Motion for Immediate Relief

Exhibit 8

U.S. Department of Justice
Civil Rights Division

SYC:JCP:DD:MRB:TDM:AA:AG:YD:dj
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

June 9, 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, Georgia 30334-1300

Re: United States v. Georgia, No. 1:09CV-119-CAP (N.D. Ga.)
Concerns Regarding Deaths at Central State Hospital

Dear Mr. Dunn:

As part of our January 15, 2009, settlement pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, Georgia is required under Section IV.H to notify the United States promptly of all deaths and other sentinel events. This provision further requires that the State send the United States copies of all completed incident reports and final reports of investigations, as well as any autopsies and death summaries in the State's possession.

We have received reports concerning eleven deaths at Central State Hospital (or at a local hospital shortly after transport) since January 1, 2009. We have already written about and provided extensive technical assistance regarding the death of patient Christopher Yates on April 5, 2009, who died of an apparent homicide.

Some of the other death investigations sent to us, however, raised significant questions regarding supervision, observations levels, and communication of relevant information to the appropriate clinicians, similar to those issues that we noted in our initial review of the apparent homicide of Christopher Yates. For example:

- On March 17, 2009, 46-year-old Carol Colvin died only 12 days after having been admitted to Central State. She was admitted because of extreme agitation and physical aggression toward others, and was placed on line of sight ("LOS") observation, which continued for her entire

hospitalization at Central State. During evening rounds on March 17, Ms. Colvin was alert and responsive in her wheelchair. At 12:00 a.m., a patient alerted staff that there was a problem. Staff found Ms. Colvin lying face-down on the floor of another patient's room. Her face and hands were blue, her back was warm to the touch. She was not breathing. CPR was unsuccessful.

According to the investigation, the staff member assigned to LOS observation of Ms. Colvin had been assigned to her beginning at 11:00 p.m., but the staff member stated to investigators that she had not observed Ms. Colvin before finding her on the floor, almost an hour after her LOS observation was supposed to commence. Ms. Colvin's observation record, however, indicated that LOS observation had been maintained. Further, a review of the staff assignment documents for that evening revealed that they had not been completed. The investigation also noted that the unit did not meet minimum staffing requirements on the evening Ms. Colvin died. Additionally, the investigation notes that the registered nurse on the unit that evening did not know how to call a Code Blue, nor did she commence CPR; CPR was not initiated until a registered nurse from another unit arrived and initiated it, approximately nine minutes after Ms. Colvin was first found on the floor. Finally, the investigation notes an almost 20 minute delay between the initial contact between the unit and the on-call physician and his arrival on the unit, although the testimony of the on-call physician suggests a much earlier arrival time than the testimony of two other witnesses and the Code Blue record.

- On May 11, 2009, 42-year-old Angela Kemp died three days after being admitted to Central State on May 8, 2009. Ms. Kemp's death does not appear to be related to the adequacy of her supervision, but we nevertheless had significant concerns about decisions made about her supervision status. Specifically, according to the investigation following her death, Ms. Kemp was admitted from a community provider "due to agitation and threatening to hurt others." Upon admission, Ms. Kemp was placed on LOS observation. The following morning, May 9, the on-call physician discontinued the LOS observation. His progress notes for that morning stated "'(Kemp) taking meds (medications), cooperative with staff. No history of assault on self or others; diagnosis is unchanged; stop

LOS.'" The investigation did not note the apparent contradiction between Ms. Kemp's reason for admission and the reason given by the on-call physician for discontinuing LOS observation.

Moreover, there are other deaths at Central State that raise troubling concerns. These deaths often involve relatively young patients, many of whom had not been at the hospital for very long, and appear to raise questions concerning the adequacy of care provided to the decedent. For example:

- On March 4, 2009, Harvey Thorton died at a local hospital. He had been admitted to the emergency room on February 25, 2009 with a diagnosis of sepsis, cardiac enzyme abnormality, and possible mild heart attack, following a series of troubling care at Central State. While at Central State, on February 14, 2009, Mr. Thorton was found slumped over in his chair, not responsive, and thought to be post seizure. He was found slumped over in his chair again on February 17. His blood sugar was high, and he was given insulin and transported to the ER. Later, it was found that the glucometer had not been calibrated prior to use and gave incorrect readings. He was sent back to Central State. On February 23, an order for blood pressures every shift for 10 days was written, but, contrary to the order, his blood pressure was not recorded in his record every shift. He was found semi-comatose on February 25, with a blood pressure of 50/30 and sent to the hospital, where he died a few days later.

- On April 1, 2009, Mary Mathis died of end stage gastric cancer, five days after her cancer was diagnosed. In the months before she was diagnosed with cancer, Ms. Mathis was losing weight and had trouble swallowing. Staff had trouble evaluating her swallowing problems because her mouth and tongue movements were so severe, evaluations were nearly impossible. Such mouth and tongue movements are a common side effect of psychotropic medications, suggesting lapses in mental health care over many years. Moreover, difficulty in performing a swallowing study is an insufficient reason not to perform other evaluations that could determine the cause of her weight loss in a timely manner.

- On April 20, 2009, at approximately 6:35 a.m., during rounds staff found Mary Gilley unresponsive. CPR was unsuccessful. The preliminary cause of death was ventricular arrhythmia. A medical evaluation on April 16 had revealed borderline hypertension and cardiac arrhythmia, that previous

evaluations had not revealed. A cardiology consult was ordered on April 17, but had not yet been obtained when Ms. Gilley was found dead on the morning on April 20.

- On April 20, 2009, 44-year-old James Greene died 14 days after having been admitted to Central State. When he was admitted, his blood glucose level was "below 250," which was "manageable." On April 7, Mr. Greene periodically refused to allow staff to obtain blood for glucose testing, but allowed it in the evening. At 6:30 a.m. on the morning of April 8, another finger stick showed his blood glucose level was 198. Later, during morning rounds, he was found lethargic and slumped over on a couch. His blood pressure was 71/46 and his blood glucose was "unreadable" as the level exceeded the test's maximum indicator of 500. Insulin was given, but his level remained over 500. His mucus membranes were dry, and his doctor suspected dehydration. He was admitted to a local hospital due to low blood pressure and elevated blood sugar and possible dehydration. He died at a local hospital on April 20. His family has requested an autopsy.

These deaths and the associated Critical Incident Reports and investigations raise significant questions about the adequacy of medical, nursing, and mental health care provided to these patients during their tenure at Central State Hospital. While we have not yet had an opportunity to have these deaths reviewed by our clinical experts, we have grave concerns about the care these patients received. Accordingly, we request that these deaths be reviewed by an expert or experts in the relevant clinical areas, and that systemic deficiencies, if any, in the care provided at Central State as indicated by these deaths are identified and resolved appropriately. Likewise, we will be forwarding these death reports and any follow-up documentation to our experts for review and recommendations.

Similarly, our review of the investigations provided to us raised significant questions about the adequacy of the investigative process. For example, we noted incidents in which it appeared that relevant fact witnesses were not interviewed, relevant documents were not reviewed, and apparent conflicts in witness and documentary evidence were not resolved. We will be forwarding these investigations to our experts for review and recommendation, and we request that you undertake a similar review.

If you should have any questions or concerns about this matter, please do not hesitate to contact me or David 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

Marvin Bailey
Central State Hospital Administrator