

FOIA Marker

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Counsel's Office, White House

Fielding, Fred - General Files

Stack:	Row:	Sect.:	Shelf:	Pos.:	FRC ID:	Location or Hollinger ID:	NARA Number:	OA Number:
W	19	23	3	2	11294	24157	10383	10821

Folder Title:

Office of Special Counsel Reports & Scott Bloch Issues [16]

Withdrawn/Redacted Material

The George W. Bush Library

DOCUMENT NO.	FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
001	Report	Analysis of Disclosures, Agency Investigation and Report...	8	N.D.	P6/b6; b7c;
002	Report	[Comments with attachments]	33	N.D.	P6/b6; b7c;
003	Report	Analysis of Disclosures, Agency Investigation and Report...	6	N.D.	P6/b6; b7c;
004	Letter	OSC File No. DI-06-1117 - To: Scott Bloch - From: Calvin Scovel	10	05/15/2007	P6/b6; b7c;
005	Letter	OSC File No. DI-06-1117 - To: Scott Bloch - From: Michael Dunkin	22	06/19/2007	P6/b6; b7c;

COLLECTION TITLE:

Counsel's Office, White House

SERIES:

Fielding, Fred - General Files

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11294

RESTRICTION CODES

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

Deed of Gift Restrictions

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006	Report	Analysis of Disclosure, Agency Investigation and Report...	8	N.D.	P6/b6; b7c;
007	Letter	[Response with attachment] - From: Valerie Taylor	6	06/01/2007	P6/b6; b7c;
008	Letter	OSC File No. DI-07-0929 - To: POTUS - From: Scott Bloch	2	12/12/2007	P6/b6; b7c;
009	Letter	[Comments with attachments] - To: Edward Flood	10	10/03/2007	P6/b6; b7c;
010	Report	OSC File Number DI-07-0929	8	N.D.	P6/b6; b7c;

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U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

April 10, 2007

The Honorable Fred Fielding
Counsel to the President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-06-0782

Dear Mr. Fielding:

Pursuant to 5 U.S.C. § 1213(e)(3), I am transmitting the enclosed letter, report, and comments to the President. If I may provide more information concerning this matter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to be "Scott J. Bloch".

Scott J. Bloch

Enclosures



U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

April 10, 2007

The President
The White House
Washington, DC 20500

Re: OSC File Nos. DI-06-0782

Dear Mr. President:

I received disclosures from Richard Conrad, a whistleblower at the Department of the Navy, Naval Air Depot (NADEP), North Island (NI), California. Mr. Conrad, Electronic Mechanic Journeyman, alleged that artisans working on generator conversion units (GCUs) for F/A-18 fighter aircraft did not have the necessary torque tools required to properly torque the screws used to assemble the GCUs. Mr. Conrad further alleged that, although GCU Shop artisans finally received torque tools in July 2005, the GCU screws on hundreds of F/A-18s currently deployed by the U.S. military still have not been properly torqued. Because GCUs provide electrical power to the aircraft, Mr. Conrad contended that GCU failure could have catastrophic consequences. An agency investigation substantiated Mr. Conrad's allegations, and the Navy has taken corrective action to ensure that all GCU Shop artisans are currently using proper torque tools on GCU screws. Nevertheless, the Navy has decided against pursuing disciplinary action against any individuals for the violations. For the reasons discussed in the Analysis of Disclosures, OSC finds that the agency's decision to refrain from disciplining any of the GCU Shop managers is unreasonable. Our military cannot afford to take unnecessary risks with its fleet of F/A-18 fighter jets while we are a nation at war. Thus, it is critical that the Navy hold the individuals who are responsible for this serious lapse in aircraft maintenance accountable.

I required the Honorable Donald C. Winter, Secretary of the Navy, to conduct an investigation into the whistleblower's disclosures pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary subsequently submitted a report to this office. Mr. Conrad provided comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1). As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the report to you.

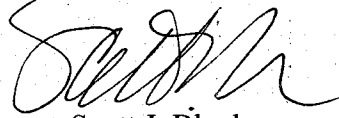
Based on the representations made in the agency report and Mr. Conrad's comments, I have determined that the agency report contains all of the information required by statute; however, I am unable to find that all of the agency's findings are reasonable. Specifically, I find that the agency's decision to refrain from taking disciplinary action against any GCU Shop managers is unreasonable. As required by § 1213(e)(3), I have sent a copy of the report and Mr. Conrad's comments to the Chairmen of the Senate and House Committees on Armed

The Special Counsel

The President
Page 2

Services. We have also filed a copy of the report and the whistleblower's comments in our public file and closed the matter.

Respectfully,

A handwritten signature in black ink, appearing to read 'Scott J. Bloch', written in a cursive style.

Scott J. Bloch

Enclosures

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Counsel's Office, White House

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Fielding, Fred - General Files

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FRC ID:

11294

OA Num.:

10821

NARA Num.:

10383

FOIA ID and Segment:

2014-0210-F

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

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U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

January 8, 2008

The Honorable Fred F. Fielding
Counsel to the President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-06-1117

Dear Mr. Fielding:

Pursuant to 5 U.S.C. § 1213(e)(3), I am transmitting the enclosed letter, report and comments to the President. If I may provide more information concerning this matter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "SJBloch".

Scott J. Bloch

Enclosure



U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

January 8, 2008

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

Re: OSC File No. DI-06-1117

Dear Mr. President:

I received a disclosure from Mr. Michael Dunkin, a former Avionics Technician, Department of Transportation, Federal Aviation Administration (FAA), Aviation System Standards 300 (AVN 300), Technical Operations Service Unit, Oklahoma City, Oklahoma and Anchorage, Alaska. Mr. Dunkin, who consented to the release of his name, disclosed to OSC that managers at the Federal Aviation Administration (FAA), purposely failed to record chronic aircraft equipment problems in the Inventory, Logistics, and Maintenance (ILM) database.

I required the Secretary of Transportation to conduct an investigation into these disclosures pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary tasked the Office of the Inspector General with conducting the investigation and writing the report. The report's findings are discussed further in the attached Analysis.

Mr. Dunkin alleged that managers did not record these problems because, once recorded, the aircraft would be grounded for maintenance and unavailable for flights. He alleged that management operated in this manner because aircraft availability is a standard used to evaluate management performance. Mr. Dunkin believed that allowing aircraft with equipment problems to fly unnecessarily placed the aircraft and crew in substantial danger and violated Federal Aviation Regulations. He also alleged that Dan Murphy, Airframe and Powerplant Mechanic, used FAA equipment and facilities for his own personal benefit in violation of federal regulations. The Department of Transportation's investigation, conducted by the Office of the Inspector General, did not substantiate the allegations. OSC's analysis of the whistleblower's disclosures, the agency's report and the whistleblower's comments are enclosed.

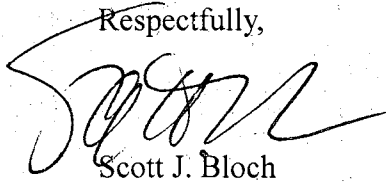
The Special Counsel

The President
Page 2

I have reviewed the original disclosures and the agency's report. Based on that review, I have determined that the agency's report contains all of the information required by statute and that its findings appear to be reasonable.

As required by law, 5 U.S.C. § 1213(e)(3), I have sent a copy of the agency report to the Chairmen of the Senate Committee on Commerce, Science and Transportation and the House Committee on Transportation and Infrastructure. I have also filed a copy of the report and the whistleblower's comments in our public file and closed the matter.

Respectfully,

A handwritten signature in black ink, appearing to read 'Scott J. Bloch', is written over the typed name.

Scott J. Bloch

Enclosures

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**U.S. OFFICE OF SPECIAL COUNSEL**1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505*Janeen
Flood
Burch* ✓**FACSIMILE COVER SHEET****TO:**

Name: The Honorable Fred Fielding	
Title: Counsel to the President	
Organization: The White House	
Office / Location: Washington, DC 20500	
Telephone: (202) 456-1414	Fax: (202) 456-6279

FROM:

Name: The Honorable Scott Bloch	
Organization: U.S. Office of Special Counsel	
Office / Location: Washington	
Telephone: (202) 254-3625	Fax: (202) 653-5151

Date: December 13, 2007	Number of pages, including this cover sheet: 12
--------------------------------	--

Message: Original, including enclosures, to follow by Federal Express delivery.
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U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

December 13, 2007

The Honorable Fred Fielding
Counsel to the President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-06-2205

Dear Mr. Fielding:

Pursuant to 5 U.S.C. § 1213(e)(3), I am transmitting the enclosed letter, reports, and comments to the President. If I may provide more information concerning this matter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Bloch".

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Re: OSC File No. DI-06-2205

Dear Mr. President:

I received disclosures from Valerie Taylor, a whistleblower at the Department of Veterans Affairs (VA), Michael E. DeBakey VA Medical Center (VAMC), Houston, Texas. Ms. Taylor, who consented to the release of her name, alleged that the nurses in the VAMC's inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. Ms. Taylor stated that the VAMC eliminated the Nursing Administrative Officer of the Day (AOD), who used to provide valuable on-site clinical and administrative assistance to the nursing staff during off-tour hours. Under the present arrangement, the nursing staff must now contact an on-call Nurse Manager at home for guidance and nursing advice during off-tour hours. Because the Nurse Managers provide nursing advice over the telephone, without examining the patient firsthand, Ms. Taylor contended that there is a high risk of medical error.

As discussed in the attached report, an agency investigation did not substantiate Ms. Taylor's allegations. The agency concluded that the VAMC's decision to eliminate the AOD position has created administrative and staffing problems and has led to low morale among the nursing staff. However, the agency did not find that the new policy posed a danger to the health or safety of the VAMC patients. Nevertheless, at OSC's request, the VA has agreed to re-evaluate the policy and to reconsider the potential health and safety ramifications of the policy.

I required the Honorable James Nicholson, former Secretary of Veterans Affairs, to conduct an investigation into the whistleblower's disclosures pursuant to 5 U.S.C. § 1213(c) and (d). The Under Secretary for Health subsequently submitted a report to this office. Ms. Taylor provided comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1); her comments are attached. As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the report to you.

Based on the representations made in the agency reports and Ms. Taylor's comments, I have determined that the agency reports contain all of the information required by statute and the findings appear to be reasonable. As required by § 1213(e)(3), I have sent a copy of the reports and Ms. Taylor's comments to the Chairmen of the Senate and House Committees on Veterans'

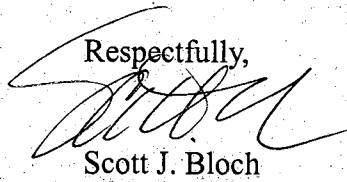
The Special Counsel

The President

Page 2

Affairs. We have also filed a copy of the reports and the whistleblower's comments in our public file and closed the matter.

Respectfully,

A handwritten signature in black ink, appearing to read "Scott J. Bloch", written over the word "Respectfully,".

Scott J. Bloch

Enclosures

Withdrawal Marker

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Report	Analysis of Disclosure, Agency Investigation and Report...	8	N.D.	P6/b6; b7c;

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FOLDER TITLE:

Office of Special Counsel Reports & Scott Bloch Issues [16]

FRC ID:

11294

OA Num.:

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NARA Num.:

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2014-0210-F

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- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

APR 13 2007

Mr. Scott J. Bloch
U.S. Office of Special Counsel
1730 M Street, N.W. Suite 300
Washington, DC 20036-4505

Dear Mr. Bloch:

Enclosed is the Department of Veterans Affairs (VA) report in response to your request of December 19, 2006, to investigate allegations of inadequate nursing supervision at the VA Medical Center, Houston, Texas, by a registered nurse, Ms. Valerie Taylor (Office of Special Counsel File Number DI-06-2205). The Secretary of Veterans Affairs has directed me to review and sign this agency report and to take any actions deemed necessary under 5 U.S.C § 1213 (d)(5).

Upon receipt of your letter, I tasked the Office of the Medical Inspector (OMI) to conduct a site visit to the Medical Center and review the issues related to the complaint. The OMI findings are set forth in the enclosed report. The OMI did not substantiate the allegations of the complainant; however, areas of improvement were identified and are outlined in the report. These have been discussed with the Medical Center Director and Chief Nurse Executive, and an action plan is being developed to address the findings.

If you have any questions about the content of the report, please have a member of your staff contact Mr. Terry A. Morrow, FACHE, Director, Operations and Administration Staff, Management Support Office, at (202) 273-8887.

Sincerely yours,

Michael J. Kussman, M.D.
Michael J. Kussman, MD, MS, MACP
Acting Under Secretary for Health

Enclosure

**Report of Investigation to the U.S. Office of Special Counsel
OSC File Number DI-06-2205**

The Office of the Medical Inspector (OMI) was asked by the Acting Under Secretary for Health to review a complaint lodged with the Office of Special Counsel (OSC) by a registered nurse (RN) employed at the Michael E. DeBakey Veteran Administration Medical Center, Houston, TX (hereafter the Medical Center). The complainant, a Nurse Manager on a mental health inpatient unit, raised allegations concerning the health and safety of patients at the Medical Center. More specifically, the complainant alleges:

1. Nurses on the Medical Center's inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. The Nursing Administrative Officers of the Day (AOD), (known in many hospitals as the evening and night nurse supervisor), no longer work on site during off-tour hours¹; these positions have been abolished. The nursing staff must now contact an on-call Nurse Manager² for guidance and medical advice.
2. The policy, initiated in January 2006, eliminating the AOD on off-tours hours, requires the on-call Nurse Manager to provide medical advice over the phone without examining the patient firsthand. The complainant contends there is a high risk of misdiagnosis or medical error.
3. The Texas Board of Nurse Examiners indicates that the Nurse Managers are jeopardizing their nursing licenses by providing clinical advice in this manner.
4. The on-call Nurse Managers provide supervision and medical advice over the phone because nursing staff do not have anyone else to consult. Residents are available in the emergency room during off-tour hours, but they are unfamiliar with the rules, procedures, and policies of the VAMC.
5. The absence of Nurse AODs during off-tour hours hinders the Medical Center's ability to thoroughly investigate medical emergencies that arise at such times. The complainant asserts that Nurse Managers have to investigate these events during their normal day shift, relying exclusively on second-hand information. She reports this time delay compromises the integrity and accuracy of the evidence they gather.

Facility Profile

The Medical Center operates 355 hospital beds; there is an additional 40-bed Spinal Cord Injury Center and 120-bed unit for long-term care. The Medical Center employs over 3,000 people. It has a large number of training programs, with over 1,000 students and 580 residents rotating through annually; from over 85 affiliate schools in 13 states.

¹ Off tour hours are hours worked during evenings, nights, weekends and holidays.

² Each nursing unit, inpatient or outpatient, generally has its own RN Nurse Manager who is clinically and administratively responsible for the unit.

The Medical Center is home to a Post Traumatic Stress Disorder Clinic; a regional Polytrauma Center; a Cardiac Surgery Program; and one of VA's six Parkinson's Disease Research, Education, and Clinical Centers. Including its satellite clinics in Beaumont, Lufkin, Galveston, and Texas City, the Medical Center logged more than 800,000 outpatient visits in fiscal year 2006. It provides care to about 137,000 veterans in its primary service area.

A member of the Veterans Integrated Service Network (VISN) 16, the current Medical Center facility was built in 1991 on a 118-acre campus in Houston; it is fully accredited by JCAHO and CARF and was awarded Magnet Recognition for Excellence in Nursing Services by the American Nurses Credentialing Center (ANCC) in August 2004. It hosts a research program with over \$17 million in annual support. The Medical Center has continued to lend support to veterans displaced by Hurricane Katrina and to sister VA facilities in the Louisiana and Mississippi regions.

Methods for Conducting the Investigation

The OMI notified the Medical Center Director of the complaint and of its plans for a January 8-9, 2007 site visit. The Chief Nurse Executive and her staff coordinated the visit. The OMI team consisted of the Medical Inspector (a physician), the OMI clinical psychologist, and an OMI investigator (a nurse practitioner), all from Veteran Affairs Central Office, in Washington, DC. The OMI team received full cooperation from the Medical Center staff as it conducted individual and group interviews, and reviewed both policy and patient care documents.

Entrance and exit conferences were held with the Medical Center leadership. The team interviewed the Director, the Chief Nurse Executive, the Chief of Staff, and the complainant. Group interviews were conducted with the Associate Chief Nurse and all 5 Care Line Nurse Executives, 6 of the previous Nursing AODs, 22 of the Medical Center's 35 Nurse Managers, over 32 Charge Nurses³ from the evening and night shifts, 4 Care Line Executives, and 11 resident physicians who were in various post graduate years of training.

The OMI reviewed the patient medical records of the cases provided by the complainant, the minutes from Nurse Manager Council meetings, nursing functional statements (job descriptions), resident physician call schedules, nursing policy and other documents relating to development of the new policy on the Nursing AOD, nursing surveys, and salary dollars expended on the previous Nursing AOD positions.

Documents Reviewed:

- *The Administrative Officer of the Day Reorganization Workgroup Report (May 5, 2005)*

³ Charge nurses are staff RNs that have, in addition to patient care assignments, administrative/ supervisory duties during a shift.

- Position descriptions for the Nursing AOD, the Nurse Manager, and the Clinical Practice Manager
- Resident physician on-call schedules for the four most recent months
- A White Paper on the issue by the Chief Nurse Executive
- Salary dollars expended in FY2005 for the Nursing AOD positions
- Nurse Manager Council minutes for 2005
- The *AOD/NOD Survey Medical Group 7 and VISN 16*
- A review of how other VAMCs (300 operating beds) operate without Nursing Supervisors
- Two patient medical records
- The Staff Nurse and Nurse Manager surveys of January 2006
- *Nursing Practice Act, Nursing Peer Review & Nurse Licensure Compact of the Texas Occupations Code and Statutes Regulating the Practice of Nursing, as amended September 2005, Section 301.002*. Retrieved from <http://www.bne.state.tx.us/nursinglaw/npa.html>, on January 25, 2007.

Background

Historically, there were two positions in the Medical Center during off-hour hours (weekdays 4:30 pm to 8:00 am, weekends and holidays) that had some overlapping duties. The Nursing AOD's duties included both clinical and administrative functions, many of which, according to the Medical Center, could be performed by non-nursing administrative personnel. The second position is the Medical Administrative Assistant (MAA). The primary function of the MAA is to coordinate and implement administrative activities facility-wide. Over time it was determined that the Nursing AOD role had evolved into that of administrative facilitator as well as clinical expert. The Nurse AOD was generally a senior experienced nurse with significant inpatient and/or critical care experience. Clinical duties performed by the Nursing AOD included managing narcotics exchanges between units (borrowing), helping manage emergencies by responding to Code Blue (medical) and Code Green (psychiatric) emergency situations, managing 'medical clearance' for mental health admissions, initiation and management of a disaster cascade to include leadership notifications, providing 'expert' nursing guidance on clinical and ethical issues, accessing blood bank personnel and requests for blood, management of operating room deaths, and, maybe most importantly, acting as a seasoned clinical nursing resource for staff nurses when guidance, advice or decision making was needed. The administrative issues handled by the Nursing AOD involved facilitating patient transfer, securing beds for patient admissions and resources from community hospitals as needed, granting leave, providing computer password codes, clearing electronic signatures, opening secured doors, and transporting supplies. The MAA identifies available beds for patient admissions, inter and intra-VA facility and community transfers, secures patient funds, provides decedent-affairs activities, and secures resources from community hospitals as needed.

The genesis of the changes affecting the nursing AOD position appears in a January 7, 2005 memorandum from the Chief Nurse Executive and the Business Office Service Line Executive. It was clear from this document that the Clinical

Practice Office (nursing office) and the Business Office had “partnered together” to reorganize the Nursing AOD positions through conversion of the positions to non-patient care nursing positions “in which funding are [is] not available given the cost efficiency measures associated with the budget.” A recommendation was made to form a redesign workgroup, although the decision to abolish the Nursing AOD role was made in January 2005.

In a partnership between the Clinical Practice Office (Nursing Service Office) and the Business Office Service Line, a multidisciplinary Nursing AOD Work group met from February – May 2005 with the overall focus of reorganizing/redesigning the Nursing AOD position. The major goal for the change was the reallocation of FTEE salary dollars for the creation of four new Clinical Practice Manager roles within the Clinical Practice Office. These positions are responsible to the Associate Chief Nurse and their primary responsibility is to direct “...practice according to established policies, standards of care, and standards of practice” (Criteria Based Functional Statement, Clinical Practice Manager, Nurse III).

The MAA is still present during off-tour hours. Since the policy change, staff nurses must go to their Charge Nurse for staffing, administrative, or nursing care issues during off-tours. If the Charge Nurse is unable to solve the problem, the Nurse Manager is called at home. Nurse Managers are now ultimately responsible for issues arising in their units during off-tour hours and are now on-call 24/7 to accommodate these additional responsibilities.

There is no agreed-upon industry standard for providing supervisory coverage during off-tour hours. A look at how other facilities handled this issue through the AOD/NOD Survey Medical Group 7 and VISN 16 revealed that of six hospitals reporting, five employ an AOD from the business office and a Nursing AOD or nursing supervisor for off-tour hours. One hospital (120 beds) reported only an AOD (Business Office) and a full-time RN Staffing Coordinator. A like-sized VA Medical Center eliminated their Nursing AOD roles, but employs a hospital wide “acute side” Charge Nurse (without any patient assignments) during off-tour hours. In addition they have a separate staffing pool of intermittent on-call employees and a staffing agency when needed. The Nurse Managers are on call but this is rotated and they receive on-call pay. They report no mandatory overtime. While there are recommendations for the number of nurses needed on specialty units (for example, acute medical and surgical wards), these would be developed at the Medical Center or VISN (Veterans Integrated Service Network) level. The need for supervisory nurses to cover evenings, nights, weekends and holidays is a decision based upon the unique needs and policies of the Medical Center.

Findings

The OMI team interviewed the complainant, who has 22 years experience as an RN, and 9 years as a Nurse Manager, in both the private sector and during her 5 years with VA. The OMI was able to talk with the complainant during our visit on two more occasions to obtain clarification and seek additional information. Issues raised included the lack of compensation for Nurse Managers taking regular on-call duties; the potential for adverse

incidents when Charge Nurses have to manage staffing and patient flow problems while continuing their patient care duties; increase in overtime; short staffing; and decreased nursing morale. The complainant admitted that Nurse Managers do not give medical advice nor diagnose over the phone, but are solicited on-call for nursing advice, staffing, patient flow, and administrative issues. The complainant has conducted a year-long campaign for re-evaluation of the abolition of the Nursing AOD role.

When asked for specific patient care events that occurred secondary to the new policy the complainant provided two patient incidents that she related to this change in policy. The OMI reviewed these events and found that both events occurred within the month prior to the implementation of the new Nursing AOD policy in January 2006. The OMI advised the complainant about the mistiming of these events. Regarding resident physicians, there were no incidents reported regarding a compromise of patient safety and the lack of resident knowledge about the policies and procedures of the VAMC.

An interview with the Chief Nurse Executive revealed that she accepted her position about 3 months after implementation of the January 2006 policy to abolish the Nursing AOD role. She reports that a multidisciplinary committee provided guidance and received feedback on the policy, prior to implementation. Many former duties of the Nursing AOD were allocated to the MAA, the Nurse Managers, or Security. The Nurse Education Office reported preliminary results of a ten-question survey of staff nurses and nurse managers, given in January 2006 and repeated in April and August 2006; although the response rates were low (in one survey, three NMs responded) and findings inconclusive. While the Clinical Practice Office reported overall positive responses for nursing satisfaction on the 2006 All Employee Survey, they provided OMI the results for their 22 separate nursing units. A collated roll-up of the data for generalization to all nurses in the Medical Center was not provided.

An interview was conducted with the five Care Line Nurse Executives; also in attendance was the Associate Chief Nurse. All concurred with the value of the previous Nursing AOD role, and there was little response when asked whether the new policy was working. They spoke of the adaptations some Care Lines had made to compensate for the gaps in off-tour coverage. Some have hired Care Line bed control/flow coordinators and some have shifted their RN staffing to enhance off-tours. The Extended Care Unit provided their Nurse Managers with cell phones to replace pagers. There were some issues with Code Green (psychiatric) and Code Blue (medical) emergencies as the Nursing AOD had attended all codes. A Code Green requires the attendance of a mental health RN and a Code Blue requires a critical care RN. These episodes have the potential to critically reduce staff in the Mental Health Unit and ICU's, as both have a greater population of patients requiring one-on-one care. Previously, the Nursing AOD would have solved issues with the movement of staff from one unit to another to accommodate temporary staffing losses. However, no specific adverse incidents were identified when we queried the Care Line Nurse Executives, nor was there specific data provided to the OMI that outcomes had been affected.

While it was stated by the Care Line Nurse Executives during interviews that the role of Nurse Manager was a 24 hours per day, 7 days a week job, the OMI could not find

documentation to support this requirement in the Medical Center's functional statement for this position. The OMI team reviewed the Medical Center's *Criteria Based Functional Statement, Nurse Manager* and *VA Handbook 5007, Part III, Chapter 8: Higher rates of pay for assignment as head nurse or possession of specialized skills* and did not locate this stipulation. The OMI requested confirmatory information regarding this role requirement from the Clinical Practice Office (Nursing Service Office) on January 24, 2007 and received this clarification: "The functional statement for the NM under Leadership #1 for Nurse II and III- states: Demonstrates knowledge of scope of practice and RN accountability in assignment, delegation and supervision of staff." They expressed that this "implies 24 hr. accountability."

The OMI interviewed 22 Nurse Managers. Within this animated group their consensus opinion was that the abolition of the Nursing AOD role imposed an additional burden upon both the nursing staff and the Nurse Managers. The Nurse Managers agreed that this change has resulted in many nights of interrupted sleep and problem solving, either by telephone or their presence on the unit. Most units have one Nurse Manager and have arranged to share the call schedule with Nurse Managers of other inpatient units within their Care Lines. Presently, the Nurse Managers, after working their normal tour, are on-call on a rotational basis and are frequently consulted. While on call, Nurse Managers may need to converse with staff, residents, the MAA, the Nurse Care Line Executive or patient families. The Nurse Managers felt the Nursing AOD had provided expert nursing oversight for the Medical Center and was viewed as a valuable resource for staffing, bed control, medical emergencies (cardiac/respiratory arrest), supply access, patient and family advocacy, and nursing advice. The Nursing AOD was a valuable resource during an emergency code situation. While the resident or attending physician assigned to the code team would be in charge of conducting the code and medical decision making, the Nursing AOD provided an extra pair of experienced hands, as well as expert guidance in ensuring the coordinated flow of persons and activities. This may include documentation, location of drugs and supplies, assisting staff, accessing pertinent patient data and patient transfer. Despite their concerns about a possible adverse affect on patient care, they were unable to give any specific examples of an untoward effect on an individual veteran.

Without the Nursing AOD, many Nurse Managers said they were functioning in "crisis mode" and, "that there is no one in the house that looks at the whole picture," ... "no one can move people around" to accommodate short staffing. The Nurse Managers do not receive compensation for these additional on-call duties nor for coming in to manage issues needing their physical presence.

The OMI interviewed six nurses who previously occupied the Nursing AOD role. They were experienced nurses, most with a critical-care background, who are able to solve staffing, supply, bed availability, manage healthcare emergencies and other problems with ease. Most had been a Nursing AOD for 10 or more years. They concurred with others interviewed regarding the global outlook of the Nurse AOD and reported that their effectiveness and efficiency was often a result of the historical authority implicit in their role. They had resources for staffing and were able to resolve bed availability concerns, acted as resource persons during a cardiac or respiratory arrest, and had staffing pools

they tapped when necessary. They reported that, as a group, they felt they were not consulted about the policy proposal, but were instead simply informed of the change.

The OMI interviewed over 30 Charge Nurses, meeting separately with the night and evening shifts. They report low morale in their group because of the Nursing AOD change. They note difficulty in patient transfers to the intensive care units (ICU), difficulty staffing, increased workload burden, and they are unclear about the new policy rationale. Charge or staff nurses contact the Nurse Manager for nursing advice; they contact a resident or attending physician for medical advice. When asked, nearly all stated they would not seek a Nurse Manager role, because of the additional, uncompensated burden and stress. They report increased required overtime, but note they may not call it mandatory overtime, as mandatory overtime is discouraged in a Nursing Magnet status hospital. Some are now required to report 30 minutes earlier (unpaid) to accommodate these additional duties. An incident was reported anonymously of a Charge Nurse being required to stay with a Code Blue patient for 3 hours, during which time she was unable to care for her normal panel of patients, while attempts were made to get an ICU bed. The burden of care for her patients fell on the other staff nurses within the unit. Another anonymous report alleged that a veteran's spouse had died in courtesy quarters and that there was no one to wrap and care for the body, as the MAA was unable to perform this task. We were advised that the facility investigated this incident. The Charge Nurses agreed that a Nursing AOD would have facilitated both events.

The OMI met with four Care Line Directors to discuss the impact of the policy. There was general consensus that the new policy has hindered communications, hand-off or transfer of patients to personnel on the next shift, access to supplies and the operating rooms, and decreased efficiency in Codes Blue and Green situations during off tour hours. The Nursing AOD often acted as the process expert in a Code situation; lending knowledge and expertise and acting as a supply resource person or substitute staff member. They sense decreased morale in Nurse Managers and Charge Nurses. They also agreed, like others, about the benefits of the Nursing AOD role; however they thought the functions of the Nursing AOD might also be handled in some other way. One Care Line has hired a patient flow coordinator. They report the Clinical Executive Board had little input opportunity prior to approval of the policy.

The OMI interviewed 11 resident physicians who were at various post graduate years of training. Most were surgical residents and only two were present prior to the implementation of the new policy, so there was little recollection of the previous process. They all noted an increased patient workload due to the patient volume effect from Hurricane Katrina. Because of the large resident physician population, we discovered that units are covered at all times by a specialty resident or attending physician who is available in person, by pager or telephone. Resident physicians receive an orientation to the VAMC regarding the rules, policies and procedures within the VA system.

A telephone interview was conducted with two consultants from the Practice Issues Section of the Texas Board of Nurse Examiners (BNE) on January 24, 2007.

The Texas Occupations Code and Statutes Regulating the Practice of Nursing, As Amended September 2005, <http://www.bne.state.tx.us/nursinglaw/npa.html> (retrieved January 25, 2007), Sec. 301.002 (2) and (5) defines "Professional Nursing" as,

The performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include actions of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves: (A) the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes; ... (E) the administration, supervision, and evaluation of nursing practices, policies, and procedures;

The Texas BNE Practice Issue consultants concurred there was no threat to a Nurse Manager's (RN) licensure when providing supervisory advice over the phone to staff nurses within her unit if this process remains within the scope of nursing activities (described under the nursing standards for the nurse's state of licensure).

Conclusions

Allegation #1: Nurses on the Medical Center's inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. The Nursing Administrative Officers of the Day (AOD) (known in many hospitals as the evening and night nurse supervisor), no longer work on site during off-tour hours: these positions have been abolished. The nursing staff must now contact an on call Nurse Manager for guidance and medical advice.

OMI Conclusion: The OMI found that the Nurse Administrative Officer of the Day (AOD) positions had been abolished and were, therefore, no longer on site and that the Nurse Managers are on-call as indicated by the complainant. The OMI found that the nurses on the inpatient units do have adequate supervision; however, these arrangements have taken a toll on the Nurse Managers. The OMI did find that most Nurse Managers and Charge Nurses felt the Nursing AOD had provided a 'safety net' over the entire Medical Center and this person had a 'global view' of the Medical Center, allowing for better, faster and more efficient problem solving. Many nurses perceive the absence of the Nurse AOD on off tours as the loss of a valued nursing resource, guide and emergency manager. However, the OMI found no specific examples of harm to patients nor was the OMI shown any data to demonstrate evidence of poor outcomes.

Allegation #2: The policy, initiated in January 2006, eliminating the AOD during off-tours hours, requires the on call Nurse Manager to provide medical advice over the phone without examining the patient firsthand. The complainant contends there is a high risk of misdiagnosis or medical error.

OMI Conclusion: Nurse Managers are not providing medical advice or diagnosis over the phone. Nurses contact resident or attending physicians when patients require medical attention. We found no evidence of any 'medical' error occurring as a result of this policy change, although the OMI feels the heightened vigilance of nursing staff has possibly prevented adverse events.

Allegation #3 The Texas Board of Nurse Examiners indicates that the Nurse Managers are jeopardizing their nursing licenses by providing clinical advice in this manner.

OMI Conclusion: The OMI found no evidence to suggest that RNs at this Medical Center, in the role of Nurse Managers, are providing advice prohibited by the *Texas Nursing Practice Act*, as outlined in *The Texas Occupations Code and Statutes Regulating the Practice of Nursing, As Amended September 2005*, Sec. 301.002 (2) and (5) <http://www.bne.state.tx.us/nursinglaw/npa.html> (retrieved January 25, 2007).

Allegation #4: The on-call Nurse Managers provide supervision and medical advice over the phone because nursing staff do not have anyone else to consult. Residents are available in the emergency room during off tour hours, but they are unfamiliar with the rules, procedures, and policies of the VAMC.

OMI Conclusion: The OMI found that Nurse Managers do not provide medical advice over the phone; they do provide nursing advice. Resident and attending physicians are available to address the medical needs of the patients 24 hours a day. Many resident physicians are in the hospital during off-tour hours while others may take call from home. There are in fact no resident physicians assigned to the emergency room on a regular basis; however, they may occasionally be present in the emergency room to answer a consultation for their service. Residents receive orientation to the rules, procedures and policies of the VAMC, and there was no evidence to suggest that adverse events were caused by a lack of this knowledge.

Allegation #5: The absence of Nursing AODs during off-tours hinders the Medical Center's ability to thoroughly investigate medical emergencies that arise at such times. The complainant asserts that Nurse Managers have to investigate these events during their normal day shift, relying exclusively on second-hand information. She reports this time delay compromises the integrity and accuracy of the evidence they gather.

OMI Conclusion: The OMI did not determine that there was any compromise to the integrity or accuracy of the reporting of serious medical events or medical emergencies. It was determined that staff nurses and charge nurses are responsible for completing reports on any medical situations or occurrences during their duty time. None of those interviewed could recall any problems with these reports and the complainant could not site any such problems.

In summary, the OMI did not substantiate the allegations made by the complainant. No violation of clinical practice or apparent violation of any law, rule, or regulation was found. The OMI did not find any evidence to suggest that this change in policy poses a substantial and specific danger to the health and safety of patients.

The OMI did discover that the nature of the duties and responsibilities of the Nursing AOD role allowed this individual a "global view" of a large, complex hospital system. These experienced clinicians provided a "safety net" for nursing staff, facilitated processes on off-tours and holidays, and managed many multidisciplinary issues, all contributing to the safety and well-being of veteran patients. These responsibilities now fall on the shoulders of the unit Nurse Manager and Charge RNs.

Recommendation

The OMI recommends that the Medical Center take a critical and formal approach to reviewing the policy to abolish the Nursing AOD role considering its impact on patient safety and employee satisfaction.



**DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420**

OCT 09 2007

The Honorable Scott J. Bloch
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW
Suite 300
Washington, DC 20036-4505

Dear Mr. Bloch:

I am providing further information regarding the Department of Veterans Affairs (VA), Veterans Health Administration's (VHA) planned follow-up actions in response to the one recommendation in VA's report submitted in connection with Office of Special Counsel File Number DI-06-2205. As you will recall, that recommendation directed the facility to "... take a critical and formal approach to reviewing the policy to abolish the Nursing Administrative Officer of the Day (AOD) role considering its impact on patient safety and employee satisfaction." Subsequent to our submission of VA's report, your office communicated its concerns regarding the adequacy of VHA's response and action plan to carry out that recommendation.

While the Office of the Medical Inspector report did not identify clinical, safety issues or adverse events resulting from the policy change, VHA identified administrative concerns related to staffing which have arisen due to the current policy, e.g., seriously low morale among affected nursing staff. I recognize that these issues have the potential to lead to negative outcomes; thus, the facility will be required to re-evaluate whether the administrative concerns caused by implementation of the policy (as identified by the Medical Inspector) will create any risk to patient safety or adversely affect or compromise the quality of care provided to patients. In other words, although the AOD was not providing nursing services and was administrative in function, we will determine whether the lack of AOD involvement interferes with the furnishing of needed nursing care.

I assure you that VHA uses a stringent performance management program evaluating hundreds of clinical measures on an ongoing basis to ensure we maintain the highest quality of care. Issues that could result in any denigration of care are taken very seriously and addressed quickly.

To date, the facility has submitted a request to the Organization Excellence Board (OEB) for re-evaluation of the nursing AOD role redesign. The

Page 2

The Honorable Scott J. Bloch

Associate Director for Patient/Nursing Services met with the Performance Improvement Coordinator who is organizing a group of multidisciplinary team members to interview doctors, nurses, administrative officers and stakeholders as an initial step in the re-evaluation process. This initial phase will begin in the next two weeks and a full assessment is expected by December 15, 2007.

The work of this team will be monitored by the office of the Clinical-Quality Liaison for the Office of the Deputy Under Secretary for Health for Operations and Management here in the Veterans Health Administration Central Office. The results will be reported to the Office of the Medical Inspector in response to their recommendation that the policy change be reviewed.

Please be assured that we take any potential threat to delivery of high quality care to veterans very seriously and we will take any necessary corrective action recommended by the review.

Sincerely yours,

M. J. J. Q. Kinnaman, M.D.

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Letter	[Response with attachment] - From: Valerie Taylor	6	06/01/2007	P6/b6; b7c;

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COLLECTION:

Counsel's Office, White House

SERIES:

Fielding, Fred - General Files

FOLDER TITLE:

Office of Special Counsel Reports & Scott Bloch Issues [16]

FRC ID:

11294

OA Num.:

10821

NARA Num.:

10383

FOIA ID and Segment:

2014-0210-F

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
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Records Not Subject to FOIA

Court Sealed - The document is withheld under a court seal and is not subject to the Freedom of Information Act.

Valerie Taylor
Michael E. DeBakey VA Medical Center
Houston Texas 77030
October 26, 2007

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

Dear Ms. Myers:

I have received a copy of the supplemental report from Michael J. Kussman, Under Secretary for Health, Department of Veteran Affairs, to The Honorable Scott J. Bloch regarding the planned follow-up actions in response to the one recommendation in VA's report submitted in connection with Office of Special Counsel File Number DI-06-2205, in response to my allegations of a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veteran Affairs (VA), Michael E. DeBakey VA Medical center (VAMC), Houston, Texas.

First let me preface my response with my gratitude and thanks to the U.S. OFFICE OF SPECIAL COUNSEL for investigating my complaints.

The Michael E. DeBakey Medical Center has gotten progressively worse since the OMI's departure. It comes as no surprise to me that the Medical Center gave a vague and inadequate response, as these responses are common and usually go unchallenged. However I will give a basic account of how things have unraveled since the investigation, and subsequent recommendation, and then I will respond to the letter.

Post OMI recommendation to the Michael E. Debakey Medical Center, to "take a critical and formal approach to reviewing the policy to abolish the AOD role considering its impact on patient safety and employee satisfaction":

Mr. Kussman begins his report by saying that "The Office of Medical Inspector did not identify clinical, safety issues or adverse events resulting from the policy change."

This is true, as the OMI team interviewed the Management team they asked us to give them specific events that resulted in safety issues, or poor outcomes for the veterans as it related to the removal of the AOD's. The Management team at this time informed the OMI team that there had been no adverse events because we as managers had preempted them by any and all means necessary, i.e.; hours of phone calls at all times of the night between management and staff, also coming in to work at all times of the day and night, to include after work hours, weekends and Holidays to handle issues. We went on to tell them that as we were doing our best to keep things under control (which was not very good), we were way overstretched, and that we would not be able to function at that

capacity much longer. We did however give them many tales of near misses which they obviously chose to ignore.

Mr. Kussman went on to say, " VHA identified administrative concerns related to staffing which have arisen due to the current policy, e.g., seriously low morale among affected nursing staff." He also says that he recognizes that these issues have the potential to lead to negative outcomes; thus the facility was required to re-evaluate whether the administrative concerns caused by implementation of the policy(as identified by the Medical Inspector) will create any risk to patient safety or adversely affect or compromise the quality of care provided to patients.

The medical Inspector did manage to get one thing right and that was his ability to recognize the potential for negative outcomes. The thing that he got wrong was that he believed that the Administration of the Michael E. DeBakey Medical Center would re-evaluate the implementation of the policy based on his recommendation.

Since the Medical Inspector's departure and subsequent findings and ruling, these are just a few of the negative outcomes that he recognized as potential:

Six Nurse Managers step out of their roles as leaders in the following areas;

- Acute and Geriatric Psychiatry
- Acute Adult Psychiatry.
- Surgical Intensive care Unit.
- Medical and Surgical Step down Unit.
- Nursing Home and Transitional care
- Medicine.

I cannot go into the circus that is still going on trying to replace all of the Manager's that stepped down, but I can assure you that it is not a pretty picture.

Mental Health- After my departure as Nurse Manager of the Acute and Geriatric Unit and the Nurse Manager of the Acute Adult Unit, the morale was so low, and the turnover rate was so high that the Administration had to implement a 10% base pay incentive increase to retain the nursing staff. To date they are still unhappy.

The nursing staff signed a petition expressing their disgust with the Mental Health Administration for allowing things to get so out of control.

The Chief of Mental Health was ordered by the Chief of staff to do rounds on the nursing units twice per day without fail to ensure support and feedback.

The Nurse Manager position for the acute unit was filled 3 months later and to date my position has still not been filled.

The Nurse executive was finally removed for her incompetence as an executive and a leader, and for harassing me after the Medical Inspector left.

The Mental Health care Line remains in turmoil.

Surgical Intensive care Unit (SICU) - After the departure of the SICU Nurse Manager, the morale was so low and the turnover rate so high that they had to hire contract nurses to fill the openings. It is said that over 10 seasoned nurses left and went to other areas of the facility. They have still not recuperated.

Within the last 3 weeks four SICU beds had to be shut down by the Chief of Staff after he made a surprise after hours visit to the unit, only to find that there were not nearly enough nurses to take care of these critically ill patients. (This is a prime example of what happens when you don't have an AOD or nursing supervisor to intervene on behalf of the veterans or staff). The Nurse Executive and Nurse Manager had to be called at home to fix the problem. What would have happened had the Chief of Staff not come in and taken a tour?

On 10/12/07 the Nurse Executive was removed from her position as Nurse Executive of the Operative Care Line for incompetence and placed in quality management after only 10 months in the job. I'm not sure but it may have had something to do with her having no clinical background in Operative Care, only Mental Health.

The Liver transplant program slated to begin in July of 07' in conjunction with another major medical facility is still on hold, because the only person that had transplant experience was the Nurse Manager who stepped down.

These are just a few things that have happened since the OMI ruling. It can be said that it is not related to the removal of the AOD's, however the removal of the AOD's have caused a trickle down effect as follows;

- The AOD's were removed.
- A complaint was filed with OSC.
- Office of The Medical Inspector investigates.

- Office of Medical Inspector rules in favor of the Hospital.
- Nurse Managers step out of their roles.
- Staff Morale extremely low, Turnover rate extremely high.
- Sub standard and poor care for our veterans.
- Poor patient outcomes.

Bed closure for any unit has a negative effect on patient care, however when it is a critical unit such as SICU the effects are even more damaging because these are your most critically ill patients. It also means that surgeries may have to be delayed and/or rescheduled and it takes months sometimes years for the veterans to be scheduled for surgery. It was also told to me by one of the medicine unit manager's that it was requested that they take some surgical patients since surgery had to close beds in their areas. This is just the beginning, it has and it is going to get worse.

Mr. Kussman also says," although the AOD was not providing nursing services and was administrative in function, we will determine whether the lack of AOD involvement interferes with the furnishing of needed nursing care.

I'm not sure why Mr. Kussman states that the AOD's were not providing nursing services, when it is clear in the policy that I gave them that they were (see attached). I'm also not sure if Mr. Kussman understands the role of an administrative nurse because he says that the AOD's were administrative in function; that's true, that is the role of an AOD, nursing supervisor, nurse executive, associate chief nurse executive and chief nurse executive, they function as administrative nurses, guiding and overseeing the care delivered by clinical nurses, ensuring safe, appropriate and timely care to patients. I am totally confused by his lack of understanding.

Mr. Kussman assured the Honorable Scott J. Bloch that the VHA uses a stringent performance management program evaluating hundreds of clinical measures on an ongoing basis to ensure maintenance of the highest quality of care. "Issues that could result in any denigration of care are taken very serious and addressed quickly."

That statement is not even a good book answer. I'm afraid Mr. Kussman has been snowed.

"To date, the facility has submitted a request to the Organization Excellence Board (OEB) for re-evaluation of the nursing AOD role redesign."

This thing has taken on a metamorphosis. Now it's the AOD role re-design. There is no role re-design. Those AOD's lost their positions and had to apply and compete for positions elsewhere, if it were a true AOD role re-design then it stands to reason that AOD's would be in those re-designed positions.

Also who is the Organizational Executive Board? If they are going to sit in their offices and read anything that the Michael E. DeBakey sends them and then plan to make an informed decision based on what's written, then rest assured we will remain in our dysfunctional state.

"The Associate Director for Patient/Nursing Services met with the Performance Improvement Coordinator who is organizing a group of multidisciplinary team members to interview doctors, nurses, administrative officers and stakeholders as an initial step in the re-evaluation process."

This sounds like the same phantom group of multidisciplinary team members that the administration claimed they interviewed before implementing the change in the beginning.

Also in the first managers meeting after the departure of the OMI, the manager group was told by the Associate Director for Patient/Nursing Services (the above mentioned individual), "You all need to stop beating a dead horse, the AOD's are gone and they are never coming back." This tidbit of information was given to the management team without provocation, and as soon as I stepped out to go to the restroom.

It was stated, " The work of this team will be monitored by the office of the Clinical-Quality Liaison for the Office of the Deputy Under Secretary for Health Operations and Management at the Veteran's Health Administration Central Office."

All of the above listed titles may sound impressive to someone who doesn't know any better; however the proof is in the pudding not in the title. Whoever is monitoring this issue needs to really find out what's going on and not get buried in a myriad of paper work sent to them for review by the Michael E. DeBakey Medical Center.

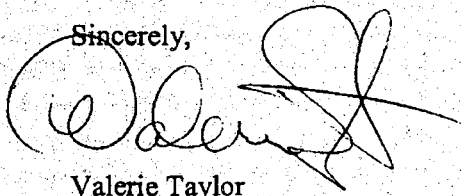
And last but not least, Mr. Kussman states, "Please be assured that we take any potential threat to delivery of high quality care to veterans very seriously and we will take necessary corrective action recommended by the review."

If this were the case then the OMI should have taken corrective action when they came to the Michael E. DeBakey medical Center, because the potential threat that he referred to was already there.

In conclusion, the Medical Inspector's Office needs to put it's money where it's mouth is and get back down here to Houston and find out first hand what has really transpired since their departure and not rely on the reports from the Medical Center.

I stepped down from my position as Nurse Manager in February of 2006 and have been moved around like a chess piece ever since. Despite this I am still very much dedicated to the care given to our veterans, and will fight every chance that I get to ensure that it happens.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valerie Taylor', with a large, stylized flourish at the end.

Valerie Taylor

**U.S. OFFICE OF SPECIAL COUNSEL**

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

October 10, 2007

Ms. Valerie Taylor
6701 Sandspoint #129
Houston, TX 77074

Re: OSC File No. DI-06-2205

Dear Ms. Taylor:

Enclosed is a copy of a supplemental report from Michael J. Kussman, Under Secretary for Health, Department of Veterans Affairs, in response to your allegations of a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veterans Affairs (VA), Michael E. Debakey VA Medical Center (VAMC), Houston, Texas.

Pursuant to 5 U.S.C. § 1213(e)(1), you may comment on the supplemental report if you wish. Your comments will be sent to the agency head, the President, and the appropriate congressional oversight committees in accordance with 5 U.S.C. § 1213(e)(3). With your consent, your comments will also become part of a public file maintained by OSC. We have enclosed a consent form for your signature, which we ask that you sign and return with your comments.

Please respond within 15 days from the date that you receive this letter. If you cannot complete your comments within this time, please call me at (800) 572-2249 or (202) 254-3625, so that we may arrange a short extension of the response date.

Sincerely,

A handwritten signature in cursive script, appearing to read "Malia S. Myers".

Malia S. Myers
Attorney
Disclosure Unit

MSM/msm
Enclosures



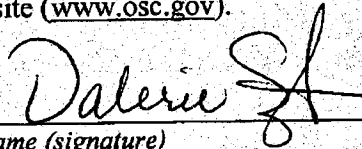
U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

CONSENT TO PUBLIC RELEASE
OF WRITTEN COMMENTS ON AGENCY REPORT

(OSC File No. DI-06-2205)

I consent to public release by the U.S. Office of Special Counsel (OSC) of my written comments on the agency report required by OSC in response to my disclosure in the file identified above. My consent includes placement of my written comments in the public file maintained by OSC pursuant to 5 U.S.C. § 1219(a)(1).*

I understand that my consent means that OSC may release my written comments in response to an outside party's request for access to the public file; as part of any press release issued by OSC about the agency report; or in other circumstances deemed appropriate by OSC. I also understand that my consent means that my written comments may be included in public file or press release documents posted from time to time on OSC's web site (www.osc.gov).



Name (signature)

VALERIE TAYLOR

Name (printed)

10/26/07

Date

* 5 U.S.C. § 1219 ("Public information") reads, in relevant part: "The Special Counsel shall maintain and make available to the public—... a list of ... matters referred to heads of agencies under [5 U.S.C. § 1213(c)], together with reports from heads of agencies under [§ 1213(c)(1)(B) about] such matters."

MICHAEL E. DeBAKEY VETERANS AFFAIRS MEDICAL CENTER
Houston, Texas

MEDICAL CENTER POLICY
MEMORANDUM NO. 118CPO-002

July 5, 2005

ADMINISTRATIVE OFFICER OF THE DAY

I. PURPOSE

This policy delineates the role and scope of the nursing supervisor functioning as the Administrative Officer of the Day (AOD) at the Michael E. DeBakey VA Medical Center (MEDVAMC).

II. PROCEDURES

The AOD serves in the absence of the Medical Center Director and Chief Nurse Executive, providing administrative and clinical direction outside of normal business hours (during the evening, night, weekends and holiday tours of duty). The AOD has authority to make decisions, serving as the highest administrative level on site after regular business hours.

III. RESPONSIBILITIES

A. The AOD provides leadership to care line and service line staff to ensure the delivery of quality care and improve outcomes at the program or care line level.

B. The AOD utilizes MEDVAMC policies as well as professional standards of care and practice to make sound decisions, proposals and recommendations to executive staff.

C. The AOD submits a daily report to the Chief Nurse Executive/Clinical Practice Office (CPO) Director, reporting activities which have impacted patient care delivery in the previous 24 hours.

D. The AOD confers with the Medical Administrative Assistant (MAA) on unusual matters regarding patient care issues to achieve positive outcomes.

E. The AOD acts as a patient advocate in matters regarding patient rights and ethical issues. In the case of significant adverse events to a patient or the facility, the AOD will contact senior management in a timely fashion to apprise them of these events.

F. The AOD provides assistance to Care Line Nurse Executives in their absence concerning staffing to support patient safety.

MEDICAL CENTER POLICY
MEMORANDUM NO. 118CPO-002

July 5, 2005

IV. REFERENCE

M-1, Part I, paragraph 1.57, *Administrative Officer of the Day*.

V. RESCISSION

Medical Center Policy Memorandum Number 118-002, *Administrative Officer of the Day*, dated April 23, 2002.

/elt/

EDGAR L. TUCKER
Medical Center Director



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

*Jarvis
Hood
Burck*

FACSIMILE COVER SHEET**TO:**

Name: The Honorable Fred F. Fielding	
Title: Counsel to the President	
Organization: The White House	
Office / Location: Washington, DC 20500	
Telephone: (202) 456-1414	Fax: (202) 456-6279

FROM:

Name: The Honorable Scott Bloch, U.S. Special Counsel	
Organization: U.S. Office of Special Counsel	
Office / Location: Washington	
Telephone: (202) 254-3625	Fax: (202) 653-5151

Date: December 12, 2007	Number of pages, including this cover sheet:
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Message: Original, including enclosures, to follow by Federal Express delivery.
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U.S. OFFICE OF SPECIAL COUNSEL

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

The Special Counsel

December 12, 2007

The Honorable Fred F. Fielding
Counsel to the President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-07-0929

Dear Mr. Fielding:

Pursuant to 5 U.S.C. § 1213(e)(3), I am transmitting the enclosed letter, report, and whistleblower's comments to the President. If I may provide more information concerning this matter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to be "S. Bloch", written over a horizontal line.

Scott J. Bloch

Enclosures

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Letter	OSC File No. DI-07-0929 - To: POTUS - From: Scott Bloch	2	12/12/2007	P6/b6; b7c;

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Fielding, Fred - General Files

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11294

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U.S. Customs and
Border Protection

SEP 18 2007

2007 SEP 24 PM 9:31

Mr. Scott J. Bloch
Special Counsel
Office of Special Counsel
1730 M Street, Suite 300
Washington, D.C. 20036-4505

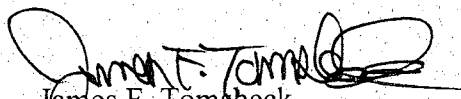
RE: OSC File No. DI-07-0929

Dear Mr. Bloch:

The enclosed unredacted report is in response to your referral of the above matters regarding alleged improper approval of overtime work and improper use of Administratively Uncontrollable Overtime (AUO) by supervisors and staff at U.S. Customs and Border Protection (CBP). The Secretary referred this inquiry to the Department of Homeland Security, CBP, Internal Affairs (IA), and designated me as the official responsible for providing your office with the Department's report pursuant to 5 U.S.C. § 1213. The unredacted version of the report should not be disseminated to the public.

Please do not hesitate to contact my office should you require further information regarding these matters at (202) 344-1800.

Sincerely,


James F. Tomsheck
Assistant Commissioner
Office of Internal Affairs

Enclosure

cc: Secretary
Deputy Secretary
Under Secretary for Management
Commissioner, U.S. Customs and Border Protection

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Letter	[Comments with attachments] - To: Edward Flood	10	10/03/2007	P6/b6; b7c;

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Report	OSC File Number DI-07-0929	8	N.D.	P6/b6; b7c;

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- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

Deed of Gift Restrictions

- A. Closed by Executive Order 13526 governing access to national security information.
- B. Closed by statute or by the agency which originated the document.
- C. Closed in accordance with restrictions contained in donor's deed of gift.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Records Not Subject to FOIA

Court Sealed - The document is withheld under a court seal and is not subject to the Freedom of Information Act.