U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

OSC Finds Shortcomings in VA Response to Spinal Cord Care Problems at Manchester, N.H., VA Hospital

FOR IMMEDIATE RELEASE
CONTACT: Jill Gerber, (202) 804-7065; jgerber@osc.gov

WASHINGTON, D.C./Jan. 25, 2018 – The Office of Special Counsel (OSC) today notified President Trump of shortcomings in the Department of Veterans Affairs' (VA) response to disclosures of wrongdoing at the VA Medical Center of Manchester, New Hampshire. Whistleblower disclosures included concerns that a large number of patients at the Manchester facility developed serious spinal cord disease as a result of clinical neglect. OSC found the VA's response largely sluggish until the media covered the problems. Even after that coverage, the agency chose not to review certain serious allegations.

"The VA did not initiate substantive changes to resolve identified issues until over seven months had elapsed, and only did so after widespread public attention focused on these matters," Special Counsel Henry J. Kerner wrote to the President. "It is critical that whistleblowers be able to have confidence that the VA will address public health and safety issues immediately, regardless of what news coverage an issue receives."

Kerner wrote that OSC referred the allegations to the VA for investigation in early January 2017, but the VA did not take any action to remove responsible management officials or initiate a comprehensive review of the facility until after the Boston Globe published an article in July. "This sends an unacceptable message to VA whistleblowers that only the glaring spotlight of public scrutiny will move the agency to action, not disclosures made through statutorily established channels," Kerner wrote.

The four whistleblowers, all medical doctors, brought forward concerns of a higher presence of a serious spinal cord condition known as myelopathy among Manchester VA patients, despite a significant decline in this condition in the general U.S. population. They alleged that transfers to another facility were not performed in a timely manner, against agency policy. They described substandard surgical procedures, leading to one patient who developed a spinal infection and possibly died from complications and another patient who developed a spinal infection after surgery but survived.

The whistleblowers alleged that the prior chief of the Spinal Cord Unit inappropriately copied and pasted chart notes for patients between 2002 and 2012, contributing to the high incidence of myelopathy in the Manchester VA patient population.

The whistleblowers also described a longstanding fly infestation in an operating room.

OSC referred the matters to the VA, which conducted an investigation and sent a report to OSC on June 20, 2017. The report contained internally inconsistent conclusions at odds with the information adduced in the investigation. OSC requested two supplemental reports to address many of these issues and provide updates on external chart reviews. Ultimately, Kerner found that the VA's findings were not reasonable.

Kerner wrote that the agency appears to have chosen not to review allegations concerning dirty and potentially contaminated surgical instruments because they did not appear in OSC's original referral letter. "This position is at odds with the conduct and disposition of prior investigations of allegations referred by OSC," Kerner wrote. "It further demonstrates a myopic approach that could potentially cause harm by ignoring allegations of substantial and specific dangers to public health and safety."

Kerner described the VA's initial sluggish response to the allegations, such as recommending additional medical chart reviews, compared to the agency's immediate and comprehensive response to the Boston Globe article, which included making major personnel changes pending the outcome of a "top to bottom" review of the facility and a pledge to spend an additional $30 million at the Manchester VA to improve patient care.

Given that potentially lengthy chart reviews of patients involved in these matters are ongoing, OSC will request updates on the progress of this analysis as well as findings when the reviews are completed. OSC will request an update in writing every six months regarding the disposition of these reviews and the expected timeline for completion. OSC will also request a summary of the findings upon completion.

OSC sent a copy of the letter to the President, unredacted versions of the agency reports, and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC also filed the letter to the President, the whistleblowers' comments, and redacted copies of the agency reports in its public file at www.osc.gov.

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The U.S. Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. Our basic authorities come from four federal statutes: the Civil Service Reform Act, the Whistleblower Protection Act, the Hatch Act, and the Uniformed Services Employment & Reemployment Rights Act (USERRA). OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing, and to serve as a safe channel for allegations of wrongdoing. For more information, please visit our website at www.osc.gov.