IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

UNITED STATES OF AMERICA,	:	
	:	
Plaintiff,	:	Civil Action No.: 3:12CV59-JAG
	:	
v.	:	Memorandum of *Amicus Curiae*
	:	
COMMONWEALTH OF VIRGINIA,	:	
	:	
Defendant.	:	

THE VIRGINIA OFFICE FOR PROTECTION AND ADVOCACY'S MEMORANDUM AS *AMICUS CURIAE* IN SUPPORT OF ENTRY OF THE PARTIES' SETTLEMENT AGREEMENT

The Virginia Office for Protection and Advocacy (VOPA) by counsel and pursuant to the Order of this Court dated 6 March 2012, submits the following Memorandum as *Amicus Curiae*.

I. Interest of the *Amicus*

VOPA is the Commonwealth of Virginia's Protection and Advocacy System for people with developmental disabilities, as required by the Developmental Disabilities Assistance and Bill of Rights Act ("the DD Act"), 42 U.S.C. § 15001, *et seq.*. *See also,* Va. Code Ann. § 51.5-39.2 (designating VOPA as Virginia's Protection and Advocacy System). As such, we are "independent of any agency that provides treatment, services, or habilitation to individuals with developmental disabilities." 42 U.S.C. § 15043(G).

This Memorandum provides our analysis of how the parties' Settlement Agreement, if entered, will impact the safety of people with intellectual and developmental disabilities living in state training centers (hereafter "residents"). Based on our experience, our review of the Agreement and, most importantly, on information we have received and conclusions we have drawn from investigating abuse and neglect in training centers, we believe the Agreement will

increase the safety of all residents - those who will be discharged, those who remain and those who may be admitted in the future.

Congress passed the DD Act after learning of "the inhumane and despicable conditions" at New York's Willowbrook State School and other state facilities housing people with developmental disabilities. *See, Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center,* 97 F.3d 492, 494 (11th Cir. 1996). Under the DD Act, Protection and Advocacy Systems, like VOPA, have the power and duty to:

- Provide information concerning programs and services for people with developmental disabilities. 42 U.S.C. § 15043(a)(2)(A)(ii); 45 C.F.R. §1386.22(g)(1);
- Investigate incidents of abuse and neglect of people with developmental disabilities. 42 U.S.C. § 15043(a)(2)(B); 45 C.F.R. 1386.22(f);
- Pursue administrative, legal, and other appropriate remedies to ensure the protection of people with developmental disabilities. 42 U.S.C. §15043(a)(2)(i); and
- Monitor facility or program compliance with respect to the safety of people with developmental disabilities. 45 C.F.R. § 1386.22(g)(2).[1]

In addition, Virginia law requires training centers to notify us whenever a resident dies or suffers a "serious bodily injury or loss of consciousness requiring medical treatment." Va. Code Ann. § 51.5-39.12.

Since 2007, we have received, reviewed and tracked 1,839 reports of deaths and serious injuries at training centers. In that time, we have investigated 184 injuries and

[1] We have similar powers and duties under several federal statutes. Under these laws, we provide legal and investigative services in areas including safety, supported employment, education and access to government programs and services. *See,* Protection and Advocacy for Individuals with Mental Illness, 42 U.S.C. § 10805; Protection and Advocacy for Traumatic Brain Injury, 42 U.S.C. § 300d-53; Protection and Advocacy for Individual Rights, 29 U.S.C. §794e; Protection and Advocacy for Beneficiaries of Social Security, 42 U.S.C. § 1320b-21; Protection and Advocacy for Assistive Technology, 29 U.S.C. § 3012; Protection and Advocacy for Voting Access, 42 U.S.C. § 15461; and Client Assistance Program, 29 U.S.C. § 732.

deaths at training centers that we had reason to believe were caused by abuse or neglect. We have also conducted systemic investigations of training center safety procedures and regularly monitor their living and safety conditions.

Accordingly, we are in a unique position to provide the Court with information and analysis regarding (1) current safety conditions at training centers and (2) how the proposed Settlement Agreement, if entered, will affect resident safety.

II. Summary of Argument

The Court should enter the parties' Settlement Agreement because it will increase the safety of current, former and future residents. The data we have reviewed and the investigations we have conducted lead to an inescapable conclusion: training centers are not safe.

Since 2007, we have opened an average of one investigation every 12 days because we had reason to believe a resident was abused or neglected. We have learned of and uncovered staff-on-resident assaults, sexual abuse, scaldings, abandonments and financial exploitation. We have documented inadequate and unfollowed safety procedures and seen the resulting injuries and deaths.[2]

The parties' Settlement Agreement calls for comprehensive and cohesive safety protections that are sorely lacking in the current system. Under the Agreement, safety will be paramount and treated as such: there will be systems to identify and address hazards before injures, deaths or other crises occur; a centralized reporting and monitoring system for swift and thorough investigations; regular data collection and analysis to prevent future incidents; and multiple layers of supervision and oversight to ensure compliance.

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[2] As discussed *infra* at 15, we have taken a range of actions to prevent such abuse and neglect from occurring or repeating - from advocacy and public reports to negotiation and litigation. Nevertheless, abuse and neglect continue to plague residents because the Commonwealth has been unwilling to take the steps necessary to prevent and correct it.

III. Individual and Systemic Investigations into the Safety of Training Center Residents

A. Individual Investigations

As required by Va. Code Ann. § 51.5-39.12, training centers have informed us of 1,839 serious injuries or deaths since 2007; an average of 25 residents seriously injured or dying each month. These reports included 203 deaths; 214 fractures (78 of which were "unexplained" or resulted from interaction with a staff member); 7 aspirations, 3 sexual assaults, 13 burns (2 of which resulted from interactions with a staff member), and 825 lacerations (54 of which were "unexplained" or resulted from interaction with a staff member).

During that time,[3] we have opened 184 investigations because we had reason to believe a resident was abused or neglected.[4] In other words, we have received or discovered evidence suggesting that a resident was the victim of abuse or neglect an average of 30 times per year, or once every 12 days.

Our investigations have uncovered abuse and neglect ranging from simple negligence to premeditated and malicious assaults. The following are just some examples:[5]

2007

- A training center staff member (hereafter "staff member" or "staff members") used sticks and other objects to beat at least four residents on several occasions.

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[3] In 2007, we began using an electronic database to track our cases and investigations. Except for reports released to the public, records of pre-2007 investigations are in storage and less accessible. Upon request of the Court, we will provide summaries of pre-2007 investigations.

[4] We have opened investigations based upon training center reports, our own observations and information provided by residents, family members, training center staff and others.

[5] The following summaries are organized by the year each investigation was completed, not the year the incident(s) occurred. To protect the privacy of residents and comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. § 300gg, we have not identified the training centers where the incidents occurred. However, it is fair to say that each training center has been the site of shocking abuse and neglect. If Ordered, we will provide additional information.

- A staff member fed marshmallows to a resident whose chart called for him to eat only fine, chopped, pea-sized food. The resident aspirated the marshmallows, went into respiratory arrest and suffered cerebral anoxia. He died after being removed from life support.
- A resident with a documented history of swallowing inedible items was left unsupervised and died after swallowing several objects, including latex gloves.

2008

- Several staff members terrorized a resident by threatening to cut off his genitals. The abuse was so pervasive they eventually did not have to verbally threaten the resident; they just held up two fingers and made a scissoring motion.
- Staff members repeatedly used a wheelchair and seatbelt to restrain a resident, who was able to walk, as punishment or for their convenience. The resident attempted to escape the restraints and suffered injuries, including a fracture.
- A resident with a long history of swallowing inedible items was left unsupervised and swallowed 19 different objects, requiring surgery.
- A resident was scalded and suffered second degree burns on his feet, hands and buttocks when a staff member bathed him in a tub with a malfunctioning water heater. The staff member did not touch the water before putting the resident in.

2009

- Staff members slapped a resident, forcibly removed his clothing and told him to perform oral sex on another resident.
- A resident suffered multiple injuries, including a broken leg, after a staff member shook her and threw her to the ground.

- Staff members repeatedly punished a resident by turning off her electric wheelchair, rendering her immobile and unable to take part in any activities.
- Staff members failed to follow a resident's treatment plan, which called for him to wear specialized shoes. The resident suffered blood deprivation to his feet, was diagnosed with Ischemic Necrosis and was to have two toes amputated. While awaiting the surgery, he was transferred to another state facility, where he choked on food, suffered cardiac arrest and died.

2010

- Two residents of two separate training centers suffered second-degree burns after staff members bathed them in scalding water.
  - One resident suffered second-degree burns to her buttocks and lower back. Staff members did not notice the burns for approximately two hours. The resident was not sent to the hospital until the next day, despite having visibly blistered and sloughing skin.[6]
  - The second resident suffered first and second-degree burns to her left arm, abdomen and thigh. Even though the resident's chart called for her to be bathed in a tub, the staff member used a shower spray, which supplied up to 167 degree water.
- A resident was left unsupervised and fled his cottage through fire doors that had been left open. The resident was injured when his wheelchair overturned.
- A resident was hospitalized for 10 days after staff members gave him the wrong medication.

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[6] With the victim's permission, we made our findings available to the public. *See,* http://www.vopa.virginia.gov/Investigations/Neglect%20of%20MS.pdf.

- A resident suffered at least 50 injuries over a four year period. None were reported to VOPA despite state law requiring reports of all such incidents.
- A staff member took residents' money and bought himself clothing and alcohol.

2011

- A staff member, tasked to buy clothing and necessities for a resident, spent almost $500 of the resident's money to buy himself clothing and cologne.
- A resident, who had standing orders to always be supervised due to a heart condition, was abandoned on a toilet in a locked unit for over an hour while staff and other residents went on a community outing.
- Staff members placed a resident on a toilet chair that was not properly secured to the wall and missing its lap bar. The resident fell and suffered a head injury.
- A resident suffered a fractured arm. Staff did not refer the resident for x-rays for 7-10 days after the injury. The examining doctor found the injury was consistent "with being dropped on his right side against a hard object or being hit by a hard object across his arm."
- A resident was found unresponsive with no pulse. It took staff members 15 minutes to report the incident and begin CPR.
- Eleven residents were placed on a training center van for an alleged community outing. Instead, staff members left the van to conduct personal business, including buying lunch at a KFC restaurant. No food was provided on the van.
- In an assault captured on video, a staff member hit an elderly resident so hard that he flew 6-8 feet across the room and crashed to the floor. Other staff members falsely stated that the resident had made sexual advances toward the assailant.

2012

- A training center had all of a resident's teeth extracted because it was more convenient than providing him with regular dental care and examinations.
- A resident suffered a head injury when she fell from her wheelchair after staff members did not properly attach her seat belt.
- A resident suffered internal bleeding, hernias, severe bruising and swelling in the groin, penis and scrotum after staff members lifted him by his support belt.

B. Systemic Investigations

We have also investigated whether training centers have appropriate procedures in place to minimize the risk of abuse and neglect and thoroughly investigate allegations of abuse and neglect. Some examples follow:

2003

- A training center violated Virginia law by failing to conduct a national criminal records check before hiring a staff member. That staff member later beat and allegedly sodomized a resident and shot two residents with a pellet gun.[7]

2005

- An expert retained by VOPA found that Central Virginia Training Center lacks "sufficient programs, services or safeguards to protect residents . . . from harm. Individuals at CVTC sustain a significant number of serious injuries that could have been prevented if programs, services and safeguards were in place as required by standards of care."

[7] With the victims' permission, we made our findings available to the public. *See,* http://www.vopa.virginia.gov/Investigations/Abuse%20or%20Neglect%20of%20RL%20and%20DS%20-%20Final.pdf.

2007

- A training center's investigation of abuse was conducted by a case manager who was not trained in conducting investigations and unfamiliar with the medical issues and aspects of the investigation.

2008

- A training center failed to report or properly investigate multiple instances of abusive threats to a resident.

2010

- Staff members did not monitor the temperature of hot water supplied to showers, even though training center procedures required them to do so. A staff member falsified logs which allegedly showed that hot water temperature had been monitored. A staff supervisor did not request or review water temperature logs, as he was required to do by training center procedures. The supervisor did not request repairs to the hot water supply system, even though there was evidence from months before that the water temperature was too high. As a result, a resident was scalded and suffered second degree burns.
- A training center's investigation of abuse was not timely or thorough and the training center did not properly inform the victim's next of kin about the incident.
- A training center's investigation failed to interview several relevant witnesses and did not properly investigate a resident's injury to determine if it was the result of abuse or neglect.
- A training center failed to properly report or investigate up to 50 incidents.

2011

- A training center's investigation did not fully review the allegations or circumstances involved in two separate incidents of alleged abuse.
- The same training center did not fully investigate the circumstances or cause of a third incident of alleged abuse. Training center employees expressed concern that the internal investigation disregarded medical evidence suggesting that the resident had been abused or neglected.
- Another training center did not properly report an incident to authorities and failed to conduct a thorough or appropriately impartial investigation.

2012

- At least 14 residents were denied routine dental care, including examinations, cleanings and x-rays. At least 4 residents had teeth extracted without justification.

IV. Safety Provisions in the Parties' Settlement Agreement

In marked contrast to the current state of affairs in training centers, the parties' Settlement Agreement provides for a consistent and cohesive focus on the safety of current, former and future residents. The Agreement requires regular monitoring of living conditions, real-time reporting of injuries and deaths and strong proactive measures to address and prevent abuse and neglect. The Agreement also provides several independent checks and layers of oversight to ensure that residents are safe, including face-to-face assessments, multiple methods of data collection, review and analysis, and reporting to the Commonwealth and this Court.

A. Safety Provisions for Residents

Under the Agreement, training centers are required to identify residents' clinical and support needs, focusing "on achieving outcomes that promote the individual's . . . well being." Agreement, p. 14, Sections V.B.4 and V. B.5.b. They are then required to help residents

identify placements that can meet those needs and protect their safety. Agreement, p. 15, Section V.B.5.d.

While residents await discharge, they - along with residents who will remain and those who may later be admitted - will benefit from the Agreement's "Quality and Risk Management System," which is designed to "help individuals achieve positive outcomes, including avoidance of harms." Agreement, p. 20, Section V.A. This program will "identify and address risks of harm . . . and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement." *Id.* at Section V.B.

The System is most notable for its use of actual, reliable data both to investigate incidents of abuse and neglect and for the "establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm." Agreement, p. 21, Section V.C.1. Safety data will be collected through "a real time, web-based incident reporting system and reporting protocol" and training centers will be required to report deaths and serious injuries to the "DBHDS Assistant Commissioner or his designee." *Id.* at Section V.C.2.

When injuries or deaths are reported, "suspected or alleged abuse, neglect, critical incidents or deaths" must be thoroughly investigated to "identify remediation steps" that have been or must be taken. Agreement, p. 21, Section V.C.3. The results of these investigations will be used to provide "guidance and training . . . on proactively identifying and addressing risks of harm," Agreement, p. 21 Section V.C.4, and to "ensure that there are effective processes in place to monitor participant health and safety," Agreement, p. 22, Section V.D.1. Data will also be used to create a "quality improvement (QI) program including root cause analysis, that is sufficient to identify and address significant service issues." Agreement, p. 24, Section V.E.1.[8]

[8] The Agreement is silent as to our involvement in this reporting and investigation system. However, Va. Code Ann. § 51.5-39.12 already requires training centers to report deaths and serious injuries to us. Similarly, state and federal law give us the authority to investigate

B. Safety Provisions for Former Residents Discharged to Community Placements

Because it applies to all providers, former residents will also benefit from the Quality and Risk Management System.[9] Moreover, the Agreement also includes provisions designed to protect the health and safety of former residents as they live in the community.

The Agreement calls for services to prevent former residents from experiencing medical or emotional crises and to address crises when they occur. Agreement, p. 7, Section III.C.6. If a former resident experiences a crisis, mobile support teams will be available - 24 hours per day, 7 days a week - to help de-escalate the situation. After a crisis has been resolved, the team will use the experience to identify "strategies for preventing future crises." *Id.*

For former residents who require more intensive supports, the Agreement requires the creation of crisis stabilization programs: "short term alternative[s] to institutionalization or hospitalization for individuals who need inpatient stabilization services." Agreement, p. 9, Section III.C.6.iii. These programs will provide up to 30 days of support designed to help former residents overcome medical or emotional crises in a safe and secure environment. *Id.*

Throughout a former resident's life in the community, the Commonwealth will collect and analyze data to "identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises or other negative outcomes." Agreement, p. 18, Section IV.C.3. First, a Post Move Monitor will visit former residents 30, 60 and 90 days after discharge to

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incidents of suspected abuse and neglect and issue reports and findings. 42 U.S.C. §15043(a)(2)(B); 45 C.F.R. § 1386.22(f); Va. Code Ann. §§ 51.5-39.4, 51.5-39.8(C)(2).

[9] Federal law gives us the authority to investigate abuse and neglect by community providers. 42 U.S.C. § 15043(a)(2)(B); 45 C.F.R. § 1386.22(f). We regularly do so and have published investigative reports and filed lawsuits against community providers that abused their residents. *See, e.g.,* http://www.vopa.virginia.gov/Investigations/Alleged%20Abuse-Neglect%20of%20PQ.pdf; *VOPA v. Brice's Enterprises Inc., et al.*, Va. Cir. (Hanover), Case No.: CH 04000125-00. However, Virginia law does not require community providers to report deaths or injuries to us. Whether or not the parties' Agreement is entered, we will continue to provide advocacy and investigations in community placements consistent with the information we receive and resources we have.

assess their health, safety and wellbeing. *Id.* Then, the Commonwealth will regularly collect and analyze data regarding former residents' "[s]afety and freedom from harm" and their "physical, mental and behavioral health and well being." Agreement, p. 23, Section V.D.3. This and other data will be used to "identify trends, patterns . . . and problems" and "develop preventative, corrective and improvement measures to address identified problems." Agreement, p. 22, Section V.D.2.

In addition, providers must submit regular reports "regarding both positive and negative outcomes for both health and safety." Agreement, p. 24, Section V.E.2. If the Commonwealth finds a providers' health and safety measures to be inadequate, it must "provide technical assistance and other oversight." Agreement, p. 24, Section V.E.3.

Furthermore, the Commonwealth must perform regular Quality Service Reviews "to evaluate the quality of services at an individual, provider and system wide level." These Reviews, which must include face-to-face interviews with former residents, will collect and assess information including "incident/injury data." Agreement, p. 26-27, Section V.I. This data will be used to "improve practice and the quality of services on the part of the provider, CSB and system wide levels." *Id.*

The Agreement also calls for multiple, independent layers of oversight. The Commonwealth is required to "take appropriate action" against any training center or provider who fails to submit required data or reports. Agreement, p. 22, Section V.C.5. An Independent Reviewer will verify compliance with the Agreement and report his findings to this Court. Agreement, p. 27, Section V.A-C. If the Commonwealth does not comply with the Agreement, the Court has authority to enforce it. Agreement, p. 32, Section II.D-E.

V. Argument: This Court should Enter the Parties' Settlement Agreement

We strongly recommend that the Court enter the parties' Settlement Agreement. At the outset, we are sure the Court will receive many submissions urging entry because the Agreement serves the public's interest in reducing the unnecessary institutionalization of people with disabilities. *See,* 42 U.S.C. § 12101(a)(3), *Olmstead v. L.C. ex rel Zimring,* 527 U.S. 581, 600 (1999) ("unjustified institutional isolation of persons with disabilities is a form of discrimination."). We agree. The public undeniably has an interest in "the full participation of the disabled in the economic, social and recreational life of the community." *Martin v. Metropolitan Atlanta Rapid Transit Authority,* 225 F. Supp. 2d 1362, 1383 (N.D. Ga. 2002). If entered, the parties' Agreement will serve this interest by enabling thousands of people to live in integrated settings consistent with their strengths and needs and by empowering them to participate fully in everyday activities that others take for granted, including "family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead,* 527 U.S. at 600-601.[10]

However, we have chosen to focus this Memorandum on how the Agreement will impact the safety of current, former and future residents because we can provide this Court with something no one else can: insight and analysis based upon thousands of data points and years of investigations into resident safety. We are sure the Court will receive submissions contending that the Agreement will hurt residents or put them at risk of injury; we know that several parents of current residents have already made this argument. These parents, and any others who may write, have our respect - the paramount role of any family is to protect its own. We simply

[10] We believe that every person with a disability can live in an integrated community setting if provided with appropriate supports and services. We have successfully secured the discharge and community placement of many former residents, including those with the most complex needs. The parties' Agreement puts appropriate procedures in place to identify residents' medical, social, safety and other needs and the placements that can fulfill them.

disagree with them; the *status quo* places their children, and all other residents, at an ongoing and unacceptable risk of abuse, neglect, serious injury and death.

Perhaps the most disturbing conclusion drawn from our investigations is that under the current system, abuse and neglect repeat themselves despite all our attempts to prevent and remedy them. Assaults, restraints, burns, abandonments and inexcusable negligence occur year after year as training center after training center fails to timely report, thoroughly investigate or effectively respond to them. As we have found abuse and neglect, we have taken a variety of actions to help the victims and prevent future victimization: we have advocated for new treatment plans or discharge; issued public reports; extracted corrective action plans; filed administrative complaints; and pursued litigation as far as the Supreme Court. Even still, we know that for every resident we help and every act of abuse we uncover, another almost certainly goes unassisted, unreported or uninvestigated.

If entered, we believe the parties' Agreement will remedy the Commonwealth's failings. Its safety provisions mark a sea change in the way training centers and other providers will prevent, address and redress abuse, neglect, serious injuries and deaths. Accordingly, the Agreement serves the public's interest in the health and safety of people with disabilities. *See, Wash. v. Glucksberg,* 521 U.S. 702, 731 (1997) ("[T]he State has an interest in protecting vulnerable groups - including . . . disabled persons - from abuse, neglect, and mistakes.").

Under the Agreement, the Commonwealth will, for the first time, collect and analyze reliable data to identify "uniform risk triggers and thresholds" and for "proactively identifying and addressing risks of harm, conducting root cause analysis and developing and monitoring corrective actions." Agreement, p. 21, Section V.C. When incidents occur, there will be consistent reporting, comprehensive investigations and corrective actions. *Id.*

As opposed to the current state of affairs in training centers - where failures to prevent, report and remedy abuse and neglect seem intractable - the Agreement creates a system where reliable, real-world data is used to protect the safety of current, former and future residents. Just as importantly, the system will use data to help identify best practices, adapt and evolve. The Agreement requires the regular collection of information from multiple sources to assess "[s]afety and freedom from harm," "[p]hysical and mental health and well begin," "[a]voiding crises;" and "[a]ccess to services." Agreement, p. 23, Section V.D.3. This information will be used to "improve the availability and accessibility of services . . . and the quality of services." Agreement, p. 22, Section V.D.2.a. Data will also be collected and reviewed to "identify trends, patterns, strengths and problems at the individual, service delivery and systemic levels;" develop, implement and track "preventative, corrective and improvement measures;" and "enhance outreach, education and training." Agreement, p. 22, Section V.D.2

Finally, the Commonwealth, the Independent Reviewer and this Court all have the authority to enforce the Agreement. The Court's oversight is particularly important because without it, we do not believe the Commonwealth will take the steps necessary to ensure that current, former and future residents are as safe as possible.[11]

Our opinion is based upon past experiences, which have shown that Court intervention is necessary to secure systemic change. In 2004, we received information that the Commonwealth was neglecting people in its institutions. We opened an investigation and requested information we are entitled to under state and federal law. When the Commonwealth refused to provide it,

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[11] We recognize that no system is foolproof and that the Commonwealth cannot be an insurer of safety. Human history proves that abuse and neglect will occur at some place and some time, whether the parties' Agreement is entered or not. What is critical, though, is how the Commonwealth responds to incidents of abuse or neglect and the steps it takes to prevent them. In diametrical contrast to the current state of affairs, the Agreement requires strong, decisive steps to prevent, address and redress abuse, neglect, serious injuries and deaths.

we filed suit in this Court and received an Order requiring the Commonwealth to provide the information in that case.[12] Since then, the Commonwealth has provided similar information upon our request in every related or similar investigation.

A few years later, we received information that the Commonwealth had abused or neglected certain training center residents. We opened investigations and requested information we are entitled to under federal law. The Commonwealth refused to provide it. When we filed suit in this Court, the Commonwealth argued that we had no right to sue. Shortly after the Supreme Court held that we have a right to sue,[13] the Commonwealth agreed to provide the information we requested in all future investigations.

In the last year, we discovered that the Commonwealth had failed to transfer dozens of people with disabilities from jails to state facilities for treatment and restoration to competency. We informed DBHDS of its failure and demanded that the people be transferred and treated. The Commonwealth refused. We then filed Motions in 16 cases[14] asking the Courts to hold the Commissioner of DBHDS in contempt for failing to implement the transfers. DBHDS

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[12] *Virginia Office for Protection and Advocacy v. Dr. James Reinhard,* E.D.VA Case No: 3:04cv54 (2004) order granting atty's fees reversed by, *Virginia Office for Protection and Advocacy v. Reinhard,* 405 F.3d 185 (4th Cir. 2005).

[13] *Virginia Office for Prot. & Advocacy v. Stewart,* 131 S.Ct. 1632 (2011).

[14] *Commonwealth v. Allen,* Va. Cir. (Newport News) Case No.: CR07062066-01; *Commonwealth v. Vinson,* Va. Gen. Dist. (Newport News), Case No.: GC11002314-00; *Commonwealth v. Shaw,* Va. Gen. Dist (Newport News), Case No.: GC10011356-00; *Commonwealth v. Goode,* Va. Gen. Dist. (Newport News), Case No.: GC11002011-00; *Commonwealth v. Gibson,* Va. Gen. Dist. (Newport News) Case No.: GC11001284-00; *Commonwealth v. Huff,* Va. Gen. Dist. (Henrico), Case No.: GC11022039-00; *Commonwealth v. Weaver,* Va. Gen. Dist. (Norfolk), Case No.: GC11000654-00; *Commonwealth v. Brooks,* Va. Gen. Dist. (Chesapeake), Case No.: CR11002025-00; *Commonwealth v. Green*, Va. Gen. Dist. (Hampton), Case No.: GC10042682-00; *Commonwealth v. Johnson*, Va. Cir.. (Chesapeake) Case No.: CR11000393-00; *Commonwealth v. Seymore*, Va. Gen. Dist. (Newport News), Case No.: GC11004144-00; *Commonwealth v. Spruill*, Va. Cir.. (Norfolk), Case No.: CR11002218; *Commonwealth v. Womack*, Va. Gen. Dist. (Hampton), Case No.: JA047816-01-00; *Commonwealth v. Frye,* Va. Cir.. (Pulaski), Case No.: CR10000822-00; *Commonwealth v. Williams*, Va. Gen. Dist. (Norfolk), Case No.:GC10008667-00; *Commonwealth v. Cuffee*, Va. Gen. Dist. (Norfolk), Case No.: GC10008747-00.

implemented the transfers prior to any of the cases being adjudicated and has been steadily transferring similarly situated people ever since.

Our experiences demonstrate the very real need for this Court to enter the parties' Agreement: when it comes to the safety of Virginia's most vulnerable citizens, even if the Commonwealth says or means well, without Court intervention it does not do well.

VI. Conclusion

The long, sad history and countless victims of abuse and neglect in Virginia's training centers cry out for this Court to approve and enter the parties' Settlement Agreement. We commend the parties for reaching their Agreement and recognize the Commonwealth for, at long last, agreeing to take strong steps to meet its responsibilities and protect current, former and future training center residents.

Should the Court request, we will be happy to appear at a future hearing to discuss and elaborate on our recommendation.

Dated: 3 April 2012

Respectfully Submitted,
Virginia Office for Protection and Advocacy
Amicus Curaie

BY: _____/s/_____

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