Motion for Immediate Relief

Exhibit 7

U.S. Department of Justice

Civil Rights Division

SYC:JCP:DD:MRB:TDM:AA:YD
DJ 168-19-74, 75;
168-19m-68, 69, 70;
168-20-45, 46

Special Litigation Section - PHB
950 Pennsylvania Avenue, NW
Washington, DC 20530

April 15, 2009

BY FIRST CLASS MAIL AND EMAIL

Dennis R. Dunn, Esq.
Deputy Attorney General
Department of Law
State of Georgia
40 Capitol Square SW
Atlanta, GA 30334-1300

Re: United States v. Georgia, No. 1:09CV-119-CAP (N.D. Ga.)

Dear Mr. Dunn:

We write to express our concern regarding conditions that endanger the residents of the Central State Hospital in Milledgeville, Georgia ("CSH" or "Hospital"), and in particular, the patients on the Green 2 Unit at the Cook Building, which is designated as housing for those patients requiring maximum levels of security. These conditions persist due to CSH's failure to take adequate measures to protect patients from harm.

As you know, on April 7, 2009, we wrote to request additional information concerning an apparent homicide on the Green 2 Unit on April 5, 2009. We then visited the Hospital on April 8 and 9, 2009, accompanied by an expert consultant in protection from harm. The on-site investigation was conducted pursuant to Section V.D. of the Settlement Agreement resolving our investigation of the Georgia Psychiatric Hospitals pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with our pledge of transparency and provision of technical assistance, we provided an exit briefing at the conclusion of the site visit. Our consultant informed the State's representatives at that meeting of significant systemic failures uncovered by our brief investigation of this incident, including the following:

- Inadequate supervision of patients to prevent harm, particularly patients for whom enhanced supervision is prescribed. In this incident, the apparent aggressor was

- supposed to receive 1:1 supervision from a staff person who left his duties without following hospital policy. Evidence suggested that inadequate patient supervision has been identified by the Hospital as an ongoing problem.

- Inadequate supervision of staff to ensure sufficient supervision of patients. Failures in supervising staff, and in particular, in enforcing patient supervision policies, had been noted months before this incident. Apparently, no effective corrective action, including retraining of staff on patient supervision practices, had been taken to address this issue.

- Falsification of nursing notes and other documentation. Both the 1:1 staff person's 15-minute checks and the nursing supervisor's notes appear to have been pre-entered and signed on the evening of this incident, which is a clear violation of generally accepted professional standards in nursing practice. Further, the evident falsification of the nursing supervisor's notes was not noted by the facility in its initial analysis of the incident.

- Inadequate assessment of the alleged aggressor. The Hospital had not done a thorough re-assessment of this patient in light of this new incident, nor had it requested or considered information about the incident in January 2009, when this patient allegedly murdered his cellmate in the DeKalb County Jail.

- Inadequate assessment of the risk of ongoing harm involving all patients on this unit. Nearly four days after the incident, the Hospital had not begun to clinically re-assess each of the patients on this unit for additional risk of harm to self or others in light of this incident, and in light of the aggressor's return to this unit after his booking on criminal charges.

As we informed State and Hospital administrators at our exit briefing, our expert believes that these failures may have contributed to the death of the resident on April 5, 2009, and are placing current patients in this unit at risk of additional harm.

State and Hospital officials displayed a commendable openness to reviewing operations in light of our consultant's findings and technical assistance. On April 8, 2009, the State

provided us with a document describing its responses to this incident, entitled a Safety Plan. The primary response is to increase staff supervision of the aggressor to 2:1 staffing, to separate this patient from other patients on the unit by scheduling his activities, including meals, recreation and hygiene tasks separately from other patients, and to implement a newly-developed behavior support plan by April 10, 2009. The State also proposed re-training staff on existing supervision policies, and modification of some policies, including locking of bedroom doors from the outside on this unit, and supervisory review of staff assignments. In light of the severity of the harm that has, and may continue to occur, we reiterate that these measures, as well as the additional measures outlined during our exit briefing, must be implemented immediately, documented, monitored, and revised as necessary. We contemplate conducting an additional short site visit to verify these remedial actions within the next month or two on mutually-agreed dates. In addition, by separate letter we will reiterate our request for documentation attesting to the implementation and efficacy of the State's efforts.

Finally, we reiterate our concern that many of the systemic deficiencies preliminarily identified in our investigation of this tragic incident are consistent with the deficiencies previously noted in our investigative findings. In particular, staff's failure to provide adequate supervision, including one-on-one supervision, was a cause of preventable harm at each of the hospitals we visited, and insufficient analysis and investigation of incidents also contributed to repeated instances of harm. Because of these similarities, and the severity of the potential harm to patients, we asked in our letter of April 7, 2009, which is attached for your reference, that the State provide evidence of the system-wide competency-based re-training of all direct care staff and supervisors on the requirements of enhanced supervision levels. In a letter dated April 13, 2009, Assistant Attorney General Jason Naunas stated his understanding that materials responsive to our April 7 letter were provided to the Department during our visit. While we appreciate the State's cooperation and responsiveness to our emergency site visit on April 8 and 9, we note that our specific request for evidence of system-wide re-training of staff on the requirements of enhanced supervision has not yet been satisfied. We further note that Section IV.F. of our Settlement Agreement requires the State to make reasonable efforts to coordinate implementation of remedial actions throughout the Georgia Psychiatric Hospitals.

As we have stated previously, we would be happy to have our consultants provide the State additional technical assistance to help remedy these deficiencies. If you should have any questions or concerns about this matter, please do not hesitate to contact me or Dave Deutsch at (202) 514-6270, Mary Bohan at (202) 616-2325, Timothy Mygatt at (202) 305-3334, or Amin Aminfar at (202) 307-0652.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

cc: Mary Lou Rahn
Settlement Agreement Implementation Coordinator

Greg Hoyt
Director of Hospital Operations

U.S. Department of Justice
Civil Rights Division

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DJ 168-19-74;
168-19m-68,69,70;
168-20-45,46; 168-19-75

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950 Pennsylvania Avenue, NW
Washington, DC 20530

April 7, 2009

BY FIRST CLASS MAIL AND EMAIL

Jason Naunas, Esq.
Department of Law
State of Georgia
40 Capitol Square SW
Atlanta, GA 30334-1300

Re: United States v. Georgia, No. 1:09CV-119-CAP (N.D. Ga.)

Dear Mr. Naunas:

We write to request your emergent attention to the following request, relating to the apparent homicide at Central State Hospital on Sunday, April 5, 2009. Pursuant to section V.D. of the Settlement Agreement in this case, conditions or practices that pose an immediate and serious threat to the life, health or safety of patients served by the Georgia Psychiatric Hospitals do not require that the State be afforded a cure period. Please provide to this office, no later than close of business tomorrow, April 8, 2009, the following:

1. A safety plan developed by a clinical team that details the State's plan for ensuring the safety of other patients and staff at the facility when the aggressor is returned to any of the Psychiatric Hospitals; the plan shall detail management of the aggressor's behavior throughout the 24-hour day, and identify who is responsible for implementing and for supervising all aspects of the safety plan.

2. Provide evidence of the provision of competency-based training to all direct care, clinical and supervisory staff who will be charged with implementing the aggressor's safety plan, and document that such training (or re-training) is provided prior to that staff person's assuming responsibility for this patient.

3. Describe the plans to protect the aggressor from potential self-harm.

4. Describe the process undertaken by the State to conduct an expedited root-cause analysis of this incident, and provide the corrective action plan responsive to any findings identified by this analysis. Notwithstanding the ongoing investigation by law enforcement personnel, we expect that this root cause analysis be completed on an expedited basis.

5. Describe the efforts undertaken at Central State Hospital to cleanse the environment of all potentially life-threatening instruments, including, but not limited, to items that might be used as ligatures.

6. In light of the Department's findings that staff's failure to provide adequate supervision, including one-on-one supervision was a cause of preventable harm at each of the hospitals we visited, please provide no later than April 14, 2009, evidence of the system-wide competency-based re-training of all direct care staff and supervisors on the requirements of enhanced supervision levels.

If you should have any questions about this request, please feel free to contact Dave Deutsch at (202) 514-6270.

Sincerely,

Mary R Bohan

Mary Bohan
Trial Attorney
Special Litigation Section

cc: Greg Hoyt