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The Special Counsel

December 10, 2015

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

Re: OSC File No. DI-14-3424

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find a Department of Veterans Affairs' supplemental report based on disclosures of wrongdoing at the Central Arkansas Veterans Healthcare System (CAVHS), North Little Rock, Arkansas. The Office of Special Counsel (OSC) has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the agency's supplemental report, whistleblower comments, and our findings.

The supplemental report addressed allegations which were still under investigation at the time of OSC's August 3, 2015 letter conditionally closing this matter. In addition to the allegations addressed in this prior correspondence, the whistleblower, Daniel Wheeler, a medical support assistant, who consented to the release of his name, alleged that Veterans Health Administration (VHA) facilities in the CAVHS network did not follow proper scheduling protocols.

The supplemental report substantiated Mr. Wheeler's scheduling allegations. The agency determined that scheduling staff were improperly directed to "zero out" patient wait times, in violation of agency policy. Notwithstanding this finding, an Administrative Investigation Board (AIB) did not recommend disciplinary action for Jacquelyn Riggins and Anthony Hatchett, two supervisory employees who participated in this practice and were not candid with investigators. Rather, the AIB deferred the assessment of disciplinary action to CAVHS. As of the date of this letter, Mr. Hatchett has been issued a proposed removal, and Ms. Riggins will be issued a proposed 30-day suspension. To resolve these issues, the report explained that CAVHS has improved training for schedulers, implemented random audits, and developed competency checklists for employees. The supplemental report showed that senior leaders at CAVHS were not responsible for improper practices and took appropriate actions to ensure patients were scheduled in accordance with VA policy. Based on my review, I have determined that the supplemental report meets all statutory requirements and the findings appear reasonable.

Mr. Wheeler's allegations were originally 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 then-Interim Under Secretary for Health Carolyn Clancy, M.D., to refer the original allegations to the Office of the Medical Inspector for investigation. Allegations regarding

scheduling were given to VA's Office of Accountability Review, which convened an AIB to review the matters. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report concerning non-scheduling related allegations. On April 9, 2015, Mr. Riojas submitted the agency's initial report to OSC. On June 22 and October 14, 2015, Michael V. Culpepper, deputy director, Office of Accountability Review, submitted supplemental reports concerning corrective actions and scheduling allegations, respectively. Mr. Wheeler provided comments to the agency supplemental report on November 11, 2015. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports to you.[1]

In his comments, Mr. Wheeler disputed the conclusion that CAVHS leadership did not know about these improper scheduling practices. He asserted that senior leadership was on notice that providers were not seeing a sufficient number of patients, but apparently did not question the accuracy of contemporaneous wait time data that reflected no appointment delays.

I have reviewed the original disclosure, the agency supplemental report, and Mr. Wheeler's comments. While Mr. Wheeler called into question the knowledge of CAVHS leadership, the supplemental report noted that the agency made extensive efforts dating back to 2008 to communicate the importance of following scheduling directives to employees, and has since implemented additional safeguards to prevent this from happening in the future. For these reasons, I have determined that the supplementary 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 supplemental report and Mr. Wheeler's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed a copy of the supplemental agency report in our public file, which is available at www.osc.gov. OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

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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).