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Washington, D.C. 20036-4505

The Special Counsel

July 28, 2021

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

Re: OSC File No. DI-17-4897

Dear Mr. President:

I am forwarding to you reports transmitted to the U.S. Office of Special Counsel (OSC) by the U.S. Department of Veterans Affairs (VA) in response to disclosures of wrongdoing at the VA Greater Los Angeles Healthcare System, West Los Angeles VA Medical Center (West Los Angeles VAMC), Los Angeles, California. The whistleblower, [redacted], a neurosurgeon and former Chief of Neurosurgery, who consented to the release of his name, disclosed that agency officials engaged in conduct that may constitute gross mismanagement, an abuse of authority, and a substantial and specific danger to public health and safety. I have reviewed the disclosures, the agency reports, and [redacted] comments, and in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency reports and my findings.[1]

The Allegations and Agency Report Findings

[redacted] reported that agency officials' mismanagement resulted in unsanitary conditions in operating rooms (ORs), lack of proper surgical supplies, and understaffing. Specifically, [redacted] alleged the following:

- From January 2017 to November 2017, a fly infestation caused the closure of multiple ORs and cancellation of patient surgeries;
- Since 2016, sewage water leaks have caused the closure of multiple ORs and cancellation of patient surgeries;
- From June 2017 to November 2017, ORs have been critically short on surgical supplies;
- Understaffing, particularly of anesthesiologists and OR nursing staff, has caused OR closures and affected the facility's ability to perform emergency surgery during the evenings and on weekends; and

[1] [redacted] allegations were referred to former VA Secretary David J. Shulkin for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The VA Office of the Medical Inspector (OMI) conducted the investigation. Former VA Secretary Robert L. Wilkie reviewed and signed the agency reports.

- The lack of an interventional neuroradiologists and neuropathologists has affected the facility's ability to diagnose and remove tumors.

As summarized below, the agency investigation partially substantiated the allegations.

West Los Angeles VAMC Fly Infestation and OR Closures. The facility offers care for over 12 surgical specialties and has 10 ORs. ORs 1-8 are in the main OR space underneath an interstitial space below the dialysis unit and ORs 9 and 10 are adjacent to the main OR. The agency substantiated that from November 2016 through February 2017, the presence of flies caused the closure of multiple ORs, which caused the cancellation of patient surgeries. The agency determined that the decision to close the ORs was appropriate to ensure patient safety, and that the facility implemented timely actions to address each fly sighting and attempted to eliminate the presence of flies in the ORs. The West Los Angeles VAMC contracted an entomologist and pest controllers, installed fly lights, and consulted with the VA Central Office (VACO) to eliminate the flies. However, the investigation determined that the facility's main entrance doors were left open at times, which allowed flies to enter, and that VAMC leadership was not tracking the presence of flies, which could have provided valuable information to identify factors contributing to the flies' presence.

The agency found no fly sightings from October 2017 to February 2018; however, following this period, 11 flies were seen in the main ORs and the center core where sterile supplies are stored. ORs 1-8 were closed on February 5, 2018, and re-opened on February 7, 2018, after more than 24 hours without any fly sightings. On February 12, 2018, staff reported 3 more flies and ORs 1-8 were closed again. In the interstitial space, the facility found debris, a pipe leaking water onto the floor, and a wet/dry vacuum cleaner full of debris. Also, disturbingly, a rodent carcass covered in hatched larvae was also found outside of the building, removed, and the area was thoroughly inspected.

During this period, 40 surgeries were cancelled. The agency report made numerous recommendations to eliminate the presence of flies, including ensuring regular facility inspections and drain treatments, completing a Standard Operating Procedure (SOP) and educating staff on pest prevention, consulting with VACO pest experts and external pest control sources, and sealing any gaps in the interstitial space through which flies could enter.

Sewage Water Leaks. The majority of West Los Angeles VAMC patients with renal failure are dialyzed in the Hemodialysis Unit on the 6th floor. Between the 6th and 5th floor OR area, there is an interstitial space that houses electrical, plumbing, and equipment for the Hemodialysis Unit. The area previously housed a dialysis waste storage tank. The pipes in this area are 20-30 years old, made of cast iron, and were corroded by the acidic dialysis waste, which caused them to leak.

The agency substantiated that since 2016, water leaks have caused the closure of multiple ORs and the cancellation of patient surgeries. In total, 26 surgeries were cancelled and rescheduled due to reported leaks. The West Los Angeles VAMC repaired the leaks and is preparing to replace all the pipes in the interstitial space. The investigation found no evidence that any of the patients whose surgeries were cancelled due to these OR leaks experienced adverse outcomes as a result of the delays. However, the report made several recommendations to the facility, including continued monitoring and repairing of leaks, taking appropriate measures to ensure patient and staff safety, and continuing with plans to replace the pipes.

Lack of Surgical Supplies. [redacted] stated that since June 2017, ORs have routinely been critically short of, or out of, surgical supplies. [redacted] further stated that, at times, he delayed surgeries up to 30 minutes in order to locate needed supplies. The agency substantiated the shortage of surgical supplies. The investigation found that the previous Logistics Service leadership team did not ensure that all supplies were entered into the electronic system for tracking and automatic reorder. The West Los Angeles VAMC replaced the Logistics Services leadership team, and since August 2017, staff have not identified any instances where surgical supplies were unavailable. Additionally, the agency found no evidence of surgery cancellations due to inadequate supplies. The report recommended that Logistics Services continue to properly track and automatically reorder supplies as needed.

Understaffing of Anesthesiologists and Nursing Staff. The agency did not substantiate that understaffing, particularly of anesthesiologists and OR nursing staff, has affected the facility's ability to perform emergency surgery. The agency found that the West Los Angeles VAMC is staffed with 2 on-call surgical teams which allows emergency surgery to continue when needed.

However, the agency substantiated that understaffing issues have contributed to scheduling and block time changes. During FYs 2016-2017, 90 of the 1,272 cancelled surgeries were cancelled due to staffing issues. The agency recommended the facility should fill all anesthesia provider vacancies and determine whether Anesthesia Services are needed to combat potential inefficient use of OR resources and increase the number of surgeries OR staff can complete.

The agency also found that lack of support from Human Resources (HR) contributed to anesthesia staff shortages. Specifically, HR's inadequate staffing and inefficient processes negatively affected the facility's ability to hire staff in a timely manner. Although facility leadership is working with VACO Workforce Management to address this concern, the report made multiple recommendations, including using available resources, such as the Education Debt Reduction Program, and salary waivers, to improve the attractiveness of VA positions. The report also recommended that the facility consider assigning a dedicated Administrative Officer or support staff member to Anesthesia Services.

Lack of Interventional Neuroradiologists and Neuropathologists. The agency did not substantiate that a lack of interventional neuroradiologists and neuropathologists affected patient diagnoses. Until 2014, the facility employed a neurovascular surgeon who was trained as an interventional neuroradiologist. The facility has attempted to hire another provider but has been unsuccessful. Notably, [redacted] stated to investigators that there were no cases in which his patient treatment plans would have differed if a neuropathologist had been available. However, all the neurosurgeons who were interviewed, envisioned scenarios during certain tumor surgeries where a neuropathologist's expertise would aid them in making more informed medical decisions. Additionally, although the agency found no evidence of adverse events related to the lack of these services, it found that the lack of a contract arrangement with other facilities for treatment of patients with acute neurovascular disease could lead to significant delays. The agency report recommended that the facility develop recruitment or sharing agreements with an affiliate or nearby facility to acquire neuroradiology and neuropathology services, given that the facility is classified as capable of providing care for the most complex patient scenarios.

First Agency Supplemental Report

OSC requested a supplemental report regarding the continued presence of flies and whether the facility implemented all the recommendations following the investigation. There were 15 fly sightings from February through June 2018, 31 total sightings from July to August 2018, and 5 during the first 2 months of FY 2019.

The agency investigation determined that despite the additional fly sightings, the West Los Angeles VAMC implemented all the recommendations. The facility also installed new entry doors with sensors to indicate when doors remain open and air curtains at the entrance to the ORs, relocated the OR breakroom, and continued to use and monitor fly lights. The agency found that one of the exit door air curtains at the loading dock was ineffective, but the facility already had plans to replace the curtain no later than February 2019.

Whistleblower Comments to First Supplemental Report

[redacted] emphasized his continued concern that patients were still at risk due to the presence of flies. He maintained that leadership had not sufficiently updated OSC or the agency about the flies, and that the fly prevention measures taken at the facility were inadequate.

Second and Third Agency Supplemental Reports

In response to OSC's request for a second supplemental report regarding the continued presence of flies, the agency found that from January to March 2019, staff reported fly sightings in the ORs, the cardiac catheterization area, and where the clean instruments are stored. The agency further found that in April 2019, there were no reported fly sightings in the OR and cardiac catheterization area, and only one in the clean area where instruments were stored. Each fly sighting was addressed, and no surgical procedures were cancelled. Additionally, the agency found that the air curtain at the exit doors in the loading dock was repaired and functioning properly.

OSC requested a third supplemental report regarding the continued presence of flies. The agency reported that from May 2019 to August 2019, there were 6 fly sightings. Each fly sighting was immediately addressed, and no surgical procedures were cancelled or rescheduled. The West Los Angeles VAMC also installed ultraviolet light insect traps throughout the facility to identify, monitor, and control the presence of flies. The facility also installed forced air curtains at all entrances to prevent flying insects from entering the building, increased the cleaning frequency of drains, and installed trash compactors throughout the facility to prevent the breeding of flies. Additionally, the VA's National Environmental Programs Service (EPS) pest control group sent pest control subject matter experts (SMEs) to determine if the fly traps throughout the facility are necessary or if additional steps, or a more appropriate solution, should be taken, and to report the findings to VACO. [redacted] declined to comment on the second and third supplemental reports.

The Special Counsel's Analysis and Findings

I have reviewed the original disclosure, agency reports, and the whistleblower's comments. I thank [redacted] for bringing these allegations to OSC. While this has been a long process, the investigation resulted in significant improvements to the facility and changes to agency policies. The agency informed OSC in September 2019 that the VA EPS pest control SME evaluated the presence of flies, provided guidance to the facility and made several recommendations, including that the facility add pest controller positions to the staff, provide weekly reports of fly activity at the front entrance to the Environmental Management Service Chief, conduct inspections of ground floor drains, and service fly lights weekly. Additionally, the pest control SME found that the contractor charged with servicing the loading docks dumpster was not fulfilling all its duties. The SME's guidance and findings were reported to VACO, and VACO approved the implementation of the recommendations.

It appears that the agency has implemented all recommendations and taken appropriate steps to address the above issues. For these reasons, I have determined that the reports meet all statutory requirements and the findings appear reasonable. As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, agency reports, and the whistleblower's comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also placed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures