Motion for Immediate Relief

Exhibit 14

U.S. Department of Justice
Civil Rights Division

SYC:JCP:DD:MRB:TDM:
RAK:EAG:AG:YD:dj
168-19M-68

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

November 25, 2009

VIA ELECTRONIC MAIL AND FIRST CLASS MAIL

Mary Lou Rahn
2 Peachtree Street, N.W.
Suite 22256
Atlanta, Georgia 30303

Jason S. Naunas, Esq.
Assistant Attorney General
Department of Law
State of Georgia
40 Capitol Square S.W.
Atlanta, Georgia 30334

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

Dear Ms. Rahn and Mr. Naunas:

We write to request your immediate attention to conditions that endanger the residents of Central State Hospital in Milledgeville, Georgia ("CSH" or "Hospital"). These conditions persist due to CSH's continued failure to protect patients from harm and to provide care and treatment that does not violate the constitutional rights of its patients.

On November 2-6, 2009, we visited CSH with expert consultants in protection from harm, nursing, psychiatry, psychology, and discharge planning. As you know, this was our third visit to CSH. We previously visited on April 8-9, 2009, accompanied by our protection from harm consultant, and on June 30 and July 1, 2009, accompanied by expert consultants in protection from harm and psychology. Additionally, we have visited four of the other State psychiatric hospitals since we entered into the Settlement Agreement on January 15, 2009: East Central Regional Hospital ("ECRH") on May 4-8, 2009, Georgia Regional Hospital at Savannah ("GRHS") on June 22-26, 2009, Georgia Regional Hospital at Atlanta on August 2-6, 2009, and Southwestern State Hospital on

October 13-16, 2009. Consistent with our pledge of transparency and provision of technical assistance, we provided an exit briefing at the conclusion of each of these site visits. At each of the exit briefings, our consultants have informed the State's representatives of serious conditions that violate the constitutional rights of the patients at the State psychiatric hospitals. Those conditions persist despite our warnings and technical assistance, and grave harm continues to occur.

Specifically, during our exit briefing on November 6, 2009, we notified the State of conditions that endanger the lives of CSH patients and require urgent attention, including:

- Suicide prevention measures that are perilously inadequate. As discussed by our expert consultants, we found numerous environmental hazards that create the opportunity for individuals to commit suicide, despite repeated warnings about many of these same hazards at other State psychiatric hospitals. We also found that psychiatric assessments are deficient and do not properly assess the risk of suicide, nor do they adequately alert community providers of the patient's risk of suicide upon discharge.

- Patient-on-patient aggression that is uncontrolled. As described during the exit briefing, CSH has some of the most disturbing incidents of aggression that our consultants have found nationwide. CSH provides inadequate behavioral treatment to address aggression. Individuals also continue to be inadequately supervised, despite our finding that inadequate supervision was a critical breakdown leading to the murder of a patient in April 2009.

- Physical and nutritional management that is grossly inadequate. In particular, individuals at risk of aspiration and choking are not provided with adequate assessments, interventions, and proactive monitoring. For example, during our tour we observed an individual choke during a meal; the individual was inadequately assessed for risk and had a meal plan that was inadequate to mitigate the risk of harm. The response to this incident was also insufficient: an appropriate assessment was not performed, nor was an adequate meal plan developed. This individual therefore remains at significant risk of harm. Furthermore, we received notice of a death on November 21, 2009, that raises significant concerns about the physical and nutritional management provided to this person as described in the Critical Incident Report.

- Emergency preparedness measures that are seriously deficient. Although CSH has made significant strides in its emergency preparedness policies, the emergency preparedness practices that we found at CSH raise significant concerns. Nurses continue not to know how to turn on oxygen tanks, despite

emergency preparedness documentation indicating that they were completing this task daily. Moreover, we found that the medical care provided at CSH is so grievously inadequate that, in many instances, deficient medical care is the very reason why an emergency code must be called.

These conditions must be remedied immediately to prevent deadly harm. We urge the State to implement immediately the remedial steps recommended by our expert consultants during our expert briefing. Additionally, most, if not all, of the technical assistance and recommendations made in our November 19, 2009, compliance letter regarding GRHS are applicable to the conditions at CSH, and we encourage the State to implement these measures immediately at CSH and not wait for our compliance letter.

Moreover, these conditions are exacerbated by the State's failure to comply with requirement of the Americans with Disabilities Act, 42 U.S.C. §§ 12132-12134, and Olmstead v. L.C., 527 U.S. 581 (1999). Hundreds of individuals are currently confined to CSH who need not be institutionalized. Indeed, during our tour, we were informed by treating professionals at CSH that whole units of individuals could be moved into the community, but adequate supports and services are not available. Our expert consultants agree. The State must take immediate action to address deficiencies in community supports and services that cause needlessly prolonged institutionalization and expose patients to serious harm.

Because of the dangerous conditions that persist at CSH, for our next compliance visit—scheduled for January 11-15, 2010—we will return to CSH. During that tour, we intend to monitor the State's effort to comply with the requirements of the Settlement Agreement and to provide additional technical assistance to the State to ameliorate the ongoing violations of individuals' constitutional and federal statutory rights. Our request for production of documents is attached. Please provide the documents to us no later than December 18, 2009.

We appreciated the collaborative attitude demonstrated by State and facility administrators and staff during our tour of CSH. As always, we remain available to discuss any questions or concerns that you might have regarding our review. If you have any questions, please do not hesitate to contact me at (202) 514-0195, or the attorneys assigned to this matter, David Deutsch at (202) 514-6270, Mary Bohan at (202) 616-2325, Timothy Mygatt at (202) 305-3334, Robert Koch at (202) 305-2302, or Emily Gunston at (202) 305-3203.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

cc: Frank Shelp, M.D.
Commissioner
Georgia Department of Behavioral Health and Developmental Disabilities