1987 FISCAL YEAR REPORT TO CONGRESS PURSUANT TO CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT

The Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 (hereinafter referred to as the Act), was enacted in May 1980. It authorizes the Attorney General to initiate or to intervene in equitable actions against public institutions which he has reasonable cause to believe are subjecting persons residing there to egregious or flagrant conditions pursuant to a pattern or practice that deprives such affected persons of rights, privileges, or immunities guaranteed to them by the Constitution or laws of the United States. This report will provide Members of Congress with information regarding actions taken under the Act in fiscal year 1987, and information concerning the progress made in federal institutions toward meeting statutory and regulatory standards for such institutions or constitutionally guaranteed minima. This report is submitted in accordance with the reporting requirements of 42 U.S.C. §1997(f) and is current through September 30, 1987.

ACTION TAKEN IN FISCAL YEAR 1987

During fiscal year 1987, the Department filed six lawsuits pursuant to the Civil Rights of Institutionalized Persons Act of 1980. Four of these lawsuits were settled by consent decrees, one was dismissed due to a comprehensive settlement in a private lawsuit, and another is awaiting approval by the Court.

The Department initiated seven new investigations: three concern mental health institutions, three involve mental retardation facilities, and one concerns a local jail. Additionally, we terminated investigations at two county jails, and one prison. Another action was terminated due to the adequate completion of all the requirements of the consent decree.

Actions taken during the fiscal year are more fully described below, and were taken in accordance with the internal guidelines previously reported.

- During fiscal year 1987, we continued our negotiations and evaluation of conditions at two mental health institutions in California: Atascadero State Hospital and Napa State Hospital. Due to voluntary remedial steps undertaken by the State to bring conditions at these facilities up to a constitutionally adequate level, we have allowed an additional short period of time for the State to implement the remainder of its corrective actions. We are monitoring the State's progress and will retour the facilities with our expert consultants to assess the scope and effectiveness of their remedial efforts. Once we complete our reevaluation, we will advise the State as to our findings.

- On February 27, 1987, we wrote to Governor Mario M. Cuomo of New York to inform him of the findings of our investigation of the Buffalo Psychiatric Center. Our letter identified the conditions at the Center that deprive patients confined there of their constitutional rights with regard to adequate medical and psychiatric care, freedom from undue bodily restraint, and reasonably safe conditions of confinement. Specifically, our investigation found general medical care that is seriously inadequate, medication practices that pose an unacceptable risk of harm to patients, seclusion and restraint practices that fail to protect residents from undue risks of harm to their personal safety, inadequate recordkeeping practices that jeopardize essential medical treatment services, inadequate professional staffing, and unsafe environmental conditions. Our letter also set forth the minimally necessary remedies required to ensure constitutionally adequate conditions at Buffalo Psychiatric Center. We have met with New York officials to discuss the possibility of settlement in this case; however, the State has been unwilling to enter into a legally binding and judicially enforceable agreement. If we are unable to obtain such an agreement, we will exercise our enforcement alternatives under the Act.

- On September 30, 1987, we informed New York Governor Mario Cuomo that we were initiating investigations into conditions of care and treatment at the Kings Park Psychiatric Center, the Central Islip Psychiatric Center and the Pilgrim Psychiatric Center on Long Island. The investigations will focus on issues concerning staffing, use of medications, medical care, staff supervision and abuse of patients. Our investigation of these facilities is ongoing.

- On October 29, 1986, we informed New Mexico Governor Toney Anaya of the findings of our investigation into conditions at the Las Vegas Medical Center, Las Vegas, New Mexico. Our letter stated that conditions exist at the Las Vegas Medical Center which deprive patients of their constitutional rights to adequate medical and psychiatric care, and freedom from unreasonable risks to personal safety. We identified deficiencies in professional and direct care staffing, professionally unacceptable medication practices, and medical recordkeeping practices that pose serious risks to the medical and psychiatric care afforded the residents. Minimally necessary remedies to correct the identified deficiencies were included in our notice. In August 1987, we retoured the facility with our consultant psychiatrist to assess current conditions there. We are reviewing the information collected during our reevaluation and will soon notify the State of our findings.

- On December 1, 1986, we sent Massachusetts Governor Michael Dukakis our notice of findings of our CRIPA investigation of Westboro State Hospital, a State operated psychiatric facility in Westboro, Massachusetts. Our notice letter advised the Governor that conditions at Westboro violate the patients' rights. Specifically, Westboro patients are not being provided with professionally designed psychiatric treatment and training programs to reduce or eliminate unreasonable risks to their personal safety and/or need for undue bodily restraint; adequate medical care and appropriate medication practices; and protection from harm to their personal safety by the conduct of staff and other patients. In addition, Westboro does not use adequate sanitary practices, does not use seclusion and restraint appropriately, and does not have a sufficient number of competent and qualified direct care and professional staff to provide patients with adequate medical care, psychiatric treatment, and training programs. Settlement negotiations are pending.

- On December 2, 1986, we notified Oregon Governor Victor Atiyeh of our findings from our follow-up expert consultant tour of the Eastern Oregon Training Center, a State-operated mental retardation facility in Pendleton, Oregon. We had previously notified the Governor on July 28, 1986, that our CRIPA investigation of the facility had found unconstitutional conditions and federal statutory violations. Our December 2nd letter advised Governor Atiyeh that a pattern or practice of the same unconstitutional conditions and federal statutory violations continue to exist at Eastern Oregon Training Center. The findings letter further advised the Governor that because voluntary remedial efforts have not taken place, a consent decree is necessary. A proposed Consent Decree was included in the letter to initiate the negotiation process.
- During fiscal year 1987, we conducted tours of the Ebensburg Center in Ebensburg, Pennsylvania, with three private consultants. As part of our investigation into conditions at that facility, we examined institutional records, interviewed professional and direct care staff, and spoke with residents. We have completed our evaluation of that data collected regarding this investigation and will soon advise the State of our findings.

- During fiscal year 1986, we informed Governor Bill Allain of Mississippi of our findings of constitutionally deficient conditions identified by our investigation of the Ellisville State School, an institution for mentally retarded persons. Since that time we have been engaged in productive settlement negotiations. We expect to file a consent decree with the Court that will rectify the deficiencies at Ellisville and ensure constitutionally adequate conditions in the near future.
- We conducted several expert consultant tours of the Embreeville Center, a mental retardation facility located in Coatesville, Pennsylvania, during fiscal year 1987 as part of our ongoing investigation into conditions at that facility. During our examination, we also reviewed resident and other institutional records, interviewed staff and spoke with residents. We are evaluating the information collected on the tours as well as the findings, conclusions and recommendations of our consultants. Upon completion, we will notify the State of our findings.

- On November 18, 1986, we notified Governor Harry Hughes of Maryland of our intent to investigate conditions of confinement at Great Oaks Center, a facility for mentally retarded individuals in Silver Spring, Maryland. The initiation of our investigation was based on allegations of federal constitutional and statutory violations of residents' rights with respect to shortages in trained staff, physical harm to residents, substandard environmental conditions, lack of communication services for deaf mentally retarded residents, and inadequate medical care and training of residents. We have since conducted expert consultant tours and reviewed institutional documents. We are currently evaluating the data that has been collected in order to prepare our notice of findings for the State.
- In April 1986, we notified Governor Richard Celeste of our intent to investigate conditions at the Howe Developmental Center, an institution for the developmentally disabled in Tinley Part, Illinois. Since that time we have conducted several expert consultant tours, reviewed institutional records, and interviewed staff. We are continuing to evaluate the data that we have thus far collected and are in the process of preparing our findings.

- On January 21, 1987, we notified Governor Garrey Carruthers that we were initiating an investigation into conditions within the Los Lunas Hospital and Training School, a facility for mentally retarded persons in Los Lunas, New Mexico. Our investigation was prompted by allegations of abuse of residents, inadequate staffing, inappropriate use of medication and physical restraints, substandard environmental conditions, and the denial of minimally adequate training for the residents. We have partially completed our consultant tours and continue to gather information on this ongoing investigation.
- On March 5, 1987, we wrote to Governor Richard F. Celeste to inform him as to our findings concerning our investigation of the Montgomery Developmental Center, a mental retardation facility in Huber Heights, Ohio. Our letter noted problems of a constitutional dimension with respect to medication practices and resident safety. The State, however, had already begun taking steps to improve conditions generally at the facility and we expect such remedial efforts to continue. In light of the State's voluntary actions, we have allowed a reasonable amount of time for the State to complete its corrective program. We will then retour the facility to assess the extent of the State's efforts.

- In fiscal year 1986, we initiated investigations of three mental retardation facilities located in northeast Ohio: Broadview Developmental Center, Cleveland Developmental Center, and Warrensville Developmental Center. We have since conducted a number of expert consultant tours of all three facilities and continue to collect additional information to keep abreast of current conditions. We will advise the State of our findings with respect to the constitutionality of conditions at these facilities once all our data has been evaluated.
- On September 30, 1987, we notified Kansas Governor Michael Hayden that we were initiating an investigation into conditions of care and treatment at the Winfield State Hospital and Training School, a mental retardation facility in Winfield, Kansas. The investigation will focus on issues concerning staffing and staff supervision, medical care, abuse of patients, use of physical restraints, and the provision of minimally adequate training. Our investigation is ongoing.

- On February 5, 1987, we advised Supervisor Paul Eckert of San Diego County of the findings of our investigation of the Edgemoor Geriatric Hospital, Santee, California. Our letter noted the very serious problems that the facility had experienced in recent years as well as the significant changes which have taken place there. We concluded that, although the facility had taken voluntary steps to improve standards of care, additional corrective measures were necessary. The area which we identified as requiring improvements dealt with nursing practices and physical plant. We noted deficiencies with respect to adequate numbers of qualified nurses and problems with the physical plant which impede proper infection control and adequate ventilation. These deficiencies placed the health and safety of the residents at risk. In light of the significant progress made by the County to bring Edgemoor up to constitutional standards, we allowed additional time for them to continue with their corrective plans. We, therefore, advised the County that we would revisit the facility in the near future to assess the scope and effectiveness of their voluntary remedial efforts.

- We continue to meet with County officials in an effort to negotiate a settlement agreement with respect to the unconstitutional conditions of confinement identified by our CRIPA investigation of the Essex County Youth House in Newark, New Jersey. We are confident that we will be able to obtain a legally binding and judicially enforceable decree in this matter to ensure that constitutionally adequate conditions are afforded the youths detained at this facility.
- Our notice to investigate the Los Angeles County Juvenile Halls was sent to Chairman Michael D. Antonovich in fiscal year 1985. After gaining access to the facilities through a permanent injunction ordered in 1986, we have conducted extensive expert consultant tours of the three facilities which compose the Juvenile Hall system: Central Juvenile Hall, San Fernando Valley Juvenile Hall, and Los Padrinos Juvenile Hall. In the course of our tours, we interviewed a large number of juveniles and staff and reviewed relevant documents. Due to the number and complexity of the issues involved in the evaluation of each of these juvenile facilities, we are continuing to analyze the data collected on our tours. We will soon notify the County of our findings.

- Since the submission of our findings regarding unconstitutional conditions of confinement at the Preston School of Industry in Ione, California, we have held several discussions with State officials in an attempt to resolve this matter. Our findings had noted an inappropriate use of chemical restraints, lack of staff, overcrowding, and serious fire safety deficiencies. A follow-up fire safety tour in April 1987 revealed that deficiencies in this area continue to exist. We are continuing our settlement negotiations with the State.
- On July 21, 1987, we wrote to Mayor Dianne Feinstein of San Francisco, California, to inform her of the results of our follow-up evaluation of the San Francisco Youth Guidance Center, a juvenile detention facility. Following our initial investigation of the Center, City and County officials voluntarily undertook to improve constitutionally deficient conditions there. Our reevaluation found that while improvements have been made, the pattern of unconstitutional conditions previously identified persist in a significant way. We continue to hold settlement discussions with City and County officials to resolve this matter and to monitor any additional corrective actions that have been taken.

- On November 7, 1986, we informed County Judge Brian Williams of Marion, Arkansas, of our intent to investigate conditions within the Crittenden County Jail. Our investigation was prompted by information indicating health and life-threatening conditions at the jail, deficient staffing and inadequate security practices, as well as inmate abuse. Based upon our extensive investigation, we concluded that conditions do exist at Crittenden that deprive the prisoners of their constitutional rights. The unconstitutional conditions identified in our June 1, 1987 findings letter included: grossly inadequate medical care; life-threatening fire safety deficiencies; inadequate staffing and security; and sanitation practices which pose unreasonable risks to the health and safety of prisoners. Our letter also noted minimally necessary remedies and proposed to enter into a consent decree with County officials to ensure that constitutionally adequate conditions at the jail are achieved. Settlement negotiations are continuing.

- On November 4, 1986, we advised the Honorable George Smith of the Hinds County Board of Supervisors of the results of our investigation into conditions at the Hinds County Detention Center, Jackson, Mississippi. Our investigation confirmed that conditions at the facility deprived noncriminal mentally ill detainees of rights secured by the Fourteenth Amendment to the Constitution. We noted that noncriminal mentally ill individuals are confined to the detention facility and are not provided adequate medical care and are exposed to conditions that subject them to unreasonable risks to their personal safety and undue bodily restraint. Since an outstanding order of the Chancery Court has enjoined the detention center from housing such mentally ill persons, we informed the County that we would monitor the facility for a reasonable period of time to ensure that the unconstitutional conditions of confinement that we observed would not recur. We are now satisfied that the Hinds County Detention Center is no longer confining noncriminal mentally ill persons without adequate safeguards and have, therefore, closed our investigation.

- On July 23, 1987, we wrote to Assistant Prosecuting Attorney Ronald J. Mayle to inform him that we were closing our investigation of the Sandusky County Jail, Fremont, Ohio. Our investigation had focused on serious fire safety deficiencies that posed undue risks to the safety of those confined to the jail. A follow-up tour by our fire safety consultant noted many improvements in this area of concern. Additionally, we anticipate vigorous enforcement of the settlement of a private lawsuit, Dominguez v. City of Sandusky. We believe that the civil rights of those confined to the Sandusky County Jail will be fully protected under this judicially enforceable settlement agreement. In view of this agreement and the able representation by qualified counsel enjoyed by the jail inmates, further action by the Department is not warranted. Also, we are satisfied that the life-threatening conditions that previously existed at the jail have been remedied by the fire safety improvements which have been completed or are otherwise in the process of completion. We have also been informed that plans for the construction of a new jail are underway.

- We notified Chairman of the Board of Supervisors Edward R. Campbell, Alameda County, on August 11, 1987, of the findings of our investigation into conditions of confinement at the Santa Rita Jail in Pleasanton, California. Our letter concluded that numerous conditions exist at the Santa Rita facility that deprive those confined there of certain rights protected by the Eighth and Fourteenth Amendments to the Constitution. Those unconstitutional conditions are: discrimination in the housing of inmates on the basis of race; inadequate supervision, staffing and security resulting in undue risks to the safety of inmates; inadequate medical care; life-threatening fire safety deficiencies; the deprivation of meaningful access to the courts; and overcrowded conditions that pose a serious threat to the health and safety of the inmates. Our letter also listed the remedial measures necessary to correct the constitutional deficiencies identified. We continue to meet with County officials in an attempt to negotiate a consent decree that would be mutually acceptable and filed with the Court.

- On January 6, 1987, we notified Governor George Deukmejian of our investigative findings as to conditions at the California Medical Facility, a hospital facility within the California Department of Corrections located in Vacaville, California. We advised the Governor of egregious and flagrant conditions in the areas of general/acute medical care, psychiatric care, medical recordkeeping, and environmental conditions. We have since retoured the facility with our consultants to assess current conditions and are evaluating the information we collected. We will soon notify the State of our findings.
- Following the conclusion of a criminal investigation of alleged guard on inmate brutality at the Clinton Correctional Facility, Clinton, New York, we found that conditions there did not rise to the level of constitutional deprivations required before action can be taken under CRIPA. We, therefore, officially closed our investigation on April 22, 1987.

- Our investigation of the Cummins Unit within the Arkansas Department of Corrections was initiated during fiscal year 1986. We have since conducted a number of expert consultant tours of the facility and have collected a large amount of documentation from the State. Once we receive the reports from our consultants and evaluate all the data provided by the State and from other sources, we will notify the State of our findings.

- On August 11, 1987, we wrote to Guam Governor Joseph F. Ada to inform him of the findings of our investigation into conditions of confinement at the Guam Adult Correctional Facility (ACF) and the Guam Department of Mental Health and Substance Abuse (DMHSA) Inpatient Unit in Agana, Guam. At the time that we conducted our consultant tours of the Guam ACF and DMHSA, the Agana Lock-Up, a local jail which we had previously noticed our intent to investigate, was closed for renovations. We, therefore, offered no findings with respect to the Agana jail. Our evaluation of ACF and DMHSA found that both facilities are subjecting persons confined there to conditions that deprive them of certain constitutional rights. At the Adult Correctional Facility we found an unacceptable level of violence which subjects the inmates to unreasonable risks to their personal safety, a wide variety of life safety hazards, inadequate access to courts and counsel, highly deficient medical and psychiatric care, and health-threatening sanitation practices. With respect to the Mental Health and Substance Abuse Inpatient Unit we identified major deficiencies regarding professional staffing, necessary psychiatric care and treatment, and appropriate medication and restraint practices. Our letter also discussed necessary remedial measures and proposed to enter into a legally binding and judicially enforceable agreement with the Territory of Guam. Settlement negotiations are continuing.

- On June 3, 1987, we informed Governor Michael Hayden of the findings of our investigation into conditions at the Kansas State Penitentiary in Lansing, Kansas. Our letter concluded that the inmates are being subjected to serious life safety risks and unconstitutional overcrowding. Further, our letter noted that mental health care at Kansas State Penitentiary is grossly inadequate and that medical care is so deficient as to demonstrate deliberate indifference to the serious medical needs of the prisoners. Minimum remedial measures were set forth in our notice and we are currently engaged in settlement negotiations with the State in an attempt to resolve this matter with a judicially enforceable consent decree.
- We have completed our review of the documents and other information received during the course of our investigation, as well as the recommendations and conclusions of our expert consultant concerning Missouri Training Center for Men at Moberly. We are now evaluating what impact a pending federal private lawsuit regarding similar conditions of confinement issues at Moberly will have on our activities there as we prepare our findings letter to the State.

- We are reviewing the compliance information that we have received concerning the Feliciana Forensic Facility in Jackson, Louisiana. This institution for the criminally insane is the subject of a consent decree entered in the case, Davis and United States v. Henderson. After evaluating the data, we will determine what enforcement actions may be necessary to ensure full compliance with the settlement agreement.

- On October 3, 1986, we filed a complaint and consent decree with the District Court for the Northern District of Illinois regarding conditions at the Elgin Mental Health Center in U.S. v. Illinois, No. 86-C-7520 (N.D. Ill.). The complaint alleged the deprivation of the constitutional rights of the residents of the Elgin Mental Health Center by failure of the State to provide adequate medical care and treatment to the residents, to provide psychiatric treatment to ensure that patients are free from undue risks to their personal safety, to ensure an adequate number of sufficiently trained staff, and to ensure that medications are appropriately prescribed and administered. District Court Judge Prentice H. Marshall signed and entered the Consent Decree on February 18, 1987, which addressed all the allegations set forth in the Complaint. We have since received the State's Plan of Compliance Report. We will continue to review all compliance information and plan on conducting expert tours to assess the scope and effectiveness of the State's implementation plans.

- In 1987, we received compliance reports from the State and conducted expert tours of both Central and Logansport State Hospitals, as part of our monitoring activities pursuant to the Consent Decree in United States v. Indiana. Our evaluation of the compliance information we have collected thus far has shown that the State has made some improvements in a few areas, such as with medication practices, but continue to be constitutionally deficient in others, especially with regard to adequate professional staffing. We have met with the State regarding the problem of staffing and we will continue to closely monitor this issue as well as all other aspects of the settlement agreement. After we conduct additional compliance tours to assess current conditions at both facilities we will determine what other enforcement actions may be necessary to ensure full compliance with the terms of the settlement agreement in this case.

- On August 25, 1987, Judge David Mazzone entered a memorandum and order endorsing the settlement agreement between the parties in United States v. Massachusetts (Civ. Action No. 85-0632-MA) our CRIPA lawsuit involving conditions at Worcester State Hospital. The settlement agreement was entered into by the parties after one week of trial. Labelling the agreement as "the paradigm of settlements between the Department of Justice and other states," Judge Mazzone endorsed the agreement as a "comprehensive, practical and proper solution to this litigation." The settlement agreement requires the Commonwealth of Massachusetts to develop and implement detailed plans in thirteen areas to ensure that Worcester State Hospital residents are afforded their constitutional rights. In addition, the agreement sets forth specific staffing ratios for professional and direct care staff that must be achieved at the Hospital. Specific timetables for developing and implementing the corrective plans are set forth in the agreement. The parties expect the provisions of the agreement will be fully implemented on or before December 31, 1989. The Commonwealth will submit quarterly status reports on progress toward implementing the agreement. The United States will monitor the Commonwealth's progress and the Court will retain jurisdiction until the case is dismissed after full

implementation of the agreements.

- During fiscal year 1987, we met with Michigan State officials regarding their compliance with the Consent Decree in United States v. Michigan addressing conditions at the Northville and Ypsilanti Regional Psychiatric Hospitals. We continue to receive and review the compliance reports submitted by the State and expect to conduct expert tours of both facilities to assess the State's progress in meeting the requirements of the settlement agreement.
- On September 16, 1987, we filed a Complaint pursuant to CRIPA in the United States District Court for the Western District of Michigan, U.S. v. Michigan, No. K87-346CAH, alleging unconstitutional conditions of confinement at the Kalamazoo Regional Psychiatric Hospital (KRPH), Kalamazoo, Michigan. At the same time, we filed with the Court a Consent Decree, signed by the parties, which would resolve all outstanding deficiencies at KRPH. The decree requires the State of Michigan to establish minimum staffing ratios at the psychiatric hospital and to develop and implement plans to address all areas of deficiencies found during our CRIPA investigation. The Decree, if approved by Judge Enslen, will become a legally binding, judicially enforceable Order.

- We continue to receive compliance information regarding the State's efforts to provide constitutionally adequate conditions of care and treatment to the residents of the South Carolina State Hospital, Columbia, South Carolina, in accordance with our Consent Decree, United States v. South Carolina. We expect to conduct expert compliance tours to assess current conditions there in order to evaluate the effectiveness of the State's implementation plan.
- In 1987, after conducting some expert tours of the Wheat Ridge Regional Center to assess current conditions there, we met with Colorado State officials regarding areas of noncompliance with our settlement agreement in United States v. Colorado. We continue to actively monitor the State's progress in attaining full compliance with the terms of the Decree and to inform the State as to those matters where improvements are still necessary.

- On December 22, 1986, Judge Burns signed the proposed consent decree in United States v. Connecticut (Civ. Action No. N-86-252-EBB) addressing conditions at the Southbury Training School, an institution for the mentally retarded in Southbury, Connecticut. The Consent Decree had been agreed upon by the parties and filed with the Court on July 25, 1986. The signing of the Decree was delayed, however, pending the resolution of a related action, Dober v. Meese (D. Ct., N-86-195-EBB). The Dober action was brought by the Connecticut Protection and Advocacy Association (P&A) seeking a writ of mandamus ordering the Attorney General and Assistant Attorney General to allow the P&A's participation in our negotiations with the State of Connecticut regarding conditions at the Southbury Training School. The Court refused to enter the writ of mandamus and granted the United States' motion to dismiss the Dober action. Following that decision, on October 10, 1986, the P&A filed a motion to intervene in our case, United States v. Connecticut. In addition, on November 3, 1986, the Home and School Association of Southbury Training School filed a motion to be designated class representative in our CRIPA action. Finally, when the Court entered our consent decree in United States v. Connecticut, the judge also denied the intervention motions of the Home and School Association and the Connecticut Protection and Advocacy Association for the Mentally Retarded. The

Consent Decree calls for specific staffing ratios to be met, the implementation of new procedures for the provision of improved delivery of medical care, the evaluation of each resident and development and implementation of training programs for each resident, improved mechanisms governing administration of behavior modifying drugs, and protection of residents from risks of harm due to the use of restraints, abuse or neglect, or environmental conditions. We are currently monitoring the State's compliance with the requirements of the Consent Decree.

- On January 5, 1987, the Department filed a Complaint in United States v. Louisiana regarding the Metropolitan Developmental Center in Belle Chasse, Louisiana, then known as the Belle Chasse State School. The Complaint charged Louisiana officials with failing to provide adequate medical care and treatment; failing to ensure that medications are prescribed and administered pursuant to the exercise of professional judgment by qualified professionals, and failing to ensure that bodily restraints are administered to persons confined to the Center pursuant to the exercise of professional judgment by appropriate professionals, rather than as punishment, in lieu of treatment, or for the convenience of the staff. A Consent Decree was negotiated by the parties and approved by the Court and filed in the case on July 23, 1987. The Decree requires the state to provide minimum staff-to-resident ratios, to provide adequate medical care and psychiatric services as well as to provide professionally designed training programs, to establish appropriate prescription and medication administration practices, and to establish guidelines for the use of bodily restraints. The state was required to provide appropriate plans detailing plans for implementing the Decree within 90 days of its entry.

- We continue to follow the State's progress of compliance with the Consent Decree in United States v. Maryland, our CRIPA case involving conditions at the Rosewood Center, an institution for mentally retarded persons in Owings Mills, Maryland. We have conducted several compliance tours of the facility during the year and continue to find deficiencies that have not yet been corrected as prescribed by the Consent Decree. We will evaluate all the compliance data we have obtained thus far to determine what additional enforcement action may be necessary.

- During 1987, we continued discussions with New Mexico State officials concerning resolution of the case, United States v. New Mexico, our CRIPA lawsuit involving conditions at the Fort Stanton Hospital and Training School, a facility for mentally retarded persons. Initially, the State had refused us access to return to the facility in order to observe current conditions. After extensive negotiations on this issue, the State permitted the inspection. Although our tour noted some improvements, however, additional corrective actions are necessary to bring the institution up to a constitutionally adequate level. Since the State has been making a concerted effort to improve conditions at Fort Stanton, we are staying further litigative actions for a short period. After this period, we will return to the faciity to assess the scope and effectiveness of the State's remedial efforts. We will then determine whether it is necessary to proceed with litigation.

- We have conducted extensive discovery during this fiscal year in United States v. Oregon, our CRIPA case involving conditions at the Fairview Training Center, a facility for the mentally retarded in Salem, Oregon. Our discovery thus far has included a number of requests for production of documents, interrogatories, expert tours, and record reviews. In November 1986, residents of the Fairview Training Center filed a Motion to Intervene in our action. The Department did not oppose permissive intervention, though we did oppose intervention as "a matter of right" due to the failure of the proposed intervenors to meet the legal requirements for such intervention. The judge denied the intervention motion on February 3, 1987, on the grounds that the United States adequately represented the interests of the facility's residents and intervention would unduly complicate the litigation and the matter is currently on appeal. We are proceeding with our discovery schedule with a tentative trial date set for mid-July 1988.

- On December 18, 1986, we filed a Motion jointly with Ada County to Dismiss our Consent Decree governing conditions at the Ada County Jail. This marks our first CRIPA Consent Decree to be completed and terminated. The investigation began on January 6, 1983 and included four tours by expert consultants. Our notice of findings letter, sent April 18, 1984, cited a failure to provide adequate protection from harm, unsafe environmental conditions and denial of access to adequate medical care. After further tours and negotiations, a settlement agreement, requiring specific corrections, was filed on May 23, 1985. Ada County has, as a result of our investigation, increased the guard staff and frequency of security checks, installed electronic surveillance, instituted medical assessments on admission, increased protection of mentally ill and suicidal inmates, improved medication storage practices, replaced flammable mattresses, unblocked exits, and developed emergency evacuation procedures. A new policy and procedure manual was developed, recordkeeping practices were improved, and improvements were made in the food service area. The Motion to Dismiss was approved and signed by Judge Callister of the District of Idaho.

- We are continuing to monitor the County's progress in constructing a new jail to meet the terms of our settlement agreement in United States v. Bedford County, our CRIPA suit concerning the Bedford County Jail, Bedford, Tennessee. We have been informed that the new jail is near completion and that it will soon be ready for occupation. Once we are satisfied that the health and life-threatening conditions that existed at the old jail have been remedied by transferring the inmates to the new facility and abandoning the original jail, we will move to terminate the Decree.

- On April 9, 1987, we filed a Complaint pursuant to CRIPA in the District Court for the Southern District of Ohio alleging unconstitutional conditions of confinement at the Jefferson County Jail, Steubenville, Ohio in United States v. Jefferson County. On April 10, 1987, a Consent Decree was entered by Judge James Graham resolving this civil suit. The Decree ensures that persons confined to the Jefferson County Jail are not subject to unreasonable risks of harm from fire hazards. We are monitoring the county's compliance with the Decree.

- During the course of 1987, we conducted expert compliance tours of the Newark City Jail pursuant to the Consent Decree in our case, United States v. City of Newark. The defendant City of Newark had previously refused us access to the Newark City Detention Facilities in direct violation of our Settlement Agreement. As a result, we filed a Motion for Contempt and the Special Masters offered recommendations to the Court on this issue, in the United States' favor. The Special Masters recommended that the City be held in contempt and proposed a fine if they did not allow the United States access within a proscribed time. Following these recommendations, the City allowed us access to the facility to conduct our fire safety inspection. Our inspections and information thus far indicates that the City has failed to comply fully with the terms of the Decree. Our compliance monitoring of the Newark City Jail will continue as we determine what further enforcement actions may be necessary.

- During fiscal year 1987, we received compliance reports from County officials and conducted expert tours of the Talladega County Jail, Talladega, Alabama, as part of our monitoring responsibilities pursuant to the Consent Decree in United States v. County of Talladega (M.D. Ala.). After touring the facility to assess the progress being made to improve conditions as prescribed by the settlement agreement, we found that the County has not fulfilled a substantial number of the requirements set forth in the settlement agreement within the time allotted. In an effort to resolve the continuing deficiencies, we have allowed the County an additional short period of time to meet its obligations under the Consent Decree. We will soon conduct another assessment of the County's compliance and will determine at that time whether further enforcement alternatives are necessary.

- On January 6, 1987, we filed with the United States District Court for the Middle District of Alabama a Complaint in United States v. Alabama, et al. The Complaint alleges the denial of equal protection for women inmates confined in the Julia C. Tutwiler Prison, Wetumpka, Alabama in violation of the Fourteenth Amendment to the Constitution. The Complaint alleges Alabama fails to provide female prisoners with vocational and educational programs substantially equivalent to those offered male inmates in other State correctional institutions. The Court stayed our action on May 4, 1987, however, pending the resolution of a private lawsuit, Nichols v. Smith. The parties in the Nichols action filed a settlement agreement on August 27, 1987, which should redress all claims raised by our suit. Therefore, on September 10, 1987, we filed a Motion to Dismiss without prejudice to reinstate in United States v. Alabama. On September 14, 1987, Judge Varner granted the United States' Motion to Dismiss in light of the comprehensive settlement in the Nichols case.

- We have participated in a number of compliance and evidentiary hearings as well as conducted compliance tours of Jackson, Ionia, and Marquette Prisons, the subjects of our CRIPA action, United States v. Michigan. Issues which have been addressed at the hearings and on the tours include fire safety, sanitation, unconstitutional overcrowding, medical care, psychiatric services, and environmental conditions. Total compliance with the terms of the Consent Decree has not yet been achieved and additional negotiations regarding appropriate relief have been necessary. We continue to actively monitor the State's progress in complying with all conditions of the Consent Decree.

- On November 21, 1986, we filed with the United States District Court for the Virgin Islands a Complaint and Consent Decree resolving our CRIPA investigation of the Golden Grove Adult Correctional Facility on St. Croix, Virgin Islands. Golden Grove is a medium and maximum security prison for both male and female prisoners. The Decree in United States v. Virgin Islands, requires the prison to make immediate corrections in certain fire safety areas, and to formulate plans that provide for adequate security, sanitation, and medical care as well as additional fire safety measures. The Decree was approved and entered by the Court on December 1, 1986. The case was then assigned to Magistrate Lenahan for action. To date the Defendants have not filed an acceptable plan of implementation as required by the Decree. Following conferences with the Magistrate, a new schedule for a revised plan of implementation has been established. We will request conferences with the Magistrate, as appropriate, and take those steps necessary to ensure full compliance with consent decree requirements.

FEDERAL INSTITUTIONS

- The Attorney General is required by Section 8(5) of the Act, 42 U.S.C. 1997f(5), to report on the progress made in federal institutions toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima. A summary of progress made toward this goal by federal institutions operated by the Veterans Administration, the Department of Health and Human Services and the Federal Bureau of Prisons follows.

- The Veterans Administration (VA) has made significant efforts to protect the civil rights of patients in its facilities. VA regulations published at 38 C.F.R. 17.34a identify the constitutionally protected rights of patients, and grant numerous other rights. They also set forth specific procedures for VA to follow when restricting rights, and they establish grievance procedures for patients. Patients are informed of these rights when admitted to a VA facility. VA also protects patient civil rights by hiring individuals to act as patient representatives. They assist patients in understanding their rights, and act as advocates in enforcement of those rights. Representatives are not present in all VA facilities, but there is an increasing number of them throughout the system. VA regulations requiring the full informed consent of patients and their representatives prior to providing care also protect patients rights. VA views the receipt of high quality medical care as the right of all patients. The VA ensures high quality care through a number of internal mechanisms. In that regard, it operates the Health Services Review Organization, a peer review program designed to discover and correct problems in the delivery of health care. The VA also periodically surveys patients to determine their satisfaction with the care provided to them. Finally, both the Office of Inspector General, and the Office of

Medical Inspector conduct investigations of complaints about the quality of health care. All of these mechanisms serve to protect the civil rights of patients.

- During fiscal year 1987, members of the Saint Elizabeths Hospital Patients' Advocate Office and other hospital staff have been involved in creating and implementing a plan for the continuation of advocacy services for Saint Elizabeths patients subsequent to the October 1, 1987, transfer of the hospital from the U.S. Department of Human Services (HHS) to the District of Columbia. Also during this time, the Patients' Advocate Office continued its administration and support of the Patients' Rights Council, the Patients' Rights Advisory Committee, Internship and Personnel Orientation Programs, and a monthly newsletter. The Patients Advocate Office also sponsored a special "Patient Awareness Day" to familiarize the patients with the expected impact of the October 1 hospital transfer. The program, which was attended by more than 500 patients, included a panel presentation by the new Commission on Mental Health Services and a D.C. Council member, and the dissimination of a 12-page informational handbook. Since the transfer of the operation of the hospital complex will have been completed by October 1, 1987, this will be the final report submitted by HHS pursuant to the reporting requirements under CRIPA.

- The correctional standards to which the Bureau of Prisons adheres are those developed by the American Correctional Association (ACA). These standards cover every area of correctional management and operation and include all the basic requirements related to life/safety and constitutional minima, including the provision for an adequate inmate grievance procedure. These standards have been incorporated into national Bureau of Prisons policy and procedure. Therefore, each Bureau institution's compliance with standards is monitored through the Bureau's internal audit program, whereby each institution program and operation is audited for compliance with national policy every 12-18 months. Over 300 separate audits of Bureau institutions were conducted during 1987 by knowledgeable, organizationally independent Bureau auditors or reviewers. In addition, 38 of the Bureau's institutions have been accredited by the Commission on Accreditation for Corrections (CAC). The standards used in this process are the ACA standards described above. Currently, staff of 17 of these facilities are preparing for reaccreditation audits by CAC. Accredited institutions are subject to interim audits by the Commission to monitor ongoing compliance with the standards, particularly in the vital areas of inmate rights, health care, security, safety and sanitation.