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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

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.[1]

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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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[1] 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).

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:

- 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.

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.[2] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[2] 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.