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-14-3337

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Vet Center, Federal Way, Washington. The U.S. Office of Special Counsel (OSC) has reviewed the report, and in accordance with 5 U.S.C. § 1213(e), provides the following summary of the agency investigation, whistleblower comments, and my findings.

Jonathan Wicks, a former clinical social worker who consented to the release of his name, disclosed that employees at the Vet Center engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and an abuse of authority. Specifically, Mr. Wicks disclosed that employees at the Vet Center repeatedly falsified clinical activity records, failed to contact veterans who requested counseling services, and maintained improper paper records, which compromised patient confidentiality.

The agency substantiated Mr. Wicks's allegations. The report determined that Amy Morris, the Vet Center team leader, repeatedly falsified clinical activity records. The report also determined that Reed Dyer, an outreach specialist, falsified and destroyed records, and failed to contact veterans who had requested counseling services. The report determined that these actions posed a risk to public health and safety. The report further substantiated that the Vet Center maintained patient records in an unsecured paper log instead of in an electronic database as required by VA policy. In response, the agency provided training to employees in proper administrative practices and issued letters of reprimand to Ms. Morris and to Deputy Regional Manager John W. Woods and Regional Manager Donald Smith, who failed to properly supervise her.

I have determined that the report meets all statutory requirements. Nevertheless, I do not find that verbal counseling and letters of reprimand are sufficient disciplinary actions in light of the serious misconduct at issue. The VA's own ethics regulations indicate removal is an appropriate penalty for the kind of

systematic falsification of government records seen in this case, a conclusion bolstered by suggestions in the original report, but ultimately disregarded.

Mr. Wicks's allegations were referred to then-Acting Secretary Sloan D. Gibson, to conduct an investigation pursuant to 5 U.S.C. §1213(c) and (d). Acting Secretary Gibson directed the Interim Under Secretary for Health Carolyn M. Clancy, MD, to refer Mr. Wicks's allegations to the Office of the Medical Inspector for investigation. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On February 12, 2015, Mr. Riojas submitted the agency's report to OSC. Pursuant to 5 U.S.C. §1213(e)(1), Mr. Wicks provided comments on the agency report on February 24, 2014. As required by 5 U.S.C. §1213(e)(3), I am now transmitting the report and Mr. Wicks's comments to you. [1]

I. Mr. Wicks's Disclosures

Mr. Wicks alleged that Ms. Morris routinely falsified her direct client contact records. According to Mr. Wicks, after a 2013 evaluation demonstrated significant deficiencies in Ms. Morris's productivity, she took improper measures to improve her performance measures. Mr. Wicks noted that Ms. Morris started misrepresenting brief non-clinical telephone calls as substantive clinical interactions. In addition, Mr. Wicks alleged that Ms. Morris counted outreach calls made by work-study students as clinical activities that she performed. Mr. Wicks also explained that Ms. Morris falsified the length of time she spent in in-person counseling sessions. According to Mr. Wicks, Ms. Morris often spent 60 minutes in a session, but entered 120 minutes into time records, approximately 5 to 6 times per week.

Mr. Wicks also alleged that Mr. Dyer improperly closed cases when clients requested follow-up contact. In June 2014, Mr. Wicks reviewed pending cases in an agency computer application and determined that Mr. Dyer had over 100 cases with delinquent counseling requests. Mr. Wicks noted that some requests were outstanding for over 120 days. Mr. Wicks alerted Ms. Morris, who thanked him for bringing the issue to her attention. One week later, Mr. Wicks reviewed Mr. Dyer's pending cases and observed that Mr. Dyer now had zero delinquent cases. Mr. Wicks reviewed Mr. Dyer's cases to determine if he documented contacting clients or created any follow-up

[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).

appointments. He found that instead of calling clients or sending letters, Mr. Dyer simply closed cases and entered a chart note indicating that the case was closed because the client did not contact the Vet Center. Mr. Wicks determined that Mr. Dyer copied and pasted this note into every delinquent case for which he was responsible.

Mr. Wicks also alleged that the Vet Center kept a paper release of information (ROI) log instead of using an electronic version as required by agency policy. When Vet Center counselors refer a client to a VA hospital for treatment, the client must consent to the transfer of his or her Vet Center records to the VA hospital. The consent is recorded in the Vet Center ROI log. Mr. Wicks alleged that the Vet Center maintained a paper version of this log. He further noted that this paper log book was often left unattended in open, unsecured office space. Mr. Wicks alleged that Ms. Morris took no measures to secure the log book nor did she mandate the use of the available electronic ROI log.

II. The Agency Report

The report substantiated that Ms. Morris repeatedly falsified clinical activity records by misrepresenting clinical hours. The agency was unable to determine if Ms. Morris documented work-study student calls as clinical activities; she denied this charge and individual outreach cards, which could have confirmed who made the calls, were destroyed after contact was made or attempted. The report further determined that in June 2014, a team leader from another Vet Center conducted a fact-finding review at the request of the regional office, addressing similar allegations. The review confirmed the allegations and recommended in a report to Deputy Regional Manager John W. Woods that the 4A Readjustment Counseling Service Western Mountain Regional Office investigate the allegations further and take corrective action as warranted. The report found no evidence that regional leadership investigated these allegations or took recommended corrective actions as suggested in the review. The report noted that despite these irregularities, Ms. Morris received fully successful performance ratings in both 2013 and 2014.

The report recommended that the regional office review Ms. Morris's noncompliance with agency requirements for the documentation of clinical activity and ethical codes of conduct, provide training, and take disciplinary action, including possible removal, if warranted. The report suggested that once these actions are completed, officials monitor Ms. Morris for a year to ensure she complies with agency policy. The report further recommended a review of notes entered by Ms. Morris between February and May 2014 to determine whether she recorded outreach calls by work-study students as clinical activities that she had performed. In addition, the report recommended that the Veterans Health Administration reinforce that regional leadership must follow-up on findings and recommendations from annual quality reviews and monitor corrective actions to completion. The report stated that the Veterans Health Administration must

provide more rigorous oversight of the regional office in its handing of alleged malfeasance by Vet Center staff members and, if warranted, hold all parties accountable.

The investigation also determined that Mr. Dyer improperly opened new counseling cases. After creating these cases, Mr. Dyer was obligated to manage them under agency policy. Nevertheless, many of these cases were closed without contacting veterans, and the associated records were improperly destroyed. The report noted that the failure to provide veterans with requested services posed a risk to public health and safety. The report recommended an administrative review of Mr. Dyer's conduct and appropriate actions if warranted. The report indicated that veterans who requested Vet Center services be identified, and contacted to determine if they still required services.

The report confirmed that the Vet Center used a paper ROI log in lieu of the required electronic database, noting that this deficiency was also identified in the quality review. The report also recounted a January 2014 incident, where a former staff member found the ROI log unsecured in an open, unattended office. Ms. Morris was apprised of this issue, but according to the report, she took no corrective actions for approximately a month. In June 2014, regional management was notified of this incident and Ms. Morris' delayed response but did not take corrective actions. The report noted that starting in September 2014, a new Vet Center office manager began scanning all ROI requests from the paper log and shredding the original documents. The report recommended the regional office provide more rigorous oversight of the Vet Center is in compliance with quality reviews and in particular the conduct of Ms. Morris.

The agency provided OSC with a supplemental report on April 14, 2015, concerning the above-referenced corrective actions. The Vet Center team has received education and training on documentation procedures. In addition, the Vet Center identified and attempted to contact 419 veterans who required outreach as the result of Mr. Dyer's misconduct. Of the 419 veterans, 34 provided no contact information, 275 were contacted but did not respond, 101 were reached and declined service, and 9 requested service. This included the 100 cases Mr. Dyer had improperly closed. Further, Mr. Dyer occupied a term-limited appointment, which was not renewed upon its expiration in May 2015.

Despite suggesting in the original report that Ms. Morris's conduct may warrant removal, the agency issued Ms. Morris a verbal counseling and a letter of reprimand for her conduct. With respect to the identified deficiencies in regional office leadership, after convening an administrative board to review the matter, two regional administrators were issued letters of reprimand.

III. Mr. Wicks's Comments

Mr. Wicks expressed concerns that the regional office would not properly oversee proposed recommendations and would not admit that problems existed at the Vet Center. He asserted that a third-party clinician should conduct reviews of counseling records and oversight of the Vet Center. Finally, Mr. Wicks noted that until there is a significant culture change within the VA focused on holding supervisors accountable for unethical conduct, wrongdoing will persist within the agency.

IV. The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and Mr. Wicks's comments. Based on that review, I have determined that the reports contain all of the information required by statute. Nevertheless, I am concerned that the mere imposition of verbal counseling and letters of reprimand are inconsistent with the gravity of the substantiated misconduct. The VA's own ethics regulations indicate removal is an appropriate penalty for the kind of systematic falsification of government records seen in this case, a conclusion also contained in the original agency report. In this case of significant employee wrongdoing, rather than pursuing employee accountability, and imposing substantial discipline, the agency instead took only minimal disciplinary action. The VA's failure to impose appropriate discipline in this case fits a pattern which requires correction.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the unredacted agency report and the whistleblower's comments to the Chairmen and Ranking members of the Senate and House Committees on Veteran's Affairs. I have also filed copies of the redacted agency report and whistleblower 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.