



U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

Whistleblower Disclosures to OSC Lead to VA Reforms, 40 Disciplinary Actions against Responsible Officials

FOR IMMEDIATE RELEASE

CONTACT: Adam Miles, (202) 254-3607; amiles@osc.gov

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Yesterday, the U.S. Office of Special Counsel (OSC) reported to the White House and Congress that the Cheyenne Veterans Affairs Medical Center (VAMC) violated Department of Veterans Affairs (VA) policies by improperly scheduling patient appointments. Some of the improper scheduling practices concealed the extent of wait times for veterans and impacted the ability of veterans to access care at the Cheyenne VAMC and its Fort Collins Outpatient Clinic.

Special Counsel Carolyn Lerner previously discussed the VA's findings in a June 2014 letter to the President and Congress and in July 2014 congressional testimony. This case was among the first in which the VA confirmed widespread improprieties in scheduling and appointment systems used to mask the extent of wait times. The new report today contains additional details regarding the disclosures made by VA whistleblowers and the steps the VA has taken to address the problems, including taking or proposing disciplinary actions against six responsible officials.

Including the disciplinary actions in Fort Collins and Cheyenne, over the last two years the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified in whistleblower disclosures to OSC. Some of the other actions include:

- Four pharmacy employees were suspended for the improper handling of prescription drugs as identified by a whistleblower in West Palm Beach, Florida.
- Two employees were disciplined, including one receiving a notice of proposed removal, for not properly reporting an alleged sexual assault, as disclosed by a whistleblower in Syracuse, New York.
- A manager was disciplined for misrepresenting time spent in counseling sessions with veterans. The VA is currently reviewing the regional leadership's responsibility for lack of oversight on this issue in a case brought to OSC by a whistleblower in Federal Way, Washington.
- A physician received a reprimand and ultimately resigned after a whistleblower in Montgomery, Alabama, exposed that the physician had cut and pasted medical records and vital signs, rather than taking current readings. OSC has requested that the VA review the appropriateness of the level of disciplinary action taken in this case.
- Five employees received disciplinary actions, including two terminations, for failing to safeguard patient information, as disclosed by a whistleblower in Jackson, Mississippi.
- A total of 12 employees in multiple locations have been disciplined for improperly accessing whistleblowers' medical records.

"Information provided by whistleblowers not only improves the care provided to veterans, it also promotes accountability and helps to deter future misconduct," stated Special Counsel Carolyn Lerner.

Some recent OSC press releases on VA whistleblowers settling retaliation claims can be found [here](#), [here](#), [here](#), and [here](#), and releases on VA whistleblower disclosures related to health care can be found [here](#), [here](#), and [here](#).

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