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The Special Counsel

July 13, 2016

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

Re: OSC File No. DI-15-3968

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding an unredacted Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Evansville Health Care Center (EHCC) operated by the Marion VA Medical Center (Medical Center), Marion, Illinois. The whistleblower, Lori Vinson, who consented to the release of her name, alleged that an anesthesiologist failed to properly administer appropriate dosages of anesthesia medication to patients and improperly instructed nurses to administer anesthesia medication. Ms. Vinson also alleged Medical Center management failed to address her reports of misconduct. I have reviewed the VA's report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency investigation and my findings

I referred Ms. Vinson's allegations to Secretary of Veterans Affairs Robert A. McDonald for investigation pursuant to 5 U.S.C. § 1213(c) and (d) on July 10, 2015. Secretary McDonald forwarded the allegations to the Under Secretary for Health, who directed the Office of the Medical Inspector (OMI) to conduct the investigation. Secretary McDonald delegated responsibility to submit the agency's report to then-VA Chief of Staff Robert L. Nabors, II, who submitted the report to OSC on January 11, 2016. Ms. Vinson declined to comment on the agency report.

The agency investigation did not substantiate Ms. Vinson's allegations. The EHCC and Medical Center staff interviewed during OMI's investigation did not corroborate Ms. Vinson's allegation that the anesthesiologist failed to administer appropriate levels of anesthesia to patients undergoing procedures. OMI reviewed medical records and interviewed witnesses regarding the specific examples Ms. Vinson provided and determined that the anesthesiologist's clinical management of his patients was appropriate and did not differ from that of other anesthesiologists. OMI found that the anesthesiologist had requested licensed nursing staff to administer anesthesia medications, but determined that the requests were proper because they were infrequent and made in response to emergent or urgent clinical situations. Finally, the investigation did not substantiate Ms. Vinson's allegation that Medical Center management failed to

take appropriate action in response to her reports of wrongdoing. OMI determined that in each instance reported by Ms. Vinson, the matter received investigative attention and review by all levels of leadership.

During the investigation, OMI found that a surgeon, rather than another anesthesiologist, had conducted the anesthesiologist's Ongoing Professional Performance Evaluations (OPPE). The surgeon, however, is not a "peer" according to Veterans Health Administration Directive 2010-025, Peer Review for Quality Management. In response to that finding, the Medical Center has assigned the anesthesiologist's OPPE monitoring to another anesthesia provider to comply with the directive. In addition, the Medical Center provided the EHCC surgical nursing and support staff with training to increase understanding of monitored anesthesia care versus general anesthesia, sedation requirements, patient reaction, responses to surgical/procedural stimulation, and accepted circumstances when registered nurses may assist in the administration of anesthesia medication.

I have reviewed the original disclosure and the agency report and have determined that the VA's report contains all of the information required by statute and the findings appear reasonable. As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency report to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency report in OSC's public file, which is available online at www.osc.gov.[1] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosure

[1]The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.