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. <u>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.</u>" (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 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

Contents

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.

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.

See comment 1.

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

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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.]

Now on p. 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.]

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 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.

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.

See comment 2.

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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

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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 <u>to obtain</u> information about our review of his statistical analysis and the progress of the FBI/OIG criminal investigation of the deaths. He was <u>not</u> 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.

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."

Now on pp. 3 and 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.

See comment 12.

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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.i. 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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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. <u>A homicide investigation was not conducted, although local law enforcement authorities had jurisdiction.</u> 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.

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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.
Now on p. 9.

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. 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* . . ."

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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.

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