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# OSC Reports on Three VA Whistleblower Investigations

FOR IMMEDIATE RELEASE

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Yesterday, the U.S. Office of Special Counsel (OSC) reported to the White House and Congress the findings of three Department of Veterans Affairs (VA) investigations into whistleblower disclosures of health and safety concerns.

## **Improper Substitution of Prescribed Antipsychotic Drugs – Beckley, West Virginia**

In April 2015, OSC reported that the Beckley VA Medical Center improperly substituted prescribed antipsychotic medications in order to save money. The VA's Office of Medical Inspector (OMI) found that these actions created a threat to the health and safety of mental health patients in Beckley and violated VA policy. In response to additional concerns raised by the whistleblower (who has chosen to remain anonymous), OSC directed the VA to address these additional disclosures and asked VA to provide information on whether it disciplined any senior Beckley managers.

While the VA did not substantiate the whistleblower's other allegations, OSC encouraged the VA to adopt and implement a consistent standard in disciplinary action reviews. The VA concluded that the Beckley Chief of Staff and Director approved a policy that violated agency wide rules, but did not find them culpable because they were unfamiliar with VA policy (the Beckley VA's Chief of Pharmacy resigned in September 2015). Requiring a "knowing and willful" violation to support a disciplinary action may excuse negligent actions, such as failure to exercise appropriate oversight, or other forms of poor performance that create risks to patient safety. In other cases, including in formal litigation, the VA has sought disciplinary action against senior officials who failed to exercise appropriate oversight. OSC believes that this is a more appropriate standard, and should have been considered in response to OMI's findings at Beckley.

## **Inadequate Training and Other Problems Related to the Veterans Crisis Line – Canandaigua, New York**

After reviewing disclosures by VA employee John M. Giunta that VA did not adequately train Veterans Crisis Line (VCL) staff and back-up call center volunteers, OSC [directed](#) that the VA investigate. Veterans who call the VCL when phone lines are busy are forwarded to back-up call centers. The VA Office of Inspector General (OIG) [found](#) that back-up call centers routed some veterans seeking help to voicemail, and sometimes neither the VCL nor back-up center volunteers immediately called veterans back. The investigation also confirmed that training was inadequate.

The VA agreed to take several steps to improve the VCL, such as training all staff and establishing a quality assurance process. However, the Special Counsel concluded these actions do not adequately address the VA's lack of oversight of its back-up call centers. The OIG report noted that VCL staff were frequently unable to confirm the outcome of calls or the well-being of veterans whose calls were forwarded to back-up centers. Notably, the VA does not currently require that back-up centers obtain American Association of Suicidology crisis center accreditation, unlike the VCL itself. Further, no agreements exist between VA and back-up centers on training or orientation curriculum.

## **Improper Endoscope Testing Prior to 2008 – Washington, D.C.**

OSC [directed](#) the VA to investigate allegations from John Leahy, a staff registered nurse, who disclosed to OSC that a clinic at the Washington, D.C. VA Medical Center did not test flexible endoscopes for leaks before 2008. At that time, using a leak testing method, Mr. Leahy discovered leaking endoscopes and, in response, developed new procedures for the clinic. He contacted OSC in 2014 because he believes the VA should have notified potentially affected patients, who he claims were put at greater risk for infections. The VA confirmed the lack of testing prior to 2008.

The VA [maintains](#) that visual leak inspections and the use of disinfects were sufficient to identify and address any biohazards in its endoscopes before reusing them. However, the whistleblower provided information, including endoscope manufacturer guidelines, which appear to contradict the VA. The VA also states that the hospital did not need to notify patients because it had not found evidence of an adverse event associated with endoscopes. Yet the VA did not convene a Clinical Review Board to fully address the matter, despite the recommendation of the VA's OMI that it do so. OSC concluded that the VA has not provided sufficient information to determine whether the VA's findings are reasonable and supported by the facts.

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*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](http://www.osc.gov).*