

**April 2, 2010
News Statement**

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Bruce Goldberg, MD, director of the Oregon Department of Human Services and director-designee of the Oregon Health Authority announced today the resignation of Roy Orr, superintendent of the Oregon State Hospital.

Orr has been superintendent at the Oregon State Hospital system since February 2008. During that time there have been marked improvements and modernizations at the Salem state hospital including policies that reduced seclusion and restraint of patients in the hospital, improvements in security practices and relations with law enforcement, the hiring of a chief medical officer and chief of nursing, and eliminating a chronic nursing staffing shortage. Other improvements include opening the patient cottages on hospital grounds and launching the electronic health records project to bring the hospital into the modern era.

Effective today Deputy Superintendent Nena Strickland will be interim superintendent, working closely with Richard Harris, head of the Addictions and Mental Health Division. Orr's resignation is effective April 16, 2010.

This transition will mean no interruption in care or in improvement progress at the hospital. The Oregon Health Authority will immediately launch an aggressive national search for a new superintendent for the state hospital.

Additionally, a report was released today by the DHS/OHA Office of Investigations and Training (OIT) regarding the care of a patient who died at the state hospital in Salem last October. The original scope of the investigation was regarding the events of the day the patient died, however OIT expanded the investigation to include the totality of the patient's care because, as the report states, "serious and significant concerns were identified regarding the overall care and treatment provided for the chronic medical conditions that ultimately resulted in death."

After five months and interviews with 39 witnesses connected to this case, the report concluded that while it was inconclusive as to whether the patient was neglected on the day of his death, his overall care was negligent and the Oregon State Hospital failed to provide adequate care and treatment. The report also noted improvements in policies related to patient care that have occurred since the death and made recommendations for further improvements.

“This death was a terrible tragedy. It is unacceptable to be negligent in our care of patients. We agree with the findings of the investigation and take very seriously our responsibility to provide nothing short of the best care for patients at the state hospital,” said Dr. Goldberg. “We will be rigorous and swift in our improvements and will not rest until the hospital is a refuge of safety and recovery.”

To assist with hastening improvements in care, the state hospital will hire a compliance officer to ensure that all policies and procedures for patient care and safety are followed and that staff has the training and understanding to implement those policies. Leadership at the state hospital will also aggressively focus on ways to more quickly improve the hospital’s culture of care, so that by the time the new state hospital opens next year, patients and staff can truly leave the history of the old hospital in the past.

“Over the past two years there have been many improvements at Oregon State Hospital. Things are better than they were, but they must be even better in the future,” said Dr. Goldberg. “It’s time for the next step forward to create the culture of care and the expectation of excellence for mental and physical health treatment and recovery that we all expect for ourselves and our families. We must make sure we build a new hospital both inside and out.”

Link - response to OIT report:

http://www.oregon.gov/OHA/docs/0402082310_001.pdf

Link - redacted OIT report:

<http://www.oregon.gov/OHA/docs/20100402084856100.pdf>