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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky

Healthcare Inspection | **25-00734-134** | **June 9, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on December 10, 2024, to assess clinical and administrative concerns at the Robley Rex VA Medical Center (facility) in Louisville, Kentucky, involving a patient who died by suicide on the grounds of the Carrollton VA Clinic (clinic). The OIG conducted a site visit February 10–13, 2025, and conducted virtual interviews through June 9, 2025. In August 2025, publication of this hotline inspection report was paused to allow the US Attorney's Office (USAO) to evaluate whether one of the findings identified during this inspection warranted criminal prosecution. In January 2026, the USAO announced its decision to decline prosecution, and in April 2026, the OIG received updated memorandums from the Veterans Health Administration (VHA).

The individuals who served as Facility Director and Chief of Staff, referenced herein, were no longer in those leadership roles as of October 30, 2025; however, they remain employed by VHA.

The OIG determined that a social worker missed opportunities to manage the patient's suicide risk. The social worker assessed the patient as intermediate acute risk for suicide during a Comprehensive Suicide Risk Evaluation but did not consider all treatable factors when determining whether to hospitalize the patient. The evaluation process directs providers to utilize a "*Therapeutic Risk Management – Risk Stratification Table.*" According to the risk stratification table, when patients are assessed as intermediate acute risk for suicide, providers are to "consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment."[1]

The OIG reviewed the patient's electronic health record (EHR) and found that consideration of inpatient hospitalization to treat the patient's symptoms of severe anxiety and depression, which are risk factors that can be treated on a psychiatric inpatient unit, was not included in the social worker's documentation. Hospitalization could have provided an opportunity for evaluation and treatment of symptoms driving the patient's risk for suicide due to availability of initial and ongoing medical evaluation, and frequent psychiatric assessment and management in a therapeutic environment.

The social worker did not ensure that the patient had immediate access to safety plan content despite documenting that the patient received a copy of the plan. The *VA Safety Planning*

[1] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. This memorandum was updated and reissued. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum. The memorandums contain similar language related to completion of the CSRE; "Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet," Risk ID.

Intervention Manual recommends that when safety planning with a patient over the phone, the provider and patient take detailed notes of the information and resources within the plan.[2] While providers may give the patient a copy of the safety plan at an upcoming appointment, providers "should still ensure that the [patient] has a copy of the safety plan that can be referenced/used immediately … [the patient] can only use the safety plan if they are able to access it."[3] The OIG found the social worker did not ensure that the patient had immediate access to a safety plan and falsely documented that the patient received a copy of the plan.

The OIG identified that a facility-implemented process for documenting Primary Care-Mental Health Integration baseline assessments in the EHR uses the practice of reauthoring, which results in notes appearing to be authored by providers who did not perform the documented actions or create the original note. The OIG reviewed the patient's baseline assessment note that appeared to be authored by the psychologist but learned through interviews that the psychologist did not complete the baseline assessment or have contact with the patient the day of the assessment; rather, a behavioral health technician independently completed the assessment.

The OIG also determined that leaders completed a root cause analysis (RCA) that was not credible. VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, defines an RCA as "a comprehensive team-based, systems-level investigation with a formal charter for review" of sentinel events, which are patient safety events that result in death, permanent harm, or severe temporary harm.[4] VHA National Center for Patient Safety emphasizes the importance of RCAs being credible, thorough, and representative of an accurate understanding of the event to allow for "rapid assessment of potential and actual causes of patient harm" with a goal of eliminating or correcting the root cause or contributing factors to "prevent the problem from reoccurring."[5] VHA outlines specific steps for an RCA team to produce a credible RCA report. Further, facility directors are responsible for ensuring RCAs are completed within 45 calendar days from the day facility leaders are aware that an RCA is needed.[6]

[2] VA, VA Safety Planning Intervention Manual, updated February 23, 2022.

[3] VA, *VA Safety Planning Intervention Manual*.

[4] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[5] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 15, July 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 16, September 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 17, October 2024. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 22, March 2025. The guidebooks contain the same or similar language regarding RCA processes unless otherwise noted. The OIG used version 16 as the primary source of reference due to the date the RCA was chartered.

[6] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*; VHA Directive 1050.01(1).

The OIG reviewed RCA documents and found that the

- Facility Director signed an RCA charter that contained inaccurate information,
- RCA team improperly executed RCA steps resulting in a limited examination of the patient event,
- RCA was not completed timely in accordance with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, and
- RCA action plan was not implemented by the target date.

The OIG determined that leaders did not ensure adequate training and oversight of the interim patient safety manager (PSM) in alignment with the National Center for Patient Safety orientation checklist.[7] These deficiencies contributed to the concerns identified with the RCA. The interim PSM told the OIG of lacking experience in RCA facilitation and being detailed to the PSM approximately one month prior to the patient event. The OIG reviewed the interim PSM's orientation checklist and found it remained incomplete approximately 11 months after being in the role. The chief of quality reported that not completing the checklist was an "oversight" and provided the OIG with an altered checklist that included back-dated entries for assessment of missing RCA training components. The chief of quality was unable to provide adequate support for the changes made to the checklist and the interim PSM reaffirmed having not received the training.

The OIG made one recommendation to the Under Secretary for Health to evaluate ways to mitigate the implications resulting from users' ability to change authors in an unsigned note to ensure that such practice is limited to those in roles with a need to have that function and take action as indicated. The Under Secretary for Health concurred with the recommendation and shared a plan to investigate ways to limit the practice of reauthoring notes.

The OIG made one recommendation to the Veterans Integrated Service Network Director to conduct a comprehensive review of the care provided to the patient prior to the event and take action as indicated. The Veterans Integrated Service Network Director concurred with the recommendation and outlined a plan to perform a review of the patient's care.

The OIG made six recommendations to the Facility Director related to the provision of safety plan content to patients, correcting inconsistencies in Primary Care-Mental Health Integration guidance documents, accuracy of EHR documentation, RCA processes and completion, PSM training, and understanding the implications of altering documentation without support. The Facility Director concurred with five recommendations and concurred in principle with one. The Facility Director committed to developing a process to provide the content of safety plans to

[7] VHA National Center for Patient Safety, *Patient Safety Manager (PSM) Orientation Checklist*, version 8, June 2024.

patients; reviewing guidance documents for consistency; discontinuing the note reauthoring process; ensuring root cause analyses comply with VHA guidelines; ensuring that patient safety managers receive required oversight, training, and support; and conducting a fact-finding regarding unsupported documentation changes.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Acting Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with recommendations 1, 3–8, and concurred in principle with recommendation 2. Acceptable action plans were provided (see appendixes A, B, and C). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Contents

Abbreviations

CSRE	Comprehensive Suicide Risk Evaluation
C-SSRS	Columbia-Suicide Severity Rating Scale
EHR	electronic health record
OIG	Office of Inspector General
PC-MHI	Primary Care-Mental Health Integration
PSM	patient safety manager
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on December 10, 2024, and conducted an on-site visit February 10 through 13, 2025, and virtual interviews through June 9, 2025, to assess clinical and administrative concerns at the Robley Rex VA Medical Center (facility) in Louisville, Kentucky, involving a patient who died by suicide on the grounds of the Carrollton VA Clinic (clinic).

In August 2025, publication of this hotline inspection report was paused to allow the US Attorney's Office (USAO) to evaluate whether elements of the inspection warranted criminal prosecution. In January 2026, the USAO announced its decision to decline prosecution and the OIG proceeded toward publication. The individuals who served as Facility Director and Chief of Staff, referenced herein, were no longer in those leadership roles as of October 30, 2025; however, they remain employed by the Veterans Health Administration (VHA).

Background

Part of Veterans Integrated Service Network (VISN) 9, the facility operates eight community-based outpatient clinics located in Carrollton, Clarkson, Fort Knox, and Louisville, Kentucky; and New Albany and Scottsburg, Indiana. VHA classifies the facility as a level 1b complexity.[1] The facility provides comprehensive services such as primary care, general medicine, surgery, and outpatient and inpatient mental health care. The clinic provides primary and mental health care, as well as other services.

Suicide Screening and Evaluation

Suicide prevention is the VA's top clinical priority.[2] According to the 2024 National Veteran Suicide Prevention Annual Report in 2022, an estimated 18 veterans died by suicide per day.[3] VHA requires a standardized suicide risk screening and assessment process to ensure "that the entire healthcare system is readily equipped to identify veterans at risk for suicide, regardless of where they are receiving care, so they can be connected to life-saving resources and interventions." As part of the standardized screening and assessment process, VHA requires the

[1] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Data Definitions VHA Facility Complexity Model." The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2 or 3, with level 1a being the most complex and level 3 being the least complex.

[2] "FY24-25 Priority Goal, Department of Veterans Affairs, Prevent Veteran Suicide," General Services Administration, accessed June 25, 2025, https://bidenadministration.archives.performance.gov/agencies/va/apg/fy-24-25/goal-6/.

[3] VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report Part 2 of 2: Report Findings,* December 2024.

use of the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Comprehensive Suicide Risk Evaluation (CSRE) tools.[4]

The C-SSRS is a protocol used to assess an individual's risk for suicide as well as determine the severity of the risk and evaluate the level of support an individual may need. The C-SSRS uses "simple, plain-language questions that anyone can ask" about a patient's past preparatory or suicidal behavior, current intent, and thoughts of a method and plan.[5] A negative screening completes the process; a positive screening requires same-day completion of the CSRE. The CSRE must be completed by a licensed independent provider or advanced practice provider, and includes detailed questions about the patient's suicidal ideation, plan, intent, and behaviors; risk and protective factors; and requires the provider to document the patient's overall level of suicide risk.[6]

OIG Concerns

In October 2024, an OIG team conducting a routine healthcare inspection at the facility learned of concerns related to a patient who died by suicide outside, on the grounds of the clinic. As a result, the OIG opened the hotline inspection in December 2024 to review the clinical care provided to the patient and to evaluate the root cause analysis (RCA) completed by facility leaders in response to the patient event.

During the inspection, the OIG identified additional concerns related to a facility-implemented process of reauthoring Primary Care-Mental Health Integration (PC-MHI) assessment notes in

[4] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network Director (10N1-23) et al., November 23, 2022. This memorandum was updated and reissued, Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network Director (10N1-23) et al., January 7, 2025, the memorandums contain similar language related to completion of the C-SSRS. "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Staff Specific Guidance," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint, accessed December 12, 2024.

[5] "About the Protocol," The Columbia Lighthouse Project, accessed March 31, 2025, https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

[6] VA, "Risk ID," Suicide Risk Identification, dated July 6, 2023; Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Staff Specific Guidance," Veterans Affairs Suicide Risk Identification and Management (Risk ID) SharePoint, accessed December 12, 2024, https://dvagov.sharepoint.com/sites/ECH/srsa/Shared%20Documents/Forms/AllItems.aspx. (This website is not publicly accessible.); "Risk ID," Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet, dated April 27, 2023; VHA, *Suicide Prevention Clinician's Guide*, June 2021.

the electronic health record (EHR), and the facility patient safety manager's (PSM's) role in RCAs.[7]

Scope and Methodology

The OIG conducted interviews during a site visit February 10–13, 2025, followed by virtual interviews through June 9, 2025. The OIG interviewed facility executive leaders; leaders and staff from Quality Management, the Suicide Prevention Program, and PC-MHI; and other leaders and staff with knowledge of the care provided to the patient.[8] The OIG also interviewed a VHA Health Information Management staff member.

The OIG reviewed applicable VHA directives and guidelines as well as facility policies and procedures related to documentation requirements. Further, the OIG reviewed the patient's EHR, and documents associated with quality reviews conducted in response to the patient event.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[9] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspections inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[10]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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[7] PC-MHI is a mental health service co-located in primary care that provides collaborative care and care management for mental health diagnoses. "Primary Care – Mental Health Integration (PC-MHI)," VA, accessed April 2, 2025, https://www.patientcare.va.gov/primarycare/PCMHI.asp.

[8] Facility executive leaders include the facility director, chief of staff, and the associate director of operations.

[9] Council of the Inspectors General on Integrity and Efficiency, Quality Standards for Inspection and Evaluation, December 2020.

[10] Executive Office of the President, Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," Memorandum for the Heads of Executive Departments and Agencies, M-21-21: § 4(a), April 3, 2025.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient, who was in their late 30s and had a history of bipolar disorder and traumatic brain injury, presented to the clinic in the summer of 2024 requesting to reengage in mental health care.[11] Later that day, a PC-MHI psychologist (psychologist) spoke with the patient by phone and documented that the patient reported depressed mood, "vague" suicidal ideation with no plan or intent of self-harm, a significant psychosocial stressor, and expressed a desire for therapy and medication management. The psychologist documented a plan to refer the patient for a "baseline assessment," and scheduled an initial assessment. Facility staff scheduled an appointment between the patient and the psychologist for two days later.[12]

The following day, a behavioral health technician (BHT) called the patient by phone and completed a baseline assessment that resulted in scores consistent with severe depressive symptoms, severe anxiety symptoms and insomnia of moderate severity, and a positive C-SSRS screen. The BHT transferred the call to a PC-MHI social worker (social worker) for completion of a CSRE. The social worker documented that the patient reported suicidal ideations, had access to firearms, and a plan to "shoot myself," and that the patient's intent was "unknown or unclear." Further, the social worker documented a number of patient-reported protective factors and reasons for living. Ultimately, the social worker assessed the patient as intermediate acute and low chronic risk for suicide. Prior to the end of the assessment, the social worker completed a safety plan with the patient that included management of firearm access and placing the safety plan by the patient's gun safe.

[11] The OIG uses the singular form of they, "their" in this instance, for privacy purposes; Bipolar disorder is a mood disorder characterized by changes in mood that include emotional highs known as mania or hypomania, and depressive episodes. Mayo Clinic, "Mood disorders," accessed April 2, 2025, https://www.mayoclinic.org/diseases-conditions/mood-disorders/symptoms-causes/syc-20365057; Traumatic brain injury is a condition that "usually results from a violent blow or jolt to the head or body," and can have a wide range of physical and psychological effects. Mayo Clinic, "Traumatic brain injury," accessed April 2, 2025, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

[12] A "baseline assessment," or baseline interview, is conducted by telephone and involves the completion of screens for a number of psychiatric disorders including depression.

The following day, the patient died by suicide from a firearm-related injury while parked at the clinic, prior to the scheduled appointment with the psychologist.

Inspection Results

1. Quality of Care

The OIG determined that the social worker missed opportunities to manage the patient's risk for suicide. Specifically, the social worker did not consider all treatable factors driving the intermediate acute risk assessment when determining whether to hospitalize the patient. Additionally, the social worker did not ensure that the patient had immediate access to a safety plan and falsely documented that the patient received a copy of the plan.

Consideration of Inpatient Hospitalization

When completing the CSRE, a VHA requirement, providers are directed to utilize a "*Therapeutic Risk Management – Risk Stratification Table*" that lists actions to be considered for each level of acute risk to help inform clinical decision-making.[13] According to the risk stratification table, when patients are assessed to be at intermediate acute risk for suicide, the first listed action is for providers to, "consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment."[14] For example, depression and anxiety are risk factors that can be treated on a psychiatric inpatient unit where services include therapy and medication management.

The OIG reviewed the patient's EHR and noted that consideration of inpatient hospitalization to treat the patient's symptoms of severe anxiety and depression was not included in the social worker's documentation. When asked why the patient's suicidal intent was documented as "unknown or unclear" in an OIG interview, the social worker clarified that while the patient was experiencing several life changes and stressors, the patient did not express an intent to complete suicide, was "able to identify reasons for living … agreeable to a safety plan … [and had] plans for the future." The social worker reported feeling assured that the patient could maintain safety after completing the CSRE and safety plan with the patient over the telephone. The social worker also recalled contacting the psychologist after the telephone visit, and explaining that the patient "sounded really sad," was interested in medication management, and was "not suicidal

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum. This memorandum was updated and reissued. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum. The memorandums contain similar language related to completion of the CSRE; "Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet," Risk ID.

[14] Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet," Risk ID.

currently." When asked if any of the information elicited from the assessment indicated that hospitalization was warranted, the social worker stated "no" because the patient was not "actively suicidal" or "in danger." When asked if the patient's ratings for severe depression and anxiety were considered when determining a disposition for the patient, the social worker stated, "no," explaining that the patient's thoughts of suicide were the focus of their telephone visit.

The OIG asked facility leaders, who reviewed the patient event, about the care:

- The Chief of Staff reported that an acceptable level of care was provided.
- The chief of mental health and section chief of PC-MHI stated that protocol was followed.
- The Suicide Prevention Program manager denied having concerns with the care the patient received.[15]

The OIG opined that the leaders' reviews of the patient event should have identified that the patient's contributing risk factors may have been responsive to inpatient treatment, and therefore, as outlined in the risk stratification table, hospitalization for these risk factors should have been considered.

The social worker did not recognize the indications to offer the patient immediate treatment with hospitalization for severe depressive and anxiety symptoms and significant psychosocial stress.[16] Hospitalization could have provided an opportunity for the health care team to evaluate and treat symptoms driving the patient's risk for suicide due to availability of initial and ongoing medical evaluation and frequent psychiatric assessment and management in a therapeutic environment. However, the OIG was unable to determine whether considering inpatient hospitalization would have changed the patient's outcome.

Access to Safety Plan

VHA Directive 1160.07, *Suicide Prevention Program*, recommends that providers collaboratively create a safety plan with patients who are determined to be at "high or intermediate acute or chronic risk" of suicide and requires documenting the plan in the EHR.[17]

[15] The facility also conducted a peer review on the social worker. Peer reviews are a quality review of care rendered by a peer. The review is to determine if clinical decision-making and management of the patient by the provider met the standard of care. Peer reviews are confidential quality management documents and as such, the peer review is not further addressed in this report. VHA Directive 1190(1), *Peer Review for Quality Management,* November 21, 2018, amended July 19, 2024.

[16] "Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet," Risk ID.

[17] VHA Directive 1160.07, *Suicide Prevention Program,* May 24, 2021. "Suicide Prevention Safety Plan Template FAQ," VHA Office of Mental Health, updated May 24, 2019, https://dvagov.sharepoint.com/sites/VACOMentalHealth/Safety%20Planning%20%20SBR/Forms/AllItems.aspx. (This site is not publicly accessible.)

The *VA Safety Planning Intervention Manual* states, "the Safety Plan serves as an emergency plan to use during crisis when problem-solving abilities often diminish." The plan has six essential steps including "lethal means counseling for making the environment safer."[18] The manual also recommends that when safety planning with a patient over the phone, the provider and patient take detailed notes of the information and resources within the plan. While providers may provide a copy of the safety plan at an upcoming appointment, providers "should still ensure that the [patient] has a copy of the safety plan that can be referenced/used immediately … [the patient] can only use the safety plan if they are able to access it."[19] Additionally, the VHA Health Information Management, *Health Record Documentation Program Guide* (VHA HIM Guide) requires that documentation entered into the EHR is thorough and correct.[20]

The OIG reviewed the patient's EHR and found that upon completion of the CSRE, the social worker and the patient continued the telephone visit to develop a safety plan. The OIG found no evidence in the EHR that the social worker asked the patient to take notes during the development of the safety plan. Rather, the social worker documented that the patient received a copy of the safety plan and discussed placing the safety plan next to the gun safe as a strategy to make the environment safer. When the OIG asked how the patient received a copy of the safety plan, the social worker stated the safety plan was sent to the psychologist to review and print for the patient at the appointment scheduled for the following day. However, the patient died prior to presenting for the scheduled appointment with the psychologist.

When asked why the EHR reflected that the patient received a copy of the safety plan, the social worker described the safety plan note as a template with only "yes" or "no" options for "I have received a copy" of the plan. Thus, the social worker explained selecting "yes," in anticipation of the patient receiving a copy of the safety plan from the psychologist the following day. During an OIG interview, the Chief of Staff reported that if the patient did not receive a copy of the safety plan during the encounter, documentation in the chart should not reflect that the patient received the plan, confirming that providers can document additional information within the template, as needed. Furthermore, the OIG confirmed that the social worker did not document asking the patient to take notes during the encounter, as recommended by VHA, when developing safety plans over the phone.

The OIG concluded that, more likely than not, the patient did not have access to the content of the safety plan for immediate use prior to death. The OIG would have expected the social worker

[18] VA, *VA Safety Planning Intervention Manual*, updated February 23, 2022. The manual identifies the five remaining steps when safety planning: (1) recognize warning signs, (2) identify internal means of coping, (3) identify social support to divert attention away from suicidal crisis, (4) identify family members who can offer support, and (5) identify mental health providers and crisis care services.

[19] VA, *VA Safety Planning Intervention Manual*.

[20] VHA HIM, *Health Record Documentation Program Guide,* version 1.3, February 13, 2025.

to ensure the patient had immediate access to the safety plan content after concluding the telephone visit and to accurately document the patient's receipt of the plan. Not ensuring the immediate availability of the safety plan content may place a patient at risk for not having access to the resource when in crisis as recall may be compromised by their psychological state. However, the OIG was unable to determine whether ensuring that the patient had immediate access to the safety plan would have changed the outcome for this patient.

Reauthoring Notes

While reviewing the mental health care provided to the patient, the OIG identified an additional concern related to the facility-implemented process for documenting PC-MHI baseline assessments in EHRs, which results in notes appearing to be authored by providers who did not perform the documented actions or create the original note. Clinical, ethical, and legal concerns can arise when a note is written, "in a manner that implies the author … obtained historical information [or] performed an exam … when the author … did not personally collect the information."[21] Additionally, the VHA HIM Guide requires that documentation in the EHR be "accurate … and readily-accessible to serve as a basis to plan patient care."[22]

The OIG reviewed the facility PC-MHI Program Operations Manual and learned that when a patient accesses PC-MHI services, a Behavioral Health Specialist refers the patient to the PC-MHI call center. The Behavioral Health Specialist, who must be, at a minimum, a licensed clinical social worker or psychologist, is described as the "gateway" to access PC-MHI services. Upon completion of the baseline assessment interview, the Behavioral Health Specialist is to enroll the patient into one of the spectrum of services available through PC-MHI such as "PCMHI [Care Management] phone monitors, Brief Therapy, and/or Medication Management for treatment or Referral Management to specialty [Mental Health] services." The patient is contacted by a BHT for completion of the baseline assessment.[23] The BHT completes the baseline assessment over the phone utilizing Behavioral Health Lab software.[24] The facility PC-MHI Program Operations Manual instructs the BHT to add the Behavioral Health Specialist as

[21] Health Information Management, Health Information Governance, Office of Health Informatics, *HIM Practice Brief Monitoring Copy and Paste*, March 2023.

[22] VHA HIM, *Health Record Documentation Program Guide*.

[23] Robley Rex VAMC, Louisville, KY, *Primary Care-Mental Health Integration Program Operations Manual*, July 2020. The OIG found several instances within the document in which the manual was referred to as a Standard Operating Procedure. VHA requires that local Standard Operating Procedures utilize a standardized VHA template. The OIG found that the template was not used, and the manual did not include required elements of the template, such as (1) responsible owner, (2) effective date, (3) recertification date, and (4) purpose and authority. VHA Directive 0999(1), *VHA Policy Management,* March 29, 2022, amended January 10, 2024.

[24] Behavioral Health Lab (BHL) is software that aids in completing "structured assessments." BHL software provides clinicians the ability to have patients complete assessments that are digitally collected, "reliably scored, and efficiently uploaded to the patient [EHR]." VHA, Office of Mental Health and Suicide Prevention, *Privacy Impact Assessment for the VA IT System Called: Behavioral Health Lab (BHL)*, eMASS #12, December 13, 2024.

an "additional signer" to the completed baseline assessment note.[25] The VHA HIM Guide states that being identified as an additional signer is not equivalent to being identified as a co-signer and does not imply responsibility for the content of the note.[26] The OIG also reviewed the facility BHT Operations Manual and found conflicting guidance that instructs the BHT to change the author of the baseline assessment note to the Behavioral Health Specialist.[27] Consequently, other providers cannot immediately view the note until signed by the Behavioral Health Specialist.[28]

The OIG reviewed the patient's baseline assessment note that appeared to be authored by the psychologist. During an interview, the OIG learned that the psychologist did not complete the baseline assessment or have contact with the patient the day the assessment was completed; rather, the assessment was completed independently by the BHT.

The BHT's supervisor confirmed that BHTs conduct baseline assessment interviews, enter notes into EHRs, and "reauthor" the notes to the referring provider. The supervisor provided the rationale that, "[The BHT is] an extension of the clinician, completing the interview with the [patient] and then turning that interview over for the clinician to then use it as part of the episode of care." However, the supervisor acknowledged that the patient interview follow-up is not always immediate, and the patient may not be contacted until "two or three days later." The chief of mental health reported awareness of the reauthoring practice and explained that it prompts the ordering provider to review the note. The chief of mental health added that, prior to becoming the service chief, the process was already implemented and that the reason for implementation was unclear. The chief of mental health was also not aware of the reauthoring practice taking place anywhere outside of the PC-MHI call center. The Chief of Staff told the OIG of being unfamiliar with the PC-MHI call center practice of reauthoring notes. In OIG interviews, the Chief of Staff and chief of mental health found the reauthoring process concerning and reported a need for further investigation.

During an OIG interview, a VHA Health Information Management staff member reported having no familiarity with the practice of reauthoring notes for this purpose and explained that the author reassignment function allows health information management staff to correct errors in the

[25] Robley Rex VAMC, Louisville, KY, "Primary Care-Mental Health Integration Program Operations Manual." The additional signer function of the EHR is "a communication tool used to alert a clinician about information pertaining to the patient." It is designed to "allow providers to call attention to specific documents and for the recipient to acknowledge receipt of the information."

[26] VHA HIM, *Health Record Documentation Program Guide*.

[27] *Behavioral Health Tech (BHT) Operations Manual PCMHI*, February 7, 2023.

[28] VHA HIM, *Health Record Documentation Program Guide.* The guide recommends that because unsigned notes are incomplete documents, allowing for editing and deletion of information that can impact treatment decisions, unsigned notes should not be viewed. Special permissions to review unsigned notes can be granted by "the appropriate medical staff committee."

chart.[29] The VHA Health Information Management staff member further stated that the BHT should instead sign the note and alert the referring provider that the note is available for review, and reported that there are numerous ways to do this, including making the provider an additional signer to the note. The VHA Health Information Management staff member identified multiple concerns with the practice of reauthoring:

- If there was information that was misunderstood or entered in error, the referring provider would have no awareness due to not being present at the time the information was collected.
- By signing the note, the referring provider is held accountable for the contents of the note although the provider was not involved in completion of the baseline assessment.
- The signature of the referring provider is a misrepresentation of who conducted the assessment.
- The EHR is a legal health record. Information contained in the record should accurately reflect what service was provided to the patient and who provided the service "[reauthoring] goes against those principles."

The facility BHT Operations Manual instructs the BHT to include the following statement in reauthored notes: "This information was collected by [name of BHT] …, using the BHL [Behavioral Health Lab] software, as part of the PCMHI initial contact." However, the VHA Health Information Management staff member told the OIG that, although the disclaimer is added, the concerns are still applicable.[30]

The VHA Health Information Management staff member shared that although the ability to change the author of an unsigned note is a functional feature in the EHR that requires no special permission, the practice should be limited primarily to those in the health information management role.[31]

Additionally, the OIG found that the baseline assessment note is not immediately accessible to other providers until the new author signs the note. The VHA Health Information Management staff member explained that unsigned notes do not appear for other users in the specific patient's

[29] The Health Information Management Program Office oversees development of VHA health record policy and provides national guidance and resources regarding EHR documentation. "Our Mission," VHA Health Information Management, accessed July 2, 2025, https://dvagov.sharepoint.com/sites/vhahealth-information-management/SitePages/Health-Information-Management-Home-Page.aspx. (This is not publicly accessible.)

[30] "Behavioral Health Tech (BHT) Operations Manual PCMHI," February 7, 2023.

[31] The facility uses an EHR record application called a Computerized Patient Record System in which clinical staff enter orders and documentation, perform reviews, and continuously update patient information. Office of Information and Technology (OIT), Software Product Management Office (SPM), Health Systems Portfolio (HSP), VistA, Education, Research, Data, and Informatics (VERDI), VistA Office (VO), *VistA Monograph*, July 18, 2023, https://www.va.gov/vdl/documents/Monograph/Monograph/vista_monograph_0723_r.pdf.

EHR. There are, however, steps that can be taken for a user to search and view unsigned notes within the specified patient's EHR.

The social worker confirmed an inability to view the baseline assessment in the EHR and reported having to log into Behavioral Health Lab software to review patient data. The social worker explained that the PC-MHI call center utilizes an instant message chat designated for communication between BHTs and providers. The social worker told the OIG that if a patient has a positive C-SSRS screening, the BHT alerts the providers who are on standby in the chat that the patient needs additional evaluation.

The OIG concluded that facility manuals provide conflicting guidance regarding notes completed by BHTs in the call center and that the facility-implemented process of reauthoring notes resulted in the patient's EHR reflecting inaccurate information. The OIG is concerned that the facility-implemented process of reauthoring notes could be occurring in other areas of the facility. Additionally, reauthoring affects providers' ability to immediately access results of the assessment interview to inform clinical decision-making and planning. The process of utilizing instant messaging to convey information from the baseline assessment may lead to miscommunication and introduce the possibility of human error.

2. Root Cause Analysis

The OIG determined that leaders completed an RCA that was not credible. The OIG found deficiencies with the RCA process related to oversight and implementation of the RCA. Specifically, the

- Facility Director signed an RCA charter that contained inaccurate information;
- RCA team improperly executed RCA steps, which resulted in a limited examination of the patient event;
- RCA was not completed timely in accordance with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*; and
- RCA action plan was not implemented by the target date.[32]

Additionally, the OIG determined that leaders did not ensure adequate training and oversight of the interim PSM, which contributed to the concerns identified with the RCA.

VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, defines an RCA as "a comprehensive team-based, systems-level investigation with a formal charter for review" of sentinel events, which are "any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, permanent harm or severe

[32] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

temporary harm."[33] The VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis* (VHA NCPS RCA Guide), emphasizes the importance of RCAs being credible, thorough, and representative of an accurate understanding of the event.[34] The completion of an RCA allows for "rapid assessment of potential and actual causes of patient harm" with a goal of eliminating or correcting the root cause or contributing factors to "prevent the problem from reoccurring."[35]

RCA Charter

The VHA NCPS RCA Guide requires the facility directors to sign a formal charter for all RCAs.[36] The purpose of the charter is to "guide the team in managing the scope of the project and making changes that are ultimately linked to the root causes identified in the RCA process."[37] Once the need for an RCA is determined, the PSM prepares the charter for facility director's review and signature.[38] Suggested charter elements are outlined in an RCA charter template that is provided by the National Center for Patient Safety.[39] These elements include relevant dates and disciplines directly involved in the event, as the knowledge of those involved must be incorporated into the RCA process.[40]

The OIG found that the RCA charter for the patient event included inaccurate information related to the date facility leaders learned of the event, as well as the disciplines involved. Facility leaders, including members of the Executive Leadership Team, told the OIG they were notified of the event the day the event occurred. This timing contradicted what was reflected in the

[33] VHA Directive 1050.01(1).

[34] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 16. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 15, July 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 16, September 2024; VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 17, October 2024. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, version 22, March 2025. The guidebooks contain the same or similar language regarding RCA processes unless otherwise noted. The OIG used version 16 as the primary source of reference due to the date the RCA was chartered.

[35] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[36] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[37] Centers for Medicare & Medicaid Services, "Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)," accessed April 3, 2025, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/GuidanceforRCA.pdf.

[38] VHA Directive 1050.01(1).

[39] "RCA Team Charter Memorandum Template," VHA National Center for Patient Safety, August 2024, retrieved from https://dvagov.sharepoint.com/sites/vhancps/SitePages/Root-Cause-Analysis-Resources.aspx?source=https%3a//dvagov.sharepoint.com/sites/vhancps/SitePages/Forms/ByAuthor.aspx. (This site is not publicly accessible.)

[40] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*; "RCA Team Charter Memorandum Template," VHA National Center for Patient Safety,

charter. In an interview, the interim PSM stated a possible reason for this discrepancy was having inadvertently placed the date when the patient safety report was reviewed.

The charter also reflected disciplines that were not involved in the event, and those that were involved were not included. The interim PSM told the OIG that the inaccurate disciplines were an administrative error, which was overlooked when the interim PSM prepared the document.

Errors remained on the charter at the time the Facility Director signed the document. When asked about the inaccuracies, the Facility Director told the OIG, "I must have missed that when I signed."

The OIG concluded that the interim PSM prepared the RCA charter with inaccurate information and the Facility Director signed the document without adequate review. The OIG is concerned that the errors in the charter affected the credibility of the RCA, which inherently relies on accuracy.

RCA Team Training

VHA Directive 1050.01(1) states the PSM is responsible for facilitating training of the RCA team.[41] The OIG found the interim PSM did not ensure that all training components were provided to the team.

VHA recommends that "Just in Time" training is provided at the initial meeting of every RCA. This training should provide an overview of the RCA process and include information regarding (1) confidentiality, (2) timelines, (3) roles and responsibilities, (4) brief details of the event, and (5) milestones.[42]

The OIG learned that the interim PSM provided a facility-developed "Just in Time" training presentation to the team at the initial meeting. The interim PSM stated the training presentation was provided by a previous PSM. The OIG reviewed the presentation and found that training elements recommended in the VHA NCPS RCA Guide were missing or incomplete, including (1) the timeline of the RCA, (2) identification of team member roles (specifically, team leader and recorder), and (3) RCA milestones and pre-scheduled meeting dates and times.[43]

The OIG found that "Just in Time" training provided to the RCA team lacked recommended components. The OIG opined that insufficient RCA team training affected the credibility of the RCA.

[41] VHA Directive 1050.01(1).

[42] "Milestones" include key phases of the RCA process (e.g. diagramming, root cause/contributing factor statement development, action planning, etc.) as well as RCA team meetings scheduled in advance to ensure participants can attend. VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[43] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

RCA Process

VHA outlines specific steps an RCA team should follow to increase understanding of a patient event; proper execution of the RCA steps is vital to produce a credible RCA report. While drafting the initial understanding of the patient event, the RCA team identifies knowledge gaps through consistent use of triage questions.[44] Per the VHA NCPS RCA Guide, "all triage questions should be addressed by the RCA team …" as a guide to collect and analyze information to determine a root cause of the patient event. Additionally, for an RCA to be credible, it must "not contradict itself or leave obvious questions unanswered."[45]

VHA Directive 1050.01(1) states facility directors are responsible for ensuring RCAs are completed within 45 calendar days from the day facility leaders are aware that an RCA is needed.[46] The Facility Director's signature on the RCA concurrence sheet signifies RCA completion.[47]

The OIG found the RCA team improperly executed the RCA steps, which resulted in a limited review of the patient event.

- The interim PSM reported to the OIG that the RCA team did not apply triage questions while completing the RCA.
- The root cause statement was vague and did not identify system vulnerabilities.
- The RCA contained contradictory and inaccurate information when compared to the patient's EHR.[48]
- The RCA was not completed timely, as the Facility Director signed the RCA 61 calendar days after becoming aware an RCA was needed.[49]

When asked, the interim PSM reported that the improperly executed steps occurred due to a lack of training and experience in completing RCAs, and due to being overworked. The OIG will discuss these concerns further in the "Lack of PSM Training and Oversight" and "Facility PSM

[44] "The initial understanding is a written narrative of the event progressing chronologically from the first known relevant fact through the final known relevant fact." VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[45] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[46] VHA Directive 1050.01(1).

[47] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[48] RCAs are confidential quality management documents and as such, the specific details included in the RCA are not further addressed in this report. VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents,* July 10, 2020.

[49] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

Roles in RCAs" sections of the report. The Facility Director reported difficulties with getting RCAs completed timely due to a backlog of RCAs from the previous PSM, who retired.

The OIG concluded that had the RCA team properly executed RCA steps, the team likely could have identified the system vulnerabilities previously discussed in this report that were related to the patient event.[50]

Action Plan Implementation

RCA action plans are critical to the RCA process and implemented to address identified vulnerabilities and to prevent the recurrence of a patient event. The VHA NCPS RCA Guide states the RCA team must assign each action within the plan to someone who has the responsibility and authority to implement the action by the designated time frame.[51]

The OIG found the RCA action plan was not completed by the target date. The interim PSM reported that when the RCA team develops an RCA action plan, they also identify and notify the process owner of each action.[52] The interim PSM further stated, after the Facility Director concurs with an RCA, the process owner is responsible for completion and closure of their action.

The interim PSM reported that the process owner for the delayed action had not taken steps to complete the action and as a result, the interim PSM initiated steps to complete the action approximately one month after the target date. The interim PSM further explained, with regard to the outstanding action, "[it] feels like you're the one trying to crank all the work [out] and no one else is really budging."

In an OIG interview, the process owner reported no awareness of the action plan. However, the OIG reviewed electronic correspondence in which the interim PSM did, in fact, notify the process owner of the request to complete the action initiated by the interim PSM. The interim PSM reported not receiving a response and that the status of the action remained incomplete as of February 2025.

The OIG found the RCA action plan was not complete by the target date. While the OIG acknowledges the interim PSM's attempt to close the action plan, delayed completion of RCA action plans may increase the potential for recurrence of sentinel events that can result in patient harm.

[50] System vulnerabilities previously identified in the report include lack of immediate patient access to a safety plan and the facility-implemented process for reauthoring notes.

[51] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

[52] The RCA action plan for the patient event consisted of only one action item assigned for follow-up.

PSM Training and Oversight

PSM completion of education provided by the National Center for Patient Safety is critical to fulfilling the responsibility of managing patient safety programs at the facility level. Training for PSMs is outlined in a standardized orientation checklist provided by the National Center for Patient Safety, which covers various patient safety topics, including RCAs. PSMs are required to complete the orientation checklist within six months of assuming the role. According to the checklist, PSMs are required to complete a formal RCA training course as well as review or observe a full RCA and participate in an RCA while on orientation.[53]

VHA Directive 1050.01(1) states the VISN Patient Safety Officer is responsible for providing "guidance as needed" to facility PSMs, promoting patient safety education and training, and conducting evaluations of the "structure, work and support systems" of each facility patient safety program "to determine if additional resources are needed." Facility directors are responsible for ensuring compliance with national quality and patient safety policies and ensuring chiefs of quality and PSM have "direct access to and participate in executive conversations" regarding quality and patient safety matters. The chief of quality is responsible for "implementing and monitoring quality management and performance improvement activities" and "supporting a culture that recognizes that quality management is the responsibility of all employees."[54]

The interim PSM told the OIG of lacking experience in RCA facilitation and being detailed to the PSM role in summer 2024, approximately one month prior to the patient event. The interim PSM reported receiving approximately six weeks of orientation before the previous PSM retired. When asked about expectations for PSM training, the VISN Patient Safety Officer told the OIG that the chief of quality at the facility is "responsible for ensuring the [PSM] is trained in the RCA process." When asked by the OIG, the interim PSM reported, though the required formal RCA training course had been completed, not having observed an entire RCA, and RCA participation was limited to "a few meetings" while being trained by the previous PSM.

The VISN Patient Safety Officer reported identifying "areas of opportunity" related to PSM training within the VISN and creating a tracker to validate progress and completion of required PSM training. The OIG confirmed the interim PSM's orientation checklist remained incomplete approximately 11 months after being in the role and that the VISN Patient Safety Officer noted on the tracker that the interim PSM was "aware [the training] is due."[55]

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[53] VHA National Center for Patient Safety, *Patient Safety Manager (PSM) Orientation Checklist 2024*.

[54] VHA Directive 1050.01(1).

[55] Multiple components of the interim PSM's orientation checklist were missing dates of assessment, assessor initials, and notation in the "Met/Not Met" portion including, but not limited to, the requirements to review or observe a full RCA and to participate in an RCA.

When asked why the interim PSM's orientation checklist had not been completed, the chief of quality reported that it was an "oversight" and provided the OIG with an altered checklist that included back-dated entries for assessment of the two missing RCA training components. The chief of quality provided additional supporting documentation that the OIG found was inadequate to support completion of the full RCA review or observation component and reported having "no proof" for the date added to the RCA participation component.

Moreover, when reinterviewed, the interim PSM reported having met with the chief of quality to review and update the incomplete checklist. However, the interim PSM reaffirmed having not received the two components of RCA training that had been altered on the orientation checklist.

The OIG also found that the chief of quality was not a reliable source regarding oversight of the RCA process due to inaccurate statements the chief of quality made to the OIG regarding the status and nature of quality activities completed after the patient event. For example, the chief of quality stated clinical and institutional disclosures related to the patient event had been completed and that the RCA action plan was closed. Some of the inaccurate statements made by the chief of quality were later corrected and clarified in correspondence with the OIG.

The integrity and thoroughness of information provided by facility leaders is required by law and is critical to the OIG's mission.[56] The OIG is concerned that the chief of quality, who altered and submitted a document that erroneously purported training had been completed, did not recognize the wrongdoing of such actions. The interim PSM also expressed concerns about a lack of support. The interim PSM explained that during the period around the patient event, "I was working like a hundred and ten hours a pay period and still having to conduct this RCA." While the interim PSM endorsed support from the chief of quality and an ability to contact the VISN Patient Safety Officer for guidance, the interim PSM reported limited or no "proactive communication from any executive leadership" and concern that PSMs did not meet frequently with executive leaders to voice concerns as expected. Additionally, the chief of quality reported that PSMs meet regularly with the VISN Patient Safety Officer. The Facility Director reported "work[ing] very closely" with the PSMs and described having a "good relationship."

The OIG concluded that the chief of quality provided insufficient oversight, training, and support to the interim PSM, which likely affected the interim PSM's ability to effectively facilitate the RCA process and contributed to the RCA deficiencies identified in this report. Moreover, the chief of quality submitted an altered document to the OIG regarding PSM training completion and was not a reliable source regarding the oversight of the RCA process.

[56] 38 C.F.R.§ 0.735-12 (2025).

Facility PSM Roles in RCAs

While reviewing the RCA process used at the facility, the OIG learned of a practice in which PSMs perform RCA team roles not consistent with VHA guidance. The VHA NCPS RCA Guide recommends RCA team roles include a team leader, advisor, and subject matter expert, and require a recorder.[57] Additionally, the VHA NCPS RCA Guide states the PSM may serve as the advisor to the RCA team to provide "expertise in the RCA process" and be "available as needed to assist the team," but "recommended that the PSM **not** be the leader of the RCA [emphasis in original text]."[58]

The OIG learned through interviews that the interim PSM has served as an RCA advisor while concurrently serving in another team role. The interim PSM told the OIG of ongoing challenges at the facility regarding holding RCA team members accountable to fulfill appointed roles. With regard to the PSM's role in completing RCAs, the interim PSM reported, "I feel like we do everything … if it wasn't for us [PSMs] pushing it along it would fall flat … nothing would happen with it." Moreover, the Facility Director reported that the previous PSM had a practice of taking the lead on the RCA as opposed to using a team approach. When asked about assignment of duties and responsibilities, the interim PSM told the OIG, "we can say you're this, you're that but … there's no expectation … the previous [PSM did] just about every single thing related to the facilitation of [RCAs]." The interim PSM further shared a recent discussion with the Facility Director who supported RCA team members taking ownership of the process.

The OIG opined that the practice of PSMs serving in another RCA team role, in addition to the recommended role of RCA advisor, may overtask PSMs and negatively affect the quality and timeliness of RCAs. The OIG is concerned that facility leaders do not effectively support a culture of RCA team member ownership of the RCA process. Overreliance on the PSM to function beyond their role as facilitator or advisor can negatively affect RCA quality and timeliness.

Conclusion

The social worker missed opportunities to manage the patient's risk for suicide. Specifically, the social worker assessed the patient as intermediate acute risk for suicide during the Comprehensive Suicide Risk Evaluation (CSRE) but did not consider all treatable factors when determining whether to hospitalize the patient. Additionally, the social worker did not ensure that the patient had immediate access to the contents of a safety plan, despite documenting in the EHR that the patient received a copy of the plan.

[57] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.
[58] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*.

The OIG learned of an additional concern related to the facility-implemented process for documenting PC-MHI baseline assessments in EHRs, which leads to notes appearing to be authored by providers who did not perform documented actions or create original notes. This practice can lead to issues, including clinical and ethical implications, and resulted in the patient's EHR containing inaccurate information.

Facility leaders completed an RCA that was not credible. The OIG identified deficiencies with the RCA process related to oversight and implementation of RCAs. Specifically, the Facility Director signed an RCA charter that contained inaccurate information; the RCA team improperly executed RCA steps, which resulted in a limited examination of the patient event; the RCA was not completed timely per VHA policy; and the RCA action plan was not completed by the target date. The OIG determined that leaders did not ensure adequate training and oversight of the interim PSM. These deficiencies contributed to the concerns identified with the RCA.

The OIG made one recommendation to the Under Secretary for Health regarding the ability to change authors of unsigned notes, and the Under Secretary concurred with a plan to explore ways to limit note reauthoring. The OIG also recommended that the Veterans Integrated Service Network Director review the patient's care, and the Director concurred. Six recommendations were issued to the Facility Director addressing safety plans, guidance consistency, documentation accuracy, RCA processes, PSM training, and documentation changes. The Director concurred with five recommendations and concurred in principle with one, and committed to improving safety plan processes, reviewing guidance, discontinuing note reauthoring, strengthening RCA compliance, ensuring PSM support, and conducting a fact-finding into unsupported documentation changes.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–8

1. The Veterans Integrated Service Network Director conducts a comprehensive review of the care provided to the patient prior to the event, and takes action as indicated.

2. The Robley Rex VA Medical Center Director ensures that the facility has a mechanism in place for how Veterans Health Administration healthcare professionals will provide content of suicide prevention safety plans when completing suicide prevention safety plans with patients over the phone.

3. The Robley Rex VA Medical Center Director reviews facility Primary Care-Mental Health Integration guidance documents and ensures consistency and alignment with Veterans Health Administration requirements.

4. The Robley Rex VA Medical Center Director reconsiders the practice of reauthoring notes in the Computerized Patient Record System by behavioral health technicians in the Primary Care-Mental Health Integration call center, identifies other facility areas that use the reauthoring process, and takes action as indicated.

5. The Under Secretary for Health evaluates ways to mitigate the implications resulting from users' ability to change authors in an unsigned note in the Computerized Patient Record System to ensure that such practice is limited to those in roles with a need to have that function, and takes action as indicated.

6. The Robley Rex VA Medical Center Director ensures that root cause analyses are completed in accordance with Veterans Health Administration policy, including root cause analysis process steps, timeliness, and team roles.

7. The Robley Rex VA Medical Center Director ensures that patient safety managers receive oversight, training, and support as required by the Veterans Health Administration.

8. The Robley Rex VA Medical Center Director ensures that the chief of quality understands the seriousness and implications of altering documentation without support, and that leaders, whose actions contributed to the deficiencies outlined in this report, receive administrative action, as appropriate.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: April 15, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report—Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky. The Veterans Health Administration (VHA) concurs with the action plan provided by the Director of the Mid-South Healthcare Network and the Director of the Louisville Healthcare System; and concurs with recommendation 5, made to the Under Secretary for Health. The associated action plans are attached.

2. We are deeply saddened by the passing of this Veteran. We are committed to improving the delivery of health care services across the system and preventing suicide among Veterans.

3. VHA greatly values OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

4. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(*Original signed by:*)

John J. Bartrum, JD, MBA

[OIG comment: The OIG received the above memorandum from VHA on September 17, 2025, and received updates to the memorandum on April 15, 2026.]

Office of the Under Secretary for Health Response

Recommendation 5

The Under Secretary for Health evaluates ways to mitigate the implications resulting from users' ability to change authors in an unsigned note in the Computerized Patient Record System to ensure that such practice is limited to those in roles with a need to have that function, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Under Secretary for Health Comments

The VHA Office of Clinical Informatics and Health Information Governance - Health Care Security will work with VA Office of Information and Technology to investigate technical ways to limit user access to and the practice of reauthoring unsigned or unauthenticated clinical notes in the Computerized Patient Record System (CPRS) based on clinical requirements and security recommendations.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of a documented evaluation of ways to mitigate the implications resulting from users' ability to change authors of an unsigned note in the Computerized Patient Record System and any actions taken as a result.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 3, 2026

From: Acting Director, Department of Veterans Affairs (VA) MidSouth Healthcare Network (10N9)

Subj: VA Office of Inspector General (OIG) Draft Report— Review of Care Provided to a Patient who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky

To: Director, Office of Healthcare Inspections (54HL04)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. We deeply regret the circumstances that impacted the quality of care delivered to one of our Veterans.

2. I have reviewed the draft report titled "Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky" with documentation provided and concur with the responses as submitted by the facility.

3. Should you need further information, please contact the Quality Management Officer, VISN 9.

(*Original signed by:*)

Jennifer L. Kizis
Acting Network Director

[OIG comment: The OIG received the above memorandum from VHA on September 17, 2025, and received updates to the memorandum on April 15, 2026.]

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director conducts a comprehensive review of the care provided to the patient prior to the event, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: November 2026

Director Comments

The Veterans Integrated Service Network (VISN) 9 Chief Medical Officer will oversee a comprehensive review of the care provided to the patient prior to the event. This review will include an assessment of policies and procedures, including screening guidelines applicable to the situation, to identify any deficiencies. Additionally, a one-year look-back for each provider involved will be conducted to ensure no other deficiencies or trends are present. Identified deficiencies will be reported to the appropriate supervisor, and appropriate actions will be taken in accordance with VHA medical staff (peer review) and human resource (disciplinary action) directives.

The Chief Medical Officer will report the findings to the VISN 9 Network Director to close out the medical record review.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 3, 2026

From: Acting Executive Director, Department of Veterans Affairs (VA) Louisville Healthcare System (603)

Subj: VA Office of Inspector General (OIG) Draft Report— Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky

To: Acting Director, VA MidSouth Healthcare Network (10N9)

1. We appreciate the opportunity to review and comment on the OIG draft report—Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky. VA Louisville Healthcare System concurs with OIG Recommendations 3-4 and 6-8 and concurs in principle with OIG Recommendation 2 and will take corrective action. We deeply regret the circumstances that impacted the quality of care delivered to one of our Veterans.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Larry D. Roberts II, CPA, MBA

[OIG comment: The OIG received the above memorandum from VHA on September 17, 2025, and received updates to the memorandum on April 15, 2026.]

Facility Director Response

Recommendation 2

The Robley Rex VA Medical Center Director ensures that the facility has a mechanism in place for how Veterans Health Administration healthcare professionals will provide content of suicide prevention safety plans when completing suicide prevention safety plans with patients over the phone.

_X _Concur in Principle

____Nonconcur

Target date for completion: May 2026

Director Comments

The facility will develop a standard operating procedure (SOP) to define options for delivering the Veteran's safety plan when completing a Safety Planning Intervention with patients over the phone.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation demonstrating a mechanism has been developed, implemented, and effectively utilized to ensure veterans have access to the content of suicide prevention safety plans when completed over the phone.

Recommendation 3

The Robley Rex VA Medical Center Director reviews facility Primary Care-Mental Health Integration guidance documents and ensures consistency and alignment with Veterans Health Administration requirements.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

The Chief of Mental Health will review the facility PC-MHI Program Operations and Behavioral Health Technician (BHT) Operations Manuals to ensure that it is in alignment VHA requirements. Portions requiring updates will be revised and routed to the Mental Health ICC [Integrated Clinical Committee] and Healthcare Delivery Committee for approval. The Chief of

Mental Health and PC-MHI Section Chief will review the PC-MHI Program Operations and BHT Operations Manuals annually and as needed with any pertinent Directive update. The review will be documented on a signature page maintained with the Manuals.

The PC-MHI Program Operations Manual will be updated to include the requirements for Safety Plan documentation for telephone visits. Documentation of training on the updated policy for staff using the Safety Plan template will be completed by September 2025.

The PC-MHI Program Operations and BHT Operations Manuals will be updated to delete the practice of reauthoring. Documentation of training on the updated policy for 100% of PC-MHI staff will be completed by September 2025.

Completion of Manual updates will be added to the ELC [Executive Leadership Committee] action item tracker and reported monthly until complete.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of evidence that a review of facility guidance documents was completed to ensure consistency and alignment with Veterans Health Administration requirements.

Recommendation 4

The Robley Rex VA Medical Center Director reconsiders the practice of reauthoring notes in the Computerized Patient Record System by behavioral health technicians in the Primary Care-Mental Health Integration call center, identifies other facility areas that use the reauthoring process, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

On August 6, 2025, the Chief of Mental Health instructed the PC-MHI Measurement Based Care Support Team Supervisor to have PC-MHI staff stop the process of reauthoring. Clinicians will create their own notes when completing PC-MHI baseline assessments. When BHTs complete baseline assessment interviews, the BHT will complete the assessment in the Behavioral Health Lab (BHL) software, this will be immediately available to the provider. The BHT will create a note in the EHR immediately upon completion of the assessment and will alert the provider. The provider will retrieve the information from the BHL software and complete their own note.

The Chief of Mental Health will update the PC-MHI Program Operations Manual and the BHT Operations Manual to include this change in practice. Documentation of training for all PC-MHI

staff will be completed by September 2025. Training rosters will be submitted to the Chief of Mental Health.

Accurate documentation in the EHR and adherence to the no reauthoring expectations will be included in the Safety section of the Performance Plan for all BHTs for the upcoming fiscal year.

Each month, the Chief of Mental Health will review the reauthor report for evidence of reauthoring, confirm the use of the approved workflow, and provide training and feedback on the current workflow to any individual identified as needing assistance. The Chief of Mental Health will monitor use of approved workflow via the reauthor report with a goal of 90% compliance for six consecutive months and report to the Healthcare Delivery Committee and ELC via the Mental Health ICC.

Compliance data will be added to the ELC action item tracker and reported monthly until complete.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of evidence that the practice of reauthoring notes in the Computerized Patient Record System is no longer being used in the Primary Care-Mental Health Integration call center and confirmation that the practice is not being used in other facility areas.

Recommendation 6

The Robley Rex VA Medical Center Director ensures that root cause analyses are completed in accordance with Veterans Health Administration policy, including root cause analysis process steps, timeliness, and team roles.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

The Medical Center Director (MCD) will ensure that root cause analyses are completed in accordance with VHA guidelines. Before the Director signs a Root Cause Analysis (RCA) charter, the Chief of Quality Management will validate the information contained within the charter to ensure its accuracy and completeness. Successful implementation will be demonstrated by achieving 90% or greater completion of RCA charter accuracy and all SPOT [Synchronized Predeployment and Operation Tracker] entries for each RCA. Compliance data will be reported to the Quality Patient Safety Committee (QPSC) and the ELC. The timeliness of completion of RCAs will also be monitored by the VISN Patient Safety Officer (PSO) and reported to the

VISN QPSC. Compliance reporting will be added to the ELC action item tracker and reported monthly until complete.

The Patient Safety Manager (PSM) will utilize the most current "Just-In-Time" training video from the National Center for Patient Safety (NCPS) website at the beginning of each RCA to ensure steps and expectations are in alignment with current practice. To verify the effectiveness of this training, a review will be conducted after the completion of each RCA. This practice will provide valuable evidence on whether the training videos were successful and if the staff are properly adhering to the established protocols. Successful implementation will be evidenced by 90% or greater compliance with adherence to these protocols, as documented in the post-completion review of each RCA. This compliance data will be documented in an Excel spreadsheet, stored securely on the Quality SharePoint drive. The recorded data will be reported to the QPSC and the ELC. Compliance reporting will be added to the ELC action item tracker and reported monthly until complete.

The PSM will provide an initial education session in the form of a presentation to the executive leadership and service chiefs at a monthly Service Chief meeting with the Director. Presentations will be ongoing for all new Service Chiefs. This training will review VHA NCPS expectations of timely completion of RCA investigations within 45 business days of when the facility became aware of the event. A sign-in roster for the presentation will be preserved as a record of training. Compliance will be monitored and provided through the auditing of all RCAs for timeliness of completion. A report of completion of an RCA within the timeframe set by NCPS of 45 business days will be reported to QPSC. This will be monitored for a period of six months with a compliance rate consistently at 100%. Compliance reporting will be added to the ELC action item tracker and reported monthly until complete.

RCA team roles will be appropriately assigned in alignment with the current VHA NCPS – Guide to Performing RCA during the initial creation of the charter and with the signed approval of the Director or acting Director. The PSM will include RCA expectations related to role assignments in the form of a presentation to the executive leadership and service chiefs at a monthly Service Chief meeting with the Director. Presentations will be ongoing for all new Service Chiefs. This training will review the VHA NCPS expectations of assigned RCA team roles. A sign-in roster for the presentation will be preserved as a record of training. Compliance will be measured by auditing all RCA completed within a six-month period to ensure the correct roles are assigned. Compliance will be reported to QPSC with a goal of greater than 95% of roles properly assigned for six months. Compliance will be reported to the QPSC and the ELC. Compliance reporting will be added to the ELC action item tracker and reported monthly until complete.

The timely completion of RCA-related actions and outcomes in accordance with VHA policy will be facilitated through monthly emails to stakeholders of all actions and outcomes assigned to them for responsibility. The PSM will include training related to this action in the educational

sessions described above, with the executive leadership and service chiefs. The training will review VHA NCPS expectations of timely completion of RCA-related actions and outcomes. A sign-in roster for the presentation will be preserved as a record of training. To promote accountability and ensure timely completion of RCA actions and outcomes, status of actions will be tracked in SPOT with a goal of 90% timely completion rate for six consecutive months. Patient Safety will report open and closed items, including timeliness of completions, monthly in QPSC. Compliance reporting will be added to the ELC action item tracker and reported monthly until complete.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of evidence that the proposed process to ensure that root cause analyses are completed in accordance with Veteran Health Administration policy is successfully implemented.

Recommendation 7

The Robley Rex VA Medical Center Director ensures that patient safety managers receive oversight, training, and support as required by the Veterans Health Administration.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

The MCD will ensure that PSMs receive oversight, training, and support as required by the VHA. The Chief of Quality Management ensured that the new PSM received oversight, training, and support. A new PSM assumed the role on November 4, 2024, and the interim PSM was no longer in this role, effective April 2025. Upon hire, the PSM met regularly with the VISN PSO over Microsoft Teams. The NCPS orientation checklist was completed. A full RCA was observed in November and December 2024. The PSM participated in an RCA with the previous PSM in January through March 2025. The PSM attended NCPS Foundations training in February 2025. The PSM spent three days visiting a peer facility for observation, mentoring, and coaching. The PSM actively engages in the NCPS monthly office hours calls or reviews the videos following the calls for content review.

The Chief of Quality Management enrolled in a four-week Foundation for Patient Safety Professionals course. The new PSM scheduled Joint Patient Safety Reporting/Learning sessions for Service Chiefs of Medicine and Nursing, and ancillary staff. Both attended an NCPS-sponsored RCA analysis conference. The Chief and PSM meet regularly to discuss cases and share information. NCPS was consulted and assisted with the new PSM with RCA processes.

The facility Chief of Quality Management has primary responsibility for ensuring that the PSM completes all required initial and continuing education and training. The Chief of Quality Management achieves this by conducting orientation meetings, facilitating preceptors and mentor experiences, providing oversight on performance and completing the training checklist with the PSM.

The VISN PSO will validate and track the completion of the PSM's education and training requirements to ensure compliance with all education and certification requirements. The VISN PSO will participate in the training process, providing additional patient safety expertise through one-on-one interactions, verbal and electronic guidance and resources, promotion of evidence-based practices, and facilitation of community of practice meetings.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of validation of the VISN Patient Safety Officer's tracking of the education and certification requirements, as well as documentation of mechanisms to support patient safety managers.

Recommendation 8

The Robley Rex VA Medical Center Director ensures that the chief of quality understands the seriousness and implications of altering documentation without support, and that leaders, whose actions contributed to the deficiencies outlined in this report, receive administrative action, as appropriate.

_X _Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

The MCD detailed the Chief of Quality Management out of her position effective August 10, 2025, while a fact-finding is conducted into the findings outlined by OIG in this report. The fact-finding will be completed by October 30, 2025. Appropriate administrative actions will be taken as indicated by the results of the fact-finding.

The MCD will conduct a fact-finding, to be completed by October 30, 2025, with Mental Health Leadership to look at the actions or inactions that may have contributed to the reauthoring process as well as the other findings included in the OIG report. Appropriate administrative actions will be taken as indicated by the results of the fact-finding.

OIG Comment

The OIG considers this recommendation open to allow the facility time to address the OIG's concerns about the credibility and conclusions of the fact-finding completed in November 2025.

In August 2025, publication of this hotline inspection report was paused to allow the US Attorney's Office (USAO) to evaluate whether the chief of quality's action of altering the PSM training checklist warranted criminal prosecution. In January 2026, the USAO announced its decision to decline prosecution.

Following the five-month pause, the OIG reviewed the facility's fact-finding report that had been completed in November 2025 and noted serious concerns regarding its credibility and conclusions. Specifically, the fact-finding did not include the PSM's knowledge of the events, a critical piece of evidence, and insufficiently scrutinized evidence, raising questions about the integrity of the investigation. In late January 2026, OIG team members met virtually with the acting Facility Director to communicate these concerns and advise the Director that OIG will monitor for a facility response during the follow-up process.

OIG Contact and Staff Acknowledgments

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