IN THE UNITED STATES DISTRICT COURT FILED BY _____ D.C.
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION 94 FEB 18 AM 11:51

ROBERT R. DI TROLIO
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W.D. OF TN, MEMPHIS

UNITED STATES OF AMERICA,

Plaintiff,

v.

STATE OF TENNESSEE, Ned Wherter, Governor of the State of Tennessee; Evelyn C. Robertson, Jr., Director, Tennessee Department of Mental Health and Mental Retardation; Mona Reeves-Winfrey, Superintendent, Arlington Developmental Center,

Defendants.

No. 92-2062-M1/A

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SUPPLEMENTAL FINDINGS OF FACT

These findings of fact supplement the Court's oral ruling delivered on November 22, 1993, and attached as Addendum I.

1. The Arlington Developmental Center (hereinafter "ADC") is a state operated, residential mental retardation facility housing approximately 432 developmentally disabled persons located in Arlington, Tennessee. (Christian, Tr. Vol. II at 149; Ex. 244.)

2. ADC's population consists primarily of individuals currently assessed as severely or profoundly retarded or developmentally disabled, some of whom have associated physical

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handicaps, medical problems, or behavior problems. (Hyman, Tr. Vol. III at 390-91; Ex. 244.)

3. Developmental disabilities include such conditions as cerebral palsy and mental retardation. (Hyman, Tr. Vol. III at 390-91.) Persons with mental retardation have substantial limitations in present functioning, characterized by significantly sub-average intellectual functioning existing concurrently with limitations in applicable adaptive skill areas, e.g., communication, self-care, social skills, self-direction, safety, functional academics, leisure and work. Mental retardation manifests before age 18. (Christian, Tr. Vol. I at 29.)

4. The functional capabilities, strengths and weaknesses of persons with mental retardation or other developmental disabilities cannot be determined absent appropriate evaluation, analysis and treatment implementation, individualized to the particular person in question. (Christian, Tr. Vol. I at 43, 49; Szymanski, Tr. Vol. IV, generally and at 775-76, 878.)

5. Persons with developmental disabilities, including mental retardation, require treatment through the use of an individualized assessment and treatment plan, known as the Individual Habilitation Plan (IHP) at Arlington. (Christian, Tr. Vol. I at 49; Winfrey, Tr. at 136.)

6. Services for persons with developmental disabilities, including mental retardation, must be developed on an individual basis by a properly constituted interdisciplinary team. An interdisciplinary team must consist of, at a minimum, those individuals who provide both clinical and direct care services for the particular individual, including any specialty services, such as speech and hearing, communication, psychiatry, physical therapy, occupational therapy, and any others whose presence is necessary to ensure each individual's needs are met. (Hyman, Tr. Vol. III at 588; Christian, Tr. Vol. II at 155-56; Szymanski, Tr. Vol. IV at 811.)

7. ADC's mission statement and obligation is to provide a broad array of services to residents in accordance with their needs which are identified in Individualized Habilitation Plans which institutional staff design for each individual. (Reeves-Winfrey, Tr. at 135; Ex. 241-44, 258.)

8. Since early 1993, Arlington has been engaged in improving its data collection system, case management system, clinical aspects of behavior analysis, activities and training system on the Daniel Boone, Spruce, and Davy Crockett units, and the quality management program, with the assistance of Behavior Management Consultants, Inc. Arlington plans to continue with those improvements and to expand them to all living units at ADC pursuant to a contract which extends to June 30, 1994. (Cox, Tr.

at 287-90; Riordan, Tr. at 525-27; Mozingo, Tr. at 425-26; Reeves-Winfrey, Tr. at 53-5; Bailey, Tr. at 609.)

9. However, the evidence shows that the conditions at Arlington Developmental Center in 1990, 1991 and 1992, at the time of testimony (even after the improvements listed above) and continuing through the present, do not comply with minimal requirements under the Fourteenth Amendment. The Defendants fail to protect ADC residents from harm and fail to provide a safe and humane environment at ADC. (Christian rebuttal, Tr. at 2845.)

10. Defendants are failing to provide residents with reasonable care and a reasonably safe environment. ADC residents are subjected to serious harm and undue risks of harm due to inadequate supervision which results, at least in part, from insufficient numbers of staff and inadequate training of the staff available given the current number of residents at the facility. (Christian, Tr. Vol. I at 48, 62-3, 67-8, 72; Christian, Tr. Vol. II at 261; Christian rebuttal, Tr. at 2766.)

11. During the past three years, ADC's own records demonstrate that there have been over 6100 reported injuries to ADC residents. (Christian, Tr. Vol. I at 79-80; Ex. 6, 7.)

12. Arlington has a system of policies and procedures for documenting incidents and injuries in which residents are

involved. (Cox, Tr. at 307-09, 331; Reeves-Winfrey, Tr. at 64-65; Bailey, Tr. at 685-86; Ex. 285, 286.) Arlington compiles statistics concerning incidents and injuries, and analyzes the data for identification of trends and ways to possibly reduce the incident rate. (Cox, Tr. at 308-14; Reeves-Winfrey, Tr. at 69-71; Ex. 287, 288.) However, ADC's recordkeeping system is inadequate and inaccurate. Thus, the 6100 reported injuries under-represents the actual number of injuries that occurred at ADC. (Christian, Tr. Vol. I at 85-86; Christian, Tr. Vol. II at 305-06; Reeves-Winfrey, Tr. at 186-97; Cox, Tr. at 394-411; Ex. 11.)

13. The ADC staff is not properly trained and accordingly they do not accurately record injuries or report them in a uniform manner. This results in data collection which is insufficient to develop behavior development plans. (Christian, Tr. Vol. I at 84-90; Christian rebuttal, Tr. at 2766-83; Cox, Tr. at 394; Ex. 295.)

14. Defendants fail to meet their own direct care staff[1] to resident ratios on three shifts of 1:4 (day), 1:4 (evening) and 1:8 (night); ratios are regularly much higher than that, at times as high as one staff member for 16 residents. (Christian, Tr. Vol. I at 64, 66; Ex. 3-5; Christian rebuttal,

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[1] The term "direct care staff" includes Developmental Technicians (DTs) and Developmental Technician Trainers (DTTs) as described in the Superintendent's testimony.

Tr. at 2763-64, 2766-68; Reeves-Winfrey, Tr. at 136-37, 149-50.) Even where 1:4 staffing was present, direct care staff members often worked with only a single individual, leaving many others idle. (Christian, Tr. Vol. I at 69; Christian, Tr. Vol. II at 226-28; Christian rebuttal, Tr. at 2762-64; Ex. 24, 26, 428.)

15. The training and skills of direct care staff are grossly substandard. (Christian, Tr. Vol. I at 48, 68; Rol. Palmer, Tr. Vol. II at 1347-49.) Direct care staff and supervisors need additional training in recording and reporting of injuries, and in the supervision of residents sufficient to ensure the residents' safety. (Christian rebuttal, Tr. at 2766-68.) Many direct care staff do not fulfill their responsibilities for the care of the residents entrusted to them. (Ex. 24, 25.) Direct care staff often leave residents unattended or ignore residents when they require attention, particularly when they are engaging in self-injurious behaviors. (Christian, Tr. Vol. II at 194-95; Christian rebuttal, Tr. at 2773-74.)

16. Many of the injuries suffered by ADC residents are serious, including numerous major fractures, lacerations, which required stitches, and major bruises and abrasions. Residents have also lost their sight. Examples of such injuries are: Sandra H. and Mary B. lost sight in at least one eye from altercations with other residents. (Christian, Tr. Vol. I at 92.) Grace M.'s elbow was pulverized. (Christian, Tr. Vol. I

at 88.) Ronny S., a blind resident, lost part of a finger when another resident slammed a door on it. Anthony W. broke his arm in a shower; Dottie B. broke six ribs. There are a number of fractures of unknown origin. Residents (e.g., Gary B., M.G. H.) were "discovered" with lacerations and large bruises which ADC lists as of unknown origin. (Christian, Tr. Vol. I at 97; Ex. 9-10.)

17. ADC's supervision is so deficient that one resident, Adrian J., was bitten 22 times by another resident in a single incident. (Christian, Tr. Vol. I at 97; Bailey, Tr. at 860; Ex. 6-7, 9-10, 20, 23, 127-95.) As of March 1993, Adrian was still being bitten.[2]

18. In addition to these severe injuries, ADC residents suffered thousands of other injuries during this period. These injuries included cuts, scratches, abrasions, bruises, and bumps. (Ex. 6, 186-90, 193-95.)

19. Defendants identify many of the injuries to ADC residents as from "unknown" causes, meaning no staff were present at the time the injury occurred to witness the event. (Christian, Tr. Vol. I at 80-81; Cox, Tr. at 385-402; Ex. 6-7, 10.)

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[2] Examples identified in these proposed findings of fact do not constitute a complete recitation of all incidents supporting a particular finding. The examples are simply illustrations of the deficiencies supported in the record.

20. Defendants do not sufficiently investigate and respond to injuries to residents and permit repeated injuries to the same residents. (Reeves-Winfrey, Tr. at 186-92; Cox, Tr. at 373, 391, 393; Davis, Tr. at 1792-93; Ex. 23, 127-90, 193-95, 270.)

21. Staffing ratios for clients such as the majority of those at ADC should be no less than that required to reasonably ensure the safety of the residents. A ratio of 1:4 is a general guideline, but many residents with self-injurious or aggressive behavior may require higher staffing ratios, including some who require 1:1 ratios for the safety of themselves and other residents. (Christian, Tr. Vol. II at 308, 311-12, 316; Rol. Palmer, Tr. Vol. VII at 1346-47.)

22. ADC does not appropriately investigate or pursue reported instances of abuse (or severe neglect which could amount to abuse) of residents by staff members. (Reb. Palmer, Tr. Vol. VII at 1432-41; Derringer, Tr. Vol. IX at 1861-68, 1871; McCollum, Tr. Vol. IX at 1839-51; Davis, Tr. Vol. IX at 1788-1802; Rol. Palmer, Tr. Vol. VII at 1354; Ex. 90, 127-90, 193-95.)

23. Conditions at ADC regarding reasonable care and safety are a substantial departure from accepted professional judgment, practice or standards. These conditions continue to be unsafe, subjecting residents to injury or a serious risk of injury.

(Christian, Tr. Vol. I at 56-58; Christian rebuttal, Tr. at 2767.)

DEFENDANTS' HABILITATION, AND PSYCHOLOGICAL SERVICES AND RELATED TRAINING ARE SERIOUSLY DEFICIENT

24. Defendants' habilitation, psychology services, and training for these services are a substantial departure from accepted professional judgment, practice or standards. (Christian, Tr. Vol. II at 262.)

25. Arlington employs an interim Assistant Superintendent for Programming Services who also serves as Director of Psychology. (Cox, Tr. at 268.) In the psychology department, there are positions for three staff behavior management specialists, one additional Ph.D. staff psychologist, six master's level staff psychological examiners, and six staff counselling associates. In addition, there are contracts for part-time work for one Ph.D. counselling psychologist and two master's level psychological examiners, and two graduate students also provide assistance. (Cox, Tr. at 271-72.) Three of the positions for psychological examiner are currently unfilled. (Cox, Tr. at 273.)

26. Defendants fail to regulate and review the use of restraints, in any meaningful way, which cause harm to ADC

residents or subjects them to significant risk of harm. (Christian rebuttal, Tr. at 2794, 2818-21.)

27. Many residents of ADC exhibit behavior problems and injure themselves or others. Professionally developed and implemented behavioral training programs, referred to as Behavior Development Programs (BDPs) at ADC, are generally accepted by professionals as the means of addressing, ameliorating and eliminating, to the extent possible, maladaptive behaviors. (Christian, Tr. Vol. I at 120-23, 125, 126; Christian Tr. Vol. II at 257.)

28. Very few of the BDPs at ADC provide replacement behaviors or skill acquisition components as professionally required. Additionally, ADC programs are deficient in properly analyzing the causes of maladaptive behaviors, e.g., there is no functional analysis. (Christian, Tr. Vol. II at 186-87, 257-58; Rol. Palmer, Tr. Vol. VII at 1324; See Ex. 92 (ADC informed of need for functional analysis by staff psychologist in 1991).)

29. As a result of inappropriate staff responses to resident behaviors, such as rewarding inappropriate behavior or failing to reinforce appropriate behavior, residents develop and continue dangerous maladaptive behaviors which, in turn, lead to increased numbers of injuries. (Christian, Tr. Vol. II at 194-95, 203-10, 327, 335; See Ex. 14, 31.)

30. Defendants' failure to provide and implement adequate training programs has led to residents engaging in self-injurious, aggressive or other dangerous behaviors. (Christian, Tr. Vol. I at 81; Tr. at 625 (staff must be constantly vigilant); See Ex. 21, 14, 31.) Residents have gouged their faces, destroyed their ears, cut and bruised themselves and broken arms and ribs. (Ex. 6, 7, 127-190, 193-95.)

31. Examples of injuries occurring as a result of ADC's failure to provide appropriate programs include: Philip R. banged his head so frequently that his lower jaw was constantly injured, open, or covered with scar tissue. He subsequently died. (Christian, Tr. Vol. I at 108; Christian, Tr. Vol. II at 306, 340.) Resident Harry J. picks at a "hole" he has developed on his cheek from his maladaptive behavior. Although this resident continues to pick at the hole in his cheek, his program has been discontinued. (Christian, Tr. Vol. I at 106; Christian, Tr. Vol. II at 164.) Leroy P. has had repeated surgeries to remove plastic bags and other objects he has ingested from his intestinal tract. (Christian, Tr. Vol. I at 108, Christian, Tr. Vol. II at 172-73.) Other residents have vomited foreign objects they have eaten. Carol W. bangs her nose and hand mouths. (Christian, Tr. Vol. II at 171-72; Mozingo, Tr. at 500-01; Ex. 24.) Dwight C. bites numerous residents, some on multiple occasions. (Christian, Tr. Vol. II at 178-80; Ex. 23.) Other

residents exhibit significant scarring from the multiple, repeated injuries each has suffered. (Ex. 6, 7, 12, 13.)

32. Defendants are failing to provide individualized, professionally designed behavior programs to all of the residents of ADC who need or can benefit from them. This is due, in part, to defendant's failure to recognize both the severity of residents' behaviors (Christian, Tr. Vol. I at 48-49 and their capacity for growth and development. (See Ex. 308.) Presently, only 68 ADC residents have behavior training programs. Many more residents need such programs. (Christian, Tr. Vol. I at 130; Rol. Palmer, Tr. Vol. VII at 1324; Ex. 18, 88.)

33. Programs to teach adaptive behaviors, including self-help skills, communication, social skills, and skills to enhance independence, are essential to the physical and mental health and safety of residents. Such programs are not professionally designed and/or implemented at ADC. (Christian, Tr. Vol. I at 31; Christian, Tr. Vol. II at 122-23, 256, 261; Szymanski, Tr. Vol. IV at 809-10.)

34. Defendants' failure to provide and implement programs which both reduce and replace maladaptive behavior and foster acquisition and maintenance of adaptive behaviors, due to the lack of adequate numbers of properly trained and supervised staff, has led to an increase in serious maladaptive behaviors by

residents that has resulted in injuries to themselves and other residents. (Christian, Tr. Vol. I at 48; Vol. II at 190-91, 261-62.)

35. Defendants' behavior programs focus solely on the reduction of inappropriate behaviors. (Szymanski, Tr. Vol. IV at 782.) The psychiatrists and psychologists at ADC are not involved in the planning for total programming, including skill acquisition. (Szymanski, Tr. Vol. V at 877-78, 937.)

36. Idleness among persons with developmental disabilities may lead to the development of maladaptive behaviors even in residents who do not currently exhibit such behaviors. (Christian, Tr. Vol. II at 192-94, 262.) Many ADC residents sit idle for prolonged periods of time, with nothing to do and without any stimulating interaction with staff. (Christian, Tr. Vol. II at 194-96; Szymanski, Tr. Vol. V at 822-24; Christian rebuttal, Tr. at 2763.)

37. ADC does not provide residents at ADC (including those who are nonverbal and/or nonambulatory) needed, consistent, positive interaction. (Christian, Tr. Vol. II at 162; Rol. Palmer, Tr. Vol. VII at 1348; Ex. 90, 91.)

38. No psychologist at ADC, including the Director of Psychology, has the necessary experience in behavioral psychology

or has been adequately trained in behavioral psychology. (Christian, Tr. Vol. II at 257, 301-02.) As the consequence, they are not able to adequately develop and implement training programs for residents with aggressive, self-abusive and other dangerous behaviors. (Christian, Tr. Vol. II at 278-79, 301-02.)

39. The few programs on the Daniel Boone unit, ADC's "model unit" for behavior training, are deficient in that they fail to adequately address skill acquisition, they are not based upon reliable, objective criteria and accurate data, (Cox, Tr. at 395-97, 402.) and they are not being appropriately and consistently implemented. (Riordan, Tr. at 566-67; Christian rebuttal, Tr. at 2767-69.)

40. Lack of adequately trained direct care staff has led to direct care staff being unfamiliar with the training programs for those residents for whose care they are responsible. (Rol. Palmer, Tr. Vol. VII at 1347; Christian rebuttal, Tr. at 2760, 2766, 2768.) This results in programs not being followed or properly implemented. Additionally, some direct care staff simply fail to implement training programs. (Christian rebuttal, Tr. at 2772-73, 2784-86, 2801-03.)

41. Defendant's failure to monitor and regulate the use of restraints, both physical and chemical, at ADC is a substantial departure from professional judgment, practice, or standards.

(Cox, Tr. at 376-80, 383-84; Rol. Palmer, Tr. Vol. VII at 1338-39; Christian rebuttal, Tr. at 2818-20; Ex. 289, 290.)

42. Defendants have no restraint log, making necessary behavior management and human rights review of restraint usage at ADC impossible. (Christian, Tr. Vol. I at 51, 53; Christian rebuttal, Tr. at 2818.) Residents are subjected to physical restraints, i.e., helmets or mitts, to control their self-destructive behaviors in lieu of training programs designed to reduce or eliminate such behaviors. In other cases, Defendants are failing to use restraints temporarily with an appropriate behavior program even where residents are exposed to serious, potentially life-threatening danger. (Rol. Palmer, Tr. at 1327-32; Christian rebuttal, Tr. at 2821.)

43. The Behavior Management and Human Rights Committees at ADC do not function in a professional manner (Christian, Tr. Vol. I at 56; Christian Vol. II at 233-35, 239, 260-61.) and exercise no professional judgment.

44. Many injuries, the use of restraints, and the intensity of maladaptive behaviors exhibited by residents could be prevented or ameliorated if residents had appropriate training programs and Defendants provided sufficient numbers of adequately trained staff to implement them. (Christian, Tr. Vol. II at 261-62; Christian rebuttal, Tr. at 2844-45; See Ex. 14, 31.)

45. Defendants' failure to review and update residents' training programs is due, in part, to insufficient numbers of psychologists and other professional staff at ADC, as well as inadequately trained professional staff, as stated above. (Christian, Tr. Vol. II at 243.)

46. Notwithstanding Defendants' claims that improvements in training and psychological services have recently been made, habilitation and training programs and psychological services, even on Daniel Boone unit, continue to be a substantial departure from accepted judgment, practice or standards, which subject residents to harm. (Christian, Tr. Vol. II at 262; Christian rebuttal, Tr. at 2766-67.)

MEDICAL CARE AND RELATED HEALTH SERVICES ARE GROSSLY DEFICIENT

47. Defendants' medical care and related health services in those areas listed below are grossly deficient, and are resulting in unnecessary resident illnesses, deformities, suffering and death.

48. Arlington employs four full-time primary care physicians and a medical director, each appropriately licensed. There is a fifth physician position that is currently unfilled. On-site physician coverage is provided 24 hours a day, seven days a week. (McLemore, Tr. at 1700-02.)

49. Within 24 hours of admission, each new resident receives a physical examination by one of the staff physicians, including a comprehensive array of routine tests, as well as tests pertinent to the resident's specific medical conditions. Thereafter, routine physical examinations and standard lab tests are performed on an annual basis. All residents receive routine immunizations, including immunizations against hepatitis. Residents are provided with routine gynecological and ophthalmological exams and mammograms. (McLemore, Tr. at 1702-05, 1710-11.)

50. On-site resources include a pharmacy, laboratory, x-ray (24 hours a day/7 days a week), EEG, EKG, ultrasound, and mammography. Other specialized diagnostic testing is available at area hospitals. Laboratory test results are obtained overnight or can be obtained on an immediate basis, as needed. (McLemore, Tr. at 1710-11.)

51. Regular, on-site specialty consultation clinics are currently conducted in neurology, psychiatry, ophthalmology, gynecology, and gastroenterology. A broad array of other off-site specialty consultations are also available and regularly utilized. There are no outside medical consultations providing needed services that Arlington is unable to obtain. (McLemore, Tr. at 1712-14.)

52. The system of primary health care at Arlington is a residential model, with each physician assigned a specific living unit/caseload. (McLemore, Tr. at 1706.) Daily rounds to each living unit by each physician are one aspect of the system for identifying potential medical problems and follow-up and monitoring of previously identified conditions. (McLemore, Tr. at 1706, 1723.) Laboratory reports and reports from specialized consultations are delivered to the nursing clinics located in each living unit area, are available during daily rounds, and are to be reviewed by the physician and placed in the resident's chart. (McLemore, Tr. at 1715-16.)

53. Defendants have recently signed a one year contract with the University of Tennessee to provide some essential medical services to ADC residents, the terms of the contract are conditional and for no longer than one year. (Hyman, Tr. Vol. IV at 624-25.)

54. Notwithstanding Defendants' claims that improvements have recently been made in the provision of medical care, any such improvements have not remedied the grossly inadequate care, which continues to subject residents to avoidable suffering, morbidity and mortality. (Hyman, Tr. Vol. IV at 648.)

Feeding Practices and Medical Management of Feeding-Related Disorders

55. Defendants' feeding practices at Arlington are dangerous, life-threatening, result in harm to residents, and continue to place residents at unreasonable risk of harm. These practices are a substantial departure from accepted professional standards or practices. (Hyman, Tr. Vol. III at 403-05, 417; Therriault, Tr. Vol. V at 993; and McEwen, Tr. Vol. VI at 1237-38.)

56. Such practices (e.g., bird feeding; inappropriately positioning residents before, during and after meals; feeding residents too much, too fast, the wrong diet or food of inappropriate texture; and inadequately supervising residents while they are eating) have caused, and continue to cause, increased risk of reflux, gagging, choking, aspiration, aspiration pneumonia, asphyxiation and death among ADC residents. (McEwen, Tr. Vol. VI at 1237-38; Hyman, Tr. Vol. III at 403-17; Therriault, Tr. Vol. V at 1000-01, 1008-16; Hinkle, Tr. at 2075-76, 2084-92; Hyman, video rebuttal Ex. 441; McEwen rebuttal, Tr. at 2912-14; Therriault rebuttal, Tr. at 2868-69.)

57. ADC places residents in bed immediately after they have eaten, a practice which increases the risk of reflux, choking and aspiration. (Hyman, Tr. Vol. III at 405; Drews, Tr. at 1245-1246.) This practice, euphemistically termed "bedroom

leisure" by ADC (See Therriault, rebuttal, Tr. at 2884), is medically inappropriate and serves no legitimate medical or programming purpose and is a substantial departure from accepted professional standards. (Hyman, Tr. Vol. III at 403-05.)

58. Significant measures have been taken within the last year to address the seating/positioning needs of residents as they relate to feeding. (Payne, Tr. at 955-56; Hyman, Tr. Vol. IV at 679-85; See Ex. 53-57, 327.) A number of facility-wide changes related to staff position while feeding, portion control, pace of feeding, increased individualization of feeding techniques, increased use of appropriate adaptive equipment, and improved positioning of residents through changes in adaptive seating systems, has resulted in some reduction in inappropriate feeding practices. (Drews, Tr. at 1240-43; Hinkle, Tr. at 2033-38.) However, dangerous feeding practices at ADC are still life-threatening and result in harm to residents. (Hyman, Tr. Vol. III at 403-05; Therriault rebuttal, Tr. at 2869.)

59. Even though some of ADC residents have feeding programs, there are too few properly trained staff to effectively implement the programs. (McEwen, Tr. Vol. VI at 1237-38; Hyman, Tr. Vol. III at 408-12; Therriault, Tr. Vol. V at 1034-36; McEwen rebuttal, Tr. at 2910-14; Hyman video rebuttal Ex. 441; Therriault rebuttal, Tr. at 2868-78.)

60. With the recent staff increase at ADC, there are now two full-time swallowing therapists, both speech pathologists. (Andreas, Tr. at 1086; Hinkle, Tr. at 2032.) There are also three full-time speech pathologists who function part-time as swallowing therapists and three occupational therapists (two part-time) who function as swallowing therapists a portion of each day and a part-time feeding therapist consultant. (Hinkle, Tr. at 2032-33.) The swallowing therapist's dual role is to provide direct feeding-related services and to act as case managers to ensure that the components of the dysphagia management system are coordinated to meet the multi-disciplinary needs of the residents. (See Andreas, Tr. at 1052-58, 1069-71.) Both direct and consultative services are being provided by William Hinkle, Ph.D. (Hyman, Tr. Vol. III at 431; Hyman, Tr. Vol. IV at 664, 672; Andreas, Tr. at 957.)

61. Following an initial facility-wide screening to prioritize at-risk individuals (Hinkle, Tr. at 2013), three basic methods now result in a resident's entry into the feeding/swallowing management system: referrals from staff and the team process; the swallowing therapist's systematic review of all dining plans in all living units; and evaluation at the time of each resident's annual staffing. (Hinkle, Tr. at 2013-15, 2019; Andreas, Tr. at 1052.) Newly developed dining plans exist for many residents and the process is on-going. (Hinkle, Tr. at 2018-19.)

62. However, these newly developed resident "dining plans," which indicate that individual staff members have been trained to implement individual feeding programs, contain multiple irregularities and staff give inconsistent statements about the training they have actually received. Some staff admitted they had not been trained, and even those that said they had received training did not follow the practices listed in the plans as they fed residents. (Hyman, Tr. Vol. III at 410-13; Therriault, Tr. Vol. V at 1020-22, 1029-36; McEwen rebuttal, Tr. at 1920-12; Therriault rebuttal, Tr. at 2870-72; and Hyman, video rebuttal Ex. 441.)

63. Sufficient numbers of adequately trained staff are not available at Arlington to monitor residents at mealtimes (Hyman, Tr. Vol. III at 464, 469, 489) and while the residents are in postural drainage. (Hyman, Tr. Vol. III at 492; Hyman, video rebuttal Ex. 441.)

64. Defendants' use of postural drainage at Arlington (i.e., placing residents in a head down position for long periods of time unattended) is dangerous and subjects residents to substantial risk of harm. (Hyman, Tr. Vol. III at 492-94.)

65. Defendants fail to provide proper medical management of residents with feeding-related disorders and illnesses, including dysphagia, reflux and respiratory illnesses associated with

aspiration and reflux. (Hyman, Tr. Vol. III at 429-30.) Defendants' failure to properly diagnose and treat these disorders has harmed residents and continues to harm residents and place residents at unreasonable risk of harm. (Hyman, Tr. Vol. III at 429-35.)

66. Although fully apprised of these dangerous practices by the United States on a number of different occasions, Defendants failed to take sufficient steps to eliminate them. (Hyman, Tr. Vol. III at 435.) Defendants' failure to act, even upon their own consultants' recommendations, has resulted in residents suffering unnecessary illnesses and even death. (Hyman, Tr. Vol. III at 445-50, 478-80.)

67. At least 28 residents have died from aspiration or reflux related causes within the last six years, and in many of these cases inadequate and improper care and medical treatment directly contributed to the continuing ill health and deaths of these residents. (Hyman, Tr. Vol. III at 450-60, 463-65, 469-71, 476-91.)

Vision, Hearing and Communication

68. Defendants fail to adequately provide for the visual, hearing and communication needs of the residents, (Christian, Tr. Vol. II at 159), preventing or at least significantly limiting residents with these needs from benefitting from any educational, behavior modification, or social affective programs or any other training or programming. (Szymanski, Tr. Vol. IV at 788-90.)

Acute and Chronic Seizure Management

69. The management of residents with chronic seizures is a substantial departure from professionally accepted clinical practice. (Hyman, Tr. Vol. III at 388-89, 501, 507, 546-47.) Defendants do not properly monitor and treat ADC residents with seizure disorders. ADC keeps residents on anticonvulsants they no longer need, keeps them on sub-therapeutic or potentially toxic levels of medication for months (and in some cases, a year or more) with no rationale documenting the efficacy of this for the residents involved. (Hyman, Tr. Vol. III at 501-74.)

70. Residents who have not had seizures for over six years are kept on one or more anticonvulsant, exposing them to the potentially harmful side effects of these medications, with no documentation as to why such medication has been continued and without plans to reduce the number of medications. (Hyman, Tr.

Vol. III at 503-10.) ADC fails to monitor blood levels to ensure that medication levels are appropriate. (Hyman, Tr. Vol. III at 512-28, 530-38.)

71. ADC does not adequately track seizures and seizure medication to ensure that a record is maintained of each seizure. Proper tracking is necessary to ensure appropriate use of medication. (Hyman, Tr. Vol. III at 502-03; Therriault, Tr. Vol. III at 1641-43; Hyman rebuttal Tr. at 2892, 2896.)

72. Although many residents are maintained on one anticonvulsant medication (monotherapy), some residents are inappropriately maintained on more than one anticonvulsant medication (polypharmacy) for years without requisite plans to reduce the number of medications. (Hyman, Tr. Vol. III at 504, 530, 534-41.) In several cases where monotherapy has been recently attempted and has failed (i.e., in some cases one medication is not sufficient to control the individuals' seizures), ADC physicians have failed to recognize the limitations of monotherapy for these residents and have continued to leave them on one anticonvulsant despite significant increases in these residents' seizures once monotherapy began, resulting in harm to these residents. (Hyman, Tr. Vol. III at 518-20, 541-43, 545-47, 571-72.)

73. Defendants' emergency response and medical treatment of acute seizure events is grossly inadequate. For example, ADC medical staff continue to treat status epilepticus, a condition with a high rate of morbidity and mortality, with intra-muscular (I.M.) medications -- a practice soundly rejected by the medical profession. (Hyman, Tr. Vol. III at 547-48, 550-51, 556, 566-71.) In one case, a higher-functioning, 15 year-old was treated with only I.M. valium during a three hour seizure. The inappropriate treatment resulted in severe, irreversible brain damage. (Hyman, Tr. Vol. III at 551-66.)

74. ADC physicians have inadequate experience with and lack of basic knowledge of both chronic and acute seizure management, and fail to properly utilize outside consultants, resulting in harm to residents and placing residents at substantial risk of harm. (Hyman, Tr. Vol. III at 534, 542, 573-78.)

Medication Use and Monitoring

75. Defendants' failures to prescribe medications appropriately, to adequately monitor blood levels, and to recognize and monitor harmful side effects is a substantial departure from accepted judgment, practice, or standards and has harmed residents and continues to harm residents and place them at substantial risk of harm. (Hyman, Tr. at 580-87; Hyman, Tr. Vol. IV at 597-02, 604-13; Hyman, video rebuttal Ex. 441.)

76. Various medications, medical procedures, and their effects are not understood or appreciated by ADC's medical staff. For example, the blood level of one resident was not monitored appropriately and she died of theophylline toxicity. (Hyman, Tr. at vol. III at 597-02.) Another resident was given four enemas in a 12 hour period and subsequently died from the effects of a high sodium level caused by the enema solution. (Hyman, Tr. Vol. III at 582-86.) Another resident was maintained on a toxic level of a psychotropic, stelazine, resulting in serious physical and behavioral side effects, and perhaps contributing to his choking to death because of the drug's known effect to increase appetite and decrease swallowing and gagging reflexes. (Hyman, Tr. Vol. IV at 604-13.)

Orthopedic Management

77. Defendants fail to provide timely and accurate diagnoses and treatment for acute orthopedic trauma, as well as for chronic and progressive orthopedic disorders, resulting in residents suffering unnecessary pain, disfigurement and loss of mobility and function. (Hyman, Tr. Vol. IV at 619-20, 632-33, 637-47.)

78. Defendants misdiagnose fractures and fail to diagnose them in a timely fashion. (Hyman, Tr. Vol. IV at 645, 647.)

Training and Response to Medical Emergencies

79. Staff training for and responses to medical emergencies at ADC are grossly inadequate, have harmed residents and continue to place residents at an unreasonable risk of harm. (Hyman, Tr. Vol. III at 441-44, 464, 469-70, 552-56; Hyman, video rebuttal Ex. 441.)

Peer Review, Including Mortality Review

80. Defendants' investigations of injuries, abuse allegations and deaths are perfunctory, and rarely result in any corrective action. The causes or circumstances of an inordinate number of serious incidents, injuries, and deaths are unknown and unexplained. (Hyman, Tr. Vol. III, at 558-66; Vol. IV at 602, 613; Christian, Tr. Vol. I at 97, 99; Rol. Palmer, Vol. VII at 1390-91; Reb. Palmer, Tr. Vol. VII at 1433-41.)

Medical Staffing and Use of Consultants

81. There are too few adequately trained and supervised medical personnel at ADC. (Hyman, Tr. at 410-12, 418, 435, 480; Christian, Tr. Vol. I at 48, 72, 127; Christian, Tr. Vol. II at 257.)

82. Defendants fail to employ or utilize needed medical consultants, (Hyman, Tr. Vol. III at 578), and, in those cases where they do seek consultants' recommendations, they do not act upon them quickly, if at all. (Hyman, Tr. Vol. III at 448-49; Hyman, Tr. Vol. IV at 648-49.)

Documentation

83. Defendants' documentation of medical diagnoses, treatment, and follow-up for individual residents, as well as Defendants' statistical reports, are grossly inadequate (Hyman, Tr. Vol. III at 447-49, 453, 481-83, 514-15), and often inaccurate, and have harmed residents, and continue to harm residents and place them at unreasonable risk of harm. (Hyman, Tr. Vol. III at 508-09.)

84. The nurses at Arlington, though, who act as "gate keepers" for the physicians, are generally not doing an adequate job of placing into the resident charts the information needed by the physicians in order to exercise their professional judgment. (Hyman, Tr. at 502.)

Community Placement

85. None of the medical staff at ADC are charged with or are taking the responsibility to evaluate or coordinate resident

discharges into the community in light of their potential medical needs. (McLemore, Tr. at 1898-1905.) Although community placement may be appropriate for residents of ADC and may serve to foster the resident's growth and development, Defendants' placement process or "dumping" does not reflect the exercise of professional judgment.

DEFENDANTS ARE FAILING TO PROVIDE ADEQUATE PSYCHIATRIC SERVICES FOR RESIDENTS

86. Defendants are failing to provide adequate psychiatric services because ADC cannot provide accurate and reliable information upon which a psychiatrist may base treatment decisions, including the use of psychotropic drugs. (Christian, Tr. at 2761.)

87. Since the addition of Dr. Horwitz in October, 1992, and the contract with Dr. Levine in the summer of 1993, Arlington has been providing psychiatric care to its residents through the services of two psychiatrists, who are employed by Arlington as consultants. (Horowitz, Tr. at 1342; Levine, Tr. at 1601.) However, defendants still fail, inter alia, to implement professionally designed training programs, to recognize and conduct proper assessments of residents needing psychological services, to train staff, and to have sufficient numbers of trained staff (both professional and direct care). (Christian,

generally and Tr. Vol. I at 48; Christian, Tr. Vol. II at 262; Christian rebuttal, Tr. at 2761, 2766-68.)

88. Integration of psychiatry into interdisciplinary team approaches to the provision of services to persons with mental retardation has been the practice in the field of mental retardation for over twenty years. (Szymanski, Tr. Vol. IV at 809, 811-12; See Ex. 349.)

89. Persons with mental retardation have the same mental health needs as persons without mental retardation -- but more intense due to their deficits and their dependence on others. (Szymanski, Tr. Vol. IV at 768.) At ADC, psychiatric recommendations for residents are not made as part of a program developed by an interdisciplinary team, which is necessary for such psychiatric care to be appropriate or meaningful. (Szymanski, Tr. Vol. IV at 809, 811-12.)

90. Severe behavior disorders in individuals with mental retardation may be treated without medication and should only be treated with medication if there is evidence that the behavior relates to an underlying mental disease. In addition, behavioral training is required even if a person is receiving medication for a severe behavior disorder. (Szymanski, Tr. Vol. V at 830.)

91. Defendants use psychotropic medications without adequate justification of the effectiveness or necessity for such drugs. (Szymanski, Tr. Vol. V at 891-92.)

92. Psychiatrists prescribe psychotropic and other potentially dangerous medications for ADC residents without the opportunity to conduct complete examinations and assessments of residents due to severe time limitations. (Szymanski, Tr. Vol. IV at 784-85; Szymanski, Tr. Vol. V at 830-32, 836-37, 842.)

93. Defendants' fail to obtain information necessary to provide mental health services at ADC, e.g., psychiatric history, initial diagnostic assessment, and etiological acquisition. (Szymanski, Tr. Vol. IV at 784, 838, 842.)

94. Accurate and reliable data is necessary to determine the efficacy of treatments, both psychiatric and behavioral, for residents. Such data is not kept at ADC. (Szymanski, Tr. Vol. VI at 792, 801-02, 806, 810, 812; Vol. V at 861-62; Rol. Palmer, Tr. Vol. VII at 1326.)

95. Defendants fail to provide sufficient psychiatric consultation time to provide necessary psychiatric and mental health services to residents. (Szymanski, Tr. Vol. IV at 810; Szymanski, Tr. Vol. V at 836.)

96. Defendants are failing to provide mental health services for residents who do not display aggressive or disruptive behavior because they only refer for psychiatric evaluation those residents who exhibit such behaviors. (See Szymanski, Tr. Vol. V at 810, 836, 841.)

NURSING SERVICES, INCLUDING PHYSICAL AND NUTRITIONAL MANAGEMENT SERVICES, AT ADC ARE INADEQUATE TO MEET THE HEALTH CARE NEEDS OF RESIDENTS

97. Nursing services at ADC, including physical and nutritional management services, are a substantial departure from accepted judgment, practice or standards, and the lack of these services has contributed to the death of ADC residents and continues to expose residents to serious risk of harm. (Therriault, Tr. Vol. V at 1568-69, 1587, 1589-90, 1620; Therriault rebuttal, Tr. at 2886-90, 2892-97, 2902-03.)

98. Defendants fail to provide a sufficient number of adequately trained nurses to meet the needs of residents. As a result, nurses consistently fail to identify and respond to the health care needs of residents, commit a range of medication errors, fail to adequately monitor the health care problems of residents, and fail to coordinate health care activities with other institutional professionals. (Therriault, Tr. Vol. V at 1016; Vol. VIII at 1644-47.)

99. ADC nurses do not identify or evaluate residents experiencing acute events such as vomiting, increased respiratory rate or other acute episodes, to determine the etiology of the event or illness. (Therriault, Tr. Vol. VIII at 1591-92, 1596-1606, 1619-20.)

100. ADC nurses do not recognize or react to significant changes in residents' nutritional and medical status. For example, staff often do not respond in a timely manner to significant changes in residents' weight or to resident dehydration. (Therriault, Tr. Vol. VIII at 1576, 1578, 1582-83, 1618-19.)

101. ADC nurses do not routinely perform ongoing monitoring of serious medical conditions, often failing to perform such basic procedures as taking vital signs. (Therriault, Tr. Vol. VIII at 1593-99, 1601, 1695-99; Therriault rebuttal, Tr. at 2891-92.)

102. ADC nurses often fail to respond to crucial information provided by other sources which should alert them to medical problems. As a result, necessary interventions are not undertaken. (Therriault, Tr. Vol. VIII at 1598-99, 1617-19; Therriault rebuttal, Tr. at 2893.)

103. ADC nurses often fail to make themselves aware of the results of medical tests such as laboratory tests, x-rays and other information essential to provide adequate nursing and medical care. (Therriault, Tr. Vol. VIII at 1613-17.)

104. ADC nurses fail to administer medications in a manner consistent with basic practices, resulting in an unreasonable number of medication errors. (Therriault, Tr. Vol. VIII at 1620-23, 1628, 1630-31, 1641-42; Therriault rebuttal, Tr. at 2886-87.)

105. ADC nurses improperly record medication administration, reporting medications as having been given when in fact they were not, and reporting medication as given before or well after it was supposed to have been given. (Therriault, Tr. Vol. VIII at 1633-40, and rebuttal, Tr. at 2886-87.)

106. ADC nurses are not adequately trained in monitoring drug side-effects. As a result, they often do not recognize toxic reactions or physical symptoms of side-effects or of an overdose. (Therriault, Tr. Vol. VIII at 1604-05, 1643-44, and rebuttal, Tr. at 2896-97.)

107. ADC nurses do not act to ensure that residents are protected from unnecessary skin breakdowns. As a consequence, residents unnecessarily develop skin disorders that could have

been avoided with appropriate nursing intervention. (Therriault, Tr. Vol. VIII at 1648-51; Therriault rebuttal, Tr. at 2889.)

Physical Therapy (PT) Services are Seriously Deficient

108. Physical therapists with particular experience and expertise with individuals with significant developmental disabilities have been utilized on a consulting basis to provide training to Arlington's physical therapists in a number of core areas. (Payne, Tr. at 948.) Training for both physical therapists and P.T. technicians in the specialized field of adaptive seating has been provided through the wheelchair clinics held at Arlington by contracted seating specialists. (Payne, Tr. at 956-57.) The physical therapists train direct care staff on body mechanics, transfer techniques, positioning, range of motion, and, with the P.T. technicians, wheelchair positioning. (Payne, Tr. at 959-60, 961-62.)

109. This physical therapy training, however, has been insufficient. Many residents are not properly positioned, provided adequate equipment, including wheelchairs, and provided adequate physical therapy intervention due to lack of a sufficient number of qualified staff. (McEwen, Tr. Vol. VI at 1128-29.)

110. The physical therapy staff at Arlington consists of four full-time registered physical therapists, six full-time physical therapy technicians, and two physical therapist assistant positions. (Ex. 247.)

111. Under ADC's new system for identification of physical therapy needs of the resident, each new admission is evaluated by a registered physical therapist and, if a physical therapy program is determined to be needed, it is developed by a registered physical therapist and formally reviewed annually. Each resident's program is also monitored by their assigned physical therapist on a monthly basis. Whether or not a resident has a physical therapy program, an interim evaluation will be conducted by a physical therapist upon referral by any of the other disciplines who work with that resident. (Payne, Tr. at 912-16.)

112. However, even in light of this recently instituted program, defendants are not providing physical therapy services to all residents who need them, and the services provided are grossly inadequate. (McEwen, Tr. Vol. VI at 1128-29.)

113. Many ADC residents have severe neuromotor impairments, cerebral palsy, and other neuro-muscular deficits. (McEwen, Tr. Vol. VI at 1113.) They require adequate physical therapy services to help them move more easily and efficiently, to help

avoid contractures, deformities, acute curvature of the spine due to scoliosis, and to permit them to learn functional skills to enhance their independence. (McEwen, Tr. Vol. VI at 1114-17.)

114. An acceptable physical therapy program must enhance the capacity of the individual to function, i.e., to help him or her to live safely and as independently as possible. Sporadic passive range of motion "therapy" is not sufficient to achieve these goals. Muscles need to be stretched for prolonged periods throughout the day. (McEwen, Tr. Vol. VI at 1118-22.)

115. Defendants are not adequately assessing all ADC residents to determine their need for physical therapy services. (McEwen, Tr. Vol. VI at 1128-29, 1243-44.)

116. PT evaluations, physical management plans, interventions, staffing, staff training, the "school based" physical therapy program and quality assurance are all a substantial departure from accepted professional judgment, practice or standards. (McEwen, Tr. Vol. VI at 1128-30, 1159-63, 1175-80, 1230-34, 1243-46, 1248-53; McEwen, Tr. Vol. VII at 1268-71.)

117. ADC's failure to provide adequate physical therapy services has precluded residents from developing functional skills, being placed in more "normal" environments, and has

caused residents to suffer increased deformities and contractures. Such deformities have posed direct threats to their health. (McEwen, Tr. Vol. VI at 1129-30.)

118. Many of the contractures, deformities, and loss of mobility and other functional skills suffered by ADC residents could have been reduced or avoided if ADC had provided adequate PT and occupational therapy (OT) services to ADC residents. (McEwen, Tr. Vol. VII at 1283-84.)

119. Defendants' failure to adequately assess residents is due, in part, to a lack of sufficient number of trained PT staff to individually evaluate each resident of ADC to determine his or her need for such services. (McEwen, Tr. Vol. VI at 1252-61.)

120. ADC's physical therapy staff lack sufficient expertise to properly evaluate residents for their physical therapy needs, including wheelchair and alternative positioning, intervention programs that promote development of motor skills that will enhance functional independence, and programs that will assist residents in achieving IHP and IEP objectives. (McEwen, Tr. Vol. VI at 1252-61.)

121. ADC's physical therapy is so deficient that passive range of motion and/or passive positioning are the primary interventions provided. (McEwen, Tr. Vol. VI at 1129-30, 1159,

1182.) Overall the emphasis is on maintenance, rather than acquisition of functional motor skills. (McEwen, Tr. Vol. VI at 1179-81.) Such a deficient level of PT services subjects the residents to harm. (McEwen, Tr. Vol. VI at 1129-30.)

122. Defendants do not provide appropriate and necessary adaptive equipment to ADC residents who need such equipment, although the defendants have begun to provide this equipment. (McEwen, Tr. Vol. VI at 1190-91, 1193-94, 1227-28.)

123. ADC does not properly assess and treat acute orthopedic disorders. ADC does not provide needed orthopedic devices, e.g., braces, splints, and body jackets, subjecting residents to unnecessary risks for further deformities and inappropriate body growth. ADC's PTs do not sufficiently refer residents for consultations or other treatments, or follow-up residents who have pain that interferes with proper positioning and motor skills such as standing and walking. These failures lead to loss of skills and increased deformities. (McEwen, Tr. Vol. VI at 1187-88, 1219-20; Hyman, Tr. Vol. IV at 619-23, 632-33, 637-40.)

124. Some ADC residents are placed in wheelchairs that are not designed for their individual needs, e.g., they have sling seats and backs and elevating footrests, or lack essential parts,

e.g., footrests. (McEwen, Tr. Vol. VI at 1193-97, 1208-11, 1219, 1225-26.)

125. Many ADC residents are often improperly positioned in wheelchairs or other adaptive equipment. (McEwen, Tr. Vol. VI at 1187-88, 1209-11, 1220-22, 1230, 1235-39.) This improper positioning can cause contractures, deformities and pain, can interfere with eating and digestion, and can even cause asphyxiation. (McEwen, Tr. Vol. VI at 1116-17, 1235; Hyman, Tr. Vol. III at 405.)

126. There are still residents who ADC has identified as needing new wheelchairs who do not have them and others who have not yet been identified by ADC as needing them in spite of obvious deficiencies in their present seating. (McEwen, Tr. Vol. VII at 1227-28.)

127. Residents are often improperly positioned because there are too few staff present to monitor residents or the staff on duty lack the training to position residents properly. (McEwen, Tr. Vol. VI at 1206-10, 1223-27; McEwen, Tr. Vol. VII at 1312-13.)

128. Occupational therapy services at ADC are also inadequate, in part due to inadequately trained occupational therapy staff. (McEwen, Tr. Vol. VII at 1277-82.)

129. Due to the lack of adequate physical and occupational therapy services, the health of ADC residents has deteriorated. (McEwen, Tr. Vol. VI at 1129-30.)

130. Although the new Director of Therapeutic Services has initiated a revised physical therapy evaluation format (Payne, Tr. at 918-27), the revised assessment procedures are still inadequate and residents continue to lack physical management plans. (McEwen, Tr. Vol. VI at 1169-74, 1230-34, 1243-47.)

131. Notwithstanding Defendants' claims that improvements have been made in physical therapy services, any such improvements have not remedied constitutional deficiencies in PT services. (McEwen, Tr. Vol. VI at 1129-30, 1233-34, 1248-53.)

EDUCATION SERVICES TO SCHOOL-AGE CHILDREN FAIL TO MEET THE REQUIREMENTS OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

132. Of the 56 school age Arlington (ADC) residents, 49 presently receive their education on the ADC campus. The number of school age residents is expected to drop to 48 and the total ADC student body will number 34. (Hansen, Tr. at 2195-97.)

133. The Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400, et seq., assures all handicapped

children of a "free appropriate public education." 20 U.S.C. §§ 1400(c).

134. Arlington's educational program is carried on in five classrooms - two in the "school area" with an additional room for music, and three in the Baker Building for more physically involved students. (Hansen, Tr. at 2200-02.)

135. Four certified special education teachers are on the Arlington staff. A certified substitute is also currently on the staff, along with 12 teacher assistants, numerous foster grandparents, a principal who oversees the program and an educational consultant. (Hansen, Tr. at 2197-2200.)

136. Teachers receive in-service and on-the-job training in numerous areas. (Hansen, Tr. at 2213-15.)

137. Defendants, however, are failing to provide special education and related services sufficient to meet the unique needs of the school-age children at ADC. (Thibadeau, Tr. Vol. VII at 1513-15; Vol. VIII at 1527-28.) Further, educational services are not being provided in the least restrictive environment. (Thibadeau, Tr. Vol. VIII at 1523-24.)

138. Individualized Education Plans (IEPs) developed at ADC are inadequate because, inter alia, ADC's assessments of children

are incomplete and inappropriate. (Thibadeau, Tr. Vol. VII at 1472-75.)

139. ADC's assessments of children fail to contain an adequate statement of the students' present level of performance or sufficiently describe the abilities and needs of students. (Thibadeau, Tr. Vol. VII at 1474-75.)

140. ADC does not provide sufficiently comprehensive training objectives in their IEPs to meet students' needs. IEPs do not seek to promote the development of new skills. (Thibadeau, Tr. Vol. VII at 1474-87.)

141. The skills identified as goals for many students in IEPs are not functional, i.e., the skill to be learned bears little relationship to activities of daily living. (Thibadeau, Tr. Vol. VII at 1477-79.)

142. The goals identified in the IEPs are often not related to one another and are often unduly repetitious. (Thibadeau, Tr. Vol. VII at 1479-87.)

143. ADC does not take steps to ensure that skills learned in the classroom are maintained or generalized to non-classroom settings. (Thibadeau, Tr. Vol. VII at 1502-04.)

144. ADC has not consistently developed goals in IEPs for the requisite one year period and multiple goals are written for the same skill. (Thibadeau, Tr. Vol. VII at 1487-89.) Goals written for students are too narrow, too limited in their scope and tend to assume children lack the capacity to grow, learn and develop. (Thibadeau, Tr. Vol. VII at 1478-87.)

145. ADC does not have an adequate recordkeeping system in place to appropriately monitor the educational status of students. (Thibadeau, Tr. Vol. VII at 1489-92, 1494-501.)

146. Teaching staff at ADC do not provide adequate and appropriate interactions with students. (Thibadeau, Tr. Vol. VII at 1504, 1508-10.)

147. Related services, including, but not limited to, physical therapy, behavioral training, and speech and language services provided by ADC are inadequate to allow children to benefit from special education services as required by the IDEA. (Thibadeau, Tr. Vol. VII at 1513-16; Vol. VIII at 1523.)

148. Although recent steps have been taken to provide children with educational services within the Shelby County Public School system, school-aged children remain at ADC who could more appropriately benefit from receiving educational services outside ADC and are therefore not being educated in the

least restrictive environment as required by the IDEA. (Thibadeau, Tr. Vol. VIII at 1523-26.) In addition, transitional services designed to facilitate students' integration into post school-age settings are inadequate. (Thibadeau, Tr. Vol. VIII at 1523-26, 1528.)

149. Notwithstanding Defendants' claims that improvements have recently been made in educational services, any such improvements have not remedied deficiencies in ADC's educational program. (Thibadeau, Tr. Vol. VIII 1524-26.)

DEFENDANTS HAVE NOT INITIATED REMEDIAL ACTION TO CORRECT IDENTIFIED DEFICIENCIES

150. The Defendants failed to begin remedial measures, even on life-threatening issues, until after the actual filing of a lawsuit in this case, even though state officials were informed as early as July 1990 that life-threatening conditions existed at ADC. In fact, some efforts undertaken by defendants did not occur until after the United States filed for a preliminary injunction in March of 1993. (See Hyman, Tr. Vol. IV at 650-651.)

151. ADC has demonstrated resistance and indifference to corrective action. Testimony of former employees and parents of residents indicated that many staff do not know residents or their needs, do not speak to them, hug the children, or even sit

on their furniture. There was substantial evidence that employees who entered the institution with the best of intentions were repeatedly rebuked when they tried to implement necessary, basic, and fundamental improvements. Indeed, various employees failed to cooperate with former employees' legitimate requests for cooperation and implementation of programs, even in life-threatening situations. Parents likewise repeatedly testified that institutional officials failed to cooperate with their reasonable requests for assistance, including requests for services, investigations into alleged abuse, and even basic information about their children. (Nuckolls, Tr. Vol. VI at 1057, 1059-64, 1066-68, 1070-71; Davis, Tr. Vol. IX 1788-1793; Tucker, Tr. Vol. IX 1820-25, 1828-1831; Rol. Palmer, Tr. Vol. VII at 1354-56, Ex. 89, and generally.)

152. There have been unexplained and suspicious irregularities in employee statements to the United States' experts and in records provided by the Defendants, such as claims by staff to have been trained when not so trained, data obviously documented long after the event recorded occurred, documentation showing data taken when in fact it was not, and obviously unauthorized and/or forged signatures on documents. (Hyman, Tr. Vol. III at 410-412; Therriault, Tr. Vol. V at 1029-1039; Therriault, Tr. Vol. VIII at 1632-37, 1639-40; Thibadeau, Tr. Vol. VII at 1497-1502; Reb. Palmer Test.).

152. In the past and during a number of recent DOJ tours, ADC put on a "show" and/or visits were staged for the experts or others touring. (Christian rebuttal, Tr. at 2765-69; Rol. Palmer, Tr. Vol. VII at 1366-67.)

153. Defendants fail to monitor resident property to protect it from theft and many ADC residents have lost unreasonable amounts of personal property. (See Derringer, Tr. Vol. IX at 1873.)

ENTERED this 17 day of February, 1994.

Jon P. McCalla

JON PHIPPS McCALLA
UNITED STATES DISTRICT JUDGE