



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas

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QUALITY STANDARDS

The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation, excluding follow-up.

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This report includes sensitive information regarding events related to a veteran's suicidal thoughts, behavior, and death by suicide that may be disturbing or upsetting for some readers. Reader discretion is advised.



Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review concerns regarding the Veterans Crisis Line (VCL) staff's management of a patient who died by suicide within the hour after VCL text contact.¹ Specifically, the OIG evaluated the adequacy of the suicide risk assessment, safety planning, and documentation that a responder (Responder 1) completed for the patient.² The OIG identified these concerns while reviewing the patient's electronic health record (EHR) for another healthcare inspection. Additionally, the OIG evaluated leaders' oversight of Responder 1's performance.

The OIG also evaluated administrative actions taken by leaders and staff at the VCL and Audie L. Murphy Memorial Veterans Hospital (facility) in San Antonio, Texas, following notification of the patient's death, including the management of a complaint, a VCL leader's potential interference in the OIG inspection, delays in updating the patient's EHR and discontinuing correspondence, and facility leaders' failure to implement the Behavioral Health Autopsy Program (BHAP).³

Synopsis of the Patient's Medical History and VCL Contact

The patient, who was in their 30's at the time of death in early 2021, had a history of [post-traumatic stress disorder](#) (PTSD), [attention deficit hyperactivity disorder](#), [major depressive disorder](#), [alcohol use disorder](#), and [obstructive sleep apnea](#).⁴ In 2018, the patient received medication for mood management from a primary care physician and psychotherapy in group and individual settings. In early 2019, a facility psychiatrist provided medication management. In late fall 2019, after the patient's report of suicidal behavior, a suicide prevention case manager

¹ VCL, *Social Science Specialist Training Participant Guide*, November 2021. The VCL refers to individuals who contact the VCL as customers. For purposes of this report, the OIG refers to the customer, who also received VHA care, as the patient.

² In 2020, the title 5 Health Science Specialists were replaced by Title Hybrid 38 Social Science Specialists. VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding the role of responders. Responders are staff who interact with individuals who contact the VCL through calls, chats, and texts.

³ VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. In 2012, VHA implemented the BHAP that requires completion of a psychological autopsy on patients known to have died by suicide. The BHAP includes an EHR review of relevant behavioral health information about the patient prior to their death such as use of mental health and crisis services and the patient's diagnoses and symptoms, as well as outreach to next of kin for an interview.

⁴ The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

placed a high risk for suicide patient record flag in the patient's EHR.⁵ In early 2020, the psychiatrist documented the patient's "overall immediate suicide risk" as moderate to low and the High-Risk Committee removed the patient's high risk for suicide patient record flag.⁶

At a scheduled appointment in early 2021, the psychiatrist documented that the patient denied "suicidality/homicidality/self harm thoughts/assaultive ideations," evaluated the "overall immediate suicide risk" as moderate to low, and noted a plan for the patient to return to the clinic in eight weeks. A week later (day 1), at 10:14 p.m., the patient contacted the VCL by text message. Responder 1 documented in Medora, the computer-based application used by responders to document VCL contacts, that the patient had a "Plan or Intent For Suicide," and access to means and firearms.⁷ Responder 1 also documented that the patient was in a "shed with a belt around a hook that hangs from the rafters of the shed," and "reached out tonight in order to stop from taking action to end [the patient's] life."

Responder 1 documented a safety plan that included the patient texting Family Member 1 to enact the safety plan, and taking additional steps to "go inside the house, [Family Member 1] will secure all means, take medications as prescribed and then turn them over to [Family Member 1], go to bed, wait for [the patient's] providers to call tomorrow, and contact VCL if in need of further support." The patient's last outgoing message was sent to the VCL at 11:02 p.m. Responder 1's last message to the patient was at approximately 11:29 p.m. and Responder 1 noted that the patient "stayed on line until the call ended normally."⁸

On days 2 and 3, a facility suicide prevention program case manager documented unsuccessful telephone calls to the patient and Family Member 1. The next day, the suicide prevention program case manager contacted the sheriff's department to request a welfare check.⁹ A sheriff

⁵ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Deputy Under Secretary for Health for Operations and Management, "Update to High Risk for Suicide Patient Record Flag Changes," memorandum to VISN Directors, VISN Chief Mental Health Officers, Medical Center Directors, and Suicide Prevention Coordinators, January 16, 2020. VHA enters a high risk for suicide patient record flag in the EHR to identify a patient as high risk for suicide and requires intensive follow-up by providers while the patient remains flagged.

⁶ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA, *Suicide Prevention Program Guide*, November 1, 2020. VHA requires facility leaders to designate an interdisciplinary committee or advisory group to assist with patient record flag recommendations and advise the suicide prevention coordinator in the determination process, including guidance about inactivation of patient record flags.

⁷ Responder 1 provided coverage as a responder for overtime pay since January 2019. Responder 1 told the OIG of being employed as a VCL responder for six years prior to assuming silent monitor duties.

⁸ VCL and mobile phone records indicate 11:29 p.m. as the time of Responder 1's final text message to the patient while the Medora and EHR documentation indicate 11:27 p.m.

⁹ VCL, *Health Science Specialist Training Participant Guide*, June 2019. A welfare check is a physical check of an individual's welfare by emergency services, prompted by a concerned person.

department staff member confirmed that the patient died by suicide on day 1, and that Family Member 1 found the patient hanging in the patient's shed.

The suicide prevention program case manager completed a suicide behavior and overdose report and documented that the contact between the patient and Responder 1 ended "with agreement [the patient] would alert [Family Member 1] to enact a plan for safety."¹⁰ The lead detective reportedly told the suicide prevention program case manager that the patient did alert Family Member 1 via text message but the patient "never went into the house which prompted" Family Member 1 to look for the patient.

The autopsy report noted the patient's time of death as 11:40 p.m., cause of death as asphyxia by hanging, and manner of death as suicide.

OIG Findings

VCL data indicated that the patient and Responder 1 engaged in a 75-minute text conversation from 10:14 p.m. until approximately 11:29 p.m. Family Member 1 provided the OIG with screenshots of 80 text messages from the patient to the VCL.¹¹ The OIG found the provided text messages to be in a coherent and logical sequence that allowed for a robust review of Responder 1's management of the patient's contact.

Inadequate Suicide Risk Assessment

The OIG found that Responder 1 did not complete an adequate assessment of the patient's suicide risk factors, including the patient's [suicidal preparatory behavior](#) and alcohol use, during the text conversation.¹²

Responder 1's Failure to Assess Suicidal Preparatory Behavior

In texts to Responder 1, the patient reported having suicidal ideation that same day, attempting suicide "Maybe a year and a half" prior, and receiving mental health treatment. Approximately 16 minutes into the conversation, at 10:30 p.m., the patient texted "I was going to hang myself and that's when I decided to call in." Responder 1 asked the patient about access to means for hanging and the patient replied, "There's a hook that always hangs from the rafters." Almost

¹⁰ VHA Acting Deputy Under Secretary for Health for Operations and Management, "Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation," memorandum to VISN Directors and VISN Chief Mental Health Officers, April 8, 2019. The Suicide Behavior and Overdose Report "provides a nationally standardized note for documenting suicide behaviors and overdoses, including fatal and nonfatal events."

¹¹ On March 17, 2022, the OIG provided the text transcript of Responder 1's interaction with the patient to the Office of Mental Health and Suicide Prevention, Executive Director, VA Suicide Prevention.

¹² VCL-S-ACT-217-1907, "Standard Operating Procedure for Positive Self-Directed Violence (SDV) Screening," July 25, 2019.

20 minutes later, the patient acknowledged not being “entirely honest” and reported “testing it out and feeling everything fade” during the text conversation with Responder 1.

During an interview with the OIG, Responder 1 reported not recalling that text and that the patient was probably “referring to the belt” used in a suicide attempt before calling VCL. The OIG found that Responder 1 did not address the patient’s likely suicidal preparatory behavior using the patient’s identified lethal means, hanging apparatus, during the text conversation. The OIG concluded that Responder 1’s failure to clarify the patient’s engagement in suicidal preparatory behavior likely contributed to Responder 1’s underestimation of the patient’s imminent suicide risk and failure to follow up after the patient’s discontinuation of texting or to consider third-party involvement.

Supervisory Review

The OIG provided VCL leaders and three non-VA subject matter experts with the text conversation between the patient and Responder 1. Two VCL staff members (Reviewers 1 and 2) reviewed the text transcript.¹³ Both reviewers rated Responder 1’s suicide risk assessment as unsuccessful in identifying and addressing the patient’s suicidal plan and intent. Reviewer 2 also noted that, “The Texter made a suicide attempt while on the call, but this was not acknowledged during the text interaction.”

Consistent with the evaluations by Reviewers 1 and 2, subject matter experts noted that the patient had “divulged to the responder that they just made a suicide attempt, by hanging” during the text conversation and “it could certainly be referring to suffocation attempt and it should have been clarified.” Further, subject matter experts suggested that the patient’s acute suicide risk might necessitate rescue and third-party involvement.

Text Contact Termination

The VCL advises responders to terminate a text session if a customer is silent for 15 minutes and to end a text conversation with a reminder for the customer to contact the VCL again if in crisis.¹⁴ The OIG determined that Responder 1’s termination of the text conversation with the patient was consistent with VCL guidance if Responder 1’s assessment was that the patient was not at imminent risk of suicide and that a safety plan was established. Although the OIG found that Responder 1 discussed elements of a safety plan with the patient, the patient discontinued responding to Responder 1’s texts without confirming follow through with the plan to go in the house or involve Family Member 1. Responder 1 closed the text conversation with no further action or explanation.

¹³ Reviewer 1 was a quality management officer and Reviewer 2 was a Division Director for Crisis Operations.

¹⁴ VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

Responder 1's Failure to Assess Alcohol Use

In addition to an individual having suicidal ideation and access to means, the American Association of Suicidology and the Centers for Disease Control and Prevention identifies alcohol use as a risk factor for suicide.¹⁵ The patient texted, "Part of me wants to get drunk enough to get it over with and part of me is scared I will." The autopsy report indicated a postmortem [blood alcohol content](#) of 0.06 percent supporting that the patient's blood alcohol content was likely between 0.06 and 0.13 percent, suggesting that the patient may have had impaired judgment and reasoning due to alcohol use.¹⁶

In an interview with the OIG, Responder 1 reported that alcohol use was not explored because the patient "didn't mention any of that" and there was "no presentation that that was a concern." Although VCL written guidance was not yet established, given the patient's report of a desire to become intoxicated, the OIG would have expected Responder 1 to, at a minimum, attempt to determine the patient's intention to consume alcohol to better understand the potential risk of intoxication, a known suicide risk factor.

Ineffective Safety Planning and Failure to Confirm Patient's Reduced Access to Lethal Means

The OIG found that Responder 1 failed to establish an effective safety plan with the patient. Specifically, Responder 1 failed to confirm the patient's actions to reduce immediate access to lethal means and actively involve Family Member 1 in the safety planning process.

The patient texted that Family Member 1 was in the house and "I'm in my shed now trying to get it right," and "Because I can't get to my guns without [Family Member 1] noticing I was going to hang myself." Responder 1 asked the patient "Would it be better to leave the shed and maybe walk a little while we talk?" The patient did not confirm leaving the shed and replied, "all I need is hope I just need to know that something is going to change and I can lie to myself for as long as it takes." The text conversation did not include confirmation that the patient left the shed or was outside the shed at any point during the VCL contact.

¹⁵ American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012. "About AAS" (web page), American Association of Suicidology, accessed May 15, 2023, <https://suicidology.org/about-aas/>. The American Association of Suicidology is a nonprofit accrediting organization that applies nationally recognized standards to crisis intervention programs; "Suicide Prevention–Risk and Protective Factors" (web page), Centers for Disease Control and Prevention (CDC), accessed December 5, 2022, <https://www.cdc.gov/suicide/factors/index.html>.

¹⁶ "blood alcohol content" (web page), Cleveland Clinic, accessed June 7, 2022, <https://my.clevelandclinic.org/health/diagnostics/22689-blood-alcohol-content-bac>. The patient's blood alcohol testing was conducted soon enough following death that results should be valid assuming other factors, such as environmental temperatures, did not contribute significantly.

Consistent with the National Guidelines for Behavioral Health Crisis Care and VCL guidance, the subject matter experts emphasized that a responder's priority should be on reducing access to lethal means.¹⁷ The OIG concluded that Responder 1's suggestion to leave the shed without further encouragement or confirmation was ineffective in reducing the patient's access to the identified lethal means and failed to reduce the patient's suicide risk.

Responder 1's Failure to Involve Family Member 1

VCL guidance promotes inclusion of supportive others in safety planning, especially when lethal means are accessible.¹⁸ Although not a VCL requirement, the Director, Quality and Training, confirmed that responders are encouraged to consider speaking with a family member or if responders determine "it would be better to have someone separately outreach the family member."

The OIG found that Responder 1 did not involve Family Member 1 even though the patient described Family Member 1 as someone who was very involved in the patient's safety plan. The patient texted several statements regarding Family Member 1's support including, "All I have to do is tell [Family Member 1]," "But I can't do that yet," "I promise I will and I'll even let you talk to [Family Member 1] by text or phone."

When asked if consideration was given to contacting Family Member 1 to confirm that the means were secured prior to ending the text conversation with the patient, Responder 1 told the OIG "I can't say that I considered it." Inconsistent with the VCL guidance in place at the time of the patient's contact, Responder 1 stated "We don't involve [family members]." The OIG determined that Responder 1's failure to involve Family Member 1 in safety planning contributed to the patient's uninterrupted access to lethal means and follow through with suicidal behavior.

Failure to Consider a Telephone Transfer

In addition to not involving Family Member 1, the OIG determined that Responder 1's underestimation of the patient's imminent suicide risk and presumption of an established safety

¹⁷ "National Guidelines for Behavior Health Crisis Care, Best Practice Toolkit" (web page), Substance Abuse and Mental Health Services Administration, accessed May 9, 2022, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>; VCL, VCL-S-ACT-216-2011, "Standard Operating Procedure for Call Flow," October 26, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-216-2103(2), "Standard Operating Procedure for Call Flow," April 2021. Unless otherwise specified, the 2021 standard operating procedure contains the same or similar language regarding guidance when a customer "reports having lethal means nearby" as the 2020 standard operating procedure.

¹⁸ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding lethal means restriction and safety planning as the rescinded 2019 guide.

plan contributed to Responder 1's failure to pursue additional interventions such as a transfer from text to telephone management. Text responders are required to transfer a text to telephone management when the customer would benefit from verbal communication.¹⁹

Given the patient's imminent suicide risk, absence of verification that Family Member 1 was aware of the patient's plan to use a hanging apparatus, and the patient's lack of reply to Responder 1's continued texts, the OIG would have expected Responder 1 to transfer to telephone communication to attempt to confirm the patient's safety. Additionally, based on the patient's suicide risk factors, including potential intoxication and suicidal preparatory behavior, the OIG would have expected Responder 1 to consider transferring the patient from text to telephone management for further risk assessment.

Documentation Deficiencies

The OIG found that Responder 1's failure to accurately document the interaction with the patient may have contributed to leaders' lack of further review of Responder 1's performance because of the misperception that Responder 1 had effectively addressed the patient's risk including restricting access to lethal means.

The OIG found that although VCL documentation guidelines are consistent with VA suicide risk levels guidelines, the Medora note template includes suicide risk-level options different from the VA guidelines.²⁰

Although the OIG did not determine that the different terms for suicide risk level contributed to Responder 1's failure to adequately assess the patient's suicide risk, use of inconsistent terms for classification may result in responders' confusion about indicated actions and inadequate documentation.

VCL Leaders' Failure to Provide Adequate Oversight and Quality Assurance

The OIG found that VCL leaders failed to ensure that sufficient silent monitored contacts were conducted for Responder 1 and other non-responder staff providing responder coverage. This failure may have resulted in unidentified deficiencies in performance. The OIG also determined that VCL leaders failed to establish a text message retention process for over 10 years of VCL's use of text messaging for crisis management. The absence of text message retention resulted in

¹⁹ VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

²⁰ VA/DoD, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019; VCL-S-ACT-218-2008, "Veterans Crisis Line – Standard Operating Procedure for Health Science Specialist Documentation Guidelines," August 26, 2020; VCL, *Social Science Specialist Training Participant Guide*, November 2021.

limited quality assurance reviews of text contact management, including Responder 1's contact with the patient.

Inadequate Oversight

As of October 2021, the Veterans Health Administration (VHA) requires VCL leaders to implement silent monitoring to oversee the quality of responders' work.²¹ However, the October 2021 policy does not specify expectations for silent monitoring staff, including Responder 1, or other oversight of staff not typically performing responder duties but providing responder coverage.²²

The OIG found that silent monitoring for Responder 1's customer contacts did not occur from January 2019 through the day OIG requested this information in early February 2022. In an interview with the OIG, the Director, Quality and Training, reported that the VCL did not have a process to conduct silent monitored contacts for staff performing responder duties for overtime.

VCL leaders' failure to ensure that sufficient silent monitored contacts were conducted for staff serving as responders, including silent monitor social science program specialists (monitor specialists) performing responder duties for overtime or compensatory time, may have resulted in unidentified deficiencies in performance.²³

²¹ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in effect at the time of the events discussed in the report. It was replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language related to the monitoring of responders' VCL interactions with customers as the replaced 2020 policy; VA OIG, [*Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*](#), Report No. 20-00545-115, April 15, 2021.

²² VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021.

²³ VCL-S-ACT-218-2008, "Veterans Crisis Line – Standard Operating Procedure for Health Science Specialist Documentation Guidelines," August 26, 2020; VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the duties of the monitor specialist and responder as the rescinded 2020 policy. Monitor specialists are staff specifically trained to assess calls, text, and chat, and provide coaching for identified areas in need of improvement immediately following monitored interactions.

Lack of Text Retention

The VCL launched text services in November 2011.²⁴ The VCL Innovations Hub program manager told the OIG that VCL leaders began work to establish a system for managing texts, including text retention in July 2019.

In mid-May 2022, almost six months after notification of this OIG inspection, the Executive Director, VCL told the OIG about an expected June 2022 implementation for responders to copy and paste text contacts and a “longer term solution which will not require the copy paste.”

The OIG determined that the leaders failed to establish a text message retention process in over 10 years of VCL’s use of text messaging for crisis management. The lack of text retention prevented leaders from conducting comprehensive quality assurance reviews of text contact management, including Responder 1’s contact with the patient.

Inadequate and Problematic Leader and Staff Actions Following the Patient’s Death

The OIG found delayed and inadequate administrative responses by VCL and facility staff following notification of the patient’s death. Although the February 2021 issue brief indicated that a [root cause analysis](#) would be completed, VCL leaders did not charter a root cause analysis until the OIG became involved almost 11 months later. The OIG found that the Executive Director, VCL did not define the patient’s death as a [sentinel event](#) or consider a disclosure because the policy that addressed disclosure procedures was not in effect at the time of the patient’s death.²⁵ Further, the OIG concluded that the Director, Quality and Training, provided advice and information to Responder 1 prior to interviews with the OIG that potentially compromised Responder 1’s candidness.

Additionally, the OIG found that another responder (Responder 2) did not submit a complaint report or request follow up as required by VHA, and as expected by VCL leaders, following

²⁴ VCL, *Orientation Participant Guide*, January 2022.

²⁵ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing Critical Incidents and Near Misses,” August 2021.

Family Member 2's February 2021 contact.²⁶ The OIG also found that facility leaders did not implement the BHAP, as required by VHA since November 2012, until January 2022.²⁷

Failure to Complete a Root Cause Analysis

The Executive Director, VCL reported that after completion of a quality assurance review it was decided that “there was insufficient information for us to really move forward with an [Root Cause Analysis].” However, leaders initiated the root cause analysis following the OIG notification of the inspection although the text conversation had not yet been obtained. The Executive Director, VCL told the OIG that “after I was alerted by [the OIG], we saw additional points related to systemic concerns” that warranted a root cause analysis, including the complaint process and the continuation of caring letters following the patient's death (as discussed below).²⁸ VCL leaders' failure to conduct a timely review of the patient's VCL contact contributed to a delay in the identification of systemic and performance deficiencies and implementation of corrective actions.

Failure to Consider Disclosure

The OIG found that the patient's death meets the VCL definition of *sentinel event* since the patient died by suicide within an hour of contact with Responder 1 who was the last contact, and that Responder 1 failed to conduct an adequate suicide risk assessment or safety planning. Given that the VCL procedures emphasize the initiation of disclosure upon recognition of a sentinel event following review, the OIG concluded that VCL leaders should therefore consider conducting a disclosure to the patient's personal representative(s).

A VCL Leader's Potential Interference in the OIG Inspection

VA regulation, 38 C.F.R. § 0.735-12, requires that VA staff cooperate with an OIG interview and answer questions freely and honestly, unless a response would incriminate the individual in a

²⁶ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, on December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the staff administrative processes related to the complaint processes as the rescinded 2020 directive.

²⁷ VHA Deputy Under Secretary for Health for Operations and Management, “Behavioral Autopsy Program Implementation,” memorandum to Network Directors, December 11, 2012. A BHAP Chart Analysis is a standardized EHR review of relevant behavioral health information about the patient prior to their death including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinician notes.

²⁸ “Memorandum of Understanding Between VA Quality Enhancement Research Initiative (QUERI) And Veteran Crisis Line,” July 30, 2019. In July 2019, the VCL established a memorandum of understanding with the VA Quality Enhancement Research Initiative to implement sending repeated “brief, nondemanding messages” for expressing “caring concern” to patients who contact VCL.

violation of law.²⁹ In interviews with the OIG, VA staff are expected to provide accurate, relevant, specific, and complete information and be forthcoming in their responses. VA leaders have a responsibility to avoid any action that could negatively influence a VA staff member's cooperation with the OIG's inspection.

During this inspection, the OIG discovered that the Director, Quality and Training, provided Responder 1 with potential responses to the OIG prior to Responder 1's interviews in instant messages.³⁰ This supervisory influence may have impacted Responder 1's openness and recollection during interviews with the OIG.

In an interview with the OIG, the Director, Quality and Training, denied recollection of communication with Responder 1 related to the inspection and prior to Responder 1's interview with the OIG. However, the OIG found that approximately one month prior to Responder 1's interview with the OIG, the Director, Quality and Training, instant messaged Responder 1 that the "main points are to only answer the question asked – don't volunteer anything extra."

The OIG found that Responder 1 reported inaccurate information about the patient to the OIG based on instant messages with the Director, Quality and Training, in which the Director, Quality and Training, incorrectly suggested to Responder 1 that the patient "had multiple head traumas." Approximately five months later, during interviews with the OIG, Responder 1 reported learning that the patient had a [traumatic brain injury](#) from the text message conversations with the patient that the OIG provided to VCL. However, in the text message conversation, the patient did not report a traumatic brain injury or head trauma to Responder 1.

The OIG also found that the Director, Quality and Training, provided Responder 1 with reassurance and emotional support. Prior to the OIG's receipt of the text conversation, the Director, Quality and Training, instant messaged Responder 1 "I have confidence that the Veteran couldn't have received better," "I wish I could have protected you from this," and "I've cried FOR you, so I can't imagine you're not upset as well."

The OIG concluded that the Director, Quality and Training, potentially compromised Responder 1's candidness and recollection by providing advice and information prior to Responder 1's interviews with the OIG. As a VA leader providing preparatory information to a staff member prior to an OIG interview may compromise the accuracy and integrity of information provided to the OIG.

²⁹ 38 C.F.R. § 0.735-12

³⁰ *Merriam-Webster.com Dictionary*, "instant messaging," accessed September 21, 2022, <https://www.merriam-webster.com/dictionary/instant%20messaging>. Instant messages are communications sent electronically; "VA Technical Reference Model v 22.8" (web page), accessed September 21, 2022, <https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=14196#>. The VA-approved technology for instant messaging allows staff to be in compliance with privacy regulations and allows for the transmission of protected health information.

VCL Staff's Failure to Alert Facility Staff of Patient's Death

Following notification of a customer's death by suicide, VCL responders are expected to inform a supervisor, submit a routine consult to the suicide prevention coordinator at the customer's facility, and report the death to VCL leaders via completion of the Report of Death by Suicide.³¹

Ten days after the patient's death, Responder 2 documented that Family Member 2 contacted the VCL and "expressed concerns and anger toward VCL stating that nobody tried to help [the patient]." Responder 2 completed the Report of Death by Suicide but did not submit a suicide prevention consult, as expected.³²

Almost three months after Family Member 2 spoke with Responder 2, a friend of the patient's family (Family Friend 1) contacted the VCL and reported a complaint on behalf of Family Member 1 regarding ongoing receipt of caring letters (as discussed below). Another responder determined that the patient was not identified as deceased in the EHR and submitted a suicide prevention coordinator consult.

The OIG concluded that Responder 2's failure to complete a suicide prevention consult contributed to the delay in facility staff updating the patient's EHR to reflect the patient's death, resulting in the patient's family continuing to receive communications for the patient.

VCL Staff and Leaders Failure to Adequately Address Family Member 2's Complaint

On day 10, Responder 2 completed a Report of Death by Suicide and Medora documentation that noted Family Member 2's reported dissatisfaction with VCL services for the patient and a request for follow up. Leaders reviewed both documents.

However, VCL leaders did not take action to ensure follow up with Family Member 2 because Responder 2 did not complete a complaint form and therefore, the complaint process was not

³¹ VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. Although the 2021 standard operating procedure does not include information regarding submission of a consult to the suicide prevention coordinator, the Director, Quality and Training, informed the OIG that this procedure remained in place. The report of death by suicide is a templated report.

³² VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. Although the 2021 standard operating procedure does not include information regarding submission of a consult to the suicide prevention coordinator, the Director, Quality and Training, informed the OIG that this procedure remained in place.

initiated.³³ In an interview with the OIG, Responder 2 was unsure why Family Member 2's complaint was not submitted to the quality assurance specialist. The OIG concluded that VCL leaders' should have addressed Family Member 2's request for a return call.

Facility Staffs' Delay in Updating the Patient's EHR

The OIG found that although facility staff and leaders were notified of the patient's death on day 4, a deceased alert was not placed in the patient's EHR until day 92, 89 days after staff received the initial patient death notification. The supervisor, Decedent Affairs attributed the delay in placing the deceased alert in the patient's EHR to an "isolated incident, contributed to by human error mainly due to COVID constraints, new employees in training and overwhelming numbers of death notices mainly due to the Pandemic."

Between 15 and 28 days after the patient contacted the VCL and died by suicide, facility staff attempted to contact the patient by phone four times and by mail once regarding healthcare appointments. Facility leaders' failure to ensure timely placement of the deceased alert in the patient's EHR exacerbated the family's distress in the months immediately following the patient's death.

VCL Staffs' Delayed Discontinuation of Caring Letters

The OIG found that VCL staff and leaders were notified of the patient's death nine days after the patient's death by suicide and failed to take actions to discontinue caring letter delivery to the patient's residence until day 85.³⁴ The OIG determined that VCL leaders' failure to develop procedures to ensure the Caring Letters Program received notification of the patient's death exacerbated the bereaved family's distress.

Facility Leaders' Failure to Implement the BHAP

VHA requires that a suicide prevention coordinator complete a BHAP chart review within 30 days of awareness of a patient suicide or suspected patient suicide, contacting the next of kin

³³ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the complaint process as the rescinded 2020 directive; Veterans Crisis Line, "Quality Assurance Complaint Tracking System Standard Operating Procedure," September 29, 2015.

³⁴ "Memorandum of Understanding Between VA Quality Enhancement Research Initiative (QUERI) And Veteran Crisis Line," July 30, 2019. In July 2019, the VCL established a memorandum of understanding with the VA Quality Enhancement Research Initiative to implement sending repeated "brief, nondemanding messages" for expressing "caring concern" to patients that contact VCL.

to inform them about the BHAP process and to initiate a family interview.³⁵ Prior to the OIG's notification of this healthcare inspection, facility Suicide Prevention Program staff did not complete behavioral health autopsies after becoming aware of patients' deaths by suicide or suspected suicide, as required by VHA since November 2012.³⁶ The Suicide Prevention Program manager told the OIG that the supervisory structure for the Suicide Prevention Program "back then was very diffuse" and that BHAPs may not have been completed due to facility staff's "lack of awareness."

Recommendations

The OIG made 11 recommendations to the Executive Director, VCL related to a review of the VCL staff's management of the patient and third-party contacts; alignment of guidelines and documentation for suicide risk assessment classification; oversight of staff who provide crisis management services; retention and oversight of text conversations; issue brief action plan accuracy; reviews of customers' deaths by suicide and accidental overdose; institutional disclosure; notification of a customer's death; review of interactions between the Director, Quality and Training, and staff in preparation for the OIG inspection; complaint submission; and discontinuation of caring letters following notification of a patient's death.

The OIG made three recommendations to the Facility Director related to death notification entry in patients' EHRs, adherence to the standard operating procedures for actions following a patient's or employee's death by suicide, and implementation of the BHAP.

Comments

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

Regarding the Under Secretary for Health's memorandum, comment 4, that the VCL "independently determined" to conduct a root cause analysis, the OIG maintains that VCL leaders initiated a root cause analysis about the patient's contact in response to concerns identified by the OIG team. VCL leaders told the OIG that the decision to not conduct a root cause analysis was based on a quality assurance review conducted 11 months prior to the OIG

³⁵ VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. A BHAP chart review is a systematic EHR review of relevant behavioral health information about the patient prior to their death, including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinician notes; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

³⁶ VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

notification and not having the text conversation between the patient and Responder 1. VCL leaders initiated the root cause analysis three weeks after the OIG notification of the inspection and the OIG obtained and provided VCL leaders with the text conversation approximately three months later. The Executive Director, VCL and the Director, Quality and Training, confirmed that the root cause analysis was conducted as a result of the OIG inspection notification.



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Abbreviations

BHAP	behavioral health autopsy program
EHR	electronic health record
OIG	Office of Inspector General
PTSD	post-traumatic stress disorder
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection to review concerns regarding the Veterans Crisis Line (VCL) staff's management of a patient who died by suicide within the hour after VCL text contact.¹ Specifically, the OIG evaluated the adequacy of the suicide risk assessment, safety planning, and documentation that a responder (Responder 1) completed for the patient. The OIG identified these concerns while reviewing the patient's electronic health record (EHR) for another healthcare inspection. Additionally, the OIG evaluated leaders' oversight of Responder 1's performance. Further, the OIG reviewed administrative actions by leaders and staff at the VCL and Audie L. Murphy Memorial Veterans Hospital (facility) in San Antonio, Texas, following notification of the patient's death. The review included the management of a complaint, a VCL leader's potential interference in the OIG inspection, delays in updating the patient's EHR and discontinuing correspondence, and facility leaders' failure to implement the Behavioral Health Autopsy Program (BHAP).²

Background

In 2007, the Veterans Health Administration (VHA) established the VCL in response to the Joshua Omvig Veterans Suicide Prevention Act, Public Law 110-110.³ The act mandated that VHA provide mental health services 24 hours per day, seven days per week, as well as a toll-free hotline for veterans.⁴

¹ VCL, *Social Science Specialist Training Participant Guide*, November 2021. VCL staff refer to individuals who contact the VCL as customers. For purposes of this report, the OIG refers to the customer, who also received VHA care, as the patient.

² VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. In 2012, VHA implemented the BHAP, which requires completion of a psychological autopsy on patients known to have died by suicide; VA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," November 1, 2020. The BHAP includes an EHR review "to identify contributory factors to suicide," including the patient's diagnoses and use of mental health services, as well as an interview of family members "to understand the circumstances impacting" the patient's life prior to death by suicide.

³ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive.

⁴ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive.

The VCL provides crisis hotline services through telephone, online chat, and text services for veterans, service members, and their family members.⁵ Since established, VCL reports that staff have answered more than five million calls, engaged in more than 704,000 chats, and responded to more than 239,000 texts.⁶ The VCL, aligned under the Office of Mental Health and Suicide Prevention, is accredited by the Commission on Accreditation of Rehabilitation Facilities and the American Association of Suicidology.⁷ VCL centers are located in three sites: Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas.⁸ VCL staff refer individuals to local VHA mental health services or initiate a dispatch of emergency services, as appropriate.⁹

The Audie L. Murphy Memorial Veterans Hospital (facility) in San Antonio, Texas, the Kerrville VA Hospital, and 15 community-based outpatient clinics comprise the South Texas Veterans Health Care System in Veterans Integrated Service Network (VISN) 17.¹⁰ From October 1, 2019, to September 30, 2020, the facility served 94,252 unique patients and had a total of 483 operating beds. The facility provides a range of inpatient, outpatient, domiciliary, and

⁵ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive; *Merriam-Webster.com Dictionary*, “chat,” accessed February 14, 2022, <https://www.merriam-webster.com/dictionary/chat>. A chat is a discussion held over the Internet by sending messages back and forth, usually in a chat room; *Merriam-Webster.com Dictionary*, “text,” accessed February 14, 2022, <https://www.merriam-webster.com/dictionary/text%20message>. A text is a message sent electronically usually to or from a mobile cellular phone.

⁶ “About Us” (web page), VCL network website, accessed February 14, 2022, <https://www.veteranscrisisline.net/about/what-is-vcl>.

⁷ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive; “Who We Are” (web page), CARF International, accessed February 24, 2022, <http://www.carf.org/About/WhoWeAre/>. The Commission on Accreditation of Rehabilitation Facilities (CARF) is an independent, nonprofit accrediting body of health and human services that includes behavioral health. American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012; “About AAS” (web page), American Association of Suicidology, accessed May 15, 2023, <https://suicidology.org/about-aas/>. The American Association of Suicidology is a nonprofit accrediting organization that applies nationally recognized standards to crisis intervention programs.

⁸ VCL, “Orientation Participant Guide,” January 2022.

⁹ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive.

¹⁰ “About Us” (web page), VA website, accessed February 28, 2023, <https://www.va.gov/south-texas-health-care/about-us/>.

community living center services. The facility is affiliated with the University of Texas Health Science Center at San Antonio.

VCL Staff Roles

VCL social science specialists (responders) are staff who interact with individuals (customers) who contact the VCL through calls, chats, and texts.¹¹ Responders are expected to engage customers through active listening, motivational interviewing, problem solving, and safety planning.¹² Responders receive training to identify a customer's level of risk for harm, and initiate dispatch of emergency services for a customer at risk of imminent harm.¹³

Responders should identify the customer's suicide risk factors and address the customer's crisis to ensure safety.¹⁴ Responders are required to identify and address a customer's suicide risk using available resources, including supervisory consultation.¹⁵ The Commission on Accreditation of Rehabilitation Facilities requires responders to demonstrate knowledge and skills in the identification of risk indicators and assessment, active engagement with callers, and decide the appropriate action to stabilize a crisis as soon as possible.¹⁶

¹¹ VCL, *Health Science Specialist Training Participant Guide*, June 2019. In 2020, the title 5 Health Science Specialist was replaced by the Title Hybrid 38 Social Science Specialist. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding the role of responders.

¹² VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding engagement processes and safety planning with customers as the rescinded 2019 guide. VCL also refers to a safety plan as a risk mitigation plan and for purposes of this report, the OIG used the term safety plan.

¹³ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of current substance use and self-directed violent behavior as the rescinded 2019 guide.

¹⁴ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of current substance use and self-directed violent behavior as the rescinded 2019 guide.

¹⁵ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of current substance use and self-directed violent behavior as the rescinded 2019 guide.

¹⁶ Commission on Accreditation of Rehabilitation Facilities, *Behavioral Health Standards Manual 2020*, July 1, 2020, through June 30, 2021.

Supervisory social science specialists (supervisors) oversee the work of responders with responsibilities that include evaluating staff work performance, giving advice or instruction, and identifying staff training needs.¹⁷ The VCL Director, Quality and Training (Director, Quality and Training), reported that responders and supervisors possess a bachelor's degree in a mental health-related field, at a minimum, and are not required to hold a professional license.

Silent monitor social science program specialists (monitor specialists) are staff specifically trained to assess calls, text, and chat, and provide coaching for identified areas in need of improvement immediately following monitored interactions.¹⁸ VCL leaders identified a goal to silent monitor 80 percent of responders at least once per pay period.¹⁹

VCL leaders developed a protocol that outlines the evaluation criteria for responder contact management and guides monitor specialists' coaching for unmet criteria.²⁰ Evaluation criteria include the responder's completion of a suicide risk assessment, offering a Suicide Prevention Program consult, developing a plan to reduce current risk, focusing on the present and current concerns, and accurately documenting the call.²¹

Prior OIG Reports

In a November 2020 report, the OIG substantiated that VCL staff did not initiate an emergency dispatch for a veteran caller who reported use of alcohol and over the counter medications that

¹⁷ VCL Position Description, *Supervisory Social Science Specialist*, December 3, 2020.

¹⁸ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders' interactions with customers as the rescinded 2020 policy.

¹⁹ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders' interactions with customers as the rescinded 2020 policy.

²⁰ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders' interactions with customers as the rescinded 2020 policy.

²¹ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders' interactions with customers as the rescinded 2020 policy.

cause drowsiness and who died the same day as the VCL contact.²² Four of the seven recommendations to the VCL Director are relevant to this inspection and were all closed as of January 19, 2022:

- (1) evaluation of the current responder training on lethal means,
- (2) establishment of policy and training for responders' assessment of callers' substance use,
- (3) completion of safety planning per VCL standards, and
- (4) a system to identify caller contacts that warrant [root cause analysis](#) or other internal reviews and to track the review process.²³

In a 2021 report, the OIG substantiated that a VCL responder failed to assess a caller's homicidal risk factors, address lethal means restriction, complete an adequate safety plan, communicate critical information to a supervisor, and take actions to prevent a family member's death.²⁴ Four recommendations in this report, three to the VCL Director and one to the Executive Director, Office of Mental Health and Suicide Prevention, are relevant to this inspection and include a review of the caller's contacts with the VCL, establishment of benchmarks for required silent monitored calls, conducting root cause analyses, as required, and consideration of disclosure of [adverse events](#).²⁵ These four recommendations were closed as of September 28, 2021.

Concerns

In November 2021, while reviewing the patient's EHR for another healthcare inspection, an OIG team member identified concerns about Responder 1's management of the patient's early 2021 text contact prior to the patient's death by suicide within the hour following the contact. Specifically, the OIG identified concerns about

Responder 1's failure to

- adequately assess the patient's suicide risk, including [suicidal preparatory behavior](#) and alcohol use, during the text conversation;

²² VA OIG, [Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died](#), Report No. 19-08542-11, November 17, 2020.

²³ VA OIG, [Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died](#), Report No. 19-08542-11, November 17, 2020.

²⁴ VA OIG, [Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison](#), Report No. 20-00545-115, April 15, 2021.

²⁵ VA OIG, [Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison](#), Report No. 20-00545-115, April 15, 2021.

- establish an effective safety plan, including confirmation of the patient's reduced access to lethal means and involvement of the patient's family member (Family Member 1); and
- document accurately.

VCL leaders' failure to

- provide adequate oversight of Responder 1, and
- ensure quality assurance of text crisis management due to a lack of text retention.

The OIG also identified concerns related to inadequate and problematic VCL leader and staff actions following notification of the patient's death by suicide including a failure to

- complete a root cause analysis,
- consider a disclosure,
- alert facility staff of the patient's death, and
- adequately address a family member's (Family Member 2's) complaint.

The OIG also evaluated

- a VCL leader's potential interference in the OIG inspection,
- VCL staff's failure to alert facility staff of the patient's death,
- facility staff's delay in updating the patient's EHR to reflect the patient's death,
- VCL staff's delayed discontinuation of caring letters, and
- facility leaders' failure to implement BHAP, as required by VHA.²⁶

²⁶ "VA launches program to send caring letters to 90,000 Veterans" (web page), Office of Public and Intergovernmental Affairs, accessed April 25, 2023, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5537>; "Memorandum of Understanding Between VA Quality Enhancement Research Initiative (QUERI) And Veteran Crisis Line," July 30, 2019. In July 2019, the VCL established a memorandum of understanding with the VA Quality Enhancement Research Initiative to implement sending repeated "brief, nondemanding" messages for expressing "simple expressions of care and concern" to patients that contact the VCL.

Scope and Methodology

The OIG initiated the healthcare inspection on November 4, 2021, and conducted a virtual site visit on January 10–13, 2022, with VCL staff located at the Atlanta and Canandaigua sites, and facility staff.²⁷

The OIG team reviewed the patient's EHR and Medora documentation; applicable VHA directives, handbooks, and memoranda; VCL and facility policies and operational procedures; VCL staff position descriptions; relevant internal VCL review documents, instant messages, and emails; and an audio recording of Family Member 2's telephone contact with VCL.²⁸ Other documents reviewed included American Association of Suicidology guidelines, Commission on Accreditation of Rehabilitation Facilities standards, non-VA crisis line policies and procedures, and the National Guidelines for Behavior Health Crisis Care Best Practice Toolkit.²⁹

The OIG team reviewed the text message conversation between the patient and Responder 1, provided by Family Member 1. Additionally, the OIG reviewed the patient's mobile phone records from a communications company, obtained by subpoena, and VCL data regarding Responder 1's crisis management activity on the day of the patient's contact.

The OIG provided three non-VA subject matter experts with a transcript of the text conversation between the patient and Responder 1.³⁰ The OIG team interviewed the patient's family members; the three non-VA subject matter experts; VCL leaders, including the Executive Director; Director, Quality and Training; Patient Safety, Risk Manager; and VCL staff who interacted with

²⁷ The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19" (web page), World Health Organization, accessed February 10, 2022, <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>; Merriam-Webster.com Dictionary, "pandemic," accessed February 15, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is an outbreak of a disease that occurs over a wide geographic area that affects most of the population." "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It" (web page), World Health Organization, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

²⁸ VCL, *Social Science Specialist Training Participant Guide*, November 2021. Medora is the computer-based application used by responders to document VCL contacts; Merriam-Webster.com Dictionary, "instant messaging," accessed September 21, 2022, <https://www.merriam-webster.com/dictionary/instant%20messaging>. Instant messages are communications sent electronically; "VA Technical Reference Model v 22.8" (web page), accessed September 21, 2022, <https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=14196#>. The VA approved technology for instant messaging allows staff to be in compliance with privacy regulations and allows for the transmission of protected health information.

²⁹ "National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit" (web page), Substance Abuse and Mental Health Services Administration, accessed May 9, 2022, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

³⁰ The three subject matter experts served on non-VA national crisis call center committees. One subject matter expert had primary academic affiliation and the two other subject matter experts served as crisis line organization leaders. The text conversation transcript was depersonalized to protect patient confidentiality.

the patient, family members, and a third-party caller.³¹ The OIG team also interviewed facility leaders including the Director; Chief of Staff; deputy chief of staff; Suicide Prevention Program manager; acting associate chiefs of staff, mental health; and the mental health providers and two suicide prevention coordinators involved in the patient's care.

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).

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 30's at the time of death in early 2021, had a history of [post-traumatic stress disorder](#) (PTSD), [attention deficit hyperactivity disorder](#), [major depressive disorder](#), [alcohol use disorder](#), and [obstructive sleep apnea](#).³²

In spring 2018, the patient initiated treatment with a facility primary care physician and, after a positive PTSD screen, was scheduled for a same-day appointment with a [primary care mental health integration provider](#). During the remainder of 2018, the patient received medication for mood management from the primary care physician and psychotherapy in group and individual settings. In late December 2018, the patient initiated contact with a VCL chat responder, reported suicidal thoughts, and was contacted by the facility's suicide prevention coordinator. In early 2019, a facility psychiatrist provided medication management and continued to see the patient regularly.

In late fall 2019, the patient reported that approximately two months earlier, Family Member 1 intervened when the patient self-directed a "loaded firearm." A facility psychologist documented a suicide behavior and overdose report and a safety plan that included "guns locked, [Family

³¹ In January 2023, the OIG was informed that the Executive Director had moved to another VHA position.

³² The OIG uses the singular form of they, "their" in this instance, for the purpose of patient privacy.

Member 1] has key, along with all opioids and all excess medications.”³³ A suicide prevention case manager placed a high risk for suicide patient record flag in the patient’s EHR.³⁴

In early 2020, the psychiatrist documented the patient’s “overall immediate suicide risk” as moderate to low, the psychologist documented the patient’s request to “taper down/further” treatment at the next visit, and the High-Risk Committee removed the patient’s high risk for suicide patient record flag.³⁵ The patient continued to meet with the psychologist routinely until early fall 2020 when the psychologist documented that the patient denied suicidal ideation in the prior three months, declined changes to the safety plan, and agreed to terminate psychotherapy. At a scheduled appointment in early 2021, the psychiatrist documented that the patient denied “suicidality/homicidality/self harm thoughts/assaultive ideations,” evaluated the “overall immediate suicide risk” as moderate to low, and noted a plan for the patient to return to the clinic in eight weeks.

A week later (day 1), at 10:14 p.m., the patient contacted the VCL by text message. Responder 1 documented that the patient had a “Plan or Intent of Suicide,” and access to means and firearms. Responder 1 also documented that the patient was in a “shed with a belt around a hook that hangs from the rafters of the shed,” and “reached out tonight in order to stop from taking action to end [the patient’s] life.” In the text conversation, the patient texted, “I was testing it out and feeling everything fade.” Responder 1 documented a safety plan that included the patient texting Family Member 1 to enact the safety plan, and taking additional steps to “go inside the house, [Family Member 1] will secure all means, take medications as prescribed and then turn them over to [Family Member 1], go to bed, wait for [the patient’s] providers to call tomorrow, and contact VCL if in need of further support.” The patient’s last outgoing message was sent to the

³³ VHA Acting Deputy Under Secretary for Health for Operations and Management memo, “Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation,” April 8, 2019. A Suicide Behavior and Overdose Report is entered into the EHR when a provider is informed of a patient’s suicidal behaviors including an attempt, suicide death, preparation for suicide, and an overdose. The Suicide Behavior and Overdose Report “provides a nationally standardized note for documenting suicide behaviors and overdoses, including fatal and nonfatal events.”

³⁴ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008; VHA Deputy Under Secretary for Health for Operations and Management memo, “Update to High Risk for Suicide Patient Record Flag Changes,” January 16, 2020. VHA enters a high risk for suicide patient record flag in the EHR to identify a patient as high risk for suicide, which requires intensive follow-up by providers while the patient remains flagged.

³⁵ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VHA, *Suicide Prevention Program Guide*, November 1, 2020. VHA requires facility leaders to designate an interdisciplinary committee or advisory group to assist with patient record flag recommendations and advise the suicide prevention coordinator in the determination process including guidance about inactivation of patient record flags.

VCL at 11:02 p.m. Responder 1's last message to the patient was at approximately 11:29 p.m. and Responder 1 noted that the patient "stayed on line until the call ended normally."³⁶

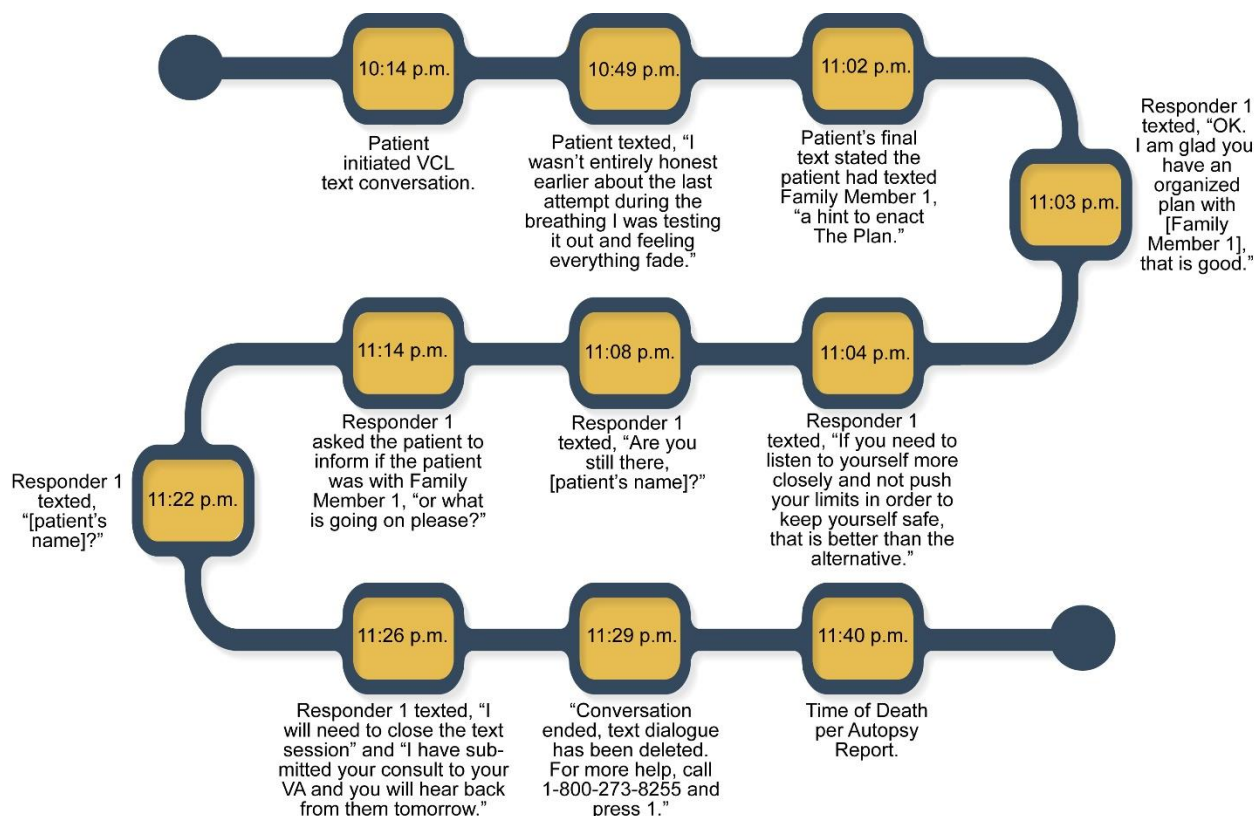


Figure 1. Select patient and Responder 1 texts timeline.

Source: OIG review of the VCL text contact between Responder 1 and the patient.

The next day (day 2), a facility Suicide Prevention Program case manager documented unsuccessful telephone calls to the patient and Family Member 1. The Suicide Prevention Program case manager documented a plan to continue to follow up with the patient or Family Member 1 for safety assessment the next day. The psychologist also attempted to contact the patient and left a voicemail offering the patient an appointment and options for contacting the VCL or walking into an emergency department "if needed to remain safe." On day 3, the Suicide Prevention Program case manager documented unsuccessful attempts to contact the patient and Family Member 1, and a plan to attempt contact the following day that, if unsuccessful, would prompt consideration of sending a welfare check.³⁷

³⁶ VCL and mobile phone records indicate 11:29 p.m. as the time of Responder 1's final text message to the patient while the Medora and EHR documentation indicate 11:27 p.m.

³⁷ VCL, *Health Science Specialist Training Participant Guide*, June 2019. "A Welfare Check is a physical check on an individual's welfare by emergency services, prompted by a concerned person."

On day 4, the psychiatrist documented making multiple telephone attempts to reach the patient and Family Member 1. That same day, the Suicide Prevention Program case manager left voicemail messages requesting the patient to return the calls and then contacted the sheriff's department to request a welfare check. A sheriff department staff member confirmed that the patient died by suicide on day 1, and that Family Member 1 found the patient hanging in the patient's shed.

Also on day 4, the Suicide Prevention Program case manager completed a suicide behavior and overdose report and documented that the contact between the patient and Responder 1 ended "with agreement [the patient] would alert [Family Member 1] to enact a plan for safety."³⁸ Further, the lead detective reportedly told the Suicide Prevention Program case manager that the patient did alert Family Member 1 via text message but the patient "never went into the house which prompted" Family Member 1 to look for the patient.

The autopsy report noted the patient's time of death as 11:40 p.m., cause of death as asphyxia by hanging, and manner of death as suicide.

Inspection Results

1. Responder 1's Mismanagement of the Patient's Contact

The OIG found that Responder 1 did not complete an adequate assessment of the patient's suicide risk factors, including the patient's suicidal preparatory behavior and alcohol use, during the text conversation.³⁹ The OIG determined that Responder 1 failed to adequately pursue actions to address the patient's suicidal preparatory behavior, including reducing access to immediate

³⁸ VHA Acting Deputy Under Secretary for Health for Operations and Management memo, "Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation," April 8, 2019. The Suicide Behavior and Overdose Report "provides a nationally standardized note for documenting suicide behaviors and overdoses, including fatal and nonfatal events."

³⁹ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of current substance use and self-directed violent behavior as the rescinded 2019 guide.

lethal means and involving Family Member 1, as expected by VCL guidance.⁴⁰ The OIG concluded that Responder 1's failure to clarify the patient's engagement in suicidal preparatory behavior and alcohol use likely contributed to Responder 1's underestimation of the patient's imminent suicide risk and failure to follow up after the patient's discontinuation of texting or consider third-party involvement.

In addition, the OIG found that Responder 1 did not accurately document the patient's text message information or disposition. Further, VCL leaders failed to ensure that monitor specialists conducted oversight of administrative staff performing responder duties, including Responder 1's interactions with customers via phone, chat, and text, as expected by VCL guidance.⁴¹ The OIG also determined that VCL leaders failed to establish a system for retention of text messages that compromised quality management oversight and increased the risk of unidentified performance concerns.

Context of the Contact Between the Patient and Responder 1

The night of the patient's VCL contact, Responder 1, a monitor specialist, was providing text responder duties for overtime pay.⁴² VCL data indicated that the patient and Responder 1 engaged in a 75-minute text conversation from 10:14 p.m. until approximately 11:29 p.m. The

⁴⁰ On March 17, 2022, following receipt of the text messages and OIG's identification of the responder's failures to mitigate the patient's suicide risk, the OIG notified the Executive Director, VA Suicide Prevention. VCL leaders reported ensuring Responder 1 was no longer "engaging in direct contact with Veterans.," VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), on December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of the VCL as the rescinded 2020 directive; VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding suicidal preparatory behavior and reducing access to lethal means as the rescinded 2019 guide; VCL-S-ACT-217-2004(2), "Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning," September 22, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-217-2104, April 2021. Unless otherwise specified, the 2021 directive contains the same or similar language regarding the suicidal preparatory behavior and reducing access to lethal means as the rescinded 2020 standard operating procedure.

⁴¹ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), on December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive.

⁴² VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the duties of the silent monitor and responder as the rescinded 2020 policy; Responder 1 provided coverage as a responder for overtime pay since January 2019. Responder 1 told the OIG of being employed as a VCL responder for six years prior to assuming silent monitor duties.

patient's text conversation was the only crisis management activity that Responder 1 was engaged in at that time.

Family Member 1 provided the OIG with screenshots of 80 text messages from the patient to the VCL while VCL and mobile phone records data identified 90 text messages from the patient to the VCL. The OIG, VCL, and mobile phone records data indicated that the text conversation included 57, 55, and 53 text messages from Responder 1 to the patient, respectively.⁴³ These differences may be due to deleted messages or different methods of counting characters to define a discrete text message. The OIG was unable to clarify the differences in number of text messages because the VCL did not retain the text messages. The VCL's failure to retain text messages is discussed below.

Further, the OIG was unable to determine the exact relationship between time stamps and text messages because the text messages provided by Family Member 1 did not include time stamps and the mobile phone company was unable to provide content associated with each time stamp. However, the OIG was able to identify the timing of the majority of the text message exchanges between Responder 1 and the patient. The OIG found the provided text messages to be in a coherent and logical sequence that allowed for a robust review of Responder 1's management of the patient's contact.

Inadequate Suicide Risk Assessment

The VCL considers assessing a customer's risk as "one of the primary jobs of a Responder" and emphasizes that to intervene successfully, the responder "needs to go beyond simply noting the presence of a risk factor by exploring the various aspects of the Customer's situation."⁴⁴

VCL responders are expected to ask the customer about current and past suicidal ideation and suicidal behaviors and, to determine the level of risk, follow up with specific questions regarding the customer's

- suicidal desire and intent,
- suicide plan and plan timeline,
- suicidal preparatory behavior, and

⁴³ The OIG reviewed non-VHA patient records obtained by subpoena and was unable to determine the exact number of messages from the patient or from Responder 1.

⁴⁴ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding risk assessment as the rescinded 2019 guide.

- “access to means to carry out plan.”⁴⁵

Responder 1's Failure to Assess Suicidal Preparatory Behavior

The VCL instructs responders to identify whether a customer has engaged in self-directed violent behavior that may be preparatory or potentially harmful.⁴⁶ Further, for a customer who has engaged in self-directed violent behavior that day, the VCL advises the responder to explore “potential need for medical attention,” and assess the customer’s current intent and if undetermined, seek supervisory consultation.⁴⁷

In texts to Responder 1, the patient reported having suicidal ideation that same day, attempting suicide “maybe a year and a half” prior, and receiving mental health treatment. Initially the patient denied suicidal desire, intent, and a specific plan, although acknowledged having “weighed options” and not wanting to die. Responder 1 texted, “Tell me more...” and the patient texted that “Everything is going pretty good. I have a job I have my family and I have my health.” (See figure 2.)

⁴⁵ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of the customer’s access to lethal means as the rescinded 2019 guide.

⁴⁶ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of self-directed violence as the rescinded 2019 guide.

⁴⁷ VCL-S-ACT-217-1907, “Standard Operating Procedure for Positive Self-Directed Violence (SDV) Screening,” July 25, 2019.

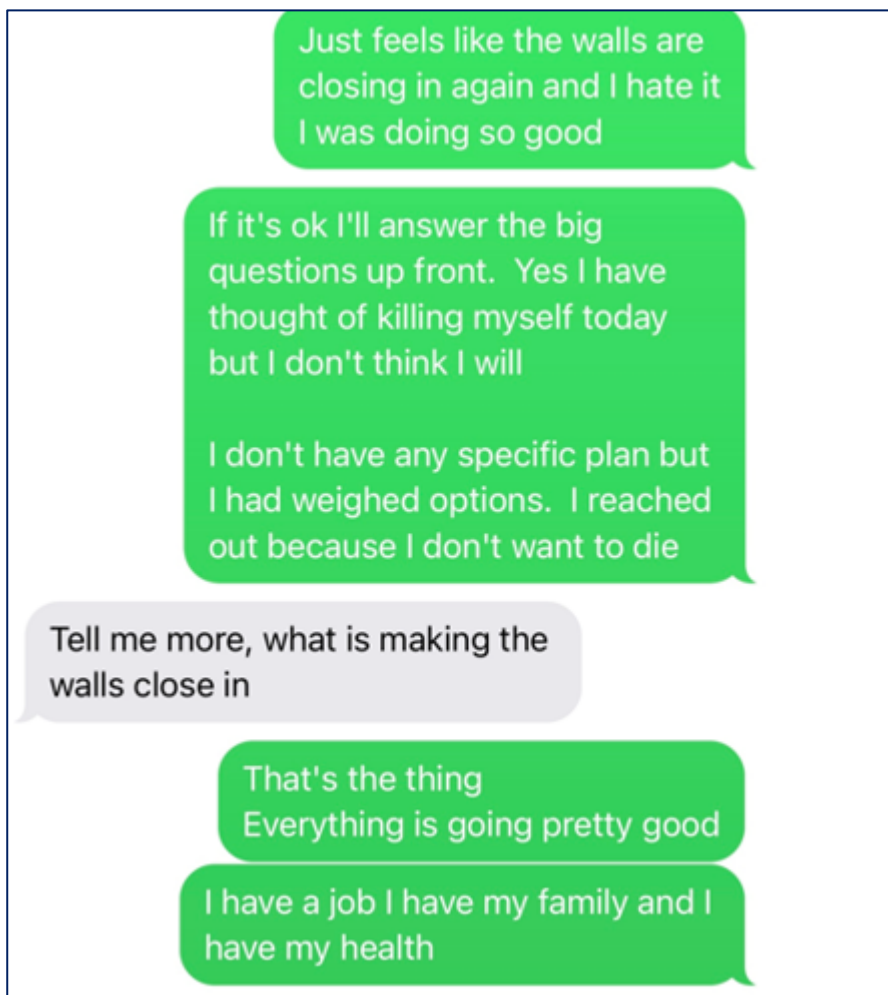


Figure 2. Excerpt from text message screen shots.
Source: Provided by Family Member 1.

After approximately 16 minutes of text contact, at 10:30 p.m., the patient texted, “I was going to hang myself and that’s when I decided to call in.” Responder 1 asked the patient about access to means for hanging and the patient replied, “There’s a hook that always hangs from the rafters.” (See figure 3.)

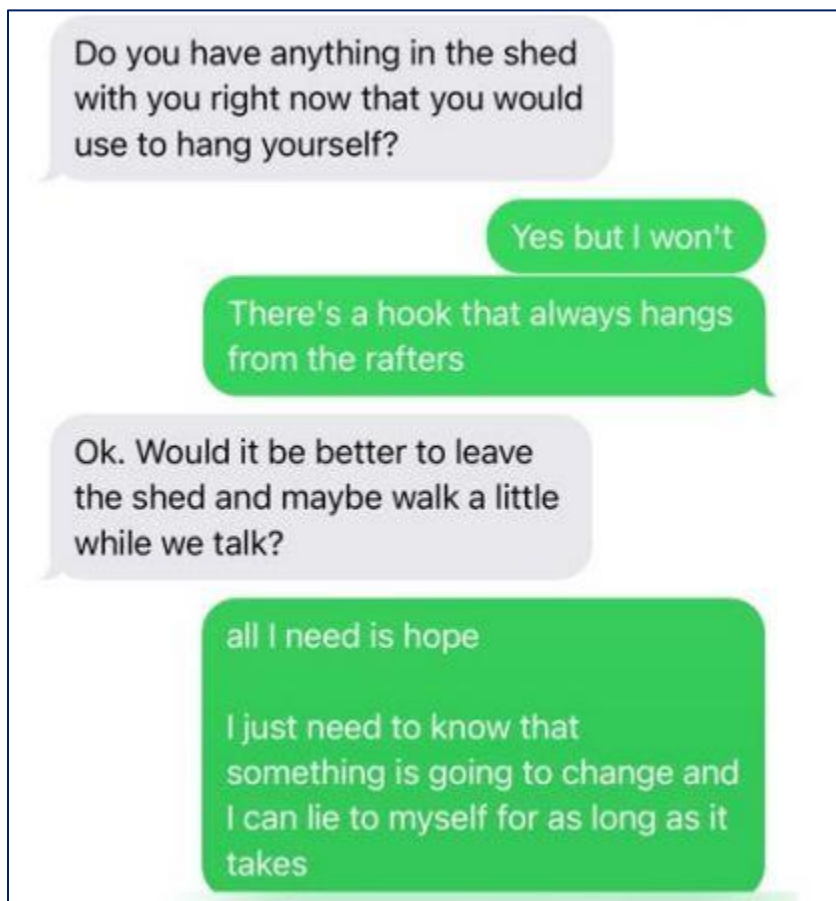


Figure 3. Excerpt from text message screen shots.

Source: Provided by Family Member 1.

The patient then texted that the suicidal thoughts were “pretty constant,” and the urge is “always with me Always chasing me I’m tired,” and that the patient didn’t want people “to know I’m [slipping] again.” Responder 1 expressed support for the patient’s reaching out for help. The patient then texted, “Thank you. When I can’t call anyone else I know I can call in before it’s too late.” Then Responder 1 proposed doing a breathing exercise and instructed the patient to “Think about things that make you feel calm and centered while you do that.”

Following the breathing exercise, Responder 1 asked the patient, “What else do you normally do when you are feeling like this to keep yourself safe?”⁴⁸ The patient acknowledged not being “entirely honest” and reported “testing it out and feeling everything fade” during the breathing exercise. The OIG and two subject matter experts interpreted this to mean that the patient tried the hanging apparatus while in the text conversation with Responder 1.⁴⁹ (See figure 4.)

⁴⁸ On March 17, 2022, the OIG provided the text transcript of Responder 1’s interaction with the patient to the Executive Director, VA Suicide Prevention, Office of Mental Health and Suicide Prevention.

⁴⁹ In response to the OIG’s question about the interpretation of the patient’s text, one of the three subject matter experts replied, “I don’t know, and nobody knows really.”

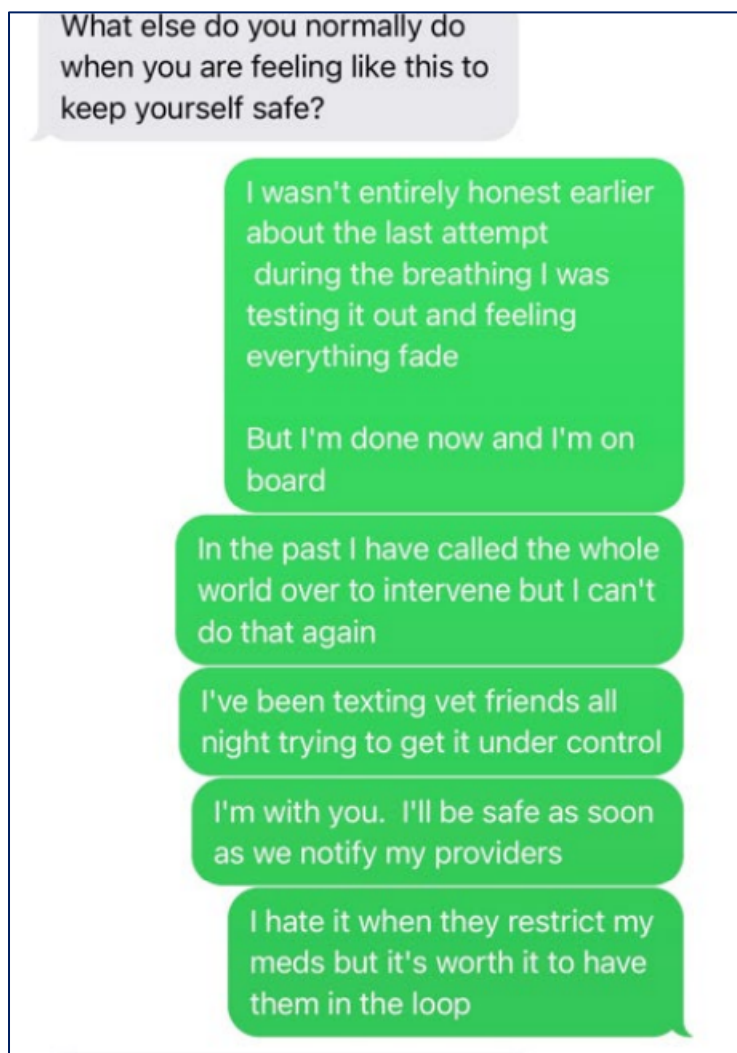


Figure 4. Excerpt from text message screen shots.
Source: Provided by Family Member 1.

In reply, Responder 1 texted suggestions such as taking a shower or talking with Family Member 1 “to distract [the patient] and keep [the patient] safe.” Responder 1 did not ask any follow-up questions regarding the patient’s likely admission of practicing hanging at the time of the text conversation, including the patient’s potential need for medical attention or current intent, as indicated by VCL guidance.⁵⁰ The OIG found that Responder 1 did not address the patient’s likely suicidal preparatory behavior using the patient’s identified lethal means, hanging apparatus, during the text conversation.

When the OIG asked what the patient was referring to in that text, Responder 1 reported not recalling that text and that the patient was probably “referring to the belt” used in a suicide

⁵⁰ VCL-S-ACT-217-1907, “Standard Operating Procedure for Positive Self-Directed Violence (SDV) Screening,” July 25, 2019.

attempt before calling VCL. Responder 1 documented that the patient had not “put any plans into action,” and told the OIG that this was “probably just an oversight” since the patient had “preparatory behavior, um, with hanging the belt.”

Supervisory Review

One week after the OIG provided the Executive Director, VA Suicide Prevention Program, with the text conversation between the patient and Responder 1, two VCL staff members (Reviewers 1 and 2) reviewed the text transcript.⁵¹ Reviewer 1 rated Responder 1's suicide risk assessment as unsuccessful and noted that Responder 1 did “not ask about the severity of their injuries if service recipient has already harmed themselves” and did “not follow up on preparatory behaviors.” Reviewer 2 rated Responder 1 as unsuccessful in identifying the patient's suicidal plan and intent. Reviewer 2 also noted that “The statement about ‘testing it out and feeling everything fade’ was not addressed by [Responder 1]” and that “The Texter made a suicide attempt while on the call, but this was not acknowledged during the text interaction.”

Consistent with the evaluations by Reviewers 1 and 2, subject matter experts noted that the patient had “divulged to the responder that they just made a suicide attempt, by hanging, during the time of the breathing exercise” and “it could certainly be referring to suffocation attempt and it should have been clarified.” Further, subject matter experts suggested that the patient's acute suicide risk might necessitate rescue and third-party involvement.

Text Contact Termination

The VCL advises responders to terminate a text session if a customer is silent for 15 minutes, “to prompt the Customer to respond once prior to the 15-minute mark,” and to “give a brief reasoning for the termination of the Text session...”⁵² The VCL expects responders to end a text conversation with a reminder for the customer to contact the VCL again if in crisis with exceptions “in cases of technical difficulties or abrupt Text termination by the Customer.”⁵³ A subject matter expert provided the OIG with written requirements for crisis management staff to contact the customer by telephone if there is an abrupt end to the chat or text and “where issues of suicide were discussed, but did not result in safety planning or final resolution in the staff's opinion.”

The patient stopped replying to Responder 1's texts and Responder 1's last text to the patient was sent at 11:29 p.m., 27 minutes later. Following the patient's report of having texted a “hint” to Family Member 1 “to enact The Plan,” at 11:02 p.m., Responder 1 texted “Ok. I am glad you have an organized plan with [Family Member 1], that is good.” The patient did not reply, and over the next 26 minutes, Responder 1 sent six more texts including a supportive message “listen

⁵¹ Reviewer 1 was a quality management officer and Reviewer 2 was a Division Director for Crisis Operations.

⁵² VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

⁵³ VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

to yourself” and do “not push your limits in order to keep yourself safe,” followed by three texts inquiring if the patient was “still there,” and “can you let me know if you are with [Family Member 1] or what is going on please?” Responder 1’s two final texts noted, “I will need to close the text session,” and advised the patient to contact VCL “[f]or more help,” at 11:26 p.m. and 11:29 p.m., respectively. (See figure 5.) Responder 1 documented that the patient “stayed on line [*sic*] until the call ended normally.”

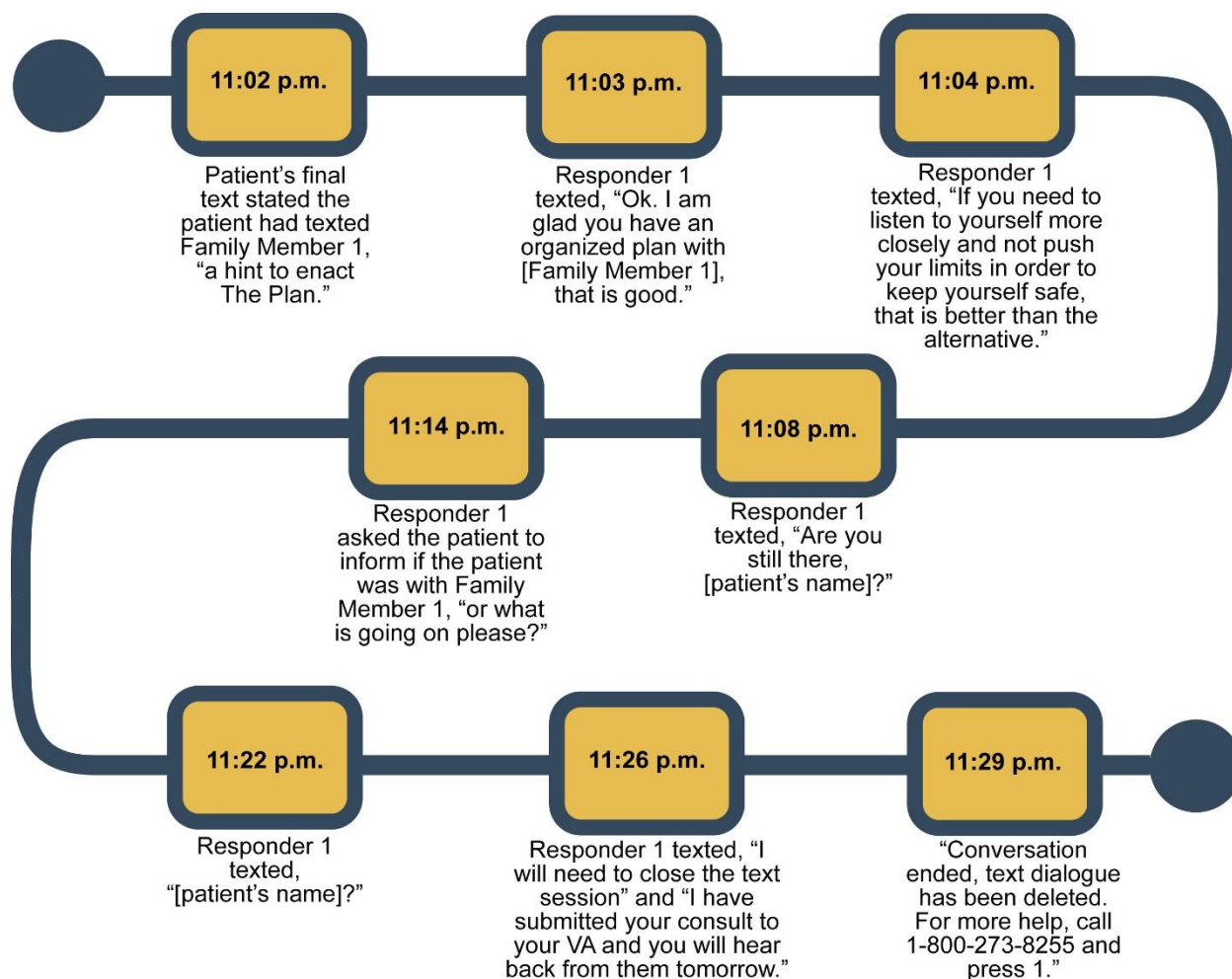


Figure 5. Select patient and Responder 1 texts timeline.

Source: OIG review of the VCL text contact between the patient and Responder 1.

The OIG determined that Responder 1’s termination of the text conversation with the patient was consistent with VCL guidance based on Responder 1’s belief that the patient was not at imminent risk of suicide and that a safety plan was established.⁵⁴ Although the OIG found that Responder 1 discussed elements of a safety plan with the patient, the patient discontinued responding to Responder 1’s texts without confirming follow through with the plan to go in the

⁵⁴ VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

house or involve Family Member 1. Responder 1 closed the text conversation with no further action or explanation.

During the conversation, the patient texted statements that suggested the patient was not at acute risk of suicide such as “I’m not going to die today and we are going to make a plan,” and “I’ll be safe as soon as we notify my providers.” However, in addition to suicidal preparatory behavior and immediate access to lethal means, the patient also texted statements that suggested acute risk of suicide such as “I will stick to the plan tonight but I feel like I need to tell someone this. Part of me doesn’t want to do this anymore.”

The OIG found that Responder 1 failed to clarify the patient’s report of suicidal preparatory behavior, immediate access to lethal means, and what “hint” for safety planning was sent to Family Member 1. These failures likely contributed to Responder 1’s underestimation of the patient’s imminent suicide risk and subsequent failure to follow up after the patient’s discontinuation of texting or to consider third-party involvement.

Responder 1’s Failure to Assess Alcohol Use

In addition to an individual having suicidal ideation and access to means, the American Association of Suicidology and the Centers for Disease Control and Prevention identifies alcohol use as a risk factor for suicide.⁵⁵

Responder 1 suggested, “So these feelings kind of came out of left field and caught you off guard tonight.” The patient replied, “Part of me wants to get drunk enough to get it over with and part of me is scared I will.” (See figure 6.) Family Member 1 informed the OIG that the patient was drinking beer while in the shed, although not much, and less than during prior occurrences of suicidal behavior. The autopsy report indicated a postmortem [blood alcohol content](#) of 0.06 percent. Prior to death, the patient’s blood alcohol content was likely between 0.06 and 0.13 percent, suggesting that the patient may have had impaired judgment and reasoning due to alcohol use.⁵⁶

⁵⁵ “Suicide Prevention–Risk and Protective Factors” (web page), Centers for Disease Control and Prevention (CDC), accessed December 5, 2022, <https://www.cdc.gov/suicide/factors/index.html>.

⁵⁶ Cleveland Clinic, “blood alcohol content,” accessed June 7, 2022, <https://my.clevelandclinic.org/health/diagnostics/22689-blood-alcohol-content-bac>. The patient’s blood alcohol testing was conducted soon enough following death that results should be valid assuming other factors, such as environmental temperatures, did not contribute significantly.

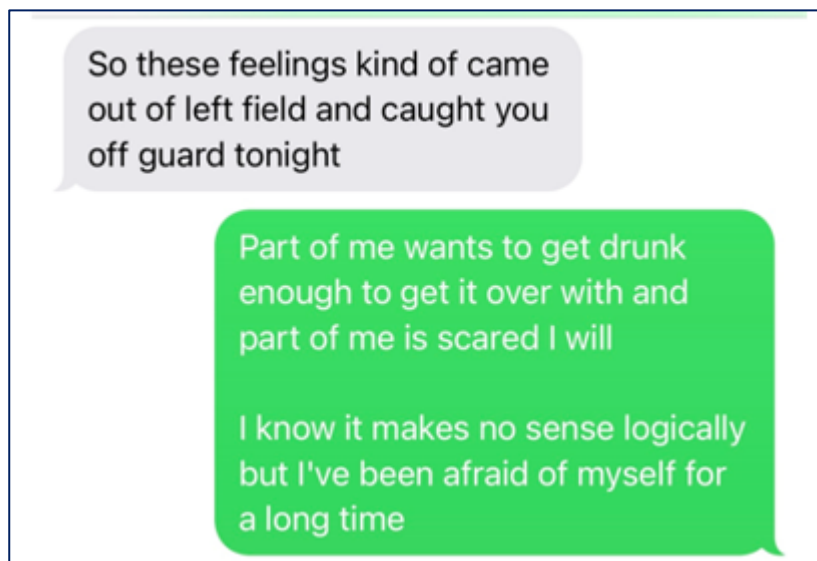


Figure 6. Excerpt from text message screen shots.
Source: Provided by Family Member 1.

Responder 1 did not inquire about the patient's alcohol use and documented that it was "Difficult to Determine" if the patient was "[c]urrently [i]ntoxicated?" In an interview with the OIG, Responder 1 reported that alcohol use was not explored because the patient "didn't mention any of that" and there was "no presentation that that was a concern."

Responder 1 further explained that in the Medora documentation template, the options are, "we have yes, we have no, and we have difficult to determine. If it wasn't addressed on the call or on the text, or chat, you can't say yes or no, you would have to choose difficult to determine because there's no other option." Responder 1 noted that, "It's usually pretty easy to tell" when a text customer is intoxicated based on the text conversation that may have "[l]ong periods of pause" between text messages or "Typing, how they type, misspelled words, a lot of carry-on sentences." However, alcohol use affects individuals differently due to multiple factors including body size, amount of food eaten, and the rate of alcohol consumption.⁵⁷ Although the text inconsistencies that Responder 1 described may suggest intoxication, the absence of these texting flaws does not indicate sobriety.

The subject matter experts described expectations for Responder 1 to assess the patient's alcohol use. One subject matter expert stated,

This was a huge missed opportunity to assess whether the customer was currently consuming alcohol and/or was under the influence as it would weigh heavily into their suicide risk. This statement, made very early in the exchange, indicates that if the

⁵⁷ "Alcohol's Effects on the Body," Harvard Health Publishing, accessed February 1, 2023, <https://www.health.harvard.edu/addiction/alcohols-effects-on-the-body>.

customer were to become intoxicated, they might carry out a suicide act. It was deeply concerning to see no exploration of this by the responder.

Responder 1 told the OIG that the expectation for responders to follow up on a customer's mention of alcohol or substance use was not in effect at the time of the patient's VCL text conversation. In a November 2020 report, the OIG recommended establishment of policy and training for responders' assessment of callers' substance use.⁵⁸ In response, in April 2021, approximately two months after the patient's death, VCL leaders updated a standard operating procedure to include guidance for responders to "Determine access to substances and potential for continued use."⁵⁹ In July 2021, VCL leaders reported to the OIG that "[a]ll available" VCL staff completed the "substance use disorder and overdose risk training and received coaching for the new monitoring standards."

Although VCL written guidance was not yet established, given the patient's report of a desire to become intoxicated, the OIG would have expected Responder 1 to, at a minimum, attempt to determine the patient's intention to consume alcohol to better understand the potential risk of intoxication, a known suicide risk factor. The OIG concluded that Responder 1's lack of follow up to the patient's text about alcohol use may have contributed to an underestimation of the patient's suicide risk.⁶⁰

Ineffective Safety Planning

The OIG found that Responder 1 failed to establish an effective safety plan with the patient. Specifically, Responder 1 failed to confirm the patient's actions to reduce immediate access to lethal means and actively involve Family Member 1 in the safety planning process. Further, the OIG found that Responder 1 did not consider transferring from text to telephone management based on the perception of having established a safety plan with the patient.

The National Guidelines for Behavioral Health Crisis Care advises the importance of reduction in access to lethal means and the two crisis management objectives of "Always knowing where an individual in crisis is" and "verifying that the hand-off has occurred."⁶¹ VCL instructs responders to collaboratively address lethal means restriction and develop an individualized safety plan with each customer or a concerned third party for customers with access to means to

⁵⁸ VA OIG, *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died*, Report No. 19-08542-11, November 17, 2020.

⁵⁹ VCL-S-ACT-217-2104, "VCL Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning," April 2021.

⁶⁰ American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012.

⁶¹ "National Guidelines for Behavior Health Crisis Care, Best Practice Toolkit," Substance Abuse and Mental Health Services Administration, accessed May 9, 2022, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

carry out suicidal behaviors.⁶² The VCL advises responders that if a customer “reports having lethal means nearby, immediately discuss options to reduce access during interaction.”⁶³

VCL guidance reminds responders:

If a responder and a Customer collaboratively work together to diffuse the Customer's crisis and create a safety plan, but the Customer's self-identified means for suicide is still readily available, is the Customer safe? Most likely not.⁶⁴

The American Association of Suicidology advises that during customer interactions “involving imminent life threatening behavior,” interventions involving third parties, such as family members, may be necessary. Consent to contact third parties should be obtained, when possible.⁶⁵

VCL specifies that safety plans “can involve supports such as individuals who the Customer can be open with about suicide” and who can take possession of the means, such as unload a firearm or untie a noose, and “to temporarily take possession of means, put means in an area that is difficult to access.”⁶⁶

⁶² VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding lethal means restriction and safety planning as the rescinded 2019 guide; VCL-S-ACT-217-2004(2), “Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning,” September 22, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-217-2104, “Veterans Crisis Line Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning, April 2021; VCL-S-ACT-216-2011, “Veterans Crisis Line- Standard Operating Procedure for Call Flow,” October 26, 2020. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-216-2103(2), “Standard Operating Procedure for Call Flow,” April 2021. Unless otherwise specified, the 2021 standard operating procedures contain the same or similar language regarding guidance when a customer “reports having lethal means nearby” as the 2020 standard operating procedures.

⁶³ VCL-S-ACT-216-2011, “Standard Operating Procedure for Call Flow,” October 26, 2020. This standard operating procedure was in effect at the time of the events discussed in the report. It was replaced by VCL-S-ACT-216-2103(2), “Standard Operating Procedure for Call Flow,” April 2021. Unless otherwise specified, the 2021 standard operating procedure contains the same or similar language regarding guidance when a customer “reports having lethal means nearby” as the 2020 standard operating procedure.

⁶⁴ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding lethal means restriction and safety planning as the rescinded 2019 guide.

⁶⁵ American Association of Suicidology, *Organization Accreditation Standards Manual Thirteenth Edition*, January 2012.

⁶⁶ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding lethal means restriction and safety planning as the rescinded 2019 guide.

Responder 1's Failure to Confirm Patient's Reduced Access to Lethal Means

Consistent with the patient's texts, Responder 1 documented that the patient was in a "shed with a belt around a hook that hangs from the rafters of the shed," and "reached out tonight in order to stop from taking action to end [the patient's] life."⁶⁷ The patient texted that Family Member 1 was in the house and "I'm in my shed now trying to get right," and "Because I can't get to my guns without [Family Member 1] noticing I was going to hang myself." Responder 1 asked the patient, "Would it be better to leave the shed and maybe walk a little while we talk?" The patient did not confirm leaving the shed and replied, "all I need is hope I just need to know that something is going to change and I can lie to myself for as long as it takes." (See figure 3 above.)

The patient's final text stated that the patient had "already texted [Family Member 1] a hint to enact The Plan." Responder 1 documented risk mitigation as including that the patient would "Go inside the house, [Family Member 1] will secure all means." Responder 1 also documented that the patient and Responder 1 "went over grounding techniques and explored risk mitigation for tonight. [The patient] stated [the patient] was still outside but texted [Family Member 1] to enact 'the plan.'" The OIG found that Responder 1 did not attempt to confirm with the patient or Family Member 1 whether the patient was outside the shed and did not clarify what "hint" the patient gave to Family Member 1.

In an interview with the OIG, Responder 1 recollected that the patient "assured me" about having "left the shed and [the patient] was just kind of pacing [the patient's] backyard during the conversation." Family Member 1 told the OIG about not seeing the patient outside the shed at any time that evening. The OIG found that the text conversation did not include confirmation that the patient left the shed or was outside the shed at any point during the VCL contact.

Prior to the OIG obtaining the text conversation, Responder 1 told the OIG about asking the patient "if [the patient] was comfortable taking [the belt] down from the rafters," and that the patient "said no, [the patient] doesn't want to touch them, I said can you leave the shed so we can talk. [The patient] said sure so [the patient] assured me" about leaving the shed "and [the patient] was just kind of pacing [the patient's] backyard during the conversation." The text conversation obtained by the OIG did not include a text from Responder 1 suggesting that the patient dismantle the hanging apparatus or assurances from the patient about having left the shed. Following review of the text conversation, Responder 1 also told the OIG that, "If [the patient] had attempted at any point in time either before contacting us or while in contact with us then despite whatever [the patient] was saying otherwise, such as, you know, I'm, you know, I'm past

⁶⁷ Family Member 1 told the OIG that the shed was approximately 30 feet from the house where Family Member 1 was during the patient's contact with the VCL.

it or whatever, but if [the patient] had confirmed it as an attempt, then yes, we would have had to send emergency services.”

In a second interview, after Responder 1 reviewed the text conversation, the OIG asked Responder 1 about the absence of text verification that the patient left the shed. Responder 1 stated that “this is not a complete text transcript and [the patient] did confirm to me from my recollection that [the patient] was outside the shed.”⁶⁸ Responder 1 also told the OIG about not knowing why securing the belt was not documented in the safety plan and suggested that “Maybe I was typing quickly and forgot to put it in.”

Consistent with the National Guidelines for Behavioral Health Crisis Care and VCL guidance, the subject matter experts emphasized that a responder’s priority should be on reducing access to lethal means.⁶⁹ The subject matter experts emphasized the importance of distancing the patient from the belt hanging from the shed rafters, including ensuring that the belt was removed, the patient was away from the shed, the shed was locked, and that means for hanging were not available elsewhere, such as in the home or garage. One subject matter expert stated that:

the responder would be expected to conduct real-time means restriction/reduction and safety planning. While these two areas are discussed in a vague way, neither is employed as tools to use in reducing the customer’s current risk for suicide. Most importantly, great effort should have been made to get the customer to exit the shed as to put some distance between them and the belt.

The OIG concluded that Responder 1’s suggestion to leave the shed without further encouragement or confirmation was ineffective in reducing the patient’s access to the identified lethal means and failed to reduce the patient’s suicide risk. Further, the OIG determined that Responder 1’s failure to confirm that the patient left the shed or was otherwise distanced from the hanging apparatus contributed to the patient’s immediate access to the means to engage in suicidal behavior.

⁶⁸ The OIG reviewed non-VHA patient records obtained by subpoena, which did not include the text messages; therefore, the OIG was unable to confirm whether the text messages received from Family Member 1 were complete.

⁶⁹ “National Guidelines for Behavior Health Crisis Care, Best Practice Toolkit,” Substance Abuse and Mental Health Services Administration, accessed May 9, 2022, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>; VCL, VCL-S-ACT-216-2011, “Standard Operating Procedure for Call Flow,” October 26, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-216-2103(2), “Standard Operating Procedure for Call Flow,” April 2021. Unless otherwise specified, the 2021 standard operating procedure contains the same or similar language regarding guidance when a customer “reports having lethal means nearby” as the 2020 standard operating procedure.

Responder 1's Failure to Involve Family Member 1

One subject matter expert provided a written policy for a non-VA crisis line organization that stated, "When available and applicable, staff will attempt to engage family/friends of the individual in crisis who can provide support and assist in resource securement." Additionally, the subject matter experts highlighted the importance of a responder's efforts to distance a customer from lethal means, including the involvement of a collaborative third-party.

VCL guidance promotes inclusion of supportive others in safety planning, especially when lethal means are accessible.⁷⁰ Although not a VCL requirement, the Director, Quality and Training, confirmed that responders are encouraged to consider speaking with a family member or if responders determine "it would be better to have someone separately outreach the family member, so for example, they're at work or you know they're not nearby, and able to talk on the phone at the same time, or in this case text separately then we would ask the supervisor to assign outreach from another responder." Further, the Director, Quality and Training, explained to the OIG that a responder may directly involve another responder to contact a family member while the responder maintains contact with the customer.

The OIG found that Responder 1 did not involve Family Member 1 even though the patient described Family Member 1 as someone who was very involved in the patient's safety plan. In the text conversation with Responder 1, the patient identified Family Member 1 as someone with whom the patient could be open about suicide and suggested that Responder 1 could communicate with Family Member 1. The patient texted several statements regarding Family Member 1's support including, "All I have to do is tell [Family Member 1]," "But I can't do that yet," "I promise I will and I'll even let you talk to [Family Member 1] by text or phone."

After 26 minutes of texting, Responder 1 initiated a breathing exercise and instructed the patient to "Think about things that make you feel calm and centered while you do that." The patient replied "And when we are all done I'll go inside and tell [Family Member 1] what's going on. [Family Member 1] knows what to do from there." Responder 1 texted that Family Member 1 "sounds like an amazing support" to which the patient responded that Family Member 1 "really is."

Prior to the OIG obtaining the text transcript, the Director, Quality and Training, described to the OIG an expectation of contact with Family Member 1 as part of safety planning after the patient offered. Responder 1 told the OIG about not having concerns about the patient's imminent safety because the patient was "extremely adamant" about not wanting to die by suicide, a safety plan was "in place," the patient was texting with Family Member 1, and Family Member 1 "was

⁷⁰ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding lethal means restriction and safety planning as the rescinded 2019 guide.

aware of what was going on.” At that time, Responder 1 reported to the OIG not considering contacting Family Member 1 because the patient stated that the patient and Family Member 1 would “sit and we’re going to talk.”

In the text conversation, the patient emphasized not wanting emergency services. Responder 1 replied, “I don’t want to send anyone out to you, I want us to talk and work on a plan to keep you safe without having to go that route.” Responder 1 told the OIG that an emergency dispatch was not considered because the patient “was future oriented,” a safety plan was established, and the patient was on the “way back into the house to speak with [Family Member 1].”

Responder 1 told the OIG that the patient reported that Family Member 1 was “keeping an eye on [the patient] from inside the house.” In an interview with the OIG, Family Member 1 reported texting with the patient while being in the house.

The obtained text transcript indicated that Responder 1 asked if the patient was “able to allow” Family Member 1 to secure the firearms. The patient replied, “Yes that’s the drill. [Family Member 1] locks up guns keys and meds.” Responder 1 asked, “What about rope or wire? whatever it was you were thinking of hanging yourself with.” The patient texted, “I have a belt hanging from the hook” and that “once I tell [Family Member 1] [Family Member 1] will lock it down I hate making [Family Member 1] responsible for that but there’s no other way.” Responder 1 replied, “It is better that [Family Member 1] handle the means if you don’t feel capable, I am good with that.”

Responder 1 documented that the patient’s “Means Type” was “Suffocation/Hanging” and that “Means given to family member/friend.” Responder 1 told the OIG that this documentation reflected that “would be the plan, would be for [Family Member 1] to handle that,” and that “in this circumstance, the means given to family member or friend is what best fit the circumstances in [the patient’s] interaction.”

Family Member 1 told the OIG that the patient had texted to put the firearms away, but had not been aware that the patient had contacted the VCL. Family Member 1 also reported that the patient’s prior suicide attempts involved firearms and if the information had been provided that the patient was considering hanging as a means, Family Member 1 could have intervened differently.

When asked if consideration was given to contacting Family Member 1 to confirm that the means were secured prior to ending the text conversation with the patient, Responder 1 told the OIG, “I can’t say that I considered it.” Responder 1 reported that “there’s no guarantee to know that I would have been texting with [Family Member 1]. And text, that is not a two-way street, uh, their texts come in, I can’t text out to a number. That’s not how text works. So it would have

required a phone call to [Family Member 1].” Inconsistent with the VCL guidance in place at the time of the patient’s contact, Responder 1 stated, “We don’t involve [family members].”⁷¹

At the patient’s request, Responder 1 agreed to contact the patient’s providers. Responder 1 replied, “I can certainly do that but they would [*sic*] be able to get back to you until tomorrow, so I want to make sure you are set tonight with your safety.” The patient replied, “Yes. The second we have done that I will turn myself in to [Family Member 1]. And you can talk to [Family Member 1] if you want then.” Responder 1 texted that the suicide prevention team will contact the patient and that Responder 1 will ask the patient’s providers to “reach out to you as well.” The patient texted agreement to follow the plan and that “Part of me doesn’t want to do this anymore.” (See figure 7.)

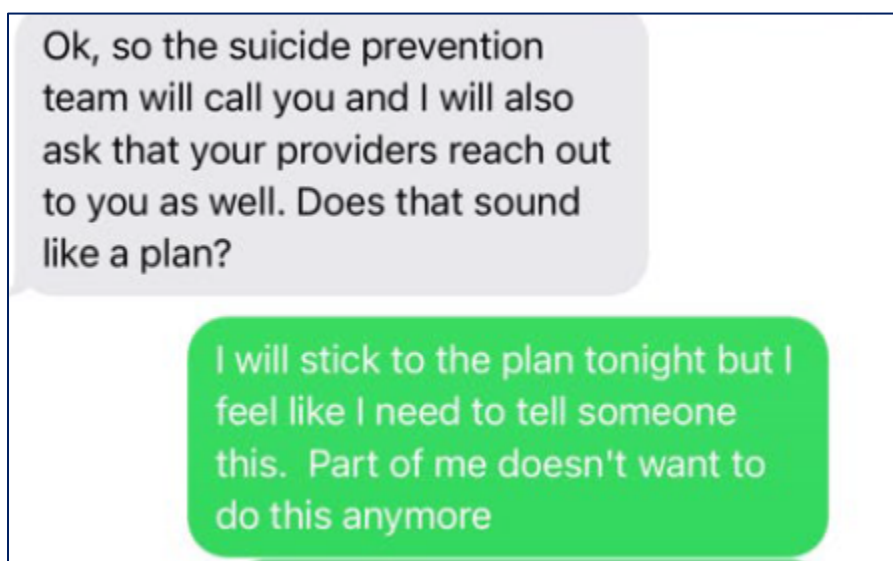


Figure 7. Excerpt from text message screen shots.
Source: Provided by Family Member 1.

Responder 1 placed a routine consult to the facility Suicide Prevention coordinator and documented that the safety plan for the patient was to “go inside the house, [Family Member 1] will secure all means, take medications as prescribed and then turn them over to [Family Member 1], go to bed, wait for” providers to call the next day.⁷²

⁷¹ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding family involvement as the rescinded 2019 guide.

⁷² VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. The 2022 directive uses the term *request* instead of *consult* when a responder refers a customer to a VA medical center suicide prevention coordinator.

The OIG found that the patient did not confirm telling Family Member 1 about the hanging apparatus and offered Responder 1 contact with Family Member 1 twice during the text conversation. Inconsistent with the subject matter experts' expectations, Responder 1 did not further pursue or verify the patient's actions to involve Family Member 1 in securing the belt or other ligatures. The OIG would have expected Responder 1 to pursue communication with Family Member 1 given the patient's report of Family Member 1's support and involvement in restricting the patient's access to lethal means.

As noted above, Responder 1 documented that "Customer stated [Family Member 1] will put everything on 'lock down' including access to [the patient's] firearms, car keys, and medication. Risk Mitigation: Go inside the house, [Family Member 1] will secure all means." However, Responder 1 did not confirm Family Member 1's awareness of the patient's suicidal plan to use a hanging apparatus. The OIG determined that Responder 1 did not adequately encourage and pursue actions to facilitate the patient's reduced access to lethal means and therefore failed to mitigate the patient's suicide risk. Responder 1's failure to recognize the patient's likely ongoing lethal means access and active preparatory suicidal behaviors during the text conversation contributed to a critical misunderstanding of the patient's imminent risk for suicide and subsequent inaction to intervene.

The subject matter experts told the OIG that they would expect a responder to contact a family member if requested by the customer, and to document the rationale if the responder declined to contact. Responder 1 did not document the patient's willingness for contact with Family Member 1 or the rationale for not directly communicating with Family Member 1. The OIG concluded that Responder 1's underestimation of the patient's imminent suicide risk and presumption of an established safety plan contributed to Responder 1's failure to involve Family Member 1. The OIG determined that Responder 1's failure to involve Family Member 1 in safety planning contributed to the patient's uninterrupted access to lethal means and follow through with suicidal behavior.

Failure to Consider a Telephone Transfer

In addition to not involving Family Member 1, the OIG determined that Responder 1's underestimation of the patient's imminent suicide risk and presumption of an established safety plan contributed to Responder 1's failure to pursue additional interventions such as a transfer from text to telephone management. Text responders are required to transfer a text to telephone management when the customer (1) is at imminent risk of harm and unable to establish a safety plan, (2) has difficulty communicating via text, or (3) would benefit from verbal communication.⁷³ Subject matter experts advise crisis management staff to attempt phone contact

⁷³ VCL, *Text Orientation and Employee Handbook*, December 14, 2018.

with a text customer who reports suicidal ideation or imminent risk to assess risk more thoroughly.

Responder 1 told the OIG that text responders are encouraged to manage the text interactions “themselves, um, unless there is a situation where the person is in immediate danger, or they stop replying to you, um, and risk hasn’t been mitigated.” The OIG would have expected Responder 1 to consider transferring from text to telephone communication with the patient and Family Member 1 to confirm that the patient’s crisis was stabilized.

Given the patient’s imminent suicide risk, absence of verification that Family Member 1 was aware of the patient’s plan to use a hanging apparatus, and the patient’s lack of reply to Responder 1’s continued texts, the OIG would have expected Responder 1 to transfer to telephone communication to attempt to confirm the patient’s safety. Additionally, based on the patient’s suicide risk factors, including potential intoxication and suicidal preparatory behavior, the OIG would have expected Responder 1 to consider transferring from text to telephone management for further risk assessment.

Documentation Deficiencies

Responders are expected to ensure “clear, concise, and accurate” documentation of interactions with customers, per VCL guidelines.⁷⁴ As mentioned above, Responder 1 told the OIG that documenting that the patient had not “put any plans into action” “was probably just an oversight” since the patient reported having a belt prepared. Further, Responder 1 documented that the patient’s “Means Type” was “Suffocation/Hanging,” and that that “Means given to family member/friend,” although the patient did not report that Family Member 1 removed the belt or other hanging apparatus.

In addition to these inaccuracies, the OIG identified documentation deficiencies consistent with Reviewer 1’s evaluation of Responder 1’s text interaction with the patient. The OIG found that Responder 1 did not respond to the patient’s text message regarding suicidal preparatory behavior. In the review, Reviewer 2 noted that “The Texter made a suicide attempt while on the call, but this was not acknowledged during the text interaction and therefore was not acknowledged in the documentation.”

The VCL requires telephone responders, but not text responders, to ask the “End of Call Satisfaction Question” that is “If you were in crisis, would you call the Veterans Crisis Line

⁷⁴ VCL-S-ACT-218-2008, “Veterans Crisis Line - Standard Operating Procedure for Health Science Specialist Documentation Guidelines,” August 26, 2020.

again?”⁷⁵ Responder 1 documented asking the patient the End of Call Satisfaction Question and noted that the patient responded “Yes.” Reviewer 2 determined Responder 1 did not ask the end of call satisfaction question but noted in Medora that it was completed.

Additionally, Reviewer 2 noted:

Responder indicated that the outcome of the call was that the Caller stayed on the line until the call ended normally, but the Texter stopped responding and [the Responder] terminated the text due to lack of response.

Based on the identified deficiencies, Reviewer 2 concluded that Responder 1 was unsuccessful in meeting VCL’s criteria of “Clear, concise, and accurate documentation.”⁷⁶ The OIG found that Responder 1’s failure to accurately document the interaction with the patient may have contributed to leaders’ lack of further review of Responder 1’s performance because of the misperception that Responder 1 had effectively addressed the patient’s risk, including restricting access to lethal means.

In 2020, the VCL provided responders with acute suicide risk documentation guidelines consistent with the VA classification of suicide risk as low, intermediate, or high risk.⁷⁷ The VA guidelines included actions indicated such as the management of low risk in outpatient primary care, consideration of psychiatric hospitalization for intermediate risk, and direct observation in a secure unit for high risk.⁷⁸ However, the Medora note template includes the suicide risk-level options of (1) high, (2) moderate to high, or (3) moderate to low, which are different from the VA guidelines.⁷⁹

Although the OIG did not determine that the different terms for suicide risk level contributed to Responder 1’s failure to adequately assess the patient’s suicide risk, use of inconsistent terms for

⁷⁵ VCL, *Text Orientation and Employee Handbook*, December 14, 2018. VCL notes that the purpose of the End of Call Satisfaction Question includes “To ensure Service Recipients’ satisfaction with VCL services” and “To highlight VCL’s 24/7/365 availability;” VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in effect at the time of the events discussed in the report. It was replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language related to End of Call Satisfaction Question as the replaced 2020 policy.

⁷⁶ VCL-S-ACT-218-2008, “Veterans Crisis Line - Standard Operating Procedure for Health Science Specialist Documentation Guidelines,” August 26, 2020.

⁷⁷ VA/DoD, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019. VCL-S-ACT-218-2008, “Veterans Crisis Line - Standard Operating Procedure for Health Science Specialist Documentation Guidelines,” August 26, 2020.

⁷⁸ VA/DoD, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

⁷⁹ VA/DoD, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

classification may result in responders' confusion about indicated actions and inadequate documentation.

In May 2022, the Executive Director, VCL informed the OIG that "Medora has not yet been updated to reflect the latest guidance at this time. The update will require an all staff training and rollout." In January 2023, VCL leaders reported that the Medora documentation update "remains in development" and that "Training is expected to be developed and commenced during calendar year 2023 with implementation completed during calendar year 2024."

2. VCL Leaders' Failure to Provide Adequate Oversight and Quality Assurance

The OIG found that VCL leaders failed to ensure that sufficient silent monitored contacts were conducted for Responder 1 and other non-responder staff providing responder coverage. This failure may have resulted in unidentified deficiencies in performance. The OIG also determined that VCL leaders failed to establish a text message retention process for over 10 years of VCL's use of text messaging for crisis management. The absence of text message retention resulted in limited quality assurance reviews of text contact management, including Responder 1's contact with the patient.

Inadequate Oversight

VHA requires VCL leaders to implement silent monitoring to oversee the quality of responders' work.⁸⁰ Monitor specialists are VCL staff trained to provide monitoring for call, chat, and text interactions, and coaching for areas identified as needing improvement immediately following monitored interactions.⁸¹ VCL leaders developed a silent monitoring protocol that outlines the evaluation criteria for responder interaction management and guides monitor specialists' coaching related to unmet criteria.⁸² VCL leaders identified a goal to silent monitor 80 percent of

⁸⁰ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in effect at the time of the events discussed in the report. It was replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language related to the monitoring of responders' VCL interactions with customers as the replaced 2020 policy.

⁸¹ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in effect at the time of the events discussed in the report. It was replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language related to the monitoring of responders' VCL interactions with customers as the rescinded 2020 policy.

⁸² VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders' interactions with customers as the rescinded 2020 policy.

responders at least once per each two-week pay period.⁸³ In response to a recommendation from the 2021 OIG report, VCL leaders updated policy to establish “consistent and evidence-based expectations” for responders’ “interactions with VCL Customers via phone, chat, and text; and to define expectations of the quality assurance silent monitoring process as well as Silent Monitor staff.”⁸⁴ However, the October 2021 policy does not specify expectations for staff who do not typically perform responder duties but may provide responder coverage, such as Responder 1.⁸⁵

As noted above, Responder 1, a monitor specialist, was providing text responder duties for overtime pay the night of the patient’s contact. In early January 2019, a supervisor approved Responder 1’s request to earn “Overtime (OT) or Compensatory Time (CT).”⁸⁶ The memorandum detailed that Responder 1 would “maintain the same standards and adhere to the same guidelines as other” responders and “be subject to silent monitors for quality.” However, the OIG found that silent monitoring for Responder 1’s customer contacts did not occur from January 2019 through the day OIG requested this information in early February 2022. Further, the Executive Director told the OIG that monitor specialists did not conduct silent monitored contacts “for other Quality Assurance staff conducting responder duties for overtime from January 2019 through March 23, 2022.” In an interview with the OIG, the Director, Quality and Training, reported that the VCL did not have a process to conduct silent monitored contacts for staff performing responder duties for overtime.

After receiving the text conversation from the OIG in March 2022, the Executive Director, VA Suicide Prevention, reported to the OIG that the VCL Director of Operations (Director of Operations) will review “all responder requests for overtime.”⁸⁷ Later that day, the Director of Operations notified all VCL staff that administrative staff previously performing responder duties for overtime “may NOT be permitted to perform any Responder or Responder-related duties.” The Director of Operations explained that this action was taken to be in compliance with VA administrative personnel requirements.

⁸³ VCL-P-ACT-229-2006, *Policy for Veterans Crisis Line Health Science Specialist Interaction Standards and Silent Monitoring*, June 18, 2020. This policy was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021. Unless otherwise specified, the 2021 policy contains the same or similar language regarding the monitoring of responders’ interactions with customers as the rescinded 2020 policy.

⁸⁴ VA OIG, [*Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*](#), Report No. 20-00545-115, April 15, 2021.

⁸⁵ VCL-P-ACT-229-2104, *Policy for Veterans Crisis Line Social Science Specialist Interaction Standards and Silent Monitoring*, October 2021.

⁸⁶ VA Notice 22-03, *Compensatory Time Off In lieu of Overtime Pay for Schedule C Employees*, December 10, 2021. “Compensatory time off is time off with pay in lieu of overtime pay for irregular or occasional overtime work.”

⁸⁷ The Executive Director, VA Suicide Prevention is responsible for oversight of the VHA Suicide Prevention Program and the VCL.

After the OIG provided VCL leaders with the text transcript in March 2022, VCL leaders assigned Reviewers 1 and 2 to evaluate Responder 1's interaction with the patient. Within three weeks, leaders "initiated a training plan to support [Responder 1's] current needs," that included Responder 1 having to "revisit a few trainings focused on risk and lethal means safety." Additionally, Reviewer 2 and another reviewer (Reviewer 3) completed retrospective silent monitoring of Responder 1's interactions with seven customers from October 16, 2020, through October 26, 2021, including one telephone contact and six chat contacts.⁸⁸

One or both of the reviewers found that Responder 1 was unsuccessful in the following criteria:

- assessment of plan, intent, capability, risk factors, and protective factors against violent behavior;
- collaborative problem solving;
- involve a customer's identified third party to address immediate access to lethal means;
- did not appropriately end interactions with customers; and
- clear, concise, and accurate documentation.

The Executive Director, VCL noted that the results of these two reviews "confirmed the challenges identified as a result of this inspection." VCL leaders assigned Responder 1 "remedial training."

VCL leaders' failure to ensure that sufficient silent monitored contacts were conducted for staff serving as responders, including monitor specialists performing responder duties for overtime or compensatory time, may have resulted in unidentified deficiencies in performance. The failure to ensure adequate oversight may have contributed to Responder 1's mismanagement of the patient's crisis contact, including an inadequate suicide risk assessment and safety plan, and inaccurate documentation.

Lack of Text Retention

The VCL launched text services in November 2011.⁸⁹ In January 2016, the VCL Business Requirements Document for text services noted that "No data will be stored, saved or otherwise archived from texting other than statistics necessary for billing and accounting purposes." The VCL Innovations Hub program manager told the OIG that VCL leaders began work to establish a system for managing texts, including text retention, in July 2019.

⁸⁸ The silent monitored contacts that were reviewed covered fiscal year 2021 from October 16, 2020, through October 26, 2021. Reviewer 3 was a supervisor.

⁸⁹ VCL, *Orientation Participant Guide*, January 2022.

The February 2021 issue brief related to the patient's death noted that the VCL did not retain text transcripts, but that text retention was "planned with new platform launch this Spring."⁹⁰ However, the VCL Innovations Hub program manager reported that in August 2021, the planned system "was no longer considered viable," and in a December 2021 internal document, VCL noted that "alternative solutions that have been reviewed to better serve VCL operational needs and gain resource efficiencies."

The Director, Quality and Training, told the OIG that silent monitoring can only occur during an active text session with a customer because text conversations are not retained. Subject matter experts provided the OIG with information about the role of text message retention for performance improvement, including supervision and service enhancement for three non-VA crisis lines.

In January 2022, almost two months following notification of the OIG inspection, the VCL Privacy and Freedom of Information Act officer advised the VCL Assistant Deputy Director of Information Management that it is permissible to place a chat or text transcript in Medora. In April 2022, the VCL Innovations Hub program manager told the OIG that "VCL has persisted with attempts to have chat and text transcripts retained." In mid-May 2022, the Executive Director, VCL told the OIG about an expected June 2022 implementation for responders to copy and paste text contacts and a "longer term solution which will not require the copy and paste." When asked in January 2023 for an update, VCL leaders informed OIG that "Text interactions have been copied into Medora since May 4, 2022."

The OIG determined that the leaders failed to establish a text message retention process in over 10 years of VCL's use of text messaging for crisis management. The lack of text retention prevented leaders from conducting comprehensive quality assurance reviews of text contact management, including Responder 1's contact with the patient. Leaders' failure to ensure a robust text contact management quality assurance review program limited supervisory oversight thereby hindering the identification of performance deficiencies and the execution of corrective actions.

3. Inadequate and Problematic Leader and Staff Actions Following the Patient's Death

The OIG found delayed and inadequate administrative responses by VCL and facility staff following notification of the patient's death. Although the February 2021 issue brief indicated that a root cause analysis would be completed, VCL leaders did not charter a root cause analysis until the OIG became involved almost 11 months later. The OIG found that the Executive

⁹⁰ VHA Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, Updated February 6, 2018. An issue brief is "drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue."

Director, VCL did not define the patient's death as a [sentinel event](#) or consider a disclosure because the policy that addressed disclosure procedures was not in effect at the time of the patient's death.⁹¹ Further, the OIG concluded that the Director, Quality and Training, provided advice and information to Responder 1 prior to interviews with the OIG that potentially compromised Responder 1's candidness.

The OIG determined that another responder's (Responder 2) failure to complete a routine suicide prevention consult to the facility further contributed to the delay in facility staff updating the patient's EHR to reflect the patient's death.⁹² Additionally, the OIG found that Responder 2 did not submit a complaint report or request follow-up as required by VHA, and as expected by VCL leaders, following Family Member 2's February 2021 contact.⁹³ The OIG also found that facility leaders did not implement the BHAP, as required by VHA since November 2012, until January 2022.⁹⁴

Failure to Complete a Root Cause Analysis

VHA requires that facility staff report adverse events so that a review occurs to identify potential underlying causes.⁹⁵ Following an adverse event, a root cause analysis team may be appointed to determine root causes of the event and establish action plans to avoid recurrence.⁹⁶ The root cause analysis process is a formal protected review with a multidisciplinary team approach that is

⁹¹ VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021.

⁹² VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. Unless otherwise specified, the 2021 standard operating procedure contains the same or similar language regarding staff administrative responsibilities following alert of a death by suicide as the rescinded 2018 standard operating procedure.

⁹³ VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, on December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the staff administrative processes related to the complaint processes as the rescinded 2020 directive.

⁹⁴ VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. A BHAP Chart Analysis is a standardized EHR review of relevant behavioral health information about the patient prior to their death including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinician notes.

⁹⁵ VHA Handbook 1050.01, National Patient Safety Improvement Handbook, March 4, 2011, was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding staff responsibility to report adverse events as the rescinded 2011 handbook.

⁹⁶ VHA Handbook 1050.01 was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The 2023 directive refers to the root cause analysis investigation as team-based investigation.

used to identify systemic and procedural factors that contribute to adverse events. Facility leaders are required to complete a root cause analysis within 45 days of awareness of the need for the review.⁹⁷

The 2018 VCL standard operating procedure instructs that, upon notification of a customer's death by suicide, the risk manager is to "Collaborate with staff member closest to event to complete [issue brief]" and "Determine if [root cause analysis] is needed."⁹⁸ An August 2021 VCL standard operating procedure designates the risk manager as responsible for the completion of issue briefs for "any [Near Miss](#), [Critical Incident](#), and/or proposed Sentinel Event."⁹⁹

Eight days after the patient's contact and death by suicide (day 9), the VCL Director, National Care Coordination, received a Heads Up Message about the patient's death by suicide and then notified VCL leaders.¹⁰⁰ The next day, VCL supervisory staff completed an issue brief that noted "a root cause analysis will be chartered." However, VCL leaders did not charter a root cause analysis until after notification of the OIG inspection, almost 11 months after the patient's death.

The Executive Director, VCL explained to the OIG that the issue brief should have stated that a root cause analysis "would be considered after quality assurance review." The Executive Director, VCL reported that after completion of the quality assurance review, it was decided that "there was insufficient information for us to really move forward with an [Root Cause Analysis]." The supervisor who conducted the quality assurance review told the OIG that Responder 1's documentation was "written based on VCL standards," including that Responder 1 "details [Responder 1's] safety plan as well as the risk mitigation" and that without the text conversation "there was really nothing for me to review other than the documentation."

The Director, Quality and Training, described feeling "a little bit relieved" upon learning it was Responder 1 who managed the patient's contact because of the "confidence in [Responder 1's] work" and the belief that the patient received "everything we could have gotten [the patient]." When asked by the OIG, the Director, Quality and Training, denied that the decision to not

⁹⁷ VHA Handbook 1050.01 was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding the required timeline for completion of the root cause analysis process as the rescinded 2011 handbook.

⁹⁸ VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021.

⁹⁹ VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021.

¹⁰⁰ VHA Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, updated February 6, 2018. "A Heads Up Message" is a notification designed to allow Facility, VISN and VHA Program Offices leadership to provide a brief synopsis of the issue while facts are being gathered to be submitted as an Issue Brief." The Heads Up Message was initiated by the facility's associate chief of staff, Mental Health.

conduct a root cause analysis was based on confidence in Responder 1's skills. The Director, Quality and Training, told the OIG:

But when we realized that it was a text and that we didn't have a source document to compare [Responder 1's] documentation to, um then it really, we looked at the documentation and I was pleased to see that it had all the elements I would expect in a high-risk case, including um some really strong, to me, what looked like really strong lethal means safety work....And so, it had all the hallmarks of having addressed everything I would have expected, but because we didn't have the source document, we couldn't compare it and say yes this is accurate, an accurate depiction of what happened in that interaction. So, we kind of reviewed it but weren't able to complete that full silent monitor using the interaction standards because we didn't have that source document.

However, leaders initiated the root cause analysis following the OIG notification of the inspection although the text conversation had not yet been obtained. The Executive Director, VCL told the OIG that "after I was alerted by [the OIG], we saw additional points related to systemic concerns" that warranted a root cause analysis, including the complaint process and the continuation of caring letters following the patient's death (as discussed below). The Director, Quality and Training, also noted that the root cause analysis was conducted as a result of the OIG inspection notification.

In an interview with the OIG, the Director, Quality and Training, reported that root cause analyses were discontinued and replaced with a minimum of an annual analysis of critical incident and near miss reports submitted through the VCL Reporting Hub since August 2021.¹⁰¹ However, the Director, Quality and Training, explained that a root cause analysis was initiated approximately 11 months after the patient's death because that was the procedure at the time of the patient's contact.

Based on VCL leaders' interviews, the OIG determined that VCL's issue brief inaccurately noted that a root cause analysis was to be initiated. VCL leaders' failure to conduct a timely review of the patient's VCL contact contributed to a delay in the identification of systemic and performance deficiencies and implementation of corrective actions.

¹⁰¹ VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. The VCL Reporting Hub is a web-based system that centralizes reporting and allows staff to input data, generate reports and notification messages.

Failure to Consider Disclosure

VHA requires that, across all VA medical facilities, an institutional disclosure of adverse events or sentinel events occur, “regardless of when the adverse event is discovered.”¹⁰² In response to the OIG’s 2021 report, VCL leaders implemented procedures for disclosure of sentinel events, including a death by suicide that occurs with VCL as the last known contact, to patients or their personal representatives. VCL leaders initiated these procedures in August 2021, over six months after the patient’s death.¹⁰³ The VCL advises that the VCL Deputy Director of Clinical Care contact a customer’s “personal representative to express concern and provide an apology, including an explanation of the facts to the extent that they are known.”¹⁰⁴ The VCL requires disclosure “if the Sentinel Event has resulted in or is reasonably expected to result in death or serious injury.”¹⁰⁵ Further, VCL procedures require disclosure to be initiated “as soon as reasonably possible and generally within seventy-two (72) hours” and that the “timeframe does not apply to Sentinel Events that are only recognized after the associated event, for example, through investigation of a sentinel event, a routine quality review, or a look-back.”¹⁰⁶

In May 2022, the Executive Director, VCL reported to the OIG that the patient’s death was not identified as a sentinel event and that a disclosure was not considered because “VCL was not using these terms and accompanying practices” at the time of the event. However, upon initiation of the inspection, the OIG found that the patient’s death met the VCL definition of sentinel event since the patient died by suicide within an hour of contact with Responder 1 as the last contact, and that Responder 1 failed to conduct an adequate suicide risk assessment or safety planning. Given that the VCL procedures emphasize the initiation of disclosure upon recognition of a sentinel event following review, the OIG concluded that VCL leaders should therefore consider conducting a disclosure to the patient’s personal representative(s).

¹⁰² VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient’s personal representative of events during the patient’s care that resulted in death or serious injury and to provide information about rights and recourse.

¹⁰³ VA OIG, [Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison](#), Report No. 20-00545-115, April 15, 2021; VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

¹⁰⁴ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

¹⁰⁵ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

¹⁰⁶ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

A VCL Leader's Potential Interference in OIG Inspection

The OIG found that the Director, Quality and Training, potentially compromised Responder 1's candor and recollection by providing advice and information prior to Responder 1's interviews with the OIG.

The Inspector General Act of 1978 authorizes the VA OIG to conduct audits, investigations, and other reviews of VA programs and operations and to obtain information from VA staff in doing so. A VA regulation, 38 C.F.R. § 0.735-12, requires that VA staff cooperate with an OIG interview and answer questions freely and honestly, unless a response would incriminate the individual in a violation of law.¹⁰⁷ In interviews with the OIG, VA staff are expected to provide accurate, relevant, specific, and complete information, and be forthcoming in their responses. Refusal to cooperate could subject a VA staff member to administrative or disciplinary action and could impede OIG's efforts to help VA provide the best possible care.

The OIG routinely requests that interviewees not discuss the substance of interviews with others. VA leaders have a responsibility to avoid any action that could negatively influence a VA staff member's cooperation with the OIG's inspection. If the OIG contacts a VA staff member regarding an inspection, that staff member may inform managers of that contact but should not discuss the content of OIG's contact with anyone else. Similarly, it is not appropriate for leaders to offer suggestions on how a staff member should respond or act during an OIG interview. Such actions, by staff or leaders, could compromise the inspection by influencing the responses and potentially affect the accuracy and integrity of the information provided to the OIG.

In two OIG healthcare inspections prior to the current inspection, the OIG provided the Director, Quality and Training, the information that the OIG requests VA staff to not discuss an OIG interview with others.¹⁰⁸ However, in instant messages between the Director, Quality and Training, and Responder 1, the OIG found that the Director, Quality and Training, provided Responder 1 with potential responses to the OIG prior to Responder 1's interviews. This supervisory influence may have impacted Responder 1's openness and recollection during interviews with the OIG.

In an interview with the OIG, the Director, Quality and Training, denied recollection of communication with Responder 1 related to the inspection and prior to Responder 1's interview with the OIG. However, the OIG found that approximately one month prior to Responder 1's interview with the OIG, the Director, Quality and Training, instant messaged Responder 1 that the "main points are to only answer the question asked – don't volunteer anything extra." Further, the OIG found that the Director, Quality and Training, offered Responder 1 suggestions

¹⁰⁷ 38 C.F.R. § 0.735-12.

¹⁰⁸ Between October 2019–May 2020, the Director, Quality and Training, confirmed understanding of the OIG's request for confidentiality in six interviews with the OIG.

about the content of Responder 1's upcoming OIG interview, including "They will ask you about the interaction and likely about related policies and procedures," and "I think they are going to be interested in the fact that you're an [silent monitor] who was working as a REsponder [*sic*]."

The OIG found that Responder 1 reported inaccurate information about the patient to the OIG based on prior communications with the Director, Quality and Training. The Director, Quality and Training, sent Responder 1 an instant message that noted the patient "had multiple head traumas." Responder 1 replied to the Director, Quality and Training, "i don't think [the patient] told me about the head trauma." However, in a subsequent interview with the OIG approximately five months later, Responder 1 reported that the patient had a [traumatic brain injury](#). In an interview with the OIG, Responder 1 reported obtaining the information that the patient had a traumatic brain injury from the text message conversations provided to VCL leaders by the OIG approximately two months prior. However, in the text message conversation the patient did not report a traumatic brain injury or head trauma to Responder 1. (See figure 8.)

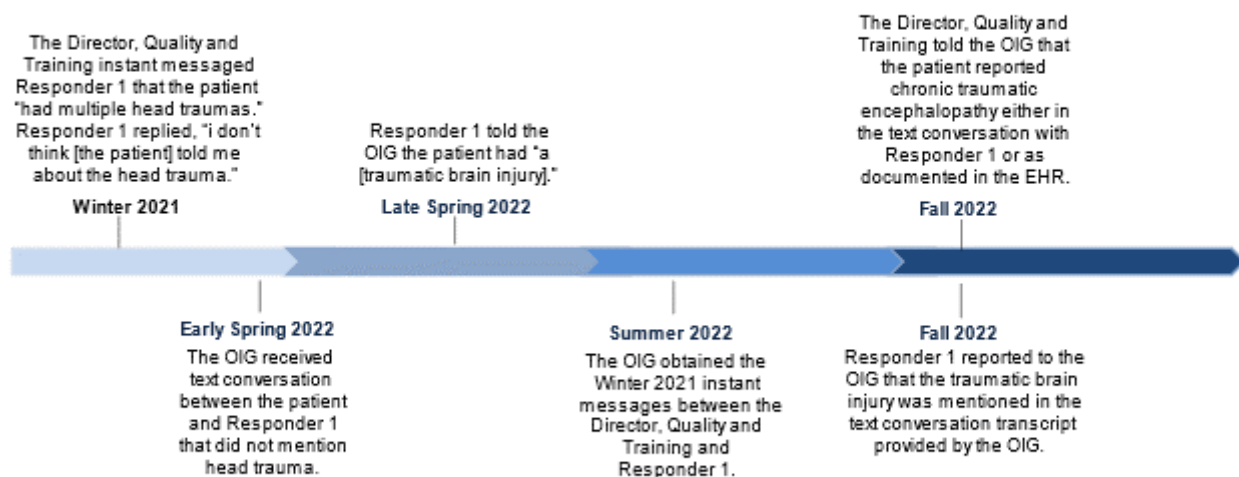


Figure 8. Timeline of conversations related to traumatic brain injury.
Source: OIG review and analysis of instant message and interview data.

The Director, Quality and Training, told the OIG about finding that the patient had [chronic traumatic encephalopathy](#) either in the patient's EHR or the patient mentioning it in the text conversation. The patient's EHR included documentation of the patient's negative traumatic brain injury screen in 2018. Approximately eight months later, at the patient's initial evaluation, the psychiatrist documented that the patient had a history of head injury. The psychiatrist told the OIG that the patient reported that during military service "there was a lot of bumping of [the patient's] head to the sides of the vehicle which sometimes led to a couple of seconds of being

dazed.” The psychiatrist also said that head injury was not a prominent problem for the patient and that the history of head injury notation was included in the patient’s initial evaluation to be thorough.

The OIG also found that the Director, Quality and Training, provided Responder 1 with reassurance and emotional support. Prior to the OIG’s receipt of the text conversation, the Director, Quality and Training, instant messaged Responder 1 “I have confidence that the Veteran couldn’t have received better,” “I wish I could have protected you from this,” and “I’ve cried FOR you, so I can’t imagine you’re not upset as well.”

The OIG concluded that the Director, Quality and Training, potentially compromised Responder 1’s candidness and recollection by providing advice and information prior to Responder 1’s interviews with the OIG. Although the OIG recognizes that the Director, Quality and Training, expressed concern about Responder 1’s well-being, a VA leader providing preparatory information to a staff member prior to an OIG interview may compromise the accuracy and integrity of information provided to the OIG. As such, the OIG’s ability to fully identify performance and system deficiencies may be hindered, resulting in recommendations that do not sufficiently address the underlying root causes.

VCL Staff’s Failure to Alert Facility Staff of Patient’s Death

Following notification of a customer’s death by suicide, VCL responders are expected to inform a supervisor, submit a routine consult to the suicide prevention coordinator at the customer’s facility, and report the death to VCL leaders via completion of the Report of Death by Suicide.¹⁰⁹ Prior to August 2021, VCL staff were required to submit the Report of Death by Suicide via email and the VCL Risk Manager was expected to review the Report of Death by Suicide and determine an action plan.¹¹⁰ Effective August 2021, VCL staff are instructed to submit a Report

¹⁰⁹ VCL-S-ACT-210-1808, “Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide,” June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021. Although the 2021 standard operating procedure does not include information regarding submission of a consult to the suicide prevention coordinator, the Director, Quality and Training, informed the OIG that this procedure remained in place. The report of death by suicide is a templated report.

¹¹⁰ VCL-S-ACT-210-1808, “Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide,” June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021. The August 2021 standard operating procedure supersedes the June 2018 standard operating procedure; VCL staff are instructed to submit a Report of Death by Suicide following alert of a death by suicide through the VCL Reporting Hub, not via email template.

of Death by Suicide through the VCL Reporting Hub.¹¹¹ The Report of Death by Suicide template includes instructions to review the patient's EHR for notification that the patient is deceased and, if not present, a suicide prevention coordinator consult should be submitted to the facility.¹¹²

On day 10, Responder 2 documented that Family Member 2 contacted the VCL and "expressed concerns and anger toward VCL stating that nobody tried to help [the patient]." Responder 2 completed the Report of Death by Suicide but did not submit a suicide prevention consult, as expected.¹¹³ Responder 2 also documented that Family Member 2 "provided necessary information in order to complete a death report by suicide. No further actions." In an interview with the OIG, Responder 2 reported being unaware of the requirement to submit a suicide prevention coordinator consult to the facility for death notification.

The Director, Quality and Training, told the OIG that responders are trained to submit a suicide prevention coordinator consult when notified of a death by suicide. In addition, the coordinator on duty the day that Responder 2 received Family Member 2's call told the OIG that Responder 2 should have completed a suicide prevention coordinator consult.

Leaders reported that Responder 2 completed a training in late fall 2018 that informed staff of the requirement to submit a routine suicide prevention consult following notification of a patient death by suicide. The OIG determined that since responders may infrequently be the first recipient of the information about a customer's death by suicide, the reporting requirement and policy may not be recalled years later.

In May 2022, when asked by the OIG about the completion of a suicide prevention consult, the Executive Director, VCL told the OIG that that the Reporting Hub "has strengthened our process" and

¹¹¹ VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. The August 2021 standard operating procedure supersedes the June 2018 standard operating procedure; VCL staff are instructed to submit a Report of Death by Suicide following alert of a death by suicide through the VCL Reporting Hub, not via email template.

¹¹² VCL-S-ACT-218-2104, "Veterans Crisis Line Standard Operating Procedure for Social Science Specialist (Crisis Responder) Documentation Guidelines," April 2021. A suicide prevention coordinator consult is a formal request from VCL on behalf of a customer to the patient's identified suicide prevention team for continued care and follow-up with the patient.

¹¹³ VCL-S-ACT-210-1808, "Veterans Crisis Line Standard Operating Procedure for Reporting Death by Suicide," June 26, 2018. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by the VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021. Although the 2021 standard operating procedure does not include information regarding submission of a consult to the suicide prevention coordinator, the Director, Quality and Training, informed the OIG that this procedure remained in place.

is just so much better...after you complete this and put it in the system, I get an alert that's automated, an email like when there's a Report of Death by Suicide that comes to me, they don't have to go and send it outside the system etc., and then it prompts other people 'there's something here for you to review' which is great for our risk manager and [quality assurance] team.

In response to the OIG's inspection notification, a supervisor completed a silent monitored contact of Responder 2's recorded telephone call with Family Member 2. The supervisor documented that Responder 2:

did not check the deceased Veteran's records to ensure if the VA was already aware of [the patient's] death, which would have informed [Responder 2] that they were not officially aware and therefore an [*sic*] [suicide prevention coordinator] consult would be appropriate.

Almost three months after Family Member 2 spoke with Responder 2, a friend of the patient's family (Family Friend 1) contacted the VCL and reported a complaint on behalf of Family Member 1 regarding ongoing receipt of caring letters (as discussed below). Another responder (Responder 3) checked the patient's EHR while speaking with Family Friend 1. After determining that the patient was not identified as deceased in the EHR, Responder 3 consulted with a supervisor and submitted a suicide prevention coordinator consult as instructed.

The OIG concluded that Responder 2's failure to complete a suicide prevention consult contributed to the delay in facility staff updating the patient's EHR to reflect the patient's death, resulting in the patient's family continuing to receive communications for the patient.

VCL Staff and Leaders Failure to Adequately Address Family Member 2's Complaint

On day 10, in response to Family Member 2's reported "anger toward VCL," Responder 2 completed a Report of Death by Suicide and Medora documentation that included Family Member 2's reported dissatisfaction with VCL services for the patient and a request for follow-up. However, VCL leaders did not take action to ensure follow-up with Family Member 2 because Responder 2 did not complete a complaint form and therefore, the complaint process was not initiated.

The Commission on Accreditation of Rehabilitation Facilities requires implementation of a policy and written procedure for formal customer complaints.¹¹⁴ VCL leaders established written procedures for management of complaints regarding VCL services, including that VCL staff are

¹¹⁴ Commission on Accreditation of Rehabilitation Facilities, "2020 Behavioral Health Standards Manual," July 1, 2020 – June 30, 2021.

required to submit a templated complaint report.¹¹⁵ Prior to August 2021, VCL staff were required to submit complaints via email to the VCL quality assurance specialist.¹¹⁶ Beginning in August 2021, staff submit the complaint report through the VCL Reporting Hub.¹¹⁷ The OIG found that VCL and VHA guidance differed; VCL instructs submission of a complaint through the Reporting Hub and the 2022 VHA directive states that “VCL tracks complaints via an email template submitted to the VCL Quality Assurance Specialist.”¹¹⁸ The inconsistent guidance may contribute to VCL staff confusion about the proper complaint submission procedures and consequent failure to properly submit complaints.

On day 10, Family Member 2 contacted the VCL and reported that the patient died by suicide after contact with Responder 1. Family Member 2 expressed being angry that “this is what counts as, you know, helping,” and said that Responder 1 “who’s supposed to be helping [the patient], just, you know, just dropped the ball.” Family Member 2 said “I just want to know” what happened and why more was not done to help the patient. Responder 2 told Family Member 2 that after the information is reported, someone from VCL would “see what happened and, um, just follow up with the information.” Family Member 2 stated

When they, you know, look into this, I would like, you know, I would like them, you know, to call me back and at least let me know, I mean, just, if anything that’s gonna be done about it, you know, I’d at least like, you know, I’d at least like to know, you know, that something’s going to be done to make sure that, you know, someone else doesn’t call up and get the same treatment.

Responder 2 informed Family Member 2 that “we can get someone to reach back out to you and just follow up with what’s going on.”

In Medora, Responder 2 documented that Family Member 2 “expressed concerns and anger toward VCL stating that nobody tried to help” the patient and that Family Member 2 “wants a follow up and want actions to be taken.” In the Report of Death by Suicide, Responder 2 documented that Family Member 2 “requested if possible a follow up on what will happen and expressed anger regarding how this has turned out knowing Veteran has reached out.”

¹¹⁵ VHA Directive 1503(1), *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the complaint process as the rescinded 2020 directive; Veterans Crisis Line, “Quality Assurance Complaint Tracking System Standard Operating Procedure,” September 29, 2015.

¹¹⁶ VHA Directive 1503(2). Veterans Crisis Line, “Quality Assurance Complaint Tracking System Standard Operating Procedure,” September 29, 2015.

¹¹⁷ VCL-P-ACT-109-2108, “Policy for Veterans Crisis Line for Managing Critical Incidents and Near Misses,” August 2021.

¹¹⁸ VCL-P-ACT-109-2108, “Policy for Veterans Crisis Line for Managing Critical Incidents and Near Misses,” August 2021; VHA Directive 1503(2).

In an interview with the OIG, Responder 2 was unsure why Family Member 2's complaint was not submitted to the quality assurance specialist. A workflow coordinator (coordinator) on duty at the time of Family Member 2's call spoke with Responder 2 prior to submission of the Report of Death by Suicide.¹¹⁹ The coordinator told the OIG that Responder 2 had described Family Member 2 as "just kind of upset about the situation" "but [Family Member 2] wasn't upset with us."

Following OIG notification of the concern about Family Member 2's call, a quality management officer conducted a silent monitor on Responder 2's call with Family Member 2. The quality management officer documented that Responder 2 "missed some opportunities to continue to build trust by not exploring the painful and negative emotions that [Family Member 2] touched on."

The OIG found that the silent monitor form reflects VCL standards for lethality risk assessments including trust building, suicide and violence risk screening, and safety planning. However, the silent monitor form does not include customers' complaints as a factor to evaluate. While the OIG found that Responder 2 appropriately inquired about Family Member 2's well-being, Responder 2 did not address Family Member 2's expressed reasons for contacting VCL, which was to report anger regarding VCL services provided to the patient and to request follow-up.

In an interview with the OIG, the Director, Quality and Training, reported that Responder 2 should have completed a complaint form and that "we would have expected that someone would speak to [Family Member 2] to hear [Family Member 2's] concerns." The OIG found that although Family Member 2 requested a follow-up to the call, Responder 2, the coordinator, and VCL leaders did not take action. Further, VCL leaders did not follow up with Family Member 2 after receipt of the Report of Death email on day 10 or after the OIG's request for information about all third-party contacts, approximately 10 months after Family Member 2's call. In March 2022, over a year after the VCL phone call, Family Member 2 told the OIG that the OIG was the only follow-up contact received regarding the patient.

At the end of the call with Family Member 2, Responder 2 emailed the Report of Death by Suicide to an email group that included the coordinator and the Director, Quality and Training. When asked by the OIG about follow-up with Family Member 2, the coordinator reported that "when I did see the note, [Family Member 2] requested follow up and to me, I took that to mean that from the [suicide prevention coordinator]." However, supervisors and leaders failed to follow up on the documented complaint. The OIG determined that Family Member 2's anger

¹¹⁹ The VCL Lead Auditor provided the OIG with an undated document, "Workflow Coordinator Duties" that states that workflow coordinators "work with shift Supervisors to meet the needs of the VCL as needed on any particular day" and assist responders "with clinical and non-clinical questions pertaining to the care of our Veterans."

was directed at Responder 1's management of the patient's contact and should have been addressed by VCL leaders, as required.¹²⁰

Responder 2 did not submit a complaint form regarding Family Member 2's dissatisfaction with VCL services for the patient, as expected by VCL leaders. However, Responder 2 did document Family Member 2's anger about the patient's VCL contact and request for follow-up in the Report of Death by Suicide and Medora, both of which included leaders' reviews. The OIG concluded that VCL leaders' should have addressed Family Member 2's request for a return call.

Facility Staffs' Delay in Updating the Patient's EHR

The OIG found that although facility staff and leaders were notified of the patient's death on day 4, a deceased alert was not placed in the patient's EHR until day 92. Upon notification of a patient's suicidal behavior, VHA requires the immediate completion of a Suicide Behavior and Overdose Report or comprehensive suicide risk evaluation.¹²¹ VHA requires that a Heads Up Message is sent to VHA and facility leaders within one business day from the time of an incident and submission of an issue brief within one business day and not to exceed two business days of the Heads Up Message.¹²²

VHA policy also specifies death notification requirements for deaths that occur "in a VA health care facility or a non-VA health care facility under authorized admission at VA expense," but does not provide guidance regarding outpatient death notifications.¹²³ At the time of the patient's death, the facility did not have a protocol that outlined the actions expected following notification of a patient's death by suicide. The supervisor, Decedent Affairs told the OIG that facility staff can notify facility Decedent Affairs staff about a patient's death through a secure instant message, phone call, or email to the Decedent Affairs email group. Further, the supervisor, Decedent Affairs reported that a medical support assistant is responsible for monitoring the email group, tracking the notification of patient deaths in a spreadsheet, canceling future clinic appointments, and placing a death notification (deceased alert) in the patient's EHR.

On day 4, the Suicide Prevention Program case manager completed a Suicide behavior and overdose report, and the associate chief, Mental Health submitted a Heads Up Message followed

¹²⁰ Veterans Crisis Line, "Quality Assurance Complaint Tracking System Standard Operating Procedure," September 29, 2015.

¹²¹ VHA Acting Deputy Under Secretary for Health for Operations and Management, "Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation," memorandum to VISN Directors and VISN Chief Mental Health Officers, April 8, 2019; VHA Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to VISN Directors, VISN Chief Medical Officers, and VISN Mental Health Leads, May 23, 2018.

¹²² VHA Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, updated February 6, 2018.

¹²³ VHA Directive 1601B.04, *Decedent Affairs*, December 1, 2017.

by an issue brief as required.¹²⁴ On day 9, the Suicide Prevention Program case manager emailed the Suicide Prevention Program manager to inquire if Decedent Affairs staff had been notified of the patient's death. On day 14, the Suicide Prevention Program manager sent the Decedent Affairs email group notification of the patient's death. However, Decedent Affairs staff did not place a deceased alert in the patient's EHR at that time.

Between 15 and 28 days after the patient contacted the VCL and died by suicide, facility staff attempted to contact the patient by phone four times and by mail once regarding healthcare appointments. (See Table 1.)

Table 1. Timeline of Outreach Documentation Following the Patient's Death

Date	Facility Staff's Action
Day 15	A facility medical support assistant unsuccessfully attempted to contact the patient by phone to schedule a mental health appointment and mailed a letter.
Day 18	The medical support assistant documented an unsuccessful phone contact to the patient.
Day 23	A primary care provider documented that the patient did not show for an appointment and was unable to be reached by phone.
Day 28	The medical support assistant documented an unsuccessful phone contact to the patient.

Source: OIG analysis of the patient's EHR.

Following contact with another friend of the patient's family (Family Friend 2), on day 84, 70 days after the Suicide Prevention Program manager initially notified Decedent Affairs about the patient's death. That same day, a medical support assistant documented in the Decedent Affairs spreadsheet that a Suicide Prevention Program case manager reported the patient's death. On day 90, Responder 3 submitted a suicide prevention consult following contact with another friend of the patient's family (Family Friend 1) (discussed below). Upon acceptance of the consult the next day, the Suicide Prevention Program case manager again emailed Decedent Affairs notification of the patient's death, noting "there is not a death notification on the chart at this time." In an email on that same day, the Suicide Prevention Program case manager requested Decedent Affairs staff to "please close this chart as to not cause the family further distress." The following day, day 92, the supervisor, Decedent Affairs placed a deceased alert in the patient's EHR.

In response to the OIG's inquiry, the supervisor, Decedent Affairs confirmed that on day 14, the Decedent Affairs email group had received the notification of the patient's death from the

¹²⁴ VHA Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, updated February 6, 2018. An issue brief is "drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue."

Suicide Prevention Program manager. The supervisor, Decedent Affairs attributed the delay in placing the deceased alert in the patient's EHR to an "isolated incident, contributed to by human error mainly due to COVID constraints, new employees in training and overwhelming numbers of death notices mainly due to the Pandemic."

In January 2022, facility mental health leaders established a standard operating procedure to outline administrative and clinical actions following a patient's or employee's death by suicide.¹²⁵ The standard operating procedure assigns the Suicide Prevention Program manager responsibility to notify Decedent Affairs staff. Additionally, a member of the suicide postvention team is assigned to outreach a family member of the deceased patient by telephone.

The OIG found that facility staff entered a deceased alert in the patient's EHR on day 92, 89 days after staff received the initial patient death notification. As a result of facility staff's failure to place a deceased alert in the patient's EHR, staff continued to leave messages on the patient's phone and send mail to the patient's home. Facility leaders' failure to ensure timely placement of the deceased alert in the patient's EHR exacerbated the family's distress in the months immediately following the patient's death.

VCL Staffs' Delayed Discontinuation of Caring Letters

The OIG found that facility and VCL staff's delay in taking actions to update the patient's EHR with the deceased alert contributed to the VCL's continuation of mailing caring letters to the patient's residence after the patient's death.

The 2019 VA/DoD Clinical Practice Guidelines recommend the mailing of "periodic caring communication ([for example], postcards) for 12-24 months in addition to usual care" following an inpatient mental health admission related to suicidal ideation or a suicide attempt.¹²⁶ In July 2019, the VCL established a memorandum of understanding with the VA Quality Enhancement Research Initiative to implement a Caring Letters program for patients that contact VCL through repeated "brief, nondemanding messages" for expressing "caring concern."¹²⁷

On day 9, the Director, VCL National Care Coordination forwarded the facility's Heads Up Message regarding the patient's death by suicide to the Director, Quality and Training. Additionally, the Director, VCL National Care Coordination noted in the email that VCL might have been the last contact with the patient. On day 84, the Suicide Prevention Program case manager forwarded an email to the Decedent Affairs email group from Family Friend 2 that

¹²⁵ South Texas Veterans Health Care System SOP 116A-22-20, "Suicide Postvention Team," Standard Operating Procedure, January 1, 2022.

¹²⁶ VA/DoD, *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

¹²⁷ "Memorandum of Understanding Between VA Quality Enhancement Research Initiative (QUERI) And Veteran Crisis Line," July 30, 2019.

notified the Suicide Prevention Program team of the delivery of caring letters to the patient's residence.

The next day (day 85), a management and program analyst from the Veterans Experience Office, VA Office of the Secretary emailed a request to the VHA Suicide Prevention Office and Office of Client Relations, Office of the VA Secretary, with a request to remove the patient's name from "the VCL list" to discontinue "follow-up letters."¹²⁸ VCL leaders told the OIG that "VCL's National Care Coordination team was notified of [the patient's] death on [day 85] and removed [the patient] from future mailings on that date." No additional correspondence was mailed to the patient after day 80.

Approximately a week later, a White House Hotline staff member contacted the VCL on behalf of Family Friend 1 regarding the family continuing to receive "welfare checks and cards initiated by the Hotline" despite the patient's death.¹²⁹ Responder 3 contacted Family Friend 1, consulted with a supervisor, and submitted a suicide prevention coordinator consult. The next day, the Suicide Prevention Program case manager documented that Family Friend 1 reported a "complaint of continued caring contacts although the Veteran is deceased." Additionally, the Suicide Prevention Program case manager documented a plan to "inform [Suicide Prevention] Program leadership regarding, what caller describes as, 'harassment to the family'." On day 99, the Suicide Prevention Program case manager emailed the Suicide Prevention Program manager asking if the Director, VCL National Care Coordination had been notified of the complaint regarding the continued caring letters and suggested notifying the Director, VCL National Care Coordination of "the allegations as the family has made a White House complaint due to 'harassing communications'."

The Director, VCL National Care Coordination told the OIG

- that the VCL Caring Letters Program team was unaware of the Death by Suicide Report for the patient.
- about becoming aware of the need to remove the patient upon receipt of the email from the Veterans Experience Office on day 85.
- that the patient was not removed from the Caring Letters delivery because, at the time of the event, there was not a process for ensuring that the Caring Letters Program was made aware of deaths by suicide.
- that when a patient's EHR is updated by facility staff with a deceased alert then the Caring Letters Program system discontinues distribution of caring letters.

¹²⁸ The Veterans Experience Office is the VA's customer service organization to support the customer experience and engagement while receiving services from VA.

¹²⁹ In June 2017, the White House Hotline opened "under direction of the Veterans Experience Office." Hotline calls are answered 24 hours per day, seven days per week, and 365 days per year.

- that following this event, VCL implemented an automated process in which the Caring Letters team will receive Death by Suicide Reports and distribution of caring letters is discontinued.

The OIG found that VCL staff and leaders were notified of the patient's death nine days after the patient's death by suicide and failed to take actions to discontinue caring letter delivery to the patient's residence until day 85. The OIG determined that VCL leaders' failure to develop procedures to ensure the Caring Letters Program received notification of the patient's death exacerbated the bereaved family's distress.

Facility Leaders' Failure to Implement the BHAP

Prior to the OIG's notification of this healthcare inspection, facility Suicide Prevention Program staff did not complete behavioral health autopsies after becoming aware of patients' deaths by suicide or suspected suicide, as required by VHA since November 2012.¹³⁰ VHA requires that a suicide prevention coordinator complete a BHAP chart review within 30 days of awareness of a patient suicide or suspected patient suicide, contacting the next of kin to inform them about the BHAP process, and to initiate a family interview.¹³¹

On day 4, facility leaders completed an issue brief regarding the patient's death by suicide that noted that social work staff would contact the patient's family. However, facility staff did not contact the patient's family, as documented in the issue brief. Seven months after the issue brief was completed, a facility quality management staff member emailed the Suicide Prevention Program manager the VHA guidance that included the Suicide Prevention Program team's role in completing the BHAP. In an interview with the OIG, the Suicide Prevention Program manager reported that the patient's BHAP "wasn't done and should have been" and acknowledged that the Suicide Prevention Program team was responsible for BHAP.¹³²

In November 2021, the Suicide Prevention Program manager emailed the chief, Quality Management and the chief, Patient Safety, and noted that the facility "has been cited by national for not having completed a behavioral health autopsy on a recent suicide as required by policy" and requested assistance establishing a BHAP. The chief, Patient Safety responded that the BHAP was the responsibility of the Suicide Prevention Program. The VISN 17 Chief Mental

¹³⁰ VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

¹³¹ VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. A BHAP chart review is a systematic EHR review of relevant behavioral health information about a patient prior to their death, including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinician notes. VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

¹³² The Suicide Prevention Program Manager reported being initially hired in May 2019 as a suicide prevention psychologist and assuming the manager role in June 2021.

Health Officer reported to the OIG that the VISN 17 Deputy Quality Management Officer inquired “whether our VISN sites did ‘autopsies’” following a death by suicide. The VISN 17 Chief Mental Health Officer noted not having “direct authority over the [Mental Health] Chiefs and cannot enforcement [*sic*] of any [Office of Mental Health and Suicide Prevention] requirement” and provided the appropriate resources for BHAP submissions.

In December 2021, the VISN 17 Chief Mental Health Officer documented a summary of responses from VISN 17 sites related to the BHAP requirement that noted the facility’s noncompliance with BHAP and facility staff was “working on creating a process.” The following day, the acting associate chief of staff, Mental Health notified the Suicide Prevention Program manager that the VISN was informed that facility staff was not completing BHAPs.¹³³ Four days later, the Suicide Prevention Program manager responded to the acting associate chief of staff, mental health that they “are now completing BHAPs.” The Suicide Prevention Program manager told the OIG that the supervisory structure for the Suicide Prevention Program “back then was very diffuse” and that BHAPs may not have been completed due to facility staff’s “lack of awareness.”

Effective January 1, 2022, facility leaders implemented a standard operating procedure that outlined required actions following a patient’s death by suicide and included that completing applicable BHAP and decedent affairs notification was the responsibility of the Suicide Prevention Program manager.¹³⁴ Additionally, a member of the suicide postvention team is assigned to outreach a family member of the deceased patient by telephone.¹³⁵

On January 14, 2022, the chief, Quality Management provided the OIG with the patient’s completed BHAP. As of June 2022, the Suicide Prevention Program manager had submitted eight BHAP reports since January 1, 2022, as required.¹³⁶ The failure to comply with BHAP requirements may have prevented the identification of contributory factors to patients’ deaths by suicide and performance improvement actions that could promote enhancements in suicide prevention strategies.

Conclusion

The OIG found that Responder 1 did not complete an adequate assessment of the patient’s suicide risk factors, including the patient’s suicidal preparatory behavior and alcohol use, during

¹³³ The chief, psychology served as the acting associate chief of staff, mental health from November 1, 2021, to December 31, 2021, and the chief, psychiatry served in the role from January 1, 2022, to March 2, 2022.

¹³⁴ South Texas Veterans Health Care System, Mental Health Service SOP 116A-22-20, “Suicide Postvention Team Standard Operating Procedure,” January 1, 2022.

¹³⁵ South Texas Veterans Health Care System, Mental Health Service SOP 116A-22-20, “Suicide Postvention Team Standard Operating Procedure,” January 1, 2022.

¹³⁶ VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

the text conversation.¹³⁷ Additionally, Responder 1 failed to adequately pursue actions to address the patient's suicidal preparatory behavior, including reducing access to immediate lethal means and involving Family Member 1, as expected by VCL guidance.¹³⁸ Responder 1's failure to clarify the patient's engagement in suicidal preparatory behavior and alcohol use likely contributed to Responder 1's underestimation of the patient's imminent suicide risk and failure to follow up after the patient's discontinuation of texting or to consider third-party involvement.

Responder 1 failed to establish an effective safety plan with the patient.¹³⁹ Specifically, Responder 1 failed to confirm the patient's actions to reduce immediate access to lethal means and actively involve Family Member 1 in the safety planning process. Further, Responder 1 did not consider transferring from text to telephone management based on the perception of having established a safety plan with the patient.

The OIG concluded that Responder 1's suggestion to leave the shed without further encouragement or confirmation was ineffective in reducing the patient's access to the identified lethal means and failed to reduce the patient's suicide risk. Further, the OIG determined that

¹³⁷ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding assessment of current substance use and self-directed violent behavior as the rescinded 2019 guide.

¹³⁸ On March 17, 2022, following receipt of the text messages and OIG's identification of the responder's failures to mitigate the patient's suicide risk, the OIG notified the Executive Director, VA Suicide Prevention. VCL leaders reported ensuring Responder 1 was no longer "engaging in direct contact with Veterans." VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1503(2), on December 8, 2022. Unless otherwise specified, the 2022 directive contains the same or similar language regarding the business and clinical operations of VCL as the rescinded 2020 directive; VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding suicidal preparatory behavior and reducing access to lethal means as the rescinded 2019 guide; VCL-S-ACT-217-2004(2), "Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning," September 22, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-217-2104, "Veterans Crisis Line Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning, April 2021. Unless otherwise specified, the 2021 directive contains the same or similar language regarding the suicidal preparatory behavior and reducing access to lethal means as the rescinded 2020 standard operating procedure.

¹³⁹ VCL, *Health Science Specialist Training Participant Guide*, June 2019. This guide was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL, *Social Science Specialist Training Participant Guide*, November 2021. Unless otherwise specified, the 2021 guide contains the same or similar language regarding safety planning as the rescinded 2019 guide; VCL-S-ACT-217-2004(2), "Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning," September 22, 2020. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VCL-S-ACT-217-2104, "Veterans Crisis Line Standard Operating Procedure for Collaborative Problem Solving and Risk Mitigation Planning, April 2021. Unless otherwise specified, the 2021 standard operating procedure contains the same or similar language regarding guidance when a customer "reports having lethal means nearby" as the 2020 standard operating procedure.

Responder 1's failure to confirm that the patient left the shed or was otherwise distanced from the hanging apparatus contributed to the patient's immediate access to the means to engage in suicidal behavior.

Responder 1 did not document the patient's willingness for contact with Family Member 1 or the rationale for not directly communicating with Family Member 1. The OIG concluded that Responder 1's underestimation of the patient's imminent suicide risk and presumption of an established safety plan contributed to Responder 1's failure to involve Family Member 1. The OIG determined that Responder 1's failure to involve Family Member 1 in safety planning contributed to the patient's uninterrupted access to lethal means and follow through with suicidal behavior.

Given the patient's imminent suicide risk, absence of verification that Family Member 1 was aware of the patient's plan to use a hanging apparatus, and the patient's lack of reply to Responder 1's continued texts, the OIG would have expected Responder 1 to maintain the text contact until the patient's safety was confirmed by Family Member 1 or another third party. Additionally, based on the patient's suicide risk factors, including potential intoxication and suicidal preparatory behavior, the OIG would have expected Responder 1 to consider implementing risk mitigation actions, such as involving Family Member 1 or transferring to telephone management.

Responder 1 did not accurately document the patient's text message information or disposition.¹⁴⁰ Although the OIG did not determine that the different terms for suicide risk level contributed to Responder 1's failure to adequately assess the patient's suicide risk, use of inconsistent terms for classification may result in responders' confusion about indicated actions and inadequate documentation.

VCL leaders' failure to ensure that sufficient silent monitored contacts were conducted for staff serving as responders, including monitor specialists performing responder duties for overtime or compensatory time, may have resulted in unidentified deficiencies in performance. The failure to ensure adequate oversight may have contributed to Responder 1's mismanagement of the patient's crisis contact, including an inadequate suicide risk assessment and safety plan, and inaccurate documentation.

The OIG determined that VCL leaders failed to establish a text message retention process in over 10 years of VCL's use of text messaging for crisis management. The lack of text retention prevented leaders from conducting comprehensive quality assurance reviews of text contact management, including Responder 1's contact with the patient. Leaders' failure to ensure a robust text contact management quality assurance review program limited supervisory oversight

¹⁴⁰ VCL-S-ACT-218-2008, "Veterans Crisis Line - Standard Operating Procedure for Health Science Specialist Documentation Guidelines," August 26, 2020.

thereby hindering the identification of performance deficiencies and the execution of corrective actions.

The OIG found delayed and inadequate administrative responses by VCL and facility staff following notification of the patient's death. Based on VCL leaders' interviews, the OIG determined that VCL's issue brief inaccurately noted that a root cause analysis was to be initiated. VCL leaders' failure to conduct a timely review of the patient's VCL contact contributed to a delay in the identification of systemic and performance deficiencies and implementation of corrective actions.

The OIG determined that the patient's death meets the VCL definition of sentinel event since the patient died by suicide within an hour of contact with Responder 1 as the last contact, and that Responder 1 failed to conduct an adequate suicide risk assessment or safety planning. Given that the VCL procedures emphasize the initiation of disclosure upon recognition of a sentinel event following review, the OIG concluded that VCL leaders should therefore consider conducting a disclosure to the patient's personal representative(s).

The Director, Quality and Training, potentially compromised Responder 1's candidness and recollection by providing advice and information prior to Responder 1's interviews with the OIG. Although the OIG recognizes that the Director, Quality and Training, expressed concern about Responder 1's well-being, a VA leader providing preparatory information to a staff member prior to an OIG interview may compromise the accuracy and integrity of information provided to the OIG. As such, the OIG's ability to fully identify performance and system deficiencies may be hindered, resulting in recommendations that do not sufficiently address the underlying root causes.

The OIG concluded that Responder 2's failure to complete a suicide prevention consult contributed to the delay in facility staff updating the patient's EHR to reflect the patient's death resulting in the patient's family continuing to receive communications for the patient.

Responder 2 did not submit a complaint form regarding Family Member 2's dissatisfaction with VCL services for the patient, as expected by VCL leaders. However, Responder 2 did document Family Member 2's anger about the patient's VCL contact and request for follow-up in the Report of Death by Suicide and Medora, both of which included leaders' reviews. The OIG concluded that VCL leaders' failure to address Family Member 2's request for a return call likely caused Family Member 2 further dissatisfaction and lack of confidence in VCL services.

Facility staff entered a deceased alert in the patient's EHR on day 92, 89 days after staff received the initial patient death notification. As a result of facility staff's failure to place a deceased alert in the patient's EHR, staff continued to leave messages on the patient's phone and send mail to the patient's home. Facility leaders' failure to ensure timely placement of the deceased alert in the patient's EHR exacerbated the family's distress in the months immediately following the patient's death.

VCL staff and leaders were notified of the patient's death nine days after the patient's death by suicide and failed to take actions to discontinue caring letter delivery to the patient's residence until day 85. The OIG determined that VCL leaders' failure to develop procedures to ensure the Caring Letters Program received notification of the patient's death exacerbated the bereaved family's distress.

Facility leaders did not implement the BHAP, as required by VHA since November 2012, until January 2022.¹⁴¹ As of June 2022, the Suicide Prevention Program manager had submitted eight BHAP reports since January 1, 2022, as required.¹⁴² The failure to comply with BHAP requirements may have prevented the identification of contributory factors to patient deaths by suicide and performance improvement actions that could promote enhancements in suicide prevention strategies.

Recommendations 1–14

1. The Veterans Crisis Line Director conducts a full review of the Veterans Crisis Line staff's management of the patient and third-party contacts, consults with Human Resources and General Counsel Offices, and takes actions as warranted.
2. The Veterans Crisis Line Director expedites the alignment of the Medora documentation template with the VA and Department of Defense Clinical Practice Guideline and Veterans Crisis Line guidelines for suicide risk assessment classification levels.
3. The Veterans Crisis Line Director ensures and strengthens the quality management oversight of staff who provide crisis management services, including overtime coverage.
4. The Veterans Crisis Line Director confirms the retention of crisis management text conversations and establishes supervisory oversight protocols.
5. The Veterans Crisis Line Director ensures issue briefs accurately reflect the action plan.
6. The Veterans Crisis Line Director identifies criteria for immediate internal reviews of customers' deaths by suicide and accidental overdose to identify crisis management and administrative performance improvement actions.
7. The Veterans Crisis Line Director conducts a full review of the patient's text contact, determines whether an institutional disclosure is warranted, and takes action as indicated.

¹⁴¹ VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. A BHAP Chart Analysis is a standardized EHR review of relevant behavioral health information about a patient prior to their death, including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinician notes.

¹⁴² VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

8. The Veterans Crisis Line Director monitors compliance with the submission and oversight of notification of a customer's death, including timely submission of a suicide prevention coordinator consult.
9. The Veterans Crisis Line Director conducts a review of the interactions between the Director, Quality and Training, and staff in preparation and during the Office of Inspector General healthcare inspection, educates staff on the importance of fully cooperating, responding in an open and transparent manner, and avoiding any appearance of coordination between employees, and take actions as warranted.
10. The Veterans Crisis Line Director clarifies and strengthens procedures for complaint submission, provides staff training, ensures consistency with the Veterans Health Administration directive, and monitors compliance.
11. The South Texas Veterans Health Care System Director ensures that processes are established for timely death notification entry in patients' electronic health records.
12. The South Texas Veterans Health Care System Director ensures that staff adheres to the January 2022 standard operating procedures for administrative and clinical actions following a patient's or employee's death by suicide.
13. The Veterans Crisis Line Director strengthens processes to ensure discontinuation of caring letters in a timely manner following notification of a patient's death.
14. The South Texas Veterans Health Care System Director makes certain that the Suicide Prevention Program ensures full implementation of the Behavioral Health Autopsy Program as required by the Veterans Health Administration.

Appendix A: Office of the Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: August 10, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas (2022-00507-HI-1224)

To: Assistant Inspector General for Healthcare Inspections (54)

1. VHA is incredibly saddened by the loss of this Veteran and our thoughts are with the Veteran's family. VHA is committed to performing at the highest standards and finding ways to improve our response to Veterans in crisis. Any Veteran suicide is one too many and VHA remains steadfast in our mission to support those in suicide crisis. We are utilizing this review to strengthen processes for improved suicide prevention.
2. One of VHA's top health care priorities is preventing Veteran suicides. Since its launch, the Veterans Crisis Line (VCL) has mailed over 2.1 million letters to over 280,000 individual Veterans, with over 150,000 Veterans completing the full 12-month intervention. This involves sending cards or letters with simple expressions of care and concern, at specified intervals, over a year or more. Regrettably, after the Veteran's death, we failed to discontinue the letters. I have included information in the attached action plan to explain how VHA will take steps to prevent this from occurring with other Veterans.
3. I appreciate the VA Office of Inspector General's (OIG) recommendation to consider retroactively applying the policy for disclosing critical incidents to this Veteran's situation. I have asked the Deputy Director for Crisis Operations to take appropriate action.
4. I also want to clarify a statement in the report that implies the VCL only conducted a root cause analysis (RCA) upon inspection of this event. The VCL did conduct a quality review at the time of notification of the Veteran's death, including a review of Responder 1's documentation and Responder 2's interaction. The determination was made that an RCA would not be conducted at that time, since VCL did not have the text message transcript to review. As additional information came to light, VCL independently determined that an RCA was justified and subsequently performed it.
5. The VA OIG expressed concerns regarding the monitoring of non-responders. VHA regularly monitors responders in accordance with policy but acknowledges there are opportunities to improve the monitoring of non-responders. In addition, the VA OIG discussed the VCL Reporting Hub. This Hub is an integral information system that captures safety-related events for analysis of future service improvements for VCL's non-clinical environment. The system also allows for immediate entry and notification of deaths by suicide to both VCL Executive Leadership and the Caring Letters program. The VCL's Risk Management Team reviews all events entered into the VCL Reporting Hub including complaints, safety events, near misses, and reports of death by suicide. All documents pertaining to each submission, review, and follow-up are retained within the Hub.
6. VHA concurs with all 14 recommendations and submits the attached action plan. Thank you again for partnering with VHA to ensure our Veterans receive the high-quality healthcare they deserve.
7. Comments regarding this memorandum may be directed to the GAO OIG Accountability Liaison Office at VACOVHA10BGOALOIG@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

OIG Addendum to the Office of the Undersecretary for Health Memorandum

The OIG received the memorandum from the Office of the Undersecretary for Health on September 5, 2023.

Regarding the Under Secretary for Health's memorandum, comment 4, that the VCL "independently determined" to conduct a root cause analysis, the OIG maintains that VCL leaders initiated a root cause analysis about the patient's contact in response to concerns identified by the OIG team. VCL leaders told the OIG that the decision to not conduct a root cause analysis was based on a quality assurance review conducted 11 months prior to the OIG notification and not having the text conversation between the patient and Responder 1. VCL leaders initiated the root cause analysis three weeks after the OIG notification of the inspection and the OIG obtained and provided VCL leaders with the text conversation approximately three months later. The Executive Director, VCL and the Director, Quality and Training, confirmed that the root cause analysis was conducted as a result of the OIG inspection notification.

Office of the Under Secretary for Health

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas (2022-00507-HI-1224)

Recommendation 1. The Veterans Crisis Line Director conducts a full review of the Veterans Crisis Line staff's management of the patient and third-party contacts, consults with Human Resources and General Counsel Offices, and takes actions as warranted.

VA Comments: Concur. The Veterans Crisis Line (VCL) is appreciative of the Office of the Inspector General (OIG) for sharing evidence gathered during its review. VCL will conduct a full review of the VCL staff's management of the Veteran and third-party contacts, consult with Human Resources and General Counsel and provide OIG with evidence supporting the resolution of this recommendation.

Status: In-Progress

Target Completion Date: January 2024

Recommendation 2. The Veterans Crisis Line Director expedites the alignment of the Medora documentation template with the Department of Veterans Affairs and Department of Defense Clinical Practice Guideline and Veterans Crisis Line guidelines for suicide risk assessment classification levels.

VA Comments: Concur. OIG's perspective on the inclusion of the suicide risk assessment classification levels in the Medora call documentation template is very much appreciated. This perspective, offered from a trusted, completely objective and independent source, is critically important to VCL's continued improvement and growth. The Risk Stratification Template will be utilized as a resource to develop an appropriate tool for VCL Crisis Responders to assess for risk. VCL will seek industry and suicide prevention-specific subject-matter expert consultation to adapt the risk stratification model to the work of VCL. Once the model is completed, VCL will utilize a pilot program to test the new rating system with a smaller number of responders to assess training needs, training concerns, successes and challenges with the new process. Once the pilot program has been completed, and tested, VCL will assess the applicability and utility of risk stratification for rollout to VCL more broadly. VCL will provide these results and future plans for implementation to OIG.

Status: In-Progress

Target Completion Date: July 2024

Recommendation 3. The Veterans Crisis Line Director ensures and strengthens the quality management oversight of staff who provide crisis management services, including overtime coverage.

VA Comments: Concur. VCL is appreciative of the OIG's recommendation to ensure and strengthen the quality management oversight of staff who provide crisis

management services, including overtime. In response to the notice of this inspection and the events it was to examine, VCL reviewed the use of non-Responder staff in performing Responder duties when the crisis center was not staffed sufficiently to meet contact demand and determined that the use of non-Responders was no longer a necessity to meet increases in contact demand. Instead, Responders working overtime alone would be sufficient, and, therefore, VA discontinued this practice in March 2022.

Existing VCL policy requires Quality Assurance to monitor 80% of all Responders at least once per two-week pay period. In addition to Quality Assurance silent monitoring, the immediate Supervisor of each Responder is expected to monitor at least 80% of eligible Responders and must reach this metric across the fiscal year to meet annual performance expectations.

VCL will update Supervisory monitoring requirements to increase the frequency and accountability of mandatory Supervisory monitoring of employees. VCL will also review reporting metrics. The updated Standard Operating Procedure (SOP) and metrics to evidence both adequate Quality Assurance and Supervisory monitoring of Responders will be provided to the OIG to substantiate the appropriate resolution of the recommendation.

Status: In-Progress

Target Completion Date: January 2024

Recommendation 4. The Veterans Crisis Line Director confirms the retention of crisis management text conversations and establishes supervisory oversight protocols.

VA Comments: Concur. OIG's perspective on the retention of crisis management text conversations and establishing supervisory oversight protocols is appreciated. As the VA OIG notes in the report, VCL examined available options for the retention of interaction transcripts in the Medora information system after current and prior text service vendors could not supply this feature. A method of retaining text transcripts was identified through copying and pasting the interaction transcript from the text service to Medora. This has been in place since May 2022. In addition, VCL will enhance procedures for Silent Monitors to verify the text interaction is pasted into Medora during their review process. VCL will provide evidence of these procedures to the OIG to substantiate that VCL has adequately addressed the recommendation.

Status: In progress

Target Completion Date: January 2024

Recommendation 5. The Veterans Crisis Line Director ensures issue briefs accurately reflect the action plan.

VA Comments: Concur. VCL appreciates the OIG's recommendation regarding the inclusion of valid action plans within the context of Issue Briefs (IBs). VCL has implemented a significant change in the preparation and clearance of IBs and other action documents. VCL now has a designated Action Team tracking the routing of such documents across the organization. This team ensures proper routing of action documents to ensure inclusion, comments and corrections by all VCL stakeholders involved in each matter. Additionally, the Action Team confirms that each Deputy Director approves the documents before they are finally routed to the Deputy Executive

Director and Executive Director for review and approval. Approvals are evidenced in the routing.

Training has been provided to all staff for the use of the VCL Reporting Hub in submitting and tracking all action items to include IBs. Additional training has also been provided to reviewers and activity heads for their responsibilities for accuracy in the submissions. This additional training includes the need to ensure IBs accurately reflect the action plan. Finally, where information on completed IBs becomes dated or in need of correction, VCL will prepare updated IBs that identify the changes accomplished and explain the rationale for the update.

VCL will prepare documentary evidence in the form of a presentation of this new process and use of the VCL Report Hub for the OIG's review to substantiate that VCL has adequately addressed the OIG's recommendation.

Status: In progress

Target Completion Date: January 2024

Recommendation 6. The Veterans Crisis Line Director identifies criteria for immediate internal reviews of customers' deaths by suicide and accidental overdose to identify crisis management and administrative performance improvement actions.

VA Comments: Concur. VCL Executive leadership is appreciative of the OIG's recommendation for VCL to identify criteria for immediate internal reviews of customers' deaths by suicide and accidental overdose to identify crisis management and administrative performance improvement actions.

Following a report of a Veteran's death by suicide, the death is logged into the VCL Reporting Hub. This action is accomplished in accordance with VCL's SOP regarding critical incidents and near misses. This process necessitates an examination, from Quality Assurance, of any/all the past interaction(s) VCL had with the Veteran and, possible follow-up actions.

In addition to assessing the Veteran's past statements and the overall tenor of past interactions, interaction reviews assess the Responders compliance with VCL's Responder interaction standards. VCL uses a standard template to perform these reviews. The template provides the reviewer a tool for ensuring adherence to all relevant interaction standards as well as assessing the significance of any exceptions to these standards both individually and in the aggregate. If, through the initial interaction reviews, Quality Assurance determines a critical incident, near miss or sentinel event occurred, VCL's Standard Operating Procedure (SOP) regarding critical incidents and near misses is followed.

VCL will prepare a desk guide for Quality Assurance staff in the methodology to use in applying these criteria when examining customers' deaths by suicide and/or accidental overdose and provide this desk guide to the OIG to substantiate we have adequately addressed the recommendation.

Status: In-Progress

Target Completion Date: January 2024

Recommendation 7. The Veterans Crisis Line Director conducts a full review of the patient's text contact, determines whether an institutional disclosure is warranted, and takes action as indicated.

VA Comments: Concur. OIG's recommendation is appreciated. VCL will apply our Standard Operating Procedure (SOP) regarding critical incidents and near misses, subsequent VCL actions and Veteran events to determine whether an institutional disclosure should occur. Additionally, the VHA Directive 1004.08 Institutional Disclosure of Adverse Events will be considered in making a determination alongside VCL's SOP. If appropriate, the Deputy Director, Crisis Operations will enact recommended actions. VCL will provide the OIG with documentary evidence of the performance of all procedures to substantiate the completion of this recommendation.

Status: In-Progress

Target Completion Date: January 2024

Recommendation 8. The Veterans Crisis Line Director monitors compliance with the submission and oversight of notification of a customer's death including timely submission of a suicide prevention coordinator consult.

VA Comments: Concur. VCL recognizes the criticality of monitoring compliance with the submission and oversight of notification of a customer's death including timely submission of a suicide prevention coordinator consult. On June 6, 2022, VCL implemented the Postvention Request for Suicide Prevention Coordinators in the Medora information system. This is a request to a facility Suicide Prevention Coordinator (SPC) alerting them that a Responder received information of a possible Veteran death by suicide. Upon receiving the notice, SPCs are to begin an outreach effort to confirm the Veteran's status and, if accurate, begin reporting and postvention processes outlined in VHA's Program Guide for Suicide Prevention. SPCs received education regarding this new request type during a National Suicide Prevention Coordinator meeting in June 2022. Existing Responders received training regarding the request type prior to implementation; since implementation, the training is provided during new employee training.

VCL will provide metrics on Postvention Request Consult submissions and close-outs as well as reports of Veteran deaths by suicide entered into the VCL Report Hub, for the period July 2022 to November 2023, as evidence of compliance monitoring.

Status: In progress

Target Completion Date: January 2024

Recommendation 9. The Veterans Crisis Line Director conducts a review of the interactions between the Director, Quality and Training, and staff in preparation and during the Office of Inspector General healthcare inspection, educates staff on the importance of fully cooperating, responding in an open and transparent manner, and avoiding any appearance of coordination between employees, and take actions as warranted.

VA Comments: Concur. VCL appreciates the concern OIG expresses for this issue and the importance of full cooperation and compliance with the OIG by all Government employees. We also appreciate the importance of our leaders exhibiting appropriate behavior in all aspects of their work. We are submitting this matter for further review to

VCL's Administrative Operations Team which assists on such matters and will consult with Human Resources and General Counsel as appropriate and provide evidence of accomplishment to the OIG. Additionally, the Suicide Prevention Program auditor will develop and deliver new training for all VCL staff on the role of the OIG and organizational expectations regarding cooperation from all staff and managers. Evidence of training attendance and completion will be provided to the OIG.

Status: In progress

Target Completion Date: January 2024

Recommendation 10. The Veterans Crisis Line Director clarifies and strengthens procedures for complaint submission, provides staff training, ensures consistency with the Veterans Health Administration directive, and monitors compliance.

VA Comments: Concur. VCL appreciates the concern OIG expresses for this issue and the importance of strengthening procedures for complaint submission, staff training and consistency with the VHA directive and monitoring compliance. To improve the program, VCL published, in February 2023, a standard operating procedure (SOP) for managing complaints regarding VCL services. All existing and new, incoming, VCL employees are trained on this SOP.

The Complaints SOP establishes that any VCL staff member can submit a complaint to the VCL Reporting Hub. Risk management staff triage complaints based on type and either review complaints themselves or route to an appropriate VCL activity for further review and action. Examples of complaint topics are Suicide Prevention Coordinators, information technology, access to VCL services, VA facilities, etc. Risk management staff track all complaints for status, progress, and final resolution; Risk management staff report on all complaints received and outcomes. To substantiate completion of this recommendation, VCL will provide the SOP, the training presentations, and compliance monitoring metrics for the period June to November 2023.

Status: In-Progress

Target Completion Date: January 2024

Recommendation 13. The Veterans Crisis Line Director strengthens processes to ensure discontinuation of caring letters in a timely manner following notification of a patient's death.

VA Comments: Concur. VCL is appreciative of the OIG's recommendation to strengthen processes to ensure discontinuation of caring letters in a timely manner following notification of a patient's death. Since the initial launch of the VCL's Caring Letters project in June 2020, all Caring Letters datasets have been synchronized with Veterans Affairs (VA) Corporate Data Warehouse and VA death data sources. Database synchronization ensures Veterans are automatically removed from the project who are reported to be deceased in VA data. VA death data is captured from all front-end deceased patient flag entries placed in VHA's Computerized Patient Record System (CPRS) and Cerner Electronic Health Records.

Beginning in April 2021, VCL implemented an additional patient death notification procedure to remove Veterans names from the Caring Letters database when Veterans are reported to VCL as deceased. This additional procedure involves leveraging third-

party reports to VCL that a Veteran is deceased. When a third-party notifies VCL that a Veteran is deceased, VCL generates a death notification report. The VCL Caring Letters team accesses those reports and uses them to manually remove Veterans names from Caring Letters mailings. Since April 2021, this additional step successfully captured information about Veteran deaths that had not been captured in other VA death data sources.

VCL will add Discontinuation of Caring Letters to the Issue Brief Template used to report a Veteran Death by Suicide as a logic check to verify letters are stopped after a report is received. VCL will provide OIG with the process map for the additional patient death notification procedure, as well as the updated Issue Brief Template that includes a check on cessation of Caring Letters to substantiate completion of the recommendation.

Status: In progress

Target Completion Date: January 2024

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 21, 2023

From: Director, VA Heart of Texas Network (10N17)

Subj: A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas

To: Director, Mental Health Hotlines (54MH01)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We deeply regret the circumstances that impacted the care delivered to one of our Veterans. I have reviewed the draft report and the Facility Response for a Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas.
2. The VA Heart of Texas Health Care System is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and the action plan of the VA South Texas Health Care System.
3. I would like to thank the Office of Inspector General for their thorough review of this case and if you have any additional questions, please contact the VISN 17 Quality Management Officer (QMO).

(Original signed by:)

Wendell Jones, MD, MHA
Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 21, 2023

From: Director, South Texas Veterans Health Care System (671/00)

Subj: Healthcare Inspection—A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas

To: Director, Veterans Integrated Service Network 17 (10N17)

1. South Texas Veterans Health Care System (STVHCS) is deeply saddened by the loss of this Veteran. I would like to thank the Office of Inspector General (OIG) for their comprehensive review of this matter and the recommendations for process improvements. The facility has learned from this tragedy, continues to improve our processes, and aims to provide continued high-quality care to Veterans. As STVHCS moves forward on our journey to high reliability, we appreciate the insight and collaboration with OIG.

2. I appreciate the opportunity to review the OIG draft report and concur with the recommendations found within the report. We are in the process of completing actions to resolve these issues and ensure sustainment of actions implemented.

(Original signed by:)

Julianne Flynn, M.D.
Executive Director

Facility Director Response

Recommendation 11

The South Texas Veterans Health Care System Director ensures that processes are established for timely death notification entry in patients' electronic health records.

Concur

Nonconcur

Target date for completion: February 2024

Director Comments

On January 1, 2022, South Texas Veterans Health Care System (STVHCS) published the Suicide Postvention SOP outlining actions to be taken following a suicide. This SOP requires the Suicide Prevention Program (SPP) manager to notify decedent affairs of identified suicides via decedent affairs email distribution group. This email address includes office staff as well as supervisory and management officials who ensure the chart is closed timely after receipt of notification. Upon receipt of notification by SPP, decedent affairs will enter the designation and future appointments will be canceled by close of business (COB) the next business day. Healthcare Administration Service will create and implement a spreadsheet to track decedent affairs designations and the cancellation of future appointments. The Healthcare Administration Service supervisor and the enrollment coordinator will audit monthly 100% of suicides reported to decedent affairs. The monthly audit results will be reported to the Scheduling Business Committee which reports to Executive Access to Care Board. Compliance with timely entry of designation and cancellation of future appointments will be monitored to ensure at least 95% compliance is maintained for six consecutive months. Additionally, a facility SOP will be developed to capture Healthcare Administration Service responsibilities following a Veteran or employee suicide. The numerator will be the number of identified suicides reported to decedent affairs in which decedent affairs designations and cancellations of future appointments. The denominator will be the number of identified suicides reported to decedent affairs.

Recommendation 12

The South Texas Veterans Health Care System Director ensures that staff adheres to the January 2022 standard operating procedures for administrative and clinical actions following a patient's or employee's death by suicide.

Concur

Nonconcur

Target date for completion: February 2024

Director Comments

A spreadsheet will be developed and completed by the Suicide Prevention Program (SPP) manager to track notifications to Decedent Affairs and that a member of the suicide postvention team reaches out to a family member of the deceased via telephone. This will be a 100% monthly audit of all identified suicides and will be reported monthly to the Mental Health Community of Practice and reported quarterly to Mental Health Executive Council which reports to Clinical Executive Board. Compliance with the administrative and clinical action requirements following a patient's or employee's death by suicide will be monitored to ensure at least 95% compliance is maintained for six consecutive months. The numerator will be the number of identified suicides in which notification to decedent affairs and family members occurred as per SOP. The denominator will be the number of identified suicides.

Recommendation 14

The South Texas Veterans Health Care System Director makes certain that the Suicide Prevention Program ensures full implementation of the Behavioral Health Autopsy Program as required by the Veterans Health Administration.

Concur

Nonconcur

Target date for completion: February 2024

Director Comments

In accordance with VHA Directive 1160.07, Suicide Prevention Coordinators (SPC) are responsible for completing the Behavioral Health Autopsy Program (BHAP) Chart Review using the BHAP Reporting System within 30 days of becoming aware of a Veteran suicide or suspected Veteran suicide. In alignment with VHA Directive 1160.07, the facility SOP requires that Behavioral Health Autopsies are to be completed and reported to the VHA Central Office Suicide Prevention Program within 30 days of the facility becoming aware of the suicide. Additionally, the SOP requires a Family Interview Contact Form (FIT-C) be submitted to the Central Office Suicide Prevention Program at the time of the BHAP report submission. The SPP manager will be responsible for ensuring both BHAP and FIT-C forms are completed on all identified suicides and submitted to Central Office Suicide Prevention Program within 30 days of the facility becoming aware. This report will be submitted via the approved Suicide Prevention SharePoint portal. Results of compliance will be reported monthly to the Mental Health Community of Practice and reported quarterly to Mental Health Executive Council which reports to Clinical Executive Board. Compliance will be monitored to ensure at least 95% compliance is maintained for six consecutive months.

The numerator will be the number of identified suicides in which BHAP reports and FIT-C forms were completed as per Directive and SOP. The denominator will be the number of identified suicides.

Glossary

To go back, press "alt" and "left arrow" keys.

adverse event. VHA defines an adverse event as a harmful or potentially harmful incident associated with care delivered by VA providers.¹

alcohol use disorder. A pattern of alcohol use within the previous year that leads to significant impairment or distress characterized by drinking larger quantities or for longer periods of time than intended, craving for alcohol, ongoing alcohol use despite recurring problems at home, socially or at work, needing increasing amounts of alcohol to be intoxicated, or experiencing symptoms of alcohol withdrawal.²

attention deficit hyperactivity disorder. A mental health disorder with persistent symptoms that may include inattention, hyperactivity, and impulsivity and can lead to problems such as relationship instability, issues at school or work, and decreased self-esteem.³

blood alcohol content. The amount of alcohol in your blood from drinking alcoholic beverages, which "can range from 0 [percent] (no alcohol) to over 0.4 [percent] (a potentially fatal level)."⁴

chronic traumatic encephalopathy. The term used to describe a rare brain degeneration disorder likely caused by repeated head traumas and can only be diagnosed by studying sections of the brain upon autopsy.⁵

critical incidents. VCL identifies critical incidents as "Any event or situation brought about by the actions, or lack of actions, by VCL staff, technical failure, or an established VCL process or gap in process, that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a Customer or Focus."⁶

¹ VHA Handbook 1050.01, National Patient Safety Improvement Handbook, March 4, 2011, was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1050.01, VHA Quality and Patient Safety Programs, March 24, 2023. Unless otherwise specified, the 2023 directive contains the same or similar language regarding staff responsibility to report adverse events as the rescinded 2011 handbook.

² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5-TR)*, "Alcohol-Related Disorders," accessed May 16, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders.

³ Mayo Clinic, "adult attention-deficit/hyperactivity disorder (ADHD)," accessed March 30, 2022, <https://www.mayoclinic.org/diseases-conditions/adult-adhd/symptoms-causes/syc-20350878>.

⁴ Cleveland Clinic, "Blood Alcohol Content (BAC)," accessed June 7, 2022, <https://my.clevelandclinic.org/health/diagnostics/22689-blood-alcohol-content-bac>.

⁵ Mayo Clinic, "chronic traumatic encephalopathy," accessed November 17, 2022, <https://www.mayoclinic.org/diseases-conditions/chronic-traumatic-encephalopathy/symptoms-causes/syc-20370921>

⁶ VCL-S-ACT-109-2108, "Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses," August 2021.

major depressive disorder. An episode of at least two weeks characterized by depressed mood or loss of interest/pleasure in activities, changes in sleeping patterns and appetite, changes in energy, feelings of worthlessness or guilt, and thoughts of death.⁷

near miss. VCL identifies a near miss as “an event or situation that could have resulted in a Critical Incident but did not, either by chance or through timely intervention. Such events have also been referred to as close call.”⁸

obstructive sleep apnea. A common type of sleep-related breathing disorder that causes an individual to stop and start breathing while sleeping.⁹

post-traumatic stress disorder. A disorder defined by exposure to a traumatic event followed by the development of characteristic symptoms. Symptoms of post-traumatic stress disorder may include fear-based emotional and behavioral reactions, loss of pleasure in activities and negative cognitions, alterations in arousal and externalizing behavior, and dissociative symptoms.¹⁰

primary care mental health integration provider. A mental health provider who is co-located in primary care and coordinates with primary care providers to offer mental health services to patients.¹¹

root cause analysis. A specific type of formal review that is used for adverse events or close calls requiring analysis.¹²

sentinel event. A critical incident involving a death by suicide when the VCL is the “last known contact.”¹³

⁷ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5-TR)*, “Major Depressive Disorder,” accessed May 16, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders#BCFJBIIA.

⁸ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

⁹ Mayo Clinic, “obstructive sleep apnea,” accessed March 30, 2022, <https://www.mayoclinic.org/diseases-conditions/obstructive-sleep-apnea/symptoms-causes/syc-20352090>.

¹⁰ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5-TR)*, “Posttraumatic Stress Disorder,” accessed May 16, 2023, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x07_Trauma_and_Stressor_Related_Disorders.

¹¹ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. Primary care mental health integration is comprised of mental health providers integrated into primary care and coordinates with primary care providers to offer mental health services to patients.

¹² VHA Directive 1050.01, VHA Quality and Patient Safety Programs, March 24, 2023.

¹³ VCL-S-ACT-109-2108, “Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,” August 2021.

suicidal preparatory behavior. Acts or preparation toward making a suicide attempt such as buying a gun or collecting pills.¹⁴

traumatic brain injury. 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.¹⁵

¹⁴ “VISN 19 MIRECC SDV Decision Tree” (web page), VISN 19 MIRECC, accessed May 16, 2023, https://www.mirecc.va.gov/vision19/education/sdvtree/sdv_tree.asp#:~:text=Preparatory%20Behavior%20Acts%20or%20preparation%20towards%20engaging%20in,%28e.g.%2C%20writing%20a%20suicide%20note%2C%20giving%20things%20away%29.

¹⁵ Mayo Clinic, “traumatic brain injury,” accessed September 20, 2022, [https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.](https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557)

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