



**U.S. OFFICE OF SPECIAL COUNSEL**

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The Special Counsel

June 12, 2017

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

Re: OSC File Nos. DI-16-3277 and DI-16-3273

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Veterans Health Administration Central Office (VHACO), Washington, D.C. and the Canandaigua VA Medical Center, Veterans Crisis Line (VCL), Canandaigua, New York. 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 whistleblowers, whose identities remain confidential, alleged that VHACO retained 35 unqualified VCL responders in positions where they assisted veterans in crisis and performed clinical duties, in violation of agency regulations, and that newly hired VCL employees are not properly trained before they are allowed to interact with veterans in crisis. The Office of Special Counsel (OSC) received these allegations from two individuals who alleged distinct issues, but because both disclosures involved the administration of the VCL, their allegations will be discussed jointly in this closure letter.

The allegations concerning unqualified VCL responders were referred to former Secretary Robert McDonald for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Secretary and VA's Office of Human Resources and Administration investigated the matter. Former Chief of Staff Robert D. Snyder was delegated the authority to review and sign the report. On October 13, 2016, Mr. Snyder submitted the agency's report to the Office of Special Counsel (OSC). The allegations of inadequate

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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 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).

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training were investigated by the VA's Office of Inspector General (OIG). Chief of Staff Vivieca Wright Simpson was delegated the authority to review and sign a cover letter to the OIG report that was transmitted to OSC on March 28, 2017. The OIG also published this report on their website on March 27, 2017. One whistleblower provided comments to the October 2016 VA report on December 6, 2016, while the other whistleblower chose not to provide comments to the OIG report.

The agency substantiated both whistleblowers' allegations. With respect to the allegations involving employee qualifications, the whistleblower alleged that 35 VCL responders, who are responsible for interacting with and providing support to veterans experiencing acute mental health crises, lacked required educational qualifications for their positions. The report explained that these prerequisites were inadvertently omitted from job vacancy announcements posted between 2012 and 2014. To avoid mass termination of staff when this deficiency was discovered in 2014, the VA reassigned these employees to a newly-established position that allows four years of crisis counseling experience to substitute for an academic degree. In order to finalize this transition, VHACO requested a qualification waiver from OPM, which OPM granted in June 2016.

The whistleblower also alleged that this reassignment placed non-clinical employees in positions where they performed clinical duties, in violation of VA regulations. The agency substantiated this allegation, acknowledging that reclassified employees continued to improperly perform clinical duties, in violation of agency rules. However, the agency asserted that despite this technical violation, due to prior experience, extensive training, and quality assurance monitoring, there was no substantial and specific danger to public health or safety.

The agency also substantiated the allegations regarding new employee training. The OIG found that social service assistants (SSAs) were allowed to coordinate emergency rescue responses independently at the end of a two-week training period, without supervision, regardless of readiness. The agency report also substantiated two instances where new employees violated agency policy in their interactions with veterans in crisis, but noted no harm resulted. The report further found that the VCL lacked a process for quality assurance and had no mechanism for determining whether staff received training on updated procedures and policies.

In comments to the report, the whistleblower asserted that the agency's actions constituted a "continued watering down of the skills and talents of the staff carrying out the mission of the VCL." The whistleblower disputed the agency's statements regarding training and quality assurance, noting that the VA OIG contradicted these conclusions. Specifically, in a February 2016 report, the OIG found "gaps in the VCL quality assurance process. These gaps included an insufficient number of required staff supervision reviews, [and] inconsistent tracking and resolution of VCL quality assurance

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issues.” See OIG Report No. 14-03540-123.<sup>2</sup> The report further noted that “supervisory staff did not complete the required number of supervision tasks associated with the quality of call responses by VCL responders.” The whistleblower also pointed out that the OIG report found the following deficiencies in VCL responder training:

Of the 33 [responders] hired during [2014], we found that 6 (18 percent) did not have orientation checklists. The 27 responders who had checklists had completed training modules related to call center rescues and consult resources. However, 24 of the 27 (89 percent) orientation checklists did not have all of the checklist items marked as completed and/or were not signed or dated by the responders’ supervisors. We also found no evidence that 18 of the 33 (55 percent) responders had taken a post-orientation test. *Id.*

The whistleblower stated: “OIG’s findings seem to call into question the VA’s ability to provide appropriate quality assurance and consistent training, which is the basis of their decision to keep otherwise unqualified employees actively involved in the crisis line. It would appear the conclusion there was not a substantial threat to health and public safety was based solely on the VA’s own internal quality assurance controls and training which OIG found to be insufficient.” The whistleblower also noted that the original 2008 reclassification of VCL employees from a Title 38 to a Title 5 classification is specifically prohibited under VA policy. See VA Handbook 5005, Part III, Appendix N (b). The whistleblower further questioned the appropriateness of reassigning employees from one Title 5 occupation to another, when the agency acknowledged these employees were still improperly performing clinical duties that must be conducted by clinical staff hired under Title 38. The whistleblower concluded by asserting that the report demonstrates that the VA failed to accept accountability for its errors and has put veterans at risk.

I have reviewed the original disclosure, the agency reports, and the whistleblower comments. I have determined that while the reports meets all statutory requirements, the findings regarding employee qualifications appear unreasonable. The whistleblower comments are particularly compelling, as they highlight that the agency’s conclusions regarding VCL responder training and quality assurance programs are contradicted by multiple VA OIG investigations and reports. The VCL is responsible for providing services to vulnerable veterans experiencing acute mental health crises. Accordingly, employees responsible for this mission must be held to the highest professional standards. The VA’s reclassification of these positions is troubling, as several OIG reports have indicated that the training and quality assurance monitoring relied upon by the VA to justify these actions is seriously deficient. The VA OIG’s findings regarding VCL

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<sup>2</sup> Available at: <http://www.va.gov/oig/pubs/VAOIG-14-03540-123.pdf>.

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responder training and quality assurance monitoring should instead prompt the VA to conduct a significant review of VCL management, take appropriate corrective action as necessary, and prioritize the training and quality assurance procedures of the VCL.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, 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 these documents in our public file, which is available at [www.osc.gov](http://www.osc.gov). This matter is now closed.

Respectfully,



Carolyn N. Lerner

Enclosures

cc: Chief of Staff Vivieca Wright Simpson