United States Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

January 3, 2025

Re: OSC File No. DI-24-000312

To whom it may concern:

My name is [redacted], MD MBA. I am an anesthesiologist and critical care physician with board certifications in Anesthesiology, Adult Cardiac Anesthesiology, Critical Care Medicine, and Advanced Perioperative Transesophageal Echocardiography. I have an MBA from the Tuck School of Business at Dartmouth, and worked for several years as a consultant in McKinsey & Company's healthcare practice. For nearly nine years I worked at the Lt Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan, and for most of that time I was the leader of the surgical critical care service. I also worked as a provider in VA's tele critical care service, providing remote care across dozens of Veteran's Affairs (VA) hospitals across the eastern united states. In March of 2023 I filed a non-anonymous whistleblower complaint with the VA Office of the Inspector General (OIG), while still employed by VA, related to deficiencies in care and management of the Ann Arbor facility.

Over the course of 2023 I worked to ensure that the VA OIG would investigate my complaint, including refiling the complaint when it was initially dismissed, which I will describe in greater detail below. Over the same time period I also filed complaints related to these ongoing issues with the Joint Commission, the US Department of Health and Human Services, the Michigan State Attorney General's office, The US House Committee on Veterans Affairs, the US Senate Committee on Veterans Affairs and ultimately with the United States Office of Special Counsel.

The Office of the Special Counsel (OSC) referred my complaint to VA Secretary Denis McDonough back in January of 2024 based on their assessment that it was likely that at least portions of my complaint constitute a violation of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health consistent with OSC requirements for making a referral. As part of that referral, and pursuant to 5 U.S.C. § 1213(e)(1), I am providing my comments on the initial response from VA dated Nov 22, 2024.

It should be noted that my complaint to OIG and OSC initially contained 14 bullet points, some representing ongoing violations, others referring to specific incidents in the past. The OIG report back to the OSC referred only to 4 areas to investigate. The response was limited to only a select few that had met OSC criteria for referral to the secretary, despite the VA OIG report opening by stating that the VA OIG was in the process of investigating my concerns at the time of the OSC referral. They make no mention of the broader complaint or unaddressed areas for investigation. And as a point of fact, they refused to speak to me about certain elements of my complaint during my interview, stating that they were not the criminal investigators for VA OIG, and thus were not willing to allow me to speak to them about circumstances which may have constituted criminal activity. This was ridiculous on the face of it, as these were the very investigators tasked by OIG to report back to OSC about the elements of my complaint which were referred, including the ongoing violation of federal criminal law related to unauthorized access of federal computers at the Ann Arbor VA based on specific direction from one of the institutions leaders.

In the report, of the four categories where the OIG did investigate and make a determination, two of my complaints were substantiated, while two were deemed “not substantiated”, refuting my claims as inaccurate or untrue.

Of the two categories that were substantiated, in my assessment the report contained an overemphasis on one of these issues, the matter of specific exemptions related to VA infrastructure requirements for facilities, while underemphasizing the matter of unauthorized computer access (and instructions to do so by a VA supervisor), both in the efforts of the investigation and the content of the report as well.

For the two categories that were deemed unsubstantiated, I fundamentally disagree with the conclusions in the report, as well as the reading of plain English in VA national directives, as well as established medical-legal responsibilities for the care of patients throughout the US. I am troubled by the methods described to conduct the investigation itself, and at the end of this experience as a whistleblower feel that VA OIG represents an inadequate mechanism for oversight of VA facilities. I also find it no surprise that in my experience most of the providers and staff who encounter issues worthy of reporting choose not to engage in this path of frustration and disappointment, and instead remain silent or leave VA, despite the 30,000-40,000 complaints that are actually filed each year. I will take on each of these issues individually below, after first providing the context for the barriers that exist for whistleblowers within the process for VA OIG based on my own personal experience.

The first thing to note about employees who are considering bringing forward a whistleblower complaint is that it is not taken lightly. There are lingering questions about whether the complaint will ultimately result in any meaningful outcome, and that is weighted against the potential downsides. Part of that will be a permanently altered work environment, as relationships with colleagues and standing within the organization are likely to become strained, and there is a real risk of isolation. The other very real consideration is the likelihood of retaliation, which is still quite real, and was part of my experience at VA over a number of years before I left, and was for much less brazen forms of whistleblowing, whether it being providing supervisors with reports of inappropriate care, lapses in professionalism or raising issues related to mismanagement. In fact just this week, as I prepared my comments on the report I reached out to a number of my former colleagues (I left the VA in December of 2023), and a fear of retaliation was expressed by a former colleague simply that speaking with me representing a risk to them if it were to become known by certain hospital leaders. Thus even speaking to the whistleblower is perceived as a risk for employees. But this is all known, and persists. What may not be known in detail are the barriers to submitting and following up on a complaint.

Given the size of the Veteran Health Administration (VHA) within Veterans Affairs, it seems bizarre, yet it is the case that the VA OIG web portal for submitting complaints does not allow the submission of protected health information. When I first attempted to submit my complaint I outlined that I had observed breaches in VA directives and standards of care that resulted in patient injury and patient death. I requested that someone from OIG reach out to me to provide me with details on how I could submit protected health information through a secure format. After hitting submit, the next page informed me that the VA OIG would evaluate my complaint against a narrow set of criteria within 6 weeks, and that if they did not determine my complaint fit their criteria, it would be dismissed and I would receive no notice, and thus if 6 weeks passed without any follow up from OIG then I should assume they had declined to investigate my complaint. It seemed inappropriate then, and still does now, to not provide complainants with closed loop communication about status determinations for opening cases related to complaints. That said, like many things within VA, the information provided to me proved inaccurate, as I did receive notification 4 weeks later. The notification was that my

complaint was closed based on inadequate information submitted. And so this represents the catch 22 related to hospital providers within VHA attempting to seek external oversight when local leaders prove not to be responding adequately. You can't submit protected health information to OIG via their web portal, but OIG won't investigate your claims without a level of detail that requires protected health information. The other primary take away from this initial rejection, was that the reviewers for OIG demonstrated no interest in protecting the lives of veterans. I had made very clear the risk associated with claims I was presenting, no one made any attempt to reach out to me to provide instructions on how to submit protected health information. After my initial rejection notice I called the OIG hotline. After reviewing the details in my complaint based on the reference number, I was instructed that the only way to provide protected health information would be via a fax. This is another hurdle for whistleblowers, as sending a fax represents a logistical hurdle and a mental one. The logistics are that it is more complicated for many employees to gain access to a fax machine without knowledge from their supervisors if the use of them is not part of their typical job description within VA, and the mental is that this now represents an additional risk for the whistleblower. An online web portal is a common sense way to submit sensitive information if it were properly secured and encrypted, a fax is one keypad error away from sending a list of highly sensitive information to the wrong destination. And if this occurred it would represent a violation of the health insurance portability and accountability act (HIPAA) law, thus leaving the whistleblower exposed to possible consequences for this HIPAA violation.

After this initial experience attempting to submit my complaint to OIG, I determined that I would need to provide a more comprehensive and detailed list of violations as the OIG reviewers had demonstrated a bias towards dismissing complaints, the opposite of what I had expected. It was several months later that I resubmitted this detailed list, along with a separate list of approximately a dozen specific patient cases that represented patient injury or death related to deficiencies in care. The list of patients, including protected health information, was submitted via fax according to the instructions I was given. Once again, I received the same notice that if I did not hear back within 6 weeks, my complaint has been dismissed. I also called the OIG hotline to confirm receipt of my fax with associated sensitive information, they refused to acknowledge if they had received any fax, stating it was their policy not to comment even though I had provided my name and reference number. Throughout the entire process, the only confirmation I received that my fax had in fact reached the OIG, and not resulted in erroneous transmission to a wrong number, was when I spoke with investigators about some of the cases I reported which was six months later during my interviews (although they refused to speak with me about certain cases, stating I had left VA employment and they couldn't speak about specific cases… despite the fact that we just had minutes earlier for other cases).

Six weeks passed and I received no notification, which somehow still surprised me. I called the OIG hotline several times over the next few weeks, and each time I received different information. At one point I was told it was not picked up as a case, but also not yet closed and so it was possible someone was looking at it still. Another time I was told that because I had not received any word by the 6 week mark, it had been closed. Feeling that this was a lost cause, I began to attempt to submit my complaint through alternate means. In December of 2022 a note to all VA employees from Secretary McDonough provided details on options available to whistleblowers via a VA policy statement. Within that statement, it provided for the allowance for release of information including protected health information to a regulatory agency with oversight responsibilities, or to law enforcement, or to US House or Senate committees or subcommittees with oversight over VA. As such I submitted short online complaints without details or protected health information to both the US House and US Senate committees on Veterans Affairs after approximately 10 weeks with no notification from VA for my second OIG submission. Within days a staffer from the senate committee called me. He stated that he would reach out to OIG, and also would speak with more senior coworkers as he was unfamiliar with how he could receive my complaint and how they would store

protected health information. When he called back, it turned out that no one he spoke with was aware of this option, or how it could be accomplished, demonstrating that practically speaking this is not a realistic option for whistleblowers. However the same week he said he would speak with the OIG, they finally made contact with me regarding my complaint, and sent a release for me to sign allowing for them to disclose me by name.

I have no idea if the OIG would have ever proceeded with an investigation without me making contact with the senate committee staff member. But I do know that on whole the entire process related to the submission of this complaint was overly burdensome on me as the whistleblower.

I felt that it was important to provide that background on my complaint process, but the primary purpose of my letter is to comment on the report from OIG itself, which I will present in four parts below as summarized in the report, and starting with the issues where my complaints were unsubstantiated (I will cover these bullet points out of the order presented in the complaint and report)

Four Complaints referred to OIG from OSC:

1) Violated VHA Directive 1220 requirements for the facility to have designation of Inpatient Complex for inpatient invasive procedures

2) Violated Joint Commission standards regarding documentation of complex or high-risk surgical procedures

3) Violated the Health Insurance Portability and Accountability Act by providers discussing protected health information in the public waiting room of the facility

4) Permitted unauthorized access to VA computer systems by physician residents who did not have credentials approved by the VA

2) Violated Joint Commission standards regarding documentation of complex or high-risk surgical procedures

According to the OIG report, they deemed my complaint “unsubstantiated” in regards to violating Joint Commission standards regarding documentation of complex or high-risk surgical procedures. I contend that this, perhaps more than any other part of the investigation, demonstrates OIG’s bias towards minimizing complaints, dismissing material risk for veterans, attempting to discredit whistleblowers, and arguably could be construed as malfeasance.

They agree and state that the Joint Commission requirement, listed as a “standard”, was not met at the time of the complaint and continues to not be met. So on the face of it, to deem this unsubstantiated is offensive. And I will tell you that the Joint Commission itself was of little help addressing this. As I had also referred this complaint to that body, and received a reply sometime later stating in a very self congratulatory tone that they had addressed the issue with the facility and it had been remedied. That same week that I received the reply from the Joint Commission, of our highest risk surgical procedure performed in our facility, none had operative notes written that week. I felt like I was in the twilight zone. And within the OIG report, they provide as supporting information to justify their determination that “The Joint Commission reviewed the facility response and took no further action.” However, as my above

example points out, the ineffectiveness and lack of meaningful response from the Joint Commission should not make anyone feel comfortable with or in any way justify the ineffectiveness and lack of meaningful conclusion by the OIG.

The explanation from OIG as to why this is "unsubstantiated" was in relation to the timing of the facility awareness of the issue (which was raised by me), and the fact that they had made unsuccessful efforts to address it. These do not justify their final determination.

I had, for years, voiced concerns related to the care provided in our facility. I was a regular in our Patient Safety office, and had a good working relationship with them. I did not save up a list of grievances to submit to OIG on my way out the door without first trying to address them myself within the facility. But as is better described in my full complaint than simply these four issues referred by OSC, this was not without challenges. The matter of documentation of procedures is not different. At the time of my initial OIG complaint, the new interim Chief of Surgery was someone I had known for 20 years, as we both attended Medical School together at Dartmouth. He is currently the permanent Chief of Surgery, and I know that he is committed to working to improve upon the current state. But we have a difference of opinion about how best to address the shortcomings for the facility's surgical program. In early 2023, I informed him of the lack of documentation for procedures. And he committed to me to address it. So when the OIG report states that a surgical work group meeting in February of 2023 first makes note of the issue, that was a direct result of my internal reporting of the issue. The fact that there was such a long delay (I made my first referral to OIG in March of 2023, and that their report back to OSC with the findings of their investigation was November of 2024 despite an initial due date in March of 2024) does not impact the accuracy of the complaint. Their stated compliance rate at the time of my complaint was near 60%. And the fact that by admission, there is continued noncompliance with this standard, also raises a question of how they could deem this unsubstantiated. Data would be helpful. It would be worth asking the OIG to provide, by surgical service line, an annual tally for the last 5 years of compliance with this directive as a percentage of procedures, broken down by inpatient and outpatient. This will demonstrate the extent of the problem, as well as the extent of improvement, and that this "standard" which should have 100% compliance still does not.

The fact that progress has been made, the fact that VA OIG works slowly which provides time between complaint and report, the fact that the Joint Commission involvement did not remedy the violation does not impact the accuracy of the complaint. VA should not be attempting to reward itself for these delays by then discrediting whistleblowers claims, in particular when they then admit to ongoing non-compliance.

And perhaps more meaningful than the lack of these procedure notes, is what this represents about the influence VA maintains over its providers who are willing to provide high complexity care in this facility, but then not to even write down what they did. This speaks to one of VAs main vulnerabilities more broadly, their exposure within the academic affiliate model. They lack the leverage to even compel compliance, which is why the facility turned to putting the onus for this on post anesthesia recovery unit nurses, which the OIG rightly calls out as both inappropriate and ineffective.

3) Violated the Health Insurance Portability and Accountability Act by providers discussing protected health information in the public waiting room of the facility

There are some things in life where seeing is believing. And if the OIG had made any attempt to go unnoticed and watch the waiting room, I believe that they would have had a harder time to justify not substantiating my claim. But per the report, they did not. They viewed the space,

the spoke with providers who denied that they were aware that this had ever been raised as an issue. And they determined that there is a space available that could be renovated in the future to allow for private conversations to alleviate the concern for privacy violations. But these two points are in direct conflict. If there is no violation now, then there is no need to expend resources renovating that space.

What they are unaware of is that this issue has been raised, by surgeons, for years. That before the most recent costly renovation of this space five years ago I had addressed this concern with the chief of staff at the time. That this same space had been evaluated for renovation for this express purpose, but ultimately the decision was made not to pursue this for reasons that I can not explain.

The OIG states that all that VA privacy policy requires is that providers "speak quietly when discussing a patient's condition with family members in a waiting room or other public area." However in the still publicly accessible VA HIPAA online training where that line can be found related to Incidental Disclosures of protected health information, they also require "avoiding using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality." The OIG report makes no mention of the use of names within our waiting area, again, because there is no evidence that they made a good faith effort to determine what actually goes on.

To be clear, the surgeons are victims in this current arrangement as well. One of the realities of providing medical care through VA is that from time to time you will suffer certain indignities as well as moral injury. This topic resulted in one of my first experiences with this indignity early on in my VA career. The daughter of a patient that I was caring for that day was present in the preoperative area for my preoperative evaluation of her father. She was polite, engaged, and allowed me to complete my history and physical, discuss the anesthetic plan, and then ask if either of them had any questions. It was at this point that she stated that she did not have any questions, but that she wanted to inform me that she too was a physician. And that she was "appalled" at the number of HIPAA violations she had witnessed while sitting in the waiting area with her father while they waited for his procedure. There was nothing that I could say, no way to justify or dismiss what we both plainly knew was true, that what she had said was an accurate representation of the current practice of our facility, which disregarded privacy requirements. And still, no one has provided the surgeons with a location that allows for privacy during these important family/provider updates.

1) Violated VHA Directive 1220 requirements for the facility to have designation of Inpatient Complex for inpatient invasive procedures

The OIG substantiated a portion of my complaint regarding violation of this requirement, but then did not substantiate other elements. For those areas where they deemed my complaint unsubstantiated I disagree with the conclusion, the methods for investigation, and feel that portions of the investigation and report on this issues do not conform to a good faith effort by the OIG. This is partly related to the fact that beyond what they have reported here, included in my complaint are other elements of the requirements of Directive 1220 that they did not address as well as interconnected VA Directives that they intentionally do not speak to, which are clearly violated.

Among those are the requirement for a blood bank to be capable of providing blood products within a specified time frame. They do not speak to this, despite the fact that one of the specific cases that I provided is a veteran who died in our facility after surgery where he slowly bled to death post operatively while the blood bank refused to release blood in an adequate

time frame according to Directive 1220, or in an adequate volume when it was ultimately provided. This same case also involved a lack of surgeon coverage. In addition to the topic of blood bank requirements, they also do not speak to elements of provider coverage related to house officers supervision, which I also included in my initial complaint.

In regards to a formal surgeon call schedule, the facility leaders provided OIG with what they claimed was a call schedule, and OIG accepted it as such. What they do not speak to once again, is the reality of what goes on within the facility and the way that it is managed. For nearly 9 years I worked there as an anesthesiologist, talking call to provide anesthesia care to patients needing emergency surgery overnight. Thought that entire time, I never had a mechanism for knowing what the call schedule was, or who was on call for surgical services other than to ask their intern. It was never listed through the affiliate paging website. This was a known systemic issue. There is a facility call schedule calendar. Only the anesthesiology attending on call was listed there, no surgeons. This issue was known by the facility and the former chief of surgery, a Urologist, who did make efforts to address the gap. However that resulted in only the Urology call schedule being updated to include more than just an intern on call. No attending coverage was provided for other surgical services. The OIG report states that an escalation process was implemented in spring of 2023 to address issues with surgeon coverage and availability. I identified to the facility in March of 2023 that I had filed an non-anonymous OIG whistleblower complaint weeks after the above case of an inexcusable veteran death. This is yet another example of the OIG suggesting that because the facility made efforts after I had become a whistleblower to address gaps that I had raised as issues, that in fact they do not qualify as gaps, which then works to discredit me as a whistleblower. And in a similar vein, they burry as footnote 7 on page 3 of the report that while the OIG is "confident" that their remedy for this has been widely accepted as a facility policy, it was not created as a formal policy, has no policy number, is signed by no authorizing official, that it in fact is not a policy. And there is no mention of the fact that by eliminating the formality of creating an actual policy, per VA bureaucratic processes, no one can be held accountable when this "not actual policy" isn't followed.

Also troubling within their report on this issue was the assertion that the OIG reviewed patient safety reports related to reaching on-call surgical providers, and that the number of safety reports submitted decreased after the spring of 2023. The reality that they neglect to mention is that sometimes people no longer complain when they are habituated to the reality that complaining results in no change. So while it is possible that there has been substantive change in terms of making the provider call schedule visible and thus more formal, it is also possible that over time people have stopped submitting complaints simply because they have learned they result in no change and thus are not worth the effort.

Another element of the requirements for Directive 1220 is that there is qualified in-house coverage for all inpatients. The requirement specifically states that this can not be provided by the Medical Officer of the Day (MOD) or Emergency Room provider. Inpatient coverage implies responsibility for the care of these inpatients. Legal responsibility for their care. The VA OIG states that they spoke with the chief of hospital medicine and verified that they facility is continuously staffed by hospitalists, which meets the requirement for qualified in-house coverage for all inpatients. This implies that the hospitalists are responsible for the care of the surgical patients admitted to the facility, but they are uninvolved in their care. In fact, one of the specific patient cases I provided to the OIG was a patient on a surgical service with no in-house coverage at all, who began to have a stroke. The covering house officer was in an operation at the university affiliate, and unavailable. Attempts were made by the nurse to elicit help from medicine service providers, which were rebuffed. It was not until the operation at the affiliate ended and that house officer returned to the VA hours later that someone came to evaluate and care for this veteran during an acute stroke.

But even if we assume that this hospitalist is now responsible for these surgical patients in accordance with Directive 1220, (which to be clear, they are not) then they still do not fulfill their obligations of care within the VA, which would result in a violation of their requirements as the qualified in-house coverage. The actual care provided to these inpatient veterans is by surgery house officers, primarily PGY-1 first year trainees. And what they deliberately leave out is any reference to my additional complaint related to violation of VA Directive 1400, which requires the direct supervision (defined as being physically present with them) of PGY-1 house officers. And I have since learned that this same requirement is also a component of VHA Directive 1101.04. The actual in-house coverage for our surgical patients is provided primarily by PGY-1 trainees on surgery rotations at the VA, some of whom are only rotating on surgery but are actually radiology PGY-1 trainees. The use of these early stage trainees as standalone providers within VA facilities is barred by this Directive. This was a component of my complaint, related to the violation of Directive 1220, that VA has made a deliberate decision to conceal in their report on this issue. And they are complicit in this misrepresentation of the true state of care within the facility. But an additional information request can help provide transparency. Per VA Directive 1400, if the hospitalist is acting as the supervising physicians for the house officers, as allowed by Directive 1400, then they are required to document their involvement in care through one of four options provided in VHA Directive 1400 8. b. (1) (a-d). These represent either cosigning progress notes, an addendum to progress notes, separate progress notes by the hospitalists etc. Of the daily surgical progress notes for these surgery patients, how many are cosigned or addended by the hospitalist staff? How many separate progress notes have hospitalist staff written? The results of these inquiries will speak for themselves.

Or, if we are to be made to believe that the hospitalists are now providing coverage for these patients independent of the house officers, then they should be writing their orders. The list of hospitalists is small. The facility could also provide data from the electronic health record detailing what percentage of orders entered for these patients are provided by the hospitalist staff.

We could also inquire about the handoff process of the hospitalist staff. If they are truly the covering physician overnight, then in practice this would involve a patient transfer of care, routinely a verbal or written sign out process. Has the OIG investigated what process is used by these hospitalists for their medical patients, and is there any evidence that the same applies for their “coverage” of surgery inpatients?

In regards to the substantiated portions of my complaint for missing infrastructure requirements, and the lengthy discussion of the VA process for waivers, rather than comment I will ask a question. At the end of the work by the OIG, where they point out that the facility was disingenuous with regards to their interactions with OIG regarding having submitted requests immediately prior to the insight OIG investigation, the end results was that the elements of the infrastructure requirements that were lacking were all provided with waivers. Was the list of specific patient injury and patient deaths I provided to the OIG related to deficiencies in care in our facility provided to the VA officials responsible for authorizing these waivers before they were approved?

4) Permitted unauthorized access to VA computer systems by physician residents who did not have credentials approved by the VA

While this part of my complaint was substantiated, the OIG deliberately downplayed the nature of the violation. And at the same time, they did not make a good faith effort to corroborate my

assertion that this was done at the direction of our service chief, now Associate Chief of Staff 2.

Unauthorized access to a federal workstation is covered by statute 18 U.S.C. § 1030. This is not simply lack of compliance with VA policy, this is a violation of federal law. This was done at the direction of a supervisor in a federal agency, instructing subordinates to violate federal cybersecurity law related to access to federal computers. This practice started under the prior anesthesia service chief, who then became the former chief of staff. So in the report, where the anesthesia staff suggest they were under the impression that hospital leaders knew, it's because they did. And the OIG report looks over the obvious gap in logic, that by admission Associate Chief of Staff 2 knew this was the practice, yet refutes that it was at her direction. However, as the supervisor, she was still responsible for the department where she knew this was the practice, where she participated in the practice. She is still intimately involved and ultimately responsible.

Thus weather or not Associate Chief of Staff 2 had provided explicit instruction to do this is less relevant in terms of culpability as a leader. However, that does not eliminate OIGs responsibility to investigate the matter. However, when their review of "written communication" which is not otherwise defined, proved not to demonstrate written instructions, they chose to ask only a small fraction of the members of the department. Any good faith effort to investigate this issue under these circumstances would have involved a more thorough interview process with current and former members of the department.

It was this matter, the fourth element of my complaint referred by OSC that had peaked the interest of the OSC attorney most when I first made contact with OSC. The violation was a breach of federal law. It was this OIG investigation that was tasked with investigating this violation of federal law. Which makes it that much more obnoxious that when I attempted to discuss additional elements of my original OIG complaint with the OIG investigators related to falsified timecards in our department, overseen by the same supervisor that instructed us to violate federal law related to computer access, that I was told that they are not the criminal offense investigators within VA OIG so they could not speak to me about that matter. It was the equivalent of trying to tell a federal official about wrongdoing that they are responsible for addressing, while they put their fingers in their ears and shout "La La La La La La La" childishly thinking that this would somehow prevent any credible claim that it had been brought to their attention. These were the investigators tasked by OIG to address the referral from OSC regarding violation of 18 U.S.C. § 1030, and they were refusing to discuss elements of my OIG complaint because they claim they can not investigate violations of federal law. It was a surreal way to end my OIG interviews.

I'd like to leave you with this picture. A VA department being overseen by someone instructing subordinates to violate federal law related to access to federal workstations, falsifying timecards, and all the while using VA time and facilities to direct one of their subordinates to give them cosmetic botox injections in their face (in the VA offices), meanwhile patients in this same facility are suffering harm due to lack of compliance with VA requirements and overall facility mismanagement. But you can find no support from within the facility leadership. And you reach out to OIG who creates hurdles to submitting complaints, dismiss complaints without reading them, and then ultimately after investigating likely only due to the insistence of the OSC and possibly US Senate, attempt to discredit you as a whistleblower by finding complaints unsubstantiated in ways that defy logic and reason. This process is perfectly designed to discourage becoming a whistleblower, or working for VA to begin with.

Lastly, in regards to my complaint, it should be noted that in the context of all of this, equally troubling is that the families who have suffered because of the lapses in care outlined in my

complaint have not been provided with the truth, through appropriate notification about what happened to their loved ones.

I would like to close by pointing out that throughout this process, and over years of raising concerns related to inappropriate risk to veterans within VA, it was not until making contact with the US OSC attorneys that I felt like I had encountered someone with oversight authority who was actually listening and wanted to affect positive change. The staff at OSC have been remarkable throughout this process and they deserve recognition for the dedication and professionalism that they bring to government service each day. I am truly grateful for their support throughout this process.

Sincerely,

/s/ [redacted]

[redacted], MD MBA