JOURNAL

of the

SENATE OF THE

TWENTY-SEVENTH LEGISLATURE

of the

STATE OF HAWAI‘I

Special Session of 2014

Convened Wednesday, October 22, 2014
Adjourned Thursday, October 23, 2014

C E R T I F I C A T E

We hereby certify that the minutes for each day's session as appears in this Senate Journal are true and correct and that the original copies have been duly signed by the President and Clerk of the Senate and are on file in the Archives of the State of Hawai'i.

President of the Senate

Clerk of the Senate

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TWENTY–SEVENTH LEGISLATURE

STATE OF HAWAI‘I

SPECIAL SESSION OF 2014

JOURNAL OF THE SENATE

FIRST DAY

Wednesday, October 22, 2014

The Senate of the Twenty-Seventh Legislature of the State of Hawai‘i, Special Session of 2014, was called to order at 11:02 a.m., by Senator Donna Mercado Kim, President of the Senate, in accordance with the following Proclamation, which was read by the Clerk and was placed on file:

"October 13, 2014

PROCLAMATION

I, Donna Mercado Kim, President of the Senate of the Twenty-Seventh Legislature of the State of Hawai‘i, pursuant to the power vested in me by Section 10, Article III of the Constitution of the State of Hawai‘i, and at the written request of two-thirds of the members to which the Senate is entitled, do hereby convene the Senate in Special Session on Wednesday, October 22, 2014, at 11:00 o'clock a.m. for the purpose of carrying out its responsibility established by Section 3, Article VI of the Constitution of the State of Hawai‘i.

/s/ Donna Mercado Kim
Donna Mercado Kim
President of the Senate"

The Roll was called showing all Senators present with the exception of Senator Ruderman who was excused.

MESSAGES FROM THE GOVERNOR

The following messages from the Governor (Gov. Msg. Nos. 1 and 2) were read by the Clerk and were disposed of as follows:

Gov. Msg. No. 1, submitting for consideration and confirmation, the nomination of JEFF CRABTREE to the State of Hawaii First Circuit Court, for a term of ten years, was referred to the Committee on Judiciary and Labor.

Gov. Msg. No. 2, submitting for consideration and confirmation, the nomination of CHRISTINE KURIYAMA to the State of Hawaii First Circuit Court, for a term of ten years, was referred to the Committee on Judiciary and Labor.

JUDICIARY COMMUNICATION

The following communication from the Judiciary (Jud. Com. No. 1) was read by the Clerk and was disposed of as follows:

Jud. Com. No. 1, submitting for consideration and confirmation, the nomination of MARGARET K. MASUNAGA to the District Court of the Third Circuit, for a term of six years, was referred to the Committee on Judiciary and Labor.

At this time, Senator Hee rose to announce that the Committee on Judiciary and Labor would be holding a public decision making meeting on Jud. Com. No. 1 and Gov. Msg. Nos. 1 and 2 at 11:30 a.m. that morning in Conference Room 016.

Senator Hee also announced that the Senate Special Investigative Committee on the Hawaii State Hospital would also be meeting that day at 12:00 p.m. in Conference Room 016 to adopt the committee's report.

Senator Espero rose to introduce two students from James Campbell High School: James Coon, a sophomore working towards his Eagle Merit badge, and Brian Johnson, a senior and Eagle Scout who was assisting James. The students were accompanied by their advisor, Susan Onkst.

Senator Chun Oakland rose to introduce U.S. Department of State Fellow Diana Ghukeyan.

STANDING COMMITTEE REPORTS

On motion by Senator Espero, seconded by Senator Slom and carried unanimously, the Clerk was authorized to receive standing committee reports on Jud. Com. No. 1 and Gov. Msg. Nos. 1 and 2. In consequence thereof, and subsequent to its recessing at 11:08 a.m., the Senate took the following actions:

Senator Hee, for the Committee on Judiciary and Labor, presented a report (Stand. Com. Rep. No. 1) recommending that the Senate consent to the nomination of JEFF CRABTREE to the Circuit Court of the First Circuit, State of Hawaii, in accordance with Gov. Msg. No. 1.

In accordance with Senate Rule 37(6), action on Stand. Com. Rep. No. 1 and Gov. Msg. No. 1 was deferred until Thursday, October 23, 2014.

Senator Hee, for the Committee on Judiciary and Labor, presented a report (Stand. Com. Rep. No. 2) recommending that the Senate consent to the nomination of CHRISTINE KURIYAMA to the Circuit Court of the First Circuit, State of Hawaii, in accordance with Gov. Msg. No. 2.

In accordance with Senate Rule 37(6), action on Stand. Com. Rep. No. 2 and Gov. Msg. No. 2 was deferred until Thursday, October 23, 2014.

Senator Hee, for the Committee on Judiciary and Labor, presented a report (Stand. Com. Rep. No. 3) recommending that the Senate consent to the nomination of MARGARET K. MASUNAGA to the District Court of the Third Circuit, State of Hawaii, in accordance with Jud. Com. No. 1.

In accordance with Senate Rule 37(6), action on Stand. Com. Rep. No. 3 and Jud. Com. No. 1 was deferred until Thursday, October 23, 2014.

ADJOURNMENT

At 4:30 p.m., the Senate adjourned until 11:00 a.m., Thursday, October 23, 2014.

SECOND DAY

Thursday, October 23, 2014

The Senate of the Twenty-Seventh Legislature of the State of Hawai'i, Special Session of 2014, convened at 11:03 a.m. with the President in the Chair.

The Roll was called showing all Senators present with the exception of Senator Ihara who was excused.

The President announced that she had read and approved the Journal of the First Day.

SPECIAL COMMITTEE REPORT

Senators Hee and Green, for the Senate Special Investigative Committee on the Hawaii State Hospital, presented a report (Spec. Com. Rep. No. 1) of its findings and recommendations.

The President then ordered the Clerk to file Spec. Com. Rep. No. 1.

ORDER OF THE DAY

ADVISE AND CONSENT

Stand. Com. Rep. No. 1 (Gov. Msg. No. 1):

Senator Hee moved that Stand. Com. Rep. No. 1 be received and placed on file, seconded by Senator Shimabukuro and carried.

Senator Hee then moved that the Senate consent to the nomination of JEFF CRABTREE to the Circuit Court of the First Circuit, State of Hawaii, for a term of ten years, seconded by Senator Shimabukuro.

At 11:04 a.m., the Senate stood in recess subject to the call of the Chair.

The Senate reconvened at 11:06 a.m.

Senator Hee rose to speak in support of the nominee as follows:

"Thank you. Members, as the Judiciary Committee was pleased to hear on the remarks regarding Mr. Crabtree, Mr. Crabtree's experience as a private litigator is well-known. He met the standards previously with the Judicial Selection Commission. Some of you may know he was on the shortlist as associate justice of the Supreme Court, the vacancy that was ultimately filled by Associate Justice Michael Wilson. There's no question in my mind and – I don't want to speak for the members of the committee, but based on the vote – the members of the committee, as his fitness to serve as a jurist on the circuit court bench, given his wide range of experience.

"There was a little concern with respect to his criminal experience. However, that is something that he will pick up, and I think that I speak for the members of the committee when I say that.

"I will finally add that the Bar Association found Mr. Crabtree qualified. So with those short remarks, members, I would urge an affirmative vote for Mr. Crabtree. Thank you, Madam President."

The motion was put by the Chair and carried on the following showing of Ayes and Noes:

Ayes, 24. Noes, none. Excused, 1 (Ihara).

Senator Hee then introduced Judge Jeff Crabtree and his daughter, as well as Chief Justice Mark E. Recktenwald, Administrative Director of the Courts Rodney Maile, and United States Congresswoman Colleen Hanabusa.

Stand. Com. Rep. No. 2 (Gov. Msg. No. 2):

Senator Hee moved that Stand. Com. Rep. No. 2 be received and placed on file, seconded by Senator Shimabukuro and carried.

Senator Hee then moved that the Senate consent to the nomination of CHRISTINE KURIYAMA to the Circuit Court of the First Circuit, State of Hawaii, for a term of ten years, seconded by Senator Shimabukuro.

Senator Hee rose to speak in support of the nominee as follows:

"Members, Christine Kuriyama presently serves as a district court judge of the family court, and those of you who have been here long enough understand that family court is a very challenging court to preside over. She has done so for 19 years. I don't think there's any question or any doubt of the fitness of Judge Kuriyama to serve as the next circuit court judge for the First Circuit.

"I will say that I believe the committee did a thorough investigation of Judge Kuriyama. Personally, the judge and I had a long discussion about cases during her tenure that were vacated, remanded, or reversed. I have great appreciation that in family court situations, with emotion involved with custody cases, parental custody cases, division of property assets, and divorces, things like that – that are a daily occurrence with the caseload in front of all judges in family court – that it should come as no surprise to anyone here that appeals are a part of the process in family court. I had the opportunity and privilege to speak to some of the jurists on the ICA who commented on the appeals and the reversals and vacated decisions. Everyone, to a person, had very positive comments about Judge Kuriyama, about her temperament, and her fitness to serve as qualified, as the Bar did find this nominee. It is a privilege for me to support Judge Kuriyama as the next circuit court judge for the First Circuit. Thank you."

The motion was put by the Chair and carried on the following showing of Ayes and Noes:

Ayes, 24. Noes, none. Excused, 1 (Ihara).

Senator Hee then introduced Judge Christine Kuriyama; her husband, Stan; her brother, Vince; her three staffers, Jan, Angel, and Will; and her two friends, Denise Hayashi Yamaguchi and Roy Yamaguchi.

Stand. Com. Rep. No. 3 (Jud. Com. No. 1):

Senator Hee moved that Stand. Com. Rep. No. 3 be received and placed on file, seconded by Senator Shimabukuro and carried.

Senator Hee then moved that the Senate consent to the nomination of MARGARET K. MASUNAGA to the District Court of the Third Circuit, State of Hawaii, for a term of six years, seconded by Senator Shimabukuro.

Senator Hee rose to speak in support of the nominee as follows:

"Thank you, Madam President. I'm pleased and privileged to support Margaret Masunaga as district court for the Third Circuit. Ms. Masunaga is well-known to some of you; she's well-known to me. I can recall when we were involved with the confirmation of Elizabeth Strance. I think Senator Hanabusa, at the time, was the Judiciary chairman. I first met Margaret Masunaga, who came forward to support Judge Strance. Since that time, I've seen her off and on in coming to encourage the Legislature on certain legislation that would benefit the Big

Island and also benefit the Third Circuit. So, those of you who've been here for some time have known and have seen Margaret Masunaga.

"Ms. Masunaga is presently an attorney as deputy court counsel in the administration of Mayor Billy Kenoi. There was some discussion with respect to this nominee that the Bar had found to be 'unqualified,' and as far as I can figure out, most of that had to do with what was perceived to be a lack of civil and/or criminal experience. Members, I would just note that under questioning on Monday and then questioning again yesterday by the Judiciary Committee, that the committee is satisfied that, in fact, Ms. Masunaga has experience in court in both civil and criminal proceedings and, in fact, is involved in a complex case as deputy court counsel defending the Planning Commission on the Big Island presently.

"I would also note that it should be of no surprise to the members of the Senate that having nominees come forward who, oftentimes, may lack civil or criminal experience to the degree that might be expected of the – in this case, let's use the Bar Association. It is fair to say, as far as I'm concerned – and I brought the folders in the event that I needed to discuss this further – that Ms. Masunaga has the equivalent of experience in civil or criminal court as the previous two nominees that have just been confirmed to the circuit court bench, and I want to make note of that. When one would examine the Judicial Selection Commission's questions on page 10 with respect to this question, all three of them have very similar background in terms of time spent in the civil or criminal calendar, with the exception of Judge Crabtree, who has spent much of his private practice as a civil litigator.

"Finally, I want to note that some of you may have received calls with respect to the fitness of Ms. Masunaga to serve and questioned her capacity upon which she is capable. I want to dwell on that just for a few moments with these remarks. All of us as members of the Senate, from time to time, have received calls on any number of individuals at the last minute, generally after a public hearing has been held, almost exclusively by individuals who wish to remain anonymous; and in that regard, Ms. Masunaga fits that category.

"Let me say to the members of the Senate: One of the questions that arose with respect to the process of the selection of district court judge is – the chief justice on Monday, I believe it was, or maybe it was Sunday, sent to me in my capacity as chair, which was subsequently circulated to each member of the Judiciary and Labor Committee, the process that the chief justice is engaged in prior to making a selection. That has been a very timely document because, in it, the chief justice made it very clear that his list is made public when he receives them, and he invites everyone – everyone, lawyers and non-lawyers – to participate and comment, if they wish, on all six, prior to him making a selection. I would just say that that was the perfect opportunity for people who may have had reservations to make comment prior to her selection. The other opportunity, obviously, would be the public hearing, which, as you know, is held in accordance with state law. No individual or individuals representing groups came forward to the Committee on Judiciary and Labor and evidently, to the chief justice during his procedure, to register any reservations that may have been made.

"One final comment: In my question to Calvin Young, the president of the Bar Association, which was, in essence, 'How much weight should the committee place on the "unqualified" rating?' And I'm paraphrasing his response, but he said, 'Our rating is one part of the process, and your committee should evaluate our rating as one part of many parts as you go about evaluating the fitness of this candidate to serve.' And that is exactly what I did; I presume that's what the members of the Judiciary and Labor Committee have done. And so I hope I speak for them when I say that there is little reservation, if any, that Margaret Masunaga is qualified and will do a good job as a district court judge of the Third Circuit. Thank you, Madam President."

Senator Kahele rose to speak in support of the nominee as follows:

"I know concerns were raised in the community and also from the Bar Association, as eloquently stated by our Judiciary chairman, and the thoroughness of the committee, having vetted her. I met with Margaret prior to the committee's hearing and also, I had the opportunity to meet again with her to go over some of the concerns that were expressed to me. And I find Margaret will make a good judge over on the Big Island, the Third Circuit Court, which encompasses South Kona, and I believe her life's experience will bring to the bench that added experience of working with people socially and so forth. So, I ask for your support for Margaret Masunaga. Thank you."

Senator Baker rose to speak in support of the nominee as follows:

"I had an opportunity to visit with Ms. Masunaga. As a matter of fact, she was the first of the three that I had an opportunity to meet with, and I was very impressed with her dedication to community, her dedication to public service and to her profession – all of the things that she'd done throughout her life experience. And to me, when the Bar Association came out with an 'unqualified,' I could find nothing, either in the conversation I'd had with her, any testimony that I had seen, or her resume, that would lead me to that conclusion.

"I think when you have an opportunity to serve, particularly in district court, you need to have someone with patience, a good understanding of the law, to be certain, but also the ability to deal with first-time entrants into the judicial system. And I think the work that she's done in the community, serving as an assistor with the new project that the chief justice has in all of our circuits to help people understand the process, help people understand what their obligations are as defendants in a courtroom, really will help not only the people who come before her, but will help her perform efficiently and effectively as a district court judge. So, I wanted to take this opportunity to stand in strong support of her nomination, and I have some written remarks that I'd like to have included into the Journal. Thank you."

The Chair having so ordered, Senator Baker's additional remarks read as follows:

"Madam President, I rise in strong support of Judiciary Communication No. 1, the nomination of Margaret K. Masunaga as a district court judge of the Third Circuit.

"Ms. Masunaga has practiced law for almost 34 years. She currently lives in Kailua-Kona where she serves the County of Hawai'i as Deputy Corporation Counsel. She has also worked as a Deputy Attorney for the State of Hawai'i.

"Ms. Masunaga has demonstrated her commitment to public service through her extensive work in the public sector as well as with various community programs and non-profit organizations on Hawai'i Island. As a staunch supporter of women in the workplace, Ms. Masunaga has served on the American Bar Association's Commission on Women in the Profession and represented Hawai'i as a delegate to the White House Forum on Women & the Economy. She's dedicated to the law and very engaged in her profession and community, all while raising two well-spoken daughters, as evident in their enthusiastic letters of support for her nomination.

"District Court, often referred to as the 'people's court,' needs judges that are not only well-grounded in the law but

judges who have patience, an ability to listen, and an ability to help translate the court environment for those individuals encountering the judicial system for the first time. Ms. Masunaga possesses these traits and more. Countless pieces of testimony received by the Judiciary and Labor Committee repeatedly praised her integrity and excellent temperament. Her colleagues also described her as being honest and fiercely ethical. These attributes, along with her love of her community, will help her in her new endeavor.

"Ms. Masunaga's strength of character and experience will be great assets to her as she serves on the bench. I believe she is well-qualified to handle the challenges inherent in the position.

"I am confident that Ms. Masunaga will be an excellent judge and I urge my colleagues to join me in voting to confirm her nomination as a District Court Judge in the Third Circuit. Mahalo."

Senator Tokuda rose to speak in support of the nominee as follows:

"First of all, we've had many very positive remarks, so I'm not going to repeat what has been said, but I have been very privileged to have known Margaret for almost 15 years now, and I can tell you that, regardless of what any organization has said, I believe she is more than qualified – in fact, highly qualified – to serve in this regard.

"She is a well-known advocate and expert in so many different fields. She has been a strong public servant, giving of her time – her personal time, her professional time. She's been an advocate for women, for families, for her community. She's recognized locally, nationally, and even abroad; and I would say that we would be well-served to have her serve on the bench in this particular regard. And so I'm very proud to stand beside her today, and I know that she will do us proud in this capacity. I have additional remarks to be inserted into the Journal, but thank you for your continued public service in this manner."

The Chair having so ordered, Senator Tokuda's additional remarks read as follows:

"Margaret Masunaga has been serving the people of Hawai'i since 1992, providing legal advice and counsel in the Office of the Corporation Counsel, County of Hawai'i, the Office of the Attorney General, and the County Planning Office on the Island of Hawai'i.

"In addition to her professional service, she has given countless hours to charitable organizations and serving on local and national boards and commissions. She has been honored by the American Bar Association, the Hawai'i Supreme Court, the United States Congress, and in 2007 received the Presidential Volunteer Service Award.

"Margaret will make an outstanding candidate for the bench, and not only will effectively carry out her duties as a judge, but will be a shining role model for young people in her community. I enthusiastically support her nomination and look forward to hearing of her success as District Court Judge of the Third Circuit."

The motion was put by the Chair and carried on the following showing of Ayes and Noes.

Ayes, 24. Noes, none. Excused, 1 (Ihara).

Senator Hee then introduced Judge Margaret Masunaga; her husband, Gail; and her daughter, Jana.

At 11:27 a.m., the Senate stood in recess subject to the call of the Chair.

The Senate reconvened at 11:41 a.m.

SENATE RESOLUTION

The following resolution (S.R. No. 1) was read by the Clerk and was disposed of as follows:

S.R. No. 1 "SENATE RESOLUTION AUTHORIZING THE PRESIDENT TO APPROVE THE JOURNAL OF THIS SENATE FOR THE SECOND DAY OF THE FIRST SPECIAL SESSION OF 2014."

Offered by: Senators Galuteria, Slom.

On motion by Senator Espero, seconded by Senator Slom and carried, S.R. No. 1 was adopted.

At this time, Senator Kidani rose to present the following remarks:

"Thank you for the opportunity to note a time of transition for the membership of this body.

"Unless something totally unforeseen occurs within the next two weeks, this will be the last time on the floor for three of our members.

"As Senator David Ige's vice chair on the Committee on Ways and Means, I was privileged to present a Senate certificate acknowledging excellence in leadership and service to Senator Ige. Members will recall that this took place on May 1st as we closed our regular session.

"Today, we bid aloha to two more senators: the senator from Windward O'ahu, the North Shore, and portions of central O'ahu; and the senator who represents part of Hilo, northward on Hawai'i Island to Waimea, and down the Kona coast to Waikoloa.

"I think it appropriate today for Senator Maile Shimabukuro, vice chair of the Committee on Judiciary and Labor, and Senator Donovan Dela Cruz, former vice chair of the Committee on Water and Land, to take the lead in saluting their respective chairs on their final day in session."

Senator Dela Cruz presented the following remarks:

"Thank you, Madam President. On behalf of the Senate, I'd like to bid fond aloha to Senator Malama Solomon, for having devoted more than two decades of her professional life to elected office in serving the people of Hawai'i.

"She is a graduate of Kamehameha Schools – I think she was also the captain of the swim team, right? – who went on to earn three degrees from two campuses from the University of Hawai'i and also a doctorate in education from the University of Oregon State. She won a seat to OHA in 1980, and then she became a member of OHA's Education Committee and successfully advocated for incorporating more Hawaiian culture into the public school system.

"Malama was elected to the State Senate in 1982, representing a district that covered half of the Big Island and half of Maui – that's a big district. She served until 1998, which was a critical transition period for Hawai'i in regards to agriculture and tourism. She returned to the family business and worked and managed Waiaka Farms and Ranch until she returned to the Senate in 2011.

"She devoted her life to teaching in public elementary and secondary schools, Hawai'i Community College, and was also an affiliate professor at UH Hilo. Malama Solomon has been a passionate advocate for Native Hawaiians and has been heavily involved in the private sector organizations that promote and preserve Hawaiian culture. She has assumed leadership positions in the Hawaiian Civic Clubs and served as coordinator for the annual Aloha Week Festival events.

"On some personal notes, I just want to note that she was part of some big things here in the Senate, which included the right to sue, the convention center, the establishment of KIRC, and many other big pieces of legislation. Her fiery spirit really helped create and push big ideas, big solutions, and really to help push the needle a little bit, so that we can define our change instead of reacting to it.

"As a legislative body prides itself on the diversity of its perspectives and ideas brought to the floor and debate, and through thorough vetting of critical issues that the people have elected us to consider, which Senator Solomon has greatly contributed to, the Senate expresses gratitude to Senator Solomon for her steadfast commitment to representing the people of her district and the state as a whole. Her experience and leadership have been of great value to our deliberations, establishing criteria for our actions that will stand beyond her term.

"So on behalf of the Senate, we wish you good health and success in all your future endeavors. Aloha."

Senator Slom rose to speak on a point of personal privilege as follows:

"I've had the privilege of knowing Senator Solomon for quite some time, and as one of the older members of the Senate, I can go back with my experiences back to 1997, the session when we truly had a bipartisan coalition. We had two Republican senators – Senator Anderson and myself – and the eight so-called dissident Democrats. And we got together and we agreed on certain things. We threw out the 90 percent of the things that we disagreed on and kept the 10 percent and worked very well together. And it was a good math lesson, that with 10 votes, it's easier to get to 13 than either from 2 or from 8.

"Senator Solomon was always a strong supporter of what was right. She's always been independent. She's a wonderful hula dancer. I would be afraid to try to arm wrestle her. I've enjoyed her in committee and on the floor. And back in '11 and '12, she sat behind me in the 'bad girls' section on the Senate floor, but the good thing was, she always kept talking all during the session – it was a running commentary. So in case I missed any of your words, Madam President… And then you rewarded her by sitting her next to me, and it was like DVD to the max because I got the same conversation all the time.

"We didn't always agree on everything, but she was and is a very passionate person, a person dedicated to ideals and to helping other people. I love her, Malama; I'll truly miss her and thank her for all of her service. Aloha."

Senator Shimabukuro presented the following remarks:

"Well, I'm honored to bid a fond aloha to our friend, Clayton Hee. First, I want to thank Senator Kidani and her staff for preparing the certificate and getting leis and setting this all up for us – thank you for doing that.

"I must admit I was intimidated at first when I was tasked to be the vice chair of Clayton, whom I'd only known by reputation. But I was surprised that I soon came to love being his vice chair. I love the way he cuts to the chase at his hearings. He provides his inclination, the scope of testimony received, and he clearly does his homework as the chair. Yet at the same time, he remains open to new information and arguments and is flexible at his hearings. So, his style is extremely efficient and saves everyone tons of time and is much appreciated by the committee and everyone in the audience.

"I also have great admiration for his philosophical views. He's an environmentalist, a Hawaiian rights advocate, and clearly a fighter for victims' rights and for civil rights.

"I really also admire his courage. He stands up to immense pressure and threat of retaliation in many areas: the gay marriage debate that he took head-on, Hoʻopili, Koa Ridge, the Hawaii State Hospital, just to name a few since I've been here. And what I found was incredible was his effectiveness. Clayton has this ability to achieve the impossible. He delivered on Turtle Bay along with, of course, Senator Ige, when the House gave us no money to fund it. He got Laniakea Highway rerouted. He pushed for Niʻihauans, for their rights; for puppy mill legislation; increased minimum wage; and so many more incredible achievements.

"And at the same time, what I really loved about Clayton was his sense of drama, as Senate President mentioned – there is never a dull moment with Clayton – and his sense of humor. And what I thought of was, I think one of his best pranks was the joke he played on our then-President Shan Tsutsui, when he presented him with the award from that female proctologist.

"Today is extra special because we've never got to shine the spotlight on Clayton because for the past four years I've been in the Senate, he always runs away on his birthday. Did you notice that? He is never there. Every time I have to say 'happy birthday,' where is he? He's gone. So I know he doesn't like being the center of attention like this, so we've got to lock the doors here.

"But Clayton, thank you so much for being a great mentor to me. I'm going to miss your passion, your effectiveness, your sense of humor, and especially your cowboy boots, will all be dearly missed. Thank you, Clayton."

Senator Slom rose to speak on a point of personal privilege as follows:

"Thank you. I'm not intimidated by Senator Hee. We come here today to bury him, not to praise him. Lock the doors. This will not be the same Senate or same state legislature without Clayton. We will miss him. Believe it or not, Senator Hee and I have actually been in agreement on several issues over the years. And what Senator Shimabukuro said about him being courageous in his efforts for his misguided legislation is true.

"While he may have some critics, every dog in the state loves Clayton Hee. (And other animals and varmints, as well.) He's been a fighter. I have seen him in various committees, and he has worked very hard. He's been very diligent. He takes his job seriously. And it has been a pleasure to serve with him.

"As I say, I can say that without being in agreement. You can agree or you can disagree on issues, but the whole idea is the process of the Senate, and I know that he has put the Senate first in things that he does. There is no argument about his cowboy boots, even though there may be a requirement about no cowboy boots on the Senate floor. He has, I think, surprised a lot of people by his style of rhetoric; his articulate nature; his total advocacy for the Native Hawaiian people; and his independence, also, on issues where he has taken a stand that was not in agreement with the majority of our colleagues or even with his political party. And for that, I salute him.

"A lot of people don't know that on a family day at a ranch in Waimānalo a couple of years ago, we were both on horseback, and as usual, he sneaked up behind me and he did throw a lariat around me. However, being the Lone Ranger, I got out of that and was able to ride safely into the sunset.

"We will miss his drama, but more importantly, we will miss the points that he makes. And we all know that he is not finished in government or in service to the people of Hawaiʻi. So, I want to lend my aloha to Senator Clayton Hee. Thank you."

Senate President Kim presented the following remarks:

"I would also like to add a couple of comments. First of all, Senator Hee and I got elected in the class of '82, back in the House of Representatives, so we go back a long way; and I'm very pleased to have served with you in the Senate, Senator Hee. He often said that he and I are cut from the same cloth, but there've been issues when I've told him that's not correct, but in all due respect. Senator Hee, I will certainly miss you as well.

"As for Senator Malama Solomon, I've always admired her, being a strong woman. When I was on the city council, I had looked forward to serving with her when I came over to the Senate, but she left the Senate. I was very pleased when you came back, Senator Solomon, and that I've had the opportunity to serve with you, and I wish you also the best in your endeavors.

"With that, I just have one other announcement to make, being that we'll be adjourned. I did want to wish a happy birthday to Senator Kouchi, who will celebrate his birthday tomorrow. So happy birthday, hauʻoli lā hānau."

Senator Hee rose to speak on a point of personal privilege as follows:

"Thank you. Thank you, all of you. It's really been an honor for me to be a part of this group for many different reasons, all of them good, but some of them not as good as others. But if I could just say a few remarks.

"Let me start with Senator Slom. He and I, quite frankly, we agree more than we disagree. I don't know if that comes across – probably not, and it's because when we disagree, we disagree. But as far as his independent nature and my independent nature, I think we have found more common agreement than disagreement. And I can recall no time that we've ever been disagreeable, and that means a lot to me.

"As far as all of you, thank you for being a part of my life. With Senator Kim, she's right; I mean, there's Senator Kim, myself, and Representative Souki in the Legislature that began in '82, and of course, Councilmember Ron Menor also was a part of the class of '82. We had a big class, 26 or so, 23. I will say this: Senator Kim and I, we're on different sides more often than not, but as far as your independent nature, I don't think there's any question about that.

"You know, the Majority Leader looked at my folder and he said, 'Hey, brah, you're really going back in time,' because one of the folders has the State of the State Address of Ben Cayetano in '02. I was thinking about today and I would like to, with your indulgence, read a couple paragraphs out of his State of the State Address in '02. This is what he said – that was his last session with us – and he said, 'This is our last session. This is the first time you've publicly asked for advice. Let me offer it.' It says a lot about why I have a high regard for him. He said, 'I really believe that the best kind of politics is getting the job done. That's what I've tried to do in my 28 years of public service. And even if you don't get it done, I believe the people will know how hard you tried and respect you for it.' Now, I'm going to change it a little bit, the issues that he raised at the time, but the comments are the same. He said, 'When you passed,' and I'm going to change it, and this is my message to you: 'When you passed the Marriage Equality Act and the minimum wage bills during the last session, that was a defining moment for many of you. It took guts to do it, and you should be proud.'

"And I'm going to close it with the last couple paragraphs that he said. He referenced a Republican in the U.S. Senate. He said:

> Senator Warren Rudman, a Republican, when asked by *Time* magazine about his retirement from the United States Senate, said that when he was a Marine captain serving in Korea, he commanded young Marines who were ready to risk their lives for their country, and many lost their lives. But he was disappointed with his colleagues in the U.S. Senate, he said, because too many of them were not even willing to risk their political lives for their country.

"'So for once,' Governor Cayetano said, 'put politics aside. Discuss the issues frankly and truthfully, so the people know what's at stake. We owe them the truth. We owe them the courage and the wisdom to make wise decisions. We owe them hope. We owe them a better and greater Hawai'i.' And, as only Cayetano could say, 'So do your job to make Hawai'i better. Even if it means losing your job, you owe it to the people, and most of all, you owe it to yourselves.'

"Thank you, members, for putting up with me. Thank you."

Senator Solomon presented the following remarks:

"Excuse me, Madam President. Before we adjourn, I just would like to submit these remarks to be put into the Journal, and this is regarding the recent activity on the top of Mauna Kea and regarding the TMT. There was a great article that came in the *New York Times*, and I'm not going to read from it. I don't want to ruin this auspicious occasion, mahalo nui.

"But I would like to speak in strong support of the last paragraph; I want to speak in very strong support of the navigator Chad Kalepa Baybayan, a Native Hawaiian who expressed his support for the efforts last year in an essay for a local newspaper. He says:

> "Our ancestors," he wrote, "sought knowledge from their environment, including the stars, to guide them and to give them a greater understanding of the universe that surrounded them. The science of astronomy helps us to advance human knowledge to the benefit of the community."
>
> "Its impact has been positive," he continued, "introducing the young to the process of modern exploration and discovery, a process consistent with past traditional practices."
>
> Denying that, he believed, [and so do I] was "the highest level of desecration."

"I, too, would like to just make a few comments about the article itself. The article, and I'm going to be sending it to all of the senators for their consideration since you're going to be in charge of the ship, to take this into consideration. Our societies have gone under tremendous, tremendous transitions, and Hawai'i is no different. I want to remind you that 'Galileo knew he would have the church to contend with after he aimed his telescope at the skies…'

"Although I want to applaud the group of Native Hawaiians who were there, drumming and chanting, who blocked the road to a construction site on Mauna Kea – that's their kuleana – I was very disappointed because they should realize that 'a triumph in astronomy's quest to understand the origin of everything' is what this telescope is all about. I begin to question as to how in Hawai'i – and I leave these with you for your kuleana to consider, in your thoughts in the future of how you're going to start to separate what motivates such protests. Is it spiritual outrage, and how much of it is politics? 'Opposition to the Mauna Kea observatories, which are run by scientists from 11 countries, has been going on for years.' And of course, Hawaiian protests have been ongoing for years. No doubt in my mind, it's a 'lingering hostility over colonization and the United States' annexation of Hawai'i in the 19th century.' But to use this telescope as a pawn is definitely a losing game for all of us.

"'Adding more complications,' I really feel that many of these indigenous protests are 'allied with environmental activists denouncing the encroachment of what they call "the international astronomy industry," as though there were great profits to be made from studying black holes and measuring redshifts.' And many of our considerations, this is what we're confronted with.

"So Madam President, I would like to submit this as my departing remarks to be part of the Journal for thought for you all as you continue our quest in creating and making Hawai'i a better place, a pono place, not only for us, but for our future.

"Again, colleagues, thank you so much for your kind words. I only came back to help and serve. I want to give my fond aloha to Senator Clayton Hee. He and I have served over 30 years together. I guess I have to admit I'm tired of fighting and I want to be able to reinvent my life, and hope that I can help you folks in any capacities; please feel free to call upon me. Thank you. Aloha."

The Chair having so ordered, Senator Solomon's additional remarks are identified as "**ATTACHMENT A**" to the Journal of this day.

ADJOURNMENT

Senator Espero moved that the Senate of the Twenty-Seventh Legislature of the State of Hawai'i, Special Session of 2014, adjourn Sine Die, seconded by Senator Slom and carried.

At 12:07 p.m., the President rapped her gavel and declared the Senate of the Twenty-Seventh Legislature of the State of Hawai'i, Special Session of 2014, adjourned Sine Die.

ATTACHMENT A

The New York Times | http://nyti.ms/1Ft9Hfc

SCIENCE | NYT NOW

Seeking Stars, Finding Creationism

OCT. 20, 2014

George Johnson

RAW DATA

Galileo knew he would have the Church to contend with after he aimed his telescope at the skies over Padua and found mountains on the moon and more moons orbiting Jupiter — and saw that the Milky Way was made from "congeries of innumerable stars." The old order was overturned, and dogma began to give way to science.

But there is still far to go. Congeries of stars have given way to congeries of galaxies, but astronomy — one of the grandest achievements of the human race — is still fending off charges of blasphemy. These days the opposition comes not from the Vatican, which operates its own observatory, but from a people with very different religious beliefs.

This month a group of Native Hawaiians, playing drums and chanting, blocked the road to a construction site near the top of Mauna Kea and stopped the groundbreaking ceremony for the Thirty Meter Telescope, often called T.M.T. Larger than any now on earth, it is designed to see all the way back to the first glimmers of starlight — a triumph in astronomy's quest to understand the origin of everything.

But for the protesters, dressed in ceremonial robes and carrying palm fronds, T.M.T. has a different meaning: "too many telescopes." For them the mountain is a sacred place where the Sky Father and the Earth Mother coupled and gave birth to the Hawaiian people.

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They don't all mean that metaphorically. They consider the telescope — it will be the 14th on Mauna Kea — the latest insult to their gods. Push them too far, the demonstrators warned, and Mauna Kea, a volcano, will erupt in revenge.

It can be difficult to tell how motivated such protests are by spiritual outrage and how much by politics. Opposition to the Mauna Kea observatories, which are run by scientists from 11 countries, has been going on for years and is tied inseparably with lingering hostility over colonization and the United States' annexation of Hawaii in the 19th century. The new telescope is a pawn in a long, losing game.

Adding more complications, the indigenous protesters were allied with environmental activists denouncing the encroachment of what they call "the international astronomy industry," as though there were great profits to be made from studying black holes and measuring redshifts.

"Mauna Kea is a Temple or House of Worship," says a statement on the website of Kahea, the Hawaiian-Environmental Alliance. "Therefore, the laws of man do not dictate its sanctity, the laws of Heaven do."

Whether the target is a scientific installation or a ski area in the West, some environmentalists have learned that a few traditionally dressed natives calling for the return of sacred lands can draw more attention than arguments over endangered species and fragile ecosystems. In this marriage of convenience, there seems to be little worry that the tactics might undermine the credibility of what may be perfectly sound scientific arguments about the effects of a mammoth construction project on vulnerable mountain terrain. The state's Board of Land and Natural Resources agreed with astronomers that the trade-off is worthwhile, and plans are proceeding.

For many this was a familiar situation. A very similar drama unfolded in the 1990s on Mount Graham in Arizona, where the construction of a complex of observatories (one is the Vatican's) was fought by a group of Native Americans swearing allegiance to different gods, while the Sierra Club agonized over the fate of the Mount Graham red squirrel.

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The astronomers prevailed, as they have so far on Mauna Kea. But both episodes are reminders that it is not just religious fundamentalists who are still waging skirmishes against science.

While biblical creationists opposing the teaching of evolution have been turned back in case after case, American Indian tribes have succeeded in using their own religious beliefs and a federal law called the Native American Graves Protection and Repatriation Act to empty archaeological museums of ancestral bones — including ones so ancient that they have no demonstrable connection to the tribe demanding their reburial. The most radical among them refuse to bow to a science they don't consider their own. A few even share a disbelief in evolution, professing to take literally old myths in which the first people crawled out of a hole in the ground.

In this turn back toward the dark ages, it is not just skeletal remains that are being surrendered. Under the federal law, many ceremonial artifacts are also up for grabs. While some archaeologists lament the loss of scientific information, Indian creationism is tolerated out of a sense of guilt over past wrongdoings. Again the spiritual is inseparable from the political.

Dismayed by all of this, I got in touch with Steve Lekson, a professor of anthropology and curator of archaeology at the University of Colorado Museum of Natural History. Dr. Lekson is known as an outspoken iconoclast, and I was expecting to hear his outrage.

"There's no question we are losing information," he said. But he had become persuaded that complying with the artifacts law was the right thing to do.

"It's bad for science, but good (I suppose) for the Native American groups involved," he wrote in an email. "Given that the U.S.A. was founded on two great sins — genocide of Native Americans and slavery of Africans — I think science can afford this act of contrition and reparation."

But how is letting Indian creationism interfere with scientific research any different from Christian creationism interfering with public education — something that he would surely resist?

Logically they are the same, Dr. Lekson agreed. But we owed the

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Indians. "I'm given to understand that the double standard rankles," he said.

I left the conversation grateful that in another part of the world, astronomers are standing their ground. Chad Kalepa Baybayan, a Native Hawaiian, expressed his support for their efforts last year in an essay for a local newspaper.

"Our ancestors," he wrote, "sought knowledge from their environment, including the stars, to guide them and to give them a greater understanding of the universe that surrounded them. The science of astronomy helps us to advance human knowledge to the benefit of the community.

Its impact has been positive," he continued, "introducing the young to the process of modern exploration and discovery, a process consistent with past traditional practices."

Denying that, he believed, was "the highest level of desecration."

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A version of this article appears in print on October 21, 2014, on page D3 of the New York edition with the headline: Seeking Stars, Finding Creationism.

SPECIAL COMMITTEE REPORT

Spec. Com. Rep. 1 Special Investigative Committee on the Hawaii State Hospital on S.R. No. 3 (2014)

The purpose of the Special Investigative Committee was to investigate the workplace safety of all Hawaii State Hospital (Hospital) psychiatric workers and alleged improprieties concerning administrative and employment matters at the Hospital, and submit its written findings and recommendations to the Legislature.

As part of its investigation, your Committee conducted ten hearings lasting over a total of nineteen hours and received testimony from fourteen testifiers. In addition, your Committee received in excess of twelve thousand pages of documents in response to subpoenas. In the course of its discussion and assessment of the documents and testimony it received, your Committee finds that the Hospital faces three main interrelated challenges:

(1) Maintaining a safe work environment for Hospital staff and patients;

(2) Meeting the current needs of Hospital patients and staff due to inefficient use of facilities and patient and staff safety practices; and

(3) Providing efficient and effective human resources practices.

Your Committee finds that the Hospital has longstanding problems maintaining a safe work environment for its staff and patients. The paramount workplace safety issue appears to be violent and unstable patients attacking staff and causing injuries. Your Committee is concerned that if this problem is not immediately addressed, a fatality will occur at the Hospital.

Your Committee further finds that the design, infrastructure, and technology of the Hospital no longer effectively meet the therapeutic mental health needs of its patients. Additionally, the Hospital's high patient census, which is entirely comprised of forensic mental health patients, poses a constant challenge for the Hospital to find enough beds as well as sufficient staffing to provide adequate patient care. However, the Hospital is forced to admit, accommodate, and treat patients with limited resources, which contributes to safety concerns for the patients, staff, and surrounding community. Your Committee is also concerned that the persistently high patient census forces the Hospital to stretch its limited resources to dangerously thin levels, which compromises patient and staff safety.

Lastly, your Committee finds that the Hospital's inefficient and ineffective human resources practices result in inefficiencies and high personnel costs. Furthermore, the lack of leadership in managing and ensuring fair and transparent Hospital human resources practices contributes to low employee morale, erodes employees' trust of and confidence in Hospital administrators and supervisors, and causes employees to fear retaliation by Hospital administrators and supervisors. Your Committee is concerned about the staffing and staff performance at the Hospital and how these issues ultimately impact patient care.

Based on its findings and conclusions, your Committee has set forth its recommendations in its report, which are summarized as follows:

(1) With regard to maintaining a safe work environment, your Committee believes that the Hospital should:

  (A) Develop standardized recording procedures to accurately report assaults occurring at the Hospital;

  (B) Educate and train all employees on workplace violence, especially with regard to the policies and procedures to report incidents of workplace violence and employees' options if they are the victim of such violence;

  (C) Develop and implement a pervasive and appropriate training program for employees to handle forensic mental health patients; and

  (D) Address and resolve the Hawaii Occupational Safety and Health Division violations cited on April 10, 2014, and collaborate with the Department of Labor and Industrial Relations to aid in strengthening its policies and procedures to create a safe workplace environment;

(2) With regard to using facilities and exercising safety practices efficiently, your Committee believes that the Hospital should:

  (A) Develop and implement a patient classification system that is based on patient need;

  (B) Consider options in designating Unit H solely for the purpose of admitting patients;

  (C) Consider obtaining a forensic care designation or accreditation for the Hospital;

  (D) Facilitate the transfer of high risk patients to out-of-state mental health facilities contracted with the State by selecting patients that may qualify and benefit from being transferred per the Hospital's newly adopted policies and procedures and determine whether such patients should be transferred;

  (E) Address the safety concerns and closure of the Psychiatric Intensive Care Unit;

  (F) Explore and develop short-term strategies for the physical improvement and renovation of the existing Hospital facility;

  (G) Explore and develop long-term strategies for the design and construction of a new facility;

  (H) Improve the monitoring and operation of the security cameras;

  (I) Improve the personal mobile transmitter devices to ensure that the devices work properly at all times;

  (J) Explore the feasibility of constructing a fence around the perimeter of the campus to ensure safety for the surrounding community and assist in preventing elopements; and

  (K) Develop procedures to alert the community when a patient elopement occurs; and

(3) With regard to providing efficient and effective human resources practices, your Committee believes that the Hospital should:

(A) Streamline and consolidate the Hospital's and Department of Health's internal recruitment and hiring processes to expedite the filling of position vacancies at the Hospital;

(B) Develop policies and procedures regarding the recruitment of temporary agency workers;

(C) Strengthen the policies and procedures for interviewing and hiring employees to work at the Hospital;

(D) Develop and implement procedures for the assignment of overtime;

(E) Explore options to limit the number of overtime shifts or hours an employee may perform;

(F) Control the opportunities for employees to abuse sick leave and overtime benefits;

(G) Collaborate with the appropriate labor unions to address the impact that collective bargaining agreements have on overtime benefits; and

(H) Strengthen and implement policies and procedures regarding employee complaints and disciplinary actions.

Your Committee presents its findings and recommendations in the attached report.

Your Committee notes that on September 19, 2014, a class action lawsuit was filed in Circuit Court by Hospital employees claiming supervisors created an unsafe environment that fostered attacks by patients on Hospital workers. In light of this pending class action lawsuit, the Department of Health refrained from submitting a detailed response to your Committee's written report; however, the Department's brief response is attached as an appendix to your Committee's report.

Signed by Senators Clayton Hee and Josh Green, Co-Chairs, on behalf of the Committee.
Ayes, 5 (Hee, Green, Baker, Shimabukuro, Slom). Noes, none. Excused, none.

PART I.
INTRODUCTION – HAWAII STATE HOSPITAL

A. PURPOSE AND ORGANIZATION OF THE HAWAII STATE HOSPITAL

The Hawaii State Hospital (Hospital) is the only publicly funded psychiatric hospital in the State that provides specialized inpatient psychiatric services to adults 24-hours a day, seven days a week. The Hospital is licensed by the Department of Health through the Office of Health Care Assurance and is accredited by The Joint Commission.

1. Mission and Purpose

The Director of Health is authorized under statute[1] to operate a secure psychiatric rehabilitation program for individuals who require intensive therapeutic treatment and rehabilitation in a secure setting. The mission of the Hospital is "to provide safe, integrated, evidence-based psychiatric assessment, treatment and rehabilitation to individuals suffering from brain, medical and behavioral disorders who are primarily court ordered to Hawaii State Hospital." The Hospital's mission is carried out by a staff of over 600 individuals employed by the State and additional staff that are contracted for with temporary employee service agencies to provide direct and indirect psychiatric inpatient services for those cases diagnosed as seriously mentally ill, including those with a co-occurring diagnosis for whom psychiatric inpatient services is a medical necessity, and for those cases referred or committed pursuant to civil and penal statutes who otherwise cannot be diverted into community-based programs and services.

The Hospital offers services to assess, treat, and rehabilitate the patients.[2] Patients at the Hospital receive psychiatric and non-psychiatric treatment to address various medical conditions, such as diabetes and hepatitis. Patients are also provided psychological services, including individual and group therapy, as well as cognitive or behavioral and educational intervention. Finally, patients receive social services to assist them in resolving legal issues; obtaining food, clothing, and shelter upon discharge from the Hospital; and engaging in community reintegration, including job training, education, and maintaining meaningful interpersonal relationships.

2. Organization

The Hospital is administered by the Department of Health with oversight provided by the Department's Adult Mental Health Division under the Behavioral Health Administration. The Deputy Director of Behavioral Health and the Adult Mental Health Administrator delegate their authority to the Hawaii State Hospital Administrator to plan, direct, and oversee the organizational structure and operations of the Hospital. As such, the Hospital Administrator works closely, cooperatively, and collaboratively with the Adult Mental Health Administrator and the administrative staff of the Adult Mental Health Division in identifying treatment and rehabilitation programming services and activities needs; problem solving; developing policy; implementing and coordinating effective corrective action; and redirecting and integrating public and private programs and services. The following organization chart displays a segment of the organization hierarchy within the Department of Health.

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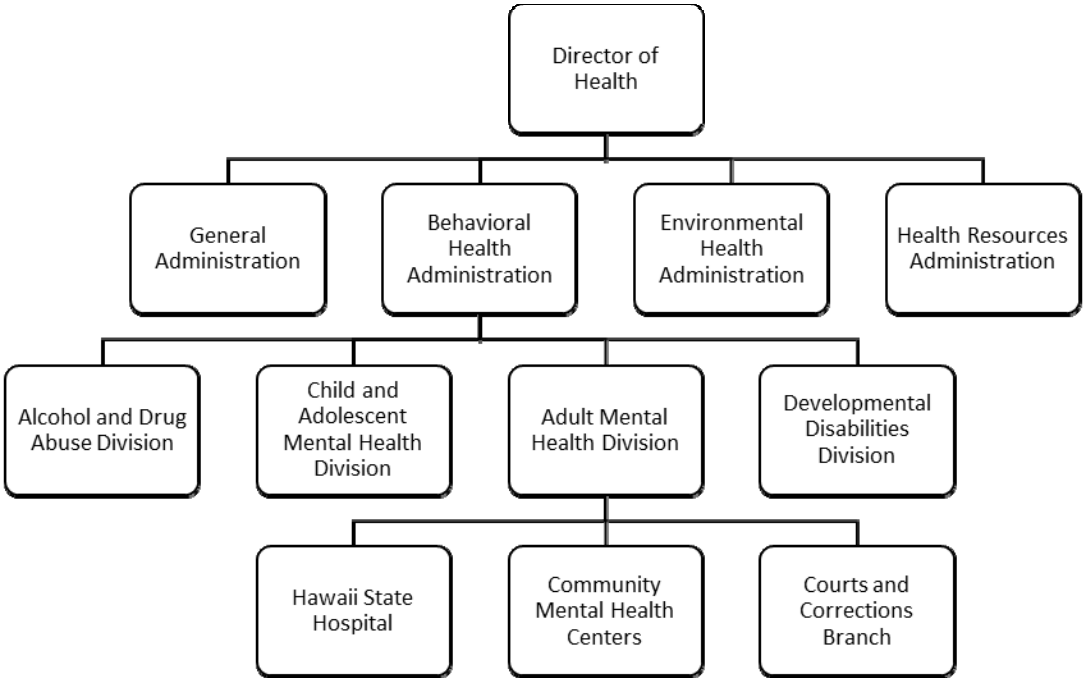
[1] See, §334-2.5(b), Hawaii Revised Statutes.

[2] See, Department of Health, *Report to the Twenty-Fourth Legislature Pursuant to S.C.R. No. 117, S.D. 1, H.D. 1 Regarding the Final Report of the Task Force Convened to Evaluate the Recommended Possible Procedural, Statutory, and Public Policy Changes to Minimize the Census at Hawaii State Hospital and Promote Community-Based Health Services for Forensic Patients*, Appendix 4: Orientation to the Hawaii State Hospital (December 2007).

Figure 1.1
Abbreviated Department of Health Organization Chart

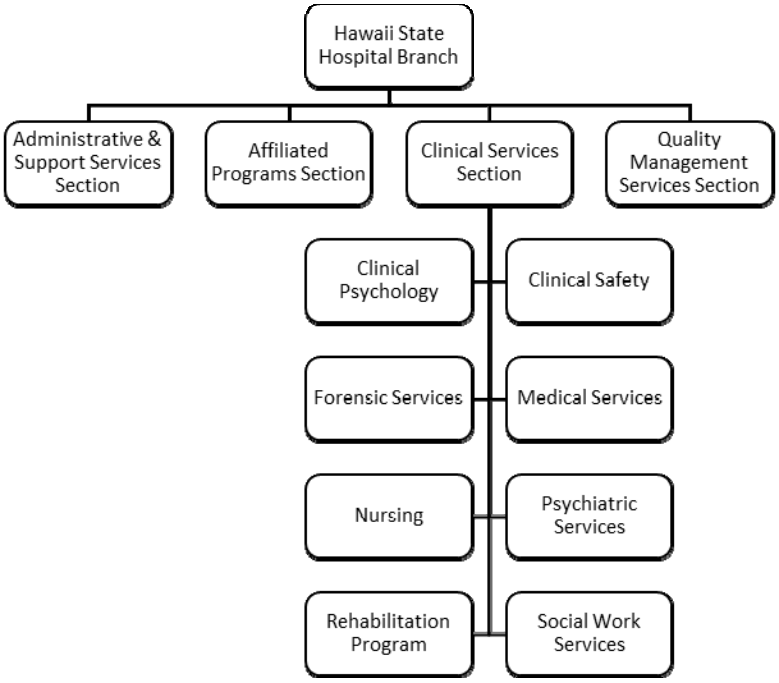


Source: Guide to State Government in Hawaii[3]

The Hospital is organized into four sections, including the Administrative and Support Services, Affiliated Programs, Clinical Services, and Quality Management Services Sections, with the Hospital Administrator serving as the head of the Hawaii State Hospital Branch. An Associate Administrator who reports to the Hospital Administrator heads each section and each section is further divided into and supported by various units and offices. Figure 1.2 illustrates the four sections of the Hospital and the various units and offices of the Clinical Services Section.

[3] Legislative Reference Bureau, *Guide to Government in Hawaii* (14th ed., LRB 2013).

Figure 1.2
Hawaii State Hospital Organization Chart



Source: Department of Health[4]

In terms of inpatient services, the Hospital operates five rehabilitation inpatient units[5] that generally serve the longer-term needs of patients and two acute units[6] with one of these units also serving as the admissions unit for the entire hospital. Furthermore, the Hospital campus also includes a State Operated Specialized Residential Program (SOSRP), which serves as a community residential resource for outpatient care. Most of the residents of this program are patients who are discharged from the Hospital and on conditional release.

3. Budget

The Hospital's operating budget is predominately financed by general funds.[7] In FY2014, the appropriated budget was $52,895,657.[8] According to the Department of Health, two-thirds ($35,343,719) of that appropriated sum[9] was expended for personnel costs. The personnel costs take a majority of the Hospital's operating budget because the budget is based on a census of 168 patients, which is about 25-30 patients less than the actual daily census. A census that exceeds the budgeted number of patients requires the regular use of overtime or adjustments to increase staffing.

In addition to the 168 budgeted beds, the Hospital has a contract with Kahi Mohala Behavioral Health,[10] a private psychiatric hospital owned by the not-for-profit corporation, Sutter Health, for 40 supplemental adult inpatient psychiatric beds or overflow beds. With these 40 overflow beds added to the average daily patient census, the Hospital routinely operates at approximately 70 patients, or 42%, over the budgeted patient census. Furthermore, the usage of the overflow beds at Kahi Mohala substantially increased during FY2012.[11] The capacity of overflow beds increased from 16 beds in February 2012 to 32 beds in June 2012 and to 40 beds in July

[4] Department of Health Position Organization Chart, Functional Chart Nos. 1 and 8 dated April 16, 2014 (MAF_043014_05_B0001 and B0008).
[5] The five rehabilitation units are Units E, I, S, T, and U.
[6] The two acute units are Units F and H. Unit H also serves as the admissions unit.
[7] An analysis of the Hospital's operating budget indicates an unsubstantial infusion of trust fund moneys comprised of donations or gifts. No awards of federal funds were reported for FY2014 or requested for FY2015.
[8] See, General Appropriations Act of 2013 (Act 134, Session Laws of Hawaii 2013).
[9] See, PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[10] Department of Health, *Report to the Twenty-Seventh Legislature Pursuant to the Hawaii Revised Statutes §334-16, Requiring the Department of Health to Submit an Annual Report on Forensic Patient Data Specific to Hawaii State Hospital* (December 2013) (LR_01_0001-0027).
[11] Department of Health, *Report to the Twenty-Seventh Legislature Pursuant to the Hawaii Revised Statutes §334-16, Requiring the Department of Health to Submit an Annual Report on Forensic Patient Data Specific to Hawaii State Hospital* (December 2013) (LR_01_0001-0027).

2012.[12] Accordingly, there is a high likelihood that the number of contracted overflow beds may increase in the future, thus increasing the Hospital's financial needs.

Figure 1.3
Hawaii State Hospital Operating Budget Appropriations, FY2011-2015

Program ID: HTH430 – Adult Mental Health – Inpatient					
	FY2011	**FY2012**	**FY2013**	**FY2014**	**FY2015**
Positions	615.00	615.00	615.00	615.00	615.00
General Funds	$50,667,161	$52,895,657	$51,617,843	$52,895,657	$57,999,657

Source: General and supplemental appropriations Acts, Session Laws of Hawaii 2010 to 2014[13]

B. PATIENTS AT THE HAWAII STATE HOSPITAL

The patient census at the Hospital typically consists of almost 200 individuals. According to the Department of Health, the spectrum of patients admitted to the Hospital has changed over the years. Virtually all admissions to the Hospital are forensic mental health admissions in which individuals are committed to the custody of the Department of Health by state courts and sent to the Hospital.

1. Spectrum of Patients

Many of the individuals hospitalized at the Hospital do not require inpatient psychiatric services, do not have a bona fide mental illness, or remain in the Hospital much longer than is clinically necessary. Individuals are committed to the Hospital due to problems, including dementia, acquired and traumatic brain injuries, developmental delays, substance abuse, and general medical conditions, primarily because the court cannot require or identify a more appropriate placement. Furthermore, most patients have co-occurring substance abuse problems. According to the *Special Action Team Report on the Revitalization of the Adult Mental Health System and Effective Management of the Hawaii State Hospital Census*, patients of the Hospital experience significant inequities compared to people without mental illness or not committed to the Department of Health in gaining access to long-term care beds, medically necessary physical health care, and housing.

Figure 1.4
Spectrum of Patients by Primary Diagnosis on December 01, 2013

Primary Diagnosis	**Number**
Schizophrenia and Related Diagnoses	124
Bipolar, Major Depression, and Other Mood Disorders	22
Substance Use Disorders	10
Other (both psychiatric and non-psychiatric diagnoses)	38
No Diagnosis	4
TOTAL	**198**

Source: Department of Health[14]

2. Admissions from the Court System

The inpatient psychiatric services at the Hospital are provided to adults who are voluntarily or involuntarily hospitalized, committed to the custody of the Director of Health under chapter 704, Hawaii Revised Statutes (HRS), or appropriately hospitalized under chapter 704 or 706, HRS. However, the Department reported that virtually all of its admissions are court ordered.

The admission of forensic mental health patients to the Hospital has increased primarily due to the transfer timeframes mandated under the Clark permanent injunction.[15] This permanent injunction applies to all state court orders to transfer persons to the custody of the Director of Health within 72 hours of an order declaring Acquittal on the Ground of Physical or Mental Disease, Disorder, or Defect Excluding Responsibility ("Not Guilty by Reason of Insanity") (§704-411(1)(a), HRS); Unfit to Proceed (§704-406, HRS); or Involuntary Civil Commitment (§706-607, HRS), and within 48 hours of an order declaring Revocation of Conditional Release (§704-413(4), HRS). Figure 1.5 illustrates the number of patients admitted to the Hospital during FY2013 by the legal status of the admission.

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[12] Department of Health, *Report to the Twenty-Seventh Legislature Pursuant to the Hawaii Revised Statutes §334-16, Requiring the Department of Health to Submit an Annual Report on Forensic Patient Data Specific to Hawaii State Hospital* (December 2013) (LR_01_0001-0027).

[13] See, Act 180, Session Laws of Hawaii 2010, for FY2011; Act 164, Session Laws of Hawaii 2011, for FY2012; Act 106, Session Laws of Hawaii 2012, for FY 2013; Act 134, Session Laws of Hawaii 2013, for FY 2014; and Act 122, Session Laws of Hawaii 2014, for FY2015.

[14] See, PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).

[15] See, Clark v. State of Hawaii, Stipulation for Amended Permanent Injunction, No. CV 99-00885 DAE/BMK (2003) (LR_07_0033-0040).

Figure 1.5
Spectrum of Patients by Type of Admission for FY2013

Type of Admission	No. of Patients	% of Total Admission
§704-411(1)(a), HRS Acquittal on the Ground of Physical or Mental Disease, Disorder, or Defect Excluding Responsibility ("Not Guilty by Reason of Insanity")	23	7%
§704-413(4), HRS Revocation of Conditional Release	0	0%
§704-413(1), HRS 72 Hour Hold on a Motion to Revoke Conditional Release	112	33%
§704-404, HRS Evaluation of Fitness to Proceed	54	16%
§704-406, HRS Unfit to Proceed	137	40%
§§704-406(3) and (4) and 706-607, HRS Involuntary Civil Commitment	13	4%
Voluntary Commitments	0	0%

Source: Department of Health[16]

As a result of the Clark permanent injunction and the increase in the admission of forensic mental health patients,[17] the Hospital's ability to admit individuals subject to involuntary civil commitment by the Family Courts is hampered, and the voluntary commitment of persons who may require longer-term psychiatric rehabilitation is effectively precluded. Thus, forensic admissions have accounted for virtually all of its admissions, with the Department of Health reporting that its current patient census is comprised solely of forensic mental health patients.

According to the Department of Health, the number of admitted forensic mental health patients who are charged with a misdemeanor offense[18] and patients who are charged with a felony offense[19] are approximately equal.[20] In addition, most of the patients at the Hospital have not been found guilty of any charges, and 40% of the criminal offense charges do not involve offenses against another person. Furthermore, patients with more serious charges generally have longer lengths of stay at the Hospital, with a small number of patients (all male) who are charged with class A felonies[21] with lengths of stay longer than 20 years.

C. EMPLOYEES OF THE HAWAII STATE HOSPITAL

The Hospital employs over 600 employees who provide direct psychiatric inpatient services, such as psychiatrists, medical physicians, registered nurses, psychiatric technicians, para-medical assistants, psychologists, laboratory technicians, occupational therapists, recreational therapists, social workers, and dieticians. The Hospital is supported by staff to perform administrative duties, such as human resources, management information systems, telecommunication services, security, fiscal management and quality management; and a staff for plant and facilities management.

As state employees, Hospital staff are civil servants unless specifically exempt and part of collective bargaining unless specifically excluded. Employees who are part of collective bargaining are represented by the Hawaii Government Employees Association, AFSCME Local 152, AFL-CIO (HGEA) or United Public Workers, AFSCME Local 646, AFL-CIO (UPW) and have certain employee rights and benefits negotiated under their respective collective bargaining agreements.

The average daily patient census for calendar year 2013 at the Hospital was 192 patients,[22] which is 24 patients over the Hospital's budgeted census of 168 patients. As a result, in addition to the Hospital's payroll of over 600 employees, the Hospital contracts for registered nurses, psychiatric technicians, and para-medical technicians to provide appropriate staffing levels for the care for its over-census patient population.

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[16] Department of Health, *Report to the Twenty-Seventh Legislature Pursuant to the Hawaii Revised Statutes §334-16, Requiring the Department of Health to Submit an Annual Report on Forensic Patient Data Specific to Hawaii State Hospital* (December 2013) (LR_01_0001-0027).

[17] See, Department of Health, *Report to the Twenty-Fourth Legislature Pursuant to S.C.R. No. 117, S.D. 1, H.D. 1 Regarding the Final Report of the Task Force Convened to Evaluate the Recommended Possible Procedural, Statutory, and Public Policy Changes to Minimize the Census at Hawaii State Hospital and Promote Community-Based Health Services for Forensic Patients* (December 2007).

[18] See, §§706-640 and 706-663, HRS.

[19] See, §§706-640, 706-660, and 706-659, HRS.

[20] See, PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).

[21] The violation of a class A felony is punishable by an indeterminate of imprisonment 20 years and a fine not exceeding $50,000. See, §§706-640 and 706-659.

[22] See, PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).

PART II.
SENATE SPECIAL INVESTIGATIVE COMMITTEE
ON THE HAWAII STATE HOSPITAL

A. IMPETUS OF SPECIAL INVESTIGATIVE COMMITTEE

The Hawaii State Hospital has garnered regrettable attention on the federal and state levels over the past 20 years regarding the conditions, census, and quality of care at the Hospital. Despite numerous efforts, the Hospital continues to be a subject of concern.

1. Federal Intervention

In 1991, the United States Department of Justice (DOJ) filed suit against the State of Hawaii for violations of the constitutional rights of patients of the Hospital pursuant to the federal Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.). It was reported that care for patients was substandard, the buildings leaked, some patients were administered too much medication, patients were left unattended lying on concrete floors or were routinely restrained, staffing was inadequate, and conditions were unsafe and unsanitary.[23] That same year, the State and the United States through the DOJ entered into a settlement agreement[24] to correct the deficiencies at the Hospital, which became an order of the federal court.

In 1995, the court found the State in contempt of court for failure to achieve important requirements of the court order. As a result, the DOJ and State negotiated a stipulation and detailed remedial plan[25] designed to address the violations and problems at the Hospital.

In 1999, the Federal District Court found that the Hospital was still grossly out of compliance[26] with significant requirements of its orders, most notably the requirements that the State provide adequate treatment and treatment planning for all patients at the Hospital. Despite the court-ordered formation of a compliance committee to identify and implement solutions to all outstanding issues of material significance for compliance, the State was unable to take adequate corrective action in accordance with the plans of the compliance committee.

Subsequently, the court appointed a special monitor to oversee compliance in 2000. The special monitor's report filed in 2001 cited that many operational problems continued at the Hospital, including overcrowding and staffing, safety, and morale problems.[27] Furthermore, HGEA filed a grievance for the nurses about the conditions. As a result, the court appointed a special master in 2001 to oversee state compliance with federal laws at the Hospital.

In 2004, the special master recommended dismissing the federal civil rights lawsuit against the Hospital and terminating federal court oversight of the Hospital. The special master reported that state officials made "substantial progress and dramatic change" at the Hospital, with patients now being treated in "a different and successful way."[28] Despite the recommendation to terminate the federal court oversight of the Hospital, the special master recommended that the federal court continue to monitor until June 30, 2006, the State's efforts in implementing a community plan for people with serious mental illnesses who are former patients or who will be released from the Hospital. On November 30, 2006, 15 years after the lawsuit was filed, the federal case was dismissed with prejudice.[29]

2. Executive Intervention

After the federal court oversight, the Hospital continued to be an area of concern, especially with regard to patient census and community-based services for forensic mental health patients. As a result, the Governor's Administration engaged in efforts to identify problems at the Hospital, recommend solutions to address these problems, and prevent the Hospital from falling under federal oversight again.

a. Governor's Task Force Pursuant to S.C.R. No. 117

During the Regular Session of 2006, the Legislature passed S.C.R. No. 117, S.D. 1, H.D. 1, to request the Governor to convene a task force comprised of consumers of public mental health services, the Hospital staff members, and representatives of state and county government agencies and advocacy agencies to evaluate and recommend possible procedural, statutory, and public policy changes to minimize the census of the Hospital as well as to promote development of community-based services for forensic mental health consumers. The task force was requested to consider a number of issues,[30] including community-based mental health services for forensic patients conditionally released by the courts; mental health interventions and jail diversion programs to assist mentally ill individuals who come into contact with the criminal justice system; chapter 704, HRS; the Judiciary's Mental Health Court; forensic mental health examiners; and post-release after-care services for severely and persistently mentally ill incarcerated patients.

The task force convened in October 2006 and met monthly until concluding in November 2007. As a result of its yearlong effort, the task force made recommendations in three areas – chapter 704, HRS, timeframes; orders to treat (involuntary medication); and mental health examinations[31] – and each area included recommendations for public policy, statutory, and procedural changes.

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[23] Ken Kobayashi, *Feds to end oversight at state mental hospital*, Honolulu Advertiser (November 13, 2004).
[24] United States v. State of Hawaii, et al., Settlement Agreement and Order, Civil No. 91-00137 DAE (1991) (LR_07_0046-0083).
[25] United States v. State of Hawaii, et al., Stipulation and Order to Remedy Defendants' Contempt of Settlement Agreement, Civil No. 91-00137 DAE (1995) (LR_07_0096-0153).
[26] United States v. State of Hawaii, et al., Order Establishing Compliance Committee, Reporting Schedule, and Setting Status Conference, Civil No. 91-00137 DAE (1999) (LR_07_0219-0221).
[27] Helen Altonn, *Federal magistrate to oversee state hospital*, Honolulu Star Bulletin (May 18, 2001).
[28] Ken Kobayashi, *Feds to end oversight at state mental hospital*, Honolulu Advertiser (November 13, 2004).
[29] United States v. State of Hawaii, et al., Order Dismissing Action with Prejudice, Civil No. 91-00137 DAE/KSC (2006) (LR_07_0324-0326).
[30] See, S.C.R. No. 117, S.D. 1, H.D. 1 (Regular Session of 2006).
[31] See, Department of Health, *Report to the Twenty-Fourth Legislature Pursuant to S.C.R. No. 117, S.D. 1, H.D. 1 Regarding the Final Report of the Task Force Convened to Evaluate the Recommended Possible Procedural, Statutory, and Public Policy Changes to*

b. Governor's Special Action Team

On June 14, 2012, the Governor issued an Executive Memorandum[32] to convene a Special Action Team to address the increasing census at the Hospital. In the memorandum, the Governor stated that in the last six months, the monthly number of admissions to the Hospital increased by 50% with no corresponding increase in the rate of discharge, which raised concerns that patient care may be compromised as a result. The Special Action Team was convened to conduct an analysis of the causes of the high census at the Hospital, consider options to address the causes, develop a priority list of recommendations for changes, propose short- and long-term solutions, and provide a summary report to the Governor.

Over a five-week period from July 17, 2012, to August 21, 2012, the Special Action Team focused its work on areas to recommend for action and consideration by the Governor's Administration for the 2013 legislative session and the biennium budget. The Special Action Team was comprised of three subcommittees covering the following areas: personnel, finance, and procurement; program capacity and clinical operations; and legal and judicial.

The Special Action Team identified several systemic factors, including the use of the Hospital to provide the majority of inpatient psychiatric treatment in the State, unlike most of the other states; the very high forensic use of the Hospital, unlike other states; and the unexplained increase in the rate of forensic evaluations ordered by Hawaii courts during FY2012. The recommendations of the Special Action Team were developed by the three subcommittees and were divided into short-term recommendations that would be substantially implemented in FY2013 and long-term recommendations that could be implemented in FY2014 and beyond. In general, these recommendations focused on developing community resources, which is more cost effective than inpatient hospitalization, and making the forensic process more efficient and effective.

3. Legislative Intervention

The Legislature also assisted in creating and improving the Hospital by implementing recommendations made by the task force established pursuant to S.C.R. No. 117 (Regular Session of 2006) and the Governor's Special Action Team. Furthermore, the Legislature also acted as an appropriate venue to receive information regarding the Hospital and address problems through legislation.

a. Reported Staff Assaults in 2007

In early August 2007, media coverage[33] called attention to a January 2007 incident involving an injury to a Hospital nurse by one of her patients and the resignation of the staff psychiatrist on account of her safety concerns at the Hospital. Nurse Terry Evans, who suffered facial injuries, including a broken orbital bone around her left eye, claimed her injuries resulted from an unsafe workplace and that she continued to suffer from post-traumatic stress syndrome. Former staff psychiatrist, Dr. Karen Ritchie, stated, "I finally decided I couldn't continue to work there because I don't believe it's a safe environment,"[34] in commenting about her resignation.

As a result, the Legislature held a news conference to build awareness of the growing number of assaults by patients against staff at the Hospital. According to the media report,[35] the Department of Health reported that during the first six months of 2007, there were 107 assaults by patients against staff members. In the years leading up to the legislative news conference it was reported that 187 assaults occurred in 2006, 133 assaults in 2005, and 170 assaults in 2004.[36] The number of reported assaults has fluctuated over the past few years. The increased incidence of patients assaulting staff was attributed to an increase in the patient census, particularly due to the increase in the court-ordered forensic mental health patients. Legislators expressed concern that if these occurrences at the Hospital continued, a fatality would occur.

b. Act 100, Session Laws of Hawaii 2008

During the Regular Session of 2008, the Legislature passed Act 100 in response to the recommendations made by the task force pursuant to S.C.R. No. 117 (Regular Session of 2006) and to address the recent rise in incidence of patients assaulting staff at the Hospital. The purpose section of part II of Act 100, Session Laws of Hawaii 2008, noted that patient-to-staff assaults at the Hospital was an area of heightened organizational focus and public scrutiny. As a result, Act 100[37] amended §707-711, HRS, to establish criminal charges against a person who intentionally or knowingly causes bodily injury to a person employed in a state-operated or -contracted mental health facility as a class C felony. Prior to Act 100, such an assault would generally be a misdemeanor.

c. Informational Briefings in 2014

Since the enactment of Act 100,[38] the Legislature has periodically received information on instances of Hospital staff injuries; failure or refusal to attend to, treat, or monitor instances of staff injuries caused by patients at the Hospital; and allegations of employment improprieties by administrative and supervisory personnel. On November 20, 2013, several Hospital employees reported at a press conference their concerns regarding workplace safety involving attacks on employees by patients, and alleged employment improprieties. At that time, Senators called for a probe into the assaults by patients on Hospital staff.

On January 7, 2014, the Senate Committees on Health and Judiciary and Labor held an informational briefing to receive an update on the state of violence against Hospital workers, explore staffing patterns at the Hospital and plans to create a safe workplace, and receive information about the spectrum of patients, including violent offenders, at the Hospital. At this informational briefing, the

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Minimize the Census at Hawaii State Hospital and Promote Community-Based Health Services for Forensic Patients (December 2007).

[32] See, Department of Health, *Special Action Team Report to the Governor on Revitalization of the Adult Mental Health System and Effective Management of the Hawaii Hospital Census* (October 2012).

[33] B.J. Reyes, *State hospital staff labors in fear*, Honolulu Star Bulletin (August 7, 2007).

[34] Id.

[35] Id.

[36] Id.

[37] See, Part II, Act 100, Session Laws of Hawaii 2008, and §707-711, HRS.

[38] Act 100, Session Laws of Hawaii 2008.

Senate Committees received information from the Department of Health, Department of Labor and Industrial Relations, Department of Public Safety, Judiciary, and several injured Hospital workers and a medical physician.

The Senate Committees on Health and Judiciary and Labor held a second informational briefing on January 27, 2014, to receive updated information from department heads, as requested during the previous informational briefing, and additional information on the state of workplace violence at the Hospital. The Senate Committees received information from the Department of Public Safety, Department of Labor and Industrial Relations, Department of Human Resources Development, Department of the Attorney General, and Department of Health. At this informational briefing, it was noted by the Chairpersons of the Senate Committees on Health and Judiciary and Labor that the Committee Chairpersons introduced S.R. No. 3 on January 17, 2014, for adoption by the Senate and that this resolution would establish a Senate Special Investigative Committee.

B. SENATE RESOLUTION NO. 3 (REGULAR SESSION OF 2014)

In light of the longstanding problems at the Hospital despite federal, executive, and legislative intervention, and due to the recent information regarding workplace violence at the Hospital and the allegations of employment improprieties, the Senate adopted S.R. No. 3 (Regular Session of 2014) to establish a Senate Special Investigative Committee pursuant to chapter 21, HRS.

1. Objectives and Powers of the Investigative Committee

Under S.R. No. 3, the objectives of the Senate Special Investigative Committee (Investigative Committee) included the following:

(1) Investigate the workplace safety of all Hospital psychiatric workers;

(2) Investigate the alleged Hospital administrative and employment improprieties; and

(3) Inquire into, gather, and analyze information, including the Hospital's personnel files, that may provide relevant information concerning worker safety and alleged administrative improprieties.

Under S.R. No. 3, the Investigative Committee was authorized every power and function allowed to an investigative committee specified under chapter 21, HRS, including without limitation the power to:

(1) Adopt rules for the conduct of its proceedings;

(2) Issue subpoenas requiring the attendance and testimony of witnesses and subpoenas duces tecum requiring the production of books, documents, records, papers, or other evidence in any matter pending before the Investigative Committee;

(3) Hold hearings appropriate for the performance of its duties at such times and places as the Investigative Committee determines;

(4) Administer oaths and affirmations to witnesses at hearings of the Investigative Committee;

(5) Report or certify instances of contempt as provided under §21-14, HRS;

(6) Determine the means by which a record shall be made of its proceedings in which testimony or other evidence is demanded or adduced; and

(7) Provide for the submission, by a witness's own counsel and counsel for another individual or entity about whom the witness has devoted substantial or important portions of the witness's testimony, of written questions to be asked of the witness by the Chair.

2. Members of the Investigative Committee

As set forth in S.R. No. 3, the membership of the Investigative Committee comprised not less than five members, including the Chairpersons of the Senate Committees on Health and Judiciary and Labor, appointed by the President of the Senate. The members of the Investigative Committee are Senator Clayton Hee, Co-Chair; Senator Josh Green, Co-Chair; Senator Maile S.L. Shimabukuro; Senator Rosalyn H. Baker; and Senator Sam Slom.

3. Hearings and Subpoenas

In the course of its investigation the Investigative Committee held hearings to receive information from subpoenaed witnesses and also subpoenaed relevant documents. The testimony received was given subject to subpoena and made under oath, subject to the penalty for perjury, which includes a civil fine up to $1,000 or imprisonment up to one year.

As part of its investigation, the Investigative Committee conducted 10 hearings lasting over a total of 19 hours and received testimony from 14 witnesses. In addition, the Investigative Committee received in excess of 12,000 pages of documents in response to subpoenas. Unless otherwise noted, the written findings and recommendations of the Investigative Committee contained in this report relied upon the testimony heard by the Investigative Committee under oath or from documents received pursuant to a subpoena.

PART III.
FINDINGS OF THE SENATE SPECIAL INVESTIGATIVE COMMITTEE ON THE HAWAII STATE HOSPITAL

S.R. No. 3 notes that on November 20, 2013, several Hospital employees informed Senators about their concerns about workplace safety involving attacks on employees and of alleged administrative and employment improprieties at the Hospital. The Investigative Committee takes these concerns seriously and notes that its formation is credited to these Hospital employees stepping forward to shed light on longstanding problems at the Hospital.

In the course of its discussion and assessment of the documents and testimony it received, the Investigative Committee finds that the Hospital faces three main challenges. These challenges are related to each other and include:

A. Maintaining a safe work environment for Hospital staff and patients;

B. Meeting the current needs of Hospital patients and staff due to inefficient use of facilities and patient and staff safety practices; and

C. Providing efficient and effective human resources practices.

These challenges and their related findings are discussed in the following sections.

A. CHALLENGES IN MAINTAINING A SAFE WORK ENVIRONMENT FOR HOSPITAL STAFF AND PATIENTS

The Investigative Committee finds that the Hospital has longstanding problems maintaining a safe work environment for its staff and patients. The paramount workplace safety issue appears to be violent and unstable patients attacking staff and causing injuries.

1. Continued Reports of Patients Assaulting Staff

The Investigative Committee finds that despite legislative intervention, the Hospital continues to have reports of patients assaulting staff or other patients. The Hospital uses a broad and inclusive definition of assault to capture information about patient clinical progress or anticipate change in clinical status prior to an extreme behavioral event. The Hospital defines assault as "any overt act (physical contact) upon the person of another that may or does result in physical injury and/or emotional distress. Examples include, but are not limited to hits, spits, sexual assaults, or any physical injury intentionally inflicted upon another person."[39]

The Investigative Committee further finds that assaults on Hospital employees have resulted in some employees being out of work for months and even years, which contributes to staff shortages. For example, in January 2007, Nurse Terry Evans suffered facial injuries, including a broken orbital bone around her left eye.[40] She claimed that her injuries resulted from an unsafe workplace and that she continued to suffer from post-traumatic stress syndrome.[41] As a result of the assault, Ms. Evans no longer works at the Hospital. On December 3, 2009, former Unit T Psychiatric Technician, Emelinda Yarte sustained injuries to her head and jaw while she assisted her coworkers in controlling a violent and unstable patient.[42] Since sustaining her injuries, Ms. Yarte has not returned to the Hospital.[43] In December 2011, a Psychiatric Technician was attacked by a patient and sustained multiple unprovoked punches to the face, which resulted in a laceration over the employee's left eye.[44] This employee was out of work for six months. The Investigative Committee notes that these are only a handful of incidents that have occurred at the Hospital. Figure 3.1 indicates the number of patient-to-staff assaults from years 2006 to 2013.

Figure 3.1
Patient-to-Staff Assaults at the Hospital

Year	No. of Assaults
2006	187
2007	179
2008	150
2009	164
2010	140
2011	132
2012	120
2013	135

Source: Department of Health[45]

The Investigative Committee finds that the Hospital is unable to adequately address this problem because the Hospital cannot accurately assess the breadth of the problem due to inconsistent reporting of assaults on staff. In addition, the Hospital has underutilized tools that could assist it in preventing assaults or mitigating the seriousness of assaults.

a. Inconsistent Reporting of Assaults on Staff

The Investigative Committee is deeply concerned regarding the number of assaults on staff but is unable to determine the breadth and pervasiveness of the problem. The Investigative Committee finds that the number of reports of patients assaulting staff are inaccurate due to inconsistent or lack of reporting. The Investigative Committee further finds that the inconsistent reporting of patient assaults on staff can be attributed to a number of factors, including conflicting data, staff failing to report assaults, and inefficient communication of patient assaults on staff up the chain of command in the Department of Health.

The Investigative Committee received conflicting data regarding assaults by patients. The Department of Health submitted to the Investigative Committee information and statistics regarding staff safety complaints, job-related injuries, and workers' compensation claims from 2009 to the present.[46] While it appreciates the amount of information received from the Department, the Investigative

[39] Department of Health, Assault Management and Psychological First Aid Policy and Procedure No. 14.040 (LR_01_121013_0016-0027 - Confidential).
[40] B.J. Reyes, *State hospital staff labors in fear*, Honolulu Star Bulletin (August 7, 2007).
[41] B.J. Reyes, *State hospital staff labors in fear*, Honolulu Star Bulletin (August 7, 2007).
[42] Testimony of Emelinda Yarte, May 14, 2014.
[43] Testimony of Emelinda Yarte, May 14, 2014.
[44] Department of Health, Documentation of a Psychiatric Technician Assaulted by Patient in the PICU (LR_07_091614_1-9).
[45] Department of Health, Information Regarding the Accuracy of the Statistic that Assaults Occur Once Every Three Days (LR_01_011514_0006-0009 - Confidential).
[46] Department of Health, Information and Statistics Regarding Staff Safety Complaints, Job-Related Injuries, and Workers' Compensation Claims from 2009 to the Present (LR_15_0001-0070 – Confidential).

Committee is unable to determine how the list of employee incident reports correlate with the list of staff injury reports because some employee incident reports, which indicate that an injury was sustained, are not documented under the list of staff injury reports and vice versa. Furthermore, under the list of staff injury reports, the number of assaults per year that were filed for records only or workers' compensation does not correlate with and is less than the number of patient-to-staff assaults per year reported by the Department under Figure 3.1. The Investigative Committee does not believe that the total number of assaults occurring at the Hospital can be less than the number of patient-to-staff assaults. Accordingly, the Investigative Committee does not understand how the Department of Health determined the number of patient-to-staff assaults at the Hospital and questions the accuracy of the numbers provided under Figure 3.1.

According to the Department of Health, the event reporting process assures that assaults are documented so that action may be taken, if appropriate, and ideally to prevent a severe event.[47] However, the Investigative Committee finds that the policies and procedures for reporting incidents of assaults are not widely implemented by staff because staff view assaults by patients as part of their job.[48] During the Investigative Committee's site visit of the Hospital in June 2014, employees disclosed incidents where they were assaulted by a patient, but did not file an employee incident report because they did not sustain any injuries, or if the assault resulted in an injury, they did not think the injury was serious enough to warrant a report, especially compared to serious injuries other employees previously sustained.[49] The Investigative Committee finds that these comments are peculiar and concerning, and indicative of the culture of workplace violence at the Hospital. As such, the failure of staff to file reports contributes to the inaccurate reports of assaults by patients.

The Investigative Committee finds that delays in and problems with filing claims for workers' compensation and receiving workers' compensation benefits may delay injured staff from returning to work in a timely manner and result in greater costs for the State. Furthermore, a former Hospital employee testified that she did not receive workers' compensation payments for a period of five months.[50] As a result, this employee hired an attorney to assist her in receiving her back payments.[51] Although her workers' compensation claim was approved three days after she sustained her injuries, the employee testified that she knew injured coworkers who waited one to three months for their claims to be approved and receive treatments for their injuries.[52] The Investigative Committee is concerned that delays in workers' compensation may discourage injured staff from reporting assaults to avoid being mired in the workers' compensation process, including having to hire an attorney to expedite the process.

The Investigative Committee finds that Department of Health administrators do not have an accurate number of assaults that occur at the Hospital because only certain information regarding assaults is reported up the chain of command. The Deputy Director of Behavioral Health, Lynn Fallin, testified that she receives reports of only serious assaults from the Administrator of the Adult Mental Health Division, Dr. Mark Fridovich.[53] A serious assault is defined by Department and Hospital administrators as an assault that results in a serious injury that requires outside medical attention other than what the Hospital can provide, such as an injury that requires emergency room medical attention.[54] Ms. Fallin testified that since she became Deputy Director in July 2011, she has received four alerts about serious assaults occurring at the Hospital.[55] The Investigative Committee believes that being aware of only the serious assaults hinders the Department administration's ability to assess the breadth of the problem and develop and implement appropriate and effective recommendations for large-scale changes for the Hospital. Furthermore, the Investigative Committee has concerns that by reporting only the serious assaults to Ms. Fallin, Dr. Fridovich may be minimalizing the number of assaults that occur at the Hospital and contributing to the inaccurate number of reports of assaults by patients.

Furthermore, the Investigative Committee finds that while the Hospital has its own definitions for attempted assault and assault,[56] it appears that Department of Health administrators do not have a clear understanding or consistent use of these definitions and how they are used to track and report assaults occurring at the Hospital. The Director of Health was unable to clearly articulate to the Investigative Committee the differences between the two acts and largely relied on whether any medical attention was sought by the assault victim or the level of medical care that was necessary to differentiate the two acts.[57] The Investigative Committee believes that the tracking and reporting of assaults should be based on an established set of definitions with clear criteria setting out the type of action, and extent and type of injury necessary to constitute an attempted assault or assault rather than whether any medical attention or care was sought or needed. The Investigative Committee wonders whether the Hospital is tracking and reporting assaults to Department administrators according to its established definitions of assault, which the Investigative Committee finds lacking of clear criteria, or another set of criteria that is based on the extent of medical attention needed. Without a clear understanding of how assaults are defined and tracked, Department administrators are unable to develop and implement large-scale plans to address the problem of assaults occurring at the Hospital.

b. Underutilization of Act 100

In 2008, the Legislature noted under part II of Act 100, Session Laws of Hawaii 2008(Act 100),[58] that patient-to-staff assaults at the Hospital was an area of heightened organizational focus and public scrutiny. As a result, the Legislature amended §707-711, HRS, to establish criminal charges against a person who intentionally or knowingly causes bodily injury to a person employed in a state-

[47] Department of Health, Information Regarding the Accuracy of the Statistic that Assaults Occur Once Every Three Days (LR_01_011514_0006-0009 - Confidential).
[48] Comments by Investigative Committee regarding Site Visit on June 11, 2014 (July 16, 2014).
[49] Comments by Investigative Committee regarding Site Visit on June 11, 2014 (July 16, 2014).
[50] Testimony, May 14, 2014.
[51] Testimony, May 14, 2014.
[52] Testimony, May 14, 2014.
[53] Testimony of Lynn Fallin, March 27, 2014.
[54] Testimony of Lynn Fallin, March 27, 2014; and Testimony of William Elliott, July 16, 2014.
[55] Testimony of Lynn Fallin, March 27, 2014.
[56] Department of Health, Assault Management and Psychological First Aid Policy and Procedure No. 14.040 (LR_01_121013_0016-0027 - Confidential).
[57] Testimony of Dr. Linda Rosen, July 16, 2014.
[58] Act 100, Session Laws of Hawaii 2008.

operated or -contracted mental health facility as a class C felony.[59] However, the Investigative Committee finds that Act 100 has not been used since it became effective on July 1, 2008.

According to the Department of Health, there have been "four instances of prosecutions advancing subsequent to the enactment of the revised statute in 2008."[60] Also former Acting Administrator, William Elliot, sent a letter dated January 9, 2014, to the Honolulu Police Department (HPD) requesting a listing of assaults on Hospital staff reported to HPD, including HPD report numbers, assault event description, and date of incident from 2008 to the present.[61] However, to date, the Hospital has not received a response from HPD, even after a follow-up request was made by Associate Administrator for Clinical Services, Dr. William Sheehan, on September 11, 2014.[62]

The Investigative Committee has concerns regarding what appears to be an underutilization of Act 100. The meaning of "four instances of prosecutions advancing"[63] is unclear to the Investigative Committee and the absence of a response from HPD fails to provide clarity. However, if the "four instances" is an accurate number of times that Act 100 has been used by Hospital staff, then the Investigative Committee questions why Act 100 has not been used more, especially in light of the number of assaults on staff that occurred at the Hospital, whether Hospital staff is aware of Act 100, and whether Hospital administration educates staff of their legal options if they are assaulted by a patient while at the Hospital.

c. Lack of Appropriate Training to Handle Violent Patients

In addition to the inconsistent reporting of assaults on staff, the Investigative Committee finds that employees are ill-prepared to handle violent patients due to a lack of appropriate training. Upon being hired, all Hospital staff are required to complete 10 hours of Conflict Prevention, Management, and Resolution (CPMR) training on how to employ de-escalation techniques[64] and receive annual training thereafter. However, the Hawaii Occupational Safety and Health Division of the Department of Labor and Industrial Relations (HIOSH) recently found that the CPMR training and practice drills were not realistic or practical enough to prepare employees for the real-life situations that they may encounter with violent, unstable patients.[65] In light of the high patient census and the spectrum of forensic mental health patients at the Hospital, the Investigative Committee strongly believes that providing staff with the appropriate training to prevent assaults or de-escalate a situation will assist in decreasing the number of assaults on staff or other patients and the severity of assaults.

2. Recently Cited for Occupational Safety and Health Violations

The Investigative Committee finds that on April 10, 2014, HIOSH issued to the Hospital seven serious occupational safety and health citations with fines totaling $40,700.[66] The Investigative Committee specifically notes the following findings from the HIOSH Citation and Notification of Penalty report:[67]

> "The employer did not furnish employment free from recognized hazards that were likely to cause death or serious physical harm in that their employees were exposed to the hazard of being physically assaulted by their own patients."[68]
>
> "Multiple employees did not know about, understand, or retain the knowledge to eliminate and control hazards associated with working in an environment with assaultive, unstable patients. More improved workplace violence training is needed to deal with the high incident rates of patient to staff assaults."[69]
>
> "Some employees are non-responsive in doing their job when PMT/Code 200 calls are made. Safety practices were not underscored through correction of unsafe performance."[70]

The Investigative Committee notes that the Department of Health is currently in the process of contesting these citations and a hearing date has not been set yet. Dr. Rosen testified that the Department was contesting certain items under the HIOSH citation and the Department of Labor and Industrial Relations (DLIR) had agreed to dismiss one of these items.[71] However, the Investigative Committee subsequently discovered from DLIR that the entire HIOSH citation must be contested, not just certain items.[72] Thus, none of the items were dismissed.[73] Accordingly, the Investigative Committee is concerned with the Director of Health's and Department of Health's lack of understanding of HIOSH violation procedures.

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[59] Act 100, Session Laws of Hawaii 2008.
[60] Department of Health, Number of Times Act 100 was Used by Hospital Workers (LR_01_011514_0003-0005).
[61] Department of Health, Number of Times Act 100 was Used by Hospital Workers (LR_01_011514_0003-0005).
[62] Department of Health, Documentation Regarding Response from HPD on Act 100 (LR_06_091614_1-2).
[63] Department of Health, Number of Times Act 100 was Used by Hospital Workers (LR_01_011514_0003-0005).
[64] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[65] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[66] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[67] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[68] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[69] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[70] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).
[71] Testimony of Dr. Linda Rosen, July 16, 2014.
[72] Committee Discussion, July 30, 2014.
[73] Committee Discussion, July 30, 2014.

Furthermore, the Investigative Committee is deeply concerned regarding the HIOSH finding that employees did not know about, understand, or retain knowledge to eliminate and control hazards associated with working at the Hospital. This lack of knowledge and understanding is indicative of the Hospital administration's failure to develop and implement effective policies and procedures to ensure a safe work environment for its staff. The Investigative Committee strongly urges the Hospital to make a serious effort in addressing and resolving these HIOSH violations rather than on contesting and mitigating the violations and the associated penalties.

B. CHALLENGES IN MEETING THE CURRENT NEEDS OF HOSPITAL PATIENTS AND STAFF DUE TO INEFFICIENT USE OF FACILITIES AND PATIENT AND STAFF SAFETY PRACTICES

The Investigative Committee finds that the design, infrastructure, and technology of the Hospital no longer effectively meet the therapeutic mental health needs of its patients. Additionally, the Hospital's high patient census, which is entirely comprised of forensic mental health patients, poses a constant challenge for the Hospital to find enough beds as well as sufficient staffing to provide adequate patient care. However, the Hospital is forced to admit, accommodate, and treat patients with limited resources, which contributes to safety concerns for the patients, staff, and surrounding community.

1. Inefficient Use of Hospital Facilities

The Hospital is accredited as an acute care facility.[74] The Hospital has 202 licensed beds[75] and 40 additional supplemental adult inpatient psychiatric beds or overflow beds under contract with Kahi Mohala Behavioral Health.[76] The average daily census at the hospital for calendar year 2013 was 192 patients. However, the per-day census typically reaches over 200 patients depending on the number of forensic admissions. Therefore, the Investigative Committee finds that the persistently high census and the legal requirements imposed by the Clark permanent injunction[77] place additional stress on Hospital facility use, which impacts patient care, and staffing needs.

a. High Patient Census and Facility Limitations Impact Patient Unit Assignments

The Investigative Committee finds that a patient's unit placement can be based on bed availability or facility accommodations rather than on the patient's clinical need. The Hospital operates five rehabilitation inpatient units (Units E, I, S, T, and U) that generally serve the longer-term needs of patients and two acute psychiatric care units (Units F and H). Upon admission and stabilization, a patient is assigned to one of these units for treatment and rehabilitation. Except for the acute psychiatric care units and the all-male unit, the other units are not designated for any specific types of patients. Thus, each unit may accommodate a wide spectrum of patients with various clinical needs as long as there is a bed available and the unit infrastructure is able to accommodate the patient.

Upon admission to the Hospital, each patient is assigned to a treatment team comprised of a psychiatrist, psychologist, nurse, and other members who meet daily to create, review, and update, if necessary, a treatment plan for the patient.[78] The treatment team collaborates with the Unit Nurse Managers to determine which unit is the most appropriate for the patient's clinical needs according to the patient's treatment plan. However, according to Unit U Nurse Manager, Vivian Cayetano, a patient's unit assignment is more likely to be based on bed availability rather than clinical need.[79] She explained that because the Hospital is over census and beyond capacity, the Hospital is forced to move patients to other units to make room for newly admitted patients in Unit H and, if necessary, use classrooms and meeting rooms for patient rooms.[80]

The Investigative Committee finds that the Hospital's design and infrastructure also have an impact on patient unit assignments. For example, patients who are medically compromised are generally assigned to units that do not have a lot of stairs or are closer to the Treatment Mall, which is located on the lower part of the Hospital campus.[81] Furthermore, the Investigative Committee notes that Unit U is limited to only male patients. Although it accepts male patients with a wide spectrum of clinical needs, the unit tends to accommodate male patients who are charged with or convicted of sexual crimes or exhibit or have a history of inappropriate sexual behaviors.[82] Unit U has additional limitations, such as size, one community bathroom, rooms with two to four patients, and stairs, which can impact patient assignments. Lastly, the use of classroom and meeting rooms for patient rooms also has its own limitations as these rooms are not designed as patient rooms and are usually more appropriate for low risk patients.

The Investigative Committee is concerned that the evident policy for patient assignments, which is based largely on bed availability, is not in the best interests of the patient or the other patients and staff on the assigned unit, and may result in an increase in patient and staff safety risks. As a result of the high patient census, the Investigative Committee has concerns regarding the pressure a treatment team is under to find an available bed when determining a patient's unit assignment. The Investigative Committee believes that classifying and assigning patients to units based on clinical need rather than other factors, such as bed availability, will assist in ensuring appropriate unit assignments as well as patient and staff safety.

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[74] Department of Health, Accreditation Authorities, Requirements, and Cycles (LR_04_0001-0193).
[75] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[76] Id.
[77] Clark v. State of Hawaii, Stipulation for Amended Permanent Injunction, No. CV 99-00885 DAE/BMK (2003) (LR_07_0033-0040).
[78] Testimony of Vivian Cayetano, May 28, 2014.
[79] Testimony of Vivian Cayetano, May 28, 2014.
[80] Testimony of Vivian Cayetano, May 28, 2014.
[81] Testimony of Vivian Cayetano, May 28, 2014.
[82] Testimony of Vivian Cayetano, May 28, 2014.

b. Overutilization of Unit H to Serve Dual Purposes

Unit H serves as one of the two acute treatment units as well as the admission unit for all patients admitted to the Hospital.[83] Due to the limited bed availability in Unit H, the Hospital moves patients to other units before the patients are stable and ready for transfer to make room for newly admitted patients who are ordered by the court for evaluation or treatment at the Hospital.[84] The Investigative Committee is concerned that introducing unstable patients into stable patient populations before these unstable patients are clinically ready increases the safety risks for the patients and staff.

The problem of bed availability on Unit H is compounded by the number of patients admitted to the Hospital. The daily count of admitted patients is largely dependent on the Hospital's legal requirements of the Clark permanent injunction.[85] According to the Department of Health, the number of forensic admissions has increased from 2009 to 2013. Figure 3.2 illustrates the number and type of admissions and the percentage increase from 2009 to 2013 as reported by the Department of Health.

Figure 3.2
Number of Admissions from 2009 to 2013

Year	Not Guilty by Reason of Insanity	Evaluation of Fitness	Restoration of Fitness	72-Hour Hold/Conditional Release
2009	16	29	91	73
2010	8	29	96	82
2011	20	29	74	84
2012	13	60	120	89
2013	23	50	146	99
% Increase from 2009 to 2013	**44%**	**72%**	**60%**	**36%**

Source: Department of Health[86]

The number of admitted forensic patients not only increases on a yearly basis, but also fluctuates on a daily basis as the Hospital fulfills its legal requirements by admitting court ordered patients. Therefore, the Investigative Committee finds that the increase and fluctuation of admitted patients poses a challenge for the Hospital to accurately plan and prepare for the number of beds that are needed to accommodate all of its admitted patients on Unit H in addition to the acute patients being treated on Unit H thereby increasing the need to move patients to other units.

The Investigative Committee has concerns regarding Unit H serving a dual purpose as an acute psychiatric care unit and as the admissions unit for the entire Hospital. While it recognizes that space is limited at the Hospital, the Investigative Committee believes that admitted patients and acute psychiatric patients can be better served and treated separately and that designating Unit H as an admissions-only unit will assist the Hospital in increasing the number of beds available for admitted patients and decreasing the need to transfer unstable patients to stable rehabilitation units. Accordingly, Unit H staff will be able to more effectively meet the care and treatment needs of its admitted patients while decreasing the safety risks.

The Investigative Committee notes that the Hospital is accredited as an acute care facility.[87] However, in light of the forensic patient admissions and census, the Investigative Committee offers for consideration the question of whether a forensic care designation and accreditation may better serve the purposes of the Hospital.

c. Underutilization of a Feasible Option to Address the Needs of High Risk or Violent Patients

The Investigative Committee finds that the Hospital underutilizes a feasible option that would provide for the transfer of certain high risk or violent patients to another mental health facility contracted by the State for appropriate treatment and rehabilitation. The Investigative Committee notes that there are currently two high risk patients who were transferred to GEO Care, Inc.'s Columbia Regional Care Center, a forensic mental health facility in South Carolina.[88] The Hospital determined that these two patients needed to be cared for at a forensic hospital-type correctional facility that provided mental and physical health services rather than an acute psychiatric hospital-type clinical facility like the Hospital.[89] The Hospital further determined that these patients and similar patients would be better managed at a facility outside of the State that is specifically designed to better meet the needs of the patients while creating a safer environment for other Hospital patients, Hospital staff, and the transferred patient.[90] The Investigative Committee further notes that one of the patients who was transferred to the South Carolina facility had been institutionalized at the Halawa Correctional Facility after seriously assaulting a Hospital staff member.[91]

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[83] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[84] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[85] Clark v. State of Hawaii, Stipulation for Amended Permanent Injunction; Order, No. CV 99-00885 DAE/BMK (2003).
[86] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[87] Department of Health, Accreditation Authorities, Requirements, and Cycles (LR_04_0001-0193).
[88] Department of Health, Documentation Relating to the Contract with GEO Care, Inc., Columbia Regional Care Center (LR_03_071614_0001-0072).
[89] Department of Health, Documentation Relating to the Contract with GEO Care, Inc., Columbia Regional Care Center (LR_03_071614_0001-0072).
[90] Department of Health, Documentation Relating to the Contract with GEO Care, Inc., Columbia Regional Care Center (LR_03_071614_0001-0072).
[91] Department of Health, Documentation Relating to the Contract with GEO Care, Inc., Columbia Regional Care Center (LR_03_071614_0001-0072).

The Investigative Committee finds that the transfer of patients to South Carolina for treatment is a cost-effective option that would provide the appropriate level of care for the transferred patient, assist in controlling patient census, and contribute to a safer work environment. Figure 3.3 illustrates the patient cost per day for a patient hospitalized at the Hospital, Kahi Mohala (for a contracted overflow bed), and GEO Care, Inc. facility in South Carolina.

Figure 3.3
Patient Cost per Day

Location	Cost per Day
Hawaii State Hospital	**$657.97**
Kahi Mohala	**$745.00** (for up to 40 beds) **$800.00** (for acute care)
GEO Care, Inc.	**$304.00 to $425.00** (three daily rates depending on level of acuity)

Source: Department of Health[92]

The Investigative Committee notes that the Hospital realizes a cost savings of approximately $350 to $230 per day per patient to hospitalize a patient at the facility in South Carolina compared to the Hospital, thus saving the Hospital and State money.

In addition to the cost savings, the Investigative Committee notes that the number of violent assaults against Hospital patients and staff are committed by a small handful of patients. The Director of Health, Dr. Rosen, estimated that 5% of the patient population is responsible for a number of the violent assaults and poses a greater danger at the Hospital.[93] Thus, for a patient population of 200 patients, approximately 10 patients are responsible for committing a number of Hospital assaults. However, the Administrator of the Adult Mental Health Division, Dr. Fridovich, clarified that this estimation may change from month-to-month or week-to-week depending on patient progress in treatment.[94] However, the Investigative Committee believes that such estimate is too high considering the number of assaults that have occurred at the Hospital, especially when options are available to ensure that violent patients receive the appropriate and necessary level of care while ensuring workplace safety. The forensic mental health facility in South Carolina provides mental and physical health services that are more appropriate than the services that the Hospital is able to provide for such patients. Furthermore, transferring high risk or violent patients will provide a safer environment for Hospital patients and staff and assist in controlling the persistently high patient census.

Despite the apparent benefits, the Investigative Committee finds that since 2010, the Hospital has transferred only two patients to South Carolina for treatment. The Investigative Committee notes that a third patient was considered for transfer in March 2014.[95] However, Dr. Fridovich held the request for transfer because the "Hospital lacked a written policy and procedure that would govern and describe the criteria and the circumstances under which individuals should be considered for that kind of special treatment."[96] The written policies and procedures would describe the considerations that must be taken into account in reviewing a patient for potential transfer, including clinical needs and alternatives, legal status and other considerations, internal and external consultation, and relative and other social support.[97] Dr. Fridovich explained that for the other two patients who were transferred to the South Carolina facility without a written policy and procedure, these determinations were based on a case-specific review, not an occurrence involving the patient. The Associate Administrator for Clinical Services, Dr. Sheehan, further explained that the decisions to transfer the two patients were "done empirically, meaning that there were other factors that came into play on cases that resulted in the decision being made to transfer an individual to the mainland" and done with "heavy administrative evaluation, and maybe not quite as strong clinical evaluation."[98]

As a result, Dr. Fridovich recommended that a set of policies and procedures be developed and implemented before any more patients were transferred to South Carolina for treatment.[99] However, the Investigative Committee notes that Dr. Fridovich served as the Hospital Administrator when the first patient was transferred to the South Carolina facility. Thus, despite Dr. Sheehan's explanation, it is still unclear to the Investigative Committee why he held the third patient transfer request in March 2014, when Dr. Fridovich was partly responsible for transferring the first patient in 2010 when no policies and procedures to transfer patients out-of-state existed.

The Investigative Committee further notes that as of August 20, 2014, the Hospital has made effective a new policy and procedure for the assessment of patients deemed unable to be safely treated at the Hospital to be transferred to a contracted out-of-state facility.[100]

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[92] Department of Health, Patient Cost per Day at HSH, Kahi Mohala, and GEO Care, Inc. (LR_01_071614_0001, LR_02_071614_0002, and LR_03_071614_0001).
[93] Testimony of Dr. Linda Rosen, July 16, 2014.
[94] Testimony of Dr. Mark Fridovich, July 16, 2014.
[95] Testimony of Dr. Mark Fridovich, July 16, 2014.
[96] Testimony of Dr. Mark Fridovich, July 16, 2014.
[97] Testimony of Dr. Mark Fridovich, July 16, 2014.
[98] Testimony of Dr. William Sheehan, July 30, 2014.
[99] Testimony of Dr. Mark Fridovich, July 16, 2014.
[100] Department of Health, Policy and Procedure on Transferring HSH Patients to Other Facilities Outside the State (LR_02_091614_1-6).

However, the Investigative Committee contemplates how long it would take the Hospital to develop and implement these policies and procedures had it not been for the Investigative Committee's insistence that the Hospital expedite their efforts.

Dr. Rosen[101] and new Hospital Administrator, William May,[102] testified that the Hospital has a duty to care for its patients in Hawaii. However, the Investigative Committee strongly believes that the option of transferring high risk patients to the mainland is a cost-effective and feasible tool that the Hospital should have the latitude to use, especially when such patients pose a risk to themselves or others and can receive more appropriate treatment and rehabilitation that the Hospital is unable to provide. The Investigative Committee urges the Hospital to use this option when appropriate.

d. Safety Concerns Close a Psychiatric Unit

The Investigative Committee finds that the Hospital's efforts to control its high patient census and ensure a safe work environment are further hindered by the closing of the Psychiatric Intensive Care Unit (PICU). In 2011, Unit F was renovated at the cost of $530,000 to create the PICU,[103] a four-bed suite off of the main unit, as part of a plan to combine the functions of Units F and H into an Acute Services Program.[104] Under this program, the admission functions of Unit H would be divided whereby Unit F would take the light admissions and Unit H would continue to accept acute admissions, thus increasing the Hospital's admissions bed count.[105] The PICU was intended to reduce risk on the acute services units (Units F and H) by assigning high risk patients to the PICU upon admission and as needed for care, treatment, and safety.[106] This placement would prevent the introduction of unstable high risk patients into the unit populations before they are clinically ready, thereby creating a safer environment for patients and staff.[107] PICU patients would be restricted from the admission areas until they were stabilized and ready to step down to the appropriate admission unit.[108] However, the PICU was ill-designed and the structure was never ready to be properly implemented into the Hospital's operations. On December 1, 2011, a Psychiatric Technician (Psych Tech) was performing a 1:1 assignment with a patient who was admitted to the PICU.[109] The Psych Tech was attacked by the patient and received multiple unprovoked punches to the face and head, which resulted in a laceration over the Psych Tech's left eye.[110] Shortly thereafter, the PICU was closed for safety reasons and concerns raised by staff and labor union representatives.[111]

While the Investigative Committee understands the important duty for the Hospital to ensure a safe work environment, it has concerns regarding the length of time that the PICU has been closed. The PICU was intended for high risk patients, and delays in addressing the safety problems result in the Hospital being forced to combine high risk patients with other acute patients in Units F and H, which may create a higher safety risk for these units. Since the PICU's closing, it has been used only a few times for low risk patients as required by patient census[112] and not used for its intended purpose. The Investigative Committee notes that the Hospital has sent letters for consultation to HGEA and UPW[113] and therefore strongly urges the Hospital and unions to address the safety concerns to enable use of the PICU as a resource for the safe management of patients who present behavioral changes.

2. Insufficient Security to Protect Patients, Staff, and Surrounding Community

While the Investigative Committee recognizes that the Hospital's purpose is to treat and rehabilitate rather than incarcerate individuals suffering from brain, medical, and behavioral disorders, it also recognizes that the Hospital is authorized by law[114] to be a state-operated secure psychiatric rehabilitation program for individuals who require intensive therapeutic treatment and rehabilitation in a secure setting, including forensic mental health patients who are hospitalized pursuant to a court order. Accordingly, it is imperative for the Hospital to maintain a safe and secure facility. However, the Investigative Committee finds that certain areas of the Hospital's security need improvement and strengthening to ensure a safe environment for patients to receive treatment, staff to provide patient care, and the surrounding community to coexist with the Hospital.

a. Inadequate Monitoring and Operation of Security Cameras

There are over 140 security cameras throughout the entire Hospital campus, which are all monitored by one security officer stationed at the Hospital's Telecommunication Office.[115] This officer is in charge of monitoring the lower level administration area and all exterior cameras during Treatment Mall hours and all upper and lower units during non-Treatment Mall hours. Moreover, this officer is responsible for positioning and monitoring all exterior cameras during a code 77 (response code for a patient elopement, elopement attempt, or absent without leave)[116] to search for a patient, acknowledging all door alarms that become active or are left

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[101] Testimony of Dr. Rosen, July 16, 2014.
[102] Testimony of William May, July 30, 2014.
[103] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[104] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[105] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[106] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[107] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[108] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[109] Department of Health, Documentation of a Psychiatric Technician Assaulted by Patient in the PICU (LR_07_091614_1-9).
[110] Department of Health, Documentation of a Psychiatric Technician Assaulted by Patient in the PICU (LR_07_091614_1-9).
[111] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[112] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[113] Department of Health, Documents Detailing the PICU (LR_08_091614_1-41).
[114] See, §334-2.5, HRS.
[115] Department of Health, Information on the Monitoring of Closed Circuit Video at the HSH (LR_01_011514_1123-1138 – Confidential).
[116] Department of Health, Elopement, Elopement Attempt, and AWOL Policy and Procedure No. 19.520 (LR_01_020714_0067-0082 – Confidential).

open by staff or a patient, and positioning the camera to the location of a code 200 (response code to mobilize staff to an area whether there is a risk for harm by a patient toward self, others, or property)[117] to assist the response team in locating, assessing, and responding to the situation. The Investigative Committee has strong concerns regarding the assigned responsibility of monitoring over 140 security cameras to just one officer. The Investigative Committee finds that this is too large and important of a responsibility to place on only one individual because closed circuit video monitoring impacts emergency and security response times as well as efforts to prevent an emergency situation or security breach.

Furthermore, during the Investigative Committee's site visit of the Hospital in June 2014, it observed that not all of the cameras were constantly working. Hospital administrators explained that some of the cameras were off because no patients were currently in the camera's view range. The Investigative Committee does not understand this justification because it believes that all cameras should be on at all times. Furthermore, the Investigative Committee is concerned about how camera inactivity may affect emergency or security response times, especially when it was reported by Emelinda Yarte,[118] a former Hospital Psychiatric Technician who was injured by a patient in December 2009, that not all of the security cameras were operating at the time she sustained her injuries. She testified that if all of the security cameras had been working, the cameras would have been able to better capture and record the incident[119] for Hospital records. The Investigative Committee finds that ensuring that all security cameras are operating at all times better enables the Hospital to prevent or respond to emergencies as well as keep a record for the Hospital for risk management purposes.

b. Issues Regarding the Personal Mobile Transmitter (PMT) Devices

The Investigative Committee notes that there are issues regarding the PMT devices.[120] The PMT device allows a person to summon for assistance quickly without the use of a telephone when duress or a harmful situation occurs.[121] Code 200 is a response code to mobilize staff to an area whether there is a risk for harm by a patient toward self, others, or property.[122] Therefore, the PMT devices are a vital piece of safety equipment for the protection of patients and staff from harm, and all employees are required to wear their devices at all times when on duty.[123]

The Investigative Committee has serious concerns regarding an incident of an employee working at the PICU sustaining serious injuries to the head and face as a result of an unprovoked attack by a patient.[124] It is reported that this employee's PMT device failed to work properly and thus, the response time for staff to render aid was delayed. Furthermore, there are reports that the PMTs fail to transmit the correct location of the code 200, thereby affecting emergency response times, or failure of staff to use the PMT during a code 200.[125] Lastly, in March 2013, HIOSH issued a citation with a penalty of $1,200 to the Hospital for violating §12-60-2(a)(3), Hawaii Administrative Rules, due to the lack of management accountability to ensure that each and every employee checks his or her PMT weekly to make sure that it is in working and functional condition.[126] The Investigative Committee strongly urges the Hospital to immediately address any issues with the PMTs, including upgrading the technology if necessary.

c. Insufficient Fencing Around the Hospital Campus

During the Investigative Committee's site visit of the Hospital in June 2014, it observed that only units F and H and the State Operated Specialized Residential Program, commonly referred to as the cottages, were fenced, but the other units as well as the Treatment Mall that accommodate patients did not have fenced enclosures. While the Investigative Committee recognizes that the Hospital is not a correctional facility, it is concerned about the absence of fencing around the perimeter of the Hospital campus. The Hospital's patient census is predominately comprised of mental health forensic patients, some of whom have been acquitted of crimes by reason of insanity,[127] or are admitted for mental health evaluations, or pursuant to the Clark permanent injunction.[128] As such, some of these patients may pose a risk to the community surrounding the Hospital, especially students and staff at the Windward Community College, which is located adjacent to the Hospital. The Investigative Committee believes that the Hospital administrators should explore options and funding mechanisms to install fencing around the perimeter of the Hospital campus to ensure safety for the surrounding community.

d. Lack of Procedures to Notify the Police and Alert the Public of a Patient Elopement

Although the Department of Health reports that the number of patient elopements from the Hospital has decreased from 2010 to 2013 due to its improved policies and procedures and staff diligence,[129] the Investigative Committee is concerned that the Hospital lacks specific procedures to notify the police and alert the public when a patient escapes or elopes from the Hospital. The Hospital defines elopements as an event for any length of time in which a patient leaves the facility grounds or leaves from a community outing without authorization and without notifying the staff of an intention to do so.[130]

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[117] Department of Health, Code 200 and Backup Calls Policy and Procedure No. 09.030 (LR_01_121013_0028-0037 – Confidential).
[118] Testimony of Emelinda Yarte, May 14, 2014.
[119] Testimony of Emelinda Yarte, May 14, 2014.
[120] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[121] Department of Health, Code 200 and Backup Calls Policy and Procedure No. 09.030 (LR_01_121013_0028-0037 – Confidential).
[122] Department of Health, Code 200 and Backup Calls Policy and Procedure No. 09.030 (LR_01_121013_0028-0037 – Confidential).
[123] Department of Health, Duress/Security Escort System Policy and Procedure No. 12.300 (LR_01_121013_0038-0045 – Confidential).
[124] Department of Health, Documentation of a Psychiatric Technician Assaulted by Patient in the PICU (LR_07_091614_1-9).
[125] Department of Health, Hospital Executive Meeting Minutes (LR_28_0622-0626).
[126] Department of Health, Documents Related to HIOSH Inspection No. 316267160 (LR_20_0001-0010 – Confidential).
[127] See, §704-411(1)(a), HRS.
[128] Clark v. State of Hawaii, Stipulation for Amended Permanent Injunction; Order, No. CV 99-00885 DAE/BMK (2003).
[129] Department of Health, Data on the Number of Elopements Over the Years (LR_01_020714_0065-0066 - Confidential).
[130] Department of Health, Elopement, Elopement Attempt, and AWOL Policy and Procedure No. 19.520 (LR_01_020714_0068-0082 - Confidential).

The Investigative Committee finds that the Hospital's improved policies and procedures fail to prescribe who is responsible for giving notice and when the police should be notified of a patient elopement from the Hospital. The established procedures for patient elopements from the Hospital only indicate that the police should be notified or 911 be called when a patient is agitated and refusing verbal redirection by staff to return to the Hospital.[131] The external notification procedures include calling the police with procedures for the Nursing Supervisor to provide information to the responding police officer,[132] but do not indicate when the police should be called. While the Investigative Committee notes that patient elopements may only be for a short time, it believes that the police could further assist the Hospital's search efforts thereby reducing the amount of time that a patient is away from the Hospital grounds.

While there are procedures to notify Hospital administrators, patient family or significant others, case management workers, and social workers, there are no procedures to notify or alert the public, especially the students and staff at Windward Community College, of a patient elopement from the Hospital. The Windward Community College campus is adjacent to the Hospital campus with only a private road separating the two properties. Without a fence around the perimeter of the Hospital campus, it is possible for a Hospital patient to wander onto campus; if the patient is gone from the Hospital long enough, the patient may be able to wander into the surrounding community, including the residential neighborhoods and public park. In light of the Hospital's forensic mental health patient census, the Investigative Committee believes that the Hospital has an absolute responsibility and duty of care to the surrounding community in addition to its patients and staff. Accordingly, the Hospital should develop and implement procedures to notify the public, especially Windward Community College, of a patient elopement to expedite the search efforts and ensure community safety.

C. CHALLENGES IN PROVIDING EFFICIENT AND EFFECTIVE HUMAN RESOURCES PRACTICES

S.R. No. 3 requested the Investigative Committee to investigate allegations of Hospital administrative and employment improprieties. The Investigative Committee finds that alleged improprieties, including favoritism, nepotism, and conflicts of interest, stem from inefficient and ineffective human resources practices.

Human resources has been a persistent challenge for the Hospital. One of the areas of concern that the Hospital needed to address under the 1991 federal settlement agreement and subsequent related stipulated orders and remedial plans was the employment and deployment of additional staff.

In 2012, the Governor's Special Action Team found that the existing allocation of human resources impedes maximal efficient use and that there are persistent staff vacancies that increase overtime costs and compromise the accomplishments of the Hospital's programmatic goals.[133]

Despite federal and state intervention, the Hospital continues to face challenges in filling vacant positions, obtaining additional staff in the most cost-effective manner, and maintaining employee morale. The Investigative Committee finds that the Hospital's inefficient and ineffective human resources practices result in inefficiencies and high personnel costs. The Investigative Committee further finds that the lack of leadership in managing and ensuring fair and transparent Hospital human resources practices contributes to low employee morale, erodes employees' trust of and confidence in Hospital administrators and supervisors, and causes employees to fear retaliation by Hospital administrators and supervisors.

1. Inefficient Hiring Practices Contribute to Persistent Vacancies

The Hospital has an overall vacancy rate of 12%,[134] which is approximately 60 direct and non-direct care positions.[135] The vacancy rate is 8% for direct care positions.[136] Direct care positions are those directly assigned to patient units while support positions are commonly referred to as non-direct care positions. According to the Former Acting Hospital Administrator, William Elliott, the Hospital has the authorization to fill these vacant positions and is constantly in the process of hiring staff.[137] Persistent vacant positions incur greater personnel expenses for overtime or temporary employee agency staffing and lead to concerns regarding patient care. Accordingly, it is vital for the Hospital to strengthen its ability to recruit staff. However, the Investigative Committee finds that the Hospital lacks efficient hiring processes and procedures to ensure that vacancies are filled in an expeditious and fair manner.

a. Inefficient Recruitment and Hiring Process

Mr. Elliott testified that a study conducted years ago found that it took the State approximately 66 working days, approximately over three months, to fill a vacant position.[138] The hiring process at the Hospital currently takes longer than 66 working days. The Investigative Committee finds that one of the reasons the Hospital is unable to fill its vacant positions is due to an inefficient recruitment and hiring process, which requires numerous steps before applicants are hired. Figure 3.4 illustrates the multiple steps required to fill a vacant position. The Investigative Committee notes that Figure 3.4 highlights the main steps in the process and does not indicate any separate steps specific to a civil service, non-civil service, or exempt position.

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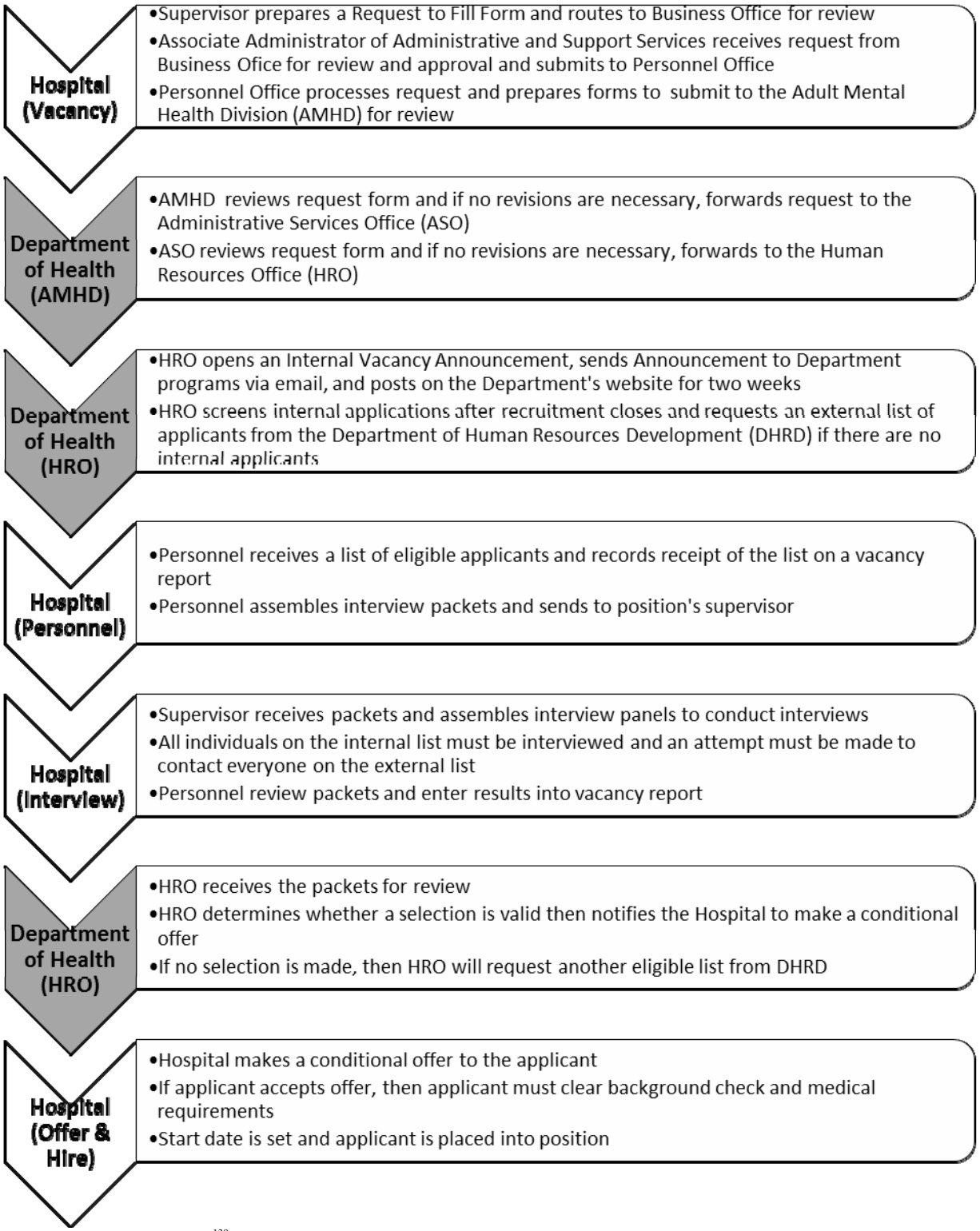
[131] Department of Health, Elopement, Elopement Attempt, and AWOL Policy and Procedure No. 19.520 (LR_01_020714_0068-0082 - Confidential).
[132] Department of Health, Elopement, Elopement Attempt, and AWOL Policy and Procedure No. 19.520 (LR_01_020714_0068-0082 - Confidential).
[133] Department of Health, *Special Action Team Report to the Governor on Revitalization of the Adult Mental Health System and Effective Management of the Hawaii Hospital Census* (October 2012).
[134] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[135] Testimony of William Elliott, April 9, 2014.
[136] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[137] Testimony of William Elliott, April 9, 2014.
[138] Testimony of William Elliott, April 9, 2014.

Figure 3.4
Simplified Hiring Process to Fill a Hospital Vacant Position



Source: Department of Health[139]

[139] Based on the material submitted by the Department of Health of a flowchart indicating the hiring process, hiring authority, and locations of each point of the hiring process (LR_12_0001-0012 and LR_13_0001-0012).

Under Figure 3.4, a request to fill a vacant position goes through five different individuals or offices at the Hospital or the Department of Health for review and approval before a vacancy announcement is posted and a list of eligible candidates to fill the position is created. Once a list of candidates is established, the interview process needs to be completed and approval from the Department of Health's Human Resources Office must be given before the Hospital is able to make a conditional offer to an applicant. The Investigative Committee notes that delays can happen at each of the multiple steps in the recruiting and hiring process that can result in further delays in recruiting and hiring Hospital staff. While the Hospital may view this process as a method to ensure that employees are carefully vetted and selected for a position, the Investigative Committee finds that the existing recruiting and hiring process can be streamlined without compromising integrity and fairness.

Despite this inefficient process, the Investigative Committee could not determine if anything has been done to improve the recruitment and hiring process. In 2012, the Governor's Special Action Team[140] recommended that the Department of Health's Human Resources Office and Administrative Services Office, Department of Human Resources Development, and others work together to prioritize recruitment and obtain administrative approval for positions that may impact the patient census and provide diversion services. The Special Action Team also recommended that the Department of Health assist the Department of Human Resources Development in screening Hospital applications. However, Mr. Elliott informed the Investigative Committee that these recommendations did not produce any additional Hospital employees.[141] Figure 3.5 indicates the number of hires the Hospital made in 2013.

Figure 3.5
Hiring of Direct Care Positions in 2013

	Licensed Practical Nurse (LPN)	Para Medical Assistant (PMA)	Psychiatric Technician (PT)	Registered Nurse (RN)
Eligible	35	455	98	148
Interviewed	5	96	65	52
Hired	0	5	6	8
Separated	1	4	14	5

Source: Department of Health[142]

The number of hires in 2013 had a minimal impact on the Hospital's vacancy rate. Accordingly, the Investigative Committee strongly believes that the Hospital Administration must make a stronger effort to improve and streamline the recruitment and hiring process.

The Investigative Committee further finds that the inefficient recruiting and hiring process creates opportunities for individuals to obtain employment at the Hospital through temporary employment agencies thereby bypassing the established hiring process. The Hospital has 13-week contracts for additional staff from private sector temporary employment agencies to meet its appropriate staffing needs. The Director of Nursing, Leona Guest,[143] and Associate Chief Nurse, Emma Evans,[144] testified that, on behalf of the Hospital, they have provided referrals to these temporary employment agencies for these referred individuals to work at the Hospital. As a result, individuals who are referred by the Hospital are provided 13-week contracts to work at the Hospital without engaging in the Hospital's formal recruitment and hiring process.

Although the Investigative Committee recognizes the need for agency workers to meet staffing demands, it is concerned that contracts with agency workers with referrals from the Hospital can create the appearance of favoritism and have a negative impact on employee morale, especially when such individuals are relatives or friends of Hospital administrators or supervisors or are individuals who were not previously hired by the Hospital for a permanent position through the formal hiring process. Ms. Guest testified that she would have discouraged her daughter from working at the hospital via a temporary employment agency if she knew that this referral would cause staff to make allegations of favoritism.[145]

Furthermore, the Investigative Committee finds that the formal recruitment and hiring process allows temporary employment agency workers to have an advantage in obtaining a permanent position at the Hospital. The Department of Health engages in an internal recruitment process, and agency staff have access to these vacancy postings.[146] In addition, since these agency workers receive training while performing their 13-week contracts, they gain Hospital work experience.[147] As a result, agency workers have an advantage over any eligible candidates without work experience at the Hospital.

While the Investigative Committee recognizes that agency workers still need to be interviewed and approved for hire, it is concerned that the hiring of certain agency workers for a permanent position at the Hospital may create the appearance of favoritism, especially if those agency workers were not previously hired for a Hospital permanent position or their names are repeatedly given to the temporary employment agencies to work at the Hospital on a 13-week contract. This can exacerbate low employee morale.

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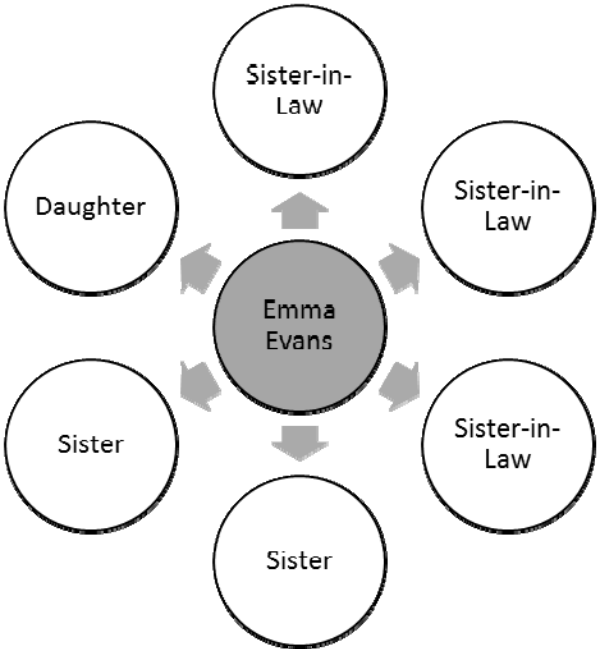
[140] Department of Health, *Special Action Team Report to the Governor on Revitalization of the Adult Mental Health System and Effective Management of the Hawaii Hospital Census* (October 2012).
[141] Testimony of William Elliott, April 9, 2014.
[142] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[143] Testimony of Leona Guest, June 18, 2014.
[144] Testimony of Emma Evans, April 30, 2014.
[145] Testimony of Leona Guest, June 18, 2014.
[146] Testimony of Emma Evans, April 30, 2014.
[147] Testimony of Emma Evans, April 30, 2014.

b. Lack of Internal Policies to Ensure a Fair Hiring Process

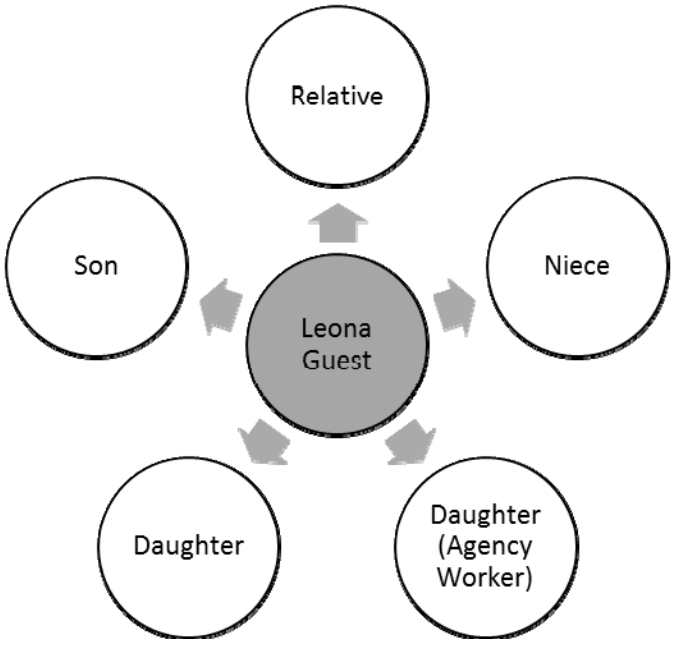
The Investigative Committee finds that there are a number of employees who are related to each other because there are no internal policies regarding the hiring of relatives of employees at the Hospital. Figures 3.6 and 3.7 illustrate the number of Hospital employees or agency workers related to the Associate Chief Nurse and Director of Nursing.

Figure 3.6
Relatives of the Associate Chief Nurse Employed at the Hospital



Source: Department of Health[148] and Emma Evans[149]

Figure 3.7
Relatives of the Director of Nursing Employed at the Hospital



Source: Department of Health[150]

[148] Department of Health, Chart Identifying Staff Members who are Related to Each Other (LR_33_0001-0007 – Confidential)
[149] Testimony of Emma Evans, April 30, 2014.
[150] Department of Health, Chart Identifying Staff Members who are Related to Each Other (LR_33_0001-0007 – Confidential)

There are a number of employees, like Ms. Evans and Ms. Guest, who have more than one relative working at the Hospital. However, the Investigative Committee notes that Ms. Evans and Ms. Guest are Hospital administrators with five or more relatives working at the Hospital, which calls into question the appropriateness and necessity of having that many related individuals on the Hospital payroll. The Investigative Committee recognizes that employing relatives on staff may not affect work performance and notes that nepotism is not a violation of state law or the State's Code of Ethics. However, without internal policies regarding the employment of relatives on staff, the Investigative Committee finds that employing relatives on staff leads to allegations of favoritism and negatively impacts employee morale, which can, in turn, impact work performance.

Furthermore, the Investigative Committee is concerned about the lack of procedures to ensure that the interview process is free from conflicts of interest or even the appearance of conflicts of interest. Mr. Elliott testified that he would expect staff members to recuse themselves from participating on panels that will be interviewing applicants related to them.[151] However, there are no internal policies or procedures to ensure that staff do not participate in interviewing their relatives and, as a result, it is possible that a relative of an applicant could serve on that applicant's interview panel.

The Investigative Committee is also deeply concerned about the number of supervisors or administrators who have relatives on staff at the Hospital and how their positions may influence the interview panel's recommendation for hire. For example, Ms. Evans, who is the Associate Chief Nurse in charge of the Nursing Office, testified that she notified certain individuals who served on an applicant's interview panel that she was related to the applicant.[152] Since Ms. Evans serves in an administrative position, the Investigative Committee is concerned that her actions could be considered as using or attempting to use her official position to secure or grant unwarranted advantages or treatment for herself or others, which is a violation of the State's Code of Ethics.[153] Without effective mechanisms in place to prevent favoritism, conflicts of interest, and undue influence or the appearance thereof, the integrity and fairness of the existing hiring process is compromised.

2. Lack of Control of Overtime and Sick Leave Costs the State Money

The Hospital uses the Johnson Behavioral Model[154] as the established methodology to assess a patient's clinical need (e.g., assess whether a patient requires a wheelchair or identify any challenging behaviors of the patient) and identify appropriate nurse staffing ratios to provide appropriate care for patients. In June 2013,[155] the Hospital adjusted its nurse staffing matrix to include the number of patients located in any patient care area due to the Hospital's growing patient census. As a result, the nurse staffing levels of each unit are adjusted daily, and the assistance of additional nurse staff is routinely requested to meet each patient's care needs and the number of patients of each unit. Additional nurse staff may be obtained from Hospital nurse staff working overtime shifts in addition to their regularly scheduled shifts or through contracted workers from temporary employee service agencies.

Each Unit Nurse Manager is responsible for contacting a Nursing Shift Supervisor in the Nursing Office to provide a number of any additional staff that is needed for each shift to achieve the appropriate nurse staffing ratios for their respective units.[156] The scheduling clerks in the Nursing Office maintain the shift schedules of the nurse staff[157] and are responsible for contacting and obtaining any additional staff to fill shifts that are open due to nurse staff who are out on sick leave or vacation or shifts that are necessary to meet the nurse staffing matrix for a particular unit.[158]

Overtime shifts are generally assigned on a rotating basis.[159] Other factors affecting the assignment of overtime include unit assignments, terms in collective bargaining agreements, and whether the nurse staff is employed by the State or under contract with the temporary employee service agency.[160] This system of assigning and using overtime is intended to be fair and in accordance with terms of collective bargaining. However, the Investigative Committee finds that the Hospital lacks mechanisms to monitor and control the use of overtime and sick leave benefits, which results in inefficiencies in assigning overtime and high personnel overtime costs for the State; contributes to low employee morale; and raises concerns regarding the quality of care received by the patients.

a. Lack of a Standardized System to Assign Overtime

The Investigative Committee finds that the procedures in assigning overtime are not standardized. Debra Ono, a scheduling clerk at the Hospital, testified that when assigning overtime shifts to nurse staff, she refers to the master schedule to determine who is available according to the rotating system, creates a list of names of available staff, then proceeds to call these staff members until she is able to fill all open shift slots.[161] She explained that she assigns overtime shifts according to the instructions and training she received by her coworkers because a written standardized procedures manual does not exist.[162] As a result, Ms. Ono testified that each of the six scheduling clerks who work at the Nursing Office assigns overtime shifts differently depending on the training received from coworkers.[163] Although the Director of Nursing, Leona Guest,[164] and Associate Chief Nurse, Emma Evans,[165] testified that written

[151] Testimony of William Elliott, April 9, 2014.
[152] Testimony of Emma Evans, April 30, 2014.
[153] See, §84-13, HRS.
[154] PowerPoint materials submitted by the Department of Health to the Senate Committees on Health and Judiciary and Labor for the Informational Briefing on January 7, 2014 (LR_01_0033-0061).
[155] Response dated January 15, 2014 from Department of Health to the Investigative Committee to the written questions and request for information (LR_01_011514_0049-0052 - Confidential).
[156] Testimony of William Elliott, April 9, 2014.
[157] Position Descriptions for Office Assistant III (Scheduling Clerks) (MAF_043014_07_0002-0026).
[158] Testimony of Debra Ono, May 14, 2014.
[159] Testimony of Leona Guest, June 18, 2014.
[160] Testimony of Debra Ono, May 14, 2014; Testimony of Leona Gust, June 18, 2014; and Testimony of William Elliott, June 18, 2014.
[161] Testimony of Debra Ono, May 14, 2014.
[162] Testimony of Debra Ono, May 14, 2014.
[163] Testimony of Debra Ono, May 14, 2014.
[164] Testimony of Leona Guest, June 18, 2014.

procedures for assigning overtime are part of the Nursing Office's standard operating procedures, the Investigative Committee believes that these standard operating procedures are not being widely and consistently implemented by the scheduling clerks in the Nursing Office.

The Investigative Committee finds that the absence of a standardized system to assign overtime shifts increases the risk of assignment discrepancies and may result in certain staff receiving more overtime shifts than others or overtime shifts that appear out of rotation. As a result, staff may file complaints that they were bypassed for an overtime shift opportunity. If a discrepancy is found, the Hospital routinely responds by providing the staff member two opportunities for overtime the next time the employee's name is next on the rotation.[166] However, overtime shift assignment discrepancies or complaints are compounded by the appearance of favoritism. Ms. Evans testified that there is a perception among staff that the Nursing Office has favorites when assigning overtime.[167] While assignment discrepancies, if any, may be cured by providing an employee with two additional opportunities for overtime, the Investigative Committee finds that the appearance or perception of favoritism is not as easily resolved and has long-term effects on nurse staff morale. Therefore, it is incumbent on the Hospital to implement a standardized system for assigning overtime so that the process is fair and transparent.

The Investigative Committee notes that former Acting Hospital Administrator, William Elliott, testified in April 2014, that for the past nine months, the Hospital was in the process of procuring a computer scheduling system to assist with assigning overtime shifts and controlling favoritism.[168] Named Kronos, the scheduling system is expected to align with collective bargaining requirements, adhere to Hospital policies and procedures, and meet staffing demands and scheduled changes to quickly identify qualified substitutes, automatically notify them, and fill the shift opening.[169] The Investigative Committee believes that this computerized scheduling system will increase efficiency and assist in minimizing the perception of favoritism. The Investigative Committee urges the Hospital to expedite its plans to install the Kronos system.

b. No Limits on the Number of Overtime Shifts an Employee May Perform

Overtime is considered a necessary measure to meet appropriate nurse staffing ratios for each unit at the Hospital. However, the Investigative Committee finds that there are a number of employees who have performed amounts of overtime hours that significantly exceed a regular 40-hour work week because there are no limits to the number of overtime shifts an employee may perform. Figure 3.8 indicates the combined total number of overtime hours and amounts of the top six overtime Hospital employee earners.

Figure 3.8
Combined Totals of the Top Six Overtime Earners for FY2013 and 2014

FY2014 (Up to January 31, 2014)	
Total Overtime Hours	**Total Overtime Amounts**
4,475.50	$159,977.56

FY2013	
Total Overtime Hours	**Total Overtime Amounts**
7,396.80	$202,837.56

Source: Department of Health[170]

Permitting staff to accumulate indefinite amounts of overtime has a fiscal impact on the Hospital as well as the State. The Hospital's personnel budget is approximately $35 million per year with an additional $3 million for overtime costs.[171] For FY2013, the combined total overtime costs for the six top overtime earners illustrated in Figure 3.8 was approximately 6.7% of the Hospital's $3 million overtime budget. Unlimited overtime shifts creates difficulties for the Hospital to accurately budget personnel costs, especially when the Hospital patient census regularly exceeds the budgeted census of 168 patients.

Overtime pay is calculated at 1.5 times the employee's base rate pay.[172] This creates a short-term financial incentive for staff to work overtime shifts because employees are able to supplement their base salaries. Under Figure 3.8, the six top overtime earners for FY2013 averaged an approximate 64-hour work week, which is approximately 24 hours in addition to their 40-hour regularly scheduled paid work week.[173] Thus, some employees who accumulate significant amounts of overtime hours are able to double their salary income with overtime pay. Furthermore, accumulating overtime pay has a long-term effect if the employee was hired by the State prior to July 1, 2012, because overtime pay is factored into the employee's retirement pension.[174] Thus, the Investigative Committee finds that overtime costs result in higher costs for the State, and the Hospital needs to implement mechanisms to control its overtime costs while still meeting its staffing demands.

Furthermore, the Investigative Committee is concerned with how unlimited amounts of overtime performed by staff, especially back-to-back shifts, affect the standards of patient care, Hospital safety, and work performance. During a 12-month period from 2013

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[165] Testimony of Emma Evans, April 30, 2014.
[166] Testimony of Leona Guest, June 18, 2014.
[167] Testimony of Emma Evans, April 30, 2014.
[168] Testimony of William Elliott, April 9, 2014.
[169] Response dated February 7, 2014 from the Department of Health to the Investigative Committee to the written questions and request for information (LR_01_020714_0001-0005 - Confidential).
[170] Department of Health, HSH – Top Six Overtime Hours (LR_25_0001 – Confidential).
[171] Testimony of William Elliott, June 18, 2014.
[172] Testimony of William Elliott, June 18, 2014.
[173] Calculations based on figures submitted by the Department of Health, HSH – Top Six Overtime Hours (LR_25_0001 – Confidential).
[174] Overtime is included in retirement compensation pursuant to §88-21.5(a), HRS, if the member became a member before July 1, 2012.

to 2014, the Hospital reported 173 employees who worked 16-hour shifts or longer.[175] The Director of Nursing, Leona Guest, testified that the Hospital does not have data to indicate whether there is a correlation between overtime and work performance.[176] Regardless of the lack of data, the Investigative Committee believes that stronger policies should be developed and implemented to control the amount of overtime that each employee may perform to maintain work performance and patient care standards.

The Department of Health's Deputy Director of Behavioral Health Administration, Lynn Fallin, testified that the Hospital has recently implemented a "wellness cap" that limits employees to 350 overtime hours per fiscal quarter.[177] However, the Investigative Committee finds that this "wellness cap" fails to adequately control the amounts of overtime an employee is allowed to accumulate. A cap of 350 hours per fiscal quarter means that an employee could accumulate up to 1,400 hours of overtime per fiscal year. If this "wellness cap" was applied to the list of the top six highest overtime earners for FY2013,[178] only the top two employees on that list would be affected by this cap. Thus, the Investigative Committee does not believe that this "limitation" substantially impacts or controls the amount of overtime, saves the Hospital and State money, or promotes wellness among staff.

c. Opportunities for Employees to Abuse Sick Leave and Overtime Benefits

Overtime shifts become available when the nurse staffing ratios require additional staff to care for a high patient census, meet the clinical needs of patients, or fill in for employees who are on sick leave or vacation. As state employees, each employee earns 14 hours of paid sick leave per month that can be accumulated. Furthermore, employees who are civil servants or included in collective bargaining will earn overtime compensation for shifts in which those employees are not scheduled to work.[179]

The Investigative Committee finds that the financial incentives of overtime combined with the employee benefits of paid sick leave creates an opportunity for employees to abuse these benefits for financial gain. When the Investigative Committee asked Ms. Guest whether she felt that the overtime system is being abused, she answered, "Yes, absolutely."[180] However, the Hospital has done little to control the risks of overtime and sick leave abuse.

Figures 3.9 to 3.11 illustrate different ways employees could combine the use of their overtime and paid sick leave benefits to earn more compensation and, in some instances, work less than a 40-hour work week. These scenarios are based on examples provided and observations made by Ms. Ono[181] and are not intended to implicate or represent an actual employee. Please note that "Reg. Shift" means a regular scheduled shift and "OT Shift" means an overtime shift.

Figure 3.9
Employee A Using a Combination of Overtime and Sick Leave

Employee A's Regular Work Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DAY OFF	REG. SHIFT	REG. SHIFT	REG. SHIFT	DAY OFF	REG. SHIFT	REG. SHIFT

Employee A's Amended Work Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
OT SHIFT	REG. SHIFT	SICK LEAVE	SICK LEAVE	OT SHIFT	REG. SHIFT	REG. SHIFT

Note: Days shaded gray indicate days Employee A is not present at work.

In the scenario illustrated in Figure 3.9, Employee A's regular work schedule is a 40-hour work week with two days off. If Employee A takes sick leave benefits during two regularly scheduled shifts and works overtime shifts during two regularly scheduled days off, Employee A will still perform a 40-hour work week, but be compensated more due to the two overtime shifts performed that week.

[175] Calculations based on list submitted by the Department of Health regarding employees working 16-hour shifts or longer over the last 12-months (LR_05_061814_0001-0004).
[176] Testimony of Leona Guest, June 18, 2014.
[177] Testimony of Lynn Fallin, March 27, 2014.
[178] Department of Health, HSH – Top Six Overtime Hours (LR_25_0001 – Confidential).
[179] Testimony of Debra Ono, May 14, 2014.
[180] Testimony of Leona Guest, June 18, 2014.
[181] Testimony of Debra Ono, May 14, 2014.

Figure 3.10
Employee B Using a Combination of Overtime and Sick Leave

Employee B's Regular Work Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
DAY OFF	REG. SHIFT	REG. SHIFT	REG. SHIFT	DAY OFF	REG. SHIFT	REG. SHIFT

Employee B's Amended Work Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
OT SHIFT	SICK LEAVE	SICK LEAVE	SICK LEAVE	OT SHIFT	SICK LEAVE	SICK LEAVE

Note: Days shaded gray indicate days Employee B is not present at work.

In the scenario illustrated in Figure 3.10, Employee B's regular work schedule is a 40-hour work week with two days off. If Employee B takes sick leave benefits during the five regularly scheduled shifts and works overtime shifts during the two regularly scheduled days off, Employee B will perform a 16-hour work week and be compensated for the five days of sick leave and two days of overtime. Thus, Employee B will receive greater compensation for working significantly fewer hours than Employee B's regular work schedule.

The Investigative Committee notes that an employee is required to submit a note from the employee's doctor for five or more consecutive days of paid sick leave, but is allowed to take five or more nonconsecutive days of paid sick leave or four or fewer consecutive days of paid sick leave as long as the employee has accumulated enough paid sick leave hours.[182] In the scenario illustrated in Figure 3.10, a doctor's note is not required because Employee B's five total days of paid sick leave are composed of three consecutive days and two consecutive days with an overtime shift between the two periods of sick leave. The Investigative Committee further notes that Employee B's five days of paid sick leave create five additional opportunities for other employees to perform an overtime shift if these employees are eligible and available.

Figure 3.11
Employee C Cooperating with Employee D to Use Employee D's Sick Leave for an Overtime Shift

Regular Work Schedule		
Shift	**Employee C**	**Employee D**
7A | 3P	OFF	OFF
3P | 11P	REG. SHIFT	OFF
11P | 7A	OFF	REG. SHIFT

Amended Work Schedule		
Shift	**Employee C**	**Employee D**
7A | 3P	OFF	OFF
3P | 11P	REG. SHIFT	OFF
11P | 7A	OT SHIFT	SICK LEAVE

Note: Shifts shaded gray indicate shifts for which Employee C or D are not scheduled.

In the scenario illustrated in Figure 3.11, Employee C is scheduled to work the evening shift from 3:00 to 11:00 p.m. and Employee D is scheduled to work the night shift from 11:00 p.m. to 7:00 a.m. Employees C and D could cooperate so that Employee D calls the Nursing Office to take sick leave for the night shift. Shortly thereafter, Employee C could notify the Nursing Office of Employee C's availability to work the night shift for which Employee D has taken sick leave, after Employee C's regular scheduled evening shift. As a result, Employee C gains an overtime shift while Employee D is compensated for a shift due to paid sick leave benefits. The Investigative Committee notes that this scenario is only possible if Employee C is in the front of the rotation. However, Ms. Ono testified that she notices this type of concerted effort about two to three times per week and that there are some employees who coincidently appear to gain overtime shifts similar to this scenario.[183]

Although the Investigative Committee recognizes that overtime and paid sick leave benefits are granted to the employees and negotiated for in their collective bargaining agreements, it believes that better mechanisms need to be implemented to control or reduce the risk of some employees taking advantage of their overtime and sick leave benefits for their own financial gain. Over time, such abuse has a financial impact to the Hospital's personnel budget and adds to the Hospital's challenges in acquiring sufficient staff to care for and meet the clinical needs of patients.

[182] Testimony of Debra Ono, May 14, 2014.
[183] Testimony of Debra Ono, May 14, 2014.

d. Collective Bargaining Agreements Impact Overtime Benefits

The Investigative Committee finds that collective bargaining impacts the Hospital's ability to limit or control overtime. In 1996, the Hospital was ordered by the federal court to "adopt and implement a policy that no [Hospital] employee works voluntary overtime on consecutive days and that limits the number of voluntary overtime shifts for each employee to a maximum of three shifts per week."[184] However, this order limiting overtime was evidently not implemented due to state collective bargaining laws.[185] The Investigative Committee is concerned with and interested in the reconciliation of the federal court order and collective bargaining agreements.

According to the Department of the Attorney General, changes in overtime opportunities afforded to public sector employees in Hawaii are generally subject to mutual consent absent a judicial decree specifically suspending collective bargaining.[186] The order directing the Hospital to implement an overtime policy did not contain a clause specifically suspending any aspect of the relative collective bargaining agreements.[187] Therefore, the Department concluded that the affected public employee unions would take the position that the proposed overtime policy modifications under the order constituted material changes to hours, wages, and condition of work set forth in their collective bargaining agreements and that mutual consent was necessary to implement these overtime policies.[188] The Hospital was not successful in obtaining consent from the United Public Workers union and accordingly, the overtime policies prescribed under the order were not implemented.[189]

While the Investigative Committee notes the conclusions submitted by the Department of the Attorney General, it believes that this conclusion only applies to the 1996 order and should not apply to or prevent the implementation of any subsequent efforts by the Hospital to control overtime. Instead, the Hospital should consult and cooperate with the respective unions to develop and implement a solution that will decrease personnel costs and follow collective bargaining laws and agreements.

The Investigative Committee further notes that in August 2014, the City and County of Honolulu and the United Public Workers union reached an agreement that allows paramedics and emergency medical technicians to work longer shifts, but shorter weeks.[190] This agreement is expected to reduce the amount of overtime of emergency medical service workers, save the City and County of Honolulu approximately $1.5 million annually in overtime, and maintain safe worker performance standards.[191] Accordingly, the Hospital should make similar efforts to reach an agreement with the unions.

Furthermore, the Investigative Committee finds that collective bargaining affects the overtime assignments. In addition to the rotation, overtime assignments are affected by whether a nurse staff member is a civil servant or under contract with a private sector temporary employee service agency.[192] Civil servants are first offered overtime opportunities.[193] When the list of eligible and available civil servants is exhausted, the Hospital then offers these shifts to private sector temporary employee agency workers.[194]

Mr. Elliott explained that this practice is based on the Konno decision.[195] [196] In Konno, the Hawaii Supreme Court noted that "the civil service, as defined by [§76-77, HRS], encompasses those services that have been customarily and historically provided by civil servants"[197] and absent express legislative authority to obtain services from other sources, civil servants must provide these services. Since the Hospital provides services that are customarily and historically provided by civil servants, overtime opportunities must first be offered to civil servants before private sector agency employees.

However, the Investigative Committee finds that the system of assigning overtime shifts to civil servants before agency workers can result in higher personnel costs for the Hospital. During the Investigative Committee's site visit to the Hospital in June 2014, it observed a Registered Nurse (RN) serving as a Psychiatric Technician (Psych Tech) for an overtime shift. Assuming that this RN's base pay is higher than a Psych Tech's base pay the RN is filling in for, the overtime costs for the RN are greater than having an agency worker serve as a Psych Tech for that overtime shift. The Investigative Committee is concerned that this priority system for assigning overtime creates a greater opportunity for civil servants with higher salaries to take advantage of the overtime system for financial gain. This is neither cost effective nor fair, especially when service contracts with private providers can enable the Hospital to obtain necessary additional staff and reduce personnel costs.

The Investigative Committee notes legislation proposed by the Department of the Attorney General[198] to provide state institutions with 24 hours a day, seven days a week staffing responsibilities greater flexibility to effectively deal with staffing shortages, excessive use of overtime by civil service staff, and consequent health and safety issues arising therefrom by specifically allowing these state

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[184] United States v. State of Hawaii, et al., Stipulation and Order, Civil No. 91-00137 DAE (1996) (LR_07_0154-0167).
[185] Testimony of Lynn Fallin, March 27, 2014.
[186] Letter to Linda Rosen, Director of Health from James Halvorson, Deputy Attorney General of the Department of the Attorney General Employment Division, dated April 8, 2014 (LR_040914_0001-0003).
[187] Letter to Linda Rosen, Director of Health from James Halvorson, Deputy Attorney General of the Department of the Attorney General Employment Division, dated April 8, 2014 (LR_040914_0001-0003).
[188] Letter to Linda Rosen, Director of Health from James Halvorson, Deputy Attorney General of the Department of the Attorney General Employment Division, dated April 8, 2014 (LR_040914_0001-0003).
[189] Letter to Linda Rosen, Director of Health from James Halvorson, Deputy Attorney General of the Department of the Attorney General Employment Division, dated April 8, 2014 (LR_040914_0001-0003).
[190] Gordon Y.K. Pang, *Agreement reached on 12-hour shifts for paramedics, EMTs*, Star-Advertiser (August 11, 2014).
[191] Gordon Y.K. Pang, *Agreement reached on 12-hour shifts for paramedics, EMTs*, Star-Advertiser (August 11, 2014).
[192] Testimony of Debra Ono, May 14, 2014; Testimony of Leona Guest, June 18, 2014; and Testimony of William Elliott, June 18, 2014.
[193] Testimony of Leona Guest and William Elliott, June 18, 2014.
[194] Testimony of Leona Guest and William Elliott, June 18, 2014.
[195] Testimony of William Elliott, June 18, 2014.
[196] Konno v. County of Hawaii, 85 Haw. 61, 937 P.2d 397 (1997).
[197] Konno v. County of Hawaii, 85 Haw. 61, 72, 937 P.2d 397, 409 (1997).
[198] Proposed legislation submitted by the Department of the Attorney to the Investigative Committee in response to inquiries regarding how the Konno decision affects the assignment of overtime opportunities and ways to address the issue. See, Attachment A.

institutions to use private staffing contractors to alleviate day-to-day staffing shortages without first offering overtime opportunities to civil service staff. This type of exemption would provide a more cost-effective alternative to controlling overtime while enabling the Hospital to meet its staffing requirements.

3. The Handling of Employee Complaints and Disciplinary Actions Lacks Transparency and Due Process

From January 2009 to March 2014, there have been over 180 complaints filed regarding workplace violence, harassment, or discrimination at the Hospital.[199] The complaints include but are not limited to inappropriate workplace behavior or the complainant feeling humiliated, targeted, or threatened.[200] These complaints appear to be generally resolved by a discussion with the employee or a written reprimand, but there are outcomes indicating that the employee is no longer with the Hospital or was transferred to another unit.[201] The Investigative Committee is concerned over the number of workplace violence, harassment, or discrimination complaints and notes the concerns raised by several Hospital employees who are not aware of the status of their complaints or the reasons for disciplinary actions taken against them. The Investigative Committee finds that the Hospital's handling of these complaints lacks transparency and due process.

a. Lack of Policies and Procedures to Assure that an Employee's Complaint is Handled in a Transparent and Fair Manner

While the Hospital has policies and procedures for filing and investigating employee complaints, the Investigative Committee finds a lack of procedures to ensure that the employee complainant is informed of the status and outcome of the complaint and to prescribe proper conduct of the employee complainant and the employee against whom the complaint is filed during the investigation. Such procedures will ensure that employee complaints and any resulting disciplinary actions are handled in a fair and transparent manner.

The Investigative Committee finds that the Hospital lacks policies and procedures to prescribe appropriate conduct during an ongoing investigation. For example, on November 4, 2013, Unit H Psychiatric Technician, Ryan Oyama, filed an employee incident report against his Unit H Nurse Manager Candace Sullivan.[202] Mr. Oyama alleged that Ms. Sullivan threatened that she could create a sexual harassment case against Mr. Oyama and have him fired[203] after he disclosed to her that he did a television news interview about the injuries he sustained while working at the Hospital.[204] As a result, Mr. Oyama feared that he would lose his job and stated in the employee incident report, "being threatened by my supervisor was an uncomfortable and fearful situation."[205] Subsequently, Mr. Oyama and his wife received voicemail messages on their personal cellular phones from Ms. Sullivan asking for Mr. Oyama to call her and clear up the situation.[206] Mr. Oyama did not call Ms. Sullivan.[207] Mr. Oyama testified that to his knowledge, his complaint is still ongoing and he has not received any updates from the Hospital regarding its status.[208] However, the Investigative Committee discovered that Ms. Sullivan received a written reprimand as a result of Mr. Oyama's complaint.[209]

The Investigative Committee has deep concerns regarding Ms. Sullivan's numerous attempts to contact Mr. Oyama while the complaint is still open. Ms. Sullivan testified that she repeatedly tried to contact Mr. Oyama because she did not understand why he would file a complaint against her due to their friendship.[210] Finally, Ms. Sullivan was advised by Ms. Guest to stop contacting Mr. Oyama and to allow the process to take care of the situation.[211] Ms. Guest testified that she is not aware of any policies or procedures that prohibit a person against whom a complaint was filed from making contact with the complainant while the complaint is still open.[212] The Investigative Committee finds that Ms. Sullivan's attempts to contact Mr. Oyama may be considered a form of intimidation and has concerns that this conduct will discourage employees from filing a complaint. Specific Hospital procedures establishing permissible and prohibited conduct while a complaint is open assists in ensuring that the investigation and disposition of a complaint are completed in a fair manner.

Furthermore, the Investigative Committee finds that the Hospital lacks policies and procedures that ensure that the employee complainant is informed of the status and outcome of the complaint. For example, in December 2013, Unit H staff member, Jayling Fernandez, filed an employee incident report against Ms. Sullivan.[213] Ms. Fernandez alleged that Ms. Sullivan accused her of writing

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[199] Department of Health, HSH Employee Incident Report – Workplace Violence/Harassment/Discrimination (LR_20_0014-0031 – Confidential).
[200] Department of Health, HSH Employee Incident Report – Workplace Violence/Harassment/Discrimination (LR_20_0014-0031 – Confidential).
[201] Department of Health, HSH Employee Incident Report – Workplace Violence/Harassment/Discrimination (LR_20_0014-0031 – Confidential).
[202] Employee Incident Report submitted by Ryan Oyama to the Investigative Committee on September 16, 2014 pursuant to a subpoena duces tecum.
[203] Employee Incident Report submitted by Ryan Oyama to the Investigative Committee on September 16, 2014 pursuant to a subpoena duces tecum.
[204] Testimony of Ryan Oyama, September 16, 2014.
[205] Employee Incident Report submitted by Ryan Oyama to the Investigative Committee on September 16, 2014 pursuant to a subpoena duces tecum.
[206] Testimony of Ryan Oyama, September 16, 2014.
[207] Testimony of Ryan Oyama, September 16, 2014.
[208] Testimony of Ryan Oyama, September 16, 2014.
[209] Department of Health, Documents relating to the closing of Employee Incident Report submitted by Jayling Fernandez (LR_092914_3_1-3 - Confidential).
[210] Testimony of Candace Sullivan, September 16, 2014.
[211] Testimony of Candace Sullivan and Leona Guest, September 16, 2014.
[212] Testimony of Leona Guest, September 16, 2014.
[213] Department of Health, Documents relating to Employee Incident Report filed by Jayling Fernandez (LR_092914_1_1-4 - Confidential).

an anonymous letter to Hospital administrators regarding Ms. Sullivan's behavior and remarks during a previous staff meeting.[214] Subsequently, Ms. Fernandez was transferred to another unit while the investigation was ongoing.[215] In June 2014, Ms. Fernandez received a copy of the employee incident report she submitted in December 2013, with handwritten comments from Ms. Guest to close the investigation.[216] To date, Ms. Fernandez has not seen a copy of the Attorney General's investigation report and does not know the outcome, if any, of her complaint. However, the Investigative Committee discovered that Ms. Sullivan received a written reprimand as a result of Ms. Fernandez's complaint.[217]

While the Investigative Committee recognizes the importance of ensuring that an employee against whom a complaint is filed is provided due process, it finds that it is equally important to keep the employee complainant informed of the status and outcome of the investigation without violating any privacy laws. In Ms. Fernandez's case, she was informed only that her complaint was closed, while Mr. Oyama still assumes that his case is still open even though Ms. Sullivan has received a written reprimand and the case is closed.[218] Policies and procedures will ensure that the handling and investigation of employee complaints are handled in a transparent manner. The Investigative Committee is concerned that failure to inform employees of the status and outcome of their complaints will discourage other employees from filing complaints.

b. Weak Policies and Procedures to Ensure Due Process for an Employee Against Whom a Complaint is Filed

While the Hospital has policies and procedures for filing and investigating employee complaints, the Investigative Committee finds that these procedures need to be strengthened to ensure that the employee against whom a complaint is filed is provided due process. For example, four patient event reports were filed against Unit H Psychiatric Technician, Kalford Keanu, Jr., for four allegations during two incidents involving the same patient that occurred on October 9, 2012.[219] The patient event reports allege that Mr. Keanu performed Controlled Patient Management Resolution (CPMR) wall containment procedures on a patient that resulted in patient injuries and he left his 1:1 assignment unattended to perform CPMR wall containment procedures.[220] Mr. Keanu was transferred out of Unit H and assigned to work in the Nursing Office while the Department of the Attorney General conducted its investigation.[221] On April 23, 2013, Mr. Keanu received a letter during his meeting with Ms. Sullivan and Ms. Guest. The letter served as a written reprimand for patient abuse and neglect and unwarranted aggressive behavior, required Mr. Keanu to attend an anger management workshop, and offered him a job transfer from Unit H to another unit.[222] Mr. Keanu testified that he refused to sign the letter, but attended the required anger management workshop and requested to be transferred to Unit U.[223] Furthermore, Mr. Keanu testified that Ms. Sullivan and Ms. Guest denied his request for a union representative to be present during their meeting.[224]

Subsequently, Mr. Keanu was able to read a copy of the Attorney General's investigation report,[225] which he was previously denied access to view. UPW filed a grievance[226] on behalf of Mr. Keanu that the Hospital failed to, among other items, establish just and proper cause before issuing a written reprimand and review and consider all evidence, data, and factors supporting Mr. Keanu before making a decision.

The Investigative Committee is deeply concerned that Mr. Keanu was disciplined without due process. The Hospital's policies and procedures generalize the rights and duties that are afforded to an accused employee, including the right to be represented by the employee's union and being provided the specific reasons for the disciplinary actions. In Mr. Keanu's case, he was provided a written reprimand without being allowed representation by his union upon his request. The written reprimand explained that he was being reprimanded for leaving his 1:1 assignment unattended to assist a co-worker with a patient and using excessive force that resulted in a patient injury.[227] However, the Attorney General's investigation did not substantiate that Mr. Keanu used excessive force or leave his 1:1 assignment unattended.[228] The Investigative Committee does not understand how Mr. Keanu was reprimanded for those actions when the Attorney General found no wrongdoing.

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[214] Department of Health, Documents relating to Employee Incident Report filed by Jayling Fernandez (LR_092914_1_1-4 - Confidential).
[215] Department of Health, Documents relating to Guidelines of Investigation into Employee Incident Report filed by Jayling Fernandez (LR_092914_9_1-5 - Confidential).
[216] Department of Health, Documents relating to Employee Incident Report filed by Jayling Fernandez (LR_092914_1_1-4 - Confidential).
[217] Department of Health, Documents relating to the closing of Employee Incident Report submitted by Jayling Fernandez (LR_092914_3_1-3 - confidential).
[218] Department of Health, Documents relating to the closing of Employee Incident Report submitted by Jayling Fernandez (LR_092914_3_1-3 - confidential).
[219] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[220] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[221] Testimony of Kalford Keanu, Jr., May 14, 2014.
[222] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[223] Testimony of Kalford Keanu, Jr., May 14, 2014.
[224] Testimony of Kalford Keanu, Jr., May 14, 2014.
[225] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[226] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[227] Investigation report and other related documents regarding Kalford Keanu, Jr., submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.
[228] Investigation report and other related documents regarding Kalford Keanu, Jr, submitted by Kalford Keanu, Jr. to the Investigative Committee on May 14, 2014.

The Investigative Committee is also concerned that Mr. Keanu was not allowed to see a copy of the Attorney General's investigation report. According to the Deputy Attorney General, James Halvorson, who is the Supervisor of the Department of the Attorney General's Employment Law Division, the Department generally advises other state departments and agencies to keep Attorney General investigation reports confidential if the state department or agency is not taking any adverse action.[229] The Investigative Committee finds that because Mr. Keanu received a written reprimand, he should have been able to receive a copy of the investigation report in order to be informed of the allegations made against him and the evidence proving these allegations.

The Investigative Committee notes that Mr. Halvorson added that there may be a situation where an investigation concludes no wrongdoing, but that a state department takes an adverse position because based on the investigation, the state department finds a lesser degree of wrongdoing.[230] In other words, the investigation substantiated a lesser degree of wrongdoing. However, the Investigative Committee finds that if the Hospital found that Mr. Keanu committed a lesser degree of wrongdoing, then he should have been informed of this. The written reprimand does not indicate this and instead informs Mr. Keanu of wrongdoing that the Attorney General's investigation report could not substantiate.

The Investigative Committee has serious concerns regarding the fairness and transparency with which the Hospital handled Mr. Keanu's case and Mr. Halvorson's reasons for keeping investigations confidential from the employee who was investigated. Employee complaints and any associated investigations could damage an employee's reputation and career. While the Investigative Committee recognizes the need to keep personnel matters confidential and notes the privacy laws under chapter 92F, HRS, it finds that Hospital policies and procedures need to be strengthened to ensure that employees who are alleged to have committed a wrongdoing are provided due process, while protecting employee privacy rights and preventing retaliation.

c. Employees Fear Retaliation by Hospital Administrators and Supervisors

It appears to the Investigative Committee that there is a history of retaliatory actions and acts of intimidation exercised by Hospital administrators and supervisors. For example, while their investigations were pending, Mr. Keanu and Ms. Fernandez were transferred out of Unit H and have not been transferred back to Unit H even after their investigations have been closed.[231] The Investigative Committee notes that these transfers could be considered a form of retaliation by the Hospital administration especially when Ms. Sullivan was not transferred out of Unit H. Furthermore, it appears that the complaints filed by Mr. Oyama and Ms. Fernandez against Ms. Sullivan were based on allegations of harassment and intimidation. Mr. Oyama alleges that Ms. Sullivan threatened Mr. Oyama's job, while Ms. Fernandez alleges that Ms. Sullivan falsely accused her of writing an anonymous letter to Hospital administrators. The Investigative Committee considers these allegations, if true, as forms of intimidation by a supervisor and strongly believes that such acts as well as forms of retaliation are unacceptable, inexcusable, and detrimental to employee morale and work performance.

The Investigative Committee is deeply concerned that fears of retaliation discourage and prevent employees from coming forward with workplace safety or human resources issues. Failure to communicate problems up the chain of command prevents the Hospital from developing and implementing solutions to provide a better work environment for its employees and creates a greater divide between Hospital administrators and staff, which can negatively impact patient care.

Additionally, the Investigative Committee has serious concerns regarding the management skills of Ms. Sullivan. The Investigative Committee notes that all three incidents mentioned above directly or indirectly involved Ms. Sullivan. Unit H serves as an acute unit as well as the admissions unit for the Hospital. Thus, it is imperative for Ms. Sullivan, as the Nurse Manager for Unit H, to ensure that the staff assigned to Unit H are provided a safe work environment in order to properly care for the unit's wide spectrum of patients. However, when Unit H employees fear retaliation from or are intimidated by Ms. Sullivan, it erodes employee trust, which, in turn, impacts employee morale and work performance.

The Investigative Committee further notes that Ms. Sullivan received a letter dated July 1, 2014, that served as written reprimand for unprofessional conduct relating to her interactions with staff, which were investigated by the Department of the Attorney General.[232] She was specifically reprimanded for her separate interactions with Mr. Oyama and Ms. Fernandez.[233] As a result, she was required to attend the "Addressing Emotions at Work" training on September 19, 2014.[234] The Investigative Committee notes that Ms. Sullivan refused to sign the letter[235] and HGEA has filed a grievance on her behalf.[236] With regard to the required class, the Investigative Committee discovered from Mr. May that due to a miscommunication, Ms. Sullivan was unable to register for the training and will be required to attend the next scheduled training in February 2015. Accordingly, the Investigative Committee has concerns regarding whether the written reprimand adequately or effectively remedies the complaints filed against Ms. Sullivan, especially when Mr. Oyama and Ms. Fernandez are unaware that Ms. Sullivan received a written reprimand, filed a grievance through her union, and that she will not be able to attend the "Addressing Emotions at Work" training until next year. In addition, the Investigative Committee is concerned that these circumstances may impact or discourage other employees from filing complaints when they experience retaliatory actions or acts of intimidation exercised by Hospital administrators and supervisors.

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[229] Testimony of James Halvorson, on behalf of Mark Fridovich, July 16, 2014.
[230] Testimony of James Halvorson, on behalf of Mark Fridovich, July 16, 2014.
[231] Department of Health, Documents relating to Guidelines of Investigation into Employee Incident Report filed by Jayling Fernandez (LR_092914_9_1-4-5 - confidential) and Testimony of Kalford Keanu, Jr., May 14, 2014.
[232] Department of Health, Documents relating to Results of the Employee Incident Report filed by Jayling Fernandez (LR_092914_4_1-3 – Confidential).
[233] Department of Health, Documents relating to Results of the Employee Incident Report filed by Jayling Fernandez (LR_092914_4_1-3 – Confidential).
[234] Department of Health, Documents relating to Results of the Employee Incident Report filed by Jayling Fernandez (LR_092914_4_1-3 – Confidential).
[235] Department of Health, Documents relating to Results of the Employee Incident Report filed by Jayling Fernandez (LR_092914_4_1-3 – Confidential).
[236] Department of Health, Documents relating to the Current Status of the Employee Incident Report filed by Jayling Fernandez (LR_092914_5_1-4 – Confidential).

Lastly, the Investigative Committee notes that during its hearing on September 16, 2014, Ms. Sullivan made contradictory statements while under oath. Specifically, Ms. Sullivan testified that Mr. Oyama was the only employee to file a complaint against her, but then retracted her statement when the Investigative Committee brought up another complaint filed by Ms. Fernandez. Ms. Sullivan stated, "I apologize. I don't look at this committee as a real courthouse, and so therefore I forgot that I was under oath."[237] The Investigative Committee is extremely disappointed that Ms. Sullivan does not take the purpose of this investigation seriously and does not appreciate her dismissive attitude. The Investigative Committee contemplates whether she exercises this same attitude when carrying out her duties as a Nurse Manager and listening and appropriately responding to the needs her staff in a respectful, professional, and fair manner. Furthermore, the Investigative Committee wonders how many complaints would be filed against Ms. Sullivan if employees were not fearful of retaliation by her or other Hospital administrators.

PART IV.
CONCLUSIONS OF THE SENATE SPECIAL INVESTIGATIVE COMMITTEE ON THE HAWAII STATE HOSPITAL

The Hospital has a duty of care not only to its patients, but to their staff who care for the patients. It appears to the Investigative Committee that the Hospital faces longstanding challenges that impact the personal safety and work environment of Hospital employees. These challenges persist despite prior federal, executive, and legislative intervention.

After listening to many testifiers over the course of the investigation and after reviewing well over a thousand pages of subpoenaed documents, the Investigative Committee has deep concerns regarding reports of violent and unstable patients attacking staff and causing serious injuries to the staff. The Investigative Committee is concerned that if this problem is not immediately addressed, a fatality will occur at the Hospital. The Investigative Committee is also concerned that the persistently high patient census forces the Hospital to stretch its limited resources to dangerously thin levels, which compromises patient and staff safety. Lastly, the Investigative Committee is concerned about the staffing and staff performance at the Hospital and how these issues ultimately impact patient care.

In light of these longstanding challenges, the Hospital cannot continue to maintain operations at the status quo. The Hospital and the Department of Health would benefit from gaining a broader perspective and utilizing additional resources for information and guidance to make the necessary changes so that it can successfully achieve its mission.

PART V.
RECOMMENDATIONS OF THE SENATE SPECIAL INVESTIGATIVE COMMITTEE ON THE HAWAII STATE HOSPITAL

The Investigative Committee has identified various shortcomings relating to the Hospital's efforts in maintaining a safe work environment, using its facilities, and implementing efficient and transparent human resources practices. In light of these longstanding challenges facing the Hospital, it is clear that further action is required to address the problems at the Hospital. The Department of Health and the Hospital must enact fundamental changes than have been discussed and recommended in the past.

The Investigative Committee notes that during the course of its investigation, a new Hospital Administrator, William May, has been hired and the Acting Administrator, William Elliott, retired. The Investigative Committee engaged in a thoughtful discussion with Mr. May regarding his experience and plans for the Hospital.[238] During this discussion, Mr. May identified four problem areas that he has observed since coming on board on July 7, 2014: (1) the physical layout of the Hospital; (2) high patient census; (3) Hospital staffing; and (4) Hospital safety.[239] Mr. May noted that these challenges are related to each other and can often be found nationwide in other mental health facilities.[240] The Investigative Committee notes that its findings are similar and related to all four problem areas Mr. May identified, which provides the Investigative Committee with some assurance that fundamental changes may be possible.

Accordingly, the Investigative Committee provides the following recommendations to the Hospital and Department of Health in an effort to assist those entities in resolving the shortcomings faced by the Hospital. To foster a framework for change, the Investigative Committee requests that the Hospital submit a written report to the Legislature providing the status of its efforts in implementing the following recommendations no later than 20 days prior to the convening of Regular Session of 2015 and Regular Session of 2016.

With regard to maintaining a safe work environment, the Investigative Committee believes that the Hospital should:

1. Develop standardized recording procedures to accurately report assaults occurring at the Hospital. Specifically:
    a. Develop data gathering and analysis procedures that:
        i. Identify the perpetrator and victim of the assault;
        ii. Identify the patient event report number, employee incident report number, or accident report number;
        iii. Describe the assault;
        iv. Categorize any resulting injury of the assault;
        v. Indicate the disposition of the assault; and
        vi. Indicate any other information that will enable the Hospital to better track the number of assaults occurring at the Hospital;

[237] Testimony of Candace Sullivan, September 16, 2014.
[238] Testimony of William May, July 30, 2014.
[239] Testimony of William May, July 30, 2014.
[240] Testimony of William May, July 30, 2014.

b. Develop and implement standard definitions and categories for attempted assault, assault, and serious assault that include and describe the level of any resulting injury;

c. Develop and implement standard definitions and categories for the types of injuries that may result from an assault to assist in determining whether an assault is an attempted assault, assault, or serious assault;

d. Revise and strengthen policies and procedures that mandate employees to file an employee incident report for every event that occurs and ensure that these policies and procedures are implemented by all employees;

e. Revise and strengthen policies and procedures regarding workers' compensation and collaborate with the Department of Labor and Industrial Relations to expedite the filing, approval, and payment of workers' compensation claims; and

f. Improve communication between Hospital administrators and Department of Health administrators regarding reports of assaults occurring at the Hospital to ensure that Department administrators can obtain a full scope of the problem;

2. Educate and train all employees on workplace violence, especially with regard to the policies and procedures to report incidents of workplace violence and employees' options if they are the victim of such violence;

3. Develop and implement a pervasive and appropriate training program for employees to handle forensic mental health patients. Specifically:

a. Explore any best practices or employee training programs on handling forensic mental health patients from similar mental health facilities in other jurisdictions that treat forensic mental health patients;

b. Explore and determine the feasibility of incorporating any type of training programs that are similar to the training correctional officers receive in handling incarcerated individuals;

c. Offer and require employees to attend training programs on handling forensic mental health patients more than once a year; and

d. Explore the feasibility of hiring additional security officers on campus to assist with monitoring patients and responding to emergency situations and security breaches within the Hospital; and

4. Address and resolve the HIOSH violations[241] cited on April 10, 2014, and collaborate with the Department of Labor and Industrial Relations to aid in strengthening its policies and procedures to create a safe workplace environment.

With regard to using facilities and exercising safety practices efficiently, the Investigative Committee believes that the Hospital should:

1. Develop and implement a patient classification system that is based on patient need. Specifically:

a. Explore any patient classification systems that are used by similar mental health facilities in other jurisdictions, especially facilities with forensic mental health patients;

b. Analyze and determine the impact a patient classification system may have on patient care and staff ratios;

c. If necessary, consult with the applicable labor unions regarding how a patient classification system may impact collective bargaining agreements; and

d. Analyze and determine the impact that a patient classification system may have on the existing Hospital facilities and the ability of the existing facilities in accommodating a patient classification system;

2. Consider options in designating Unit H solely for the purpose of admitting patients. Specifically:

a. Explore best practices at similar mental health facilities regarding separating the admissions unit from other units;

b. Determine the feasibility of sharing admission responsibilities with Unit F to increase the number of available beds for admitted patients and the impact the sharing of admission responsibilities between Units H and F will have on the other units;

c. Consult with the applicable labor unions regarding how designating Unit H for admissions only or sharing admission responsibilities with Unit F may impact collective bargaining agreements; and

d. Collaborate with the Department of Public Safety and the Judiciary to improve and strengthen communication and the sharing of information with respect to the status of patients who are transferred to the Hospital pursuant to a court order to enable the Hospital to better plan, prepare, and provide for patients being transferred and admitted to the Hospital for evaluation and treatment;

3. Consider obtaining a forensic care designation or accreditation for the Hospital. Specifically:

a. Explore mental health facilities in other jurisdictions that have a forensic mental health designation or accreditation to analyze the pros and cons of having such a designation and accreditation for the Hospital;

b. Determine the impact that a forensic mental health designation or accreditation may have on the Hospital; and

[241] Department of Labor and Industrial Relations, Citation and Notification of Penalty, HIOSH Inspection Number 316273333 (April 10, 2014).

c. Collaborate with the Department of Public Safety to explore and develop long-term strategies for the Department of Public Safety to establish a forensic mental health unit at the prisons to reduce the number of forensic mental health patients being admitted to the Hospital;

4. Facilitate the transfer of high risk patients to out-of-state mental health facilities contracted with the State by selecting patients that may qualify and benefit from being transferred per the newly adopted policies and procedures and determine whether such patients should be transferred;

5. Address the safety concerns and closure of the PICU. Specifically:

a. Address the safety concerns of the PICU by expediting the ongoing consultations with HGEA and UPW; and

b. Explore and determine the feasibility of alternative uses for the PICU;

6. Explore and develop short-term strategies for the physical improvement and renovation of the existing Hospital facility. Specifically:

a. Assess and prioritize the areas of the Hospital that need improvement, upgrade, repair, or replacement, and establish a feasible timeline for the completion of these projects;

b. Explore design options by considering the designs of forensic mental health facilities in other jurisdictions to better meet the needs of forensic mental health patients and the staff who provide patient care, as well as to address the Hospital's security needs;

c. Explore additional funding mechanisms to support the repair and improvement of the existing facility, and request additional funding from the Legislature, if necessary;

d. Analyze and determine the impact of any repair and improvement projects on patient care and staff-to-patient ratios; and

e. If necessary, consult with the applicable labor unions regarding how any repair and improvement projects may impact collective bargaining agreements;

7. Explore and develop long-term strategies for the design and construction of a new facility. Specifically:

a. Determine the feasibility of building a new facility or renovating and upgrading the existing facility;

b. Explore additional funding mechanisms to support the demolition of the existing facility, if appropriate, and design, construction, and maintenance of a new facility; and

c. Explore design options by considering the designs of forensic mental health facilities in other jurisdictions to better meet the needs of forensic mental health patients and the staff who provide patient care, as well as to address the Hospital's security needs;

8. Improve the monitoring and operation of the security cameras. Specifically:

a. Revise policies and procedures to increase the number of security officers to divide the duties associated with monitoring the security cameras; and

b. Ensure that all security cameras are operating at all times and develop policies and procedures to routinely check the operation of all cameras;

9. Improve the PMT devices to ensure that the devices work properly at all times. Specifically:

a. Upgrade the PMT devices to ensure that the devices work properly at all times and accurately transmit the location of a Code 200;

b. Strengthen and implement policies and procedures to ensure that staff respond when a Code 200 is transmitted; and

c. Require that all PMT devices are routinely inspected for proper operation;

10. Explore the feasibility of constructing a fence around the perimeter of the campus to ensure safety for the surrounding community and assist in preventing elopements. Specifically:

a. Explore different types of fencing options to enclose the entire campus or parts of the campus; and

b. Request additional funding from the Legislature, if necessary, for construction; and

11. Develop procedures to alert the community when a patient elopement occurs. Specifically:

a. Revise policies and procedures to establish when HPD is to be notified of a patient elopement so that HPD may assist in the search efforts; and

b. Develop and implement policies and procedures to alert the students and staff at Windward Community College of a patient elopement.

With regard to providing efficient and effective human resources practices, the Investigative Committee believes that the Hospital should:

1. Streamline and consolidate the Hospital's and Department of Health's internal recruitment and hiring processes to expedite the filling of position vacancies at the Hospital. Specifically:

a. Determine which steps in the Hospital's and Department's internal recruitment and hiring processes may be streamlined or consolidated to create a more efficient and expeditious process;

b. Collaborate with the Department of Human Resources Development in streamlining and consolidating the steps in the internal recruitment and hiring processes to ensure adherence to all applicable hiring laws and rules; and

c. Explore options in improving the internal recruitment and hiring processes to expedite the filling of position vacancies at the Hospital;

2. Develop policies and procedures regarding the recruitment of temporary agency workers. Specifically:

a. Collaborate with the Department of Human Resources Development to ensure such policies adhere to applicable laws and rules; and

b. Establish a policy to prohibit the Hospital from providing names of individuals to the temporary employment agencies to work at the Hospital;

3. Strengthen the policies and procedures for interviewing and hiring employees to work at the Hospital. Specifically:

a. Develop and implement a policy and procedure regarding the employment of relatives of current staff to reduce allegations of favoritism and nepotism;

b. Develop and implement policies and procedures to ensure that the interview process is free from conflicts of interest and require disclosure and recusal of interview panelists if a conflict of interest exists;

c. Collaborate with the Department of Human Resources Development to ensure that such policies and procedures adhere to applicable laws and rules; and

d. Consult with the Hawaii State Ethics Commission to ensure that such policies and procedures adhere to and are consistent with the State's Code of Ethics;

4. Develop and implement procedures for the assignment of overtime. Specifically:

a. Establish written policies and procedures regarding the assignment of overtime and ensure that such procedures are consistently followed;

b. Expedite the installation of the Kronos computer system to assist in the assignment of overtime; and

c. If necessary, consult with the applicable labor unions regarding how the assignment of overtime may impact collective bargaining agreements;

5. Explore options to limit the number of overtime shifts or hours an employee may perform. Specifically:

a. Explore how other state agencies or similar mental health facilities in other jurisdictions have successfully reduced or limited overtime; and

b. Develop and implement policies and procedures regarding performing back-to-back shifts;

6. Control the opportunities for employees to abuse sick leave and overtime benefits. Specifically:

a. Explore the options to reduce the number of consecutive days of sick leave after which an employee is required to submit a doctor's note or require a 24-hour waiting period before an employee who is back from sick leave may perform an overtime shift; and

b. Consult with the applicable labor unions to ensure that collective bargaining agreements are followed;

7. Collaborate with the appropriate labor unions to address the impact that collective bargaining agreements have on overtime benefits;

a. Discuss and develop alternative options to amend collective bargaining agreements to place limits on the amount of overtime an employee may perform;

b. Discuss and develop options to address the Konno decision and the impact that it has on assigning overtime shifts to civil service employees; and

c. Introduce legislation proposed by the Department of the Attorney General[242] that provides an exemption from the applicability of Konno[243] for state institutions with 24-hours-a-day, seven-days-a-week staffing responsibilities by using private staffing contractors to alleviate day-to-day staffing shortages without having to first offer overtime opportunities to civil service staff (See, Attachment A); and

8. Strengthen and implement policies and procedures regarding employee complaints and disciplinary actions. Specifically:

a. Develop and implement policies and procedures to assure that an employee complaint is handled in a fair and transparent manner, including keeping the complaining employee informed of the status and outcome of the complaint;

b. Develop and implement policies and procedures regarding permissible and prohibited conduct while a complaint is open and under investigation;

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[242] Proposed legislation submitted by the Department of the Attorney to the Investigative Committee in response to inquiries regarding how the Konno decision affects the assignment of overtime opportunities and ways to address the issue. See, Attachment A.

[243] Konno v. County of Hawaii, 85 Haw. 61, 937 P.2d 397 (1997).

c. Strengthen policies and procedures to ensure that an employee against whom a complaint is filed is provided due process;

d. Consult with the applicable labor unions to ensure that any policies and procedures regarding employee investigations adhere to collective bargaining agreements; and

e. Collaborate with the Department of the Attorney General to ensure that any policies and procedures regarding employee investigations adhere to privacy laws and applicable employment practices.

The Investigative Committee recommends the Legislature take the following action on during the Regular Session of 2015:

1. Introduce legislation requesting the State Auditor conduct a management audit of the Hospital;

2. Introduce legislation proposed by the Department of the Attorney General[244] that provides an exemption from the applicability of Konno[245] for state institutions with 24-hours-a-day, seven-days-a-week staffing responsibilities by using private staffing contractors to alleviate day-to-day staffing shortages without having to first offer overtime opportunities to civil service staff (See, Attachment A); and

3. Consider the infusion of additional funds and additional funding resources to assist the Hospital in its efforts to address and resolve the problem areas identified in this Report by the Investigative Committee.

[244] Proposed legislation submitted by the Department of the Attorney to the Investigative Committee in response to inquiries regarding how the Konno decision affects the assignment of overtime opportunities and ways to address the issue. See, Attachment A.
[245] Konno v. County of Hawaii, 85 Haw. 61, 937 P.2d 397 (1997).

APPENDIX A

ACT X

PART I

SECTION 1. The legislature finds that those state institutions which have 24/7 operational responsibilities caring for or watching over patients, wards, inmates or detainees, such as Hawaii State Hospital, Hawaii Youth Correctional Facility, Hawaii Health Systems Corporation, the Department of Public Safety, and the Judiciary, have longstanding and intractable problems with maintaining adequate daily staffing ratios due to absences caused by sick leave, vacation leave, industrial injuries and vacancies.

The legislature also finds that these chronic staffing shortages lead to excessive use of overtime, which not only imposes unacceptable costs, but gives rise to potentially serious safety issues for both staff and wards.

In this regard, the State and counties have long used the private sector to provide public services to Hawaii's citizens, and in fact, certain of the above referenced institutions have traditionally utilized the services of private staffing contractors as a last resort in attempting to fill day-to-day staffing shortages only after first offering overtime opportunities to civil service staff.

However, the legislature finds that even those institutions which have been able to rely upon the services of private staffing contractors as a last resort nevertheless continue to suffer from chronic day-to-day staffing shortages, excessive use of overtime by civil service staff, and consequent health and safety issues arising therefrom.

Accordingly, the legislature finds that all of the state institutions which have such 24/7 staffing responsibilities are in need of additional flexibility in dealing with staffing shortages by the most efficient, safe and expeditious means possible.

Because of the Hawaii supreme court's decision in the consolidated cases *Konno v. County of Hawaii*, 85 Haw. 61 (1997) and other occurrences, the basic authority of state and county government to deliver public services through the private sector has been called into question.

In *Konno,* the Hawaii supreme court invalidated a contract between the county of Hawaii and a private landfill developer and operator after concluding that under the State's civil service laws, only civil servants could perform the services and fill the positions historically and customarily provided or filled by civil servants. While the supreme court in *Konno* "emphasize[d] that nothing in this opinion should be interpreted as passing judgment, one way or the other, on the wisdom of privatization," and acknowledged that "[w]hether or not, as a policy matter, private entities should be allowed to provide public services entails a judgment ordinarily consigned to the legislature", it also noted that "the civil service encompasses those services that have been customarily and historically provided by civil servants", and concluded that, absent express legislative authority to obtain services from other sources, civil servants must provide these services.

Consequently, state and county agencies, in some instances, were precluded from entering into service contracts with private providers to obtain the services they needed, reduce direct labor, material, and equipment costs, and take advantage of indirect savings through contractual provisions for insurance and indemnification against third-party and regulatory liability claims.

Recognizing the negative fiscal impact the *Konno* decision would have on government, in 2001 the legislature enacted Act 90, Part II of which specifically provided that privatization could be included as a management tool to assist government in remaining fluid in its ability to effectively provide services for the ever changing needs of its constituency. However, Act 90 provided that Part II of the Act would sunset on June 30, 2007 and no action was subsequently taken by the legislature to extend Part II.

The purpose of this Act is to provide those state institutions which have such 24/7 staffing responsibilities with greater flexibility to effectively deal with staffing shortages, excessive use of overtime by civil service staff, and consequent health and safety issues arising therefrom, by specifically allowing them to utilize private staffing contractors to alleviate day-to-day staffing shortages without regard to first offering overtime opportunities to civil service staff.

Part II "CHAPTER PRIVATIZATION

§ -1 Scope and application. This chapter preempts and supersedes all other state law with regard to determining the manner in which state institutions which have 24/7 staffing responsibilities caring for or watching over patients, wards, inmates or detainees, are permitted to effectively deal with chronic staffing shortages, excessive use of overtime by civil service staff, and consequent health and safety issues arising therefrom, if need be by utilizing private staffing contractors without regard to first offering overtime opportunities to civil service staff. Procurement laws shall be applied, as appropriate, if a determination is made pursuant to this chapter that a service should be obtained by contract from the private sector.

§ -2 Determination; standards. (a) Notwithstanding any law to the contrary, including but not limited to chapters 46, 76, 77, 78, 89, and 89A, any other applicable civil service law, customary or historical past practices, or the fact that the services hereinafter described may have been performed by persons or positions in civil service, any state official of any state institution which has 24/7 staffing responsibilities in whom procurement authority, or his designee may contact a private entity to obtain day-to-day on-call services to relieve staffing shortages without first offering overtime opportunities to civil service staff, when there is a reasonable basis to believe that the service is necessary to fill a staffing shortage efficiently, safely and expeditiously.

(b) For purposes of this chapter, a "private staffing contractor" is any individual, company, or organization that offers day-to-day on-call staffing services, and is not an employee or agency within the federal, state, or county government.

(c) For purposes of this chapter, "any state institution which has 24/7 staffing responsibilities caring for or watching over patients, wards, inmates or detainees" means those state facilities which are manned by staff 24 hours every day of every week, 12 months a year.

(d) In the determination made pursuant to this chapter, before utilizing a private staffing contractor to fill a staffing shortage without first offering overtime opportunities to civil service staff, the state official shall first consider whether doing so is in fact reasonable and necessary to effectively address present staffing shortages, excessive use of overtime by

civil service staff, and consequent health and safety issues arising therefrom.

APPENDIX B

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LINDA ROSEN, M.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

October 20, 2014

The Honorable Senator Josh Green
Co-Chair, Committee on Health
State Capitol
Honolulu, Hawaii 96813

✓ The Honorable Senator Clayton Hee
Co-Chair, Committee on Judiciary and Labor
State Capitol
Honolulu, Hawaii 96813

Dear Senator Green and Senator Hee:

In regards to the Draft Report on the Findings and Recommendations of the Senate Special Investigative Committee on the Hawaii State Hospital (HSH), please accept this as the Department of Health's response to the report dated October 6, 2014.

There is a class action civil suit that has been filed which contains allegations which closely resemble many of the conclusory findings, assertions and concerns contained in the report involving individual defendants which the Department of the Attorney General (AG) is currently reviewing. Upon the advice of the Department of the Attorney General, we have been asked to refrain from a detailed response to these matters at this time. Accordingly, we will focus our response on the recommendations in the report and our efforts to move forward and implement improvements in our operations.

Many of the recommendations contained in Part V of the report fall within one of the following categories: items with which we concur and are either completed or action is being taken; items with which we concur but cannot be addressed without additional funding; and finally, items with which we do not concur or that are out of our control. In accordance with guidance from the AG to refrain from a detailed response, although there are several recommendations which fall into each category, one example will be provided for each.

1. Recommendations with which we concur and are either complete or action is being taken.

   Item #4 on page 70 recommends that HSH select patients that may qualify and benefit from transfer to an out-of-state facility and determine whether a transfer should occur.

   The policy for this process has been written and approved and is ready to be utilized when patients appropriate for transfer are identified.

2. Recommendations with which we concur but that cannot be addressed without additional funding.

   Item #10 on page 72 recommends that the hospital explore the feasibility of constructing a fence around the campus.

   Depending on scope, this project will be expensive, and as the committee points out, will need financial support from the Legislature.

3. Recommendations with which we do not concur or that are out of our control.

   Item #3 (a) on page 70 recommends pursuing a forensic mental health accreditation for HSH.

   We do not concur, as our research on this subject indicates that there is no special forensic accreditation available for hospital facilities.

We thank the committee for the opportunity to respond to the report and, moving forward, we look forward to partnering with the entire Legislature as we seek to develop innovative solutions to provide our specialized services in the most appropriate setting possible.

Sincerely,

Linda Rosen MD MPH

Linda Rosen, M.D., M.P.H.
Director of Health

APPENDIX C

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LINDA ROSEN, M.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
ADULT MENTAL HEALTH DIVISION
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

October 17, 2014

The Honorable Senator Josh Green
Chair, Committee on Health
State Capitol
Honolulu, Hawaii 96813

The Honorable Senator Clayton Hee
Chair, Committee on Judiciary and Labor
State Capitol
Honolulu, Hawaii 96813

Dear Senator Green and Senator Hee:

Thank you for the opportunity to make a written response to the draft report of the Senate Investigative Committee.

There is a class action civil suit that has been filed which contains allegations resembling closely many of the conclusory findings, assertions and concerns contained in the report involving individual defendants. The Department of the Attorney General is currently reviewing this class action civil suit. Upon advice of the Department of the Attorney General I have been asked to refrain from a detailed response to the report at this time.

I will not be commenting on the conclusions and recommendations contained in Part V of the report, some of which were previously part of or have already been incorporated into Hawaii State Hospital (HSH) policies and procedures. Instead, my response is focused on the larger context that influences issues contained in this report and related HSH operations.

Thirty two years ago, the Hawaii Crime Commission, on behalf of the Legislature, completed a study to address the functioning of the insanity defense and to make recommendations regarding its implementation and made a report to the Legislature. The report was titled: *The Mentally Ill and the Criminal Justice System* (April 1982). Among its recommendations: **Create a Hawaii State Forensic Center** that would centralize responsibility for the examination, treatment, and custody of those persons raising mental illness as an issue pursuant to HRS 704 including the administration of a maximum security component of HSH. The proposed Center would collect and maintain data, provide training, and monitor those persons on conditional release status. The authors of the report noted that the creation of a Hawaii State Forensic Center was the primary recommendation of the Governor's State Commission on Mental Health and Justice in 1980 and was intended to improve administration of the law and foster public safety. There have been many analogous efforts in the more than three decades since this report, some of which efforts the Senate Investigational Committee report documents.

It may be worthwhile for decision makers and those involved in policy development in this area to reflect on why, since 1980, it has been so difficult to sustain a focus on the need for statutory and structural changes in addressing the needs of individuals with mental illness involved with the Criminal Justice

System in Hawaii. Now these issues are being re-visited, again, through the lens of workplace safety considerations.

I am very concerned that the report might be read as oversimplifying the issues that the citizens of Hawaii face with regards to our state hospital. The matter of workplace safety at HSH, and the role of the Department of Health (DOH) and HSH administration in maintaining it, are inextricably bound to other, broad issues, affecting many departments, indeed all three branches of government, which decision makers and those involved in policy development have grappled with for over 30 years.

A partial list of related issues:

- Behaviors which are symptomatic of mental illness or non-adherence with treatment plans are frequently addressed through the criminal justice system and in the process are criminalized.
- The criminal justice apparatus which commits individuals to HSH frequently effects a social outcome for individuals through force of law (for instance, removal from home island, removal from the community in general, and avoidance of a criminal sentence).
- There are insufficient numbers of non-forensic hospitalization alternatives for those who require inpatient treatment.
- Once placed at HSH, a change in commitment status is often driven by legal consideration (e.g. timing of court hearings and change in attorneys) rather than clinical need, and these legal considerations can result in extended continuations of hospitalizations.
- Health Care and Psychiatric Health Care will always involve inherent risk, and this is particularly so for Psychiatric Inpatient Treatment for forensically committed adults. This last requires a need to balance patient rights/self-determination with organizational and worker concerns for safety; this balancing effort is impacted by compelled confinement and, in some cases, compelled treatment over the person's objection.

As we move forward, it is critically important to focus on actively addressing the need for the statutory and structural changes in how the needs of individuals with mental illness involved with the Criminal Justice System are addressed in Hawaii. A significant amount of time and resources have been spent over the last thirty years generating recommended solutions to address these needs. The proposed solutions by each successive body have been remarkably similar and when taken in total, represent a consensus on the need to develop innovative solutions. I welcome the Investigative Committee's recommendation for the Legislature to partner with concerned parties and take action to address the needs of the mentally ill in the Criminal Justice System including the infusion of additional funds to assist DOH, the Adult Mental Health Division, and HSH in their efforts to do so.

I affirm my commitment to continuing to work together with others to improve services, to staff, patient and public safety, for advocating for improvements to the HSH campus and to assuring that HSH continues to be a place where workers can be proud of the work they do and where their concerns are heard and addressed properly.

Very Truly Yours,

Mark A. Fridovich, Ph.D., M.P.A.
Administrator
Adult Mental Health

STANDING COMMITTEE REPORTS

SCRep. 1 Judiciary and Labor on Gov. Msg. No. 1

Recommending that the Senate consent to the nomination of the following:

CIRCUIT COURT OF THE FIRST CIRCUIT, STATE OF HAWAII

G.M. No. 1 JEFF CRABTREE, for a term to expire in ten years

Your Committee has reviewed the resume and statements submitted by the appointee and finds Jeff Crabtree to possess the requisite qualifications to be appointed to the Circuit Court of the First Circuit, State of Hawaii.

Your Committee received testimony in support of the appointment of Jeff Crabtree to the position of Circuit Court Judge of the First Circuit from thirteen individuals. Comments were submitted by the Board of Directors of the Hawaii State Bar Association.

The Hawaii State Bar Association Board of Directors found the appointee to be qualified for the position of Circuit Court Judge, First Circuit, based on established criteria for determining the qualifications of judicial and executive appointments generally using the American Bar Association Guidelines for Reviewing Qualifications of Candidates for State Judicial Office. Specifically, the Board uses the following criteria in its deliberations: integrity and diligence, legal knowledge and ability, professional experience, judicial temperament, financial responsibility, public service, health, and ability to perform the responsibilities and duties required of the position for which the applicant has been nominated. The Board's rating system includes the categories of "qualified" and "not qualified".

Mr. Crabtree graduated with honors and earned his Bachelor of Arts degree from the University of San Francisco. During his undergraduate studies, he participated in the VISTA outreach program to assist senior citizens and disabled persons obtain social security benefits; organized the Vietnamese Orphans Airlift program by staffing an emergency nursery and pediatrics ward for orphans flown from Vietnam in an emergency airlift; and initiated department-level faculty evaluations at the University of San Francisco. He later earned his Doctorate of Jurisprudence from the New York University School of Law where he was awarded the Root-Tilden Scholarship in Public Interest Law. The Root-Tilden Program provided him mentoring and internship opportunities, including internships with the Newark United States Attorney's Office, American Civil Liberties Union, New York University Criminal Law Clinic, and Special Litigation Unit of the New York Legal Aid Society.

Mr. Crabtree currently is a sole proprietor of his own private law practice specializing in areas of consumer protection, personal injury and professional malpractice litigation and arbitration, and end-of-life medical decision making. Prior to establishing his own private practice, he served as a Partner or an Associate at various law firms in Honolulu, including Bronster, Crabtree & Hoshibata; Paul, Johnson, Park & Niles; and Cronin Fried Sekiya & Kekina. He has successfully litigated, arbitrated, or mediated hundreds of cases and over a dozen jury trials.

Of particular note, Mr. Crabtree successfully brought the first "right to die" case in Hawaii when he and his sister filed a petition in Family Court requesting permission to withdraw the feeding tube from their mother who had suffered a severe and debilitating brain injury that caused her to be totally and permanently disabled. The Family Court held that his mother did not want to be kept artificially alive, that her feeding tube did not provide comfort or pain relief, and that withdrawal of her feeding tube was consistent with state laws regarding medical treatment issues. Furthermore, even if there was any doubt as to whether state laws prohibited the withdrawal of his mother's feeding tube, the Family Court held that his mother had a right to privacy under article I, section 6 of the Hawaii State Constitution. Following the Family Court's ruling, his mother's feeding tube was removed and she passed away. As a result of this experience, Mr. Crabtree has been involved in amending Hawaii's medical treatment decision laws and is committed to advising people on end-of-life medical treatment issues on a pro bono basis. He speaks to dozens of community, legal, and medical organizations statewide, advises and represents individuals, and provides consultation services for other attorneys who have questions in this area. In 1991, the *Honolulu Star-Bulletin* named him as one of the "Ten Who Made a Difference in 1991" and the Hawaii State Bar Association awarded him the Justice Award.

Mr. Crabtree is licensed to practice law in Hawaii and is active in the legal community. He currently serves as an arbitrator for the Court Annexed Arbitration Program; a member of the International Society of Primerus Law Firms, Plaintiff's Consumer Law Institute; an instructor for the Hawaii Professionalism Course, Solo Practice; the Hawaii State Coordinator for the National Association of Consumer Advocates; a panelist for the Hawaii State Bar Association Annual Update on Tort Cases; and a member of the Board of Directors of the Hawaii Association for Justice. He previously served as Vice-Chair for the Judiciary's Rule 19 Committee that conducts judicial evaluations and was a member of the Board of Directors of the Hawaii State Bar Association, Governor's Blue Ribbon Panel on Death and Dying With Dignity, and Planning Committee for the Citizens' Conference on the Judicial Selection Process. Also, for the past ten years, Mr. Crabtree has trained Judge Advocate General (JAG) offices on consumer protection issues, including automobile fraud, debt collection, and fair credit reporting. Lastly, he is involved in community youth baseball and organizes clinics twice a year to deliver the most current information available on youth baseball; the role of nutrition and physical and mental conditioning; and the importance of doing well in school and respecting opponents, coaches, and teammates.

Mr. Crabtree is a published author of legal articles relating to jury instructions in civil cases and effective prevention against legal malpractice in the *Hawaii Bar Journal* and articles relating to the right-to-die issues in the *Hawaii Medical Journal*. He also contributes to *Personal Injury Judgments Hawaii* by preparing a Point of Law Index and publishes a regular blog of recent decisions and opinions of the Hawaii Supreme Court and Intermediate Court of Appeals.

Testimony in support of Mr. Crabtree's appointment commends his dedication to law, high degree of integrity, and willingness to share his insight on trial strategies and complex legal issues. Testifiers describe him as an energetic scholar and writer with a demeanor and temperament that is befitting of a good judge. He is described as one who listens carefully to all points of view, is compassionate and objective, and treats people fairly.

Accordingly, based on testimony submitted on his behalf, your Committee finds that Jeff Crabtree has the experience, temperament, judiciousness, and other competencies to be a Circuit Court Judge. He has a good sense of where the equities, rights, and responsibilities lie in a case, which is essential for a Circuit Court Judge.

As affirmed by the record of votes of the members of your Committee on Judiciary and Labor that is attached to this report, your Committee, after full consideration of the background, experience, and qualifications of the appointee, has found the appointee to be qualified for the position to which appointed and recommends that the Senate consent to the appointment.

Signed by the Chair on behalf of the Committee.
Ayes, 7. Noes, none. Excused, none.

SCRep. 2 Judiciary and Labor on Gov. Msg. No. 2

Recommending that the Senate consent to the nomination of the following:

CIRCUIT COURT OF THE FIRST CIRCUIT, STATE OF HAWAII

G.M. No. 2 CHRISTINE KURIYAMA, for a term to expire in ten years

Your Committee has reviewed the resume and statements submitted by the appointee and finds Judge Christine Kuriyama to possess the requisite qualifications to be appointed to the Circuit Court of the First Circuit, State of Hawaii.

Your Committee received testimony in support of the appointment of Judge Christine Kuriyama to the position of Circuit Court Judge of the First Circuit from forty-three individuals. Comments were submitted by the Board of Directors of the Hawaii State Bar Association.

The Hawaii State Bar Association Board of Directors found the appointee to be qualified for the position of Circuit Court Judge, First Circuit, based on established criteria for determining the qualifications of judicial and executive appointments generally using the American Bar Association Guidelines for Reviewing Qualifications of Candidates for State Judicial Office. Specifically, the Board uses the following criteria in its deliberations: integrity and diligence, legal knowledge and ability, professional experience, judicial temperament, financial responsibility, public service, health, and ability to perform the responsibilities and duties required of the position for which the applicant has been nominated. The Board's rating system includes the categories of "qualified" and "not qualified".

Judge Kuriyama graduated with distinction and earned her Bachelor of Arts degree in Psychology from the University of Hawaii at Manoa. She later received her Doctorate of Jurisprudence from the University of California Hastings College of the Law. Since May 2004, she has served as the presiding District Family Court Judge of the First Circuit where she currently serves as Lead Judge in the Domestic Division handling contested and uncontested matters involving divorce. Since her appointment to the bench, she has been assigned to the Juvenile Division where she handled cases involving juvenile law violators and status offenders as well as Child Welfare Services abuse and neglect cases, and to the Special Division where she handled domestic abuse, paternity, adoption, guardianship, and civil commitment cases.

Judge Kuriyama serves as the presiding judge of the Hawaii Zero to Three Court, which is a Family Court Specialty Court that focuses on addressing the needs of infants and toddlers who are involved in the child welfare system and achieving permanency for these young children in an expeditious manner. She is also responsible for the Oahu Child Welfare Mediation Program and co-chairs the Chapter 587A Task Force, which is responsible for reviewing the State's Child Protective Act to bring state law into compliance with federal regulations. Furthermore, she co-chairs a Juvenile Division committee that is assigned to revise the court calendar and hearing procedures in juvenile and abuse and neglect cases to expedite and streamline the Juvenile Court hearing process.

Prior to her appointment to the District Family Court bench, Judge Kuriyama was a sole practitioner concentrating in the areas of private arbitration and civil litigation. During this time, she served as a Per Diem Judge for the District Family Court of the First Circuit. She was previously a Partner in the law firms of Greeley Walker & Kowen and Fukunaga Matayoshi Hershey & Ching where she specialized in areas of product liability defense, commercial litigation, and appellate work. She also served as a Deputy Attorney General at the Department of the Attorney General where she handled leased fee condemnation cases and was an administrator of time share plans at the Department of Commerce and Consumer Affairs.

Judge Kuriyama is licensed to practice law in Hawaii and is an inactive member of the State Bar of California. She is an active participant in the legal community by serving as President of the Hawaii State Trial Judges Association and member of the Permanent Committee on Family Court Rules and Per Diem Judge Committee. In recognition of her work and accomplishments on the Family Court bench, she received the Hawaii Women Lawyers' Outstanding Judicial Achievement Award in 2013.

Testimony in support of Judge Kuriyama's appointment indicate that with her combined nineteen years of experience as a Per Diem District Family Court Judge and full-time District Family Court Judge, she has developed all of the necessary judicial skills that will make her an experienced adjudicator on the Circuit Court bench. Your Committee notes the amount of testimony submitted by employees of the Judiciary who commend her professionalism, high level of preparation, and excellent demeanor and judicial temperament. She is also commended for her dedicated work and commitment to the Zero to Three Court where she is able to clearly communicate the legal process and consequences to parties who are involved in the child welfare system.

Accordingly, based on testimony submitted on her behalf, your Committee finds that Judge Christine Kuriyama has the experience, temperament, judiciousness, and other competencies to be a Circuit Court Judge. She has a good sense of where the equities, rights, and responsibilities lie in a case, which is essential for a Circuit Court Judge.

As affirmed by the record of votes of the members of your Committee on Judiciary and Labor that is attached to this report, your Committee, after full consideration of the background, experience, and qualifications of the appointee, has found the appointee to be qualified for the position to which appointed and recommends that the Senate consent to the appointment.

Signed by the Chair on behalf of the Committee.
Ayes, 7. Noes, none. Excused, none.

SCRep. 3 Judiciary and Labor on Jud. Com. No. 1

Recommending that the Senate consent to the nomination of the following:

DISTRICT COURT OF THE THIRD CIRCUIT, STATE OF HAWAII

J.C. No. 1 MARGARET K. MASUNAGA, for a term to expire in six years

Your Committee has reviewed the resume and statements submitted by the appointee and finds Margaret K. Masunaga to possess the requisite qualifications to be appointed to the District Court of the Third Circuit, State of Hawaii.

Your Committee received testimony in support of the appointment of Margaret K. Masunaga to the position of District Court Judge of the Third Circuit from the Honorable Mazie K. Hirono, member of the United States Senate for the State of Hawaii; Honorable Colleen Hanabusa, member of the United States House of Representatives for the State of Hawaii; Honorable William P. Kenoi, Mayor of the County of Maui; Hawaii State Commission on the Status of Women; and fifty-nine individuals. Testimony in opposition was received by one individual. Comments were submitted by the Board of Directors of the Hawaii State Bar Association.

Ms. Masunaga earned a Bachelor of Arts degree from the University of California at Berkeley, with distinction, and she was the recipient of the Japanese American Citizens League Award. She later obtained her Doctorate of Jurisprudence from the University of the Pacific McGeorge School of Law where she was a recipient of the Asian American Law Students Association (AALSA) Scholarship and served as the President of AALSA and Minority Representative on the Minority Admissions Committee.

After graduating from law school Ms. Masunaga was an Associate at Goodsill Anderson Quinn & Stifel specializing in general practice and litigation representing financial institutions, hotels, hospitals, doctors, and businesses as well as defendants in criminal cases. She later served as a Deputy Attorney General at the Department of the Attorney General in Kealakekua, where she handled Family Court cases involving paternity and child support. From 2009 to 2013 Ms. Masunaga served as the Deputy Director for the Planning Department of the County of Hawaii assigned to West Hawaii and represented Mayor Kenoi at community meetings and events. From 1992 to 2007 and again since 2013, Ms. Masunaga has served as the Deputy Corporation Counsel for the Office of the Corporation Counsel for the County of Hawaii. In this capacity, she represents various County of Hawaii departments and offices and is the only county attorney in the West Hawaii Civic Center. She handles contract drafting and agency appeals, and cases involving aging and disability, domestic violence prevention, collections, public access, Native Hawaiian issues, cultural practices, trespass, neighbor disputes, zoning violations, land use, restraining orders, and ethics.

Ms. Masunaga is licensed to practice law in Hawaii and has extensive work with the legal community, including the American Bar Association (ABA), Hawaii State Bar Association (HSBA), and West Hawaii Bar Association. She currently serves as a member of the ABA Commission on Women in the Profession and is the ABA State Delegate for Hawaii. She previously served as the President and Treasurer for the West Hawaii Bar Association, Secretary of the HSBA Young Lawyers Division, and Board Member and Treasurer of the HSBA. She also has served as Chairperson of the Hawaii State Commission on the Status of Women and a member of the Supreme Court's Rule 19 Committee regarding judicial performance and Board of Examiners.

Ms. Masunaga is a published author of various articles for ABA publications and has served as a speaker at numerous events in Hawaii and on the mainland. She has also been the recipient of various awards and recognitions, including the ABA Nelson Award for outstanding contributions to the ABA by a government lawyer, the HSBA Young Lawyers Division Justice Award, and the ABA Family Law Section Pro Bono Service Award.

Testimony in support of Ms. Masunaga's appointment commends her commitment to public service as evident in the numerous positions of leadership and responsibilities she has assumed in the public sector, especially in the County of Hawaii. Testifiers describe her has an enthusiastic, professional, and caring attorney with deep ties to Kona and the Big Island community and who is able to communicate with local community clients, which is essential and befitting of a District Court Judge. District Court is often referred to as the "People's Court", and her legal background coupled with her patience, empathy, and willingness to listen to people who are experiencing the court system for the first time will be valuable assets for the District Court.

Despite the numerous testimony received in support of the appointee, your Committee notes that the HSBA Board of Directors found Ms. Masunaga to be unqualified for the position of District Court Judge of the Third Circuit, based on established criteria for determining the qualifications of judicial and executive appointments generally using the American Bar Association Guidelines for Reviewing Qualifications of Candidates for State Judicial Office. Specifically, the Board uses the following criteria in its deliberations: integrity and diligence, legal knowledge and ability, professional experience, judicial temperament, financial responsibility, public service, health, and responsibilities and duties required of the position for which the applicant has been nominated. The Board's rating system includes the categories of "qualified" and "not qualified".

Your Committee notes that the extremely confidential nature and procedures of the process that HSBA uses to rate judicial nominees have been longstanding concerns. Testimony submitted by the HSBA Board of Directors states that the Board "seriously questions the nominee's legal knowledge, diligence, ability to fulfill the responsibilities and duties of the position, and professional experience in legal practice and in civil and criminal proceedings and trials." However, due to the confidentiality rules and processes of the Board, the HSBA President would not disclose to your Committee how this determination was made or what factors, including any weighting of these factors, were used in this determination. Accordingly, your Committee is unable to determine whether the Board's "unqualified" rating is substantiated.

All of the actors in the appointment process, including the Judicial Selection Commission, HSBA, Governor, and Senate, are essential in assuring that the individual who ultimately assumes the weighty mantle of judicial responsibility has been thoroughly vetted, is qualified for the position, and possesses the requisite qualities to fairly, intelligently, and impartially interpret and apply the law that governs our society. Your Committee notes the letter dated October 20, 2014, submitted by the Chief Justice of the Hawaii Supreme Court that discloses the process he employs and the information he takes into account when selecting nominees for positions

as District and District Family Court Judges. Specifically, the Chief Justice states, "I take my authority to select nominees with the utmost seriousness, and strive to select individuals who will excel as judges if they are confirmed by the Senate and have the opportunity to serve." As such, your Committee strongly believes that the Chief Justice used great care in selecting an appointee who will be able to fulfill the responsibilities of the particular judicial vacancy.

Like the Chief Justice, your Committee takes its role in the judicial appointment process seriously. Despite the HSBA Board's finding of Ms. Masunaga as "unqualified", your Committee is not aware of the basis for the HSBA Board's finding. Testimony from the legal community and members of the Kona community reflect the nominee as being multi-faceted, which is an important quality of a jurist.

Accordingly, based on testimony submitted on her behalf, your Committee finds that Margaret K. Masunaga has the experience, temperament, judiciousness, and other competencies to be a District Court Judge. She has a good sense of where the equities, rights, and responsibilities lie in a case, which is essential for a District Court Judge.

As affirmed by the record of votes of the members of your Committee on Judiciary and Labor that is attached to this report, your Committee, after full consideration of the background, experience, and qualifications of the appointee, has found the appointee to be qualified for the position to which appointed and recommends that the Senate consent to the appointment.

Signed by the Chair on behalf of the Committee.
Ayes, 7. Noes, none. Excused, none.

NUMBER AND TITLE	Offered	Referred	Report of Committee	Adoption
S.R. No. 1 AUTHORIZING THE PRESIDENT TO APPROVE THE JOURNAL OF THIS SENATE FOR THE SECOND DAY OF THE FIRST SPECIAL SESSION OF 2014.	4			4