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VA HEALTH CARE

Improvements Needed for Monitoring and Preventing Sexual Assaults and Other Safety Incidents

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Highlights

Highlights of GAO-11-736T, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

During GAO's recent work on services available for women veterans (GAO-10-287), several clinicians expressed concern about the physical safety of women housed in mental health programs at a Department of Veterans Affairs (VA) medical facility. GAO examined (1) the volume of sexual assault incidents reported in recent years and the extent to which these incidents are fully reported, (2) what factors may contribute to any observed underreporting, and (3) precautions VA facilities take to prevent sexual assaults and other safety incidents.

This testimony is based on recent GAO work, *VA Health Care: Actions Needed To Prevent Sexual Assaults and Other Safety Incidents*, (GAO-11-530) (June 2011). For that report, GAO reviewed relevant laws, VA policies, and sexual assault incident documentation from January 2007 through July 2010. In addition, GAO visited five judgmentally selected VA medical facilities that varied in size and complexity and spoke with the four Veterans Integrated Service Networks (VISN) that oversee them.

What GAO Recommends

GAO reiterated recommendations that VA improve both the reporting and monitoring of sexual assault incidents and the tools used to identify risks and address vulnerabilities at VA facilities. VA concurred with GAO's recommendations and provided an action plan to address them.

View GAO-11-736T or key components. For more information, contact Randall B. Williamson at 202-512-7114 or williamsonr@gao.gov.

What GAO Found

GAO found that many of the nearly 300 sexual assault incidents reported to the VA police were not reported to VA leadership officials and the VA Office of the Inspector General (OIG). Specifically, for the four VISNs GAO spoke with, VISN and Veterans Health Administration (VHA) Central Office officials did not receive reports of most sexual assault incidents reported to the VA police. Also, nearly two-thirds of sexual assault incidents involving rape allegations originating in VA facilities were not reported to the VA OIG, as required by VA regulation.

GAO identified several factors that may contribute to the underreporting of sexual assault incidents. For example, VHA lacks a consistent sexual assault definition for reporting purposes and clear expectations for incident reporting across its medical facility, VISN, and VHA Central Office levels. Furthermore, VHA Central Office lacks oversight mechanisms to monitor sexual assault incidents reported through the management reporting stream.

VA medical facilities GAO visited used a variety of precautions intended to prevent sexual assaults and other safety incidents. However, GAO found some of these measures were deficient, compromising medical facilities' efforts to prevent sexual assaults and other safety incidents. For example, medical facilities used physical security precautions—such as closed-circuit surveillance cameras to actively monitor areas and locks and alarms to secure key areas. These physical precautions were intended to prevent a broad range of safety incidents, including sexual assaults. However, GAO found significant weaknesses in the implementation of these physical security precautions at the five VA medical facilities visited, including poor monitoring of surveillance cameras, alarm system malfunctions, and the failure of alarms to alert both VA police and clinical staff when triggered. Inadequate system configuration and testing procedures contributed to these weaknesses. Further, facility officials at most of the locations GAO visited said the VA police were understaffed. (See table below.) Such weaknesses could lead to delayed response times to incidents and seriously erode VA's efforts to prevent or mitigate sexual assaults and other safety incidents.

Weaknesses in Physical Security Precautions in Residential Programs and Inpatient Mental Health Units at Selected VA Medical Facilities

Monitoring precautions	Security precautions	Staff awareness and preparedness precautions
• Inadequate monitoring of closed-circuit surveillance cameras	• Alarm malfunctions of stationary, computer-based, and personal panic alarms • Inadequate documentation or review of alarm testing • Failure of alarms to alert both unit staff and VA police • Limited use of personal panic alarms	• VA police staffing and workload challenges • Lack of stakeholder involvement in unit redesign efforts

Source: GAO.