Department of Justice Activities
Under the
Civil Rights of Institutionalized Persons Act
Fiscal Year 2012

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I. Introduction and Overview

Individuals confined in institutions are often among the most vulnerable in our society. Recognizing the need to protect the rights of those residing in public institutions, Congress in 1980 passed the Civil Rights of Institutionalized Persons Act (CRIPA) codified at 42 U.S.C. § 1997. CRIPA gives the Attorney General the authority to investigate conditions at certain residential institutions operated by or on behalf of state or local governments—including facilities for individuals with psychiatric or developmental disabilities, nursing homes, juvenile justice facilities, jails, and prisons—to determine whether there are violations of the Constitution or other federal laws. CRIPA enforcement has been delegated to the Department of Justice's Civil Rights Division ("the Division"). CRIPA is enforced by the Division's Special Litigation Section ("the Section").

If a pattern or practice of unlawful conditions deprives individuals confined in the facilities of their constitutional or federal statutory rights, the Division can take action. As required by the statute, the Section engages in negotiation and conciliation efforts and provides technical assistance to help jurisdictions correct deficient conditions. If these efforts fail, the Section may file a lawsuit to correct the violations of rights.

The Division takes very seriously its responsibility to protect the rights of individuals residing in institutions. Over the last year, the Division has achieved important successes throughout all areas of its CRIPA authority. The Division has opened new investigations that are targeted to maximize their impact on the issues and populations that fall within our statutory authority. The Division has issued letters describing the findings of our investigations that break new ground on cutting-edge problems in its civil rights enforcement. The Division has entered into landmark settlements that have significantly changed the civil rights landscape in its

statutory areas and has vigorously enforced settlements to ensure that the rights of the individuals protected by those decrees are vindicated. The Division has engaged in extensive outreach to stakeholders and the community to ensure that their concerns are reflected in its enforcement efforts. Finally, the Division has been involved in policy initiatives that implicate the work of the Section and advance the civil rights of those protected by CRIPA.

In Fiscal Year 2012, the Division filed one complaint, settled two contested litigations, entered into two consent decrees**,** and entered into one out-of-court settlement. The Division also initiated CRIPA investigations of one publicly-operated facility and issued five findings letters outlining findings of significant constitutional and federal statutory violations at five facilities.[1] At the end of Fiscal Year 2012, the Division had active CRIPA matters and cases involving 154 facilities in 30 states, the District of Columbia, the Commonwealths of Puerto Rico and the Northern Mariana Islands, and the Territories of Guam and the Virgin Islands.

As envisioned by Congress, enforcement of CRIPA continues to identify egregious and flagrant conditions that subject residents of publicly-operated institutions to grievous harm. 42 U.S.C. § 1997a (a). In addition to its enforcement efforts at state and local facilities, pursuant to Section f(5) of CRIPA, the Division provides information regarding the progress made in each federal institution (specifically from the Bureau of Prisons and the Department of Veterans Affairs) toward meeting existing promulgated standards or constitutionally guaranteed minima for such institutions. See attached statements.

[1] The full text of these findings letters can be found at the Division's website at http://www.usdoj.gov/crt/split/index.html.

II. Filing of CRIPA Complaints/Resolution of Investigations and Lawsuits

A. Resolution of Investigations

1. Virginia Developmental Disabilities

In January 2012, the Division reached a comprehensive agreement with the State of Virginia that will transform Virginia's service system for individuals with developmental and intellectual disabilities from an institution-based system to a community-based system. This agreement resulted from a CRIPA investigation into the Central Virginia Training Center that began in 2008. In 2010, the Division expanded this investigation to examine the Commonwealth's entire system of serving individuals with developmental and intellectual disabilities. In February 2011, the Division issued findings that the Commonwealth was subjecting thousands of individuals with these disabilities to needless institutionalization or significant risk of institutionalization, and to the harms associated with unnecessary institutionalization. In August 2012, the agreement was approved and issued as a court order by a federal district court in Richmond, Virginia. The settlement agreement will require the state to expand the availability, range, and quality of community-based services to provide tangible opportunities for individuals with intellectual and developmental disabilities to live safely in integrated community settings. The agreement is monitored by an independent reviewer who issues public compliance reports. The Division is also closely tracking the Commonwealth's compliance with the agreement.

2. St. Elizabeths Hospital, District of Columbia

In October 2011, the Division and the District of Columbia filed a joint motion to modify a 2007 settlement agreement. The modified and narrowed settlement agreement requires the District to improve nursing and mental health care and ensure that individuals are served in the

most integrated setting. The District must achieve substantial compliance within 12 months, sustain substantial compliance for a year, and develop and implement clinical audits and oversight procedures. On October 26, 2011, the court approved the joint motion to modify the settlement agreement. The Division will continue to monitor compliance in this case**.**

B. Contested Litigation

1. Terrell County Jail, Georgia

In December 2010, the Division filed a motion for contempt against Terrell County for noncompliance with a 2007 remedial order. The areas of noncompliance included inadequate staffing, medical care, mental health care, and suicide prevention. On October 17, 2011, the District Court entered the parties' modified remedial order, resolving the Division's motion for contempt. The order requires Terrell County to remedy areas of noncompliance. Additionally, the order removed areas of substantial compliance and the bright-line termination date from the preceding order.

III. Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626, enacted on April 26, 1996, covers prospective relief in prisons, jails, and juvenile justice facilities. The Division has defended the constitutionality of the PLRA and has incorporated the PLRA's requirements in the remedies it seeks regarding improvements in correctional and juvenile justice facilities.

IV. Compliance Evaluations

During Fiscal Year 2012, the Division monitored defendants' compliance with CRIPA consent decrees, settlement agreements, and court orders designed to remedy unlawful conditions in numerous facilities throughout the United States, as follows:

A. Facilities for persons with developmental disabilities:

Facility or Facilities	Case or Agreement	Court/Date
Arlington Developmental Center	United States v. Tennessee, 92-2026HA	W.D. Tenn. 1992
Clover Bottom Developmental Center, and Harold Jordan Center	United States v. Tennessee, 3:96-1056	M.D. Tenn. 1996
Centro de Servicios Multiples Rosario Bellber	United States v. Commonwealth of Puerto Rico, 99-1435	D. P.R. 1999
Woodbridge Developmental Center	United States v. New Jersey, 3:05-CV-05420(GEB)	D. N.J. 2005
Beatrice State Developmental Center	United States v. Nebraska, 08-08CV271-RGK-DL	D. Neb. 2008
Abilene State Supported Living Center, Austin State Supported Living Center, Brenham State Supported Living Center, Corpus Christi State Supported Living Center, Denton State Supported Living Center, El Paso State Supported Living Center, Lubbock State Supported Living Center, Lufkin State Supported Living Center, Mexia State Supported Living Center, Richmond State Supported Living Center, Rio Grande State Supported Living Center, San Angelo State Supported Living Center, and San Antonio State Supported Living Center	United States v. Texas, A-09-CA-490	E.D. Tex. 2009

B. Facilities for persons with mental illness:

Facility or Facilities	Case or Agreement	Court/Date
Metropolitan State Hospital, Napa State Hospital, Atascadero State Hospital, and Patton State Hospital	United States v. California, 06-2667 GPS	M.D. Cal. 2006
St. Elizabeths Hospital	United States v. District of Columbia, 1:07-CV-0089	D. D.C. 2007
Los Angeles County Juvenile Camps, California	2012 Revised Settlement Agreement	N/A

Georgia Regional Hospital in Atlanta, Georgia Regional Hospital in Savannah, Northwest Georgia Regional Hospital, Central State Hospital, Southwest State Hospital, West Central Georgia Regional Hospital, and East Central Georgia Regional Hospital	United States v. Georgia, 1-09-CV-0119 United States v. Georgia 01-10-CV-0249	N.D. Ga. 2009 N.D. Ga. 2010
Connecticut Valley Hospital	United States v. Connecticut, 3:09-CV-00085	D. Conn. 2009
Kings County Hospital Center	United States v. City of New York, CV-10-0060	E.D.N.Y. 2010
Delaware Psychiatric Center	United States v. Delaware, 1-11-CV-00591	D. Del. 2011

C. Nursing homes:

Facility or Facilities	Case or Agreement	Court/Date
Ft. Bayard Medical Center and Nursing Home	United States v. New Mexico, CV-07-470 WJ/DIS	D. N.M. 2007
Laguna Honda Hospital and Rehabilitation Center, California	2008 Settlement	N/A
C.M. Tucker Nursing Care Center	United States v. South Carolina, 3:09-CV-98	D.S.C. 2009

D. Juvenile justice facilities:

Facility or Facilities	Case or Agreement	Court/Date
Bayamon Detention Center, Centro Tratamiento Social Bayamon, Centro Tratamiento Social Humacao, Centro Tratamiento Social Villalba, Centro Tratamiento Social Guayama, Guali Group Home, and Ponce Detention and Social Treatment Center for Girls	United States v. Commonwealth of Puerto Rico, 9 4-2080 CCC	D. P.R. 1994
Kagman Youth Facility	United States v. Commonwealth of the Northern Marianas Islands, CV 99-0017	D. Mar, I. 1999
Arkansas Juvenile Assessment and Treatment Center	United States v. Arkansas, 03CV00162	E.D. Ark. 2003

Oakley Training School	United States v. State of Mississippi, 3:03-cv-1354	S.D. MS. 2005
Circleville Juvenile Correctional Facility, Indian River Juvenile Correctional Facility, Cuyahoga Hills Juvenile Correctional Facility, and Scioto Juvenile Correctional Facility	United States v. Ohio, C2 08 0475	S.D. Ohio 2008
Lansing Residential Center, Louis Gossett, Jr. Residential Center, Tryon Residential Center, and Tryon Girls Center	United States v. New York, 10-CV-858	N.D. N.Y. 2010

E. Jails:

Facility or Facilities	Case or Agreement	Court/Date
Hagatna Detention Center, and Fibrebond Detention Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Harrison County Jail	United States v. Harrison County, Mississippi, 1:95 CV5-G-R	S.D. Miss. 1995
Sunflower County Jail	United States v. Sunflower County, Mississippi, 4:95 CV 122-B-O	S.D. Miss. 1995
Coffee County Jail, Georgia	1997 Settlement Agreement	N/A
Saipan Detention Facility, Tinia Detention Facility, and Rota Detention Facility	United States v. Commonwealth of the Northern Mariana Islands, CV 99-0017	D. N. Mar. I. 1999
Muscogee County Jail	United States v. Columbus Consolidated City/County Government, Georgia, 4-99-CV-132	M.D. Ga. 1999
Los Angeles Mens Central Jail, California	2002 Settlement Agreement	N/A
Wilson County Jail, Tennessee	2008 Settlement Agreement	N/A
Oahu Community Correctional Center	United States v. Hawaii, CV-08-00585	D. Haw. 2008
Sebastian County Detention Center, Arkansas	2009 Settlement Agreement	N/A
Grant County Detention Center, Kentucky	2009 Settlement Agreement	N/A
Oklahoma County Jail and Jail Annex, Oklahoma	2009 Settlement Agreement	N/A
Cook County Jail	United States v. Cook County, Illinois, 10-cv-2946	N.D. Ill. 2010
Lake County Jail	United States v. Lake County, Indiana, 2:10-CV-476	N.D. Ind. 2010
Terrell County Jail	United States v. Terrell County, Georgia, 04-cv-76	M.D. Ga. 2011

Baltimore City Detention Center, Maryland	2012 Revised Settlement Agreement	N/A
Dallas County Jail, Texas	2012 Settlement Agreement	N/A

F. Prisons:

Facility or Facilities	Case or Agreement	Court/Date
Golden Grove Correctional and Adult Detention Facility	United States v. Territory of the Virgin Islands, 86-265	D. V.I. 1986
Saipan Prison Complex	United States v. Commonwealth of the Northern Mariana Islands, CV-99-0017	D. N. Mar. I. 1991
Guam Adult Correctional Facility	United States v. Territory of Guam, 91-00-20	D. Guam 1991
Delaware Correctional Center, Howard R. Young Correctional Institution, Sussex Correctional Institution, and Delores J. Baylor Women's Correctional Facility, Delaware	2007 Agreement	N/A
Taycheedah Correctional Institution	United States v. Doyle, 08-C-0753	E.D. Wis.2008
Erie County Detention Center and Holding Facility	United States v. Erie County, New York, 09-CV-0849	W.D. N.Y. 2009

V. Termination of CRIPA Settlements

In Fiscal Year 2012, seven CRIPA cases were terminated after jurisdictions successfully came into compliance with court orders and settlement agreements.

In October 2011, the Division and the State jointly moved to close United States v. New Mexico, CV-07-470 WJ/DIS (D.N.M. 2007), regarding conditions at Ft. Bayard Medical Center and Nursing Home. Following the Division's investigation of this facility, the Division and the State entered into a settlement agreement in 2007 to resolve the Division's findings of unlawful conditions at the nursing home. The settlement required the state to improve conditions at Ft. Bayard and to serve individuals in the most integrated setting appropriate to their needs. In March 2011, the Division toured the facility and found Ft. Bayard to be in substantial

compliance with the settlement agreement. The Division and the State then filed a Joint Motion to dismiss the case, which was granted on October 17, 2011.

During the Fiscal Year, in United States v. Marion County Superior Court, Indiana, 1:08-CV-0460-LJM-T (N.D. Ind. 2008), the Division and the County jointly moved to dismiss the case, based on compliance with remedial measures to improve protections from harm, environmental health and safety, special education services, and quality assurances at Marion County Superior Court Juvenile Detention Center. The parties agreed to a letter agreement to remedy the remaining areas of noncompliance. The Division provided monitoring and technical assistance to help the County achieve substantial compliance with the agreement. Based on steps taken by the County to address the identified deficiencies, the case was closed on October 19, 2011.

The Division ended it oversight of McCracken County Jail in Paducah, Kentucky, in the case of United States v. McCracken County, Kentucky, 5:01CV-17-J (W.D. Ky. 2001). The Division and the County had entered into a consent agreement to remedy the conditions at McCracken County Jail. After the County made significant improvements, particularly in physical and mental health care, the case was closed on October 20, 2011.

During the Fiscal Year, the court dismissed United States v. Kentucky, 3:06-CV-63 (E.D. Ky. 2006), the Division's CRIPA case involving conditions at the Oakwood Developmental Center, in Somerset, Kentucky. The Division had entered into a settlement agreement to implement measures to address treatment planning; psychiatric, neurological, general medical, nursing, psychological and behavioral, and therapy services; risk management; and transitions to the community. Based on the successful implementation of the agreement, the case was closed on October 27, 2011.

During the Fiscal Year, the Division ended its oversight of United States v. Oklahoma, 06-CV-673-TCK FHM (E.D. Okla. 2006) regarding L.E. Rader Center in Sand Springs, Oklahoma. A 2004 investigation found a pattern and practice that violated the constitutional rights of youth by failing to adequately protect them from harm. In 2008, after contested litigation, the Division entered into a consent decree with the State to remedy the conditions at the facility. The consent decree expired, and the case was closed on November 18, 2011.

The Division successfully ended its oversight of United States v. King County, CV-9-0059 (W.D. Wash. 2009) regarding King County Jail in Seattle, Washington. Following an investigation, the Division had found that the jurisdiction failed to provide adequate protection from harm; suicide prevention; medical care; and environmental health and safety. In January 2009, the parties entered into a memorandum of agreement to improve the conditions at the facility. The agreement required the County to undertake numerous improvements, develop a quality assurance program, and undergo monitoring from a team of independent experts. It also contained a fixed expiration date. At the expiration date of the agreement, the jurisdiction was in substantial compliance with the agreement, and the case was closed on February 7, 2012.

Lastly, the Division ended its oversight of Wilson County Jail in Tennessee, after the jurisdiction achieved substantial compliance with a Memorandum of Agreement and implemented policies to improve protection from harm, psychiatric care, and suicide prevention. The jurisdiction also increased physician hours and licensed practical nurse time per week. The matter was closed on August 6, 2012.

VI. New CRIPA Investigations

The Division initiated one CRIPA investigation during Fiscal Year 2012, involving two Pennsylvania State Correctional Institutions, Cresson and Pittsburgh.

VII. Findings Letters

During the Fiscal Year, the Division issued five findings letters regarding five facilities, setting forth the results of its investigations, pursuant to Section 4 of CRIPA, 42 U.S.C. § 1997b.

On December 1, 2011, the Division issued its findings letter regarding conditions at the Arthur G. Dozier School for Boys and the Jackson Juvenile Offender Center, which together constituted the Northern Florida Youth Development Center. Earlier that year, during our investigation, the state closed the facilities and transferred the residents to juvenile justice institutions throughout the state. Nevertheless, the Division found that Florida's oversight system had failed to detect and sufficiently address harmful conditions at the facilities, and was so deficient that it called into question the state's oversight system for all of its juvenile justice facilities. In addition, the Division found an unconstitutional failure to protect youths from harm; unconstitutional uses of disciplinary confinement; deliberate indifference to youth at risk of self-injurious and suicidal behaviors; violations of youth's due process rights; and a failure to provide necessary rehabilitation services. At the end of the Fiscal Year, the Division encouraged the jurisdiction to review the applicability of our systemic findings to its remaining facilities, and closed our investigation concerning the now-closed facilities.

On March 20, 2012, the Division found widespread and significant deficiencies in the Walnut Grove Youth Correctional Facility, in Walnut Grove, Mississippi, a prison housing 1,500 prisoners aged 13-22 who have been convicted as adults. Specifically, the Division found that conditions in the prison violated the youth's rights to be adequately protected from harm and to receive adequate medical and mental health care. The Division found deliberate indifference to staff sexual misconduct and inappropriate behavior with youth; use of excessive use of force by facility staff on youth; inadequate protection from youth-on-youth violence; deliberate

indifference to the serious mental health needs of its youth; deliberate indifference to the risk of self-injurious and suicidal behaviors; and deliberate indifference to the medical needs of youth. As of the end of the Fiscal Year, the Division was negotiating settlement with the jurisdiction.

On July 12, 2012, the Division issued its findings letter regarding conditions at the St. Tammany Parish Jail in Covington, Louisiana. The Division found that this facility, which holds approximately 1,200 pre-trial prisoners, subjected suicidal and mentally ill prisoners to unconstitutional mental health and suicide prevention care. The Division found: that prisoners waited weeks or months before receiving mental health treatment; that the care prisoners eventually received fell below constitutional minima; that the facility placed suicidal prisoners in small metal cages as a suicide prevention mechanism; that observation of suicidal prisoners was inadequate; that the facility's medication administration practices put prisoners at risk of harm from themselves and others; that staff members were not sufficiently trained in suicide prevention; and that the facility's quality assurance mechanisms were grossly inadequate. At the end of the Fiscal Year, the Division was negotiating settlement with the jurisdiction.

On September 6, 2012, the Division issued a letter of findings, reporting on the Division's investigation into conditions at the Piedmont Regional Jail in Farmville, Virginia, under both CRIPA and the Religious Land Use and Institutionalized Persons Act (RLUIPA). The letter found reasonable cause to believe that the Jail denied prisoners necessary medical and mental health care and consequently placed prisoners at an unreasonable risk of serious harm, in violation of the Constitution. The investigation also found that the Jail did not currently violate RLUIPA. At the end of the Fiscal Year, the Division began negotiating settlement with the jurisdiction.

On September 6, 2012, the Division issued findings regarding the Topeka Correctional Facility, in Topeka, Kansas, which imprisons about 550 women. The investigation focused on whether prisoners were subject to sexual abuse in violation of their constitutional rights. The Division found that the facility failed to protect women prisoners from sexual abuse and misconduct from correctional staff and other prisoners in violation of their constitutional rights. At the end of the Fiscal Year, the Division began negotiating settlement with the jurisdiction.

In these investigations, the Division made significant findings of constitutional and federal statutory deficiencies. As envisioned by Congress, enforcement of CRIPA continues to identify conditions that subjects residents of publicly operated institutions to grievous harm. 42 U.S.C. § 1997a (a).

VIII. Investigation Closures

In Fiscal Year 2012, the Division closed its investigation of the Bellefontaine Habilitation Center in Missouri after the State voluntarily took remedial measures to address the Division's findings with respect to conditions at the facility. Additionally, the Division closed its investigation of Northwest Habilitation Center in Missouri after the State closed the facility and placed residents in community-based settings.

The Division closed its investigation of the Ancora Psychiatric Hospital in New Jersey after the State entered into a separate statewide settlement agreement to improve its community-based service system. The Division will monitor the settlement agreement.

Lastly, the Division closed it investigation of the North Florida Youth Development Center in Florida after the State closed the facility.

IX. Technical Assistance

Where federal financial, technical, or other assistance is available to help jurisdictions correct deficiencies, the Division advises responsible public officials of the availability of such aid and arranges for assistance where appropriate. The Division also provides technical assistance through the information provided to jurisdictions by the Division's expert consultants at no cost to state or local governments. After the expert consultants complete on-site visits and program reviews of the subject facility, they prepare detailed reports of their findings and recommendations that provide important information to the facilities on deficient areas and possible remedies to address such deficiencies. The Division routinely provides such reports to cooperative jurisdictions. In addition, during the course (and at the conclusion) of investigatory tours, the Division's expert consultants meet with officials from the subject jurisdiction and provide helpful information to jurisdictions regarding specific aspects of their programs. These oral reports permit early intervention by local jurisdictions to remedy highlighted issues before a findings letter is issued.

In addition, to ensure timely and efficient compliance with settlement agreements, the Division issued numerous post-tour compliance assessment letters (and in some cases, emergency letters identifying emergent conditions) to apprise jurisdictions of their compliance status. These letters routinely contain technical assistance and best practices recommendations.

X. Responsiveness to Allegations of Illegal Conditions

During Fiscal Year 2012, the Division reviewed allegations of unlawful conditions of confinement in public facilities from a number of sources, including individuals who live in the facilities, relatives of persons living in facilities, former staff of facilities, advocates, concerned citizens, media reports, and referrals from within the Division and other federal agencies. The

Division received almost 5,000 CRIPA-related citizen complaint letters, and received more than 540 CRIPA-related telephone complaints during the Fiscal Year. In addition, the Division responded to 554 CRIPA-related inquiries from Congress and the White House.

The Division prioritized these allegations by focusing on facilities where allegations revealed systemic, serious deficiencies. In particular, with regard to facilities for persons with mental illness or developmental disabilities and to nursing homes, the Division focused on allegations of abuse and neglect, adequacy of medical and mental health care, and the use of restraints and seclusion. Consistent with the requirements of Title II of the ADA and its implementing regulations, 42 U.S. C. §§ 12132 et seq.; 28 C.F.R. § 35.130(d), the Division, through its CRIPA work, also ensured that facilities provided services to institutionalized persons in the most integrated setting appropriate to meet their needs. Similarly, with regard to its work in juvenile justice facilities, the Division focused on allegations of abuse, adequacy of mental health and medical care, and provision of adequate rehabilitation and education — including special education services.

The Division also began expanding its juvenile practice into new areas. Using its authority under a section of the Violent Crime Control and Law Enforcement Act of 1994, the Department has investigated the conduct of police in arresting children for school-based offenses, and has examined whether entities involved in the administration of juvenile justice, including police, juvenile courts, and juvenile probation systems, comply with children's procedural due process rights, with the constitutional guarantee of Equal Protection, and with federal laws prohibiting racial discrimination. The Department has made findings of civil rights violations regarding the administration of juvenile justice in two jurisdictions. In one of these matters, in Shelby County, Tennessee, the Department and the jurisdiction entered into a

settlement and are working cooperatively to resolve concerns. The second matter, *United States v. City of Meridian, et al., (S.D. Miss*) is currently in litigation.

In addition, in a settlement involving the Los Angeles City juvenile justice camps, the Division looked beyond institutional conditions by expanding a long-standing conditions agreement to incorporate youth's access to community-based alternatives to detention.

XI. CRIPA Subpoena Authority

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119. Part of this law grants the Department, for the first time, subpoena authority under CRIPA. Specifically, Section 10606(d)(2) of the Act amends CRIPA by inserting after CRIPA Section 3 ("Initiation of Actions," 42 U.S.C. § 1997a), a new CRIPA Section 3A entitled "Subpoena Authority," 42 U.S.C. § 1997a-1. The new law sets forth the specific CRIPA subpoena authority, parameters with regard to issuance and enforcement of CRIPA subpoenas, as well as direction on the protection of subpoenaed records.

On December 21, 2011, the Attorney General issued an order delegating his authority to issue, serve, and seek enforcement of subpoenas pursuant to Section 3A of CRIPA to the Assistant Attorney General for the Civil Rights Division, with authorization to redelegate this authority to any Deputy Assistant Attorney General in the Division.

XII. Conclusion

In Fiscal Year 2013 and beyond, the Division intends to continue aggressive investigation and enforcement under CRIPA, ensuring that settlements resulting from its enforcement efforts are strong enough to adequately address unlawful deficiencies. The Division will also continue to work with jurisdictions to craft agreements that focus on bringing them into

compliance; and will only terminate agreements when, but not before, the jurisdiction has engaged in and sustained the necessary reforms.

DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

JAN 28 2013

In Reply Refer To:

Judy C. Preston, Deputy Chief
Special Litigation Section Civil Rights Branch
U. S. Department of Justice
601 D Street, N.W.
Washington, D.C. 20004

RE: Information for inclusion in the Attorney General Report to Congress on the Civil Rights of Institutional Persons Act (42 USC 1997f)

Dear Ms. Preston:

Thank you for the opportunity to submit a contribution to the Attorney General's Report to Congress pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department of Veterans Affairs believes we meet all existing promulgated standards for CRIPA and, in so doing, ensure the constitutionally guaranteed rights of our patients and residents. The enclosed information is provided for inclusion in your report.

Sincerely yours,

Will A. Gunn
General Counsel

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) has multiple ongoing programs to protect the civil rights of patients in its facilities. VA regulations published at 38 C.F.R. 17.33 identify the rights of patients. All patients are advised of these rights on their admission to a facility. The statement of patients' rights is required to be posted at each nursing station, and all VA staff working with patients receive training regarding these rights. *Id.* at 17.33(h).

The applicable regulations set forth that the specified patients' rights "are in addition to and not in derogation of any statutory, constitutional or other legal rights." *Id.* at 17.33(i). The regulations set forth specific procedures for VA to follow when restricting any rights, *id.* at 17.33 (c), and establish grievance procedures for patients to follow for any perceived infringements of rights. *Id.* at 17.33(g). In addition to the regulations, the Veterans Health Administration (VHA) has issued a directive prohibiting discrimination based on race, color, national origin, limited English proficiency, age, sex, handicap, or as reprisal. VHA Directive 2008-024 (April 29, 2008).

VA further protects patients' civil rights through its program of hiring individuals to serve as Patient Advocates. The purpose of VA's Patient Advocacy Program is "to ensure that all veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner." VHA Handbook 1003.4, paragraph 3 (September 2, 2005). The Advocates assist patients in understanding their rights and represent them in the enforcement of those rights. VA also facilitates the representation of patients by external stakeholders, including, but not limited to, veterans service organizations and state protection and advocacy systems, which seek to represent patients in VA facilities. *Id.* at paragraph 8.

In addition, patients are also protected by VA regulations requiring the full informed consent of patients or, where applicable, their surrogates, before any proposed diagnostic or therapeutic procedure or course of treatment is undertaken. 38 C.F.R. 17.32.

VA believes the receipt of high-quality medical care is the right of all patients, and takes action to achieve its provision through a number of internal mechanisms. VA operates ongoing active peer review programs designed to discover and correct problems in the provision of care. Additionally, pursuant to Presidential Executive Order 12862 (1993) which requires patient surveys and use of the resultant feedback to manage agency operations, patients are periodically surveyed to determine their satisfaction with the health care provided to them. Also, the VA Office of the Inspector General and the VA Office of the Medical Inspector conduct investigations of complaints concerning the quality of health care. All of these mechanisms serve to protect the civil rights of patients in facilities operated by VA.

(VA participates in two grant-in-aid programs with the states, to provide construction and renovation funds and to provide per diem payments for care of eligible veterans in State homes; however, such homes are not Federal facilities).

U.S. Department of Justice

Federal Bureau of Prisons

Washington, DC 20534

December 27, 2012

MEMORANDUM FOR JUDY C. PRESTON, DEPUTY CHIEF
SPECIAL LITIGATION SECTION
CIVIL RIGHTS DIVISION, DOJ

FROM: Sara M. Revell, Assistant Director
Program Review Division, BOP

SUBJECT: Response for the Attorney General's Report to Congress for FY 2012 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997

The Bureau of Prisons appreciates the opportunity to report our actions during FY 2012 as related to the Attorney General's Report to Congress for FY 2012 Pursuant to the Civil Rights of Institutionalized Persons Act of 1997.

The following is provided for insertion into the report:

FEDERAL BUREAU OF PRISONS

The Federal Bureau of Prisons (Bureau) adheres to the correctional standards developed by the American Correctional Association (ACA). These standards cover all facets of correctional management and operation, including the basic requirements related to life/safety, constitutional minima, and provisions for an adequate inmate grievance procedure.

These standards have been incorporated into the Bureau's national policy, as well as program review guidelines. Currently, 116 of the Bureau's 118 institutions and the Bureau's Headquarters are accredited by the Commission on Accreditation for Corrections. The newly activated facility in Berlin, New Hampshire is preparing for

their initial accreditation, as is the National Training Academy. MCC San Diego lost accreditation, but will reapply for accreditation in FY 2013.

Accredited institutions are subject to interim audits by the Commission to monitor standards compliance, particularly in the vital areas of inmate rights, healthcare, security, safety, and sanitation. The institutional staff utilize the operational review process, to review the standards at least annually for continued compliance. In addition to operational reviews, program reviews are conducted at all federal prisons in each discipline at least once every 3 years to monitor policy compliance. In FY 2012, there were 424 separate program reviews conducted by organizationally independent Bureau examiners, which included a review of ACA standards. This number is lower than FY 2011 partially because of the closure of some UNICOR Factory operations.

The Bureau utilizes a medical classification system that identifies each inmate's medical and mental health needs, along with the forensic needs of the court. Additionally, the Bureau assigns inmates to facilities (identified as Care Levels 1 through 4) with appropriate in-house and community health care resources. All Care Level 2, 3, and 4 institutions are required to be accredited by The Joint Commission on Accreditation of Healthcare Organizations. Currently, all 102 sites are accredited by The Joint Commission.

If you require additional information, please contact Chuck Ingram, Administrator, External Auditing Branch at (202)305-7301.