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The Special Counsel

December 5, 2016

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

Re: OSC File Nos. DI-15-1267 and DI-15-2012

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am transmitting Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Phoenix VA Healthcare System (PVAHCS), Phoenix, Arizona. I have reviewed the agency reports and, in accordance with 5 U.S.C. §1213 (e), provide the following summary of the reports, whistleblower's comments, and my findings.[1]

The whistleblowers in this matter, PVAHCS employees Brandon W. Coleman, Sr. and Jared Kinnaman, consented to the release of their names. They disclosed failures of PVAHCS to provide adequate training for mental health counselors and social workers in managing veterans with suicidal ideation and in monitoring and providing suitable care and treatment for veterans presenting to the emergency room with suicidal ideation. The whistleblowers also disclosed a persistent failure to monitor patients presenting to the emergency room after 4:00 p.m. while under the influence of drugs or alcohol, particularly those with substance abuse problems. The whistleblowers further disclosed that PVAHCS engaged in gross mismanagement by failing to staff Emergency Department (ED) social work positions adequately; violated policy by requiring employees to work excessive overtime; provided inadequate support to staff to handle patient deaths; and discontinued Mr. Coleman's Motivation for Change counseling program without providing follow-up services

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging a violation 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 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).

to participants. Finally, the whistleblowers also disclosed that PVAHCS employees improperly accessed Mr. Coleman's medical records, in violation of privacy laws. As discussed below, the investigation partially substantiated these allegations.

The whistleblowers' allegations were referred to Secretary of Veterans Affairs Robert A. McDonald on February 13, 2015 for investigation pursuant to 5 U.S.C. § 1213(g). Secretary McDonald tasked the VA's Office of the Medical Inspector (OMI) with the investigation. The VA, through then-Chief of Staff Robert L. Nabors II, submitted an agency report on August 12, 2015. OSC received supplemental reports on February 9, 2016 and June 8, 2016. Mr. Coleman provided comments on the initial agency report and the first supplemental report, but declined to comment on the second supplemental report. Mr. Kinnaman declined to comment on the agency reports.

OMI's investigation substantiated that PVAHCS failed to adequately monitor and provide suitable care and treatment for veterans who presented to the emergency room with suicidal ideation, finding that PVAHCS was not in compliance with VA Policy 11-98 and Directive 2010-008 requiring 1:1 observation of potentially suicidal patients. The investigation also found that some patients had eloped as a result of this failure to adequately monitor patients in the ED. However, the report notes that PVAHCS leadership had recognized this issue prior to the investigation and redesigned both the physical space and facility practices to reduce the elopement of patients with suicidal ideation. OMI also substantiated that PVAHCS employees improperly accessed Mr. Coleman's medical records and found that two of the twelve accesses of Mr. Coleman's medical records were impermissible. OMI determined that, while impermissible, the two accesses were inadvertent, and PVAHCS management took appropriate action upon learning of the accesses.

OMI did not substantiate that PVAHCS was providing inadequate training on recognizing and treating patients with suicidal ideation for its mental health counselors and social workers. However, the report recommended that the facility consider allotting additional time for suicide training in new employee orientation. Although OMI did not substantiate that the Medical Center failed to adequately monitor patients who present to the emergency room after 4 p.m. while under the influence of drugs or alcohol, it did find that the lack of routine communication between PVAHCS and the community-based detoxification centers results in a gap in the continuity of veteran care. OMI did not substantiate the allegation that PVAHCS failed to provide the requisite services for staff members dealing with patient loss. Finally, OMI determined that staffing and overtime practices at PVAHCS, while not ideal, were acceptable.

In his comments, Mr. Coleman identified a number of concerns about the investigation, in particular, the implementation of recommended revisions of policies and practices at PVAHCS. Mr. Coleman also noted that a recording of a staff meeting for the Department of Social Work at PVAHCS, in which an ED employee stated that five suicidal patients had eloped from the ED in a one-week period, was included in the initial referral for investigation, but the report did not reference it. He questioned whether OMI reviewed the recording and whether it factored into OMI's conclusions. He also questioned why some of

the information in the report appeared to contradict the contents of the recording. In addition, Mr. Coleman provided a list of seven police reports that he believed showed instances of suicidal patients leaving the ED, some of which occurred following the completion of the OMI report. Mr. Coleman questioned why those occurring prior to the completion of the report were not included and, for those occurring after the OMI report, why PVAHCS's new practices and policies did not prevent the elopements. Mr. Coleman also requested clarification about how OMI determined that ten of the twelve accesses of his medical records were "proper." In his comments, Mr. Coleman disclosed additional accesses of his medical records and requested that they be investigated to determine whether they were authorized.

OSC requested a supplemental report addressing Mr. Coleman's concerns. OMI responded that PVAHCS implemented or was in the process of implementing many of the recommendations. In particular, OMI outlined the various ways the facility handled patients presenting with suicidal ideation to prevent elopements, noting that the observation rooms for suicidal patients are now in one area toward the rear of the ED, away from exits, and that both patient rooms and restrooms have been modified by installing one-way door locks and removing any ligature risks and sharps containers. In addition, patients now dress in hospital gowns or pajamas instead of their own clothing, and each suicidal patient has a 1:1 observer. OMI noted that investigators were not able to listen to the recording provided due to a compatibility issue with the audio files, but they interviewed the employee in the recording. During the interview, the employee stated that she could not recall the incidents mentioned in the recording. The report also explained that the seven police reports identified by Mr. Coleman were not reviewed as part of the investigation, because two of the reports involved patients presenting to the ED for alcohol detoxification who left after declining treatment and four did not involve the ED. The remaining case number did not have a corresponding report with the PVAHCS Police Department; therefore, the VA was unable to evaluate the incident.

Further, OMI found that the accesses of Mr. Coleman's records were related to his personal medical care, attempts to access records for a patient with a similar name, or conducted by privacy officers and supervisors investigating employees who had improperly accessed Mr. Coleman's records. OMI also noted that the Interim Medical Center Director sent emails to all PVAHCS employees explaining proper and improper patient record access in an attempt to prevent future instances of improper access. Along with the supplemental report, OMI enclosed a table listing all accesses to Mr. Coleman's medical records within the timeframe in question, the parties responsible for each access, the reason for the access, and whether the access was permissible.

In his comments on OMI's supplemental report, Mr. Coleman expressed appreciation for some of the steps the VA had taken to improve monitoring of suicidal patients. However, he noted concerns about new assessment tools implemented by PVAHCS, specifically, what assessments PVAHCS had developed and the results of these assessments. Mr. Coleman also expressed frustration at having the VA investigate itself regarding alleged violations of the Health Insurance Portability and Accountability Act and sought assurance that the VA and

PVAHCS would work to prevent future improper accesses of patient and employee medical records.

OSC requested a second supplemental report from the VA addressing Mr. Coleman's concerns with the first supplemental report. In its second supplemental report, OMI noted that PVAHCS had developed an assessment to determine professional competence in providing suicide risk assessments, which would be included in a clinician's Ongoing Professional Practice Evaluation, to be completed every six months. OMI also reported that PVAHCS had performed random, unannounced observations in the ED on a monthly basis between April and December 2015 to ensure compliance with new guidelines for 1:1 monitoring of suicidal patients resulting in 100 percent compliance. PVAHCS also performed chart reviews between January and May 2016 to assess whether the nurses' notes documented that a sitter had always been assigned to and was present with veterans requiring 1:1 observation. OMI again found 100 percent compliance. OMI also reported that PVAHCS developed additional staff training on suicidal ideation and suicide risk assessment and included it as part of new employee orientation. Lastly, OMI reported that the VHA Office of Informatics and Analytics had submitted a new service request to modify the existing warning displayed to users when accessing a record flagged sensitive; add an additional warning based on set criteria for suspicious accesses; and create a new report listing all suspicious accesses for more efficient auditing and identification of unauthorized accesses. According to the report, this service request is awaiting notification about prioritization and funding.

I have reviewed the original disclosures, the agency reports, and Mr. Coleman's comments. In light of the steps the VA has taken to improve monitoring of patients presenting with suicidal ideation and prevent future instances of improper accesses of sensitive medical records, I have determined that the reports contain all of the information required by statute and the findings appear reasonable. I have sent a copy of this letter, the unredacted agency reports, and Mr. Coleman's comments, 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

cc: Robert D. Snyder, Chief of Staff

Enclosures