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VIA EMAIL TO: jpennington@osc.gov

January 19, 2016

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. Dl-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 currently under investigation. This letter is sent in response to OSC's letter dated December 21, 2015, received by this office on December 24, 2015 requesting Ms. Riviello's comments on the second supplemental report of the Department of Veterans Affairs, TRIM 2014-D-1254, dated November 5, 2015, in her disclosure case.[1] *See* 5 U.S.C. § 1213(e)(l). This letter is sent on her behalf as the whistleblower and contains her timely comments and concerns on TRIM 2014-D-1254.

As set forth herein, the second supplemental report, like the first supplemental and the original 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, most unfortunately, has simply lost sight of what was investigated in the first place: the obvious physical distress of a female veteran with military sexual trauma kept in restraints for hours at a time without food, water, personal hygiene or most importantly, without reason. The latest and most surely, the last report of the VA investigators makes assumptions of fact as laypersons that have no place in a modern hospital and ignores the emergent nature of the veteran's condition. The report also continues to conflate two instances of improper restraint and, continues to hold Ms. Riviello to a finding that she was present on February 14-16, 2014 (when she most obviously was not), but addresses only issues arising on November 5 the year before. There is no evidence that Ms. Riviello had anything to do with the patient in February 2014 as the first report incorrectly noted, and its follow on report does not deal with that weekend at all – again, conflating the November and February instances of admission for this patient to Ms. Riviello's detriment. It is therefore both factually and legally insufficient. Moreover, this report continues to contain deliberate falsehoods and false information provided by management and staff at Stratton to the Inspectors. As shown herein, the statements and information relied upon by the

[1] The VA transmittal letter to OSC is dated November 20, 2015. We asked for and were granted an extension until today, January 19, 2016 to respond to the latest VA Inspection Report.

Inspectors in the supplemental report continue to be false and misleading and reliance thereon by the Inspectors has directly lead to the incorrect conclusions they have drawn therein in addition to the improper conclusions drawn as to the standard of care provided by all nurse managers at all hospitals across the country, VA or otherwise.

As the supplemental 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").

DISCUSSION OF MOST RECENT INSPECTION REPORT

1. Patient A's Hospitalization on November 5, 2013: The second amended report continues to be inaccurate in its assessment of the nurse manager's role in general and on November 5, 2013.

Initially, the Inspection Team found, *erroneously*, "based on the *Medical Center's position* that they did not have a policy in place on that day" that "Ms. Riviello released Patient A from restraints on November 5, 2013 without proper authority." (Emphasis added). That statement in the original report which was provided deliberately by Stratton Management to the Team was shown to be factually inaccurate, as Ms. Riviello provided the Inspection Team with policies which the Team acknowledged were in fact in place. *(See* April 30, 2015 Supplemental Report, p. 3). The second amended report acknowledges this inaccuracy again ("There was a nursing policy (Policy NSG 1-007-12 July 23, 2014) and procedure (Nursing Procedure 2-026-12 *Restraint Minimization*, August 5, 2013) in effect between January 2013 and February 2014.") But again, instead of questioning *why* Medical Center management would mislead the Inspection Team with respect to policies management knew existed and failed to share with the Inspectors, the Inspectors now find again, based on a faulty layman's understanding of what supervisory nurse managers do for a living that, despite the fact that there was indeed a policy in place allowing Ms. Riviello to remove the subject patient's restraints, Ms. Riviello was not on duty that day on the 10b unit, and/or was not the patient's primary nurse and thus, the valid and extant policy (that management first hid from them) did not apply to her actions.

This finding is again based on patent falsehoods perpetrated by the management at Stratton upon the Inspectors, VA senior management and OSC. Indeed, Stratton management has *again* deliberately misled the Inspectors, falsified records, and removed Ms. Riviello's time keeping records from the official files in order to cover up the fact that she was indeed on duty on 10b and acting within her authority to remove a patient from restraints. The facts remain the same: Ms. Riviello was the nurse manager on 10b on Nov 5th 2013. She received reports, made out the assignments, certified the nurse's time, and was scheduled to attend the 12 noon meeting on the patient at issue. In fact, she was sitting at the conference room table with her supervisor Mr. Maloney waiting for the 12 noon meeting to begin when they were both called out to the sally port by Dr. Haley who informed them that the meeting was being cancelled. That is the only reason she was not in the patient meeting. She maintained all nurse manager duties for 10b, including staff supervision, patient care supervision, staff proficiency, staff time cards, the posting of time, conducting of staff meetings, attending the 0730 am

supervisors report each morning and gave a report to Ms. Spath and other nursing supervisors on both 7b and 10b. She was given a collateral duty on 7b to orient new assistant nurse manager and to do team building which she did. She also completed proficiencies for staff on 7b as well. She attended treatment team meetings on 10b daily. At no time did Mr. Maloney assume any 10b nurse manager duties – he is not qualified for such a roll. Again, why later, as is documented, was Ms. Riviello asked to "step down from 10b nurse manager" after the Nov 5th incident if she was not the nurse manager at the time. Finally, Ms. Riviello also met with Ms. Spath and Mr. Maloney on Nov 5th and each day afterward, wherein Ms. Spath told her that she "had done nothing wrong;" that she "followed the policy; that she "was always all about policy:" and that "to spare her from things getting ugly and the director removing her to a place she would not like, Ms Spath was moving [her] to develop and run a nurse residency program."[2]

Moreover, even if she had not been on duty that day (on the ward she manages and directs), contrary to the *Inspector's lay opinion* of the matter, the policy itself does not eliminate any nursing staff from taking appropriate actions to properly treat a patient. *See* NSG Policy 1-007-12. Indeed, now, to continue to justify its findings (which by now are far afield from what it was supposed to investigate), the Inspectors, without any corroboration patently state that it is their *opinion* that the phrase 'The decision to discontinue restraint is the responsibility of the registered nurse or provider" excludes licensed nurse managers with overall responsibility for all patients on the ward. (*See* Supplemental Report, p. 3). To agree with the Inspectors here would be to find Ms. Riviello's role, or indeed all nurse managers' roles at all hospitals (not just VA hospitals) does not extend to oversight, management and/or treatment of persons admitted to their wards to nurses under their authority. It excludes any possibility that Ms. Riviello could take any action on any patient if her name was not specifically attached to the chart or to the patient. Not only is this far-reaching in its implication for nurse managers, it is nonsensical.

It is undisputable that the nurse manager is responsible for patient safety. (*See* NSG Policy 1-007-12, Restraint Minimization policy, responsibility A- giving all supervisors overall responsibility for ensuring policy is adhered to, minimizing restraints, and providing for patient rights and dignity; *see* NSG Policy 1-007-12, Restraint Minimization policy, responsibility D -- the nurse manager is responsible for ascertaining that restraints are only used as emergency interventions). The inspectors lay theories cannot overcome valid and in force VA policy.

Ms. Riviello as nurse manager in charge of 10b followed the restraint policy, the same policy she has followed for 28 years. She had in fact built nurse-patient relationships with this patient and many other 10b patients over 28 yrs. This time span is in fact 3 times longer than Dr. Haley's tenure who in fact is not even the 10b attending who made a contrary call (but then never placed this patient back into restraints). Moreover, Nurse Harris had only worked on 10b for 2 years at the time and was a new graduate nurse of less than 3 year at the time. Ms. Riviello has intimate knowledge of all of the patients on the ward including Patient A, who was admitted just weeks prior in October 2013 and who also had numerous admissions prior to that time. The

[2] It has been reported widely in the media that the director referenced, Ms. Linda Weiss, has been removed from her director position by the VA Secretary due to retaliation and a culture of mismanagement at the Stratton VA, including possibly, upon information and belief, the handling of Ms. Riviello's cases.

inspectors layperson's opinion that the policy excludes the nurse manager flies in the face of the policy and the facts of life in a hospital in this case and in all cases.[3]

Finally, there is no doubt that this patient was in need of medical and nursing intervention that afternoon on November 5, 2013. The latest report notes instead that Nurse Liptak stated that at 9:18 am the patient displayed symptoms of agitation overnight which were interpreted as an intent for self-harm. (*See* supplemental report at 2). This note is irrelevant, even if true. This note is 5 hours before Ms. Riviello removed the restraints within the policy guidelines. Indeed that policy also states that past violent or unsafe behaviors are not to be reasons to keep someone in restraints. *(See* policy 1-007-12 section iii A, B, C, D, E, F). Patient A was not angry or violent for hours prior to the restraints being removed – and they were removed only for humanitarian reasons now quickly overshadowed by the need to blame someone for VA management errors, oversights and wrongly denied policies.

2. Ms. Riviello was not on duty February 14-17. 2014 and could not have "coerced" Nurse St. Denis to remove restraints from Patient A – the supplemental report continues to conflate the two instances of abuse of the patient:

The Report also continues to assert that Ms. Riviello somehow coerced the nurses over the November 5, 2013 incident, but it acknowledges that OSC is requesting an explanation of the February 2014 incident instead wherein Ms. Riviello was not on duty. (*See* Supplemental Report at pps. 2-3). In its most recent submission, OSC sought the Inspector's clarification on its evidence that Ms. Riviello was on duty the weekend on February 14-17, 2014 and somehow coerced Nurse St Denis to remove restraints when the record evidence is clear Ms. Riviello was not on duty and the patient was never unrestrained. Instead of responding to that direct question (which it acknowledges is in fact the question) the inspection team rehashes the November 2013 incident *which is not in question* in this OSC supplemental request number 2. In fact, the evidence is not in any doubt: Ms. Riviello never coerced anyone, especially during February 14-17, 2014 as she was not on duty for 3 days over the long holiday weekend. No nurse was coerced to take the patient out of restraints during that time because the record evidence is clear that the patient was instead kept in restraints for over 50 consecutive hours. There could have been no coercion to remove restraints from a non-existent supervisor on a patient whose restraints remained in place. The fact is that at the time in February, the nurses on duty that weekend later stated they were afraid to take the patient out of restraints due to their concern for retaliation like what happened to Ms. Riviello the preceding November -- they were intimidated by Dr. Haley and Nurse Spath and therefore allowed a patient to remain tied up for days, despite clear and documented periods of time when the patient was calm and sleeping.

[3] Indeed, it was only *after* Ms. Riviello reported the abuse by the physicians to proper authority that she was retaliated against and told by Nurse Spath that if she did not *thereafter step down as Nurse Manager of 10b*, "things would get very ugly." *If she really had nothing to step down from,* this verbal threat and later management's action to idle her with no work or work that had already been accomplished would have been completely unnecessary (as she would not have been nurse manager of 10b as management now states). That unnecessary work included Spath tasking her to solely develop and run a nurse residency program which would entail a 2 step decrease in pay. She was instructed to put this program in place as a Nurse of one. Shortly thereafter, Ms. Riviello found 2010 nursing journal article containing interviews of Ms. Spath and Linda Mock (nurse recruiter at the time) wherein they both bragged of the wonderful nurse residency program they already had in place. Therefore, this "job" she was given was one that had already been completed.

DISCUSSION OF THE IMPLICATIONS OF THIS CASE FOR VA AND FOR PATIENT CARE

Throughout this case, from Ms. Riviello's first resort to the patient advocate's intervention in 2013 to this date, the only motivating factor for Ms. Riviello was the health and welfare of the patients in her care and in the VA's care. Patient A, when encountered by Nurse Manager Riviello on November 5, 2013 at 1 pm was calm, but had removed all of her clothing such that she was only covered by a sheet and was complaining that she was hot. She also complained about back pain caused by the restraints and the fact she could not use the bathroom. By this time, she was hot, tired, dirty and had been unable to use the bathroom for hours. Ms. Riviello spoke to the patient for approximately half an hour to thoroughly assess her mental status, lethality risk, and ability to process information. As a result of this assessment, Ms. Riviello, Ms. Lombardo, Latwana Harris, RN, and Mr. Rabady, *all agreed* that the patient needed to be released from her restraints. Ms. Riviello reported this conclusion to Dr. Gorospe. However, Dr. Gorospe again stated she did not want the patient released and would reevaluate her at 2:30 p.m. Ms. Riviello then informed her supervisor, Ed Maloney, of the situation. Mr. Maloney *agreed with Ms. Riviello's conclusion* that the patient needed to be released, and approved the release of the patient from restraints over the phone. Others heard Ms. Riviello's end of the conversation. Ms. Lombardo and others released the patient from restraints at approximately 1:35 p.m. As the nursing staff cared for the patient following her release from the restraints, the patient remained calm and cooperative. The patient had been improperly restrained for over 5 hours as she was calm and cooperative as early as 9:30 am and remained so thereafter. At no time did any doctor reapply restraints or even suggest that such was required. At all times, Ms. Riviello acted as the nurse manager, within the confines of policy and with the approval of her supervisor.

Subsequent to this incident, where the restraints were removed from a calm and otherwise cooperative patient, Ms. Riviello has faced nothing but retaliation for trying to do the right thing for this patient and all VA patients subject to such harsh and unlawful treatment. Hospital management not only did nothing about these patient abuses, but instead retaliated against Ms. Riviello for opposing such practices, including going so far as to lie to and deceive the very investigators sent to investigate the incident. Documents have gone missing, files destroyed – all because the senior staff knew Ms. Riviello was right and did not want to cross the physicians who wrongfully treated this patient in the first place.

The VA inspectors have simply lost sight of the VA's mission and charge and the policies themselves which are in place: to protect the patients and their safety from undue restraint and to leave them in the least restrictive environments. That goal here was accomplished by Ms. Riviello by removing restraints and thereby in protecting a veteran wrongfully restrained for hours who was the victim of military sexual trauma and who was weak and in need of assistance. Ms. Riviello did what any professional of long standing would do – practice her nursing trade to the best of her ability to be sure that no patient was harmed by the application of undue restraint. It is too bad no one stepped up to the plate to do the same in February 2014 where this patient was restrained for 50 hours without a break. Ms. Riviello cannot be faulted for carrying out the policies in place and treating a veteran with care and dignity – something sorely lacking from VA management and the inspectors in their treatment of Ms. Riviello and the other dedicated professionals who give their professional lives to these veterans at Stratton.

CONCLUSION

For the foregoing reasons, the whistleblower requests that the conclusions reached in the Second Supplemental Report of the Department of Veteran's Affairs be reviewed and revised in light of the evidence and argument she has presented herein. She requests that the final report correctly note that she was in fact on duty as nurse manager of 10b on November 5, 2013 (and in fact at all times from August 2013- December 2013) and that she acted in accordance with a valid policy memoranda allowing a nurse to remove patients from restraints without a physician's order; and issue a finding that she was not on duty in February 15-17, 2014 when the second incident of prolonged restraint of Patient A occurred and that she did not by words or actions "coerce" Nurse St. Denis to remove restraints from a patient she never saw nor interacted with on those days. The accurate record reflects that Nurse St. Denis and she had no contact whatsoever over that weekend.

Ms. Riviello appreciates the opportunity to comment on this Supplemental Report and asks that the attack on her professional reputation due to obvious factual inaccuracies and oversights by the inspection team which have been engendered by false and misleading statements and documentation from Stratton VA be removed from the amended Report that it submits to OSC for review a final time.

Sincerely,

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

Encls: as stated

EXHIBIT 1

CONSENT FORM

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. ·20036-4505
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 supplemental 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 A Riviello

Name (signature)

Valerie Riviello

Name (printed)

JAN. 19, 2016

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)(1)(B) about] such matters."