Motion for Immediate Relief

Exhibit 9

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

July 16, 2009

BY FIRST CLASS MAIL AND EMAIL

Jason S. Naunas, Esq.
Assistant 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.)
Conditions at Central State Hospital

Dear Mr. Naunas:

We write to express our continuing concern regarding conditions that endanger the residents of the Central State Hospital in Milledgeville, Georgia ("CSH" or "Hospital"), and in particular, the patients in Forensic Services at CSH. These conditions persist due to CSH's and the State's ongoing 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 visited the Hospital on April 8 and 9, 2009, accompanied by an expert consultant in protection from harm, and again on June 30 and July 1, 2009, accompanied by expert consultants in protection from harm and forensic psychology services. The on-site investigations were 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 each site visit.

During the exit conference following our initial 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;

- Inadequate supervision of staff to ensure sufficient supervision of patients;

- Falsification of nursing notes and other documentation;

- Inadequate assessment of the alleged aggressor; and

- Inadequate assessment of the risk of ongoing harm involving all patients on this unit.

Unfortunately, as we informed State and Hospital administrators at our exit briefing concluding our second tour, many of these deficiencies still exist, along with related systemic deficiencies that we uncovered during our follow-up tour, and are placing current patients in this unit and throughout Forensic Services at CSH at risk of additional harm. Specifically, as our expert consultants mentioned during our recent exit briefing, we found the following systemic deficiencies, some of which are identical to those we found during our first site visit:

- Inadequate supervision of patients to prevent harm, particularly patients for whom enhanced supervision is necessary. As our expert consultant noted during our exit briefing, we found situations where there was insufficient staff on a unit to provide increased supervision on those patients who required it and also provide adequate supervision of the remaining patients. On at least one occasion, the lack of adequate supervision likely exacerbated a situation in which several patients' behavior began escalating toward violence, and serious harm could easily have occurred.

- Inadequate implementation of intervention strategies once individuals at risk for violence or victimization have been identified, including inadequate supervision of staff to ensure sufficient supervision of patients. For example, we found that, even when individuals have been identified as needing increased supervision, and when staff have been trained to provide that supervision, there is no system in place to ensure that the trained staff are those who are actually assigned to provide increased supervision. Thus, individuals previously identified as needing increased

supervision may not receive the supervision they require, placing them and those around them at risk of substantial harm.

- Inadequate assessment of individuals with the potential for aggression. As discussed during the exit briefing, we found several individuals for whom adequate assessments had not been performed, but who presented a likelihood for aggression based on their history, present status, and the recent trend of adverse incidents in which they had been involved.

- Inadequate use and implementation of Behavior Support Plans ("BSPs"). Our review found several individuals whose history, present status, and recent incidents indicated that a BSP was necessary, but BSPs were not in place. Even when a BSP had been prepared, however, the BSP substantially departed from generally accepted professional standards. BSPs must be based on an adequate functional analysis, and the psychology staff does not appear to have the skills and training necessary to perform an adequate functional analysis and use the analysis to develop a BSP that meets professional standards. Indeed, the BSPs that we reviewed appeared to be identical in many respects, despite significant differences in the maladaptive behaviors presented by the individuals for whom the plans had been developed. Further, implementing a BSP depends on adequate data collection regarding the target behavior, and we found that CSH's data collection efforts did not meet this standard. In one instance, we found that over 50 percent of the data collected was inaccurate; even more troubling was that CSH was unaware of its inaccuracy, and has no system in place to monitor the collection of data and ensure its accuracy.

- Inadequate use of active treatment. From our observations, little active treatment is occurring on the forensic units. Instead, increased supervision levels are being used as a substitute for active treatment in an effort to control the behaviors, rather than treating the causes of those behaviors.

Overall, the State's and CSH's response has been fragmented, lacking the systemic and comprehensive approach necessary to remedy the problems that were exposed by the alleged homicide and identified by our expert consultants. CSH staff members are not being provided with the training and resources necessary to

respond effectively to this incident. The State must take comprehensive measures to respond to this incident, including:

- Obtaining outside expertise to provide skills, training, and resources to hospital staff throughout the State system, if the State does not have sufficient expertise internally to provide these essential elements. As you know, at the State's request we provided the name of an expert consultant who may be able to provide the State with the necessary expertise.

- Evaluating current staffing levels and implementing measures to ensure that sufficient staffing is available to supervise patients adequately across all of the State's psychiatric hospitals.

- Taking comprehensive measures to identify individuals who are at risk of aggression or victimization based on their history, present status, and the recent trend of adverse incidents in which they had been involved.

- Providing training on assessments, functional analyses, BSP development and implementation, active treatment, supervision, and data collection.

- Implementing quality assurance measures to ensure that intervention strategies, including increased supervision, BSPs, and active treatment, are being implemented as prescribed.

As we stated after our last review of this incident at Central State, in light of the severity of the harm that has, and may continue to occur, these measures, as well as the additional measures outlined during our exit briefing, must be implemented immediately, documented, monitored, and revised as necessary. We ask that the State provide us no later than Thursday, July 30, a plan of correction outlining the measures the State will implement at CSH. Further, we reiterate our concern that many of the systemic deficiencies preliminarily identified in our investigation of this tragic incident are consistent with the deficiencies noted in our investigative findings and during the exit briefings of our compliance tours to East Central Regional Hospital and Georgia Regional Hospital at Savannah. We will continue to monitor the measures taken by the State to respond to this incident and to institute measures to address patient-on-patient aggression systemwide as required by the Settlement Agreement during our upcoming compliance tours, and we

contemplate scheduling additional tours focused on the State's measures to remedy these deficiencies.

Once again, State and Hospital officials displayed a commendable openness to reviewing operations during our visit to CSH, and we appreciate the cooperative spirit in which we were received. 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