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INSPECTORS GENERAL

**Veterans Affairs Special
Inquiry Report Was
Misleading**

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



Inspectors General: VA OIG Special Inquiry Was Misleading

Mr. Chairman and Members of the Subcommittee:

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

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

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

- The VA OIG conducted the Special Inquiry as a management review to determine how Hospital and VA Central Region management had responded to "an 'out of norm' situation" regarding the unexplained deaths. We determined that the OIG did not collect or analyze evidence in a manner that would identify intentional cover-up efforts. Thus, the Special Inquiry's conclusion that no evidence of an intentional cover-up had been found was not consistent with the inquiry conducted and was misleading.
- The OIG failed to comply with its own reporting policies on completeness and accuracy by presenting statements in its report that were not supported by the evidence contained in the OIG's files. These statements included, for example, reference to a discussion that the Special Inquiry never verified.
- The OIG attributed the nearly 2-year delay in acting on the cover-up allegations received in February 1993 to administrative error.

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

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

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

Special Inquiry Report’s Conclusion Regarding Alleged Cover-Up Is Misleading

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

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

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

evidence of a cover-up,” as the OIG did not investigate the cover-up allegations. Therefore, the Special Inquiry’s conclusion was not supported by work done and evidence collected and is misleading.

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

Review Planned and Executed From a Management Perspective

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

Frequently a single act taken by itself is not sufficient to establish that the act was done willfully and intentionally with improper purpose. However, a series of acts considered collectively may suggest a pattern of conduct indicative of intentional impropriety rather than accident or error. If certain actions by the Hospital Director had been linked or followed up on, the need for further investigation and additional lines of inquiry would have been apparent. For example, the Hospital Director (1) did not inform law enforcement authorities about the unexplained deaths although District Counsel advised him to do so; (2) did not inform the OIG that a staff physician had accused the nurse in question of killing his patients; and (3) did not provide the Peer Review Board with the statistical analysis that established a relationship between a nurse and the unexplained patient deaths. Also, the Hospital Director instructed the staff physician who had prepared the statistical analysis to have no further contact with the Federal Bureau of Investigation (FBI). The OIG did not pursue or connect these events.

Based on our review of relevant memorandums and tape recordings of interviews, we determined that the analysts questioned the Hospital Director and the Central Region Chief of Staff about compliance with VA

policy. The analysts told us that they accepted “I don’t know” answers instead of asking follow-up questions. For example, the analysts accepted, without probing further, the Hospital Director’s response that he did not recall the District Counsel’s advice in August 1992 that he notify the FBI or OIG about the unexplained deaths. At a minimum, the analysts should have provided the Hospital Director available information to refresh his recollection.

OIG Noncompliance With Policies, Report Inaccuracies, and Unsupported Statements

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

- The report states that the Hospital Director followed the VA Central Region Chief of Staff’s advice and did not inform law enforcement authorities of the suspicious deaths and the possible relationship of a particular nurse to the deaths. Our review of memorandums of interview and transcripts of recorded interviews found insufficient documentation to support the OIG report’s conclusion that the Central Region Chief of Staff had told the Hospital Director not to report the issue to law enforcement authorities.
- The report states that the Central Region Chief of Staff and the Hospital Director withheld the complainant’s statistical analysis—which identified a statistical relationship between the increase in patient deaths and a particular nurse—from the Hospital Peer Review Board so as to allow the Board to look at patient deaths objectively. However, documentation shows that the Central Region Chief of Staff told the OIG that he had never issued instructions to deny the Peer Review Board access to the statistical analysis. The Hospital Director told the OIG that he recalled no one asking to see the statistical data and it did not occur to him to provide the Peer Review Board with the data.
- In a March 1994 letter, the Hospital Director instructed the complainant, “You should . . . refrain from further contacts with the FBI and OIG about this case. If you are contacted directly by either the FBI or OIG you should inform me of the content of your discussion.” The Special Inquiry report rightly states that the Hospital Director could not keep the complainant

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

from talking with the FBI and the OIG and noted that the complainant was under no obligation to report those conversations to the Hospital Director. However, the report concludes that the Hospital Director's action did not limit the OIG or the FBI in obtaining appropriate information from the complainant or other Hospital employees. We found no evidence in the documentation of any investigative effort to support this conclusion. At a minimum, one would expect to find documentation that the OIG had talked to the complainant and the cognizant FBI and OIG criminal investigators before arriving at such a conclusion.

VA OIG Officials Did Not Address the Complainant's Cover-Up Allegations for Nearly 2 Years

As reflected in the Special Inquiry report, the OIG received the complainant's allegations of a cover-up of patient deaths in February 1993, acknowledged its receipt to the complainant, and filed the complainant's letter without investigating the allegations. The Assistant IG for Investigations told us that at the time the OIG received the allegations the criminal investigation with the FBI was ongoing,⁴ and available resources were being devoted to that investigation. The OIG did not begin its Special Inquiry until after the complainant had discussed the allegations with the media in January 1995.⁵ The OIG's Special Inquiry report issued in September 1995 attributed the delay to administrative error. Further, the Assistant IG for Investigations characterized the OIG's failure to follow up on the allegations as a failure of its process.

VA OIG Breached Complainant's Confidentiality

When the complainant sent his allegation letter to the OIG in February 1993, he requested confidentiality.⁶ In the Special Inquiry report, the OIG acknowledged that it had twice released the name of the complainant and that it should have been more careful in protecting the

⁴In 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.

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

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

complainant's confidentiality. We found yet a third instance in which the complainant's contact was provided to Hospital management.

- In one instance, the OIG Office of Investigations received documents from the FBI that had been prepared by the complainant. In turn, the Office of Investigations passed the information to the District Counsel, who forwarded it to the Central Region and the Hospital Director, one of the subjects of the allegations. The Special Inquiry report characterized this incident as an error.
- In another instance, in March 1994, the Assistant IG for Healthcare Inspections gave Central Region officials a report of contact that they had had with the complainant. In the Special Inquiry report, the OIG said that (1) in this instance, the OIG had an obligation not to release the complainant's identity to other VA officials without the complainant's consent and (2) controls to prevent such release were not properly applied. The report characterized the release of the information as an honest mistake.
- We found a third instance in which the complainant's contact with the OIG was provided to Hospital management, but the Special Inquiry report did not identify this incident. On January 11, 1995, the Hospital Total Quality Improvement (TQI) Coordinator asked the Assistant IG for Healthcare Inspections (1) if the complainant had had recent contact with the OIG and (2) if the OIG planned to investigate the complainant's obstruction-of-justice allegation. The Assistant IG acknowledged recent contact with the complainant and stated that the OIG would not investigate unless forced to do so. That same day, the Hospital Chief of Human Resources and the Associate Director had the TQI Coordinator contact the FBI and the Kansas City OIG to determine if they had recently been in contact with the complainant. In contrast with the Assistant IG's previously discussed answer acknowledging contact with the complainant, the Kansas City OIG advised that it would have to consult with OIG Counsel prior to any discussions concerning the complainant. The Kansas City OIG later contacted the TQI Coordinator and stated that OIG Counsel had advised that it could not respond to the Hospital's inquiry. The Hospital Chief of Human Resources⁷ told us he was not sure why he and the Associate Director had the TQI Coordinator make inquiries concerning contact with the complainant but thought it concerned a March 9, 1994, letter from the Hospital Director advising the complainant not to have any contact with the FBI or the OIG.

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

Revised Policies and Procedures

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

Scope and Methodology

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

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

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