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VA Whistleblowers Disclose Ongoing Mental Health Wait Times Inspector General Fails to Investigate Whistleblower Claims

FOR IMMEDIATE RELEASE

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The Department of Veterans Affairs (VA) Office of Inspector General (OIG) failed to adequately investigate whistleblower disclosures about veterans' access to mental health care, the U.S. Office of Special Counsel (OSC) reported to the White House and Congress in a [letter](#) today.

The two VA whistleblowers are Germaine Clarno, a social worker and union president at the Edward Hines, Jr., VA Hospital (Hines) in Chicago, Illinois, and Christopher Shea Wilkes, a social worker at Overton Brooks VA Medical Center (Overton Brooks) in Shreveport, Louisiana.

The whistleblowers alleged that supervisors directed Mental Health Service employees at both hospitals to violate VA scheduling protocols. This created a false appearance of acceptable wait times while masking significant delays in veterans' access to care.

While the OIG found evidence that employees were using separate spreadsheets outside of the VA's official scheduling and patient records systems at both hospitals, the OIG limited its investigation to whether those spreadsheets were "secret." The OIG failed to adequately address the whistleblowers' core concerns about access to care and whether these practices violated VA directives.

"The OIG's decision to investigate this straw man resulted in inadequate reviews that failed to address the whistleblowers' legitimate concerns about access to care for mental health patients at Hines and Overton Brooks," wrote Special Counsel Carolyn Lerner in the letter.

At Overton Brooks, the VA OIG [learned](#) that 2,700 veterans were waiting to be assigned to a mental health provider. Yet the OIG did not review whether a spreadsheet confirming this fact reflected the whistleblower's concerns about access to mental health care or whether the Mental Health Clinic was short-staffed. Instead, the OIG simply determined that the spreadsheet was not "secret. At Hines, the OIG's [report](#) notes that "delays in access to care remain an ongoing issue." However, the OIG does not include any discussion of patient wait times or recommendations for addressing the ongoing delays. The OIG report appears to undermine its own limited findings by characterizing a manager's improper directions to manipulate wait time data as "arguably practical."

"The focus and tone of the IG's investigations appear to be intended to discredit the whistleblowers by focusing on the word 'secret,' rather than reviewing the access to care issues identified by the whistleblowers and in the OSC referrals," wrote Special Counsel Lerner. Special Counsel Lerner expressed her concerns about Hines and Overton Brooks directly to VA leadership. In response, Deputy Secretary Sloan Gibson agreed to review the OIG investigations and OSC's analyses to determine what steps should be taken to improve access to care at Hines and Overton Brooks. Specifically, the Office of the Medical Inspector will develop a set of recommendations that the facilities will use to develop corrective action plans to address ongoing concerns about veterans' access to care.

The U.S. Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. Our basic authorities come from four federal statutes: the Civil Service Reform Act, the Whistleblower Protection Act, the Hatch Act, and the Uniformed Services Employment & Reemployment Rights Act (USERRA). OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing, and to serve as a safe channel for allegations of wrongdoing. For more information, please visit our website at www.osc.gov.