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The Special Counsel

May 31, 2018

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

VIA ELECTRONIC MAIL

Re: OSC File No. DI-16-4382

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), I am forwarding to you reports from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Durham VA Medical Center, Durham, North Carolina. The whistleblower, who chose to remain anonymous, disclosed that Durham VAMC employees purchased and stored unused computer and other equipment, violated the agency's food storage policy, and mishandled medical and information technology (IT) equipment turn-ins. On June 8, 2017, VA submitted its report in response to OSC's referral. Based on a review of that report, OSC requested additional information, and the agency submitted three subsequent supplemental reports in response. OSC has reviewed the agency reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the reports and my findings.[1] The whistleblower declined to comment on the agency's reports.

The whistleblower alleged that the Durham VAMC purchased a large amount of equipment, including a $385,000 purchase of computer equipment, which was never used. The whistleblower also alleged that the Durham VAMC stored and distributed long-expired bottled water in violation of VHA Handbook 1109.04.[2]

The agency substantiated the whistleblower's allegation that in 2014, the Durham VAMC purchased approximately $385,000 of anesthesia computer equipment from Picis, Inc. An Administrative Investigation Board (AIB), which conducted the agency's investigation, also identified approximately $1 million in new, unboxed equipment, including "vital signs machines, a sterilizer, dental chairs, a dental sink, and cabinets …." The equipment was stored in an off-site storage facility for several years with no plan in

[1] The whistleblower's allegations were referred to former VA Secretary David J. Shulkin for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Acting Under Secretary for Health directed the investigation of the allegations, and former Chief of Staff Vivieca Wright Simpson reviewed and signed the report.
[2] VHA Handbook 1109.04 states that, "Bottled water for drinking must be in a sealed, plastic container with a shelf life of 1 year, and rotated prior to expiration."

place to put the equipment into use, or to place it at another VA facility with a "bona fide need."

In response to these findings, the agency recommended that the facility develop an immediate action plan to put all new, unused equipment to use within the facility, or to reutilize it at another VA facility. The agency further recommended that the local Veterans Integrated Service Network (VISN) improve its processes to ensure that purchasing facilities have a valid need for equipment procurements and that they are capable of using the equipment for patient care.

The agency's August 18, 2017, supplemental report stated that additional analysis was required to determine if the purchase of $400,000 of vital signs equipment in fiscal year 2013 constituted a violation of either the Bona Fide Need Rule or the Anti-Deficiency Act.[3] In its November 7, 2017, supplemental report, the agency stated that, in following up with Medical Center leadership, it determined that no violation occurred, but offered no basis for this determination. In response to OSC's request for more information, the agency submitted a third supplemental report on December 5, 2017, which referenced an additional $150,000 purchase of anesthesia record keeper (ARK) workstations in 2014.[4] The agency explained that the vital signs equipment purchase was part of an effort to standardize vital signs monitors within the VISN, and the ARK purchase was part of a "national implementation initiative." The agency determined that while there was a bona fide need for the equipment, a lack of staff and expertise in Durham VAMC's Biomedical Engineering Service delayed its deployment.

The agency also substantiated the allegation that the Durham VAMC stored and distributed bottled water that expired in September 2010, in violation of agency policy. The AIB determined that the facility provided the long-expired water for handwashing and flushing toilets, but it was mixed with newly purchased drinking water during water shutdowns in the facility, and patients consumed it. Based on these findings, the agency recommended that the facility immediately dispose of the expired water, and ensure compliance with relevant agency policy in the future. The report found the Chief Logistics Officer (CLO) responsible for the shortcomings, and the facility issued the CLO an admonishment.

The whistleblower also alleged that Durham VAMC logistics employees failed to properly account for approximately 900 equipment turn-ins and failed to properly document turn-ins on bills of lading.[5] The whistleblower further alleged that logistics management directed employees to fabricate final dispositions for the turn-ins and that

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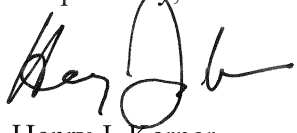
[3] 31 U.S.C. § 1341.
[4] The ARK workstations were part of a larger $417,372.31 purchase that included equipment that was repurposed when the facility determined it could not be inspected and installed in a timely manner.
[5] Employees initiate turn-ins to dispose of durable equipment, including computers, printers, and certain medical equipment, when it is no longer useful or becomes outdated.

the Veterans Integrated Service Network (VISN) directed employees to request turn-ins for equipment they did not intend to turn in, in order to manipulate budget options.

The investigation did not substantiate these allegations. However, the agency noted in its initial report that the Durham VAMC Chief Logistics Officer acknowledged "significant failures in the turn-in program" attributable to a lack of "employee/supervisory ownership and accountability." The investigation identified thousands of items in equipment asset management records that showed a "turned-in" status with no actual turn-in date recorded, and highlighted evidence showing inadequate management of the turn-in program for a number of years. In response, the agency recommended that the facility establish an employee training program and evaluation process to ensure proper execution of the equipment turn-in process. In its November 7, 2017, supplemental report, the agency confirmed the facility's ongoing efforts to implement this recommendation, including revising and updating its standard operating procedures for inter-service communication and its guidance on the use and management of warehouse storage agreements.

I have reviewed the original disclosure and the agency reports. It is regrettable that the agency required four individual reports to fully explain and support its findings. However, I am satisfied that the agency took appropriate corrective actions to address the substantiated violations and to ensure that future management of logistics at Durham VAMC is held to a high standard. Thus, I have determined that the reports meet all statutory requirements and the findings appear reasonable. As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter and the agency reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,



Henry J. Kerner
Special Counsel

Enclosures