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

The Special Counsel

April 7, 2016

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-15-1216

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Canandaigua VA Medical Center, Veterans Crisis Line (VCL), Canandaigua, New York. I have reviewed the report and in accordance with U.S.C. § 1213(e), provide the following summary of the agency report, whistleblower comments, and my findings.[1] The whistleblower, John M. Giunta, who consented to the release of his name, alleged that the VCL has mismanaged the training of new employees and that back-up call centers do not appropriately respond to callers in crisis.

I referred Mr. Giunta's allegations to Secretary Robert A. McDonald for investigation pursuant to 5 U.S.C. § 1213(g)(2). Secretary McDonald delegated investigation of the matter to the VA Office of Inspector General (OIG). Interim Chief of Staff Robert D. Snyder reviewed and signed the report. On February 12, 2016, Mr. Snyder submitted the agency's report to the Office of Special Counsel. Mr. Giunta provided comments on February 26, 2016.

The agency substantiated Mr. Giunta's allegations in part. The investigation determined that VCL management did not provide employees responsible for coordinating emergency service responses with an adequate orientation before allowing them to function independently, nor did they provide ongoing training to these

[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).

employees. The investigation could not substantiate that back-up call center staff did not receive adequate training, because the VCL program does not provide or monitor this training. The report noted that while the VCL staff develops back-up call center training programs, the VA is not required to oversee or implement this curriculum. The VA OIG made a number of recommendations, including the development of an orientation and ongoing training for all VCL staff and the establishment of a formal quality assurance process to identify system issues and ensure that corrective actions are implemented.

In an update, the agency noted that the VCL has made organizational changes and improvements since the time of the original referral, improving both employee training and quality assurance processes. This update explained that the VA has made extensive organizational and process changes to ensure the VCL provides improved service. These changes include hiring new quality management staff, implementing quality assurance programs, and developing new training programs for staff. While this update demonstrates many improvements to the VCL, it does not directly respond to or address the whistleblower's ongoing concerns about adequate supervision of back-up call centers.

I have determined that the report and update meets all statutory requirements. While the commitment to improving training and implementing a quality assurance process is a positive and overdue step, I am concerned by the serious lack of oversight with respect to the function of back-up call centers. Notably, VA does not require that back-up centers obtain American Association of Suicidology (AAS) Crisis Center Accreditation, an endorsement demonstrating that their services meet nationally recognized standards, even though AAS is the organization that VA itself selected for VCL accreditation. Indeed, no agreements exist between VA and back-up centers mandating a specific training or orientation curriculum. The report also questioned the quality of back-up call center services, noting that VCL staff was frequently unable to confirm the outcome of calls and the wellbeing of veterans who were routed to back-up centers due to VCL volume. Accordingly, while significant progress has been made, I find the corrective actions unreasonable in light of the issues concerning at-risk individuals addressed in this report.

Mr. Giunta echoed these concerns in his comments. He noted that on several occasions, VCL personnel needed to give back-up center staff step-by-step instructions on how to initiate an emergency dispatch, or how to physically locate a veteran who contacted the center via cell phone. He also asserted that frequently the back-up centers do not provide adequate information to VCL employees responsible for determining the status of a veteran following an emergency dispatch. As a result, he reported situations where VCL employees were later unable to verify the health and safety of callers routed to back-up centers, whose lives were in imminent danger, scenarios that occur almost daily. He reported these scenarios occur almost daily. Mr. Guinta also commented on the agency update, noting that the corrective actions were inadequate to resolve the above identified issues, and that the training programs under development did not solicit or incorporate input from employees experienced in conducting rescues.

As the VLC provides a critical service to a vulnerable population dealing with serious mental and behavioral health issues, the VA's minimal oversight of back-up call centers is concerning. While the agency has made recent improvements to the operation of the VCL, due to the grave implications posed to at-risk individuals, I urge the VA to take immediate measures to increase agency supervision of the back-up call centers and the quality of their services. For these reasons, I have determined that the report and update meet all statutory requirements, but the proposed corrective actions are unreasonable because they are incomplete in light of the OIG's findings on back-up call centers.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, the agency update, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of these documents in our public file which is available at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures