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October 9, 2015

The Honorable Carolyn Lerner
Office of Special Counsel
1730 M Street, NW
Suite 300
Washington, DC 20036

RE: OSC File Nos. DI-15-1267 & DI-15-2012, attention: David Tuteur

Dear Ms. Lerner:

Mr. Brandon Coleman and counsel at GAP have reviewed the VA investigation report into his disclosure referred for investigation under 5 USC 1213(b). While the investigative team substantiated several of his allegations, he is concerned that it failed to exercise due diligence in investigating other relevant aspects of the disclosure.

Most explicitly, the investigative team inexplicably overlooked key evidence including an authenticated audiotape wherein the elopement of 5 veterans was verified and the inappropriate training of VA safety observers was discussed, as well as other victimized veterans. The VA investigative team also made faulty conclusions regarding the inappropriate entry into Mr. Coleman's medical records.

A major enabling factor for the above errors is that the report was incomplete, both with respect to the requirements of 5 USC 1213(d) and the OSC's own evaluation guidelines. Initially, the Secretary did not sign the report, the first requirement of section 1213(d). The buck for these concerns must stop with the Secretary, not his chief of staff. With respect to substance, the report –

* failed to credit and analyze the audiotape of a January 2015 Phoenix VA social work team in which, contrary to the report's blanket denial, no participants disputed the elopement of five patients.

* failed to credit the testimony of confidential witnesses;

* failed to consider the suicide note of Veteran 4, which flatly contradicted the report's conclusion that he had not sought VA help.

* did not include any specific recommendations for how to handle suicide risks who at first admit to being suicidal with one clinician and later deny suicidal tendencies.

* failed both to consider violations of law on grossly excessive overtime, such as 24 hours shifts that severely undermined patient care, or to offer corresponding, specific corrective action recommendations.

* failed to offer specific recommendations for event briefings to facilitate treatment for staff when a patient commits suicide.

Attached is Mr. Coleman's assessment of the agency response for reasonableness and completeness pursuant to the OSC's evaluation criteria. He respectfully requests that the OSC direct the VA to fulfill its responsibilities under 5 USC 1213(d).

Sincerely,

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Thomas Devine

Christopher Leo
Government Accountability Project

Counsel for Mr. Coleman

STATEMENT OF BRANDON COLEMAN ON
AUGUST 12, 2015 REPORT OF INVESTIGATION

1. **Despite having access to indisputable objective evidence that five veterans eloped from the Phoenix VA Emergency Department (ED), the investigative team inexplicably stated it could not substantiate the loss of those patients.**

I gave the Office of Special Counsel an audiotape of a January 2015 Phoenix VA social work meeting wherein a Phoenix VA social worker and the Chief of Social Work discussed the elopement of five veterans within a one week period in January 2015. The staff on the audiotape clearly stated five suicidal patients left the ED. On the recording none of the employees on the audiotape disputed that fact. I have been told that this audiotape was provided to the VA.

The investigative team stated that it could find no evidence of patient elopement by looking at police logs or ED patient lists. By relying on those methods, the team demonstrated its fundamental lack of knowledge regarding how the Phoenix VA ED staff enroll and evaluate potentially suicidal veterans. If a veteran is suicidal, he or she is taken to the triage waiting room without having the process of enrollment completed initially. If the veteran then leaves triage waiting room before either the VA enrollment process is completed, there is no record generated that the veteran ever came to the ED. In practice, the ED staff does not make police notification of veterans who left before ED enrollment was complete.

The five veterans who expressed suicidal ideation left because they did not have 1:1 observation/safety implemented and were not yet enrolled. Because those veterans did not stay for the enrollment process, they would not have been reported as elopements to the VA police. This is the reason there is no written documentation of the elopements in the VA log or ED records when clearly the audiotape in the VA's possession is indisputable proof that 5 elopements occurred in the ED.

**** As per 5 USC § 1213(d)(1) (b,c,d) the agency makes no mention of the audio recording that the OSC submitted as part of its findings. As per 5 USC § 1213 (d)(2) c the findings from the agency make no mention that those interviewed were offered confidentiality for their responses.*

2. **Despite indisputable audiotaped evidence that sitters were not properly trained, the VA illogically contended that all "sitter"/"safety observers" are properly trained.**

On page 7 of its report, the VA stated that all sitters/safety observers "have completed the required training in basic suicide precautions, environmental safety, and a competency evaluation." However, per the audiotape of the 1/23/15 Social Work meeting, "sitters are untrained and will walk away from them [veterans]...first thing we need are staff that are trained to watch... [those veterans] who are suicidal." It is clear from that audiotaped conversation that the sitters/safety observers do not possess the skills to ensure safe patient monitoring. It is equally clear that social work staff is aware of those deficits. The investigative team should have

recommended that the Phoenix VA immediately re-evaluate the quality of training it provides to such safety observers.

**** As per 5 USC § 1213(d)(1) (b,c,d) the agency makes no mention of the audio recording that the OSC submitted as part of its findings. As per 5 USC § 1213 (d)(2) c the findings from the agency make no mention that those interviewed were offered confidentiality for their responses.*

3. **While emphasizing some aspects of provider training on suicides, the VA investigative team failed to acknowledge that no training is routinely provided to relevant VA health care providers on how to properly complete the mandatory Suicide Risk Assessments (SRA).**

The Suicide Risk Assessment (SRA) is an important tool by which a plan of care is established for potentially suicidal patients. The information entered into that form is crucial to determining the suicide risk and developing of a safe, appropriate plan for the suicidal patient. Failure to correctly complete the form leads to a dangerous under-rating of patient suicide risk as well as an inadequate plan of care for the potentially suicidal patient.

Although the team recommended reviewing completed SRAs for general quality reviews, that recommendation is extremely short-sighted. Currently there is no standardized education to any VA employee on the correct method of completing the SRA. The investigative team should have recommended that the Phoenix VA institute such standardized training.

**** As per 5 USC § 1213(d) (4) the report did not state whether the investigation revealed a violation of law, rule or regulation.*

4. **Despite the failure to cite any proof to the contrary, the investigative team stated that the unauthorized access of my medical records by Penny Miller was "inadvertent" and does not warrant further recommendations. The investigative team also stated the unauthorized access to my medical records by two additional employees was a harmless error that also doesn't rate any additional recommendations. There has also been a new breach that was learned of when a third SPAR report was pulled on August 12, 2015 by PVAHCS Administrative Officer Troy Briggs. I am asking for an addendum to be added to my OSC complaint so this 3rd breach of my records can be properly investigated by a party independent from PVAHCS.**

I am the only "Brandon Coleman" listed in the Phoenix VA electronic health records nor are there any other veterans with variations in names similar to "Brandon Coleman" within the Phoenix VA system. Neither "Brandon" nor "Coleman" is easily confused with other names.

As an employee-veteran, my electronic medical record is automatically flagged with a specific warning notifying users that it is a sensitized chart. This warning temporarily halts the electronic opening of the chart unless the user choses to override the warning flag. At that point, the only

way for the chart to be opened is for the individual to deliberately click on the icon to proceed with opening the record. Opening an employee-veteran chart is thus a two-step process that requires very deliberate actions.

Penny Miller has been employed as a licensed health care professional at the Phoenix VA Medical Center (VAMC) for many years. I am also a long standing mental health employee working with Ms. Miller and her clients for many years. She thus has known me for an extensive amount of time. It is incomprehensible for her to state that she accidently confused me for a patient discussed earlier with another individual. The excuse she gave doesn't have any logical basis. The entry into my chart was her deliberate attempt to garner additional information about me by illegally accessing my mental health records.

The investigative team inexplicably relied upon the Phoenix VAMC's assessment that Ms. Miller's access to my chart was "inadvertent". Although the National Security Operations Center (NSOC) deemed the access a low risk for breach of information, to my knowledge, the NSOC did not determine that the breach was inadvertent. To the best of my belief and because I have not been told otherwise, this determination was done by the Phoenix VA privacy office. The investigative team should have asked for the evidence that supports such a chart breach was "inadvertent." Failure to check renders the findings unreasonable.

The program analyst who entered my chart on 11/10/14 has known me for years. Because there are no other veterans with like sounding names in the Phoenix VA health records system, her stated reason that she was working with a veteran with a like-sounding name is not credible. Indeed, to my knowledge, the program analyst actually has no duties wherein she is responsible for accessing veteran-employee electronic health records for any reason. In addition, to the best of my belief, at no point has the program analyst ever provided the name of the veteran supposedly with the like-sounding name whom she can prove that she had reason to access his record on the same date. Without such information, the only logical conclusion is that the program analyst accessed my medical record to gain additional sensitive medical information about me.

I do not personally know the LPN who accessed my chart on 4/7/15, shortly after I was on several news programs and met with Secretary McDonald. I again want to emphasize that there are no other veterans in the Phoenix VA electronic health records system that possess a similar name to mine. I had not received any medical care at the Phoenix VA since 1/2/15. To my knowledge, the LPN has never provided any plausible explanation for accessing my medical records. The only logical reason for her to enter my chart was to learn additional medical information about me.

As reported on page 15 of the report, the Phoenix VA determined that 10 out of 12 people "were conducting official duties related to treatment, payment, or health care operations." However, I remain quite concerned that the Phoenix VA, not an independent investigative team, was allowed to determine who accessed my records in their official duties without ever sharing with me exactly what official duties those individuals were performing. Without such information, I

cannot independently verify that the Phoenix VA is accurate in its determination that 10 of 12 instances of chart entry were justified.

On August 12, 2015 I learned of a new breach by PVAHCS Administrative Officer Troy Briggs. This has yet to be formerly investigated and is relevant to my overall case. Mr. Briggs entered my treatment records on both April 20 & 22, 2015. On April 20, 2015 PVAHCS director Glen Grippen placed a "gag order" on me saying I could still get care at PVAHCS as a disabled veteran, but forbid me from speaking to any other PVAHCS employees. The same day April 20, 2015 this employee Mr. Briggs was in my HIPAA protected record and Mr. Briggs is even CC'd to the "gag order" letter sent to me by director Grippen. Again I ask the valid question, why is Mr. Briggs in my treatment record the same day he is CC'd to the gag order letter written by Director Grippen?

The Phoenix VA should have implemented additional safeguards for my medical records that would prevent unauthorized users from accessing them for purposes that clearly were not within the scope of their duties. Because I can no longer trust the confidentiality of my veteran health care, I have not used my veteran benefits for health care at the Phoenix VA since 1/2/15. It remains incredibly psychologically distressful to me that these employees were given free rein to access my medical chart with sensitive physical and psychological information with no significant repercussions for the employees or for the Phoenix VA Medical Center.*** *As per 5 USC § 1213(d)(4) a & b the report states that my disclosure substantiates a violation however the agency continues to downplay the events in stating they feel these violations did not involve malicious intent.*

*** *As per 5 USC §1213(d)(5)(A) – (D) the agency fails to provide any change in rules, regulations and practices regarding the continued records violations of veteran/employee/whistleblowers. There has been no restoration provided to the aggrieved employee regarding any of the documented instances of employees entering his medical records even though they are not involved in his heath care treatment. There has been no substantial disciplinary action against employees documented to have entered my HIPAA protected records and there has been no referral to the Attorney General regarding evidence of a criminal violation in these instances.*

5. **Although the investigation team stated that Veteran 4 had not come to the VA seeking services for pain management, the content of Veteran 4's suicide note stated otherwise.**

On page vi of the Executive Summary, the investigation team wrote "VA did not substantiate that Veteran 4 had presented to the Medical Center's ED for care related either to suicide ideation or pain management." Although the veteran did not specify the VA location where he sought pain management, his suicide note clearly indicates that he presented to the VA in January 2015 and received what he believed to be grossly inadequate care for pain management. *** *As per 5 USC § 1213(d)(4) the agency makes no mention of the veterans suicide note as if it does not exist. The report fails to offer explanation as to why the agency felt its evidence was*

more credible than the suicide note provided by the veteran stating he came to the VA for care in 2015. The report fails to offer the full factual legal basis for the agency's conclusions. Please advise if the agency continues to content that the suicide note from veteran 2 does not exist and I will be happy to supply it.

6. **While the VA transferred veterans from the Motivation for Change program to other services, none of the Phoenix VA services provide the intense level of case management that those veterans were receiving in my Motivation for Change program. As a result, each of those veterans is now placed at unacceptably high risk for recidivism in terms of re-incarceration and/or return to substance abuse.**

The Motivation for Change (M4C) program was a unique 52 week substance use disorder program for veterans convicted of drug and alcohol felonies who were participating in one of five Maricopa County area Veterans' Courts. Utilizing intense case management not found anywhere else within the Phoenix VA, on an ongoing basis the program actively addressed multiple complex psychosocial risk factors that were intertwined with each veteran's substance use disorder. Such psychosocial risk factors included persistent homelessness, unemployment, unmet physical health needs, co-occurring mental health disorders, lack of access to veteran benefits, and general distrust of the VA.

Although the VA stated it transitioned the M4C veterans to other equivalent programs, there literally are no other equivalent programs in the Phoenix VA or, for that matter, within the VA in general. Those veterans essentially were given piece-meal care in social service and mental health areas without the benefit of prolonged and intense case management normally required for such high risk veterans. By failing to consider the nature of comparative treatment programs, the report's conclusion is unreasonable that they are equivalent.

While the Phoenix VA has personally given the public and me varying reasons for shutting down the Motivation for Change program, it is clear that the Phoenix VA is unable to provide equivalent service to these high risk veterans. Currently, the Phoenix VA only provides 6 to 8 weeks of intensive outpatient substance abuse treatment. The M4C program provided 52 weeks of ongoing treatment and case management. The M4C program graduated 51 veterans of whom the vast majority were able to maintain their sobriety, complete probation terms early, and receive reduction in the felony charges. None of the Phoenix VA mental health or social work programs are currently structured to produce similar results.

7. **The investigative team failed to interview the alleged victims of its misconduct.**

The agency failed to interview any of the 71 veterans who were currently enrolled in the 52 week Motivation for Change program as to what happened to them after I was placed on administrative leave and the M4C program was shut down. Many veterans turned to the media to voice their concerns. (a) I was not interviewed at the outset of the investigation. (c) Witnesses were not offered confidentiality because they were never interviewed. (d) There is no list of witnesses interviewed because no veterans were interviewed. (e) There is no report of witnesses interviewed that were suggested by the whistleblower. (f) The report did not disclose the

methodology used in the investigation. (g) There was no notice provided for onsite investigations to these veterans. (h) There is no report describing the level of inquiry with each witness as none were even interviewed. (i) The agency failed to rely on any other investigative report for the findings. By systematically avoiding the evidence, the agency rendered its findings unreasonable.

8. **The investigative team failed to recognize the potentially severe consequences that can occur when there is inconsistency between the intensive outpatient mental health evaluation performed by the mental health provider and the subsequent preliminary initial assessment done by the ED triage nurse.**

In the outpatient mental health clinic, I performed intense mental health evaluations of patients who verbalized suicidal and/or homicidal ideation. After 4pm, when I deemed a patient to be a danger to self or others based on patient statements/actions, I would escort the veteran to the triage nurse in the Phoenix VA Emergency Department (ED). I would give verbal hand-off to the ED triage nurse, explain that I had rated the patient high risk for suicide based on his statements and/or actions, and inform the nurse that I would complete my written note as soon as the patient was in a secure location in the ED. I would then return to the clinic to complete chart documentation of that high suicidal/homicidal risk. However, on multiple occasions, the ED triage nurse would ignore my suicide risk assessment as soon as I left. If the patient suddenly stated to the ED triage nurse that he or she was no longer suicidal, the ED staff member would no longer monitor the patient. The patient would often leave.

Releasing the potentially suicidal/homicidal patient without performing a detailed ED mental health assessment is a gross failure on the part of the ED triage nurse. According to community mental health standards, the verbal assessment by a licensed mental health provider of high suicide risk should be sufficient indication to warrant placing the patient on immediate 1:1 safety observation. Instead, the triage nurses immediately would release the potentially suicidal/homicidal patient from monitoring without having a qualified ED provider perform another suicide risk assessment.

I brought Veteran 3 to the ED based on his serious statements that he was going to harm himself. After I appropriately communicated the pertinent details to the triage nurse, I returned to my duty station to complete the necessary chart documentation. In the meantime, after the patient made a simple statement denying that he was suicidal, the triage nurse immediately decided that the patient did not need to be monitored 1:1 for safety. After being allowed to go unescorted to the restroom, the veteran simply walked out of the hospital without ever receiving an appropriate mental health assessment in the ED. Ignoring my high risk suicide assessment of this patient, the triage nurse did not report this elopement to the police because that nurse inappropriately decided the patient was not a danger to self without ever completing the required suicide risk assessment.

When there is clear and convincing evidence/report that a patient is suicidal, the ED triage nurse station is not the appropriate place to evaluate the mental health status of a patient who suddenly denies being suicidal. Such patients should be placed on 1:1 observation for safety until an in-depth mental health assessment can be completed by a qualified mental health provider.

Presently at the Phoenix VA, there still is no policy established on how veterans should be handled when a patient suddenly denies being suicidal to an ED staff member after having verbalized suicidal ideation to a non-ED staff member.

**** As per 5 USC § 1213(d)(4) (a-d) the report from the agency severely downplays the full scoop of this issue. The agency attempted with great effort to make it appear that this was a onetime incident that happened in the ER due to a training issue. There is much evidence already supplied to the contrary describing multiple incidents were veterans were not properly rated on suicidal evaluations and were in turn not monitored. The report failed to disclose which evidence was more credible and failed to explain why. The report offered no factual basis for the conclusions on this element of the investigation.*

9. **In terms of ED Social Work overtime scheduling, the investigative team failed to note significant violations of federal law and VA policy in terms of scheduling one particular VA social worker for overtime in the Emergency Department (ED).**

The violations involve a social worker who worked 110 hours of overtime in one 2-week pay period. This included one day where the social worker was paid for Emergency Department overtime at a time that corresponded to his travel to/duties at his other VA job. It also involves that social worker not having the required 8 hour break between his shift duties.

The ER was severely short staffed in covering all social work shifts 24 hours a day, 365 days a year. Social Work Chief David Jacobson even spoke about this issue in media interviews in which he stated there were always going to be gaps in coverage. This was contrary to his earlier media interviews in which Mr. Jacobson, along with other PVAHCS leadership reported the ER was always fully staffed and that when a veteran was suicidal the veteran was always monitored one on one by a licensed clinical social worker. This again is simply not true as per the audio recording from January 23, 2015 in which ER social workers speak freely about suicidal veterans walking out of the PVAHCS ER.

PVAHCS attempted to fix the staffing shortages by allowing one social worker David Stephenson to work 110 hours of OT in one pay period, and a 24 hour straight shift. An email chain was provided as evidence showing that this practice was supported by the PENTAD to include Dr. Darren Deering the Chief of Staff and director Glen Grippen as they are included on the emails. Assistant Social Work Chief Michael Leon even questions patient safety by allowing one social worker to try and work all these hours in a row without a mandated break to sleep or eat.

On this issue, the report from the agency is unreasonable, because it severely downplays the full scoop of this issue. The agency attempted with great effort to make it appear that overtime incident that happened in the ER falls within accepted VA health care guidelines for safe medical practice It does not. The report failed to disclose which evidence was more credible and failed to explain why. The report offered no factual basis for the conclusions on this element of the investigation.

10. Although the VA acknowledged a lack of continuity of care between the Phoenix VAMC and the local community-based detoxification center, the investigation team failed to recognize that there currently is no detailed policy regarding communication to/from that detoxification center.

On page 14 of its report, the investigative team discussed this "lack of routine communication". It recommended that the medical center "continue efforts to establish consistent communication with the non-VA detoxification center about Veterans under their care consistent with and to the extent permitted by law and VA policy." Unfortunately, the team failed to recognize that there currently is no detailed policy regarding such hand-offs to/from that detoxification center. The team should have recommended that such a policy be put in place.

**** As per 5 USC § 1213(d)(4) the report failed to cite rules and regulations relevant to the whistleblower's regulation and instead attempts to state that no such policy is in place to properly coordinate care of this severely at risk veterans with community providers. The report again downplays that no such policy exists which is a direct violation of safe patient care practices. The report fails to state which employees were interviewed (if any) and if these employees were offered anonymity for telling the truth. The report fails to offer a full legal basis for its conclusions and only states that further efforts are needed to coordinate with community mental health providers.*

11. Although the VA acknowledged an Employee Assistance Program in place to help employees when a veteran/patient commits suicide, this is not nearly enough to properly address the needs of employee clinicians who are treating said veteran.

On page 18 of its report the investigative team discussed a meeting was held in early October 2014 to address the suicide of a patient. This was not a meeting held to address this particular veteran committing suicide. This was a normal weekly staffing meeting in which I brought up this veteran successfully committing suicide the week before. This is the only reason it was even discussed.

There is currently no debriefing system in place at the Phoenix VA for employees who are involved in the care of a veteran to readily discuss this issue when a patient successfully completes suicide. This is a dark issue that the agency needs to address as many clinicians become deeply involved in the care of these veterans who successfully complete suicide. There are many within the mental health treatment team that become involved in the coordination of care for a high risk veteran.

On page 18 the investigative team also discusses that all other employees know about the EAP services. This is due to the fact I brought up the issue repeatedly after this suicide and many other clinicians throughout the Phoenix VA agreed with me that nothing is currently done to help us productively process the suicide as a team.

This is an issue the VA should take the lead on in order to ensure the treatment team as a whole is able to productively move forward in the treatment of other veterans. It is not an issue that should simply be pawned off to EAP for employees to seek treatment in an individual basis.

Suicide event briefings should be a mandatory part of the process in healing for clinicians not only at the Phoenix VA, but nationwide.

**** As per 5 USC §1213(d)(5)(A) – (D) there is no mention that there is going to be a change in current policy, regulation, rules and practices to require more is done in order to help PVAHCS employees who have a veteran commit suicide. There is no policy in place and the PVAHCS seems content on trying to shift the burden to the EAP program.*