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Via Hand Delivery

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March 20, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington D.C. 20036

Re: Valerie Riviello, OSC File No. DI-14-2519

Dear Ms. Lerner:

As you know, this firm represents Ms. Valerie Riviello, Nurse Manager of the Inpatient Psychiatric Unit at the Samuel S. Stratton VA Medical Center, Albany, New York, in her whistleblower disclosure case, OSC File No. DI-14-2519, and in her whistleblower reprisal case which is under investigation. This letter is sent in response to OSC's letter dated February 27, 2015, received by this office on March 2, 2015 requesting Ms. Riviello's comments on the initial report of the Department of Veterans Affairs, TRIM 2014-D-1254, dated February 5, 2015, in her disclosure case. *See* 5 U.S.C. § 1213(e)(1). This letter is sent on her behalf as the whistleblower and contains her comments and concerns on TRIM 2014-D-1254.[1]

As set forth herein, the named report contains both erroneous and groundless factual findings, lacks clarity and transparency, reflects a clear VA bias against the whistleblower in continued retaliation for her disclosure of patient abuse at Stratton, and does not comply with the statutory requirements for a whistleblower disclosure report to OSC. It is therefore both factually and legally insufficient. As the report taken as a whole is both factually inaccurate and legally unsound, Ms. Riviello requests that the Special Counsel take into consideration her comments below in making its findings and recommendations to the President and the appropriate congressional oversight committees of Congress. *See* 5 U.S.C. § 1213(e)(3). As set forth in the attached consent, Ms. Riviello consents to the public release of these comments. (*See* Exhibit 1, "Consent Form").

[1] This letter is timely as Ms. Jennifer Pennington of your office advised via email that the deadline for this response was March 20, 2015.

DISCUSSION

A. *The foundation upon which Allegation 1 is addressed is factually inaccurate and contains internal inconsistencies which require further Veterans Administration and OSC review.*

The initial specific allegation by the whistleblower in this case was that

> "[o]n November 5, 2013, and again on February 14-16, 2014, a patient admitted to the Inpatient Psychiatry Unit was improperly restrained for excessive lengths of time in violation of VA regulations, policies, and directives."

The Report by the Office of the Medical Inspector incredibly does not substantiate this allegation. As set forth herein, its finding is rife with factual inaccuracies and internal inconsistencies and is therefore not a credible or supportable finding. First, and without any support whatsoever, the report finds that the nurse manager (the whistleblower) was not on duty that day on 10b and had been detailed to another location in the hospital that day. This is factually inaccurate. Ms. Riviello came on duty on the unit after the restraints had been applied. She is the nurse manager of the unit. She was present on the unit for duty and was engaged in this patient's care for most of the day.[2] Indeed, evidence that was provided to OSC and within the reach of the Office of Medical Inspector during the investigation – the patient's medical chart/records – contain several entries by Ms. Riviello on that day attesting to her ongoing involvement in the patient's care. This ongoing involvement was not while she was working on another floor, instead she was properly on duty on the floor that day. There is overwhelming evidence of such, should the Medical Inspector look into it.

To the extent the Medial Inspector finds that Ms. Riviello was not a part of the "interdisciplinary treatment team" that assertion is due to the fact that the Chief of Staff of the Department, Dr. Haley, who, after the whistleblower questioned openly the continued use of restraints on this patient, deliberately excluded Ms. Riviello from treatment team meetings about this patient. As the Report indicates, there was indeed an Interdisciplinary Team meeting to discuss the patient's case.[3] But Dr. Haley specifically excluded Ms. Riviello from it because she was voicing concerns about patient abuse with respect to this patient. Ms. Riviello continued to receive briefings from her staff however, as they continued to report the patient was stable and

[2] She was also working on another unit that day *in addition to* 10b; that detail did not mean she was not on duty or not on the team or not supposed to exercise her authority as nurse manager of the unit. This subtle difference has apparently escaped the inspection team.

[3] The report also finds numerous deficiencies in how that team documented this patient's care. Ms. Riviello cannot be held responsible for the team's clear failures, for which no one has been held to account. While attacking Ms. Riviello's professionalism, the Report does not do the same with respect to management's.

not a danger to herself, other patients or to the treatment team. If she had not been on duty that day on 10b, she would not have been on the unit receiving briefings from her staff.[4]

Second, and perhaps most incredulously, the Report finds that there was no authority for Ms. Riviello to release the patient from restraints, because the policy granting RNs the authority to release patients from restraints had expired on June 24, 2012 over a year before the incident. (Citing to VISN 2 Memorandum 10N2-95-05-09). This assertion is patently and demonstrably false. Attached hereto is the "Restraint Minimization Policy," NSG Policy 1-007-12, May 3, 2012 which superseded the named pre-existing policy and is in force until May 2015. In this obviously pre-existent policy, it is made clear Nurse Riviello's obligations and responsibilities: "Restraint will be discontinued as soon as possible. *A written order is NOT required to discontinue restraint*. *The decision to discontinue restraint is the responsibility of the registered nurse or provider*." (*Id.* at ¶ III F, p. 1 of 4)(emphasis supplied).[5] So, far from being non-existent, this policy, which either management clearly hid from the inspection team or which the team was not capable of finding on its own, authorized the nurse in question and indeed, all of the nurses, to release this patient from restraints if it was in their judgment that it was safe to do so. Such release, by policy, and despite the doctor's alleged and *post hoc* concerns, did not require a physician's order in writing to accomplish the release. This whistleblower clearly did nothing medically incorrect and certainly performed no act which violated any VA or local hospital policy, whether discovered or left undiscovered by the inspection team.

Moreover, the inspection team's erroneous finding that the nurse manager had no authority to release the patient from restraints due to "expired policy" guidance begs the question of what then was the other hospital employees' and treatment team's authority to place this patient in restraints initially or again in February 2013, if there was no policy on restraints in place either time as to the use of restraints. If the inspection report is correct, then all of the doctors and nurses who placed this patient and *any other* patient in restraints after May 2012 at Stratton were operating outside VA policy and should therefore be held accountable for violation of VA policy. The team's conclusion on allegation 1 makes no sense whatsoever in light of this incredible finding.[6]

Further findings of the team make equally as much sense. The team reports that Ms. Riviello was "aware of the patient's *treatment plan* to continue restraints," but then goes on to say on the

[4] The Report also ignores the fact that Ms. Riviello received approval from her supervisor, Mr. Maloney, to release the patient from restraints. This failure of the Report is despite the fact that several of the nurses overheard the telephone conversation wherein Mr. Maloney approved the patient's release from restraints. There is nothing about this exchange in the Report.

[5] The two psychiatrists interviewed clearly disregarded this policy or do not wish to follow it as to the nursing staff's responsibilities to discontinue treatment and the clear guideline that a written order from a physician is *not necessary* to do so.

[6] Indeed, the Report concludes that "Between June 2009 and July 2014, in violation of the Joint Commission standards, the Medical Center did not have a written policy regarding restraint or seclusion." Why is it then no one in a senior VA management role has had action taken against the responsible management team for this failure to have such a policy?

same page that "*we did not find its treatment plans* specifically recorded." (*See* Report at p. 5). Either Ms. Riviello was aware of a treatment plan and disregarded it or there was no plan to follow in the first instance. Indeed, the latter is true – there was no written treatment plan by the "team" (from which Ms. Riviello had been deliberately excluded due to her concerns about patient safety and abuse), and even if there had been a treatment plan, VA policy set forth above clearly allowed Ms. Riviello to make an informed judgment to release this patient in any event.[7]

What is perhaps the most troubling aspect of this error-ridden Report is not that the inspectors missed the fact that Ms. Riviello was in fact on duty as nurse manager that day, nor is it that she had explicit policy authorization to appropriately act as she did and they missed the policy during their review of policy, nor that the treatment team which excluded her from meetings failed to document a treatment plan for this patient, but instead what is most troubling is the direct, factually inaccurate and insulting professional character assassination the team engages in through its last "conclusion" as to allegation 1 regarding Ms. Riviello, the acknowledged whistleblower.

This "conclusion" is but one more example of the continued retaliation and abuse Ms. Riviello has suffered at the hands of the VA for bringing legitimate concerns of patient safety to those with the ability to correct them when it was clear her supervisors would not address on-going abuse. In its conclusion, the Report states: "[t]he professional conduct of the Nurse Manager (the whistleblower) in removing restraints in conflict with the treatment plan is concerning, especially since she was not a part of the treatment team and not working on the Inpatient Psychiatry unit that day." This conclusion takes an unnecessary and indeed harsh tone towards a person who has spent her entire life caring for our most seriously at risk veterans. It strikes at the heart of the very reason there are whistleblower protection laws: to prevent such false and scurrilous attacks on those for whom taking care of the veterans is the most important work to be done. There is nothing in this "conclusion" supported by actual fact or indeed, law. This conclusion should be removed from the revised and amended Report and its false allegations should be stricken from the record. This conclusion is simply a transparent effort by the Inspection Team to provide ammunition for the VA to take an unwarranted personnel action against Ms. Riviello despite the absence of any factual or evidentiary foundation for the conclusion. Senior VA management should indeed be concerned about this conclusion for what it says about its medical inspection team, not about Ms. Riviello.

[7] Indeed, the inspectors concluded that "in violation of the Joint Commission Hospital Standards on Accreditation, Record of Care, Treatment, and Services (RC.02.01.01), and VA Health Information Management and Health Records (VHA Handbook 1907.01, September 2012), the Inpatient Psychiatry unit at the Medical Center did not consistently document interdisciplinary Treatment Plans." (Report at 7). The team, which so excluded Ms. Riviello from participation in it, did not document a plan for this patient as there was no plan for this patient, and thus, there is no conceivable way Ms. Riviello could have acted in contravention of a non-existent plan.

B. While properly substantiated, the inspection report findings as to Allegation 3 fail to take into account that restraint logs and other official documentation which the report finds missing or deficient did in fact exist, but was removed by Stratton management or staff prior to the medical inspection team's visit in order to hide evidence from the team.

Allegation 3 was not a part of the whistleblower's initial disclosures of wrongdoing at Stratton to OSC. Allegation 3 came to light only after the Veterans Administration medical inspectors notified the Stratton Medical Center leadership that the inspection was forthcoming in the fall of 2014. Allegation 3 states:

> "The whistleblower alleged that all electronic and hardcopy patient restraint logs, change-of shift reports, and 'tracker' logs from November 2013 forward are missing in violation of VA policy and Joint Commission standards."

(*See* Report at p. 10).

Allegation 3 was not made at the time of the initial disclosures in the spring of 2014 *precisely because* the noted documentation *was not missing* at the time. Ms. Riviello came upon the discovery that the documentation was missing only days prior to the inspection team's arrival (knowing that the team was en route). The documentation was not only missing from VA paper files that had previously existed, but also entire files were deleted or otherwise improperly eliminated from the VA's electronic records system by someone with access to do so. Had the inspector's report correctly followed the OSC disclosure statute, 5 U.S.C. § 1213(d), it would have noted how the team came into possession of its knowledge of the missing files, how it investigated the missing files, and how it came to the conclusion and recommendations it did in fact make. But it did not. Thus, while the inspection team's report correctly takes the Medical Center to task for the missing documentation, and quite correctly notes that the logs must be properly documented in every instance that a patient is placed in restraints, and further properly recommends that audit systems be in place to ensure that the data is captured where it is not, it does not completely describe the violations that were referred for investigation, which involved allegations of the deliberate removal and destruction of records prior to the inspection itself in order to hide wrongdoing at Stratton.

Because the report does not adequately describe the evidence obtained on this allegation nor analyze it in any meaningful form (*see infra* section C), the report is deficient and leaves a gap between the allegations accepted for investigation, its actual investigation and its findings. The report fails to even mention the last minute disappearance of these paper and electronic files or any actions taken by the team to determine who was responsible for the missing files and logs (*i.e.*, how it conducted the investigation). It fails to state if any forensic analysis was done on the electronic records as to their "loss" only days before the inspection. It also fails to address whether any personnel have been held accountable for such loss should their culpability be

established or how any correction of this problem can be implemented in the future to prevent another intentional or even accidental loss of files, electronic or otherwise.

Along with all of the other factual and legal deficiencies in investigation, analysis, and reporting in this matter as set forth above, the wholesale failure and indeed, ignorance by the inspectors of apparent intentional acts of destruction and misconduct in advance of their team's arrival runs completely counter to any inference that there was a transparent, thorough, well-executed investigation, audit or inspection seeking to get to the truth of the matters at issue. The inspector's failures as to Allegation 3 are simply more evidence of the fact that the report fails in all ways to be a credible work product of a creditable agency watchdog and constitutes only a minimum effort to pass the buck on so as to get to the next case in the apparently quite lengthy queue.

C. *The report's contents do not meet the statutory mandate of 5 U.S.C. § 1213(d) and thus must be re-accomplished properly.*

5 U.S.C. § 1213(d) describes the requirements which Agencies must meet when returning a report to the Special Counsel pursuant to this statutory scheme. It states:

> "(d) Any report required under subsection (c) shall be reviewed and signed by the head of the agency and shall include—
> (1) a summary of the information with respect to which the investigation was initiated;
> (2) a description of the conduct of the investigation;
> (3) a summary of any evidence obtained from the investigation;
> (4) a listing of any violation or apparent violation of any law, rule, or regulation; and
> (5) a description of any action taken or planned as a result of the investigation, such as—
> (A) changes in agency rules, regulations, or practices;
> (B) the restoration of any aggrieved employee;
> (C) disciplinary action against any employee; and
> (D) referral to the Attorney General of any evidence of a criminal violation."

This report is deficient in that it does not contain an adequate summary of the evidence obtained (which in part has directly led to erroneous factual conclusions, such as set forth extensively above, with absolutely no evidentiary basis to support them),[8] a description of the conduct of the investigation in any meaningful way,[9] and does not describe with particularity the actions taken or planned to be taken as a result of the investigations, instead falling back on "recommendations" for action. There is no reference whatsoever to actual changes being made or in the process of being made as to the rules, regulations and practices the report makes recommendations upon.[10] Thus, for these reasons the report is insufficient as a matter of law.[11]

[8] 5 U.S.C. § 1213(d)(3)
[9] 5 U.S.C. § 1213(d)(2)
[10] 5 U.S.C. § 1213(d)(5)
[11] The report might pass muster with the VA executive management team if this was a "regular" OIG or medical inspection team report prepared for management use, but it does not pass statutory muster under 5 U.S.C. § 1213.

In short, the Medical Inspection Team has provided OSC nothing to show for its weeks long investigation other than conclusions based on non-existent evidence, and recommendations for management action, when the clear mandate of the statute requires a description of actions taken by the Agency to cure the substantiated allegations. The statute requires that action be taken to cure what the Inspection Team has found and report the action back to OSC. The statute requires VA to support its conclusions with a description/summary of the evidence collected. Without the proper foundation upon which to make findings, the report rings hollow and there can be no accountability for the substantiated claims whatsoever. While it is not surprising that there are several recommendations which require work on the part of the Stratton VA, the VA needs to actually take the recommendations seriously, take action on the ones with credence, make changes to agency rules, regulations and practices that need to be changed, hold persons accountable for the documentation lapses and missing electronic and other files, and document those results in a fuller more robust evidence-based report.

CONCLUSION

For the foregoing reasons, the whistleblower requests that allegations 1 and 3 be reviewed in light of the evidence and argument she has presented. She requests that the report correctly note that there is in fact valid policy memoranda allowing nurses to remove patients from restraints without a physician's order, that she was indeed on duty the day in question in November 2013 in accordance with the evidence, and that the treatment team from which she was excluded failed to document a treatment plan, for which she cannot be held accountable either in failing to document or in somehow violating.

Ms. Riviello appreciates the opportunity to comment on this Report and asks that the attack on her professional reputation due to obvious factual inaccuracies and oversights by the inspection team be removed from the amended Report that it submits to OSC for review.

Sincerely,

Cheri L. Cannon
Partner
Chairperson
Federal Labor and Employment Law Team

Encls: as stated

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202-254-3600

CONSENT TO PUBLIC RELEASE OF WRITTEN COMMENTS ON AGENCY REPORT

(OSC File No. DI-14-2519)

I consent to public release by the U.S. Office of Special Counsel (OSC) of my written comments on the agency report required by OSC in response to my disclosure in the file identified above. My consent includes placement of my written comments in the public file maintained by OSC pursuant to 5 U.S.C. § 1219(a)(1).*

I understand that my consent means that OSC may release my written comments in response to an outside party's request for access to the public file, as part of any press release issued by OSC about the agency report, or in other circumstances deemed appropriate by OSC. I also understand that my consent means that that my written comments may be included in public file or press release documents posted from time to time on OSC's web site (www.osc.gov).

Valerie Riviello
Name (signature)

Valerie Riviello
Name (printed)

3·13·2015
Date

* 5 U.S.C. § 1219 ("Public information") reads, in relevant part: "The Special Counsel shall maintain and make available to the public—... a list of ... matters referred to heads of agencies under [5 U.S.C. § 1213(c)], together with reports from heads of agencies under [§ 1213(c)( )(B) about] such matters."

EXHIBIT
1

RESTRAINT MINIMIZATION POLICY

I. PURPOSE: To establish policy for the Stratton VA Medical Center on restraint mineralization for acute areas, behavioral health, and community living centers. It is the philosophy of the VA Healthcare Network Upstate New York to seek to prevent, reduce and strive to eliminate the use of restraints. When a restraint is to be used it is to protect the patient's health and safety while preserving dignity, rights and well-being.

II. PERSONS AFFECTED: All nursing staff.

III. POLICY STATEMENT:

A. The Stratton VA Medical Center recognizes that restraint have the potential to produce serious consequences, such as, but not limited to: physical and psychological harm, loss of dignity, violation of patient's rights and even death. Due to the associated risks and consequences of use, this facility is committed to explore ways to not only minimize restraint use, but also facilitate discontinuation as soon as possible and provide the least restrictive environment.

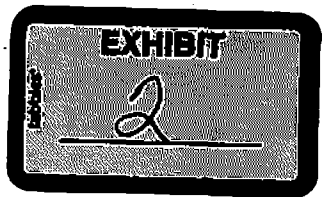
B. Appropriate alternatives and preventative strategies will be explored before initiating restraint of the patient. If restraint becomes necessary, the least restrictive method will be used.

C. Restraint use is limited to those situations with adequate, appropriate clinical justification. Therefore, restraints are only to be used in emergency situations where there is imminent risk of the patient physically harming self and/or others and when all other alternative strategies have failed.

D. Use of restraints for the purpose of punishment, coercion, retaliation, convenience or as a substitution for treatment programs is strictly prohibited. The use of restraint is not based on the patient's restraint past history or solely on a history of dangerous behavior.

E. The protection of the patient's health and safety, while preserving dignity, rights and wellbeing will be considered at all times.

F. Restraint will be discontinued as soon as possible. A written order is NOT required to discontinue restraint. The decision to discontinue restraint is the responsibility of the registered nurse or provider.



G. PRN orders for restraint are strictly prohibited.

DEFINITIONS:

A. Restraint: Any method (chemical or physical) of restricting patients freedom of movement, including seclusion, physical activity or normal access to his or her body that:
   1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or legal representative has consented;
   2) is not indicated to treat the patient's medical condition or symptoms; or
   3) does not promote the patient's independent functioning.

B. Chemical Restraint: The inappropriate use of sedating psychotropic drugs to manage or control behavior.

C. Physical Restraint: Direct application of physical force to the patient, with or without the patient's permission, with the intent of restricting freedom or movement. Physical restraint includes, but it not limited to: locked cuff and belt, vest, soft wrist, Geri-chair with locked tray, secured mitts, wheelchair pelvic roll bar, full side rails in up position, and four side rails in up position. It is the device's intended use, involuntary application and/or the identified patient need that determines whether a device is a restraint.

RESPONSIBILITY:

A. All supervisors will have overall responsibility for:
   1) Distribution of this policy and the education regarding restraint practices within the Medical Center.
   2) Ensuring that their interdisciplinary treatment team members actively participate in the minimizing of restraints, while protecting patient's rights and dignity.

B. Providers are responsible to order the use of restraints : The specific requirements for Behavioral health and medical Surgical are:
   1. Behavioral health reasons
      i. The provider must perform an in-person (face to face) assessment of the patient and enter the order within one hour of the initiation of the restraint and every eight hours thereafter. An order for restraint based on behavioral reasons is time limited to four hours duration.
      ii. The provider must enter all restraint orders into the electronic medical record with appropriate justification.

   2. Medical surgical reasons
      i. A face-to-face evaluation by the provider must be performed and documented in the electronic medical record within 12 hours of initiation of restraint.

ii. For every calendar day of restraint use, all provider in-person justification and examinations of the patient are documented in the electronic medical record prior to reordering restraint use.
iii. An order for restraint for medical surgical reasons is time limited to 24 hour duration.

C. The interdisciplinary treatment team will be responsible for ensuring that:
1) alternative approaches have been utilized;
2) the restraint use is clinically indicated; and
3) the assessment and documentation are completed per SOP.

D. The Nurse Managers are responsible for the monthly collection of restraint data to:
1) ascertain that restraint are used only as emergency interventions;
2) identify opportunities for improving the rate and safety of restraint use; and
3) identify any need to redesign care processes.

Using a patient identifier, data on all restraint episodes are collected monthly, for all settings/units/locations. This data will include:

a) Shift;
b) Staff who initiated the process;
c) The length of each episode;
d) Date and time each episode was initiated;
e) Day of the week each episode was initiated;
f) The type of restraint used;
g) Whether injuries were sustained by the patient or staff;
h) Age of the patient;
i) Gender of the patient
j) Multiple instances of restraint experienced by a patient;
k) The number of episodes per patient;
l) Instances of restraint that extend beyond 12 consecutive hours; and
m) All appropriate alternative and preventative strategies were attempted prior to the initiation of restraint. .

IV. References:

a. Network 2 Restraint Minimization Policy for Acute Medical/Surgery/Behavioral Health/ Geriatrics & Extended Care https://vaww.visn2.portal.va.gov/sites/is/Shared%20Documents/Restraint%20Minimization%20Policy%20for%20Acute%20Medical-Surgery-Behavioral%20Health-Geriatrics%20%20Extended%20Care.docx
b. The Joint Commission: "Comprehensive Accreditation Manual for Hospitals"; 2012.

c. The Joint Commission: "Comprehensive Accreditation Manual for Behavioral Health"

V. AUTHOR/OWNER: Nursing Standards Committee

VI. VERSION HISTORY: Rescind Memorandum No. SI-118-1010 dated May 28 2009

VII. REVIEW/REVISE DATE: May 2015

VIII. DEVELOPED BY: Diane Kozak, MS, RN-BC Clinical Education Specialist

IX. CONCURRENCE:

Executive Committee of the Medical Staff (ECMS)

Executive Committee of the Nursing Staff (ECNS)
//Approved May 3rd, 2012