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The Special Counsel

February 2, 2016

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

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

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding to you a Department of Veterans Affairs (VA) report based on disclosures received from three employees of the Tomah Veterans Administration Medical Center (Tomah VAMC), Tomah, Wisconsin. I reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency investigation and whistleblower comments as well as my findings.

At the time of their disclosures, staff nurse Daniel Hannan, psychologist Dr. Diane L. Todd, and peer support specialist (PSS) Glen Moseley (the whistleblowers) were employed in the Mental Health Services Line, Psychosocial Rehabilitation and Recovery Center (PRRC) of the Tomah VAMC.[1] The whistleblowers, all of whom consented to the release of their names, alleged that Tomah VAMC librarian Tammy Elsing engaged in an improper relationship with a veteran being treated at the facility. The whistleblowers further alleged that despite being made aware of the improper relationship, management failed to respond appropriately, thus jeopardizing the veteran's safety and well-being.

OSC referred the allegations to Secretary Robert A. McDonald for investigation under 5 U.S.C. § 1213(c) and (d). Secretary McDonald delegated responsibility for investigating the matter to the VA's Office of Accountability Review (OAR) and delegated authority to review OAR's findings and report to Robert L. Nabors, II, then-VA chief of staff, who provided the agency's report to OSC.[2] In accordance with

[1]Since submission of her disclosure, Dr. Todd transferred from the Tomah VAMC to the Nebraska-Western Iowa Health Care System, Grand Island, Nebraska.

[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) and (g). Upon receipt, I review the agency report to determine whether it contains all

5 U.S.C. § 1213(e)(1), a copy of the report was provided to all three whistleblowers. Mr. Moseley commented on the report.

I. Agency Report and Updates

The VA investigation substantiated the whistleblowers' allegation that Ms. Elsing engaged in an improper relationship with a veteran/patient. The investigation found that, once notified of the improper relationship, management acted properly by initiating a fact-finding inquiry and issuing written instructions to Ms. Elsing prohibiting further contact with the veteran. The report concluded, however, that management failed to act with appropriate urgency after learning that Ms. Elsing ignored the instruction and continued to interact with the veteran. The report did not substantiate the allegation that management's delayed response jeopardized the veteran's recovery, contributed to his relapse, or resulted in threats of suicide. Following OSC's referral of this matter, Ms. Elsing was removed from VA employment.

OSC sought and received two updates from the agency based on concerns expressed by Mr. Moseley in his comments. In a December 15, 2015 update, the agency confirmed that Ms. Elsing was terminated. The report recommended that appropriate administrative actions and/or education be considered for five senior Tomah VAMC officials, but the update indicated that three of these five employees have either been terminated or have resigned. According to the update, Tomah VAMC director Mario Desanctis resigned effective September 2, 2015; associate director for patient care services Carlo Piraino resigned effective October 3, 2015; and chief of staff Dr. David Houlihan was removed effective November 9, 2015.[3]

The second update, dated January 6, 2016, indicated that VA Great Lakes Health Care System (VISN 12) officials reviewed the OAR report and its recommendations. According to the update, VISN 12 officials determined that administrative action against Dr. David Skripka, associate chief of staff, Mental Health Service Line, was not warranted because Dr. Skripka was not in Ms. Elsing's supervisory chain of command and acted appropriately in forwarding concerns about Ms. Elsing's relationship with the veteran to Tomah VAMC upper management and human resources in a timely manner. The update also stated that VISN 12 officials determined that administrative action against Tomah VAMC human resources director David Dechant was not appropriate. In reaching this conclusion, VISN 12 officials noted that Mr. Dechant proposed placing Ms. Elsing on administrative leave pending removal, but VISN 12 officials recommended

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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). I 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).

[3]According to the update, Dr. Houlihan was removed for matters unrelated to the issues raised in the OSC referral. Dr. Houlihan has appealed the termination action with the VA Disciplinary Appeals Board. The appeal is currently pending.

against this in favor of detailing Ms. Elsing to a non-patient care area. The Tomah VAMC director agreed with the VISN 12 recommendation. The update indicated that Dr. Skripka and Mr. Dechant, as well as VISN 12 Leadership, VISN 12 Executive Leadership Council attendees, VISN 12 human resource and individual VAMC human resource offices will receive in-person training and guidance concerning the appropriate use of detailing employees to non-patient care areas versus putting them on authorized absence from the VA's Office of Human Resources Management's Employee Relations Department and the Office of General Counsel.

II. The Special Counsel's Findings

Based on my review of the original disclosure, the agency's report, Mr. Moseley's comments, and the agency's updates provided to OSC, I have determined that the report contains all of the information required by statute and that the findings appear reasonable. I commend Mr. Hannan, Dr. Todd, and Mr. Moseley for coming forward with their disclosures.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report and Mr. Moseley's comments to the Chairman and Ranking Member of the Senate Committee on Veterans' Affairs and the Chairman and Ranking Member of the House Committee on Veterans' Affairs. I have also filed a copy of this letter, the agency report, and Mr. Moseley's comments in our public file, which is available online at www.osc.gov, and closed the matter.

Respectfully,

Carolyn N. Lerner

Enclosures