

Theodore R. Kulongoski
Governor



September 21, 2004

Gary Weeks
Director
Department of Human Services
500 Summer St. NE, E-15
Salem, OR 97301

Dear Director Weeks,

There is no job I take more seriously as governor than my responsibility to ensure the health and safety of Oregonians - particularly those who are most vulnerable, including children, senior citizens, people with disabilities and those in state custody. As you are aware, recent media reports have unveiled disturbing stories of past abuse at the Oregon State Hospital. Although the abuses contained in these reports took place over a decade ago, I believe we must ensure that the state is providing the best possible care to Oregonians with mental illness being served at the State Hospital.

Clearly, the state must have zero tolerance for abuse or neglect of individuals in our care. There must be established, effective protocol for identifying, reporting and responding to allegations of abuse and patient mistreatment. This protocol must ensure that, when necessary, intervention and corrective action—including holding abuse perpetrators accountable—is immediate and prevents further harm.

In response to my inquiries yesterday, you provided me with information about changes in policy and protocol regarding patient abuse or neglect reports at the State Hospital that have taken place since 1991. Before amending or adding to the protocols included in that policy, I need to understand whether in fact those newly existing protocols are effective.

Accordingly, by this letter, I am asking for a report from you within 30 days that includes the following:

1. A detailed timeline of changes that have taken place in policy and protocol governing the reporting of patient abuse or neglect.
2. A detailed description of current protocol for the reporting of patient abuse and neglect, including information regarding the role of the State Hospital Superintendent, the Oregon State Police, the Department's Office of Investigations and Training, and a description of the process for reporting patient abuse information to DHS leadership and to you.
3. A review of all patient abuse reports beginning in 1992 that came out of the child and adolescent wards at the State Hospital. Included in that review should be a listing by year of how many patient abuse reports were made; how many were substantiated, unsubstantiated, or inconclusive; and, of those that were substantiated, a brief description of: (a) the type of abuse that occurred (for example, verbal, neglect, physical or sexual); (b) information regarding the abuse perpetrator (for example, state hospital employee, family member, etc.); (c) the process of investigation; and (d) the action that was taken, including corrective action regarding state employees.
4. An annual listing of the total number of State Hospital patient abuse reports received since 1992 and a breakdown by year of how many of those reports were substantiated, unsubstantiated, or inconclusive. In addition, for each year beginning in 1992, a review of a random sample of those abuse reports. Each of those samples should detail how many abuse reports were substantiated, unsubstantiated, or inconclusive and, of those that were substantiated, a brief description of: (a) the type of abuse that occurred (for example, verbal, neglect, physical or sexual); (b) information regarding the abuse perpetrator (for example, state hospital employee, family member, etc.); (c) the process of investigation; and (d) the action that was taken, including corrective action regarding state employees.

It should go without saying that the Department's report of all of the above data should protect the privacy of hospital patients and comply with the laws regarding state employee records while providing accurate and detailed information about the events that occurred.

The Department's report should be submitted to Stephen Schneider, my Senior Advisor. I have asked Mr. Schneider to review and evaluate the information in the report - in consultation with a select group of experts in public safety, abuse and neglect reporting and investigation, and mental health service delivery and administration - to determine whether the policies and procedures currently in place at the State Hospital are

effective. I have also asked Mr. Schneider to submit a report to me by December 3, 2004, detailing his conclusions. Mr. Schneider's report will also include any recommendations about how to strengthen the current patient abuse and neglect protocols to assure that the state is doing all it can to prevent abuse from happening in the first place, and to respond appropriately and effectively when abuse occurs. If we find that change is needed, I intend to ensure that it is implemented quickly and thoroughly.

As I know you are aware, my commitment to this issue could not be more clear. Since taking office in January, 2003, I have established several advisory groups including a Mental Health Task Force, an Elder Abuse Task Force, and a Child Welfare Critical Incident Response Workgroup, to review and analyze the systems we have in place to identify, respond and treat the health and safety needs of our most vulnerable citizens. I expect within the next 45 days to receive recommendations from each of those groups about how to improve services and supports for individuals with mental illness, seniors, and children in state custody.

I know that you share my commitment to the health and safety of Oregonians and to strengthening the accountability of state government. I look forward to hearing back from you in the next 30 days so we can continue to move forward in making Oregon safe and secure for our citizens.

Sincerely,



THEODORE R. KULONGOSKI
Governor

TRK:ejb

c: Karen Minnis, Speaker of the Oregon House of Representatives
Peter Courtney, Oregon Senate President
Barry Kast, Assistant Director, DHS Health Services
Bob Nikkel, Administrator, Office of Mental Health and Addiction Services
Dr. Marvin Fickle, State Hospital Superintendent