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OSC Finds Flaws in VA Investigations of Whistleblower Disclosures

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In a letter to the White House and Congress today, the U.S. Office of Special Counsel (OSC) reported that the findings in three Department of Veterans Affairs (VA) investigations concerning whistleblower disclosures of scheduling data manipulation at several Texas VA hospitals and clinics are deficient and unreasonable. OSC determined that the agency's investigations, which were conducted by VA's Office of Inspector General (OIG), failed to appropriately address the whistleblowers' allegations.

The three cases are:

Phillip Turner, a VA medical support assistant, alleged that staff at VA facilities in San Antonio and Austin, Texas, were directed to "zero out" patient wait times for appointments, which could have negatively affected patient health. The VA substantiated that systemic improper scheduling was occurring at these locations, but did not address whether improper scheduling may have endangered public health and safety.

Virgie Hardeman, a whistleblower from the VA medical center in Temple, Texas, disclosed scheduling manipulation at her medical center and at locations across the Central Texas Veterans Healthcare System. The VA did not substantiate Ms. Hardeman's allegations that it investigated, but the OIG's investigation failed to address her allegation that the VA categorized hundreds of requests for fee-basis consults for non-VA care as "scheduled" or "complete," even though the VA did not actually complete them.

An anonymous whistleblower, also at the Temple VA medical center, alleged that a senior staff member at Temple inappropriately canceled and rescheduled radiology consults in order to shorten patient wait times and directed others to do the same. The VA OIG did not substantiate the whistleblower's allegations, but its investigation failed to fully address all of the allegations that OSC referred and also failed to reconcile seemingly contradictory information.

OSC found similar problems in two other OIG reports involving scheduling and access to care in February.

In response to OSC's concerns about the completeness and quality of its reports, the VA reiterated that it will examine and improve its processes for investigating OSC whistleblower disclosure referrals. In pending cases, the VA said it will consult with the OIG and ensure that the the investigations address all allegations OSC referred. The VA also restated its intent to facilitate greater communication between its investigative teams and OSC. These process changes, implemented, will help ensure that the VA fully investigates and resolves serious issues that whistleblowers raise.

"These employees raised important concerns about access to care issues within their hospitals and I applaud their efforts to improve care for veterans," said Special Counsel Carolyn Lerner. "While these investigations failed to fully address the serious disclosures concerning the health and safety of our veterans, I am encouraged by the VA's commitment to improve its investigative processes moving forward."

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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.