



**Department of
Veterans Affairs**

Office of Inspector General

**Review of the Reliability of an
Administrative Board of Investigation
Concerning a Patient Search and Recovery,
VA New Jersey Health Care System, Lyons Campus**

**Report No. 9PR-A01-110
Date: June 4, 1999**

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Date: June 4, 1999
From: Assistant Inspector General, Office of Investigations (51)
Subj: Review of the Reliability of an Administrative Board of Investigation Concerning a Patient Search and Recovery at VA NJHCS, Lyons Campus, Report No. 9PR-A01-110
To: Under Secretary for Health (10)

1. The Office of Inspector General reviewed the reliability of an Administrative Board of Investigation (Board) into the search for a patient and the recovery of his body at the Lyons Campus of the VA New Jersey Healthcare System (NJHCS). NJHCS officials initiated many corrective actions in response to the Board's report. We made additional recommendations to the Veterans Integrated Service Network (VISN) 3 Director and the NJHCS Director as a result of our review. However, in general, they did not concur with these recommendations. We are, therefore, issuing our report with the unresolved issues, and request your assistance in bringing them to closure. In this regard, we request that you appoint an independent review team to examine our evidence and any additional evidence the team deems appropriate.

2. We conducted our review at the request of Congressman Rodney P. Frelinghuysen. The Congressman raised concerns about the thoroughness and accuracy of the Board's report, including issues concerning the patient's care and efforts to locate him. The Congressman was also concerned about the appropriateness of management's decision to initiate an internal investigation into this matter.

3. We concurred with the Board's findings and conclusions regarding the patient's clinical assessment and privileging. We also concurred with the Board's finding that nurses did not recognize, in a timely manner, the patient was missing. However, we concluded that the Board's efforts to identify individual responsibility for this delay were insufficient. Further, we found the Board did not accurately assess the responsibility of individual police officers during the search. We addressed management's responsibility for some search deficiencies, including inadequate search policies and employee training. We found that, while the Board made several recommendations to improve the management of future medical emergency scenes, it did not accurately assess some actions that occurred after the patient's body was found. For example, the Board did not correctly assess police officers' role in preserving the scene, or correctly determine who was responsible for requesting the patient's body be moved. Based on the autopsy findings, we concluded that, even if nurses had noticed the patient's absence when they should have, his death likely could not have been prevented. Finally, we concluded that the NJHCS Director's decision to convene the Board was appropriate, but that management failed to assess adequately the sufficiency of the evidence before taking administrative action against the employees involved.

4. We recommended that the NJHCS Director correct weaknesses in how the Nursing Service accounts for patients' whereabouts. We also recommended that the VISN 3 Director review the NJHCS Director's role in maintaining local search policies that contradicted VHA policy. We recommended both officials, as appropriate, take

administrative action against managers responsible for the deficient local patient search policies and police officer training, including the NJHCS Director, Associate Director (Lyons Campus), and Chief of Police and Security Section. We further recommended administrative action against officials, including the NJHCS Director and Associate Director (East Orange), for proposing and sustaining disciplinary charges against nurses and police officers without ensuring the charges were adequately supported by the evidence. Finally, we recommended the VISN Director review the appropriateness of the charges against these employees and the adequacy of the VISN's administrative investigations procedures. The attached report contains additional recommendations.

5. The VISN 3 Director and NJHCS Director generally did not agree with the recommendations presented in our draft report. The VISN 3 Director criticized the manner in which we reviewed the accuracy of the Board's findings and the validity of our conclusions regarding management's charges against some employees. However, the VISN 3 Director neither thoroughly reviewed our supporting evidence nor provided us specific evidence to rebut our findings. With the exception of one recommendation, which we have resolved with the VISN Director, we consider the recommendations unresolved.

6. I would appreciate your prompt attention to this matter and a response by July 9, 1999. In accordance with OIG policy, if we are unable to reach a resolution, we will submit the report to the Deputy Secretary for his decision. If you have any questions, please contact me or Ms. Judy Shelly, Acting Director, Administrative Investigations Division, at (202) 565-8617.

(Original signed by:)
MICHAEL J. COSTELLO

Enclosure

TABLE OF CONTENTS

Memorandum to the Under Secretary for Health (10)	i
INTRODUCTION	1
Purpose	1
Background	1
Scope	2
RESULTS AND RECOMMENDATIONS	
Issue 1: The Completeness and Accuracy of the Board’s Report on the Appropriateness of Mr. B’s Clinical Assessment	3
Issue 2: The Completeness and Accuracy of the Board’s Report on the Nursing Service’s Roster Checking Procedures and Initiating a Local Missing Patient Search	6
Recommendation 1	10
Issue 3: The Completeness and Accuracy of the Board’s Report on Activities Relating to the Extended Search for Mr. B	12
Recommendation 2	18
Recommendation 3	20
Issue 4: The Completeness and Accuracy of the Board’s Report on Activities Relating to the Site Where Mr. B’s Body was Found	21
Recommendation 4	25
Issue 5: Whether Patient Neglect and Mismanagement Occurred	26
Issue 6: The Appropriateness of Management’s Efforts to Investigate the Search for Mr. B and the Recovery of His Body	28
Recommendation 5	31
APPENDICES	
Maps of the Lyons Campus of the New Jersey Healthcare System	A-1
VISN 3 Director Response	B-1
OIG Comments on VISN Director 3 Response	C-1

**REVIEW OF THE RELIABILITY OF AN
ADMINISTRATIVE BOARD OF INVESTIGATION
CONCERNING A PATIENT SEARCH AND RECOVERY
VA NEW JERSEY HEALTHCARE SYSTEM, LYONS CAMPUS**

**REPORT NO. 9PR-A01-110
(9IQ004HQ)**

INTRODUCTION

Purpose

The Office of Inspector General (OIG) reviewed the reliability of an Administrative Board of Investigation (Board) into the search for a patient and the recovery of his body at the Lyons Campus of the Department of Veterans Affairs (VA) New Jersey Healthcare System. The OIG's Administrative Investigations Division and the Office of Healthcare Inspections conducted the review at the request of Congressman Rodney P. Frelinghuysen. Congressman Frelinghuysen expressed concern about the accuracy and thoroughness of the Board, including issues involving the patient's supervision prior to his disappearance, the length of time that elapsed before Lyons officials initiated a search for him, and the basis for certain search decisions. The Congressman also questioned whether the incident, in which the patient died, raised issues of neglect and mismanagement, and whether it was appropriate for an administrative Board to conduct the investigation.

Background

The patient, referred to in this report as Mr. B, was a 67-year-old male with prior multiple admissions to the Lyons Campus for **(b)(3)(b)(6)**.....
Mr. B was **(b)(3)(b)(6)**.....
May 14, 1998, after **(b)(3)(b)(6)**.....
..... Beginning May 18, 1998, Mr. B was authorized to leave the ward by himself for 2 hours in the morning. On Saturday, May 30, Mr. B did not return to his ward and was reported missing that evening. Lyons Campus officials began an extended search for Mr. B, but terminated it before he was found.

On the morning of Monday, June 1, 1998, Mr. B was found unresponsive, lying in a construction trench near an administrative building in an area of the Campus known as Circle I. (The Lyons Campus has multiple buildings, organized into two groups, Circle I and Circle II. Maps of the facility are provided in Appendix A.) A VA medical emergency team responded to the situation, as well as the Campus fire department personnel, three police officers, and several bystanders. A physician examined Mr. B and pronounced him dead at 7:45 a.m. Rescue workers then moved the body to the morgue and, at 8:10 a.m., management notified the regional medical examiner for

Somerset County, New Jersey. The medical examiner concluded that Mr. B's death was accidental.

In response to the incident, on June 1, 1998, the Director of the New Jersey Healthcare System, Mr. Kenneth Mizrach, established a Board of Investigation, as required by Veterans Health Administration (VHA) policy. In accordance with that policy, the Board was staffed by professional peers rather than trained investigators. The Board evaluated Mr. B's care from admission through referral of his death to the medical examiner. It obtained testimony from 46 witnesses. In its June 25, 1998, report, the Board identified problems with the manner in which ward nursing staff accounted for patients, the extent of search activities undertaken, and the degree of police control at the investigative scene. The Board recommended procedural improvements and administrative action against several Nursing Service and Police and Security Section employees. In response to a request from Mr. Mizrach, the VA Office of Security and Law Enforcement also reviewed and reported on select aspects of the patient search.

Scope

OIG's Office of Healthcare Inspections reviewed Mr. B's clinical assessment and supervision at Lyons, and the clinical decisions made in the search for him and the recovery of his body. The Administrative Investigations Division reviewed administrative aspects of the search and recovery. We took sworn, taped testimony from Mr. Mizrach, the Associate Chief of Staff, three Associate Directors, the three Board members, the personnel technical advisor to the Board, and approximately 26 other witnesses. We reviewed Mr. B's medical records, testimony and documentation obtained by the Board, relevant Department and local policies, and other pertinent documentation.

RESULTS AND RECOMMENDATIONS

Issue 1: The completeness and accuracy of the Board's report on the appropriateness of Mr. B's clinical assessment

Congressman Frelinghuysen expressed concern about whether Lyons Campus clinical employees adequately supervised Mr. B on May 30, 1998, given the seriousness and chronicity of his psychiatric conditions, and the clinical history of his becoming episodically confused.

Clinical history

Mr. B was a 67-year-old veteran who had a **(b)(3)(b)(6)**.....
..... **(b)(3)(b)(6)**.....
..... **(b)(3)(b)(6)**.....
....., he had lived in a VA sponsored community residence facility (CRF) since 1988.

Mr. B's medical records show that for the 10 years prior to his death he had been provided a structured, living situation at the CRF. He had been visited routinely by a social worker. The social worker continuously assessed the appropriateness of his need for such a living arrangement and recorded this information in social work progress notes. The last five social work progress notes reported changes in the patient's medical condition (e.g., **(b)(3)(b)(6)**.....) and mental health status (e.g., **(b)(3)(b)(6)**.....). These progress notes were obtained from the community care social worker and were not found in the patient's VA medical record. The social worker recalled that Mr. B had adjusted well to this supervised living environment, but that he often **(b)(3)(b)(6)**.....

Mr. B was admitted to the Lyons campus twice in 1998. Both of these **(b)(3)(b)(6)**.....
..... The second admission was on May 14, 1998, when Mr. B's CRF sponsor requested that he be admitted to the Lyons Campus because **(b)(3)(b)(6)**.....
..... According to the CRF sponsor, **(b)(3)(b)(6)**.....
..... Mr. B was brought to the Lyons Campus and assessed by the Emergency Room physician. The Emergency Room physician **(b)(3)(b)(6)**.....
..... A May 15 nursing progress note shows that, **(b)(3)(b)(6)**.....

On May 15, following his admission, an interdisciplinary treatment team met and developed a care plan to (b)(3)-(b)(6).....
..... Mr. B was (b)(3)-(b)(6).....
..... (b)(3)-(b)(6).....
..... (b)(3)-(b)(6).....
..... (b)(3)-(b)(6).....
.....

Results of the Board of Investigation

The Board concluded that the evaluation and cause for admission was handled and documented appropriately, according to accepted and normal practices and facility policies. The Board concluded that the assessment for granting privileges was handled appropriately according to testimonies, but documentation in the medical records was deficient in presenting the explanation for the granting of the levels of privilege.

Subsequent to the patient's death, a psychological autopsy was conducted by a psychiatrist who is the coordinator of the Seriously Mentally Ill Program and the Associate Chief of Psychology in the New Jersey Healthcare System. The purpose of the psychological autopsy was to determine if the care provided to Mr. B was appropriate and whether the privileges granted to this patient were consistent with his clinical condition. The reviewer concluded that the treatment provided to the patient was appropriate. Nonetheless, he asserted that the advancement of privileges just 4 days after being admitted on more restrictive privileges, may have been premature. The reviewer noted, however, that Mr. B had managed his more liberal privileges for 12 days, without apparent problems, and suggested that he would have merited these privileges sometime within the intervening 12-day period.

OIG clinical review regarding the granting of privileges

Testimony to the Board indicates that the decision to increase the patient's privileges was appropriately made in a team meeting. However, the decision process and the considerations that went into this privilege upgrade were insufficiently documented in the medical record.

Nursing progress notes of May 19 and May 23 show that (b)(3)-(b)(6).....
..... There was no evidence of (b)(3)-(b)(6)..... He received (b)(3)-(b)(6).....
He was evaluated by the (b)(3)-(b)(6)....., (b)(3)-(b)(6)..... and (b)(3)-(b)(6).....
Furthermore, there was no evidence in the medical records or Board report that, during the 2 weeks Mr. B was on Level 3 privileges, he "wandered" or failed to comply with the requirements of the privileges granted him. In view of this overall clinical picture, we

consider the granting of privileges to leave the ward was a reasonable clinical judgment. However, the decision process was not well documented in the medical record.

Conclusion

The Board properly concluded that the patient assessment was accurate and documented. The Board accurately reported on the patient privileging process and correctly identified a deficiency in the documentation relative to advancing the patient to Level 3 privileges.

Issue 2: The completeness and accuracy of the Board's report on the Nursing Service's roster checking procedures and initiating a local missing patient search

Congressman Frelinghuysen expressed concerns that Lyons Campus officials did not initiate search procedures until Mr. B had apparently been missing for an extended period of time, well beyond the time that he was due back on the ward. This is of particular concern given the patient's history and chronicity of his mental illness.

Results of the Board of Investigation

The Board concluded that nursing personnel were deficient in assigning and understanding roster checks of patients. In addition, the Board noted that roster-checking practices lacked consistency, and that communication among staff members was ineffective.

The Board found no document that "explicitly states a process to be followed for roster check. Other documents reviewed contain language that is suggestive of when communication is necessary, but nothing comprehensive could be found." From the testimony rendered during the investigation, the Board found that there was "a general understanding that when a patient is not present at either a roster check, a mealtime, or for some other activity, the Charge Nurse should be informed." The Board characterized the patient roster checking process on Ward **.(b)(3)(b)(6)**, Mr. B's ward, as "chaotic."

The Board also reported that there was no knowledge deficit in the process for initiating a local search for missing patients, but "these circumstances reflect subtle, complex, interrelated and interdependence performance management issues related to decision-making skills and their perceived versus actual impact on patient outcome." In simpler terms, the OIG interprets this statement as meaning that employees knew what their responsibilities were, but for various reasons, such as inadequate communications, flawed interpersonal relationships, lack of attention to important details, etc., did not carry them out.

The Board concluded that the "Charge Nurses on the day and evening tours failed to solicit the results of roster checks or to validate that the Patient Count form was signed as required;" and, that "the Nursing Assistant(s) who assumed responsibility for change of shift roster check failed to sign the form as is required and to inform the Charge Nurses of the results."

The Board recommended developing a standard protocol for roster checking. It also recommended administrative action against nursing personnel referenced in the report who were involved in the lapses in roster checking and the delay in initiating a local

search. The Board recommended efforts to improve communication and decision-making. The Board did not identify any deficiencies on the part of the nursing staff in initiating a search once nurses recognized that Mr. B was not on the ward.

Assessment of the Nursing Service roster check

The Board appropriately noted that the policies were unclear, particularly with respect to documenting roster checks. Notwithstanding the absence of a written policy explicitly stating a process to be followed for documenting roster checks, the testimony showed that a process was in place, was known to the staff, and was consistently not followed. Although there was no specific policy delineating responsibilities in place, there were existing assignment sheets for each shift.

Responsibility for this flawed system would logically extend beyond the particular individuals on duty on May 30, 1998, and to the former head nurse on Ward **.(b)(3)(b)(6)**, who was responsible for ensuring that appropriate policies and procedures were in place and complied with. The Board also notes serious interpersonal and interprofessional issues on the ward, which is also a responsibility of the head nurse. However, the Board did not assess specific responsibility or accountability to the former head nurse for Ward **.(b)(3)(b)(6)**.

With respect to the issue of individual responsibility for failing to monitor Mr. B's whereabouts on May 30, 1998, we reviewed the findings and conclusions of the Board, the testimony and written statements of the employees, the charges cited in the proposed disciplinary actions issued to members of the nursing staff, the responses filed by the nurses to the charges, and other relevant documentation. We found that since the Board primarily addressed policies and procedures, it did not fully and adequately investigate the issues surrounding the failure to identify in a timely manner and report that Mr. B did not return to the unit at 11:00 a.m. As a result of the Board's findings and recommendations, the New Jersey Healthcare System took personnel actions based on charges not always supported by the evidence.

According to the testimony presented during the Board of Investigation, Mr. B was observed leaving the ward at approximately 9 a.m. on May 30, 1998. According to his assigned privilege level, he was due back at the ward at 11 a.m. on the same day. There is conflicting testimony to the Board concerning discussions among nursing employees about Mr. B's absence when the noon meal was served and whether Mr. B's absence was properly reported to the charge nurse. When the evening shift replaced the day shift, no one determined whether Mr. B was present or missing. There is testimony that the evening charge nurse was told on one or more occasions that Mr. B was on a day pass and not expected back until 8 p.m. that same day. However, the Board failed to elicit testimony or other evidence to corroborate or refute this testimony. By 8 p.m. on May 30, 1998, the responsible charge nurse realized that Mr. B was missing and initiated the local search as required by policy. Nursing Service properly requested the police initiate a general search at 9:19 p.m.

The Board's investigation was deficient in that Board members did not identify a specific policy, memorandum, or directive when questioning employees and failed to ask questions or elicit testimony from the nursing staff regarding a specific policy or directive. For example, none of the witnesses was presented with a specific policy and asked to describe his or her familiarity with or understanding of it. In our view, this is a significant deficiency because Lyons Campus management used the Board's findings to support disciplinary actions based on charges that cited violations of one or more policies or directives without evidence that the employee was knowledgeable about the policy or its interpretation by the staff. Charges relating to a violation of a specific policy are inconsistent with the Board's finding that the policies were unclear. In response to a proposed disciplinary action, one of the nurses stated that she had never seen the policy cited, and could not find a copy of it on the unit or anywhere else. In another case, the nurse provided evidence to refute the Lyons Campus interpretation of a non-specific section of the policy.

A more significant deficiency is that the Board did not adequately investigate the issue of what happened on May 30, 1998, when Mr. B failed to return to the ward at 11:00 a.m. Although the Board conducted interviews with the relevant nursing staff and addressed the issues of roster checks and 30 minute rounds in each interview, the Board failed to discover what more precisely happened that day on Ward **(b)(3)(b)(6)**. In conducting the investigation, the Board failed to follow-up on inconsistencies in the testimony, failed to seek evidence to corroborate or refute testimony, and failed to clarify incomplete or vague statements. In writing its report, the Board included selected quotes from individual witnesses. The Board relied on testimony that was internally inconsistent, questionable, or inconsistent with other evidence. The Board also failed to cite or acknowledge the existence of contradictory evidence, thus leading the reader to conclude statements were not disputed.

Moreover, Medical Center management failed to review the evidence and reconcile its inconsistencies before drafting charges. As a result, some of the charges against the nursing staff were not supported by the evidence and were easily refuted by statements and documents not cited by the Board in its report. For example, the Board cited testimony from one of the nursing assistants on the day shift that she informed the charge nurse on three separate occasions, at 11:00 a.m., 11:30 a.m. and again at 12:00 p.m., that Mr. B was not there. Although the finding by the Board and the testimony by this witness were not corroborated by any other witness, and were in direct conflict with other evidence, neither the Board nor management reconciled the inconsistencies. The Board's use of this statement is out of context and, without acknowledging the conflicting testimony of the charge nurse, the other nursing assistant, and the witness herself, leads to the erroneous conclusion that the testimony was credible and substantiated. As a result, Lyons Campus management subsequently used this statement to support a removal action against the charge nurse.

As another example, the evening charge nurse testified that she was told on three occasions that Mr. B was on pass for the day, and, therefore, she did not expect him to return to the unit until 8:00 p.m. The Board failed to elicit testimony or obtain other evidence from this witness to verify her testimony. For example, the Board did not ask her who provided this information or at what time she was told Mr. B was on a pass. Although the testimony by one of the nursing assistants provides some corroboration, the testimony is vague and ambiguous, and the Board did not attempt to seek clarification. More importantly, this potentially exculpatory testimony was not cited in the Board's report.

Initiation of the missing patient search

Standard: Lyons Nursing Memorandum No. 46 provides that each nursing employee in direct contact with patients will demonstrate continued awareness of responsibility for prompt reporting of missing patients. Medical Center Policy Memorandum 00-1, Section II, Chapter 2, provides for three levels of missing patient searches. The first level, *local search*, is to be conducted by nursing personnel and includes the patient's home ward and notification to all other inpatient wards. The policy provides that within 1 hour, the search should be escalated to the next level. The second search level, *general search*, is to be conducted under the supervision of police officers and includes nursing personnel. The required general search coverage includes the tunnel areas adjoining the home ward building, all places and public areas where people normally congregate at the medical center, and roads and establishments in the immediate vicinity. The policy also provides that the time of the general search should not exceed 2 hours before escalating the search to the next level, an *extended search*. The extended search level is optional, depending on a physician's assessment of the patient and concurrence by an authorized official.

Discussion: At 8:00 p.m., on May 30, 1998, Lyons Campus Nursing Service employees initiated a preliminary search of the unit and all areas in the vicinity. They did not locate the patient, so nurses notified the Police and Security Section.

As previously noted, the patient's Level 3 privileges allowed him to leave the ward unescorted from 9:00 a.m. until 11:00 a.m. on May 30, 1998. If the process for roster checks had been followed, the local search would have commenced at or about 11:00 a.m., not 8:00 p.m. Therefore, the failure to recognize and report that Mr. B did not return to the ward at 11:00 a.m. delayed the initiation of the search by about 9 hours.

Overall, from the Board report alone, it was not clear when the local nursing search, the general search, and the extended search began and were terminated. Nevertheless, the Board did accurately assess during its investigation that the nursing staff were familiar with and able to verbalize the policy and procedures for conducting a missing patient search. The Board did not find fault with the actions of the nursing staff once they recognized that Mr. B was missing. We concur.

Conclusion

We agree with the Board's conclusions and recommendations regarding the "chaotic" nature of the roster checking process in place at the time of the incident, and the recommendation to develop a standard protocol for roster checking.

We agree with the Board's finding that Nursing Service employees did not provide Mr. B adequate supervision. This was demonstrated by their 9 hour delay in recognizing that he had not returned and initiating a missing patient search. We also agree with the Board's recommendation for appropriate administrative action against the responsible parties. However, we found that the Board failed to conduct a complete and thorough investigation, which resulted in disciplinary actions against nursing personnel that contained charges not supported by the evidence of record. It also resulted in some employees not being charged with acts or omissions that caused the delay in recognizing Mr. B did not return to the unit.

Recommendation 1

The Director, New Jersey Healthcare System, should consider patient supervision and accounting for patients' whereabouts, such as responsibility for roster checks and 30 minute rounds, as material weaknesses of the Lyons Campus operations, and aggressively pursue these issues to correct the problems.

Veterans Integrated Service Network (VISN) 3 Director/ New Jersey Healthcare System Director Response

The VISN Director and New Jersey Healthcare System Director concurred that patient supervision and accounting for patients' whereabouts were material weaknesses of the Lyons Campus operations. However, they stated that corrective actions had already been taken. They noted that the functional statements and competencies for Registered Nurses and Head Nurses had been changed, policies current at the time of Mr. B's disappearance had been re-emphasized, and numerous meetings of the nursing staff had been held.

The VISN Director provided us a lengthy response, including numerous attachments. We have not included these in our report. However, the VISN Director's memorandum transmitting his response is included as Appendix B. Our comments on his memorandum appear as Appendix C.

Office of Inspector General Comments

Although the New Jersey Healthcare System and the VISN made a conscientious effort to educate the nursing staff regarding existing policies and procedures, and issued some new directives, considerable effort was focused on searching for missing patients.

This was not the root of the problem with respect to Mr. B. Once the nursing staff recognized Mr. B was missing, they initiated the proper procedures in a timely manner. The nursing staff's weakness was failing to recognize in a timely manner that Mr. B had not returned to the unit at 11:00 a.m. This was due to the fact that the staff assigned responsibility for roster checks and 30 minute rounds did not meet their responsibilities. It was also due, in part, to the absence of monitors to ensure that the procedures in place at the time were being followed.

VISN and New Jersey Healthcare System officials did implement more specific policies and procedures, such as a new roster sheet and a more specific policy regarding communication when a patient is missing. However, these efforts did not address the failure of certain staff to meet their assigned responsibilities and management's failure to ensure that the policies and procedures in place were being followed. Furthermore, the functional statements and competencies for Registered Nurses and Head Nurses that were provided to us were dated prior to the disappearance of Mr. B.

Management needs to initiate a long-term monitor to ensure compliance with policies and procedures for conducting and documenting 30 minute rounds and roster checks, and take appropriate administrative action for non-compliance. We consider this recommendation unresolved.

Issue 3: The completeness and accuracy of the Board's report on activities relating to the extended search for Mr. B

The Board accurately assessed and reported most aspects of the extended search for Mr. B as coordinated by the Police and Security Section. The Board accurately identified the need to improve local search procedures, including the process for terminating an unsuccessful search, and the need to improve relevant police officer training. Board members also correctly concluded that police officers did not adequately search the facility after Mr. B was reported missing. However, we identified significant issues not addressed by the Board. These involved management's responsibility for some search deficiencies, and a contradiction between VHA and local policy. We also reviewed two issues which were not specifically assigned to the Board, but which Congressman Frelinghuysen questioned. These issues pertained to actions taken by Lyons Campus officials to notify outside law enforcement agencies of the incident, and the relevancy of overtime concerns to management's decision to terminate the search. Finally, we found that the Board's recommendation to take administrative action against one of the police officers involved in the search was unsupported.

Adequacy of the local search plan

Standard: VHA Directive 96-029 requires VHA facility directors to ensure that "a detailed Search for Missing Patients Plan is developed and implemented at VA clinical facilities." The Directive notes that "VA health care facilities vary greatly in size, activity and number of buildings: thus, each facility shall adopt a plan suited to its particular needs and circumstances." The Directive provides examples of areas requiring coverage during a full facility search, such as all ground areas, parking lots, ball fields, tennis courts, outdoor seating areas, and woods. To ensure that all areas are searched and to avoid random or uncoordinated searches, the Directive requires that facility plans provide for specific staff assignments to given areas. Finally, the Directive requires local policies to address time to be spent searching for an incapacitated, missing patient before the full search process is considered to be unsuccessful.

Discussion: The Board noted that the Lyons Campus' search procedures needed improvement, and recommended adoption of more organized procedures and criteria for ending extended searches. The Board recommended, and Mr. Mizrach approved, using a grid map of the facility's grounds to be checked off as each area is searched. The recommendation included a provision that the grid map be updated as needed, including at the beginning of new construction projects. In July 1998, the Office of Security and Law Enforcement took a position similar to the Board's by concluding that the Lyons Campus missing patient search procedures "do not contain specific and detailed instructions to the police officers to assure that a consistent and systematic search of the entire facility is completed." In August 1998, in response to the Board's recommendation, Mr. Mizrach approved a new detailed extended search plan.

During the incident we reviewed, the Lyons Campus “Missing Patient Search Procedures” required extended search coverage to include all patient wards other than the home ward building and other areas not accessible to other persons (i.e., construction sites, utility areas and administrative/office/clinical areas, whether open or not). The procedures neither identified individual structures and areas on campus, nor did it specifically require searching all areas. The scope of interior and exterior searches was not addressed, such as whether an assignment to search a patient ward also required searching the grounds around the building where the ward was located. Although there was no explanation of how search assignments were to be made, the procedures provided that searchers were supposed to notify the radio dispatcher of search areas and times to avoid duplication. In addition, the procedures did not establish a minimum time frame regarding how long an unsuccessful extended search was to be continued.

When asked why the Lyons Campus did not previously have detailed search procedures for missing patients, the Chief of Police and Security Section told us that, since taking over as Chief at the combined New Jersey Healthcare System in 1997, he had not had time to address the matter. Mr. Mizrach told us that he accepted the contents of the Office of Security and Law Enforcement report, but noted that, in reference to the search for Mr. B, local procedures specifically called for searching the construction site where he was eventually found.

Conclusion: The Board accurately identified that the local search procedures needed improvement. However, it did not identify the Director as responsible for failing to ensure that detailed procedures were in place.

Compliance of local policy with VHA policy regarding executive notification and search approval requirements

Standard: VHA Directive 96-029 mandates that designated senior clinical and administrative officials at healthcare facilities be notified, regardless of the hour, of the results of preliminary searches, and provides that extended searches require approval by an executive management official.

Discussion: The Lyons Campus June 1996 Missing Patient Search Procedures did not specifically provide that executive management be notified of the results of preliminary missing patient searches, or that they approve initiating extended searches. In a January 1998 memorandum, Mr. Mizrach directed his staff to initiate physician-approved extended searches prior to obtaining executive management’s approval. The memorandum provided that the Director or Associate Director should be notified during the extended search. Mr. Mizrach said that the purpose of the change was to ensure that extended searches were not delayed while waiting for executive approval. Several days later, an unsigned amendment to the memorandum deleted the requirement for

executive notification during the extended search, providing instead that notification be given at the next Director's morning meeting.

In February 1999 testimony to us, the Lyons Campus **(b)(6)** discussed the memorandum regarding notification procedures and the amendment to the memorandum. A few weeks later, she told us that she prepared the amendment at the request of the Lyons Campus Associate Director, Ms. Mary Ellen Piche. In April 1999, the **(b)(6)** asserted to us for the first time that the amendment was only a draft, not policy. She said she distributed the amendment to Nursing Service, Medical Administration Service, and the Medical Officers-of-the-Day. The **(b)(6)** testified that she did not mark the amendment as a draft, included no cover memorandum or distribution sheet informing recipients it was a draft, and did not receive comments on it. No other officials we asked said they considered the amendment to be a draft, including officials in the Medical Administration Service, the service responsible for notifying executive management. Further, we found no evidence the document was officially circulated to other services, as a draft might be. In addition, Ms. Piche did not assert to us that the amendment was merely a draft. An employee in the executive offices testified that the official file copy of the amendment was not labeled as a draft when it was initially filed, but that a "few months" ago, she noticed that someone had altered the document by stamping it as a draft.

Ms. Piche told us the amended language was mistakenly omitted from the initial memorandum, which was signed by Mr. Mizrach. She said the amendment was approved by a group of senior management officials during a teleconference meeting, and that she then issued it. We questioned the officials who attended the meeting. While not all of them could recall what was discussed and who was present, several attendees testified that Mr. Mizrach participated and that the amendment was consistent with the group's discussion. However, Mr. Mizrach denied approving, or having knowledge of, the amendment.

The Board's chairman told us that he discussed the amended memorandum with Ms. Piche, but she did not tell him it was a draft. The Board identified that there was confusion concerning authorities related to the extended search phases and recommended revising policies to clarify responsibilities. However, the Board did not discuss local requirements for notifying executive management about missing patient searches, or whether the local notification and extended search process complied with VHA policy. Without fully determining relevant policy requirements, the Board could not resolve whether search actions by employees, such as the Medical Administrative Assistants, complied with local and VHA policy provisions.

Conclusion: The Director, New Jersey Healthcare System, maintained a local policy to initiate extended searches prior to approval by executive management, contrary to VHA guidance. In addition, the Lyons Campus Associate Director issued local guidance that further delayed notification to executive management and inappropriately removed executive management from approving important decisions for missing patient

searches at the Lyons Campus. The amendment also inappropriately attempted to shift responsibility for approving extended searches from VA executive management to Medical Officers-of-the-Day, who are not always regular VA employees or trained in crisis management. While the initial policy change potentially improved the timeliness of search efforts, we identified no official benefit to conducting these critical activities without the knowledge of the responsible executive officials, which was the effect of the amendment. Finally, we concluded that the Board did not sufficiently review and resolve employee responsibilities concerning executive management notification and search approval during the search for Mr. B.

Adequacy of police training in search procedures

Standard: VHA Directive 96-029 requires that facilities' guidance on missing patient searches shall include systematic training of all staff, including VA police, who may be involved in the search for missing patients. The Lyons Campus "Missing Patient Search Procedures" required the Chief of Police to ensure all police officers are aware of their responsibilities pertaining to coordinating and directing a search, from the time they are notified a patient is missing until the patient is either found or the search is cancelled.

Discussion: The Board recommended establishing a special search team and conducting semiannual extended search drills. The Board's recommendation implied that organized search training would help address search deficiencies. Mr. Mizrach approved the recommendation and, as a consequence, Lyons Campus employees received specialized search training in September 1998. However, in its report, the Board overstated the extent of search training, and failed to hold the Chief of Police and Security Section accountable for the lack of systematic training.

The Board inaccurately summarized the testimony when establishing the extent of participant training. Board members cited testimony by a **(b)(6)**..... that "all the officers involved were trained in search procedures and had been involved in previous searches." However, we found that, according to his statements before the Board, this individual testified that the officers in question were experienced in searches, but did not testify concerning search training.

The Chief, Police and Security Section, told us that prior to the search for Mr. B, no formal training specifically for patient searches existed, and no procedures were in place to ensure that officers received uniform training on conducting searches on the Lyons Campus. He said police officers were told how to perform patient searches as a part of their initial orientation and were given on-the-job training by police supervisors. The Assistant Chief provided similar testimony, stating that since he arrived at Lyons in 1993, the police received no formal training in patient searches. He said officers learned their duties by reading the local policy and by having experienced officers convey information about practices. In July 1997, several Lyons Campus police officers did receive instruction on using the night vision equipment. Furthermore, in October

1998, after the Board issued its report, Lyons Campus police officers received formal training on missing patient searches.

The Board did not pursue general assertions about police experience to determine the extent of specific officers' knowledge of local search procedures and how that was conveyed. Board members also told us they did not review training records or curricula to determine the frequency or content of search training. The Board should have been aware that simply following the established local practices was insufficient to ensure systematic training, since police supervisors during the search for Mr. B did not consistently follow their local "Missing Patient Search Procedures." For example, police supervisors did not assign anyone to search the administrative offices, as specifically required by the policy. In addition, one police supervisor told us he directed officers not to search tall grassy areas because of ticks.

Conclusion: The Board inaccurately summarized the testimony of a police supervisor when concluding that the police officers had been trained. The Board did not identify the absence of required systematic training or assess its impact on the effectiveness of the search for Mr. B. The Chief of Police and Security Section did not ensure that all police officers received systematic training in conducting extended searches, as required by local policy. The numerous and widespread procedural errors committed by the police during the search for Mr. B suggest that the Chief did not meet his obligation to ensure that his officers were fully cognizant of their search duties.

Accountability of police officers to search the construction site

Standard: VHA Directive 96-029 requires that extended searches include all areas of the facility. According to the Lyons Campus' "Missing Patient Search Procedures," extended searches are conducted under the supervision of police officers and consist of two phases. The first phase includes a search of "all patient wards other than the 'home ward' building and other areas normally not accessible to other persons (i.e., construction sites, utility areas, and administrative/office/clinical areas whether they are open or not)." The second phase includes a search of local roads and establishments off-station and contacting outside law enforcement agencies.

Discussion: The Board correctly noted that Police and Security Section personnel did not adequately search the Lyons Campus after it was reported to them that Mr. B was missing, and that supervision of the search effort was lax. Board members concluded that the search was terminated prematurely without searching all areas of the facility, as required, and made appropriate recommendations for administrative action against most of the officers involved. However, the Board erroneously concluded that one officer, referred to here as Officer A, was responsible for searching all of the "Circle I" area of the facility, including the construction site where Mr. B's body was later found. Officer A resigned as a VA employee effective **(b)(6)**.....

At 10:45 p.m. on May 30, following a general search by police officers, Police and Security Section personnel initiated an extended search for Mr. B. The police officer in charge assigned an officer to search the "Circle I" area of the facility, another to search the "Circle II" area, and Officer A to search the interior of specific patient buildings and the Circle I courtyard. The Circle I courtyard is not adjacent to the site where Mr. B's body was later found. In his June 7 statement, the officer in charge wrote that he assigned Officer A to "make a check of all patient buildings and wards and the courtyard of Circle I. Bldgs 4, 9, 7, 2, 135." In addition, Officer A told the Board he was specifically assigned to search certain patient wards and, at approximately 12:20 a.m. on May 31, the Assistant Chief assigned him to assist another officer in operating infrared camera equipment. He said this continued until 12:50 a.m., when the Assistant Chief canceled the search. The officer who Officer A assisted told the Board the two of them used infrared camera equipment to search areas near one of the facility's gates and parts of the golf course before the search was canceled. He told the Board the area they were assigned to search would have included the construction site, but that the search was canceled before they had an opportunity to go there. A recording of police communications indicated that Officer A reported to the police dispatcher that he completed checking four patient wards before being assigned to conduct the infrared camera search.

Conclusion: The Board's recommendation to take appropriate administrative action against Officer A for failing to check the construction site where Mr. B's body was found was unsupported.

Notification to outside law enforcement agencies

Standard: VHA Directive 96-029 requires VA police to report missing patients to outside law enforcement agencies when a full patient search is unsuccessful. Consistent with this policy, Lyons Campus search procedures provide that during extended searches, the Police and Security Section will notify local and state police officials of the missing patient. Local procedures also provide that, upon authorization, the Police and Security Section could request the use of outside dog search teams and helicopters. However, there is no VHA requirement for this form of search assistance.

Discussion: According to the Uniform Offense Report and relevant testimony, the Lyons Campus Police and Security Section notified police in the local township and Bloomfield; they also reported the patient missing to the National Crime Information Center. However, the physician who authorized the extended search concluded that Mr. B's condition did not require the use of search dogs or helicopters, and the police officer in charge did not request them. Additionally, police management told us they had not used dogs or helicopters in recent years to conduct extended searches.

Conclusion: Lyons Campus officials properly notified outside law enforcement agencies that Mr. B was missing. Policy did not require the use of dog search teams or helicopters, and there was no current practice to do so.

Relevancy of overtime concerns to the decision to terminate the search

Discussion: According to the police dispatcher's testimony to the Board and to us, when the Assistant Chief arrived at the Lyons Campus after being informed of the extended search, he immediately telephoned the Chief. The dispatcher testified that when the Assistant Chief ended the call, he told the dispatcher that the Chief ordered him not to request additional officers because he did not want to pay them overtime. We found no record of a telephone call to the Chief's residence around the time the Assistant Chief arrived at the facility. The Chief and Assistant Chief did communicate by telephone about an hour later and around the time the extended search was canceled.

In slightly different testimony, the officer who was in charge before the Assistant Chief's arrival at the facility told us the Assistant Chief informed the Chief he was terminating the search because he did not want to pay overtime. However, this officer previously testified to the Board that he had no idea why the search was terminated. Furthermore, another officer told the Board that when the Assistant Chief dismissed him and others from the extended search, he said, "I don't want [to authorize] OT, you guys can go home." However, that officer subsequently told us he could not recall the Assistant Chief referencing overtime as an explanation for terminating the search.

The Chief denied discussing overtime with the Assistant Chief, and both denied canceling the search to avoid overtime. Further, the Assistant Chief denied having any conversation about overtime with the radio dispatcher.

Conclusion: Because of inconsistencies in testimony, and the absence of a record of a telephone call made to the Chief's residence around the time the Assistant Chief arrived on station, we concluded the allegation was not substantiated. Since some officers did work overtime during the search for Mr. B, it is possible a discussion of overtime occurred. However, we found no credible evidence that overtime was a conscious factor when determining the course of the search for Mr. B.

Recommendation 2

The Director, VISN 3, should:

- a) Take appropriate administrative action against Mr. Kenneth Mizrach for failing to ensure that the Lyons Campus had a sufficiently detailed plan to search the facility for missing patients, including a minimum time frame before calling off an unsuccessful extended search for an incapacitated patient; and
- b) Review Mr. Mizrach's actions with respect to maintaining a local policy to initiate extended searches prior to approval by executive management. Also, review

Mr. Mizrach's actions with respect to the policy amendment that Ms. Piche initiated. Ensure that Mr. Mizrach complies with VHA policy unless, and until, it is changed.

VISN Director Response

The VISN Director did not concur with our recommendation to take appropriate administrative action against Mr. Mizrach for failing to ensure the Lyons Campus had a sufficiently detailed search plan. The VISN Director told us the policy in effect at the time of the search for Mr. B was not deficient, and had been followed numerous times in the past with successful results. He stated that extended searches should not have a minimum time period. In addition, he did not concur that the policy failed to address the required scope of searches.

The VISN Director concurred with our recommendation to review Mr. Mizrach's actions with respect to maintaining a local policy to initiate extended searches prior to approval by executive management. He indicated he would pursue with VHA management changing VHA policy, which states that an extended search should not be initiated until after executive management approves the search. Regarding the amendment to the local policy, the VISN Director stated it was a draft only and was never implemented. He noted that only one extended search occurred between the date of the amendment and the search for Mr. B, and that executive management was notified of that search in a timely manner.

Office of Inspector General Comments

Regarding recommendation 2a, the VISN Director did not dispute that VHA policy required facility Directors to have a detailed local search plan, including a minimum timeframe for conducting unsuccessful extended searches. Furthermore, as noted earlier, Mr. Mizrach concurred with the recommendation of the Board to adopt more organized search procedures and criteria for ending extended searches. Therefore, our position on this issue remains the same and we consider the recommendation to enforce management accountability under VHA policy unresolved.

Regarding recommendation 2b, we slightly revised the wording of the recommendation to reflect our position that the VISN Director should ensure Mr. Mizrach follows VHA policy unless, and until, it is changed. Regarding the amendment to the local policy, the VISN Director's comment that the amendment was not implemented is erroneous. Medical Administration Service officials and Ms. Piche testified to us that, at the time of the search for Mr. B, local policy did not require the Medical Administration Assistants to notify executive management of an ongoing missing patient search. Furthermore, contrary to the VISN's position that only one extended search occurred between the date of the amendment and the search for Mr. B, we have documentation of other extended searches. The VISN Director needs to determine when executive management was notified of these extended searches and re-examine Mr. Mizrach's

role in implementing the policy amendment. We consider this recommendation unresolved.

Recommendation 3

The Director, New Jersey Healthcare System should:

- a) Take appropriate administrative action against Ms. Piche for issuing guidance to delay notifying executive management of missing patients, contrary to VHA policy; and
- b) Take appropriate administrative action against the Chief, Police and Security Section, for failing to ensure that the Lyons Campus had a sufficiently detailed missing patient search plan, and for failing to ensure all police officers received systematic training to conduct extended searches.

VISN Director/New Jersey Healthcare System Director Response

The New Jersey Healthcare System Director did not concur with the recommended action concerning Ms. Piche. He asserted that the guidance to delay executive management notification until the next morning report was only in draft and was not implemented.

The VISN Director and the New Jersey Healthcare System Director did not concur with the recommended action concerning the Police Chief. As indicated above, the VISN Director told us the policy in effect at the time of the search for Mr. B was not deficient, and had been followed numerous times in the past with successful results. On the issue of police training, Mr. Mizrach told us search training was available to officers as part of the Law Enforcement Training Center curriculum, and was reinforced by on-the-job training, which included police officer participation in 20 extended searches between June 1997 and June 1998.

Office of Inspector General Comments

We consider recommendation 3a unresolved. As noted above, the assertion that the amended policy was only a draft and was not implemented is incorrect. Medical Administration Service employees followed the amended policy in the months preceding the search for Mr. B.

We also consider recommendation 3b unresolved. At the time of Mr. B's disappearance, the Lyons Campus did not have a detailed search plan or systematic search training for police officers. The grid search plan officials created after the incident is an acknowledgement that they previously did not have a sufficiently detailed local search plan. The New Jersey Healthcare System Director has not provided a satisfactory explanation for not holding management accountable for complying with VHA policy on these matters.

Issue 4: The completeness and accuracy of the Board's report on activities relating to the site where Mr. B's body was found
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We found that, while the Board made several helpful recommendations aimed at improving the management of future medical emergency scenes, it did not accurately assess some of the actions that occurred at the construction site after Mr. B's body was found. The Board did not accurately assess and report available testimony establishing that the medical emergency team physician was primarily in charge of efforts at the death scene and that he requested firefighters move Mr. B's body. Complicating the Board's assessment of activity at the construction site was the fact that the physician denied he ordered Mr. B's body be moved. The Board recommended action against police officers for not establishing a controlled "crime scene" without adequately explaining what created this obligation. In another issue relating to the construction site, the Board criticized Engineering Service employees for their selection of a protective fence without determining whether the fence violated a specific policy or regulation.

Assessing responsibility for control of the scene and moving the body

Standard: VHA Manual M-2, Part VI, Chapter 8.03 (5) requires deaths with medicolegal significance be reported to the local medical examiner or equivalent, but does not specify that the body shall not be moved before being seen by the medical examiner. Local policy defines a medicolegal death as including an unnatural or violent death, whether by accident or undetermined means.

Discussion: In response to a report of a non-responsive man in the construction ditch, the medical emergency team arrived on the scene at approximately 7:17 a.m. A respiratory therapist determined the man had no pulse and obtained information that helped identify the man as Mr. B. A total of 16 employees responded to the scene in an official capacity, including the employee who first noticed Mr. B, the Safety Officer, the medical emergency team, firefighters who assisted with the rescue efforts, and three police officers. The police officers arrived at 7:31 a.m. in response to a request for a camera. In addition to these employees, many bystanders from a nearby parking lot arrived on the scene. During the incident, employees knocked down portions of the fence, assembled on the edge above the trench, moved a ladder, made several trips into the muddy trench, adjusted Mr. B's clothing, and removed his wallet. The Deputy Fire Chief took photographs from several locations within the trench. At approximately 7:45 a.m., the medical emergency team physician, accompanied by two firefighters, entered the trench to examine the patient. At the physician's request, the firefighters turned the patient over. The physician determined that the patient was dead.

The Board reported that no one in particular appeared to be in charge at the construction site following the discovery of Mr. B's body. However, most clinicians, firefighters, and police officers who we interviewed testified that the medical emergency

team physician was in charge of the incident response. They told us that, until the physician examined the body, they considered the scene a medical emergency, as it was initially reported. Shortly after the physician pronounced Mr. B dead, he left the scene. At this point, there was no consensus among those remaining at the scene regarding who was in charge.

The Board reported that a witness claimed the physician ordered the body be moved from the trench, but the Board also reported that “no witness specifically recalled hearing the physician order the removal of the body, nor did they remember anyone at the site giving this order.” Although Board members acknowledged that several witnesses reported being told the physician had given the order, he denied it, and the Board concluded the allegation was not corroborated. However, in a June 1, 1998, statement provided to the Board, the Deputy Fire Chief wrote that, after the patient was pronounced dead, “The fire department was instructed by the medical team Dr. to move the body to building 4.” The Deputy Fire Chief testified before the Board that “...the doctors told me to put the body in the Stokes basket” (a device which the rescue team uses to move patients). Although the Deputy Fire Chief referred to “doctors,” the medical emergency team physician was the sole physician present at the site. In testimony to us, the Deputy Fire Chief specifically referred to the physician by name as the person who told him to move the body.

The Deputy Fire Chief told us that while he and the physician were in the trench, he asked the physician if he wanted to wait for the medical examiner. He said, despite his objections to the physician, the physician directed him to remove the body from the trench. The Safety Officer told us that while she was standing at the edge of the trench above the two officials at this time, she heard the physician direct the Deputy Fire Chief to move the body to Building 4 and observed the Deputy Fire Chief become angry during this exchange. Other firefighters told us that the Deputy Fire Chief complained to them the same morning that the physician had directed him to move the body.

The Board received, but did not report, an allegation that members of executive management were on the scene and also failed to prevent removal of the body. We did not substantiate that members of the executive management team were present at the construction site.

Conclusion: The testimony of witnesses clearly indicates that the medical emergency physician was considered to be in charge of the incident response, which had been reported as a medical emergency. Furthermore, we found persuasive the testimony of the Deputy Fire Chief and the Safety Officer that the physician was responsible for directing the rescue team to move the body, particularly because no witness provided an alternate explanation for why the body was moved. The Board inaccurately summarized the testimony concerning responsibility for requesting that firefighters move Mr. B prior to involvement by the medical examiner.

Responsibility of subordinate police officers to establish a crime scene

Standard: The Lyons Campus facility is an exclusive Federal/VA jurisdiction. VA policy and Lyons Campus Police and Security Section "Standard Operating Procedures" in effect at the time of Mr. B's death required police to protect crime scenes until more qualified personnel arrived.

Discussion: The Board report characterized the scene as a crime scene and claimed that police violated "Standard Operating Procedures" because they did not take charge of the scene. The Board also criticized the police officers because they did not stop others from removing Mr. B's body before the medical examiner arrived. For these reasons, Board members recommended that administrative action be taken against the police officers involved.

The Board report did not identify any evidence that a crime had been committed against Mr. B. The Board report did not cite specific "Standard Operating Procedures," other policies, or training materials that instructed police officers to treat the scene of an unexpected death as a crime scene. The Board report did not identify any routine practice on the Lyons Campus of protecting scenes of unexpected deaths as crime scenes. The Board correctly reported that the **(b)(6)**..... was present at the scene and did not take action to secure it. In his testimony, the **(b)(6)**..... told the Board that, while he recognized the construction site as a crime scene, he left the scene without providing any instructions to the two remaining subordinate police officers. The Board asked one subordinate police officer present at the scene if anyone present identified it as a crime scene and was told no. The Board did not ask either subordinate police officer to verbalize his understanding of policies or past practices relevant to police responsibilities at scenes of unexpected deaths.

Police officers told us they were not routinely called to secure the scenes of unexpected deaths or medical emergencies at the Lyons Campus, and there was no police record of this occurring within the previous year. The subordinate police officers present at the site told us that the Assistant Chief was senior officer at the site and he did not request that they secure the scene. One police officer told us a complaint would be filed immediately against any officer who tried to override the instructions of a physician. Similarly, firefighters told us that they believed they would be subject to harsh criticism if they did not defer to the physician's instructions. When asked why the Board recommended action against officers for not securing the scene when there was no VA policy or training requiring that, no request from anyone at the scene that they do that, and no evidence of a crime, the Board member with a police background responded, "Good question." In response to a Board recommendation, Police and Security Section policy now requires that the police be called simultaneously to similar incidents and that accidental death scenes be controlled and preserved as crime scenes.

VA policy required a medical examiner review of Mr. B's death, particularly because the death was unattended and in a non-clinical setting. The best practice in medical examiner death cases is to preserve the scene. In this incident, the activities of the employees connected with the medical emergency response already compromised the scene prior to the arrival of the police. The physician requested the body to be moved prior to completing his examination (when Mr. B was turned over) and afterwards when he requested moving Mr. B's body away from the site. Although protecting the scene would have been advisable, the Board did not identify evidence that the subordinate officers knew, or should have known, that they were responsible for securing the scene and preventing the physician from having the body moved. Police policies and practices may vary among jurisdictions. The Board's recommendation to provide clear policy guidance on this issue demonstrates that the recommended administrative actions against subordinate officers for not protecting the scene were not sufficiently supported.

Conclusion: The Board erroneously concluded that not protecting the scene where Mr. B's body was found and permitting the body to be moved violated "Standard Operating Procedures" and used this as its basis for recommendations against police officers they held responsible for doing so.

Appropriateness of the fencing surrounding the construction site

Standard: Occupational Safety and Health Administration (OSHA) Regulations [29 CFR 1926.501(b)(7)(ii)] require that employees working at the edge of a well, pit, shaft, and similar excavation 6 feet or more in depth be protected from falling by guardrail systems, fences, barricades, or covers. Although this is a general industry standard to protect workers, it implies a buffer zone for non-workers as well. However, the OSHA standard provides no precise specifications for such barriers or barricades.

Discussion: The construction site where Mr. B's body was found was protected by a clearly visible orange, plastic fencing. Although the Board recommended administrative action against the employee responsible for selecting what Board members considered the "least appropriate" fencing, it did not cite a violation of any rule or regulation which required fencing other than the type used. In response to the Board's report, Engineering Service officials determined the fence complied with OSHA standards. Witnesses established that the fence was intact at the time the patient was first observed in the trench, suggesting that Mr. B voluntarily stepped or climbed over it when gaining access to the construction site. Management did not take action against the employee responsible for the fencing, but in response to another of the Board's recommendations, took action to increase the height and strength of construction fencing to afford greater protection than required by OSHA standards.

Conclusion: The Board inappropriately recommended that administrative action be taken against the employee responsible for selecting the fence surrounding the

construction site where Mr. B's body was found. However, since management did not implement this recommendation, we consider the matter resolved.

Medical Officer-of-the-Day Knowledge of Emergency Procedures

Discussion: The medical emergency team physician, who was the Medical Officer-of-the-Day, is not a regular VA employee. Although the Board recommended action to improve the qualifications of the Medical Officers-of-the-Day, it failed to address specific deficiencies in the physician's knowledge of local policy or adequately address his role in protecting the integrity of the scene for the medical examiner. When questioned on the course of the rescue effort, the physician told us that he relied on the expertise of the police officers who arrived at the scene in T-shirts and were assisting him in the trench. In fact, these employees were Lyons Campus firefighters who responded to the emergency prior to fully dressing. Lyons VA police wear police uniforms.

Conclusion: The emergency medical team physician's failure to distinguish between firefighters who were assisting in the rescue efforts and VA police officers may explain why he did not request police support after the respiratory therapist determined that the patient had no pulse and appeared to be dead.

Recommendation 4

The Director, New Jersey Healthcare System, should consider the appropriateness of continuing the Medical Officer-of-the-Day's services, in light of the inaccurate testimony he provided to the Board.

VISN Director/New Jersey Healthcare System Director Response

The VISN Director told us he and Mr. Mizrach considered the appropriateness of the Medical Officer-of-the-Day's services and found the physician "wholly suitable." The VISN Director noted that the Medical Officer-of-the-Day met the rigorous standards of the medical staff and possessed the necessary credentials and qualifications for clinical appointment. The VISN Director stated he did not believe the physician's actions, judgment, or testimony warranted any adverse action.

Office of Inspector General Comments

The emergency medical team physician provided inaccurate testimony to the Board. Since the physician is not a regular VA employee, the only adverse action available is termination of his contract. The VISN Director and Mr. Mizrach determined that no adverse action was warranted. Given their oversight responsibilities, we assume they will closely monitor the physician's future performance. We consider the recommendation closed.

Issue 5: Whether patient neglect and mismanagement occurred

It is undisputed that the nursing staff neglected to appropriately monitor the whereabouts of Mr. B on May 30, 1998, which resulted in a delay in initiating a search. It is also undisputed that the VA police neglected to conduct an adequate search of the premises, which delayed finding Mr. B's body. We consider the above actions evidence of mismanagement at the supervisory level in the Nursing Service and the Police and Security Section.

Based on our review of the medical evidence, the autopsy report and our discussions with the Chief Medical Examiner of New Jersey and the Deputy New Jersey State Medical Examiner regarding the results of the autopsy, we cannot conclude that these errors proximately resulted in or caused Mr. B's death. A precise and indisputable cause of the death of this patient is not, and we have concluded, probably cannot be known. Nonetheless, the autopsy findings and other evidence, lead us to conclude that, more likely than not, Mr. B died shortly after he left the ward on May 30, 1998, and before a search of the construction site would have been required under Lyons Campus policy and procedures.

The evidence on which we base this conclusion includes:

- Mr. B was seen leaving Ward **.(b)(3)(b)(6)** at or about 9:00 a.m. on May 30, 1998. At or around 9:00 a.m. he was given his prescribed morning dose of 25 mg. of **.(b)(3)(b)(6)**, a medication used to treat **.(b)(3).(b)(6)**.....
- At the time of autopsy, **.(b)(3)(b)(6)** was found in the gastric juices at a very high concentration (3.45 milligrams per kilogram) relative to the blood concentration of the same drug (0.02 milligrams per liter). The most logical and probable explanation for these widely differing drug levels is that the patient died before the drug had time to be fully digested and passed into the blood stream.

The Chief Medical Examiner for New Jersey advised that the contents of the stomach empty within 3-5 hours. Therefore, it is more likely than not that Mr. B died sometime before 2:00 p.m. on May 30, 1998.

Findings regarding the state of decomposition of the body that further suggest an early death include:

- The autopsy noted skin slippage, despite the fact that Mr. B wore a long sleeve shirt; and,
- The body was quite malodorous.

Had the nursing staff recognized at 11:00 a.m. that Mr. B had not returned to the unit, Lyons Campus policy required a local search, which takes approximately 1 hour. If the patient is not found, the policy next required a general search. If the patient is not found within 2 hours after the general search begins, then a decision is made whether an extended search is warranted. Neither the local nor the general search procedures required searching construction sites.

If the local search commenced at 11:00 a.m., the earliest a decision would have been made to conduct an extended search would be 2:00 p.m. Based on the autopsy results, Mr. B, more likely than not, died sometime prior to 2:00 p.m. We concluded that, even if Mr. B's failure to return had been noted timely, he was probably dead prior to the earliest time a decision to search construction sites would have been considered under Lyons Campus policies.

Issue 6: The appropriateness of management's efforts to investigate the search for Mr. B and the recovery of his body

The Director's decision to investigate the search for Mr. B and the subsequent recovery of his body was appropriate. However, the short time frame for the Board to review the incident and issue a report affected efforts to assess individual responsibility, and some issues were not thoroughly investigated. Management used the Board's results to propose, sustain, and take administrative action against employees without ensuring that the evidence adequately supported the charges. As previously discussed, certain Nursing Service staff were charged with violations based on inconsistent evidence. In one case, management sustained an unsupported charge against a police officer even though the Board did not recommend this action.

Appropriateness of convening an Administrative Board of Investigation

Standard: VHA Directive 1051/1 requires healthcare facilities to maintain a Patient Safety Improvement program to prevent injuries to patients, visitors, and personnel. The Directive defines an unexpected loss of life as a sentinel event, and mandates that the local facility conduct either a focused review or a Board of Investigation into the event. When there is a likelihood that the review's findings will become the basis for administrative action, the Directive requires use of a Board of Investigation. The Board must consist of representatives from the same professions as the employees under review. The Directive prohibits Board membership by persons directly involved in the incident under review, or by the direct supervisors of persons involved. The Directive further requires sentinel events to be reported to the VISN within 24 hours. In addition, facilities are responsible for reporting suspected criminal activity to the appropriate law enforcement agency and for notifying the Office of the Deputy Assistant Secretary for Security and Law Enforcement.

Discussion: The members of the Board of Investigation that reviewed the search for Mr. B and the recovery of his body consisted of a physician, a nurse, and a police officer, representing the professions of the employees under review. The Board members were from the East Orange Campus of the New Jersey Healthcare System, and were not the direct supervisors of persons involved. The Board received support from the Lyons Campus Risk Manager and a Human Resources Management Service official who participated in the interviews and assisted in preparing the report. We identified no evidence that the Board members, Risk Manager, the Human Resources Management Service official, or the Director were personally involved in the activities under review (i.e., Mr. B's privileging, supervision, the search, or control of the accident scene).

Lyons Campus officials made the required notifications concerning the disappearance and death of Mr. B, and also notified the Federal Bureau of Investigation (FBI). Once

the New Jersey Medical Examiner ruled out foul play, the FBI elected not to pursue an investigation since there was no evidence a crime had occurred.

Conclusion: Mr. Mizrach was required to establish the Board of Investigation. His selection of the Board members was not improper. We found no indication that he inappropriately assigned subordinates to investigate himself, as he was not directly involved in the incident.

Thoroughness of the Board of Investigation

Standard: The local Guide for Administrative Investigations, as provided to the Board by the **(b)(6)**, reminded Board members that “findings and conclusions presented in the report must always rest soundly on the testimony and other backup evidence,” and that “a report which omits relevant or mitigating information can result in a report which fails to provide enough information to justify corrective and/or disciplinary action.”

Discussion: In accordance with the VHA Directive, the Board members were professional peers rather than trained investigators. In the June 1, 1998, memorandum establishing the Board, Mr. Mizrach directed that the review be completed and a report submitted by June 12, 1998. Completion of the review was subsequently extended by 2 weeks. The Director’s assignment to the Board specified 10 issues to be addressed during the investigation, the vast majority of which dealt with policy, procedures and process, and not with the events that occurred between May 30 and June 1, 1998.

Despite differences in testimony, the Board did not adequately follow up on inconsistencies or request clarification when provided with vague responses. In addition, the Board did not always seek information necessary to establish personal responsibility, such as knowledge and understanding of specific policies or objective standards used to assess performance or conduct. The Board did not consistently obtain employees’ responses to derogatory evidence against them before concluding that it was true.

The Board members were sometimes careless when formulating and reporting their results. Despite the fact that Board members did not always attend interviews, two of the Board members told us that they also did not review the transcribed testimony when preparing the report. There were instances, such as police search training, when the Board inaccurately described the evidence obtained. In many cases, instead of presenting the relevant evidence on an issue, the Board did not cite evidence or only reported select evidence that supported its conclusion. As previously discussed, the Board did not correctly report that eyewitnesses had identified the physician as requesting that Mr. B be moved.

Conclusion: Despite success in identifying procedural improvements, the Board did not adequately establish what occurred during key events and did not thoroughly assess

personal responsibility. The emphasis on evaluating process, the volume of information requiring review, and the short time frame appear to have contributed to these weaknesses. These factors also limited the Board's ability to comply with the requirements of the Guide for Administrative Investigations, as they relate to the need for findings and conclusions to rest soundly on the evidence and to include relevant and mitigating information.

Appropriateness of administrative charges against employees

Standard: VA Manual MP-5, Part I, Chapter 752, provides that the official authorized to initiate administrative action against an employee should determine the facts in a case, consider extenuating or mitigating circumstances, and consult with the Human Resources Management Officer to determine the action to be taken. When an action is contemplated, an evidence file must be established before the action is proposed. When information from an official investigation appears inadequate to support a contemplated action, management is required to consult with the Human Resources Management Officer concerning the necessity of developing additional information. The responsible approving official on the proposed action is required to give full and impartial consideration to the employee's replies and all evidence of record before making a final decision on the proposed action. Human Resources Management Service officials are responsible for assisting management throughout the disciplinary and adverse action process.

Discussion: The Board report did not always cite the specific evidence against individual employees and seldom presented exculpatory evidence. Management was obligated to review the relevant portions of the record when contemplating proposed action. Despite this responsibility, there were a number of instances in which management proposed and sustained unsupported charges against employees. For example, management implemented one of the Board's recommendations, discussed earlier, by charging subordinate police officers with failure to designate the area where Mr. B died as a crime scene and permitting the rescue team to move the patient's body. These charges were proposed and sustained even though no policy defining the scene of a medical emergency as a crime scene existed, no supervisory guidance was given to the subordinate officers, and the officers had no routine practice of responding to unexpected deaths or medical emergency scenes. Management proposed and sustained action against one officer for not searching the construction site, even though the record is clear that management directed his assignments and he had no opportunity to complete a search of the construction site before management cancelled the search.

With respect to the Nursing Service, a single statement by a nursing assistant was used to support a charge in a removal action against another nurse. In addition to being uncorroborated and inconsistent with the evidence, the statement appears to lack credibility. On the other hand the nursing assistant received a less severe disciplinary action than others, even though others had stronger evidence against them.

The Associate Director (East Orange Campus), who proposed removal for most of the police officers receiving administrative action, told us that since Directors usually mitigated proposed administrative actions, he proposed more severe actions to provide the Director with ample latitude in the decision making process. In many cases, the severity of the proposed actions against the nurses, i.e., removal, was supported by the finding that the misconduct cited was more egregious because Mr. B was found dead. This suggests that more severe action was warranted because the patient's death could have been prevented if actions were taken in a timely manner. However, the charges that linked nursing performance with Mr. B's death were proposed prior to issuance of the final Medical Examiner's report on August 11, 1998. A representative for one of the employees told management in August 1998 that they did not provide evidence as to the timing of Mr. B's death to support the proposed charges. Despite this notice, Mr. Mizrach continued to cite Mr. B's death as an aggravating factor when approving the final disciplinary actions against nurses. It is not clear what evidence existed to support management's decision to link the nurses' actions with Mr. B's death. But, based on analysis of the final medical examiner results, this aggravating factor is unsupported.

Conclusion: Management proposed, sustained, and took administrative action against employees without consistently ensuring that the evidence adequately supported the charges. As specific examples, the charges against two police officers (.(b)(6)..... and .(b)(6).....) for failing to search the construction site during the extended search, and the charges against two subordinate officers (.(b)(6)..... and .(b)(6).....) for failing to take charge of a crime scene or prevent the removal of Mr. B's body, were unsupported. In addition, charges against two nurses (.(b)(6)..... and .(b)(6).....) were unsupported. The claim that the severity of the nursing actions was aggravated by Mr. B's death was also unsupported.

Recommendation 5

The Director, VISN 3, should:

- a) Review the charges brought against the employees in the Police and Security Section and Nursing Service to determine whether the charges, as stated in the proposed actions, are supported by the evidence. Charges and other disciplinary factors that are not supported, including those cited in our conclusion, should be expunged from the employees' Official Personnel Files. Also, ensure that the remaining administrative actions are appropriate in light of the corrected record.
- b) Take appropriate administrative action against New Jersey Healthcare System employees who proposed and sustained charges that were not supported by the evidence.

- c) Review VISN Board of Investigation procedures to identify ways of preventing similar quality control problems in future administrative investigations, especially when the urgency of resolving issues of patient safety may conflict with the need to accurately assess individual responsibility.

VISN Director Response

The VISN Director did not concur with our recommendation to review the charges brought against employees in the Police and Security Section and the Nursing Service. He stated the employees have well defined appeal processes for disciplinary actions and he told us a review at the VISN level was unnecessary. Further, he noted that Mr. Mizrach appropriately reviewed the Board's findings and recommendations, and personally interviewed the affected employees. Nevertheless, the VISN Director told us that, at his request, the Human Resources Management Service at the VA Medical Center in the Bronx, New York, reviewed all the disciplinary actions. He said officials at that facility found the actions supportable.

The VISN Director also did not concur with our recommendation that he take appropriate administrative action against the employees who proposed and sustained charges not supported by the evidence. The VISN Director told us that, based on the results of the review conducted by Bronx Medical Center's Human Resources Management Service, no disciplinary action would be taken.

Finally, the VISN Director did not concur with our recommendation that he review VISN Board of Investigation procedures. He told us he did not agree there were quality control problems with the manner in which the Board investigating the search for Mr. B was conducted. He said, on the contrary, the Board fulfilled its responsibilities in a professional and timely manner.

Office of Inspector General Comments

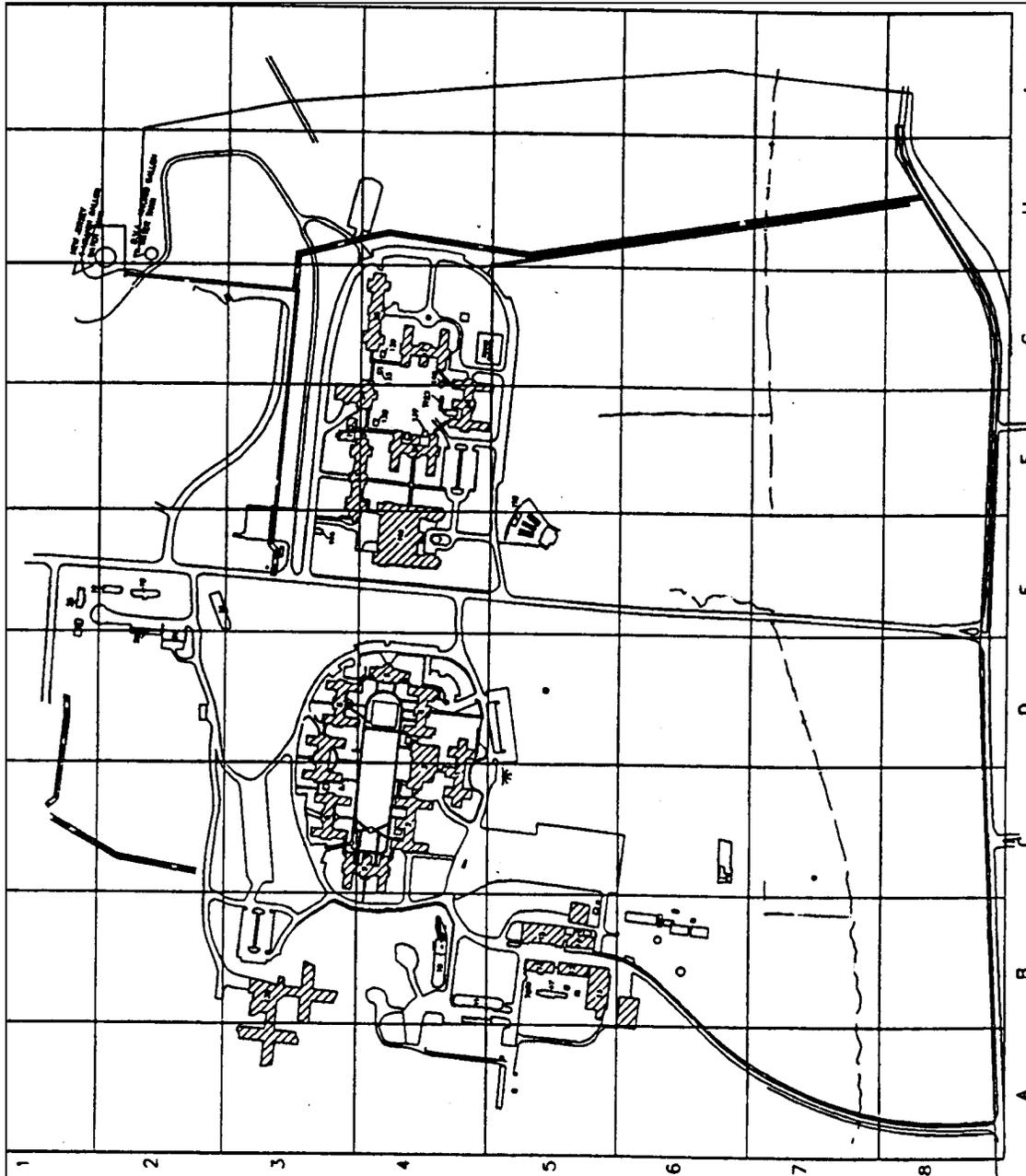
Regarding recommendation 5a, despite the favorable review by the Bronx Medical Center, we found the evidence did not support some of the charges proposed and sustained against the police officers and nurses. In his response, the VISN Director did not provide any specific evidence to explain why he considered the charges to be supported. To give one example of an unsupported charge, management officials charged Police Officer A with violating the local policy requiring searches of construction sites during the extended search phase. The official who prepared the charge against Officer A told us that, during the general search, Officer A did not check the construction site where Mr. B's body was found, even though he checked another nearby site. However, the charge against Officer A referred to the extended search and not activities that took place during the general search. Furthermore, local policy did not require searching construction sites during the general search. The official who prepared the charge told us he also based the charge on evidence that Officer A had

another opportunity to search the site when performing the night vision search. We found the search was terminated before Officer A had an opportunity to get to that area. Furthermore, night vision equipment is not generally effective for detecting objects beneath the surface.

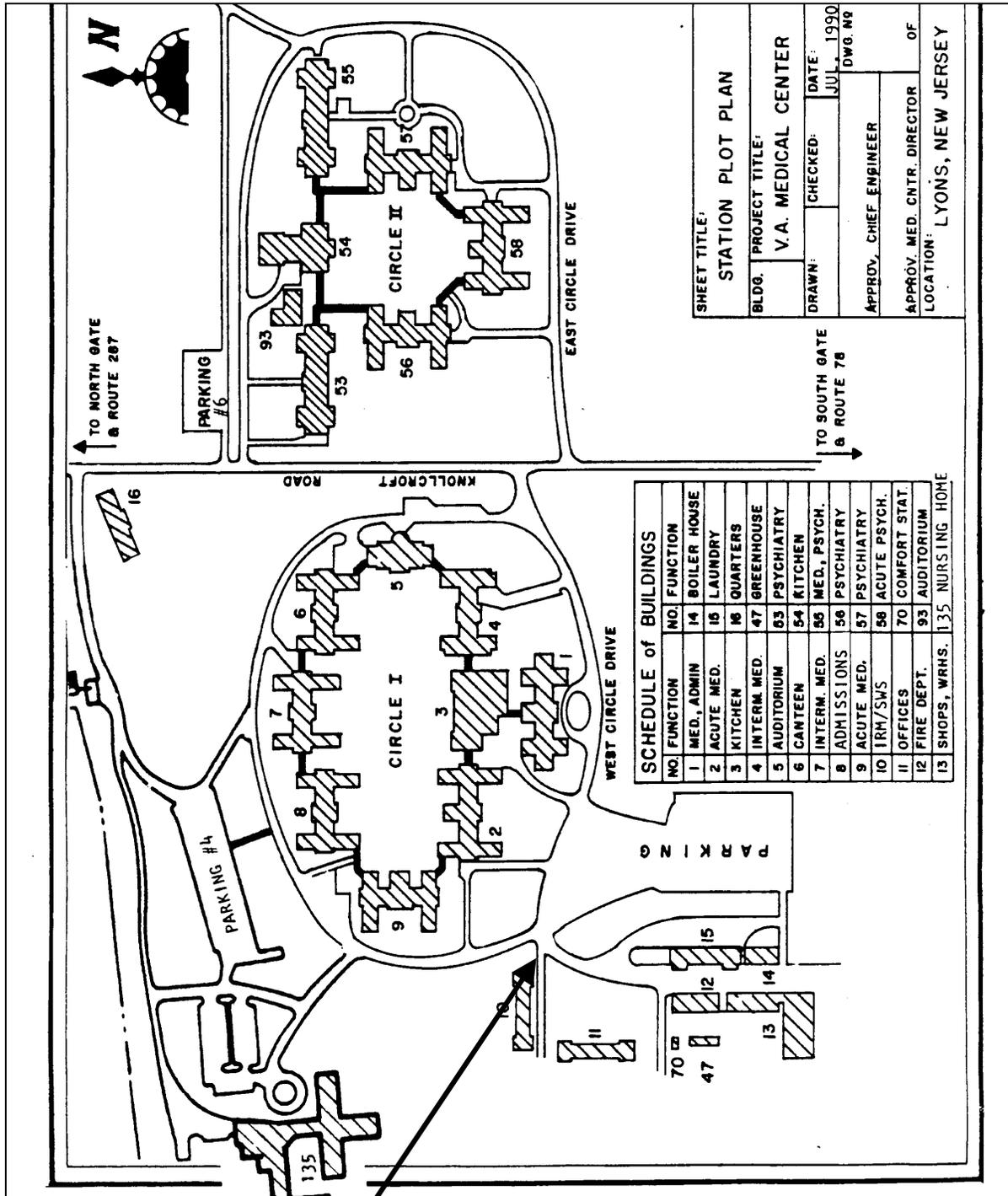
Because we continue to believe that the evidence does not support some of the charges brought against employees, our position on recommendation 5b remains the same. Administrative action against the employees who proposed and sustained the charges is warranted. Additionally, although the VISN Director did not concur with recommendation 5c, he did not provide additional information to refute the deficiencies cited in this report.

We consider recommendations 5a, 5b, and 5c unresolved.

MAP OF LYONS CAMPUS
COMPLETE VIEW



MAP OF LYONS CAMPUS
AREA OF CIRCLES 1 & 2



Area where patient was recovered.

VISN 3 DIRECTOR RESPONSE

**Department of
Veterans Affairs****Memorandum**

Date: May 27, 1999
From: Network Director (10N3)
Subj: Response to Office of Inspector General Comments to Draft Report dated May 4, 1999
To: Assistant Inspector General for Investigations (51Q)

1. Upon review of the Office of Inspector General's (OIG) comments to our May 18, 1999 response to the draft report (project # 91Q004HQ) we offer the following additional comments.
2. It is apparent from the comments of the OIG that there is concurrence that the investigative board conducted their investigation in good faith and without any untoward conduct. As professionals in their given occupations, each board member relied upon their expert knowledge of requirements for their professions which is not always inherently written in a policy statement. As subject matter experts, as opposed to highly skilled investigators, the Board acted appropriately and within their abilities to gather information, draw conclusions and propose recommendations. The manner in which they interviewed witnesses, analyzed events to decide facts, and determined the sufficiency of evidence is based moreover on this orientation rather than on backgrounds as expert investigators.
3. It is the opinion of the OIG that "the Board did not ask appropriate or in-depth questions, and did not address all relevant issues. . ." It appears that the OIG will not defer from this opinion because it is essential to their conclusion that 'the disciplinary actions and the Board's review must be the primary focus of criticism'. We can only add that the analysis conducted by the OIG is limited by the use of the written report and therefore negates the effect of the professionalism each Board member relied upon in their deliberations. Since it is not customary to create a record of the deliberations of each administrative board, it is requested that the OIG exercise great care in characterizing the actions of the Board without this additional information.
4. In referencing the Board's report, it does not appear that the OIG comments and statements gave consideration to what the Board members witnessed through their collective understanding as subject matter experts. The inference by the OIG appears to merely be a criticism, rather than a conclusion based on the results of subsequent inquiry. Without being given the opportunity to actually conduct the additional inquiry stipulated by the OIG, we find it is impossible to conclude that the deficiencies cited by the OIG, if resolved, would have resulted in different conclusions by the Board. Unless the OIG can at this time concretely establish what impact additional inquiry or follow up by the Board would have on the resulting disciplinary action, we request the OIG not imply that harmful errors have occurred.
5. At a number of points in the report, the OIG questions the Board's findings, the appropriateness of the charges contained in proposed disciplinary actions as well as the appropriateness of the penalties proposed. The concern appears in a number of forms throughout the report.
Why did the Board fail to pursue all of the potential relevant issues?

How did the Board and proposing officials reconcile contradictory testimony?
 How did the Board and proposing officials decide credibility?
 How did the Board and proposing officials determine the probative weight of each piece of evidence?
 What were certain assumptions made about professional responsibility?

Viewed in their entirety, the OIG comments seem to point to a dispute over the “burden test.” The comments seem to imply a “clear and convincing” evidence test rather than “preponderance of the evidence.” In the OIG’s review of the disciplinary actions, we believe the OIG must apply the preponderance test as we did. Preponderance of evidence requires that a reasonable person would find the charge is more likely true than not true or more than 50% true. This difference in perspective led to the OIG constructing a different narrative than we constructed from substantially the same evidence.

6. We are also concerned about the OIG’s willingness to make credibility decisions based largely on the written record. We believe that credibility can only be determined by listening to the witness, by looking for non-verbal cues and by observing the witness’ demeanor. We further believe that that one needs to consider the recollection within one’s shared tacit knowledge of the standards of practice within separate occupational cultures and within the shared context of the organizational culture. Even the MSPB defers to the presiding official on matters of credibility. We suggest that the OIG defer to our credibility decisions.
7. We agree with the OIG’s conclusion that the patient’s death weighed heavily on our determination of the proposed penalty in the disciplinary actions. The consequences of an action or failure to take an action are appropriate to consider in determining that penalty (Douglas v VA, 5 MSPB 280, 306, 1981).
8. We believe that the disciplinary process answered the question of whether we met our burden of proof. The Board arrived at a number of conclusions and recommended a number of appropriate actions. A line official reviewed those recommendations as well as the evidence and proposed action from within the context of that official’s experience at the Lyons Campus. The deciding official added meaning and context to the board’s findings. The employees responded. A deciding official considered the response and communicated a decision to the employee. Most employees did not appeal or grieve the actions; nor did the union chose to pursue the decisions from an organizational justice perspective. The reason seems clear – the actions were reasonable within the context of our collective experience.
9. The Human Resources Management Service at the Bronx reviewed all disciplinary actions and found the actions supportable . See attached narrative.
10. If you have any questions or require further information, please contact me at (718) 579-3590.

JAMES J. FARSETTA, FACHE
 Network Director

Attachment

**OIG COMMENTS ON THE VISN 3 DIRECTOR'S
MAY 27, 1999 COVER MEMORANDUM**

The VISN Director criticizes the manner in which the OIG reviewed the accuracy of the Board of Investigation's findings and the validity of our conclusions regarding management's charges against some employees. However, the fundamental question remains whether the evidence of record supports these findings and charges. Despite being told of several specific inaccuracies in the Board's report, the VISN Director neither thoroughly reviewed the supporting evidence nor provided us specific evidence to rebut our findings.

We disagree with the VISN Director's assertion that the "analysis conducted by the OIG is limited by the use of the [Board's] written report and therefore negates the effect of the professionalism each Board member relied upon in their deliberations." In addition to reviewing the report of investigation submitted by the Board, we reviewed the transcripts of the interviews the Board conducted, all documentation the Board reviewed in reaching its conclusions, and other documentation Board members and New Jersey Healthcare System officials had available but did not review. We personally interviewed all members of the Board, the Board advisor, Lyons Campus management, and most of the witnesses previously interviewed by the Board. Contrary to the VISN Director's assertion, we did consider the professionalism of each Board member. However, as the VISN Director acknowledged, the deliberations of the Board were not documented. Therefore, such deliberations were not, and should not have been, the basis for any of the disciplinary actions.

The VISN Director indicates he does not have sufficient information to determine whether resolution of the deficiencies we cite would have resulted in a different conclusion by the Board, or what impact additional inquiry would have had on the resulting disciplinary actions. Although the VISN Director may not have had sufficient time to conduct a new investigation, none was required. On three occasions, we offered to travel to the VISN office and present him a detailed review and analysis of the evidence we obtained and relied upon in reaching our conclusions. The VISN Director declined our offers.

The VISN Director's assertion that we appeared to use the "clear and convincing" evidence test and not the required "preponderance of evidence" test is erroneous. We are aware of the standard of proof required in disciplinary action cases and applied the correct standard in considering the evidence in this case.

Similarly, the VISN Director's statement that we made credibility determinations largely on the written record is incorrect. As indicated above, we conducted our own interviews and, in the few instances where we questioned the credibility of certain witnesses but were unable to interview them personally, we found their testimony to be inconsistent with other testimony or evidence provided by the same employee and/or others. The VISN Director suggests that the OIG should follow the lead of the Merit Systems

Protection Board (MSPB) in deferring to the presiding official on matters of credibility. We agree that the MSPB ordinarily defers to the administrative judge's findings of fact and credibility determinations. However, this occurs only in those circumstances where the administrative judge's initial decision identifies all material issues of fact and law, summarizes the evidence, resolves issues of credibility, and includes the administrative judge's conclusions of law and his legal reasoning, as well as the authorities on which that reasoning rests. Spithaler v. Office of Personnel Management, 1 M.S.P.R. 587, 589 (1980). Clearly, there is no report or other documentation that shows the reasoning behind the Board's findings of fact or credibility determinations. Further, the MSPB and the OIG have different authorities and functions. Interpreting evidence is an essential part of our responsibility to investigate allegations. Accordingly, absent a thorough written analysis, there is no basis for relying on the results of the Board on issues of conflicting evidence and credibility determinations.

Finally, in his initial response to the draft report, the VISN Director told us that all the disciplinary actions were reviewed and approved by an attorney in Regional Counsel's Office. We contacted the attorney and she told us she reviewed some, but not all, of the proposed actions and advised New Jersey Healthcare System officials that the charges were well written but not supported by the evidence. After this information was presented to the VISN Director, he requested a review by the Human Resources Management Service at the Bronx Medical Center, a facility within his jurisdiction. This review was conducted without direct input from the OIG and did not specifically address the issues we identified in our review. The one page narrative prepared by officials at the Bronx Medical Center does not contain sufficient information to demonstrate that all, or even sufficient, evidence was reviewed.