



U.S. OFFICE OF SPECIAL COUNSEL

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Washington, D.C. 20036-4505

The Special Counsel

February 12, 2016

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-13-1868

Dear Mr. President:

Pursuant to my duties as Special Counsel, I have enclosed Department of Veterans Affairs (VA) reports based on disclosures of wrongdoing at the Central Alabama Health Care System (CAVHCS), Montgomery, Alabama. The Office of Special Counsel (OSC) reviewed the VA reports and provides the following summary of the investigation and my findings. The whistleblower, Dr. Mark Taylor, disclosed that a staff pulmonologist at CAVHCS, Dr. Raghu Sundaram, copied prior provider notes from patient medical records to reflect current readings in violation of the VA Handbook and CAVHCS policy, which constituted a misrepresentation of health care data and potentially endangered patient health. In addition, Dr. Taylor disclosed that as early as May 2012, management was informed of these incidents of malfeasance and failed to take any action, which constituted gross mismanagement.

The agency substantiated Dr. Taylor's allegations concerning Dr. Sundaram's misconduct in copying and pasting prior notes as well as his allegation that the copying and pasting constituted misrepresentation of health care data. In his disclosure, Dr. Taylor noted six instances in which Dr. Sundaram improperly copied and pasted patient health information. After substantiating each of those instances of misconduct, the agency recommended that CAVHCS review all of Dr. Sundaram's consults performed between 2011 and 2012. The additional CAVHCS review revealed that Dr. Sundaram engaged in the improper copying and pasting in 1,241 additional patient records. The initial report did not substantiate Dr. Taylor's allegations of gross mismanagement by VAMC leadership for failing to adequately address the misconduct prior to OSC's transmittal of the allegations. Specifically, the report indicated that management took steps prior to OSC's transmittal of the allegations to attempt to address Dr. Sundaram's misconduct.¹

¹ The report explains that prior to OSC transmittal of Mr. Taylor's allegations, as early as 2012, CAVHCS was aware of some of the instances of Dr. Sundaram's improper copying and pasting, and accordingly, placed him on a focused professional practice evaluation (FPPE) for additional oversight through March 2013. He was removed from the FPPE after 90 days; however, OMI determined there was evidence of continued improper copying and pasting after this 90-day period.

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Dr. Taylor's allegations were referred to then-Secretary Eric K. Shinseki 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 (OMI). Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On August 21, 2013, Mr. Riojas submitted the agency's report to OSC. Dr. Taylor declined to comment on the reports. As required by 5 U.S.C. §1213(e)(3), I am now transmitting the report to you.²

Following OMI's initial report, OSC requested supplemental information from the VA. Specifically, OSC sought to determine what, if any, disciplinary action the VA took against Dr. Sundaram after finding that he improperly copied and pasted patient health information in an additional 1,241 records. Further, OSC asked whether any adverse patient outcomes resulted from Dr. Sundaram's misconduct. Accordingly, CAVHCS's chief of staff and Quality Management Office conducted a review of VA records and determined there were no adverse patient outcomes arising from Dr. Sundaram's improper copying and pasting. CAVHCS further advised OSC that Dr. Sundaram received a formal reprimand in accordance with CAVHCS human resources policy as a result of the 1,241 additional instances of misconduct. Finally, CAVHCS advised OSC that Dr. Sundaram retired from the VA on July 18, 2014.

Subsequently, OSC requested that the VA conduct an additional supplemental review to determine whether a formal reprimand was appropriate disciplinary action given the seriousness of Dr. Sundaram's misconduct. Accordingly, the VA informed OSC that more severe disciplinary action had been proposed, but that because of miscommunication within the VA's Resource Management Services Division (RMSD), he only received the formal reprimand.

While I am concerned that a miscommunication within the VA's RMSD resulted in a lack of accountability for this serious misconduct, I recognize that Dr. Sundaram retired from the VA in 2014, and the agency review found no adverse patient outcomes resulted from his misconduct. Accordingly, I have determined that the agency reports contain the information required by statute and that the findings appear reasonable.

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). 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(c)(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).

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As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,



Carolyn N. Lerner

Enclosures