Memorandum

U.S. v. Tennessee
MR-TN-003-002

AEP:BPS:SGB:eh
DJ 168-72-30

Subject	Date
Arlington Developmental Center Proposed S. 10 Investigation	JUN 18 1990

To	From
John R. Dunne Assistant Attorney General Civil Rights Division	Arthur E. Peabody, Jr. Chief Special Litigation Section

Pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §1997 et seq., we recommend the initiation of an investigation into the conditions of confinement at Arlington Developmental Center (Arlington). Arlington is a residential facility for the mentally retarded operated by the Tennessee Department of Mental Health and Mental Retardation. The facility, located in Arlington, Tennessee, was established in 1965. It serves mentally retarded adults and children and has a capacity of 490 beds. As of April 27, 1990, there were 470 residents.

The information that we have obtained contains allegations which indicate that residents of Arlington are being subjected to conditions that violate their constitutional rights. The alleged unconstitutional conditions include: abuse and neglect of residents; undue use of restraints and isolation; absence of training programs; unsafe and unsanitary conditions; and undue risk of harm from physical violence and fire hazards. These deficiencies appear to subject residents at Arlington to unreasonable risks to their personal safety and violate their constitutional rights. See Youngberg v. Romeo, 457 U.S. 307 (1982).

Sources

We were contacted in this matter by the United States Attorney for the Western District of Tennessee, W. Hickman Ewing, Jr., who asked us to look into conditions at Arlington because of numerous reported incidents of mistreatment and abuse. Mr. Ewing informed us that Tennessee State Representative David Shirley had requested his assistance after having received a number of complaints from parents of residents at Arlington and from past and present employees.

Representative Shirley stated that employees are fearful that retaliatory actions will be taken against them. Based upon that fear, the United States Attorney initially requested that

we delay interviewing anyone until a proposed Tennessee whistleblower statute was enacted. Soon after the statute was passed, Mr. Ewing contacted our office to request that we meet with Representative Shirley and several of the Arlington employees and parents. Interviews were held on April 17, 1990 in Memphis, Tennessee. 1/ We also reviewed the Federal Bureau of Investigation's (FBI) file that focused, in part, upon physical and sexual abuse of residents at Arlington. 2/

Based upon the information we received from our sources, we recommend an investigation focused on (1) neglect and abuse of residents, (2) misuse of restraints and seclusion, (3) inadequate staff training, (4) health and safety deficiencies, and (5) fire code violations.

Information Relating to a Failure to Protect Residents from Harm

Every person interviewed reported that a number of the DTs, the direct care staff at Arlington, routinely physically abuse residents. All employees interviewed stated that injuries are often reported as having been inflicted by other residents,

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1/ The following persons were interviewed: Representative Shirley; Mary Simpson, a DT; Victoria Moore, a parent; Laverne Franklin, a former DT who was fired by the previous Director; Rose Morrell, a DT supervisor; Frances McMahan, a registered nurse; Rose Flynn, the Head of Security; Mrs. (first name unknown) Flynn, a DT trainer; and a parent who requested confidentiality whose child has been a resident of Arlington for more than 20 years and who has been quite active with its Parents' Association, who is identified throughout the memorandum as "Parent."

2/ The FBI file, 144-72-1569 (FBI Report) was closed by the Criminal Section of the Civil Rights Division on November 27, 1989, based upon a decision that the case had "no prosecutive merit." The FBI's investigation was predicated upon a complaint by Karen Conner, a DT at Arlington, of ongoing physical and sexual abuse of residents by DTs. A decision to initiate an investigation under CRIPA is based upon a different standard than a decision to initiate a criminal prosecution. We note that a number of the allegations that were brought to our attention by the United States Attorney, Representative Shirley, and the witnesses we interviewed are confirmed by FBI interviews with a different set of witnesses. FBI Report, interviews with Karen Conner, a DT; Nita Greene, sister of a resident; Peggy Perkins, parent; Rebecca Searight, parent.

rather than by the employees who actually inflicted them. 3/ Additionally, the employee whose complaint initiated the FBI investigation stated that physical assaults are "covered up" by nurses and doctors who are "afraid" of the administration. 4/ All employees whom we interviewed believe that, if they were to report staff abuse of residents, they would be fired. At least one employee was apparently fired for reporting abuse. 5/ A parent reported that her child had been "tortured" after she reported abuse and that to protect her son she paid the abuser and apologized for having accused him. 6/ This parent and some

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3/ Injuries inflicted by residents upon one another may indicate that the level of care and supervision in a facility is inadequate: If the injury reports demonstrate that a large number of injuries are the result of residents attacking other residents, that may well signify that Arlington is failing to protect its residents from harm as well as failing to provide training programs. Such a failure to provide reasonable safety in and of itself could constitute a constitutional violation, even in the absence of widespread staff abuse of residents.

4/ FBI Report, memorandum of July 20, 1988 telephone conversation with Ms. Conner, supra.

5/ Ms. Franklin's complaint of a retaliatory discharge is presently being litigated. However, it is interesting to note that an internal investigation which approved Ms. Franklin's termination found that:

> While we readily acknowledge that abuse can and does occur at Arlington, we are satisfied that this is kept to a minimum. . . .
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> Ms. Franklin has made unsubstantiated allegations about abuse of residents in Mark Twain II. While her concern for residents may be genuine, her actions have repudiated this concern.

Fact Finding: Arlington Developmental Center, May 28-29, 1985.

6/ Telephone conversation of April 17, 1990, with the parent who requested confidentiality. She stated that when she had been assured confidentiality in the past it had not been honored and her son was later brutalized. She reported that since her meeting with the Governor she is being watched when she visits her son and is often escorted to her car. Staff confirmed that when parents report abuse, the abuse gets worse. Morrell, McMahan, supra. Additionally, the FBI Report included an interview of March 8, 1989, with Ms. Perkins in which she stated that she did not pursue suspected physical abuse of her daughter for fear that retribution would be taken against her child.

employees stated that they had heard that other parents had paid DTs not to abuse their children. 7/

The following are reported examples of abuse related during the interviews:

> A male resident was found dead on the floor of his unit. A number of employees recounted that a DT sprayed him in the face with an aerosol spray in order to control him. They believe that an autopsy was not conducted. 8/
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> In March 1989, a male resident had his jaw broken in two places by a DT. The supervisor who is charged with writing up injury reports requested Arlington's dentist to state that he had broken the resident's jaw while extracting his wisdom teeth. The dentist refused to write such a report. 9/
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> On a number of occasions, DTs placed a female resident into a locked room with high-functioning male residents (residents of the Mark Twain Unit) as a disciplinary measure. Those residents were directed to beat the female resident. They did. 10/ Employees reported that a number of residents have been sent into the Mark Twain unit for "disciplinary reasons," i.e., beatings. 11/ One parent told Representative Shirley that she feared that her son, who is profoundly mentally retarded, would be sent there if she complained. 12/
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> At least two female residents have lost eyes because of physical abuse by DTs. In one of the injury reports, the resident who is identified as having caused the injury to the other resident's eye is non-violent, passive, and apparently not physically or mentally capable of having committed such an assault. 13/

7/ Franklin, Parent, supra.

8/ Simpson, Morrell, McMahan, supra.

9/ Id.

10/ McMahan, Morrell, supra.

11/ McMahan, Morrell, Simpson, supra.

12/ Shirley, supra.

13/ Simpson, Morrell, supra.

> A parent recounted that her 11 year old son has received innumerable bruises and burns at Arlington. When she questioned a DT about one such bruise, she was told it was a "birthmark." Another injury, which she believed was a burn, was explained as having occurred when her son fell over the table and hit the wall. Her son has been found unconscious twice in the two years he has been at Arlington. 14/ Recently, he was beaten with a paddle by a DT. The DT was reported as abusing the child after a social worker overheard a supervisor and the DT discussing how another resident was to be blamed for the assault. The social worker apparently would not allow the fraudulent report to be written and the DT was, therefore, fired. However, neither the mother nor the Sheriff's office was immediately notified, as policy required, of the abuse. 15/

Sexual abuse is present as well. Our sources informed us that DTs have sexually assaulted both male and female residents. 16/ When assaults have been confirmed, the DTs have been transferred to other units rather than being fired. 17/ There were reports of one female resident having been assaulted by two employees who inserted a broom or cane into her rectum. 18/ Additionally, there was a recent report of a sexual assault of a resident by another resident. Both men had been left unattended during their baththimes. 19/

Additionally, there are two deaths not tied to physical abuse which merit concern. In January 1990, a male resident choked to death. Apparently, sunctioning equipment was either not available or was old, obsolete, and useless. 20/ Another male resident was found, during a visit home, to be running a high fever. When his parents brought him to the hospital it was

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14/ Ms. Moore stated that she asked that her son be given a brain scan after each incident. She was informed that there was no need, such tests were only done once a year.

15/ Moore, McMahan, Rose Flynn, supra.

16/ Id.

17/ Morrell, McMahan, supra.

18/ Simpson, Morrell, Franklin, supra.

19/ Rose Flynn, supra.

20/ Simpson, Rose Flynn, supra.

found that he had untreated gangrene or peritonitis of the intestines. He died shortly after admission. 21/

Another type of abuse involved depriving residents of food. One employee related that residents are punished by either withholding a meal or seconds. 22/ The residents' meals are thrown into the garbage in front of them. Another employee confirmed that residents who have been sent to the infirmary often seem to be malnourished. 23/ The above examples of abuse and neglect illustrate that Arlington is failing to protect residents from harm and failing to provide staff with training adequate to enable them to appropriately attend to the mentally retarded residents entrusted to their care.

Information Relating to Misuse of Seclusion and Restraints

While Arlington apparently has appropriate policies concerning the use of seclusion and restraints, i.e., seclusion and restraint are to be used only with a physician's approval and for limited periods of time, we were informed that these policies are not followed. Employees recount stories of residents being locked in closets, tied to wheelchairs with sheets and left in vacant rooms, and placed in garbage cans. 24/

A particularly egregious example of the misuse of seclusion and restraints concerns a seven year old mentally retarded autistic child who, a number of employees stated, has been left, often unsupervised, in a locked room for as long as 24 hours at a time. This room is often bare and at one time was unheated. It sometimes contains a mattress and a few toys. Some employees related that the boy has injured himself (knocked out his front

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21/ Parent, supra. A third death was discussed in the FBI Report, supra, interview with Ms. Perkins, an Arlington parent and a nurse. On one of her visits to her daughter, Ms. Perkins observed the medical treatment of an infant with bronchio-pulmonary displasia. She noted that the infant was receiving oxygen that was not being routed through a mixer. Ms. Perkins stated that without a mixer, there was no way of controlling the oxygen percentage being furnished to the child. She also observed that the infant was not hooked to an oximeter, which measures the percentage of oxygen actually saturating a patient's bloodstream. The infant died a few months later. A nurse told Ms. Perkins that the baby had died as a result of disconnecting herself from the oxygen supply.

22/ Franklin, supra.

23/ Mrs. Flynn, supra.

24/ Franklin, Flynn, McMahan, supra.

teeth) by hitting his face and head against the bare floor or the sink. The child wears a helmet at all times, and sometimes his hands have been swathed in bandages in order that he not injure himself. He has, at times, chewed and mangled his shoulder to the extent that it "looks like hamburger meat." The employees related that he is sent to the room because he is difficult to look after and demands a lot of attention. He screams when placed in the room and quiets down when he is permitted out. 25/ One nurse who became particularly interested in his case and complained to her superiors concerning his treatment has been forbidden to see him except when she is providing him with "nursing services." 26/

Information Relating to Health and Safety Deficiencies

Employees and parents reported a number of apparent health violations, i.e., shortages of toothbrushes, razors, soap, disinfectant. Apparently, prior to State audits such items appear; however, they are not replenished and are often simply put away until the next audit. 27/ A DT reported shaving as many as 18 men for one week with the same razor. 28/ Often the same toothbrush and bathwater are used for a number, if not all, residents in the unit. 29/ A number of residents have been identified as Hepatitis carriers, which increases the health risks to the population when personal items are shared.

There appears to be a general lack of supervision which creates a safety risk for some of the residents. 30/ Our sources report that residents are often uncared for and left unattended,

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25/ McMahan, Morrell, Flynn, Parent, supra. Ms. McMahan also provided us with informal notes that she has taken, often contemporaneously, confirming the events related.

26/ Disciplinary Action, dated 2/6/90, of Frances McMahan.

27/ Parent, Franklin, Simpson, McMahan's notes, supra.

28/ Simpson, supra.

29/ Morrell, McMahan's notes, supra.

30/ Our sources reported that, on certain shifts, there are staff shortages of both nurses and DTs. Additionally, a number of the staff are reputed to drink or take drugs while on duty and have allegedly engaged in sexual misconduct. Parent, Simpson, McMahan, Franklin, Rose Flynn, supra.

sometimes naked, while the DTs watch TV. 31/ One employee reported seeing a resident, who was left unattended at the canteen for more than 20 minutes, eating from a garbage can. She also reported seeing residents wandering about outside during the winter, without shoes and wearing only pajamas. 32/

Information Relating to Fire Hazards

The Head of Security voiced a concern that certain residents, particularly those in the Baker Building, would not be able to evacuate their units in the event of a fire. The infirmary which houses the most physically restricted patients is located on the top floor of the Baker Building, which does not have a fire escape. When a fire occurs, these patients are directed to go to the roof. The sprinkler system has not been tested and the Head of Security (who is also the Safety and Environmental Inspector) is not certain whether that system or the alarms are functional. She has reported these and other safety concerns to her superiors, but it does not appear any follow-up actions have been taken. 33/

Conclusion

Based upon the information received to date, State officials may be subjecting residents at Arlington to conditions that deprive them of their constitutional rights, pursuant to a pattern and practice of resistance to the full enjoyment of their rights. In our opinion, the information we have obtained with respect to conditions at Arlington warrants an investigation, pursuant to CRIPA, into the areas specified above. Funds are available to conduct this investigation.

Accordingly, we have attached for your signature the appropriate letters notifying State and Federal officials of our intent to investigate the Arlington Developmental Center.

Attachments

31/ Parent, Moore, McMahan's notes, supra. FBI Report, supra, March 17, 1989 interview with Ms.Greene in which she complained that DTS are "grossly inattentive."

32/ Rose Flynn, supra.

33/ Rose Flynn, supra.

Approved: J R Dunne

Disapproved: _____

Comments: