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The Special Counsel

February 3, 2016

The President
The Whitehouse
Washington, D.C. 20500

Re: OSC File No. DI-15-2216

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am enclosing a Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at New Mexico VA Healthcare System, Raymond G. Murphy VA Medical Center (Murphy VAMC), Albuquerque, New Mexico. I have reviewed the VA's report and, in accordance with 1213(e), am providing the following summary of the agency investigation and whistleblower comments as well as my findings.

The whistleblower, Vanessa Lech, who consented to the release of her name, alleged that Building 1 on the Murphy VAMC campus lacks appropriate access controls and that the Health Care for Homeless Veterans Program (HCHV Program) lacks sufficient resources to complete its mission.

The agency substantiated allegations concerning access controls, determining that Building 1 lacked proper security controls which allowed public access to the building's interior, and compromised employee safety. The report also confirmed that employees were not properly trained on the use of duress notification systems. In response, the agency implemented security recommendations made during an April 2015 vulnerability assessment, secured access points to the building, placed personnel in positions to greet and escort visitors, and trained employees on the use of duress notification systems. While the report did not substantiate the allegations concerning a lack of resources, it noted that the HCHV Program was inappropriately managing its assigned vehicles, and two assigned vehicles had a protracted history of mechanical problems making them unsuitable for use. The report recommended managing the fleet more effectively and evaluating vehicles with chronic mechanical issues. Based on my review, I have determined that the report meets all statutory requirements and the findings appear reasonable.

Ms. Lech's allegations were referred to Secretary Robert McDonald to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). Investigation of the matter was delegated to the Office of the Medical Inspector. Then-Chief of Staff Robert L.

Nabors, II, was delegated the authority to review and sign the report. On December 7, 2015, Mr. Nabors submitted the agency's report to the Office of Special Counsel (OSC). Ms. Lech commented on the report on December 26, 2015. As required by 5 U.S.C. §1213 (e)(3), I am now transmitting the report and Ms. Lech's comments to you.[1]

With respect to the unsubstantiated allegation concerning inadequate resources, Ms. Lech asserted that the HCHV Program lacked a sufficient number of operating vehicles to transport homeless veterans to appointments and services throughout the community. The report noted that Murphy VAMC had a total of 117 vehicles, of which 16 were assigned to the HCHV Program. Engineering Department reports indicate that vehicles used by the HCHV Program were consistently underutilized, a condition that was attributed to confusing vehicle reservation procedures. The report explained that as a result, vehicles were frequently unavailable when they were needed. The report noted, however, that vehicle unavailability did not have an impact on patient care, as investigators could find no evidence that health care appointments were missed or cancelled for this reason. The report further explained that two aging vehicles with chronic mechanical problems contributed to the availability issues.

In response, the Engineering Department is implementing a monthly service utilization report to ensure accurate usage reporting, realigning vehicles between service lines as needed, and it is working to obtain funding for GPS systems that will log vehicle data usage to ensure better resource allocation. The two chronically unavailable vehicles are undergoing review to assess their functionality and safety.

In her comments, Ms. Lech asserted that security issues took too long to correct, especially given frequent threats to VA employees. She feels that leaders at Murphy VAMC need to be held accountable for these issues. She also asserts that notwithstanding the report's findings, there were frequent critical vehicle shortages that managers were aware of, but took no action to correct.

I have reviewed the original disclosure, the agency report, and Ms. Lech's comments. While Ms. Lech questioned the findings in the report, it appears that the agency has made appropriate efforts to resolve security and access control issues and is

[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).

working to better utilize the Murphy VAMC's vehicle fleet. 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. Lech'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 agency report and Ms. Lech's comments in our public file which is available at www.osc.gov. [2] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[2] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.