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SENT VIA EMAIL [redacted]) ONLY
John Young, Esquire
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1730 M Street, NW, Suite 218
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RE: Special Counsel OSC File Numbers DI-16-5687, DI-16-5688, DI-16-5689, and DI-16-5690

Dear John,

This letter is in response to the two supplemental reports of the OMI to the OSC, dated October 4, 2017 and December 1, 2017. These supplemental reports were necessitated by the incomplete and inadequate investigation done by the OMI from January 2017 until they issued their initial report on June 6, 2017.

As a result of the indefensible and substandard investigation of the abuses and neglect suffered by Veterans at the hands of providers in both the Manchester, NH Medical Center and the Boston, MA Medical Center, both the OSC and the Whistleblowers issued lengthy rebuttals to said initial report, resulting in a list of questions sent to the OMI team.

Their responses to your questions as evidenced in the October report were likewise inadequate, and you, again, requested that they further investigate the Whistleblowers complaints. The December 1, 2017, report to the OSC is the third attempt of the OMI to issue an independent and neutral report.

These three so-called independent investigations are absolute evidence that this agency is incapable of conducting anything close to an independent and thorough investigation of itself.

In regard to each response to your questions which asserted that the matter has been "referred to external, independent non-VA specialists"… Dr. Kois has again raised the concern that the OMI has offered no proof that the patient charts were actually reviewed, because there is no evidence of such provided. Such evidence would be the time stamps on said charts that are generated each time someone looks at a chart, and it documents the sign-out time as well. Although these time stamps have been requested by the Whistleblowers two (2) times, the OMI has failed to provide them.

In addition to time stamps, the patients should be contacted and interviewed so as to affirm the accuracy of the medical chart. Finally, Dr. Kois should be consulted since he has the most complete knowledge of both the patient and the chart. Thus far, nothing of the kind has occurred.

A perfect example of the OMI's lack of concern about the truth involves their refusal to consult with Dr. Chima Ohaegbulam, the neurosurgeon at New England Baptist Hospital who wrote the letter detailing the incredibly poor condition that these Veterans were in post surgery from the Boston VA, as well as aftercare at Manchester. Although his letter was highlighted in the Boston Globe expose, and they were specifically asked by you to address his concerns, they again failed to contact him. The OMI claimed that his notes were contained in the medical charts and so there was no need to interview him!

In response to Question #2 about the cut and pasted condition of the charts that were reviewed, the OMI claimed that because there were other providers' notes in the chart, those other notes filled in the gaps. Unfortunately this fails to consider the fact that these other providers also relied on the tainted chart notes in their care of the patients, and so the problems were just compounded, not remedied. In legal terms, as a famous US Supreme Court decision held, the fruit of the poisonous tree must be excluded due to the original violation that occurred; this is clearly the problem here.

The point made by Dr. Kois about correlating the provision of assistive devices to the patients to the chart notes would provide a fuller picture of the true condition of the patient, has yet to be done by the OMI.

The OMI's response to Question #3 regarding the dirty surgical instruments boggles the mind. To not follow up on the information provided by the attorney for the 11 Whistleblowers, merely because it wasn't one of the three (3) questions originally forwarded to them to investigate by you, and because it was "second hand" shows their lack of concern about substantive matters and more concern for form and procedure.

Likewise on their response about the lack of a functioning nuclear camera, if they cared about the treatment that the Veterans were receiving in Manchester, why wouldn't they have followed up with the Chief of Medicine or the Chief of Staff, and ask to interview additional providers while they were onsite?

Are they including these issues in the continuing investigation in light of the three (3) additional Whistleblower Form 12's filed in March of 2017 by two (2) nurse anesthetists and the APRN in Cardiology? These reports contain lengthy details about the lack of a nuclear camera for cardiology and the horrific conditions in the OR.

As to the response to Question 8 regarding wait times, the articulated concerns raised by Dr. Kois and Dr. Levenson, clearly state that Boston VA failed and refused to schedule appointments for seriously impaired patients in need of surgical consults on an immediate basis. It does no good to point to the wait times of 30 days and the like, if the patient dies on day 28… Does that result show up in their statistics as a good one, because they met the 30 day rule? How

absurd is this system if those are the concerns of the VA Agency? The Whistleblowers would try to avoid those types of results by referring their patients to fee-based non-VA providers, such as Dr. Ohaegbulam; until both Dr. Schlosser, the Chief of Staff, and Danielle Ocker, the Medical Center Director, refused to approve such referrals.

Finally, it should be pointed out that the OMI originally requested a list of interviewees be provided to them by Dr. Schlosser and the other members of the Quadrad. Although there was no actual Chief of Spinal Cord Injuries at the time, Dr. Schlosser failed to list Dr. Kois as a person to be interviewed, even though he was the only doctor in the Spinal Cord Clinic. Dr. Schlosser spoke to the OMI team about the Spinal Cord Clinic although he had no independent knowledge of the Spinal Clinic patients. The only reason that Dr. Kois was interviewed was because he accosted the team from the OMI outside his office and introduced himself as the doctor who treated spinal cord patients in Manchester. But for his action, the OMI team would have never have interviewed Dr. Kois, and the resulting OMI investigation would have been even more abysmal.

Thereafter, Dr. Levenson was interviewed as the Chief of Medicine and I was present as his legal counsel. The team was less interested in exposing dangerous conditions in Manchester, than in engaging in arguments with Dr. Levenson about the proper locations for colonoscopies to be performed in the facility. They narrowly fashioned their questions and limited the scope of Dr. Levenson's answers, even though he was the direct supervisor to most of the providers at the facility and had a wealth of information to convey to them. As to the OMI Response referring to the small number of procedure cancellations due to the fly infestation in the OR, Dr. Levenson attempted to tell them that the Manchester Administration was in the habit of cancelling appointments and then notating it as a "patient cancellation" or a "no show", so that the metrics looked good and to obscure the actual consequences of the fly problem.

In summary, it should be evident that, after one year of so-called independent review by the OMI, the VA is incapable of conducting a neutral, thorough and unbiased investigation of both specific and systemic wrongdoing at its facilities.

The sad fact is that the VA will continue to conduct business as usual and our Veterans will be deprived of their part of the bargain when they signed up to defend our country, i.e., excellent medical care!

Sincerely,

Andrea Amodeo-Vickery

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