U.S. Department of Justice

Civil Rights Division

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

August 22, 2008

Via Electronic and US Mail

Emily Sweet, Esq.
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The City of New York
Law Department
100 Church St.
New York, NY 10007

Re: Investigation of Kings County Hospital Center

Dear Counsel:

We write to memorialize the concerns we raised during our July 28, 2008 through August 1, 2008 tour of the Kings County Hospital Center ("KCHC"). As you know, we conducted this initial investigatory tour pursuant to our authority under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA").[1]

As we noted during the post-tour briefing we held with you and your clients, the City of New York ("City") and the Health and Hospital Corporation ("HHC"), we have not yet reached a conclusion as to whether KCHC is engaging in a pattern or practice of violating the constitutional and federal statutory rights of patients. However, as set forth below, there are several policies and practices at KCHC which pose imminent risks of serious harm to patients and which should be addressed immediately.

[1] As you also know, we have a concurrent investigation of KCHC pursuant to the pattern or practice provision of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("14141").

1. Inadequate Mental Health Assessments.

Frequently, patients with mania are not being clearly diagnosed and assessed by KCHC physicians. As a result, these patients, instead of receiving appropriate mood stabilizers, are being treated with anti-depressants. This improper treatment serves to exacerbate rather than treat the patients' mania. Physicians and other staff should be trained immediately as to how to assess and treat mania to avoid further harm to patients with this disorder.

2. Inappropriate Drug Combinations.

KCHC physicians are routinely prescribing both Thorazine (chlorpromazine) and Seroquel (quetiapine) to both children and adults. This is a potentially dangerous drug combination which can cause hypotension (decreased or lowered blood pressure) and result in falls and injuries. Prescribing these two medications together is contrary to generally accepted professional standards. KCHC should discontinue this practice immediately or, at a minimum, implement strict controls and monitoring on the use of this combination of drugs.

3. Inappropriate Use of Drugs for Sedative Effect.

KCHC physicians also routinely prescribe medications apparently only for their secondary sedative effect, including Ativan (lorazepam), Thorazine (chlorpromazine) and Seroquel (quetiapine). The dosage levels at which KCHC prescribes these medications do not have therapeutic value to address the patients' underlying disorder. Prescribing such medications primarily for their sedative effects – and not to treat or address a patient's underlying disorder – is inappropriate and violates generally accepted professional standards.

4. Inadequate Medical Care for Patients With Diabetes.

We have serious concerns regarding the adequacy of KCHC's medical management of patients with diabetes. For example, we reviewed the records of a patient on Unit G-53 who had uncontrolled diabetes; her blood sugar readings ranged from 40 to 400 over the course of one 24-hour period. The patient's charts

indicated that nothing was done to stabilize her condition. This put the patient at immediate risk of harm, including diabetic coma or shock. Given the metabolic changes that some medications cause, including atypical anti-psychotic drugs, KCHC must also pay more careful attention to the treatment and care of patients with diabetes. It should also develop policies to screen and manage metabolic issues relating to the use of anti-psychotic drugs.

5. Inadequate Medical Emergency Response.

Our review of records and materials, including videotape, in connection with the death of Esmin G. in KCHC's CPEP unit on June 19, 2008, raises substantial concerns regarding the adequacy of patient supervision and the monitoring of patients by the staff, including medical personnel and hospital police, and systems of accountability which appeared to have failed. Specifically, we note that, although medical and hospital police staff apparently observed Esmin G. lying on the floor of the CPEP waiting area, during the course of the entire hour she lay there, no one approached her to check on her status. Further, it appears that video monitors which should have conveyed images of Esmin G. on the floor were not adequately monitored.

We also have concerns regarding the conduct of medical staff in running the emergency code operation beginning at approximately 6:40 A.M. As an initial matter, it appears that no one was clearly in charge of coordinating or directing the code for several potentially crucial minutes. From the video, it also appears - contrary to generally accepted medical practice - medical staff did not address airway, breathing or cardiac issues, but rather, first took a "finger stick" to assess Esmin G.'s blood sugar.

Our review of emergency medical code drills procedures during our recent tour buttresses these preliminary findings. During these drills, KCHC staff failed to respond in an appropriate manner and staff apparently were not adequately trained in conducting medical codes.

Accordingly, we urge the City to take immediate measures to ensure that: 1) KCHC mental health patients are adequately supervised and monitored at all times; 2) medical emergencies are responded to swiftly and adequately; and 3) KCHC staff are adequately trained in dealing with medical codes and emergencies. We make this recommendation with the recognition that KCHC already has begun to implement changes to try to address these issues. We encourage KCHC to continue to take all necessary measures to ensure the safety and appropriate medical treatment of all patients in the CPEP.

6. Falsification of Medical Records.

Finally, we note that the entries in Esmin G.'s medical records are directly contradicted by the video. Specifically, the records state that she was walking around and went to the bathroom at 6:00 A.M., at a time that she is seen in the video lying prostrate on the CPEP floor. Additionally, during our site visit, we were also informed by HHC President Alan Aviles that HHC staff had discovered that a nurse had falsified a restraint record of patient Patricia R. These incidents raise serious concerns about the reliability of medical records in the mental health units. Intentionally or otherwise inaccurate records can cause error in treatment resulting in patient harm. We urge KCHC to take immediate measures to address not only the two incidents described in this paragraph, but also to ensure that medical records accurately reflect treatment. This should include training and education of mental health staff regarding the importance of accurate record-keeping and the potential harm to patients if false or inaccurate entries are made in patients' charts.

As noted above, these conditions were raised during our recent tour, and we were given assurances that they would be addressed expeditiously. Accordingly, we would appreciate an update on KCHC's efforts to address the concerns as soon as possible, but no later than September 2, 2008.

Finally, we appreciate the cooperation and professionalism demonstrated by counsel and KCHC staff during the tour. If you have any questions, please contact either of us using the information provided below, or through Special Litigation Section attorneys Cathy Trainor at (202) 616-9009, or Laura M. Welp at (202) 353-3759.

Sincerely,

/s/ David Deutsch

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