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

www.osc.gov

The Special Counsel

January 25, 2018

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

Re: OSC File Nos. DI-16-5687, DI-16-5688, DI-16-5689, and DI-16-5690

Dear Mr. President:

Pursuant to 5 U.S.C. §1213(e)(3), I am forwarding reports from Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), VA Medical Center Manchester (VAMC Manchester), Manchester, New Hampshire. The four whistleblowers in this matter, Dr. Ed Kois, Dr. Stuart Levenson, Dr. Ed Chibaro, and Dr. Erik Funk (the whistleblowers), who consented to the release of their names, disclosed that a large number of VAMC Manchester patients have developed serious spinal cord disease as a result of clinical neglect at the VA; that the former Chief of the Spinal Cord Unit, Dr. Muhammad Huq improperly copied and pasted patient chart notes for over 10 years; and that VAMC Manchester's operating room (OR) has repeatedly been infested with flies.

These cases are representative of VA's ongoing difficulties in providing appropriate and expeditious patient care and appear to demonstrate issues with VA's efforts to ensure allegations are appropriately reviewed. The agency reports received by the Office of Special Counsel (OSC) were not fully responsive and were frequently evasive in their reluctance to acknowledge wrongdoing.[1]

It appears that the VA acknowledged and responded to confirmed wrongdoing after the publication of a July 15, 2017, *Boston Globe* article based on information provided by the

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, he is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

individuals identified above and others.[2] The VA was on notice of these allegations when OSC referred them for investigation in early January 2017, but did not take any action to remove responsible management officials or initiate a comprehensive review of the facility until after the *Boston Globe* article was published 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.

I. Background

The whistleblowers' allegations focused on the care of patients with a serious spinal cord condition known as myelopathy. They noted that despite the significant decline in prevalence of this condition in the general population of the United States, 100 out of approximately 170 patients treated in the VAMC Manchester Spinal Cord Unit had some degree of myelopathy. The whistleblowers attributed this high incidence to a number of factors, including:

- Under VA policy, patients with these conditions are referred to VA's Boston Spinal Cord Injury and Disorder (SCI/D) Center for more complete evaluation. The whistleblowers alleged that transfers between the VAMC Manchester and the Boston SCI/D Center were not performed in a timely manner, in violation of agency policy.

- The whistleblowers alleged that surgical care at the Boston SCI/D Center was also substandard. They provided two illustrative examples: (1) a patient who developed a spinal infection and eventually died from surgical complications after surgeons damaged his dura mater during a procedure; and (2) an instance where a patient developed a spinal infection after surgery but survived.

- The whistleblowers alleged that the prior chief of the Spinal Cord Unit, Dr. Muhammad Huq, engaged in the inappropriate practice of copying and pasting chart notes for patients between 2002 and 2012. They asserted that this misconduct contributed to the high incidence of myelopathy in the VAMC Manchester patient population.

In addition to the allegations connected to myelopathy, the whistleblowers further alleged that the VAMC Manchester OR has been repeatedly infested with flies. Starting in 2012, after the OR was remodeled, the rooms in this suite have consistently been infested with flies during warmer months. While the VAMC Manchester has attempted to remediate this problem by hiring exterminators to perform pest-control measures and installing UV fly lights, the flies have returned during the spring and summer every year. The whistleblowers asserted that surgeries have been cancelled and delayed due to these unsanitary and unsterile conditions.

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[2] Jonathan Saltzman and Andrea Estes, "At a four-star veterans' hospital: Care gets 'worse and worse,'" *Boston Globe* (July 15, 2017), *available at* https://www.bostonglobe.com/metro/2017/07/15/four-star-case-failure-manchester/n9VV7BerswvkL5akCgNzvK/story.html.

II. The Agency Reports

OSC found that a substantial likelihood of wrongdoing existed based on the information provided by the whistleblowers, and referred the matter to former VA Secretary Robert McDonald to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). The matter was investigated by the Office of the Medical Inspector (OMI), which provided OSC with a report 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. With respect to spinal cord care:

- VA Investigators found that in fiscal years 2015 and 2016, 11 consult appointments, or 20 percent of appointments, were not made in the required time, and in more than half of these instances there was no documented reason for the delay. In spite of these findings, VA Investigators were "unable to substantiate" that the referral process from VAMC Manchester to the Boston SCI/D Center created undue delays in care.

- Regarding the patient who died from surgical complications, the VA noted it was "unclear" if the surgery contributed to his disease progression, but later concluded that his care was appropriate. Nevertheless, it stated that the treatment of this patient, as well as six others, would be reviewed by an independent, non-VA external reviewer, raising questions regarding the sufficiency in the initial review of this information.

During his interview, Dr. Kois provided OMI with 97 patient charts that he viewed as evidence of substandard care. OMI initially determined that in 74 of 97 cases, care was appropriate. However, in supplemental reports, the VA indicated that external non-VA reviewers would examine these charts to determine whether appropriate care was provided. The VA anticipates this review will be completed in February 2018. In light of the ongoing review of patient charts, OSC finds the VA cannot yet conclude whether the whistleblowers' allegations were unsubstantiated.

The VA's decision not to interview Dr. Chima Ohaegbulam, a non-VA employed neurosurgeon with experience treating myelopathy patients, is at odds with the VA's prior assertion that review by external experts was necessary. Dr. Ohaegbulam treated many of the patients at issue in this matter on a fee basis after referral from the VAMC Manchester, and was uniquely positioned to assist in the review of the patient care rendered. In a supplemental report, the agency asserted that it was unnecessary to interview Dr. Ohaegbulam as Dr. Kois provided sufficient documentary evidence.

The findings regarding Dr. Huq were flawed due to their inconsistency. The report first acknowledged that he engaged in the practice of inappropriately copying and pasting chart notes between 2008 and 2012, but asserted no harm resulted because associated patient records did not contain any indicia of adverse patient outcomes. The report subsequently acknowledged that

investigators only reviewed his charts from a limited time period, yet claimed they had sufficient information to broadly conclude that no patients were harmed.

VAMC Manchester management was on notice of Dr. Huq's misconduct as early as 2008; however, no disciplinary or corrective action was taken until 2010. Despite the fact that nurses raised concerns to facility leadership during this time, there was no explanation for the delay. Dr. Huq received a verbal counseling in November 2010, but continued copying and pasting chart notes. He was issued a written counseling for this continued misconduct in late 2011. In early 2012, he was counseled again after the discovery of additional instances of copying and pasting. Finally, in July 2012 VA reassigned Dr. Huq to Primary Care on a full-time basis, then transferred him to another VA facility in August 2015.

Despite this long-established history of misconduct, investigators determined that there were no adverse patient outcomes attributable to this practice, after reviewing the care of patients whose charts were copied and pasted. Notwithstanding this conclusion, investigators indicated they were unable to review Dr. Huq's notes prior to 2008. Rather, their conclusions relied on a review of the audits associated with prior disciplinary action. Accordingly, OMI was unable to review six years of patient outcomes, or more than half of the total time Dr. Huq worked in this unit. Given the seriousness of the medical issues involved, a review of Dr. Huq's entire history with the unit appears appropriate, especially given the ease of obtaining these medical records, which under agency policy, must be maintained for 75 years.

With respect to the alleged fly infestation, the report found that the OR #2 was repeatedly infested with cluster flies starting in the early fall of 2014. The room was terminally cleaned, but flies returned later in the fall and the following winter. A pest control company was hired in April 2015, but did not spray insecticides outside the building during that summer. In August and September of 2015, staff again began noticing cluster flies in OR #2. The room was eventually closed due to this issue from September 2015 until January 2016. Despite additional efforts, flies were still observed in the room in January 2017. The report stated that cluster flies pose no known health problems to humans, but subsequently acknowledged that "flies of various types" were found in a light trap during a site visit, suggesting that additional species of insects were present. The report explained that despite the closure of this room, no surgeries were delayed.

III. The Whistleblowers' Comments

The whistleblowers' comments highlighted inconsistencies in the reports, and were the basis for OSC requesting two supplemental reports from the VA. Notably, the whistleblowers' comments questioned the sufficiency of the investigation, explaining that OMI appeared dismissive of Dr. Kois' efforts to provide patient charts, and that their findings did not appear to analyze the large number of assistive durable medical devices given to patients as evidence of worsening function and clinical neglect.

The whistleblowers also voiced concerns regarding the failure to interview Dr. Ohaegbulam, and challenged the specific clinical conclusions reached regarding the two

illustrative examples provided in their initial disclosure. The comments further reflected the concern that the review of Dr. Huq's patients was limited and appeared to ignore the connection between his conduct and the decline in function of many spinal cord patients.

Finally, the comments noted that OMI appeared to dismiss and ultimately did not investigate serious allegations provided to them by the whistleblowers, including dirty and rusted surgical instruments. The whistleblowers asserted that it was "clear that [OMI] had no interest in a fair and impartial and complete investigation into the systemic problems that directly impacted patient care in Manchester."

IV. The Special Counsel's Analysis and Findings

I have reviewed the original disclosures, the agency reports, and the whistleblowers' comments. I have determined that the reports meet the statutory requirements, but the findings do not appear reasonable.

First, I note 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. It further demonstrates a myopic approach that could potentially cause harm by ignoring allegations of substantial and specific dangers to public health and safety.

I take further issue with the recommendations in the report when viewed in light of the VA's response after the *Boston Globe* article was published in July. Notably, the initial OMI report simply recommended additional chart reviews, routine monitoring of chart entries, and that OR staff continue checking for flies in the suite before starting procedures.

The *Boston Globe* article was published late in the day on Saturday, July 15, 2017. It discussed the spinal cord care issues, Dr. Huq's conduct, flies in the OR, and dirty surgical instruments. On Sunday July 16, within hours of the *Boston Globe*'s publication, VA Secretary David J. Shulkin removed VAMC Manchester's Director Danielle Ocker and Chief of Staff James Schlosser pending the outcome of a "top to bottom" review of the facility. On August 4, Secretary Shulkin visited the hospital, and subsequently removed the Head of Patient and Nursing Services, Carol Williams. Secretary Shuklin also indicated that the department planned on spending $30 million dollars at VAMC Manchester to improve care.

Significantly, OSC had already referred these same allegations to the VA in early January 2017, six months before the *Boston Globe* story ran. The contrast between the VA's response to the *Boston Globe* vis-à-vis OSC highlights the issues OSC has with VA's reply to OSC's referral and the whistleblowers' 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. 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.

Given the ongoing and potentially lengthy chart reviews of patients involved in these matters, OSC will request updates on the progress of this analysis as well as findings when the reviews are completed. Specifically, 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.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, 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. I have also filed the letter to the President, the whistleblowers' comments, and redacted copies of the agency reports in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures