Office of the Washington State Auditor
Pat McCarthy

Whistleblower Investigation Report

Department of Social and Health Services

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May 6, 2024

Jilma Meneses, Secretary
Department of Social and Health Services

Report on Whistleblower Investigation

Attached is the official report on Whistleblower Case No. 24-003 at the Department of Social and Health Services.

The State Auditor's Office received an assertion of improper governmental activity at the Department. This assertion was submitted to us under the provisions of Chapter 42.40 of the Revised Code of Washington, the Whistleblower Act. We have investigated the assertion independently and objectively through interviews and by reviewing relevant documents. This report contains the results of our investigation.

If you are a member of the media and have questions about this report, please contact Director of Communications Kathleen Cooper at (564) 999-0800. Otherwise, please contact Assistant Director for State Audit and Special Investigations Jim Brownell at (564) 999-0782.

Sincerely,

Pat McCarthy, State Auditor

Olympia, WA

cc: Governor Jay Inslee
Richard Meyer, External Audit Compliance Manager
Kate Reynolds, Executive Director, Executive Ethics Board
Andrew Colvin, Discovery & Ethics Administrator
Erin Anderson, Special Investigations Program Manager

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WHISTLEBLOWER INVESTIGATION REPORT

Assertion(s) and Results

Our office received a whistleblower complaint asserting that mandatory reporters at Eastern State Hospital did not comply with state law by failing to investigate, report or immediately report known and suspected patient abuse or neglect.

We found no reasonable cause to believe an improper governmental action occurred.

Background

The Department of Social and Health Services' (DSHS) Behavioral Health Administration operates three state psychiatric hospitals including Eastern State Hospital (ESH). ESH is an inpatient psychiatric hospital accredited by the Joint Commission, an independent nonprofit organization, and certified by the federal Center for Medicare and Medicaid Services. The hospital provides evaluation and inpatient treatment for individuals with serious or long-term mental illness that were referred to the hospital through a behavioral health organization, a civil court order for involuntary treatment or the criminal court system. The hospital is in Medical Lake, Washington.

The complaint listed five subjects who are employees and mandatory reporters of abuse and neglect at ESH: the Chief Executive Officer, Deputy Chief Executive Officer, Chief Nursing Officer, Assistant Chief Nursing Officer and a Registered Nurse 4.

RCW 70.124.030 requires employees of the state hospital to report incidents of abuse with reasonable cause. If there is reasonable cause to believe a patient has suffered abuse or neglect, employees must make an immediate oral report to either a law enforcement agency or DSHS, and must make a report in writing if requested.

The law does not define “immediate.” It is common for governments to establish their own policies or procedures that describe their methods to ensure compliance with laws and rules. The Hospital has an Allegations of Abuse Committee (AOA) that meets twice weekly to address all allegations of abuse or neglect as a part of the Hospital’s patient safety program.

About the Investigation

We received a whistleblower complaint asserting the subjects were aware of two incidents that occurred on April 2 and April 7, 2023, which were not reported and investigated as required by state law. Our understanding of the incidents is as follows:

Incident #1

Department records describe an employee witnessing an altercation between a patient and an employee on April 2, 2023, which was deemed to be an unusual occurrence. The witness made an oral report to the witness’s direct supervisor, who submitted a written report for the incident on

April 4, 2023. On April 5, 2023, the Hospital's Allegation of Abuse Committee (AOA) received the report and began reviewing the claim and related evidence, including video surveillance footage. Based on all available evidence, the AOA concluded there was not reasonable cause to believe abuse or neglect, as defined by RCW 70.124.030, had occurred. The incident was not forwarded to law enforcement, because the Committee determined no reasonable cause.

Incident #2

Department records describe two employees witnessing an altercation between a patient and an employee on April 7, 2023. Both witnesses submitted written reports of the incident that same day. The AOA Committee received these reports the next business day on April 10 and scheduled a review of related evidence for the following day. After reviewing all available evidence, including video surveillance footage, the Committee forwarded the allegation to the Chief Executive Officer with a recommendation to initiate an investigation into potential patient abuse.

The Chief Executive Officer reviewed the Committee recommendation and related evidence and submitted a report to law enforcement on April 27, 2023. Law enforcement acquired the video evidence on May 5, 2023, and subsequently declined to open an investigation.

To determine whether an improper governmental action occurred, we reviewed the following information for the two incidents identified in the complaint:

- Incident reporting records
- Video surveillance footage
- Policies and procedures on patient safety and incident reporting
- Allegations of abuse assessment and determination records

We also interviewed multiple witnesses and all five subjects.

Our review found no evidence contradicting the AOA Committee's conclusions on reasonable cause; however, the scope of our review is compliance with state law, and we make no conclusive determinations on the patient's physical condition during or after the incident.

Investigative Conclusion

For incident #1, the Hospital concluded there was not reasonable cause to believe a patient had suffered abuse. Based on this, no further reporting or action was required by RCW 70.124.030.

For incident #2, the Hospital concluded there was reasonable cause to believe a patient had suffered abuse. Our review of documentation found that the incident was reported to the Hospital the same day it occurred. We determined this reasonably met the legal requirement of immediate reporting to the department. The Hospital subsequently relayed this report to the appropriate law enforcement agency, as required by RCW 70.124.040. Since law enforcement declined to open an investigation, no further action was required of the Hospital.

In our judgment, we believe the subjects followed the law. We found no reasonable cause to believe mandatory reporters at ESH did not follow state law by failing to investigate, report or immediately report known and suspected patient abuse or neglect. Based on our review of the information, we found no evidence contradicting the AOA Committee's conclusions on reasonable cause; however, the scope of our review is compliance with state law, and we make no conclusive determinations on the patient's physical condition during or after the incident.

Further, we determined the Assistant Chief Nursing Officer and the Registered Nurse 4 had no involvement in these two incidents.

Recommendation

During our review of Department policies and interviews with the Chief Executive Officer and other witnesses, we noted there was no clear expectation or definition for timely reporting to law enforcement when required. We recommend the Hospital clarify policy expectations over incident reporting to ensure it relays reasonable cause reports to law enforcement in a timely manner.

State Auditor's Office Concluding Remarks

We thank Department officials and personnel for their assistance and cooperation during the investigation.

WHISTLEBLOWER INVESTIGATION CRITERIA

We came to our determination in this investigation by evaluating the facts against the criteria below:

RCW 42.40.020(4) – State employee whistleblower protection, states in part:

> (4) "Gross mismanagement" means the exercise of management responsibilities in a manner grossly deviating from the standard of care or competence that a reasonable person would observe in the same situation.

RCW 74.34.035 – Reports-Mandated and permissive-Contents-Confidentiality:

> (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department**.**
>
> (3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:
>
> > (a) Mandated reporters shall immediately report to the department; and
> >
> > (b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.
>
> (8) Each report, oral or written, must contain as much as possible of the following information:
>
> > (a) The name and address of the person making the report;
> >
> > (b) The name and address of the vulnerable adult and the name of the facility or agency providing care for the vulnerable adult;
> >
> > (c) The name and address of the legal guardian or alternate decision maker;
> >
> > (d)The nature and extent of the abandonment, abuse, financial exploitation, neglect, or self-neglect; …

RCW 70.124 030 – Reports of abuse or neglect:

> (1) When any practitioner, social worker, psychologist, pharmacist, employee of a state hospital, or employee of the department has reasonable cause to believe that a state hospital patient has suffered abuse or neglect, the person shall report such incident, or cause a report to be made, to either a law enforcement agency or to the department as provided in RCW 70.124.040.
>
> (2) Any other person who has reasonable cause to believe that a state hospital patient has suffered abuse or neglect may report such incident to either a law enforcement agency or to the department as provided in RCW 70.124.040.
>
> …