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The Special Counsel

December 3, 2015

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

Re: OSC File Nos. DI-15-0499 and DI-15-2813

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find a Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the White River Junction Health Care System (the Medical Center), White River Junction, Vermont. The Office of Special Counsel (OSC) has reviewed the VA's report and, in accordance with 5 U.S.C. § 1213 (e), provides the following summary of the agency report, and my findings. The whistleblowers, who chose to remain anonymous, alleged that the Medical Center Emergency Department (ED) was chronically short staffed, mismanaged, and not properly disinfected, and that the Medical Center lacked appropriate pharmacy coverage.

The agency substantiated that the ED was improperly disinfected, which posed a danger to public health and safety. The report also acknowledged that significant staffing shortages previously existed in the ED between 2012 and 2014, but were resolved during fiscal year 2015. The report did not substantiate that the ED nurse manager engaged in unsafe practices and provided medically inappropriate care when treating patients, or that the Medical Center lacked sufficient pharmacy coverage. In response to the substantiated allegation, the Medical Center developed and implemented new cleaning schedules, added additional cleaning shifts, trained cleaning staff, and increased the frequency with which ED equipment is replaced or cleaned. Based on my review, I have determined that the report meets all statutory requirements and that the findings appear reasonable.

The whistleblowers' allegations were referred to Secretary Robert A. McDonald to conduct and investigation pursuant to 5 U.S.C. § 1213 (c) and (d). Investigation of the matter was delegated to the Office of the Medical Inspector (OMI). Chief of Staff Robert L. Nabors, II was delegated the authority to review and sign the report. On September 11, 2015, Mr. Nabors submitted the agency's report to OSC. The whistleblowers declined to

comment on this report. As required by 5. U.S.C. §1213(e)(3), I am now transmitting the report to you.[1]

The agency determined that the ED was improperly disinfected in violation of Occupational Safety and Health Administration regulations, Centers for Disease Control guidelines, and VHA directives, posing a danger to public health and safety. The investigation revealed a lack of cleanliness in the ED, a lack of cleaning during the overnight shift, and that cleaning staff were not properly trained in ED disinfection protocols. Contrary to the whistleblowers' allegations, the investigation did not find evidence of insects, or any indication that patients or employees contracted a rash from being in the unit, as was originally alleged. To correct these deficiencies, the Medical Center took the following measures, which were completed in the summer of 2015: They accelerated maintenance schedules, created an overnight shift to provide 24-hour housekeeping coverage, began to regularly clean and replace equipment such as curtains and stretchers, and provided ED specific training for all housekeeping staff.

While the report did not substantiate that the ED was currently short staffed, it acknowledged the unit was in violation of staffing requirements from 2012 to 2014, and during this time often scheduled just one nurse per shift. The nurse on duty frequently served as the chief nursing officer for the entire Medical Center. In response to this staffing shortage, managers instituted a plan to hire new nurses, authorized overtime, and utilized nurses from other units as well as traveling nurses to cover shifts. Six nurses were eventually hired, and the ED presently meets all staffing requirements. The report did not substantiate that nurses were frequently asked to supervise multiple trainees, and explained that this allegation stemmed from an apparently isolated incident.

The agency did not substantiate allegations regarding the ED nurse manager. A VA Office of Inspector General investigation into these matters determined that these allegations were based on the conflation and misrepresentation of several clinical scenarios, and that the clinical care and oversight provided by the ED nurse manager was appropriate. In addition, the agency did not substantiate that the Medical Center lacked pharmacy coverage, in violation of VHA policy, as the Medical Center acquired virtual pharmacy services which provided 24-hour coverage in May 2014. The report further noted that the actions described by the whistleblowers did not constitute filling

[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).

prescriptions for medications, and as such did not constitute a violation of agency policy or state nursing regulations.

I have reviewed the original disclosure and the agency report, and have determined that the report contains all the information required by statute and that the findings appear reasonable. After substantiating the serious allegations concerning the cleanliness of the ED, the agency took appropriate measures to resolve the deficiencies.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency report to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency report in our public file, which is available at www.osc.gov. OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures