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The Special Counsel

September 22, 2016

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

Re: OSC File No. DI-14-1789

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding the Department of Veterans Affairs' (VA) reports, based on disclosures of wrongdoing at the West Los Angeles Medical Center (Medical Center), Imaging Radiology Service, in Los Angeles, California. I reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the investigation and my findings.[1]

The whistleblower, Oliver B. Mitchell III, who consented to the disclosure of his name, was a patient services assistant at the Medical Center. Mr. Mitchell disclosed that employees improperly deleted a backlog of medical orders and requests for imaging services dating as far back as ten years, involving over 1,000 patients, without following proper procedures or obtaining appropriate approval. He also alleged that inappropriately deleting imaging requests compromised patient health and safety, because it delayed patient care and impeded the provider's ability to observe, track, and diagnose medical conditions.

OSC referred Mr. Mitchell's allegations to the Honorable Robert A. MacDonald, Secretary, VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). On July 20, 2015, the VA submitted its report to OSC based on an investigation conducted by the VA's Office of Inspector General. OSC requested additional information from the VA to address Mr. Mitchell's concerns. On September 11, 2015, the VA submitted a supplemental report to OSC.

[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) and (g). 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).

Mr. Mitchell asserted that VA officials were deleting the magnetic resonance imaging exam (MRI) requests and files so that there would be no record of them, thus reducing the backlog of orders at the facility. The VA did not find that officials had deleted or mass purged MRI orders, or that they improperly destroyed records. Nor did the investigation conclude that patients suffered adverse or clinically significant consequences as a result of the facility's cancelling of MRI orders in 2008. However, the VA did identify quality of care issues because of delayed and unscheduled MRIs. Specifically, the investigation found that the Medical Center's failure to schedule, or to timely schedule, MRIs placed "patients at risk for more complicated and prolonged management" and concluded that the facility had not "consistently implemented its process to cancel orders older than 1 year."

As a result of its investigation, the VA is requiring that Radiology Department managers confirm that ordered MRI exams are scheduled and completed within the required time frame. Further, the VA charged the facility director with ensuring that "[s]urrogate physicians [are] designated for providers who are absent or leave their positions;" that "managers [] ensure that MRI exams are scheduled within 30 days from the date specified by the ordering provider;" and that managers document the reasons for cancelled orders. The VA has also tasked the facility director with guaranteeing that responsible providers are notified of cancelled MRI orders, that managers confirm that "ordered exams are scheduled and completed within the Veterans Health Administration required timeframe," that pending lists of MRI exams are reviewed to monitor compliance; and that the facility "develop and implement a consistent procedure for cancelling MRI orders." In its supplemental report, the VA confirmed that it has completed or is in the process of completing all of these corrective actions.

I have reviewed the original disclosure and the agency reports. Based on that review, I have determined that the reports meet all statutory requirements and the findings of the agency appear reasonable. I thank Mr. Mitchell for bringing this matter to our attention. As a consequence, the VA has taken a number of actions to ensure a more reliable process for the timely conduct and review of MRIs. I am satisfied with the breadth and the scope of the VA's review and the resulting changes implemented by the agency.

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

Respectfully,

Carolyn N. Lerner

Enclosures