The City of New York
Department of Investigation

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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 Esmin 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:

- <u>Falsification of Records</u>
  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.

- <u>Patient Care</u>
  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.

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