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Washington, D.C. 20036-4505

The Special Counsel

June 8, 2017

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

Re: OSC File No. DI-16-2463

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a Department of Veterans Affairs (VA) report based on disclosures of wrongdoing at Department of Veterans Affairs (VA), VA Montana Health Care System, Fort Harrison, Montana (Fort Harrison VA). I have reviewed the VA report, and in accordance with 5 U.S.C. § 1213(e), provide the following summary of the report and my findings. The whistleblower, who chose to remain confidential, disclosed that Fort Harrison VA Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) managers engaged in conduct that may violate VA policies and directives, and may constitute gross mismanagement and a substantial and specific danger to public health.

The whistleblower's allegations were referred to former VA Secretary Robert A. McDonald for investigation pursuant to 5 U.S.C. § 1213(c) and (d). VA's Office of the Medical Inspector (OMI) was tasked with investigating the matter. On October 11, 2016, former VA Chief of Staff Robert D. Snyder submitted the agency's report to the Office of Special Counsel (OSC). The agency did not substantiate the whistleblower's allegations. The whistleblower declined to provide comments to the report.

The agency did not substantiate the whistleblower's allegation that the acting chief, Behavioral Health (a licensed clinical social worker), and a psychologist, Behavioral Health Services, maintained an unofficial waitlist of veterans seeking treatment from the SARRTP, in violation of VHA Directives 1082 and 2010-027 and VHA Handbook 1160.04. Nor did OMI substantiate the allegation that the mismanagement of the SARRTP resulted in a delay of substance abuse treatment, creating a substantial and specific danger to public health.

Even though the OMI investigation did not substantiate the allegations, OMI recommended that the Fort Harrison VA immediately request and schedule a consultative visit from the National Mental Health Residential Rehabilitation Treatment Program and complete additional training related to the VA Bed Management System. In response to

this recommendation, on August 2-3, 2016, the Mental Health Service and the Office of Mental Health Operations conducted a site visit of the SARRTP. During the site visit, the team reviewed residential program staffing, access, clinic data, current policies and procedures, and responded to consultative questions from the facility.

I have reviewed the original disclosure and the report. I have determined that the report meets all statutory requirements and the findings appear reasonable. While OMI may not have substantiated the specific allegations regarding mismanagement of the SARRTP, the whistleblower's disclosures led to an important investigation that resulted in recommendations for improved health care at the Fort Harrison facility. As required by 5 U.S.C §1213(e)(3), I have sent copies of the unredacted report to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed a redacted copy of the report in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures