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Analysis of Disclosures, Agency Investigation and Report, Whistleblower Comments, and Comments of the Special Counsel

OSC File No. DI-08-2370

Summary

The whistleblower, Mario Mancini, former Vocational Rehabilitation Specialist[1], disclosed to the Office of Special Counsel (OSC) that employees at the Department of Veterans Affairs (VA), Dayton VA Medical Center (VAMC), Dayton, Ohio, failed to follow proper procedures after being notified that a VA patient, [redacted], reported she was raped by another VA patient. Mr. Mancini alleged that this constituted a violation of law, rule, or regulation and gross mismanagement.

The Honorable James B. Peake, former Secretary of the VA, delegated authority to the Honorable Michael J. Kussman, former Under Secretary for Health, to address the whistleblower's allegation. The Human Resources Management Group (HRM) was tasked with conducting the investigation. In its investigation HRM relied on the official file and the final report, issued on August 7, 2008, of a Board of Administration Investigation (Board). The Board had previously investigated the alleged sexual assault of Ms. [redacted] and other matters related to the facility's care of Ms. [redacted]. As a result of the investigation, Mr. Mancini's allegation was substantiated and additional violations, as described in greater detail below, were identified.

OSC finds that the agency's report contains all of the information required by statute and that its findings appear to be reasonable.

The Whistleblower's Disclosures

Specifically, Mr. Mancini disclosed that VA medical staff failed to investigate and report to police the alleged rape of Ms. [redacted], who was under the care of VA medical staff at the Hospitality House (House). Mr. Mancini informed our office that the House is a VA facility that provides temporary lodging to the families of VA patients undergoing treatment. Ms. [redacted] resided and worked part-time at the House. Part of her duties were to be available to House guests in order to distribute blankets, pillows, toiletries, and other products the guests may need during the day or evening.

Mr. Mancini asserted that Ms. [redacted] reported to him that [redacted], another VA patient residing at the House, propositioned her for sex and made other inappropriate sexual

[1] Mr. Mancini ceased his employment at the VA in December 2008.

remarks. This complaint occurred on March 14, 2008, on the first day that Mr. [redacted] began living at the House. She continued to complain to Mr. Mancini, about every other day, regarding similar sexual advances from Mr. [redacted]. After each complaint Mr. Mancini informed Janine Wert, Social Worker, about the alleged sexual advances, and recommended Mr. [redacted]' removal from the House. Mr. [redacted] was undergoing treatment for sexual addiction, and Mr. Mancini believed that his advances towards Ms. [redacted] were improper, extremely dangerous and warranted removal. Despite multiple reports from Ms. [redacted] to Mr. Mancini regarding the inappropriate advances and numerous requests by Mr. Mancini that Mr. [redacted] be relocated, VA medical staff did not remove him. Ms. Wert often referred to Ms. [redacted] as a "whore" or "prostitute" in Mr. Mancini's presence. She also stated to Mr. Mancini her belief that Ms. [redacted] was the aggressor, not Mr. [redacted], and that she did not plan to do anything about Ms. [redacted]'s allegations.

On or about March 25, 2008, Ms. [redacted] informed Mr. Mancini that she was raped by Mr. [redacted]. The previous night, Ms. [redacted] heard a knock on her door. She assumed that the person needed supplies and opened the door. Mr. [redacted] forced his way into her room and raped her. After hearing Ms. [redacted]'s account, Mr. Mancini immediately reported the allegation to VA personnel including, Ms. Wert, Charlotte Lynch, Nurse Practitioner, and William Wall, Social Worker.[2] Mr. Mancini stated that these individuals did not interview Ms. [redacted], report the incident to the police for investigation, transport her to a hospital for a medical examination, or take any other appropriate action.

On March 28, 2008, Ms. [redacted] informed Mr. Mancini that Mr. [redacted] made additional sexual advances towards her. Mr. Mancini advised Ms. [redacted] to leave the premises until he could resolve the issue, and then he notified Ms. Wert and Ms. Burney about the problem. Ms. Burney had Mr. [redacted] removed from the House on March 28, 2008. Mr. Mancini believes that the failure to timely remove Mr. [redacted] from the House led to the alleged sexual assault on March 25, 2008.

As a result, the former Special Counsel concluded that there was a substantial likelihood that the information provided by the whistleblower disclosed a violation of law, rule, or regulation, including, but not limited to, Dayton VA Medical Center Policy No. 11-41, Reporting of Abuse and Neglect Cases (Reporting Policy). 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. None of these actions were taken regarding Ms. [redacted]'s claims of sexual assault and rape. It was also concluded that there was a substantial likelihood that the actions of the employees constituted gross mismanagement.

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[2] In January 2008, Dr. Florence Coleman, Mr. Mancini's immediate supervisor at that time, instructed him to contact Ms. Wert, Ms. Lynch, or Mr. Wall if there were any complaints of sexual abuse, rape or other related problems. Anna Burney, Patient Advocate, was to be notified afterwards, only if necessary. Dr. Coleman further directed that Mr. Mancini was not to directly contact the police or any outside entities himself.

The Agency's Investigation and Report

In order to determine whether VA employees followed proper procedures after being notified about the alleged assault, HRM obtained information from the Dayton VA Regional Counsel, VAMC, the Human Resource Manager, VAMC, and the Health Systems Specialist staff in the VA Central Office. It also reviewed VAMC policies related to this matter and the final report of the Board, and interviewed management officials at the VAMC. As a result, HRM found that although VA employees became aware of the alleged assault on different dates, only the Chief of Staff complied with the Reporting Policy and notified the appropriate people after learning about the incident on Friday, April 25, 2008. The investigation concluded that Ms. Lynch learned about the rape allegation on April 11, 2008, but failed to properly follow the Reporting Policy because she only notified Dr. Coleman. In its final report the Board concluded that Dr. Coleman's testimony was not credible and that she learned about the incident as early as either March 26, 2008, or April 11, 2008, and failed to take appropriate action.

Additionally, the Board also found that Mr. Mancini learned about the alleged rape as early as March 25, 2008, but also neglected to follow the reporting procedures. It was further discovered that although Mr. Mancini claimed that Ms. [redacted] began complaining about Mr. [redacted]' behavior on March 14, 2008, Mr. Mancini did not record any of these issues in Ms. [redacted]'s medical records as required by VA policy. The Board concluded that the evidence of record did not establish that Mr. Mancini notified any VA staff of Ms. [redacted]'s allegations until he sent an electronic alert to Ms. Lynch on March 26, 2008. In the Board's final report Mr. Mancini's testimony was not deemed credible. At the conclusion of the investigation the allegation was substantiated that VA employees, including Mr. Mancini, failed to follow proper procedures after being notified that Ms. [redacted] reported she was raped by Mr. [redacted].

The Board further concluded that the practice of referring veterans to the Hospitality House (House)[3] for temporary lodging violated the terms of the lease agreement between the VA and the VFW. It also found that Mr. Mancini failed to properly document entries into Ms. [redacted]'s medical record "as required by VA Handbook 1907.01, Health Information Management and Health Records, dated August 25, 2006."

As part of the corrective action resulting from the investigation, the VAMC has pursued disciplinary action against Dr. Coleman for failing to appropriately respond after receiving notice of Ms. [redacted]'s allegation of being sexually assaulted by Mr. [redacted]. The VA issued a proposed involuntary change of assignment memorandum against Dr. Coleman, which involves a reduction to a non-supervisory role with a commensurate reduction in pay. The VAMC was further advised that appropriate action should be taken in regard to Ms. Lynch's failure to adhere to the requisites of the Reporting Policy and follow-up with her supervisor about Ms. [redacted]'s case. The VA also terminated Mr. Mancini based, in part, on his "failure to properly manage

[3] In its report the VA explained that the House is not a VA operated treatment facility, although it is on the Dayton VAMC campus. The VA leases the House to the Veterans of Foreign Wars (VFW), and the VFW manages the property and uses it to furnish temporary lodging to families of patients visiting the medical center at a discounted rate. The VA does not supervise the activities within the House.

Ms. [redacted]'s case and to properly document and report Ms. [redacted]'s allegations of having been sexually assaulted . . ." Ms. [redacted]'s therapeutic employment, related counseling, and all necessary mental health care was transferred to another facility. It was further recommended that the Reporting Policy be revised to account for the decisions and preferences of the victim in alleged cases of sexual assault. VAMC management officials have concurred with these recommendations.

The Whistleblower's Comments

Mr. Mancini provided comments expressing his discontent with the manner in which the investigation was conducted. He believes that the investigation was biased and was accomplished with the intent of discrediting Ms. [redacted] and anyone who supported her, namely Dr. Coleman and Mr. Mancini. Mr. Mancini emphasized that Ms. [redacted] has an IQ of approximately 76 and a "Global Assessment Functioning of 25 . . . and has been diagnosed with Borderline Intellectual Functioning." Mr. Mancini asserted that the VA medical staff ignored these facts and refused to provide appropriate care and counseling to Ms. [redacted].

In regard to the Hospitality House, Mr. Mancini stated that he did assist in Ms. [redacted]'s placement in the House, which was not an uncommon practice. He believes that the placement of Mr. [redacted], a man with sexual compulsion issues, jeopardized the welfare of the veterans residing at the house. Contrary to the agency's report, Mr. Mancini does not agree that he had ample opportunity to dispute or address any of the Board's findings. Mr. Mancini further asserted that he did not violate the Reporting Policy and was not aware that it had to be followed in rape cases. He maintains that he notified Ms. Lynch, Dr. Coleman, Ms. Wert, Mr. Wall, and Ms. Burney, about Ms. [redacted]'s allegation of rape. He believes that the paper records support his claims that he reported the matter. However, in retrospect, Mr. Mancini agrees that he should have documented the issues between Ms. [redacted] and Mr. [redacted]. According to Mr. Mancini, the record also revealed that Mr. Wall failed to accurately document Mr. [redacted]' file. In addressing the apparent inconsistencies in his testimonies, Mr. Mancini stated that because he had been on administrative leave for over two months and did not have an opportunity to review his notes, he was unable to recall the answer to some of the questions he was asked. Mr. Mancini also emphasized that although he notified the VA that he was suffering from stress due to military related Post Traumatic stress disorder (PTSD), he was denied leave and was not afforded any other type of assistance. He also declared that everything he did while working for the VA was done in order to promote the best interest of the veterans.

Moreover, Mr. Mancini does not agree that enforcing the lease provisions will eliminate these issues and prevent such problems from happening again. He believes that preventing veterans from residing at the House removes necessary services without replacing them with a viable alternative. Mr. Mancini is skeptical that any disciplinary action will be enforced and does not believe that the VA is being truthful with OSC. He further explained his rationale for believing that the expert witness used in the investigation was not qualified to act in that capacity. His problem with the entire investigation is that everyone quickly discounted the possibility that Ms. [redacted] was raped without fairly evaluating the situation.

Mr. Mancini concluded by listing his account of the wrongdoing that the agency has engaged in and specifically noted that although multiple employees failed to follow the reporting policy and document patient files, he is the only one who was terminated. Mr. Mancini stated that he was wrongly terminated after nearly twenty years of service and was treated unfairly for advocating for the rights of veterans. He believes that the VA's system is severely flawed and that appropriate changes need to be implemented in order to safeguard veterans' rights.

Conclusion

Based on my review of the original disclosures, the agency's report, and the whistleblower's comments, I have determined that the agency's report contains all of the information required by statute and that its findings appear to be reasonable.