



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

Johnson & U.S. v. Florida



MH-FL-001-003

November 9, 1995

Honorable Lawton Chiles
Governor of Florida
Governor's Office
The Capitol
Tallahassee, FL 32399-0001

Re: G. Pierce Wood Memorial Hospital

Dear Governor Chiles:

On May 17, 1995, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, of our intent to investigate conditions at G. Pierce Wood Memorial Hospital ("G. Pierce Wood") in Arcadia, Florida. The purpose of this letter is to advise you of the constitutional and statutory violations ascertained during this investigation, the supporting facts, and recommended minimum remedial measures.

By way of background, after notifying you of our intent to investigate G. Pierce Wood, we sent counsel for the State a letter dated May 31, 1995 to advise the State of our desire to conduct an on-site inspection of the facility to assess and evaluate current conditions. We also requested that the State provide the Department with certain documents and information prior to the on-site inspection. Such inspections and requests for documents are a routine part of our CRIPA investigations.

In late July, the State provided us with "public records," only after the Department agreed to pay for copying and labor costs. When we inquired about the other information we had requested, counsel advised the Department that the State would neither provide further information nor grant access to the facility by our attorneys and expert consultants retained by the United States to assist in the conduct of this investigation until the Department provided the State with more specific information regarding the allegations it had received concerning G. Pierce Wood. Counsel also indicated that the State intended to depose a representative of the Department pursuant to Fed. R. Civ. P. 30(b)(6) to ascertain whether the Department had any

evidence of possible violations of the Johnson v. Bradley consent decree.

In an effort to resolve this matter amicably, the Department offered to meet with Florida Assistant Attorney General Jason Vail. On September 15, 1995, Mr. Vail met with Deputy Assistant Attorney General Loretta King, and other members of my staff who discussed the nature and purpose of our investigation. We also discussed the nature of the allegations we have received about unlawful conditions at G. Pierce Wood and provided the State with a six page list of the allegations along with numerous newspaper reports and the August 1994 Health Care Financing Administration survey of the facility. Mr. Vail advised us that he lacked the authority to grant the Department access to the facility or to provide any additional documents. At our request, on September 19, 1995, Deputy Assistant Attorney General Loretta King and other members of my staff further discussed this matter in a telephone conference call with your General Counsel, W. Dexter Douglass, HRS General Counsel Kimberly Tucker, and Assistant Attorney General Vail. The State continued to deny the Department access to the facility and to additional documents and suggested that the Department's concerns should be addressed in the context of on-going litigation in Johnson v. Bradley, a private class action lawsuit involving G. Pierce Wood. On September 27, 1995, Mr. Vail advised us by letter that the State continued to deny the Department access to the facility and additional documents, and directed us, instead, to the Johnson v. Bradley lawsuit.

Over the last five months, we have endeavored to work cooperatively with the State and regret that the State has insisted that this matter be resolved only through litigation rather than through the non-adversarial method we have proposed repeatedly. Notwithstanding lack of access, we have gathered numerous facts from public documents provided by the State, including the August 1995 Inspector General's Report (hereinafter "IG report") on G. Pierce Wood, the September 5, 1995 G. Pierce Wood Memorial Hospital Review Team Report to the Florida Secretary of Health and Rehabilitative Services (hereinafter "Review Team Report") and information obtained from former patients and staff, advocates, concerned citizens, and newspaper articles which indicate that conditions at the facility deprive G. Pierce Wood patients of their constitutional rights and violate the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 et seq. and regulations promulgated pursuant to the ADA.

Patients of state operated psychiatric facilities have a fundamental Fourteenth Amendment due process right to reasonable safety and adequate medical care, including psychiatric services. Youngberg v. Romeo, 457 U.S. 307 (1982). Patients have a right to adequate psychiatric treatment which includes treatment programs designed to protect their liberty interests. Such

treatment programs must be sufficient to permit each patient an opportunity to improve or be cured and to function as independently as their psychiatric conditions permit. See, e.g., Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D. Ala. 1971). Such programs must provide opportunities for patients to acquire and maintain skills that will enable them to cope more effectively with the demands of their own person, their environment, and to raise the level of their mental, behavioral, physical, and social efficiency. Gary W. v. Louisiana, 437 F.Supp. 1209, 1219 (E.D. La. 1976); see also, Thomas S. by Brooks v. Flaherty, 699 F.S. 1178 (W.D. N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990), cert. denied, Flaherty v. Thomas S. by Brooks, 498 U.S. 951 (1990). Moreover, a state cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in the community either independently or with assistance. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975). Federal statutes and regulations also create rights and place obligations on state institutions.

The numerous constitutional and statutory deficiencies which were previously summarized during our September 15, 1995 meeting with counsel for the State include the following:

I. **G. Pierce Wood Has Failed to Protect Patients From Harm.**

Based upon information we have received, we conclude that the lack of adequate staff supervision places patients at G. Pierce Wood at risk of significant harm and even death. In particular, our sources report and the IG report confirms that staff fail to properly supervise suicidal and self-injurious patients, patients likely to elope, and patients at risk of choking at mealtimes.

A. Failure to Provide Adequate Special Precautions For Patients in Need of Supervision

The IG report and other information in the public domain reveals numerous instances in which G. Pierce Wood staff fail to adequately monitor patients requiring close supervision, including those patients who have a physician's order for one-to-one supervision. For example, in August 1994 a twenty-five year old female patient died while on one-to-one staffing. A physician had ordered one-to-one supervision because this patient had recently attempted suicide. According to hospital policy, an assigned staff person may not leave the patient unsupervised until replaced by another employee. The staff person is also responsible for documenting the patient's location and activities every 15 minutes. On the night of this patient's death, however, the assigned staff person left at the 11:00 p.m. shift change before the oncoming staff person arrived. The staff person assigned to monitor the patient on the 11:00 p.m. to 7:00 a.m. shift never took over the one-to-one watch. In addition,

documentation on the precautions checklist revealed that the patient was not checked every fifteen minutes and "face checks" required at the beginning of each shift were not completed on a timely basis. According to the IG report, the combination of the failure to complete fifteen minute checks, failure to conduct face checks in a timely fashion, and the failure of the staff to take responsibility for one-to-one supervision resulted in the patient's demise. When the patient was found, rigor mortis had already begun to set in.

In another incident, the IG report concluded that there was inadequate care and supervision of a patient who attempted suicide while on eye-to-eye contact precaution. Hospital policy requires a staff person assigned eye-to-eye contact to constantly be in a situation to observe or see the resident at all times. Inadequate supervision contributed to the near death of this patient because the staff person directly responsible for supervision did not maintain uninterrupted eye-to-eye contact at all times. As a result, the patient was able to smuggle a sheet into the bathroom, lock the bathroom stall door, and attempt to hang himself. Another patient on eye-to-eye precautions for suicidal behavior disappeared from the facility for more than nineteen hours before he was discovered walking nude along the highway.

The IG report also found that G. Pierce Wood staff failed to adequately perform their special precautions responsibilities which, in turn, enabled a patient to self-mutilate in eight incidents in 1994. Those eight incidents included self-mutilation by a plastic comb and knife, glass from a framed picture, a coke can, and a razor blade. In all, the patient was involved in 43 reported self-injurious incidents that year with the majority of the incidents occurring while the patient was on special precautions supervision. Nineteen incidents occurred while on one-to-one suicidal precautions, 10 occurred while on two-to-one suicidal precautions, and one while on 15 minute precautions.

Another patient was found dead, slumped in a geri-tray chair with her throat and chin on the chair's table top. Despite hospital policy classifying a geri-tray as a mechanical restraint necessitating one-to-one supervision, no staff person was assigned to monitor the patient on a one-to-one basis and the patient was unsupervised at the time of death.

The Review Team Report also concluded that one-to-one assignments are problematic due to staffing shortages and the staff's lack of training and understanding of their roles and accountability. In sum, G. Pierce Wood's failure to ensure that staff monitor patients who need close supervision and that staff properly observe and document the patient's condition places

patients at significant risk of serious injury and death and violates their constitutional rights.

B. Failure to Take Adequate Steps to Prevent Elopements

Our sources indicate that a significant number of patients have eloped from G. Pierce Wood in recent years. Some of these patients were later discovered dead. For example, in 1993, a male patient who suffered from delusions, amnesia, and physical handicaps eloped from the Hospital and was found dead a month later. His body was discovered leaning against a tree about a mile from Hospital grounds. The cause of death could not be established. Despite the patient's history of eloping, he was suddenly removed from elopement precautions and granted full privileges only three days prior to his disappearance. The IG report reviewed this incident and concluded that G. Pierce Wood's policies on how to respond to an elopement are deficient.

Another male patient eloped from G. Pierce Wood several times before finally eloping and committing suicide in an orange grove near the facility. A female patient eloped from the facility and was later struck and killed by a car on the Pennsylvania Turnpike. A third patient, who was committed to G. Pierce Wood after having been found not guilty of murder by reason of insanity, escaped soon after she was sent to facility. She was later found in another state.

These incidents indicate that G. Pierce Wood fails to take adequate measures to prevent patients in need of supervision from eloping. As a result, a number of patients who pose a danger to themselves and others have eloped over the years, several of whom were later found dead.

C. Failure to Monitor and Supervise Patients with Dietary Restrictions

Our sources report and the IG report confirms that G. Pierce Wood also fails to adequately monitor and supervise patients with dietary restrictions. In the last year, at least two patients who were restricted to a soft food diet choked to death at mealtime. The IG report concluded that the direct care staff's failure to provide adequate supervision and care contributed to the choking death of a patient during a noon meal as recently as July 1995.

The report based its findings on several facts. First, the patient neither received his physician ordered mechanical soft diet tray nor was he offered any other food during the noon meal. Records also indicated that the patient may not have eaten since the prior evening's meal, some nineteen hours earlier. Staff did not follow appropriate facility procedures to ensure that the patient received his proper meals. Second, the staff person

responsible for supervising the patient was not aware of this assignment until after the patient's death. Staff responsible for supervising patients were not present at all times, thereby allowing the patient to leave undetected and potentially obtain food elsewhere. Apparently, the patient had a history of wandering off to pick up food off the ground or take food from other patients.

This recent serious incident followed a similar incident in August 1994 when another patient on a pureed diet swallowed and choked on a piece of meat which was lodged in his airway. The IG report found that the staff person assigned to observe the patient for signs of choking on the day of his death was unaware of this responsibility. The report also found that G. Pierce Wood fails to ensure that patients with dietary restrictions receive the correct meals. For example, when this patient was inadvertently placed on a regular diet, the error went unnoticed by the treatment team for a period of nineteen days until it was discovered by a psychiatrist. The IG report found that staff do not check pureed meals to ensure that they meet the consistency ordered by doctors. In fact, the inspectors found that pureed meals contain discernible meat fragments, pieces of tomatoes, and rice.

According to the Review Team Report, the hospital administration ordered residents on mechanical soft and pureed diets to eat their meals in their residences in July 1995. When the review team recently toured G. Pierce Wood and observed residents with dietary restrictions eating in their residences, the team found patients eating standing up at the nursing station and sitting on couches with their trays on their laps. Due to overcrowding in day rooms and quiet rooms, staff were unable to properly observe patients' eating behaviors and monitor residents on choking precautions. Moreover, the Review Team found that staff did not know how to intervene properly when patients exhibited unsafe eating behaviors. The Review Team Report concluded that meals in the residences fail to provide an appropriate atmosphere for a therapeutic dining experience.

In sum, G. Pierce Wood's has failed to ensure that patients receive their correct meals in a timely manner, that staff follow physician ordered dietary restrictions and provide necessary supervision during mealtimes, and that staff complete the appropriate documentation. These deficiencies pose life-threatening risks and violate the patients' constitutional rights.

D. Failure to Take Adequate Steps to Prevent Patient Injuries

Reliable sources report that G. Pierce Wood fails to take adequate steps to keep patients from injuring each other.

Patients continually commit acts of violence against each other. Patients have been raped and beaten by other patients. In addition, patients who are unable to protect themselves are placed in quarters with other patients whose propensity towards violence places them in danger. Moreover, patients who are HIV positive reportedly regularly engage in sexual activity with other patients. A number of other injuries at the facility apparently occur for unknown reasons because staff are not monitoring patients.

There appear to be a number of systemic problems at G. Pierce Wood that underscore the facility's failure to protect patients from harm. There are problems with adequate deployment and supervision of staff on the units, staff failing to perform required duties or sleeping on the job, staff lacking knowledge of facility policies and protocols, and staff failing to communicate important information about patients' conditions at shift changes. In addition, there have been delays in investigations of significant incidents, retaliation and alleged disincentives for reporting staff abuse and neglect, and falsification of records. All of these serious deficiencies contribute to G. Pierce Woods's failure to ensure that patients are protected from harm, in violation of their constitutional rights.

II. G. Pierce Wood Has Failed to Provide Adequate Treatment.

Our sources report that patients at G. Pierce Wood are not receiving adequate treatment. According to the Review Team Report, staff fail to develop treatment plans in accordance with the results of functional and clinical assessments. Treatment plans fail to integrate and track the progress of behavioral intervention programs. Some interventions are not being implemented. Treatment plans also fail to track medical issues noted in patient records.

Treatment teams fail to develop and implement appropriate treatment plans and to review and revise them when necessary, particularly when there is a change in a patient's status. As a result, treatment teams are unable to adequately respond when a patient's condition deteriorates. For example, the IG report found that despite the fact that a patient exhibited suicidal ideations just days before he killed himself, the patient remained in an unstructured program with full privileges. Another patient frustrated by delays in release from the hospital cut off both his hands with a circular saw. The Review Team confirmed problems with treatment plan review and revision. For example, the Review Team Report documents instances in which staff failed to revise the treatment plan or develop new interventions despite the identification of significant problems such as suicidal and homicidal statements and aggression.

We have also received reports that patients are not properly diagnosed and treatment plans do not adequately address dangerous behaviors in which they engage. For example, some female patients regularly sell sex to other patients to obtain money for cigarettes. Although staff is aware of this conduct, patients are not counselled on their behavior. As noted earlier, the facility fails to provide adequate suicide precautions and to respond to situations where patients are in danger of hurting themselves or others.

G. Pierce Wood also fails to provide adequate and appropriate activities/training programs to teach patients skills that enable them to function as independently as their psychiatric conditions permit. Many of the patients sit idly in day rooms or pace the halls and do not regularly attend programming. There are an insufficient number and array of therapeutic activities to meet patients' rehabilitative needs.

We have also received information that patient records lack vital information that is essential for proper patient care. Treating psychiatrists fail to routinely record progress notes in the medical record in a timely manner. Medical records also lack documentation in such key areas as changes in medication, responses to psychiatric treatments, and changes in psychiatric treatment plans. Direct care staff fail to recognize and document important behavior differences such as mood swings. Also, treatment plans lack measurable short- and long-term goals for patients. Treatment goals are set for the convenience of staff rather than to meet patient needs. Proper documentation is important to ensure consistency of treatment and to track a patient's progress toward cure and eventual discharge.

Reliable sources also indicate that mechanical and chemical restraints are used inappropriately and without necessary precautions and supervision. For some patients, drugs are the only therapy they receive. There is not enough effort to provide alternative or supplementary therapeutic treatment.

In sum, treatment at G. Pierce Wood fails to comport with generally accepted professional standards. The absence of such treatment directly threatens the health and safety of patients, impairs their potential to improve or be cured, and violates their constitutional rights.

III. G. Pierce Wood Has Failed to Follow Accepted Medical Care and Medication Practices.

Our sources report and the IG report confirms that G. Pierce Wood's fails to provide its patients with adequate medical care placing them at significant risk of life-threatening illness and death. For example, in July 1994, a patient died from an undiagnosed hernial condition. The Inspector General's medical

consultant opined that an adequate physical examination the night before or the morning the patient died may have detected the hernial condition which caused his death.

The lack of adequate care at G. Pierce Wood is particularly evident in emergency situations. The IG report cited several medical emergencies in which the staff failed to utilize appropriate life saving techniques. When staff tried to revive the patient suffering from an undiagnosed hernial condition, complete life saving techniques were not utilized by the Code Blue response team in that an intravenous infusion (IV) was not started. In another emergency, the Code Blue response team was called twice and it did not arrive until five minutes after the initial call. When a patient was found choking to death in August 1994, staff did not commence basic life saving techniques until after the patient had been removed from the dining room. The paramedic who treated the patient who choked to death in July 1995 told IG inspectors that the physicians and the Code Blue response team at G. Pierce Wood need to be trained and certified in Advanced Cardiac Life Support and practice these skills on a regular basis to improve their proficiency in dealing with these types of emergencies.

We have also received reports that G. Pierce Wood fails to follow accepted medication practices. Staff fail to coordinate the use of multiple psychotropic medications administered to patients. In the weeks before her death in August 1994, a patient was taking a combination of powerful psychotropic medications. The medical examiner was unable to rule out increased dosages as a contributing factor to her death. The same patient was given the wrong drug by mistake a few weeks before her death. We have received complaints from other sources about medication errors. In addition, staff are not adequately trained to detect and recognize drug side effects. Until recently, unlicensed staff were permitted to administer medication to patients.

The failure to provide adequate medical care, particularly in emergency situations, and to follow accepted medication practices places G. Pierce Wood patients at significant risk of harm and violates their constitutional rights.

IV. G. Pierce Wood Has Failed to Provide Adequate Staffing.

We have received information that G. Pierce Wood lacks adequate number of psychiatrists, physicians, and nurses. According to the Review Team Report, only two of the six authorized positions for general health care physicians in the medical unit are currently filled. In addition, the deployment of direct care staff is not adequate to meet the needs of the patients. Without sufficient staff, the facility is unable to

provide patients with constitutionally required treatment, care and supervision.

V. G. Pierce Wood Has Failed to Provide Treatment in the Most Integrated Setting Appropriate to Patients' Needs.

Our sources report that a number of patients at G. Pierce Wood have been evaluated by facility professionals and determined to be ready for discharge to the community. These patients remain institutionalized because of an inadequate number of placements available in the community. As a result, discharge ready patients continue to be segregated from the rest of society. In other situations, patients have been discharged without appropriate discharge plans and have not received adequate aftercare services. The State's failure to implement professional judgments about the appropriate setting in which to serve patients and to provide adequate treatment in the most integrated setting appropriate to patients' needs violates the patients' constitutional rights and their rights under the ADA.

MINIMUM REMEDIAL MEASURES

The following remedial measures need to be implemented in order to meet constitutional and statutory requirements:

I. Protection from Harm

G. Pierce Wood must identify patients who require one-to-one or close supervision and ensure that such supervision is provided. Patients who have dietary restrictions must receive appropriate meals in a timely manner and adequate supervision to ensure that they receive such meals. G. Pierce Wood must take adequate steps to identify, assess, and prevent patients who pose a danger to themselves and others from eloping and to respond appropriately when elopements occur. The facility must also take adequate steps to protect patients from being victimized by other patients.

II. Treatment

G. Pierce Wood must evaluate, diagnose, and treat patients consistent with generally accepted professional standards. Patient treatment plans must be appropriate, coordinated, and properly managed. Such programs must allow each patient a reasonable opportunity to be cured, function as independently as possible, and cope as effectively as possible with his or her needs. Mechanical and chemical restraints may only be used in accordance with accepted professional standards. Patient records must contain essential information and properly document the patient's course of care.

III. Medical Care and Medication Practices

G. Pierce Wood must provide adequate medical care, particularly in emergency situations. Staff must be properly trained and qualified to respond to medical emergencies. All use of drugs must be professionally justified, carefully monitored, documented, and reviewed.

IV. Staffing

G. Pierce Wood must retain and deploy adequate numbers of qualified professional and direct care staff to develop and implement treatment programs, to care for patients, and to provide appropriate supervision and adequate medical care.

V. Discharge Planning

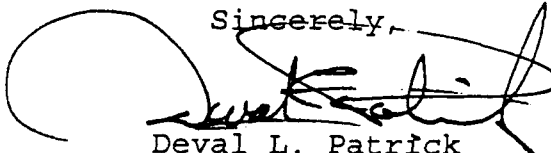
G. Pierce Wood must appropriately assess each patient to determine which patients are appropriate for discharge. The facility must develop and implement adequate discharge planning, including appropriate community-based mental health services, to meet the needs of the patient upon discharge. In addition, the State must develop adequate quality assurance mechanisms to ensure the appropriateness of post-discharge services.

Pursuant to CRIPA, the Attorney General may move to intervene in a pending lawsuit to correct deficiencies at an institution fifteen days after appropriate officials are notified of them or may initiate an independent action after forty-nine days. See 42 U.S.C. § 1997c(b)(1), 1997b(a)(1). Therefore, we anticipate hearing from you within fifteen days upon receipt of this letter with any response you may have to our findings. If you do not respond within the stated time period, we will consider intervening in the pending action Johnson v. Bradley or initiating our own action to remedy the conditions that violate patients' constitutional and federal statutory rights. In light of this case, we have served a copy of this letter on the appropriate federal court.

Finally, we note we did not have the benefit of the on-site review of institutional conditions contemplated by CRIPA prior to determining these findings. Your own IG report, however, has substantiated many of the allegations we received. Consistent with the legislative history of CRIPA, we have been obliged to infer that many of the allegations we have received regarding G. Pierce Wood are true in view of your failure to permit an inspection or provide requested documentation, and the findings of your IG report.

If you or any member of your staff have any questions, please feel free to contact Tawana Davis at (202) 514-6534 or Bill Maddox at (202) 514-6251.

Sincerely,

A handwritten signature in black ink, appearing to read "Deval L. Patrick", written over the word "Sincerely,".

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: The Honorable Robert Butterworth
Attorney General
State of Florida

Jason Vail, Esquire
Assistant Attorney General
State of Florida

Mr. Myers Kurtz
Director
G. Pierce Wood Memorial Hospital

Charles R. Wilson, Esquire
United States Attorney
Middle District of Florida

The Honorable Susan C. Bucklew
U.S. District Judge
Middle District of Florida