



U.S. Department of Justice

Civil Rights Division

U.S. v. Oregon



MR-OR-001-001

Office of the Assistant Attorney General

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

15 MAR 1985

Honorable Victor Atiyeh
Governor
State Capitol Building
Salem, Oregon 97310

Re: Notice of Findings Regarding Fairview
Training Center, 42 U.S.C. §1997b(a)(1)

Dear Governor Atiyeh:

On May 13, 1983, we notified you that pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997, we were commencing an investigation into conditions at the Fairview Training Center in Salem. As contemplated by the statute, 42 U.S.C. §1997b, we are writing to inform you of the findings of our investigation and the minimum measures required to remedy the unconstitutional conditions and deprivations of federal statutory rights at Fairview.

As you are aware, the actual initiation of our investigation was delayed eleven months as a result of the State's objections to our standard investigatory practices. Once these differences were resolved, we were able to conduct our investigation in a relatively smooth and unhampered fashion. The cooperation of Attorney General Frohnmayer and his staff, and Fairview Superintendent McGee and his staff, provided us with substantial assistance and facilitated our investigation.

Our investigation consisted, first, of comprehensive tours of Fairview by two independent experts. The experts observed conditions in all of the residential buildings at Fairview, formally and informally interviewed administrators, staff, and residents, and examined a variety of records. Further, we conducted interviews with parents of residents and members of advocacy and consumer groups. Finally, we gathered and analyzed extensive documentation related to Fairview. The documentation included: a variety of Fairview's standard policies and procedures; information related to Fairview's staffing patterns; minutes from Fairview Committees; Disposition Board actions; State Training Center Review Board minutes; police reports; abuse investigation reports; death

records; incident/injury reports; medication and treatment cottage logs; medical progress sheets; information related to residents with pica behavior; "special need for time-out procedure or restraint" forms; monthly restraint reports; and a sampling of residents' records. We have also reviewed the findings of the 1984 validation survey conducted by the Health Care Financing Administration of the United States Department of Health and Human Services.

Based upon our extensive investigation, we believe that conditions exist at Fairview which deprive residents of their constitutional and federal statutory rights. The United States Supreme Court has clearly stated that institutionalized mentally retarded persons have a constitutional right to adequate medical care, reasonable safety, and such training as an appropriate professional would consider reasonable to ensure safety and freedom from undue bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 324 (1982). In addition to these constitutional rights, persons institutionalized at Fairview have a federal statutory right pursuant to Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, not to be deprived of services because of the severity of their handicap. Those institutionalized residents under age 22 also have a federal statutory right to a free, appropriate public education consistent with Part B of the Education of All Handicapped Children Act, 20 U.S.C. §§1401-1420 (EHA).

Set forth below are our findings and recommendations. These findings and recommendations relate to conditions that are violative of the constitution, e.g., those that seriously threaten the lives, health, and safety of Fairview residents and their right to be free from undue bodily restraint, and those that violate Section 504 or the EHA. These unconstitutional conditions and statutory violations include:

1. Lack of minimally adequate training for those residents in need of protection from undue risks to their personal safety and unreasonable use of bodily restraints.
2. Inadequate medical care.
3. Inadequate numbers of and insufficiently qualified staff to render professional judgments regarding necessary care, medical treatment, and training, and to implement such professional judgments.

4. Failure to protect residents from abuse and neglect.
5. Serious health hazards due to unsanitary and unsafe environmental conditions.
6. Insufficient and inadequate recordkeeping and administrative practices.

Supporting Facts: The facts supporting our conclusions include the following:

1. Lack of Minimally Adequate Training Programs To Ensure Safety

As previously noted, the Supreme Court recognized in Youngberg that institutionalized mentally retarded people are constitutionally entitled to such training as an appropriate professional would consider reasonable to ensure freedom from undue risks to their personal safety. Such training for those residents who need and can benefit from it is virtually non-existent at Fairview. Our consultants believe that this lack of minimally adequate training results in a serious level of self-injurious and aggressive behaviors.

The number of injuries caused by a failure to address residents' self-injurious and aggressive behaviors through appropriate training programs causes us grave concern. While touring residential cottages at Fairview, we observed numerous residents with open wounds, gashes, abrasions, contusions, and fresh bite marks. Many other residents had deep scars and scabs from a long history of self-abuse or victimization. 1/

1/ Records provided by Fairview officials also reveal an alarmingly high number of injuries. An analysis of the 651 Fairview incident reports completed during the month of January 1984 has revealed that there were 377 serious behavior episodes and 197 injuries resulting from self-abuse or aggression. Based upon a review of entries made in the Medication and Treatment Logs during May and June, 1984, there were a total of 641 injuries from resident on resident abuse, self-abuse, and unobserved causes. These injuries included lacerations, cuts, abrasions, bruises, contusions, fractures, bites, and scratches. An additional 103 instances of self-abuse and 27 incidences of sexual abuse were reported in the logs without identifying the consequences resulting from the abuse.

Of the few training programs that exist at Fairview for self-abuse and aggression, many are based on aversive techniques, such as overcorrection, aversive stimulation, time out, and restraints. In most situations, need for such aversive techniques is not professionally reviewed on a timely basis. Often, the specific behavior problem to be addressed has abated significantly, yet the aversive techniques are continued. As such, our experts were of the opinion that the use and review of these techniques represent a substantial departure from any accepted professional standard with respect to such methods of behavior control.

Additionally, programs for school-aged residents provided under EHA are insufficient under that statute. Residents are not educated in the least restrictive educational environment and are not provided with individualized education programs on a regular basis consistent with statutory requirements. Twelve month education programs are not provided to residents when needed to prevent deterioration. Residents who are "behavior problems" are either totally or partially excluded from participation in classes at the Fairview School. Efforts to provide such educational services on the residents' wards do not meet statutory minima. These practices and deficiencies fail to protect residents' rights under EHA.

2. Unreasonable Use of Restraints

The lack of minimally adequate training to those at Fairview in need of it results in another serious problem of constitutional dimensions -- excessive use of physical and chemical restraints.

Fairview records reveal that during the month of April 1984, physical restraints were used on a programmatic, emergency, medical, and special needs basis a total of 2,503 times. During the month of May 1984, they were used on the same bases a total of 2,132 times. Both of our experts concluded that such restraints are used at Fairview in lieu of training and for the convenience of staff. Moreover, the decision of when to employ many physical restraints is often determined by untrained, unqualified, or unsupervised staff. These practices depart significantly from acceptable professional standards.

Potent psychotropic medications are also used as chemical restraints at Fairview on a continuous or pro re nata (PRN) basis to manage behavior in lieu of training. This practice is contrary to accepted professional standards. Four hundred

thirteen Fairview residents received neuroleptic medications during May 1984. Haldol and Droperidol are routinely administered PRN for behavioral disturbances. Dually restraining residents by placing them in physical restraints concurrent with chemical restraints imposed by potent psychotropic drugs is not an uncommon practice. The use of such medication under these circumstances constitutes a substantial departure from legitimate medical judgment and violates residents' right to be free from unreasonable bodily restraints.

Because Fairview does not provide adequate training for those residents who are self-injurious or physically abusive to others, restraints are used as the only way to deal with these negative behaviors. Inadequately trained and insufficient staff who believe they have no other alternative use restraints to control behavior. This combination of factors results in the unreasonable use of restraints and constitutes a significant departure from the exercise of any legitimate professional judgment.

3. Inadequate Numbers and Insufficiently Qualified Staff

Both of our expert consultants agree with Fairview officials that the institution is understaffed with respect to direct care and professional personnel. The Fairview Training Center is responsible for caring for approximately 1,400 residents, and its population is currently increasing. Most of the residents are profoundly and severely mentally retarded people who require intensive care and training due to their high level of medical, basic self-care, and behavioral needs. The current staffing patterns at Fairview are simply inadequate to provide for these needs.

a. Lack of direct care staff: The number of direct care staff on the day and evening shifts is grossly inadequate. While touring Fairview, we observed several units with fifteen to twenty severely and profoundly retarded residents where no direct care staff were present. In other units of comparable size and level of retardation, one staff person was present but was engaged in toileting, bathing, stripping beds, sorting laundry or mopping up urine on floors. Most of the residents were therefore left unattended. According to staff, these staffing patterns are not uncommon. While an attempt is made to have one staff person on each unit during the day, in actuality, with staff breaks and absences, units are oftentimes left unattended or attended on an ad hoc basis by a staff

person responsible for another unit. During the evening, most cottages, some with as many as sixty residents, have only one or two direct care staff assigned to supervise them.

Given the lack of adequate staff, direct care staff are oftentimes unable to meet the substantial basic care needs of many residents. Many residents therefore suffer from the unhealthy effects of poor oral and other bodily hygiene. We observed several residents who were laying or sitting in their own urine or soiled diapers or clothes.

Additionally, the insufficient number of direct care staff results in an inability to adequately monitor the resident population. As a consequence, some residents have died and many others suffer serious injuries from self-abuse, aggression, pica, and runaway behaviors. Due to lack of staff, residents who require supervision wander unmonitored outside the facilities at Fairview, sometimes with serious consequences that pose a real threat to the residents' health and safety.

In sum, our findings indicate that there is an insufficient number of direct care staff at Fairview to provide minimally adequate supervision and care of residents. This paucity of staff results in residents suffering deleterious health conditions, numerous accidents, and life-threatening injuries due to neglect. Our medical expert concluded that a sufficient number and type of staff may have prevented some of the deaths that have occurred at Fairview within the past two years.

The lack of staff is also directly correlated to the frequent use of restraints at Fairview. Records from the Restraint and Time Out Procedure Review Committee reveal clearly that restraints are being used because there is insufficient staff. In the majority of instances where restraints were employed, Fairview records indicate their use was necessary because insufficient staff was available to handle various behavior problems of residents.

b. Lack of professional staff: Professional staffing is also inadequate at Fairview. There are an insufficient number of personnel to check residents for illness or injuries and to perform needed treatments. Oftentimes, medical treatment is left to Medication and Treatment Aides who are qualified only to dispense medications. As will be discussed in greater detail in the Medical Care and Treatment Section, the number of dental personnel, physical therapists, and occupational

therapists is inadequate to meet the basic medical and health care needs of residents. Equally severe shortages of psychologists, who average current caseloads of close to two hundred residents, result in an inability to assess each resident of Fairview and to develop training programs for those residents who can be trained to modify their physically abusive and/or self-injurious behavior such that the need for restraints is reduced or eliminated.

Overall, the inadequate professional staffing at Fairview results in a failure to provide residents with minimally adequate care, medical treatment, and such training as is reasonably necessary to protect residents from unreasonable risks of physical injury and to ensure their freedom from undue bodily restraints.

4. Inadequate Medical Care and Treatment

Unprofessional medication practices, inadequate responses to pica behavior (ingesting non-edible substances), and the failure to provide essential medical services constitute inadequate and unsafe medical care at Fairview.

a. Unprofessional medication practices: Medication practices at Fairview pose some unacceptable risks to residents and represent significant departures from accepted professional medical standards. At least two drugs are currently being used on a number of residents for conditions which the drugs are not designed to treat. Tylenol #3 (a combination of analgesics, one of which is a narcotic) is being prescribed for disruptive, assaultive or agitated behaviors. Inderal, a potent beta blocker used to control hypertension, cardiac arrhythmia and migraine, is being prescribed for self-abuse and aggression. The use of these drugs for these behaviors is contrary to acceptable professional practices.

According to our medical expert, the number of residents receiving neuroleptic medications is double what one would normally expect at an institution like Fairview. In addition, ten per cent of the residents receiving neuroleptics are on tranquilizers and anti-depressants, which in combination have extremely potent sedative/anticholinergic effects. Neuroleptic drugs are sometimes prescribed without any justification being noted in the record. In other instances, no effort is made to coordinate the use of neuroleptics with other aspects of the resident's plan of care, behavioral program, or use of physical restraints.

The efficacy of and continued need for neuroleptics are oftentimes not assessed on a regular or timely basis. Of particular concern is the failure to monitor toxic drug side-effects. For example, a resident became toxic on a multitude

of anti-convulsants and an anti-depressant which resulted in vomiting for ten days before he was transferred to the infirmary for detoxification. Monitoring of long-term drug side-effects, such as tardive dyskinesia, is also virtually non-existent at Fairview, despite institutional policies which call for such screening.

b. Inadequate response to pica behavior: The frequency of pica behavior is particularly high at Fairview and causes severe, life-threatening consequences. Residents have had to undergo surgery, sometimes on a repeated basis, to remove foreign objects or to relieve bowel and other obstructions caused by pica. Physicians at Fairview have indicated that some residents have had surgery so frequently that any more operations resulting from pica would jeopardize their lives.

While touring Fairview, we observed unsupervised residents eating garbage, cigarette butts, and grass. In several cottages, staff indicated that a high percentage of residents exhibit some form of pica behavior. No comprehensive effort has been made, however, to specifically identify residents with such behavior with the exception of two cottages where 84 of the 180 residents were reported to have pica behavior.

Oftentimes, the pica behavior is undetected until health and life-threatening consequences occur. Even when detected, appropriate intervention does not occur. Fairview's failures to identify residents with pica behavior, to supervise their behavior, and to respond appropriately to their behavior constitute practices which subject residents to unreasonable risks of harm to their personal safety.

c. Failure to provide essential medical care: The lack of health maintenance and surveillance are significant deficiencies at Fairview. Because of lack of supervision, serious and avoidable injuries are not prevented and early signs of illness and disease go undetected. Basic health care needs of residents, such as diaper changing, toileting, and tooth-brushing, are not met.

Dental services are a particular problem at Fairview. According to Fairview staff, basic dental care is "unacceptable" in fifty percent of the residents in intensive care cottages. Seventy percent of residents institution-wide have gum disease. A delay in examination and treatment of two and a half years for those residents requiring general anesthesia for dental problems is not uncommon. Dental care services are thus not minimally adequate to meet the health care needs of Fairview residents.

The lack of physical therapy and occupational therapy services are also serious deficiencies in residents' medical care. Residents who have a medical need for physical therapy services, including adaptive equipment, in order to reduce the risk of developing contractures, body deformities, atrophy of muscles, and decubiti, are not receiving minimally adequate physical therapy. The absence of such care often results in significant problems in skin care, circulation, and infection. Additionally, several residents with identified feeding disorders are not receiving essential training in feeding despite a doctor's referral order, subjecting them to unreasonable health threats.

5. Serious Health Hazards Due to Unsanitary and Unsafe Environmental Conditions

Our consultant physician noted many unsanitary practices and conditions at Fairview which pose unreasonable risks to residents' health. Many of the cottages we toured smelled of urine and waste. Sewage backup in cottage basements, up to three feet high on the walls, is permitted to remain for days. Aspects of Fairview's food preparation, storage, and handling also pose sanitation and contamination problems, as evidenced by the Health Care Financing Administration's validation survey. These and other unsanitary conditions result in the rapid spread of infectious diseases. For example, an August 1983 random sample of Fairview residents revealed that 35% had pinworm infection, a parasite which is spread by fecal and oral routes in unclean environments.

6. Insufficient and Inadequate Recordkeeping and Administrative Practices

Deficient recordkeeping and administrative practices are of constitutional significance in that inaccurate or incomplete records can constitute an active danger to residents by depriving professional and other staff of information necessary to make appropriate and safe decisions regarding care, medical treatment, and training. The recordkeeping practices at Fairview are deficient in this respect. Resident records regarding such critical information as medication orders are oftentimes not kept up-to-date. Nursing entries are not made on a scheduled basis, thus failing to provide timely written documentation of health care needs and treatment. Other data, such as frequency of behavioral problems, is similarly not collected or recorded in a consistent fashion, resulting in inadequate data bases for making and revising decisions with regard to training required under Youngberg.

7. Minimally Necessary Remedies:

The aforementioned conditions constitute a pattern and practice of egregious and flagrant conditions resulting in deprivation of Fairview residents' constitutional and federal statutory rights. We believe that this pattern and practice has been permitted to exist for a long period of time and at least since 1981. We would be remiss, however, if we failed to commend Fairview's many conscientious and dedicated staff who strive to make the most of the inadequate resources available to them.

To rectify the deficiencies at Fairview, to ensure that constitutionally adequate conditions are maintained thereafter, and to ensure that residents' federal statutory rights are protected, we propose to enter into a legally binding and judicially enforceable agreement with the State of Oregon, providing at a minimum, the following remedies:

1. Training programs must be professionally designed for those residents who need them and for whom such training will reduce or eliminate unreasonable risks to their personal safety and/or the need for undue bodily restraint. Immediate attention must be given to residents with self-injurious, physically abusive and other destructive behaviors by identifying them and providing necessary training.
2. Fairview must hire and deploy a minimally adequate number of qualified direct care and professional staff necessary to provide residents with minimally adequate medical care and the training described in paragraph 1. above so as to protect residents from undue risks to personal safety and unreasonable bodily restraint.
3. The practice of using restraints for the convenience of staff, or in lieu of the training described in paragraph 1. above must cease immediately. Restraints may be employed only pursuant to the exercise of professional judgment by a qualified professional.
4. Residents must be provided with necessary medical care, and medication practices must be modified, as necessary, to ensure that they comport with accepted professional medical standards.
5. The unsanitary practices described earlier must be halted.

6. Recordkeeping and administrative practices designed to ensure residents' rights to freedom from undue risks to personal safety, freedom from unreasonable bodily restraint, and minimally adequate training must be implemented.

We stand prepared to make our experts available to the State of Oregon to provide such technical assistance as may prove helpful in remedying the deficiencies we have identified. Information about federal financial assistance which may be available to assist with the remediation process can be obtained through the United States Department of Health and Human Services' Regional Office (James D. Hughes, Director, Intergovernmental and Congressional Affairs; (206) 442-1290) and through the United States Department of Education by contacting individuals listed in the attached information guide. I am aware that the State has been developing plans in response to the Health Care Financing Administration's validation survey. To the extent that these plans, if implemented, will rectify statutory violations and unconstitutional conditions of confinement, they could possibly serve as a basis for reaching a legally binding and judicially enforceable agreement.

Our attorneys will be contacting Attorney General Frohnmayer's office shortly to arrange for a meeting to discuss this matter in greater detail. We seek to resolve these matters in a reasonable manner and in the spirit of cooperation intended by the Civil Rights of Institutionalized Persons Act, and look forward to working with state officials toward that end.

Sincerely,



Wm. Bradford Reynolds
Assistant Attorney General
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cc: David Frohnmayer, Esq.
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