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The Special Counsel

August 7, 2014

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

Re: OSC File No. DI-13-4505

Dear Mr. President:

I am providing you with the U.S. Office of Special Counsel's (OSC) findings on whistleblower disclosures from a former psychiatrist at the Department of Veterans Affairs (VA) Community Living Center (CLC) in Brockton, Massachusetts, part of the Boston Healthcare System. The whistleblower in this case, Dr. Mohit Chopra, alleged that employees at the CLC failed to provide appropriate medical and mental health care to individuals residing in the long-term care units of the CLC.

Dr. Chopra's concerns were first summarized in my June 23, 2014, communication to you and the Committees on Veterans Affairs. That communication highlighted a series of recent cases in which the VA, and particularly the VA's Office of the Medical Inspector (OMI), confirmed serious instances of patient neglect or other misconduct, yet failed to acknowledge and address the impact these problems may have on the health and safety of veterans. In response to my June 23 communication, the VA overhauled the OMI and has taken additional steps to improve its investigation and responses to whistleblower disclosures. OSC will continue to work closely with the VA to help ensure success in these efforts. I am optimistic that the changes will result in better care and more accountability moving forward.

This letter concludes OSC's role in the allegations stemming from Dr. Chopra's disclosure. The detailed analysis below is also a reminder of the VA's prior pattern of deficient responses to disclosures from VA physicians, nurses, schedulers, and other health care providers, and why the recent efforts to improve responsiveness are so critical. Specifically, Dr. Chopra disclosed evidence of patient neglect concerning three veterans at the CLC:

- Patient 1, a resident of the CLC admitted for a service-connected major depressive disorder, went more than five years without appropriate psychiatric consultation, treatment, or medication.

- Patient 2, a resident of the CLC, diagnosed with a service connected mental health

disorder, went more than eleven years without any psychiatric treatment or lab monitoring.[1]

- Patient 3, a CLC resident, received psychotropic medication for two years without any attempt to decrease or discontinue its use, in violation of agency policy.

- Dr. Chopra further reported his belief that these instances of patient mistreatment were not isolated and that other patients may have been similarly neglected at the facility.

Despite substantiating Dr. Chopra's allegations, the VA found no violations of law, rule, or regulation.

- The OMI investigation determined the CLC admitted Patient 1 in March 2003 with significant, chronic mental health issues, but the patient did not receive a comprehensive psychiatric evaluation until eight years later, in June 2011.

- The agency also substantiated Dr. Chopra's allegations regarding Patient 2. The OMI investigation determined that Patient 2 had serious mental health issues, and was a CLC resident from June 2005 to May 2013. During this time, he had only one psychiatric note written in his chart. This was the only entry to address treatment recommendations. In addition, there was no evidence that, until Dr. Chopra's recommendation, the CLC tried to lower or eliminate doses of psychotropic medications he received.

- The agency did not substantiate allegations with respect to Patient 3. The OMI investigation determined doses of psychotropic medications administered to this individual were significantly reduced over a two-year period.

- The OMI did not engage in a broader review of patient care beyond these three identified patients, despite Dr. Chopra's concerns.

OSC requested a supplemental report from the VA to explain OMI's conclusion that no patient's rights were violated. However, in its supplemental report the agency reiterated: "in some areas [the veterans'] care could have been better but [the agency] does not feel that their patient's rights were violated." In a second supplemental communication, the agency presented additional facts concerning the care received by Patient 1 and Patient 2. While the second supplemental communication provided helpful context it did not alter the conclusions OMI reached in its earlier reports. Ultimately, the VA failed to acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. In addition, the OMI report did not address Dr. Chopra's belief that patient neglect in the CLC was not limited to the three individuals identified in his disclosure. OMI failed to look beyond these

[1] Note that Dr. Chopra's initial allegations were that Patient 1 went five years without psychiatric care, while OMI determined it was actually eight years. Dr. Chopra initially alleged Patient 2 went 11 years without psychiatric care, and OMI determined it was seven years.

individuals to examine whether the serious care issues extended to other patients at the CLC or to other facilities within the VA Boston Healthcare System. Because of these deficiencies, OSC finds the agency's reports unreasonable.

Procedural History

Dr. Chopra's allegations were initially referred November 26, 2013, to then-Secretary Erik K. Shinseki to conduct an investigation pursuant to 5 U.S.C § 1213 (c) and (d).[2] The Secretary then referred the matter to the Under Secretary for Health, who tasked OMI to conduct the investigations. Chief of Staff Jose D. Riojas submitted the agency's report on Dr. Chopra's allegations to this office on March 12, 2014. In response to OSC's request for information clarifying conclusions in the initial report, the agency provided a supplemental report on May 27, 2014. Dr. Chopra commented on the agency's report and supplemental report, noting that the patients' neglect "violated [VA Boston Healthcare System] VABHS policies as well as other laws and regulations." The three veterans in Dr. Chopra's disclosures "represent the most vulnerable individuals in the patient population being served by the VA," and their "rights...were violated." On July 22, 2014, James Tuchschmidt, acting principal deputy under secretary for health, submitted a letter providing additional details concerning Patient 1 and Patient 2. Dr. Chopra commented on the content of this letter noting: "[the] letter does not alter OMI's...findings, which supported [my] whistleblower allegations," and reiterated that he believes that the rights of these veterans were violated.

Dr. Chopra's Disclosures

Patient 1

The Allegations

Between 2010 and 2012, Dr. Chopra worked in the Department of Psychiatry and provided psychiatric consultation-liaison services to the primary Geriatrics and Extended Care (GEC) treating team at the CLC. In April 2012, Dr. Chopra was asked to evaluate a CLC patient who began expressing suicidal ideation and strong death wishes, including the refusal of medical care. This individual was initially admitted to the CLC in 2003 for a 100%

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[2] 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 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).

service-connected disability resulting from a major depressive disorder. This patient also had significant neurological disorders, was bedridden, and required total medical care.

When Dr. Chopra reviewed this patient's medical records, he discovered that despite the original psychiatric diagnosis, disability determination, and subsequent admission to the CLC, the patient had never been evaluated by a psychiatrist during his seven years at the CLC. Additionally, Dr. Chopra discovered this patient had not received basic lab tests intended to identify vitamin and hormonal deficiencies commonly associated with depression.

When these tests were ordered and the results received, they indicated that the patient suffered from both vitamin and hormonal deficiencies. Dr. Chopra prescribed an appropriate course of treatment that alleviated the severity of the patient's depression. Dr. Chopra alleged that this patient's medical neglect violated VA quality of care standards and rose to the level of gross mismanagement. Specifically, under these quality of care standards, "each resident must receive and the facility management must provide the necessary care and services to attain the highest practicable physical, mental and psychosocial wellbeing." *See* 38 CFR § 51.120.

The Agency's Findings and Recommendations

The agency substantiated the allegation that from 2003 to 2011 Patient 1 had one psychiatric evaluation. The investigation determined that Patient 1 was admitted to the CLC in March 2003 with significant, chronic mental health issues. He had a history of multiple suicide attempts, including stabbing himself and overdosing on medications.

At the time of his admission to the CLC, Patient 1 was expressing suicidal ideation. He had two brief contacts with psychiatric providers in 2003 and 2008. In 2003 the patient saw a psychology intern, and the investigation stated it was unclear whether Patient 1 actually saw a physician. In 2008 the patient briefly saw an emergency room psychiatrist, who told CLC staff there was no reason for intervention or medication modifications at that time. In response to ongoing pain and depression, Dr. Chopra performed the first comprehensive psychiatric evaluation for this individual on June 17, 2011. Medication assessments and modifications did not occur until Dr. Chopra's consultation.

The agency made a number of recommendations as a result of its findings, including ensuring that the consultative liaison psychiatrist assess all CLC residents receiving antipsychotic/psychotropic medications at least annually to verify that the particular medication and dosage amount is consistent with desired effects and VA standards of care. In addition, the agency recommended that current CLC residents taking antipsychotic/psychotropic medications, who have not seen a psychiatrist in the last twelve months, be seen as soon as possible. The agency did not address the fact that the individual received no comprehensive mental health evaluation for more than eight years, and made no recommendations regarding this serious deficiency. In addition, the agency did not consider or determine if other residents were similarly neglected.

Patient 2

The Allegations

In the spring of 2012, Dr. Chopra recommended that the CLC create a list of all long-term care patients in the CLC receiving antipsychotic medication. Prior to this, no list of these individuals existed. The list was intended to track the administration of antipsychotic medications and reduce and eliminate their use, where appropriate, in conformance with VA regulations and policies.

Dr. Chopra became aware of Patient 2 when the antipsychotic medication list was assembled. The list indicated that a CLC resident with a primary diagnosis of a schizo-affective disorder and drug-induced Parkinson's had been receiving sodium valproate and quetiapine, a mood-stabilizer and antipsychotic medication, respectively, for over eleven years. When Dr. Chopra reviewed this patient's medical records, he discovered that the patient had never received any of the clinical monitoring or evaluation required by VA regulations and policies. This resident did not receive serum valproic acid level testing, nor was there any attempt to decrease the dosage of antipsychotic medication, in violation of both VA regulations and professional practice standards. *See* 38 CFR § 51.120 (m)(2)(ii), 38 CFR § 17.33 (e), and 38 CFR § 51.210 (s).

VA quality of care regulations state, "facility management must ensure that...residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." *See* 38 CFR § 51.120 (m)(2)(ii). Regarding the administration of medication generally, VA regulations state, "a review by an appropriate health care professional of the drug regimen of each inpatient shall take place at least every thirty (30) days. It is recognized that administration of certain medications will be reviewed more frequently." *See* 38 CFR § 17.33 (e). Additionally, VA regulations mandate "each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used...for excessive duration, or without adequate monitoring." *See* 38 CFR § 51.120 (m)(1). Finally, VA administrative regulations require that facilities "operate and provide services in compliance with all...accepted professional standards and principles that apply to professionals providing services in such a facility."

In the context of antipsychotic and psychotropic medications, professional practice guidelines established by the American Psychiatric Association require that individuals taking psychotropic medications, such as sodium valproate, have specific laboratory tests, including complete blood counts, liver function tests, and serum valproic acid levels, performed on a routine basis to ensure that the medication is not causing unsafe side effects. These professional standards further indicate that efforts should be made to reduce or eliminate the administration of these medications.[3]

[3] *See:* American Psychiatric Association- Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias, 2013.

The Agency's Findings and Recommendations

The agency investigation confirmed that Patient 2 had a 100% service-connected mental health condition and was transferred to the CLC from the Brockton Campus inpatient psychiatry unit. He was subsequently transferred to a foster home but was readmitted to the CLC in 2005, where he stayed until his death in 2013. OMI reviewed his electronic health record and found only one psychiatric note, which was written by Dr. Chopra in 2012.

The VA's report found that while at the CLC, Patient 2 had approximately two liver function tests per year and approximately three complete blood count tests per year. OMI found no evidence that any attempts were made to reduce or eliminate the administration of antidepressant and psychotropic medications. OMI noted, "Given [Patient 2's] extensive mental health issues, more frequent assessments by psychiatry service would have been beneficial."

The agency recommended that the Brockton Campus develop a process to minimize or eliminate the need for psychotropic medications by considering other methods such as behavior techniques or counseling to achieve the desired resident outcomes. The report did not address the fact that Patient 2 received no comprehensive mental health evaluation for more than seven years, and made no recommendations regarding this serious deficiency.

Patient 3

The Allegations

In February 2010, Dr. Chopra was asked to consult on an elderly CLC patient suffering from dementia. The individual was originally transferred into the CLC unit from the long-stay inpatient psychiatry unit in October 2009. Medical records indicated that this patient had been prescribed benzodiazepine, a psychotropic medication. As with antipsychotic medications, barring clinical contraindications, efforts must be made to reduce and eliminate the administration of psychotropic medications and routinely evaluate their use. *See* 38 CFR § 17.33 (e). Additionally, as noted above, VA quality of care regulations state that each resident must be free from the administration of drugs for excessive duration, without adequate monitoring, or where clinical indications suggest that the dose should be reduced or discontinued. *See* 38 CFR § 51.120 (m)(1).

At Dr. Chopra's February 2010 consultation, he concluded that the administration of benzodiazepine was clinically inappropriate for Patient 3, and he ordered that its usage should be gradually tapered and stopped.

In August 2012, Dr. Chopra was again asked to evaluate Patient 3. When he reviewed the patient's medical records, Dr. Chopra discovered that his original recommendation was ignored and the patient was still receiving benzodiazepine at the same dose as in February 2010. There was no indication of an attempt in the two years between consultations to reduce the dosage of the medication, or to discontinue its use. This was in direct violation of (1) Dr. Chopra's 2010 consult recommendations, (2) clinical indications

that benzodiazepine administration should be discontinued, and (3) both VA Boston Healthcare System policy and VA regulations and clinical practice guidelines.

The Agency's Findings and Recommendations

The agency report noted that Patient 3 was transferred to the CLC in October 2009 after a six year period in the Brockton Campus inpatient psychiatry unit. This individual did not receive a psychiatric consultation in the CLC until February 2010, which Dr. Chopra conducted. Dr. Chopra recommended a reduction in his medications and ordered the discontinuation of one prescription. The agency determined that subsequent to these orders, the medication was discontinued and dosages of other prescriptions were reduced appropriately. The agency made no recommendations with respect to this allegation.

The Agency's Supplemental Report

OSC requested that the agency provide supplementary information on the status of implementation of the OMI report's recommendations. OSC also asked the agency how it could substantiate Dr. Chopra's allegations, but find no violations of law, rule, or regulation, or threats to patient care.

The agency reported that as of May 1, 2014, all CLC residents receiving antipsychotic/psychotropic medications with a stay of more than ninety days were identified and assessed by the consultative liaison psychiatrist. In addition, the VA developed a tracking tool to ensure that residents are assessed at least annually. Further, the consultative liaison psychiatrist assessed all residents receiving these drugs who were not seen in the last year.

The agency did not modify its initial conclusion, and reiterated its assessment that the veterans received adequate care. The supplemental report noted, "The Veterans discussed in the report were in a VA long term care facility in which they were provided with a safe and humane environment at the correct level of care.... OMI feels that in some areas their care could have been better but OMI does not feel that their [*sic*] patient's rights were violated."

The Agency's Second Supplemental Communication

On July 22, 2014, the agency provided a letter signed by Acting Principal Deputy Under Secretary for Health Dr. James Tuschmidt. The letter included additional details concerning Patient 1 and Patient 2, and discussed recent improvements to mental healthcare within the CLC.

Patient 1

The July 22, 2014 letter noted that this patient was admitted with longstanding stable PTSD and chronic pain. According to the letter, this patient was evaluated by psychology and psychiatry at the time of his admission, and received multiple psychological evaluations

during the course of his stay. The letter further noted the patient remained stable while in the CLC, and his care team wrote more than 3,000 chart notes.

Patient 2

The July 22, 2014 letter stated this patient had long-standing, severe Parkinson's disease and dementia, in addition to a history of PTSD and psychosis prior to his admission. The letter explained that this patient received regular, continuous care by a geriatric care team, who consulted with neurologists and psychologists intermittently. The letter further noted this patient was on a stable medication regimen for his mental health problems. The letter acknowledged that Patient 2 was only evaluated by a psychiatrist once during his stay in the CLC.

Additional Comments

The July 22, 2014 letter also noted that the VA Boston Healthcare System viewed OMI's recommendations as an "opportunity to augment the mental health care of CLC patients with regularly scheduled psychiatry visits." The letter confirmed the corrective action plan identified by the OMI that CLC patients on antipsychotic medications receive psychiatric consultations at least once per year. It further noted that nursing personnel have undergone additional training in behavioral measures to reduce the need for psychotropic medications.

The July 22, 2014 letter also stated that the Boston VAMC has multiple mechanisms for staff to report patient care, safety, and ethical concerns. It notes that in addition to reporting concerns through the chain of command, staff can report issues anonymously through software tools available on every computer. Dr. Tuchschmidt stated: "I firmly believe the leadership has fostered a just culture of improvement and provided staff with multiple mechanisms to raise concerns."

Dr. Chopra's Initial Comments

Dr. Chopra was provided an opportunity to review and comment on the agency's reports and the supplemental letter. In his comments to the initial agency report, Dr. Chopra noted that Patient 1 and 2 were admitted for mental health problems and went eight and seven years, respectively, before they received appropriate mental health treatment. However, OMI's conclusion was "dismissive and aimed at avoiding any substantive discussion of the law and violation thereof." Dr. Chopra firmly believes that the OMI's findings confirm that the "CLC violates VABHS [VA Boston Healthcare System] policies as well as other laws and regulations," and "demonstrates a pattern of gross mismanagement and a specific danger to public health and safety."

Comments Regarding OMI's Factual Findings and Conclusions

Patient 1

Dr. Chopra noted that OMI concluded he "recommended *changes* to [this veteran's] antidepressant medication" (Emphasis added). Dr. Chopra explained that at the time he first provided care to this patient, the patient was not on any antidepressant medication and had not received such medicine for the preceding eight years, despite his history of multiple suicide attempts. Dr. Chopra asserted that he was the first to prescribe antidepressants for the patient. Therefore, he commented that OMI's use of the phrase "changes to" should be replaced with "initiation of." Dr. Chopra also noted that OMI's report appeared to indicate that after his initial evaluation of Patient 1, this individual waited another nine months before he received another psychiatric visit.

Patient 2

Dr. Chopra contends that OMI wrongly concluded that Patient 2 received antidepressant medications. Rather, when he treated Patient 2, the veteran was on quetiapine, an antipsychotic medication. Dr. Chopra noted that quetiapine is only FDA-approved for use as an antidepressant at high does for individuals diagnosed with bipolar disorder. Dr. Chopra called attention to the fact OMI's report noted Patient 2 was not bipolar. The report indicated Patient 2 had Parkinson's disease, plus a number of psychiatric and neurological conditions, including dementia.

Dr. Chopra noted that quetiapine carries an FDA black-box warning concerning the high risk of stroke, stroke-like events, and sudden death, in patients diagnosed with dementia, as this veteran was. According to Dr. Chopra, this patient was receiving high doses of this medication at the time of his evaluation.

Additionally, Dr. Chopra recalled that in the seven years before his assessment, Patient 2's medical records indicated his serum valproic acid level had not been checked. Dr. Chopra stated that OMI's conclusion that Patient 2 received appropriate lab testing was "by no means comprehensive or complete." He also noted that VA's own records indicate that unmonitored valproate therapy when coupled with quetiapine greatly increases the risk of serious side effects.

Dr. Chopra directly addressed OMI's conclusion regarding Patient 2 that stated: "more frequent assessments…would have been beneficial," noting that this is an "understatement that serves to obfuscate the extent of the neglect of this veteran, who waited no less than seven years for a substantial and appropriate psychiatric assessment."

Patient 3

Dr. Chopra disagreed with OMI's conclusions regarding Patient 3. He contended that for two-and-a-half years following his initial assessment of the patient, "Primary medical care providers of an [elderly] veteran with diagnosed dementia made no apparent effort to

evaluate the need for, or continue to decrease the dose of benzodiazepine…[a drug] associated with a multitude of problems in older adults, including an increased risk of mortality." Dr. Chopra explained that OMI's conclusions were inconsistent with his recollection of the facts. In addition, he noted that the reduction in dosage OMI reported was not sufficient given the high doses of benzodiazepine Patient 3 received.

Dr. Chopra recalled that during his first evaluation of Patient 3, which was not requested until more than three months after the patient's admission, he determined that the greatest cause of the patient's "'worsening mental status' was the very high dose of olanzapine," which was "alarmingly high" for a patient his age. Furthermore, Dr. Chopra insisted that the CLC made no effort to progressively decrease Patient 3's benzodiazepine level; rather, the dosage was decreased once and then only by half.

Comments Regarding Other Findings and Recommendations

Dr. Chopra noted that OMI's report indicated that the agency is transitioning from a dated nursing home model of care, to a "person-centered care model" in CLCs. Dr. Chopra stated: "based on the OMI's report and its substantiation of [his] allegations, there were instances of a deplorable failure to achieve the goals of a person-centered model at the…CLC." In addition, he was deeply troubled that these instances of patient neglect occurred during a time, according to the OMI report, that the Brockton Campus actively pursued a strategy to "phase out existing long-term residents."

Dr. Chopra also strongly objected to OMI's first two recommendations. With respect to the recommendation suggesting CLC residents receiving antipsychotic and psychotropic medications receive assessments "at least annually" Dr. Chopra questioned how OMI could set standards that are less rigorous than the VA Boston Healthcare System's own policies. Specifically he noted that local policy requires the evaluation of residents on these medications every six months. *See* PCM-181-001-GEC. Further, OMI's recommendation that residents receiving these drugs, who have not been evaluated by a psychiatrist in the last 12 months, should be seen as soon as possible is at odds with local VA policy requiring more frequent evaluations. Dr. Chopra questioned how OMI's recommendation could set lower standards, especially given their substantiation of these allegations.

Dr. Chopra agreed with OMI's third recommendation, regarding the need to develop a process to minimize and eliminate the necessity for psychotropic medications by utilizing other therapeutic methods. He noted that given their vulnerable conditions, long-term care residents should be evaluated at four-month intervals.

Comments Regarding OMI's Summary Statement

Dr. Chopra noted that OMI's report contained the summary statement that the investigation "…did not find violation of statutory laws, rules, or regulations." He further noted that after OSC requested clarification, OMI continued to assert no violations occurred and no patients' rights were violated.

He commented that the supplemental report stated that 38 CFR 51.120(m)(1) and (m)(2) did not apply to VA's CLCs, because these regulations set standards for state veterans' homes. Dr. Chopra asserted that this response seems to suggest that OMI believes state-run veterans homes are held to a higher standard of care than the standard of care required by the VA's own facilities. However, Dr. Chopra stated that agency policies and procedures clearly specify that long-term care institutions outside the VA must meet VA standards to qualify as VA-designated facilities. *See* VHA Handbook 1145.01 and 1143.2. Based on these policies, the standard of care for facilities outside the VA is the same as those within VA's own facilities, and it "would therefore be illogical for the standards outlined in 38 CFR 51.120(m)(1) and (m)(2) to be inapplicable to the CLCs." Dr. Chopra also explained that the CLC purports to follow the Federal Nursing Home Reform Act. *See*: 42 CFR § 483. This law contains a number of quality of life and medical care standards for residents, which VHA policy states serve as a means to facilitate comparisons between VA CLCs and private-sector nursing homes. *See* VHA Handbook 1142.03.

Dr. Chopra found dismissive and troubling OMI's conclusion that "in some areas [patients'] care could have been better but OMI does not feel that their patient's rights were violated." He stated that such extended waits for appropriate care were neither safe nor humane. He explained that Patient 2 "was rendered so severely incapacitated from the combination of his neuro-psychiatric disorder and the high doses of unmonitored medications…that this veteran was unable to talk and ask for help, let alone inform his nurse that he has not been seen by a psychiatrist or other physician for many years." He concluded by noting that he remained "steadfast in his conviction that the rights of these veteran-patients, two of whom are now deceased, were violated," and asserted that his disclosures demonstrated a pattern of gross mismanagement and a substantial and specific danger to public health and safety.

Dr. Chopra's Comments to the July 22, 2014 Letter

Dr. Chopra commented that the July 22, 2014 letter is "characteristic of the institutional denial that led to the neglect in the first place, symptomatic of the disregard that caused it to persist even after [Dr. Chopra] sounded the alarm…and consistent with the dismissive conclusion of VA's own OMI."

Comments Regarding Patient 1

Dr. Chopra noted that the July 22, 2014 letter: "repeatedly glosses over, and avoids mentioning seemingly important, albeit disturbing facts…such as the fact that [Patient 1] was first admitted to the CLC 'due to suicidal ideation.'" He further stated that the letter appears to directly contradict the findings OMI detailed in its reports. Specifically, Dr. Chopra refuted the new assertion that Patient 1 was seen by a psychiatrist at the time of his admission, which was not supported by any evidence and contradicted four OMI medical investigators who examined the matter and were unable to find evidence of an initial psychiatric evaluation. Dr. Chopra concluded that even if Patient 1 had received a full psychiatric evaluation upon admission, it does not alter the fundamental fact that this patient did not receive another full psychiatric evaluation for more than eight years.

Dr. Chopra questioned the suggestion that the number of chart notes in Patient 1's file suggested appropriate medical care. He noted this statistic was provided without context. According to Dr. Chopra, given the length of Patient 1's stay in the CLC, he should have had roughly 4,000 chart notes. Dr. Chopra also doubted the efficacy of an "extraordinarily detailed mental health evaluation" referenced in the July 22, 2014 letter, as this evaluation was likely performed by a psychology intern, which is the lowest level trainee in the agency's psychology service.

Dr. Chopra concluded his comments regarding Patient 1 by noting: "Despite the VA's efforts in its July 22, 2014 letter to downplay the psychiatric problems of [this patient], the fact that he had serious psychiatric problems is not open to debate." He noted that the letter emphasized Patient 1's "stability" but concluded, "While stability might be considered desirable in a vacuum, remaining 'stable' in a severely depressed and strongly suicidal state is bad, not good."

Comments Regarding Patient 2

Dr. Chopra emphasized that the July 22, 2014 letter did not contain any affirmative assertion that OMI's factual findings were in any way erroneous. He noted that the letter "seeks to emphasize certain facts and de-emphasize or avoid other facts in order to paint the [VA Boston Healthcare System] in a better light."

Dr. Chopra again questioned the frequent use of the term "stability" in reference to Patient 2. He noted the "stable medication regimen" Patient 2 received was partly responsible for his serious medical issues. Dr. Chopra explained that because Patient 2 died prior to the OMI site visit, neither OMI nor Dr. Tuchschmidt witnessed Patient 2's condition. When Dr. Chopra evaluated Patient 2, the patient "had a blank, mask-like face and unblinking gaze. He was drooling...and was unable to wipe away the saliva himself." Dr. Chopra noted that Patient 2 was unable to verbalize responses to Dr. Chopra's questions. Dr. Chopra posited this physical condition was the result of excessive anti-psychotic medication and insufficient Parkinson's medication. Dr. Chopra highlighted the fact that the July 22 letter acknowledged Patient 2 had an "inability to communicate," but omitted any mention of the fact that his "stable" medication regime may have contributed to the severity of this condition.

In conclusion, Dr. Chopra asserted that: "The VA had a duty to provide these Veterans with the appropriate level of *psychiatric* care." He noted that the July 22, 2014 letter does not alter or refute OMI's findings, which substantiated his allegations. Dr. Chopra reiterated his belief that patient rights were violated and these instances of neglect constituted violations of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health and safety.

The Special Counsel's Findings

I have reviewed the original disclosure, the agency's reports, the July 22, 2014 letter and the whistleblower's comments. I find the agency's report and supplemental report deficient. While the July 22, 2014 letter suggests a greater degree of agency responsiveness and sensitivity to disclosures, it does not refute the contents of the original report. The original agency report specifically acknowledged two vulnerable patients were subject to egregious neglect, but refused to confirm that their rights were violated. This is an unreasonable conclusion given the confirmed facts.

Dr. Chopra's comments provide insight into the VA's response to serious patient health and safety issues and its recommended corrective actions. Specifically, Dr. Chopra noted that the recommended corrective actions actually set a lower bar than local policy, and the superficial assessment of patient's rights standards disserves veterans with serious mental health issues.

Further, the OMI report did not address Dr. Chopra's belief that patient neglect in the CLC was not limited to the three individuals identified in his disclosure. OMI failed to look beyond the three individuals specifically cited by Dr. Chopra, and thus whether the serious care issues extended to other patients at the CLC or to other facilities within the VA Boston Healthcare System. Because of its narrow focus, OMI's response did not put VA leadership on notice regarding these problems. It also prevented meaningful agency-wide review, more widespread corrective actions, or changes to agency policy. The July 22, 2014 letter states that, measures to improve patients' psychiatric care have been implemented in the Boston VA Healthcare system. This is encouraging moving forward. However, in this case, OMI's conclusions and its refusal to acknowledge the severity of patient care issues are not reasonable.

In my June 23, 2014 letter to you, I reported numerous disclosures regarding patient care, highlighting cases where OMI substantiated serious allegations implicating patient health and safety, while at the same time denying any harm to patient care or violation of any law, rule or regulation. OSC continues to receive significant health and safety disclosures, often daily. I am encouraged that new VA leadership has communicated a new approach regarding these matters and am optimistic that future reports will contain appropriate information and corrective action plans, including disciplinary actions and whether substantiated concerns indicate broader or systemic problems requiring attention.

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As required by 5 U.S.C. § 1213(e)(3), I have sent unredacted copies of the agency's reports and the whistleblowers' comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and whistleblowers' comments in our public file, which is now available online at www.osc.gov.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures