THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 27, 2007

MEMORANDUM FOR THE UNDER SECRETARY FOR HEALTH

SUBJECT: Delegation of Authority to Review and Sign an Agency Report to the Office of Special Counsel

1. DELEGATION. This memorandum delegates to the Under Secretary for Health the authority to review and sign agency reports regarding Veterans Health Administration (VHA) matters referred to the Secretary by the Office of Special Counsel pursuant to 5 U.S.C. § 1213. VHA matters that also may relate to other Administrations or offices must be coordinated with those offices. This delegation includes the authority to take any actions deemed necessary under 5 U.S.C. § 1213(g).

2. AUTHORITY. 38 U.S.C. § 512.

3. RESTRICTIONS. None. This delegation cancels and supersedes all previous delegations of authority.

4. REDELEGATION. The Under Secretary for Health may not redelegate this authority.

5. EFFECTIVE DATE. This delegation of authority is effective upon signature and will expire two years after the date delegated.

R. James Nicholson

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAR 13 2009

In Reply Refer To:

William E. Reukauf
U.S. Office of Special Counsel
1730 M Street, N.W.
Suite 218
Washington, DC 20036-4505

Re: OSC File No. DI-08-2370

Dear Mr. Reukauf:

Enclosed is the Department of Veterans Affairs' (VA) report in response to your request of September 23, 2008, to investigate actions taken by VA employees in response to a veteran's allegation of rape by a fellow veteran while residing in a VA facility, the Hospitality House, which is located on the Dayton VA medical center campus. VA's report was initially due on November 23, 2008. Your office granted an extension of the deadline pending completion of our investigation.

If you have any questions about the contents of the report, please have a member of your staff Demetrious Harris, Esq. VA Regional Counsel, Cleveland, Ohio at 937-267-5365

Sincerely yours,

Michael J. Kussman

Michael J. Kussman, MD, MS, MACP

Enclosure

Investigation of Allegations of Sexual Assault
VA Medical Center Dayton, Ohio
OSC File No. DI-08-237

By letter dated September 23, 2008, you directed the Secretary of Veterans Affairs to investigate the actions taken by VA employees in response to a veteran's (b) (6)) allegation to VA officials that she had been sexually assaulted by a fellow veteran (b) (6) while residing in a VA facility, the Hospitality House, which is located on the Dayton VA medical center campus. The complainant in this case is (b) (6) (b) (6) , a former VA employee. In your charge letter, you point out that facility policy No. 11-41 required employees to take specified steps none of which were reportedly taken in the instant case. You therefore concluded there is a substantial likelihood that the action of the VA employees constituted gross management as well as a violation of policy.

Pursuant to the enclosed delegation of authority, the Secretary has delegated to me the responsibility for conducting both the investigation and report required in this matter. This report is being submitted in accordance with the requirements of 5 U.S.C. § 1213(d).

Summary of the information with respect to which the investigation was initiated

The complainant in this case, a former VA employee at the Dayton VA Medical Center (VAMC), alleges that employees at the Dayton VAMC failed to follow proper procedures after a VA outpatient patient, (b) (6) , reported to VA officials that she had been sexually assaulted by another VA patient while residing in a VA residential facility located on the Dayton VAMC grounds, known as the Hospitality House ("House").

The VAMC, part of the VA Healthcare System of Ohio, Network 10 (VISN 10), is one of the three oldest VA facilities, providing continuous service to veterans for over 140 years. The Medical Center offers comprehensive health care through medical, surgical, mental health, geriatric, physical & rehabilitation services, neurology, oncology, dentistry, and hospice. The Medical Center has 500 hospital beds (265 nursing home beds, 120 acute care beds, and 115 domiciliary beds). The Medical Center also has sharing agreements with Wright Patterson Air Force (military base), in the State of Ohio, and eleven (11) community hospitals. The Medical Center is a national referral center for hyperbaric oxygen therapy and provides a wide variety of special programs as well, including a hospice unit, geriatric evaluation and management, respite care, an Alzheimer's unit, home base primary care, residential and outpatient post-traumatic stress disorder (PTSD) and substance abuse programs, as well as homeless, sleep disorder, and women's health programs. The Medical Center supports four Community Based Outpatient Clinics (CBOCs) in Lima, Middletown and Springfield, Ohio and Richmond, Indiana.

It is important to note, however, that the House is not a VA-operated treatment or residential facility. While it is on the Dayton VAMC campus, VA leases that building to the Veterans of Foreign Wars (VFW). The VFW manages the property and uses it to furnish temporary lodging to families of patients visiting the medical center at a discounted rate. VFW staffs the House with volunteers 24 hours a day, 7 days a week. The Dayton VAMC does not staff the House, supervise the activities within the House, or provide care to temporary lodgers residing in the House (outside of humanitarian care necessitated by a medical emergency).

The House was, however, the site for (b) (6) outpatient therapeutic employment under VA's Incentive Therapy Program (IT Program). Under the IT program, veterans are placed in therapeutic work settings during the day to help assist them in their transition to independent living and full rehabilitation. The VFW served as (b) (6) employer, providing what is tantamount to sheltered employment to (b) (6) (b) (6) therapeutic employment was overseen and supervised by various VA staff, including the complainant. The VFW, apparently with the assistance of the complainant, permitted (b) (6) to reside in the House at nights because she (b) (6) . VA staff also assisted in placing (b) (6) in the House. Thus, the VFW permitted other veterans who were receiving outpatient services at the Dayton VAMC to stay there as well, including the veteran who allegedly perpetrated the sexual attack on (b) (6) . Permitting veterans to stay at the House was, however, in violation of section 2(a)(4) of the VFW's lease agreement with the Dayton VAMC.

Description of the Conduct of the Investigation

I tasked my Human Resources Management Group (HRM Group) with conducting this investigation. In preparation, the HRM Group contacted and obtained information from the Dayton VA Medical Center Director, Dayton VA Regional Counsel, the Human Resource Manager at the Dayton VAMC, and Health Systems Specialist staff in VA Central Office. It then reviewed documents from the Medical Center, including policies relevant to the instant matter, and interviewed officials at the Dayton VAMC. The HRM Group also relied on the official file and the final report (issued on August 7, 2008) of a Board of Administration Investigation, which investigated the alleged sexual assault/rape of (b) (6) (at issue here) and other matters related to the facility's care of (b) (6) under the IT program. The Group also reviewed daily and weekly briefing reports submitted by the Medical Center relevant to the complainant's allegation here.

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Evidence Obtained from the Investigation

The Board's final report reflects that the Dayton VAMC conducted a comprehensive, extensive, and formal investigation into not only (b) (6) allegations of sexual assault by a fellow veteran while residing at the House but also the adequacy of the supervision rendered by the Dayton VAMC's Mental Health Service Line during her participation in the IT program. As part of that investigation, witnesses were interviewed under oath and verbatim transcripts were obtained. This includes information provided by the complainant, who supervised (b) (6) receipt of therapeutic employment at the House and who had full opportunity to dispute/address any of the Board's findings.

Upon review of this investigative file, the HRM Group found the report and depositions, which include those of the complainant and (b) (6), to be credible and reliable. Moreover, the HRM Group concluded that the issues covered in the Board's investigative file adequately addressed the specific issues raised by the complainant to the Special Counsel. It therefore reasonably relied on the findings of the Board and found no reason to duplicate the investigation into the handling of the alleged sexual assault of (b) (6)

Specific Complaints: (b) (6) *advised* (b) (6) *Social Worker, about the alleged sexual advances of* (b) (6) *and no action was taken. VA medical staff failed to investigate and report to police the alleged rape of* (b) (6), *in violation of* Dayton VA Medical Center Policy No. 11-41, Reporting of Abuse and Neglect Cases. This policy requires that all suspected sexual assault and rape cases must be immediately reported to the police, the victim must be assessed in the emergency room for necessary medical care prior to transfer to the hospital for evaluation and treatment, and that the Patient Safety Coordinator be notified immediately.

The letter from OSC states, in part:

> (b) (6) asserted that (b) (6) reported to him that (b) (6) another VA patient residing at the House, propositioned her for sex and made other inappropriate sexual remarks. This complaint occurred on March 14, 2008 (b) (6) (b) (6) (b) (6) She continued to complain to (b) (6), about every other day, regarding similar sexual advances from (b) (6) After each complaint (b) (6) informed (b) (6) Social Worker, about the alleged sexual advances, and recommended (b) (6) removal from the (Hospitality) House.

A review of the sworn testimony from the investigative file reveals that the initial contact to make lodging arrangements for (b) (6). at the House was made on March 14, 2008.

(Testimony of (b) (6), pages 61, 62 and 63.) The Board therefore reviewed the progress notes in (b) (6)'s medical record after (b) (6) began living at the House. The first progress note authored by the complainant is dated March 24, 2008, at 0724 hours, ten days after (b) (6) took up residence at the House. The progress note states: "Veteran stated all is going well at the Hospitality House and she is now working the hours required for her incentive therapy." The complainant's documented assessment for that encounter was: "Veteran is a (b) (6) (b) (6), (b) (6) veteran, with issue related to (b) (6)."

The complainant entered another progress note in (b) (6) medical record on March 25, 2008, at 1437 hours. It stated: "The u/s (under signed) asked about her IT work activities at the Hospitality House and if everything was going okay. Veteran became teary eyed and stated she did not want to talk about it. She added she would like to move out of the Hospitality House as soon as possible. No further discussion was made on this issue." Complainant's assessment of this encounter was: "Veteran appears to be processing her life situation at this point and is not pleased with her progress. Due to recent awareness of a sensitive development, the u/s did not want to pursue the emotional topic per veteran's request and the matter would also be best served through her therapist, (b) (6)." (b) (6) electronically signed this medical record entry on March 26, 2008, at 0836 hours. An electronic alert was also sent to (b) (6) (b) (6) via the electronic medical record.

Based on the complaint from (b) (6) left the House on March 28, 2008, and moved into (b) (6) which is located (b) (6).

The complainant's allegation to the Special Counsel is inconsistent with the testimony and evidence furnished to, and obtained by, the Board of Investigation. If complainant states that he was aware of (b) (6) allegations as early as March 14, 2008, there is no evidence in the investigative file to support a claim by complainant that he documented those allegations in the patient's medical record, as required by VA policy. The HRM Group found no documentation in the investigative file that the complainant informed VA staff of the patient's concerns or reports of sexual coercion before he issued the electronic alert to (b) (6) on March 25, 2008. Further, a review of the complainant's documents on the network storage drive revealed a copy of a report of contact that the complainant created on Tuesday, April 1, 2008, but was dated March 28, 2008, which states that (b) (6) had contacted him on Friday, March 28, 2008 at 0900 hours and told him that an older veteran was habitually coercing her to have another sexual encounter. The complainant recorded that (b) (6) reported feeling abused, that she was fearful of being alone with the individual and the she did not feel he would accept "No" as an answer and was demanding a repeat sexual encounter. The complainant recorded in this backdated document that he had contacted the (b) (6)

(b) (6), (b) (6), and (b) (6) and that messages were left with the (b) (6) (b) (6) and (b) (6) to return his call on an urgent matter. However, the complainant did not indicate in the medical record progress note that he had referred the matter to anyone except (b) (6), RN.

VA policy requires all therapeutic patient-interaction to be recorded in the patient's electronic medical record. It may violate Federal Privacy Act laws governing patient information to place patient information, especially sensitive patient information, outside of the medical record. Also, unless such patient information is included in the patient's medical record or there is evidence that such information was sent and received by the clinical staff on the case, other VA staff involved in the patient's care would not have access to the report of contact and would not be aware of the patient's allegations of sexual assault. In light of the evidence, the Board concluded that the evidence of record did not establish that the complainant notified any VA staff of (b) (6) allegations until he sent the electronic alert to (b) (6) regarding his entry into the medical record, dated March 26, 2008. The Board also based its conclusion on the following testimony:

- (b) (6) was asked about this report of contact during testimony in the investigative board, specifically why he backdated the report of contact. (b) (6) answered, "Because I was probably trying to get a hold of (b) (6) (b) (6) to talk with her about it." When asked if he did speak with her, (b) (6) replied, "To be honest, I – I can't even recall."

- (b) (6) was also asked if (b) (6) had spoken to him on or about March 24, 2008 about her concerns relative to (b) (6) alleged sexually aggressive behavior towards her prior to the alleged assault on March 25, 2008. (b) (6) testified, "I don't recall." When pressed for an answer about what he would have done with that information if he had received it from her, (b) (6) further testified, "I would have done a progress note." When reminded that no note or report of contact exists that contains such information, he was asked if it was possible that (b) (6) was wrong in her assertion that she warned him of (b) (6) alleged behavior prior to the alleged assault, responded, "I believe she may be wrong, sir." Finally, (b) (6) was asked if it were possible that the alleged rape never occurred, to which he responded, "I'm saying that it – it is possible." (b) (6) testimony, pages 151 – 153 and pages 156 – 159 and page 161.)

- (b) (6), Social Worker for (b) (6) testified that he advised (b) (6) not to have any further contact with (b) (6) after hearing from (b) (6) on March 25, 2008, that (b) (6) was not comfortable with him.

- (b) (6) had disclosed to (b) (6) that he did have a consensual sexual encounter with (b) (6).

The Board found that (b) (6), RN, Clinical Nurse Specialist, electronically signed her alert notification at 1730 hours on March 26, 2008. (b) (6) testified before the investigative board and was asked if (b) (6) alerted her in any other way regarding the issues concerning (b) (6). (b) (6) testified, "He came to the Mental Health Clinic, passed me in the hall way, and said, oh, have you heard about our girl? And I did not know who he was meaning. And I said who? He said (b) (6) And I said, no, I have not heard anything. And I believe that was the time he told me that she had gotten involved with someone else in the – Hospitality House."

(b) (6) was further queried whether (b) (6) used the terms rape or sexual assault in reference to (b) (6). (b) (6) testified, "No, rape, sexual assault has never been mentioned to me by either (b) (6) and/or (b) (6), ever." (Lynch testimony, page 14, lines 2 – 25.)

(b) (6)'s next note in the medical record is dated April 11, 2008, at 1010 hours. The note reads: "Vet was asked about the reported incident in the past few weeks which involved an incident with a male veteran who was also staying that the Hospitality House. (Although unclear as to a specific person, the testimony confirms that (b) (6) later believed (b) (6) to be referring to (b) (6). Vet was pointedly asked if the incident was a consensual event. She stated, 'from his perspective it probably was but not from my perspective.' She states she does not trust anyone here any longer and feels she can no longer be involved in counseling with this writer. She was advised that this writer will be required to share this information with the Chief of the Care Line who will then share the information with the Director of the hospital."

The Board found that (b) (6) had interviewed (b) (6) on April 11, 2008, based on a request from (b) (6) Mental Health Services. (b) (6) then learned from (b) (6) that the sexual encounter with (b) (6) was not consensual. She advised the patient that she would need to make a police report. (b) (6) further testified that she reported this information to (b) (6) the same day. ((b) (6) testimony, pages 7 – 12.)

(b) (6) testified that she initially became aware of an incident between (b) (6) (b) (6) and (b) (6) through (b) (6). She contacted the Quality Management office on March 26, 2008, the day after the alleged sexual assault and left a voice message. (b) (6) further testified that the next day, March 27, 2008, she spoke with a staff member from the Quality Management office and advised that there had been an incident in the Hospitality House between a veteran – a female veteran and a male veteran. (b) (6) was asked how she characterized the nature of the incident and

she testified, "I was not aware that the nature may have been an assault. I am almost positive I didn't use that term assault. I can't – I wouldn't think that I would us that term assault." (b) (6) testimony, page 20.)

(b) (6) stated her understanding was that the sexual encounter had happened and that (b) (6) was now again seeking a second encounter. Her understanding of the resolution of that incident was that (b) (6) was asked to leave. (b) (6) testimony, page 23.) (b) (6) did not acknowledge that (b) (6) told her that (b) (6) had made an allegation of sexual assault on April 11, 2008.

It is noted that the Board concluded that (b) (6) testimony was not credible. The Board believed that (b) (6) understood the essence of the allegations made by (b) (6) as early as either March 26 or April 11, 2008 and failed to take appropriate action.

Appropriate action was initiated on Friday, April 25, 2008, when the Chief of Staff of the Dayton VAMC became aware of the sexual assault allegations made by (b) (6). The Board members met with the Dayton VAMC leadership on this day to provide a close out of the investigation they had conducted regarding the allegation of an inappropriate relationship between (b) (6) and (b) (6). During the meeting, Board members disclosed that veterans were being permitted to stay at the Hospitality House and that (b) (6) had made an allegation of a sexual assault while staying at the Hospitality House.

The Chief of Staff contacted VA Regional Counsel, a Uniformed Offense Report was completed and (b) (6) was interviewed by a female VA Police Officer and (b) (6) Case Manager, on the same day, April 25, 2008.

The Board's charge was thereafter amended to investigate whether there was an intentional disregard for the safety and security of (b) (6) and whether appropriate action was taken in reaction to (b) (6) allegations.

The Dayton VAMC Police referred the investigation and consideration of formal criminal charges to the VA Office of Inspector General who coordinated their efforts with the Dayton Police Department, Special Victims Unit. The Board found that (b) (6) was reluctant to cooperate further with investigators from both the VA Office of Inspector General on May 5 – 6, 2008 and the Dayton Police Department Special Victims Unit on May 13, 2008.

The Dayton Medical Center Policy No. 11-41 assumes there is cooperation and consent by the victim in carrying out the requirements of the policy. If, however, the victim refuses to cooperate with the police investigation and/or refuses the

forensics/medical exam, the requirements of the policy may not be satisfied, as VA cannot compel the veteran-patient to cooperate or consent to the physical examination. By not cooperating, however, the Board concluded that (b) (6) unnecessarily delayed the resolution of the allegations she made concerning the sexual assault by (b) (6). I note, however, that it would have been doubtful that any physical evidence of the alleged rape would still have existed by the time law enforcement attempted to interview (b) (6).

Listing of Any Violations of Law, Rule, or Regulation

- The Board found that the referral by VA staff of veterans to the VFW-operated House on the Dayton campus and the VFW's acceptance of these veterans into the House violated the terms of the property lease entered into by VA and VFW on May 1, 2006.

- Although the various VA officials became aware of (b) (6) allegations pertaining to the sexual assault/rape by (b) (6) on different dates, only the Chief of Staff complied with local VA Medical Center Policy No. 11-41, Reporting of Abuse and Neglect Cases upon learning of the allegation. This provision requires that all suspected sexual assault and rape cases must be immediately reported to the police, the victim must be assessed in the emergency room for necessary medical care prior to transfer to the hospital for evaluation and treatment, and that the Patient Safety Coordinator be notified immediately. The Board properly found that the complainant failed to respond as required by the policy when he learned of the allegation. (b) (6), who was the only one other than the Chief of Staff to respond timely to the information, reported it only to her supervisor and violated the policy by advising the patient that she would need to report it to VA police, but then failed to carry through. As the Board found, (b) (6) failed, among other things, to respond properly to the information regarding the purported sexual assault on (b) (6).

- The complainant failed to properly document entries into the patient's medical record as required by VA Handbook 1907.01, Health Information Management and Health Records, dated August 25, 2006. Paragraph 8a of this policy states, "Health record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The health record documents the care of the patient and is an important element contributing to high quality care."

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Description of any Action Taken or Planned as a Result of the Investigation.

As part of the correction actions resulting from the Board's investigation, the Dayton VAMC has taken action to enforce its lease with VFW to ensure the organization does not permit veterans under VA outpatient care (including the IT program) to reside in the House. Discussions have occurred along with a review of the terms of the lease agreement so that all parties are aware of the provisions in the lease agreement. All parties have agreed to monitor and enforce the agreement.

VA also has pursued discipline for (b) (6) on the basis of her inaction on receiving notice of allegations of being sexual assaulted/raped by Specifically, VA issued a proposed involuntarily change of assignment memorandum on November 10, 2008. This proposed action involves (b) (6) . (b) (6) requested three requests for extensions to provide an oral response, all of which was granted. A further delay incurred when the Medical Center Director's father passed away. The oral response was scheduled for March 3, 2009. After full and complete consideration of the evidence and the oral response provided by (b) (6), VA will make a final decision.

VA also terminated the complainant from Federal employment based, in part, on his failure to properly manage (b) (6) s case and to properly document and report (b) (6) allegations of having been sexually assaulted by (b) (6) while residing in the House.

(b) (6) 's therapeutic employment (and related counseling) and all necessary mental health care was transferred quickly to the VA (b) (6) medical facility.

By virtue of this review, further recommendations were made to the Dayton VAMC to for the following actions:

The Dayton VA Medical Center Policy 11-41, "Reporting of Abuse and Neglect Cases, dated October 1, 2007, should be revised so that it accounts for the decisions of the victim to pursue criminal investigation in cases of sexual assault or rape."

Appropriate action should be taken in regard to (b) (6) failure to take action in conformance with the Dayton VA Medical Center Policy, 11-41, in particular the responsibility to have notified the VA Police immediately and to have followed up with her supervisor regarding any other action she should have taken.

The Dayton VA Medical Center Leadership have concurred with these additional recommendations. In conclusion, based on the information provided, appropriate action was not timely taken to investigate the reported alleged sexual assault of (b) (6) .

including the actions of the complainant himself. VA staff involved in her IT program did not comply with facility policy in reporting the allegation to the appropriate law enforcement officials. VA has disciplined the responsible VA staff, including the complainant. However, when medical center leadership was made aware of the allegations the record indicates that immediate action was taken. (b) (6) was offered multiple avenues to pursue a criminal report of sexual assault but chose not to do so.

Thank you for the opportunity to respond to this matter.

Michael J. Kussman

Michael J. Kussman, MD, MS, MACP