The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-21-000799

Dear Mr. President:

I am forwarding to you reports transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA) in response to the Special Counsel’s referral of disclosures of wrongdoing at the Sheridan VA Medical Center (Sheridan VAMC), Sheridan, Wyoming. The whistleblower, [NAME], a former dispatcher who consented to the release of his name, alleged a substantial and specific danger to public health and safety and gross mismanagement. I have reviewed the disclosure and the agency reports, and, in accordance with 5 U.S.C. § 1213(e), I have determined that the reports meet all statutory requirements, and the findings appear reasonable. The agency did not substantiate the allegations, and [AGENCY] did not comment on the reports.

The Allegations

[NAME] alleged that agency officials failed to evaluate and remediate structural damage to Sheridan VAMC Building 9 that occurred during a construction project in June 2021. [NAME] also alleged that Sheridan VAMC buildings suffer from persistent bat infiltrations in ceiling spaces, resulting in maggot infestations in Buildings 86 and 87. In addition, [NAME] alleged that Sheridan VAMC Police Department Chief [DEPARTMENT] prevented the investigation of a motor vehicle accident involving minor children that occurred on federal property; and that [OFFICER] and former Deputy Chief [DEPARTMENT] improperly interfered in psychological evaluations of police officers in the Sheridan VAMC Police Department.

[1] Allegations were referred to VA Secretary Denis R. McDonough for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, directed the VA Office of the Medical Inspector to conduct the investigation. Secretary McDonough reviewed and signed the agency reports.
The President  
June 6, 2023  
Page 2 of 4

The Agency Reports

1. The Agency Found that Officials took Necessary Precautions when Allowing Staff to Return to Building 9, and that Maggot Infestations Were Not a Recurring Problem.

The agency investigation did not substantiate the allegations. Investigators first determined that the removal of a load-bearing “I-beam” during construction of a dental facility in Sheridan VAMC Building 9 caused significant structural issues around the construction zone. On July 9, 2021, Sheridan VAMC officials learned that a sudden subsistence of the third floor above the construction zone threatened to break the sprinkler water supply lines in the ceiling and rendered the sprinkler system non-functional. Consequently, management immediately evacuated Building 9 while a team of engineers and contractors developed a plan to remediate the damage through additional shoring. The investigation found that on July 12, 2021, the structural engineer verbally approved a plan to re-occupy the area, except for rooms on the south and west sides. By the morning of July 13, 2021, the structural engineer had given written approval to re-occupy rooms on the south and west sides of the building. Later that day, Sheridan VAMC officials notified occupants of the south and west sides of the building that they could return to their offices. The report, therefore, concluded that agency officials took appropriate precautionary measures in response to their discovery of the damage to Building 9 because the building was not occupied until a structural engineer approved temporary repairs, and portions of the third floor remained closed pending further assessment.

With respect to the allegation that persistent bat infiltrations in ceiling spaces led to maggot infestations in Buildings 86 and 87—the report identified one incident involving maggots. In June 2021, staff members reported maggots on the floor of an interior hallway leading to Buildings 86 and 87. The report surmised that a dead animal carcass in the ceiling likely attracted maggots that subsequently fell onto the floor of the hallway through a ceiling vent. The investigation found that agency officials initially covered two ceiling vents with plastic, and then subsequently removed the carcass. Ultimately, agency officials sealed the vents permanently from the inside. Upon inspection, investigators observed no animal carcasses or maggots. Thus, the report concluded that agency officials appropriately addressed the isolated incident involving maggots in Buildings 86 and 87 when staff members reported the issue.

Although the agency did not substantiate the allegation concerning maggot infestations, the report nonetheless acknowledged an ongoing issue with bat incursions on the Sheridan VAMC campus. The report identified a total of 29 bat removals from Sheridan VAMC buildings.

---

2 The investigation found that the police dispatch area on the north side of the third floor required additional shoring after July 13, 2021.
3 The report also found that the structural engineer stated in an email on July 21, 2021, that additional shoring was necessary before the vacated offices in rooms 310, 311, and 312 could be re-occupied; however, the additional shoring had already been completed on July 14, 2021.
in fiscal years 2020 and 2021 but stated that agency officials manage these bat incursions appropriately by taking corrective action when they arise.

2. After OSC Follow Up, the Agency Took Additional Steps to Mitigate Bat Incursions.

OSC requested a supplemental report addressing the extent of the bat incursions, as well as any preventative actions agency officials have taken to mitigate the risk of future bat incursions. The supplemental report clarified that Sheridan VAMC averages 8-12 brown bat removals annually and that Sheridan VAMC has constructed bat houses around the west side of the facility to encourage the bats to nest there instead of inside the buildings. In conjunction with the Wyoming Game and Fish Department, any reported bats are removed and taken to the local animal shelter. Furthermore, in February 2021, Sheridan VAMC officials completed a bat mitigation project that resealed Building 2 (the Wellness Center) following complaints of bat intrusions. Additionally, the supplemental report noted that Sheridan VAMC officials planned a construction project to expand bat mitigation on an additional 37 buildings—including all patient care buildings. OSC requested an update on this additional construction project, and in its April 2023 response, the agency stated that Sheridan VAMC officials awarded the contract for the bat mitigation project on February 17, 2023, and the scheduled completion date was May 14, 2023.


Next, the investigation concluded that [Redacted] did not prevent the investigation of a motor vehicle accident involving minor children on federal property. The report acknowledged that an incident on April 4, 2021, matched the description of [Redacted] allegation. The accident involved an unlicensed underage driver, determined to be [Redacted] son, as well as an unidentified VA employee. Due to the involvement of a family member of the Sheridan VAMC police force, the officer who responded to the accident attempted but failed to secure the assistance of the Sheridan County Sheriff’s Office and the Wyoming Highway Patrol. Consequently, [Redacted] appointed the responding officer to conduct the investigation. On April 5, 2021, the responding officer contacted the Assistant U.S. Attorney to assess any potential violations of federal law, but that review found none. The responding officer subsequently received an email from [Redacted] indicating that the VA employee involved in the accident would not provide a statement. The responding officer closed the investigation on April 7, 2021, and the involved VA employee was referred to their supervisor for administrative actions. The responding officer told investigators that he did not believe [Redacted] had attempted to interfere with the investigation.

Finally, the investigation did not conclude that [Redacted] and [Redacted] improperly interfered with police officer psychological evaluations. Specifically, the report disputed [Redacted] assertion that [Redacted] and [Redacted] provided evaluators with social media
posts from employees to negatively bias their psychological evaluations as a basis for removing disfavored employees from their positions. [Redacted] denied researching any police officer’s social media posts or providing any such posts to the evaluating psychologist(s). Moreover, [Redacted] indicated that he was not involved in any component of police officer psychological evaluations. Other police officers interviewed as part of the agency’s investigation also denied having any knowledge that [Redacted] or [Redacted] provided evaluators with social media posts.

The Report’s Recommendation

Nonetheless, the report provided a recommendation to Sheridan VAMC concerning potential non-compliance with a VHA Directive related to police officer psychological evaluations conducted via telehealth. VHA Directive 0730(1), Psychological Evaluations of VA Police Officers, Telehealth Considerations, provides that “[r]emote audio-visual monitoring, even with self-administered instruments, is essential” when conducting a psychological evaluation in a telehealth environment. The investigation found that during [Redacted] psychological evaluation, conducted in June 2021 as part of the hiring process, the proctor failed to respond to a question from [Redacted] for approximately seven minutes. The report noted that the seven-minute unresponsive period raised concerns regarding Sheridan VAMC’s potential violation of VHA Directive 0730(1). Consequently, the report recommended that the Contracting Officer Representative should, in consultation with mental health clinicians, ensure that psychological evaluators comply with VHA Directive 0730(1) and with clinical standards for appropriate psychological evaluations conducted via telehealth.

The Special Counsel’s Findings

I thank the whistleblower for bringing forward these allegations to OSC. Based on the findings of the investigation, I have determined that the agency reports meet all statutory requirements, and their findings appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter and the agency reports to the Chairs and Ranking Members of the Senate and House Committees on Veterans’ Affairs. I have also placed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures