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**The Special Counsel**

November 30, 2017

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

Re: OSC File No. DI-15-4906

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am transmitting Department of Veterans Affairs (VA) reports based on disclosures of wrongdoing at the Raymond G. Murphy VA Medical Center (Albuquerque VA), Albuquerque, New Mexico. I have reviewed the agency reports and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the reports, whistleblower comments, and my findings.<sup>1</sup>

The whistleblower, who chose to remain confidential, alleged that Albuquerque VA Suicide Prevention Coordinator (SPC) [REDACTED] regularly failed to fulfill her assigned duties according to VA regulations, resulting in unsatisfactory care for suicidal veterans. Specifically, the whistleblower alleged that [REDACTED] regularly failed to manage the High Risk for Suicide list by failing to flag patients' records as high risk for suicide in a timely manner and failing to ensure that patient record flags were up to date; failed to respond to consults of veterans who had survived a suicide attempt or were identified as at high risk for suicide; and failed to respond to calls transferred to the New Mexico VA Suicide Prevention Group from the Veterans Crisis Line.

The whistleblower's allegations were referred to then-Secretary of Veterans Affairs Robert A. McDonald on April 11, 2016, pursuant to 5 U.S.C. § 1213(c). Secretary McDonald tasked the VA's Office of the Medical Inspector (OMI) with the investigation.

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<sup>1</sup> The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging a violation 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, he is required to advise the appropriate agency head of his 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) and (g). 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).

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The VA, through then-Chief of Staff Robert D. Snyder, submitted the agency report on November 7, 2016. OSC received a supplemental report on April 10, 2017. The whistleblower provided comments on the initial agency report, but declined to comment on the supplemental report.

The agency substantiated that [REDACTED] did not perform 90-day evaluations for some veterans who had been assigned a patient record flag, but noted that this was due to [REDACTED] decision to focus on suicidal veterans in more urgent need of care. The agency also substantiated that [REDACTED] failed to transfer ownership of a patient record flag of a veteran who had relocated to a different facility and did not acknowledge the receipt of a BEACON Clinic consult<sup>2</sup> for an extended period of time in a number of cases. The VA noted, however, that there is no required timeframe for a response. The agency recommended more clearly defining the role and responsibilities of each Suicide Prevention Team member and revising policies, procedures, and guidelines to increase clarity regarding the handling of suicidal veterans.

The agency did not substantiate that [REDACTED] regularly failed to manage the High Risk for Suicide List in a timely manner, stating that there is no time limit by which a suicide prevention coordinator must flag a patient record. Nor did the agency substantiate that [REDACTED] failed to respond to consults of veterans who survived a suicide attempt or were identified as a high risk for suicide. Finally, the agency did not substantiate that [REDACTED] failed to carry out her duties related to responding to calls from the Veterans Crisis Line, but acknowledged there were instances in which she had a delayed response to specific calls.

I find the agency's initial report disappointing. The issue of veteran suicide is a national crisis, with over twenty veterans committing suicide every day. It was unfortunate that the VA had no policy in place setting a required timeframe for a response to consults from the BEACON Clinic or for a patient record flag to be placed on a patient's record. As seen from the agency reports, a lack of requirements leads to delays and delays lead to veteran deaths. Furthermore, OSC found the agency's contention that [REDACTED] succeeded in carrying out her duties related to responding to calls from the Veterans Crisis Line surprising, as it simultaneously noted that [REDACTED] had delayed responses to multiple calls from suicidal veterans. In the context of responding to a suicidal veteran's call to the Crisis Line, a delayed response can be as harmful as no response. As Suicide Prevention Coordinator, it is [REDACTED] responsibility to respond to calls transferred to the Suicide Prevention Group from the Veterans Crisis Line. If [REDACTED] responses to calls are even occasionally delayed, I would contend she is not successfully performing her duties.

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<sup>2</sup> The Medical Center's Behavior Health Care Line established a BEACON Clinic at the facility, providing a "BEACON of Hope" to Veterans in need of urgent MH care services on a 24/7 basis. *The BEACON Team pamphlet*, New Mexico VA Health Care System Behavior Health Care Line, November 2012.

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Based on the above concerns, OSC requested a supplemental report from the agency. Specifically, OSC sought the rationale behind VA regulations governing the handling of suicidal veterans, particularly why there was no standard timeframe for placing a patient record flag on a veteran's record once the veteran is identified as a high risk for suicide. OSC also requested updates regarding the implementation of recommendations the VA outlined in its report. Additionally, OSC noted that many of the issues in the handling of suicidal veterans at the Albuquerque VA stemmed from a lack of staffing, and asked whether there would be staffing adjustments to the Suicide Prevention Team.

In its supplemental report, the agency stated that a standard timeframe for placing a patient record flag should be required and noted that revisions to the HRS Patient Record Flag Directive were being drafted to establish that standard. The agency also outlined proactive steps it had taken to both clarify rules and regulations surrounding the handling of suicidal veterans, and implement the recommendations described in the report including developing new SOPs and trainings for employees. Finally, the agency stated that it completed a review of the Suicide Prevention team workload and made changes to employee approval powers to make the workload more manageable. The agency noted that the Suicide Prevention team is currently successfully meeting the demands and requirements of the program.

OSC recently requested a status update regarding the revisions to the HRS Patient Record Flag Directive. In a November 8, 2017 update, the agency stated that the HRS Directive revisions were completed in April 2017 and entered into the concurrence process, but have since been removed from that process to allow the Directive to be combined with a separate Directive concerning patient record flags. In October 2017, the agency published a memo highlighting the proposed changes to the patient record flag (PRF) directives:

The key recommendation directs that Veterans clinically determined to be HRS shall have an HRS flag placed in their electronic health records (EHR) as soon as possible, but certainly within 24 hours of the determination, and staff must be trained in accurately entering, maintaining, and reviewing this PRF. Should an HRS Veteran move to another city, the SPC will work with the SPC of the VA facility nearest the Veteran's new home to set up an initial appointment and to transfer ownership of the HRS flag to that facility as soon as the new address is confirmed. While the EHR automatically follows the Veteran, this "warm handoff" between SPCs assures that his special care will continue uninterrupted.<sup>3</sup>

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<sup>3</sup> E-mail from Nhi Nguyen, Executive Writer, Department of Veterans Affairs, to Catherine McMullen, Chief, Office of Special Counsel, Disclosure Unit (November 13, 2017, 8:30AM EST).

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I have reviewed the original disclosures, the agency reports, and the whistleblower comments. The agency initially appeared slow in recognizing the tragedy that suicide by veterans represents, seemingly implying that certain delays in care and a lack of adequate regulations governing the handling of suicidal veterans were tolerable. Ultimately, following the receipt of the supplemental reports, I have determined that the reports contain all of the information required by statute and the findings appear reasonable. I also recommend that the agency establish a required timeframe within which an SPC from a veteran's original hospital reach out to the SPC of the VA facility nearest a veteran's new home to set up an initial appointment. I have sent a copy of this letter, the unredacted agency reports, and the whistleblower comments, to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed copies of this letter, the redacted agency reports, and the whistleblower comments in OSC's public file, which is available online at [www.osc.gov](http://www.osc.gov). This matter is now closed.

Respectfully,



Henry J. Kerner  
Special Counsel

Enclosures