HEARING ON GAO REPORT ON VA INSPECTOR GENERAL SPECIAL INQUIRY REGARDING PATIENT DEATHS AT THE VA HOSPITAL IN COLUMBIA, MISSOURI, AND ON VA QUALITY ASSURANCE IMPROVEMENT

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

MAY 14, 1998

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HEARING ON GAO REPORT ON VA INSPECTOR GENERAL SPECIAL INQUIRY REGARDING PATIENT DEATHS AT THE VA HOSPITAL IN COLUMBIA, MISSOURI, AND ON VA QUALITY ASSURANCE IMPROVEMENT

THURSDAY, MAY 14, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Spence, Mascara, Snyder, and Evans (ex officio).

Also present: Representative Hulshof.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. The hearing will come to order.

Good Morning. First, some background because the subject matter of this hearing has a 6-year history. On October 25, 1995, the Subcommittee on Hospitals and Healthcare held a hearing on the unexplained patient deaths which occurred in 1992 at the VA hospital in Columbia, MO. The VA's IG office presented testimony regarding its report on the special inquiry into allegations that there was a cover-up in the patients' death. The IG's special inquiry report concluded that, while the hospital's management had been dysfunctional, it could find no evidence of a cover-up. Dr. Gordon Christensen, the hospital employee who was a whistleblower on the problems at the hospital, disagreed and charged in his testimony that the IG report was flawed and incomplete, among other things.

Dr. Christensen, I believe, is in our audience this morning, and I would like to ask him to stand and be recognized.

Thank you, Dr. Christensen. I believe that considerable efforts within the VA and IG's office to discredit you have failed. Dr. Christensen, it would be hard not to see your vindication in GAO's report released this morning. I want to thank you for your public service.

At the hearing in 1995, Chairman Tim Hutchinson, now Senator Hutchinson, seemed skeptical of the IG's conclusion. He said calling this "dysfunctional management" understates it. It appears that was, basically, the consensus of the panel at the time. This subcommittee decided to follow up issues raised at the hearing and

again have oversight of selected IG activities with a thorough look into the work of the IG's office on the unexplained patient deaths at Columbia. This was an important case and the IG work should be able to stand close scrutiny.

The subcommittee essentially asked GAO to investigate whether the IG's special inquiry complied with generally-accepted standards for investigations; why the special inquiry took over 2 years; and how well the IG protected the identity of whistleblowers. We also want to continue monitoring the progress the VA has made in improving the quality assurance and risk management mechanisms for detecting and responding to situations similar to Columbia's unexplained deaths. The Veterans Health Administration's effort is now called the Patient Safety Program. It's my hope that this hearing will allow a clear, factual picture of the IG's special inquiry into the alleged cover-up. Then perhaps we can begin to draw conclusions and reach closure on at least some of these troubling issues.

I'd like to welcome Congressman Kenny Hulshof, who represents the district in which Columbia's VA Hospital is located. He asked if he could attend his hearing even though he was not a committee member. I'm glad to agree. Mr. Hulshof has followed this subcommittee's inquiry very closely, and has been kept fully informed of its progress, and I will recognize him after subcommittee members.

I also would like to recognize our ranking member, Mr. Evans, who is the former chairman of this subcommittee.

And now I recognize—well, Mr. Clyburn isn't here yet, so I'd like to at this point recognize Mr. Evans for any statements he may have.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I must say that I am equally troubled by the circumstances which have led to the need for this type of follow-up hearing 6 years after 13 to 42 veterans died from unexplained causes at the Harry S. Truman VA Medical Center in Columbia, MO in 1992. I am sure that Chairman Everett will agree that this hearing will not answer all the lingering questions about what happened 6 years ago. It will, however, raise new questions about how the VA IG's office conducted its review into these allegations. It may also lead to other lessons learned on the part of the VA IG's office and reinforce our Government's strong belief that a fully-funded, aggressive and independent Inspector General's office is a critical priority as the VA moves into the next century.

Finally, and perhaps more importantly, I'm hopeful that today's hearing will prompt a renewed commitment to discover what went wrong at the Truman Hospital in 1992.

Mr. Chairman, I look forward to the testimony and thank you for allowing me to make a statement.

Mr. EVERETT. Thank you, Lane.

Mr. Mascara.

Mr. MASCARA. Thank you, Mr. Chairman. I have no opening statement. It is very hard for me to believe that this even occurred,

but how could those responsible for this special report say—and I read this in the GAO report that is being released today—say that there is no conclusive proof of an intentional cover-up by medical center's central region officials and no evidence of criminal conduct by the management? How can that be said when the report says that they didn't even do that study? I'm looking to ask that question a little later on, but I thank you for holding this hearing. I look forward to hearing from the panels.

Thank you.

Mr. EVERETT. Thank you. Mr. Hulshof.

OPENING STATEMENT OF HON. KENNY C. HULSHOF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. HULSHOF. Mr. Chairman, I want to thank you for giving me the opportunity to join the committee today to hear testimony relating to a veterans' medical facility that is located in my district in Columbia, MO in the 9th Congressional District. I want to, first of all, emphasize to the committee and to all of those present that the incidents which have provided the basis for this investigation involve a series of events which did take place in the past.

I do want to point out that these events are not indicative of the excellent medical care currently being provided by the men and women of mid-Missouri who care for veterans day in and day out at the Harry S. Truman VA Medical Facility. Harry S. Truman was, of course, the only Missouri President that we have had, and I think everyone is familiar with the quote attributed to Harry S. Truman, "the buck stops here."

Unfortunately, regarding the investigation by the Inspector General, the buck has not stopped. As the gentleman has pointed out, after almost 6 years we are still here talking about these events, and it's extremely frustrating. I'm a first-term Member and I know the former Congressman from the 9th District also was similarly interested, because we don't know many of the answers to the basic questions which initially surrounded that very tragic, horrible situation. We still don't know the who's, the what's, the where's, the when's, or the why's, and probably never will.

I'm afraid that things have been distorted enough by some individuals at the Department of Veterans Affairs, many of whom worked outside the Veterans' Hospital in Columbia, that we will continue to be left with those doubts, as the gentleman pointed out, without any possible conclusion or explanation. But I do believe that this report by the General Accounting Office of Special Investigations Office does represent probably the best, most independent look at much of what occurred, and offers the best chance to, hopefully, put this whole episode behind the families of the veterans who lost their lives on Ward 4 East.

In following this situation, I had hoped that the Department of Veterans Affairs would finally accept responsibility for obvious mistakes that had been made. Instead, it looks as if we will be treated to continued attempts to deploy political spin control, to talk down some of the serious findings of the GAO investigation. And again, as the representative of many of the constituents and families in the 9th District, spin control has a very tragic affect on the families who have lost loved ones.

And we cannot begin to imagine here in Washington, DC how it feels for the families to face 2 years of delay because of what the agency calls, quote, "an administrative error." In my book, and I think Mr. Chairman, in your book, and certainly back home in the Court of Public Opinion, common sense tells us that the agency has dragged its feet from day one. It has failed to accept responsibility for the serious mistakes one made on its watch, and unfortunately, footdragging and artful dodging have left us without enough evidence to fully ascertain what happened to these honorable veterans.

Why are we sitting here, Mr. Chairman, on May 14, 1998, nearly 6 full years after the facts still searching for answers and hoping for a conclusion? If it had not been for the perseverance of the gentleman you pointed out, a constituent of mine, Dr. Gordon Christensen, I'm convinced—I am completely convinced—that efforts by former hospital administrators and others within the Department of Veterans Affairs to sweep this whole matter under the rug might have been successful. I, too, share your commendation to Dr. Gordon Christensen, and I feel in many ways that this GAO report vindicates many of the concerns that he's raised during this 6-year struggle.

Again, thank you for allowing me to participate and I, too, look forward to the witnesses here today.

Mr. EVERETT. Thank you. Of course, one of the great tragedies of this is the fact that we will probably never know how these 42 patients died.

Dr. Snyder, we recognize you for any opening statements.

Before we welcome our panelists, I want to play ABC's PrimeTime live segment on the Columbia VA Medical Center. This aired on January 7, 1998. It runs about 11 minutes, and I'd advise the members who have not seen it, that might be interested, to move to this side of the room, because I think it's an excellent report.

If somebody could dim the lights for us also and turn up the volume.

[Video.]

Mr. EVERETT. We showed the video for two reasons. No. 1, to show the very human side of what happened at Columbia; No. 2, to show that trust in our Government is at the very essence of this case. We wonder why the public from time to time mistrusts the Government so much. And, I'd have to tell you, too, that Columbia, MO represents that reason—or one of those reasons. The truth is that this goes to the very fiber of trust in our Government, and we obviously will never get the truth of what happened at Columbia now because of a few bad Government employees. It's just simply the fact.

I'd ask each witness to limit your testimony to 5 minutes. The complete written statements will be made part of the official record. I ask that we hold all our questions until the entire panel testifies, and because of the nature of today's testimony, I've decided to have the witness panels with direct knowledge of events and investigative activities testify under oath.

I now recognize panel one and welcome Mr. Eljay Bowron, Assistant Comptroller General for Special Investigations, Office of

Special Investigations of the General Accounting Office. And, if you will, sir, please introduce the rest of your panel. Mr. Bowron, if you would please introduce the rest of your staff?

TESTIMONY OF ELJAY B. BOWRON, ASSISTANT COMPTROLLER GENERAL FOR SPECIAL INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ROBERT E. LIPPENCOTT, ASSISTANT DIRECTOR FOR INVESTIGATIONS, CHICAGO FIELD OFFICE, GENERAL ACCOUNTING OFFICE, AND DONALD FULWIDER, DEPUTY DIRECTOR FOR INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE

TESTIMONY OF ELJAY B. BOWRON

Mr. BOWRON. Thank you, Mr. Chairman.

I have with me today Assistant Director Robert Lippencott of our Chicago office who led this particular review and, also, Mr. Don Fulwider, our Deputy Director of Investigations who supervised this effort from our headquarters.

Mr. EVERETT. Will the panel please rise and raise your right hands and repeat after me.

[Witnesses sworn.]

Thank you, please be seated.

We're going to experience a vote at this point. Let me take care of some housekeeping. As I said earlier, we'll have 5 minutes for each—if you'll limit your testimony to 5 minutes, we'll have your complete testimony made a part of the official record. And, I think at this time, rather than trying to get into the opening of the first panel, that it might be a good idea if we decide to go ahead and get the vote over with and come back as quickly as possible.

So, I'm going to recess the committee hearing at this time.

Thank you.

[Recess.]

Mr. EVERETT. You all can be seated and I'll call the committee back to order.

Mr. Bowron, on behalf of the subcommittee, I want to thank you and commend you and the Office of Special Investigations for the year-long effort that went into your review of the IG's special inquiry. GAO is an independent review and investigative organization for Congress and enjoys the credibility few others have here in Washington these days. As Assistant Comptroller General for Special Investigations and the former Director of the U.S. Secret Service, you bring impressive credentials to the witness table.

Let me ask you, did I, my staff, or anyone else suggest to you what conclusions were desired or try to influence your report conclusions in any way?

Mr. BOWRON. No, sir.

Mr. EVERETT. Does GAO have an axe to grind in this matter?

Mr. BOWRON. No, sir.

Mr. EVERETT. Okay. Your report has concluded that the IG special inquiry report was misleading. I'm not surprised that your report is critical of the way in which the IG investigation was done, but I am very surprised and dismayed to hear that you believe it was misleading. You have already stated the reasons for your con-

clusion in your report and statement. As you know, Dr. Gordon Christensen, who is one of the whistleblowers of the Columbia VA Hospital situation, alleged in his October 1995 testimony before the Hospitals and Healthcare Subcommittee that the IG report was an incomplete, dishonest, flawed, and distorted presentation of the events that took place in Columbia. Was it any of those things?

Mr. BOWRON. Mr. Chairman, I think, as we indicate in our report, that it was misleading. It was in places inaccurate, and it was certainly in some respects incomplete.

Mr. EVERETT. Was it a cover-up?

Mr. BOWRON. On the part of the Office of Inspector General, no.

Mr. EVERETT. Was it a shoddy job at investigating a cover-up?

Mr. BOWRON. I would say that, in terms of addressing the allegations of a cover-up, it was a shoddy job at best and arguably the allegations of a cover-up were really not pursued and investigated.

Mr. EVERETT. And, your description of the investigation is that it was a shoddy job or an incomplete job?

Mr. BOWRON. Yes.

Mr. EVERETT. Does the GAO find any basis for believing that the IG report or testimony was intentionally misleading or that there was possible misconduct on the part of the IG officials that should be explained further.

Mr. BOWRON. No. We didn't determine any misconduct on the part of IG officials in terms of being intentionally misleading. I don't believe that the report was intentionally misleading. In terms of whether or not the VA OIG deliberately delayed its special inquiry, the Office of the Inspector General has, I think, provided the subcommittee with information that attributes to the delay to an administrative error. If you include a lack of oversight and communication under the umbrella of administrative error, I think that is an accurate description.

Mr. EVERETT. It's my understanding that a VA employee told GAO of a comment from the IG's office that the hospital director was stonewalling the investigation. Is that correct?

Mr. BOWRON. That particular comment was included in a document prepared by the analyst who conducted the special inquiry.

Mr. EVERETT. As the subcommittee chairman, I asked GAO to review the 2-year delay in the IG investigation. That's why it is in the report. I understand that a VA employee interviewed by GAO has stated that she was told by an IG official that the IG's office was not going to investigate the cover-up allegations unless it had to. Did that happen? Do you find reason to believe that the delay was deliberate, and if it was not, how would you characterize it?

Mr. BOWRON. Mr. Chairman, as I said, first of all with respect to whether that comment was made, that's a conversation that was documented by one party in the conversation, and that particular statement is documented as a part of that telephone conversation. As to whether it was a deliberate or intentional delay, I think that I already stated that we don't find that they deliberately or intentionally delayed their investigation to keep the investigation from occurring. And to a large extent, I think the best indication that mitigates that with respect to the Office of Inspector General is to say that, if they were trying as an organization to prevent the investigation from taking place, they would not have referred the

complainant's allegation to the FBI in a timely fashion, which they did.

Mr. EVERETT. The IG responds by alleging many shortcomings in the GAO's work—and it, essentially, does not concur with GAO's overall conclusions about the misleading nature of the IG report and the shortcomings in the investigation. How do you respond to the assertion that says your report is the bad one, not theirs? That yours is inaccurate, erroneous, takes statements out of context, says things people didn't say, didn't interview people who should have been, and so forth?

Mr. BOWRON. Well, I would respond to that by saying that, in conducting our review, we had complete access to all of the workpapers associated with this review and all of the evidence that the VA OIG had to consider. In addition to that, we interviewed knowledgeable employees of the Office of Inspector General as well as the hospital and since we, basically, have all the information they had to consider, we really have no reason to mislead or to come to one conclusion or another. As I responded to one of your opening questions, we don't have an axe to grind in this matter.

As far as taking out of context what people said, we did detailed interviews. We provided people with information to refresh their memories. In contrast, the Office of Inspector General's criticisms are based on its review of the draft report, their only evidence.

And the VA OIG went back out, I believe, and talked to some of the people that we interviewed and those people either provided the OIG with different information or mitigated statements that they may have made to us. Well, I can imagine that people who worked for the VA Office of Inspector General might have mitigated their statements to representatives of the Office of the Inspector General versus what they said to us. So I think that they didn't have as much information to review. They didn't even have the information to be able to put it into context because, appropriately, they didn't have our reports of interview. They don't even know the full scope of who we interviewed, let alone what they said to us.

Mr. EVERETT. At this point, I will recess because there is a vote going on, and we'll be back as quickly as possible.

[Recess.]

Mr. EVERETT. In my enthusiasm to get to the questioning, I missed the opening statements and at this point you will go ahead and give your opening statements.

TESTIMONY OF ELJAY B. BOWRON

Mr. BOWRON. Thank you, Mr. Chairman. I'll just—in fact, I'll just make a couple of brief remarks that kind of summarize what we were asked to do and what the result was.

Mr. Chairman, you asked us to determine whether the Office of Inspector General's processes and procedures were adequate for ensuring confidentiality requested by individuals; and, also, whether the Office of Inspector General protected the confidentiality of the staff physician who made the allegations of a cover-up. We found that the current policies and procedures are adequate, and consistent adherence to and ongoing awareness of those policies should result in the effective protection of complainants and sources of infor-

mation. As to the Office of Inspector General's protection of the confidentiality of the complainant in this particular instance, there were breaches of that confidentiality.

You also asked us to look at whether the Office of Inspector General complied with its policies and procedures in conducting this special inquiry. We found some instances where they did not comply with policies for accuracy and completeness. We found statements in the report that were either not supported or were inconsistent with the evidence contained in their files.

Another issue that you asked us to look at, and we've already talked about it a little bit, is the 2-year delay between the receipt of cover-up allegations in February of 1993 and the beginning of the special inquiry in January of 1995. As part of that, the allegation suggested that the OIG was part of the cover-up based on that delay, but we found that the suggestion of the OIG being part of the cover-up is really greatly mitigated by the OIG's timely referral of the complainant's February 1993 letter to the FBI. I think that they did in a timely fashion refer this to their Office of Investigations and through an investigator. There were also indications that at least initially, they believed that those allegations would have been included in the criminal investigation being conducted jointly by the FBI and the Office of Inspector General.

Really, the heart of the issue you asked us to look at is whether the special inquiry report represents the results of the Office of Inspector General's review. I think that is the primary focus of our criticism. The question really gets down to—or our position I think would be—that the Office of Inspector General's work did not reflect an intention to get to the bottom of the cover-up allegations. A fair reading, I think, of their report and its conclusions leaves the reader with the impression that they made a comprehensive effort to address the allegations. They didn't. That makes the report misleading.

You have already indicated, Mr. Chairman, that my complete statement will be submitted for the record and that concludes my brief remarks.

[The prepared statement of Mr. Bowron appears on p. 42.]

Mr. EVERETT. Any other member of your panel wish to make statements?

Mr. BOWRON. No, sir.

Mr. EVERETT. When we left off earlier, you mentioned that it didn't surprise you that perhaps VA employees would make mitigating statements to the VA IG as compared to the statements they may have made to you. But in the essence of what's perhaps wrong with our system here, for those of you who've followed some of the hearings I've had, I insist that there's a culture that exists within the VA. Frankly, I think it's a huge cancer that's consuming the VA. It's a culture that defies oversight—congressional oversight—we've seen time and time again hospital directors that defied, not only their superiors, but congressional oversight also. When you start mitigating your statements, to me, that means change. I know that some folks would say that means shading. But mitigating statements, isn't that one of the problems we have getting to the truth of what happened at Columbia?

Mr. BOWRON. I think that that is one of the problems that is exhibited here. I spoke about the employees that might have been interviewed by the Office of Inspector General—employees of the Office of Inspector General that we interviewed—and who then, based on the results of our interviews and our subsequent draft report, were re-interviewed by representatives of the Office of Inspector General. I don't think that it's surprising that they would say things to us that were damaging to the Office of Inspector General, but when they were talking to representatives from the Office of Inspector General, try to err on the side of not being as harmful to the Office of Inspector General, and probably not even repeating some of the things that they said to us. That doesn't surprise me.

The Office of Inspector General does have a vested interest in the outcome of this review. We don't. I can just say that every statement in our report can be traced either to an individual interview, statement, or document. At the conclusion of this hearing, if you've got questions about our documentation or how we came to any statement in our report, we'd be happy to sit down with the members or their respective staffs and explain exactly what we're relying on to make that statement for everything that's in our report.

Mr. EVERETT. Well, I won't belabor the issue, but I will again remark on the fact that I think there's a certain culture that exists within the VA that, ultimately, if it's not changed, will destroy the organization.

GAO received a letter dated February 24, 1998 from the FBI. Each member has a copy. I ask unanimous consent that it be made a part of the record.

[The information follows:]

U.S. Department of Justice

Federal Bureau of Investigation

Washington, D. C. 20535

February 24, 1998

Mr. Donald G. Fulwider
Deputy Director
for Investigations
Office of Special Investigations
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fulwider:

On February 9, 1998, your letter to FBI General Counsel Larry R. Parkinson was referred to my office for a response. The following information is provided in answer to your inquiries concerning the investigation of an alleged cover-up of unexplained patient deaths at the Harry S. Truman Memorial Veterans Hospital in Columbia, Missouri, in 1992.

In your February 9 letter, you asked whether the Veterans Affairs (VA) Office of Inspector General (OIG) provided the FBI with a copy of a letter it received from a staff physician at the Truman Memorial Veterans Hospital. The letter was erroneously dated February 16, 1992 (instead of 1993). A review of FBI files indicates that a copy of the letter from Gordon D. Christensen, M.D., was provided to the FBI on March 2, 1993, by Special Agent James Cole, VA OIG.

Your second query was whether the FBI criminal investigation included an inquiry into specific allegations of a cover-up by VA management. Given the fact that Dr. Christensen's letter primarily concerned "the issue of the administrative response" of VA managers which would not in itself fall within the investigative jurisdiction of the FBI, and in the absence of any finding of criminal activity in connection with the unexplained deaths, the FBI criminal investigation did not include an inquiry into allegations of a cover-up on the part of VA management. However, had the FBI investigation developed evidence of criminal activity at the hospital, logical inquiry would have been conducted to explore potential culpability of any person, including management and employees, before, during, and after the deaths, to include deliberate attempts to cover up.

Mr. Donald G. Fulwider

If you require further FBI assistance in this matter, please contact SSA J. Chris Warrener at (202)324-3395, or Margaret Tremblay at (202)324-5492.

Sincerely yours,

A. Robert Walsh
Unit Chief

Mr. EVERETT. What led up to the letter and what did it state regarding whether the scope of the FBI's criminal investigation included a cover-up?

Mr. BOWRON. Well, what led up to the letter—and I made reference to this earlier—we wanted to determine, as part of the 2-year delay in the start of this special inquiry, at what point and time the Office of Inspector General referred the complainant's allegations to the FBI. We found that they referred those allegations to the FBI in a timely fashion. That was a request that we made for the FBI to tell us, did you get this information and when did you get it?

The second part of that was, did you incorporate this into your investigation? In other words, did you investigate these allegations of a cover-up? The response essentially was that in view of the fact that they did not identify criminal activity, they did not conduct an investigation relative to the allegations of the cover-up. Had they found criminal—evidence of criminal activity—they would have done an investigation that would have included elements of a cover-up before, after, or during—I'm not quoting their letter exactly, but that was the message.

Mr. EVERETT. Did the IG investigation adequately investigate the issue of nepotism that the IG report addressed? The former Director's son is still the Chief of Human Resources at Columbia, isn't he?

Mr. BOWRON. I believe he is, Mr. Chairman. With respect to the allegation of nepotism, we determined that the Office of Inspector General referred that to management at the hospital for their inquiry and review. They then reviewed the steps that were taken by management at the hospital which detailed the personnel practices and procedures and the basis for the selection and the timing of different events. The Office of Inspector General was satisfied that the review done by the hospital management was sufficient and was complete. That's what is reflected in their documentation. If the question is, was there an independent investigation of that allegation of nepotism, there wasn't an independent investigation of it because management, in fact, investigated their own actions; that investigation was reviewed by the Office of the Inspector General, but the allegation of nepotism was not investigated by the Office of the Inspector General.

Mr. EVERETT. Thank you. Mr. Mascara.

Mr. MASCARA. Thank you, Mr. Chairman.

There must be some professional tension between GAO and the IG considering the nature of their respective functions. Can you give us some general background into the duties and responsibilities of the GAO compared to the VA IG? In what respects would you say that your roles are similar? In what respect would you say that they differ? How often does GAO sit in judgment concerning the work of the IG, and vice versa?

Mr. BOWRON. Well, GAO's role is to respond to requests from Congress and from the Legislative branch to review and investigate the matters that concern the various committees and subcommittees. Our job and our mission is to provide accurate and impartial results and report on the facts we're able to determine by our investigations and reviews. In many respects, our work is similar to

the work done by the Office of Inspector General within their own departments and with respect to the investigations that they do. In this instance, we've been asked to review the investigative work of the Office of Inspector General; that's not uncommon. We do that work probably several times each year. It's not something that we have a vested interest in and it's not something that we necessarily enjoy doing, obviously, but it's part of the job, and it's our job to try and be fair and objective and professional in the conduct of that work.

Mr. MASCARA. When you were asked—or the GAO was asked—to pursue this investigation, what was the mission or the goals or objectives assigned to this investigation? What did they ask you to ascertain?

Mr. BOWRON. Our investigation?

Mr. MASCARA. Yes, yes.

Mr. BOWRON. Well, really to determine the matters that I outlined earlier and there were four or five specific areas that we were asked by the chairman to review that included their hotline policies; protecting confidentiality; whether they followed policies for accuracy and completeness of their investigation; and whether they appropriately protected the identity of the confidential complainant in this particular instance. The heart of the matter really was, did their report accurately reflect the results of their work.

Mr. MASCARA. And it did not?

Mr. BOWRON. With respect to allegations of a cover-up, we conclude their report does not accurately reflect the results of their work.

Mr. MASCARA. Did your investigation ascertain the patient level at the VA center? In that particular ward, how many patients were assigned to a nurse? Did you deal with those kinds of information?

Mr. BOWRON. We didn't examine that kind of information, although it was certainly a part of the documentation that we looked at. But we didn't reinvestigate this. We didn't investigate the unexplained deaths. We didn't investigate whether or not there was a cover-up. We reviewed what the Office of Inspector General did and that's the scope of our report.

Mr. MASCARA. No one ever suggested that perhaps a State grand jury or Federal grand jury be convened? You know, after seeing the piece there from ABC, it just boggles my mind that if the director at the facility had to give a report—I was responsible for running a 250-bed nursing home back in Washington County where I was a commissioner. We got a report every day of deaths. I'm just wondering this director sat there each morning and looked down at his sheet and said, well, there's one today; there's two tomorrow; there's three next week; now there's 30; now there's 40. How anybody could continue to allow this to happen boggles my mind. I mean, it doesn't take a rocket scientist—even a person in the medical field could figure out there's something wrong. I mean, does the nurse have too many patients that he can't care for and he says, "Well, I'll get rid of this one tonight and that one tomorrow."? I just can't believe that we've let this go on.

I want to associate myself with your opening statement, Mr. Chairman. That's why there's cynicism out there about elective service and this government, that somehow the GAO, the IG, the

FBI, the Justice Department could let this happen and not convene some kind of a grand jury to find out—we're going to nail this guy or this person, whoever it is that took these lives.

Then he went on to another home and—I don't know, what did it say—how many more were killed in this private nursing home, alleged to be killed? I just don't know. Your report didn't deal with that. You were just looking at what the IG did and the IG didn't do what they were supposed to do. Was anybody ever reprimanded because they didn't do what they were supposed to do in their report?

Mr. BOWRON. That's covered in the IG's report.

Mr. MASCARA. Well, I haven't had an opportunity to read, fully read, both reports, but I've scanned through them. The more I read, the more upset I get.

Mr. BOWRON. Yes, sir. If I could add one thing—I mean, I think it's only important to note that our work and our report is specific to what was requested by the chairman of the committee. So our response is specific to those requests.

Mr. MASCARA. My staff person said that Boone County had one grand jury and there were no indictments—is that correct, Don? Yes, he's saying yes.

Mr. EVERETT. That is correct, no indictments. The number you were searching for is an additional 30 people died at the institution, although we have no evidence of what happened.

Mr. MASCARA. Seventy deaths and we don't have an answer? Maybe we ought to look at the budget of everybody, especially these investigations. They're not doing a very good job. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Bowron, many members of the committee believe that the VA IG's office lacks sufficient resources to do its job properly. In the case of the Columbia inquiry, is it your view that the IG committed sufficient resources into the inquiry? Did you ever get an indication that the IG was hampered during this inquiry because of a lack of resources?

Mr. BOWRON. We didn't really address in the scope of our inquiry their utilization of resources. Certainly the resources that they devoted to this was a limited number. I think that this is a high-profile matter for their office. Although I don't have a specific piece of evidence that I could point to, my own belief is that the limited number of resources devoted to this high-profile matter probably is in some way related to a lack of resources.

Mr. EVANS. Is the GAO in a position to judge the quality of work done by the IG's office on a more systemic basis? What do your findings say, if anything, about the work of the IG's office on a broader scale?

Mr. BOWRON. Well, this particular Office of Inspector General? We really didn't do work that would judge them on a broader scale in this case. So, I mean, there were certain things in this particular instance that we found that were not adequate with regard to the investigation, the accuracy, and the thoroughness. But we can't necessarily paint the full breadth of their work with that same brush—I mean, because we wouldn't have a basis for doing that.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you, Mr. Evans. Now the gentleman from Missouri.

Mr. HULSHOF. Thank you, Mr. Chairman.

Mr. Bowron, let me just take a minute or two to tell you what perspective I bring here before coming to Congress. I've spent 13 years in the criminal justice system in Missouri—3 years as court-appointed public defender and then 10 years as a prosecuting attorney, many times having to investigate and prosecute murder cases; indeed, capital murder cases. I've also been paying very close attention to representatives of the Office of Inspector General today who have been reacting to parts of your testimony.

So I want to—regarding your conclusion that you believe that the Office of Inspector General did not have an intention—and I'm paraphrasing your conclusion—did not have intention to get to the bottom of the matter, can you give us some examples of when the Office of Inspector General did not follow up in its inquiry, perhaps to link individual pieces of evidence to suggest further lines of inquiry?

Mr. BOWRON. Yes. Maybe the best example, in part, because it was featured on the videotape that was played—they had the hospital pathologist, I believe, Dr. Adelstein, discussing a telephone conversation which he claims he was a party to. It was a conference call with the pathologist, the total quality manager, the hospital director, and the regional chief of staff. Now, Dr. Adelstein alleges that during the course of that conversation, when the issue of notifying law enforcement and the seriousness of the circumstances was raised, that there was a statement made by the regional chief of staff to the effect that, you know, the last time—and this isn't a quote—but the last time we brought in the FBI, the hospital director got fired, and are you sure you still have a problem down there? To which the hospital director responded: "I think we can handle this locally."

Well, I don't know whether that telephone conversation took place or not. I can't say that conclusively. Certainly, Dr. Adelstein says it did. The Office of Inspector General interviewed one other person having information that that conversation took place. They interviewed another person with respect to that which I believe they have characterized as a neutral third party, who expressed that she didn't recall words like that being said. Well, if you were really trying to get to the bottom of a cover-up and there's a specific allegation that part of the reason for the cover-up is that people are protecting their jobs, you want to get to the bottom of that conversation. You want to know whether that happened or not.

So, first off, there was information that the neutral third party who said she didn't recall had conversations with at least one other person who wasn't a part of that telephone conversation, that conference call, wherein she expressed that the regional chief of staff had made statements of coercion to cover up the deaths. Now she said that to someone else—allegedly. Well, that wasn't investigated.

Furthermore, if you really want to get to the bottom of that conversation, you're not going to stop asking questions until you've at least discussed it with the person who allegedly made the state-

ment and the person who the statement was made to. If either one of those persons was interviewed with respect to that information, it's not reflected in their documentation. As a matter of fact, the only interview of the regional chief of staff that's documented is a relatively brief telephone interview. From an investigative standpoint, if you're going to be asking somebody a question like that—and you know this from your background—you ought to be sitting right across from them. You want to see the expression on their face and you want to see their body language. You're trying to find out whether or not they're telling the truth. That kind of effort wasn't made. That is an important allegation. Now, I'm not offering any proof that it happened, but I'm offering that there wasn't a deliberate attempt to get to the bottom of that.

Now take that in conjunction with the fact that resulting from that same telephone conversation a board of inquiry was convened that was very limited in scope and did not include the statistical analysis. You combine that with other information that they had from an Office of Inspector General employee that suggested—and this was made mention of earlier—that the hospital director was stonewalling and encouraging hospital employees not to speak with the IG. You begin to have circumstances there that make you want to pursue a line of questioning that wasn't pursued.

Mr. HULSHOF. Well, as you pointed out in your statement and in the GAO report, even such simplistic things of accepting at face value the hospital director's response, not recalling whether he got advice from the district counsel whether to even notify the FBI. I don't want to pull these things out and take them completely out of context, but let me make a comment and I will be happy to let the representatives of the Office of Inspector General also comment and allow you to do the same.

But it seems that the attitude of those who have been watching this closely from Columbia, MO—it seems that the Inspector General—when they got the information from Dr. Christensen regarding a nurse statistically linked to over 40 deaths, that the IG suspected the worst of the doctor. Yet, when finally the Inspector General turned his gaze upon Mr. Kurzejeski, who was the director, who let the same hospital nurse continue on in his capacity, as we saw from the piece, it gave the hospital administrator the benefit of the doubt. That is perhaps an unfair assessment.

Do you have a comment? I filled that out so that the Inspector General can maybe comment as well a little bit later. Do you have any comment on that statement of mine?

Mr. BOWRON. Well, only that included in our report there are a number of pieces of information and statements that are all related to the hospital director and/or his actions that I think, if linked together, cause you to really ask a lot of questions about why he did what he did in certain instances. To pursue a line of questioning, that was not pursued. That's why I say that there really wasn't an effort that was focused or intended to get to the bottom of those allegations, for two there reasons.

I say that based on the things that weren't done—the lines of inquiry that were not pursued and the linking of information that was not done. I also say that because in the interviews of the people that did this work—and I think that this is an oversight and

communications issue—regardless of whether you put this in the context of an investigation, management review, or administrative review; or whether you say that this was criminal or noncriminal, the fact of the matter is that based on what the people that were doing this work (the lead analyst in this case and his supervisor) said to us, the cover-up was off the table. Cover-up is not what they were looking at.

They were looking at management response, management issues—whether management took the steps that they were supposed to take when they were supposed to take them. Now, I can only say that if they believed they were supposed to be investigating a cover-up and getting to the bottom of a cover-up, they couldn't have said more clearly to us that, in their view, anything to do with cover-up was obstruction of justice; that anything to do with cover-up relates to criminal activity and a criminal investigation; and that that kind of information is not what they were looking at. Therefore, they were not looking at a cover-up.

Now, again, I don't base it just on what they said. I base it also on what they did and what they didn't do. Despite the fact that the lead analyst in this case, if you look at his draft report, the original report written on this—comes to the conclusion, based on the limited information provided to the Administrative Review Board that the limited scope of the Administrative Review Board didn't make sense. Based on all the information they had, that limited scope didn't make sense. But then there wasn't the kind of investigative or review effort you would undertake to say, well, why did they do that?

Mr. HULSHOF. As a final—my time is drawing short—we would very much like to have some closure in Columbia, MO regarding this. And after 6 long years, the obvious "what next?" question raises itself: What are the pros and cons of attempting to reinvestigate some of the things you've mentioned—whether there was a cover-up, obstruction of justice, witness tampering? What are your thoughts on any further review at this point?

Mr. BOWRON. Well, first of all, I have to say that there was a large body of work done here by the FBI that I really don't have any information about, other than that it was lengthy. They referred to it as an extensive investigation that I know covered a lot of forensic work. But I don't know the details of really what questions they asked of what people. But I have to say this: They said they did an extensive investigation. They didn't come to the conclusion that there was evidence of any criminal activity. So you have to view "what's next?" in light of that.

The Office of Inspector General did a considerable amount of work and developed a lot of information with respect to who did what administratively and, from a management standpoint, who knew what at what time. And there's been a lot of interviews conducted by them—and now by us. There's been an awful lot of information put into the public domain and even more with the issuance of our report.

So I have to say that my own view is that the likelihood of having any significant results from further investigation based on the FBI's conclusions, the amount of time that has gone by, the further erosion of people's recollection of events, with an eye toward what

the end goal will be—I mean, if it's criminal prosecution, there's not—based on what I've just said—a likelihood that you're going to go there. If it's administrative action against the employees, just about all the employees that were the focus of this are no longer employed by the VA.

So I really have to say that I don't think that there's a lot of benefit to additional investigations being undertaken. I know that's not good news, but, honestly, I don't see it being a productive effort.

Mr. EVERETT. Mr. Hulshof, we certainly appreciate that line of questioning. It's one that I had been thinking about myself. Did not the FBI in the letter to the GAO point out that they did not investigate a cover-up?

Mr. BOWRON. Yes, they did.

Mr. EVERETT. For the record, I'd also like to point out that this committee has contacted the FBI on a number of occasions and asked for information, and we have not been given that information. We were told at one point that there was criminal investigation going on. Then after that criminal investigation was closed, we still have not received any information from the FBI.

Mr. MASCARA. I'm still bewildered. Apparently, Mr. Bowron—so in other words, your investigation was done in a vacuum without concern—and I shouldn't maybe use the word "concern"—without directing any attention to the fact that over 40 lives have been taken. You were doing some kind of an investigation that you had to set that aside and ignore the fact that some 40 people were killed, or allegedly killed.

Mr. BOWRON. Well, our charter, our mission was to respond to the chairman and the committee's request. That's what we specifically responded to. In addition to that, you had until very recently an ongoing FBI investigation relative to the unexplained deaths. So that role was being fulfilled by the FBI in terms of investigating the deaths. I guess I just want to make it clear that our focus was narrow. It wasn't to reinvestigate this; that's not what we were asked to do. We were asked to review what the Office of Inspector General did and to determine whether or not its report accurately reflects the efforts that it made. There's a few other things, but that was the crux of the matter.

Mr. MASCARA. I disagree with you, but continuing to pursue this and in response to my colleague's question that—and I'll defer to him because he's a lawyer—the statute of limitations on the murder, there isn't any statute of limitations.

Mr. HULSHOF. If the gentleman would yield, that's exactly correct. The State of Missouri, I know from State law that there is no statute of limitations on intentional homicide.

Mr. MASCARA. Has any of the members here talked to the FBI or can we subpoena them to come in here for——

Mr. EVERETT. This chairman has threatened to subpoena the FBI to come in. To this point, we've gotten almost no cooperation, and unless—so as a last resort, I have threatened to subpoena the FBI to come in. The scope of the investigation that GAO was asked to conduct, Mr. Bowron has described that. At the time, Justice Department was conducting a criminal investigation into the matter. You know, the good patriotic American would have seen that there would be some follow-through on that. As we now know, we've had

no information from the FBI. That may be something that we should pursue.

Mr. MASCARA. Well, I would certainly be interested in pursuing that. I mentioned earlier the grand jury investigation, and you all know what can happen with a grand jury investigation; by getting some of those people in there and giving them immunity, we might get to the bottom of it. I would like to see the chairman and this committee pursue this. I just don't think we can let this rest; I really don't.

Mr. BOWRON. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you, Mr. Bowron. I thank this panel for the good work that you've done over this year in looking into this situation and the professionalism that you brought to it. Again, thank you, and I will now dismiss this panel.

Mr. BOWRON. Thank you, Mr. Chairman.

Mr. EVERETT. Let me call up panel two, please.

I would like to recognize the Honorable Richard Griffin, the new Inspector General of the VA. If you will, please introduce the staff with you.

Mr. GRIFFIN. With me today is Mr. Bill Merriman, the Deputy Inspector General, and Ms. Maureen Regan, the Counselor to the Inspector General.

Mr. EVERETT. Thank you.

[Witnesses sworn.]

Mr. EVERETT. Thank you very much. Please be seated. If you will, Mr. Griffin, please go ahead with your statements.

TESTIMONY OF RICHARD GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BILL MERRIMAN, DEPUTY INSPECTOR GENERAL, AND MAUREEN REGAN, COUNSEL TO THE INSPECTOR GENERAL

Mr. GRIFFIN. Thank you. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before you today for the first time in my capacity as Inspector General of the Department of Veterans Affairs. I look forward to maintaining a proactive partnership with the committee as we pursue our common goal of ensuring that veterans and their families receive the care, support, and recognition that they have earned by virtue of the sacrifices they have made for our country.

Since assuming the duties of Inspector General, I have undertaken a review of a wide range of policies and procedures to assure that we operate as an independent, professional organization. This review will include investigative priorities, audits, healthcare inspections, and hotline activities and will continue throughout the coming months. It has been my observation in the time that I have been Inspector General, that the OIG is staffed with dedicated, hard-working public servants who are committed to carrying out their jobs in a responsible manner.

While the subject of this hearing pre-dates my tenure as IG, I take any indication that our reports do not meet appropriate standards as cause for serious concern. For that reason, I directed that the issues raised in the GAO report be thoroughly examined. This task was complicated by the years that have passed since this case first originated and by the retirement of several of the principals.

We have contacted these former OIG employees who were associated with the special inquiry conducted at the VAMC Columbia, MO in 1995 to validate the facts as they recall them and, in particular, to respond to statements attributed to them in the GAO report.

The results of this examination raised questions concerning the accuracy of statements made in the GAO report and some of the conclusions drawn from their work. Of particular importance are statements attributed to the former Assistant Inspector General for Departmental Reviews and Management Support and the lead analyst on the special inquiry. Both of these individuals expressed serious concerns about the accuracy and context of comments associated with their interviews by GAO. While GAO addressed some of our concerns in the final report, a number of issues still exist.

The most significant issue that remains with the GAO report is their conclusion that the OIG special inquiry is misleading in finding that there was no evidence of a cover-up. The basis for their conclusion is the mistaken belief that, because the OIG limited its review to the issue of management's response to the increase in deaths, that the OIG did not investigate the issue of a cover-up. As discussed in exhaustive detail in our response to GAO, the complainant's allegation that there was a cover-up was based on his assessment of management's response to the increase in deaths. These are one and the same issue and not separate, distinct issues, as the GAO report suggests. A comprehensive evaluation of the issues that have been raised is attached to my statement for the committee's review.

In closing, I'd like to add that the OIG is responsible for reviewing allegations of fraud, waste, abuse, and mismanagement. The credibility of the OIG rests in our ability to conduct these reviews in an independent and objective manner. This cannot and will not be compromised.

Thank you, Mr. Chairman, for the opportunity to provide my views on this matter. I will be pleased to respond to any questions you or other committee members may have. With your indulgence, I may call upon my colleagues to respond to specific questions that occurred during their time prior to my arrival at the IG for which they would have first-hand information.

Mr. EVERETT. Without objection.

Mr. GRIFFIN. Thank you.

[The prepared statement of Mr. Griffin, with attachment, appears on p. 103.]

Mr. EVERETT. Mr. Griffin, now, as you point out, you were not the Inspector General at the time that these events occurred and they occurred before your tenure began. I understand the fact that you would want to defend the organization you now lead. As a former Deputy Director of the Secret Service, you bring excellent credentials to the witness table, and I appreciate those credentials and your public service. I hope you will consider any criticism directed at the IG organization as constructive and in no way intended to harm your office. I believe the IG organization should be strengthened and it is essential to have it independent from VA management and resources.

I'm very keenly aware that IG staffing is not at adequate levels and, as you know, on February 17—over 3 months ago—1998, I sent a letter to the Secretary about the subject. I'm still, after 3 months, awaiting a reply from the Secretary, who I understand has consulted you on the matter.

Let me get into the questioning. Did the IG special inquiry, which I'm going to refer to as "the investigation" hereafter, include a check of the background of former VA nurse, Richard Williams, his employment history and management's personnel decisions regarding him?

Mr. MERRIMAN. If I may, Mr. Chairman——

Mr. EVERETT. Yes, Mr. Merriman, certainly go right ahead.

Mr. MERRIMAN. I don't know if the special inquiry looked into that, but I believe that the FBI investigation did.

Mr. EVERETT. The reason I asked is because reliable information has come to my attention that he was fired from his previous job in 1989 as a licensed practical nurse with St. Johns Hospital in Springfield, MO, and the VA hospital knew it before hiring him. How could that have happened? Do we have any idea?

Mr. MERRIMAN. I'm sorry, I——

Mr. EVERETT. You have no knowledge of that, either way?

Mr. MERRIMAN. I believe it was referred to by the FBI, but I——

Mr. EVERETT. The IG's conclusion that the hospital management at Columbia was dysfunctional but not engaged in misconduct has loomed very large in this whole affair. The IG report did not find a cover-up, but turned on a memorandum dated March 9, 1994 from a former hospital director to Dr. Christensen ordering him not to have—ordering him—not to have further contact with the FBI or IG and the IG said it was improper. Each member has a copy of the memo, and I ask unanimous consent it be made a part of the record.

[The information follows:]

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: March 9, 1994

From: Director (00)

Subj: Reporting Responsibilities to Missouri State Board of Nursing (3-1-94)

To: ACOS/Research & Development (151)
THRU: Chief of Staff (-FD)

1. Before I respond to Paragraph 4 of the above referenced memorandum, I need to discuss a matter that has been brought to my attention.

2. I have been informed that a signed copy of the letter that you said you would not send was, in fact, sent to the Federal Bureau of Investigation (FBI), who faxed it to the Inspector General's Office (IG) who faxed it to the Region, etc., etc. Needless to say, I am very disappointed. The memorandum you sent to me was marked CONFIDENTIAL. Any confidentiality intended was certainly breached when copies were sent by you to others inside and outside of this hospital.

3. As I reflect on this matter, I can appreciate your frustration. However, you know as well as I do, that the FBI and IG have yet to come to a decision on this case. Until such time as a determination is made by them, our official position is to continue to provide assistance to both agencies in whatever way we can. When a decision is made by these agencies, I assure you appropriate action will be taken.

4. Your responsibility in this matter has been carried out. You did what was asked of you and provided your interpretation of that data to all involved. It is now solely my responsibility to decide what further analysis, intervention and/or action is necessary. You should, therefore, refrain from further contacts with the FBI and IG about this case. If you are contacted directly by either the FBI or IG, you should inform me of the content of your discussion.

5. In answer to Paragraph 4 of your memorandum, the guidance I am giving you is that I alone accept responsibility both institutionally and professionally in this matter and will take appropriate action when and if warranted.

J. L. KURZEJESKI

Mr. EVERETT. You know what obstruction of justice is. It includes witness tampering.

The Federal Criminal Code, Title 18, Section 1512, states: "Whoever knowingly threatens or corruptly persuades another person, or attempts to do so"—let me repeat that part: "attempts to do so"—"or engages in misleading conduct toward another person with intent to hinder, delay, or prevent communications to a law enforcement officer or information related to the commission, or possible commission of a Federal offense, shall be fined under the title of imprisonment, or imprisoned not more than 10 years, or both."

It also states, "whoever intentionally harasses another person and thereby hinders, delays, prevents, or dissuades any person from reporting to a law enforcement office the commission, or possible commission, of Federal offense or attempts to do so"—again: "or attempts to do so"—"shall be fined under this title or imprisoned not more than one year, or both."

I'm not a lawyer, but as a former newspaper editor, I can read and comprehend pretty well. Now how is it that none of the conduct described in the GAO's report and in your report and the director's memo to Dr. Christensen is not covered by criminal provisions?

Mr. GRIFFIN. Mr. Chairman, I would join you in saying that I'm not a lawyer. I think there's been previous testimony that he was wrong in instructing anyone that they couldn't come to the IG; that's pretty clear in the IG Act. The criminal code, though, as you point out, talks about knowingly and willingly and with criminal intent, and that "knowingly" portion, from the layman's perspective, from my previous time in law enforcement, has a burden of having knowledge that the person who wants to come forward has "criminal" investigative information. Perhaps my counselor can clean that up for me because she has looked at this matter.

Mr. EVERETT. Ms. Regan, certainly go ahead, please.

Ms. REGAN. One part that is missing is that there has to be proof of motive. If I can just read you from one case, *U.S.* v. *San Martin*, 575F.2d 317, they have to prove—the Government has to prove the defendant knew or reasonably believed that the recipient of the threat had information which he or she had given or would give to the agents of the FBI, and that he called and threatened the individual in response to that belief in order to prevent, obstruct, or delay further communications. There was no evidence that the director knew that the individual he instructed not to go to the FBI had any specific information that the director didn't want given to the FBI. In fact——

Mr. EVERETT. How can you possibly make that statement?

Ms. REGAN. Because of the circumstances at the time that memo was created; plus, the fact that the individual was not involved in any of the care given to the patients. That individual had had numerous contacts with the FBI regarding the statistical analysis and other things and was never stopped from talking to the FBI. What was going on at that time had to do with the letter going to the licensing board. There was concern about releasing confidential information that shouldn't have been released from the hospital. That was what happened at the time that that instruction was given. It was not given to say to this person who had evidence of

a crime that "I don't want you to give it to the FBI" and that's pretty much what our workpapers show. It was researched.

We've also discussed this with the criminal people and even more recently with our people, some of the U.S. attorneys, and they didn't see any evidence of criminal activity.

Mr. EVERETT. With all due respect, that's exactly the type of explanation that infuriates the American public. I mean, it's exactly that sort of double-talk that just absolutely infuriates. You mean this director just contacted this guy and wasn't trying to get to the bottom of this; he had no interest in getting to the bottom of these 40 deaths?

Ms. REGAN. I'm sorry, but I——

Mr. EVERETT. All right, you have 40 deaths over here. You've got a whistleblower who, again, as some of you know from my previous committee meetings, I am determined to protect, and we have not only in this situation, but other situations that have been before this committee. We've had whistleblowers threatened and not a single thing has been done to the person who threatened them. To me, I don't understand why this is not the same situation.

Ms. REGAN. The problem—the difference is that the threat to a whistleblower may be relevant to an administrative action, but we're talking about a criminal obstruction-of-justice charge. The criteria is different for bringing a criminal charge. Now from an administrative standpoint, if somebody does threaten an employee for talking to the IG or talking to the FBI, then there should be some administrative action. The initial question was whether or not it rose to the level of being a criminal violation such as obstruction of justice. With respect to the 40 deaths, by the time that order was given, the FBI was almost 2 years into the investigation, or at least a year and a half. By that time, the FBI had interviewed over 200 people, including that individual on several occasions, had exhumed bodies, had conducted autopsies, and had interviewed everybody related to the care provided to those patients, including the people who responded to the codes and who were there at the time of the death. There was no indication that justice had been obstructed or that witnesses were not allowed to talk to the FBI. The interviews are there. Nobody was told they couldn't talk to the FBI.

Mr. EVERETT. How do you know what Dr. Christensen may have wanted to talk to the FBI about?

Ms. REGAN. Dr. Christensen talked to the FBI after that, and we can go by those interviews and what he said at that time. There was no indication that he had any specific information he wanted to impart to them or did he tell us that when he was interviewed.

Mr. MERRIMAN. If I may?

Mr. EVERETT. Certainly, Mr. Merriman.

Mr. MERRIMAN. I think also that this took place in March of 1994. As early as April or May, Dr. Christensen was back to us with additional allegations of reprisal. According to Mr. Kroll, when he read the GAO report and responded to us, he said that he sat down with Dr. Christensen—which he did—before we issued our report to go over the draft report with him. Although Dr. Christensen was not buying some of our conclusions in the report, according to Mr. Kroll, he didn't bring up at that time any evidence

that he was—unable to provide. In other words, he wasn't saying that there were things that he knew about that he did not provide to authorities because of the director's letter to him. We don't condone what the director did. It was wrong. He's not allowed to write letters like that. We say in our report that, had he still been there, we would have asked for administrative action against him. Unfortunately, it's not that uncommon in the Department—in frustration or stupidity—for these types of statements to be made. As you know, you've heard of other cases in some of our other reviews where a director will tell their staff not to talk to the IG. We do try to take immediate steps to prevent that from happening or to correct the situation when we're aware of it. But we know of nothing that Dr. Christensen had to provide to authorities that he did not provide because of that admonition.

Mr. EVERETT. I thought—I'm getting my dates mixed up a little bit, I guess. I thought he retired a year after that, after the time period you're discussing?

Mr. MERRIMAN. He did, but at the time we did our review I believe he was retired.

Mr. EVERETT. Okay. So the VA did not only not take any action against him for doing that, but gave him a $5,000 retirement bonus and $25,000 buyout.

Mr. MERRIMAN. I believed he received an $8,000 bonus. I don't know whether he got a buyout or not.

Mr. EVERETT. I think it was—I've got it—a little bit later we'll get to it, but I think it was a $25,000 buyout.

My time is up and I'll yield to Mr. Evans at this moment.

Mr. EVANS. Mr. Griffin, I understand your office disagrees strongly with the GAO's findings with respect to your investigation of allegations at the facility. Your response to the GAO's report spells this out in exhaustive details. Despite these strong objections, are there any GAO criticisms that you believe to be legitimate? If so, what steps can or has your office taken to address those kinds of errors?

Mr. GRIFFIN. I think that the GAO report did make some legitimate points. As I indicated in my opening statement, as the new Inspector General in the Department, I'm in the process of reviewing all of the procedures there. Certainly, there's no denying by anyone that any time you're involved in an investigation whether it's a special inquiry, which in our parlance is an administrative reviewer, or a criminal investigation, a timely response is critical. Without that timely response, you have witnesses whose memories have faded; you lose what might be the best available evidence—whether it's written documents, whether it's statements made that were overheard, or other forensic materials that could be key to making a case.

You also have all of the key people still available to be interviewed. Clearly, the passage of time caused a number of people—both within the IG staff and at the hospital—to have retired and moved on. Certainly, that's not a good time to try and probe their memory as to what happened 5 years ago—or 6 years ago, when the case had its first origins.

I would agree that there's a need for better coordination within our office. Sometimes you can get a breakdown, even though you're

trying to do something good. We have a group of criminal investigators who must carry out their work based on Federal Rules of Criminal Procedures, who must protect grand jury information, and who must conduct themselves in a manner focused on eventual prosecution of the case. In doing that, when you're dealing with grand jury material, that material is not to be shared with people who are not cleared to have it.

What has happened in the past, frankly, is there's been a breakdown in communications by virtue of trying to put a fence around that sensitive information. Sometimes information that has application in our special inquiry section or in our healthcare section doesn't always get communicated in the way that it should. So we're in the process right now of establishing a better system of controls, so that everyone in the organization will at least be aware of ongoing initiatives. This will be accomplished by using identifiers which might include the location of a facility, the name of a suspect, a victim, or complainant or what have you. We're still putting the system together to make sure that we can't have something get lost in one section of the organization when it may still have some application in another area.

We certainly take great concern from reading that there's a perception that we do not protect the confidentiality of witnesses or complainants that come to us. From my 26 years in law enforcement, I certainly learned that you would be out of business quickly if the word was on the street that you didn't protect your sources. So you need to be constantly vigilant to protect people who bring information to you. That will be a priority that we make sure that happens in the future.

Finally, there's the independence that must always be identified with Inspector General organizations. Clearly, in order to perform the role which has been established by the act of 1978, you have to be independent. You can't be bullied into accepting anyone's position. You have to go out and find the facts, report the facts, and let the facts speak for themselves. That's a very high standard.

Very often the outcome that you reach might not be the desired outcome in the eyes of everyone that's out there. That doesn't mean that you alter the facts. We have a mandate to identify the facts and report truthfully, and that's what we will do.

Mr. EVANS. Thank you. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. Mr. Merriman, as a Deputy IG you testified at the October 1995 hearing on the Columbia deaths and presented a report that GAO has described as misleading. Do you agree that the report's conclusions were overstated, as a former Assistant IG has reportedly told the GAO? What role did you have in it, in it's preparation, review, and approval?

Mr. MERRIMAN. No, I don't believe it's overstated. At the time we began that review, which was about January of 1995, Dr. Christensen had gone to the press and made allegations about the destruction of records and mentioned that he had come to us with other evidence. The Inspector General at that time decided we would initiate a two-pronged review. We'd have our criminal investigators look at the destruction of documents, which would clearly be in the criminal area. We would also have our administrative in-

vestigators look at Dr. Christensen's other allegations. They would work together.

Initially, they conducted joint interviews with Dr. Christensen. They went and they sat down with him. He backed away from his allegation of destruction of records. Records were being shredded—they were copies not originals. He said he was satisfied that there was no problem there.

He also turned over to our criminal investigator and our administrative investigator the material he had at that time. They went through the material. They decided that on its face the information looked like administrative issues.

We started out on our review of what he alleged. Now during the review, he came in on March 27, 1995 with a fairly extensive document that broke out his allegations in terms of cover-up, obstruction of justice, and other things. When that came in, the Inspector General read it. He wrote a note on it to the AIG involved and said that he wanted these allegations looked at extensively. We patterned our review on looking at Dr. Christensen's allegations. He is the one that called certain actions to be obstruction of justice or cover-up. He established what they were, and we picked up on that pattern and that's what we looked at.

If you look at our report, it's in four sections. A section will start out by saying that it is alleged that there is a cover-up. In conversations with the informant, he identified those activities that indicated a cover-up. We looked at those activities. So in our mind, Dr. Christensen established the charge of either cover-up, obstruction of justice, or whatever else it was. He established what the events were that led him to believe that. We believe we looked at those events. You may challenge the conclusions we reached, but I don't see how anybody can say that we didn't look at the issues that he raised. I think the report accurately represents his allegations. Our testimony in 1995 accurately represented what was in the report.

Mr. EVERETT. Thank you. Before I dismiss this panel, let me—Mr. Griffin, Ms. Regan, and Mr. Merriman—my anger is not directed at you personally and I know that you know that. I have expressed many times my appreciation for the dedicated work and hard work that professional people in your organization—that you've done. But we still have 42 deaths in Columbia, MO and we have no idea how they occurred. As a matter of fact, the evidence that I have seen indicated that those deaths did not—were not caused by natural means. There's a strong possibility that we have at least some of those 42 people—if not all those 42 people—murdered. Because of the way this has been handled over the past few years, I'm just simply frustrated that we can't get to the bottom of it.

Again, I do appreciate the work that you've done on it. You're right, Mr. Merriman, we may not—we may have different opinions on the conclusions that you have reached and that GAO has reached, but we have a terrible situation here, one that in my estimation, my mind, is simply inexcusable. We have 42 deaths and there's a strong possibility that these were not by natural causes. We have no way to get to the bottom of it.

Again, I thank you for your appearance here today. At this point, I'll dismiss this panel and call up the third panel. Thank you again.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Mr. EVERETT. The Honorable Thomas Garthwaite, Deputy Under Secretary of the Veterans Health Administration if you'll introduce your panel, please. Dr. Wilson, I believe?

Dr. GARTHWAITE. Yes, Dr. Nancy Wilson, our Chief, Office of Performance and Quality.

Mr. EVERETT. Okay.

[Witnesses sworn.]

If you will proceed with your testimony, I ask you to hold it to about 5 minutes. Your complete statement will be put into the record.

TESTIMONY OF THOMAS GARTHWAITE, DEPUTY UNDER SECRETARY, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY NANCY WILSON, CHIEF, OFFICE OF PERFORMANCE AND QUALITY

Dr. GARTHWAITE. Thank you. I have a summary discussion around the full statement.

Mr. Chairman, I'm here to discuss the Veterans Health Administration's Patient Safety Program and changes that have been made to reduce adverse outcomes related to medical treatment. Before discussing our current patient safety initiatives, I'd like to briefly discuss elements of policy that relate directly to the Office of Inspector General and others' review of deaths that occurred at the Harry S. Truman VA Medical Center in 1992.

First, the Veterans Health Administration agreed with the Inspector General's 1995 report that the management team in place at the time did not act as promptly and as fully as we would have expected. The 1995 report also contained recommendations for important policy and systems changes that we have implemented. These changes should guide management to promptly and appropriately respond to any similar circumstances in the future.

For example, current policy provides guidance on (1) reporting to appropriate law enforcement officials if a statistically-significant association between a practitioner and increases in mortality, morbidity, or other adverse occurrence is found and there's no other credible explanation; (2) for promptly removing a practitioner from clinical duties when suspected of criminal activity; and (3) reporting to the appropriate State licensing board when a practitioner leaves VA employment and a statistically-significant association with adverse events is found. This policy will apply to all employees, currently employed employees, effective early June.

Ongoing review of mortality data and review of statistical findings by designated statistical consultants are now available in every network. They have specific individuals designated with this expertise to aid facilities regarding data analysis for patient safety, for quality assessment, and performance management purposes.

These policies and systems changes were developed from the review of the events that occurred at Columbia in 1992. Had these policies been in place at that time, I believe and hope the response would have been different.

I'd like to turn now to our current Patient Safety Program. We have designed our program with an ambitious goal. We want to be national leaders in improving patient safety for VA and non-VA healthcare systems.

A number of well-publicized and tragic events during the last few years have made it clear that increasing patients' safety should be a national priority for all healthcare systems. In the Harvard Medical Practice Study, researchers reviewed over 30,000 records in 51 non-Federal hospitals, and estimated that over 1 million patients are injured or disabled annually because of adverse events. Two-thirds of the injuries are thought to be preventable.

In response to the growing recognition that systems are more often at fault than are the people in those systems, we have recently implemented an improved Patient Safety Program that I believe will place VA at the forefront of efforts to provide safer medical care. Indeed, various private sector organizations have been highly complimentary of our policies and plans.

We're using several different strategies to identify making the changes. First, our facilities routinely analyze all service delivery systems and processes to identify redesigns that are likely to reduce the likelihood of errors. For example, because of reported blood transfusion errors, by early July, we will implement an additional barcode check to match the patient with the blood being transfused at the time it is being administered.

A second procedure to increase safety is to intensively review all adverse events from two points of view: the point of view of the local site and the point of view of the entire system. Locally, these reviews identify the root causes of each incident and the changes in design of systems needed to prevent recurrence in any indicated personnel actions.

All reviews of adverse events are sent to the network and then to headquarters, where they are reviewed to identify the adequacy of the facilities review, the patterns of adverse events or system problems, and any redesigns in the system that should be adopted throughout the network or nationally. Any needed changes in national policies and procedures and lessons that have been learned can be shared throughout VA and hopefully into other healthcare systems as well.

The sharing of patient safety information between our facilities, particularly innovative system designs, is a key aspect of our improved program. All current VHA communication media is being used for this purpose. VHA is determined to further enhance the design of our patient care systems to reduce preventable adverse events and untoward outcomes. Implicit in this process is the need to breakdown current disincentives for addressing medical errors. These disincentives include the traditional culture that finds it difficult to acknowledge errors and mistakes, and fears of litigation and adverse media coverage.

We are working now to create a culture that permits medical care personnel to acknowledge the occurrence of errors and encourage open and complete reporting of adverse events. Of course, the system also has to ensure that, where appropriate, personnel actions will be taken against employees whose negligence led to the patient injury. We are convinced that the real payoff in improving

patient safety will come from addressing the root causes and designing into the systems a greater margin of safety.

In addition to our internal Patient Safety Program, we have taken the lead in forming a national Patient Safety Partnership, since the issue of patient safety is not one that individual healthcare organizations can or should take on alone. Members of this public/private partnership besides the Veterans Health Administration include the American Hospital Association, the National Patient Safety Foundation at the American Medical Association, the American Nurses Association, the Joint Commission on Accreditation of Healthcare Organizations, and the Association of American Medical Colleges. The primary goal of this partnership is to focus these healthcare leadership organizations on preventing adverse events in healthcare.

Finally, we are developing a quality control system modeled after the Aviation Incident Safety Reporting System, a system using aviation for the last 22 years. In aviation, this system is voluntary, nonpunitive, confidential, objective, and independent of the FAA and the airline industry. Its goal is the accumulation of knowledge that can be used to increase safety.

Our voluntary incident reporting system will require substantial changes in thinking on the part of our employees and stakeholders. We must learn to recognize dangerous situations, near misses, and to acknowledge honest mistakes, whether these mistakes cause injury or not. An honest mistake made once, leading to permanent improved system design, is unavoidable and in our opinion, should be acceptable. The same mistake, never analyzed, repeated by every healthcare system until it is learned, and then repeated until it is fixed, in our mind, is unacceptable.

We're committed to establishing a system that enables the Veterans Health Administration to acknowledge, understand, and address today's barriers for improving patient safety. We believe it is critical and the right thing to do.

Overall, Mr. Chairman, while I believe VA's record on patient safety is a good one when compared to other healthcare systems, all of healthcare has room for improvement. To carry the airline industry analogy of this further, the only tenable goal for airlines is no crashes sustained forever. The only tenable goal for healthcare is zero preventable errors sustained forever. I believe our present framework for ensuring quality of care which includes a new patient safety policy will move VA closer to that goal.

That concludes our statement and I welcome questions.

[The prepared statement of Dr. Garthwaite appears on p. 132.]

Mr. EVERETT. Thank you, Doctor.

As I understand it, the cause of many of those deaths is still officially declared as undetermined at Columbia—the 42 deaths there?

Dr. GARTHWAITE. The cause of death on the death certificate is made by a clinician caring for the patient, unless there's an autopsy. So it's made based on the clinical circumstances surrounding that death. The official cause of death on the death certificates I'm not aware of at this time. We could——

Mr. EVERETT. In other words, you're not aware of whether or not they're listed as undetermined or not?

Dr. GARTHWAITE. I'm not aware of that.

Mr. EVERETT. Thank you. I'm sure that you agree that one of the best ways to ensure quality of patient care is to have the very best healthcare professionals you can employ. Yet, it's come to my attention that Nurse Richard Williams had been fired in 1989 from a previously licensed practical nurse job at St. Johns Hospital in Springfield, MO before the VA hired him. The VA knew that when they hired him. Can you tell me how that would happen?

Dr. GARTHWAITE. Well, sir, as I understand—and I have relatively sketchy details on this—is that the individual who interviewed and was responsible for hiring Mr. Williams noted on the application that he had correctly filled out his application; that he had been released in a dispute with his supervisor over the administration of a medication at the previous facility. They did call the facility, who declined to elaborate further on it. The more forthcoming of the two individuals was Mr. Williams at the time. Based on that, they weighed the evidence and other information that they had from other references and made a decision to hire.

I think, looking back in the record myself, I would love to have seen a better description of this decisionmaking process by those individuals as to why—how they weighed that evidence. But I wasn't there at the time and I don't know.

Mr. EVERETT. In your Patient Safety Program, have you addressed this problem?

Dr. GARTHWAITE. Not to my knowledge. I was not aware of this particular fact until about a week and a half ago or a week ago.

Mr. EVERETT. Okay. I was not at the October 1995 hearing. Is it correct that the former hospital director at Columbia, who was dysfunctional, Mr. Kurzejeski, who retired in 1994 with a good performance appraisal, a $5,000 SES bonus, and a $25,000 buyout?

Dr. GARTHWAITE. I had not heard the buyout. I know he did receive a performance bonus the last year that he worked for us.

Mr. EVERETT. On page 2 of your oral testimony, you state, when a practitioner is suspected of criminal activity, it harms patients. The practitioner is to be removed from clinical duties until the suspicion has been resolved. Also, physical materials that could provide proper evidence are to be collected and stored for possible analysis by law enforcement officials. Who's supposed to collect these physical materials?

Dr. GARTHWAITE. Obviously, we would like to bring law enforcement officials instantly and have them sustain a chain of evidence on collected materials, if that's possible. But the sensitivity we're trying to alert our practitioners to is not to discard it and protect it until we can make those contacts and allow proper chain of evidence to be maintained.

Mr. EVERETT. In other words, you have a system set up to—so that practitioners undergo training to preserve evidence that they may be involved in?

Dr. GARTHWAITE. The policy is to raise management's awareness that it's their responsibility and to think of those things when it happens. Most of what we do is not about collecting evidence; we're about improving healthcare.

Mr. EVERETT. You've stated that the fatality rate data is reviewed by all VA healthcare facilities. Who's designated to do that?

Dr. GARTHWAITE. Which data?

Mr. EVERETT. Mortality rate.

Dr. GARTHWAITE. Quality management in the facilities review that on a routine basis.

Mr. EVERETT. Whose team—which team?

Dr. GARTHWAITE. Quality management. Each medical center will have a quality management coordinator usually and quality management teams. Various medical centers will have different arrays of committees and teams.

Mr. EVERETT. Which are normally appointed by the director?

Dr. GARTHWAITE. Everyone works for the director in our facilities.

Mr. EVERETT. Can you tell me how this would work when you get a red flag-type situation?

Dr. GARTHWAITE. I'll let Nancy.

Mr. EVERETT. Sure. Dr. Wilson, please.

Dr. WILSON. Thank you. What we've specified is that, when a red flag comes up, the appropriate committees that are designated to look at this will search for any kind of association between that death or rate of adverse events, looking specifically for associations with locations, such as particular wards, particular timeframes—is it always on the nightshift versus the dayshift? Also, looking for associations with particular practitioners. The team really has to look for the pattern across the array of services that are given at that facility.

In our patient safety policy we have a step-by-step procedure for the facility. If they find that to be the case with a practitioner I would refer you to our Patient Safety Policy.

Mr. EVERETT. When is the VISN notified?

Dr. GARTHWAITE. We expect the VISN to be notified almost instantaneously whenever they have any significant deviation.

Mr. EVERETT. Is that spelled out in your policy?

Dr. WILSON. The policy does not specify when—for a statistical association—the network is notified. We have two things in place. One is that any untoward death is to be called to the network office within 24 hours of that unexpected death—every single death; then within another 24 hours, the network is to call headquarters. So, in addition to relying on their surveillance at the facility to look for statistical associations in the death rate, we're insisting that they—and the policy is in place—that they call every single death forward. We are all looking at—and we are all counting—those numbers and looking at the data.

Mr. EVERETT. Correct me if I'm wrong here, but if this system had been in place at Columbia, still nothing would have left the hospital? None of these deaths were red-flagged?

Dr. WILSON. I would think that—I certainly don't want to disagree with you, but——

Mr. EVERETT. If I'm wrong, please correct me. I have no problem with that.

Dr. WILSON. Given that any death—any death that occurs that is not basically a "do not resuscitate" patient—a patient with advance directives that is defined as expected—every single death is, by policy, called to the network office within 24 hours. So it's not just that the facility director is saying "gee, I had one; gee, I had two"—such as had been described before. But we have a quality

management officer at the network office overseeing this data plus the network director, the chief medical officer of the network, plus a Patient Safety Oversight Committee in headquarters that is comprised of the medical inspector, a physician representative from Patient Care Services, my office, and the office of the chief network officer.

So we feel, with those layers of—with all layers of the organization calling the data in and tracking the numbers, that we would find—we would find these and explore and evaluate each of these deaths.

Dr. GARTHWAITE. As I remember the data surrounding Columbia, this was really discovered by the quality management group. Nancy, I believe, has a call every week with all the quality managers around the country. So this is—the communication and the number of routes of communication around the potential obstruction to the flow of information I think has been significantly changed.

Mr. EVERETT. Of course, what I'm searching for is we had 42 deaths within a 6-month period here and nobody ever raised a red flag.

Dr. GARTHWAITE. It's my understanding that the total number of deaths during the period was not increased—in fact, decreased from the previous year. It was the number of codes that triggered the investigation and led to the further understanding in the statistical association. So that the characterization that there were a lot of extra deaths is, in my understanding, not correct. In fact, there was an increased number of codes—increased number of deaths that weren't expected at that time. Virtually everyone who died had significant illnesses. The question was the timing—the timing during the day, and so forth.

Mr. EVERETT. I think I'm referring to exactly that—the timing during the day and, plus, the fact that things were on one ward under the care of one nurse. You know, that's what concerns me—nothing went up. Is there a possibility of this kind of thing repeating itself?

Dr. GARTHWAITE. The answer is that——

Mr. EVERETT. Before you answer, let me say that, if there is, then we've got something really wrong that we need to straighten out. We're talking—I mean, there's evidence that was presented that, in my opinion, should have triggered a red flag somewhere. Okay.

Dr. GARTHWAITE. Yes. I understand, sir. If everything were stable, then monitoring the number of deaths, comparing it to the number of employees, and achieving a statistical significance for which you could then accuse someone of murder is—would be hard enough if it were all stable. In the last 3 years, to improve the efficiency and effectiveness of our care, we've reduced the number of beds in half; we've combined wards; we've changed how practice is done; we have turnover of staff—the mathematical complexity of determining what you're asking is not simple.

Now, the answer is, are we looking at that? Are we making efforts to look at the association of deaths with who's on the ward and the locations, and so forth? Yes. Is it a perfect system, you

know, and what level can it pickup sensitive and minor changes? It's not a system that's perfect.

Mr. EVERETT. What concerns me—I'm sorry, Dr. Wilson, go ahead.

Dr. WILSON. I think that the issue of needing multiple mechanisms of communication is an important one. We feel that it is going to take time to change the culture of this organization such that people at all levels of the organization feel comfortable coming forward and letting people know that any kind of adverse event is occurring. That is, our recognition of the need to change that culture is precisely why we're putting in a whole quality control system where people can call all of these things in with confidentiality protected, so that we can have multiple mechanisms in learning about these things.

My one other point is that we conduct a meeting every month. The Under Secretary personally conducts our Quality Management Integration Council that communicates with all levels of the organization. He is constantly reiterating the importance of people coming forward and not allowing any barrier at any level of the organization to block reporting of these untoward events.

Mr. EVERETT. Well, that's one of the things that concerns me. Hopefully, we can change that culture—you know, I have to tell you that this committee has seen case after case where people have come forward, have been threatened or penalized, or chastised, or whatever. Perhaps communication is the answer. It's obviously either an open secret or a whispered secret that there was something very wrong in Ward 4 on the nightshift. Somehow or other, that did not trigger a red flag.

Mr. Mascara.

Mr. MASCARA. I didn't have the benefit of your testimony, but—and I missed the second panel, which is the one I wanted to dearly speak to and ask some questions, and I might submit some questions to that second panel.

Mr. EVERETT. Without objection. As a matter of fact, all panelists will be given additional questions.

Mr. MASCARA. Good. Thank you, Mr. Chairman.

(See p. 137.)

Mr. MASCARA. You spoke, Dr. Wilson, about changing the culture at these facilities—that somehow that would encourage people to come forward. People that we hire, and I am hoping this includes the VA when they hire somebody, that they hire decent human beings who are moral and have ethics and would feel free to come forward to someone. If it's not the hospital administrator, then the head nurse, or the physician on duty, and speak out about a death they felt somehow was caused by an employee of that facility. Somehow we have to engender them in some meetings that we might hold to tell them what one supposed to do in these situations. If you hear about or you see someone being mistreated, that you'll feel free to come forward. Do we need to reschool these people about coming forward?

If the Whistleblower Act has any significance, I think they should feel comfortable about coming forward. I can see not wanting to go to the former administrator, you know, because he con-

dones it, apparently, and would possibly engage in a possible cover-up of what occurred there.

Dr. GARTHWAITE. I think there are two issues of culture here. One is the culture in all of healthcare which makes it relatively hard because of tort claims and other reasons to think—to admit you made a mistake and to bring forward the sense that you're going to improve the systems. We have a tendency to blame the individual and not fix the things that support the systems. Pilots have a lot of systems in place to help them do their job. We tend to blame individuals for not knowing everything, instead of developing better systems to help them remember those sort of things.

The second issue of culture that I think the chairman has spoken to is about management culture. Dr. Kizer and I have been involved with the help of many, many people for about 3 years trying to dramatically change the way the Veterans Health Administration does its business. We have fundamentally put into place about 15 things we think will help to improve the culture. They range from signed performance agreements where bonuses for leaders are given because the outcomes for patients improve, to surveying our employees. We've started a 360-degree evaluation. That is to say, my evaluation will be, in part, dependent upon the people that I serve and that I interrelate with, that will be fed back and given to me to help me improve but also can become part of my assessment. We're starting with top management. We're not starting in lower parts of the organization. We've surveyed employees as to their working environment. We've developed an external recruitment process, so that a fairly inbred system where we've almost always had our leaders chosen from within also brings in the best from the outside to help give us new ideas and fresh eyes to see if there are things we can do better.

We're teaching everyone how to interview prospective applicants, so that the interviewing and selection process of employees is not left to chance, because it's not done that often for most of us, so that they use the best scientific method they possibly can. We have new ways of discipline and taking action about senior management where we get more people involved, because we've learned that sometimes communication can be an issue. We've issued a statement and are teaching all employees about our values: trust, respect, excellence, compassion, and commitment.

We believe that, when we move employees around the system, that we have to do that clearly for a reason. We have a new policy that says, if someone's going to go to a new medical center, there will be a reason unless they go into a competitive process and compete for that directorship. If they're moved because they need a new environment, there's an expectation of how they're going to improve their performance at the new place. It's the first step in understanding.

Those are just a few of the things that we've put into place. Because I really do believe the chairman is correct that the culture of the VA was not perfect. It is not perfect today, but I think it's vastly improved and on its way to being a much better organization.

Mr. MASCARA. In response to the chairman's question regarding the number of deaths, you said that's not unusual for that period of time?

Dr. GARTHWAITE. If you compare the number of deaths during the period of time in question, it's my understanding——

Mr. MASCARA. What was the period of time? You want to refresh my memory?

Dr. GARTHWAITE. I can probably——

Mr. EVERETT. Through August of 1992.

Dr. GARTHWAITE. Yes. It's in August, December——

Mr. EVERETT. Six to 8 months.

Mr. MASCARA. So you have—but if you compared the deaths there in an 8-month period——

Dr. GARTHWAITE. We compared the exact same period the year before, the number of deaths——

Mr. MASCARA. But not increased in one ward. You've never had that experience before?

Dr. GARTHWAITE. But what triggered the investigation, to my understanding, is that there were an increased number of codes called——

Mr. MASCARA. Certainly where people rush and try to resuscitate the individuals.

Dr. GARTHWAITE. That seemed to be an unusual number of those and an unusual number in a particular area.

Mr. MASCARA. They were unusual? What do you mean by unusual?

Dr. GARTHWAITE. I'm sorry, more codes than were expected.

Mr. MASCARA. Regardless of how they died, is it unusual to have that number of people die in a certain ward with a certain nurse on duty at certain times?

Dr. GARTHWAITE. Yes.

Mr. MASCARA. I hate to make light of this, but I recall back in my district, when I was county commissioner a number of years ago—and this reminds me of that—and I hate to make light of it, but the district attorney said, after a man was found at a garbage dump with his hands tied behind his back and shot from behind his head, he suspected foul play. It almost seems to me that somehow people just overlooked the obvious. Didn't they have some idea, some clue that something was happening? This administrator—administrator, director, or whatever you call him—he gets these reports every day in his office. Was anybody able to determine or ascertain whether he gets these reports daily of the deaths that occur at the facility?

Dr. GARTHWAITE. I think at the time he probably received the deaths and he would have—and the quality assurance folks would be reviewing those, and they would not have noted that the number of deaths was any different from the previous year during that time period. They had made some ward changes where they combined some wards and they put some of the sickest people on this particular ward. So that at that time, the number of deaths didn't stand out just as the number of deaths. What stood out was that they weren't expected right at that moment. These were sick people, but they were expected to die and codes were called.

Mr. MASCARA. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you for your questions. Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman.

I don't want to flog this horse if he's dead. But Dr. Garthwaite, you used the term "significant deviation." The word "significant" is open to interpretation. Dr. Wilson, you mentioned any untoward death, and again, that's somewhat subjective as to what is untoward. I think the chairman asked the question—it's a bit beyond my bailiwick because I'm not on this committee, but I'm compelled to follow up with this.

The quality management team—let's talk about the changes that have been made that you envision and that you're trying to implement, but the quality management team still answers to the hospital director, correct? So let's assume these facts to be true for the purpose of this hypothetical. Let's say that you have a hospital director that is receiving information that on a particular ward there are these additional codes that are being called; that this particular hospital director makes a decision: We shall keep this internal. Even Dr. Wilson, if you were to call up the hospital and to ask—this particular director, says, there's nothing untoward happening in our hospital.

Let's assume further that this same hospital director is strongly suggesting, and some perhaps even say intimidating, people that are working there from going to the authorities under threat of losing their jobs——

Mr. EVERETT. Would the gentleman yield?

Mr. HULSHOF. Yes.

Mr. EVERETT. That's exactly what happened. We had a situation that we had to introduce legislation to correct when the EEOC officer had to report to the director. It was the director who was guilty of the sexual harassment. So this is a possibility—certainly a possibility—the situation that you're describing.

Mr. HULSHOF. Well, I thank the chairman. Let's assume that this hospital director is again strongly encouraging those not to talk beyond—that it would be handled internally. Do you believe that the mechanisms you now have in place would root out this type of situation? So that we can have the confidence and I can go back to Columbia, MO and everybody here can go back to their respective constituents and say, look, something positive has happened from the Columbia, MO situation. Can you give me that confidence, Dr. Garthwaite, that the procedures that you have in place now would prohibit something like this from happening in the future?

Dr. GARTHWAITE. Yes, I can. I feel very confident that we've changed dramatically the openness which our people have the ability to report. The quality managers don't just report to the medical center director; they can have direct communication on a weekly basis and do, with quality and performance.

So I think that better data systems can help us assure that, and we're moving to some of those things as well, and have some good national data systems that transcend all that. But I think, to the maximum extent possible, we have good communication, direct communication, and openness. Dr. Kizer and I receive direct communication on a regular basis and have routinely examined that information and followed up on it personally to make sure that we're getting to the bottom of things.

Mr. EVERETT. Dr. Wilson, anything to add?

Dr. WILSON. I would agree completely with Dr. Garthwaite. I would add that having 22 network directors responsible for hospitals within their area is an additional structure that really helps with the oversight of what is going on in each of the facilities. I would reiterate that the quality management officers at the network office also help with that process. So, unlike when there were four regions and the regional person was trying to pay attention to a much larger number of facilities, we have a responsible person overseeing perhaps 5 to 10 facilities. The oversight is much stronger.

Mr. HULSHOF. Dr. Garthwaite, just in general, what are the most important lessons that you and your Department have learned from this situation?

Dr. GARTHWAITE. I think if you look at management's response at the time, the first priority you have to have is patient safety. So the first action you have to take is to guarantee patient safety.

The second thing that I think—I know Dr. Kizer and I believe strongly—is you need to lay all the facts bare. We often use the Inspector General or a medical inspector or others to lay the facts open. We'll deal with whatever the facts are.

The third after that is to fix whatever you find. You have to take into account the rights of the patient first, but you still have to take into the rights of the individuals who are involved. So that becomes, you know, the third order of mechanics here. Patient safety first, baring of all the facts, good assessment and fix everything we can.

Mr. HULSHOF. We will hold you to that standard. I probably should state for the record that in the contact that I've had with the men and women, the employees, of the Truman Hospital that your goal of providing good quality healthcare is being accomplished by those who are walking the wards. To the families of the veterans who have met these, I believe, untimely deaths, I suppose I could apologize, but I think an apology falls woefully short of what is necessary here.

Mr. Chairman, I appreciate you letting me participate in this. I think that the actions regarding this whole situation have been shameful. I think that America's veterans and their families deserve much better than this. I hope and pray that the light from this hearing will somehow shine to help us learn from the mistakes we've made; that we can put this tragic event behind us, and again, hopefully, to those who are present here, that this hearing has provided some vindication for coming forward. Because had that not happened, I struggle to think of how many additional, untimely, untoward deaths may have occurred.

But, Mr. Chairman, again, thank you for the opportunity to be here.

Mr. EVERETT. Mr. Hulshof, I appreciate your participation here today and also very much appreciate your interest in this matter from the very first day you became a Member of this Congress.

Whatever you want to call it—this dysfunctional cover-up, whitewash, stonewalling, damage control—I think there's ample evidence in the whole record to support a reasonable belief that a former VA hospital director was attempting to keep the patient

death situation from going outside the hospital. On at least one occasion, he attempted to impede or obstruct the FBI and the IG investigations. I have no authority to direct the IG or the FBI to reach any conclusion. It seems likely that there will be no criminal investigation, no grand jury, and no trial on obstruction, although it's been pointed out here there is no time limit on prosecuting murder.

In any event, whatever was being attempted did not succeed in the end. I do not believe that it's feasible to reinvestigate cover-up allegations, as much as I'd like to have it done.

I do believe that nepotism question regarding the hiring of the former hospital director's son has never had anything more than a self-serving explanation by the Columbia VA Hospital management. It should be objectively investigated, and I'm going to ask the GAO to do that.

In fact, we have a fairly clear picture of what occurred within the VA on the patient deaths and now the IG investigation. I know there is anger and frustration over what has happened; I personally have anger and frustration over it. We can't change it. But we are taking, and seeing, steps taken to minimize the possibility that something like the unexplained Columbia deaths can happen again. The subcommittee will continue to look into the FBI investigation of these deaths, and hopefully, from that investigation, we can see something move forward on the possible murders that took place at Columbia.

I also intend to send a letter to Chairman Mica regarding the problem of VA hospital directors, and this is not the first time we've seen this—of VA hospital directors being allowed to retire with impunity, with bonuses, even without ever being held accountable for their misconduct and mismanagement. These get-out-of-jail-free cards for senior government management must stop.

Members will have 5 legislative days to submit the statements and questions to the witnesses.

The meeting is adjourned. Thank you all very much for attending.

Whereupon, at 12:30 p.m., the subcommittee adjourned subject to the call of the chair.]

APPENDIX

STATEMENT BY THE HONORABLE FRANK MASCARA FOR THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS HEARING ON 5/14/98.

THANK YOU MR. CHAIRMAN, I DO NOT HAVE A STATEMENT FOR THE RECORD, BUT I AM APPALLED AT THE ALLEGATIONS THAT 42 PATIENTS MAY HAVE BEEN MURDERED AT THE TRUMAN FACILITY IN MISSOURI WITHOUT A DEFINITIVE ANSWER. I AM SURE THAT THE LEVEL OF CARE AT THE VA HOSPITAL IS ADEQUATE, BUT I WOULD LIKE TO KNOW HOW THIS HORRIBLE STRING OF EVENTS COULD BE ALLOWED TO GO ON FOR SUCH A SUSTAINED PERIOD OF TIME WITHOUT CLOSURE.

I LOOK FORWARD TO QUESTIONING THE PANELISTS AFTER THEY HAVE GIVEN THEIR STATEMENTS TO THE SUBCOMMITTEE.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

For Release on
Delivery Expected
at 9:30 a.m., EDT
Thursday
May 14, 1998

INSPECTORS GENERAL

Veterans Affairs Special Inquiry Report Was Misleading

Statement of Eljay B. Bowron
Assistant Comptroller General for Special Investigations
Office of Special Investigations

GAO/T-OSI-98-12

Inspectors General: VA OIG Special Inquiry Was Misleading

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to discuss the results of our review of the Special Inquiry conducted by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) and its resulting report entitled Special Inquiry: Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, Missouri.[1]

Our review focused on how the VA OIG planned, conducted, and reported the results of its inquiry. In its Special Inquiry report,[2] the OIG analyzed and criticized VA management's response to the deaths, calling the top management team "dysfunctional." It concluded that management's actions could be attributed to bad judgment and found no conclusive proof of an intentional cover-up and no evidence of criminal conduct by top managers.

From our examination and analysis of the evidence in the OIG files and from interviews with individuals having knowledge of the events, we conclude the following:

- The VA OIG conducted the Special Inquiry as a management review to determine how Hospital and VA Central Region management had responded to "an 'out of norm' situation" regarding the unexplained deaths. We determined that the OIG did not collect or analyze evidence in a manner that would identify intentional cover-up efforts. Thus, the Special Inquiry's

[1]See also Inspectors General: Veterans Affairs Special Inquiry Report Was Misleading (GAO/OSI-98-9, May 13, 1998).

[2]In February 1993, the OIG received specific allegations that the Hospital Director and the VA Central Region Chief of Staff had attempted to cover up the unexplained increase in patient deaths, including by not referring the matter to law enforcement authorities. In January 1995, the OIG initiated an administrative investigation (known as a Special Inquiry) after the complainant notified the media of allegations of a cover-up and an additional allegation.

conclusion that no evidence of an intentional cover-up had been found was not consistent with the inquiry conducted and was misleading.

- The OIG failed to comply with its own reporting policies on completeness and accuracy by presenting statements in its report that were not supported by the evidence contained in the OIG's files. These statements included, for example, reference to a discussion that the Special Inquiry never verified.

- The OIG attributed the nearly 2-year delay in acting on the cover-up allegations received in February 1993 to administrative error.

- The confidentiality of the staff physician who had made the allegations of a cover-up was breached by the OIG on at least three occasions.

- Current OIG policies and procedures on confidentiality are adequate.

SPECIAL INQUIRY REPORT'S CONCLUSION REGARDING ALLEGED COVER-UP IS MISLEADING

The title and text of the Special Inquiry report suggests that allegations of a cover-up on the part of the Hospital Director and the Central Region Chief of Staff had been investigated. We determined that the OIG did not plan or conduct its review or analysis in a way that could determine if a cover-up had occurred. Had the OIG conducted such a review, its efforts and documentation would have included linking individual pieces of evidence that together would suggest additional lines of inquiry–including elements of a cover-up. Further, both the lead analyst who conducted the review and the Assistant IG who wrote the final report told us that the issue of cover-up was "off the table" because,

in their view, their "charge" from OIG management did not include looking at cover-up allegations.

The lead analyst completed the interviews and field work and wrote a draft report entitled Special Inquiry: Management Response to Unexplained Patient Deaths, Harry S. Truman VA Medical Center, Columbia, Missouri. The body of that draft report made no reference to allegations of a cover-up by the Hospital Director and Central Region Chief of Staff. In the draft report, only one issue was addressed–whether management officials complied with VA and Hospital policies when responding to the revelation of the unexplained deaths.

According to the Assistant IG who prepared the final report, he neither reviewed the underlying evidence while preparing the final report nor reconciled the stated facts in the report with the underlying evidence prior to issuing the report. He stated that in writing the final Special Inquiry report, he changed the original title to Special Inquiry: Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, Missouri and edited the report in an attempt to tie the text to the complainant's allegations. Although the Assistant IG stated that there was no intent to mislead, the report title and two of the report's three major sections–"Alleged Cover-up by Medical Center and Central Region Officials Subsequent to the Criminal Investigation" and "Alleged Cover-up by the Office of Inspector General"–specifically refer to the cover-up allegations. The Assistant IG characterized this as wordsmithing. He concluded that in hindsight he probably should not have changed the title and that the report probably overstated its case concerning "no evidence of a cover-up," as the OIG did not investigate the cover-up allegations. Therefore, the Special Inquiry's conclusion was not supported by work done and evidence collected and is misleading.

Inspectors General: VA OIG Special Inquiry Was Misleading

The then IG told us that he had intended for the Special Inquiry to investigate allegations of a cover-up and that, based on his reading of the report, it appeared that it had. He added that if the review did not include an investigation of the cover-up allegations, he believes that the report, as written, is misleading.

REVIEW PLANNED AND EXECUTED FROM A MANAGEMENT PERSPECTIVE

We determined that the OIG did not plan or conduct its Special Inquiry in a manner to determine if improper acts pertaining to cover-up had occurred. The Assistant IG directly responsible for the inquiry stated that when he prepared the report, he examined components of the complainant's allegation separately, rather than linking or relating the information gathered. He added that had the inquiry included investigation of a crime, it would have been appropriate to show whether a pattern of conduct existed. One method of establishing such a pattern, as required by the OIG's Policy and Procedure Guide for special inquiries, is to create a chronology of events and actions. The OIG did not do this.

Frequently a single act taken by itself is not sufficient to establish that the act was done willfully and intentionally with improper purpose. However, a series of acts considered collectively may suggest a pattern of conduct indicative of intentional impropriety rather than accident or error. If certain actions by the Hospital Director had been linked or followed up on, the need for further investigation and additional lines of inquiry would have been apparent. For example, the Hospital Director (1) did not inform law enforcement authorities about the unexplained deaths although District Counsel advised him to do so; (2) did not inform the OIG that a staff physician had accused the nurse in question of killing his patients; and (3) did not provide the Peer Review Board with the statistical analysis that established a relationship between a nurse and the unexplained patient deaths. Also, the Hospital Director instructed the staff physician who had

prepared the statistical analysis to have no further contact with the Federal Bureau of Investigation (FBI). The OIG did not pursue or connect these events.

Based on our review of relevant memorandums and tape recordings of interviews, we determined that the analysts questioned the Hospital Director and the Central Region Chief of Staff about compliance with VA policy. The analysts told us that they accepted "I don't know" answers instead of asking follow-up questions. For example, the analysts accepted, without probing further, the Hospital Director's response that he did not recall the District Counsel's advice in August 1992 that he notify the FBI or OIG about the unexplained deaths. At a minimum, the analysts should have provided the Hospital Director available information to refresh his recollection.

OIG NONCOMPLIANCE WITH POLICIES, REPORT INACCURACIES, AND UNSUPPORTED STATEMENTS

The OIG failed to follow its own policies concerning the completeness and accuracy of its report.[3] Specifically, statements in the report purported to be factual were inconsistent with or unsupported by the evidence in the OIG's files. The following three instances are examples of such statements.

- The report states that the Hospital Director followed the VA Central Region Chief of Staff's advice and did not inform law enforcement authorities of the suspicious deaths and the possible relationship of a particular nurse to the deaths. Our review of memorandums of interview and transcripts of

[3]The Quality Standards for Investigations established by the President's Council on Integrity and Efficiency are guidelines applicable to all types of federal investigative efforts. The VA OIG has adopted these standards and incorporated them into the standards in its policy and procedure guide. VA OIG reporting policy states, in part, "Reports must cover all relevant aspects of the investigation (complete); [and] correctly and succinctly describe the facts uncovered and the evidence obtained (accurate). . ."

recorded interviews found insufficient documentation to support the OIG report's conclusion that the Central Region Chief of Staff had told the Hospital Director not to report the issue to law enforcement authorities.

- The report states that the Central Region Chief of Staff and the Hospital Director withheld the complainant's statistical analysis–which identified a statistical relationship between the increase in patient deaths and a particular nurse–from the Hospital Peer Review Board so as to allow the Board to look at patient deaths objectively. However, documentation shows that the Central Region Chief of Staff told the OIG that he had never issued instructions to deny the Peer Review Board access to the statistical analysis. The Hospital Director told the OIG that he recalled no one asking to see the statistical data and it did not occur to him to provide the Peer Review Board with the data.

- In a March 1994 letter, the Hospital Director instructed the complainant, "You should . . . refrain from further contacts with the FBI and OIG about this case. If you are contacted directly by either the FBI or OIG you should inform me of the content of your discussion." The Special Inquiry report rightly states that the Hospital Director could not keep the complainant from talking with the FBI and the OIG and noted that the complainant was under no obligation to report those conversations to the Hospital Director. However, the report concludes that the Hospital Director's action did not limit the OIG or the FBI in obtaining appropriate information from the complainant or other Hospital employees. We found no evidence in the documentation of any investigative effort to support this conclusion. At a minimum, one would expect to find documentation that the OIG had talked

to the complainant and the cognizant FBI and OIG criminal investigators before arriving at such a conclusion.

VA OIG OFFICIALS DID NOT ADDRESS THE COMPLAINANT'S COVER-UP ALLEGATIONS FOR NEARLY 2 YEARS

As reflected in the Special Inquiry report, the OIG received the complainant's allegations of a cover-up of patient deaths in February 1993, acknowledged its receipt to the complainant, and filed the complainant's letter without investigating the allegations. The Assistant IG for Investigations told us that at the time the OIG received the allegations the criminal investigation with the FBI was ongoing,[4] and available resources were being devoted to that investigation. The OIG did not begin its Special Inquiry until after the complainant had discussed the allegations with the media in January 1995.[5] The OIG's Special Inquiry report issued in September 1995 attributed the delay to administrative error. Further, the Assistant IG for Investigations characterized the OIG's failure to follow up on the allegations as a failure of its process.

VA OIG BREACHED COMPLAINANT'S CONFIDENTIALITY

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[4]In October 1992, the FBI and the VA OIG initiated a joint investigation into a possible crime on a government reservation. They soon learned, however, that the Truman Memorial Veterans Hospital is one of the approximately 20 "proprietary" VA hospitals and is not a federal reservation. The FBI and the OIG then began a civil rights investigation immediately after the Department of Justice determined that they could properly investigate the matter as a civil rights case. The focus of the investigation--to determine whether a crime (homicide) had occurred at the Hospital and, if so, who was responsible--never changed.

The FBI made a February 2, 1998, report to the Congress on its investigative results regarding the 1992 suspicious deaths at the Hospital. The FBI concluded that, after extensive investigation, the federal statute of limitations had expired without a determination that a crime had, in fact, been committed.

[5]On January 10, 1995, a newspaper identified the complainant as the source of cover-up allegations and an additional allegation.

Inspectors General: VA OIG Special Inquiry Was Misleading

When the complainant sent his allegation letter to the OIG in February 1993, he requested confidentiality.[6] In the Special Inquiry report, the OIG acknowledged that it had twice released the name of the complainant and that it should have been more careful in protecting the complainant's confidentiality. We found yet a third instance in which the complainant's contact was provided to Hospital management.

- In one instance, the OIG Office of Investigations received documents from the FBI that had been prepared by the complainant. In turn, the Office of Investigations passed the information to the District Counsel, who forwarded it to the Central Region and the Hospital Director, one of the subjects of the allegations. The Special Inquiry report characterized this incident as an error.

- In another instance, in March 1994, the Assistant IG for Healthcare Inspections gave Central Region officials a report of contact that they had had with the complainant. In the Special Inquiry report, the OIG said that (1) in this instance, the OIG had an obligation not to release the complainant's identity to other VA officials without the complainant's consent and (2) controls to prevent such release were not properly applied. The report characterized the release of the information as an honest mistake.

- We found a third instance in which the complainant's contact with the OIG was provided to Hospital management, but the Special Inquiry report did not identify this incident. On January 11, 1995, the Hospital Total Quality

[6]Section 7(b) of the Inspector General Act of 1978, 5 U.S.C., App. 3, provides that "[t]he Inspector General shall not, after receipt of a complaint or information from an employee, disclose the identity of the employee without the consent of the employee, unless the Inspector General determines such disclosure is unavoidable during the course of the investigation."

Improvement (TQI) Coordinator asked the Assistant IG for Healthcare Inspections (1) if the complainant had had recent contact with the OIG and (2) if the OIG planned to investigate the complainant's obstruction-of-justice allegation. The Assistant IG acknowledged recent contact with the complainant and stated that the OIG would not investigate unless forced to do so. That same day, the Hospital Chief of Human Resources and the Associate Director had the TQI Coordinator contact the FBI and the Kansas City OIG to determine if they had recently been in contact with the complainant. In contrast with the Assistant IG's previously discussed answer acknowledging contact with the complainant, the Kansas City OIG advised that it would have to consult with OIG Counsel prior to any discussions concerning the complainant. The Kansas City OIG later contacted the TQI Coordinator and stated that OIG Counsel had advised that it could not respond to the Hospital's inquiry. The Hospital Chief of Human Resources[7] told us he was not sure why he and the Associate Director had the TQI Coordinator make inquiries concerning contact with the complainant but thought it concerned a March 9, 1994, letter from the Hospital Director advising the complainant not to have any contact with the FBI or the OIG.

REVISED POLICIES AND PROCEDURES

Our review of the August 1995 revision of the OIG Policy and Procedure Guide, Part I, Chapter 12 Hotline, indicates that the OIG's policies and procedures concerning Protection of Complainants (Section 5) mirror other hotline policies and procedures in

[7]The Chief of Human Resources at the Hospital is the son of the Hospital Director, one of the subjects of the allegations.

federal agencies. Consistent adherence to and ongoing awareness of these policies by OIG personnel should result in effective protection of complainants.

SCOPE AND METHODOLOGY

We conducted our investigation from April 1997 to March 1998 at the VA OIG headquarters in Washington, D.C., and the Harry S Truman Memorial Veterans Hospital in Columbia, Missouri. Initially, we reviewed the draft and final OIG Special Inquiry reports and related files and workpapers. We interviewed both current and former OIG officials and Hospital personnel involved with the review of the suspicious deaths. We also reviewed (1) all congressional testimony and related documents, (2) the OIG Investigative Policy and Procedure Guide, and (3) all transcripts and tapes of the recorded interviews conducted during the Special Inquiry. We transcribed all tapes that had not been transcribed by the OIG. We reviewed available files at the Hospital and documentation provided by individuals interviewed. In conducting our review, we also assessed the OIG's policies and procedures concerning confidentiality.

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Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions that you or Members of the Subcommittee may have.

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

May 1998

INSPECTORS GENERAL

Veterans Affairs Special Inquiry Report Was Misleading

GAO/OSI-98-9

GAO

United States
General Accounting Office
Washington, D.C. 20548

Office of Special Investigations

B-279646

May 13, 1998

The Honorable Terry Everett, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

This letter responds to your request that we review the Special Inquiry conducted by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) and its resulting report, entitled Special Inquiry: Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, Missouri. Specifically, you asked that we determine (1) whether the Special Inquiry report represents the results of the OIG's review, (2) whether the OIG complied with its policies in conducting the Special Inquiry, (3) why a delay occurred between receipt of the cover-up allegations in February 1993 and the beginning of the Special Inquiry in January 1995, (4) whether the OIG protected the confidentiality of the staff physician who made the allegations of a cover-up, and (5) if OIG processes and procedures are adequate for ensuring confidentiality requested by individuals.

Background

An unexplained increase in patient deaths occurred in one ward at the Harry S Truman Memorial Veterans Hospital (hereinafter referred to as Hospital) in Columbia, Missouri, during the spring and summer of 1992. In October 1992, based on information provided by a Missouri state legislator, the Federal Bureau of Investigation (FBI) and the VA OIG initiated a joint criminal investigation into the suspicious deaths.[1] In February 1993, the OIG received specific allegations that the Hospital Director[2] and the VA Central Region Chief of Staff[3] had attempted to cover up the unexplained

[1]In October 1992, the FBI and the VA OIG initiated a joint investigation into a possible crime on a government reservation. They soon learned, however, that the Truman Memorial Veterans Hospital is one of the approximately 20 "proprietary" VA hospitals and is not a federal reservation. The FBI and the OIG then began a civil rights investigation immediately after the Department of Justice determined that they could properly investigate the matter as a civil rights case. The focus of the investigation—to determine whether a crime (homicide) had occurred at the Hospital and, if so, who was responsible—never changed.

The FBI made a February 2, 1998, report to the Congress on its investigative results regarding the 1992 suspicious deaths at the Hospital. The FBI concluded that, after extensive investigation, the federal statute of limitations had expired without a determination that a crime had, in fact, been committed.

[2]The Hospital Director retired in June 1994.

[3]The Central Region Chief of Staff resigned in September 1994.

increase in patient deaths, including by not referring the matter to law enforcement authorities.

In January 1995, the OIG initiated an administrative investigation (known as a Special Inquiry),[4] which focused on management's response to the patient deaths. Subsequent to the start of the Special Inquiry, the VA OIG received a series of additional letters from the complainant alleging that the cover-up (1) involved not only Hospital and VA management but the VA OIG as well and (2) had continued even after the October 1992 start of the joint FBI and VA OIG investigation. The OIG issued the Special Inquiry report in September 1995. In its report, the OIG analyzed and criticized Hospital and VA management's response to the increase in deaths and noted that it had "found a dysfunctional top management team [in the Hospital] . . . in place." The OIG reported that while the evidence might indicate to some individuals that at least the appearance of a cover-up existed, management's actions could be attributed instead to bad judgment. The OIG further reported that it had found no conclusive proof of an intentional cover-up by Hospital and Central Region officials and no evidence of criminal conduct by top managers. As to its own role, the OIG stated that it had made mistakes but avowed that it had not participated in a cover-up. (A more extensive background is provided in app. I.)

Results in Brief

The VA OIG conducted the Special Inquiry as a management review to determine how Hospital and VA Central Region management had responded to "an 'out of norm' situation" regarding unexplained deaths at the Hospital. We determined that the OIG did not collect or analyze evidence in a manner that would identify intentional cover-up efforts. Thus, the Special Inquiry's conclusion that no evidence of an intentional cover-up had been found was not consistent with the inquiry conducted and was misleading.

Concerning the additional questions raised in your request, we determined the following:

- The OIG failed to comply with its own reporting policies concerning completeness and accuracy by presenting statements that were not supported by the evidence contained in OIG files, including reference to a discussion that the Special Inquiry never verified.

[4]The OIG opened a Special Inquiry after the complainant notified the media of allegations of a cover-up and an additional allegation.

- The OIG attributed the delay in acting upon the cover-up allegations received in February 1993 to administrative error.
- The confidentiality of the staff physician who had made the allegations of a cover-up was breached on at least three occasions.
- The OIG's current policies and procedures on confidentiality are adequate.

VA OIG's Conclusion Regarding Alleged Cover-Up Is Misleading

The title and text of the Special Inquiry report suggest that allegations of a cover-up had been investigated. We determined that the OIG did not plan or conduct its review or analysis in a way that could determine if a cover-up had occurred. Had the OIG conducted such a review, its documentation would have included an effort to link individual pieces of evidence that together suggest additional lines of inquiry—including elements of a cover-up. Further, both the Assistant IG[5] and the analyst[6] responsible for the Special Inquiry told us that the OIG did not review or investigate the allegations of cover-up. The Assistant IG told us that the Special Inquiry report overstates its conclusion regarding no evidence of a cover-up. Therefore, the Special Inquiry's conclusion was not supported by work done or evidence collected and is misleading.

Misrepresentation of Facts and Misleading Report Language

In the Special Inquiry report, the OIG represents that its review included the allegation of a cover-up on the part of the Hospital Director and the Central Region Chief of Staff. However, according to the lead analyst who conducted the review and the Assistant IG who wrote the final report, the issue of cover-up was "off the table" because, in their view, their "charge" from OIG management did not include looking at cover-up allegations. They defined cover-up as being related to criminal issues and added that neither of them was a criminal investigator.

Prior to his retirement, the lead analyst responsible for the Special Inquiry completed the interviews and field work and wrote a draft report entitled Special Inquiry: Management Response to Unexplained Patient Deaths, Harry S. Truman VA Medical Center, Columbia, Missouri. The body of that draft report made no reference to allegations of a cover-up by the Hospital Director and Central Region Chief of Staff. In the draft report, only one issue was addressed—whether management officials complied with VA policy when responding to the revelation of the unexplained deaths.

[5]The Assistant IG retired in July 1997.

[6]The lead analyst responsible for conducting the Special Inquiry retired in July 1995 after completing the field work and writing the draft report.

According to the Assistant IG who prepared the final report, he did not review the underlying evidence while preparing the final report, nor did he reconcile the stated facts in the report with the underlying evidence prior to issuing the report. He stated that in writing the final Special Inquiry report, he changed the original title and edited the report in an attempt to tie the text to the complainant's allegations. He characterized this as wordsmithing and added that he had no intent to mislead. He concluded that in hindsight he probably should not have changed the title and that the report probably overstated its case concerning no evidence of a cover-up, as the OIG did not investigate the cover-up allegations.

Although the Assistant IG stated that there was no intent to mislead, the report title—Special Inquiry: Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, Missouri—and two of the report's three major sections—"Alleged Cover-up by Medical Center and Central Region Officials Subsequent to the Criminal Investigation" and "Alleged Cover-up by the Office of Inspector General"—specifically refer to the cover-up allegations. Further, the OIG reported that it had found "no conclusive proof of an intentional cover-up by Medical Center and Central Region officials" and "no evidence of criminal conduct by top management." This language is misleading, because the OIG did not conduct its Special Inquiry so as to support its conclusion concerning an intentional cover-up. Instead, it addressed whether management had complied with VA and Hospital policy and procedures in its response to the increase in deaths.

The then IG[7] told us that he had intended for the Special Inquiry to investigate allegations of a cover-up and that, based on his reading of the report, it appeared that it had. He added that if the review did not include an investigation of the cover-up allegations, he believes that the report, as written, is misleading.

Review Planned and Executed From a Management Perspective

We determined that the OIG did not plan or conduct its Special Inquiry in a manner to determine if improper acts pertaining to a cover-up had occurred. According to the Assistant IG, in preparing the report, he examined components of the complainant's allegation separately, rather than linking or relating the information gathered. He added that had the inquiry included investigation of a crime, it would have been appropriate to show whether a pattern of conduct existed. One method of establishing such a pattern, as is required by the OIG's Investigative Policy and

[7]The Inspector General retired in January 1996.

Procedure Guide for special inquiries, is to create a chronology of events and actions. The OIG did not do this.

Frequently a single act, taken by itself, is not sufficient to establish that the act was done willfully and intentionally with improper purpose. However, a series of acts considered collectively may suggest a pattern of conduct indicative of intentional impropriety rather than accident or error. For example, the following actions or alleged actions concerning the Hospital Director were not linked or followed up on by the OIG. If the OIG had done so, the linkage would have suggested a pattern of conduct requiring additional investigation and lines of inquiry by the OIG.

- The Hospital Director did not notify law enforcement authorities of the unexplained deaths despite the District Counsel's recommendation that he do so.
- The Hospital Director did not notify law enforcement authorities of a statistical relationship between a nurse and the unexplained deaths despite telling the staff physician who had developed the analysis that he would do so.
- The Hospital Director, after learning that a staff physician had accused the nurse in question of killing his patients, did not refer the matter to the OIG.
- The Hospital Director demoted the Hospital's Chief of Police reportedly because of the Chief's efforts to obtain information about the Hospital's response to the unexplained deaths.
- The Hospital Director did not provide the Peer Review Board examining the unexplained deaths with the statistical analysis that established a relationship between a nurse and the deaths.
- The Hospital Director's initial reaction to the FBI investigation was to attempt to obtain confidential information provided to the FBI, potentially to identify the source of that information.
- The Hospital Director, in an apparent attempt to impede an investigation, instructed the staff physician who prepared the statistical analysis to have no further contact with the FBI.
- The Hospital Director's son—the Chief of Human Resources at the Hospital—instructed the TQI Coordinator to determine from the FBI and the OIG whether they had had recent contact with the complainant.

Our review of the OIG case files, interviews with individuals involved with the Special Inquiry, and statements from knowledgeable Hospital employees reflected that potential lines of inquiry were not pursued. For example, in the incident of a conference call between the VA Central Region Chief of Staff, the Hospital Director, the Hospital pathologist, and

the TQI Coordinator, it was alleged that the Central Region Chief of Staff, in response to the issue of notifying law enforcement, stated that the last time law enforcement authorities had been called in, both the Chief of Staff and the Hospital Director were fired. The Special Inquiry analysts interviewed the pathologist and the TQI Coordinator. One individual recalled the statement being made; the other did not. However, the analysts never interviewed the Hospital Director or the Central Region Chief of Staff about this issue. Because of this, it was never verified that the conversation had taken place as alleged; and the OIG never attempted to resolve the conflicting testimony by questioning the person who had allegedly made the statement or the person to whom the statement had allegedly been made.

Based on our review of relevant memorandums and tape recordings of interviews, we determined that the analysts questioned the Hospital Director and the Central Region Chief of Staff about compliance with VA policies. The analysts told us they accepted "I don't know" answers instead of asking follow-up questions. For example, the analysts accepted, without probing further, the Hospital Director's response that he did not recall the District Counsel's advice in August 1992 that he notify the FBI or OIG about the unexplained deaths. In another instance, the Hospital Director responded to the analysts that he could not recall the actions he had taken to monitor Hospital management's investigation of the deaths. At a minimum, the analysts should have provided the Hospital Director available information to refresh his recollection.

OIG Noncompliance With Policies, Report Inaccuracies, and Unsupported Statements

In conducting the Special Inquiry, the OIG failed to follow its own policies concerning completeness and accuracy of its reports.[8] As a result, the OIG's Special Inquiry report contained statements that were either inconsistent with or unsupported by the evidence contained in the OIG's files. We noted inaccuracies in the way the OIG (1) reported the Hospital Director's failure to notify law enforcement[9] of the possible association of a particular nurse to an unexplained increase in deaths, (2) attributed remarks to the Hospital Director and the Central Region Chief of Staff about withholding

[8]The Quality Standards for Investigations established by the President's Council on Integrity and Efficiency are guidelines applicable to all types of federal investigative efforts. The VA OIG has adopted these standards and has incorporated them into the standards in its policy and procedure guide. VA OIG reporting policy states, in part, "Reports must cover all relevant aspects of the investigation (complete); [and] correctly and succinctly describe the facts uncovered and evidence obtained (accurate) . . . ."

[9]The Hospital Director never reported the suspicious deaths to the FBI or any other law enforcement organization.

statistical analysis information from a Peer Review Board, and (3) assessed the Hospital Director's instructions to the complainant that he refrain from making further contacts with the FBI and the OIG about the case.

Failure to Inform Law Enforcement

The Special Inquiry report stated that the Hospital Director had asked the Central Region Chief of Staff for his opinion on whether to report to authorities the unexplained deaths and the possible relationship of a particular nurse to the deaths. According to the report, the Central Region Chief of Staff responded that he "thought the situation warranted far more review before [the Hospital Director] either relieved [the nurse] of patient care duties or notified law enforcement authorities [and he] advised the Hospital Director not to notify law enforcement authorities until the reviews were completed." The OIG report concluded that "[the Hospital Director] followed the advice of the Central Region Chief of Staff and did not report the issue to law enforcement."

As written, the report leads one to believe that the Hospital Director followed the advice of the Central Region Chief of Staff not to report the situation to law enforcement authorities. However, we found insufficient documentation to support the OIG report's conclusion that the Central Region Chief of Staff had told the Hospital Director not to report the issue to law enforcement authorities. Our review of memorandums of interview and transcripts of recorded interviews found inconclusive evidence that the Central Region Chief of Staff and the Hospital Director discussed whether to report the issue.[10] Further, when asked to do so, the OIG was unable to cite the evidence supporting its conclusion.

Misinformation About Withholding the Complainant's Statistical Analysis

On September 3, 1992, a Hospital Peer Review Board was convened to evaluate five August deaths on Ward 4 East at the Hospital; but the Board was not provided with a staff physician's statistical analysis that had reported a statistical relationship between the increase in deaths and a particular nurse. The Special Inquiry report concludes that "The Peer Review Board was not a 'sham' as alleged by the complainant, but was limited in scope and did not consider the statistics developed by [the staff physician]." According to the report, the Central Region Chief of Staff and the Hospital Director stated that they had withheld the statistical analysis

[10]A telephone interview of the Central Region Chief of Staff's remarks is documented in a memorandum. The Hospital Director's interview was recorded and a memorandum of interview was also prepared.

from the Board members to allow them to take an objective look at the cases.

However, documentation shows that the Central Region Chief of Staff told the OIG that he had never issued instructions to deny the Peer Review Board access to the data. According to the memorandum of interview prepared by the OIG, the Hospital Director told the OIG that he recalled no one asking him whether the Peer Review Board could look at the statistical data and that it did not occur to him to let the Board members have the data.

Limitations on Complainant's Communications With Law Enforcement

In a March 1994 letter, the Hospital Director instructed the complainant, "You should . . . refrain from further contacts with the FBI and OIG about this case. If you are contacted directly by either the FBI or OIG you should inform me of the content of your discussion." Noting that the Director had improperly attempted to limit the complainant's communications with the OIG and the FBI in March 1994, the Special Inquiry report stated that nothing requires an employee to provide information to a supervisor regarding discussions with the FBI or the OIG. The report also noted that

> "By making such a requirement, management is in effect stifling an employee's ability to discuss matters openly and freely with the investigators. The Director's action can be viewed as an effort to impede an official investigation by intimidating employees, and is clearly improper. However, from a practical standpoint, [the Hospital Director's] action to the best of our knowledge did not limit the OIG or the FBI in obtaining appropriate information from [the complainant] or other [Hospital] employees." (Emphasis added.)

We found no documentation to support the Special Inquiry report's conclusion that the Hospital Director's action did not limit the OIG or the FBI in obtaining information from the complainant or other Hospital employees. Except for an OIG memorandum of interview with the Hospital Director, we found no evidence of an investigative effort in support of the report's conclusion. At a minimum, one would expect to find documentation that the OIG had talked to the complainant and the cognizant FBI and OIG criminal investigators before arriving at such a conclusion.

Circumstances Surrounding Special Inquiry's 2-Year Delay

The OIG received the complainant's allegations of a cover-up of patient deaths in February 1993, immediately acknowledged its receipt, provided a copy of the letter to the FBI in March 1993, and filed the complainant's letter without investigating the allegations. The OIG did not begin its inquiry

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until after the complainant discussed the allegations with the media in January 1995.[11] The OIG's Special Inquiry report issued in September 1995, attributed the delay to administrative error.

Complainant's Allegation Letter Filed Without Investigation

In February 1993, when the OIG received the complainant's allegations of a cover-up of patient deaths, it referred the allegations to its Office of Investigations. The OIG investigator told us that he had contacted the complainant to acknowledge receipt of the allegations and had advised him that all his assets were being expended on other matters. Further, he told us that in addition to a murder investigation, he was investigating a death threat and a sexual assault. Although the OIG criminal investigator and the Assistant IG for Investigations did not recall if they had sent a copy of the allegation letter to the FBI, we learned that a copy of the letter containing the allegations had been provided to the FBI in March 1993. The original letter was filed in the OIG's field office in Kansas City, Missouri; and no follow-up action was initiated.

The Assistant IG for Investigations told us that when his office received the complainant's letter in February 1993, the criminal investigation with the FBI was ongoing and all resources were being devoted to that investigation. He said that it was a "collective decision" on the part of the Office of Investigations that no further investigation was necessary. Further, according to the Assistant IG, the FBI and OIG criminal investigation had not disclosed any evidence that VA officials were involved in a cover-up, and the complainant's letter contained no new information. He stated that the OIG's failure to follow up on the allegations was a failure of its process.

The former IG told us that he was upset in January 1995 when he became aware, as a result of media inquiries, that the complainant's allegations had not yet been investigated. He further stated that when the OIG received the allegations in February 1993, the most important thing in his mind was the unexplained deaths.

FBI Perceived Allegations to Be Administrative

In response to our inquiries, the FBI told us that because the complainant's February 1993 letter primarily concerned "the issue of the administrative response" of VA managers, the allegations were not within the investigative jurisdiction of the FBI. Also, because the FBI found no evidence of criminal activity in connection with the unexplained deaths, the FBI criminal

[11]On January 10, 1995, a newspaper article identified the complainant as the source of cover-up allegations and an additional allegation.

investigation did not inquire into the allegations of a cover-up on the part of VA management. Further, according to the FBI, had the FBI investigation developed evidence of criminal activity at the VA, it would have explored the potential culpability of any person—whether management, employee, or staff—before, during, and after the deaths, to include deliberate attempts to cover up.

OIG Attributed Delay to Administrative Error

The Special Inquiry report stated that, due to administrative error, the OIG had waited too long to initiate the Special Inquiry. During the interval (February 1993 to January 1995), the Hospital Director retired and the Central Region Chief of Staff resigned from the VA.

VA OIG Failed to Protect Complainant's Confidentiality

When the complainant sent his February 1993 letter to the OIG alleging cover-up by the Hospital Director and the Central Region Chief of Staff, he requested confidentiality.[12] The Special Inquiry review looked at whether the OIG protected the complainant's right to confidentiality. In the Special Inquiry report, two instances were discussed in which the OIG had disclosed its contacts with the complainant to the Central Region and, ultimately, to the Hospital Director. The OIG report concluded that the OIG should have been more careful in protecting the complainant's confidentiality, and it attributed one of the confidentiality disclosures to an "error" and the other to an "honest mistake." We found a third instance in which the complainant's contact with the OIG was provided to Hospital management. All three disclosures were related to the March 1994 Hospital Director's letter to the complainant advising him not to have contact with the FBI or OIG.

OIG Office of Investigations Gave Complainant's Documents to District Counsel

In March 1994, the OIG Office of Investigations received documents from the FBI that had been prepared by the complainant. In turn, the Office of Investigations passed the information to the District Counsel,[13] who forwarded it to the Central Region and the Hospital Director. The complainant alleged that the ultimate disclosure to the Central Region indicates that the OIG was participating with the Central Region to

[12]Section 7(b) of the Inspector General Act of 1978, 5 U.S.C. App. 3, provides that "The Inspector General shall not, after receipt of a complaint or information from an employee, disclose the identity of the employee without the consent of the employee, unless the Inspector General determines such disclosure is unavoidable during the course of the investigation."

[13]The OIG investigator perceived the information received from the FBI as dealing with quality assurance issues and forwarded the materials to the District Counsel in the mistaken belief that the Counsel had responsibility for quality assurance issues.

suppress an inquiry of a cover-up. The Special Inquiry report, however, characterized what happened as an error, stating that the OIG had provided the documents to the Office of the District Counsel, which represents both the Hospital and the Central Region, without any restrictions on their dissemination.

OIG Office of Healthcare Inspections Released Information to VA Central Region

The complainant alleged that in March 1994, the Assistant IG for Healthcare Inspections[14] gave Central Region officials a report of contact with the complainant as part of an OIG effort to suppress information about actions by Hospital and Central Region officials. The Special Inquiry report stated that (1) in this instance the OIG had an obligation not to release the complainant's identity to other VA officials without the complainant's consent and (2) controls to prevent such release were not properly applied.

OIG Office of Healthcare Inspections Released Information to Hospital Management

The Hospital Total Quality Improvement (TQI) Coordinator told us that on January 11, 1995, prior to the Special Inquiry, the Assistant IG for Healthcare Inspections telephoned her and requested information concerning the Hospital's original response to the unexplained deaths on Ward 4 East. During the conversation, the TQI Coordinator asked about OIG plans to investigate the complainant's obstruction-of-justice allegation. The Assistant IG acknowledged recent contact with the complainant and stated that the OIG had no plans to investigate the allegations unless it was forced to do so. The Special Inquiry did not identify this incident, which involved the same Assistant IG who had released the complainant's name once before to the Central Region.

On the same day of this incident, the TQI Coordinator, at the request of the Hospital Chief of Human Resources and the Associate Director, contacted the FBI and the Kansas City OIG to determine if they had recently been in contact with the complainant. The FBI referred her to the Kansas City OIG. In contrast with the Assistant IG's previously discussed answer acknowledging contact with the complainant, the Kansas City OIG advised that it would have to consult with OIG Counsel prior to any discussions concerning the complainant. The Kansas City OIG later contacted the TQI Coordinator and stated that OIG Counsel had advised that it could not respond to the Hospital's inquiry.

[14]The Assistant IG for Healthcare Inspections retired in June 1996.

The Hospital Chief of Human Resources[15] told us he was not sure why he and the Associate Director had the TQI Coordinator make the inquiries concerning contact with the complainant but thought it concerned a March 9, 1994, letter from the Hospital Director advising the complainant not to have any contact with the FBI or the OIG.

Revised Policies and Procedures

Our review of the August 1995 revision of the OIG Policy and Procedure Guide, Part I, Chapter 12 - Hotline, indicates that the OIG's policies and procedures concerning Protection of Complainants (Section 5) mirror accepted standard hotline policies and procedures in federal agencies. Consistent adherence to and ongoing awareness of these policies by OIG personnel should result in effective protection of complainants.

OIG Comments and Our Evaluation

The Department of Veterans Affairs' Office of Inspector General provided written comments on a draft of this report. The IG disagreed with our report, stating that the OIG had found a number of errors in the findings and conclusions presented in the report and in the analyses offered to support the conclusions. The IG is of the opinion that there is no evidence to support our overall conclusion that the OIG Special Inquiry report was misleading.

Mainly, the IG disagrees with (1) our statement that the OIG did not investigate the cover-up allegation, (2) one of the three statements in the Special Inquiry report—an OIG conclusion—that we cite in our report as being inaccurate and unsupported by evidence, and (3) the inclusion in our report of a finding—based on an alleged violation of confidentiality—that "lacks credibility." Concerning the first point, regardless of how the OIG characterizes its work, its review was not planned or executed in a manner that would support its conclusions. Neither did the OIG link or follow up on information it had available during its review. Concerning the second point, as we have shown, no underlying documentation supports the OIG's conclusion that the complainant's communication with law enforcement entities had not been limited. With regard to the third point, our discussion of an alleged breach of confidentiality is based on substantive documentation and testimonial evidence that the improper disclosure occurred. The fact that the media had disclosed the complainant's name did not relieve the OIG from its

[15]The Chief of Human Resources at the Hospital is the son of the Hospital Director, one of the subjects of the allegations. The son was selected for the position in July 1994.

responsibility to maintain confidentiality. The OIG had an obligation not to release the complainant's identity without his authorization.

An underlying theme of the IG's comments is that we took individuals' comments out of context or misrepresented facts. Also, according to his comments, some of the individuals that we interviewed either denied or did not recall discussing a particular matter with us. It is important to note that our findings and conclusions are based on in-depth analyses of documentation we obtained and interviews of witnesses that are documented in our reports of interview. We have included additional information in our report supporting our findings.

The IG objected to a proposed recommendation regarding the adequacy of the OIG policies and procedures for protecting the privacy of complainants. He stated that the issue is compliance and training, not formulating or rewriting existing policy. We concur with the IG and have withdrawn the proposed recommendation. The IG's complete written comments, and our evaluation, are presented in appendix II.

Scope and Methodology

We conducted our review from April 1997 to March 1998 at the VA OIG headquarters in Washington, D.C., and the Harry S Truman Memorial Veterans Hospital in Columbia, Missouri. Initially, we reviewed the draft and final OIG Special Inquiry reports and related files and workpapers. We interviewed both current and former OIG officials and Hospital personnel involved with the review of the suspicious deaths. We also reviewed (1) all congressional testimony and related documents, (2) the OIG Investigative Policy and Procedure Guide, and (3) all transcripts and tapes of the recorded interviews conducted during the Special Inquiry. We transcribed all tapes that had not been transcribed by the OIG. We reviewed available files at the Hospital and documentation provided by individuals interviewed. In conducting our review, we also assessed the OIG's policies and procedures concerning confidentiality.

As agreed with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies of the report to interested congressional committees; the Secretary of Veterans Affairs; and the Inspector General, Department of Veterans Affairs. We will also make copies available to others on request. If you have any questions concerning this report, please contact me at (202) 512-6722 or Assistant Director

Robert E. Lippencott at (312) 220-7600. Major contributors to this report are listed in appendix III.

Sincerely yours,

Eljay B. Bowron
Assistant Comptroller General
for Special Investigations

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Abbreviations

FBI	Federal Bureau of Investigation
GAO	U.S. General Accounting Office
IG	Inspector General
OIG	Office of Inspector General
OSI	Office of Special Investigations
TQI	Total Quality Improvement
VA	Department of Veterans Affairs

Background

From March 8, 1992, through August 23, 1992, when a certain registered nurse worked the night shift alone on Ward 4 East at the Harry S Truman Memorial Veterans Hospital, the number of deaths on the ward increased, with dramatic spikes in May, June, and July. The death rate returned to normal when the nurse was assigned to another unit. A statistical analysis conducted by a Hospital staff physician in September 1992 confirmed that a statistically significant relationship existed between increased deaths on Ward 4 East and the duty times of the nurse. The staff physician concluded in his original statistical analysis that the probability that no relationship existed between the deaths and the duty times of the nurse was less than 1 in 1,000 (in 1994, it was determined to be less than 1 in 1 million). The VA Central Region Chief of Staff requested in October 1992 that the OIG Office of Healthcare Inspections help resolve questions involved with the Hospital staff physician's study. The OIG Office of Healthcare Inspections issued a report in September 1994, confirming the results of the initial statistical study.

In October 1992, based on information provided by a Missouri state legislator, the FBI and the OIG initiated a joint civil rights criminal investigation concerning the suspicious deaths at the Hospital. On February 2, 1998, the FBI issued a report to the Congress concluding that it had conducted an extensive investigation and that the federal statute of limitations had expired in August 1997 without any determination that a crime had, in fact, been committed.

In a February 1993 letter, the staff physician who conducted the statistical study at the Hospital alleged to the OIG that both the Hospital and VA Central Region management had covered up the increase in patient deaths on Ward 4 East. In the letter, the staff physician requested confidentiality. The Inspector General referred the allegations of a cover-up to the OIG's Office of Investigations for investigation. The Office of Investigations determined that due to the priority of the investigation of the suspicious deaths, no immediate action would be taken on these allegations. The letter was placed in the investigative file, and a copy was provided to the FBI in March 1993.

In January 1995, after the complainant went to the media, the IG instructed the Assistant IG for Departmental Reviews and Management Support to conduct an administrative review (known as a Special Inquiry) of the allegations that included a cover-up. In a series of letters that followed the start of the Special Inquiry, the complainant reiterated his allegations of a cover-up, not only by Hospital and VA management but by VA OIG as well.

He also alleged that the cover-up had continued even after the start of the joint FBI/VA OIG investigation. In the Special Inquiry report issued in September 1995, the OIG concluded that the evidence pointed to bad management rather than to a deliberate plan to cover up or suppress information.

A congressional hearing was held in October 1995, and VA healthcare and OIG officials testified about the Special Inquiry and other matters. In their testimony, VA and OIG officials agreed with the findings of VA OIG Special Inquiry report and stated that no evidence of a cover-up by management had been found. OIG officials admitted, however, that the OIG had taken too long in dealing with the complainant's allegations and attributed the 2-year delay to other priorities and administrative error. OIG officials concluded that even though no evidence of criminal misconduct had been found, they did find "a dysfunctional management team . . . in place" that had made significant judgmental errors in responding to the unexpected deaths. In its prepared statement, the OIG expressed concerns about its shortcomings in protecting the complainant's identity and stated that it had issued a written apology to the complainant.

Appendix II

Comments From the Office of Inspector General Department of Veterans Affairs

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

April 24, 1998

Mr. Eljay B. Bowron
Assistant Comptroller General
for Special Investigations
United States General Accounting Office
Washington, D.C. 20548

Re: GAO draft report: "Veterans Affairs Special Inquiry Report Was Misleading."

Dear Mr. Bowron:

Thank you for the opportunity to review and comment on the draft report. Our comments and concerns are detailed in the attached White Paper. In general, we found a number of errors in the findings and conclusions presented in the report and in the analyses offered to support the conclusions. Once these issues are addressed, there is no evidence to support the conclusion stated in the title of the report, i.e., that the OIG Special Inquiry was misleading.

The most serious error in the draft report is the conclusion that we misrepresented in the Special Inquiry that there was no evidence of a cover-up. The basis for this finding was the mistaken belief that because we limited our review to the issue of management's response to the increase in deaths, we did not investigate the issue of a cover-up. As discussed in exhaustive detail in the attached White Paper, the underlying facts on which the complainant based his allegation that there was a cover-up was, in fact, management's response to the increase in deaths. These are one and the same issue, not separate and distinct issues as the draft report suggests.

We agree that two of the three statements, identified by GAO as inaccurate and unsupported by the evidence, were imprecisely worded. However, these are insignificant findings because they do not in any way impact on the Special Inquiry's overall findings and conclusions. They certainly did not make the report "misleading" as stated in the title of the report. At a minimum, the GAO report should be amended to put these errors in proper perspective. We disagree with GAO's finding on the third statement identified in the draft report as being inaccurate.

We also found sections in the draft report that consist of nothing more than statements taken from the Special Inquiry report. GAO did not offer any specific

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or independent findings or conclusions with respect to these issues nor did GAO state the obvious, that the OIG's findings on these issues were accurate. Without such an acknowledgement, and because these issues are included in a report entitled "Veterans Affairs Special Inquiry Was Misleading," the reader is erroneously led to believe that our findings and conclusions on these issues are inaccurate and misleading, when, in fact, no such finding has been made. Unless GAO has evidence to show that our findings and conclusions on these issues were inaccurate or incomplete, these sections should be deleted from the final report.

In the section which discusses the issue of maintaining confidentiality of employees who file a complaint with the OIG, the draft report contains a finding regarding a disclosure that was not identified during the Special Inquiry. The allegation involves a conversation that the former Assistant Inspector General for Healthcare Inspections allegedly had with the TQI Coordinator at the Columbia, Missouri VA Medical Center in January 1995. We found the inclusion of this allegation in the draft report to be particularly disturbing for a number of reasons, not the least of which is the fact that the former Assistant Inspector General was not interviewed by GAO. Not only has he indicated in discussions with us that he has no recollection that the event occurred, but, as discussed in the attached white paper, even if it had occurred, the statements attributed to him would not have violated the complainant's request for confidentiality because the complainant had publicly stated that he had brought the issues of a cover-up to the attention of the IG.

In summary, there is no evidence that the Special Inquiry was inaccurate or misleading. At most, the Special Inquiry contains two statements that are imprecisely worded but have no impact on the report's findings and conclusions. Given the evidence we have provided in the attached White Paper, it is our position that the report needs to be amended, if it is to be issued.

Thank you again for the opportunity to review and provide comments on the draft report. Should you wish to discuss this matter further, please call me at 565-8620.

Sincerely,

RICHARD J. GRIFFIN

WHITE PAPER
COMMENTS ON GAO DRAFT REPORT ON VAMC, COLUMBIA

On April 2, 1998, the General Accounting Office (GAO) provided the VA Office of Inspector General (OIG), for comment, a copy of a draft GAO report entitled: "Veterans Affairs Special Inquiry Report Was Misleading." The Special Inquiry referred to in the GAO report is entitled "Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, MO." We have reviewed GAO's findings and concluded that the report contains statements and conclusions that are both erroneous and inconsistent with the evidence that GAO was provided. The following is a summary of the most significant concerns we have with the GAO report.

A. GAO Concluded:
"VA OIG's Conclusion Regarding the Alleged Cover-up is Misleading".

Now on pp. 3-6.

In this section of the report, (pages 6-9), GAO discusses the OIG's finding that there was no evidence of a cover-up by VAMC management officials and concludes that the OIG's finding is misleading. Similar statements are found in the "Results in Brief" section of the report. The basis for GAO's conclusion is that the OIG personnel responsible for the review stated that they did not review or investigate the allegations of a cover-up but, instead, conducted a review of management's response to the increase in deaths. GAO also criticizes the Assistant Inspector General responsible for the report for not reviewing the underlying evidence while preparing the report, and for not probing for additional information when interviewing the former Medical Center Director and the former Central Region's Chief of Staff.

OIG Response: GAO's findings and conclusions are not supported by a thorough analysis of the documents and other evidence that were provided to its staff during the investigation.

Now on p. 3.

On page 6 of the draft report, GAO states: "The OIG's conclusion that there was no evidence of an intentional cover-up is . . . misleading." This finding is based on statements GAO attributes to the Assistant Inspector General (AIG) responsible for the report and the analyst who conducted the review that "the OIG did not review or investigate these allegations of cover-up." Based on our knowledge of the facts in this case and the information we obtained from the AIG and the analyst, we conclude that GAO's finding is erroneous.

See comment 1.

The following statement in GAO's draft report demonstrates that GAO misunderstands the basis for the complainant's allegation of a "cover-up" by senior management at the VAMC:

> The OIG reported that it found "no conclusive proof of an intentional cover-up by Medical Center and Central Region officials" and "no evidence of criminal conduct by top management." This language is misleading, as the Special Inquiry was conducted to address management's response to the increase in deaths, not the allegations of a cover-up.

GAO draft report, p. 8. (emphasis added). The issues of "cover-up" and "management's response to the increase in deaths" are one and the same issue, not separate and distinct issues as the draft report appears to conclude.

The term "cover-up" originated with the individual who made the initial complaint to the OIG; not by the OIG. In his February 1993 letter to the OIG, the complainant used the term "cover-up" to describe what he called "administrative forces that discouraged top officials from handling this affair in a prompt and responsive manner." He also stated that the actions of his supervisors "obstructed a criminal investigation." The complainant asked us to "review the administrative response to [the increase in deaths] and in particular, the actions of my two superiors, the Hospital Director . . . and the Chief of Staff for the Central Region . . . ." In his March 27, 1995 letter to the OIG, the complainant stated that "VA officials worked together to obstruct the criminal investigation and cover up the obstruction." He went on to define what he meant by these terms and clearly identified specific acts or omissions by Medical Center management that he thought supported these charges. Specifically, he alleged that Medical Center officials: delayed in notifying responsible officials (FBI, local police, OIG) of the situation; refused to respond in good faith to allegations of patient abuse; prevented boards of inquiry from conducting "good faith" investigations; discredited the quality assurance investigation; and, threatened employees with prosecution if they revealed the results of the quality assurance investigation. A comparison of the OIG report and the allegations contained in the complainant's letters, shows that the OIG addressed each of the acts or omissions the complainant cited to support his allegations of "obstruction" and "cover-up." It was the complainant who referred to the identified acts and/or omissions by VAMC management as a "cover-up" and he is the one who defined what he meant by a "cover-up."

If management's response to the increase in deaths was not the basis for the allegation of a "cover-up," what was? There is nothing in GAO's draft report that identifies any act or omission, other than the management issues cited by

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the complainant, that we should have investigated before concluding that there was no evidence of a "cover-up."

In support of the conclusion that the OIG did not investigate the issue of a "cover-up," GAO refers to statements they attribute to Jack Kroll, the former Assistant Inspector General who prepared the report, and Howard Lucas, the former Special Inquiries' analyst who conducted the investigation, in which Mr. Kroll and Mr. Lucas purportedly admitted that they did not look at the issue of a "cover-up."

The following are examples of the statements GAO attributes to Mr. Kroll and Mr. Lucas to support its conclusion:

> "Contrary to the instructions of the Inspector General (IG), the review did not include investigation of the alleged cover-up. The Assistant Inspector General for Departmental Reviews and Management Support stated that because the allegations of a cover-up were not part of the Special Inquiry, the resulting report 'probably' overstated its conclusion that there was no evidence of an intentional cover-up." [Draft Report, pp. 3-4.]

> "The text of the Special Inquiry report often refers to allegations of a cover-up, but both the Assistant IG and the analyst responsible for the report said that the OIG did not review or investigate these allegations of a cover-up." [Draft Report, p. 6.]

Now on p. 4.

> ". . . the lead analyst who conducted the review and the Assistant Inspector General who wrote the final report told us that the issue of cover-up was 'off the table' because, in their view, their 'charge' from OIG management did not include looking at the allegations of a cover-up. They added that cover-up and conspiracy relate to criminal issues, and neither of them was a criminal investigator." [Draft Report, p. 7.]

Now on p. 4.

See comment 2.

We believe that the statements attributed to Mr. Kroll and Mr. Lucas are taken out of context. Mr. Kroll has advised us that he told the GAO investigators that the Special Inquiry was not a criminal investigation. He further explained that based on the findings of the administrative investigation there was no evidence of criminal activity such as criminal obstruction of justice by the responsible VA managers. Mr. Kroll informed us that he told GAO that the investigation identified poor management and this was how the report was written. Mr. Lucas advised us that he also told the GAO investigators that the Special Inquiry was not a criminal investigation. He told us that he does not recall the GAO investigators asking him if he investigated a "cover-up." However, he said that he did evaluate the evidence to determine if there was a "cover-up," and

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See comment 1.

concluded that there was not. Part of the confusion may be an interpretation of the term "cover-up." The term has been used interchangeably to refer to a criminal violation, such as obstruction of justice, as well as administrative or management deficiencies.

The GAO draft report implies that the allegations of criminal "cover-up" activity were not investigated. However, GAO does not identify any Federal or state criminal statute that would apply to any of the acts or omissions by VA management officials that were cited by the complainant as the basis for his allegations of "obstruction' and "cover-up." Although the complainant alleged criminal misconduct by VHA management, he did not cite any statute or other legal authority to support his position. It is clear from the complainant's March 27 letter to the OIG that his assertion that VHA management's actions were criminal in nature was based on his belief that "Criminal law requires all individuals to immediately report all reasonable suspicions of murder." Complainant's March 27, 1995 letter, p. 3. Although we can understand that citizens with no law enforcement background may believe this is a crime, there is no applicable Federal or state statute that requires the reporting of "reasonable suspicions of murder." Furthermore, whether the statistical analysis of the deaths in the hospital would rise to the level of a "reasonable suspicion of murder" is certainly debatable.

The issue of whether any of the conduct cited by the complainant in his 1995 correspondence as the basis for his allegations of "obstruction" and "cover-up" was criminal in nature was discussed and researched by the OIG during the Special Inquiry. None of the conduct cited by the complainant in his correspondence to support his allegation of a "cover-up" by VAMC managers constituted criminal activity under any Federal or State of Missouri criminal statute. This was explained to the GAO investigators; and, they were provided copies of relevant documents. The only allegation the complainant raised that was criminal in nature was that VAMC management was destroying documents. The allegation was investigated jointly by our criminal and administrative investigators. This allegation was made in a public forum in 1995 and was not included in any of the complainant's correspondence to the OIG. This allegation of criminal activity quickly dissipated when the complainant admitted in his interview, in the presence of his attorney, that the documents that were destroyed were copies not originals.

It is unclear in the GAO draft report what type of investigation, if not an administrative investigation of management's response to the increase in deaths, GAO believes we failed to conduct. If it is GAO's position that in 1995 the investigation should have been criminal, we disagree. When allegations are received by the OIG, they are reviewed to determine whether, if substantiated, they would be criminal in nature. When allegations, such as those received from the complainant, do not appear to be criminal, it is customary for the OIG to

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begin an administrative investigation and refer the matter to the criminal investigators if the investigation identifies evidence to support a criminal violation.

In this case in particular, it was appropriate to conduct an administrative investigation. The numerous pages of documentation the complainant submitted to the OIG consisted of little more than suppositions, hearsay and his personal arguments to support his theory that management concealed evidence of the deaths. In the absence of any solid or direct evidence to support the basic allegations of mismanagement, much less a criminal charge of obstruction of justice, the OIG needed to first establish what happened, when it happened, who knew about it, when they knew about it, what action was taken and why. The analysts who conducted the review were experienced in conducting Government audits and administrative investigations. The Government Auditing Standards requires these individuals to identify and report illegal acts. Government Auditing Standards, § 7.26 through § 7.33. In addition, they were under the supervision of a GS-14 analyst who, prior to transferring to the Special Inquiries Division, had spent a number of years with the OIG as a series 1811 criminal investigator.

Based on their findings in the ongoing criminal investigation, the OIG Office of Investigations found no reason to suspect criminal activity with respect to management's response to the increase in deaths, such as obstruction of justice. Within the first 3 months of the investigation, and months before the complainant came forward with his allegations of "cover-up," the FBI/OIG investigation had conducted over 170 witness interviews and secured numerous records and other evidence for review. None of the testimony or evidence led the FBI or OIG criminal investigators to pursue a criminal obstruction of justice investigation. Mr. Lucas asked the Office of Investigations if it planned to pursue a criminal obstruction of justice investigation and was told it did not inasmuch as nothing had surfaced in the criminal investigation to indicate "cover-up" or "obstruction of justice." Our position that an administrative investigation was appropriate is further supported by the FBI's statement to GAO that the issues raised by the complainant appeared to be administrative, not criminal, in nature. The FBI further stated that had there been any indication of criminal activity, "*it [the FBI], would have explored the potential culpability of any person, whether management, employee or staff - before, during and after the deaths, to include deliberate attempts to cover-up.*" Draft report, p. 16. (Emphasis added.) It is also noteworthy that the complainant did not raise the issue of a "cover-up" in his interview with the FBI. Given the absence of an identifiable criminal violation and the fact that the FBI was already involved, an administrative investigation was the appropriate method of review

Now on p. 10.

Although the issues were considered administrative in nature and the OIG investigation proceeded along this line, Mr. Kroll explained to the GAO

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investigators that he discussed the findings with the criminal investigators and OIG's legal counsel and had them review the report before it was issued. None of these individuals identified any potential criminal activity in the conduct of the Medical Center's managers that were discussed in the report. As a result of this review, legal counsel identified an issue with respect to the fact that the complainant intentionally disclosed confidential information to the State of Missouri Licensing Board and others in violation of the Privacy Act and the VA statute that prohibits the disclosure of quality assurance records, 38 U.S.C. § 5705. The matter was referred to the criminal investigators who presented it to the U.S. Attorney's Office who declined prosecution. As will be discussed later, this was the reason for the criminal investigator contacting the Office of Regional Counsel to determine whether the release of the information contained in the complainant's letter to the State of Missouri licensing board, which the complainant provided the FBI, would violate the Privacy Act or any other confidentiality law.

Now on p. 4.

See comment 2.

On page 7 of the draft report, GAO states that Mr. Kroll told them that "he did not review any underlying evidence while preparing the final report nor did he reconcile the stated facts with the underlying evidence prior to issuing the report." Mr. Kroll denies making this statement. He has advised the OIG that what he told GAO was that he "*never reviewed the FBI or OIG criminal investigative workpapers or files.*" The information contained in these files was part of a criminal investigation and was "off limits" to the Special Inquiry staff. Because he and his staff were unable to review the criminal investigative files and needed to ensure that the findings were consistent with information contained in the investigative files, Mr. Kroll had the criminal investigator review the Special Inquiry report before it was issued.

See comment 3.

Mr. Kroll did review the Special Inquiry work papers, i.e., the evidence obtained during the administrative investigation, when he wrote the final report. He admits, however, that he cannot testify that he reviewed every single document. Mr. Kroll's statement is supported by OIG personnel who worked with him on the report. In addition to reviewing work papers prepared by his staff, Mr. Kroll personally contacted Medical Center officials to obtain information, including specific documentation. In addition, Mr. Kroll was personally involved in gathering information relating to the allegations that the OIG was involved in the "cover-up."

See comment 4.

The finding that Mr. Kroll did not reconcile the stated facts in the report with the underlying evidence prior to issuing the report is inaccurate. Drafts of Sections B,C and D were formally referenced, i.e., the referencing was documented, before the report was issued. Although the formal referencing for Section A was not completed before the report was issued, because the analyst responsible for the referencing retired, statements in this section were reconciled with the

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evidence, as the report was being written. However, this was not formally documented.

Now on p. 4.

GAO's criticism of the OIG for examining each issue separately, "rather than linking the issues that were alleged by the complainant," is unclear. (Page 9 of the draft report.) Each issue must be reviewed to make a determination whether the allegation can be substantiated. Although we investigated each issue separately, we linked the individual findings to reach the overall conclusions in the report regarding whether there was a "cover-up" or poor management.

Now on p. 6.
See comment 5.

On pages 9 and 10 of the draft report, GAO criticizes the OIG for accepting "I don't know" answers from the former Medical Center Director and the former Chief of Staff instead of probing. GAO does not specify what issues they believe the OIG should have probed further, nor is there any evidence that further probing would have elicited additional information. GAO represents that the decision not to probe further was because the administrative investigators "did not suspect the two individuals of being involved in a cover-up." We do not believe this is an accurate representation of the facts. Mr. Kroll has advised us that he carefully explained to the GAO investigators that these individuals were former VA employees who were under no obligation to talk with the analysts conducting the review. The OIG does not have testimonial subpoena authority and cannot compel non-VA employees to submit to an interview. Mr. Kroll further advised GAO that when he and the Special Inquiries staff went to the former Director's home, there was considerable tension about the interview and it was questionable whether the interview would be conducted. The situation was complicated by the fact that the former Director's wife was present and was encouraging her husband not to cooperate with, or submit to, the interview. The uncertain position the analysts found themselves in when they interviewed the former Director is supported by the transcript of the interview. The transcript shows that because of interference by the former Director's wife, Mr. Kroll and the Special Inquiry analysts were unable to take the former Director's statement under oath.

See comment 2.

See comment 2.

GAO states that "One of the analysts involved with the Special Inquiry told us that she thought that because the Hospital Director and the Central Region Chief of Staff had retired, they were beyond the reach of the VA system." GAO draft report, pp. 9-10. GAO goes on to conclude "The OIG, therefore, expected little useful information from them." *Id.* The implication in the draft report is that this was the reason given by the analyst for not probing during these interviews. The analyst has advised us that her statements were taken out of context. Although she did make these statements, or statements similar to this, they were not made in response to questions relating to the issue of why she and/or the other analysts did not ask more "probing" questions of these witnesses.

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In addition to the fact that the former employees were voluntarily consenting to an interview and could have ended it at any time, it is important to note that they were being asked to remember specific events that occurred more than 2 years earlier. The fact that they didn't recall specific details regarding certain events was neither surprising nor unusual.

In addition to the statements cited above, there are several statement in the "Results in Brief" section of the draft report that are inaccurate for the reasons stated above. They include:

- On page 3 of the draft report, GAO states "Contrary to the instructions of the Inspector General (IG), the review did not include investigation of the cover-up." The IG asked Special Inquiries to investigate the allegations the complainant set forth in his letters to the OIG and, as evidenced by the Special Inquiry report, these allegations were the focus of the review.

- On page 4, GAO states: "The Assistant Inspector General for Departmental Reviews and Management Support stated that because the allegations of a cover-up were not part of the Special Inquiry, the resulting report 'probably' overstated its conclusion that there was no evidence of an intentional cover-up." The former Assistant Inspector General has advised us that his statement is misrepresented in the draft report. As previously stated, he advised GAO that the investigation was not a criminal investigation. He also told GAO something to the effect that the report's conclusions would probably be overstated if the reader misunderstood that this was a criminal investigation. He denies making the statement attributed to him in the first paragraph on page 4 of the draft report.

See comment 2.

B. GAO Concluded: VA OIG Report Was Inaccurate and Contained Facts Unsupported by the Evidence

Now on pp. 6-8.

In pages 10-14 of the draft report, GAO concludes that we failed to follow our own policies concerning completeness and accuracy of reports which resulted in the report containing stated facts that were inconsistent with or unsupported by the evidence contained in the OIG files. GAO cites three statements in the OIG report to support this conclusion: (1) the Medical Center Director's failure to notify law enforcement of the possible association of a particular nurse to an unexplained increase in deaths, (2) remarks attributed to the Hospital Director and the Central Region Chief of Staff about withholding statistical analysis information from the peer review board; and (3) the Medical Center Director's instructions to the complainant that he refrain from making further contacts with

the FBI and OIG about the case. GAO documents similar findings in the "Results in Brief" section of the draft report.

OIG Response: As discussed in detail below, we agree that two of the three statements cited by GAO could have been worded more precisely. We do not agree that there are any inaccuracies with the third statement. However, GAO needs to put its finding in perspective. The two statements are but single sentences, or portions of sentences, that have been extracted from lengthy discussions on specific issues. The imprecise wording cited by GAO has no impact, whatsoever, on the overall findings and conclusions. These statements, whether considered individually or together, do not support GAO's conclusion as stated in the title of the section, i.e., the "OIG Report Was Inaccurate." Absent an acknowledgment that the statements were not material to the OIG's conclusions, the GAO report leads the reader to an erroneous conclusion.

Now on p. 6.

For the reasons stated below, the conclusion on page 10 of the draft report, i.e., that the "OIG failed to follow its own policies concerning completeness and accuracy of its reports" and the accompanying footnote, are inaccurate. The cited policy and procedures were followed, the findings and conclusions in the report are both accurate and complete. This finding should be deleted from the report.

The first statement that GAO identifies as being inaccurate is in a paragraph on page 22 of the OIG report relating to whether the former Director was told by the former Chief of Staff for the Central Region not to report the increase in deaths to law enforcement authorities. GAO's finding is only partially correct. The OIG report states:

> [Dr. Falcon] was asked by Mr. Kurzejeski for his opinion on whether to report the unexplained deaths and possible relationship of Nurse H with these deaths to law enforcement authorities. Dr. Falcon said he thought the situation warranted far more review before the Medical Center either relieved Nurse H of patient care duties or notified law enforcement authorities. He advised Mr. Kurzejeski not to notify law enforcement authorities until the reviews were completed.

Special Inquiry report, p. 22. GAO states, incorrectly, that there was no evidence that Dr. Falcon and Mr. Kurzejeski "even discussed whether to report the issue." There was discussion on whether to report the issue; but the discussion was whether to report it to the VA Office of the Medical Inspector, not law enforcement authorities as the OIG report states. The work papers show that Dr. Falcon was of the opinion that far more review was warranted before Nurse H was removed from patient care duties so he directed that certain reviews be conducted. The work papers also show that he further directed that

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the VA Medical Inspector not be informed about the sudden increase in deaths until those reviews were completed.

The OIG report should have stated that Mr. Kurzejeski "was instructed not to notify the Office of the Medical Inspector," instead of " was instructed not to notify law enforcement authorities." However, whether it was the Medical Inspector or law enforcement authorities, the evidence supports the overall conclusion that Dr. Falcon wanted further review before any action was taken, including notifying outside entities; and to this end, he instructed Mr. Kurzejeski to have the internal reviews conducted before anyone outside the Medical Center and the Region was notified. If Dr. Falcon didn't want an investigative group from VHA headquarters notified, it is not unreasonable to conclude that he would not have approved notifying the OIG or other law enforcement authorities of the issue before the additional reviews were conducted. Although the sentence in question is not accurately worded, the inaccuracy is not material to any of the report's ultimate conclusions.

Now on pp. 7-8.

On page 12 of the draft report, GAO finds that the following statement in the OIG report was not consistent with the work papers:

> Dr. Falcon and Mr. Kurzejeski told [the OIG] that they withheld the . . . statistical analysis from the Board members to allow them to take an objective look at the cases.

Special Inquiry, p. 25. GAO states that the documentation shows that the Central Region Chief of Staff, Dr. Falcon, told the OIG that he never issued instructions to deny the Peer Review Board access to the data. Although the sentence in the report contains an error, it is not the error GAO cites; i.e., the OIG report did not state that Dr. Falcon told us that he "issued instructions to deny the Peer Review access to the data;" rather, we stated that he and Mr. Kurzejeski "told us they withheld the . . . statistical analysis." (emphasis added.) The OIG report does not state that they issued instructions not to provide the data to the Boards.

The statement, as written in the OIG report, is not accurate because the work papers do not support that Dr. Falcon and Mr. Kurzejeski "told [the OIG]" that they withheld the statistical analysis from the Board. However, we believe the evidence supports the conclusion that, notwithstanding their testimony, they did decide to withhold it. The fact is, both Mr. Kurzejeski and Dr. Falcon were aware of the statistical analysis regarding the deaths, and neither took the initiative to provide the information to the Board tasked with reviewing five of the deaths. When we asked them if they thought the statistical analysis would have been useful to the Board, Mr. Kurzejeski told us he was not sure it would have been wise to give the data to them because it would have interfered with their objectivity. Dr. Falcon told us he doubted the data would have been helpful to

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the Board. Having knowledge of the statistical analysis prior to convening the Board, and in not providing such data to the Board, a reasonable conclusion is that they did decide to withhold the statistical analysis from the review Board.

GAO states that the former Director told the OIG that the thought of giving the Board the statistical analysis did not cross his mind. Although we agree that the former Director made this statement, we did not find it to be credible. In addition to the fact that the statistical analysis was the impetus for these reviews, the complainant provided us with evidence to show that he raised the issue of presenting his statistical data to the Boards and/or other reviews being conducted at the request of the Central Region, but was told that Mr. Kurzejeski did not want the information presented. The OIG work papers contain documentation that supports the complainant's assertion. Considering the totality of the circumstances at the time, including the fact that the statistical analysis was the underlying reason the review Boards were being conducted, it seems highly unlikely, if not impossible, that the thought of giving the data to the Board did not cross Mr. Kurzejeski's mind. For these reasons, we believe that our original finding, that Mr. Kurzejeski and Dr. Falcon withheld the statistical analysis from the Board, is accurate.

We agree that the statement in the report should have been written more accurately, i.e., the sentence should have stated that "they withheld the data," not that they "told us that they withheld the data." However, the inaccuracy had no impact whatsoever on our overall findings and conclusions.

See comment 6.

GAO's last finding in this section is that there was no documentation to support the OIG's conclusion that neither the FBI nor the OIG was limited in obtaining information from the complainant or other medical center employees as the result of the former Medical Center Director's instruction to the complainant to refrain from further contacts with either the FBI or the OIG about the case. We agree with GAO that this specific statement, as written in the OIG report, is not contained in the documents in the OIG work papers. However, we strongly disagree with the conclusion on page 10 of the draft report that the OIG finding is inaccurate. We also disagree with the statement on page 14 of the draft report that "at a minimum one would expect to find such documentation."

Now on p. 8.
Now on p. 8.

Mr. Kroll has advised us that he does not recall discussing this issue with the GAO investigators. Had he been asked, he would have stated that the conclusion in the OIG report is self evident because the complainant continued to discuss the case with the FBI, the OIG and others after he received the former Director's instruction.

The statement in the OIG report is a conclusion based on our review and analysis of the evidence. We were not citing specific testimony nor were we referring to a specific statement in the documents. By their very nature,

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conclusory statements represent the reviewers' interpretation of the evidence and are not, or necessarily, found in the work papers.

See comment 6.

As a final point, we qualified the statement in the report with the words "to the best of our knowledge," to acknowledge the possibility that evidence to refute our conclusion may exist but was not discovered during our review. Unless GAO or anyone else provides us with credible evidence to show that the former Director's actions did, in fact, limit the FBI/OIG from obtaining information from the complainant or anyone else, we stand behind our conclusion as stated in our report. The draft GAO report cites no specific evidence in support of its conclusion on this point.

The "Results in Brief" section of the draft report contains similar statements that are erroneous and need to be deleted or amended to reflect the above discussion. One statement, in particular, that should be amended is: "However, [the IG] was concerned that the Office of Investigations had failed to follow up on the allegations." Draft report, p. 5. For accuracy, the statement should be amended to state: "However, [the IG] was concerned that the Office of Investigations had failed to follow up on, *or otherwise address, the management issues raised in the complainant's February 1993 letter.*

C. GAO Comment: "Circumstances Surrounding the 2-Year Delay"

Now on pp. 8-10.

Pages 14-17 of the draft GAO report contain statements relating to the circumstances for the 2-year delay before the OIG began investigating the complainant's allegations that Medical Center management did not act appropriately when they learned of the increase in deaths on Ward 4E.

OIG Response: We cannot identify any valid reason for including this section in the GAO report because it contains no independent findings, conclusions, recommendations, or even comments. This section of the GAO report consists of little more than a reiteration of selected portions of our own findings and conclusions regarding this issue.

Considering the title of the GAO draft report, "Veterans Affairs Special Inquiry Report Was Misleading," the inclusion of this section in the report misleads the reader into believing that the OIG's findings on this issue were inaccurate and misleading when, in fact, GAO has not reached this conclusion. Absent any finding that the OIG's findings and conclusions on this issue were erroneous or inaccurate, this section should be deleted from the report in its entirety.

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See comment 7.

We also found statements in this section that inaccurately or incompletely represent facts and/or statements in the OIG report. In the first paragraph of the section, GAO states: "The OIG did not begin its Special Inquiry until after the complainant discussed the allegations with the media in January 1995." The statement is incomplete. To be accurate, the paragraph should be amended to include a statement that in 1995 the complainant raised a new allegation regarding the destruction of records which was the impetus for the IG's decision to conduct the inquiry.

Now on p. 9.

In the subsection which begins on page 14 of the draft report, titled "Complainant's Allegation Letter Filed Without Investigation," GAO states: "The OIG investigator contacted the complainant to acknowledge receipt of the allegations and advised him that the OIG would take no immediate action concerning the allegations due to investigative priorities - the investigation of the suspicious deaths and other unrelated investigations." This statement, as written in the draft report, is not found in the OIG report. The OIG report states: "Shortly after receiving the letter, [the investigator] called the complainant to acknowledge receipt of the letter, and to explain that the criminal investigation was on-going and all his resources were being devoted to it." (OIG report, p. 41.) GAO does not explain why the sentence in the draft report differs from the statement contained in the OIG report.

See comment 8.

We reviewed the OIG work papers and were unable to find any evidence that the criminal investigator told the complainant that "the OIG would take no immediate action concerning the allegations due to investigative priorities" or that he used the phrase "other unrelated activities." The criminal investigator has advised us that he explained to the complainant that the investigation of the deaths took priority. He also stated that he was looking at two other situations at the Medical Center, one involving an alleged threat against Nurse H and another involving a physician at the Medical Center. If GAO decides not to remove this section from the report, at a minimum GAO should either identify the evidence upon which its statement is based or it should accurately cite statements in the OIG report.

The next subsection discusses the FBI's perception that the allegations were administrative in nature. It is unclear why this statement is included in this section of the draft report. The information contained in this subsection is information the FBI provided to GAO; it is not information that the OIG obtained or relied on in reviewing the reasons for the 2-year delay. This subsection is more relevant to the issue of why the OIG conducted an administrative review of the issues raised by the complainant instead of a criminal investigation than it is to a discussion of the reasons for the delay.

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D. GAO Comment: VA/OIG Failed to Protect the Complainant's Confidentiality

Now on pp. 10-12.

Pages 17-21 of the draft report addresses three occasions in which the OIG entered into discussions with Medical Center management regarding the complainant which GAO concludes were in violation of Section 7(b) of the IG Act. GAO concluded that although the OIG revised its policies and procedures for protecting confidential sources following this incident, those policies and procedures are still inadequate.

OIG Response: The first two subsections in this section merely summarize the OIG's findings regarding two disclosures about the complainant by OIG staff. GAO does not provide any independent findings, conclusions, or recommendations on the disclosures discussed in these two subsections. Accordingly, we see no reason for including these issues in the report. The third subsection contains a discussion regarding a third incident in which the former AIG for Healthcare Inspections allegedly released the complainant's identity. For the reasons stated below, we believe that GAO did not fully investigate this incident; therefore, the finding and conclusion lack credibility. In addition, even if the incident occurred, it was not a violation of the IG Act because the complainant effectively waived confidentiality when he publicly disclosed the fact that he made a complaint to the OIG. In the last subsection, GAO concludes that the OIG's policies and procedures to protect the confidentiality of complainants are inadequate. As discussed below, we do not agree with GAO's conclusions.

Now on pp. 10-11.

With respect to the first two subsections, (draft report, pp. 18-19), GAO merely provides a summary of the OIG's findings on the two identified disclosures. These subsections do not provide the reader with a complete and comprehensive understanding of the facts and circumstances relating to the events in question, and are thus misleading. For example, the subsection on page 18 summarizes the OIG's finding with respect to the incident wherein the criminal investigator gave the District Counsel documents that the complainant had sent to the FBI who, in turn, sent them to the OIG. The summary omits critical facts such as the fact that the documents in question included a letter addressed to the Medical Center Director that the complainant had already provided to the Director. The section also omits the fact that the documents in question showed that the complainant was about to violate the Privacy Act and a VA statute protecting quality assurance information which have criminal implications. The fact that the complainant was about to intentionally commit a crime is a mitigating factor in determining whether the investigator acted appropriately. The reason the criminal investigator approached the Regional Counsel on this issue was to determine whether the information the complainant was about to release was, in fact, confidential. In addition, by adding the

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phrase "The OIG, however, characterized what happened as . . . ." GAO leads the reader to mistakenly believe that the OIG's findings were inaccurate. In fact, GAO does not reach this conclusion. For these reasons, this subsection should be deleted from the report.

The next subsection in the draft report summarizes the OIG's findings with respect to disclosures made by the OIG's Office of Healthcare Inspections. As with the prior subsection, GAO does not provide any comments, criticisms or other independent findings on this issue. Therefore, we question why it is included in the report. As with the prior incident, because the reader is not provided with all the relevant facts, the reader is likely to either misinterpret the OIG's findings and conclusions or to erroneously conclude that the OIG's findings are inaccurate or misleading. This subsection should be deleted from the report.

Although our report was critical of the criminal investigator and the AIG for Healthcare Inspections for not following OIG policy and procedures regarding the confidentiality of complainants, we did not conclude that the disclosures were in violation of the IG Act. Section 7(b) of the IG Act protects the identity of employees who make complaints or provide information to the IG. With respect to the disclosure by the AIG for Healthcare Inspections, the subject matter of the disclosure was that the individual had contacted the OIG to obtain information about our review of his statistical analysis and the progress of the FBI/OIG criminal investigation of the deaths. He was not filing a complaint or otherwise providing information to the IG. His confidentiality, as a complainant or someone who provided information to the OIG, was never breached because the AIG for Healthcare Inspections was unaware that the employee had filed a complaint. Contrary to GAO's findings regarding our policies on maintaining confidentiality of complainants, the OIG for Healthcare Inspections was unaware that the employee was a complainant because neither the letter nor its contents had not been shared with him because he had no reason to know to conduct business.

With respect to the disclosure made by the criminal investigator, the issue disclosed was a letter the complainant sent to the FBI, not the OIG. In addition, he sent the same letter to the former Director. Although the investigator did not follow procedures, it is questionable whether the disclosure was a violation of the IG Act. Moreover, because the subject matter of the letter indicated that the individual was about to commit a criminal act, i.e., intentionally disclose confidential information, had the investigator followed procedures, the IG would have been derelict to have maintained confidentiality and allowed the employee to knowingly and willfully violate the law. The criminal investigator never breached the employees confidentiality with respect to the complaint in filed in February 1993

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Now on p. 11.

See comment 9.

On page 19 of the report, GAO details an occurrence in which the former Assistant Inspector General for Healthcare Inspections allegedly released information to the Medical Center's Total Quality Improvement (TQI) coordinator. This event allegedly occurred in January 1995, prior to the commencement of the Special Inquiry. This subsection of the report is particularly disturbing because the issues relating to this incident were not discussed with the affected OIG personnel. The finding appears to be based solely on statements made to GAO by the TQI coordinator. We contacted the former AIG for Healthcare Inspections who informed us that he was not interviewed, or even contacted, by GAO during its review. He further advised us that he has no recollection that this event occurred, and he doubts that the event, as represented in the report, ever occurred. GAO should delete this finding from its report because the findings lack credibility. The statements by the TQI coordinator are inconsistent with the recollections of the former AIG for Healthcare Inspections and, based on the information provided in the draft report, have not otherwise been verified or corroborated. At a minimum, GAO should have interviewed the AIG for Healthcare Inspections to be fair, balanced and thorough.

This subsection also contains a discussion about a similar communication between the TQI coordinator and the criminal investigator. The former OIG criminal investigator has advised us that he was not interviewed by GAO regarding this issue. Furthermore, we do not understand the reason for including the discussion of this issue in the report. If this discussion is included to suggest to the reader that, if the AIG for Healthcare Inspections had contacted legal counsel, he would have been advised not to respond to the TQI coordinator's question, we disagree with this conclusion.

OIG legal counsel was not interviewed by GAO on this subject. However, it is her position that the two requests for information from the TQI coordinator were different and, because of these differences, legal counsel would most likely have given different responses. Based on the facts contained in the draft report, when the TQI coordinator contacted the FBI and subsequently the OIG criminal investigator, she was trying to find out if the complainant had recently contacted them. In short, she was fishing for information about the complainant's interactions with the OIG and FBI. In contrast, when she supposedly spoke to the AIG for Healthcare Inspections, she asked whether the OIG was going to conduct an investigation of a specific allegation that she knew the complainant had made. Because the complainant had publicly disclosed his allegations and the fact that he had made complaints to the OIG about a "cover-up," he essentially waived his right to confidentiality. Under such circumstances, it would not be unusual for the OIG to respond to inquiries like or similar to those made by the TQI coordinator.

Now on p. 12.

The last paragraph in this subsection, (GAO draft report, p. 20), is irrelevant and inflammatory and should be deleted from the report. The paragraph relates an

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interview that GAO had with the Medical Center's Chief of Human Resources (HR) during which the Chief, HR, was asked why Medical Center management instructed the TQI coordinator to make inquiries about the complainant. The Chief, HR, informed GAO that he did not know why the request was made; he could only speculate on the reason. This paragraph, and in particular the accompanying footnote, has no place in this report. The Chief, HR was not the one who made the request and doesn't appear to be involved in the issue at all. Therefore, his testimony on this issue is both wholly speculative and irrelevant. The management officials who supposedly asked the TQI Coordinator to make the inquiries should have been interviewed on these issues and referenced in this section. This paragraph results in a footnote inferring some impropriety with respect to the appointment of the Chief, HR, because of his relationship to the former Medical Center Director. This issue was fully investigated and reviewed during the Special Inquiry and the allegation of nepotism and any other impropriety was unsubstantiated. If there is evidence to show that our finding on this issue was erroneous, GAO should present the evidence and affirmatively state a conclusion. Otherwise, this paragraph is irrelevant and inflammatory and should not be included in the report.

See comment 10.

See comment 11.

Now on pp. 3 and 12.

On pages 6 and 21 of the draft report, GAO discusses policies and procedures that were reportedly issued in August 1995 for protecting the identity of sources who request confidentiality. GAO criticizes the OIG for lacking specific procedures about how to handle handwritten correspondence to protect the identity of the author prior to referring an allegation outside the OIG, and for allowing the dissemination of complainant identity or information throughout the OIG to individuals not involved in the matter. Other than stating an opinion, GAO does not provide any specific evidence that demonstrates that these policies and procedures are not adequate or that the identity of complainants is inappropriately disseminated "throughout the OIG."

See comment 12.

GAO does not accurately represent OIG Hotline policies for protecting sources who request confidentiality. Such policies have been in effect since June 1993. No new policies and procedures related to the confidentiality of OIG complainants were implemented in August 1995. The draft report apparently refers to an August 29, 1995, meeting that the OIG had with staff of Veterans Health Administration (VHA) to discuss the expeditious handling and referring of Hotline cases. We requested this meeting with the department to address the referral of Hotline complaints once VHA completed its VA Central Office downsizing of program staff. Several revised procedures for referring cases to VA Central Office were agreed upon. In addition to these revised procedures, the Chief, Hotline Section, included some notes to her staff on the same document to remind them of the need to ensure that records remain confidential. Without additional information, we can only assume that GAO took these notes to be OIG's only policy. This is incorrect.

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The existing OIG policy for protecting Hotline sources is contained in our Policy and Procedure Guide, Part I, Chapter 12, dated June 1993. The policy prescribes the Hotline policies and procedures to be followed for protecting the confidentiality of complainants. Section 3.d. of the policy informs staff of their responsibility to comply with the Inspector General Act when they are processing Hotline complaints. The policy states that the identity of employees who make complaints or provide information regarding alleged wrongdoing will be held confidential unless the individual gives express permission for the disclosure of his/her name, or unless the Inspector General determines that such disclosure is unavoidable during the course of an investigation.

The policy also requires all OIG personnel to be alert for the possibility of retaliation against employees or indications of retaliatory actions. Complaints of retaliation (reprisal for whistleblowing) will be referred as indicated in paragraph 4.r. of this same policy.

The policy states that only the Inspector General may authorize the disclosure of the identity of a complainant without that person's permission, and only if necessary to the conduct of an investigation. The intent of Congress in inserting this provision in the law was that it would be necessary only on the rarest occasions. This authority has not been delegated.

Section 5. b. of the policy discusses procedures our Hotline staff follow to protect complaints. We try to follow procedures to ensure that the names of all VA employees who do not specifically relinquish the right of confidentiality will be protected from disclosure.

The OIG Guide describes the following Hotline procedures:

(1) The case file history log will be marked "Confidential Source" in a prominent location.

(2) The OIG Hotline referral memorandum to an OIG office will disclose the complainant's name, only if considered necessary, followed by the words "Confidential Source." When the complainant's name is known but not provided, the referral should indicate that the complainant's name is available upon request.

(3) All referrals of complaints to other VA components, as well as to non-VA offices, will be without any identification of a complainant who is an employee unless the employee has agreed to a release of identity. Where necessary, extracts of complaint letters will be made to avoid identifying the complainant. Handwritten letters from employees will be disseminated outside the OIG only in rare cases, and only with the authorization of the complainant.

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(4) If the VA component receiving the complaint for action requests the source be identified so an inquiry can be conducted, the OIG office referring the complaint will contact the complainant, inform the person of the request, and determine if he or she will authorize the disclosure of their identity as the complainant to their employer for the purpose of the inquiry. When possible, the authorization should be obtained in writing.

(5) Requests for authorization to disclose the name of a complainant, without that person's permission, must be related to a pending investigation. The request will be forwarded in a memorandum by the appropriate Assistant Inspector General to the Inspector General and contain an explanation and justification of the need to reveal the complainant's identity.

The policy notes that while veterans and the general public are not included in the statutory protection from disclosure, the Hotline staff will honor requests by such individuals for confidentiality, provided the allegations can be adequately reviewed without releasing the complainant's identity. The IG has rarely used his authority to release the name of an employee who has requested confidentiality. In most cases in which we have determined that we cannot review the allegations without releasing the identity of the employee or without management otherwise knowing the identity of the complainant, we present the issue to the employee and ask him or her to decide if they want us to pursue the allegation. In cases where the employee has asked us not to conduct a review of the allegations, we have honored that request.

Section 3.c. of the OIG policy discusses the way we process Hotline complaints. The Hotline staff processes telephonic, personal, and written allegations or complaints, keeping in mind that: "In this process it is again brought to the attention of Hotline staff that they must obtain permission to disclose a complainant's identity when required."

Procedures for protecting the privacy of complainants is also outlined in our Special Inquiry policy, OIG Policy and Procedure Guide, Part VII, Chapter 2. Section VII-2-8 discusses the procedures special inquiries staff use to protect the disclosure of identity, and to obtain releases of identity. The Confidentiality Release form we utilize is shown in Appendix B.

See comment 13.

In summary, without citing specific evidence to the contrary, the GAO draft report does not provide an adequate or credible basis for the conclusion that the OIG's policies and procedures are not adequate. The fact that from time to time employees may not follow a policy or procedure is a compliance issue, not an indictment against the policy or procedure. Corrective action would include training, not formulating or rewriting policy.

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51-114 98 - 4

Now on p. 3.

In addition to the statements cited above, pages 5-6 of GAO's draft report contain two paragraphs on these issues. The first paragraph infers that the OIG violated the complainant's request for confidentiality and the second states that the OIG policies and procedures are inadequate to protect the employee's request for confidentiality. For the reasons stated above, the conclusions in these paragraphs are inaccurate and should not be included in the final report.

E. MISCELLANEOUS ISSUES

See comment 14.

In addition to the comments cited above, we found several statements in the draft report which we found to be inaccurate and misleading. The more significant are as follows:

1. Footnote #2 states as follows:

> The FBI/OIG then began a civil rights investigation immediately after the Department of Justice determined that the FBI and OIG could properly investigate the matter as a civil rights case. The focus of the investigation - to determine whether a crime had occurred at the Hospital and, if so, who was responsible - never changed. A homicide investigation was not conducted, although local law enforcement authorities had jurisdiction. They deferred to the investigation conducted by the FBI/OIG. (emphasis added).

Now on p. 1.

GAO Draft Report, footnote no. 2, p. 2. This statement is misleading because it suggests that a proper investigation, i.e., a homicide investigation, was never conducted. The draft report does not explain the difference, if any, between the investigation that was conducted and a "homicide investigation." In fact, there is no difference. The only difference between the FBI/OIG criminal investigation and one which would be conducted by local authorities is the potential charge the Department of Justice (DOJ) had authority to bring, i.e., a Civil Rights violation, versus the charge(s) the local authorities could bring, e.g., murder or manslaughter charges, based on the same evidence. Whoever conducted the investigation, whether it was the Department of Justice or the local authorities, first had to prove that a homicide occurred. This was the focus of the FBI/OIG investigation. In fact, the FBI identified the investigation as a "murder" investigation when its agents interviewed VA employees and other witnesses. Because the lengthy investigation did not find evidence that any of the deaths were the result of foul play, there was no need to proceed to the second stage of the investigation which was to identify the person or persons responsible for the deaths.

The primary reason for citing a possible Civil Rights violation was to give DOJ and the FBI the authority to expend appropriated dollars to investigate this matter, particularly when local authorities indicated that they were not interested in pursuing the case. The footnote should be deleted from the report because it is extraneous. However, if it remains, the sentence should be amended to read: "Although local authorities had jurisdiction with respect to the enforcement of state and local homicide statutes, they deferred to the FBI/OIG to conduct a criminal investigation of the same events."

Now on p. 18.

2. A similar statement is made in the last paragraph on page 24, Appendix 1; GAO states: "In October 1992, based on information from a Missouri state legislator, the FBI and the OIG initiated a joint civil rights criminal investigation concerning the suspicious deaths at the Hospital." For the reasons stated above, we see no valid reason for defining the investigation as a "civil rights criminal investigation." This phrase erroneously suggests that the nature and scope of the investigation was limited because the potential charge was a civil rights violation. This is not accurate.

Now on p. 18.

3. The last sentence of page 24 of the draft report states, "On February 4, 1998, the FBI issued a report to Congress concluding that the federal statute of limitations had expired in August 1997, without any determination that a crime had, in fact, been committed." This is but one part of a sentence from an eight page report. The complete sentence in the report references the fact that it was an extensive investigation. This is significant because even though the statute of limitations of the potential Federal criminal charge expired, it is doubtful that any further investigation would produce a different result. Other than the statistical analysis, there is no evidence that a crime had been committed. GAO's statement incorrectly implies that insufficient evidence was found because the statute of limitations expired, preventing a full and complete investigation.

Now on p. 18.

4. The next to last sentence in the first paragraph on page 25 of the draft report states: "The Office of Investigations determined that, due to other priorities, including the investigation of suspicious deaths, no immediate action would be taken on these allegations." The phrase "due to other priorities" is inaccurate and misleading. As previously stated, this investigator informed the complainant that "the criminal investigation was ongoing and all of his resources were being devoted to it."

5. We do not see any reason for including the Appendix in the report. Any significant information in the Appendix is also contained in the body of the report.

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Now on p. 9.
Now on pp. 6-7.

6. There are several places in the report in which GAO states that the "OIG" did or did not do something or remember something. For example, p. 4, "Although the OIG was not sure that the allegation had been shared with the FBI . . .;" p. 10, "the OIG failed to follow its own policies . . .;" and, p. 15, "He characterized the OIG's failure to follow up on the allegations . . ." Unless GAO interviewed every OIG employee who could possibly be involved in the cited activities, the statements are inaccurate. They should be amended to identify the person or persons who were interviewed on the issue.

Now on p. 9.

Now on p. 13.

7. On page 22 of the draft report in the "Scope and Methodology" section, GAO states that it "interviewed both current and former OIG officials and Truman Memorial Veterans Hospital personnel involved with the review of the suspicious deaths." This statement should be amended to reflect that GAO interviewed "some" of these individuals. We are aware of individuals who had relevant information who were not interviewed.

Now on p. 13.

8. This section on page 22 of the draft report also states that OIG investigative procedure manuals were reviewed. It is our understanding that the manuals reviewed were the Hotline and Special Inquiry Guidelines and that the manuals for the other OIG divisions were not reviewed.

Now on p. 18.

9. On page 25, the draft report states: "In January 1995, after the complainant went to the media, the IG instructed the Assistant IG . . ." To be accurate, this sentence should be amended to read: "after the complainant went to the media, *with a new allegation that documents relevant to the investigation were being destroyed* . . ."

Addendum

Information regarding the Hotline policy guidance referred to in our response to your draft report was compiled by our staff and presented to the Counselor for the Inspector General on April 20, 1998. In obtaining copies of the existing policy guidance, our staff went to a centralized manual in the office and pulled out the June 1993 issuance, and August 1995 notes regarding discussions with the Department on how to proceed with cases at the VA Central Office level. The revised August 1995 guidance was missing from the binder and subsequently was not given to the Counselor for the Inspector General, for incorporation into the response. Regrettably, this led to the miscommunication on the effective date of the current Hotline policy to your office.

In reviewing the matter further, we found each individual analyst in the Hotline section retained in their own files the revised August 1995 guidance, and that the steps in protecting complainants' identities, as described in Section 5, and other Sections of the policy, are similar to the previous policy guidance issued in June 1993. The case history log is still marked "Confidential Source" in a prominent location. Hotline staff make every effort not to disclose the complainants' names. With regard to certain personnel issues, Hotline staff advise the complainant that their identities must be disclosed to pursue their specific "personnel" issue. Otherwise, Hotline staff advise the complainants of the various "personnel" related processes they should follow, and will work to refer them to the appropriate management process (e.g., EEO, OSC avenues). All other referrals of complaints to Departmental program as well as to non-VA offices, are without any identification of an employee complainant, unless the employee has agreed to a release of identity. The centrally located binder next to the Administrative Assistant desk has been updated to include the August 1995 guidance.

While we regret the miscommunication concerning the date of the policy, our concerns remain the same. Without citing specific evidence to the contrary, the GAO draft report as written did not provide an adequate or credible basis for the conclusion that the OIG's policies and procedures are not adequate. The fact that from time to time employees may not follow a policy or procedure is a compliance issue, not an indictment against the policy or procedure. Also, whether you refer to the June 1993 or August 1995 guidance, the organization clearly attempts to make every effort to protect the privacy of complainants. Corrective action would include training, not formulating or rewriting policy. Please note that we have made pen changes to the policy to reflect our new hours of operation.

The following are GAO's comments on the Department of Veterans Affairs Office of Inspector General's letter dated April 24, 1998.

GAO Comments

1.Despite how the OIG may characterize its work, we determined that its review was not planned or executed in a manner that would support the conclusion that it had found "no conclusive proof of an intentional cover-up" by Hospital and Central Region officials and "no evidence of criminal misconduct by top management." The work done, as described by those who did it and as reflected in the workpapers, did not include collecting and analyzing evidence to identify intentional cover-up efforts.

2.In addition to in-depth analyses of pertinent documentation, our findings and conclusions are based on extensive interviews of witnesses, including the Assistant IG and lead analyst. Further, these interviews were conducted without the presence of OIG management and the influence that may result from such presence. Information contained in our report was taken from documentation we examined and witnesses we interviewed. To help refresh their recollections and focus them on the issues, we provided the witnesses with copies of relevant sections of the OIG manual and supporting documentation for the Special Inquiry. We have also included additional information in our report to support our findings.

3.According to the VA OIG criminal investigator who conducted the criminal investigation with the FBI, he never read the Special Inquiry report that was issued in 1995. Further, he said he has no idea as to whether statements in the report were true or accurate.

4.Section A of the Special Inquiry report is the Hospital and Central Region management's response to the unexplained deaths. That section concludes that the OIG found "no conclusive proof of an intentional cover-up by Medical Center and Region officials" and "no evidence of criminal conduct by top management." No attempt was made to formally reconcile the final Special Inquiry report to the underlying evidence until we asked whether such a reconciliation had been done. Further, following our request in 1997, the analyst who was responsible for referencing the report told us that she was unable to reconcile some of the stated facts.

5. We have added to our report a discussion of the types of issues we believe the OIG should have probed further and examples of instances in which further probing could have elicited additional information.

6.We disagree that a conclusion needs no supporting evidence. Since conclusions represent review and analysis of evidence, it is essential to include documentation and its analysis in the workpapers. But the OIG had no evidence or analysis to support its conclusion. Further, contrary to the OIG's conclusion, documentation in the OIG file suggested that the Hospital Director's actions limited access. For example, according to a memorandum for the record prepared by the lead analyst, the criminal investigator told the analyst that he suspected that the Hospital Director had told Hospital staff not to talk to investigators.

7.We have added a reference to our report about the OIG's receipt of an additional allegation from the complainant.

8.We have clarified our report to show the source of our statement about the reason for the OIG's delaying action on the complainant's allegations.

9.While we did not interview the Assistant IG for Healthcare Inspections, the IG is incorrect in his assumption that the facts as stated in our report are based solely on the statements made to us by the TQI Coordinator. Rather, the reason that we interviewed the TQI Coordinator was to corroborate statements contained in a January 1995 contact memorandum that she had prepared—immediately following the contact—to document her telephone conversation with the Assistant IG.

10.We have revised our report to reflect that the TQI Coordinator contacted the FBI at the request of the Associate Director and the Chief of Human Resources.

11.The referenced footnote has nothing to do with the Hospital management's investigation of alleged nepotism concerning the appointment of the Director's son as Chief of Human Resources. Rather, the purpose of the footnote is to inform the reader that the person who requested the TQI Coordinator to make calls concerning the complainant is the son of the individual on whom the complainant focused his allegations.

12.The IG's characterization of its June 1993 Hotline policies as the most recent is incorrect. The current policy was issued in August 1995 as reflected in our report. The OIG's May 1, 1998, acknowledgement of this fact appears in the appended addendum.

13.We have withdrawn our proposed recommendation for revising the OIG's August 1995 policies and procedures for protecting the privacy of

complainants. We concur with the IG that any corrective action would require training and compliance with policy, not formulating or rewriting policy. Accordingly, we have made the appropriate changes to our report.

14. We have considered these comments and made changes to the report where appropriate.

Appendix III

Major Contributors to This Report

Office of Special Investigations, Washington, D.C.	Jim Locraft, Special Agent Barbara W. Alsip, Communications Analyst Trudy Moreland, Project Manager Thomas A. Luttrell, Senior Evaluator
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PRINTED ON RECYCLED PAPER

STATEMENT OF

THE HONORABLE RICHARD J. GRIFFIN

INSPECTOR GENERAL

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

MAY 10, 1998

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Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before you today for the first time in my capacity as Inspector General of the Department of Veterans Affairs. I look forward to maintaining a proactive partnership with the committee as we pursue our common goal of ensuring that veterans and their families receive the care, support, and recognition that they have earned by virtue of the sacrifices they have made for our country.

Since assuming the duties of Inspector General, I have undertaken a review of a wide range of policies and procedures to ensure we operate as an independent, professional organization. This review will include investigative priorities, audits, healthcare inspections, and hotline activities and will continue throughout the coming months. It has been my observation, in the time that I have been Inspector General, that the OIG is staffed with dedicated, hard working public servants who are committed to carrying out their jobs in a responsible manner.

While the subject of this hearing predates my tenure as IG, I take any indication that our reports do not meet appropriate standards as cause for concern. For that reason, I directed that the issues raised in the GAO report be thoroughly examined. This task was complicated by the years that have passed since this case first originated and by the retirement of several of the principals. We have contacted these former OIG employees who were associated with the special inquiry conducted at the VAMC Columbia, Missouri in 1995 to validate the facts as they recall them and, in particular, to respond to statements attributed to them in the GAO report.

The results of this examination raised questions concerning the accuracy of statements made in the GAO report and some of the conclusions drawn from their work. Of particular importance, are statements attributed to the former Assistant Inspector General for Departmental Reviews and Management Support and to the lead analyst on the special inquiry. Both of these individuals expressed serious concerns about the accuracy and context of comments associated with their interviews by GAO. While GAO addressed some of our concerns in their final report, a number of issues still exist.

The most significant issue that remains with the GAO report is their conclusion that the OIG special inquiry is misleading in

finding that there was no evidence of a cover-up. The basis for their conclusion is the mistaken belief that because the OIG limited its review to the issue of management's response to the increase in deaths, the OIG did not investigate the issue of a cover-up. As discussed in exhaustive detail in our response to GAO, the complainant's allegation that there was a cover-up was based on his assessment of management's response to the increase in deaths. These are one and the same issue, not separate and distinct issues as the GAO report suggests.

A comprehensive evaluation of the issues that have been raised is attached to my statement for the committee's review.

In closing, I would like to add that the OIG is responsible for reviewing allegations of fraud, waste, abuse, and mismanagement. The credibility of the OIG rests in our ability to conduct these reviews in an independent and objective manner. This cannot and will not be compromised.

Thank you Mr. Chairman for the opportunity to provide my views on this matter. I will be pleased to respond to any questions you or other committee members may have. I am accompanied for this purpose by the Deputy Inspector General, Mr. William Merriman and the Counselor to the Inspector General, Ms. Maureen Regan.

WHITE PAPER
COMMENTS ON GAO DRAFT REPORT ON VAMC, COLUMBIA

On April 2, 1998, the General Accounting Office (GAO) provided the VA Office of Inspector General (OIG), for comment, a copy of a draft GAO report entitled: "Veterans Affairs Special Inquiry Report Was Misleading." The Special Inquiry referred to in the GAO report is entitled "Alleged Cover-up of an Unexplained Increase in Deaths, Harry S. Truman Memorial VA Medical Center, Columbia, MO." We have reviewed GAO's findings and concluded that the report contains statements and conclusions that are both erroneous and inconsistent with the evidence that GAO was provided. The following is a summary of the most significant concerns we have with the GAO report. This summary has been amended since it was submitted in response to GAO's draft report to reflect relevant information not previously identified which further supports our position on these issues. All of the documents and information cited in this White Paper were made available to GAO during its review. All references in this White Paper to the GAO report are to the draft report. Because we were not provided with a copy of GAO's final report prior to the deadline for submitting our testimony for the hearing, we were unable to amend our comments to correspond with the final report.

A. GAO Concluded:
"VA OIG's Conclusion Regarding the Alleged Cover-up is Misleading"

In this section of the report, (pages 6-9), GAO discusses the OIG's finding that there was no evidence of a cover-up by VAMC management officials and concludes that the OIG's finding is misleading. Similar statements are found in the "Results in Brief" section of the report. The basis for GAO's conclusion is that the OIG personnel responsible for the review stated that they did not review or investigate the allegations of a cover-up but, instead, conducted a review of management's response to the increase in deaths. GAO also criticizes the Assistant Inspector General responsible for the report for not reviewing the underlying evidence while preparing the report, and for not probing for additional information when interviewing the former Medical Center Director and the former Central Region's Chief of Staff.

OIG Response: GAO's findings and conclusions are not supported by a thorough analysis of the documents and other evidence that were provided to its staff during the investigation.

On page 6 of the draft report, GAO states: "The OIG's conclusion that there was no evidence of an intentional cover-up is . . . misleading." This finding is based on statements GAO attributes to the Assistant Inspector General (AIG) responsible for the report and the analyst who conducted the review that "the OIG did not review or investigate these allegations of cover-up." Based on our knowledge of the facts in this case and the information we obtained from the AIG and the analyst, we conclude that GAO's finding is erroneous.

The following statement in GAO's draft report demonstrates that GAO misunderstands the basis for the complainant's allegation of a "cover-up" by senior management at the VAMC:

> The OIG reported that it found "no conclusive proof of an intentional cover-up by Medical Center and Central Region officials" and "no evidence of criminal conduct by top management." <u>This language is misleading, as the Special Inquiry was conducted to address management's response to the increase in deaths, not the allegations of a cover-up.</u>

GAO draft report, p. 8. (emphasis added). The issues of "cover-up" and "management's response to the increase in deaths" are one and the same issue, not separate and distinct issues as the draft report appears to conclude.

The term "cover-up" originated with the individual who made the initial complaint to the OIG; not by the OIG. In his February 1993 letter to the OIG, the complainant used the term "cover-up" to describe what he called "administrative forces that discouraged top officials from handling this affair in a prompt and responsive manner." He also stated that the actions of his supervisors "obstructed a criminal investigation." The complainant asked us to "review the administrative response to [the increase in deaths] and in particular, the actions of my two superiors, the Hospital Director . . . and the Chief of Staff for the Central Region . . ." In his March 27, 1995 letter to the OIG, the complainant stated that "VA officials worked together to obstruct the criminal investigation and cover up the obstruction." He went on to define what he meant by these terms and clearly identified specific acts or omissions by Medical Center management that he thought supported these charges. Specifically, he alleged that Medical Center officials: delayed in notifying responsible officials (FBI, local police, OIG) of the situation; refused to respond in good faith to allegations of patient abuse; prevented boards of inquiry from conducting "good faith" investigations; discredited the quality assurance investigation; and, threatened employees with prosecution if they revealed the results of the quality assurance investigation. A comparison of the OIG report and the allegations contained in the complainant's letters, shows that the OIG addressed each of the acts or omissions the complainant cited to support his allegations of "obstruction" and "cover-up." It was the complainant who referred to the identified acts and/or omissions by VAMC management as a "cover-up" and he is the one who defined what he meant by a "cover-up."

If management's response to the increase in deaths was not the basis for the allegation of a "cover-up," what was? There is nothing in GAO's draft report that identifies any act or omission, other than the management issues cited by the complainant, that we should have investigated before concluding that there was no evidence of a "cover-up."

In support of the conclusion that the OIG did not investigate the issue of a "cover-up," GAO refers to statements they attribute to Jack Kroll, the former Assistant Inspector General who prepared the report, and Howard Lucas, the former Special Inquiries' analyst who conducted the investigation, in which Mr. Kroll and Mr. Lucas purportedly admitted that they did not look at the issue of a "cover-up."

The following are examples of the statements GAO attributes to Mr. Kroll and Mr. Lucas to support its conclusion:

> "Contrary to the instructions of the Inspector General (IG), the review did not include investigation of the alleged cover-up. The Assistant Inspector General for Departmental Reviews and Management Support stated that because the allegations of a cover-up were not part of the Special Inquiry, the resulting report 'probably' overstated its conclusion that there was no evidence of an intentional cover-up." [Draft Report, pp. 3-4.]

> "The text of the Special Inquiry report often refers to allegations of a cover-up, but both the Assistant IG and the analyst responsible for the report said that the OIG did not review or investigate these allegations of a cover-up." [Draft Report, p. 6.]

> ". . . the lead analyst who conducted the review and the Assistant Inspector General who wrote the final report told us that the issue of cover-up was 'off the table' because, in their view, their 'charge' from OIG management did not include looking at the allegations of a cover-up. They added that cover-up and conspiracy relate to criminal issues, and neither of them was a criminal investigator." [Draft Report, p. 7.]

We believe that the statements attributed to Mr. Kroll and Mr. Lucas are taken out of context. Mr. Kroll has advised us that he told the GAO investigators that the Special Inquiry was not a criminal investigation. He further explained that based on the findings of the administrative investigation there was no evidence of criminal activity such as criminal obstruction of justice by the responsible VA managers. Mr. Kroll informed us that he told GAO that the investigation identified poor management and this was how the report was written. Mr. Lucas advised us that he also told the GAO investigators that the Special Inquiry was not a criminal investigation. He told us that he does not recall the GAO investigators asking him if he investigated a "cover-up." However, he said that he did evaluate the evidence to determine if there was a "cover-up," and concluded that there was not. Part of the confusion may be an interpretation of the term "cover-up." The term has been used interchangeably to refer to a criminal violation, such as obstruction of justice, as well as administrative or management deficiencies.

The GAO draft report implies that the allegations of criminal "cover-up" activity were not investigated. However, GAO does not identify any Federal or state criminal statute that would apply to any of the acts or omissions by VA management officials that were cited by the complainant as the basis for his allegations of "obstruction' and "cover-up." Although the complainant alleged criminal misconduct by VHA management, he did not cite any statute or other legal authority to support his position. It is clear from the complainant's March 27 letter to the OIG that his assertion that VHA management's actions were criminal in nature was based on his belief that "Criminal law requires all individuals to immediately report all reasonable suspicions of murder." Complainant's March 27, 1995 letter, p. 3. Although we can understand that citizens with no law enforcement background may believe this is a crime, there is no applicable Federal or state criminal statute that requires the reporting of "reasonable suspicions of murder." Furthermore, whether the statistical analysis of the deaths in the hospital would rise to the level of a "reasonable suspicion of murder" is certainly debatable.

The issue of whether any of the conduct cited by the complainant in his 1995 correspondence as the basis for his allegations of "obstruction" and "cover-up" was criminal in nature was discussed and researched by the OIG during the Special Inquiry. None of the conduct cited by the complainant in his correspondence to support his allegation of a "cover-up" by VAMC managers constituted criminal activity under any Federal or State of Missouri criminal statute. This was explained to the GAO investigators; and, they were provided copies of relevant documents. The only allegation the complainant raised that was criminal in nature was that VAMC management was destroying documents. The allegation was investigated jointly by our criminal and administrative investigators. This allegation was made in a public forum in 1995 and was not included in any of the complainant's correspondence to the OIG. This allegation of criminal activity quickly dissipated when the complainant admitted in his interview, in the presence of his attorney, that the documents that were destroyed were copies not originals.

It is unclear in the GAO draft report what type of investigation, if not an administrative investigation of management's response to the increase in deaths, GAO believes we failed to conduct. If it is GAO's position that in 1995 the investigation should have been criminal, we disagree. When allegations are

received by the OIG, they are reviewed to determine whether, if substantiated, they would be criminal in nature. When allegations, such as those received from the complainant, do not appear to be criminal, it is customary for the OIG to begin an administrative investigation and refer the matter to the criminal investigators if the investigation identifies evidence to support a criminal violation.

In this case in particular, it was appropriate to conduct an administrative investigation. The numerous pages of documentation the complainant submitted to the OIG consisted of little more than suppositions, hearsay and his personal arguments to support his theory that management concealed evidence of the deaths. In the absence of any solid or direct evidence to support the basic allegations of mismanagement, much less a criminal charge of obstruction of justice, the OIG needed to first establish what happened, when it happened, who knew about it, when they knew about it, what action was taken and why. The analysts who conducted the review were experienced in conducting Government audits and administrative investigations. The Government Auditing Standards requires these individuals to identify and report illegal acts. Government Auditing Standards, § 7.26 through § 7.33. In addition, they were under the supervision of a GS-14 analyst who, prior to transferring to the Special Inquiries Division, had spent a number of years with the OIG as a series 1811 criminal investigator.

Based on their findings in the ongoing criminal investigation, the OIG Office of Investigations found no reason to suspect criminal activity with respect to management's response to the increase in deaths, such as obstruction of justice. Within the first 3 months of the investigation, and months before the complainant came forward with his allegations of "cover-up," the FBI/OIG investigation had conducted over 170 witness interviews and secured numerous records and other evidence for review. None of the testimony or evidence led the FBI or OIG criminal investigators to pursue a criminal obstruction of justice investigation. Mr. Lucas asked the Office of Investigations if it planned to pursue a criminal obstruction of justice investigation and was told it did not inasmuch as nothing had surfaced in the criminal investigation to indicate "cover-up" or "obstruction of justice." Our position that an administrative investigation was appropriate is further supported by the FBI's statement to GAO that the issues raised by the complainant appeared to be administrative, not criminal, in nature. The FBI further stated that had there been any indication of criminal activity, "*it [the FBI], would have explored the potential culpability of any person, whether management, employee or staff - before, during and after the deaths, to include deliberate attempts to cover-up.*" Draft report, p. 16. (Emphasis added.) We interviewed the FBI Special Agent in Charge (SAC) during our Special Inquiry investigation. He could not say that the VAMC should have notified the FBI of the deaths prior to September 26, 1992, when the FBI received a referral from a local congressman, because it had not been established that a crime had been committed. He further noted that prior to the completion of the statistical analysis, there were only rumors and innuendo concerning the deaths and, had the VAMC called the FBI before the statistical analysis was completed, the medical center may have been told that that there was insufficient information for the FBI to pursue the matter. He stated that the delay of several weeks between the time the statistical analysis was completed in early September and the notification of the FBI on September 26 probably did not affect the outcome of the FBI investigation. It is also noteworthy that the complainant did not raise the issue of a "cover-up" in his interview with the FBI in early October 1992.

In summary, given the absence of an identifiable criminal violation and the fact that the FBI was already involved, an administrative investigation was the appropriate method of review.

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Although the issues were considered administrative in nature and the OIG investigation proceeded along this line, Mr. Kroll explained to the GAO investigators that he discussed the findings with the criminal investigators and OIG's legal counsel and had them review the report before it was issued. None of these individuals identified any potential criminal activity in the conduct of the Medical Center's managers that were discussed in the report. As a result of this review, legal counsel identified an issue with respect to the fact that the complainant intentionally disclosed confidential information to the State of Missouri Licensing Board and others in violation of the Privacy Act and the VA statute that prohibits the disclosure of quality assurance records, 38 U.S.C. § 5705. The matter was referred to the criminal investigators who presented it to the U.S. Attorney's Office who declined prosecution. As will be discussed later, this was the reason for the criminal investigator contacting the Office of Regional Counsel to determine whether the release of the information contained in the complainant's letter to the State of Missouri licensing board, which the complainant provided the FBI, would violate the Privacy Act or any other confidentiality law.

On page 7 of the draft report, GAO states that Mr. Kroll told them that "he did not review any underlying evidence while preparing the final report nor did he reconcile the stated facts with the underlying evidence prior to issuing the report." Mr. Kroll denies making this statement. He has advised the OIG that what he told GAO was that he "*never reviewed the FBI or OIG criminal investigative workpapers or files.*" The information contained in these files was part of a criminal investigation and was "off limits" to the Special Inquiry staff. Because he and his staff were unable to review the criminal investigative files and needed to ensure that the findings were consistent with information contained in the investigative files, Mr. Kroll had the criminal investigator review the Special Inquiry report before it was issued.

Mr. Kroll did review the Special Inquiry work papers, i.e., the evidence obtained during the administrative investigation, when he wrote the final report. He admits, however, that he cannot testify that he reviewed every single document. Mr. Kroll's statement is supported by OIG personnel who worked with him on the report. In addition to reviewing work papers prepared by his staff, Mr. Kroll personally contacted Medical Center officials to obtain information, including specific documentation. In addition, Mr. Kroll was personally involved in gathering information relating to the allegations that the OIG was involved in the "cover-up."

The finding that Mr. Kroll did not reconcile the stated facts in the report with the underlying evidence prior to issuing the report is inaccurate. Drafts of Sections B,C and D were formally referenced, i.e., the referencing was documented, before the report was issued. Although the formal referencing for Section A was not completed before the report was issued, because the analyst responsible for the referencing retired, statements in this section were reconciled with the evidence, as the report was being written. However, this was not formally documented.

GAO's criticism of the OIG for examining each issue separately, "rather than linking the issues that were alleged by the complainant," is unclear. (Page 9 of the draft report.) Each issue must be reviewed to make a determination whether the allegation can be substantiated. Although we investigated each issue separately, we linked the individual findings to reach the overall conclusions in the report regarding whether there was a "cover-up" or poor management.

On pages 9 and 10 of the draft report, GAO criticizes the OIG for accepting "I don't know" answers from the former Medical Center Director and the former Chief of Staff instead of probing. GAO does not specify what issues they believe the OIG should have probed further; nor is there any evidence that further probing would have elicited additional information. GAO represents that the

decision not to probe further was because the administrative investigators "did not suspect the two individuals of being involved in a cover-up." We do not believe this is an accurate representation of the facts. Mr. Kroll has advised us that he carefully explained to the GAO investigators that these individuals were former VA employees who were under no obligation to talk with the analysts conducting the review. The OIG does not have testimonial subpoena authority and cannot compel non-VA employees to submit to an interview. Mr. Kroll further advised GAO that when he and the Special Inquiries staff went to the former Director's home, there was considerable tension about the interview and it was questionable whether the interview would be conducted. The situation was complicated by the fact that the former Director's wife was present and was encouraging her husband not to cooperate with, or submit to, the interview. The uncertain position the analysts found themselves in when they interviewed the former Director is supported by the transcript of the interview. The transcript shows that because of interference by the former Director's wife, Mr. Kroll and the Special Inquiry analysts were unable to take the former Director's statement under oath.

GAO states that "One of the analysts involved with the Special Inquiry told us that she thought that because the Hospital Director and the Central Region Chief of Staff had retired, they were beyond the reach of the VA system." GAO draft report, pp. 9-10. GAO goes on to conclude: "The OIG, therefore, expected little useful information from them." *Id.* The implication in the draft report is that this was the reason given by the analyst for not probing during these interviews. The analyst has advised us that her statements were taken out of context. Although she did make these statements, or statements similar to this, they were not made in response to questions relating to the issue of why she and/or the other analysts did not ask more "probing" questions of these witnesses.

In addition to the fact that the former employees were voluntarily consenting to an interview and could have ended it at any time, it is important to note that they were being asked to remember specific events that occurred more than 2 years earlier. The fact that they didn't recall specific details regarding certain events was neither surprising nor unusual.

In addition to the statements cited above, there are several statement in the "Results in Brief" section of the draft report that are inaccurate for the reasons stated above. They include:

- On page 3 of the draft report, GAO states "Contrary to the instructions of the Inspector General (IG), the review did not include investigation of the cover-up." The IG asked Special Inquiries to investigate the allegations the complainant set forth in his letters to the OIG and, as evidenced by the Special Inquiry report, these allegations were the focus of the review.

- On page 4, GAO states: "The Assistant Inspector General for Departmental Reviews and Management Support stated that because the allegations of a cover-up were not part of the Special Inquiry, the resulting report 'probably' overstated its conclusion that there was no evidence of an intentional cover-up." The former Assistant Inspector General has advised us that his statement is misrepresented in the draft report. As previously stated, he advised GAO that the investigation was not a criminal investigation. He also told GAO something to the effect that the report's conclusions would probably be overstated if the reader misunderstood that this was a criminal investigation. He denies making the statement attributed to him in the first paragraph on page 4 of the draft report.

B. GAO Concluded: VA OIG Report Was Inaccurate and Contained Facts Unsupported by the Evidence

In pages 10-14 of the draft report, GAO concludes that we failed to follow our own policies concerning completeness and accuracy of reports which resulted in the report containing stated facts that were inconsistent with or unsupported by the evidence contained in the OIG files. GAO cites three statements in the OIG report to support this conclusion: (1) the Medical Center Director's failure to notify law enforcement of the possible association of a particular nurse to an unexplained increase in deaths; (2) remarks attributed to the Hospital Director and the Central Region Chief of Staff about withholding statistical analysis information from the peer review board; and (3) the Medical Center Director's instructions to the complainant that he refrain from making further contacts with the FBI and OIG about the case. GAO documents similar findings in the "Results in Brief" section of the draft report.

OIG Response: As discussed in detail below, we agree concerning two of the three statements cited by GAO. We do not agree that there are any inaccuracies with the third statement. However, GAO needs to put its finding in perspective. These statements, whether considered individually or together, do not support GAO's conclusion as stated in the title of the section, i.e., the "OIG Report Was Inaccurate." Absent an acknowledgment that the statements were not material to the OIG's conclusions, the GAO report leads the reader to an erroneous conclusion.

The first statement that GAO identifies as being inaccurate is in a paragraph on page 22 of the OIG report relating to whether the former Director was told by the former Chief of Staff for the Central Region not to report the increase in deaths to law enforcement authorities. GAO's finding is partially correct. The OIG report states:

> [Dr. Falcon] was asked by Mr. Kurzejeski for his opinion on whether to report the unexplained deaths and possible relationship of Nurse H with these deaths to law enforcement authorities. Dr. Falcon said he thought the situation warranted far more review before the Medical Center either relieved Nurse H of patient care duties or notified law enforcement authorities. He advised Mr. Kurzejeski not to notify law enforcement authorities until the reviews were completed.

Special Inquiry report, p. 22. GAO states, incorrectly, that there was no evidence that Dr. Falcon and Mr. Kurzejeski "even discussed whether to report the issue." There was discussion on whether to report the issue; but, according to Dr. Falcon and Mr. Kurzejeski, the discussion was whether to report it to the VA Office of the Medical Inspector, not law enforcement authorities as the OIG report states. However, there was testimony from two other witnesses involved in these discussions that contradicted the testimony of Dr. Falcon and Mr. Kurzejeski. Both witnesses testified that there was a discussion with Dr. Falcon regarding whether to report the matter to the OIG and that Dr. Falcon wanted further review of the matter before it was reported. The OIG work papers show that Dr. Falcon directed that further reviews be conducted before Nurse H was removed from patient care duties and before the matter was reported to anyone. This position is further supported by the testimony of Thomas Garthwaite, M.D., the Deputy Undersecretary for Health for VA, at the hearing October 25, 1995, hearing before the Subcommittee on Hospitals and Healthcare of the House Committee on Veterans' Affairs.

For clarity, the OIG report should have stated:

> Dr. Falcon thought the situation warranted far more review before the Medical Center either relieved Nurse H of patient care duties or notified the Office of Inspector General or the Office of the Medical Inspector. He directed that these reviews be conducted before any action was taken.

However, whether it was the Medical Inspector, the Office of Inspector General or other law enforcement authorities, the evidence supports the overall conclusion that Dr. Falcon wanted further review before any action was taken, including notifying outside entities; and to this end, he instructed Mr. Kurzejeski to have the internal reviews conducted before anyone outside the Medical Center and the Region was notified. Even assuming for the purpose of discussion that Dr. Falcon's specific instructions were limited to reporting the matter to the Office of the Medical Inspector, it is logical to conclude that if Dr. Falcon didn't want an investigative group from VHA headquarters notified, he would not have approved notifying the OIG or other law enforcement authorities of the issue before the additional reviews were conducted. In summary, although the sentence in question is not accurately worded, the inaccuracy is not material to any of the report's ultimate conclusions.

On page 12 of the draft report, GAO finds that the following statement in the OIG report was not consistent with the work papers:

> Dr. Falcon and Mr. Kurzejeski told [the OIG] that they withheld the . . . statistical analysis from the Board members to allow them to take an objective look at the cases.

Special Inquiry, p. 25.

When we asked them if they thought the statistical analysis would have been useful to the Board, Mr. Kurzejeski told us he was not sure it would have been wise to give the data to them because it would have interfered with their objectivity. Dr. Falcon told us he doubted the data would have been helpful to the Board. Having knowledge of the statistical analysis prior to convening the Board, and in not providing such data to the Board, a reasonable conclusion is that they did decide to withhold the statistical analysis from the review Board.

GAO states that the former Director told the OIG that the thought of giving the Board the statistical analysis did not cross his mind. Although we agree that the former Director made this statement, we did not find it to be credible. In addition to the fact that the statistical analysis was the impetus for these reviews, the complainant provided us with evidence to show that he raised the issue of presenting his statistical data to the Boards and/or other reviews being conducted at the request of the Central Region, but was told that Mr. Kurzejeski did not want the information presented. The OIG work papers contain documentation that supports the complainant's assertion. The evidence file also contained a sworn statement from a witness who testified that she had a discussion with the former Director about Dr. Christensen presenting his statistical analysis to the Board. The witness further testified that the Director told her that it would not be appropriate because the data was still being collected and revised. The witness corroborated Dr. Christensen when she testified that she relayed Mr. Kurzejeski's decision to Dr. Christensen. Considering the totality of the circumstances at the time, including the fact that the statistical analysis was the underlying reason the review Boards were being conducted, it seems highly unlikely, if not impossible, that the thought of giving the data to the Board "did not cross" Mr. Kurzejeski's mind. For these reasons, we believe that our original finding, that Mr. Kurzejeski and Dr. Falcon withheld the statistical analysis from the Board, is accurate.

We agree that the statement in the report should have been written more accurately, i.e., the sentence should have stated that "they withheld the data," not that they "told us that they withheld the data." However, the inaccuracy had no impact whatsoever on our overall findings and conclusions.

GAO's last finding in this section is that there was no documentation to support the OIG's conclusion that neither the FBI nor the OIG was limited in obtaining information from the complainant or other medical center employees as the result of the former Medical Center Director's instruction to the complainant to refrain from further contacts with either the FBI or the OIG about the case. We agree with GAO that this specific statement, as written in the OIG report, is not contained in the documents in the OIG work papers. However, we strongly disagree with the conclusion on page 10 of the draft report that the OIG finding is inaccurate. We also disagree with the statement on page 14 of the draft report that "at a minimum one would expect to find such documentation."

Mr. Kroll has advised us that he does not recall discussing this issue with the GAO investigators. Had he been asked, he would have stated that the conclusion in the OIG report is self evident because the complainant continued to discuss the case with the FBI, the OIG and others after he received the former Director's instruction. These contacts are documented in our files.

The statement in the OIG report is a conclusion based on our review and analysis of the evidence. We were not citing specific testimony nor were we referring to a specific statement in the documents. By their very nature, conclusory statements represent the reviewers' interpretation of the evidence and are not, or necessarily, found in the work papers.

As a final point, we qualified the statement in the report with the words "to the best of our knowledge," to acknowledge the possibility that evidence to refute our conclusion may exist but was not discovered during our review. Unless GAO or anyone else provides us with credible evidence to show that the former Director's actions did, in fact, limit the FBI/OIG from obtaining information from the complainant or anyone else, we stand behind our conclusion as stated in our report. The draft GAO report cites no specific evidence in support of its conclusion on this point.

The "Results in Brief" section of the draft report contains similar statements that are erroneous and need to be deleted or amended to reflect the above discussion. One statement, in particular, that should be amended is: "However, [the IG] was concerned that the Office of Investigations had failed to follow up on the allegations." Draft report, p. 5. For accuracy, the statement should be amended to state: "However, [the IG] was concerned that the Office of Investigations had failed to follow up on, *or otherwise address, the management issues raised in the complainant's February 1993 letter.*

C. GAO Comment: "Circumstances Surrounding the 2-Year Delay"

Pages 14-17 of the draft GAO report contain statements relating to the circumstances for the 2-year delay before the OIG began investigating the complainant's allegations that Medical Center management did not act appropriately when they learned of the increase in deaths on Ward 4E.

OIG Response: We cannot identify any valid reason for including this section in the GAO report because it contains no independent findings, conclusions, recommendations, or even comments. This section of the GAO report consists of little more than a reiteration of selected portions of our own findings and conclusions regarding this issue.

Considering the title of the GAO draft report, "Veterans Affairs Special Inquiry Report Was Misleading," the inclusion of this section in the report misleads the reader into believing that the OIG's findings on this issue were inaccurate and misleading when, in fact, GAO has not reached this conclusion. Absent any finding that the OIG's findings and conclusions on this issue were erroneous or inaccurate, this section should be deleted from the report in its entirety.

We also found statements in this section that inaccurately or incompletely represent facts and/or statements in the OIG report. In the first paragraph of the section, GAO states: "The OIG did not begin its Special Inquiry until after the complainant discussed the allegations with the media in January 1995." The statement is incomplete. To be accurate, the paragraph should be amended to include a statement that in 1995 the complainant raised a new allegation regarding the destruction of records which was the impetus for the IG's decision to conduct the inquiry.

In the subsection which begins on page 14 of the draft report, titled "Complainant's Allegation Letter Filed Without Investigation," GAO states: "The OIG investigator contacted the complainant to acknowledge receipt of the allegations and advised him that the OIG would take no immediate action concerning the allegations due to investigative priorities - the investigation of the suspicious deaths and other unrelated investigations." This statement, as written in the draft report, is not found in the OIG report. The OIG report states: "Shortly after receiving the letter, [the investigator] called the complainant to acknowledge receipt of the letter, and to explain that the criminal investigation was on-going and all his resources were being devoted to it." (OIG report, p. 41.) GAO does not explain why the sentence in the draft report differs from the statement contained in the OIG report.

We reviewed the OIG work papers and were unable to find any evidence that the criminal investigator told the complainant that "the OIG would take no immediate action concerning the allegations due to investigative priorities" or that he used the phrase "other unrelated activities." The criminal investigator has advised us that he explained to the complainant that the investigation of the deaths took priority. He also stated that he was looking at two other situations at the Medical Center, one involving an alleged threat against Nurse H and another involving a physician at the Medical Center. If GAO decides not to remove this section from the report, at a minimum GAO should either identify the evidence upon which its statement is based or it should accurately cite statements in the OIG report.

The next subsection discusses the FBI's perception that the allegations were administrative in nature. It is unclear why this statement is included in this section of the draft report. The information contained in this subsection is information the FBI provided to GAO; it is not information that the OIG obtained or relied on in reviewing the reasons for the 2-year delay. This subsection is more relevant to the issue of why the OIG conducted an administrative review of the issues raised by the complainant instead of a criminal investigation than it is to a discussion of the reasons for the delay.

D. GAO Comment: VA/OIG Failed to Protect the Complainant's Confidentiality

Pages 17-21 of the draft report addresses three occasions in which the OIG entered into discussions with Medical Center management regarding the complainant which GAO concludes were in violation of Section 7(b) of the IG Act. GAO's draft report also contained a finding that the OIG's policies and procedures for protecting confidential sources were inadequate. We have been advised that these findings were not included in the final report, therefore, we have deleted our comments on this issue from this White Paper.

OIG Response: The first two subsections in this section merely summarize the OIG's findings regarding two disclosures about the complainant by OIG staff. GAO does not provide any independent findings, conclusions, or recommendations on the disclosures discussed in these two subsections. Accordingly, we see no reason for including these issues in the report. The third subsection contains a discussion regarding a third incident in which the former AIG for Healthcare Inspections allegedly released the complainant's identity. For the reasons stated below, we believe that GAO did not fully investigate this incident; therefore, the finding and conclusion lack credibility. In addition, even if the incident occurred, it was not a violation of the IG Act because the complainant effectively waived confidentiality when he publicly disclosed the fact that he made a complaint to the OIG. In the last subsection, GAO concludes that the OIG's policies and procedures to protect the confidentiality of complainants are inadequate. As discussed below, we do not agree with GAO's conclusions.

With respect to the first two subsections, (draft report, pp. 18-19), GAO merely provides a summary of the OIG's findings on the two identified disclosures. These subsections in the draft report do not provide the reader with a complete and comprehensive understanding of the facts and circumstances relating to the events in question, and are thus misleading. For example, the subsection on page 18 summarizes the OIG's finding with respect to the incident wherein the criminal investigator gave the District Counsel documents that the complainant had sent to the FBI who, in turn, sent them to the OIG. The summary omits critical facts such as the fact that the documents in question included a letter addressed to the Medical Center Director that the complainant had already provided to the Director. The section also omits the fact that the documents in question showed that the complainant was about to violate the Privacy Act and a VA statute protecting quality assurance information which have criminal implications. The fact that the complainant was about to intentionally commit a crime is a mitigating factor in determining whether the investigator acted appropriately. The reason the criminal investigator approached the Regional Counsel on this issue was to determine whether the information the complainant was about to release was, in fact, confidential. In addition, by adding the phrase "The OIG, however, characterized what happened as . . . ," GAO leads the reader to mistakenly believe that the OIG's findings were inaccurate. In fact, GAO does not reach this conclusion. For these reasons, this subsection should be deleted from the report.

The next subsection in the draft report summarizes the OIG's findings with respect to disclosures made by the OIG's Office of Healthcare Inspections. As with the prior subsection, GAO does not provide any comments, criticisms or other independent findings on this issue. Therefore, we question why it is included in the report. As with the prior incident, because the reader is not provided with all the relevant facts, the reader is likely to either misinterpret the OIG's findings and conclusions or to erroneously conclude that the OIG's

findings are inaccurate or misleading. This subsection should be deleted from the report.

Although our report was critical of the criminal investigator and the AIG for Healthcare Inspections for not following OIG policy and procedures regarding the confidentiality of complainants, we did not conclude that the disclosures were in violation of the IG Act. Section 7(b) of the IG Act protects the identity of employees who make complaints or provide information to the IG. With respect to the disclosure by the AIG for Healthcare Inspections, the subject matter of the disclosure was that the individual had contacted the OIG to obtain information about our review of his statistical analysis and the progress of the FBI/OIG criminal investigation of the deaths. He was not filing a complaint or otherwise providing information to the IG. His confidentiality, as a complainant or someone who provided information to the OIG, was never breached because the AIG for Healthcare Inspections was unaware that the employee had filed a complaint. Contrary to GAO's findings regarding our policies on maintaining confidentiality of complainants, the OIG for Healthcare Inspections was unaware that the employee was a complainant because neither the letter nor its contents had been shared with him because he had no reason to know to conduct business.

With respect to the disclosure made by the criminal investigator, the issue disclosed was a letter the complainant sent to the FBI, not the OIG. In addition, he sent the same letter to the former Director. Although the investigator did not follow procedures, it is questionable whether the disclosure was a violation of the IG Act. Moreover, because the subject matter of the letter indicated that the individual was about to commit a criminal act, i.e., intentionally disclose confidential information, had the investigator followed procedures, the IG would have been derelict to have maintained confidentiality and allowed the employee to knowingly and willfully violate the law. The criminal investigator never breached the employees confidentiality with respect to the complaint in filed in February 1993.

On page 19 of the report, GAO details an occurrence in which the former Assistant Inspector General for Healthcare Inspections allegedly released information to the Medical Center's Total Quality Improvement (TQI) coordinator. This event occurred in January 1995, prior to the commencement of the Special Inquiry and after Dr. Christensen went to the media with his complaints. This subsection of the report is particularly disturbing because the issues relating to this incident were not discussed with the affected OIG personnel. The finding appears to be based solely on the statements of the TQI coordinator We contacted the former AIG for Healthcare Inspections who informed us that he was not interviewed, or even contacted, by GAO during its review. He further advised us that he has no recollection that this event occurred, and he doubts that the event, as represented in the report, ever occurred. At a minimum, GAO should have interviewed the AIG for Healthcare Inspections to be fair, balanced and thorough.

Because GAO did not provide us with any evidence relating to this finding, we contacted the TQI Coordinator and obtained a copy of a Report of Contact she prepared relating to her discussions with the former AIG for Healthcare Inspections. This document shows that GAO's summary of the incident is inaccurate and misleading. It also shows that the former AIG for Healthcare Inspections did not violate the IG Act or OIG policy.

On page 19 of the draft report, GAO states:

> The Hospital Total Quality Improvement (TQI) Coordinator told us that in January 1995, prior to the Special Inquiry, the Assistant IG for Healthcare Inspections telephoned her and requested information concerning the Hospital's original response to the unexplained deaths on Ward 4 East. During the conversation, the

> TQI coordinator asked about OIG plans to investigate the complainant's obstruction of justice allegation. The Assistant IG acknowledged recent contact with the complainant and stated that OIG had no plans to investigate the allegations unless forced to do so.

As written this paragraph implies that the "contact with the complainant" referred to by the former AIG for Healthcare Inspections was a contact protected by Section 7(b) of the IG Act. It also implies that the both the TQI coordinator and the former AIG for Healthcare Inspections identified Dr. Christensen as a "complainant" to the IG. In fact, both of these implications are wrong. The Report of Contact prepared by the TQI Coordinator summarizes a conversation that she had with the former AIG for Healthcare Inspections on or about January 11, 1995. The date, which is not included in the GAO report, is significant because it is after Dr. Christensen went to the media with his allegations of a "cover-up." The Report of Contact states:

> I returned a call from [the former AIG for Healthcare Inspections] at approximately 3:00 PM, 1/11/95. [The former AIG] told me that he had been tasked in developing a response for Mr. Trodden to questions being posed regarding the obstruction of justice. He asked if I could provide him with the steps this hospital took in reviewing 4E deaths prior to the story breaking. He was interested in what had been done before Dr. Christensen was asked to provide statistical assistance. I told him that I had maintained a summary and that I would fax it to him.
>
> During this conversation, I asked [the former AIG] if Dr. Christensen had contacted their office recently. He told me that Dr. Christensen had come into the office in December (not sure of exact date). He (Dr. Christensen) requested a copy of the OIG Report on 4E Deaths. He (Dr. Christensen) was told he would have to request it through FOIA. He (Dr. Christensen) had a FOIA request in his pocket, he produced it and was provided a copy.
>
> I also asked [the former AIG] if the OIG was planning on conducting an investigation regarding the obstruction of justice charges. He told me that at this point there were no plans to conduct an investigation. However, they may be forced into doing so.
>
> I asked [the former AIG] if they were aware prior to the newspaper article of shredded documents. He said No. Their first knowledge of this was when they read it in the newspaper article.

Clearly, contrary to GAO's implication, the discussion regarding Dr. Christensen's contacts with the former AIG for Healthcare Inspections was limited to his request, under the Freedom of Information Act, for an OIG report. Such contacts are not protected by either the Privacy Act or the IG Act. There is nothing in the remaining part of the discussion to even remotely suggest that the issues being discussed related to any disclosure Dr. Christensen had made to the IG that would be protected under Section 7(b) of the IG Act. Clearly, the discussion related to the allegations Dr. Christensen made to the media, particularly the allegation relating to the destruction of documents which Dr. Christensen never reported to the OIG. There is absolutely nothing in this discussion to indicate that the former AIG violated the IG Act or any related OIG Policy or Procedure. GAO should delete this finding from its report because the findings are contrary to the evidence.

This subsection of the draft GAO report also contains a discussion about a similar communication between the TQI coordinator and the criminal investigator in which, after consulting with OIG legal counsel, the investigator did not provide the TQM coordinator with any information regarding contacts with Dr. Christensen. The former OIG criminal investigator has advised us that he was not interviewed by GAO regarding this issue. Furthermore, we do not understand the reason for including the discussion of this issue in the report. If this discussion is included to suggest to the reader that, if the AIG for Healthcare Inspections had contacted legal counsel, he would have been advised not to respond to the TQI coordinator's question, we disagree with this conclusion.

OIG legal counsel was not interviewed by GAO on this subject. However, OIG legal counsel has since reviewed the documentation relevant to the two conversations and has concluded that the circumstances regarding the two requests for information from the TQI coordinator were different and, because of these differences, legal counsel would have given different responses to the criminal investigator and the former AIG for Healthcare Inspections.

The last paragraph in this subsection, (GAO draft report, p. 20), is irrelevant and inflammatory and should be deleted from the report. The paragraph relates an interview that GAO had with the Medical Center's Chief of Human Resources (HR) during which the Chief, HR, was asked why Medical Center management instructed the TQI coordinator to make inquiries about the complainant. The Chief, HR, informed GAO that he did not know why the request was made; he could only speculate on the reason. This paragraph, and in particular the accompanying footnote, has no place in this report. The Chief, HR was not the one who made the request and doesn't appear to be involved in the issue at all. Therefore, his testimony on this issue is both wholly speculative and irrelevant. The management officials who supposedly asked the TQI Coordinator to make the inquiries should have been interviewed on these issues and referenced in this section. This paragraph results in a footnote inferring some impropriety with respect to the appointment of the Chief, HR, because of his relationship to the former Medical Center Director. This issue was fully investigated and reviewed during the Special Inquiry and the allegation of nepotism and any other impropriety was unsubstantiated. If there is evidence to show that our finding on this issue was erroneous, GAO should present the evidence and affirmatively state a conclusion. Otherwise, this paragraph is irrelevant and inflammatory and should not be included in the report.

In addition to the statements cited above, page 5 of GAO's draft report contains a paragraphs which infers that the OIG violated the complainant's request for confidentiality. For the reasons stated above, this paragraph is inaccurate and should not be included in the final report.

E. MISCELLANEOUS ISSUES

In addition to the comments cited above, we found several statements in the draft report which we found to be inaccurate and misleading. The more significant are as follows:

1. Footnote #2 states as follows:

> The FBI/OIG then began a civil rights investigation immediately after the Department of Justice determined that the FBI and OIG could properly investigate the matter as a civil rights case. The focus of the investigation - to determine whether a crime had occurred at the Hospital and, if so, who was responsible - never changed. A homicide investigation was not conducted, although

> local law enforcement authorities had jurisdiction. They deferred to the investigation conducted by the FBI/OIG. (emphasis added).

GAO Draft Report, footnote no. 2, p. 2. This statement is misleading because it suggests that a proper investigation, i.e., a homicide investigation, was never conducted. The draft report does not explain the difference, if any, between the investigation that was conducted and a "homicide investigation." In fact, there is no difference. The only difference between the FBI/OIG criminal investigation and one which would be conducted by local authorities is the potential charge the Department of Justice (DOJ) had authority to bring, i.e., a Civil Rights violation, versus the charge(s) the local authorities could bring, e.g., murder or manslaughter charges, based on the same evidence. Whoever conducted the investigation, whether it was the Department of Justice or the local authorities, first had to prove that a homicide occurred. This was the focus of the FBI/OIG investigation. In fact, the FBI identified the investigation as a "murder" investigation when its agents interviewed VA employees and other witnesses. Because the lengthy investigation did not find evidence that any of the deaths were the result of foul play, there was no need to proceed to the second stage of the investigation which was to identify the person or persons responsible for the deaths.

The primary reason for citing a possible Civil Rights violation was to give DOJ and the FBI the authority to investigate this matter, particularly when local authorities indicated that they were not interested in pursuing the case. The footnote should be deleted from the report because it is extraneous. However, if it remains, the sentence should be amended to read: "Although local authorities had jurisdiction with respect to the enforcement of state and local homicide statutes, they deferred to the FBI/OIG to conduct a criminal investigation of the same events."

2. A similar statement is made in the last paragraph on page 24, Appendix 1; GAO states: "In October 1992, based on information from a Missouri state legislator, the FBI and the OIG initiated a joint civil rights criminal investigation concerning the suspicious deaths at the Hospital." For the reasons stated above, we see no valid reason for defining the investigation as a "civil rights criminal investigation." This phrase erroneously suggests that the nature and scope of the investigation was limited because the potential charge was a civil rights violation. This is not accurate.

3. The last sentence of page 24 of the draft report states, "On February 4, 1998, the FBI issued a report to Congress concluding that the federal statute of limitations had expired in August 1997, without any determination that a crime had, in fact, been committed." This is but one part of a sentence from an eight page report. The complete sentence in the report references the fact that it was an extensive investigation. This is significant because even though the statute of limitations of the potential Federal criminal charge expired, it is doubtful that any further investigation would produce a different result. Other than the statistical analysis, there is no evidence that a crime had been committed. GAO's statement incorrectly implies that insufficient evidence was found because the statute of limitations expired, preventing a full and complete investigation.

4. The next to last sentence in the first paragraph on page 25 of the draft report states: "The Office of Investigations determined that, due to other priorities, including the investigation of suspicious deaths, no immediate action would be taken on these allegations." The phrase "due to other priorities" is inaccurate and misleading. As previously stated, this investigator informed the complainant that "the criminal investigation was ongoing and all of his resources were being devoted to it."

5. We do not see any reason for including the Appendix in the report. Any significant information in the Appendix is also contained in the body of the report.

6. There are several places in the report in which GAO states that the "OIG" did or did not do something or remember something. For example, p. 4, "Although the OIG was not sure that the allegation had been shared with the FBI . . .;" p. 10, "the OIG failed to follow its own policies . . .;" and, p. 15, "He characterized the OIG's failure to follow up on the allegations . . ." Unless GAO interviewed every OIG employee who could possibly be involved in the cited activities, the statements are inaccurate. They should be amended to identify the person or persons who were interviewed on the issue.

7. On page 22 of the draft report in the "Scope and Methodology" section, GAO states that it "interviewed both current and former OIG officials and Truman Memorial Veterans Hospital personnel involved with the review of the suspicious deaths." This statement should be amended to reflect that GAO interviewed "some" of these individuals. We are aware of individuals who had relevant information who were not interviewed.

8. This section on page 22 of the draft report also states that OIG investigative procedure manuals were reviewed. It is our understanding that the manuals reviewed were the Hotline and Special Inquiry Guidelines and that the manuals for the other OIG divisions were not reviewed.

9. On page 25, the draft report states: "In January 1995, after the complainant went to the media, the IG instructed the Assistant IG . . ." To be accurate, this sentence should be amended to read: "after the complainant went to the media, *with a new allegation that documents relevant to the investigation were being destroyed . . .*"

STATEMENT OF

THOMAS L. GARTHWAITE, M.D.

DEPUTY UNDER SECRETARY FOR HEALTH

DEPARTMENT OF VETERANS AFFAIRS

ON VA'S RISK MANAGEMENT PROGRAM

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MAY 14, 1998

Mr. Chairman, I am here to discuss VHA's Patient Safety program and changes that have been made to reduce adverse outcomes related to medical treatment. However, before discussing our current Patient Safety policy, I will briefly discuss the elements of that policy that relate directly to the Office of the Inspector General's and others' reviews of deaths that occurred at the Harry S. Truman VA Medical Center in Columbia, Missouri in 1992.

First, I want to reiterate what was discussed during the October 25, 1995 Subcommittee on Hospitals and Health Care hearing on these issues. Management's response to the pattern of deaths reported several years ago was not adequate. The VHA agreed with the Inspector General's 1995 report that the management team in place at the time did not act as promptly and as fully as we would have expected. The 1995 IG report also contained

recommendations for important policy and systems changes that we have implemented. These changes should guide management to promptly and appropriately respond to any similar circumstance in the future. For example, current policy provides that:

- Appropriate law enforcement officials are to be notified immediately if a statistically significant association between a practitioner and increases in mortality, morbidity, or other adverse occurrence is found and there is no credible alternative explanation.

- When a practitioner is suspected of criminal activity that harms patients, the practitioner is to be removed from clinical duties until the suspicions have been resolved. Also, physical materials that could provide relevant evidence are to be collected and stored for possible analysis by law enforcement officials.

- When a practitioner leaves VA and a statistically significant association with an adverse event as described above is found, the VA reports those findings to the appropriate State Licensing Board(s). This policy will apply to all employees, effective in early June.

- Mortality rate data stratified by major service and DRG are reviewed at all VA healthcare facilities to detect statistically significant increases.

- Each VISN has a designated statistical consultant to assist VISN facilities regarding data analyses for patient safety, quality assessment, and performance management purposes.

These policies and systems changes were developed from the review of the events that occurred at Columbia in 1992. Had these policies been in place at that time, I believe the response would have been different. Management would have promptly validated the statistical significance of the association to the practitioner, promptly removed the individual from clinical duties, reported to law enforcement, gathered available evidence, conducted additional internal investigations while cooperating with law enforcement, and reported the individual to the State Licensing Board.

Patient Safety in VHA

I would like to turn now to our current patient safety program -- a program that focuses primarily on adverse events that are related directly or indirectly to medical treatment.

A number of well-publicized and tragic events during the last few years have made it clear that increasing patient safety should be a national priority for all healthcare systems. We know a perfect health care system would have no errors. We also know that health care systems across the United States and in all other countries fall short of perfection. Research findings certainly support this conclusion. Consider the Harvard Medical

Practice Study. Researchers reviewed over 30,000 records in 51 non-federal hospitals. An adverse event, defined as "an injury that was caused by medical management (rather than underlying disease)," occurred in 3.7% of all hospitalizations. This small percentage gains significance when applied to the large number of hospitalizations that occur each year. The 3.7 % means that for every 1,000 admissions to a hospital, 37 patients suffer adverse events. Five of these patients would die, with two to three of these deaths resulting from negligent care. Given that there were approximately 30 million admissions to U.S. hospitals last year, one would predict 150,000 deaths related to adverse events annually. The Harvard Study indicated that over 1 million patients are injured or disabled annually because of adverse events, two-thirds of which are thought to be preventable. Other studies also have found that about 5 of every 1,000 inpatients experience an adverse event that results in their death.

VHA has recently implemented an improved Patient Safety program that I believe will place it at the forefront of efforts to provide safer medical care. Indeed, upon our sharing this policy with various private sector organizations, they all have been highly complimentary.

We are using several different strategies to identify and make needed changes. First, our facilities routinely analyze all service delivery systems to identify redesigns of those systems that will increase patient safety. These analyses involve: (1) identifying those medical care processes most in need of redesign, and (2) introducing checks and balances for each of these processes so that the likelihood of errors is zero. The well-established

procedure of having two staff members independently check a patient's identity before administering a transfusion is a simple example of checks and balances. Another is the use of bar coding to prevent medication errors by electronically verifying the patient, drug, route, and time against the original order before a drug is given to a patient. Efforts are currently underway in VA to implement bar code checks for both blood transfusions and administration of medications.

A second procedure to increase safety is to intensively review all adverse events from a care-site-specific and system-wide focus. These reviews identify the root causes of each incident, the changes in design of systems needed to prevent recurrence, and any indicated personnel actions.

Under VHA's new Patient Safety policy, all reviews of adverse events are sent to the network office and to VHA headquarters where they are reviewed to identify:

(1) the adequacy of the facility review and the appropriateness of the actions taken;

(2) the frequency with which particular care delivery systems have been problematic so managers know where the best opportunities for improvement exist;

(3) system redesigns that should be adopted throughout the network or nationally;

(4) needed changes in network and national policies and procedures; and

(5) lessons learned that can be shared throughout VHA on an Intranet database.

Within Headquarters, a Patient Safety Improvement Oversight Committee accomplishes this review with representatives from the Offices of the Chief Network Officer, Performance and Quality, Medical Inspector, and Patient Care Services. As needed, the committee obtains the input of subject matter experts from throughout VHA.

The sharing of patient safety information between our facilities, particularly innovative system redesigns, is another key aspect of our improved program. All current VHA communication media, such as weekly VISN director conference calls and regularly scheduled, nation wide risk management conference calls, are being used for this purpose. In addition, a Lessons Learned Database on VA's Intranet has been developed as an interactive medium for the sharing of patient safety information throughout our system. Information will be routinely entered by facility staff as well as the Patient Safety Improvement Oversight Committee, the Office of the Medical Inspector, and the Performance and Quality Office.

As mentioned earlier, current policy also requires medical facilities to review morbidity and mortality data generated by national monitoring programs to identify problems in quality of care; it includes specific guidance regarding the notification of law enforcement authorities and other appropriate actions when review of morbidity and mortality data indicate an association between a specific practitioner and increased morbidity or mortality rates.

VHA's Patient Safety policy continues VHA's emphasis on minimizing the negative consequences of injuries to patients. It requires facility staff to inform patients and their families promptly about the clinical facts associated with injuries resulting from medical care, assuring them that measures have been taken to maintain life and minimize disability and discomfort. In addition, facility staff are required to advise patients and their families of any remedial options including clinical care and possible compensation.

To encourage rapid and effective implementation of its improved Patient Safety program, VHA has included a patient safety measure in its network director performance measures for FY 1998. To be fully successful in achieving this measure, a network must redesign a number of major service delivery systems to improve patient safety at all applicable network facilities.

At the heart of VHA's Patient Safety initiative is the creation of a more open environment in which caregivers are genuinely committed to learning from errors and enhancing patient safety. As efforts are focused on understanding how and why the incident occurred, not who was responsible, an increase in the reporting of incidents has been observed. This apparent increase in the frequency of sentinel events and unplanned clinical occurrences should not simply be construed as an increase in the number of errors associated with the care of veterans. Rather, it should be understood as increased reporting of adverse events resulting from the transition to a more open and safety-focused environment.

VHA is determined to design patient care systems that will reduce preventable adverse events and untoward outcomes of healthcare-related processes. Implicit in this design is the need to break down currently prevalent disincentives for addressing medical errors. These disincentives include the traditional culture that finds it difficult to acknowledge errors and mistakes, and fears of litigation and adverse media coverage. We are working now to create a culture that permits medical care personnel to acknowledge the occurrence of errors and encourages open and complete reporting of adverse events. Of course, the system also has to ensure that when appropriate, personnel actions will be taken against employees whose negligence led to a patient injury. However, we are convinced that the real payoff in improving patient safety will come from changing the way medical care is provided in the VA and in the healthcare system overall.

In addition to its internal Patient Safety program, VHA has also taken the lead in forming a National Patient Safety Partnership (NPSP) to address the problem of unintended consequences of healthcare since it is not one that individual health care organizations can solve alone. Members of this public-private partnership besides VHA include the American Hospital Association, the National Patient Safety Foundation at the American Medical Association, the American Nurses Association, the Joint Commission on Accreditation of Healthcare Organizations, and the Association of American Medical Colleges. The primary goal of NPSP is to align the essential elements – people, including patients, processes, and structures – into a strategic framework that can be applied to reduce untoward consequences of healthcare. In addition, experts in human factors analysis and aviation safety are helping VA to enhance its current approach to

patient safety. VHA plans to adopt an additional quality control system modeled after the Aviation Incident Safety Reporting System (ASRS). The NASA-ASRS system, which has been used in aviation for the last 22 years, is voluntary, non-punitive, confidential, objective and independent of the FAA and the airline industry. Its goal is the accumulation of knowledge that can be used to increase safety.

The voluntary incident reporting system being developed by VHA will have the same attributes and goals as the NASA-ASRS system. It will be a groundbreaking development in medicine, and many non-VA observers predict that the rest of U.S. medicine will eventually follow VA's lead. The current mandatory sentinel event reporting system will continue to exist and will be supplemented, as necessary, by the Office of the Inspector General and the Office of the Medical Inspector reviews. In fact, a major benefit of the new voluntary reporting system is that it will serve as a quality control for the current system.

Implementing the new incident reporting system will require substantial attitudinal changes on the part of all employees as well as our stakeholders. But the very shortcomings with respect to patient safety in health care in general and medicine's failure to create an environment that fosters the open reporting of medical accidents and near misses only underscores VHA's resolve to move forward. What is needed is a system that enables VHA to honestly acknowledge, understand and address the barriers to improving patient safety. It is the right thing to do for our nation's veterans.

Overall, Mr. Chairman, while I believe VA's record on patient safety is a good one compared to other healthcare systems, we are continuing efforts to make improvements. I believe VA's present framework for assuring quality of care, which includes the new patient safety policy, will translate into far fewer adverse events related to medical care.

This concludes my statement. I will be pleased to respond to your questions.

Post-hearing Question
Concerning the May 14, 1998 Hearing

for
Dr. Thomas Garthwaite
Deputy Under Secretary for Health
Veterans Health Administration
Department of Veterans Affairs

from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives

Question: To what extent could VA's initial failure to respond have contributed to the lack of direct toxicological evidence that exists today with respect to the suspicious deaths at the Columbia facility?

Response: While the question posed is important and altogether legitimate, the information it requires is not something we at VA are able to produce.

We are unable to know how another agency, the Federal Bureau of Investigation, would have reacted or what evidence it may have collected had the matter of suspicious deaths at the Columbia, Missouri VAMC been reported to it sooner. We simply are insufficiently aware of FBI investigative techniques, nor have we the necessary forensic expertise, to permit us to assess what (if any) additional toxicological evidence may have been available but for the passage of time. Moreover, the availability of evidence may have turned on such factors as whether probable cause existed to support issuance of required search warrants, a matter on which we could only speculate.

We do acknowledge that medical center management should have erred on the side of early law-enforcement notification rather than first trying to develop the statistical evidence. We have modified our policy to emphasize the need for timely notification of law-enforcement authorities whenever suspicions of foul play against patients arise.

GAO

United States
General Accounting Office
Washington, D.C. 20548

Office of Special Investigations

June 19, 1998

The Honorable Lane Evans
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

This letter responds to the three questions in your May 27, 1998, letter regarding our May 14, 1998, testimony before the Committee's Subcommittee on Oversight and Investigations. That testimony provided the results of our review of the Special Inquiry conducted by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) on the alleged cover-up of an unexplained increase in patient deaths at the Harry S Truman Memorial Veterans Hospital in Columbia, Missouri, in 1992. Our responses to your questions follow.

Question 1: What one or two findings in your report would you consider to be the most troubling or damaging to the IG, and please explain your answer.

Response: The most troubling finding in our report[1] is our primary finding–that the VA OIG's conclusion regarding an alleged cover-up is misleading. (See p. 3 of our report.) The title and text of the Special Inquiry report suggest that the allegations of a cover-up had been investigated. Further, a fair reading of the report and its conclusions leaves the reader with the impression that the OIG made a comprehensive effort to address the cover-up allegations. However, we determined that the OIG did not plan or conduct its review or analysis in a way that could determine if a cover-up had occurred and that its report is, therefore, misleading.

Question 2: The GAO's criticism of the IG points out an apparent failure of the IG to examine whether a pattern of conduct on the part of VA management would suggest a cover-up took place. Page 5 of your report states that the IG never attempted to link a series of events in an effort to establish a pattern of behavior on the part of management. Can you explain to the members of this Committee how you were actually able to determine that no such analysis took place?

Response: We based our determination that the OIG did not link or follow up on actions or alleged actions concerning the Hospital Director on our review of the OIG case files, interviews with individuals involved with the Special Inquiry, and statements from knowledgeable Hospital employees.

For example, during our interviews with the Assistant IG and the lead analyst directly responsible for the Special Inquiry, we asked specific questions concerning the OIG's planning and execution of the Special Inquiry. These two individuals acknowledged that because they were not investigating cover-up allegations, they did not seek to establish a pattern of conduct by creating a chronology of events and actions as required by the OIG's Investigative Policy and Procedure Guide. Rather, they used a chronology of events relating to the cover-up allegations that was prepared for an unrelated purpose and provided by Hospital management. That chronology (1) was incomplete and inaccurate as to specific events and actions by management, (2) was inconsistent with establishing a pattern of conduct, and (3) omitted key events.

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[1]Inspectors General: Veterans Affairs Special Inquiry Report Was Misleading (GAO/OSI-98-9, May 13, 1998)

Further, the Assistant IG told us that because the OIG did not consider the Hospital Director or the VA Central Region Chief of Staff to be subjects of the cover-up allegations, these two individuals were not questioned about their actions. Had the OIG done so, it could have developed and pursued potential lines of inquiry that might have suggested a pattern of conduct indicative of a cover-up.

Question 3: In your view, would it still be possible to conduct a thorough investigation into allegations that the VA management covered up criminal allegations at the Columbia facility? Would your office be equipped to handle such an inquiry?

Response: While it may still be possible to investigate the cover-up allegations, it appears at this point in time that additional investigation would not be beneficial. It is important to note that a large body of work has already been done by the OIG during its Special Inquiry and by the Federal Bureau of Investigation (FBI) and the OIG during the joint criminal investigation.

With the issuance of the OIG Special Inquiry report and our report and testimony for the Subcommittee, a significant amount of information has been put into the public domain which, in our opinion, would complicate any further inquiry. Further, in a February 2, 1998, report to the Congress, the FBI stated that it had conducted an extensive investigation and could not conclude that there was evidence of any criminal activity.

We believe that it is highly unlikely that any additional inquiry of cover-up allegations with a view toward criminal prosecution would be successful. We base our belief on (1) the FBI's investigation and conclusion, (2) the amount of time that has elapsed since the cover up was alleged to have occurred, (3) the abundance of information already in the public domain, and (4) the probable diminished recollections of key people who should be interviewed about specific events. If the intent of such an investigation is to take administrative or other action against employees, it should be noted that most employees who were the focus of the Special Inquiry no longer work at VA.

Sincerely,

Eljay B. Bowron
Assistant Comptroller General
for Special Investigations

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Questions for the Honorable Richard Griffin
Inspector General
Department of Veterans Affairs

Questions from the Honorable Lane Evans

1. What role, if any, did a lack of resources and staff play in the ability of the IG's office to conduct a thorough and comprehensive inquiry into the allegations at the Columbia facility?

Response: Lack of resources and/or staff was not an issue in February 1993 when Dr. Christensen first raised his allegations of a "cover-up." Because his letter addressed possible criminal violations, we sent the allegations to our criminal investigators, who in turn provided them to the FBI. Because, after reviewing the complaint, the FBI determined that the allegations were administrative, not criminal, in nature, they took no further action to investigate the complaints. As stated in our Special Inquiry report, the OIG should have ensured that the matter was referred back to the Hotline/Special Inquiry Division for administrative review. It was this oversight, not lack of staff or resources, which caused the 2-year delay in initiating the review. However, lack of staffing and resources was an issue around the time the administrative investigation was being conducted. Government downsizing in 1995 resulted in the early retirement of the senior analyst responsible for the administrative review and his immediate supervisor. This resulted in a lack of continuity and additional time needed to complete the review.

2. Can you give this Subcommittee an idea of the present workload in your office? How strapped are you for money, personnel, and resources? Is there anything we can do as Members of this Subcommittee to help you out on this front?

Response: The decline in appropriated dollars over the past several years has made it difficult to provide an acceptable level of oversight. An ever-increasing requirement to perform mandated work, coupled with a growing demand for Office of Inspector General (OIG) services across all business lines, creates oversight vulnerabilities for the Department of Veterans Affairs (VA), the Congress, and the veterans we serve. The following highlights some of these vulnerabilities and what we would achieve with additional resources:

Office of Investigations (OI)

Resource limitations have resulted in the OI having to decline investigating about 70 percent of the allegations of criminal activity referred to the OIG each year. This totaled about 310 of the 444 referrals received in 1997. In the first quarter of 1998, referrals increased to 332. At this rate, OI may have to decline over 1000 cases in 1998. While OI has implemented a new priority system for ensuring that the more egregious cases are investigated, remaining a successful deterrent to criminal activity necessitates an expanded and adequately staffed investigative organization. An additional 55 FTE would enable OI to almost double the number of cases investigated annually. The primary focus of this expanded effort will be on worker's compensation fraud, drug diversion, public corruption, benefits fraud, and health care fraud. The additional investment is expected to return around 330 new indictments and over $17 million in recoveries and savings, each year.

Office of Audit (OA)

OA faces substantially equivalent circumstances. Budget cuts, combined with increasing audit requirements associated with the Chief Financial Officers' Act and the Government Performance and Results Act (GPRA), seriously limit OA's ability to provide an acceptable level of performance auditing coverage for an organization as large and

diverse as VA. Without adequate funding, OA cannot conduct many of the high-priority, self-initiated audits designed to address systemic issues at the national level. Nor is OA able to achieve its goal to conduct cyclical audits intended to provide VA and Congress with recurring evaluations of VA facilities and programs. With an additional 55 FTE, OA would be able to address several areas of potential vulnerability to VA, including GPRA data reliability, VA Strategic Plan implementation (2 business lines per year), cyclical audits of VHA's 22 Veterans Integrated Service Networks (3 per year), information systems, and fraud-oriented audits, to include workers' compensation, health care, monetary benefits and procurement. The additional investment will produce about 12 substantive audit reports and an additional estimated $55 million in reported monetary benefits each year.

Office of Departmental Reviews and Management Support (DRMS)

The DRMS Hotline and Special Inquiries Division is the major access point for receiving and reviewing allegations of fraud, waste, abuse and mismanagement. The OIG Hotline receives about 20,000 contacts a year. Because of insufficient staffing, the Hotline cannot provide live-call answering and has had to limit call backs to one per contact. This resulted in the OIG being unable to respond to 3,000 potential complainants in 1997. Another consequence of limited staffing is that the OIG has only been able to perform about 15 percent of the Hotline cases it opens each year in-house. The remaining 85 percent are referred to VA for review, a practice that has received some criticism in recent years. In 1997, 733 Hotline cases were opened, of which 628 were referred to VA. Our experience with these referrals is that many of them would benefit from a more independent, objective review by the OIG. An additional 15 FTE for the Hotline and Special Inquiries Division would allow the OIG to respond to all potential complainants and adequately evaluate and follow-up on allegations referred to VA. It would also allow the OIG to address a larger percentage of cases in-house, thereby providing VA and Congress with added assurance that serious allegations are investigated and reported with the high degree of independence expected from the OIG.

Office of Healthcare Inspections (OHI)

OHI conducts program evaluations, quality program assistance (QPA) reviews, and reviews of allegations involving individual patient care cases. Current resources provide OHI a capability to conduct QPA reviews at only 7 VA medical facilities per year, and as few as 6 program evaluations per year. Conducting even this limited number of reviews is becoming more difficult each year due to the growing number of allegations related to VA medical care received from veterans, families and congressional sources. OHI ended 1997 with a backlog of 41 serious Hotline cases. An additional 15 FTE would provide OHI an opportunity to address some of the additional 23 program evaluation projects that merit attention. OHI would conduct more QPA reviews each year and conduct its Hotline cases in a more timely manner. Collectively, this will provide VA more comprehensive objective coverage of its programs and on the quality of patient care.

3. It seems as if all the Members of this Subcommittee agree when I say that an aggressive and independent IG is in the best interests of veterans. Are there times, however, where limited time and resources compel your office to refer inquiries back to the region or facility management for investigation? How do you respond to GAO's criticisms in this regard?

Response: The OIG always has acted, and will continue to act, aggressively and independently in the best interests of the veterans we serve, the Department of Veterans Affairs, and the Congress. Because of limited time and resources, however, we are compelled to refer many allegations back to the region or the facility for investigation. Before these referrals are made, we review the issues presented to us to ensure that the more egregious and sensitive cases remain with the OIG for review. During the past 3 years, we have only been able to perform 303 or 15 percent of the Hotline cases in-house. The remaining 1,616 or 85 percent of the Hotline cases were referred back to VA program offices for review. We do maintain oversight of these cases in that we

request that management provide its response to us so that we have the opportunity to review the response before responding to the complainant. If we find that the response is not adequate, we will either seek additional information or clarification, or conduct a review ourselves. Our experience with these referrals is that many of them would benefit from a more independent, objective review by the OIG. We simply do not have sufficient staff to perform all the work we should be doing for a Department as large and diverse as VA.

We disagree with GAO's testimony regarding the referral of the nepotism issue to the VHA's Central Region for investigation. Contrary to GAO's assertion, the allegation of nepotism was not referred to the person accused of the charge for investigation. During our investigation of Dr. Christensen's allegations of a cover-up, a VA employee brought up the issue of the appointment of the former Medical Center Director's son as the Chief, Human Resources. At the time the allegation was made, the former Director had been retired for some time and, in fact, had retired before his son was selected for the position. Therefore, the person accused of nepotism was not involved in the investigation. Consistent with our practice, we performed and in-depth review of the facility's response and independently conducted some follow-up interviews.

Question from the Honorable Frank Mascara

1. How could those responsible for the special report say "It had found 'no conclusive proof of an intentional cover-up by medical center and central region officials' and no evidence of criminal conduct by top management," when the OIG did not conduct its special inquiry to support its conclusion?

Response: We do not agree with GAO's finding that the OIG special inquiry did not investigate whether there was a cover-up by Medical Center management. As noted in our special inquiry report, in our response to GAO and in our testimony at the hearing, the OIG did conduct a thorough review of the allegations of a cover-up by top management officials at the VA Medical Center and the Central Region.

One of the problems with GAO's statement is that it is not supported by any facts or other data to show what issues relating to the allegations of a cover-up were not investigated. In fact, as the documentation of record shows, Dr. Christensen sent us letters which delineated the specific acts or omissions that he believed were attempts by management to cover-up the deaths and/or to obstruct justice. A comparison of our special inquiry report with Dr. Christensen's letters, shows that each and every act or omission identified by Dr. Christensen as evidence of a cover-up was thoroughly reviewed and investigated. Accordingly, any statement by GAO that the OIG did not conduct an investigation of the alleged cover-up is inconsistent with the facts and erroneous.

With respect to the specific allegation of criminal obstruction of justice, GAO was both informed during interviews and provided documentation to show that this issue was considered and addressed. As stated by GAO in its report, the FBI, who was fully aware of Dr. Christensen's allegations, concluded that the allegations were administrative not criminal in nature. In addition, the allegations, the evidence, and the relevant statutory and case law were reviewed by legal counsel and it was determined that the evidence would not support a criminal obstruction charge.

Although GAO is critical of the OIG special inquiry, it is noteworthy that GAO did not cite any statutes, cases or evidence to refute the OIG's conclusion that there was no "conclusive proof of an intentional cover-up by medical center and region officials" and "no evidence of criminal conduct by top management."

Of particular note is the fact that Dr. Christensen did not raise the issue of cover-up or obstruction of justice in interviews and discussions he had with the FBI and the

OIG in October 1992. Although he had the opportunity to do so, he did not come forward with these allegations until almost five months after he was interviewed by the FBI and the OIG as part of the investigation into the increase in deaths on Ward 4E. Although Dr. Christensen and others would like to believe there was an intentional cover-up or even criminal obstruction of justice, no one with knowledge of the facts in this case, including the FBI, the OIG, and GAO has found any evidence to support such charges.

It is also noteworthy that in January 1995, Dr. Christensen went to the media with allegations that the Medical Center Director was destroying documents relevant to the criminal investigation. He further indicated that he had previously raised allegations of a cover-up with the OIG. Immediately after learning of the allegation regarding the destruction of documents, OIG criminal investigators conducted an investigation. However, the allegations were quickly dismissed when Dr. Christensen admitted during his interview that the documents being destroyed were duplicates, not originals.

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