

**Testimony of Carolyn Lerner, Special Counsel  
U.S. Office of Special Counsel**

**U.S. Senate  
Committee on Homeland Security and Governmental Affairs**

**“Improving VA Accountability: Examining First-Hand Accounts of Department of  
Veterans Affairs Whistleblowers”**

**September 22, 2015, 9:30 A.M.**

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our work with whistleblowers at the Department of Veterans Affairs (VA). Since April 2014, our office has seen a sharp increase in the number of whistleblower cases from VA employees. These cases fall into two categories: retaliation complaints and disclosures of wrongdoing.

In response to retaliation complaints, and working in cooperation with the VA, we have secured relief for dozens of whistleblowers, helping courageous employees restore successful careers at the VA. The number of victories for whistleblowers is increasing steadily. In 2015, we will more than double the total number of favorable outcomes for whistleblowers achieved in 2014. OSC recently settled a retaliation complaint filed by Joseph Colon, who testified on the first panel. We are actively reviewing the retaliation complaints and whistleblower disclosures filed by Brandon Coleman and Shea Wilkes, who also testified today.

In disclosure cases, OSC’s work with whistleblowers improves the quality of care for veterans. Whistleblower disclosures also can play a pivotal role in promoting accountability. The VA has disciplined or proposed to discipline 40 employees as a result of wrongdoing whistleblowers identified in disclosures to OSC. This is substantial progress. However, as detailed below, our review of disciplinary actions in response to recent whistleblower disclosures indicates that discipline is being inconsistently imposed.

This statement describes our process for investigating retaliation complaints and reviewing whistleblower disclosures. It provides updated statistical information on case numbers and outcomes, and it summarizes recent cases in which OSC secured relief for whistleblowers. Finally, it highlights ongoing challenges and issues the Committee may want to consider to strengthen OSC’s ability to investigate whistleblower retaliation complaints.

**OSC Investigations of Whistleblower Retaliation Complaints**

**A. Process**

OSC investigates allegations of whistleblower retaliation, one of the thirteen “prohibited personnel practices” that federal employees may challenge with our office. After receiving a retaliation complaint, we conduct an investigation to determine whether the employee has been fired, demoted, suspended, or subjected to another personnel action for blowing the whistle. If

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OSC can demonstrate that a personnel action was retaliatory, we work with the agency to provide relief to the employee. This can include reinstatement, back pay, and other remedies, including monetary damages. OSC also commonly works with the agency involved to implement systemic corrective actions, such as management training on whistleblower protections. Frequently, we resolve cases through alternative dispute resolution, including mediation. If the agency does not agree to provide the requested relief to the employee, either through mediation or based on our investigative findings, we have the authority to initiate formal litigation on behalf of the whistleblower before the Merit Systems Protection Board (MSPB). In egregious cases, we can also petition the MSPB for disciplinary action against a subject official.

### B. VA Retaliation Complaints, by the Numbers

Government-wide, OSC is on track to receive over 4,000 prohibited personnel practice complaints in 2015. Over 1,400 of these complaints, or approximately 35 percent, will be filed by VA employees. In 2014, for the first time, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

We have taken a number of steps to respond to this tremendous surge in VA complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise investigations of VA cases, and we hired an experienced senior counsel to further coordinate our investigations of VA cases. We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Working with the VA's Office of General Counsel (OGC), we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process, saving significant time and resources. To date, we have obtained approximately thirty corrective actions for VA whistleblowers through this process.

In July, OSC announced the resolution of Mr. Colon's case, as well as the retaliation complaint filed by Ryan Honl of the Tomah, Wisconsin VAMC, which I know has been of great interest to the Chairman, Senator Baldwin, other members of this Committee, and Mr. Kirkpatrick's family. These cases are summarized here:

**Ryan Honl** – Mr. Honl was a secretary in the mental health unit at the Tomah VA Medical Center in Tomah, Wisconsin. In addition to other concerns, he disclosed the alleged excessive prescription of opiates to patients. On the same day he made a disclosure to the VA Office of Inspector General, the VA stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from co-workers. Shortly thereafter, he resigned. The VA and Mr. Honl settled his complaint through the expedited process with Mr. Honl receiving several corrective actions, including the removal of negative information from his personnel file and monetary damages.

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**Joseph Colon Christensen** – Mr. Colon is a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico. Mr. Colon reported concerns relating to patient care at his facility and information about alleged improper conduct by the director of his facility. In September 2014, two days after a newspaper called the facility's director asking for comment on a story about the director's conduct, the facility's chief of staff issued Mr. Colon a notice of proposed removal. In late December, the VA replaced the proposed removal with a three-day suspension and detailed him to a different position. Prior to his disclosures, Mr. Colon had an unblemished disciplinary history and had received "outstanding" performance reviews. The VA and Mr. Colon settled his retaliation complaint through the expedited process with Mr. Colon receiving several corrective actions, including the repeal of his suspension, a return to his position, and compensatory damages.

These are important victories for employees who risked their professional lives to improve VA operations and the quality of care provided to veterans. Additionally, in the last two weeks, in cooperation with the VA, OSC resolved two additional significant retaliation claims, summarized below:

**Philo Calhoun** – Dr. Calhoun was a surgeon at the VA Roseburg Health Care System in Oregon. He raised numerous patient care issues with senior VA officials, the press, and Congress, both while he served as chief of surgery and after he stepped down from that post in 2013. In August of 2014, Dr. Calhoun reported that the new chief of surgery was performing colonoscopies incorrectly. A subsequent review by the chief of gastroenterology concluded that, out of the 80 colonoscopies reviewed, the new chief performed more than 90 percent incorrectly. After Dr. Calhoun reported these results to VA officials, the chief of surgery retaliated against him by taking away his surgical duties, giving him a lowered performance evaluation, and blocking his reassignment to another facility where he could maintain his surgical skills. OSC settled Dr. Calhoun's case through the expedited process. At Dr. Calhoun's request, the VA reassigned him to the Portland, Oregon VA Health Care System and reissued his 2014 Proficiency Report with an "outstanding" rating, consistent with his previous evaluations.

**Bradie Frink** – Mr. Frink is a disabled Army veteran who was hired at the Baltimore Regional Office (BRO) of the Veterans Benefits Administration in February 2013. VA policy required the BRO to transfer Mr. Frink's benefits claims folder to another VA facility for processing. However, the VA lost Mr. Frink's claims folder. Despite several requests to the VA to locate his claims folder, it remained lost. Mr. Frink sent a request for assistance to Senator Barbara Mikulski. The Senator's office contacted the BRO about Mr. Frink's claim. Shortly thereafter, the VA terminated Mr. Frink during his probationary period. OSC settled the complaint through the expedited process. The VA provided full corrective action for Mr. Frink, including reemployment with the VA, back pay for the months of unemployment, and compensatory damages for emotional distress. OSC further recommended that the VA consider disciplinary action against two of Mr. Frink's supervisors.

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In addition to cases resolved through the expedited relief program, we are steadily increasing the number of corrective actions in all VA cases. In 2014 and 2015 to date, OSC has secured either full or partial relief 116 times for VA employees who filed whistleblower retaliation complaints, including 84 in fiscal year 2015 alone. These positive outcomes are generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution, or mediation, program. In addition, OSC is currently reviewing the retaliatory conduct of six managers in three locations for possible disciplinary action.

OSC currently has 279 active VA whistleblower retaliation cases in 44 states, the District of Columbia, Puerto Rico, and VA hospitals abroad. Approximately 100 of these pending cases allege retaliation for blowing the whistle on a patient health or safety concern. We will continue to update the Committee as we resolve additional cases in the coming months.

### **Whistleblower Disclosures**

#### **A. Process**

In addition to protecting employees from retaliation, OSC also provides federal workers a safe channel to disclose violations of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health or safety. Unlike our role in retaliation complaints, OSC does not have investigative authority in disclosure cases. Rather, OSC plays a critical oversight role in agency investigations of alleged misconduct.

After receiving a disclosure from a federal employee, OSC evaluates the information to determine if there is a "substantial likelihood" that wrongdoing exists. If OSC makes a "substantial likelihood" determination, we transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings. The whistleblower is given the opportunity to comment on the agency report. After we review the agency report and the whistleblower comments, we transmit them with our analysis to the President and Congress and place the information on our web site.

This process promotes accountability and is transparent. We require agencies to investigate complex wrongdoing. And, the process empowers whistleblowers, the subject matter experts in the issues they have raised, to assess the quality of the agency investigation and provide comments on the agency's report.

In recent years, the OSC disclosure process has prompted significant changes in government operations and saved taxpayer dollars. For example, whistleblower disclosures to OSC about rampant overtime abuse in the Department of Homeland Security (DHS) prompted a successful legislative effort to modernize the pay structure for Border Patrol Agents. The pay reform, spearheaded by Members of this Committee after hearings with DHS whistleblowers and OSC, saves taxpayers \$100 million a year—an amount over four times the size of OSC's annual budget.

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At the VA, our work with whistleblowers led to an overhaul of the VA's internal medical oversight office, the Office of the Medical Inspector (OMI), and has prompted positive changes throughout the department. VA whistleblowers identified and set in motion corrective action plans to address significant threats to the health and safety of veterans. For example, numerous whistleblowers at the Jackson, Mississippi VAMC helped to remedy chronic under-staffing in the Primary Care Unit, improper prescription of narcotics, and unsanitary medical equipment. A whistleblower at a Brockton, Massachusetts VA community living center exposed extreme shortcomings in the care provided to long-term mental health patients. And, two whistleblowers at a VA clinic in Fort Collins, Colorado, were among the first to identify manipulation of data on patient wait times. These efforts all led to positive changes at the facility involved, leading to better care for veterans.

### B. Inconsistent Application of Discipline in VA Whistleblower Cases

Government-wide, OSC will receive nearly 2,000 whistleblower disclosures from federal employees in 2015.<sup>1</sup> At current levels VA employees will file, approximately 774, or 38 percent, of these disclosures.

As I noted in recent testimony before the Senate Appropriations Committee, whistleblower disclosures not only improve the care provided to veterans, but also help to promote accountability and deter future misconduct. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified by whistleblowers in disclosures to OSC.

This is substantial progress toward greater accountability and deterring future misconduct, and I applaud the VA for taking these important steps. Unfortunately, as explained below, our review of several recent disclosure cases indicates that disciplinary actions are being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can actually undermine accountability, impede progress, and discourage whistleblowers from coming forward.

I highlighted my concerns about the disciplinary action process in a September 17, 2015 letter to the President and the Chairmen of the Veterans' Affairs Committees (attached). I raised specific concerns about the lack of accountability in response to confirmed mismanagement at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC), and other locations. I provided the following examples:

- At the Hayden VAMC, not a single nurse in the emergency department (ED) had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31

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<sup>1</sup> Each year, OSC receives a number of cases that are inadvertently filed by federal employees as disclosures of wrongdoing, and properly should have been filed as retaliation complaints because the employee is seeking to remedy a personnel action. OSC is in the process of modernizing its online complaint filing system to make it more user-friendly and intuitive. With a smarter, more user-friendly interface for federal employees, the new system will greatly diminish the historical problem of wrongly-filed disclosure forms. By diminishing the number of wrongly filed disclosure cases, the new system will provide a more accurate, but lower number of disclosure cases received in FY2016 and beyond. The changes may increase the number of retaliation complaints.

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Phoenix ED nurses received any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. This resulted in at least 110 cases that the whistleblower identified in which ED patients were improperly triaged and experienced dangerous delays in care. OMI concluded that the lapses in ED triage “constitute a significant risk to public health and safety” of veterans. Despite these findings, the VA has taken no disciplinary action against responsible officials.

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent counseling veterans. Regional leaders were aware of the manager’s misconduct, yet failed to take action to address it. Although OMI substantiated both sets of allegations, the manager and regional leaders received only a reprimand, the lowest form of available discipline.
- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director’s actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. The director received only a written counseling.
- Officials at the Beckley, West Virginia VAMC attempted to meet cost savings goals by requiring mental health providers to substitute prescriptions for veterans, requiring them to prescribe older, cheaper, and less effective antipsychotic medications. These actions violated VA policies, undermined effective treatment of veterans, and placed their health and safety at risk. To date, no one has been disciplined.
- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, including the patients’ chief complaint, physical examination findings, vital signs, diagnoses, and plans of care, resulting in inaccurate recordings of patient health information and in violation of VA rules. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management apparently did not provide the appropriate information to human resources, which only approved a reprimand.

These cases stand in stark contrast to disciplinary actions taken against VA whistleblowers. My September 17, 2015 letter summarizes seven additional cases in which the VA attempted to fire or suspend whistleblowers for minor indiscretions or for activity directly related to the employee’s whistleblowing. OSC has worked with VA headquarters to rescind the disciplinary actions in these cases. Nevertheless, the severity of the initial punishments chills other employees from stepping forward to report concerns.

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I have encouraged VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties. Based on the VA leadership's positive response to my prior recommendations, I am optimistic that the VA will work to appropriately address this problem.

In fact, just last week, Deputy Secretary Sloan Gibson issued a memorandum setting forth a new process for responding to OSC referrals of whistleblower information. The new process will route all OSC referrals through the VA Executive Secretariat, ensuring the highest level review of all whistleblower allegations and corresponding investigations. I am hopeful that this centralized, high-level review will address the concerns expressed in my September 17 letter and promote better and more consistent outcomes in whistleblower disclosure cases.

### **Additional Areas for Congressional Consideration**

In prior testimony, I highlighted several ongoing areas of concern in our investigation and review of VA whistleblower cases. I previously discussed the improper accessing of whistleblowers' medical records, retaliatory investigations, and the role of regional counsel in whistleblower investigations. I would be happy to provide additional detail on each of these subjects.

Today, I want to focus on some specific measures that Congress could take to assist OSC in its investigations. OSC has not been formally reauthorized since 2007. While this does not prevent OSC from receiving appropriations, reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. While the Committee may want to consider any number of issues in connection with OSC reauthorization legislation, I would like to focus on two of particular importance.

First, Congress may want to clarify OSC's authority to seek information from other government agencies to assist OSC in its independent investigations of whistleblower retaliation and prohibited personnel practice claims. It would be helpful to provide OSC with direct, statutory authority to gain access to all agency information, much like the authorities Congress has provided to Inspectors General and the Government Accountability Office. Currently, OSC's authority to request documents is regulatory. Office of Personnel Management (OPM) regulation directs agencies to comply with document requests from OSC. While agencies typically comply with our OPM civil service rule 5.4 requests, we have had some difficulty in VA investigations with the timeliness and completeness of responses. Direct statutory authority would better ensure that OSC obtains all relevant facts during investigations.

Second, in light of our steadily increasing workload, especially in the number of VA whistleblower cases, Congress may want to consider the procedural requirements imposed on OSC in all prohibited personnel practice cases as a possible area for revision. Changes to section 1214 of title 5 would allow OSC to spend its limited resources on the investigation and prosecution of meritorious cases, providing OSC with the ability to generate more positive outcomes on behalf of whistleblowers, the merit system, and the taxpayers. Section 1214 currently requires OSC to provide an employee with repetitive status reports, a detailed, fact-based letter, the reason for terminating the investigation, and an opportunity to comment before OSC may close a complaint file, regardless of the merits of the complaint. In light of our

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skyrocketing caseloads, these requirements require us to devote significant resources to closing non-meritorious complaints, instead of focusing on prosecuting and resolving meritorious cases. These requirements are unique to OSC.

**Conclusion**

We appreciate the Committee's attention to the issues we have raised and your interest in our efforts to protect and promote VA whistleblowers. I thank you for the opportunity to testify, and am happy to answer your questions.

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**Special Counsel Carolyn N. Lerner**

The Honorable Carolyn N. Lerner heads the United States Office of Special Counsel. Her five-year term began in June 2011. Prior to her appointment as Special Counsel, Ms. Lerner was a partner in the Washington, D.C., civil rights and employment law firm Heller, Huron, Chertkof, Lerner, Simon & Salzman, where she represented individuals in discrimination and employment matters, as well as non-profit organizations on a wide variety of issues. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was a mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights.

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Harry S. Truman Scholar, and her law degree from New York University (NYU) School of Law, where she was a Root-Tilden-Snow public interest scholar. After law school, she served two years as a law clerk to the Honorable Julian Abele Cook, Jr., Chief U.S. District Court Judge for the Eastern District of Michigan.

**U.S. OFFICE OF SPECIAL COUNSEL**1730 M Street, N.W., Suite 300  
Washington, D.C. 20036-4505**The Special Counsel**

September 17, 2015

The President  
The White House  
Washington, D.C. 20510

Re: OSC File No. DI-14-2754

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC). The Office of Special Counsel (OSC) reviewed the VA reports and provides the following summary of the whistleblower's allegations and my findings. The whistleblower, Dr. Katherine Mitchell, disclosed serious threats to the health and safety of veterans seeking care in the Hayden VAMC Emergency Department (ED). According to Dr. Mitchell, Hayden VAMC did not properly train ED nurses. Patients were harmed because nurses failed to conduct appropriate triage.

The VA's Office of the Medical Inspector (OMI) substantiated Dr. Mitchell's allegations. Specifically, at the time of OMI's investigation in 2014, the ED did not employ a single nurse who had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31 Phoenix ED nurses had completed any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. Dr. Mitchell identified at least 110 cases in which ED patients were improperly triaged and experienced dangerous delays in care, including a patient with a history of strokes waiting almost eight hours for treatment after presenting to the ED with low blood pressure. OMI concluded that the lapses in ED triage "constitute a significant risk to public health and safety" of veterans. In response to OMI's findings, Hayden VAMC initiated steps to implement comprehensive triage training protocols and improve ED staffing levels, something Dr. Mitchell first suggested in 2009, in correspondence and disclosures to senior Hayden VAMC officials.

The commitment to improve training in Phoenix is a positive and long-overdue step; however, I am concerned by the VA's decision to take no disciplinary action against responsible officials. The lack of accountability for Hayden VAMC leaders sends the wrong message to the veterans served by this facility, including those who received substandard emergency care. OSC sought additional information from the VA on its

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decision not to impose discipline on any responsible officials, but the VA did not provide an adequate justification.

I have determined that the agency reports contain the information required by statute. However, the VA's failure to impose disciplinary action is troubling, given the seriousness of OMI's findings. A detailed analysis of Dr. Mitchell's disclosures, and the agency investigation and reports regarding patient care at the Hayden VAMC are included as an attachment to this letter.<sup>1</sup>

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As part of OSC's broader review of pending VA whistleblower disclosure cases, I have identified recent additional cases in which the VA confirmed serious misconduct brought to light by whistleblowers, yet failed to appropriately discipline responsible officials.

Similarly, in June 2014, I highlighted a pattern of deficient patient care at VA facilities nationwide, and the VA's resistance, and OMI's in most cases, to acknowledge and address the impact on the health and safety of veterans. In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. This review resulted in positive changes. With increasing consistency, patient care challenges, like those OMI identified in response to Dr. Mitchell's disclosures, are being acknowledged as threats to the health and safety of veterans, allowing the VA to consider and take the corrective actions needed to improve care for veterans.

The next and critical step is to hold officials accountable after lapses in care have been identified. Whistleblower disclosures, like those Dr. Mitchell submitted, can play a pivotal role in promoting accountability at the VA. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct that whistleblowers identified. This is substantial progress. Nevertheless, as explained below, disciplinary action is being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can undermine accountability, impede progress, and discourage whistleblowers from coming forward.

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<sup>1</sup> The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

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The following examples are illustrative:

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent in face-to-face counseling sessions with veterans. Regional leaders were aware of the manager's misconduct, yet failed to take action to address it. OMI substantiated both sets of allegations, yet the manager and regional leaders received only a reprimand, the lowest form of available discipline.
- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director's actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. Yet the director received only a written counseling.
- Officials at the Beckley, West Virginia VAMC attempted to meet cost savings goals by requiring mental health providers to substitute prescriptions for veterans, requiring them to prescribe older, cheaper, and less effective antipsychotic medications. These actions violated VA policies, undermined effective treatment of veterans, and placed their health and safety at risk. To date, no one has been disciplined.
- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, resulting in inaccurate recordings of patient health information and in violation of VA rules. The pulmonologist copied and pasted other physicians' earlier recordings, including the patients' chief complaint, physical examination findings, vital signs, diagnoses, and plans of care. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management did not provide the appropriate information to human resources, which only approved a reprimand.

The lack of accountability in these cases stands in stark contrast to disciplinary actions taken against VA whistleblowers. The VA has attempted to fire or suspend whistleblowers for minor indiscretions and, often, for activity directly related to the employee's whistleblowing. While OSC has worked with VA headquarters to rescind the disciplinary actions in these cases, the severity of the initial punishments chills other employees from stepping forward to report concerns. OSC has obtained corrective action, or is working to correct the actions taken against the following employees:

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- At the Philadelphia VAMC, a food services manager who blew the whistle on VA sanitation and safety practices was fired after being accused of eating four expired sandwiches instead of throwing them away.
- In Puerto Rico, the VA sought to remove an employee who blew the whistle on the hospital director's misconduct. Puerto Rico officials claimed the employee made an "unauthorized disclosure of information." But the employee's communication was protected and related to his concerns about hiring violations at the facility. The VA also sought removal of a second Puerto Rico employee, the privacy officer, in part because she concluded that the whistleblower had not made an unauthorized disclosure, and refused management pressure to change her finding.
- A VA employee in Wisconsin sent an email expressing her concerns about ongoing improper disclosures of veterans' health information. The employee sent the email to an internal list of VA privacy and compliance officers, yet the VA fired the employee for sending the email because it contained personal information about a veteran.
- The VA fired an employee and disabled veteran in Baltimore for pretextual reasons after he petitioned Congress for assistance with his own VA benefits claim.
- In Kansas City, the VA fired an employee who blew the whistle on improper scheduling practices, claiming for the first time after her disclosures that she was acting "too slowly" in scheduling appointments for veterans.
- At the Wilmington, Delaware VAMC, a registered nurse blew the whistle on improper treatment of opiate addiction. The employee received a 14-day suspension for charging one colleague \$5 for notary services, an event that occurred a year prior to his whistleblowing, and other minor allegations of misconduct.

In 2015, OSC received over 2,000 cases from VA employees. The large number of VA cases OSC has received and processed provides us with the ability to compare the actions taken against whistleblowers with those taken, or not taken, against officials who engage in substantive misconduct. I highlight these cases to demonstrate the disparity in punishments for whistleblowers and those who have engaged in misconduct that negatively impacts patient care.

I encourage VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties.

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As required by 5 U.S.C. §1213(e)(3), I have sent copies of the unredacted agency reports and Dr. Mitchell's comments to the Chairmen and Ranking members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and Dr. Mitchell's comments in our public file, which is available at [www.osc.gov](http://www.osc.gov).<sup>2</sup> OSC has now closed this file.

Respectfully,



Carolyn N. Lerner

Enclosures

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<sup>2</sup> The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.