrist has insufficient time to monitor medications, interact with staff, and examine residents. Many residents do not receive psychiatric follow up or consultation on a timely basis. Complications that may result from administration of psychotropic medications are not adequately documented nor responded to, e.g., inadequate attention and response to positive signs of tardive dyskinesia. These deficiencies harm many residents suffering from psychiatric illnesses.

Our investigation revealed that there is inadequate follow up to consultants' recommendations for specialized tests or

changes in treatment. For example, a neurologist's order for a Magnetic Resonance Imaging (MRI) study was not acted upon for more than two years. The predictable result of such delays is unnecessary risk of harm to Embreeville residents.

2. Embreeville residents are subjected to abuse and neglect.

It is our understanding that the Embreeville administration has recognized that there is a serious problem of abuse and neglect at the facility and has initiated efforts to address this critical issue. However, our investigation confirms that there are inadequate controls to identify and remedy what appears to be a systemic problem at Embreeville.

As was widely reported in the press and was also revealed in documents provided us by Embreeville, an undercover agent working at Embreeville for some nine weeks in 1991 personally observed eight incidents of abuse or neglect of residents in just this brief period of time. Embreeville took immediate action to discipline all employees so identified. However, it is disconcerting to note that none of those incidents came to the attention of Embreeville through its normal reporting channels, even though a number of additional incidents were reported and investigated during that time period. We have concluded that Embreeville's internal control system of incident reports and abuse investigations is simply not effective in uncovering and addressing abuse and neglect at the facility. The direct consequence of that failure is harm to residents.

We have previously informed counsel of our desire to resolve the problems existing at the facility through a judicially enforceable agreement. However, the Commonwealth remains unwilling to negotiate or enter into any such agreement.

In our February 9, 1990 findings letter, we recommended remedial measures aimed at correcting the unconstitutional conditions discovered by the Department and its experts. In light of our findings regarding inadequate medical care and abuse at Embreeville, we must advise you that remedial measures to eliminate the additional deficiencies identified in this letter should be taken immediately. Such measures are:

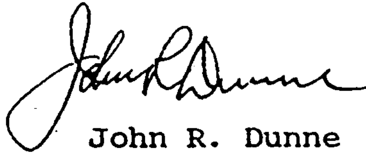
a) The State must provide adequate medical care to Embreeville residents, including adequate management of medical emergencies, appropriate monitoring of residents who suffer from psychiatric illnesses, and timely response to consultants' recommendations for specialized tests or treatments.

b) The State must not abuse or neglect Embreeville residents and must establish a system to assure that

allegations of abuse and neglect are investigated thoroughly and that appropriate action, commensurate with the nature of the offense, is taken against anyone who inflicts, condones, or fails to report abuse or neglect.

If you or your staff have any questions, or better, desire to enter into negotiations leading to a consent decree, do not hesitate to contact Arthur E. Peabody, Jr., Chief, Special Litigation Section, (202) 514-6255.

Sincerely,



John R. Dunne
Assistant Attorney General
Civil Rights Division

Enclosure

cc: Honorable Ernest D. Preate, Jr.
Attorney General
Commonwealth of Pennsylvania

Mr. John F. White, Jr.
Secretary, Department of Public Welfare

Mr. Reuben Shonebaum
Director, Embreeville Center

Michael M. Baylson, Esq.
United States Attorney
Eastern District of Pennsylvania