U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

September 25, 2013

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

Re: OSC File No. DI-13-0603

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find an agency report substantiating disclosures received from a former Outpatient Pharmacy Technician that employees of the Department of Veterans Affairs (VA), West Palm Beach VA Medical Center (VAMC) may have violated laws, rules, or regulations, and created a substantial and specific danger to public health and safety. The whistleblower, Cara A. Borosky, who consented to the release of her name, alleged that West Palm Beach VAMC Outpatient Pharmacy employees violated VA and Food and Drug Administration (FDA) rules and regulations by failing to properly dispose of prescription drugs that are returned to the pharmacy. Ms. Borosky further alleged that these employees violated VA and FDA rules and regulations by retaining and restocking prescription drugs that are returned to the pharmacy as a means of managing and reconciling the pharmacy inventory. According to Ms. Borosky, the restocking of previously dispensed prescription drugs created a substantial and specific danger to public health and safety as the potential existed that the drugs may have been contaminated or otherwise adulterated while outside the custody of the pharmacy.

Ms. Borosky's allegations were referred to the Honorable Eric K. Shinseki, Secretary of Veterans Affairs, on December 7, 2012 for an investigation and report.[1] On June 20, 2013, Secretary Shinseki submitted a report based on the results of an investigation conducted by an Administrative Investigation Board convened by the Network Director, Veterans Integrated Service Network (VISN) 8. On June 28, 2013, a copy of the report was forwarded to Ms. Borosky, who declined to comment.

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[1] 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 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).

Upon receipt, the Special Counsel reviews the agency's 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). The Special Counsel 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's report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The agency report substantiated Ms. Borosky's allegations, finding that employees restocked and re-dispensed prescription drugs, improperly reconciled the inventory using returned and restocked drugs, and violated Veterans Health Administration Handbook regulations, medical center policies, and FDA compliance guides by failing to destroy previously dispensed and returned drugs. Corrective actions recommended by the agency report include halting the practice of restocking and re-dispensing medications, the development of a system to track chain of custody of returned drugs, and training in controlled substance management. Finally, the report recommended that consideration be given to disciplinary and/or other administrative action with respect to the employees deemed responsible.

Subsequent communications between my office and agency officials indicate that the corrective actions recommended by the report have been implemented. In addition, disciplinary actions ranging from three to five day suspensions have been proposed against Nick Beckey, Pharmacy Chief, Laura Locke, Supervisory Outpatient Vault Pharmacy Technician, Joyce Trapp, Outpatient Vault Pharmacy Technician, and John Burkett, Program Support Assistant, Controlled Substance Coordinator.

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

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency report to the Chairman and Ranking Member of the Senate Committee on Veterans' Affairs and the Chairman and Ranking Member of the House Committee on Veterans' Affairs. I have also filed a copy of the redacted report in our public file, which is now available online at www.osc.gov, and closed the matter.[2]

Respectfully,

Carolyn N. Lerner

Enclosure

[2] The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA relies on Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version as an accommodation.