



**Department of
Veterans Affairs**

Office of Inspector General

SPECIAL INQUIRY

**CONDUCT ISSUE CONCERNING A VETERANS HEALTH
ADMINISTRATION PROGRAM OFFICIAL IN
VA CENTRAL OFFICE, WASHINGTON, DC**

**Report No. 8PR-A99-076
Date: March 16, 1998**

FULLY-REDACTED ELECTRONIC COPY FOR PUBLIC RELEASE



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

MAR 6 1998

TO: Chief Patient Care Services Officer (11)

SUBJECT: Conduct Issue Concerning a Veterans Health Administration Program
Official in VA Central Office, Washington, DC – Report No. 8PR-A99-076

1. The Department of Veterans Affairs (VA), Office of Inspector General (OIG) received allegations of inappropriate conduct by the Director, Blind Rehabilitation Service (BRS). We conducted an inquiry to determine the validity of an allegation that the Director of BRS repeatedly made inappropriate comments of a sexual nature to and about blind rehabilitation personnel.

2. We substantiated the allegations that the Director used insulting and obscene language in conversations about employees in his Service. The Director admitted to the practice of “talking trash [sex]” with those who broach such subjects with him. Discussing rumors about BR employees’ personal relationships, and engaging in sexually oriented conversations either in the office or at national program meetings or conventions fails to evidence the courtesy and respect expected among VA employees.

3. We recommended appropriate administrative action against the Director of BRS to ensure he refrains from spreading rumors and engaging in inappropriate sexually oriented conversations with VA employees in business settings in the future. You concurred with the finding in the report and agreed to take appropriate administrative action.

4. We will continue to follow-up until the administrative action is complete. Thank you for your cooperation in this sensitive matter.

/s/

JON A. WOODITCH

Assistant Inspector General for

Departmental Reviews and Management Support

Enclosure

SPECIAL INQUIRY
CONDUCT ISSUE CONCERNING
A VETERANS HEALTH ADMINISTRATION PROGRAM OFFICIAL

REPORT NUMBER SPR-A99-076

(Hotline No. (b)(2).....)

INTRODUCTION

Purpose

The Department of Veterans Affairs (VA), Office of Inspector General (OIG) conducted a special inquiry concerning allegations of inappropriate conduct by the Director, Blind Rehabilitation Service (BRS), at the Veterans Health Administration Central Office in Washington, DC. The purpose of the inquiry was to determine the validity of an allegation that the BRS Director, repeatedly made inappropriate comments of a sexual nature to and about blind rehabilitation personnel.

Background

VA's Blind Rehabilitation Program provides adjustment-to-blindness training, medical, physiological, social and financial counseling and assistance to eligible blind veterans. Ninety-two Visual Impairment Services Teams coordinate outpatient services at Medical Centers nationwide and in Puerto Rico. A team is comprised of the Coordinator, a Chairperson, and representatives from disciplines such as ophthalmology, audiology, speech pathology, and social work.

VA also has 5 Blind Rehabilitation (BR) Centers located throughout the country that provide comprehensive inpatient rehabilitation services. At the BR Centers, veterans receive training in orientation and mobility, manual skills, daily living skills and low vision skills designed to assist them in achieving a realistic level of independence and the ability to function as productive members of society. The BR Centers also provide Computer Access Training. BR staff assess the blinded veteran's need for adaptive computer related devices, prescribe equipment, and provide related training.

The Director, BRS is Mr. Don E. Garner, who has served in this capacity since 1980. Mr. Garner is responsible for developing blind rehabilitation program policies and initiatives for implementation throughout the VA health care system. Mr. Garner also provides direction and advice to staff at the BR Centers.

As the BRS Director, Mr. Garner participates in monthly conference calls with Medical Center service chiefs. He attends national service chief meetings, such as one held last April 1997 in Tucson, Arizona. He also participates and interacts with staff at Blinded Veterans Association Conferences.

Scope

We examined whether Mr. Garner repeatedly made sexual comments to and about various BR staff employed throughout the VA health care system as alleged by the complainant. We obtained a list of witnesses from the complainant, and interviewed those individuals identified as having first hand knowledge of Mr. Garner's comments.

We also interviewed other individuals as necessary to resolve the allegation. We took sworn, taped testimony from Mr. Garner and others in the Washington, DC area. We also conducted telephone interviews with witnesses outside Washington, DC. We reviewed personnel documentation and the results of related internal investigations. We also researched and applied current regulations, policies and case law as necessary during the review.

RESULTS AND RECOMMENDATION

Issue: The Conduct of a Veterans Health Administration Program Official in Allegedly Making Comments of a Sexual Nature about VA Employees.

Discussion

We substantiated that the Director, BRS, Mr. Garner, inappropriately spread rumors and engaged in sexually oriented conversations with and about some BR staff. Mr. Garner's actions constituted disrespectful conduct.

Witnesses told us Mr. Garner made inappropriate remarks of a sexual nature in business settings, sometimes in telephone conversations from his office, and sometimes following professional meetings or conferences at after-hour socials. The remarks included questions, speculation or rumors about co-workers' sexual affairs. The situations witnesses told us about were frequently one-on-one conversations, but sometimes involved 2 or more witnesses. The following describes examples of the behavior witnesses complained to us about during the review.

Mr. Garner testified that he heard a rumor about **(b)(6)**..... who was allegedly having an affair with a senior official of the Medical Center where she worked. He told us that he was concerned about the impact of the rumor, whether true or not, on the **(b)(6)**..... program. In short, Mr. Garner's position was that the alleged affair caused the perception that **(b)(6)**..... received favorable or preferential treatment from upper management because of the affair, thereby injuring the creditability of the service.

At the August 1996 Blinded Veterans of America (BVA) conference in New Orleans, Louisiana, Mr. Garner spoke with **(b)(6)**..... about this issue privately. We believe this conversation was a reasonable response to his concerns. However, Mr. Garner testified that he also discussed the rumor with one of **(b)(6)**..... subordinates with the hope that the employee could make **(b)(6)**..... understand what he was trying to do to resolve the situation. We questioned whether this action was necessary or appropriate.

Mr. Garner denied that he commented on the rumor publicly. Yet, two witnesses told us that he talked about the rumored relationship at a social gathering while attending the 1996 conference in New Orleans. Two other witnesses told us that they overheard Mr. Garner talking about the rumored relationship at an April 1997 Service Chiefs'

meeting in Tucson, Arizona. We were also told by two other VA officials that Mr. Garner asked them what they knew about the rumored relationship. Thus, six individuals, in addition to (b)(6)..... and the subordinate, heard Mr. Garner publicly discussing the rumor.

In our opinion, it does not appear that Mr. Garner took any action to determine whether there was any truth to the rumor in question. He provided no evidence whatsoever that would support that there was any truth to the rumor or that the rumor actually had a negative impact on the Service. Furthermore, by discussing the rumor with several other individuals, particularly in non-business settings, he may have done irreparable damage to the reputation of (b)(6)..... (and the other person) allegedly involved in an affair. In addition to the damage to (b)(6)..... personal reputation, the person's professional reputation may have been significantly damaged by the implication that the employee's professional accomplishments were attributable to favoritism or preferential treatment based on an alleged sexual relationship rather than abilities. The BR program was rife with such rumors and allegations about a number of individuals. As the program leader, Mr. Garner is responsible for setting an appropriate example. To the contrary, his misconduct set an example of inappropriate and possibly damaging behavior.

There are other examples of inappropriate speech of a sexual nature by Mr. Garner to or about other employees in the BRS which indicate that he engaged in a pattern of such misconduct. For example, a witness told us that, at the August 1995 BVA Convention in Washington, DC, Mr. Garner told a Visual Impairment Service Team (VIST) coordinator that, "If she sat on his lap,...how her star could really rise or his star would rise or something." According to the witness, the VIST coordinator protested with something like, "I don't think we will be doing that tonight." The woman to whom this statement was made was unwilling to pursue possible sexual harassment charges against Mr. Garner as the result of this statement. Mr. Garner testified that he may have jokingly made sexually suggestive remarks to this woman but that, prior to a work related rift in their relationship, such remarks were the kind of thing this woman would have said to Mr. Garner.

The VIST coordinator to whom the "rising star" comment was made told us that she disregarded Mr. Garner's sexual comments until the Fall of 1996 when he repeated a rumor about her allegedly having an affair with a Vet Center employee. Mr. Garner said that he did not remember making the statement about the woman having an affair with a Vet Center employee. Again, his testimony was contradicted by another witness who told us that he heard Mr. Garner, at the August 1996 New Orleans conference, say that the woman in question and a Vet Center employee were sleeping together.

Conclusion

Mr. Garner best summed up his behavior himself. He told us: "I talk trash [sex] with people that talk trash to me first.... If they come on talking – you know, I was in the Navy, I know a few four-letter words, I can do that back with them. But that would be where it would be, and not just go up and seek somebody out." Mr. Garner's admitted practice of "talking trash" with those who broach such subjects with him is not indicative of what should reasonably be expected of a VA Program Director. VA employees are expected to treat each other with courtesy and respect. Discussing rumors about BR employees' personal relationships, and engaging in sexually oriented conversations either in the office or at national program meetings or conventions fails to evidence that expected courtesy and respect.

We concluded that Mr. Garner's actions constituted disrespectful conduct. He used insulting and obscene language in conversations about employees in his Service. His actions have also had a negative impact on the morale in his Service.

Recommendation

We recommend the Chief Patient Care Services Officer take appropriate administrative action against Mr. Garner for the disrespectful conduct exhibited, and ensure he refrains from spreading rumors and engaging in inappropriate sexually oriented conversations with VA employees in business settings in the future.

Chief Patient Care Services Officer Comments:

The Chief Patient Care Services Officer concurs with the findings of this report and will take appropriate administrative action as we recommended. He expects to complete action on this matter by April 1, 1998. Attached is a copy of his response letter.

VA Office of Inspector General Comments:

With the Chief Patient Care Services Officer comments, we consider this case resolved. We will conduct timely follow-up of the administrative action.

Chief Patient Care Services Officer Comments



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

March 2, 1998

In Reply Refer To:

Michael L. Staley
Director, Hotline and
Special Inquiries Division
Department of Veterans Affairs
Office of Inspector General
Washington, D.C. 20420

Subject: Special Inquiry – Conduct Issue Concerning a Veterans Health
Administration Program Official – Project No. [REDACTED] (DRAFT
REPORT)

(b)(2)

1. I concur with the findings of the draft report. Based on the information presented in the draft, I plan to take appropriate administrative disciplinary action. I will defer a final judgement on the level of disciplinary action pending my review of the actual sworn statements of the witnesses to the events described in the report, and I expect to complete action on this matter by April 1, 1998.
2. If you have any questions, please contact my Executive Assistant, Greg Neuner, at 273-8474.

A handwritten signature in cursive script that reads "Thomas V. Holohan" followed by a stylized flourish.

Thomas V. Holohan, M.D., FACP

FINAL REPORT DISTRIBUTION

VA Distribution

Chief Patient Care Services Officer (11)
Management Review Service (10/105E)
DAS Congressional Liaison (60C), (Redacted)

Non-VA Distribution

Chairman, Senate Committee on Veterans' Affairs
Ranking Member, Senate Committee on Veterans' Affairs

Chairman, House Committee on Veterans' Affairs
Ranking Member, House Committee on Veterans' Affairs
Chairman, House Veterans' Affairs Subcommittee on Oversight and Investigations



**Department of Veterans Affairs
Office of Inspector General
Hotline and Special Inquiries Division (53E)
Post Office Box 50410
Washington, DC 20091-0410**

Phone: 1-800-488-8244

**Home Page: <http://www.va.gov/oig>
E-Mail: vaoig.hotline@forum.va.gov**
