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

After Whistleblower Disclosures, Phoenix VA Hospital Improves Care of Suicidal Veterans

Despite Changes, Whistleblower Concerns Persist

FOR IMMEDIATE RELEASE **CONTACT: Nick Schwellenbach, (202) 254-3631; nschwellenbach@osc.gov**

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The U.S. Office of Special Counsel (OSC) reported to the White House and Congress yesterday that whistleblower disclosures prompted improvements to the monitoring and care provided to suicidal patients at the Department of Veterans Affairs (VA) hospital in Phoenix, Arizona. Brandon Coleman and Jared Kinnaman, VA counselors at the hospital, blew the whistle on problems that adversely impacted the care provided to veterans with mental health and substance abuse problems. A VA investigation confirmed a number of their disclosures.

Mr. Coleman and Mr. Kinnaman reported to the OSC, and the VA confirmed, that the Phoenix VA hospital's Emergency Department was not in compliance with a VA directive requiring that at least one qualified hospital employee observe each potentially suicidal patient at all times. Furthermore, the Emergency Department lacked safeguards preventing elopement, a situation where a patient is not permitted to leave, because they pose a danger to themselves or others, but intentionally does so. As a result of these deficiencies, Mr. Coleman and Mr. Kinnaman reported to OSC that suicidal patients regularly eloped from the Emergency Department.

The VA investigation validated the whistleblowers' concerns and found that "10 patients deemed at high risk for suicide" eloped between October 2014 and February 15, 2015. Although these issues had been recognized by Phoenix VA leadership prior to the investigation, only after Mr. Coleman made his disclosures to OSC and went public in the press did the hospital come into compliance with the VA's directive and move the rooms for these patients farther from the exit door. The facility also installed a delayed release on the door.

Since these changes were implemented on February 15, 2015, the VA reports no further cases of elopement from the Emergency Department. However, the VA's supplemental report confirmed Mr. Coleman's concern that, since February 2015, some potentially suicidal veterans treated elsewhere in the hospital have left the premises, as have veterans with substance abuse issues in the Emergency Department.

The VA investigation led to a number of recommendations that were agreed to by the Phoenix VA, such as additional suicide training during new employee orientation. The VA also found a lack of routine communication between the hospital and the non-VA community-based detoxification centers that resulted in a gap in care for veterans. In response, the Phoenix VA has improved communication with these centers.

In spring of this year, OSC facilitated the resolution of Mr. Coleman's whistleblower retaliation claim through its Alternative Dispute Resolution program.

"Mr. Coleman and Mr. Kinnaman likely saved lives by speaking up for the veterans in the Phoenix VA's care. We owe them our gratitude. They prompted long-overdue changes to better protect veterans who are seeking help for their mental health and substance abuse issues. However, based on recent reports suggesting continuing problems, I urge the Phoenix VA to keep working with whistleblowers to improve veterans' care," said Special Counsel Carolyn Lerner.

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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.