DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

December 1, 2017

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

RE: OSC File No. DI-16-5687/88/89/90

Dear Mr. Kerner:

I am responding to your October 13, 2017, email request for supplemental information on the Manchester Department of Veterans Affairs Medical Center, Manchester, New Hampshire, about which you asked three specific questions. The enclosed supplemental report answers your questions.

If you have any other questions, I would be pleased to address them.

Sincerely,

Carolyn M. Clancy, M.D.
Executive in Charge

Enclosure

Department of Veterans Affairs Supplemental Report
To The
Office of Special Counsel
OSC File Number DI-16-5687/88/89/90
Manchester VA Medical Center
Manchester, New Hampshire

TRIM 2017-D-2840

At the direction of the Secretary of the Department of Veterans Affairs (VA), the Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a VA team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Manchester VA Medical Center (the Medical Center), Manchester, New Hampshire. The whistleblowers, who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of law, rule or regulations, and gross mismanagement, an abuse of authority, and a substantial and specific danger to public health. The VA team conducted site visits to the Medical Center on February 6–8, 2017, to the VA Boston Healthcare System (Boston HCS) on February 8–10, 2017, and submitted its report to OSC on June 9, 2017.

On July 26, 2017, OSC requested a supplemental report to address 15 specific questions related to VA's June report. VA provided responses to these questions on October 4, 2017. On Oct 13, 2017, OSC requested an additional supplemental report to address the three following questions:

Question 1. In multiple places in the supplemental report, VA notes that medical records have been provided to external non-VA reviewers. See: Conduct of the investigation. Question 2; Spinal cord Care- Question 1 and 2; Dr Huq- Question 3. Could you please provide us with a status update on the progress of these reviews, and an anticipated time table for completion? In addition, can you provide us with information on the identity of the external reviewers and their areas of expertise?

VA Response

The external non-VA reviewers have started reviewing the cases and have completed and returned 38 reviews to VA. We are in the process of reviewing them and summarizing their findings. Barring any unforeseen issues, we expect all to be completed by February 2018.

All physician reviewers must have an active medical license, be in active clinical practice at least 20 hours per month, and have current board certifications in their specialties. The areas of expertise of the physician reviewers include Physical Medicine and Rehabilitation (PM&R), Neurology, Neurosurgery, and Pain Management. The PM&R reviewers have 13–22 years of practice; one was the Chief, Spinal Cord Injury, of his facility during his time in practice. The Neurology reviewers have 19–22 years of practice, the Neurosurgeon reviewers have 12–28 years of practice, and the Pain Management reviewer has 13 years of practice.

Question 2. The response to Question 2, under the "Conduct of the Investigation" section, VA notes that Dr. Ohaegbulam was not interviewed, in part because documentary evidence concerning spinal cord care provided by Dr. Kois was "sufficient." However, if this evidence was sufficient, why was OMI "unable to substantiate" allegations concerning spinal cord conditions? While VA acknowledges that it is the general practice not to interview non-VA employees, if the agency intends to rely on external experts in reviewing the medical records at issue in this matter, why was Dr. Ohaegbulam's expertise not initially consulted regarding the condition of Manchester VA spinal cord patients?

VA Response

The list of patients provided by Dr. Kois included Veterans that he referred to Dr. Ohaegbulam: the condition and care of each (including care provided by Dr. Ohaegbulam) were thoroughly documented in the patients' Electronic Health Records (EHR). We determined that the documentary evidence available in the EHR is sufficient. At the time, we could not substantiate the allegations concerning spinal cord conditions because we had not completed the review of the 23 cases initially identified as needing additional review.

Question 3. With respect to Question 3, under the "Conduct of the Investigation" section, in the past, VA has investigated allegations not included in OSC referral letters. Specifically, in OSC File No. DI-14-2519; OMI investigated two additional allegations based on information provided by the whistleblower during her interview. (See P. 1 of the report) Additionally, in OSC File No. DI-14-4602; PL&O investigated and expanded OSC's two original allegations into 16 issues, including matters not included in the original referral letter, which were raised by the whistleblower in his interview. (See P. 21 of the report). Notably, in OSC File No. 14-2953, VA investigated an allegation raised in the whistleblower's interview, noting that: "although these matters were not included in OSC's referral, the allegation was nonetheless investigated to ensure that proper action was taken in response to the alleged ... incidents."

As additional allegations provided to VA in this matter included issues involving a serious potential risk to patient safety, please explain why they were not investigated. We note that the failure to review allegations that have a direct impact on patient care, such as dirty surgical instruments, appears to violate VHA Directive 1038, which notes that "OMI must investigate the quality of VA health care and report its findings."

VA Response

We investigated the three specific allegations that OSC included in its referral to the Agency. These did not include the allegation of dirty surgical instruments. We interviewed an individual (with his attorney present), who was later identified by an article in the Boston Globe as one of the whistleblowers. At the end of the interview, the attorney interjected, "you have the Chief, Surgery on the fly issue and the dirty surgical instruments?" The interviewee had no reaction or response to the attorney's comment. In a subsequent interview with the Chief, Surgery, we inquired about any concerns he

had with the operating room and he made no mention of dirty instruments. We did not investigate this matter further as the accusation was second hand information and was not corroborated by the Chief, Surgery. At the time of our investigation, we were unaware of the matters reported by the Boston Globe in July 2017 about the lack of a nuclear medicine camera or any of the other issues mentioned in that article.