U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

U.S. v. Virginia

MR-VA-002-003

The Honorable James S. Gilmore, III
Attorney General
Commonwealth of Virginia
Supreme Court Building
101 North Eighth St.
Richmond, VA 23219

MAY 31 1994

Re: Northern Virginia Training Center

Dear Mr. Gilmore:

In May 1990, we notified then Governor Wilder that, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq., the Civil Rights Division of the United States Department of Justice was commencing an investigation into conditions at Northern Virginia Training Center ("NVTC"), a facility for approximately 275 developmentally disabled persons located in Fairfax, Virginia. Our investigation, which included a number of tours of NVTC by independent experts, found that conditions at NVTC deprived residents of their constitutional rights. We informed Governor Wilder of our findings in a letter dated April 9, 1991 (attached).

Many meetings between this Department and Commonwealth officials and several more expert tours followed, with the Commonwealth consistently asserting that the numerous deficiencies had been or were being corrected. In 1993, after the latest representations by the Commonwealth, this Department again conducted expert tours of NVTC. Our experts' recent findings make it clear that conditions at NVTC continue to violate the constitutional rights of the residents there, subjecting them to serious harm and unnecessary risk of harm. Inadequate medical care, physical therapy, feeding practices and training programs continue to contribute to unnecessary resident illnesses, injuries and deaths. Residents continue to suffer fractures, serious lacerations and contusions, kicks, punches and bites from fellow residents; to injure themselves through self-mutilation; to endure unnecessary physical and chemical restraints; to develop acute and chronic respiratory illnesses from aspirating food; to be malnourished and dehydrated; to swallow or choke on inedible objects; to have prolonged and unnecessary seizure activity; and to develop chronic deformities

and concomitant illnesses due to years of neglect and inadequate physical therapy services.

Given the nature of these deficiencies, the harm that residents have continued to suffer, and the time in which the Commonwealth has had to correct the deficiencies, we can no longer delay legal action if the Commonwealth refuses to sign a consent decree.

I. Background

Subsequent to Governor Wilder's receipt of the United States' letter of April 1, 1991, which set forth the findings of our experts, several meetings were held between attorneys for this Department and attorneys from the Virginia Attorney General's Office and officials from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services ("DMHMRSAS"). Following our receipt of an outline of remedial measures Commonwealth officials intended to implement at NVTC, the parties resumed negotiations regarding an agreement to ensure the implementation of corrective measures.

Based on further assertions that corrective measures had been taken, we agreed to retour NVTC twice in the fall of 1991 with expert consultants. We found that conditions at the facility continued to violate the constitutional rights of NVTC residents and we continued to pursue a negotiated agreement to ensure correction of these violations. In fact, the United States and the Commonwealth appeared to be in substantial accord regarding the terms of an agreement to correct the violations at NVTC -- indeed, many if not most of the substantive terms of the agreement had been worked out. However, in December 1992, former Commonwealth Attorney General, Mary Sue Terry, declined to enter into any enforceable agreement.

In early 1993, the Commonwealth's Attorney General's office informed us that additional corrective actions had been taken and that the facility was now in full compliance with constitutional standards. Accordingly, it was agreed that Department attorneys and expert consultants would yet again tour NVTC to evaluate the conditions there and that the findings of the experts would be turned over to the Commonwealth's Attorney General's office prior to the Department taking any additional action.

The findings of the five experts who toured NVTC, as embodied in their attached reports, make it clear that while some corrective actions have been taken at the facility, violations of the residents' constitutional rights continue and the residents continue to suffer serious harm. The deficiencies cited by the five experts (two psychologists, a physician, a registered physical therapist, and a pharmacist) are consistent with the

whether individualized habilitation programs can meet the needs of residents.

B. Failure to provide and implement training programs results in the excessive use of restraints without justification.

The expert consultants also found that NVTC fails to provide adequate training programs, especially for individuals who exhibit maladaptive behaviors. NVTC's assessments of the underlying function of maladaptive behavior such as aggression and self-injury are inconsistent with professional standards, and the resulting individualized behavior plans are insufficient to meet the needs of the residents. For example, there is inadequate management of, and training programs for, individuals with serious pica behavior (eating inedibles). The absence of individualized behavior plans based upon appropriate functional analyses, subjects clients to the risk of an over-dependence and misuse of physical or chemical restraint and physical and psychological harm. The excessive use of restraints without adequate justification has been an issue that has been continually brought to the attention of NVTC, and while progress has been made in this area since our first tours, the psychology and medical experts discovered that this is still a serious problem at NVTC.

In addition, many residents who could greatly benefit from systematic behavior management programs do not have them. Training in communication, social, self-help, and related skills is essential to promote and protect the health and well-being of these individuals and permit them to function as independently as possible. Such training at NVTC is grossly inadequate. For example, safe eating skills often must be taught to individuals who otherwise may be at risk of choking and asphyxiation. However, both psychology and physical therapy experts noted that eating skills simply were not addressed by the staff and the failure to do so has resulted in both an increased risk of injury and the failure of residents to learn these skills. This finding also applies to programs designed to teach residents the activities of daily living, e.g., dressing, toileting, and other self-care skills.

The psychology consultants also found that training and service planning are not directed towards facilitating resident transition into community-based programs which are or can be made available to meet their individual needs.

III. Professional and Direct Care Staff are Inadequate Both in Terms of Numbers and Qualifications.

The expert consultants were unanimous in their findings that, while NVTC has apparently made some recent progress in

hiring and training both professional and non-professional staff, NVTC still does not employ a sufficient number of trained personnel to meet the basic needs of its residents. NVTC is critically in need of more psychologists, and physical and occupational therapists. NVTC also employs insufficient numbers of medical personnel to cover some shifts and weekends. The staff that is presently employed require considerably more training before they will be able to provide adequate care. This lack of adequate numbers of trained staff may contribute in part to the lack of adequate staff supervision and some employees' unfamiliarity with the residents under their care.

IV. Medical Care is Inadequate.

The medical consultant found substantial deficiencies in a number of key medical areas that are resulting in harm and unnecessary risk of harm to the residents of NVTC. These deficiencies include, inter alia: delayed and inadequate response to medical emergencies; inadequate seizure charting and management, including emergency management of prolonged, life-threatening acute seizures; insufficient coverage and communication by physicians on nights and weekends; over-reliance on use of psychotropic medications without clear indications for their use; lack of quality assurance; and lack of adequately trained professional medical staff. In a number of cases, these deficiencies or a combination of them, led to potentially avoidable injuries, illnesses and death.

V. Medical Charting and Medication Practices are Seriously Deficient.

The pharmacy and medical experts also found medical charting and medication practices to be generally inadequate and observed a lack of documented communication between care providers, physicians, nurses and pharmacists. Adequate record keeping and interdisciplinary communication are essential if residents are to be provided adequate medical care. Both experts found significant deficiencies in individual medical plans, quality assurance mechanisms and data collection. They also found inconsistent monitoring of and follow-up on medication side effects. The pharmacist noted that, although some new policies and procedures had recently been written, they were very new and had not been fully implemented as of the date of our review.

VI. Feeding Practices are Dangerous.

The medical, physical therapy and psychology experts all found feeding practices to be dangerously deficient. Residents were observed coughing, gagging and choking due to staff feeding the residents inappropriately, e.g., feeding residents too much too quickly, or feeding residents with their necks hyperextended. Staff are insufficiently trained to feed residents safely or

properly assist residents to feed themselves or train them in safe eating skills. Such dangerous practices have devastating results for residents who are medically fragile, or have poor chewing, swallowing skills or compromised gag reflexes.

VII. Physical and Nutritional Management is Deficient.

NVTC has a severe shortage of sufficiently trained physical therapists, occupational therapists and dieticians to adequately meet the basic needs of the residents, over 100 of whom have severe physical disabilities. This shortage of trained professionals has resulted in inadequate training and oversight of direct care staff, inadequate identification and comprehensive treatment of health and nutritional problems, and resident idleness, immobility, physical and mental deterioration, and ill health. A number of residents are substantially underweight, malnourished or dehydrated. In many cases, the residents' physical deformities, and the pain and ill health caused by the deformities, are a result of years of neglect by NVTC. Physical therapy and therapeutic equipment are entirely inadequate to meet the needs of the physically disabled NVTC residents.

VIII. Recordkeeping Fails to Comport with Professional Standards.

Institutional care-providers such as NVTC must keep accurate, comprehensive and accessible records in order to permit professional judgment to be exercised and to ensure the provision of adequate care to the residents. The expert consultants were unanimous in their finding that recordkeeping at NVTC is grossly deficient. In some areas essential data on resident behavior or health is not recorded, and where it is recorded, it is inaccurate or incomplete. Important behavioral or medical information contained in residents' records is not acknowledged in the residents' comprehensive plans or elsewhere in their treatment planning. Necessary quality assurance mechanisms do not appear to be working or in place.

IX. Conclusion

The long-standing problems cited above continue to pose a substantial threat to the health and safety of NVTC residents, deny them adequate care, and skills necessary to permit them to function as normally and as independently as possible. Given the nature of NVTC's long-standing constitutional violations, the time that has already passed, and the additional time needed to remedy these violations, we can no longer delay legal action if the Commonwealth continues to refuse to resolve this matter by a mutually negotiated and agreed upon consent decree. While we believe that it would be mutually beneficial to settle this

matter and are still willing to do so, action must be taken expeditiously in order to protect NVTC residents. We would appreciate being informed of your decision at an early date.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

Enclosures

cc: King E. Davis, Ph.D.
Commissioner
Virginia Department of Mental Health,
Mental Retardation and Substance Abuse

Mr. David H. Lawson
Director
Northern Virginia Training Center