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The Special Counsel

March 4, 2021

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

Re: OSC File Nos. DI-19-0294, DI-19-0833, DI-19-1271, and DI-19-1876

Dear Mr. President:

I am forwarding reports transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA), in response to disclosures of wrongdoing at the White River Junction VA Medical Center (WRJ VAMC), White River Junction, Vermont. The whistleblowers, [redacted] (the whistleblowers), who consented to the release of their names, alleged that [redacted], the former WRJ VAMC chief of anesthesia, who retired shortly after this matter was initiated, engaged in serious professional misconduct, including the physical assault of nursing staff, falling asleep while on duty, misuse of agency IT resources, and aggressive intervention in a surgical case that caused serious injury to a patient. I have reviewed the disclosure, the agency reports, and the whistleblowers' comments, and in accordance with 5 U.S.C. §1213(e) provide the following summary of the agency investigation and my findings.[1]

The agency's report largely failed to substantiate the allegations made by the whistleblowers. The report was unable to substantiate that [redacted] struck [redacted]. However, this determination appears to ignore both the details of a prior confirmed incident in which [redacted] struck [redacted], and the sworn testimony of the whistleblowers who testified that several confrontational incidents involving [redacted] occurred. In so doing, the agency seems to have disregarded a concerning and significant pattern of violent physical behavior by [redacted] directed toward staff. Similarly, the agency was also unable to substantiate the allegation that [redacted] fell asleep while on duty, during times when he was responsible for supervising other anesthesia providers in surgery and in possession of the code pager which would alert him to respond to an emergency. This allegation was supported by the testimony of at least five employees who witnessed this behavior. Additionally, while the investigation substantiated that [redacted] was present during a procedure where a patient suffered a potentially life-threatening iatrogenic injury,[2] the report instead found fault with a

[1]The whistleblowers' allegations were referred to former Secretary Robert L. Wilkie. The Office of the Medical Inspector (OMI) was tasked with investigating the matter pursuant to 5 U.S.C. §1213(c) and (d). Former Secretary Wilkie reviewed and signed the reports.
[2]Iatrogenic injury is harm resulting from medical examination or treatment.

medical resident, a conclusion that again contravened eyewitness testimony. Finally, the agency noted they could not find any evidence indicating that [redacted] accessed pornographic materials or used his personal device in the operating room to stream video during a procedure. Based on the foregoing and for the reasons discussed below, I have determined that the agency findings do not appear reasonable.

The agency report explained that while [redacted] asserted that [redacted] struck her on two separate occasions during surgical preoperative procedures that occurred in November 2017 and February 2018 in a manner consistent with a confirmed prior incident, she did not report either of these incidents to her supervisor or leadership and no other staff witnessed these events. The report, however, discussed a June 2018 incident involving [redacted] which was corroborated by an agency investigation, where [redacted] struck her during a procedure when she reportedly did not move when he requested, explaining that he did not conduct himself in a "respectful and courteous" manner and was counseled by the facility. However, the report failed to acknowledge that this incident was so serious that the VA police were involved and that four employees who witnessed the event provided official statements to the police. The police then conducted an investigation in conjunction with WRJ VA Human Resources staff which "determined that [redacted] did strike [redacted]."

The agency states that it was also unable to substantiate that [redacted] routinely fell asleep while on duty. This conclusion is inconsistent with testimony provided by three interviewees who observed him "definitely sleeping" and two other staff members who observed him in his office with his "eyes closed." The report further noted there were 12 documented instances over the last 24 months where the Anesthesia Service did not respond to tests of the code pager. However, the agency did not conduct additional analysis to see who was in possession of the pager when non-responses occurred, or why such serious deficiencies occurred, until OSC requested it. This subsequent review determined that the facility lacked a standard operating procedure for the code pager and that pager logs did not contain sufficient information about which anesthesiologist possessed the pager to conduct further analysis of this issue.

The agency did substantiate that [redacted], while supervising a medical resident during surgery, was involved in an intubation where a patient was seriously injured. The report explained that even though the injury may have been caused by the resident, as the supervising physician [redacted] was nonetheless responsible. The investigation did not address whether [redacted] surgical report misrepresented the incident, but the agency did find that adequate follow-up review of the case was not conducted and that required institutional disclosures were not made to the injured patient.

Finally, the agency noted it could not find any evidence indicating that [redacted] accessed pornographic materials or used his personal device in the operating room to stream video during a procedure.

The whistleblowers provided compelling comments that directly challenged the basis of the reports' findings. Citing the VA police report of the prior incident involving [redacted], they noted that [redacted] allegations, "coupled with other reported incidents, shows a

troubling pattern of abuse that the [agency] seems to have missed, or worse, ignored." Additionally, the whistleblowers noted that [redacted] did report the second incident to her nurse manager, and subsequently to the WRJ VA Acting Director, as well as to a supervisory physician and a Human Resources employee, in direct contradiction of the reports' findings. Beyond this, they stated that [redacted] experienced a similar confrontation with [redacted] where he directed a threatening gesture toward her, which she reported to her superiors.

The whistleblowers also objected to the agency's failure to substantiate that [redacted] fell asleep while on duty when at least five witnesses indicated that [redacted] "appeared to be or definitely was asleep at his desk." They took further issue with the fact that the agency did not conduct an additional investigation into the repeated failure to answer the code pager. The whistleblowers also disputed the characterization of the intubation incident as caused by the medical resident, and that [redacted] was only responsible as a supervisor. They note that the report did not provide a basis for this finding and explained that witnesses, including [redacted] stated that [redacted] entered false or misleading information into the patient's record.

While I note that [redacted] subsequently retired following these incidents, thereby rendering any follow up action moot, I am nevertheless troubled by this matter. Notably, the agency reports appear to reach conclusions at odds with evidence adduced by the investigation. This is most significant in the allegations concerning [redacted] aggressive behavior. Here, the VA determined, notwithstanding the testimony of multiple employees and prior internal complaints to WRJ VA management, that there was no "evidence or concerns regarding his behavior…nor interactions with staff." In reality, there were significant institutional disclosures by multiple employees regarding [redacted] behavior, particularly when directed toward subordinate female employees.

Additionally, even where the agency substantiated allegations, it did not conduct additional review until OSC requested it. Notably, while investigators found multiple instances where the code pager tests were ignored, they did not conduct further review into these issues until OSC asked, and only then determined that the facility did not even keep adequate documentation of these instances. Perhaps most concerning was that no institutional review of the surgical injury occurred. When institutional review is omitted after such events, patients and their families are deprived of knowledge that could substantially affect their medical care. Here, the patient was not informed of the nature of the harm until over a year had elapsed after the procedure.

Beyond not substantiating these allegations, the VA impugned the character and credibility of [redacted] in a press statement featuring a distasteful *ad hominem* attack in response to an inquiry from the *Boston Globe* for a June 2019 article on the investigation into her assault allegations. In addressing the article reporting on [redacted] allegations concerning [redacted], the VA stated: "The fact that [redacted] is more concerned about [redacted] …reaction to avert her own dangerous behavior than the fact that her actions potentially put a patient's life in danger speaks volumes about her

professionalism, or lack thereof."[3] The statement continues: "Characterizing this incident as an 'assault' is not only blatantly dishonest, it's disrespectful to actual assault victims, which [redacted] is clearly not." This statement is an appalling attack on a VA employee who was struck by a supervisor while appropriately discharging her duties, then followed appropriate reporting procedures. Investigations by the VA police and WRJ VA Human Resources substantiated her version of events and disciplinary action was taken. When OSC asked the VA to address propriety of issuing such a statement as an official response to a press inquiry, in June 2020, the agency's supplemental report stated: "We were not aware of this press release. Therefore, we are not able to address the statement." In comments to the VA's supplemental report, the whistleblowers provided additional information indicating that this press statement was not only approved, but was also drafted by, officials at high levels of the agency, including the former official who served as both the Deputy Assistant Secretary for Public Affairs and Press Secretary. They condemned the statement, saying "It is never acceptable for an employer to publicly (and falsely) blame a victim of assault."

The reports evince a willingness to resolve issues in favor of the agency, despite significant evidence to the contrary and a reluctance to conduct further review to resolve unanswered and potentially troubling questions. For these reasons, I have determined that the agency's findings do not appear reasonable.

I am also disturbed that high level agency officials would attack the character of an employee to discredit her allegations. While individuals involved have subsequently separated from the agency, the VA must remain vigilant to ensure that the rights of employees are appropriately protected.

Finally, I strongly commend the whistleblowers for their persistence in this matter and their willingness to challenge an agency culture that appears to shield senior officials from accountability. As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter and the agency reports to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures

[3]See https://www.bostonglobe.com/metro/2019/07/28/hospital-swirling-accusations-harassment-retaliation-and-negligence/El7CDjsgvIW3BGZVKqSxdP/story.html Last accessed 12/17/2020.