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U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

"Addressing Continued Whistleblower Retaliation Within the VA"

April 13, 2015, 4:00 P.M.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our ongoing work with whistleblowers at the Department of Veterans Affairs (VA).

In July of last year, I spoke to this Committee about OSC's early efforts to respond to the unprecedented increase in whistleblower cases from VA employees. Since that time, and as detailed in the sections below, there has been substantial progress. For example, OSC and the VA implemented an expedited review process for retaliation claims. This process has generated timely and comprehensive relief for many VA whistleblowers. In addition, in response to OSC's findings, the VA overhauled the Office of Medical Inspector (OMI), and has taken steps to better respond to the patient care concerns identified by whistleblowers. Finally, in response to the influx of whistleblower claims, the VA became the first cabinet-level department to complete OSC's "2302(c)" whistleblower certification program. The program ensures that employees and managers are better informed of their rights and responsibilities under the whistleblower law.

Despite this significant progress, the number of new whistleblower cases from VA employees remains overwhelming. These cases include disclosures to OSC of waste, fraud, abuse, and threats to the health and safety of veterans, and also claims of retaliation for reporting such concerns. OSC's monthly intake of VA whistleblower cases remains elevated at a rate nearly 150% higher than historical levels. The percentage of OSC cases filed by VA employees continues to climb. OSC has jurisdiction over the entire federal government, yet in 2015, nearly 40% of our incoming cases will be filed by VA employees. This is up from 20% of OSC cases in 2009, 2010, and 2011.

These numbers provide an important overview of the work OSC is doing. And, while these numbers point to an ongoing problem, it is important to put them in context. The current, elevated number of VA whistleblower cases can be viewed as part of the larger effort to restore accountability at the VA, and do not necessarily mean there is more retaliation than before the scheduling and wait list problems came to light, or that there are more threats to patient health and safety. Instead, these numbers may indicate greater awareness of whistleblower rights and greater employee confidence in the systems designed to protect them.

The current VA leadership has shown a high level of engagement with OSC and a genuine commitment to protecting whistleblowers. As many VA officials and Members of this Committee have repeatedly stated, culture change in an organization the size of the VA is

difficult and will take time. But, if the current number of whistleblower cases is an indication of employees' willingness to speak out, then things are moving in the right direction.

I. Whistleblower Retaliation – Collaboration with the VA to Provide Expedited Relief to VA Employees

My July 2014 statement to the Committee summarized a series of whistleblower retaliation cases. I noted, "The severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns." I further noted that Acting (now Deputy) Secretary Gibson had committed to resolving meritorious whistleblower retaliation cases with OSC on an expedited basis.

Since that time, OSC, working in partnership with the VA's Office of General Counsel (OGC), implemented an expedited review process for whistleblower retaliation cases. This process has generated significant and timely results on behalf of VA employees who were retaliated against for speaking out. To date, we have obtained 15 corrective actions for VA whistleblowers through this process, including landmark settlements on behalf of Phoenix VA Medical Center (VAMC) employees. Summaries of the cases in which the employees consented to the release of their names are included below:

- **Katherine Mitchell, Phoenix VAMC** – Dr. Mitchell blew the whistle on critical understaffing and inadequate triage training in the Phoenix VAMC's emergency room. According to Dr. Mitchell's complaint, Phoenix VAMC leadership engaged in a series of targeted retaliatory acts that included ending her assignment as ER Director. Dr. Mitchell has 16 years of experience at the Phoenix VAMC, and also testified twice before this Committee last year. Among other provisions, Dr. Mitchell's settlement included assignment to a new position that allows her to oversee the quality of patient care.

- **Paula Pedene, Phoenix VAMC** – Ms. Pedene was the chief spokesperson at the Phoenix VAMC, with over two decades of experience. She made numerous disclosures beginning in 2010, including concerns about financial mismanagement by former leadership at the medical center. Many of the allegations were substantiated by a November 2011 VA Office of Inspector General review. Subsequently, according to Ms. Pedene's reprisal complaint, Phoenix VAMC management improperly investigated Pedene on unsubstantiated charges, took away her job duties, and moved her office to the basement library. Among other provisions, Ms. Pedene's settlement includes assignment to a national program specialist position in the Veterans Health Administration, Office of Communications.

- **Damian Reese, Phoenix VAMC** – Mr. Reese is a Phoenix VAMC program analyst. He voiced concerns to Phoenix VAMC management about the amount of time veterans had to wait for primary-care provider appointments and management's efforts to characterize long wait times as a "success" by manipulating the patient records. After making this disclosure, Mr. Reese had his annual performance rating downgraded by a senior official

with knowledge of his email. Mr. Reese agreed to settle his claims with the VA for mutually agreed upon relief.

- **Mark Tello, Saginaw VAMC** – Mr. Tello was a nursing assistant with the VAMC in Saginaw, Michigan. In August 2013, he told his supervisor that management was not properly staffing the VAMC and that this could result in serious patient care lapses. The VAMC then issued a proposed removal, which was later reduced to a five-day suspension that Mr. Tello served in January 2014. The VA again proposed his removal in June 2014. OSC facilitated a settlement where the VA agreed, among other things, to place Mr. Tello in a new position at the VA under different management, to rescind his suspension, and to award him appropriate back pay.

- **Richard Hill, Frederick, MD** – Dr. Hill was a primary care physician at the Fort Detrick, Community Based Outpatient Clinic (CBOC) in Frederick, Maryland, which is part of the Martinsburg, West Virginia VAMC. In March 2014, Dr. Hill made disclosures to VA officials, the VA Office of Inspector General, and others regarding an improper diversion of funds that resulted in harm to patients. Specifically, Dr. Hill expressed serious concerns about the lack of clerical staff assigned to his primary care unit, which he believes led to significant errors in patient care and scheduling problems. In early May 2014, the VA issued Dr. Hill a reprimand. Dr. Hill retired in July 2014. As part of the settlement agreement between Dr. Hill and the VA, the VA has agreed to, among other provisions, expunge Dr. Hill's record of any negative personnel actions.

- **Rachael Hogan, Syracuse VAMC** – Ms. Hogan is a registered nurse (RN) with the VAMC in Syracuse, New York. She disclosed to a superior a patient's rape accusation against a VA employee and, when the superior delayed reporting the accusations to the police, warned the superior about the risks of not timely reporting the accusations. Later, she complained that a nurse fell asleep twice while assigned to watch a suicidal patient and that another superior engaged in sexual harassment, and made a number of other allegations regarding the two superiors. In spring 2014, the two superiors informed Ms. Hogan that they would seek a review board to have her terminated because of her "lack of collegiality" and because she was not a good fit for the unit, and gave her an unsatisfactory proficiency report. The VA agreed to stay the review board for the duration of OSC's investigation. As part of the final settlement, the agency permanently reassigned Ms. Hogan to a RN position under a new chain of command, corrected her performance evaluation, and agreed to cover the costs for an OSC representative to conduct whistleblower protection training at the facility.

- **Charles Johnson**, **Columbia VAMC** – Mr. Johnson, a technologist in the radiology department at the VA Medical Center in Columbia, South Carolina, disclosed that a doctor ordered him to hydrate a patient using a new, unfamiliar method in February 2014. Due to his concerns about the new hydration method, Mr. Johnson consulted with two physicians about the method, neither of whom would verify the method's safety. Mr. Johnson then contacted his union, which suggested he send an email seeking clarification of the method under the VA's "Stop The Line For Patient Safety" policy. In July 2014,

Mr. Johnson was issued a proposed five-day suspension by the same doctor whose hydration method Mr. Johnson had questioned. In October 2014, at OSC's request, the VA agreed to stay Mr. Johnson's suspension. In February 2015, Mr. Johnson and the VA settled his case, under which the VA will, among other things, rescind the proposed suspension and evaluate the hydration method.

- **Phillip Brian Turner, San Antonio, TX** – Mr. Turner is an advanced medical support assistant in a VA Behavioral Health Clinic in San Antonio, Texas. In April 2014, Mr. Turner emailed his supervisor and others about his concerns that the agency did not follow proper scheduling protocols and may have falsified or manipulated patient wait times for appointments. The next day, VA management instructed him to stop emailing about the VA's scheduling practices. Several weeks later, in May 2014, VA management directed Mr. Turner to sign four copies of the VA's media policy, which he refused to do. On May 9, 2014, an article in the San Antonio Express-News—one of the largest newspapers in Texas—quoted a high-level VA official as stating that the agency had conducted an investigation into Mr. Turner's allegations and that Mr. Turner retracted his comments about the improper scheduling practices. Mr. Turner denies making any such retraction. The VA's actions in this case raise important concerns due to the potential chilling effect on other whistleblowers. The case was settled in February 2015 and the VA agreed to several corrective actions.

- **Debora Casados, Denver, CO** – Ms. Casados is a nurse in the VA Eastern Colorado Health Care System. In August 2014, she reported that a coworker sexually assaulted two other VA staff members and made inappropriate sexual comments to her. Human resources told Ms. Casados and the other staff that they were not permitted to discuss the allegations and threatened them with disciplinary action if they did so. In October, human resources removed Ms. Casados from her nursing duties at the clinic and reassigned her to administrative tasks. In January 2015, she was moved again, this time to a windowless basement office to scan documents. In February, her superior denied Ms. Casados leave to care for her terminally ill mother. On April 3, 2015, the VA agreed to OSC's request for an informal stay on behalf of Ms. Casados, returning her to nursing duties at another clinic while OSC investigates her whistleblower reprisal claims to determine if additional corrective action and disciplinary action are appropriate.

Including these cases, in 2014 and 2015 to date, OSC has secured either full or partial relief for over 45 VA employees who have filed whistleblower retaliation complaints. OSC is on track to help nearly twice as many VA employees in 2015 as in 2014. These positive outcomes have been generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution program. OSC is currently examining about 110 pending claims of whistleblower retaliation at the VA involving patient health and safety, scheduling, and understaffing issues. These pending claims involve VA facilities in 38 states and the District of Columbia. We look forward to updating the Committee as these cases proceed.

II. Whistleblower Disclosures and the Office of Medical Inspector

In my July 2014 testimony, I raised concerns about the VA's longstanding failure to use the information provided by whistleblowers as an early warning system to correct problems and prevent them from recurring. I summarized a series of cases in which the Office of Medical Inspector (OMI) identified deficiencies in patient care, such as chronic understaffing in primary care units, and the inadequate treatment of mental health patients in a community living center. In each case, OMI failed to grasp the severity of the problems, attempted to minimize concerns, and prevented the VA from taking the steps necessary to improve the quality of care for veterans.

In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. Overall, we believe this review has resulted in positive change. A recent whistleblower case is demonstrative.

The case concerns a whistleblower disclosure from a VA employee in Beckley, West Virginia. In response to OSC's referral, OMI conducted an investigation and determined that the Beckley VAMC attempted to meet cost savings goals by requiring mental health providers to prescribe older, cheaper antipsychotic medications to veterans, to alter the current prescriptions for veterans over the objections of their providers, with no clinical review or legitimate clinical need for the substitutions, in violation of VA policies. The investigation additionally found the substituted medications could create medical risks and "may constitute a substantial and specific risk" to the health and safety of impacted veterans. In addition, the OMI investigation found that the formal objections of at least one mental health provider were not documented in the meeting minutes at which the provider raised concerns.

The OMI investigation called for a clinical care review of the condition and medical records of all patients who were impacted, and an assessment of whether there were any adverse patient outcomes as a result of the changed medications. OMI also recommended that, where warranted, discipline be taken against Beckley VAMC leadership and those responsible for approving actions that were not consistent with VA policy, and which could constitute a substantial and specific danger to public health and the safety of veterans.

While the facts of this case are troubling, the OMI response is encouraging. In an organization the size of the VA, problems will occur. Therefore, it is critical that when whistleblowers identify problems, they are addressed swiftly and responsibly. And OMI is an integral component in doing so.

In recent days, we have received additional information from whistleblowers indicating that the OMI recommendations may not have been fully implemented by Beckley VAMC management. Accordingly, we will follow up with the VA to verify that all OMI recommendations in the Beckley investigation, including disciplinary action and necessary changes to the prescription protocol, have been taken.

III. Training Initiatives and Areas of Ongoing Concern

A. OSC's 2302(c) Certification Program

In my July 2014 statement to the Committee, I referenced the VA's commitment to complete OSC's "2302(c)" Certification Program. In October 2014, the VA became the first cabinet-level department to complete OSC's program. The OSC Certification Program allows federal agencies to meet their statutory obligation to inform their workforces about the rights and remedies available to them under the Whistleblower Protection Act, the Whistleblower Protection and Enhancement Act (WPEA), and related civil service laws. The program requires agencies to complete five steps: (1) Place informational posters at agency facilities; (2) Provide information about the whistleblower laws to new employees as part of the orientation process; (3) Provide information to current employees about the whistleblower laws; (4) Train supervisors on their responsibilities under the whistleblower law; and (5) Display a link to OSC's website on the agency's website or intranet.

The most important step in this process is the training provided to supervisors. Ideally, this training is done in person with OSC staff, to provide an opportunity for supervisors to ask questions and engage in a candid back and forth session. However, in an organization the size of the VA, with tens of thousands of supervisors, in-person training is extremely difficult to accomplish. Nevertheless, at the VA's initiative, we are working to develop "train the trainer" sessions, so we can reach as many supervisors as possible in real time. We also anticipate presenting information on the whistleblower law at an upcoming meeting of VA regional counsel.

Based on the claims OSC receives, VA regional counsel will benefit from additional training on whistleblower retaliation. Such training will assist in preventing retaliatory personnel actions from being approved by the legal department at local facilities, and will also help to facilitate resolutions in OSC matters. The commitment we are seeing from VA leadership to correct and eliminate retaliation against whistleblowers has not consistently filtered down to regional counsel. Supplemental training for regional counsel may go a long way to address that issue.

B. Investigation of Whistleblowers

An additional and ongoing area of concern involves situations in which a whistleblower comes forward with an issue of real importance to the VA—for example, a cover-up of patient wait-times, sexual assault or harassment, or over-prescription of opiates—yet instead of focusing on the subject matter of the report, the VA's investigation focuses on the whistleblower. The inquiry becomes: Did the whistleblower violate any regulations in obtaining the evidence of wrongdoing? Has the whistleblower engaged in any other possible wrongdoing that may discredit his or her account?

There are two main problems with this approach. First, by focusing on the individual whistleblower, the systemic problem that has been raised may not receive the attention that it deserves. And second, instead of creating a welcoming environment for whistleblowers to come

forward, it instills fear in potential whistleblowers that by reporting problems, their own actions will come under intense scrutiny.

The VA's focus—not just at headquarters, but throughout the department—should be on solving its systemic problems, and holding those responsible for creating them accountable. While there may be instances in which an individual whistleblower's methods are particularly troublesome and therefore require investigation, such an investigation should be the exception and not the rule, and should only be undertaken after weighing these competing concerns.

C. Accessing Whistleblowers' Medical Records

A final, related issue of ongoing concern is the unlawful accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed and information in those records has apparently been used to attempt to discredit the whistleblowers. We will aggressively pursue relief for whistleblowers in these and other cases where the facts and circumstances support corrective action, and we will also work with the VA to incorporate these additional forms of retaliation into our collaborative training programs.

IV. Conclusion

We appreciate this Committee's ongoing attention to the issues we have raised. I thank you for the opportunity to testify, and am happy to answer your questions.

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Special Counsel Carolyn N. Lerner

The Honorable Carolyn N. Lerner heads the United States Office of Special Counsel. Her five-year term began in June 2011. Prior to her appointment as Special Counsel, Ms. Lerner was a partner in the Washington, D.C., civil rights and employment law firm Heller, Huron, Chertkof, Lerner, Simon & Salzman, where she represented individuals in discrimination and employment matters, as well as non-profit organizations on a wide variety of issues. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was a mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights.

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Truman Scholar, and her law degree from New York University (NYU) School of Law, where she was a Root-Tilden-Snow public interest scholar. After law school, she served two years as a law clerk to the Honorable Julian Abele Cook, Jr., Chief U.S. District Court Judge for the Eastern District of Michigan.