U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

Analysis of Disclosures, Agency Investigation and Report, and Comments of the Special Counsel

OSC File No. DI-07-2512

Summary

The disclosures in this matter were made by Darryl Young, a former Psychological Technician at the Department of Veterans Affairs (VA), New Mexico VA Healthcare System (the Hospital), Behavioral Health Care Line, Albuquerque, New Mexico. Mr. Young alleged that as a result of poor management, supervision, and staffing in the VA Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) unit, a patient committed suicide by overdose. Mr. Young also disclosed that VA physicians routinely prescribe medication to patients without notation to the patient chart.

The VA Office of the Medical Inspector (OMI) conducted an investigation into Mr. Young's allegations of a violation of law, rule or regulation, gross mismanagement and a substantial and specific danger to public health and safety at the Hospital. OMI did not substantiate the allegations disclosed. However, OMI did make findings during its investigation regarding issues of concern with the operation of the SAARTP. The Secretary of Veterans Affairs reports that these issues have been addressed with senior management of the Hospital.

The Special Counsel finds that the agency's report contains all of the information required by statute and that its findings appear to be reasonable.

The Whistleblower's Disclosures

Mr. Young disclosed that until April 2007, he was a Psychological Technician in the Post Traumatic Stress Disorders (PTSD) Clinic at the Hospital. During his employment, on August 10, 2006, a 53-year-old veteran, with a history of recurrent suicide attempts, severe PTSD, depression and substance abuse, was admitted to the SARRTP unit. Mr. Young alleges that during his s17-day stay, the patient was not seen by a clinician for treatment, other than to be offered the opportunity to participate in a substance abuse group focusing on sobriety. Although he had a history of severe PTSD and recurrent suicide attempts, he was not offered treatment for these issues other than medication. According to Mr. Young, shortly thereafter, the patient committed suicide by overdose while a patient in the SAARTP unit.

Mr. Young alleged that the psychologist charged with supervision of the SARRTP during this time, Jennifer Rielage, Ph.D., was not licensed. According to Mr. Young, Dr. Rielage acted as the Director of the SAARTP and was supervised by Dr. Ann Waldorf, Associate Chief, Behavioral Health Care Line, and Chief of Psychology.

In addition, Mr. Young alleged that in December 2006, another patient contacted a social worker in the Behavioral Health Care Line in crisis. According to Mr. Young, the social worker felt that the patient posed a threat to himself or others, and he repeatedly paged Chief of Psychiatry Dr. Jeff Katzman, who was on call, to request that the patient be picked up and brought to the Hospital. Dr. Katzman did not return the pages, and the patient never received adequate treatment, nor did the facility issue an order for local law enforcement to pick up and deliver the patient to the facility for observation. Shortly thereafter, it was reported that the patient killed a family member. Mr. Young alleged that because of the poor management and inadequate care of patients such as these, such incidents could happen more frequently, veterans are not receiving the care to which they are entitled, and the situations themselves pose a danger to public health and safety.

Finally, Mr. Young alleged that VA physicians in the Behavioral Health Care Line prescribe pain medication to patients, but fail to document the prescription in the patient records. In December 2006, a patient called and spoke to Mr. Young, who was then the first point-of-contact for the PTSD Behavioral Health Care Line. The patient requested a refill of Percocet, a narcotic pain medication. Upon review of the patient's chart, Mr. Young found no indication that the patient was receiving this medication from a physician in Behavioral Health, and he informed the patient that he should contact his primary care physician. The patient stated that Dr. Thomas B. Vosburgh, Staff Psychiatrist, PTSD Clinic, always wrote him a prescription and that he would fill it outside the VA. Mr. Young reported that this occurred with patients of Dr. Vosburgh's at least three times while Mr. Young was employed in this position. Over the course of a year, Mr. Young estimates that he received calls of this nature, involving other patients and doctors whose names he did not record, two to three times each month.

Mr. Young reported the incident involving Dr. Vosburgh to his supervisor, Milton Lasoski, Staff Psychologist. Dr. Lasoski responded by instructing Mr. Young to re-write the progress notes he had made in a way that would not reflect that the patient was receiving medication that was not documented in his medical record. Mr. Young indicated that he wrote the facts accurately; however, Dr. Lasoski amended the notes to reflect what he had instructed Mr. Young to write.

The Department of Veterans Affairs' Investigation and Report

The Secretary of Veterans Affairs delegated investigative authority for this matter to the Under Secretary for Health, who directed OMI to investigate Mr. Young's allegations. OMI's investigation team included the Director, Clinical Investigations, Senior Medical Investigator, and a Clinical Psychologist from the VA Central Office, Washington, D.C. (the Team). During the Team's site visit to the Hospital on October 17, 2007, the Team toured the residential unit, reviewed policies, procedures, and related documents, and conducted individual and group interviews with staff, and entrance conferences with Hospital leadership.

According to the agency report, the Team interviewed Mr. Young's supervisor, the Supervisory Social Worker, the SARRTP Director and Clinical Nurse Manager during the time of the reported incidents, the Chief of Psychology, the Acting Chief of Pharmacy, and psychiatrists assigned to the PTSD, SARRTP and primary care mental health programs. In addition, the Team interviewed approximately 20 counselors and social workers in the

Behavioral Health Care Line. The Team subsequently conducted an exit conference by telephone with the Hospital Director and Chief of Staff. According to the agency report, the Team spoke with Mr. Young prior to and during the site visit.

The agency report indicates that OMI's investigation did not substantiate Mr. Young's allegations. During the course of its investigation, however, the Team did make several observations concerning the operation of the SARRTP, which OMI indicated required consideration by Hospital senior management.

August 2006 Patient Suicide

According to the agency report, the Team was unable to ascertain the name of the 53-year-old patient who Mr. Young alleged committed suicide while in the SARRTP unit on August 27, 2006. However, the Team learned that an internal investigation of a 53-year-old patient's death in the SARRTP on August 27, 2006 had been conducted by the VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), Dallas Regional Office. OMI determined that this patient was "most probably" the same patient described by Mr. Young in his allegation, as there was only one reported death in the SARRTP unit in August 2006. The Team's investigation included interviews with staff, a review of the patient's medical records, OHI's investigation summary, the Hospital's written review of the incident, and the Report of Autopsy Findings issued by the Office of the Medical Investigator, University of New Mexico, October 2, 2006.

The agency report indicates that the patient was admitted to the SARRTP on August 10, 2006. He was diagnosed with generalized anxiety disorder and had a history of heroin and cocaine addiction since 1989. Records indicated past suicide attempts, the last of which was reported in 1995. He did not have a diagnosis of PTSD. A review of the patient's medical record revealed that during his admission to the SARRTP unit, he was evaluated regularly by staff and was involved in numerous treatment groups generally conducted by Substance Use Disorder (SUD) program staff. Staff members who were interviewed confirmed that the patient was involved in his groups and was "happy to be participating in the program." There was no indication of suicidal ideation during his stay.

The agency report explains that SARRTP patients are eligible for passes to leave the Hospital after they have been in the program for two weeks. The patients are required to undergo urine drug screens and breathalyzer tests upon their return to the SARRTP. According to the report, the patient received passes to leave the facility on August 25 and 26. Upon his return each day, his urine drug screens were positive for Benzodiazepine, which was prescribed to him, and negative for opiates. The breathalyzer tests were negative. A clinical note indicated that the patient reported mild anxiety with no pain upon his return to the SAARTP on the evening of August 26. The patient was found dead on his bed in the SARRTP unit on the morning of August 27, 2006. Empty syringes were found in the patient's trash and in his car, which was parked in the Hospital lot. A bottle of urine was found in his pocket.

The autopsy report revealed that the patient's blood tested positive for the prescribed Benzodiazepine, and morphine, which was not prescribed to him. The autopsy conclusion was that the combination of these two drugs could cause respiratory failure leading to death. The

coroner determined the patient's death was accidental. Based on its review, the Team concurred that the patient's death resulted from an accidental overdose rather than from suicide. The Team concluded that the patient received appropriate treatment, including proper medication for his depression and anxiety, while in the SAARTP unit, but that the evidence indicated the patient was engaging in ongoing illegal drug use during his treatment in the SARRTP.

Licensure and Supervision of the SAARTP Director

The agency report states that VHA Handbook 5005 provisions relating to staffing provide that "[a]ppointing officers may . . . appoint unlicensed or uncertified candidates who have successfully completed the educational requirements to obtaining the required licensure and certification within 2 years following entry on duty. This is a condition of employment required by law and is mandatory for retention beyond the 2-year period." OMI determined that the Director of the SARRTP unit during the August 2006 time frame, who Mr. Young indentified as Jennifer Rielage, was hired consistent with this provision and received her licensure within the requisite two-year period. In addition, the Team found that she was appropriately supervised during the period in which she was not licensed.

The Team's investigation of this issue revealed that Dr. Rielage was hired in October 2005. She had previously completed a one-year post doctoral fellowship in Substance Abuse Treatment and Education at the VA Puget Sound Health Care System, Seattle, Washington. The report indicates that Dr. Rielage was first supervised by another licensed staff psychologist, and then directly supervised by the Chief of Psychology, who provided the required one hour of formal supervision per forty hours of clinic contact. In addition, the Chief of Psychology stated that she was available to Dr. Rielage via Blackberry, telephone or drop-in, to answer questions or discuss SARRTP issues. The agency report indicates that Dr. Rielage became a licensed psychologist in New Mexico in October 2006.

December 2006 Patient Incident

According to the agency report, the Team was unable to determine the identity of the patient who Mr. Young alleged contacted the Hospital in December 2006 in crisis prior to killing a family member. The Team interviewed the Hospital's Supervisory Social Worker and 16 social workers within the Behavioral Health Care Line. None of the individuals interviewed recalled the incident alleged by Mr. Young.

The Chief of Psychology advised the Team of an incident in December 2006 involving a patient who killed his adult son in self-defense. The Team reviewed the Hospital's issue brief regarding this incident, as well as the medical records of the involved patient. The records reflected that the patient was seen by a social worker at the Santa Fe Community Based Outpatient Clinic (CBOC) on December 7, 2006. The social worker documented the patient's issues with a "turbulent home situation including a violent, drug-abusing son," and a plan for the patient to see the Chief of Psychiatry at the Hospital the following week. The next note, the date of which was not provided in the agency report, was written by the same social worker. The note indicated that St. Vincent's Hospital advised the social worker that the patient had shot and killed his son in self-defense and was hospitalized at St. Vincent's. The documentation reflected that the social worker visited the patient at St. Vincent's, and that "subsequent encounters

demonstrated a comprehensive and caring approach to the patient's distressing problems." The Team found no documentation that the patient, who continues to be seen at the Hospital and the Santa Fe CBOC, contacted the Hospital in distress. The Team further determined through interviews with approximately 20 Behavioral Health Care Line staff members that the staff felt supported by the Chief of Psychiatry and physician staff, and did not experience difficulty in obtaining consultative support or timely approval for involuntary pick-ups of patients.

Undocumented Prescriptions of Pain Medication

The Team investigated Mr. Young's allegation regarding Dr. Vosburgh's failure to document a prescription for Percocet in a patient's record. In addition, the Team asked the Behavioral Health Care Line staff members interviewed whether they had observed any instances in which medications ordered by psychiatrists or physicians were not documented in patient treatment records. Based on its investigation, the Team found that Dr. Vosburgh had in fact recorded the prescription for Percocet in the patient's file. The Team further determined that staff members had not observed any instances in which Dr. Vosburgh or any other physician who ordered medication failed to document the prescriptions in patient treatment records.

According to the agency report, the Team interviewed Mr. Young's supervisor, Dr. Lasoski, regarding the Percocet prescription. Dr. Lasoski provided a copy of Mr. Young's December 26, 2006 patient treatment note, which stated that Dr. Vosburgh had not documented the Percocet prescription in the patient's treatment record. In addition, Dr. Lasoski provided a copy of an August 8, 2006 psychiatry medication management note for this patient written by Dr. Vosburgh, which included an order for Percocet with a four-month follow-up due in December 2006. Dr. Lasoski advised the Team that after Mr. Young did not revise his treatment note to reflect this corrected information, Dr. Lasoski wrote an addendum to the note.

OMI Findings

Based on its investigation, OMI did not substantiate Mr. Young's allegations of a violation of law, rule or regulation, gross mismanagement and a substantial and specific danger to public health and safety. However, the Team did make findings during its investigation regarding the operation of the SAARTP. In particular, the Team questioned whether allowing SARRTP patients access to their vehicles was in the best interest of recovering substance abusers, given that drugs and paraphernalia may be stored in their vehicles. In addition, the Team observed that SARRTP patients were admitted to the program with "no appreciable periods of abstinence" from drugs, and suggested that these patients may require "more aggressive use of replacement therapy under a more structured detoxification program." The Team noted that this raised questions regarding the program's self-medication policy, which required patients to obtain their medications from their primary physicians. The letter from the Secretary of Veterans Affairs accompanying the agency report states that these observations and findings were raised with Hospital senior management, and that an action plan is being developed to address these issues.

The Whistleblower's Comments

Mr. Young provided comments on the agency's report. He expressed his opinion that the investigation was flawed and that the report reflects some inconsistencies. He noted that OMI

contacted the Hospital prior to beginning its investigation, which gave the Hospital advance notice that it was under investigation. In addition, he contended that OMI failed to interview key individuals, and that the agency report erroneously reflects that the Team communicated with him to a greater extent than it actually did.

In relation to his allegation of the patient suicide, Mr. Young noted that there is no indication that the Team interviewed Dr. Irene Ortiz or read her report relating to the investigation of the patient suicide. Mr. Young stated that Dr. Ortiz was directed by the Hospital Chief of Staff to investigate this incident, which prompted her to file a complaint with the New Mexico Psychologists Examiners Board. He stated that it is his understanding from Dr. Ortiz's report that the patient overdosed on prescription medication he had horded over a period of time, and that the patient did not receive adequate treatment during his stay in the SARRTP unit. He further noted that he did not believe the evidence found at the time of the patient's death was consistent with the profile of a longtime heroin and cocaine user. He expressed his opinion that the patient should have been more closely monitored in light of his history of suicide attempts.

Regarding the allegation involving the patient who killed a family member in December 2006, Mr. Young pointed out that it is unclear from the agency report who the Team interviewed regarding this incident. He noted that the social worker who received the call from the patient in crisis, and attempted to reach Chief of Psychiatry Jeff Katzman, is no longer employed by the Hospital, and thus was not interviewed. He also noted that the Team did not interview Dr. Leo Kreuz, the patient's primary physician, who Mr. Young contends filed a complaint against Dr. Katzman regarding this incident. He further indicated that most of the staff did not know about this incident.

In addition, Mr. Young expressed his dissatisfaction with the Team's investigation of his allegations regarding Dr. Vosburgh's and other physicians' failure to record prescriptions in patient treatment records. He refuted Dr. Lasoski's account of the incident, contending that the August 2006 psychiatry medication management note was not in the patient's medical record as of the date Mr. Young left his position at the Hospital in April 2007. In addition, he expressed surprise that the Team did not interview Dr. Vosburgh regarding this issue, given that he was the subject of this particular allegation. He further noted that not all staff members dealt with patients' prescription refill requests, and thus would not have had the opportunity to observe instances in which prescriptions were not documented in patient treatment records.

Conclusion

Based on my review of the original disclosures and the agency report, I have determined that the agency's report contains all of the information required by statute and that its findings appear to be reasonable. Although OMI did not substantiate the specific allegations disclosed by Mr. Young, OMI did find issues concerning the operation of the SARRTP unit, which warrant the attention of Hospital management and the agency in order to ensure the competent care of veteran patients.