



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

June 1, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File Nos. DI-15-1050; DI-15-1055; and DI-15-1056

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by whistleblowers at the Department of Veterans Affairs (VA) Medical Center in Tomah, Wisconsin. The whistleblowers alleged that an employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency and that despite being made aware of the situation, Tomah management failed to respond to concerns about this relationship; and further that management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide.

The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary directed the Office of Accountability Review (OAR) to conduct an investigation. In its investigation, the OAR concluded that the employee did engage in an improper relationship with a Veteran being treated at the Tomah VA Medical Center. The OAR investigation further found that Management properly initiated a fact-finding inquiry and issued timely written instructions to the employee prohibiting contact with the Veteran. Thereafter, however, Management did not act with an appropriate sense of urgency to prevent further contact after the employee continued to interact with the Veteran. The employee was ultimately removed from VA employment in March 2015.

Findings from the investigation are contained in the enclosed report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. We may also send your office a follow-up response describing actions which have been and will be taken in response to this report.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert L. Nabors II".

Robert L. Nabors II
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of the Special Counsel

OSC File Nos. DI-15-1050, DI-15-1055, DI-15-1056

Department of Veterans Affairs
Tomah VA Medical Center
Tomah, Wisconsin



Any information in this report that is subject to the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty of those statutes.

Executive Summary

Pursuant to its authority in 5 United States Code (U.S.C.) Section 1213(c), the Office of Special Counsel (OSC), by letter dated February 4, 2015, to the Secretary of Department of Veterans Affairs (VA) referred for investigation specific allegations made by VA employees, Daniel Hannan, RN, Dr. Diane Todd, and Glen Moseley (hereinafter, the whistleblowers) that an employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency and that despite being made aware of the situation, Tomah Management failed to respond to concerns about this relationship; and further that Management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide.

The Secretary authorized the Office of Accountability Review (OAR) to investigate this complaint. OAR conducted an administrative investigation via telephone interviews and document review from March 12-26, 2015.

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. An allegation **was not substantiated** when the facts showed the allegation was unfounded. An allegation **could not be substantiated** when there was no conclusive evidence to either sustain or refute the allegations.

This constitutes the Department's response as required by 5 U.S.C. Section 1213(d).

Summary of Conclusions

OAR conducted an investigation of the whistleblowers' allegations. The investigation included telephone interviews with the whistleblowers, key witnesses, and review of pertinent documents. A summary of the findings follows:

- Allegation #1, that an employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency was substantiated.
- Allegation #2, that despite being made aware of the situation, Tomah Management failed to respond to concerns about this relationship; and further that Management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide was partially substantiated. The OAR investigation found that Management immediately initiated a fact-finding inquiry and issued timely written instructions to the employee prohibiting contact with the Veteran. Thereafter, however, Management did not act with an appropriate sense of urgency to prevent further contact after the employee continued to interact with the Veteran. The employee was ultimately removed from VA employment in March 2015. Management's actions or inactions were not, however, a factor in the Veteran's original substance abuse relapse. The relapse occurred in October 2014 prior to any Management official being aware of the relationship and is not attributable to Management's actions. Similarly, Management's actions or inaction does not appear to have caused the Veteran's subsequent statement on November 21, 2014, that he would drink himself to death if the employee did not decide. This statement related to the nature of the relationship itself, not Management's actions, and occurred only a day or two after his entrance into the inpatient program.

Summary of Recommendations

Appropriate administrative actions and/or education are being considered for the Medical Center Director, Chief of Staff, Associate Chief of Staff for Patient Care Services, Human Resources Officer, and the Associate Chief of Staff for Mental Health to emphasize that adequate and timely action must be taken in the future to effectively address ongoing improper relationships of this type, particularly those with potential for patient harm.

Report to the Office of Special Counsel

I. Introduction

The Secretary of Veterans Affairs directed the Office of Accountability Review (OAR) to investigate a complaint lodged with Office of Special Counsel (OSC) by three whistleblowers employed by the Tomah VA Medical Center. The whistleblowers, Daniel Hannan, RN, Dr. Diane Todd, and Glen Moseley, alleged that an employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency and that despite being made aware of the situation, Tomah Management failed to respond to concerns about this relationship; and further that Management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide.

II. Facility Profile

The Tomah VA Medical Center provides primary care, rehabilitation, extended care, and mental health services to Veterans in Western/Central Wisconsin. In addition to the main medical center, Tomah offers services to patients in four community-based outpatient clinics in LaCrosse, Clark County, Wausau, and Wisconsin Rapids.

III. Allegations

By letter dated February 4, 2015, The Special Counsel (Exhibit 2) referred the following allegations to the Secretary of Veterans Affairs:

- An employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency; and
- Despite being made aware of the situation, Tomah Management failed to respond to concerns about this relationship; and further that Management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide.

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. An allegation **was not substantiated** when the facts showed the allegation was unfounded. An allegation **could not be substantiated** when there was no conclusive evidence to either sustain or refute the allegations.

IV. Conduct of Investigation

Two OAR team members conducted an administrative investigation, including telephone interviews with the whistleblowers, key witnesses, and reviewed pertinent documents on March 12-26, 2015. The team members were John Davis and Michael Rhodes, both Human Resources (HR) Consultants assigned to OAR.

The following persons were interviewed and provided sworn written statements¹:

Caroll Berndt, Psy.D, Director, Residential Mental Health Treatment Program;
Daniel Hannan, RN, Whistleblower, Psychosocial Rehabilitation and Recovery Center (PRRC);
Glen Moseley, Whistleblower, Peer Support Specialist, PRRC;
Lisa Noe, RN, Director, Mental Health Service Line;
Catherine Routh, Medical Foster Home/Community Residential Care Program² Coordinator, Social Work Service Line;
David Skripka, M.D., Associate Chief of Staff, Mental Health Service Line;
Diane Todd, PhD, Whistleblower, Staff Psychologist, PRRC; and,
Debra Young, Chief, Education and Training Service.

David Dechant, HR Officer, and Angela Steinhoff, Assistant HR Officer, provided background information regarding the timeline of the disciplinary action and other procedural matters.

In May 2014, Glen Moseley, Whistleblower, Peer Support Specialist, PRRC, met a male Veteran at Tomah VA Medical Center while teaching an anger management class. Mr. Moseley maintained contact with the Veteran and in September 2014 the Veteran mentioned that he was having difficulties with a personal relationship, but did not disclose any other details. Around October 1, 2014, the Veteran informed Mr. Moseley that the woman with whom he was having the relationship was married and was a Tomah employee (Ex. 5). Although the Veteran did not tell Mr. Moseley the employee's name, a few days earlier on September 28, 2014, the Veteran had informed Jacob Mason, Vocational Rehabilitation Specialist, that the employee's name was Tammy Elsing who worked in the Tomah Library. The Veteran also informed Mr. Mason that the relationship was sexual. According to his report of contact (ROC), Mr. Mason told the Veteran that the relationship should not be happening since she (Ms. Elsing) is a VA employee (Ex. 10).

On October 15, 2014, the Veteran presented to the Tomah Emergency Room following a fall while intoxicated. During his visit, he again spoke to Mr. Mason about the relationship, including identifying Ms. Elsing by name. The Veteran informed Mr. Mason, in part, that he and Ms. Elsing had "great sex" and then she later told him the relationship had to end. According to the Veteran, Ms. Elsing spoke to him the next day like nothing had happened. When asked why he began drinking after staying sober for so long, the Veteran told Mr. Mason it was to "help with the pain of not being able to be with Tammy". Mr. Mason prepared an ROC regarding the conversation which was provided to Catherine Routh, Medical Foster Home/Community Residential

¹ All witnesses were employees of the Tomah VA Medical Center at the time of their interview. Dr. Berndt transferred to another VA facility in April 2015.

² Ms. Routh previously served as the Chief of Social Work and Chaplain Services.

Care Program Coordinator, Social Work Service Line on October 16, 2014 (Exs. 7, 10). Ms. Routh was Acting Director of Education Service and was supervising Ms. Elsing at the time.

On October 17, 2014, Ms. Routh conferred with Angela Steinhoff, Assistant HR Officer, and prepared a series of fact-finding questions to ask Ms. Elsing about the relationship. Ms. Routh met with Ms. Elsing the same day and Ms. Elsing admitted having a friendship with the Veteran, which became sexual in July 2014. Ms. Routh verbally informed Ms. Elsing that this was a serious matter which could result in disciplinary action or removal. Ms. Routh also verbally instructed Ms. Elsing not to have any further contact with the Veteran. At that time, Ms. Elsing told Ms. Routh that she had already terminated the relationship (Exs. 12, 13 pgs. 5-6). Later that day, Ms. Elsing provided a written statement to Ms. Routh in which she indicated she had informed her husband about her actions and recommitted herself to her marriage. Ms. Elsing included in the statement that she and the Veteran had mutually agreed to end the relationship (Ex. 13, pg. 7).

On October 27, 2014, after further consultation with Ms. Steinhoff, Ms. Routh presented Ms. Elsing with a memo entitled, "Boundary Violation with Veteran," in which Ms. Routh referenced the prior meeting with Ms. Elsing and stated, "You must stop all contact with [the Veteran] telephone, written, electronic, individual, or personal" (Ex. 13, pg. 8). Ms. Routh does not recall any conversation at that time about placing the employee on authorized absence, but did recall that Ms. Steinhoff mentioned that Ms. Elsing might be terminated. Ms. Routh pointed out that Ms. Elsing was not detailed from the library at that time since the Veteran was an outpatient and, according to Ms. Elsing, had agreed not to come to the library (Ex. 7).

On November 5, 2014, Mr. Moseley, Daniel Hannan, RN, Whistleblower, PRRC, Gordon Aleckson, Vocational Rehabilitation Director, and Richard Vela, a Social Worker, placed a telephone call to the Veteran to check on his welfare. The Veteran was inebriated during the call and openly talked about his relationship with Ms. Elsing. Mr. Moseley prepared an ROC regarding the telephone conversation and it was provided to Ms. Routh (Exs. 4, 5, and 14). Dr. Carroll Berndt, Psy.D, Director, Residential Mental Health Treatment Program was also aware of this interaction with the Veteran and stated that the clinical focus was on quickly getting him in the substance abuse treatment program since he had relapsed (Ex. 3). Ms. Routh provided the ROC to Ms. Steinhoff and Debra Young, Chief, Education and Training Service who had become the permanent Chief of Education Service on November 2, 2014 (Ex. 7).

The Veteran was admitted to the Tomah substance abuse treatment program on November 19, 2014. On November 20, 2014, Dr. Todd Cannon, staff psychiatrist, submitted an ROC to Ms. Routh and Mr. Dechant regarding the relationship's effect on the Veteran, however, the following morning, Dr. Berndt asked Ms. Routh and Mr. Dechant to disregard the memo because it identified the wrong Veteran and she did

not want a misunderstanding.³ She stated Dr. Cannon would provide a corrected memo (Ex. 15).

On November 21, 2014, Mr. Hannan notified Mr. Aleckson, Lisa Noe, RN, Director, Mental Health Service Line, and Drs. Berndt and Dr. David Skripka, M.D., Associate Chief of Staff, Mental Health Service Line, via e-mail that the Veteran spoke to Mr. Moseley again and insinuated that the relationship with Ms. Elsing was continuing. Mr. Hannan also stated that the Veteran indicated he might harm himself if Ms. Elsing did not make up her mind about the relationship.⁴ Mr. Hannan stated the matter had been discussed with the suicide prevention coordinator and the substance abuse case manager to ensure that the Veteran was currently safe (Ex. 16). Dr. Skripka forwarded the e-mail to Dr. David Houlihan, the Chief of Staff, on the same day to ensure the Quadrad and HR were aware of these concerns and to ask whether any further actions were needed by Mental Health. Dr. Houlihan responded on November 24, 2014 and stated that the Quadrad was aware and the matter was likely going to end in the employee's termination (Ex. 16, Ex. 30 p. 61, p. 11 – p. 62, line 15).

On November 24, 2014, Ms. Young detailed Ms. Elsing in writing from the library to Sterile Processing Service (SPS) and reminded her that she was not to have further contact with the Veteran (Ex 13, pg. 2). Dr. Diane Todd, PhD, Staff Psychologist, PRRC, pointed out that SPS was in the same building and hallway where the Veteran ate his meals, so the detail actually resulted in more, not less, opportunity for contact between the Veteran and Ms. Elsing (Ex. 9).

Mr. Moseley told Ms. Noe on December 4, 2014, that he and the others were filing a complaint with Office of Special Counsel. On December 5, 2014, the Veteran told Mr. Moseley that Ms. Elsing had been moved from the library to SPS (Exs. 5, 6).

On Friday, December 5, 2014, at 4:28 p.m., Mr. Moseley sent another e-mail to Mr. Aleckson, Dr. Berndt, Ms. Noe, and Dr. Skripka in which he stated that the Veteran stopped by his office that day and said contact is still occurring. The e-mail further stated: "Specifically today in the solarium they talked and she cried and told him that she still cares for him and misses him." At that point, the e-mail was forwarded to several different recipients. Ms. Noe forwarded the e-mail to Mario DeSanctis, Medical Center Director, Dr. David Houlihan, Chief of Staff, and Carlo Piraino, Associate Director for Patient Care Services, requesting assistance (Ex. 17). Mr. Piraino forwarded the e-mail to Ms. Young, the employees' supervisor, and requested verification that Ms. Elsing had been given written instructions to have no further contact with the Veteran. Mr. Piraino also asked to be updated on the HR action (Ex. 17). Dr. Skripka responded to Mr. Moseley and stated, "Thanks Glen. I'll pass this up the chain. I know that leadership has been aware of the issue and working to investigate and address it (Ex 18).

³ Ms. Routh, in her witness statement, incorrectly refers to Dr. Cannon's ROC as being received on November 9, 2014 (Ex. 7).

⁴ The Veteran had indicated he would end up back at the motel and drink himself to death if the employee doesn't decide.

Separately, Dr. Skripka forwarded the e-mail to Cathy Routh, David Dechant, Lisa Noe, and Dr. Houlihan with the statement, "Cathy, I know you're no longer in the acting role but I wasn't sure who is in the lead at this point. Can you please help to forward on as needed?" (Ex. 19)

On Monday, December 8, 2014, Ms. Young sent the December 5th e-mail to Ms. Steinhoff and Mr. Dechant which included the statement, "It appears that there was contact on Friday, 12/5/14 (see below). Karen Long [Deputy Associate Director for Patient Care Services] just called me and wants me to find out if we should do another fact-finding session this morning and perhaps put her on Authorized Absence. Thoughts?" (Ex 17).

Between December 8 and 12, 2014, the Veteran allowed Mr. Moseley to make copies of several letters Ms. Elsing had given him. Mr. Moseley gave the letters to Mr. Aleckson who said he gave them to Ms. Noe who gave them to HR (Ex. 5).

On December 11, 2014, Ms. Young restricted Ms. Elsing to her work area during her 15 minute break periods and reminded her not to have any contact with the Veteran (Ex 13, pg. 1).

On December 12, 2014, Ms. Steinhoff submitted the proposed removal package to Regional Counsel's office for legal review and notified Dr. Skripka that Dr. Todd had not submitted the corrected ROC from November 20, 2014. Ms. Steinhoff, at Mr. DeSanctis' direction, also contacted Ike Lusk and Randy Spahos, VISN 12 HR Officer, and ER/LR Supervisor respectively, for guidance regarding whether Ms. Elsing should be placed on authorized absence (Ex. 30, p. 64, line 16 – p. 65, line 25). As part of her request, Ms. Steinhoff provided Mr. Lusk and Mr. Spahos a timeline of events and a summary of the case. In part, Ms. Steinhoff stated,

The main concern regarding this continued contact is to ensure that this Veteran's care is not compromised. The Veteran is currently an inpatient in the Substance Abuse program. The Veteran has stated that he started drinking again because he was trying to help with the pain of not being able to be with the employee, has also made statements that he might harm himself if she "doesn't make up her mind." Since this continued contact is occurring frequently and the most recent interaction was this week, the recommendation from HR in Tomah is to put her on Administrative Absence (AA) to ensure that she does not have the capability as an employee in the facility to compromise the care of this Veteran any further, this will also allow for the Veteran to focus on his road to recovery (Ex. 20).

Dr. Todd submitted the corrected ROC to Ms. Steinhoff on December 16, 2014 (Ex. 21). In his ROC he stated in part,

Professionally, it is my opinion that if the Veteran has an intimate relationship with a VAMC employee here on the grounds of the Tomah VAMC while enrolled in a treatment program it would seriously interfere in his recovery. It is also a violation of the trust our veterans place in the VAMC to have an employee engaged in an improper relationship with them. I also believe there is potential risk of escalation of this Veteran's emotional wellbeing with such a relationship (Ex. 22).

Ms. Steinhoff informed Mr. DeSanctis on December 16, 2014, that Mr. Lusk responded earlier that day and recommended that Management avoid placing Ms. Elsing on AA at that time. Mr. DeSanctis asked Ms. Steinhoff to find out whether Mr. Lusk offered any alternatives to AA and then determine the best course of action with Mr. Piraino and the employee's supervisor. Ms. Steinhoff responded that no alternatives were offered, but noted that "they wanted to wait and see if the employee complies with the [December 11, 2014] no contact order." (Ex. 23, Ex. 30, p. 64, line 16 – p. 66, line 14).

On December 29, 2014, Ms. Young issued a proposed removal memo to Ms. Elsing for engaging in a sexual relationship with a patient and failing to follow supervisory instructions by continuing to have contact with the Veteran on two occasions (Ex. 24).

On January 5, 2014, Ms. Elsing scheduled her personal presentation with the Director for January 30, 2015 (Ex. 25).

On January 22, 2015, Mr. Hannan and Mr. Moseley saw Ms. Elsing in the Canteen eating and, as they left, saw the Veteran standing at the door looking into the Canteen. Mr. Moseley acknowledged that he did not actually see the Veteran and Ms. Elsing interacting (Exs. 4, 5).

On January 23, 2015, Mr. Hannan sent an e-mail to Ms. Noe in which he stated:

Witnessed yesterday:

Veteran waiting for employee outside cafeteria. Later they were then seen together outside the cafeteria by another VA employee. As stated before this Veteran has threatened suicide related to this sexual relationship between the Veteran and this Tomah VA employee. The members of the PRRC team listed in the cc line and I believe that harm continues [to] occur to this Veteran due to improper handling of this case by both HR and Management (Ex. 26).

Mr. Dechant became aware of the January 23, 2015 e-mail and discussed placing Ms. Elsing on AA or detailing her to a Community Based Outpatient Clinic (CBOC) with Mr. Piraino and the Associate Director. At the Director's request, Mr. Dechant contacted Mr. Lusk who recommended Ms. Elsing be detailed to a CBOC. The Director accepted the recommendation and a memo was prepared to detail Ms. Elsing to the Wisconsin Rapids CBOC (Exs. 27, 28). When Ms. Young was issuing the memo, Ms. Elsing denied having contact with the Veteran. Ms. Young notified Mr. Dechant and, due to lack of corroboration from either Mr. Moseley or Mr. Hannan, Mr. Dechant made the

decision to conduct additional fact-finding before detailing Ms. Elsing to the CBOC (Ex. 27).

On Monday, January 26, 2015, Mr. Dechant was unable to obtain additional corroboration from Mr. Moseley that Ms. Elsing actually had contact with the Veteran so a decision was made to alternatively have Ms. Elsing return from SPS to an office in Education Service where she would be closely monitored by Ms. Young (Ex 29).

Ms. Elsing's personal presentation to the Director was rescheduled from January 30, 2015, and held on February 2, 2015. Douglas Factors were prepared and submitted for Regional Counsel review on February 4, 2015, and returned on February 12, 2015. The approved Douglas Factors were submitted to the Director for review and signature on February 13, 2015, and returned on February 18, 2015. The signed Douglas Factors were provided to Ms. Elsing for comment on February 19, 2015, and returned on February 23, 2015. On March 3, 2015, the Director notified HR of his decision to remove Ms. Elsing. On March 12, 2015, the Director presented Ms. Elsing with the removal decision memo (Ex. 25, Ex. 30, p. 66, line 25 – p. 67, line 20).

V. Background:

Policy

VA Handbook 5021, Part I, Chapter 1, Paragraph 7b, provides that employees who are pending inquiry or investigation ordinarily remain in a paid active duty status, however, in those instances where it is determined that the employee's continued presence at his or her worksite during an inquiry or investigation might pose a threat to the employee or others, result in loss of or damage to Government property, or otherwise jeopardize legitimate Government interests, a detail to other duties, approved leave, or placement in a paid non-duty status may be considered.

Tomah Medical Center Memorandum 11-14, "Staff and Veteran Beneficiary Relationships", provides that social, sexual, or financial relationships between any staff and a Veteran beneficiary, in any setting, are contrary to the best interest of the therapeutic relationship and, are therefore, prohibited.

VI. Conclusions

Allegation #1: An employee engaged in an improper personal relationship with a Veteran being treated at Tomah for alcohol dependency.

Conclusion: Substantiated. On October 17, 2014, Ms. Elsing admitted having a friendship with the Veteran which became sexual in July 2014. Such relationships are prohibited by Tomah Medical Center Memorandum 11-14, "Staff and Veteran Beneficiary Relationships".

Allegation #2: Despite being made aware of the situation, Tomah Management failed to respond to concerns about this relationship; and further that Management's inaction hampered the Veteran's recovery, contributed to his relapse, and resulted in fears of suicide.

Conclusion: Partially Substantiated. Overall, VAMC leaders did not adequately respond to concerns about Ms. Elsing's alleged relationship with the Veteran. A fact-finding inquiry was properly and timely conducted in October 2014 when the alleged relationship was first reported. Initial instructions to the employee prohibiting contact with the Veteran were also appropriate since the Veteran was not an inpatient at that time. However, once the Veteran enrolled in an inpatient treatment program in November 2014 and the employee continued to interact with the Veteran despite the earlier instructions, Management did not act with an appropriate sense of urgency to prevent additional contact from occurring. The employee's placement in SPS did not effectively prevent her from maintaining contact with the Veteran. Also, despite a local HR recommendation that the employee be placed on AA in December, the Director deferred to VISN 12's advice to wait and see whether additional "no contact" instructions and restrictions placed on the employee during her break periods would be effective. The Director's reliance on VISN 12 HR guidance in this situation was misplaced since this was a local patient care issue in which local advisors would be in a better position to understand and appreciate the impact of these issues. Additionally, HR staff are not clinicians and may not have fully appreciated the potential adverse effect continued interaction would have on the patient's recovery.

Ms. Elsing's admission on October 17, 2014, effectively removed any factual dispute regarding the nature of the relationship. Nevertheless, the proposed removal action was not submitted for legal review until December 12, 2014. The final disposition did not occur until March 2015. This matter, the facts of which were not disputed by the employee, was unnecessarily prolonged.

With regard to the effect these events had on the Veteran, the Board adopts the professional opinions of Drs. Cannon and Berndt, and concludes that Management's delays in ensuring the employee had no further contact with the Veteran seriously interfered with and had a negative effect on the Veteran's recovery. Management's actions or inactions were not, however, a factor in the Veteran's original substance abuse relapse. The relapse occurred in October 2014 prior to any management official being aware of the relationship and is not attributable to management's actions. Similarly, management's actions or inaction do not appear to have caused the Veteran's subsequent statement on November 21, 2014, that he would drink himself to death if the employee did not decide. This statement related to the nature of the relationship itself, not management's actions, and occurred only a day or two after the Veteran's entrance into the inpatient program.

VII. Recommendations

We recommend issuing appropriate administrative actions and/or education to the Medical Center Director, Chief of Staff, Associate Chief of Staff for Patient Care

Services, Human Resources Officer, and the Associate Chief of Staff for Mental Health emphasizing that adequate and timely action must be taken in the future to effectively address ongoing improper relationships of this type, particularly those with potential for patient harm.

VIII. Listing of any Violation or Apparent Violation of Any Law, Rule, or Regulation

The Tomah employee violated facility policy by engaging in a prohibited relationship with a Veteran. Otherwise, no violation or apparent violation of any law, rule, or regulation was identified.

IX. Description of Any Action Taken or Planned as a Result of the Investigation

Appropriate administrative actions and/or education are recommended for the persons identified in Paragraph VII herein. No changes in VA rules, regulations, or practices are recommended.

Exhibit Index
Administrative Investigation
Alleged Improper Employee/Patient Relationship and Alleged Management Failure to
Respond; Office of Special Counsel File Nos. DI-15-1050; DI-15-1055; and DI-15-
1056

Exhibits	Description	Source
1	Appointment Memo	Office of Accountability Review
2	OSC Referral dated 2/4/15	Office of Special Counsel
3	Statement – Dr. Carol Berndt	Witness
4	Statement – Daniel Hannan, RN	Whistleblower
5	Statement – Glen Moseley	Whistleblower
6	Statement – Lisa Noe, RN	Witness
7	Statement – Catherine Routh, MSW	Complainant
8	Statement – Dr. David Skripka	Witness
9	Statement – Dr. Diane Todd	Whistleblower
10	Report of Contact dated 10/15/14	Jacob Mason
11	Statement – Debra Young	Witness
12	Report of Contact dated October 16, 17, 2014	Catherine Routh, MSW
13	Redacted Evidence File	Tomah HR Office
14	Report of Contact dated 11/5/14	Glen Moseley
15	E-mail string from 11/20/14 – 12/11/14	Dr. David Skripka
16	E-mail string from 11/21/14 – 11/24/14	Dr. David Skripka
17	E-mail string from 12/5/14 – 12/9/14	Dr. David Skripka
18	E-mail string dated 12/5/14 between Mr. Moseley and Dr. Skripka	Dr. David Skripka
19	E-mail string dated 12/5/14 between Dr. Skripka and Ms. Routh	Dr. David Skripka
20	E-mail string dated 12/12/14 – 12/16/14	Angela Steinhoff
21	E-mail string dated 12/12/14 – 12/16/14 between Ms. Steinhoff, Dr. Skripka and Dr. Cannon	Angela Steinhoff
22	Report of Contact dated 11/19/14 (provided to HR on 12/16/14)	Dr. Todd Cannon
23	E-mail string dated 12/12/14 – 12/16/14 between Ms. Steinhoff and Mr. DeSanctis	Angela Steinhoff

Exhibit Index (page 2 of 2)

Administrative Investigation
Alleged Improper Employee/Patient Relationship and Alleged Management Failure to
Respond; Office of Special Counsel File Nos. DI-15-1050; DI-15-1055; and DI-15-1056

24	Proposed Removal Memo dated 12/29/14	Tomah HR Office
25	E-mail dated 3/12/15 providing timeline of removal action	Tomah HR Officer
26	E-mail dated 1/23/15	Dan Hannan
27	E-mail dated 3/6/15	Tomah HR Officer
28	Unsigned Memo dated 1/23/15	Tomah HR Officer
29	E-mail dated 1/27/15	Tomah HR Officer
30	Transcript (redacted) – Mario DeSanctis	Mario DeSanctis