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Recommendation to Investigate
Whitten Center
Clinton, South Carolina

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

Arthur E. Peabody, Jr.
Chief
Special Litigation Section

INTRODUCTION

We recommend that the Department initiate an investigation into the conditions of confinement at the Whitten Center ("Whitten") in Clinton, South Carolina, pursuant to its authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. Whitten is a state-operated institution housing approximately 800 developmentally disabled children and adults.

Residents of state-operated facilities for the developmentally disabled and mentally retarded have a fundamental Fourteenth Amendment due process right to reasonable safety, adequate medical care and training. Youngberg v. Romeo, 457 U.S. 307 (1982). Such training must be sufficient to protect each resident's liberty interests and permit each resident an opportunity to function as independently as their individual handicapping conditions permit. See, e.g., Halderman v. Pennhurst State School & Hosp., 154 F.R.D. 594 (E.D. Pa. 1994); United States v. Tennessee, No. 92-2062, slip op. at 12 (W.D. Tenn. Feb. 17, 1994); Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178 (W.D.N.C. 1988). See also 42 C.F.R. § 483.440.

Information we have obtained indicates that residents of Whitten are being harmed and exposed to unreasonable risks of harm in violation of their constitutional and statutory rights. Alleged unconstitutional conditions include abuse and neglect of residents, inadequate medical and psychiatric care, and failure to provide residents with adequate training. Such deficiencies subject residents at Whitten to unreasonable risks to their personal safety and violate their constitutional rights. In addition, Whitten is a large and isolated institution which unduly segregates its residents from the rest of society solely on the basis of their disabilities. As a result, the facility is failing to provide services to its residents in the least separate, most integrated setting as required by the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12101 et seq.,

cc: Records Chrono Peabody Frohboese Farano Wilkinson Hold

and Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 et seq.

POSSIBLE VIOLATIONS

A. The State Fails to Ensure that Whitten Residents are Free from Abuse and Neglect.

Abuse

Abuse against clients is far more prevalent at Whitten than at any other similar state-run facility in South Carolina.[1]/ A recent state-generated compilation of total abuse incidents at all the South Carolina institutional facilities reveals that in fiscal year 1992-93, Whitten had forty-four separate allegations of abuse.[2]/

Another local advocate indicated that there is "plenty" of staff abuse at Whitten.[3]/ She indicated that the Whitten staff regularly "whup their young'ins" at home, so it's natural that they would carry the same attitudes with them to work.[4]/ Naturally, this can lead to abuse of the residents. This account is corroborated by a Whitten parent who indicated that the staff at the facility can be "violent."[5]/ Last Fall, she noticed that one resident had a clearly marked shoe print on his buttock area revealing that he had been kicked.[6]/

State surveyors, who annually enforce the Health Care Financing Administration's ("HCFA") Title XIX regulations, have noted that Whitten staff are abusive in that they verbally insult residents. For example, for one resident with a urostomy bag, a staff member commented, "She can't come over here smelling like

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[1]/ Telephone Interview with Kimberly McAllister, South Carolina Protection & Advocacy System for the Handicapped, Inc., May 10, 1994.

[2]/ Id.

[3]/ Telephone Interview with Sharon Bellwood, Regional Coordinator, South Carolina Protection & Advocacy System for the Handicapped, Inc., May 10, 1994.

[4]/ Id.

[5]/ Telephone Interview with Jean Shirley, parent of a Whitten resident, September 14, 1994.

[6]/ Id.

this ... The smell burns my eyes."[7]/ The surveyor noted that the client was aware of the comment.[8]/ Staff also refer to adult clients inappropriately as "baby," "good little girl," "sweetie" or good boy."[9]/ Moreover, contrary to state law, the facility is failing to report the results of all abuse and/or neglect investigations to the administrator or other officials in a timely fashion.[10]/

The local Protection and Advocacy ("P&A") group expressed concerns about the compromised impartiality of the Whitten abuse and neglect investigator, stating "[w]e have some questions about the investigator being a paid department employee."[11]/ A parent of a client at the facility indicated that "there IS abuse" occurring at Whitten and that it occurs everyday.[12]/ She indicated that many of the incidents are not uncovered because the Whitten internal investigator is not to be trusted. In fact, she indicated that she trusts the Whitten abuse investigator "as far as she can throw him."[13]/ The parent implied that the Whitten facility director, Judy Johnson, may aid in covering up the truth. The parent said that the director "talks out of both sides of her mouth" and that she "tells parents what they want to hear regardless of the truth."[14]/

Neglect

It is clear that the staff at Whitten subject the residents to neglect. For example, on a recent site visit by Title XIX surveyors, they found that for over an hour, no staff intervened to assist one Whitten client who had urinated in her pants.[15]/

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[7]/ State Title XIX survey conducted for the Health Care Financing Administration ("HCFA Survey"), March 19, 1993, at 31.

[8]/ Id.

[9]/ Id.; HCFA Survey, June 16, 1993, at 17.

[10]/ HCFA Surveys, August 26, 1993, at 6, March 17, 1994, at 1.

[11]/ Letter from the South Carolina Protection & Advocacy System for the Handicapped, Inc. ("P&A Letter"), Sharon Bellwood, Regional Coordinator, Genia Batson, Institutional Advocate, Mary Barr Behlke, PAIMI Advocate, June 7, 1994 at 2.

[12]/ Telephone interview with Jean Shirley, September 14, 1994.

[13]/ Id.

[14]/ Id.

[15]/ HCFA Survey, June 16, 1993, at 7.

Staff also neglected to intervene to stop one female resident who had been repeatedly hitting her head on her knee.[16]/ Similarly, staff failed to intervene to assist a blind client who was sitting on a couch hollering and hitting himself for ten minutes.[17]/ The surveyors found that the staff allowed many residents to leave the dining area with food on their mouths and faces.[18]/ The staff also subject the Whitten residents to neglect by leaving them to sit for prolonged periods of time unengaged in any purposeful activity. On one of their recent visits, the surveyors observed the following during the day: clients not actively engaged in specified activities, clients sleeping in wheelchairs or in regular chairs, and clients sitting or laying by themselves.[19]/ One staff member was smoking outside leaving the residents unengaged.[20]/

The facility neglects to provide a sanitary environment for its residents. For example, on a recent visit, surveyors noted full urinals, commodes with unflushed feces, and dirty clothes with bad odors.[21]/ Staff made no effort to clean or disinfect a chair where one client had been sitting with urine soaked pants.[22]/ On a more recent visit, surveyors noted one client sitting in urine which had seeped down her legs and saturated her socks.[23]/ A staff member discarded the socks in the hamper, but then dispensed evening snacks without washing her hands.[24]/

B. The State Fails to Provide Whitten Residents with Adequate Medical Care.

The P&A group expressed great concern about the large number of recent deaths at the facility. The group indicated that "[d]uring the past month or so there have been approximately ten

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[16]/ Id.

[17]/ Id.

[18]/ Id.

[19]/ HCFA Survey, March 19, 1993, at 24.

[20]/ Id.

[21]/ Id. at 32.

[22]/ Id.

[23]/ HCFA Survey, September 24, 1993, at 15.

[24]/ Id.

deaths at Whitten."[25]/ They added "some of these deaths were totally unexpected."[26]/ One parent characterized some of the deaths as "out of the blue."[27]/ These comments are troubling and imply deficient medical care. This parent believed that more Whitten residents have died in the first six months of 1994 than the total number who died in all of 1993.[28]/

This parent indicated that the physician to client ratio is poor at Whitten. She believed there were only four doctors on staff to care for about 800 residents -- about a 1:200 ratio.[29]/ This ratio is well outside any acceptable limits. She also believes that Whitten does not provide the many epileptic individuals with the services of a consult neurologist.[30]/ She said that her son is epileptic, and yet, she is forced to transport him to a neurologist off-site.[31]/

Surveyors enforcing the Title XIX regulations have repeatedly cited Whitten for its failure to provide adequate preventive and general medical care for its residents. For example, the facility program team did not address the diagnosis of degenerative arthritis for one resident for either prevention or general care.[32]/ In another instance, a resident who was initially described as being hearing impaired and is listed as being deaf, has not had an audiological test in five years.[33]/ Two residents without a plan for alternate positioning have experienced skin breakdown from their inability to adjust their bodies independently.[34]/

Many of the cited medical deficiencies center on feeding or on the provision of meals and mealtime services to the residents. For example, during the swallowing assessment of one Whitten

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[25]/ P&A Letter, June 7, 1994, at 2.

[26]/ Id.

[27]/ Telephone Interview with Jean Shirley, September 14, 1994.

[28]/ Id.

[29]/ Id.

[30]/ Id.

[31]/ Id.

[32]/ HCFA Survey, September 17, 1992, at 14.

[33]/ Id.

[34]/ Id.

resident, an outside consultant recommended that the resident be provided with oral motor exercises to decrease his tongue thrust. The consultant recommended that the exercises be performed by a competent therapist with a goal to enable the client to swallow small bites of food. However, Whitten completely failed to follow up on the recommendation.[35]/

Facility staff present at mealtimes provide little prompting to self-feeders.[36]/ For example, the surveyors observed that clients stuff large amounts of food in their mouths at one time.[37]/ This is potentially dangerous. Clients who had been assessed as being independent in dining skills, were allowed to use their spoons inappropriately.[38]/ The surveyors also noticed that some clients were allowed to eat with their fingers and to eat off the tables and off their bibs.[39]/

The facility staff does not always observe strict dietary orders for certain residents. For example, staff have fed diabetic individuals foods that do not comport with their dietary orders.[40]/ In addition, staff fed a resident on a low salt, 1800-calorie diet a full bag of potato chips.[41]/ The facility also fails to coordinate weight reduction diets with plans for exercise. Some clients who are on weight reduction plans have actually gained weight. For example, one client, whose ideal body weight is 95-115 lbs., currently weighs 220.50 lbs.[42]/

Surveyors found that some clients never leave their wheelchairs despite a physical therapy recommendation to the contrary. For example, the facility ignored a physical therapist's recommendation that one client be taken out of his wheelchair regularly. As a result, this client's legs have turned blue and cold to the touch.[43]/ Another client was to be out of his wheelchair every third hour, yet, the staff indicated

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[35]/ HCFA Survey, March 17, 1994, at 8.

[36]/ Id.

[37]/ HCFA Survey, June 16, 1993, at 7.

[38]/ HCFA Survey, March 19, 1993, at 25.

[39]/ HCFA Survey, June 16, 1993, at 7.

[40]/ HCFA Survey, June 30, 1993, at 13.

[41]/ Id.

[42]/ Id.

[43]/ HCFA Survey, September 24, 1993, at 7.

that they were unaware of this order.[44]/ In fact, the surveyor observed that the client never left his wheelchair.[45]/

C. The State Fails to Ensure Appropriate Use of Psychotropic Medication at Whitten.

Chemical restraints are unduly utilized at Whitten Center.[46]/ The facility fails to ensure that prior to the use of more intrusive techniques that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.[47]/ For example, the facility increased one client's medications without attempting other less restrictive interventions to control his behavior.[48]/

In March 1993, the Title XIX surveyors noted that the facility had attempted no reduction of the behavior modifying medication for one resident since February of 1990 -- over three consecutive years.[49]/ The unsuccessful reduction in 1990 was attempted with no other accompanying revisions to the client's program plan.[50]/ The surveyors discovered that for another client, the facility provided no indication of systematic programmatic intervention between the discontinuation of Lithium and the implementation of Tegretol to assure success of the attempted medication change.[51]/ One resident with extreme attention getting behavior was seen by the hospital staff on three different occasions, approximately two weeks apart, for emergency suturing from self-inflicted wounds for more than fifty-five sutures.[52]/ The resident's dosage of Mellaril had been increased three times in four months but the incidents had increased in severity with no programming intervention.[53]/

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[44]/ Id. at 5.

[45]/ Id.

[46]/ HCFA Survey, September 24, 1993, at 11.

[47]/ HCFA Survey, June 30, 1993, at 11.

[48]/ Id.

[49]/ HCFA Survey, March 31, 1993, at 2.

[50]/ Id. at 3.

[51]/ HCFA Survey, September 24, 1993, at 4.

[52]/ HCFA Survey, August 10, 1992, at 6.

[53]/ Id.

Moreover, after one resident had been chemically restrained, the facility failed to convene the IDT within one working day, pursuant to facility policy.[54]/ Furthermore, the facility psychologist was only vaguely aware of the incident leading up to the restraint.[55]/

D. The State Fails to Provide Adequate Programming to Whitten Residents.

Restraint

Mechanical and physical restraint use appears to be common at Whitten.[56]/ Whitten staff frequently use various forms of restraint as a convenience instead of as a means of aiding the resident.[57]/ Whitten currently employs the papoose chair and other forms of restraint including masks, a full-bed, four-point restraint and a bed-net restraint.[58]/ Surveyors found that staff used restraint as a substitute for active treatment programs.[59]/ For example, one client's behavior support plan indicates that if staff suspect that the client is about to bite someone, he is to be placed in "full face mask and helmet."[60]/ When the face mask was used after a biting incident, the facility psychologist did not even attend the meeting that discussed the procedure.[61]/ Surveyors found that another resident had been placed in a papoose chair six times since his admission only a

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[54]/ HCFA Survey, September 24, 1993, at 11.

[55]/ Id.

[56]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[57]/ Id.

[58]/ Id.

[59]/ HCFA Survey, August 26, 1993, at 23. Staff behavior also exacerbates problematic situations. For example, the surveyors noticed that one client had been hollering and yelling for over an hour. In attempting to redirect the individual, the staff told her that if she did not stop, she would be restrained. However, the behavior program only directed staff to speak to her in a calm, low voice. HCFA Survey, June 16, 1993, at 13.

[60]/ HCFA Survey, August 26, 1993, at 24.

[61]/ Id.

few months earlier.[62]/ However, his behavior management program did not address the use of the chair, and after each use of the chair, his program was not revised.[63]/ Surveyors noted that because another client's verbal aggression and self-abuse increased, the staff felt compelled to restrain the resident.[64]/ A local advocate observed that Whitten employs the papoose chair inappropriately to teach.[65]/ Surveyors observed staff put one client in the papoose chair even though they never contacted the client's physician to get approval for the restraint.[66]/

Behavior Programs

Whitten fails to provide the professional program services and needed interventions necessary to implement successfully the active treatment programs defined on each resident's individual program plan.[67]/ Whitten's failure to adequately provide program services and needed interventions has been documented in eleven separate surveys from 1992 to the present.[68]/

This is having a very real and negative effect on the Whitten residents. For example, Title XIX surveyors recently found residents with PICA behavior outside picking up debris and putting it in their mouths.[69]/ They also observed another client sit unengaged for thirty minutes during which time she bit

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[62]/ Id. at 11. A papoose chair restraint involves placing a large strap over the chest and across the legs of a seated individual. Sometimes this restrictive procedure can be used for as long as an hour and a half. Telephone Interview with Jean Shirley, September 14, 1994.

[63]/ HCFA Survey, August 26, 1993, at 1.

[64]/ Id.

[65]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[66]/ HCFA Survey, June 16, 1993, at 19.

[67]/ HCFA Surveys, March 19, 1993, at 23, May 14, 1992, at 5-7, September 24, 1993, at 8.

[68]/ HCFA Surveys, January 31, 1992, May 14, 1992, May 22, 1992, August 10, 1992, September 17, 1992, March 19, 1993, June 16, 1993, July 29, 1993, August 26, 1993, September 24, 1993, and March 17, 1994.

[69]/ HCFA Survey, September 24, 1993, at 8-9.

her hand three times and twirled her head thirteen times.[70]/ On another visit, the surveyors observed one client biting her hand, but noticed that the staff did not redirect her into an activity nor hand her an object to manipulate as stated in her behavior program.[71]/ They observed that staff did not verbally correct or redirect another resident's repeated hand mouthing behavior even though this was specified in the client's behavior program.[72]/ Staff did not redirect another client who was constantly tugging and pulling at a surveyor's tie.[73]/ The surveyors found that in one year, another resident had engaged in 27 different episodes of physical aggression towards staff or other clients, and yet, the staff never intervened.[74]/

As a result, the Whitten residents are subjected to injuries from their own behaviors or from the behaviors of others. One local advocate reported that in her visits to Whitten, she routinely notices scratches, bruises and occasionally bite marks on the residents.[75]/ She also indicated that injuries from falls are quite common.[76]/

The attitude of the staff towards programming is troubling. For example, a staffer commented in front of a client, "He's not on a program for PICA. He's too low level for a program."[77]/ There is no one who is too "low level" for a program. Anyone can benefit from programming. This comment, therefore, was not only inconsiderate, it was also grossly inaccurate.

The P&A group indicated that Whitten males with "sexual acting out problems" are provided "no counseling ... in order to help with their needs."[78]/ The facility fails to provide individuals with deviant sexual behaviors with adequate

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[70]/ Id.

[71]/ HCFA Survey, March 19, 1993, at 23.

[72]/ HCFA Survey, June 16, 1993, at 13.

[73]/ Id.

[74]/ Id. at 8.

[75]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[76]/ Id.

[77]/ HCFA Survey, March 19, 1993, at 31.

[78]/ P&A Letter, June 7, 1994, at 2.

programming, qualified psychology staff or proper implementation of whatever programs are in place.[79]/

Training Programs

The facility is failing to promote the growth, development, and independence of the clients.[80]/ The facility is failing to ensure that individual program plans include opportunities for client choice and self-management.[81]/ For example, the facility has chosen to keep certain verbal residents in diapers. This impedes their growth and independence.[82]/ The facility has denied communication devices to other residents who could achieve greater independence and self-management with such devices.[83]/ Staff fail to reinforce sign language training with the Whitten clients.[84]/ Surveyors observed one client, who was on an objective to change into fresh clothing on a daily basis, wearing the same clothes throughout the survey.[85]/ Staff also open containers and other sealed items for clients instead of allowing them to do it.[86]/ Staff pour drinks for the clients and they fail to encourage or assist them to pour their own drinks.[87]/ The surveyors also noted that the facility staff missed many opportunities to reinforce independence already gained and reinforce on-going training as identified in the individual program plan.[88]/

The facility fails to ensure that written training programs are actually implemented. For example, Title XIX surveyors found that one client performed the same task repetitively for over an

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[79]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

[80]/ HCFA Surveys, June 16, 1993, at 17, June 30, 1993, at 1, July 29, 1993, at 3, September 24, 1993, at 3, 12.

[81]/ HCFA Survey, March 17, 1994, at 5-6.

[82]/ Id. at 6.

[83]/ Id.

[84]/ HCFA Survey, September 24, 1993, at 9.

[85]/ Id.

[86]/ HCFA Surveys, March 19, 1993, at 31, June 16, 1993, at 17, September 24, 1993, at 12.

[87]/ HCFA Surveys, June 16, 1993, at 17, Sept. 24, 1993, at 12.

[88]/ HCFA Surveys, March 19, 1993, at 25, August 25, 1993, at 16.

hour despite having performed it correctly the first time.[89]/ Later, he sat doing nothing for thirty minutes instead of completing tasks as provided in his program. Apparently, the client had been working with the same program for the past five years with little progress.[90]/ Staff revealed that they were unaware of his and other clients' residential training objectives and behavior management program targeted behaviors and interventions.[91]/

The facility is failing to adequately review and revise individual program plans where the resident is failing to progress towards identified objectives after reasonable efforts have been made.[92]/ Some individuals have been kept on programs for months with no progress and no revision by the facility.[93]/ Surveyors found clients who had made no progress for five to six months on their residential training objectives, and yet, staff did not make any revisions to the clients' programs.[94]/ After no progress is made, staff often discontinue the objective entirely instead of revising it to achieve success.[95]/

In addition, the facility is failing to revise individual program plans as necessary when an individual has successfully completed an objective identified in the individual program plan.[96]/ For example, the surveyors noted that one client who had succeeded in independently washing his face was placed on another program to wash his face.[97]/ Other clients met program objectives to brush their teeth, drink from a cup, and take a bath, and yet, no revisions were made in their programs.[98]/

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[89]/ HCFA Survey, March 19, 1993, at 4.

[90]/ HCFA Survey, March 19, 1993, at 4.

[91]/ Id.; Surveyors found that staff were repeatedly not aware of the details of important client programs. HCFA Survey, August 26, 1993, at 3-4, 9-12.

[92]/ HCFA Survey, March 17, 1994, at 11-2, 29.

[93]/ Id. at 12.

[94]/ HCFA Survey, June 16, 1993, at 16.

[95]/ HCFA Survey, March 19, 1993, at 30.

[96]/ Id. at 28-29.

[97]/ Id.

[98]/ Id.

independence.[100]/ Often, staff feed the residents themselves instead of implementing their program by providing hand over hand assistance.[101]/ Surveyors noticed staff failing to provide training during the course of all meals observed.[102]/

Even for residents provided with training programs, the facility often fails to provide the direct care staff with the necessary methodology to actually implement the programs.[103]/ This has adversely affected individual residents' speech, ambulation, washing, brushing and dressing objectives.[104]/ The facility does not ensure that the staff are provided with current copies of the clients' training programs.[105]/

E. The State Fails to Provide Adequate Staff to Meet the Needs of the Whitten Residents.

The local advocacy group in South Carolina characterized Whitten as a "large facility, located in a rural area, with a limited draw for staff."[106]/ The P&A stated that some of the problems at Whitten are directly caused by "not enough direct care staff."[107]/ The P&A stressed that the "quality" of the staff was problematic in that "[m]ost have very limited 'people' skills, even after their required on job training."[108]/ A Whitten parent also expressed concerns about inadequate numbers and quality of staff at the facility.[109]/ She indicated that staff often do not show up for work, causing other staff to be "pulled" from other units to meet staffing ratios. She indicated

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[100]/ Id.

[101]/ Id. at 23-4.

[102]/ HCFA Survey, September 24, 1993, at 8.

[103]/ HCFA Surveys, March 19, 1993, at 3, June 30, 1993, at 7.

[104]/ HCFA Survey, March 19, 1993, at 3.

[105]/ HCFA Survey, June 16, 1993, at 12.

[106]/ P&A Letter, June 7, 1994, at 1.

[107]/ Id.

[108]/ Id.

[109]/ Telephone Interview with Jean Shirley, September 14, 1994.

staff often do not show up for work, causing other staff to be "pulled" from other units to meet staffing ratios. She indicated that this is a problem because the pulled staff are often unfamiliar with the residents they are to care for.[110]/

The surveyors noted that the facility is failing to provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. As a result, clients are left unattended while staff assisted wheelchair clients in bathing and toileting.[111]/ Staff are forced to hold, chase, and corral clients with challenging behaviors.[112]/ The surveyors noted that staff were so busy "catching and corralling" clients that behavioral data was not recorded. The psychologist responded that there was "nothing" he could do.[113]/ Staff were unable to engage clients in meaningful activities or to document the behaviors that were occurring because of the severity and frequency of interfering behaviors.[114]/

F. The State of South Carolina Fails to Provide Whitten Residents with Services in the Least Separate, Most Integrated Setting.

An isolated, self-contained, institutional environment which separates residents from the rest of society on the basis of their disabilities, necessarily subjects these individuals to conditions which are violative of the ADA and Section 504. Whitten is the largest such institution in the state, currently housing approximately 800 individuals with developmental disabilities. One local advocate indicated that most of these individuals should be placed in the community.[115]/

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[110]/ Id. This is exactly what the surveyors have found on their visits. Staff are pulled from other units and are forced to care for unfamiliar residents simply because of staff shortages. As a result, the pulled staff are totally unaware of the clients' individual programs or needs. HCFA Survey, March 19, 1993, at 24.

[111]/ HCFA Survey, March 19, 1993, at 12.

[112]/ Id. at 12.

[113]/ Id. at 11, 26.

[114]/ Id. at 13.

[115]/ Telephone Interview with Sharon Bellwood, May 10, 1994.

CONCLUSION

The information gathered thus far indicates that the inadequate conditions at Whitten deprive residents of their constitutional and statutory rights. We therefore recommend that an investigation of Whitten be instituted under our CRIPA authority. Funds are available to conduct this investigation.

Approved: _____

Disapproved: _____

Comments: