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WBR:AEP:MHN:CLK:MEM:eh  
DJ 168-58-13

Honorable Richard Celeste  
Governor of Ohio #90078  
State House  
Columbus, Ohio 43215

Re: Broadview, Cleveland, and Warrensville  
Developmental Centers

Dear Governor Celeste:

On April 1, 1986, 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 Broadview, Cleveland, and Warrensville Developmental Centers. I am writing to provide an interim report with respect to the status of this matter, our current findings, and our future course of action.

As part of our investigation, attorneys conducted tours of these facilities with several consultants. These consultants examined resident records, interviewed facility administrators, and spoke to staff and residents. We also reviewed numerous documents, including facility policies and procedures. At the time of these tours, each facility was in the process of reorganization, hiring additional staff, reviewing and revising various policies and procedures, and otherwise striving to improve conditions. In sum, our investigation found institutions in transition, administrators acknowledging deficiencies, and plans contemplated to address serious institutional problems.

Our investigation disclosed, however, a number of conditions which we believe are violative of the constitutional rights of residents. Each of the facilities fails to provide professionally designed training programs as an appropriate professional would consider reasonable to ensure residents are free from unreasonable risks to their personal safety and undue bodily restraint. In the absence of such training programs, staff overuse psychotropic medication to control the behavior of residents. Finally, some deficiencies exist with respect to the delivery of adequate medical care.

Consultants who reviewed the adequacy of training programs at Broadview, Cleveland, and Warrensville, each noted a lack of professionally designed training programs for residents exhibiting self destructive or aggressive behaviors. Moreover, each noted an over reliance on powerful psychotropic medications to control these behaviors. Medication deficiencies extended to the failure to review medication orders on a timely basis, objectively assess the need for medication, to coordinate the use of drugs with a training program, to evaluate drug side effects, and to maintain adequate medical records to enable professionals to exercise competent judgment with respect to the management of these drugs. The failure to provide necessary training programs sufficient to avoid undue risks to the personal safety of residents and the undue use of chemical restraint and associated medication deficiencies violate the constitutional rights of residents.

General medical care appears adequate once medical problems have been identified. At Warrensville, one of our consultants noted a problem in the timely detection of illness and serious injury. Cleveland lacks sufficient physical therapy services to identify the medical needs of physically handicapped residents, to treat contractures, and other conditions which threaten their health and safety. Medical recordkeeping deficiencies were noted at all three facilities. These deficiencies jeopardize adequate medical care.

In view of many changes in progress during our consultant tours and the intervening period of time which has passed since our last review of these facilities, we will be in contact with the Attorney General's office in the near future to arrange mutually agreeable times for our consultants to retour these facilities to determine if planned improvements have eliminated these violations. Moreover, there remain unresolved a number of allegations of abuse of residents which merit further investigation.

I wish to thank you for the cooperation you have extended to us during the course of this inquiry. I remain confident that we can work together to amicably resolve this matter in a reasonable manner.

Sincerely,

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