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1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

November 2, 2026

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

Re: OSC File No. DI-25-001246

Dear Mr. President:

I am forwarding to you a report transmitted to the U.S. Office of Special Counsel (OSC) by the U.S. Department of Veterans Affairs (VA), in response to the Special Counsel's referral of allegations that officials at the Harry S. Truman Memorial Veterans' Hospital, in Columbia, Missouri (Hospital), engaged in conduct that constitutes a violation of law, rule, or regulation and a substantial and specific danger to public health or safety.[1] In conformance with 5 U.S.C. § 1213(e), OSC reviewed the disclosure and agency report[2] and I have determined that the report contains the information required by statute and the findings appear reasonable. The following is a summary of the findings.

The whistleblower, [redacted], a Registered Nurse, who consented to the release of his name, disclosed that Hospital officials are improperly admitting into the Acute Psychiatric Care Unit (APCU), Unit 2B, veterans who pose a safety risk to other veterans receiving inpatient psychiatric care, contrary to VA rules. [redacted] alleged that current admission practices for Unit 2B contravene the safety measures established under Veterans Health Administration (VHA) Directive 1160.06 and the APCU Standard Operating Procedure (SOP) BH-6.

The agency investigation did not substantiate the specific allegation that the Hospital violated the SOP, but found that the allegation had merit in that it revealed a discrepancy between the Hospital SOP and the VA-wide directive. The investigation found that SOP BH-6 includes restrictive standards against admitting patients with chronic mental health concerns that do not align with the access to care guidelines of VHA Directive 1160.06(1), which provides that admission to inpatient mental health units must be available to all eligible veterans who require hospital level care for a mental health condition. As such, investigators determined that the SOP could not be used as a standard to assess whether the Hospital had been non-compliant with admission procedures, and did not question whether violations of the SOP

[1] The whistleblower's allegations were referred to the Secretary of Veterans Affairs, Douglas A. Collins, on May 7, 2025, for investigation pursuant to 5 U.S.C. §§ 1213(c) and (d). The VA Office of Medical Inspector conducted an onsite investigation June 24-26, 2025. Secretary Collins reviewed and signed the report on November 14, 2025.
[2] Under 5 U.S.C § 1213(e)(1), whistleblowers may submit comments on the agency report. Here, the whistleblower elected not to submit comments.

occurred. While the report acknowledges that a 2013 patient fatality in Unit 2B led leadership to update SOP BH-6, including providing nursing staff greater input in the admission decision,[3] the investigation found that staff had misconstrued their ability to provide input as having the ability to disregard a provider's admission decision. According to the report, this presented "the risk of an obstructed admission process and delayed or decreased access for Veterans requiring acute inpatient mental health care."[4] In other words, it resulted in staff potentially blocking admissions for patients who otherwise would have qualified for admission. The report further noted that a lack of training on special care populations, such as those with dementia, could be contributing to the nursing staff's resistance to accept patients with complex clinical needs.

As to VHA Directive 1160.06(1), the investigation did not find evidence of admission practices for Unit 2B that contravene the specified safety measures,[5] or that resulted in patient harm or an unsafe environment for staff.[6] The investigation found that the whistleblower's account of the August 2024[7] incident—an altercation between a patient with known tendencies toward violence and a geriatric patient with dementia, which the whistleblower referenced in support of his allegation—was not consistent with the written record.

Based on the findings, the VA adopted the Office of Medical Inspector's recommendations that the Hospital: (1) review and revise SOP BH-6 to ensure compliance with VHA Directive 1160.06(1); (2) provide training on the revised SOP, including instruction on nurses' roles in the admission process, to all relevant staff; and (3) deliver clinical skills training to Unit 2B staff on caring for special populations, including patients with dementia. The VA sent the Office of Medical Inspector's report to Hospital leadership and requested a corrective action plan.

The VA recently confirmed that the Hospital implemented all three recommendations. The Hospital revised and published SOP BH-6 on July 18, 2025, and the VHA Inpatient Mental Health Services National Director determined that the revised SOP was consistent with VHA Directive 1160.06(1). The SOP was posted on the facility's SharePoint site and, as of October 2025, the Hospital had provided training to all employees who work or float to Unit 2B. The Hospital continues to provide SOP training to new and existing staff as needed. In addition, between August 26 and September 16, 2025, the Hospital conducted simulation-based training on the care of special populations, including patients with dementia, with 100 percent participation by Unit 2B staff.

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[3] The policy change to the admission process included evaluating an incoming patient's condition relative to the milieu of the unit to determine the environmental safety for all unit patients.
[4] The report detailed an instance in which a patient with chronic mental health concerns had an acute behavioral concern that warranted admission to Unit 2B and was nearly denied admission.
[5] The report noted that "when frail or cognitively impaired patients are admitted to the unit, they will be housed close to the nurses' station, they may have a one-to-one observer assigned, and fall precautions will be taken to ensure safety."
[6] In evaluating the safety of the staff's environment, the investigation relied on occupational safety reports of staff injuries on Unit 2B for fiscal year 2023 through May 2025, which totaled 13 and were all minor in nature.
[7] The investigation confirmed the event occurred in August 2023.

I thank the whistleblower for bringing these allegations to OSC. 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. OSC has also filed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available online at osc.gov. This matter is now closed.

Respectfully,



Charles N. Baldis
Special Counsel

Enclosures