



U.S. OFFICE OF SPECIAL COUNSEL

1730 M Street, N.W., Suite 300  
Washington, D.C. 20036-4505

The Special Counsel

April 10, 2013

The President  
The White House  
Washington, D.C. 20500

Re: OSC File Nos. DI-12-1562; DI-12-1564; DI-12-1578; and DI-12-1580

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find an unredacted agency report based on disclosures received from four Medical Record Technicians at the U.S. Department of Veterans Affairs (VA), VA Western New York Healthcare System (WNYHS), Health Information Management System Department (HIMS), Buffalo, New York. The whistleblowers, Leon Davis III, Cathleen A. Manna, Tracy Harrison, and Pamela G. Hess-Wellspeak, alleged that the HIMS Department managers engaged in conduct that may constitute violations of law, rule, or regulation and gross mismanagement. The whistleblowers have consented to the disclosure of their names.

**The agency report substantiated the majority of the whistleblowers' allegations. Specifically, the investigation affirmed the whistleblowers' allegation that VA records at both the Buffalo and Batavia sites of WNYHS were not maintained in accordance with the requirements for records management as defined by the National Archives and Records Administration (NARA). The investigation further substantiated the whistleblowers' allegation that the HIMS manager authorized the transfer of 227 boxes of records to the VA Records Center & Vault in Neosho, New York (Neosho RC&V) five of which were damaged by water and mildew. The report recommended numerous steps, including the development of a strategic plan for the creation of an effective records management program that allows the facility to properly create, maintain, and dispose of records in accordance with VA Directives and the Code of Federal Regulations. Based on my review of the original disclosure, the agency's report and the whistleblowers' comments, I have determined that the report contains all of the information required by statute and that the findings appear to be reasonable.**

The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise

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the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g).

Upon receipt, I review the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). I will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The whistleblowers' allegations were referred to the Honorable Eric K. Shinseki, Secretary of the VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d) on May 1, 2012. The Secretary's response, dated September 6, 2012, included a report submitted to him by the Under Secretary for Health based on the results of an investigation conducted by personnel from the Veterans Health Administration's Privacy Compliance Assurance Office and Health Information Management Office. The whistleblowers provided written comments on the report on October 17, 2012. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the report and the whistleblowers' comments to you.

#### **I. The Whistleblowers' Disclosure**

The whistleblowers disclosed that the HMS Department collected and stored records without regard to department-wide regulations governing the effective management of records. According to the whistleblowers, WNYHS cardiac records, agent orange registry records, and dental records were, for at least eight years, stored in approximately 160 boxes each containing approximately 40 files at a storage facility in Batavia, New York (Batavia files). While the whistleblowers stated that the boxes containing these records were labeled, "Cardiac," "Agent Orange," or "Dental," the records contained in the boxes were filed randomly rather than in accordance with any type of system (by name, date, or social security number, for example). Further, these boxes were never inventoried. Thus, a search for a particular individual's records required a search of all the boxes in a particular category. As a result of the lack of a record keeping system, when a veteran's record was requested, HIMS clerks deemed the record "unavailable" rather than initiate a search for the documentation. The four whistleblowers personally know of at least 15 instances where veterans' records were requested and deemed unavailable because the records could not be located.

In addition to their allegation regarding the Batavia files, the whistleblowers disclosed that in the process of participating in a record retirement project of records contained in approximately 240 boxes, they discovered approximately five boxes containing files which were contaminated with mold. When they brought the moldy files to the attention of Elizabeth M. Kane, HIMS Manager, they were directed to repackage the files in new boxes and send the files to the Neosho RC&V despite the mold. The whistleblowers maintain that Ms. Kane's handling of the mold-infested files constituted a violation of VA Handbook Section 6300.1, as well as the

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Code of Federal Regulations, which outlines a procedure for responding to the "...accidental destruction, defacing, alteration or removal of VA records..." and requires that such incidents be reported to the Director of the VA Enterprise Records Service who must in turn notify NARA. This protocol, according to the whistleblowers, was never followed.

By letter dated January 17, 2012, the whistleblowers brought their concerns about damaged and disorganized files to the attention of VA Health Care Upstate New York Director David J. West. On January 27, 2012, Mr. West charged Jason Petti, WNYHS Associate Medical Center Director, with responsibility for conducting a supervisory review of the allegations. By letter dated January 27, 2012, the same day Mr. West directed Mr. Petti to review the allegations, Mr. Petti informed the then-Acting Medical Center Director Craig Howard that he had completed the assignment from Mr. West and determined that "[t]he review did not substantiate any of the concerns identified in the letter related to the processes being utilized by the VAWNYHS HIMS department or actions of the VAWNYHS HIMS manager."

With respect to the Batavia files, Mr. Petti concluded that the cardiac, agent orange registry, and dental records, are stored "in compliance with VHA Directive 6300.1, which governs the storage of medical information." In support of this finding, Mr. Petti stated that the records are stored in a locked vault accessible only to VA employees. Mr. Petti attributed the whistleblowers' concern that veterans' records have been deemed "unavailable" rather than retrieved to one records clerk's failure to follow standard operating procedures. Mr. Petti indicated that this clerk has "been re-educated" on the appropriate record request procedures. With respect to the mold-infested files, Mr. Petti's January 27, 2012, letter indicated that when Ms. Kane became aware of the damaged files, she directed that they be stored in a separate secured location in Batavia and that, in December 2011, the mold-infested files began to be shipped to a vendor for restoration in accordance with VA regulations.

On February 8, 2012, the whistleblowers met with Mr. Petti. During the course of this meeting, they reiterated their complaint about the Batavia records. They expressed disagreement with Mr. Petti's finding that records have been deemed "unavailable" as a result of a lack of training on the part of one particular clerk and again indicated that records are unavailable because they are not organized and maintained in accordance with regulation. In addition, they clarified that, contrary to Mr. Petti's January 27, 2012, letter, the mold-infested records discovered during the course of the record retirement project were not stored in a separate secured location in Batavia but were shipped to the Neosho RC&V.

By memorandum dated February 13, 2012, Mr. Petti responded to the concerns raised by the whistleblowers during the February 8 meeting. With respect to the Batavia files, Mr. Petti stated that he conducted a review of the files and determined that, while five of the boxes appeared to have some water damage, there was no indication that the files were moldy. Although Mr. Petti ordered that all the boxes be removed from the Batavia warehouse and returned to and stored in Buffalo, he did not address the whistleblowers' concerns that the records contained in the boxes were not organized, inventoried, and labeled. In addition,

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according to the whistleblowers, the Batavia records have not been shipped from Batavia to Buffalo as Mr. Petti had directed. In response to the whistleblowers' complaint about the 240 boxes sent to the Neosho RC&V, Mr. Petti ordered that the boxes be recalled to the Buffalo Medical Center. Mr. Petti charged the four whistleblowers with responsibility for sorting through the 240 boxes and identifying the molded files. At the time of our § 1213 referral to Secretary Shinseki, the boxes had not been returned to the Buffalo Medical Center and, according to the whistleblowers, there was no indication at that point that any action had been taken to initiate their transfer.

## **II. The Agency's Investigation**

The agency report substantiated the majority of the whistleblowers' allegations. Specifically, the investigation confirmed that VA records at both the Buffalo and Batavia sites of WNYHS were not maintained in accordance with records management requirements established by NARA. The report further substantiated the whistleblowers' allegations that VA records were stored in a substandard storage warehouse in the Batavia location with no inventories of the records and with some boxes exhibiting evidence of water damage. The investigation revealed that veteran records found in some boxes were not documented on the accession inventory. The investigation also found that some veteran records contained on the accession inventory lists were missing from the boxes. The investigation indicated that large numbers of social security numbers were not properly attributed to the correct veteran name on the accession inventories and that there were a number of typographical errors on the inventory lists, including incorrect veteran names or social security numbers. Finally, the investigation substantiated the whistleblowers' contention that in one accession inventory list, the names on the list did not correspond to the records in the boxes.

With respect to the whistleblowers' allegation that boxes containing mold contaminated files were transferred to the Neosho RC&V, the investigation determined that five out of 227 boxes which were transferred were damaged by water and mildew. The report acknowledged that the Records Manager failed to report the damaged boxes to the VHA Records Officer in accordance with regulation and VA policy.

The report made a number of recommendations, including the development of a strategic plan for the creation of an effective records management program that allows the facility to properly create, maintain and dispose of records in accordance with VA policy and regulation. The report further recommended that all records in both the Buffalo and Batavia storage facilities be processed to determine if they should be filed or scanned into Veteran health records or disposed of. It was recommended that both storage facilities be evaluated and modified to ensure that they comply with all applicable NARA requirements for on-site storage facilities. Finally, the report recommended that all accession inventory lists be recalled and validated against the records in the boxes and updated as needed.

### **III. Whistleblowers' Comments**

The whistleblowers' written comments expressed satisfaction with the "quality of attention" devoted to the investigation and to the overall outcome of the investigation which substantiated the majority of their allegations. In a follow-up February 6, 2013, telephone conversation, the whistleblowers indicated that significant steps have been taken to implement the recommendations suggested in the report. Both in writing and by telephone, the whistleblowers expressed frustration that they were forced to elevate their disclosure to OSC as a result of their local senior management's lack of responsiveness to their complaints. In particular, they expressed dissatisfaction with Mr. Petti's failure to conduct a fair and balanced investigation into their original disclosures. They also expressed frustration that the report deemed the record storage and mismanagement problems "unintentional" and failed to hold anyone accountable for the problems through disciplinary action.

### **IV. OSC Follow-up to Whistleblower Concerns**

In response to the concerns raised by the whistleblowers in their comments, my office contacted the VA to determine whether any disciplinary action was taken as a result of the agency investigation. The VA's Office of General Counsel, indicated that Ms. Kane received a Written Counseling on July 12, 2012, as a result of the investigation, "to ensure [she] understood the severity of the findings of the...site visit." The counseling letter provided Ms. Kane with a point of contact for future guidance and charged her with responsibility for ensuring that the Action Plan generated as a result of the site visit is completed. With respect to Mr. Petti, the VA confirmed that he was not disciplined for his role in the situation. Rather, Mr. Petti was credited with responding quickly, providing appropriate oversight, and fully cooperating.

### **V. Findings**

I have reviewed the original disclosure, the agency report, and the whistleblowers' comments. Based on that review, I have determined that the agency's report contains all of the information required by statute and that its findings appear to be reasonable.

As a result of our referral and the agency investigation, steps have been taken at WNYHS to create an effective records management program that ensures that veterans' records are stored in accordance with all applicable NARA requirements. The agency confirmed that corrective actions related to recommendations made in the report were completed as of February 4, 2013. In addition, the agency indicated that WNYHS' continued compliance with the records management program will be assessed annually. I would, however, recommend that the VA take additional steps to ensure that all VA facilities operate an effective records management program that allows for the proper creation, maintenance, and disposal of veterans records in accordance with all applicable laws, rules, and regulations.

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As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency report and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed a copy of the redacted report and the whistleblowers' comments in our public file, which is now available online at [www.osc.gov](http://www.osc.gov), and closed the matter.

Respectfully,

A handwritten signature in cursive script that reads "Carolyn Lerner".

Carolyn N. Lerner

Enclosures