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Acronym Guide

Housing and Urban Development-Veterans Administration Supportive Housing (HUD-VASH)

Mental Health Intensive Care Management (MHICM)

Healthcare for Homeless Veterans program (HCHV)

Veterans Affairs Medical Center (VAMC)

Behavioral Health Care Line (BHCL)

Medical Support Assistant (MSA)

Registered Nurse (RN)

Veterans Affairs (VA)

New Mexico (NM)

Introduction

My name is Vanessa Lech. I come from a military family, I served in the U.S. ARMY, I am married to an active duty service member and I am a tireless advocate of the military community. I aspired to become a professional social worker with the sole intent to work with the military community at Veterans Affairs for the rest of my working life.

October 2014 is the date that I began working at the Albuquerque, NM Veterans Affairs Medical Center. I reported my former supervisor's misconduct and I was then subjected to countless months of retaliation. I no longer work at the Albuquerque, NM VAMC due to the retaliation that I was forced to endure inside of the HUD-VASH Health Care for Homeless Veterans (HCHV) program.

VA protects employees that retaliate and persecutes employees that come forward to report issues. I found the report that Veterans Affairs submitted to be troublesome for a number of reasons, one of which is that the VA report contains false information. The VA's internal investigation did NOT address the fact that my former supervisor and her program coordinator placed my life in danger by sending me to provide services for her clients on her caseload with behavioral flags; one of these clients had a behavioral flag for threatening to kill staff and was NOT supposed to be seen away from the facility. However, I was not only sent away from the facility but I was also sent alone. I was never notified of these behavioral flags. This was also apart of the ongoing retaliation against me. I did report this information to OSC alongside the other safety issues.

VA should **never** be allowed to investigate itself. I have thoroughly reviewed the report that VA has submitted and this is my official response. I have addressed each issue individually in an effort to organize my official response. I have included an "Additional Information & Summary" section at the end.

#### Page 2, IV. Conduct of Investigation

Not all Behavioral Health Care Line (BHCL) Health Care for Homeless Veterans (HCHV) employees were interviewed. All but 1 of the employees that were interviewed were cherry picked to ensure that Veterans Affairs (VA) management would be protected.

It also appears that two of the witnesses, Julie Gutierrez, MHICM RN Case Manager and Joseph Gutierrez, HUD-VASH Social Worker may be married to each other. I worked with Joseph Gutierrez whom repeatedly informed my colleagues and I that he was married to a female RN that worked at the Albuquerque NM Veterans Affairs Medical Center. While I cannot be certain if this is a strange coincidence or if these two employees are actually married; this issue needs further investigation as it may have caused the internal VA investigation to become further skewed in VA management's favor.

#### Page 4, VI. Findings, Conclusions, and Recommendations (Lynx Duress and Emergency Notification System)

The Lynx Duress and Emergency Notification System does not protect staff. The response time of Albuquerque, NM Veterans Affairs Medical Center police is slow. Albuquerque, NM VAMC police are understaffed. This was confirmed when I worked there by the Albuquerque, NM VAMC police chief, Alex Magallanez and another Albuquerque, NM VAMC police officer whose name I do not recall at this time. I do remember that when I asked why there was a VA police shortage that both policemen had told me on two separate occasions that were some ongoing issues with HR and hiring VA police in a timely manner. Albuquerque, NM VAMC staff were aware of the slow police response due to the shortage of police resulting in an overall lack of confidence in the Lynx Duress and Emergency Notification System. Albuquerque, NM VAMC staff did not believe nor did I believe that our safety was protected at all by the Lynx Duress and Emergency Notification System.

Page 5, VI. Findings, Conclusions, and Recommendations  
(b. Response)

The response of the Albuquerque, NM VAMC displays the callous attitude towards employees needs to function at their highest level possible within the workplace. Albuquerque, NM VAMC ignored the needs of the staff instead of correcting the mechanical lock and replacing it with swipe card access. VA's choice to blow off staff and to give staff (primarily clinical) the run around absolutely impedes "maintaining quality and fluency in patient care and expedited service with minimal interruptions".

Page 5, VI. Findings, Conclusions, and Recommendations  
(c. Response)

The response states, "Recommendation made to consult with the safety office to ensure the north exit door on the second floor meets proper safety code and access control." Was this recommendation ever implemented? What proof exists that this recommendation was implemented? After all, VA is being allowed to investigate and to police their organization. Clearly, VA has failed and should NOT be trusted.

Page 5, VI. Findings, Conclusions, and Recommendations  
(d. Response)

The response states in part that the, "Recommendation that was made to consult with engineering to place a locking device on the door in order to control or limit access".... Was this recommendation ever implemented? What proof exists that this recommendation was implemented? After all, VA is being allowed to investigate and to police their organization. Clearly, Veterans Affairs has failed and should NOT be trusted.

Page 6, VI. Findings Paragraph 1

"There was insufficient evidence for the VA team to confirm that any of the recommendations in the April 2015 Vulnerability Assessment survey had been

implemented.” This statement is vague. Either the VA did or did not implement the recommendations from the April 2015 Vulnerability Assessment. VA’s failure to provide concrete answers and information displays a cavalier attitude towards the serious matters that prompted this investigation in the first place.

Page 6, VI. Findings Paragraph 2

The VA sat on information regarding safety violations for countless months. The “VA team” took a maximum of 3 days, “August 11, 2015, the first day of the visit” and “August 13, 2015, immediately prior to exit briefing” to investigate. The report regarding this investigation is sloppy and clearly the internal VA investigation was rushed.

Page 6, VI. Findings Paragraph 4

“This situation has led to incidents of Veterans becoming angry and irate, largely due to the lack of direction.” This statement is false. The truth is that the homeless military Veteran population that HUD-VASH HCHV serves tends to routinely become angry and irate due to mental illness, substance use disorder(s) and/or poor program management. This is the reality. Staff safety is NOT a priority. Quality services for Veterans are NOT a priority due to horrible managers at the Albuquerque NM VAMC. Instead status, bonus money, large salaries and large comfortable offices are the main priority of the Albuquerque NM VA management. I doubt that this mindset is isolated to just this facility.

“HCHV program staff asked why the electronically operated door could not be replaced by a locked door or one where only use of a personal identity verification card would allow access.” This is a common sense safety implementation that could have and should have been facilitated long ago. VA is allotted billions of dollars, which increases each year. Unfortunately, VA management routinely squanders money that should be utilized elsewhere, which would include protecting staff. This particular Veteran population that these staff members are working with tend to be volatile.

Of course, this is NOT the case 100% of the time. However, volatility in this population’s behavior was so common that I clearly remember staff to include myself receiving death threats and verbal abuse on a daily basis inside of this program. The program management was horrible and did NOT value the wellbeing of staff. Boundaries were NOT implemented with Veterans to ensure staff safety or Veterans’ compliance with the program. This resulted in chaos and dysfunction. Veterans were routinely non-compliant with program requirements or even the law. The program supervisor did NOT care and the sole focus was on bonus money, status, future promotions and retaliating against anyone who got in the way of that agenda by reporting misconduct.

“MSA had been posted in the lobby of the third-floor to check patients in after they entered and direct them to their appointment location, but the Medical Center’s Space Committee reassigned the booth space, originally assigned to the HCHV Program”. This statement made by VA communicates just how illogical VA operations are on a daily basis.

Page 8 Recommendations to the Medical Center 1. a.

“All employees must take appropriate action to report security violations to their leadership, and leadership must follow up appropriately.”

Employees will NOT choose to report security violations to their leadership when their leadership chooses to engage in retaliation and condones retaliation against employees. Leadership chooses NOT to follow up appropriately when misconduct, safety violations or other issues are reported so this will not occur. Furthermore, managers are NOT fired for not following up appropriately, retaliating or engaging in other forms of misconduct. Therefore, nothing will ever change.

Page 8 Recommendations to the Medical Center 7.

“VHA reviews the circumstances surrounding the failure to address the Vulnerability Assessment Survey and determines whether there is any senior leadership accountability for the matter.”

Will anyone be fired and if so who and when?

Page 9 Findings

“The review of records by the Chief of Engineering indicated underutilization of vehicles by the facility.”

Albuquerque NM VAMC HUD - VASH were always critically short on vehicles during my time in the HUD - VASH program, which was from October 2014 - April 23<sup>rd</sup> 2015. All levels of management were aware. The vehicle shortage was an extraordinarily hot topic during one of the “All Social Work Meeting” where Ms. Melissa Harding, Albuquerque NM VAMC social work executive, had multiple social workers bring up the vehicle shortage issue and how it was directly impacting our ability to do our jobs day in and day out. Ms. Melissa Harding callously disregarded the vehicle shortage and it’s impact upon HUD-VASH.

Furthermore, I spoke with Mr. Andrew Welch’s “acting assistant director” whom was a woman at the time and informed her of this vehicle shortage. I do not remember the acting assistant director’s name but this occurred during Mr. Andrew Welch’s employee meet and greet for his initial entrance into the Albuquerque, NM VAMC. The acting assistant director chose NOT to pay attention and chose NOT to ensure that these issues were addressed. Instead, the acting assistant director literally laughed in my face about this issue while fully acknowledging that there was a vehicle shortage in HUD-VASH. She informed me that there was no intention to actually address the vehicle shortage. This conversation occurred right next to Mr. Welch during his initial employee meet and greet.

I have included an e-mail from Mrs. Taryn Alvarez because I cannot remember if I originally submitted this as evidence or not. Mrs. Alvarez assisted my former supervisor with retaliating against me. Mrs. Alvarez was also cherry picked for the internal VA investigation regarding this matter and her name was misspelled in the sloppy VA report. Mrs. Alvarez's e-mail can be found in the final pages of the Additional Information & Summary. Mrs. Alvarez's e-mail not only clearly articulates her disdain for other staff members but also states among other things that, "We all know there are not enough vehicles to go around."

Page 10 Findings Paragraph 2

"While this periodic non-compliance appears to have resulted in inconvenience for staff, we did not find that it had a negative impact on patient care" .....

The VA's language "periodic non-compliance" is victim blaming the staff members that were forced to tolerate not having the vehicles needed to perform essential work duties. VA's language "inconvenience for staff" clearly communicates the callous disregard that VA management has towards their employees and the absolute lack of remorse and the absolute lack of empathy that VA's continued mismanagement has had on VA employees. VA chose NOT to find that there was a vehicle shortage and the VA chooses to deny that this vehicle shortage has had a negative impact upon patient care because this internal VA investigation is nothing more than another VA cover up.

Page 10 Findings Paragraph 3

...."problems with two particular vehicles assigned to HCHV; a 1991 Monte Carlo (a two-door vehicle with a reported history of extensive mechanical problems, including a broken driver's seat belt, requiring repeated repairs)"....

The VA does NOT mention that the brakes went out in this vehicle. I have included the brake repair receipt, which proves that the front brakes were "95% worn". Those brakes went out when I was driving the vehicle to Veterans' homes in the community. The VA has the original copy of that brake receipt and always has but chose NOT to mention this.

Additionally, the VA chose NOT to mention nor address that social workers were routinely being tasked with vehicle maintenance, which the social workers were NOT skilled to perform. There was NEVER a mechanic on staff that was actually conducting routine maintenance of the HUD-VASH vehicles to ensure safety. Management were well aware of this and could have cared less to take action to ensure the safety of both staff and Veterans.

...." Is exploring options to improve this situation. These include: distributing a monthly utilization report to all services to assure accurate reporting of vehicle usage; realigning vehicles.....and approving funding to purchase GPS data logging equipment to ensure real-

time data on all vehicles. The Chief of Engineering reports that she is also researching best practices on vehicle usage from other VA Medical Centers.”

“Is exploring options to improve this situation” is vague and does not provide concrete evidence that the HUD-VASH vehicle shortage will ever improve. Furthermore, the message that the VA is sending is one of dysfunctional bureaucracy instead of choosing to utilize common sense. The VA does not need to waste more American taxpayer money on “GPS data logging equipment”. Instead VA needs to utilize common sense. VA needs to provide safe and reliable vehicles for HUD-VASH social workers and other relevant staff members to perform their daily job functions without undue stress and hardship. This is simple, however VA continues to refuse to address the needs of both their employees and their Veterans to ensure the wellbeing of both.

#### Page 10 Conclusions for Allegations 2

- “VA **did not substantiate** the allegation that the HCHV program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.”
- “VA confirmed that the HCHV program had a sufficient amount of vehicles to complete the mission but was inappropriately managing its assigned vehicles.”

The above statements from VA are FALSE. I have addressed these false statements made by VA throughout my own response to the VA report. However, I will reiterate. Albuquerque, NM VAMC HUD-VASH program does NOT have enough vehicles for the social workers to complete required job functions. This has caused severe stress and hardship upon the social workers working in the Albuquerque, NM VAMC HUD-VASH program. This has also caused social workers to miss appointments with Veterans. The vehicle shortage has prevented social workers from being able to provide essential transportation to Veterans. This has had an adverse impact upon Albuquerque, NM VAMC HUD-VASH Veterans and social workers.

#### Page 11 Recommendations to the Medical Center 2. 3. 4.

“2. Ensure that the Chief of Engineering continues to explore options to appropriately manage fleet vehicles.”

The above statement from VA is once again vague lacking concrete evidence that real change will ever occur.

“3. Ensure that HCHV program staff members comply with established reservation and other procedures to enable workers to maintain timely access to assigned vehicles and develop a reliable system to monitor compliance.”

The above statement from VA is victim blaming staff members and making false allegations that “workers” are to blame for the vehicle shortage. The above statement indicates VA’s refusal to take ownership of chronic vehicle shortages in the Albuquerque, NM VAMC HUD - VASH program, blaming subordinate employees instead of management.

“4. Assess the use of the 1991 Monte Carlo and van for functionality and safety and take appropriate action as warranted. Review the utilization of the van to determine whether another vehicle would be more suitable for individual patient use.”

The above statement from VA indicates an utter lack of common sense. VA has already confirmed on [Page 10 Findings Paragraph 3](#) a “history of extensive mechanical problems”. Therefore, this vehicle should be removed to ensure staff and Veteran safety. The van has already been specified as not functional for daily use in the VA report. Therefore, common sense would indicate that another vehicle would be much more appropriate.

#### Additional Information & Summary

It is clear that VA is NOT ever going to be forced to be accountable to the taxpayers, military Veterans or VA employees that tell the truth. VA received multiple extensions and produced a sloppy report with minimal information. It is clear that no one will ever be fired and that no real systemic changes will ever occur.

The VA’s internal investigation did NOT address the fact that my former supervisor and her program coordinator placed my life in danger by sending me to provide services for her clients on her caseload with behavioral flags. One of these clients had a behavioral flag for threatening to kill staff and was NOT supposed to be seen away from the facility. However, I was not only sent away from the facility but I was also sent alone. I was never notified of these behavioral flags. This was also apart of the ongoing retaliation against me. I did report this information to OSC alongside the other safety issues.

Albuquerque, NM VAMC management’s sole focus was to hide misconduct, to silence truthful employees and to obtain bonus money. Bonus money was the primary focus of my former supervisor even when it meant increasing caseloads upon the staff (primarily social workers), which resulted in decreased quality of services for Veterans and a drastic decline in the well being of staff (primarily social workers). My former supervisor sat me down in her office during my initial weeks to inform me of how important the VA bonus money was to her and that this should be my priority as well.

The work environment was so toxic that staff were too afraid to speak up and report unsafe working conditions and misconduct within management. The fear to come forward became permanently engrained after members of the HUD - VASH staff witnessed the retaliation that I was forced to endure, the impact that the retaliation had upon my wellbeing and the fact that I was forced out of my permanent position. Albuquerque, NM VAMC management refused to assist me even though I begged for help in person, via e-mail and over the phone. Albuquerque, NM VAMC management condoned my former supervisor’s behavior. This went on for countless months.

Staff members that aligned themselves with management received preferential treatment in the workplace that went so far as to include advanced preference for potential promotions. I was used as an example of what will happen to anyone that dares to report issues. I have suffered and continue to suffer greatly due to the retaliation that I was forced to endure at Albuquerque, NM VAMC. Management at Albuquerque, NM VAMC refused to prevent and to stop the retaliation. I was in the middle of working towards professional licensure, which has come to a screeching halt. I came to work afraid, always having to watch my back.

Eventually, I relocated to be with family and to have the much needed support throughout this difficult time. VA refused to provide me with a transfer to another VA facility. I am working tirelessly to move on in a positive direction with the rest of my life. I continue to advocate for change and for military Veterans to be empowered to choose where they receive their healthcare without any interference from VA. To this day, I have had trouble dealing with the trauma and the grief that the retaliation has caused in my life and in the life of my family.

The VA is extraordinarily well insulated from any form of actual accountability and this will never change. I appreciate and admire OSC's work. It is clear that OSC cannot hold the VA accountable. Our government has epically failed the military community on all fronts to include recent military benefit cuts.

**From:** Alvarez, Taryn N.  
**Sent:** Thursday, December 18, 2014 9:04 AM  
**To:** ABQ BHCL HCHV  
**Subject:** Taryn's Office

Good morning team,

I have held back my words for some time now but I feel it is time for me to send out a message to the team regarding my office.

Today when I came into work, my door was wide open and a Veteran was hovering around my office. This is not the first time but the second time that this has happened. Luckily, I had locked my drawers.

Also since I have been in here, the key box has been broken, my brand new shelf has been broken (the next day after I got it) and most importantly I am missing food vouchers.

Many of the staff members just walk in the office without a courtesy knock. As a pregnant woman, I will be breastfeeding and pumping in this office. It would behoove you to get in the habit of knocking first unless you want to see where the milk comes from. Per regulation, I am allowed to pump in my office and supposed to. I refuse to pump in a bathroom and bathroom pumping is against regulation.

I have received complaints from Veterans during walk-in clinic that people are coming and going when they are trying to explain their personal information. From the Veteran stand point, they are in an office and they have no idea who you are coming in while they are speaking to a clerk. They view it as rude and they feel that their personal privacy is being jeopardized. A quick "hi" and "I'm part of the team" or whatever courtesy you want to say would probably work just fine.

I am here to assist with the vehicle keys, but I am not the keeper of the keys. Many times I get interrupted to be asked questions regarding vehicles. "are there any available vehicles" "where are the keys" "what do I do if there are no cars" All of these questions can be answered by looking at the vehicle book. There is a section in the book that says AVAILABLE CARS. If there is a car available, this section will report that a vehicle is free. The free vehicle is assigned on a first come first served bases. If there are no available cars, then you can look to see if there is someone absent today or call other team members to see if they are going to be utilizing their reserved vehicles. I will help to make these calls and try to find you a vehicle but it is ultimately your responsibility to secure a car. Once you secure a car you MUST SIGN IT OUT!

ALSO, you cannot take another team members reserved car without first checking with them. This is happening more and more and it is not only rude, it is unacceptable.

One of the main reasons why people cannot find keys is because the keys are being misplaced in the key box. Please take a look throughout the box before you involve me in the

search for the missing keys. Please do not take keys home. Please return all keys at the end of the day. Everyone has a key to this office so there should not be a reason the keys are not returned (barring special circumstances)

I understand the key/vehicle system is flawed but this is all we got right now. We all know there are not enough vehicles to go around. I ask for your help as much as you ask for mine!

This office is used to store the vehicle keys, however this is not a shared space, this is my personal space. All I ask is for the same courtesy that I show you and your space when I enter your offices. I do not break things, I do not barge in, and I do not take things that do not belong to me. I send this message with all due respect and do not mean to offend. Thank you all for your cooperation.

*Thank you,*

*Taryn Alvarez  
Program Support Assistant  
Healthcare for Homeless Veterans  
Raymond G. Murphy VAMC  
265-1711 ext. 2784*

# BRAKE MASTERS #126

Complete Car Care

5749 Gibson Blvd., SE Albuquerque, NM 87108

57841 Phone (505) 262-9555

57947

NAME	ADDRESS	PLATE#	VEHICLE ID
VA HOSPITAL	ALBUQUERQUE, NM 87108	VAL14983	31011
505-506-9042		1996 CHEVROLET	INVOICE# 57932
		MONTE CARLO	DATE 03-18-2015 09:39AM
		MILEAGE 32792	EMP# 794

  

TECH	DESCRIPTION	PART CODE	QTY	TOTAL
	FRONT BRAKES APPROX 95%WORN			
	REAR BRAKES APPROX 10%WORN			
	RIGHT FRONT DISC/927			
	LEFT FRONT DISC/932			
	RIGHT REAR DISC/8898			
	LEFT REAR DISC/8870			
			Subtotal	0.00
990	LIFETIME FRONT DISC BRAKES	LABOR		68.00
	BENDIX F CERAMIC PADS	#04-FDBS% BDXD376	1.0	71.95
	DISC BRAKE ROTOR	PRT5064FC	2.0	179.90
	F DISC HARDWARE KIT	*BILLABLE	1.0	24.95
	REPLACED LEFT FRONT ROTOR			
	REPLACED RIGHT FRONT ROTOR			
	DISPOSAL FEE	WASTE	1.0	3.50
	COUPON	*IC%	1.0	-25.00
	F MACHINE TO LIMIT: .987			
			Subtotal	323.30
	RAYBESTOS R WHEEL CYLINDER	#07-RDRB% RAYWC37677	2.0	79.90
990	R&I & O/H WHEEL CYLINDER BOTH	LABOR		89.00
	DISPOSAL FEE	WASTE	1.0	3.50
	MANAGER'S SPECIAL	MS0%	1.0	-25.00
	COUPON	*IC%	1.0	0.00
			Subtotal	147.40
990	BRAKE FLUID FLUSH SERVICE	LABOR		28.00
	DOT 3 BRAKE FLUID 2232	PYBF32	1.0	11.95
	BLEED AND ADJUST BRAKING SYSTEM OK			
	ROAD TEST VEHICLE COMPLETED			
	DISPOSAL FEE	WASTE	1.0	3.50
	COUPON	*IC%	1.0	0.00
			Subtotal	43.45