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April 8, 2010

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

Re: OSC File No. DI-08-2379

Dear Mr. President:

The Office of Special Counsel (OSC) received disclosures from Jerri Bedell, a whistleblower, formerly employed as a Registered Nurse at the Department of Veterans Affairs (VA), VA Medical Center (VAMC), Geriatric Extended Care Unit, Prescott, Arizona. Ms. Bedell, who consented to the release of her name, alleged that patients were neglected and abused by medical staff. Ms. Bedell also contended that there were severe staffing shortages, unsafe conditions, unsanitary practices, and that employees falsified VAMC records. She asserted that the actions of these employees constituted a violation of law, rule, or regulation, gross mismanagement, an abuse of authority and a substantial and specific danger to public health and safety.

Ms. Bedell's allegations were referred to the Honorable James B. Peake, then-Secretary of the VA, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Honorable Eric K. Shinseki, Secretary of VA, submitted a report to this office on June 30, 2009. A supplemental report was received on September 1, 2009. Ms. Bedell provided comments on the reports pursuant to 5 U.S.C. § 1213(e)(1). As required by law, 5 U.S.C. § 1213(e)(3), OSC is now transmitting the reports and Ms. Bedell's comments to you.

The VA's Office of the Medical Inspector (OMI) investigated this matter. Ms. Bedell's allegations were substantiated in part. In its investigation, OMI concluded that patients received excessive amounts of laxatives, patient doses of narcotics were increased too rapidly in a few cases, there were insufficient housekeeping services, as well as difficulties in maintaining desired staffing ratios, and that medical errors were made by VAMC staff. OMI did not substantiate Ms. Bedell's allegations of patient abuse and neglect, an excessive use of catheters, falsification of documentation, unsanitary and unsafe conditions, and management officials' failure to respond to Ms. Bedell's concerns.

As a result of the investigation, the VA has revised the assessment and documentation process for patient admission, implemented safeguards to ensure appropriate administering and monitoring of narcotics, laxatives, and other medication, and provided additional training for medical staff. Moreover, a palliative care physician was engaged to review patient care at the

VAMC and to provide consultative services. Additionally, management officials and their designees will continue to monitor sanitation practices and report their findings to the VA's oversight committee for infection control.

In Ms. Bedell's comments, she expressed her belief that whistleblowers are not afforded adequate protection under the current system. She also conveyed her dissatisfaction with the OMI investigation. Ms. Bedell asserted that some of her witnesses were not contacted, she was not properly interviewed, there were errors in the investigation report, and the VA failed to hold medical staff accountable. Furthermore, Ms. Bedell does not believe the investigation was conducted in good faith.

We have reviewed the original disclosure, the agency's reports, and Ms. Bedell's comments. Based on that review, OSC has determined that the agency's reports contain all of the information required by statute, and the findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), we have sent copies of the agency's reports and Ms. Bedell's comments to the Chairman and Ranking Member of the Senate Committee on Veterans Affairs, and the Chairman and Ranking Member of the House Committee on Veterans Affairs. We have also filed copies of the agency's reports and Ms. Bedell's comments in our public file and closed the matter. OSC's public file is now available online at www.osc.gov.

Respectfully,

William E. Reukauf
Associate Special Counsel

Enclosures