



U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

July 15, 2014

The President  
The White House  
Washington, D.C. 20510

Re: OSC File No. DI-13-2349

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by a whistleblower at the Department of Justice (DOJ), Bureau of Prisons (BOP), Federal Medical Center (FMC Rochester), Rochester, Minnesota. The whistleblower, Adam Berg, a nursing assistant at FMC Rochester, alleged that employees engaged in conduct that constituted an abuse of authority and a substantial and specific danger to public health or safety by failing to provide adequate care to incontinent inmates, and refusing to provide physical care, such as feeding and bathing, to an inmate in hospice care who was HIV-positive. Mr. Berg consented to the release of his name.

**The agency investigation partially substantiated Mr. Berg's disclosures. Specifically, the agency determined that there appeared to be instances in which some of the incontinent inmates were "double diapered" and that nursing assistant Jessica Nierman behaved unprofessionally when she made comments about an HIV-positive inmate. The investigation also found sufficient evidence to support additional allegations raised during the course of the investigation, such as that nursing assistants Joshua Geier and Jeremiah Lockie did not bathe an inmate or provide him with his dinner meal on August 29, 2013, and that Mr. Geier and nursing assistant Heidi Wiplinger behaved unprofessionally when they joked about not feeding an inmate.**

**In response to the report, FMC Rochester provided training to all nursing staff members on perineal and incontinence care, pledged to update the "Patient Care Manual" to address the inappropriate practice of excessive padding in incontinence briefs, and took disciplinary action against two employees. I have determined that the agency reports contain all of the information required by statute and that the findings appear to be reasonable.**

The President  
July 15, 2014  
Page 2 of 7

On August 16, 2013, OSC referred Mr. Berg's allegations to Attorney General Eric H. Holder, Jr., to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).<sup>1</sup> On December 16, 2013, Julie Zebrak, deputy chief of staff of the Office of the Deputy Attorney General, submitted the agency's report to OSC. The BOP Office of Internal Affairs (OIA) conducted the investigation. In response to OSC's request for additional information, the agency submitted a supplemental report on February 19, 2014. Pursuant to 5 U.S.C. § 1213(e)(1), OSC provided Mr. Berg with the opportunity to submit comments on the agency's report and supplemental report, but he declined to comment. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports.

### *I. The Whistleblower's Allegations*

Mr. Berg disclosed that nursing assistants failed to provide adequate care to incontinent inmates and refused to provide physical care to one HIV-positive inmate. More specifically, Mr. Berg alleged that two nursing assistants failed to change inmates' soiled undergarments for long periods of time or after instances of incontinence; two nursing assistants did not regularly empty urine from full bed pans, which prevented inmates from being able to relieve themselves; and four nursing assistants failed to provide physical care such as feeding, bathing, and dressing to an HIV-positive inmate.

#### **A. Nursing Assistants Failed to Provide Adequate Care to Incontinent Inmates**

Mr. Berg disclosed that two nursing assistants, Jeremiah Lockie and Jessica Nierman, provided inadequate care to incontinent inmates. He stated that both Mr. Lockie and Ms. Nierman worked during the day shift and were required to change each inmate's undergarments before the end of their shift, between 4:30 and 5:30 p.m. Mr. Berg indicated that upon his arrival at 6:00 p.m. to begin the night shift, he checked on all the inmates.

Mr. Berg explained that nursing assistants at FMC Rochester are trained to change inmates' undergarments every two hours, or immediately if the undergarment becomes wet or soiled. For example, if an inmate informs a nursing assistant that he has had a

---

<sup>1</sup>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) and (g).

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

The President  
July 15, 2014  
Page 3 of 7

bladder or bowel movement, the nursing assistant should change the inmate's undergarment as soon as possible. Furthermore, if a nursing assistant smells an odor, she or he is required to check the inmate's undergarment and change it if the inmate has had a bladder or bowel movement.

According to Mr. Berg, on several occasions he observed numerous inmates with soiled and wet undergarments when he checked on them at the beginning of his shift. He believed that Mr. Lockie and Ms. Nierman did not change some of the inmates' undergarments near the end of their shifts because the disposable undergarments were overflowing and leaking onto the inmates' clothes or bed linens, and more than once turned dark brown and had begun to disintegrate. Additionally, Mr. Berg stated that at times when he had arrived early for his shift, he heard Mr. Lockie and Ms. Nierman tell an inmate to wait for the nursing assistant working the night shift to change the undergarment. Furthermore, on several occasions he observed unemptied bed pans. As a result, inmates who were unable to move without assistance had nowhere to relieve themselves. Mr. Berg calculated that two to five inmates were affected daily by Mr. Lockie and Ms. Nierman's neglect.

Mr. Berg stated that failing to adequately change inmates' undergarments poses health problems such as skin sores, skin irritation or breakdown, and infections. He recalled four specific inmates who experienced skin sores and skin breakage from not being changed or cleaned in a timely manner. Moreover, he stated that when inmates have nowhere to relieve themselves because their bed pans are full, they are more likely to have an accident.

#### **B. Nursing Assistants Fail to Provide Physical Care to an HIV-Positive Inmate**

Mr. Berg stated that in the fall of 2012, an HIV-positive inmate was admitted to FMC Rochester and was receiving hospice care. Mr. Berg disclosed that on a number of occasions, he heard Ms. Nierman state that she would not provide physical care for the inmate because he was HIV-positive and she was "afraid of catching it." Ms. Nierman refused to shave, bathe, dress, or feed the inmate.

As a result of Ms. Nierman's failure to care for the inmate, management officials decided to move his bath time from the day shift to the night shift. Although the inmate was bathed regularly during the night shift, Mr. Berg believed that the inmate was not fed regularly. According to Mr. Berg, the inmate always asked for more food when Mr. Berg arrived for his shift. Mr. Berg also noted that since the inmate was in hospice, he should have received a meal whenever he requested one. Additionally, Mr. Berg stated that the inmate informed him that Ms. Nierman, Mr. Lockie, Mr. Geier, and Ms. Wiplinger did not treat him with dignity and refused to feed him. Moreover, Mr. Berg stated that sometime around May 2013, he heard Mr. Lockie, Mr. Geier, and Ms. Wiplinger brag about not feeding this inmate.

The President  
July 15, 2014  
Page 4 of 7

According to Mr. Berg, Ms. Nierman, Mr. Lockie, Mr. Geier, and Ms. Wiplinger failed to provide adequate medical care to this inmate by refusing to feed him. Furthermore, Mr. Berg asserted that Ms. Nierman had abused her authority by failing to provide physical care to the inmate in order to avoid any interaction with him based on her fear of contracting HIV.

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

The agency investigation did not substantiate Mr. Berg's claim that Mr. Lockie and Ms. Nierman failed to change inmates' soiled undergarments for long periods of time or following instances of incontinence. During the investigation, Mr. Berg stated that he believed Mr. Geier and Ms. Wiplinger also failed to provide proper nursing care to incontinent patients and that the total number of inmates affected was nine rather than two to five. The agency investigation did not substantiate Mr. Berg's allegation that Mr. Geier and Ms. Wiplinger failed to provide proper care to incontinent patients.

The report detailed that the agency interviewed six of the inmates Mr. Berg identified.<sup>2</sup> Five of the inmates denied that they had been "double diapered," had Chux pads<sup>3</sup> placed inside their undergarments, had not had their bed pans emptied, or had been unable to relieve themselves when needed. The sixth inmate denied that he was ever "double diapered" but stated that the nursing staff used an extra "dinner napkin" to place inside his undergarments to absorb his urine. The inmate indicated he thought the practice was a good idea due to his incontinence.

The report concluded that there appeared to be some instances in which incontinent inmates were "double diapered." Nonetheless, there was insufficient evidence to determine who specifically had done this or that any of the four nursing assistants identified by Mr. Berg was responsible. The report also stated that there was insufficient evidence that the four nursing assistants had ever failed to empty inmates' bed pans. A review of the medical records of the nine identified inmates revealed no evidence of any skin breakdown or pressure ulcerations.

In response to the findings, the report recommended that management officials within the FMC Rochester Nursing Department formally address with all nursing staff members that "double diapering" or placing disposable Chux pads inside incontinent inmates' undergarments was prohibited and could result in disciplinary action. The report also recommended that all pertinent local procedure sections of the FMC

---

<sup>2</sup> The agency interviewed only six of the nine inmates Mr. Berg identified because at the time of the investigation, one inmate had been released and two suffered cognitive impairment and/or dementia and were not lucid enough to be interviewed.

<sup>3</sup> Chux pads are disposable pads used in hospitals, nursing homes, and private homes for ill and/or elderly patients who have bladder control problems.

The President  
July 15, 2014  
Page 5 of 7

Rochester Nursing Care and Patient Care Manuals include specific documentation about the practice of “double diapering” or placement of disposable Chux pads inside inmates’ undergarments.

The investigation did not substantiate Mr. Berg’s allegation that Mr. Geier, Mr. Lockie, Ms. Nierman, and Ms. Wiplinger failed to provide physical care to an inmate who was HIV-positive. The report stated that the agency reviewed the “Non-Medical Orders Activities” records of the inmate from March 2013 through August 2013. A review of the records showed that Mr. Berg documented six activities, Mr. Geier documented twenty-six activities, Mr. Lockie documented sixty-five activities, Ms. Nierman documented forty-four activities, and Ms. Wiplinger documented one activity. The types of activities documented included assisting the inmate with feeding and Activities of Daily Living, providing palliative care, bathing or showering the inmate, checking vitals, and tending to wounds.

However, the investigation revealed sufficient evidence that Ms. Nierman behaved unprofessionally when she made comments about the HIV-positive inmate and his decision to discontinue his medications. The report explained that Ms. Sublett reported hearing Ms. Nierman say, “Well that’s one less mouth to feed.” Mr. Geier also recalled that he heard Ms. Nierman make a statement about the inmate discontinuing his medication. Mr. Geier stated Ms. Nierman made the statement while the two were in the inmate television room, and he did not think it was the “best place” for her to comment about the inmate’s medications.

Moreover, the report detailed three additional allegations that arose during the course of the investigation. First, Mr. Berg and Ms. Sublett both reported hearing Mr. Geier and Ms. Wiplinger joke about not feeding an inmate. The agency concluded there was sufficient evidence that Mr. Geier and Ms. Wiplinger behaved unprofessionally when they joked about not feeding the inmate.

Second, Mr. Berg reported that when he began his shift on August 29, 2013, he observed that Mr. Geier and Mr. Lockie failed to bathe and provide an inmate with his dinner meal tray during the previous shift. Mr. Geier and Mr. Lockie admitted that they unintentionally missed giving the inmate his bath and dinner meal tray on that day and that their mistake was due to understaffing. Accordingly, the agency determined that there was sufficient evidence that Mr. Geier and Mr. Lockie did not provide an inmate with his dinner meal tray and did not bathe him on August 29, 2013.

Third, Ms. Sublett cited her observation that Mr. Lockie and Ms. Nierman tended not to respond to an inmate’s request to be laid down in bed. Similarly, Mr. Pease relayed that he had observed Mr. Lockie and Mr. Geier ignore the inmate’s request to be laid down in bed.

The President  
July 15, 2014  
Page 6 of 7

In response to the findings, the report stated disciplinary action would be taken against the following employees: 1) Mr. Geier for Inattention to Duty and Unprofessional Conduct; 2) Mr. Lockie for Inattention to Duty; 3) Ms. Nierman for Unprofessional Conduct; and 4) Ms. Wiplinger for Unprofessional Conduct.

### ***III. The Agency's Supplemental Report***

As noted, in response to OSC's request for additional and updated information on the corrective and disciplinary actions taken, the agency provided a supplemental report on February 19, 2014. The supplemental report confirmed FMC Rochester Nursing Department management officials addressed the inappropriate practice of "double diapering" of inmate patients with all members of the nursing staff. According to information provided by the director of nursing, Loreli Klema, all nursing staff members attended FMC Rochester's mandatory "Annual Correctional Nurse Training Days" on January 6, 13, 27, and February 3 and 10, 2014. All nursing assistants attended the session on January 27, which included a lesson titled "Patient Rounds." One part of this lesson addressed the importance of ensuring a regular toileting schedule and not using excessive padding or "double diapering" with patients. Perineal and incontinence care was also reviewed and all participants were introduced to the "Mosby" nursing skills series, an online training resource which outlines standard care practices. Finally, the report states that FMC Rochester's "Patient Care Manual" is in the process of being updated to include instructions on not using padding in incontinence briefs.

In addition, the supplemental report addressed the agency's decision not to further investigate Ms. Sublett and Mr. Pease's reported observations that Mr. Lockie, Ms. Nierman, and Mr. Geier ignored an inmate's request to be laid down in bed. The report explains that upon investigation, the agency determined there was nothing specific in the inmate's medical record or in BOP policy or procedures that required nursing assistants to lay the inmate down in bed at his request. Furthermore, according to the BOP's chief nurse, nursing assistants are not expected to immediately respond to all inmate requests, especially if they are engaged in other duties. Lastly, the agency found that Ms. Sublett's specific order on April 30, 2013 (i.e., that the inmate should only be in his wheelchair for one-and-a-half to two hours at a time), sufficiently addressed the matter.

On May 5, 2014, OSC requested another update regarding the proposed disciplinary actions issued to the four employees. On May 23, the agency responded to OSC's request and provided the following information: Ms. Wiplinger's proposed two-day suspension was mitigated to a Letter of Reprimand; Mr. Geier's proposed five-day suspension was mitigated to a Letter of Reprimand; Mr. Lockie's proposed two-day suspension was mitigated, resulting in no disciplinary action; and Ms. Nierman's proposed three-day suspension was mitigated and resulted in no disciplinary action.

The Special Counsel

The President  
July 15, 2014  
Page 7 of 7

***IV. The Special Counsel's Findings***

I have reviewed the original disclosure, the agency reports, and the whistleblower's comments. Based on that review, I have determined that the reports contain 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 reports to the Chairmen and Ranking Members of the Senate and House Committees on the Judiciary. I have also filed copies of the redacted agency reports in OSC's public file, which is available online at [www.osc.gov](http://www.osc.gov). The whistleblower declined to publicly comment on the reports, and thus his comments have not been included in the public file. This matter is now closed.

Respectfully,



Carolyn N. Lerner

Enclosures