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The Special Counsel

April 10, 2019

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

Re: OSC File Nos. DI-18-0169; DI-18-0225; and DI-18-0226

Dear Mr. President:

I am forwarding to you a report from the Department of Veterans Affairs (VA), based on disclosures of wrongdoing at the Richard L. Roudebush VA Medical Center (Medical Center), Indianapolis, Indiana. The whistleblowers disclosed that Medical Center employees engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. I have reviewed the agency report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of my findings.¹

██████████ and ██████████ social workers at the Medical Center who consented to the release of their names, along with a third whistleblower who chose to remain anonymous, alleged that Medical Center management directed social workers to stop entering home health care consults into the Computerized Patient Record System without training other staff to perform this function. They also alleged that a lack of adequate planning, training, and communication resulted in significant delays in care and harm to veterans.

The agency substantiated both allegations. First, the investigators found that Social Work Service leadership, including the Chief and the Assistant Chief, directed social workers to stop entering home health care consults due to concerns it was outside the social workers' scope of practice. These actions resulted in a system breakdown because leadership attempted to implement the change without collaborating with key services or allowing time for coordination and education.

Second, the agency found that the lack of adequate planning, training, and communication resulted in significant delay in at least one veteran's care. In June 2017, a veteran was discharged from the Medical Center after receiving treatment for diabetic ketoacidosis and an ulcerated foot abscess. A home health care consult was entered to provide the veteran assistance dressing his foot wound at home. However, the consult was not properly processed and the veteran did not receive the necessary home health

¹The whistleblowers' allegations were referred to former VA Secretary David J. Shulkin, M.D., for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The VA Office of the Medical Inspector conducted the investigation. Secretary Robert L. Wilkie reviewed and signed the agency's report.

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care. The investigation found that the veteran's wound became infected and required below-the-knee amputation due to the delay in receiving dressing changes from a home care agency. The agency concluded that the lack of coordinated care from the inpatient to outpatient setting posed a risk to public health and safety.

In response to these findings, the Medical Center updated and implemented the home health care consult standard operating procedures (SOPs), including the standard processes for monitoring consults and post-discharge follow-ups. The Medical Center has provided training to all key staff members. The new SOPs clarified that entering home health care consults is within the scope of practice for social workers. In addition, the practice of discontinuing incomplete consults was halted at the Medical Center; referral nurses now immediately contact the provider or social worker to address the incomplete consult. An external peer review of the veteran who did not receive timely wound care is currently underway.

The whistleblowers were satisfied with the outcome of the investigation and declined to submit written comments on the agency's findings.

I have reviewed the original disclosure and the agency report and have determined that the report contains the information required by statute and that the findings appear reasonable. While I commend the VA for taking the necessary steps to prevent similar problems from occurring in the future, I am nonetheless distressed that such a situation occurred in the first place. It is unacceptable that a situation should ever arise where our nation's veterans are provided such substandard care that it resulted in a loss of limb, because of a mistake by the agency entrusted to take care of them. I look forward to an update from the VA upon completion of the peer review of the affected veteran's case.

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

Respectfully,



Henry J. Kerner
Special Counsel

Enclosure