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**DOI ISSUES FINDINGS ON ITS INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE DEATH OF ESMIN GREEN AT KINGS COUNTY HOSPITAL CENTER**

ROSE GILL HEARN, Commissioner of the New York City Department of Investigation ("DOI"), announced that serious gaps in medical care, including repeated failures to carry out medical tests and orders, a lack of monitoring, and falsification of medical records were among the disturbing findings of DOI's investigation into the circumstances surrounding the death of Esmine Green on June 19, 2008, in Kings County Hospital Center's ("KCHC") psychiatric emergency room. Ms. Green was brought to the hospital by ambulance at 6:30 a.m. on June 18, 2008. Even though she was diagnosed with schizophrenia and psychosis and ordered to be admitted involuntarily that morning, she was still awaiting care 24 hours later when she died on the floor in the hospital's psychiatric emergency room.

The New York City Health & Hospitals Corporation ("HHC") operates KCHC, which is licensed by New York State as a Comprehensive Psychiatric Emergency Program.

DOI Commissioner Rose Gill Hearn said, "DOI's painstaking review of the facts revealed a systemic failure of the hospital's psychiatric emergency program to treat and care for Ms. Green over a 24-hour period. This is a case of omission and commission that ranged from doctors who failed to examine Ms. Green to medical personnel who falsified the hospital's records regarding her condition and treatment. We hope that our factual findings will ensure that the troubling events that surrounded Ms. Green's death are never repeated."

DOI's report documents the striking breakdown in Ms. Green's care during four medical shifts on June 18-19, 2008, in which medical and nursing personnel failed to administer blood work and an EKG, failed to monitor vital signs, and doctors failed to conduct a medical examination as warranted by hospital protocol and neglected her for approximately nine hours while she was in a hospital waiting room. DOI's investigation found that these failures were not aberrations at the facility but the result of systemic weaknesses in the emergency room's operating procedures, such as the practice of suspending treatment at night for patients who were sleeping.

No opinion is expressed in DOI's report as to what facts and circumstances, medical or otherwise, caused Ms. Green's death.

DOI reviewed voluminous records, including Ms. Green's medical file; hospital security, nursing and physician log books and personnel records; HHC policy and procedure memoranda; 911 and New York City Fire Department/Emergency Medical Services' reports; a copy of the official autopsy and toxicology report and 24 hours of KCHC psychiatric emergency room surveillance video from multiple cameras. DOI also conducted interviews of medical, nursing and security staff who were on duty during Ms. Green's stay and other KCHC staff who had administrative responsibility for the facility.

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Facts gathered by DOI regarding the chronology of events include:

- Contrary to protocol, Ms. Green was not added to the June 18, 2008, "24-Hour Observation Sheet," in which nursing staff are required to note observations of patients on an hourly or more frequent basis. Senior Nurse Bernardita Cabildo, who was Head Nurse during the First Shift on June 18, 2008 between midnight to 8 a.m. and responsible for adding incoming patients to the sheet, testified in substance that her failure to add Ms. Green to the sheet was an oversight.
- Under KCHC protocol, a medical examination of the patient is required before the patient can be transferred from the emergency room to the inpatient psychiatric ward. Ms. Green never received a medical examination. In addition, although a physician ordered blood work and an EKG for Ms. Green, neither was administered.
- Dr. Rashed Abedin, MD, testified that he made three unsuccessful attempts to examine Ms. Green during the second shift on June 18, 2008, between 8 a.m. and 5 p.m., but was unable to do so because she was uncooperative. DOI's investigation found that Dr. Abedin's testimony, the note he wrote in Ms. Green's record, and the video surveillance reflected differences about the attempts. A note marked "1 p.m." was contradicted by the surveillance video, which indicated no interaction between Dr. Abedin and Ms. Green between 9:45 a.m. and 1 p.m. In addition, Dr. Abedin did not make notes in Ms. Green's records reflecting two attempts he made to examine her at 2:30 p.m. and 4:45 p.m. which are depicted in the video record.
- DOI's review of surveillance tape and medical notes revealed that during the third shift on June 18, 2008, from 5 p.m. to midnight, Drs. Dimitru Magardician and David Estes made no attempt to examine Ms. Green.
- During the fourth shift, on June 19, 2008, Ms. Green had no contact with any doctors and received little attention from the nursing staff from about midnight until 6:35 a.m. when she died.

DOI's investigative findings include:

- Falsification of Records
Senior Nurse Aida Gonzalo made three false entries in Ms. Green's medical records, making it appear that in the 45 minutes before Ms. Green was discovered on the floor she had been in normal physical condition, which was not the case.

Nursing Aide Royal Easton made false entries regarding Ms. Green in the "24-Hour Observation Sheet," for June 19, 2008, indicating he observed Ms. Green asleep between 5 and 6 a.m. and again between 6 and 7 a.m., when, in fact, Easton was on break.
- Patient Care
The surveillance video on the night of June 18-19, 2008, confirmed that any apparent lack of attention to patients, including Ms. Green, was not the result of the emergency room's being overwhelmed with work and patients. In particular, the video showed that throughout the night shift nurses were able to take significant breaks and double-up with other nurses in duties such as sitting outside the room of a sleeping child patient. In fact, Nurses Gonzalo and Cabildo were in a closed room on break at the time that Ms. Green collapsed, writhed for a time and then went still.

DOI has forwarded its report to the Office of Kings County District Attorney Charles J. Hynes for whatever action it deems appropriate.

DOI Commissioner Rose Gill Hearn thanked President Alan D. Aviles for his assistance and cooperation in this matter.

This investigation was conducted by DOI Inspector General Christopher Staackmann, Special Counsel to the Inspector General Andrea Hecht and Special Investigator Danielle Caruso.

DOI is one of the oldest law-enforcement agencies in the country. The agency investigates and refers for prosecution City employees and contractors engaged in corrupt or fraudulent activities or unethical conduct. Investigations may involve any agency, officer, elected official or employee of the City, as well as those who do business with or receive benefits from the City.

Get the worms out of the Big Apple. To report someone ripping off the City, call DOI at (212) 825-5959.



DOI's Investigation into the Circumstances Surrounding the Death of Esmin Green

**New York City Department of Investigation
Commissioner Rose Gill Hearn**

June 2009

EXECUTIVE SUMMARY

At about 6:30am on June 18, 2008, 49-year-old Esmin Green was brought by EMS ambulance to the Kings County Hospital Center ("KCHC") psychiatric emergency room, a facility under the control of the New York City Health & Hospitals Corporation ("HHC") and licensed by New York State as a Comprehensive Psychiatric Emergency Program ("CPEP"). Although doctors diagnosed Ms. Green with schizophrenia and psychosis and ordered her to be involuntarily admitted to the KCHC psychiatric inpatient ward, twenty-four hours later, she was still in the CPEP, where she died on the floor of the Main Waiting Room.¹ After having spent the night in the Women's Waiting Area of the CPEP, at about 5:29am on June 19, Ms. Green walked across the hall into the Main Waiting Room and sat down in a chair. A few minutes later, at 5:32am, video cameras captured her falling from that chair to the floor; she lay there face down for more than an hour before a nurse noticed her at approximately 6:35am. On video, she was seen moving periodically, and at one point, at approximately 6:03am, she had a series of spasmodic movements. Shortly thereafter she went still. Nobody came to Ms. Green's aid during that hour that she lay on the floor notwithstanding that: (a) the area where she fell and lay was continuously monitored by live video display in both the CPEP's Nursing Station and the Security Substation; (b) there were at least three senior nurses, one attending psychiatrist, one nursing aide and two security guards in the CPEP during that time period, several of whom looked into the Main Waiting Room in the direction of where Ms. Green lay face down on the floor; (c) where she was situated on the floor of the Main Waiting Room was right under the clear glass window of the Security Substation; and (d) the place on the floor where she lay and then died was approximately 20 feet diagonally across from the Registration Area, which is also fronted with clear glass.

After collapsing to the floor of the Main Waiting Room at 5:32am, it was not until 6:35am that staff finally checked on Ms. Green and began attending to her. The first staff interaction with Ms. Green was that of a nurse seen on the video using her foot to push Ms. Green's leg. Thereafter, Ms. Green was found in cardiac arrest. Advanced life support measures then were initiated to no avail. At about 7:10am, a KCHC Attending Physician pronounced Ms. Green dead. The New York City Office of the Chief Medical Examiner conducted an autopsy of Ms. Green and concluded that the cause of her death was *pulmonary emboli* caused by *deep venous thrombosis*.

After being contacted by New York City Corporation Counsel, Michael A. Cardozo, the New York City Department of Investigation ("DOI") undertook an external investigation of the circumstances surrounding Ms. Green's death. DOI

¹ A copy of the CPEP's floor plan is attached to this report as Exhibit 1.

collected and analyzed voluminous records, many obtained by court-ordered subpoenas, including Ms. Green's medical file, hospital security, nursing and physician log books and personnel records, HHC policy and procedure memoranda, 911 and FDNY/EMS reports, a copy of the official autopsy and toxicology report, and nearly 24 hours of KCHC psychiatric emergency room surveillance video from multiple cameras.² DOI also conducted interviews of medical, nursing and security staff who were on duty at the CPEP during Ms. Green's stay, and of other KCHC staff with administrative responsibility for the facility. Lastly, DOI conducted several site visits of the CPEP, including one guided by Dr. Jorge Pettit, MD, who was hired as a consultant by HHC in January 2008.

DOI adhered strictly to all patient confidentiality laws in obtaining the evidence required to properly investigate this matter – in every instance all material containing private health information as defined in the relevant privacy statutes was obtained through court-ordered subpoenas. Moreover, DOI took the additional measure of obtaining a waiver of confidentiality from the Estate of Esmin Green. Obviously, patient privacy laws are vital, and DOI fully understands the right to privacy surrounding patient confidentiality statutes. But on occasion, including in cases of this nature, there is an important public policy and safety-related need to fully investigate and vigorously pursue potential problems and even criminal wrongdoing in a hospital as it relates to actions taken or not taken with respect to a patient. In that regard, we found the very statutory confidentiality laws designed to protect individuals also made it challenging for investigators to determine what happened in the case of Ms. Green.³

This Executive Summary contains factual findings of DOI's investigation. In the first section, we present a chronology of events that we reconstructed based on the available evidence. The chronology is organized in four parts, corresponding to the four personnel shifts that spanned Ms. Green's stay at the CPEP. In the second section, we present our findings regarding (a) procedural failures that came to light during our investigation, and (b) potential misconduct by KCHC personnel who were responsible for Ms. Green's care. We note that no opinion is expressed in this report as to what facts and circumstances, medical or otherwise, caused Ms. Green's death.

² DOI investigators spent hundreds of hours reviewing the video over and over again in coming to the factual findings in this report.

³ We note, further, that widespread public disclosure of Ms. Green's medical information took place before DOI undertook this investigation – the media, among other things, obtained and widely aired footage from CPEP video cameras that recorded Ms. Green lying on the floor of the CPEP waiting room, and reported various medical issues that she had experienced.

I. CHRONOLOGY

A. MS. GREEN'S PRIOR PSYCHIATRIC ADMISSIONS

Ms. Green's June 18, 2008 admission to the KCHC CPEP was not her first. In 2007, she had been admitted there on three separate occasions, which resulted in her staying at the CPEP almost uninterruptedly from January 26 to March 12, 2007.⁴ In the course of her three CPEP admissions from January to March 2007, Ms. Green had been diagnosed with psychosis and/or schizophrenia, and had been prescribed medications including the anti-psychotics Haldol and Risperidal and the anti-anxiety medications Ativan and Xanax. The CPEP's records revealed that Ms. Green tended to be non-compliant with her medications. The records of these admissions were available to KCHC's medical staff when Ms. Green was brought to the CPEP on June 18, 2008.⁵

B. FIRST SHIFT – June 18, 2008, approximately midnight to 8am

On June 18, 2008, Ms. Green was brought to the CPEP by an EMS ambulance at about 6:30am, which was near the end of the night shift (this was the first of four shifts that spanned the time Ms. Green spent in the CPEP leading up to her death, hereinafter, the "First Shift"). During the First Shift, Senior Nurse Aida Gonzalo conducted the initial screening or triage of Ms. Green and classified her, under the CPEP triage protocol, as a "Priority 2-High Priority" patient. Ms. Green then was seen briefly by a Resident-On-Call who prescribed 2mg of the anti-anxiety drug Ativan, after noting that Ms. Green had a previous psychiatric history and was "pacing, restless, [and] crying out loud in the hallway." At about 6:55am, the Resident-on-Call ordered that Ms. Green be fully evaluated by the next available psychiatrist.

DOI's investigation determined that CPEP protocol would have required that after her arrival Ms. Green's name be added to the 24-Hour Observation Sheet – a document on which CPEP nursing staff are required to note observations of CPEP patients on an hourly or more frequent basis. Contrary to CPEP protocol, Ms. Green was not added to the June 18 24-Hour Observation Sheet. Senior Nurse Bernardita Cabildo, as the Head Nurse during the First Shift, was the person responsible for adding incoming patients – including Ms.

⁴ In early January 2007, before her extended hospitalization at the KCHC CPEP, Ms. Green also had been hospitalized for depression at Coney Island Hospital.

⁵ Two months earlier, on April 23, 2008, Ms. Green had been hospitalized at another CPEP in Brooklyn. In that instance, EMS had responded to a call from a security guard at a residence in Brooklyn, that Ms. Green was trespassing at the location and "not acting right." EMS responded to the call and brought Ms. Green to the CPEP at Brookdale Hospital.

Green -- to the 24-Hour Observation Sheet. Cabildo testified that her failure to add Ms. Green to the document on June 18 resulted from "an overlook."

C. SECOND SHIFT – June 18, 2008, approximately 8am to 5pm

Between 9:00am and 11:00am Ms. Green was psychiatrically evaluated by two CPEP doctors – a psychologist and an Attending Psychiatrist (Dr. Thomas Kowacz, MD). Dr. Kowacz and the psychologist diagnosed Ms. Green as psychotic and schizophrenic. They observed that she was agitated, suspicious, paranoid, talking to herself and expressing the thought that she "lost her soul." In addition, the psychologist spoke by telephone to a Ms. Pauline Robinson - the only contact that Ms. Green gave during her triage interview - who said that Ms. Green had moved out of her own apartment four days earlier, moved in with Ms. Robinson, and had then started "trashing" Ms. Robinson's apartment during the night of June 18. It was shortly thereafter that EMS was called to take Ms. Green to the hospital.

By 11:15am on the morning of June 18th, Dr. Kowacz formally ordered that Ms. Green be involuntarily admitted to KCHC's Inpatient Service pursuant to New York Mental Health Law Section 9.39. Dr. Kowacz made written orders at approximately 11:40am that Ms. Green receive a full medical examination, blood work and an EKG. DOI's investigation determined that a medical examination is one of the steps that, under KCHC protocol, must be completed in the CPEP before a patient can be transferred from the Emergency Room to the inpatient psychiatric ward.

Notwithstanding protocol, during the Second Shift, Ms. Green was not medically examined and neither an EKG nor blood work was performed on her. Dr. Rashed Abedin, MD was the Attending Physician who was responsible for conducting the medical examinations of CPEP patients during the Second Shift. According to Dr. Abedin's testimony, he made three attempts to examine Ms. Green, but he was blocked from doing so because she was uncooperative. Dr. Abedin made only one note marked "1pm" in Ms. Green's record that he attempted to medically examine her, but was unable to do so because she was uncooperative. According to the video, Dr. Abedin made two concerted efforts to examine Ms. Green - at about 2:30pm and 4:45pm - but was unable to do so because she was uncooperative, waiving her hands at him, and refusing to speak to him. Thus, Dr. Abedin's testimony, the note he wrote and the video each reflect differences about the attempts to examine Ms. Green. The one note Dr. Abedin made, marked "1pm," was contradicted by the CPEP video, which showed no interaction between Dr. Abedin and Ms. Green between 9:45am and 1pm. In addition, Dr. Abedin did not make notes in Ms. Green's records reflecting the two afternoon attempts that are seen on the video at 2:30pm and 4:45pm. With respect to the procedure for handling how to proceed with a patient who is blocking and refusing the necessary treatment, Dr. Abedin testified that there was no clear policy.

During the Second Shift, Dr. Abedin completed a *deep vein thrombosis/pulmonary emboli* risk assessment for Ms. Green in the CPEP computer, which was conducted without a direct examination due to her lack of cooperation. This assessment generated a “low” risk score. Dr. Abedin testified that the information that he relied on to make this risk assessment was data regarding Ms. Green that was already in the CPEP computer (from Ms. Green’s previous admissions) and his observations of her physical condition and demeanor from seeing her in the CPEP hallway without actually examining her.

D. THIRD SHIFT – June 18, 2008, approximately 5pm to midnight

At the start of the June 18 evening shift (the “Third Shift”), at approximately 5pm, Ms. Green had been at the CPEP for nearly 12 hours. DOI’s investigation revealed that during the entire Third Shift none of the medical orders issued by Dr. Kowacz earlier that day at approximately 11:40am were carried out.

No attempt was made during the Third Shift to conduct a medical examination of Ms. Green. DOI’s investigation revealed that the medical doctors who were responsible for medical examinations of CPEP patients during the Third Shift were Drs. Dimitru Magardician and David Estes. Dr. Magardician made a notation in Ms. Green’s records that he attempted a medical examination of Ms. Green at about 6:45pm but that he was unable to complete it because she was uncooperative. However, the videotaped evidence provided to us by HHC showed that Dr. Magardician never, in fact, made any attempt to medically examine Ms. Green.⁶ Similarly, Ms. Green’s file reflects no notes by Dr. Estes of any attempt to examine Ms. Green, and the video showed that Dr. Estes made no attempt to medically examine Ms. Green. DOI received court-ordered subpoenas for sworn testimony from Drs. Magardician and Estes. Both asserted their 5th Amendment privilege against self-incrimination and refused to answer questions.

The video showed that during the Third Shift, no EKG or blood-work were

⁶ Dr. Magardician was on duty at the CPEP from 5pm to 7pm on June 18, covering for Dr. Estes. As the Attending Physician, he was responsible for conducting the physical examination of Ms. Green. Dr. Magardician made a notation in Ms. Green’s records that at 6:45pm he attempted an exam but was unable to do it because she was uncooperative and refused to be examined. DOI carefully reviewed continuous video from 4:30pm to 7:30pm, following Ms. Green uninterruptedly. In the video Dr. Magardician was seen passing by Ms. Green several times in the CPEP’s main hallway without ever making any eye-contact with her. He was evidently occupied with other patients or tasks while she was pacing up and down the hallway, and he made no attempt to examine her. Ms. Green was on camera the entire time. Dr. Magardician went off duty at 7pm and was no longer seen on CPEP video after that time. DOI obtained a court-ordered subpoena for Dr. Magardician’s testimony. Dr. Magardician declined to testify, asserting his 5th Amendment right against self-incrimination through an attorney.

performed on Ms. Green. Likewise, Ms. Green's medical files contained no record of such tests, or attempts to take such tests, even though individual members of the CPEP nursing staff had been assigned to perform such procedures during the Third Shift.

During this shift, at approximately 8:30pm, Ms. Green entered the Women's Waiting Room and remained there, outside of camera view, until 5:29am the next morning. Before 8:30pm, from the time that she arrived, the CPEP video showed Ms. Green pacing up and down the main CPEP hallway area, often gesticulating with her arms, in full view of medical, nursing and security staff.

E. FOURTH SHIFT - June 19, 2008, approximately midnight to 8:00am

The fourth consecutive shift coinciding with Ms. Green's stay at KCHC was the night shift of June 19th, which ran from approximately midnight to 8am, (the "Fourth Shift"). This was the shift during which Ms. Green died.

From midnight until 6:35am Ms. Green had no contact with any doctors and received little attention from the nursing staff. The Attending Physician on duty at the CPEP during the Fourth Shift was Dr. Estes. The video and documentary evidence showed that Dr. Estes did not perform, or attempt to perform, a medical examination of Ms. Green during this shift. Likewise, the nursing staff did not measure Ms. Green's vitals and did not perform an EKG or lab work. This was the case even though records reviewed by DOI revealed that CPEP nursing staff had specifically been assigned to perform EKGs and blood work on Ms. Green during the Fourth Shift.

Towards the end of the Fourth Shift, at about 5:28am, Ms. Green came out of the Women's Waiting Room, where she had been unattended since 8:30pm the night before, approached the Nursing Station window, spoke briefly with a Security Officer sitting across the hallway, and then entered the Main Waiting Room. There, at approximately 5:31am, she sat in a chair, looked up at the TV, stretched out her legs, placed her hands in her lap, and then lowered her head. The site visit conducted by DOI showed that the chair she sat down in was in front of a clear glass window of the Security Substation. In addition, the chair she sat down in was approximately 20 feet diagonally across from the Registration Area that also is fronted with clear glass. The Main Waiting Room is approximately 16 by 11 feet. A diagram of CPEP and the Main Waiting Room is attached as Exhibit 1.

At 5:32am, Ms. Green's left arm went limp and her body collapsed to the floor. Ms. Green lay motionless, face down on the floor with her head partly under the chair, until about 6:03am when, for a period of about five minutes, her

body (mainly her left leg) underwent a series of approximately 29 spasmodic movements. Her last visible body movement was at 6:08am. After that, she lay motionless on the Main Waiting Room floor, face down with her legs splayed apart. The video showed that at least two security guards and one doctor looked into the Main Waiting Room in the direction of Ms. Green lying on the floor. They took no action on video and no action was recorded in the documents DOI was provided. Indeed, two security officers were seen on the video looking directly into the Main Waiting Room at Ms. Green more than once. One of the officers was even seen wheeling his swivel chair (that he did not get out of) to the entrance of the Main Waiting Room, whereupon he appeared to look directly at Ms. Green, only to swivel out of the area without taking any action. Various other individuals who appear not to be associated with the hospital, possibly other patients or family members, were featured on the video going in and out of the Waiting Room and saw Ms. Green lying on the floor. Several of those individuals were seen talking into the Reception Area glass window.

At approximately 6:35am, Senior Nurse Adelaida Sarmiento-Villaroman entered the Waiting Room and used her foot to nudge Ms. Green's motionless body. Nurse Villaroman did not immediately start CPR. Instead, she alerted Nurse Gonzalo who, instead of initiating CPR, apparently alerted Senior Nurse Bernardita Cabildo. At 6:40am, Dr. Estes arrived by Ms. Green's side, started life saving measures and was joined shortly afterwards by members of the KCHC Code Team and FDNY/EMS. The efforts to resuscitate Green, which went on for almost 30 minutes, failed. Dr. Estes pronounced Ms. Green dead at 7:10am.

II. FINDINGS

A. Falsification of records and false testimony

DOI's investigation revealed that Senior Nurse Aida Gonzalo provided false testimony and created false entries in Ms. Green's medical records, and Nursing Aide Royal Easton created false records in Ms. Green's medical file.

1. Nurse Gonzalo

Dr. Estes declared Ms. Green officially dead at about 7:10am. Nurse Gonzalo admitted to DOI that, shortly after Ms. Green was pronounced dead, she made three false entries in Ms. Green's Progress Notes to make it appear that in the forty-five minutes before Nurse Villaroman discovered Ms. Green on the floor, Ms. Green had been under Nurse Gonzalo's observation and in normal physical condition when, in fact, this was not the case. Nurse Gonzalo, who feared she would lose her job, admitted to DOI that she fabricated portions of the entries in Ms. Green's Progress Notes in order to mislead. The events depicted in the CPEP video reviewed by DOI also verified that those portions of her entries were false.

Nurse Gonzalo also lied in her two interviews at DOI when she claimed, with respect to her 6:00am and 6:30am Progress Notes entries, that she in fact saw Ms. Green at 5:00am and 5:30am, implying that her false entries were “only” inaccurate as to the time. The CPEP video directly contradicted these assertions in that nowhere on the video, including at 5:00am, 5:30am, 6:00am and 6:30am, is action taken by her shown. Nurse Gonzalo also lied to DOI when she testified that the vital signs marked in her 6:40am entry were taken by Nurse Villaroman before the code was called. The CPEP video directly contradicted this testimony in that the video at no time shows Villaroman taking Ms. Green’s vital signs.

2. Nursing Aide Royal Easton.

Nursing Aide Royal Easton, who was on duty during the early morning of June 19, 2008, made false entries regarding Ms. Green in a document called the “24-Observation Sheet” for June 19, 2008. For the hours 5-6am and 6-7am on June 19, 2008, Easton indicated that he observed Ms. Green “asleep.” In fact, Easton admitted to hospital officials that he did not observe Ms. Green during those two hours because he was in fact on a break inside the CPEP Registration Area for most of that time. The CPEP video confirmed that he was in the Registration Area during most of that time. Furthermore, the CPEP video showed that between 5:32am and 7am Ms. Green was not “asleep,” but lying face down on the floor of the Main Waiting Room alone from about 5:32am to 6:45am, and then surrounded by doctors and nurses who were attempting to revive her out of cardiac arrest. DOI subpoenaed Easton to provide testimony, but he declined after invoking his 5th Amendment right against self-incrimination through an attorney.

B. Factual inconsistencies

DOI’s investigation revealed factual inconsistencies in several entries made by Drs. Abedin, Magardician, Rubel and Estes in Ms. Green’s record.

1. Dr. Rashed Abedin

Dr. Abedin wrote a statement in a CPEP Medical Database Form that on June 18, 2008, at or before 1pm, he attempted to medically examine Ms. Green. In his testimony to DOI, Dr. Abedin maintained that he had attempted a medical examination of Ms. Green at or before 1pm. However, once DOI obtained the CPEP video, it revealed that Dr. Abedin had no contact with Ms. Green before 1pm. When he was asked to return to DOI to explain that discrepancy, among other things, he asserted his 5th Amendment right against self-incrimination.

2. Dr. Dimitru Magardician

Dr. Magardician wrote a statement in Ms. Green’s CPEP Medical

Database Form that on June 18, 2008, at or before 6:45pm, he attempted to medically examine Ms. Green. However, the CPEP video reveals that Dr. Magardician had no contact with Ms. Green at or before 6:45pm on June 18, 2008. Dr. Magardician declined to offer testimony to DOI after invoking his 5th Amendment right against self-incrimination through an attorney.⁷

3. Dr. Steven Rubel and Dr. David Estes

Drs. Rubel and Estes made entries in Ms. Green's Progress Notes that repeated some of the aforementioned false statements made by Nurse Gonzalo in the Progress Notes entries, including that Ms. Green had been seen "going to the bathroom" at 6:00am, and that normal vital signs had been measured on her at 6:30am and 6:40am. DOI was unable to determine whether Drs. Rubel and Estes repeated these false statements in their entries knowing that they were false, or innocently, by virtue of their reliance on Nurse Gonzalo's account. DOI served subpoenas on both doctors to obtain their testimony on the subject of these Progress Notes entries, but both doctors declined to testify after invoking their 5th Amendment right against self-incrimination through their respective attorneys.

Nurse Gonzalo testified at a second interview with DOI that after Ms. Green died on the morning of June 19, she observed one of the doctors remove a sheet of paper from Ms. Green's Progress Notes. According to Nurse Gonzalo, this sheet supposedly included entries made by Nurse Gonzalo during Ms. Green's emergency "code" – two entries measuring vital signs and one entry recording her death. A review of the records provided to DOI, and a specific request for a search for this document, did not yield the sheet of paper that Nurse Gonzalo described, and the doctor who Gonzalo said she saw take the record asserted his privilege against self-incrimination.

III. OBSERVATIONS

A. Gaps in Ms. Green's Care

As recounted in the above chronology, DOI's investigation revealed a series of gaps in Ms. Green's care at the CPEP on June 18-19, 2008:

- Notwithstanding a doctor's order at 11:15am on June 18, she was never medically examined by the attending physicians on duty during the

⁷ The only written record of purported attempts to medically examine Ms. Green consisted of two entries in the CPEP Medical Database Form where Drs. Abedin and Magardician made the entries that were clearly not corroborated by the CPEP video. This document was separate from Ms. Green's medical Progress Notes. Dr. Pettit testified that the CPEP Medical Database Form is a stand-alone document that was already in use when he arrived in January 2008, and that its specific purpose was for Attending Internists to make notes regarding medical clearance examinations.

Second, Third or Fourth Shifts.

- Ms. Green's blood work and EKG were never performed, though they were ordered by Dr. Kowacz on the morning of June 18 and notwithstanding the presence of more than a dozen nursing staff at the CPEP during the relevant period.
- Dr. Kowacz's order during the Second Shift to administer Risperdal to Ms. Green (the same type of medication given to her during her three prior stays at the hospital) was not followed as Ms. Green was not given this medication at any time during Shifts Two through Four.
- Ms. Green's vital signs were not measured after her triage in the early morning of June 18 and before she was found unconscious nearly 24 hours later.
- One Head Nurse, followed by at least two others, failed to include Ms. Green on the list of patients in the 24-Hour Observation Sheet on June 18 notwithstanding that she was in the CPEP for the better part (18 hours) of that 24-hour period.
- As more fully discussed below, Ms. Green received no attention from a physician, and little attention from nursing staff, for more than a 10-hour period (from approximately 8:30pm on June 18 until 6:42am on June 19th).

B. Fragmented Medical Records

In the course of reviewing produced documents and interviewing witnesses, DOI continually became aware of additional documents containing relevant medical information that had not been produced pursuant to subpoena, including paper documents as well as records created and maintained on a CPEP computer. This put DOI in the position of repeatedly having to make additional requests to HHC, many months into the investigation, including as recently as January 2009. During this process, HHC representatives expressed the view that certain records constituted the "official" patient record whereas other documents that also contained notations regarding Ms. Green that were relevant to DOI's investigation were not initially produced because they were so-called "administrative" or "working" documents used by CPEP staff. All of those records were highly relevant, and were all covered by court-ordered subpoenas that had been issued. Indeed, DOI learned of the very existence of some of these documents containing information regarding Ms. Green's care from witnesses interviewed who happened to mention them.

In addition, our investigation revealed that no one person had the full picture of what constituted Ms. Green's medical file. Dr. Pettit acknowledged that when he arrived at the CPEP he found that the patient records were fragmented. In particular, there were paper records and electronic records. He said that this issue has been addressed by implementing a centralized electronic records system for the CPEP. The system apparently went "live" sometime after Ms.

Green's death.

The fragmented nature of the CPEP medical records and HHC's distinction between "official" and "administrative" patient records – where the "administrative" records clearly included information regarding Ms. Green's medical care (or lack thereof) – significantly complicated and delayed DOI's efforts to fully reconstruct the events surrounding Ms. Green's stay at the CPEP on June 18-19, 2008. We have been told by HHC that an electronic medical record (EMR) system has been implemented, which presumably addresses this records issue. The benefits and improvements are more fully discussed in Section V infra.

C. The Care Gap at the CPEP During the Nighttime Shifts

DOI's investigation revealed that during the approximately 10 hours from 8:30pm on June 18 to 5:29am on June 19 Ms. Green was inside the Women's Waiting Room. Review of the video footage of this room's entrance showed that during this entire period no KCHC doctor ever entered the room. On two occasions, the video showed KCHC nurses briefly entering the Women's Waiting Room during this timeframe. The first occasion was at 12:43am, when Nurses Gonzalo and Villaroman, with a third CPEP nurse, entered the room and then exited two minutes later.⁸ The second instance was at 4:45am, when Nurse Gonzalo entered and exited the room in the space of fifteen seconds.⁹ The only record in Ms. Green's file relating to these two instances of nursing staff entering the Women's Waiting Room were notations by Nurse Gonzalo that Ms. Green was observed "asleep" in the hours of midnight-1am and 4am-5am. These notations were made in the 24-Hour Observation Log discussed supra in Section I(B).

After Ms. Green exited the Women's Waiting Room at 5:29am on June 19, she had no contact with any CPEP personnel -- nurses or doctors – for more than one hour, until she was discovered lying on the floor of the Main Waiting Room at 6:42am.

This extended period in which Ms. Green received little to no attention from hospital personnel appeared inconsistent generally with the CPEP operating as an emergency room, and specifically with the fact that Ms. Green had previously been diagnosed with psychosis and schizophrenia and involuntarily admitted for transfer to KCHC's inpatient ward.

⁸ The group of three nurses seen entering the room were a combination of personnel from the prior shift and the incoming shift; the nurses had clipboards in their hands; and the nurses were seen on the video going from area to area throughout the CPEP.

⁹ Nurse Gonzalo had been sitting in the corridor doing paperwork, got up at approximately 4:45am, walked down the corridor into the Main Waiting Room, then into the Women's Waiting Room, and then returned to where she had been doing paperwork.

Medical and nursing staff interviewed by DOI testified that it was standard practice during the night shift not to wake a sleeping patient and to delay until 7am in the morning previously-ordered procedures such as blood work, EKGs, or the measurement of vital signs.¹⁰ Dr. Pettit confirmed this point, testifying that he understood that medical clearances (including medical review, blood tests and EKGs) were not customarily performed at the CPEP during evening or night shifts if patients were sleeping. He testified that this was “the standard of care” before Ms. Green’s death. He further testified, however, that now there is “more a sense that we are an emergency room 24/7” and that efforts have been made to perform procedures in shorter time frames.

D. Medical Consultations with Uncooperative Patients

This investigation revealed that Ms. Green was not medically examined and was not given an EKG or blood work during the three shifts after Dr. Kowacz ordered, at approximately 11:40am on June 18, that this care be provided to her. We note one doctor’s good faith efforts to medically evaluate Ms. Green and his inability to do so because the patient was uncooperative. Nevertheless, we express a concern as to why no attempt was made to medically examine this patient during the next two shifts, spanning a period of approximately 12 hours. The physician who was responsible for the CPEP during most of this time frame, Dr. Estes, is a senior doctor at KCHC. We further note that the investigation revealed no evidence that a consultation was held among medical professionals on how to proceed with Ms. Green after she had proven uncooperative regarding her medical examination during the Second Shift on June 18.

Dr. Pettit testified that sometime after he arrived at KCHC in January 2008 he had noted issues with the “medical clearance” piece of patient care flow at the CPEP, specifically as to “how far could we go to force a patient refusing” a medical exam. To encounter and be impeded by patients who are uncooperative is common in a CPEP. Thus, for the testing and examinations not to have been done on Ms. Green, because, as the witnesses stated, she was uncooperative and resistant, raised an unaddressed and important problem – one subject to recurrence. Dr. Pettit testified that there is now in place a written policy regarding protocol on how to handle medical examinations of uncooperative patients.

¹⁰ Review of the CPEP video on the night of June 19 confirmed that any apparent lack of attention to CPEP patients, including Ms. Green, was not the result of the CPEP being overwhelmed with work and patients. In particular, the video showed that throughout that night shift nurses were able to take significant breaks or to double up with other nurses in duties like sitting outside the room of a sleeping child patient. Nurse Gonzalo, for example, spent more than ½ hour having dinner with Nurse Cabildo and others inside the Nursing Station; she then spent nearly one hour sitting outside a child patient’s room chatting and having coffee or tea with Nurse Cabildo; she then spent approximately one hour sitting next to a security guard at the Y Intersection while doing paperwork; and then, towards the end of the shift, Nurse Gonzalo spent nearly one hour on a break in a triage room with Nurse Cabildo. Nurses Gonzalo and Cabildo were thus in a closed room on break at the same time that Ms. Green collapsed in the Main Waiting Room, writhed for a time, and then went still.

E. Difficulties in the Identification of CPEP Staff on Duty

One initial step in our investigation was to identify all personnel – doctors, nurses, security and administrative staff – who were on duty during each of the four shifts that spanned Ms. Green's stay at the CPEP on June 18 and 19, 2008. We encountered significant difficulties in identifying who, in fact, was working at those times, especially with respect to doctors.

It appeared that KCHC maintained separate staffing rosters for each professional discipline, *i.e.*, doctors, nurses, security officers and administrative staff. The CPEP, or KCHC, does not appear to maintain a centralized roster that would allow anyone readily to identify with certainty all personnel who, in fact, worked at the CPEP during a given shift, and what actual hours they worked.

These circumstances complicated DOI's investigation and also raised a concern as to whether KCHC has adequate systems and supervision in place to account for, and ensure the accountability of, its staff during any given tour.

F. Quality Assurance Committee ("QAC")

The Health and Hospitals Corporation has an internal Inspector General who reports to the President of the Corporation, with responsibility for, among other things, investigating allegations of potential misconduct and wrongdoing by HHC employees, including criminal wrongdoing. KCHC also has a statutorily-mandated Quality Assurance Committee ("QAC") whose function is to review/investigate work performed by caregivers.¹¹ Pursuant to the Public Health Law, QAC's overall mission is to improve patient care. Under the statutory privilege established in the Public Health Law,¹² statements and evidence collected during the QAC process are confidential and not subject to disclosure. As a result of this statutory scheme, DOI is not permitted to get evidence collected during a hospital's QAC process, and although the office of the HHC Inspector General has access to QAC material, it cannot disclose or refer that material, even if it contains evidence of criminal wrongdoing, to any party outside of HHC, including prosecutors, regulators and other law enforcement officials. Thus, DOI or any other law enforcement office may conduct an investigation and not know if inconsistent evidence or statements were obtained in a hospital's QAC process. Additionally, the QAC process shields information from law

¹¹ Section 2805-j of the New York Public Health Law states in part that : "1. Every hospital shall maintain a coordinated program for the identification and prevention of medical (. . .) malpractice. Such program shall include at least the following: (a) the establishment of a quality assurance committee with the responsibility to review the services rendered in the hospital in order to improve the quality of medical (. . .) care of patients and to prevent medical (. . .) malpractice." (emphasis added)

¹² PHL Section 2805-l.

enforcement scrutiny, meaning that an agency such as DOI may not obtain all of the relevant evidence. These restrictions on the dissemination of potentially critical information present serious issues given that the purpose of any and all investigations should be a search for the truth.

DOI's investigation provides an example of how the good intentions of the statutes that created QACs and related evidentiary privileges can shield from other investigators such as DOI, information and evidence about potential criminal conduct affecting the very patients that the statutes seek to protect. In the Esmin Green matter, DOI learned that KCHC's QAC employees conducted interviews of CPEP employees who, at the outset, clearly faced potential criminal liability in connection with the falsification of medical records and other acts or omissions. Because of the QAC statutes, DOI may not have access to the statements obtained by KCHC's QAC in the Esmin Green matter.

The Green investigation puts into sharp focus the fact that a QAC review regarding patient care can also yield evidence of criminal conduct at HHC facilities by HHC employees. The statutory prohibition against providing that information can shield a hospital from law enforcement investigations, a matter of public policy that merits some discussion.¹³

Accordingly, while we fully respect the basis for non-disclosure rules in protecting people's privacy and addressing the need for people to speak openly, when the barriers become almost or completely insurmountable to conducting necessary criminal investigations, we are not sure the public is well served.

G. Failure to Utilize Cameras Installed to Facilitate Monitoring of Patients from the Nursing Station and the Security Substation.

At some point in late 2007 and/or early 2008, computer monitors were installed in the CPEP Nursing Station and Security Substation that received live feeds from video cameras throughout the CPEP. According to testimony obtained by DOI, this monitoring equipment was installed by KCHC directly in response to a New York Civil Liberties lawsuit alleging serious deficiencies at the CPEP and a United States Department of Justice investigation into the same matter. The purpose of the computer monitors installed in the Nursing Station and Security Substation was to allow CPEP nurses and security officers to monitor CPEP patients from those locations.

¹³ Thus, DOI understands that QAC must and should conduct its review in accordance with New York's statutory mandates, but we have proposed to HHC that the QAC be held in abeyance when a matter clearly involves potential criminality until such time that law enforcement or other criminal investigative officials have concluded their investigations or there has been a determination that the QAC inquiry proceeding would not compromise same. HHC has indicated that they are amenable to considering such requests.

This investigation revealed that the CPEP video, and the live video feeds to the two CPEP monitors, were in working order at the time when Ms. Green fell out of a CPEP waiting room chair and face down onto the floor at about 5:32am. The spot where Ms. Green fell was squarely within the camera views that were fed live to the Nursing Station and Security Substation computer monitors. Yet Ms. Green lay face down on the floor of the waiting room for over an hour before a CPEP senior nurse discovered her and, instead of performing CPR, called for assistance.

This finding raises the issue as to whether the live security video feeds installed in the CPEP Nursing Station and Security Substation were being utilized, as intended, by the relevant CPEP personnel. DOI learned that as of June 18-19, 2008, monitoring the Nursing Station camera was not a task assigned to any particular nursing staff member. It is DOI's position that this should be a specific assignment. In addition, security officers should be touring the hallways and the rooms in the CPEP continuously, and should not be sitting in a Security Substation from which they cannot monitor the whole facility.

IV. CONCLUSION

The death of Esmin Green on the floor of the psychiatric emergency room of Kings County Hospital was a tragedy. DOI's investigation into the facts and circumstances preceding her death led to the disturbing findings set forth in this report. There were failures of omission and commission.

The neglect of Ms. Green in a 24-hour period that included four shifts and over two dozen nursing and medical personnel was striking. Across three staff shifts, medical and nursing personnel ignored medical orders to administer tests and medication. On the night of June 18-June 19, when, for approximately nine hours she was in the Women's Waiting Room, Ms. Green had no contact with any doctors and received little attention from the nursing staff.

The failures of commission were equally glaring. Upon discovering Ms. Green's unresponsive body on the ER floor on June 19, Nurse Villaroman was seen on the video taking no action other than callously and appallingly using her foot to nudge Ms. Green's motionless body; Villaroman then disappears alerting other personnel. Nursing staff seemingly flew into a panic rather than administering CPR. At least one nurse and one nursing aide then created false entries in Ms. Green's medical record to cover up the staff's neglect of her in the hours before she was discovered dead.

In addition, discrepancies were uncovered that called into question the accuracy of medical records created by certain KCHC doctors. DOI's investigation further disclosed that the failures documented in Ms. Green's ill-fated stay at the facility in all likelihood were not aberrations, but rather the result of systemic weaknesses in the emergency room's operating procedures such as

the lack of any protocol for administering necessary care to uncooperative patients – including care required to transfer a patient from the ER to the inpatient facility – or the medical and nursing staff's practice of suspending treatment at night for any patient who might be sleeping.

DOI's investigation into this matter highlighted two other concerns – the difficulty in identifying and obtaining all relevant documents, and QAC commencing an immediate investigation in a potential criminal matter, a problem given that the statements and evidence QAC gathers are confidential and not subject to disclosure, even to law enforcement agencies. It would be beneficial for a QAC investigation regarding any incident that appears very likely to involve potential criminal conduct, await completion of the criminal investigation or a determination that the QAC investigation would not interfere with the criminal investigation.

As stated at the outset, DOI's report offers no view on whether the circumstances uncovered during its investigation precipitated Ms. Green's death. It is hoped, however, that the findings presented in this report will assist in any efforts to ensure that the failures of omission and commission that occurred will not be repeated.

DOI has forwarded this report to the Office of the Kings County District Attorney, the Honorable Charles J. Hynes, for whatever action they deem appropriate.

DOI thanks HHC President Alan D. Aviles for his significant assistance and input with this matter.

V. REFORM MEASURES AND CORRECTIVE ACTIONS IMPLEMENTED SINCE THE DEATH OF ESMIN GREEN BY KCHC

Recognizing the systemic weaknesses and procedural failures outlined above as tragically evidenced by the death of Esmine Green, HHC has informed DOI that many reform measures and corrective actions have been implemented at KCHC, including the following:

- 1. Leadership and Culture Change** - The then-incumbent Administrator of Behavioral Health Services was terminated by HHC in June, 2008 and an interim administrator was appointed. HHC also immediately terminated the Director of Security (responsible for supervising hospital police) and one of the physicians who did not go to the aid of Esmine Green. Two nurses involved resigned in lieu of termination, as did one hospital police officer.

A new Administrator of Behavioral Health Services and a new Executive Director of Kings County Hospital were appointed on February 2, 2009. All key Behavioral Health clinical and administrative management were reviewed and assessed and new leaders have been installed in most key management positions.

- 2. Staffing** - More than 300 individuals have been hired, including physicians, psychologists, nurses, social workers, activity therapists, peer counselors and the newly-created title of behavioral health associates. Both new and existing staff have received an array of extensive training and their skill competencies are now assessed on a regular and on-going basis. In addition, the medical consultation service, consisting of internists and nurse practitioners, has been expanded. A member of this service is assigned to each adult inpatient unit and a member is now always present in the CPEP.
- 3. CPEP Improvements** - Patients arriving at the psychiatric emergency services now are seen promptly by a triage nurse, and a preliminary assessment by an attending psychiatrist is conducted, on average, within an hour of the patient's arrival. While in the CPEP, each patient is checked by clinical staff every 15 minutes and evaluated by a registered nurse every hour. The average census in the CPEP has been reduced from sometimes as many as 50 patients in the CPEP at one time a year ago to seldom more than 25 patients now. In addition, the average length of stay in the CPEP before admission or discharge went from more than 13 hours a year ago to under 9 hours today.

There now is a Rapid Response Team in the CPEP 24 hours a day, 7 days a week for any patient that might require sudden acute medical care. Regular and frequent mock medical code drills are also conducted on all shifts.

New protocols and standardized tools have been implemented to better

assess and manage patients at risk of violence, suicide and sexual acting out. A new comprehensive violence reduction program includes training for all staff in crisis prevention techniques as well as a violence reduction protocol based on a standardized assessment of violence risk.

In November 2008, hospital police were removed from the CPEP and replaced by fifteen specially trained Behavioral Health Associates, a new job title at KCHC. These Associates are trained in crisis management, de-escalation techniques, safety and security. Since November, peer advocates also have been incorporated on every tour in the CPEP.

- 4. Quality** - A new quality management division for behavioral health was created. Quality management responsibilities include training staff on identification of all incidents, timely reporting requirements, and proper and accurate documentation.

An electronic medical record (EMR) was implemented in the psychiatric emergency service. Electronic systems now offer the CPEP staff instant access to critical patient information in real time and electronically log any and all changes to medical record documentation. The EMR has also allowed for improved tracking of patient flow, length of stay, triage categories, regulatory timeframes, medical clearances, lab abnormalities and other critical clinical data.

- 5. New Behavioral Health Pavilion** - On February 8, 2009, the 70-year old building that housed both the psychiatric emergency department and inpatient units was replaced by a \$153 million, state-of-the-art behavioral health pavilion. Nearly all behavioral health services have been relocated into this new Pavilion from seven separate buildings spread across the Kings County campus.

Exhibit 1
(2 pages)

AREA OF ENLARGEMENT



