Investigation of Assault and Sexual Assault Allegations at the Arizona State Hospital

January 2013 – June 2015

Submitted to
Arizona Governor Doug Ducey

by

Ruth V. McGregor

November 10, 2015

I. INTRODUCTION

The Arizona State Hospital (ASH) , located in Phoenix, Arizona, provides long-term inpatient psychiatric care to Arizonans with serious mental illness.[1] ASH has three components: the Civil Adult Rehabilitation Program, which provides services to adults who are civilly committed as a danger to self or to others or those who are gravely disabled and/or persistently and acutely disabled; the Forensic Adult Program, which provides services to patients committed by court order as part of a criminal process; and the Arizona Community Protection and Treatment Program, which provides care, supervision and treatment for persons who enter the program through a court order involving sexually violent person status.

During the spring of 2015, media sources reported that ASH failed to investigate and/or report multiple assaults, including sexual assaults, that had occurred on ASH premises. In May 2015, Arizona Governor Doug Ducey requested that I conduct an independent investigation to determine whether patients' allegations of physical and/or sexual abuse at ASH were in fact being investigated. If the independent investigation revealed areas in which the reporting and investigative process could be improved, I agreed to make recommendations in those areas. Legal and support staff at the law offices of Fennemore Craig in Phoenix, Arizona, provided support in the investigation.[2]

In assembling records related to reports of and failures to report abuse allegations, I received assistance and documents from the Arizona Department of Health Services (ADHS), including ASH, the Arizona Department of Economic Security's Adult Protective Services (APS), and the Phoenix Police Department (Phoenix PD). To obtain information about past and current practices at ASH, I spoke with Dr. Cara Christ, Director of ADHS, and with ASH leadership, including Dr. Aaron Bowen, ASH Chief Executive Officer; Dr. Steven Dingle, Chief Medical Officer; Tiffany Williams, Director of Quality Management; and Tim Stanley, QRM policy analyst.[3] Rhonda Coates, Deputy Assistant Director, Division of Aging and Adult Services, Arizona Department of Economic Security, provided access to and an explanation of relevant APS records. Anni Foster, General Counsel, Arizona Department of Public Service, provided needed

[1] *See* Ariz. Rev. Stat. (A.R.S.) § 36-202.A.

[2] Stephanie A. Martinez, paralegal, and Gary Hilton, IT support specialist, provided primary support and were involved in all aspects of this investigation.

[3] References to ASH policies and procedures, other than those for which I cite a specific provision, rely on information provided during my conversations with these ADHS and ASH employees.

assistance in procuring reports from the Phoenix PD. All the agencies and their employees cooperated fully in providing the information and documents requested.

Two important changes at ASH occurred near the end of or shortly after the time period covered by this investigation. First, ADHS and ASH leadership changed substantially. On May 14, 2015, Dr. Cara Christ was named Director of ADHS. Soon thereafter, most of ASH leadership changed: Dr. Aaron Bowen was hired as Chief Executive Officer, Dr. Steven Dingle as Chief Medical Officer, Lori Lynn as Chief Nursing Officer, Tiffany Williams as Chief Quality Officer, and Margaret McLaughlin as Chief Compliance Officer.[4] The second major change occurred when ASH adopted a new case management system, effective July 2015. That system, described on page 12 below, revised portions of the system for investigating and tracking Incident Reports (IRs).

II. SCOPE OF THE INVESTIGATION

With the agreement of the Governor's Office, I limited this investigation to incidents that occurred during 2013, 2014, and the first six months of 2015. Several factors affected that decision. First, I concluded that, given the turnover among staff and patients, reviewing matters that occurred before 2013 would be of relatively limited use in defining and correcting current areas of concern. Second, ASH began retaining electronic records of IRs in 2013. Given the volume of documents involved, the availability of these basic records in electronic format allowed a more detailed and complete review of the records.

As described in greater detail below, no single entity possesses all documents required to determine whether ASH or another governmental body investigated any particular assault allegation. To gain as complete a perspective as possible, Fennemore Craig staff and I reviewed thousands of pages of documents prepared and maintained by the ADHS, ASH, APS, and the Phoenix PD. ASH provided access to all IRs prepared by ASH employees during the relevant time period, as well as documents related to internal investigations and copies of security logs. ADHS provided documents related to accrediting reviews at ASH. APS provided access to all investigations conducted on behalf of ASH patients. The Phoenix PD provided copies of all police reports that involved responses to calls from ASH. Because not all relevant documents were retained by ASH, or at least cannot be located, I cannot be certain that this report is complete. It is, however, as comprehensive as available records allow.

[4] *See* Arizona Department of Health Services Agency Management Organizational Chart, attached as **Exhibit 1**.

The investigation involved highly sensitive, often statutorily-protected, records related to patients at ASH.[5] To protect against disclosure to any person not specifically given authority to see the documents, we maintained all paper documents in a locked room at Fennemore Craig with highly restricted access. We obtained access to APS and ASH electronic records only after complying with statutory and agency requirements. Documents downloaded from the State's secure FTP server were saved on the firm's litigation drive under a secured folder. All Fennemore Craig desktop and laptop hard drives were encrypted at the time of imaging, and we used only secure, encrypted flash drives to transfer electronic files. In addition, the law firm established a secure matter workspace in its document management system, at which we stored all electronic documents created as part of this investigation and report.

To avoid improper disclosure of patient information referred to in this report, I developed a Confidential Appendix, which includes any confidential information on which this report relies. The Appendix is available to only those persons who have explicit authority to review ASH and APS records. At various times in this report, therefore, I generally describe findings and conclusions, but the confidential information supporting those descriptions appears only in the Appendix.

III. ASH INVESTIGATIVE PROCEDURES

A. INCIDENT REPORTS AT ASH

The Incident Report Policy for ASH[6] states that its purpose is to "establish a uniform procedure for identifying and reporting all occurrences within or outside the hospital which may affect the welfare of patients and personnel, the security of the hospital, or may require the attention of various supervisory offices including the Office of the Chief Operating Officer, the Office of the Chief Executive Officer and/or the Director of the Arizona Department of Health Services," and that all hospital and contract employees are to initiate an Incident Report "on all occurrences which are significant, unusual, or irregular."[7] During the time period covered by this investigation, hospital employees filed 6,161 IRs.

---

[5] *See* 42 USC §§1320c-9, 11101 through 11152, 45 CFR § 164E, A.R.S. §§ 36-2401 through 2404, 36-2917, 8-542, 36-441, 36-445, 36-509, and 41-1959.B.C. and D.

[6] Incident Reports, ADHS, ASH Adm. Spec. Admin. 009 (Oct. 15, 2012).

[7] *Id.* As a condition of participation in Medicare, hospitals must develop and maintain a Quality Assessment and Performance Improvement (QAPI) plan to "track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital." 42 CFR § 482.21(c)(2).

Each IR is assigned one of twenty-eight "Class Codes," ranging from assault to suicide to smoking in an unauthorized area. Of those codes, we identified seven that relate to assault and sexual assault: sexual interaction; patient assaulted by peer; patient assault on peer; patient assault on staff; staff assaulted by patient; staff alleged misconduct/mistreatment; and staff alleged patient abuse. Of the total number of IRs, 1,461 fell within these seven areas for the time studied and constitute the body of IRs examined in this investigation.

B. INVESTIGATIONS OF REPORTED ASSAULTS

Determining whether ASH or another governmental entity investigated an allegation of abuse proved to be a difficult task. As is described below, multiple groups or employees within ASH, as well as other entities, could be involved in any particular investigation. No entity, however, maintained records that show the relationship between the identifying number assigned an incident by one entity and the number assigned by another entity. Instead, each entity operated as a separate "silo," maintaining its own records but not connecting them with the related records maintained by another entity. The lack of connecting identification required that we develop a data base that includes identifying information about each incident from the several entities involved. After doing so, primarily by using name and date searches, we were able to match many investigations and reports from other entities with the initial IR number assigned by ASH. The computer search, however, was incomplete, primarily because entities assigned different incident dates to the same occurrence and/or used different forms of or misspelled patients' names. When we could not obtain a computer match, we physically examined the documents to find, for instance, an IR and an APS report that involved the same occurrence. This process, while time-consuming, did produce more "matches." In some instances, despite these efforts, we were unable to identify any investigation that was or may have been undertaken for a particular incident.

Investigations of assaults at ASH begin with an Incident Report. The IRs, to which numbers are automatically assigned by ASH,[8] were completed by the person with the most comprehensive knowledge of the incident by the end of the shift during which the incident occurred. ASH procedures required that the completed IR be submitted to Quality Resource Management (QRM), by drop box or email, by the end of the shift. QRM then reviewed, coded, and classified the incidents the

[8] The IR numbers first set out the year and then, beginning on January 1 of each year, receive sequential numbers. The first IR Report for 2013 thus would be numbered IR 13-0001.

next morning. As far as I can determine, QRM timely carried out these procedures.

QRM then distributed the IRs to the Executive Risk Management Team (ERMT), which generally met every three days to review the IRs distributed since its previous meeting. While membership on ERMT varied slightly during the time covered by the investigation, the team always included top administrative personnel and up to approximately thirty other hospital employees. ERMT assigned its own number to the incident.

At its meetings, ERMT could take one of several actions as to each incident:

- ERMT could report the incident to Adult Protective Services, under the auspices of Ariz. Rev. Stat. Ann. (A.R.S.) §§ 46-452.A and 46-454.[9] Until December 2013, however, while ASH reported incidents involving assaults and sexual assaults on vulnerable adults to APS, APS did not accept the reports as claims. That procedure changed in late 2013, and APS began accepting reported incidents for investigation.[10] In 2014, when the Arizona Legislature revised Section 46-452 to exempt reports involving patients at ASH from the reports that require evaluation by an APS protective services worker,[11] ASH and APS entered a Memorandum of Understanding, under which APS agreed to continue accepting reports from ASH as claims that require evaluation.[12]
- ERMT could direct that QRM or another ASH employee undertake an internal investigation. Some internal investigations involved matters designated as "Critical Incidents," which include a range of serious incidents, such as patient death, suicide, and serious physical injury.[13] In addition to these categories of incidents, ASH personnel developed a practice of labelling an incident that required off-site medical treatment of a patient as a "critical incident." In addition to Critical Incidents, ERMT assigned other matters for follow-up, as discussed below.
- ERMT could decide that no further action was needed.

[9] In 2014, the Arizona legislature revised A.R.S. § 46-452.A to eliminate the requirement that an APS worker evaluate the need for protective services if the vulnerable adult involved is a patient at ASH. ASH and APS then executed a Memorandum of Understanding, under which APS retains responsibility for investigating claims involving ASH patients.

[10] Not all IRs involving assaults fit the criteria of A.R.S. § 46-454, which defines the obligation of those who care for vulnerable adults to report an incident to APS. The APS social work department reviews all assault reports to determine whether they involve a vulnerable adult and whether appropriate reporting has been completed.

[11] *See* A.R.S. § 46-452.D.

[12] See Memorandum of Understanding Between The Arizona Department of Health Services and the Arizona Department of Economic Security, attached as **Exhibit 2**.

[13] "Critical Incidents" include matters such as "patient death by other than natural causes, allegations of sexual assault, allegations of patient abuse, attempted suicide/suicide, serious physical injury to patients and/or personnel," and other matters. Az. Dept. of Health Serv., Az. State Hosp., Adm. Spec. Admin. 001 (Nov. 15. 2012).

1. QRM Investigations

At least since 2013, staff at ERMT meetings made hand-written notes on the list of incidents reviewed in each meeting.[14] The notes indicate whether a particular person was to take some action to resolve an incident. Someone might agree, for instance, to review relevant video records or to speak with a member of a patient's treatment team. As far as we could determine, no documents exist that explain the goal of the investigation undertaken, describe the extent of the investigation, or report corrective action taken.[15]

In addition to the handwritten notes made during each meeting, ERMT followed the course of internal investigations by means of a separate document. Through May 2013, the top of the ERMT form included a list of matters referred for internal investigation, which indicated which investigations were in progress and which had been completed.[16] At the end of May 2013, ERMT began using a document referred to as a "follow-up chart." The chart, maintained as a Word document, notes whether a matter is "in progress" or "completed."[17] When ASH completed its actions related to a particular incident, the incident involved "rolled off" the follow-up chart. We could determine whether or when a particular incident was "completed" only by reviewing these individual charts. Although ASH did not maintain an electronic version of the chart that included all entries, employees did make available copies of the various charts, which we were able to incorporate into the electronic records developed for this investigation.

The revised procedures adopted in May 2013 appear to be related to, but do not comply with, a Plan of Correction adopted by ASH in 2013. The Division of Licensing Services, Arizona Department of Health Services, completed a regularly-scheduled survey on May 15, 2013.[18] One of the deficiencies noted refers to the failure of the administrator to implement an appropriate QRM plan.[19] The plan of correction developed by ASH requires that QRM document all findings from a record review of all incidents that met the definition of critical

[14] A sample form, with confidential information redacted, is attached at **Exhibit 3**. A non-redacted version is **Exhibit A** to the Confidential Appendix.

[15] Reports about ASH procedures and documents, unless they involve a particular citation, derive from my discussions with the State employees identified on pages 1 and 2 of this report.

[16] A sample form, with confidential information redacted, is attached as **Exhibit 4**. A non-redacted version is **Exhibit B** to the Confidential Appendix. Through the first five months of 2013, however, only three matters related to assault incidents appear on the list of matters being investigated. We located no documents that show the results of those investigations.

[17] A sample form, with confidential information redacted, is attached as **Exhibit 5**. A non-redacted version is **Exhibit C** to the Confidential Appendix.

[18] *Plan of Corrections and Complaints Investigated for May 2013*, submitted to Arizona Department of Health Services on August 23, 2013.

[19] *Id*., Prefix Tag C346.

incident. The Risk Manager was then to ensure that any actions taken were completed and to identify where to find documentation of the actions. In addition, AHS agreed to perform an audit on 100 percent of the critical incident files, demonstrating that action items were followed up and documented.[20] The Plan of Correction also referenced two forms that AHS planned to use to document the planned actions. When asked during this investigation, AHS could not locate the documents to which the Plan of Correction referred and could not verify that the agreed-upon audits were undertaken or completed.

ASH did complete some Critical Incident reports during the period covered by this investigation. Those reports, identified by both IR number and CI number, were included in the documents made available by ASH.

2. APS Investigations

When ERMT referred an incident to APS for investigation, APS assigned its own case number. Neither entity maintained a chart that shows the relationship between either the ERMT case number or the IR number and the case number assigned by APS. Comparing APS case files with ASH IRs proved particularly difficult, because the two entities maintain their files very differently. As noted above, an IR describes a singular incident and lists all persons involved in that occurrence. APS, in contrast, often maintains a single case file for multiple incidents that involve a particular client. APS file number 0000, for Patient X, thus could report multiple incidents for Patient X, each occurring on a different date and each involving a different "alleged perpetrator." The APS file includes a date of assignment and a date of closure, but those relate to the earliest incident reported for a client. We matched most of the case files involving a single incident to the comparable IR. For those case files involving multiple incidents, we related as many as possible to an IR.

In addition to the inherent difficulties resulting from the entities using two unrelated filing methods, ASH had no method for tracking the progress of an APS investigation. Occasionally, ASH received notice from APS that an investigation was complete. Under APS procedures, however, a notice of completion or closure was sent only to the person who initiated the report to APS. If that person was no longer employed by ASH, ASH received no notice. In addition, APS typically did not send a copy of its report with the notice of completion. Finally, if ASH did receive an APS notice or report, no formal procedure defined to whom such a notice or report should be distributed or how the information from the report should be used to further the goals of the IR policy.

[20] *Id*., Attachment 3: Critical Incident Case Review, revised May 28, 2013.

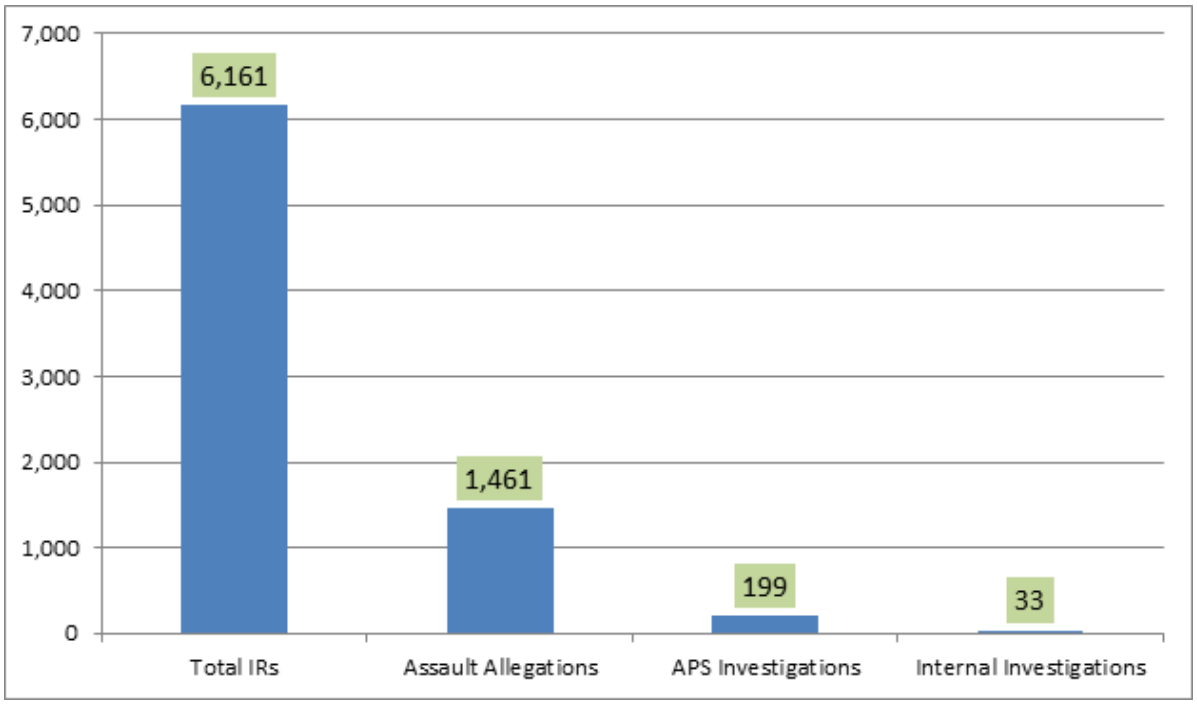
IV. RESULTS OF THIS INVESTIGATION

A. SUMMARY

ASH employees must report and attempt to resolve thousands of incidents that occur at the hospital. During the time period covered by this investigation, January 2013 through June 2015, ASH employees prepared 6,161 IRs. As noted above, 1,461 of that group involved allegations of assault or sexual assault. After reviewing IRs, internal ASH investigation records, APS reports, and Phoenix PD reports, I can report investigation results with certainty only as to a relatively small number of the IRs.

The Executive Risk Management Team received and considered all 1,461 IRs that were part of this investigation. In addition, ERMT completed its review of IRs in a timely manner, within a matter of days. Nearly all of the IRs reviewed were not referred for further investigation. This result is not surprising: most occurrences giving rise to an IR involve a straightforward factual situation, and most are resolved immediately by staff. Unfortunately, the ERMT records available from ASH do not include notations of the reason a matter was not further reviewed. I can surmise that the explanation is that noted above: the matter had been fully resolved by staff at the time of occurrence, and that fact was apparent to ERMT members at the time of their review. Because ERMT did not document the reason for concluding no further review was needed, however, I cannot be certain the explanation applies. A much smaller number of IRs did become the subject of further investigation.

ASH IRs and Investigations 2013 – June 2015



As Chart 1 shows, our investigation found 199 APS reports involving incidents from ASH that fell within the classes of IRs reviewed. In addition, we know, by comparing the date the matter was placed on the internal follow-up list and the date it was designated "completed," that ASH regarded twenty-six internal investigations as complete. ASH maintained no records that show the scope of or conclusions drawn from the review or investigation. We also know that ASH designated certain reports as "critical incidents." We found sixty-five reports summarizing the results of inquiries involving those incidents, including seven that fell within the classes of IRs reviewed. Finally, seventy-seven matters were the subject of both an IR and an investigation carried out by the Phoenix PD after being called to the hospital.

B. ASH SECURITY LOGS AND PHOENIX POLICE DEPARTMENT REPORTS

Near the time this investigation began, some former and current ASH employees informed ASH executives, under promise of confidentiality, that employees occasionally had been instructed not to file an IR when an assault occurred, and that we could verify that practice by comparing the IRs for a particular date with records maintained by ASH Campus Support and Safety

Department, referred to as security logs, and/or reports from the Phoenix Police Department. To evaluate these allegations, we obtained copies of the security logs, which detail significant events during each shift, and Police Department reports that involved a call to investigate reports of assaults at ASH.

1. Security Logs

ASH employees receive an independent study guide that, among other matters, instructs employees how to respond to codes identified as a "call for help."[21] Employees used "Code Grey" "to summon additional staff to the site of an emergency behavioral situation whenever it is determined that adequate staff are not present at the site of the emergency to effectively deal with the situation."[22]

As a general matter, the security log reports those occasions on which safety officers respond to a Code Grey call. During the time period reviewed, we found twenty-eight incidents involving potentially serious actions that are recorded in a security log but for which we could find no corresponding IR. Two security logs are prepared for each 24-hour period, so the number of incidents without a corresponding IR represent a small percentage of security log entries, but the lack of related IRs is troubling. Each security log entry involves an incident of sufficient import that employees involved with a patient signaled a Code Grey. Nearly all involve incidents that arise from conduct appropriately described as violent or assaultive. In six of these twenty-eight incidents, the Phoenix PD also responded and filed a report.[23] I did not identify any pattern that explains the instances in which no employee prepared an IR; the incidents do not center around any particular unit or involve any particular type of allegation.[24] Because ASH investigations begin with an IR, these instances obviously never were considered for filing with APS or for an internal ASH investigation. I recommend in Section V, below, that ASH examine these occurrences to determine how better to assure the IRs are filed in all appropriate instances.

2. Phoenix Police Department Reports

When we compared Phoenix PD reports with IRs filed on the same date, we found forty-two instances in which the PD responded to a call from ASH and filed a report for which we could find no related IR.[25] Ten of the PD reports involved an

---

[21] Arizona State Hospital, "Direct Service Contractors' Independent Study Guide 2013," at 5.

[22] *Id*. at 6.

[23] ASH staff places a call to the PD if requested by a patient.

[24] **Exhibit D** to the Confidential Appendix lists those "Code Grey" matters entered on the ASH security logs for which we found no corresponding IR.

[25] **Exhibit E** to the Confidential Appendix lists those Phoenix PD reports for which we found no corresponding IR.

ASH employee as the victim of an assault. Although ASH policy requires an employee to file an IR describing an assault on the employee by a patient, a number apparently chose not to file a report. A few of the calls to which the PD responded involve minor incidents, such as a patient who threw a water bottle at another, who wanted to file a police report. But other incidents seem clearly to involve the type of behavior that would require filing an IR, including instances or allegations of hitting or punching another patient in the face; instances of assault by two patients described by the police report as "mutual combat"; hitting sufficient to cause a split lip or small cuts on the face; and sexual contact. In all instances, ASH staff knew police officers had been called. These occurrences, like the security log matters not the subject of an IR, were never considered by ASH for an investigation, and I recommend that ASH examine these occurrences also to determine how to assure that IRs are filed in all appropriate instances.

C. APS INVESTIGATIONS

As noted above, beginning at the end of 2013 and continuing to the present, APS accepted 199 reports from ASH involving vulnerable adults who reported abuse.[26] These matters relate to an important but relatively small group of IRs alleging abuse or sexual abuse.

When APS accepts a report, workers note the date the case was reported and the date the case was assigned, two dates that generally are in very close proximity. A protective service worker then undertakes an investigation of the allegations. When APS completes its investigations, it closes the matter, noting the reason for closure. As discussed earlier in this report, those procedures work well for tracking the progress of an investigation when an APS client file includes only one matter, but the reported and closing dates are not reliable when a client file includes several, unrelated matters. After APS completes its investigation, it closes the matter with an indication of the reason for closure.[27]

In most instances involving ASH patients, because the client was under treatment, APS closed the matter as "Needs Met. No Services Required." After

[26] Most, but not all, reports to APS involving an ASH patient come from ASH employees. In a small number of instances, a person other than an ASH employee provides oral or written information about a patient, which APS can accept. *See* A.R.S. § 46-452.A.2

[27] For those instances we could tie to an IR, the APS records allowed us to determine the time required to investigate a matter once it reached APS. Although the average amount of time to close the matters reviewed in this investigation is 450 days, that number is skewed by earlier referrals that languished for some time. In recent months, APS has made substantial effort to resolve the matters involving ASH patients. As of September 2015, APS reported having accepted 236 matters involving ASH patients and having closed approximately half of them. By November 8, 2015, APS had investigated and closed 130 of the 199 matters that fell within the matters reviewed in this investigation.

closing a file, APS typically did not send notice to ASH and did not send a report of the findings of its investigation.

D. Internal Investigations

Tracking internal ASH investigations proved the most difficult task related to this investigation. As noted above, ERMT assigned and tracked internal investigations and could proceed either by calling for a Critical Incident report or by placing the matter on the ERMT "follow-up chart." Because ASH retained only limited information about matters listed on the follow-up chart, drawing conclusions about whether investigations actually were conducted and the findings of any investigation proved impossible. We were able to determine that, from assignment of a matter to the chart to the date the matter was deemed completed averaged nineteen days; whatever investigation was undertaken was conducted in a timely manner.

ASH records reveal more about the limited number of Critical Incidents investigated. During the time period studied, ASH produced sixty-five CI reports, but only seven fall within the categories studied, making any conclusions about timeliness of dubious significance.[28] The reports, however, generally reveal attention to the details of the incident involved.

As is apparent, ASH must better track and document its internal work if the reviews or investigations are to provide information intended to improve patient care.[29]

V. RECOMMENDATIONS

The purpose of maintaining a hospital plan for tracking adverse patient events is to allow hospitals to analyze the causes of the adverse events and then to implement actions and mechanisms that include feedback and learning throughout the hospital."[30] For ASH to benefit fully from the information it obtains from IRs and the analysis and/or investigation of them, ASH should consider methods to improve its processes and procedures in two primary areas. First, ASH should adopt procedures that allow employees to track incidents, from initial report to completed investigation, efficiently and accurately.[31] Second, ASH should adopt

[28] **Exhibit F** to the Confidential Appendix is a list of matters designated Critical Incidents.
[29] The spreadsheet included as **Exhibit G** to the Confidential Appendix summarizes, as to each IR included in this study, the matters submitted for investigation.
[30] *See* footnote 6, *supra*.
[31] As a result of the disconnect between investigating agencies, for instance, we encountered difficulty in learning the results of an investigation occasioned by an IR, even if the investigation was documented, as many were not.

procedures that ensure that ASH makes full use of information developed by APS, the Phoenix PD, and ASH's own internal investigations and security division.

ASH already has taken steps to improve its procedures. In July 2015, ASH substantially revised its procedures for managing IRs by implementing a comprehensive, organization-wide Quality Management (QM) program. The program, as explained by Dr. Aaron Bowen, ASH CEO, is designed to evaluate systems and processes in order to identify patterns that may impact patient care and safety. Identified either as the Quality Management System or the ASH Incident Reporting System, the program requires, as did the prior system, that all hospital staff promptly report any "significant, unusual or irregular" event. Two important changes represent improvements to the system in place during the time covered by this investigation.

First, after the unit supervisor reviews the event description and unit response in an IR, the Quality Assurance Team (QAT) identifies those events that trigger additional quality assurance review. The team then forwards these events to the CEO, CMO, CNO, or other appropriate source for review. The QAT is responsible for completing a thorough review of each incident and documenting the review. Second, each week all quality of care reviews go before the QAT, CQO, CNO and CMO, rather than the ERMT formerly used, to determine whether the allegations can be substantiated and whether ASH should develop a plan of correction to address the problematic system or process issue identified.

These changes in procedure should permit more effective use of the information reported in IRs. I recommend several additional changes, which will enhance the ability of ASH to meet its goal of identifying and responding to patterns that may impact patient care and safety.

A. SPECIFIC RECOMMENDATIONS

1. Adopt procedures that permit ASH personnel to track investigations, whether conducted by ASH or by another governmental agency. ASH also should ensure that those involved in patient care learn the results of all relevant investigations and that the results are used to further the goals of the reporting system.

The most important change ASH can make to its procedures is to develop a method that allows ASH employees to follow an incident from beginning to conclusion, with immediate access to documentation of investigative steps taken,

---

Absent the electronic storage and use of data developed for purposes of this investigation, obtaining full information about any particular incident would have been, for all practical purposes, impossible.

decisions reached, and corrective action recommended or taken as part of the investigation.

In 2013, ASH began retaining IRs in electronic format. One of the benefits of electronic records is that they provide an opportunity to combine and compare relevant records through a single reference number. That benefit cannot be fully realized by ASH if identifying numbers change as an investigation progresses. I therefore recommend that the IR number initially assigned to an incident should be used as the identifying number throughout the investigation. No apparent reason supports the ASH practice of assigning a separate number as part of the Quality Assurance procedures, and that practice should end.

Fully implementing this approach will require the cooperation of APS. ASH referrals to APS receive an APS case number, unrelated to the IR number. APS may well wish to continue to use its own numbering and filing systems, particularly because it receives referrals from entities and individuals other than ASH. Adding a field that records the IR number should not be difficult, however, as the IR number should always be available at the time of the ASH report to APS. I therefore recommend that APS add the IR number to its APS file. If that change is made, the difficulties in tracking an incident through the APS case file system will be eliminated.

To make certain that ASH can use the results of the APS investigations, I also recommend that APS send its completed reports to ASH and reference both its case number and the IR number when it does so.

I also recommend that, in those instances in which the Phoenix PD becomes involved, ASH obtain the PD report number from the responding officer at the time the officer comes to the hospital. In those few instances when doing so is not possible, ASH should assign an employee or group responsibility for contacting the Police Department within a prescribed time to add the PD report number to the IR file. Under current procedures, the results of PD investigations are not reviewed by ASH and are not part of the IR file. The PD report, however, often will provide valuable information to ASH: the responding officers usually interview both victim and suspect, as well as any witness to an incident. In addition, if privacy concerns permit, a department detective views any video tape of the incident. I therefore recommend that the results of the PD investigation be reviewed and incorporated into the ASH IR file.

In sum, to fully use all resources available in its analysis of adverse events, ASH should develop procedures that assure that the results of any investigation conducted by ASH, by APS, or by the Phoenix PD be submitted to the appropriate employees for recording in the IR file and for analysis.

2. ASH should consider developing a "summary tracking system" that allows employees to quickly and accurately determine the status of any investigation. This investigation would have been much assisted by a system that includes the relevant IR number, date of incident, date assigned for investigation, date completed and conclusions of investigation, and corrective action taken. For internal investigations, the system also should include the name of the person assigned to oversee the investigation. For matters transferred to APS, the system also should note the date of transfer, the date ASH received a report from APS, and the persons to whom the report was distributed.

3. Clearly identify the goals of the ASH Incident Reports and consider revising the IR Form to further those goals.

The general purpose of hospital incident reporting systems is to address patient safety problems.[32] By reporting and considering adverse events, hospitals can develop comprehensive patient safety improvement plans that set goals for improvement, direct resources, and assess the effectiveness of prevention strategies.[33] Many hospitals limit the use of IRs to serious allegations of abuse, death or serious injury and to significant incidents that may result in harm to or compromise the health, safety or welfare of a vulnerable person.[34] The decision by ASH to define broadly the "occurrences" that trigger an IR[35] raises several potentially negative effects. First, the broad definition, by including matters unrelated to patient and staff safety, exaggerates the number of reportable incidents, as that term is commonly understood, that occur at ASH. Second, because each "occurrence" requires an employee to prepare an IR, the broad definition results in a substantial expenditure of employee time, both to write an IR that calls for detailed information and to follow up on the incident reported.

The new case management system adopted by ASH partially addresses these concerns by identifying those instances that involve patient safety and then requiring additional quality assurance review of those IRs. ASH policy, however, continues to use the same IR form for matters of patient safety as it uses for a broad range of other activities, including burglaries, automobile accidents involving state vehicles, theft of property, and damage to State property, including hospital keys and badges. This process conflates matters of patient safety with

---

[32] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm*, OEI-06-09-0091 (Jan. 2012), at 2.

[33] *Id.* at 2, 18.

[34] *See, e.g.*, Section 244, New York State Social Service Law; Incident Reporting Forms for Level 1 and Level 1, Maine Dept. of Health and Human Services, www.maine.gov/dhhs/.

[35] ASH currently requires an IR for "all occurrences that are significant, unusual, or irregular." Incident Reports, *supra*, footnote 5.

unrelated matters. After consideration, ASH may conclude that a more limited definition of the "occurrences" that require an IR would better identify those matters most deserving of attention. I recommend that APS reserve its current, detailed IR form for matters involving patient and staff safety problems and develop a less complex form for administrative matters, with separate reporting lines established for the two types of reports.

4. Improve training for employees who prepare IRs.

In reviewing IRs, we noted inconsistencies among the reports. Patient names were recorded in a variety of ways: Some reports used a patient's first name, some the patient's middle name, and yet others a nickname. Many used an incorrect spelling of a patient's name. Such inconsistencies made searching for or grouping reports by patient name difficult. Some incorrect entries appeared to be simply a result of carelessness, as occurred when the same patient was reported as resident at two different units at the same time or when a male 36-year-old patient was identified as a 63-year-old female patient. Some IRs confused the aggressor patient and the victim patient. These and other errors, considered as a group, reveal a lack of attention to detail that could affect the accuracy of essential portions of an IR. The widespread errors in the IRs indicate that employees need additional training and an understanding of the importance of recording information accurately.

5. Improve training for employees who make security log entries and revise the security log format.

We found similar inconsistencies in reviewing the security logs. Finding references to particular patients was made more difficult by the variations in referring to patients: some references used a patient's first and last name, some a first initial and last name, and some two initials. Because security log entries are not tied to an IR number, we could compare log entries with IRs only by searching patient names; the varied approaches to recording names made that task more difficult. Training employees to use a consistent form of name would make the logs more useful.

Inconsistencies also exist between IRs and the logs as to whether security officers were called to assist in a Code Grey situation. Employees should be encouraged to include that information when they prepare an IR.

I also recommend that AHS consider revising the security log format. Currently, the log reports both employee personnel matters, such as who called in sick or left a shift early, and patient safety matters on one form, in chronological

order. The security log entries would be more useful in evaluating matters of patient safety if the logs had separate sections for personnel and patient safety entries.

6. ASH should examine the situations in which a matter that was reported in the security logs or a PD report was not reported in an IR. A number of the matters reported by ASH security or investigated by the PD never became the subject of an IR. Because many of those matters involved the type of activity for which an IR seems to be required, the lack of IRs is perplexing. The lack of IRs means, of course, that ASH never includes these incidents in its data base and thereby loses the opportunity to learn how better to manage such situations. If employees have developed the view that a matter for which security or the PD was called does not require an IR, additional training should correct this problem. Certainly supervisors should never instruct employees to avoid filing an IR in a situation that falls within the IR policy. If, as I recommended above, ASH adopts procedures that include PD reports in IR files, omissions like these will be quickly detected.

V. CONCLUSION

This investigation examined the 1,461 Incident Reports involving allegations of abuse at the Arizona State Hospital from January 2013 through June 2015. The investigation revealed that all IRs were submitted to the Executive Risk Management Team for review. Of the 1,461 cases, ASH submitted 199 to Adult Protective Services for investigation of allegations involving a vulnerable adult. Another thirty-three became the subject of internal investigations, with seven of those classified as a Critical Incident. In addition, the Phoenix Police Department, after being called on behalf of a patient, independently investigated seventy-seven of the matters reflected in the 1,461 IRs. Although the remainder of the IRs appear on ERMT agendas, no documents exist that explain the reasons that ASH concluded that those incidents did not require investigation or review beyond that provided by the ERMT.

I recommended that ASH take several steps to continue to improve its case management system to allow complete tracking of IRs, from beginning to conclusion. Doing so will further the goal of the ASH reporting system: to permit full analysis of adverse events and then to implement actions and mechanisms that include feedback and learning. An improved case management system will provide the tool needed to record and, as needed, retrieve, decisions related to investigations undertaken by ASH and other entities. I also recommended that ASH work with other agencies, particularly Adult Protective Services and the Phoenix Police Department, to develop methods for coordinating case

identification numbers and for ASH to include investigative results from those agencies in the ASH IR files. Finally, I recommended additional training for ASH employees to assure accurate and complete reporting in the IRs.

Throughout the investigation, I was struck by the open attitude displayed by ADHS and ASH and by their employees' willingness to make changes that will enable them to better serve the patients of ASH.