THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

OCT 07 2019

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-19-0294/DI-19-0833 and DI-19-1271/DI-19-1876

Dear Mr. Kerner:

I am responding to your November 27, 2018, letter regarding whistleblower allegations that an employee at the White River Junction Department of Veterans Affairs (VA) Medical Center in White River Junction, Vermont, engaged in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health or safety.

The Executive in Charge, Office of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We investigated this matter from February 8-11, 2019, and substantiated one of the whistleblowers' five allegations. We make two recommendations to the White River Junction VA Medical Center.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Wilkie

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the Office of Special Counsel

OSC File Numbers DI-19-0294, DI-19-0833
DI-19-1271, and DI-19-1876

White River Junction VA Medical Center
White River Junction, Vermont

Report Date: August 7, 2019

TRIM 2018-C-84

Executive Summary

The Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning the White River Junction VA Medical Center located in White River Junction, Vermont. The four whistleblowers, [redacted] (Whistleblower 1), [redacted] (Whistleblower 2), [redacted] (Whistleblower 3), and [redacted] (Whistleblower 4), agreed to the release of their names, and alleged that an employee engaged in conduct that may constitute violation of a law, rule, or regulation; engaged in gross mismanagement or an abuse of authority; or created a substantial and specific danger to public health or safety. We conducted a virtual site visit to the facility on February 8–11, 2019.

Specific Allegations of the Whistleblower(s)

1. *Employee 1 routinely falls asleep in [redacted] office while on duty and in possession of the code pager;*
2. *Employee 1 has purposely circumvented web filters to view restricted content on agency computers, including streaming video and viewing images that appear to be pornographic in nature and may include child pornography;*
3. *Employee 1 was observed using [redacted] personal device in the operating room during a procedure to stream video of the Ford-Kavanaugh hearing on Thursday, September 27, 2018;*
4. *On [redacted] 2018, Employee 1 was involved in an endotracheal intubation during surgery where [redacted] was allegedly responsible for serious injury to a patient; and*
5. *On two occasions, Employee 1 struck Whisteblower 3 in a manner that was similar to incidents alleged by other whistleblowers.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **unable to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations:

Conclusion(s) for Allegation 1

- We are **unable to substantiate** that Employee 1 routinely falls asleep in [redacted] office while on duty and in possession of the code pager.

- While some staff members stated that [redacted] appeared to be asleep, we could not confirm that this was a routine event, or that it occurred during [redacted] tour of duty hours.

- There were at least 12 occasions in the past 24 months when the Anesthesia Service did not respond to the morning test of the Code Blue pager. There is no information about who was responsible for the code pager on the days when there was no response. There was no evidence of a plan to improve the response rate.

- There is no evidence that the Anesthesia Service did not respond to a Code Blue as required by facility policy.

- There is no standardized procedure for management of the code pager. There is no guideline for where the code pager should be kept when pager responsibility is assigned to different anesthesia providers.

Recommendation(s) to White River Junction

1. Establish a policy describing the responsibilities of individuals when carrying the code pager. Ensure that the policy includes responsibility for responding to test code pages. Provide training on the policy and establish a method to monitor compliance with the policy; address noncompliance with additional training and administrative action, as indicated.

Conclusion(s) for Allegation 2

- We **do not substantiate** that Employee 1 purposefully circumvented Web filters to view restricted content on agency computer, including streaming video and viewing images that appear to be pornographic in nature and may include child pornography.

- There is no evidence that Employee 1 accessed pornographic Web sites or materials on [redacted] VA computer.

Recommendation(s) to White River Junction

None.

Conclusion(s) for Allegation 3

- We **do not substantiate** that Employee 1 was observed using [redacted] personal device in the operating room during a procedure to stream video of the Ford-Kavanaugh Hearing on Thursday, September 27, 2018.

Recommendation(s) to White River Junction

None.

Conclusion(s) to Allegation 4

- We **substantiate** that while supervising a medical resident during surgery, Employee 1 was involved in an endotracheal intubation in which [redacted] was allegedly responsible for serious injury to a patient. This type of injury is a recognized complication of endotracheal intubation. Even though the injury may have occurred while the medical resident was performing the intubation, as the supervising anesthesiologist, Employee 1 is responsible for the care of the patient.
- The electronic health record contained no evidence that the patient experienced long-term adverse health effects from the injury.
- There is no evidence that an adequate follow-up review of this case was conducted.

Recommendation(s) to White River Junction

2. Conduct a formal quality review of this case and determine if an institutional disclosure to the patient and/or family is warranted. Once the review is complete, take appropriate action based upon the results of the reviews.

Conclusion(s) to Allegation 5

- We are **unable to substantiate** that Employee 1 struck Whistleblower 3 in a manner that was similar to an incident discussed by other whistleblowers. No one we interviewed witnessed the incidents with Whistleblower 3.
- We found evidence that Employee 1 had struck a coworker during a surgical procedure, and the facility took action based on that incident.

Recommendation(s) to White River Junction

None.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that White River Junction may have violated a law, rule, or regulation; engaged in gross mismanagement or an abuse of authority; or created a substantial and specific danger to public health or safety. In particular, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found no violations of VA and VHA policy, and do not note that a substantial and specific danger to public health or safety exists at White River Junction.

Table of Contents

Executive Summary i

I. Introduction 1

II. Facility Profile 1

III. Specific Allegations of the Whistleblower(s) 1

IV. Conduct of Investigation 2

V. Findings, Conclusions, and Recommendations 3

Allegation 1 3

Findings 3

Conclusion(s) for Allegation 1 5

Recommendation(s) to White River Junction 5

Allegation 2 5

Conclusion(s) for Allegation 2 7

Recommendation(s) to White River Junction 7

Allegation 3 7

Conclusion(s) for Allegation 3 7

Recommendation(s) to White River Junction 7

Allegation 4 7

Conclusion(s) to Allegation 4 8

Recommendation(s) to White River Junction 8

Allegation 5 9

Conclusion(s) to Allegation 5 10

Recommendation(s) to White River Junction 10

VI. Summary Statement 10

Attachment A 11

I. Introduction

The Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning the White River Junction VA Medical Center located in White River Junction, Vermont. The four whistleblowers, (Whistleblower 1), (Whistleblower 2), (Whistleblower 3), and (Whistleblower 4), agreed to the release of their names, and alleged that an employee engaged in conduct that may constitute violation of a law, rule, or regulation; engaged in gross mismanagement or an abuse of authority; or created a substantial and specific danger to public health or safety. We conducted a virtual site visit to the facility on February 8−11, 2019.

II. Facility Profile

White River Junction is part of Veterans Integrated Service Network 1. It is a 50-bed surgical complexity level 2 facility, which serves approximately 26,000 Veterans across Vermont and four contiguous counties of New Hampshire.[1] As a level 2 facility, it hosts five National VA Centers of Excellence and is closely affiliated with over 40 nursing and medical health teaching institutions. The facility actively supports research and residency training programs. There are 43 medical/surgical beds at White River Junction with six of these beds assigned for surgical patients. There are also seven intensive care unit beds and of these, three are designated for surgical patients. At the time the allegations were made, Anesthesia Services for operative procedures at White River Junction were provided by a Chief of Anesthesia, three anesthesiologists and four Certified Registered Nurse Anesthetists (CRNA).

III. Specific Allegations of the Whistleblower(s)

1. *Employee 1 routinely falls asleep in office while on duty and in possession of the code pager;*
2. *Employee 1 has purposely circumvented web filters to view restricted content on agency computers, including streaming video and viewing images that appear to be pornographic in nature and may include child pornography;*
3. *Employee 1 was observed using personal device in the operating room during a procedure to stream video of the Ford-Kavanaugh hearing on Thursday, September 27, 2018;*
4. *On 2018, Employee 1 was involved in an endotracheal intubation during surgery where was allegedly responsible for serious injury to a patient; and*
5. *On two occasions, Employee 1 struck Whisteblower 3 in a manner that was similar to incidents alleged by other whistleblowers.*

[1] A complexity level 2 facility typically has medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs. VHA Office of Productivity, Efficiency, & Staffing (OPES). 2017.

IV. Conduct of Investigation

The original complaint from OSC contained the first four allegations. During the investigation, we received a fifth allegation by email from OSC. The VA team investigating all five allegations consisted of two Senior Medical Investigators and a Clinical Program Manager from OMI, the Chief of Anesthesiology at the Miami VA Medical Center (VAMC), the Associate Chief Consultant, Pharmacy Benefits Management, an Assistant Human Resources Officer and an Employee/Labor Relations Specialist. We reviewed relevant policies, procedures, professional standards, reports, memos, and other documents listed in Attachment A. Because inclement weather prevented travel to the region, we conducted the employee interviews virtually, and held virtual entrance and exit briefings with Medical Center leadership.

We interviewed a total of 32 people, including one former anesthesiologist and the [redacted], who was named in the referral letter. The four whistleblowers were included in the staff interviews.

We interviewed these Medical Center employees:

- Chief Anesthesia
- Chief of Staff
- Health Systems Specialist to the Chief of Staff
- Chief of Surgery
- Chief of Medicine
- Chief of Cardiology
- Risk Manager
- Patient Safety Manager
- Nurse Manager, Operating Room (OR)
- Chief of Pharmacy
- Controlled Substance Coordinator
- Information Technology (IT) Supervisor
- Human Resources (HR) Specialist
- Labor and Employee Relations Specialist
- Five OR Nurses
- Three Anesthesiologists
- One previously employed Anesthesiologist
- Three CRNAs
- Four Surgeons
- One OR Technician
- Retired Chief of Anesthesia

V. Findings, Conclusions, and Recommendations

Allegation 1

Employee 1 *routinely falls asleep in office while on duty and in possession of the code pager.*

VHA Handbook 1123, *Anesthesia Service,* establishes the structure and procedures that are used for the practice of anesthesiology in VHA. Per the handbook, are responsible for the assessment and preparation of patients for anesthesia; the provision of insensibility to pain during surgical, therapeutic and diagnostic procedures; and the monitoring and restoration of homeostasis during the perioperative period. Additionally, are responsible for the clinical management and teaching of cardiac and pulmonary resuscitation and the evaluation of respiratory function and application of respiratory therapy in all its forms. may supervise, teach, and evaluate the performance of medical personnel in anesthesia, respiratory, and critical care.[2]

At White River Junction, a care team approach to anesthesia is used, with anesthesiologists and nurse anesthetists working together to provide anesthesia care. Per the Handbook, while the ultimate responsibility for the patient's care during the peri-procedure period rests with the practitioner performing the procedure, the choice of anesthetic technique and treatment of intra-operative physiologic changes rests with the anesthesia practitioner of record, whether it is an anesthesiologist or a nurse anesthetist.[3] Qualified personnel must be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.[4]

Findings

White River Junction is currently staffed with a Chief of Anesthesia, three Anesthesiologists and four CRNAs. There is currently one vacancy for an anesthesiologist. The facility uses the team approach previously described to provide anesthesia care.

VHA Directive 1177, *Cardiopulmonary Resuscitation,* requires VHA facilities to maintain an appropriate emergency response capability to manage cardiac arrests on VHA property, including access to appropriate resuscitation equipment and trained responders.[5] White River Junction Memorandum 002-17-11, *Management of Medical Emergencies,* defines the procedures for responding to medical emergencies on the White River Junction campus.[6] According to the memo, when a code blue (the need for cardiopulmonary resuscitation) is called, the operator announces "Code Blue" three times on the overhead speaker system throughout the facility. In addition to the

---

[2] VHA Handbook 1123. *Anesthesia Service.* March 7, 2007.
[3] Ibid.
[4] Ibid.
[5] VHA Directive 1177. *Cardiopulmonary Resuscitation.* August 28, 2018.
[6] White River Junction VA Medical Center Memorandum 002-17-11. *Management of Medical Emergencies.* May 1, 2017.

overhead code blue announcement, clinicians who are required to respond to a code are alerted by means of a pager, often referred to as the "code pager." The task of carrying the Anesthesia Service code pager is shared by the providers Monday through Friday, during day shift hours. Anesthesia service must respond to the code and immediately go to the patient location for the purposes of managing the patient's airway during a resuscitation event. During weekend, holiday, and evening/night hours, the anesthesia provider carrying the code pager must arrive at the facility within 1 hour after being paged. A respiratory therapist responds to codes 24-hours a day, 7-days a week, and has primary responsibility for managing patients' airways when an anesthesia provider is not on duty.[7]

The code pager is tested twice each day by the hospital operators. The test of the code pager is not a patient Code Blue event. Records of response to the code pager test are maintained by the hospital operators. We reviewed the response log for the Code Blue tests for the 2 calendar years prior to our site visit. During this 24-month period of daily code pager testing, there were 12 test occasions when the code pager was not answered by anyone from the Anesthesia Service. We observed similar response rates for other services. There was no data available to indicate which [redacted] was carrying the code pager on the days when there was no response to the Code Blue test page. We were told by Whistleblower 1 that the Anesthesia Service planned to provide the Critical Care Committee information about how they intended to address the non-response to the test pages. We reviewed minutes of the Critical Care Committee and did not find evidence of any discussion or plan for improvement.

We asked staff about problems with Employee 1 response to the code pager during both operator-initiated test code pages and actual patient events. Except for one whistleblower, who indicated that Employee 1 did not consistently answer the test code pager, the staff interviewed stated that they were not aware of problems with responses to Code Blue pages. We were told that there was variation in the location of the code pager depending on which [redacted] was assigned to carry the pager. We were told by Employee 1 that [redacted] kept the pager on [redacted] desk and that it was loud enough to alert [redacted] for the daily test and if a code was called. Some staff told us that the pager was often left on a table in the common area in the anesthesia suite. Other [redacted] told us that they kept the code pager on their person when they were assigned pager responsibility. We requested Code Blue reports and patient safety reports and found no evidence of any occasion during which [redacted] did not respond to an actual Code Blue during the daytime hours as required by facility policy.

We interviewed 18 clinical staff who worked directly with Employee 1 and specifically asked each person if they observed [redacted] sleeping on duty. Two interviewees told us that they observed Employee 1 in [redacted] office with [redacted] eyes closed but were unable to confirm if [redacted] was actually sleeping. Employee 1 was reportedly very responsive and opened [redacted] eyes when approached. Three staff stated that Employee 1 was "definitely sleeping" in [redacted] office but were not able to provide specific information about how they knew [redacted] was asleep and could not specify whether [redacted] was post-call, or on

---

[7] Ibid.

duty. We asked staff how they observed Employee 1 with ███ eyes closed, and we learned that Employee 1 maintained an open-door office. Employee 1 desk faced the door and staff were able to look in the office and see Employee 1 face when ███ was sitting at ███ desk. There was no evidence from any clinical staff that Employee 1 was groggy or unable to make decisions upon opening ███ eyes.

Conclusion(s) for Allegation 1

- We are **unable to substantiate** that Employee 1 routinely falls asleep in ███ office while on duty and in possession of the code pager.
- While some staff members stated that ███ appeared to be asleep, we could not confirm that this was a routine event, or that it occurred during ███ tour of duty hours.
- There were at least 12 occasions in the past 24 months when the Anesthesia Service did not respond to the morning test of the Code Blue pager. There is no information about who was responsible for the code pager on the days when there was no response. There was no evidence of a plan to improve the response rate.
- There is no evidence that the Anesthesia Service did not respond to a Code Blue as required by facility policy.
- There is no standardized procedure for management of the code pager. There is no guideline for where the code pager should be kept when pager responsibility is assigned to different anesthesia providers.

Recommendation(s) to White River Junction

1. Establish a policy describing the responsibilities of individuals when carrying the code pager. Ensure that the policy includes responsibility for responding to test code pages. Provide training on the policy and establish a method to monitor compliance with the policy; address noncompliance with additional training and administrative action, as indicated.

Allegation 2

Employee 1 *has purposely circumvented web filters to view restricted content on agency computers, including streaming video and viewing images that appear to be pornographic in nature and may include child pornography.*

According to VHA Directive 6001, *Limited Personal Use of Government Office Equipment Including Information Technology*, employees are permitted to use Government office equipment, including information technology for non-Government purposes, when it involves minimal additional expense to the Government; is performed on the employee's non-work time; does not interfere with VA's mission or operations; and does not violate standards of ethical conduct for Executive branch employees. The personal use of the technology must not result in the loss of employee productivity or interfere with official duties. Employees may not use technology for activities that are

illegal, inappropriate, or offensive to fellow employees or the public. Employees do not have a right to privacy while using Government office equipment; and by using the equipment, VA employees imply their consent to disclose the content of information passed through Government office equipment.[8]

We were told by anesthesia staff that Employee 1 frequently accessed YouTube on his VA-issued computer to watch television programs, including news programs and Russian soap operas. Employee 1 also told us that enjoyed these programs and found it relaxing to watch them at the end of shift. There was no evidence about the specific time that Employee 1 was watching these programs or if these programs were watched during shift. There was no indication from any person we interviewed that this activity in Employee 1 office violated policy by interfering with VA's mission or operations. YouTube is an allowed Web site on VA computers, and access to programming with appropriate content is not restricted.

VA Web filters prohibit accessing Internet content that is inappropriate, sexual, or unethical in nature. Only IT system administrators can circumvent Web filters. We were told by one of the whistleblowers that Employee 1 provided her with the instructions used to bypass VA Web filters to access inappropriate Internet content. When we interviewed the Chief of IT and the Information Security Officer (ISO) at White River Junction and repeated these instructions for them, both stated that the instructions provided could not bypass the Web filters. In addition, even if the bypass instruction sequence had been correctly entered, Employee 1 did not have administrative rights or permissions on computer to bypass Web filters.

Whistleblower 1 was very descriptive when we asked her about the child pornography that she viewed on Employee 1 computer. She described being called into Employee 1 office with another female employee to view this image. She stated that when she and the other female employee saw the image of a topless adolescent girl, they left the office. This event was not reported to leadership or the ISO at the facility. When we questioned the second employee who allegedly saw the pornographic image with Whistleblower 1, she denied seeing this image on Employee 1 computer.

When we interviewed the Chief of IT and the ISO, we requested that they search the computer that was in use by Employee 1 prior to . They could not extract the Internet history from hard drive. We then consulted with VA's Office of Information and Technology staff who were able to access Employee 1 emails and attachments; they could not locate any pornographic images. Because the allegation of child pornography was criminal in nature, we referred this matter to VA's Office of the Inspector General, whose staff conducted a forensic analysis of Employee 1 computer. The Office of Inspector General did not find any evidence that Employee 1 accessed pornographic Web sites or other pornographic materials.

---

[8] VHA Directive 6001, *Limited Personal Use of Government Office Equipment Including Information Technology*. July 28, 2000.

Conclusion(s) for Allegation 2

- We **do not substantiate** that Employee 1 purposefully circumvented Web filters to view restricted content on agency computer, including streaming video and viewing images that appear to be pornographic in nature and may include child pornography.

- There is no evidence that Employee 1 accessed pornographic Web sites or materials on ███ VA computer.

Recommendation(s) to White River Junction

None

Allegation 3

Employee 1 was observed using ███ personal device in the operating room during a procedure to stream video of the Ford-Kavanaugh hearing on Thursday, September 27, 2018.

We were told that it is common practice at White River Junction for anesthesiologists and other providers to carry their personal cell phones into the OR for purposes of communication. According to White River Junction MCM 00-17-111, *Use of Personal Cellular Phone and Devices,* March 31, 2017, personal cell phones may be used as a tool in patient case areas to manage work–related information.[9]

We asked each of our interviewees if they had knowledge of Employee 1 streaming the Ford-Kavanaugh Hearing on ███ personal device during a procedure. No staff member interviewed stated that they had observed Employee 1 watching the Ford-Kavanaugh Hearing on ███ personal cell phone.

Conclusion(s) for Allegation 3

- We **do not substantiate** that Employee 1 was observed using ███ personal device in the operating room during a procedure to stream video of the Ford-Kavanaugh Hearing on Thursday, September 27, 2018.

Recommendation(s) to White River Junction

None.

Allegation 4

On ███ 2018 Employee 1 was involved in an endotracheal intubation during surgery where ███ was allegedly responsible for serious injury to a patient.

[9] White River Junction MCM 00-17-111, *Use of Personal Cellular Phone and Devices,* March 31, 2017.

On [redacted] 2018, during a scheduled Ear, Nose and Throat (ENT) surgical case, a patient's soft palate and tonsil were injured during the endotracheal intubation process.[10] This type of injury is a known complication of endotracheal intubation. The intubation was initiated by a medical resident who was under the supervision of Employee 1. When we reviewed the electronic health record, we found documentation showing that following the patient injury, Employee 1 successfully completed the intubation process, and the operating ENT surgeon disclosed the incident to the patient and their wife. The injury to the patient's tonsil and soft palate was repaired, and then the scheduled surgical procedure was completed. We reviewed the patient's electronic health record and did not find evidence of any long-term adverse health impacts.

Accounts differed regarding whether the resident or Employee 1 injured the patient. Some of the staff told us that Employee 1 was unnecessarily aggressive in completing the intubation, thus causing the patient injury. Conversely, we were also told that the medical resident caused the injury, and that Employee 1 swift intervention was necessary to maintain patient oxygenation and "save his life." The nurse in the OR told us that she reported the injury to Patient Safety. We reviewed the patient safety report but could not find evidence of follow-up to the incident. We also determined that the case had not been reviewed in Morbidity and Mortality Conference or Peer Review Committee. We did not find evidence of a review to determine if this event met criteria for institutional disclosure.

Conclusion(s) to Allegation 4

- We **substantiate** that while supervising a medical resident during surgery, Employee 1 was involved in an endotracheal intubation in which [redacted] was allegedly responsible for serious injury to a patient. This type of injury is a recognized complication of endotracheal intubation. Even though the injury may have occurred while the medical resident was performing the intubation, as the supervising [redacted], Employee 1 is responsible for the care of the patient.

- The electronic health record contained no evidence that the patient experienced long-term adverse health effects from the injury.

- There is no evidence that an adequate follow-up review of this case was conducted.

Recommendation(s) to White River Junction

2. Conduct a formal quality review of this case and determine if an institutional disclosure to the patient and/or family is warranted. Once the review is complete, take appropriate action based upon the results of the reviews.

[10] National Institutes of Health, National Library of Medicine, Medline Plus Medical Encyclopedia. https://medlineplus.gov/ency/article/003449.htm. Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth to help with breathing. Intubation may also be known as obtaining an airway. The tube is guided past the vocal cords to the place where the trachea branches into the lungs. During surgery when the patient is anesthetized and is not breathing independently, the tube can be connected to a mechanical ventilator to assist with breathing.

Allegation 5

Employee 1 allegedly struck Whisteblower 3 in a manner that was similar to an incident discussed by other whistleblowers.

The allegation regarding Employee 1 physically striking Whistleblower 3 was not part of the original referral from OSC but was added after the investigation was in process. During the interviews, numerous staff members referenced a different situation that occurred on 2018, when Employee 1 physically struck a CRNA (not Whistleblower 3) in the OR during a case. We reviewed the incident report and statements related to the 2018, event and found the following:

The situation on 2018, was described to us as a life-threatening situation. Employee 1 was having difficulty obtaining an airway on a patient with a laryngeal tumor. As previously described, to obtain an airway, the tube must pass through the mouth and the vocal cords and the upper part of the trachea to reach the place just above the lungs for ventilation during surgery.[11] The vocal cords are located just above the trachea in a structure called the larynx or voice box. The location of the tumor in the larynx possibly restricted the amount of space for passage of the tube, thus making it difficult to obtain an airway. We reviewed the incident report and written testimony of staff who witnessed the alleged assault on the CRNA. All witnesses recalled that a CRNA was in the way of the video screen used to view the patient during the intubation. All witnesses recalled that Employee 1 asked the CRNA to move. When she did not move but, instead without an order, started to manually ventilate the patient, Employee 1 admitted that struck her arm to force her to stop ventilating the patient and to move out of the way, so could see the video screen. As a result of the incident report and review of statements, it was determined that Employee 1 did strike a CRNA and may not have conducted self in a manner that was respectful and courteous, and Employee 1 was counseled by the facility.

Whistleblower 3 stated that in two other cases, Employee 1 struck her hand during the preparation of a patient for surgery. In one case, Employee 1 allegedly struck her hand when she attempted to move the blanket up on the patient's chest prior to the start of the procedure. On another occasion, Whistleblower 3 reported to us that she was moving a patient's arm prior to a surgical procedure and Employee 1 needed to access the intravenous line in that arm, and struck her hand to limit her movement of the patient. Whistleblower 3 told us that she did not report either of these two incidents to her supervisor or any other leadership or HR official at the time but addressed the issues directly with Employee 1 after the second incident and said apologized. She documented these two incidents in her personal journal but was not able to provide any other form of documentation of these incidents. No other staff we interviewed witnessed these events.

We reviewed Employee 1 Ongoing Professional Practice Evaluations, peer reviews, and patient safety reports. Other than the 2018, incident previously described,

---

[11] Ibid.

we did not find any evidence or concerns regarding his behavior or manner in the OR nor in any interactions with staff.

Conclusion(s) to Allegation 5

- We are **unable to substantiate** that Employee 1 struck Whistleblower 3 in a manner that was similar to an incident discussed by other whistleblowers. No one we interviewed witnessed the incidents with Whistleblower 3.
- We found evidence that Employee 1 had struck a coworker during a surgical procedure, and the facility took action based on that incident.

Recommendation(s) to White River Junction

None.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that White River Junction may have violated a law, rule, or regulation; engaged in gross mismanagement or an abuse of authority; or created a substantial and specific danger to public health or safety. In particular, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found no violations of VA and VHA policy, and do not note that a substantial and specific danger to public health or safety exists at White River Junction.

Attachment A

Documents in addition to the Electronic Medical Records reviewed:

VHA Handbook 1123. *Anesthesia Service.* March 7, 2007.

VHA Directive 1177. *Cardiopulmonary Resuscitation.* August 28, 2018.

White River Junction VA Medical Center Memorandum 002-17-11. *Management of Medical Emergencies.* May 1, 2017.

VHA Directive *6001 Limited Personal Use of Government Office Equipment Including Information Technology.* July 28, 2000.

White River Junction Medical Center Memorandum 00-17-111 *Use of Personal Cellular Phone and Devices.* March 31, 2017.

National Institutes of Health, National Library of Medicine, Medline Plus Medical Encyclopedia. https://medlineplus.gov/ency/article/003449.htm.

Investigative Team – Name Key

- [redacted], Senior Medical Investigator
- [redacted] Senior Medical Investigator
- [redacted] Clinical Program Manager
- [redacted] Chief Anesthesiology, Miami VAMC
- [redacted] Associate Chief Consultant, Pharmacy Benefits Management
- [redacted] Assistant Human Resources Officer
- [redacted] Supervisor, Employee/Labor Relations

Interviewees – Name Key

- [redacted], Chief, Anesthesiology
- [redacted] Chief of Staff
- [redacted] Health Systems Specialist to the Chief of Staff
- [redacted] Chief, Surgery
- [redacted] Chief, Cardiology
- [redacted] Chief, Medicine Services
- [redacted] Risk Manager
- [redacted] Patient Safety Manager
- [redacted] Chief Nurse, OR
- [redacted] Chief, Pharmacy
- [redacted] Controlled Substance Coordinator
- [redacted] Information Technology Manager
- [redacted] Facility Information Security Officer
- [redacted] Human Resources Specialist
- [redacted] Labor and Employee Relations Specialist
- OR Nurses
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
- Anesthesiologists
  - [redacted]
  - [redacted]
  - [redacted]
- [redacted], Previously employed Anesthesiologist
- CRNAs
  - [redacted]
  - [redacted]
  - [redacted]

Surgeons

-
-
-
-

- OR Technician
- Retired Chief of Anesthesia