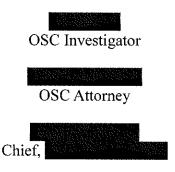


U.S. OFFICE OF SPECIAL COUNSEL

Memorandum

U.S. Office of Special Counsel Report of Prohibited Personnel Practice OSC File No. MA-14-3308 (Teresa Gilbert)



June 8, 2017

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INTRODUCTION

This report by the U.S. Office of Special Counsel (OSC) contains the investigative findings
in OSC File Number MA-14-3308, a complaint of prohibited personnel practices filed by Teresa
Gilbert against the U.S. Department of the Army. Gilbert was a health technician in Infection
Prevention and Control at the Womack Army Medical Center (WAMC). She alleged that the Army
- principally through the and her first-line supervisor,
- retaliated against her for making disclosures to
management officials, the Joint Commission, and the Office of the Inspector General.
The evidence obtained in OSC's investigation demonstrates that retaliated against
Gilbert. From January to May 2014, Gilbert made numerous disclosures regarding WAMC's failure
to follow established infection control protocols and directives and solve 's lack of qualifications'
to serve as
detailed her out of infection control, placed her under investigation, and ultimately sought her
removal. In September 2015, Gilbert settled her complaint for corrective action against the Army. 1
This report summarizes OSC's investigative findings for potential disciplinary action against
OSC concludes that engaged in prohibited personnel practices in violation of 5
U.S.C. §§2302(b)(8) and (b)(9) by taking personnel actions against Gilbert in retaliation for her
protected activity. OSC recommends that the Army take appropriate disciplinary action against
as provided in 5 U.S.C. §1215.

STATEMENT OF FACTS

A. Background

WAMC is one of the Army's largest military hospitals, providing medical services to more than 200,000 people at Ft. Bragg, NC. Ex. 51(B). In 2008, WAMC hired Teresa Gilbert as a GS-8 health technician in Infection Prevention and Control. Ex. 51(A), p. 2. At the time, Gilbert was board-certified by both the American Society of Clinical Pathologists and the American Medical Technologists Organization. During her tenure at WAMC, she also became board-certified as an Infection Preventionist by the Board of Infection Control and Epidemiology. Ex. 51(A).

In September 2013, WAMC commissioned a mock survey of health and safety practices from health care consulting firm in order to prepare the hospital for a May 2014 official inspection by the Joint Commission. Ex. 38(3A). The Joint Commission is the nation's oldest and largest accreditation entity for health care organizations, setting national standards and providing accreditation for health care institutions across the country. The

¹ Because of issues regarding effectuation of the original settlement agreement, Gilbert entered into a final settlement of her claim for corrective action in January 2017.

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Department of Defense mandates that military hospitals, such as WAMC, meet or exceed the standards of the Joint Commission. Ex. 51(D1).

On October 7, 2013, issued its survey results identifying serious infection control failures, and finding that WAMC staff failed to follow infection-control policies and sterilization guidelines, placing hospital patients at serious risk for infection. Ex. 38(3A). For example, found laryngoscope blades out of their sterile packages, temperature logs that did not record the appropriate temperature for storing breast milk, ophthalmoscopes covered in dirt, dirty and unsterilized ophthalmic equipment, deficient reporting of infection control data, and sterilization and safety issues with urology equipment. Ex. 38(3A), pp. 20-22. determined that these unsafe conditions resulted from poor hospital leadership, posed an immediate threat to life, and likely would justify the Joint Commission's denial of preliminary accreditation. Ex. 38(3A), pp. 21-22. "The findings... are extremely serious and put patients at risk. Immediate correction is needed," the report stated. Ex. 38(3A), p. 22.

Notwithstanding the alarming findings of way. WAMC leadership took no effective action to correct the infection control failures. Neither WAMC Commander took the survey results seriously. I later acknowledging will did not "have an appreciation for the significance of the mock survey results," Ex. 38 (12B), and way admitted that following the survey the "hospital went around acting like it was business as usual." Ex. 38 (14E), p.5. The hospital continued to be in non-compliance with infection control policies and procedures throughout Fall 2013, thereby endangering all patients at the facility. Ex. 59, p. 3. Though Gilbert repeated her concerns to both on several occasions, they dismissed her concerns and did nothing to address or correct the reported deficiencies and violations. Ex. 40, pp. 4-5; Ex. 59, p. 3.

On January 4, 2014, WAMC assigned at WAMC and Teresa Gilbert's direct supervisor. Ex.

at WAMC and Teresa Gilbert's direct supervisor. Ex. 35, Tab A, p. 34. had no prior experience or training to serve as board-certified in infection control, Ex. 43(A), p.7, as required by accreditation protocols. When was assigned, the plan apparently was that board obtain the necessary training while serving in the position, *id.*, but during the nine months served as position, *id.*, but during the nine months served as position, *id.*, p. 3.

B. Changes Gilbert's Working Conditions After She Challenges 's Qualifications and Provides the Survey Results to the Joint Commission

Shortly after says appointment, Gilbert had several discussions with regarding the Infection and Control Unit's most significant challenges. Ex. 32, p. 85; Ex. 35(A), p. 18; Ex. 35(B), pp. 51, 69; Ex. 40, p. 3. She told that the hospital continued to fail to address the serious lapses in infection control uncovered by the survey in October 2013. Ex. 40, p. 4. She also on multiple occasions expressed concern regarding states as a serious lapse of the unit. Ex. 35(A), p. 18; Ex. 40, p. 3; Ex. 43(A), p. 7. When became states of the unit. Ex. 35(A), p. 18; Ex. 40, p. 3; Ex. 43(A), p. 7.

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16. And although she had training in infection control and could identify the problems, Gilbert had no authority as a GS-8 to solve them. Gilbert believed the nature and extent of the infection control problems at WAMC required a who was board-certified and trained in infection control, knowledgeable about the issues, and capable of solving them. Ex. 35, pp. 20-21. The Army echoed these same concerns in a subsequent investigation at Womack. Ex. 38(1A), pp. 8-9.

The Joint Commission responded to Gilbert the same day, assuring her that it would examine WAMC's infection control practices and policies during the survey. Ex. 1(H). After receiving Gilbert's disclosures, the Joint Commission advanced its accreditation survey of WAMC by two months. Ex. 43(A), p. 5.

On January 24, 2014, Gilbert told that she had disclosed the survey results to the Joint Commission. Ex. 1(D); Ex. 7, p. 4; Ex. 40, p. 4; Ex. 52, p. 26. Immediately after this, began excluding Gilbert from routine meetings, decisions, and important projects in the unit. Ex. 43(C), pp. 20-23; Ex. 46, pp. 1-2; Ex. 67, pp. 1-3. In no longer allowed Gilbert to attend the Department of Nursing/Daily Nursing Report that convened to discuss the emergency room patient population and pending infection issues. Ex. 67, p. 1. In no longer allowed her to attend the Commander's Morning Report or the Infection Control Representative Meetings. *Id.*also excluded Gilbert from the Functional Management Team (FMT) meetings that occurred monthly to review the hospital's compliance with JC standards and qualification for accreditation. Ex. 38(9C), pp. 1-2; Ex. 52, pp. 20-23; Ex. 67, pp. 1-2. As was later told by who was on detail in IC, felt Gilbert could not be trusted because "she sent the mock survey to joint commission and now they are after us." Ex. 52, p. 26.

C. Excludes Gilbert From Joint Commission Activities and Imposes a Half-Day Schedule Following the Joint Commission's Expedited Review

The Joint Commission originally had scheduled its accreditation review of WAMC for May 2014. Based on Gilbert's disclosures, however, the Joint Commission advanced the survey date by two months. On March 11, 2014, the Joint Commission notified WAMC that it would begin the accreditation survey in one week's time, on March 18, 2014. Ex. 38(12B), p. 8; Ex. 43(A), p. 5.

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On the first day of the survey, wrote to the Northern Regional Medical Command (NRMC) that, "[O]ne of our disgruntled staff [Gilbert] contacted the JC and told them that our IC lead is not qualified to be in that role. Ex 38(7B). We'll see what the JC has to say about all this, however the acting IC nurse is and is doing an outstanding job." *Id.*

On March 21, 2014, the Joint Commission finished its on-site survey and provided an outbrief to WAMC senior officials. Ex. 16(C). The Joint Commission reported deficiencies of such significance that immediate changes at the hospital were required. *Id.* The Army Surgeon General intervened, and ordered WAMC's leadership to stand down. Ex. 35(A), p. 57. U.S. Army Medical Command (MEDCOM) placed elective surgeries at the hospital on hold for several days until protective procedures were established. Ex. 7, p. 4. As explained, "[the Joint Commission and WAMC leadership] were in communication with...the Army Surgeon General...because they were discussing all the issues and trying to decide if they were going to shut down the hospital...." Ex. 35(B), p. 29.

Finally, the Joint Commission calls back, and they're saying we have a serious concern that could potentially be in the threat of life category. . . . [T]he Joint Commission representative called and says . . . you've got some major issues with infection control. Your command is involved. Next thing I know is when I get back to work on Monday [March 24, 2014] is here, and everybody is here and it's a full assault on Womack, and it's just—you know it's horrific, and then, the nightmare began.

Ex. 38(13A), p. 18-19.

Ultimately, four members of WAMC's leadership, including and and received reprimands based on the Joint Commission's findings. Ex. 36(A)-(B). received a reprimand for dereliction of duty:

You had first-hand knowledge that the WAMC infection control problem was not doing well and you did not establish an effective structure to monitor corrective actions following two mock surveys that highlighted problem areas.... You failed to seek assistance from either the Northern Regional Medical Command (NRMC) or MEDCOM. Additionally, you declined offers of assistance from NRMC, erroneously claiming all was well with the infection control program.

Ex. 36(A), p. 1.

's disciplinary action faulted for failing to mitigate against the infection control problems despite knowledge of them:

With your over 20 years of service to Army Medicine, you knew the importance of infection control and knew of issues with Prohibited Personnel Practice Report OSC File No. MA-14-3308 Page 6 of 14

infection control at Womack, yet your command failed to have a structure in place to mitigate the shortcomings revealed in two mock surveys leading up to the Joint Commission survey. As a result, I have lost all faith in your ability to lead.

Ex. 36(B).

During and immediately following the Joint Commission survey, Gilbert to join FMT and Joint Commission meetings, although Gilbert was arguably the most knowledgeable person in the area of infection control. Ex. 42(A)-(D); Ex. 43(C), p. 14. Gilbert complained about her exclusion to and other agency officials, arguing that her knowledge and experience would help the hospital address the Joint Commission's findings. Ex. 42(A)-(D); Ex. 43(C), pp. 13-14; Ex. 43(D), p. 5. But did not reverse actions and no hospital official intervened. Ex. 2 (B2); Ex. 38(8A)-(8B), (9A); Ex. 42(D), pp. 1-2.

Just two weeks after the Joint Commission finished its survey, notified Gilbert that was restricting her to a half-day work schedule and would require her to take four hours of leave each day. Ex. 2(B6)-(B7); Ex. 42(F); Ex. 43(D), p. 6. Gilbert protested the action unsuccessfully. Ex. 34(L); Ex. 40, pp. 6-7; Ex. 42(F)-(G); Ex. 43(C), pp. 23-47.

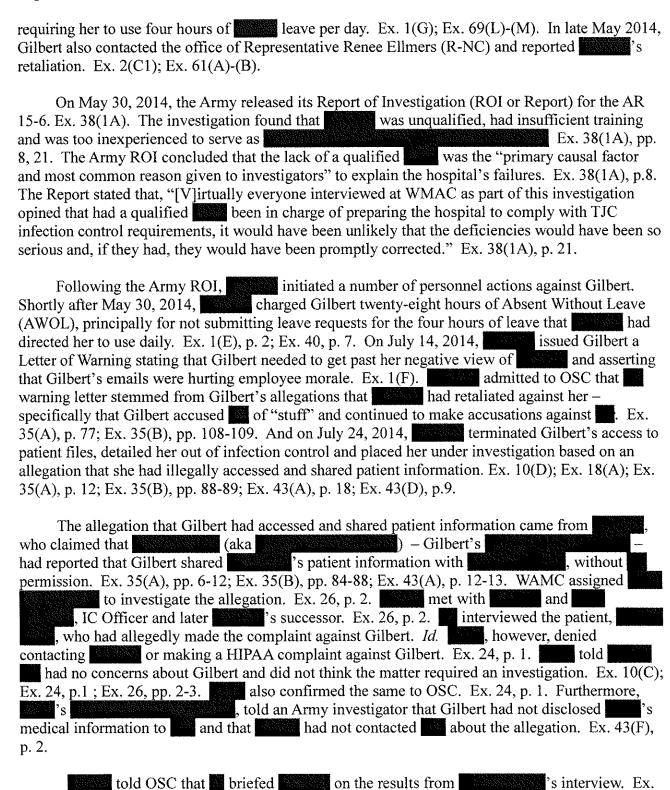
D. Gilbert's Additional Disclosures Result in an Escalating Series of Personnel Actions Ending in a Proposed Removal

Gilbert continued to make disclosures regarding the ongoing deficiencies in the infection control unit, in addition to which she added numerous concerns regarding the stream of the infection control unit, in addition to which she added numerous concerns regarding the stream of the infection control unit, in addition to which she added numerous concerns regarding the stream of the infection control unit, in addition to which she added numerous concerns regarding to stream of the infection control unit, in addition to which she added numerous concerns regarding to streating an atmosphere of secret withholding necessary information. Ex. 2 (B2); Ex. 38 (8B), (9A). Gilbert said that was abusing authority, creating a hostile work environment, and creating an atmosphere of secrecy and exclusion. Id. Within four days, sent an email to Gilbert and other IC staff ordering them not to communicate via email with each other, but to direct all emails to Ex. 2 (B3).

On April 24, 2014, Gilbert cooperated with an Army AR 15-6 investigation of the findings by the Joint Commission. Ex. 38(14G), p. 5. Gilbert disclosed to investigators additional infection control failures at the hospital and secondary actions against her. Ex. 43(C), pp. 20-24. Gilbert also disclosed that the hospital had failed to correct deficiencies identified by the Joint Commission, telling investigators that two dirty cystoscopes with biological residue had been sent to the operating room for use, and that the packaging serial numbers and the numbers on the scopes did not match. Ex. 43(C), p. 49.

On May 5, 2014, Gilbert contacted the Joint Commission again to disclose that WAMC's infection control program continued to deteriorate. Ex. 1(H); Ex. 43(C), p. 12. She relayed a complaint from a doctor who noticed new incidents of "visible matter" and nonmatching serial numbers on several scopes. Ex. 1(H). She also filed a second complaint with the OIG alleging that retaliated against her by excluding her from meetings, restricting her work to half days, and

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26, pp. 4-5. Instead of dropping the matter as requested, however, pressed forward and told to conduct an audit of Gilbert's work for HIPAA violations. Ex. 26, p. 4.

The evidence showed that Gilbert routinely reviewed patient records as part of her duties to ensure

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that patients received correct medication for drug-resistant infectious diseases. Ex. 7, p. 1. Gilbert accessed hundreds of patient records daily, depending on the number of patients admitted into the hospital or seen in the Emergency Department. Ex. 7, p. 1; Ex. 32, pp. 30-32; Ex. 43(C), p. 51.

was a patient at WAMC. Ex. 7, p. 2; Ex. 26, p.5. Thus, and a sudit verified that Gilbert reviewed stream records for approximately two minutes, but concluded that Gilbert's review could have been in the proper course of business. Ex. 10(B); Ex. 26, p.4.

Despite sinconclusive finding, worked with and and personnelist, to seek Gilbert's removal based on the incident. Ex. 43(A), pp. 14-16. however, could not finalize Gilbert's proposed removal before transfer from WAMC. Ex. 32, pp. 21, 24, 85; Ex. 64, pp. 109-110. The task was reassigned to was not Gilbert's supervisor and had not been involved in second sign Gilbert's proposed removal and did on October 20, 2014. Ex. 64, pp. 78-79, 81-87, 90-91; Ex. 5; Ex. 65(A)-(B). A few days later, and decided that it was improper for to propose Gilbert's removal as was not Gilbert's supervisor. Ex. 32, p. 22; Ex. 64, pp. 73, 107-109, 116. They rescinded the proposed removal and reissued it with the same charges on November 10, 2014. Ex. 14(A)-(B). In addition to the charges regarding that Gilbert violated HIPAA by having accessed her own medical records. *Id.* however, confirmed to OSC that accessing one's own medical records is not a violation of HIPAA. Ex. 26, p. 5. OSC obtained a voluntary stay of Gilbert's removal from the agency on December 17, 2014, and the Army never effected it. Ex. 60(A)-(B).

LEGAL ANALYSIS

It is a prohibited personnel practice to take or threaten to take a personnel action because an employee discloses information that she reasonably believes evidences a violation of an agency rule or poses a specific danger to public health or safety. 5 U.S.C. § 2302(b)(8). In order to establish a violation of the statute, four elements must be present: (a) protected disclosure; (b) personnel action; (c) knowledge; and (d) causal connection. To establish a causal connection in a disciplinary action case, preponderant evidence must show that a protected disclosure was "a significant motivating factor in the action, even if other factors also motivated the decision." 5 U.S.C. § 1215(a)(3)(B). The responsible employee, however, may avoid discipline if "the employee demonstrates, by preponderant evidence, that the employee would have taken, or threatened... the same personnel action, in the absence of such protected activity." *Id.*; S. Rep. No. 112-155, at 14-15 (2012) (discussing significant factor test).

In this case, as we demonstrate below, the evidence is clear that Gilbert made protected disclosures, that had knowledge of those disclosures, that they were a significant

testified that no one asked at the time whether Gilbert had legitimate reasons to access 's medical records. Ex. 64, p. 52. said that the Agency failed to examine the circumstances of Gilbert's review of records when it proposed her removal. Ex. 64, p. 64-68. Not until 2016 did anyone ask to analyze whether Gilbert had a legitimate reason to review 's records. Ex. 64, pp. 52-53. concluded in 2016 that there was no legitimate reason for Gilbert to be in 's records and an appropriate penalty would be a reprimand. Ex. 64, pp. 113-114.

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motivating factor in the personnel actions that took against her, and that those actions would not have been taken in the absence of Gilbert's protected disclosures. Thus, OSC concludes that discipline is warranted. While OSC lacks independent authority to discipline a member of the uniformed services for a prohibited personnel practice, OSC has statutory authority to transmit recommendations for disciplinary and other appropriate action to the head of the agency for consideration. 5 U.S.C. § 1215(c)(1).

A. Gilbert Made Protected Disclosures and Engaged in Protected Activity

A disclosure is a formal or informal communication or transmission that the employee reasonably believes evidences any violation of any law, rule, or regulation, gross mismanagement, gross waste of funds, abuse of authority, or a substantial and specific danger to public health or safety. 5 U.S.C. § 2302(a)(2)(D); Mithen v. Dep't of Veterans Affairs, 119 M.S.P.R. 215 (2013).

The standard for evaluating "reasonableness" is an objective one: could a disinterested observer with knowledge of the essential facts known to and readily ascertainable by the employee reasonably conclude that the information evidences an impropriety defined in the statute. <u>Lachance v. White</u>, 174 F.3d 1378, 1381 (Fed. Cir. 1999), codified by Whistleblower Protection Enhancement Act of 2012, 5 U.S.C. § 2302(b). An employee need not prove an actual violation to establish that she had a reasonable belief that her disclosure met statutory criteria. <u>Stiles v. Dep't of Homeland Sec.</u>, 116 M.S.P.R. 263 (2011).

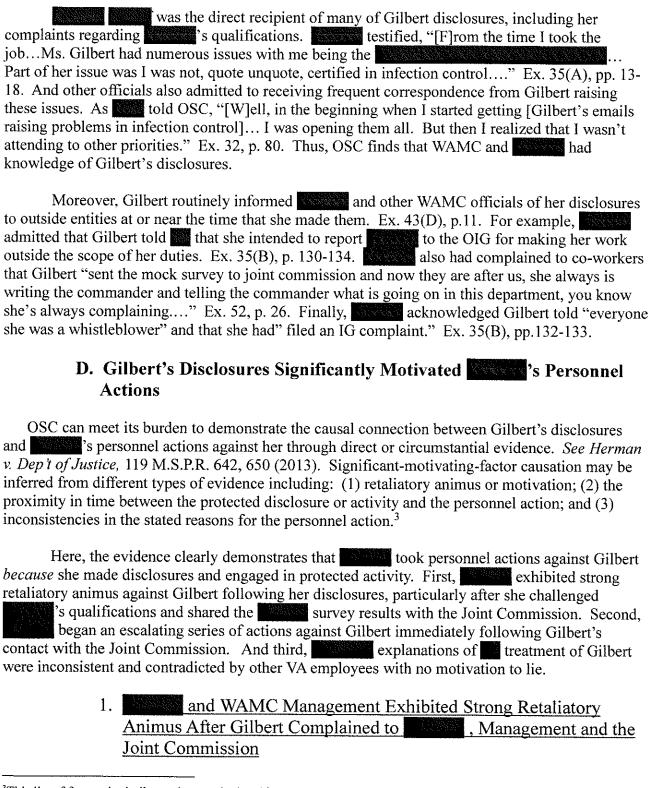
Based on the results of OSC's investigation, OSC concludes that Gilbert made protected disclosures and engaged in other forms of protected activity on multiple occasions between January and May 2014. As discussed in the facts, *supra*, at 3, 4 and 6, Gilbert provided information to other WAMC officials, the OIG, the Joint Commission, agency investigators, and a congressional office that evidenced specific and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of infection protocols and serious danger to patient health because of lax enforcement of the lax enforcement danger to patient health because of lax enforcement danger to patient health because of lax enforcement danger to patient health because of lax enforcement da

B. Took a Number of Personnel Actions Against Gilbert

A "personnel action" is defined in 5 U.S.C. § 2302(a)(2)(A) and includes disciplinary or corrective actions, a detail, a decision concerning benefits, and a significant change in duties, responsibilities, or working conditions. OSC found that took or threatened a series of personnel actions against Gilbert, specifically: (1) excluding Gilbert from important infection control meetings and business, (2) forcing Gilbert to take leave involuntarily, (3) placing her in AWOL status, (4) issuing her a letter of warning, (5) detailing her out of infection control; and (6) subjecting her to a misconduct investigation that resulted in a proposed removal from service.

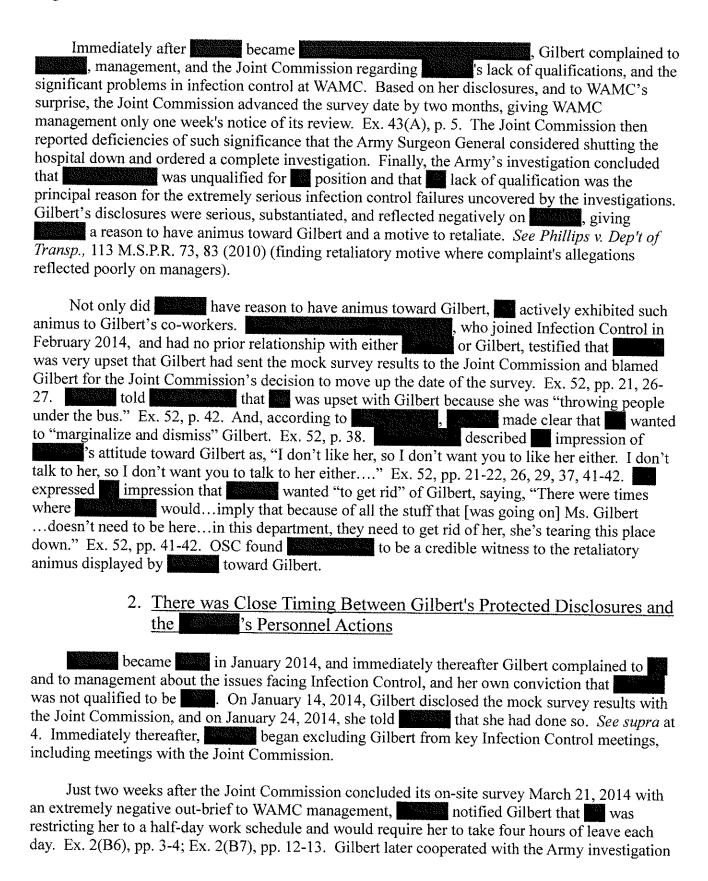
C. Had Knowledge of Gilbert's Disclosures

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³This list of factors is similar to those articulated in case law applying the "significant factor" standard under civil service laws and the "motivating factor" standard under the Uniformed Services Employment and Reemployment Rights Act. See, e.g., Mt. Healthy City Sch. Dist. Bd. of Educ. v. Doyle, 429 U.S. 274, 287 (1977); Sheehan v. Dep't of the Navy, 240 F.3d 1009, 1014 (Fed. Cir. 2001); Marshall v. Dep't of Veterans Affairs, 111 M.S.P.R. 5, 13 (2008).

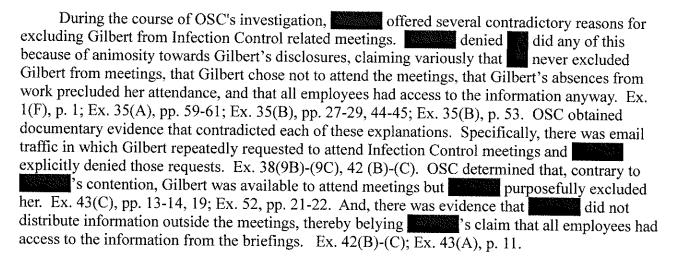
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into the findings of the Joint Commission, the Report of Investigation of which was released on May 30, 2014. Shortly thereafter, charged Gilbert twenty-eight hours of AWOL for not submitting leave slips for the leave she was required to take. See Fitzgerald v. Dep't of Homeland Sec., 107 M.S.P.R. 666, 676 (2008)(holding that an inference of retaliatory intent can be drawn from evidence of suspicious timing). And following the Army ROI, engaged in the escalating series of personnel actions, including removing her authority to access patient records, placing her under investigation, and seeking her removal. See supra at 7.

3. Gave Inconsistent and Contradictory Explanations for Personnel Actions



Moreover, while schedule based on Ex. 2(B6)-(B7); Ex. 42(F); Ex. 43(C), pp. 23-47. When confronted, said was following instructions from HR Liaison Ex. 35(B), pp. 5,8; Ex. 43(A), p.11. however, contradicted nequivocally that was not involved in the decision to keep Gilbert on a half-day schedule once and, further, that it was illegal to force Gilbert to use leave under the circumstances. Ex. 58, p. 43. Similarly, disputed so claim that had told to place Gilbert on AWOL when Gilbert did not submit leave slips. Ex. 58, pp. 57-58, 64. said management mishandled Gilbert's case and that eventually resigned over too many improper management tactics. As put it, "I was washing my hands of ... [what] was going on because it was just so much." Ex. 58, pp. 64.

's decisions in late July to terminate Gilbert's access to patient files, detail her out of infection control, and investigate her for misconduct, were not supported by the results of investigations by the hospital, the Army, or OSC. See discussion, *supra* at 7. Rather, the results of those investigations demonstrated that consistently denied to investigators having ever made a HIPAA complaint against Gilbert, and that Gilbert's access to the patients' files was consistent with the discharge of her normal duties. Ex. 1(C); Ex. 24, p. 1.

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E. Cannot Show that Would Have Taken the Same Personnel Actions in the Absence of Gilbert's Protected Activity

Because the direct and circumstantial evidence described above demonstrates that Gilbert's protected disclosures were a significant motivating factor in the Army's multiple personnel actions against her, OSC has established a prima facie case of whistleblower retaliation justifying discipline. The burden thus shifts to to show that would have taken the same personnel actions against Gilbert in the absence of Gilbert's protected disclosures. 5 U.S.C. § 1215(a)(3)(B).

We conclude that cannot establish by preponderant evidence that would have taken the same personnel actions against Gilbert even had Gilbert not blown the whistle. As noted above, supra at 12, the reasons that gave for each of the personnel actions took were either inconsistent with the documentary evidence, inconsistent with wown prior statements, or directly contradicted by other witnesses. The lack of clear and consistent explanations for contested personnel actions makes it difficult to prove that they were taken for a reason other than Gilbert's engaging in protected activity. Moreover, the facts showed a clear pattern of personnel actions that had the effect of restricting Gilbert's access to information concerning infection control practices by excluding her from meetings, eliminating her access to patient charts, limiting her to half-days in the workplace, detailing her out of the unit, and seeking her removal. There does not seem to be any logical explanation for this pattern of using personnel actions to limit access to information that formed the basis for Gilbert's disclosures other than that they were taken to prevent her from whistleblowing and therefore would not have been taken absent her protective activities. In short, spattern of retaliatory actions cannot be explained by causes independent of Gilbert's protected activity. Therefore, it is unlikely that could present an affirmative defense that would have taken those actions anyway.

RECOMMENDATION FOR DISCIPLINARY ACTION

While a single retaliatory personnel action is sufficient to warrant discipline, OSC's investigation found evidence that engaged in a pattern of retaliatory personnel actions against Gilbert. Based on these findings, OSC concludes that violated 5 U.S.C. § 2302(b)(8) and should be disciplined for committing prohibited personnel practices.

In mitigation, the evidence showed that was not prepared for the responsibility and challenge of managing the hospital's infection control program. I lack of experience and credentials were cited as major factors in the program's failures. It assignment was intended only to be temporary. The evidence also showed that higher-level officials at the hospital, from whom took direction, displayed such a lax attitude toward the program that they failed to take the mock survey or Gilbert's whistleblowing disclosures seriously.

Still, "'s pattern of actions against Gilbert aggravated the seriousness of the hospital's infection control problems, increased the risk of harm to hospital patients, and likely served as a

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deterrence to others to blow the whistle on threats to patient health and safety. The latter is of particular importance because the government depends on the courage of employees like Teresa Gilbert to speak up when they see dangers and inefficiencies, especially when patient health and safety is at stake.

OSC has jurisdiction to recommend that the Secretary of the Army take appropriate disciplinary action against for personnel actions took or threatened against Gilbert because of protected activity. 5 U.S.C. § 1215(c)(1). By statute, the Army is required to provide OSC with a report of the actions it takes or proposes against within 60 days of receiving this report. 5 U.S.C. § 1215(c)(2).