



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

March 22, 2006

The President
The White House
Washington, DC 20500

Re: OSC File No. DI-04-2859 *et al.*

Dear Mr. President:

Four whistleblowers, who have requested anonymity, disclosed to the Office of Special Counsel (OSC) that the U.S. Department of Veterans Affairs (VA), Greater Los Angeles Healthcare System (VAGLAHS), West Los Angeles Medical Center (Medical Center), Los Angeles, California was providing allegedly substandard care to veterans with mental illnesses. Among other allegations, the whistleblowers alleged that the Medical Center was warehousing mentally ill veterans in its Emergency Department (ED), where they were exposed to conditions that were neither therapeutic nor safe for patients in need of psychiatric care.

More specifically, the whistleblowers disclosed that the VAGLAHS management has reduced the number of psychiatric beds available at the Medical Center and closed its Psychiatric Emergency Service (PES) in violation of 38 U.S.C. § 1706. The whistleblowers further alleged that the allocation of psychiatric resources adopted by VAGLAHS management has endangered patients, staff, and the public. According to the whistleblowers, during the frequent bed shortages experienced by VAGLAHS, psychiatric patients presented for emergency care are either admitted to a fictitious ward, Ward 1 East, or are denied immediate treatment and referred to an outpatient facility that is not equipped to treat their serious psychological conditions. The whistleblowers asserted that patients admitted to Ward 1 East are left on gurneys in the ED without the supervision of adequately trained nursing staff or psychiatrists for as many as three days. In addition, the whistleblowers alleged that VAGLAHS management is engaging in an ongoing waste of funds in connection with the administration of long-term care contracts, needlessly extending the amount of time patients spend in high-cost hospital wards and refusing to renew cost-effective, long-term care contracts for mentally ill veterans subject to conservatorships. According to the whistleblowers, the policies and practices adopted by VAGLAHS management are detrimental to the mental health of the patients, present a danger to the safety of patients, staff, and the public, and, in some cases unnecessarily consume VA resources devoted to psychiatric care.

I required the Secretary of Veterans Affairs to conduct an investigation into the whistleblowers' disclosure pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary of Veterans Affairs delegated responsibility for investigating the whistleblowers' allegations to Dr. Jonathan B. Perlin, Undersecretary for Health. Undersecretary Perlin submitted a report on October 13, 2005. The agency's report found that the Medical Center experienced some complications in its provision of psychiatric services when the PES and ED were merged but that there was little evidence these complications produced lasting conditions in which patients were receiving substandard care. In

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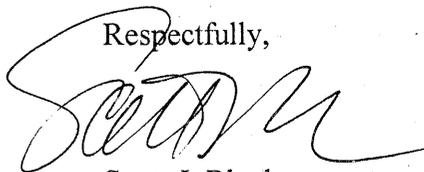
addition, the agency concluded that the whistleblowers' allegations regarding the administration of long-term care contracts were largely unfounded. Finally, where the agency identified shortcoming in psychiatric programs at the Medical Center, it made recommendations for improvement.

Only one whistleblower chose to submit comments regarding the agency's report. In these comments, the whistleblower acknowledged that the situation in the ED had improved by the time the agency's investigative board visited but questioned why the agency did not hold management accountable for the poor planning surrounding the merger of the PES and ED. The whistleblower also maintained that over the past ten years, there has been "major reduction on mental health spending" throughout the Greater Los Angeles Healthcare System, including the elimination of "professional treatment services for alcohol and drug problems." In short, the whistleblower appears to suggest that decisions regarding the allocation of mental health resources within the VAGLAHS system are not made with a view to the wellbeing of psychiatric patients. As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the agency's report along with the whistleblower's comments to you.

Having reviewed the agency's submission and the comments submitted by one whistleblower, I have determined that the agency's report contains all of the information required by statute. As discussed in the enclosed Analysis of Disclosure, I have also concluded on the basis of the evidence available to my office that the report is reasonable within the meaning 5 U.S.C. § 1213(e)(2).

As required by law, 5 U.S.C. § 1213(e)(3), I have sent copies of the agency's report and the whistleblower's comments to the Chairmen of the Senate and House Committees on Veterans Affairs. We have also filed copies of the agency's reports and the whistleblower's comments in our public file and closed the matter.

Respectfully,



Scott J. Bloch

Enclosures