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The Special Counsel

June 9, 2015

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

Re: OSC File No. DI-14-3321

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Syracuse VA Medical Center (Syracuse VAMC), Syracuse, New York. The Office of Special Counsel (OSC) has reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

Rachael Hogan, a registered nurse (RN), who consented to the disclosure of her name, alleged that employees at Syracuse VAMC engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health and safety. Specifically, Ms. Hogan disclosed that managers in the Inpatient Behavioral Health Care unit failed to report an alleged sexual assault in violation of Veterans Health Administration (VHA) protocol, that staff engaged in actions that compromised patient health and safety, and that managers were frequently absent without excuse.

The agency substantiated Ms. Hogan's allegations in part, concluding that a patient's sexual assault allegations were not properly reported, and that the nurse manager and assistant nurse manager of the unit were frequently absent during required working hours. The VA could not substantiate that a RN repeatedly fell asleep during one-on-one suicide watches, nor that a RN failed to appropriately respond to a crisis in the unit, putting patients at risk. The report recommended administrative action for employees who failed to report the alleged sexual assault and training on reporting requirements for staff in the unit. The agency issued a proposed fourteen-day suspension to the nurse manager, and a letter of reprimand to the assistant nurse manager for time and attendance violations. The agency provided OSC with an update indicating that a notice of proposed removal was recently issued for the nurse manager, and an additional reprimand or proposed suspension will be issued to the assistant nurse manager, for their failure to properly report sexual assault allegations. This update further indicated that all employees received and were tested on newly developed sexual assault reporting procedures. Based on my review, I have determined

that the report meets all statutory requirements and that the findings appear to be reasonable.

Ms. Hogan's allegations were referred to then-Acting Secretary Sloan D. Gibson, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Acting Secretary Gibson asked the Under Secretary for Health to refer Ms. Hogan's allegations to the Office of Accountability Review. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On March 4, 2015, Mr. Riojas submitted the agency's report to OSC. Pursuant to 5 U.S.C. §1213(e)(1), Ms. Hogan provided comments on the agency report on April 7, 2015. As required by 5 U.S.C. §1213(e)(3), I am now transmitting the report and Ms. Hogan's comments to you.[1]

I. Ms. Hogan's Disclosures

A. Sexual Assault Allegations Were Not Properly Reported

Ms. Hogan asserted that in October 2013, a patient in the Inpatient Behavioral Health Care Unit reported to nurses that she was raped by several staff members. Ms. Hogan informed Kelly DeVaul, the nurse manager, and urged her to report the matter immediately to VA police. The allegations were disclosed by the patient on a Friday afternoon; however, Ms. DeVaul did not inform VA law enforcement officials until Monday morning. According to Ms. Hogan, officers discovered the reporting delay when interviewing nurses about the matter.

Inpatient mental health care units must report these types of allegations of adverse events within 24 hours of any incident. *See* VHA Handbook 1162.02 § 11.h. In addition, VA regulations require that all potential felonies, including rape allegations, must be immediately referred to the VA Office of Inspector General (OIG). *See* 38 C.F.R. § 1.204 (2010). VHA directives also state: "All employees of the [VHA] are required to report sexual assaults…to supervisory personnel. Supervisory personnel must inform law enforcement officials." *See* VHA Directive 2012-026. This directive further notes that: "All allegations of sexual assault…must be reported within 2 hours."

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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 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).

B. Managers Were Absent During Required Working Hours

Ms. Hogan asserted that Ms. DuVaul and Nancy Baker, the assistant nurse manager, did not record absences on time sheets and attendance logs, in violation of agency policy. *See* VA Handbook 5021/15 Part II Appendix A. According to Ms. Hogan, Ms. DuVaul and Ms. Baker were frequently absent from the unit when their posted time sheets indicated they were working. Ms. Hogan alleged that Ms. DuVaul and Ms. Baker used the remote location of the nurse manager's office to leave work undetected and take unexcused absences on a weekly basis.

According to Ms. Hogan, these absences were often discovered during rapid response or behavioral emergency response team situations (BERTs), when they are required to manage emerging crises. According to Ms. Hogan, these situations occurred approximately once per week. She noted that during her time on the unit, Ms. Duval and Ms. Baker were absent for approximately 75 percent of BERTs.

According to Ms. Hogan, Ms. DuVaul and Ms. Baker were also often absent for routine staff meetings. After a number of instances, Ms. Hogan reviewed time and attendance sheets and determined that Ms. DuVaul and Ms. Baker did not enter annual or sick leave during periods when they were not in the unit. Ms. Hogan further asserted that Ms. DuVaul and Ms. Baker were typically one to two hours late in arriving and left one to two hours early in the afternoon.

C. Staff Slept During One-on-One Suicide Watches

Ms. Hogan alleged that on multiple occasions, she discovered RN Kimo Cortini asleep during one-on-one suicide observations. Ms. Hogan explained both VA-wide policy and Syracuse VAMC policy require one-on-one constant observation of designated patients. *See* VHA Directives 1036 and 2010-008.

In January 2014, Ms. Hogan worked a regularly scheduled overnight shift. She reviewed charts when she started her shift and noted that a suicidal patient was on observation status. Mr. Cortini was assigned to observe the patient during Ms. Hogan's overnight shift. According to Ms. Hogan, when she went on required rounds she found Mr. Cortini asleep at the patient's bedside. She woke him and asked if he needed a break. When Mr. Cortini's observation shift ended, Ms. Hogan discussed the incident with him. He apologized and stated it would not occur again. On a subsequent evening in the same month, with the same patient, Ms. Hogan again discovered Mr. Cortini asleep again. She reported this incident to Ms. DuVaul, who indicated that she would speak with Mr. Cortini.

D. Staff Failed to Appropriately Respond to a Crisis in the Unit

Ms. Hogan also reported an incident where Mr. Cortini did not respond to an emerging crisis in the unit. During the week of April 7, 2014, two patients simultaneously became physically aggressive toward other patients and staff. At the time Mr. Cortini was the designated charge nurse. As such, he was responsible for responding to these threats.

According to Ms. Hogan, Mr. Cortini took no action while the incident escalated, even though he was responsible for reporting the incident and coordinating appropriate measures to resolve it. *See* VHA Directive 2012-026. Ms. Hogan explained that nurses took action and called VA police, and when police arrived they asked Mr. Cortini for directions. She explained that he was initially silent when police questioned him, then after repeated requests for directions, he provided non-responsive answers. During this delay, the incident continued to escalate. Eventually police worked with nurses to sedate the patients and place them in seclusion rooms. According to Ms. Hogan, Mr. Cortini was non-responsive during this entire period.

II. The Agency Report

The report substantiated that sexual assault allegations were not reported properly. The report noted that several staff members knew about the incident on Thursday, October 31, 2013, the day it allegedly occurred. However, police were not notified until Sunday, November 3, 2013. The report explained that Ms. DuVaul recorded a note in the patient's record indicating that the patient did not want the incident reported to police; however, this was immaterial, as Ms. DuVaul was required by regulation and policy to report the alleged incident immediately. The report recommended that Syracuse VAMC should consider issuing disciplinary action to Ms. DuVaul, and should provide training to appropriate staff members on reporting requirements for allegations of sexual assault or other potentially criminal activity. The agency provided OSC with additional information on May 13, 2015, explaining that Ms. DuVaul was recently issued a notice of proposed removal. Additional disciplinary action, likely in the form of an additional reprimand or proposed suspension, will be issued to Ms. Baker for her failure to appropriately report these allegations. The agency further informed OSC that all employees in the unit were trained and tested on two newly developed sexual assault notification procedures created in response to this incident.

The report also substantiated that Ms. DuVaul and Ms. Baker were frequently absent during required working hours. The report noted that the Ellen Dougherty, the Behavioral Health Care Line Manager, was put on notice of Ms. DuVaul's and Ms. Baker's alleged behavior when the facility received notice of OSC's 1213(c) referral letter dated July 29, 2014. Ms. Dougherty conducted her own investigation into the matter and determined that Ms. DuVaul and Ms. Baker frequently were late to work and that their time and attendance records were inaccurate. Ms. Dougherty requested that the Human Resources Unit issue a fourteen-calendar-day suspension to Ms. DuVaul for her behavior and requested that a letter of reprimand be included in Ms. Baker's personnel file.

The agency was not able to substantiate the allegations regarding Mr. Cortini. The report noted that there were no records supporting the assertion that he fell asleep during a one-on-one suicide watch. While Ms. Hogan stated that she informed Ms. DuVaul when the incident occurred, Ms. Hogan did not document the matter, and when interviewed, both Ms. DuVaul and Mr. Cortini denied that it ever occurred.

With respect to Ms. Hogan's allegations that Mr. Cortini failed to appropriately respond to a crisis on the unit, investigators reviewed the Restraint and Seclusion Data

Collection Log for the relevant time, and identified a possible date for the incident. Investigators interviewed all the parties who were present for the incident, including Mr. Cortini, but no one could recall the alleged incident. Thus, the charge could not be substantiated.

III. Ms. Hogan's Comments

Ms. Hogan provided brief comments to the report. She called attention to the fact that while there was no documentation concerning Mr. Cortini falling asleep during a one-on-one suicide watch, she personally observed this and informed Ms. DuVaul. Ms. Hogan explained that Ms. DuVaul stated she would address the issue. With respect to the allegations concerning Mr. Cortini's failure to respond to a crisis on the unit, Ms. Hogan asserted that the medical records reviewed by investigators were not correct, indicating that the records intentionally omitted necessary details in order to protect the employees at issue. She further stated that she believed Mr. Cortini and Ms. DuVaul released the patients prematurely in violation of unit policy, but noted that this allegation was also not documented in the medical records, and as a result it could not be substantiated.

IV. The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and Ms. Hogan's comments. While Ms. Hogan's comments highlight the inability of investigators to substantiate some allegations, it appears that the agency took appropriate measures to address the allegations they could conclusively substantiate. For these reasons, I have determined that the report meets all statutory requirements and the findings appear reasonable.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency report and Ms. Hogan's comments to the Chairman and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed copies of the agency report and Ms. Hogan's comments in our public file, which is available at www.osc.gov. OSC has not closed the file.

Respectfully,

Carolyn N. Lerner

Enclosures