U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

May 24, 2017

The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20510

Re: OSC File No. DI-16-0193

Dear Mr. President:

In accordance with law, I am submitting to you a report of an internal investigation by the U.S. Department of Veterans Affairs (VA). The U.S. Office of Special Counsel (OSC) requested this investigation and report after receiving information about possible dangers to patients at certain veterans' healthcare clinics in Georgia and South Carolina.[1]

The investigation found that in 2015, some patients did not promptly receive urgent medical advice about their critical, life-threatening blood test results that were processed in the Ralph H. Johnson VA Medical Center laboratory in Charleston, South Carolina (Medical Center). At least three veterans were seriously harmed as a result, including one patient who experienced a cardiac arrest and resuscitation.

According to the report, Medical Center employees maintained inaccurate and confusing on-call schedules, repeatedly experienced below-standard reporting times for critical test results, and failed to update Medical Center policies to reflect new procedures. An anesthesiologist also failed to meet the standard of care during a preoperative examination, which may have, in part, caused the patient's cardiac arrest. The VA confirmed to OSC that it took appropriate action to address the anesthesiologist's conduct.

The VA determined that ultimately, the danger to veterans was exclusively attributable to a physician who had habitually neglected to communicate critical test results to patients, including the three veterans who suffered serious harm. According to

[1] OSC File No. DI-16-0193. *See* 5 U.S.C. § 1213(c).

the report, the physician is no longer employed with the Medical Center; the agency confirmed that the physician is also no longer employed with the VA.

Although the Medical Center had experienced numerous problems in its critical test result procedures and compliance, it appears that the Medical Center has generally resolved the problems and—in response to OSC's referral—has updated its policies. The VA Office of the Medical Inspector has made several additional recommendations to the Medical Center. I have determined that the report contains the information required by statute and that its findings are reasonable.

As required by law, I am submitting to you and the House and Senate Committees on Veterans' Affairs the VA report as well as a letter from the federal employee who made these disclosures.[2] I am also making these documents available to the public.[3] I have no additional comments or recommendations.[4] Our file is now closed.

Respectfully,

Carolyn N. Lerner
Special Counsel

Enclosures

[2] *See* 5 U.S.C. § 1213(e)(3).
[3] *See* 5 U.S.C. § 1219(a)(1); *https://osc.gov*.
[4] *See* 5 U.S.C. § 1213(e)(3).