DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

DEC 05 2017

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-16-4382

Dear Mr. Kerner:

I am responding to your request for supplemental information on the investigation at the Durham Department of Veterans Affairs (VA) Medical Center in Durham, North Carolina.

The enclosed supplemental report describes the manner and method of Durham's investigation into alleged violations of the Anti-Deficiency Act and Bona Fide Needs Rule, along with the legal and factual bases for its determination that no violations of appropriations law occurred with respect to equipment that had never been used but had been improperly listed as in-use.

The Agency has no further findings or recommendations regarding this case. Thank you for the opportunity to respond.

Sincerely,

Carolyn M. Clancy, M.D.
Executive in Charge

Enclosure

Department of Veterans Affairs
Supplemental Report
to the
Office of Special Counsel
OSC File Number DI-16-4282

Department of Veterans Affairs
Durham Veterans Affairs Medical Center
Durham, North Carolina

Report Date: November 27, 2017

Background

At the direction of the Secretary of the Department of Veterans Affairs (VA), the Under Secretary for Health (USH) appointed an Investigating Officer (IO) to identify and coordinate a team to investigate complaints lodged with the Office of Special Counsel (OSC) by a whistleblower at the Durham VA Medical Center (hereafter, the Medical Center). The whistleblower alleged that:

1) Logistics employees failed to properly account for approximately 900 equipment turn-ins and failed to properly document turn-ins on bills of lading;
2) Logistics management directed employees to fabricate final dispositions for the turn-ins in order to close them out;
3) Veterans Integrated Service Network (VISN) employees directed facility employees to request turn-ins for equipment they did not intend to turn in, in order to manipulate budget options;
4) In 2014, the Durham VAMC spent approximately $385,000 to purchase computer equipment that has never been used but is improperly listed as in use, along with other unused equipment; and,
5) The Durham VAMC has stored and distributed to patients long-expired bottled water, in violation of VHA Handbook 1109.04.

The VA team conducted an initial on-site Administrative Investigation Board (AIB) at the Medical Center from April 10, 2017 – April 21, 2017, to investigate the allegations. On June 13, 2017, OSC requested and VA provided a supplemental report that addressed:

1) Whether the substantiated allegation that the Durham VAMC has spent approximately $385,000 to purchase computer equipment that has never been used, but is improperly listed as in-use, along with other unused equipment is a violation of the Anti-Deficiency Act, 31 U.S.C. § 1341 *et seq.* Specifically, in light of the large amount of purchased but unused equipment.
2) If any individual employees were found to be responsible for the improper purchase and storage of the equipment or for the failure to properly dispose of expired water pursuant to VHA policy.

On November 14, 2017, OSC responded to VA in an email from Employee 1 indicating that OSC reviewed the supplemental report dated October 5, 2017, and requested a second supplemental report to address these issues. *"Specifically, the report explains that the AIB believed that Anti-Deficiency Act and Bona Fide Needs Rule violations occurred. However, the report concludes that no such violations were found. Despite providing detail regarding the allegations and why a violation was suspected, the report provides no explanation, background, justification, or other supporting information for how the facility determined no violations occurred. Please provide a report fully describing the manner and method of the facility's investigation into these possible violations and the legal and factual bases for its determination that no violations occurred."*

The AIB lead member contacted following the individuals to obtain the necessary information required:

1. Mark Shelhorse, Acting Network Director, Veterans Integrated Service Network (VISN) 6
2. DeAnne M. Seekins, Medical Center Director, Durham VAMC

This supplemental report answers the supplemental inquiries from OSC.

Findings, Conclusions, Recommendations from Follow-up Activities

Findings:

The AIB team identified approximately $400,000 of new Welch Allyn vital signs monitors and approximately $150,000 in Anesthesia Record Keeper (ARK) workstations that had been purchased for the Medical Center and received into the Automated Engineering Management System/Medical Equipment Reporting System (AMES/MERS) in 2013 and 2014, respectively, and still had not been put into use as of April 2017.

The Welch Allyn vital sign monitors identified during the investigation were part of a purchase to standardize the type of vital sign monitors used at all medical centers throughout the network. The ARK equipment was obtained as part of a national implementation initiative.

VISN 6 purchased all of the ARK equipment and vital signs monitors, Biomedical Engineering Service was responsible for the incoming inspections of the equipment since vital sign monitors and ARK equipment are considered biomedical devices, and Logistics Service was responsible for the deployment of equipment throughout the health care system, following completion of required incoming inspections.

The determination of need and subsequent acquisition of the vital signs monitors and ARK equipment was based on calculations prepared by the network in coordination with the Medical Center leadership to determine the quantity needed for medical center operations. The quantity calculations included the purchase for the replacement of existing monitors and ARK equipment, estimated growth inpatient workload, and a need to outfit new outpatient clinics.

There was a b*ona fide* need at the time of purchase, but deployment was delayed due to an unfortunate combination of lack of support/staffing and expertise in Biomedical Engineering Service, overall extremely poor management and oversight of the medical equipment program by Logistics Service, and poor preparation for equipment receipt. The required site preparation included installation of new drops through the Office of Information and Technology (OI&T) and electrical outlets through Engineering Service, which oversight and coordination was lacking. Due to this poor planning and oversight, procedures of all Equipment Committees at all VISN 6 facilities have been revised, that upon equipment purchasing, site preparation and support will be coordinated between Logistics Service, Engineering Service, Biomedical Engineering Service, and OI&T prior to executing an acquisition.

This appeared to be a *bona fide* need rule violation because the goods/supplies were purchased in one fiscal year (FY), but not deployed until the next. However, the goods/supplies were actually needed in the FY in which they were ordered, but because of logistical/inventory mismanagement, were not deployed until the following FY. Since *bona fide* need rule holds that funds are available during their period of availability to fund obligations, and needs arising during that period (see 31 U.S.C., § 1502), the rule was satisfied here: there was no true *bona fide* need rule violation.

Based on this explanation from the Medical Center leadership and upon analysis from VA's Office of General Counsel, it was determined that there was neither a violation of the Anti-Deficiency Act, 31 U.S.C. § 1341, nor the *Bona Fide* Need Rule, 31 U.S.C. § 1502.

Conclusion

A final determination was made that neither a violation of the Anti-Deficiency Act, 31 U.S.C. § 1341, nor the *Bona Fide* Need Rule, 31 U.S.C. § 1502 occurred as a result of any of the findings identified.

Recommendation:

None.