3.25.2016

To: The Office of Special Counsel
From: Brandon Coleman
Re: OSC File Nos. DI-15-1267 & DI-15-2012
VA Response dated 2.9.16

The last 16 months of my life has been hell. The VA has destroyed my professional career for doing nothing wrong other than telling the truth. I exposed that the Phoenix VA was allowing suicidal veterans to elope from the ER and that my medical records were being illegally entered seemingly at will by my coworkers and administrators both before and after I became a whistleblower and EEO disclosure.

I will keep my response to the VA's attempt at truthfully answering the 20 questions posed to them by the OSC brief because at this point does it even matter what I say. Time and time again the VA is allowed to skirt around the truth and also blatantly lie not only to the OSC, but to Congress, the media and most importantly to Veterans. This document summarizes my comments on why the report is not a reasonable resolution for my concerns. Appendix 1 was prepared by my attorney, and summarizes why the report is incomplete with respect to statutory requirements in 5 USC 1213.

Question A – Again why is the VA allowed to investigate itself on HIPAA related issues? We have previously shown that the Phoenix VA wrongfully assigned the impermissible assessing of my medical records by coworker Penny Miller as "low risk" and thus dishonestly influenced the investigation. But now we are supposed to trust that the VA was only allowing individuals into my medical records who had a right to be in there? I have never disputed any of the employees from New Mexico who were in my records. I have open appeals with the Department of Veterans Affairs and they are worked out of the New Mexico Regional Office. What I do dispute is Phoenix VA Administration Officer Troy Briggs being in my medical records on April 20, 22, 2015. More to follow on later questions.

B. This is a step in the right direction. Hopefully the Phoenix VA can be monitored to make sure they keep the 45 minutes of training for new employees in place. However, the VA has not provided any researched or experience basis why 45 minutes is reasonable for sufficiently expanded training.

C. This case should not be closed until the Phoenix VA is forced to provide the results to assess how clinician's complete suicide risk assessments. The VA's response states at the time of the response written by the VA 2.9.16 the results are still pending for both psychiatry and social work. If the VA is not ordered to do so by the OSC, they will never release these findings.

D. This is simply untrue. The Phoenix VA has a very "loose" definition of what is considered random. Can the VA please further clarify this answer? Is random once a year, twice a year?

They have been incidents of non-compliance, just none have been reported to date, or if they have been reported the VA has again chosen to overlook this information.

E. Please ask the VA to give a drop dead date as to when the staff training will be complete and how are we going to ensure that the Phoenix VA follows through on this? Again, it is unreasonable to say that incomplete corrective action is adequate to solve an ingrained, long-term breakdown.

F. Let us remember here that the Phoenix VA was not proactive in this matter to help keep suicidal veterans safer. The only reason the VA looks like they "got a jump" on this issue is because in good faith I met one on one with PVAHCS acting director Glen Grippen on January 21, 2015 and showed him my actual OSC complaint. I even gave him a copy because at that time I thought they actually would care about what I had brought forward. How wrong was I? In reality the only reason the VA appeared to be proactive in making these changes is that my disclosures to the OSC triggered the OMI inspection. The Phoenix VA knew the ER had been messed up for years and because of my meeting with Grippen was able to look like they actually were trying to be proactive.

I will add that I am proud I came forward and would not change it, even after all the retaliation and harassment from the Phoenix VA. I am proud that these changes were forced in question F. The Phoenix VA is on the right path to making it a safer environment for when a veteran presents wanting to possibly harm themselves or someone else.

Regarding the 7 police reports, I find it simply mind numbing that a room full of VA lawyers probably had meeting after meeting to come up with a definition for elopement that works for the VA. I also find it horribly disturbing that the VA chooses to focus more on their statements that of these seven reports some of the veterans were not eloping from the ER. Does it matter which department the veteran was eloping from if the veteran is at risk to themselves or someone else? The distinction is irrelevant and unreasonable as a response to my disclosure.

Please remember that the important fact here is that in the report written by the VA dated 6.17.15 and signed by Rob Nabors and authorized by Dr. Carolyn Clancy, the VA stated very clearly there had been no further elopements since 2.15.15, from ER or anywhere else. The fact that these seven reports were uncovered after 2.15.15 shows the lengths the VA will go to in order to not only lie to the OSC but to the President of the United States. Let me state that again. The VA's admission in this report dated 2.9.16 proves that they lied in their report dated 6.17.15. How can anyone take anything the VA says it will do to correct problems seriously when they blatantly lie and can mislead the OSC and the POTUS? This fundamental flaw disqualifies the findings from being credited as "reasonable." To the contrary, the contradiction raises questions about false statements to a government agency and possible violation of 18 USC 1001.

G. The creation of a Community Liaison Social Worker Position is a step forward in the right direction. However training should have been conducted with front line employees to ensure that proper hand offs, and behavioral health transportation arrangements are made for veterans presenting needing alcohol or drug detoxification since no such ability to detoxify currently exists at PVAHCS.

H. In the VA's initial response instead of telling the truth the VA tried to focus on saying the vet who shot himself in the head at the regional office parking lot did not present to the ER. Again in what has become typical VA fashion it is like pulling teeth to get real answers out of the VA.? I am thankful in this new report that the VA admitted they did view the suicide note left by this veteran. It surprises me with all the problems the VA has with "technology" they were able to open the suicide note and actually admit to viewing it. I could continue to go on and ask many questions concerning this veteran trying to force the VA to give us answers. Again, what's the point? The VA has this veteran's blood on its hands and I truly hope whichever VA lawyer tried to skirt around this issue feels a bit of shame for disregarding the life of yet another troubled veteran.

The VA also has flatly contradicted itself again, raising the near certainty of false statements. Although referencing an attached January 15 suicide note by the veteran complaining of grossly inadequate pain management care, the VA concludes, "There is no documentation that the Veteran was dissatisfied with care received during the January 2015 visit...." The contradiction is so fundamental that the answer goes beyond "unreasonable" and in intellectually insulting.

I. Again 45 minutes, over the previous 15 minutes of suicide prevention training is a positive step in the right direction for all new hires. It's a start, but the question remains unanswered whether it is enough. .

J. When will all employees required to complete the mandatory training? Should it take over a year for all required employees to finish training that the agency considers to be a high priority to ensure proper care for our most at risk veterans?

K. The answer the VA gives is "There is nothing else to see here, let's move on." Glad to see that the supervisor was reeducated as well. It makes one wonder how many times this untrained social worker improperly diagnosed suicidal veterans and had them released while intoxicated, because as per what he said to me in December 2014, "We do not rate veterans anything other than low for suicide risk if they present under the influence." The answer is hopelessly unreasonable.

L. This patient twice made statements to me as an independently licensed clinician that he wanted to harm himself. There is a break down still in the hand off process when an RN who is possibly untrained, or a social worker who is also untrained can be allowed to overrule the clinical judgment of the clinician who brings the veteran to the ER in the first place. The VA's contrary premise for its judgment call is unreasonable.

M. When an investigation such as this occurs let us remember that OMI carefully selects who they will speak to. Often time's employees with vital information are purposely not interviewed. Again according to the VA's definition of elopement in this instance if a veteran presents but is not triaged as suicidal or homicidal and simply walks out the door the Phoenix VA would have no record of this veteran eloping? There is still something gravely wrong with this process and high risk suicidal veterans continue to be put at undue risk. This continues to be a patient safety issue. Since the VA's records admittedly and inherently are incomplete, the supplemental report's conclusions also are incomplete and unreasonable.

N. Let's get this one out in the open. The VA who spends billions and billions of dollars on technology each year and is able to divert whistleblower emails to VACO for review, is saying they do not have the capability to open a Drop Box audio file? This file was played on CNN "The Lead" with Jake Tapper on 3.19.15. It was also played on ABC 15 and Fox 10 Arizona the same week. Jonah Bennett from The Daily Caller also reported on this fact this past week and stated he was able to open the file the first time. It was also sent to Representative Jeff Miller, Representative Kyrsten Sinema, Representative Ann Kirkpatrick, Senator John McCain, Senator Chuck Grassley and Senator Ron Johnson's offices. Each of their offices were amazingly able to open the drop box file and review it. I am thankful that each of these members of congress, along with several media outlets were able to afford the free technology needed to open this audio file that the VA somehow says they could not? The VA needs to be held accountable in this instance and should be made to open the file, conduct a proper review and file a report with the OSC as to the findings, along with recommendations to fix the problems. Why is the VA allowed time and time again to make statements like that can't open a simple media file and get away with it. Hell no, not on my watch. The VA's excuse for not resolving this issue is unreasonable.

O. When can we expect the other 6% of social workers to have completed the mandatory training for suicide risk assessments? Please remember that the Chief of Social Work for PVAHCS is currently David Jacobson. Mr. Jacobson recently sent an email urging other employees to stand by Dr. Darren Deering the chief of staff during the scandal of 2014 in which 40 veterans died. Mr. Jacobson completed this email on VA time from his VA computer. Mr. Jacobson is one of the current leaders the VA is referring to that evaluates competencies of his subordinates. Kind of tough to trust the VA is taking care of this issue correctly within social work when the chief has been shown to engage in unethical practices during work hours. Further, in light of the tragic consequences it is unreasonable that the report does not include any requirement for specific training on proper records for suicide risks. It is unacceptable that si percent of the staff in life and death situations are flying blind, acting without key training.

P. Most basic, the VA's response was that NSOC does not make findings whether breaches are inadvertent. That means the underlying question remains unaddressed. It also means that in ytthe absence of getting the answer from an appropriate agency with relevant duties, the report unreasonable fails to include corrective e actions recommendation on a system to determine whether data breaches are inadvertent or intentional.

With respect to the smokescreens that were provided, thank you VA for making your explanation here about as confusing as possible so no one understands it. This system should be reevaluated. If a coworker can enter a disabled veteran / coworker's medical record and it is deemed low risk then I feel strongly there is something inherently wrong with the criteria as to increase the risk level. This should never be allowed to happen at any VA facility and the VA should be forced to come up with a method to properly ensure the protection of veteran / employee / whistleblower medical records.

Q. I do not dispute any of the accesses of my medical records from employees working on my appeals out of New Mexico. Where I find dispute is that PVAHCS Administration Officer had any reason to EVER enter my veteran medical records.

R. Really, come on VA, this excuse is just about as bad as the one you gave regarding not being able to open the audio file of the recorded social work meeting. The problem here in saying that I have a similar name to another veteran is nothing more than another diversionary tactic. It is irrelevant. The fact that I am their coworker with a sensitive file is what is at issue here. There is no way on God's Green earth that PVAHCS Administration Officer Marilyn Poland was attempting to go into a record of Brian Coleman. The VA should be forced to prove that Ms. Poland actually had a reason why she would have been in a veteran named Brian Coleman's file. This excuse she has given does not add up. Prove she was in Brian Coleman's file and also show what she was doing in my file? How long was she in my file? What pages did she view? I find it deeply disturbing that after I had filed a privacy complaint that an Administration Officer went into my medical records and shortly after I became a whistleblower one of the mental health chiefs started to question my mental health? Again the finding is insultingly unreasonable.

S. Please note that this is the same privacy office ran by Mary Monet at PVAHCS that so bungled my initial request for an investigation and wrongfully gave the record violation by Penny Miller a rating of "low risk." With this being proven, I'm supposed to believe that Ms. Monet was able to act ethically in determining that employees were allowed in my medical records. If this is the case the standard procedures do not go far enough to protect veteran/ employee / whistleblower medical records at PVAHCS. Please note many of these same supervisors are involved in either my whistleblower or EEOC cases. Quite positive we can expect to get honest answers out of each of them as usual. Again according to the VA, "Nothing else to see here, please move on." What is most frustrating is that the VA asserts talking "appropriate action," without specifically describing it or explaining how it will prevent recurrences.

T. Again the VA tries to downplay the incidents by starting off their answer saying they were "mistakes." This is untrue when the employee that was selected happens to be a coworker that you have spoken to in the past named Brandon Coleman. I will again state I am the only Brandon Coleman in the PVAHCS database and just because Glen Grippen decided to send an email it does not let employees off the hook for violating HIPAA.

The supplemental report references two emails (without summarizing their contents) and a request for unexplained improvements. These answers leaved the reader just as ignorant as before reading the report on how any corrective action will be adequate. Where does the request stand submitted by VHA Office of Informatics and Analytics to modify sensitive patient warning methodology? What is being done to protect not only my, but other veteran / employee / whistleblower medical records from being freely rifled through by coworkers and administrators? The VA needs to be ordered to follow through and fix this issue so NO other employees ever have to go through the horrors I have been put through.

Attachment A – Please note that Troy Briggs is CC'd to the gag order placed against me by then director Glen Grippen on 4.20.15 forbidding me from speaking to any other PVAHCS employees and violating my 1st amendment right to free speech. The excuse given on the attachment that Troy Briggs was ordered into my medical record on the same day as the gag order simply does not fly. It actually smells. Privacy Officer Mary Monet has already been

shown to have messed up the first investigation into the illegal accessing of my medical records by employee Penny Miller. But now all of a sudden, Ms. Monet can be expected to be ethical and order an admin officer WHO HAS NEVER HAD ANYTHING TO DO WITH MY MEDICAL TREATMENT into my HIPAA protected records. Again I am asking for a proper investigation from outside of the VA be performed into the illegal accessing of my HIPAA protected records on at least 4 different occasions. The Office of Civil Rights currently has a nationwide investigation into this phenomenon occurring to VA employees across the country. Please either flunk this report, or order an unbiased investigation or please coordinate with the Office of Civil Rights to help ensure that those within the VA who illegally entered my records are appropriately reprimanded.

APPENDIX 1

SUMMARY OF NONCOMPLIANCE WITH OSC EVALUATION CRITERIA IN DEPARTMENT OF VETERANS AFFAIRS SUPPLEMENTAL REPORT ON BRANDON COLEMAN REFERRAL

In addition to being unreasonable, the VA supplemental report on Mr. Coleman's disclosures, OSC File No. DI-14-3657, failed the following OSC criteria for a complete response.

3. Did the agency report include a summary of the information with respect to which the investigation was initiated? 5 USC § 1213(d)(1) No. Although theoretically answering additional OSC questions about Mr. Coleman's disclosure, the supplemental response did not reference or specifically address any of Mr. Coleman's evidence.

a) Did the report set forth allegations submitted by the Special Counsel for investigation? Not applicable for the supplemental response.

b) Did the report summarize the material evidence relating to each of the allegations? No, the supplemental report did not discuss or otherwise recognize the existence of any evidence from Mr. Coleman.

4. Did the agency report include a description of the conduct of the investigation? 5 USC § 1213 (d)(2)

a) Was the whistleblower interviewed at the outset of the investigation? No, there is no reference to interviewing Mr. Coleman for the supplemental report, although his testimony would be crucial as with respect to circumstances for the five elopements.

b) Did the report identify the personnel who investigated the whistleblower's charges? No.

d) Did the report list witnesses interviewed, including the subjects of the investigation and witnesses suggested by the whistleblower? Yes, the report listed supervisors who were interviewed. But this methodology is unreasonable *per se*. It means the alleged wrongdoers were not interviewed; only their supervisors to speak for them. This violates the most basic standards for fact-finding.

g) Did the report state whether notice was provided for on-site investigations? No.

h) Did the report reveal the areas of inquiry covered with each witness? No, only their answers.

i) *Did the agency rely on any other investigative report as a substitute for investigation in direct response to the referral under 5 USC § 1213(c)?* Yes, such as the ancillary privacy investigations or agency reviews of training. *If so, did the agency answer Question 4, (a) through (h) above in that report?* No. In one case, an OPPE report on suicide risk documentation, the report has not even been completed.

5. *Did the report include a summary of any evidence obtained from the investigation? 5 USC § 1213(d)(3)* No. in some cases it listed categories of records. But it did not identify specific documents, quote or paraphrase the contents of those documents. The report's consistent approach was to make references to general categories of record to support sweeping conclusions of self-exoneration, while skipping references to either citation or substantive specifics to back up those conclusions.

6. Did the report summarize all relevant and material evidence that the agency considered in making its conclusions on each of the allegations? No, it only listed the conclusions and referenced the process of obtaining them (such as conducting interviews).

7. *Did the agency report include a listing of any violation or apparent violation of any law, rule, or regulation? 5 USC § 1213(d)(4)*

a) Did the report cite any law, rule, or regulation relevant to the whistleblower's allegations, whether or not the report concludes that the disclosure and evidence substantiates a violation? No, the report did not reference any legal authority, even authority to justify the actions Mr. Coleman challenged.