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**Office of Inspector General**

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## VA Inspector General Michael J. Missal's Statement following the Sentencing of Reta Mays for Second-Degree Murder of Seven Veterans and Assault with the Intent to Commit Murder of an Eighth

WASHINGTON – The following is the statement of VA Inspector General Michael J. Missal delivered at the Department of Justice press conference May 11, 2021, following the sentencing of Reta Mays for second-degree murder of seven veterans and assault with the intent to commit murder of an eighth veteran at the Louis A. Johnson VA Medica Center in Clarksburg, West Virginia. Mays pleaded guilty to deliberately administering insulin to these patients in 2017 and 2018, resulting in profound hypoglycemia and death.

"The Office of Inspector General conducts independent oversight of VA. With respect to the criminal investigation, we were on-site within 24 hours of being notified of a possible problem. Very shortly thereafter, through the great work of our agents, we were able to persuade VA to take Ms. May off of patient service. That act alone likely saved lives.

The agents continued to doggedly pursue every lead in this case which resulted in the sentencing which we had today. But for their efforts along with the US Attorney's Office, the FBI, and our other law enforcement partners we would not be standing here today.

So that answers who did it. The next question is, 'How could something like this happen?' So, our Office of Healthcare Inspections, which consists of physicians, nurses, and other providers, conducted a healthcare inspection to determine the environment of care, the controls, and what actually occurred.

We completed that inspection and we are publishing our report today. Our report found serious, pervasive, and deep-rooted clinical and administrative deficiencies at the medical center. It was a series of missed opportunities that contributed to the criminal actions occurring, not being stopped, and for allowing it to go on for as long as they did. So, let me go through some of the more significant ones that are detailed in our report.

First, there was a failure to review Ms. Mays's prior employment. Prior to coming to VA, she was employed at the North Central Regional Jail. Had VA, as required, gone back and looked at that employment, they would have realized allegations of excessive use of force against her. The question is, 'If somebody has those kinds of allegations, should they be involved with patient care?' So, that was one missed opportunity where they could have not hired her in the first place.

There's a second opportunity with respect to her background. She actually received a Secretary's Award for Excellence in 2017. As part of receiving that award, they were required to go back to make sure that her background check had been done. They checked it had when it actually hadn't. So, there's yet another missed opportunity where if they looked at it, they could have identified an issue.

The second broad area is with respect to the security of the medication room and the medication cart; there was insulin in both of those. So, everybody on Ward 3A where Ms. Mays worked had full access to the medication room and the medication cart. This was a violation of policy, as they should have been secured. With respect to the medication room, to bring people back from severe hypoglycemic events, there's a rescue medication referred to as D50. With one event after another, the use of D50 was used very extensively on the ward. Again, nobody realized what was happening. They should have had this in their inventory. It should have popped up automatically. Somebody should have communicated, 'Why are we using so much D50?' Hypoglycemia is very rare in patients who do not take diabetic medicines. So, somebody should have been asking a question. They didn't do so in that situation. Another missed opportunity.

With respect to the physicians, the hospitalists, and the other providers including the nurses—with respect to the providers, no diagnostic testing was ordered for seven of the eight patients who were included in the plea agreement. Again, hypoglycemia, particularly unexplained hypoglycemia, is very rare. They should have ordered some kind of diagnostic test to get to the bottom of what happened there. With respect to the one patient where they did order the test, they actually ordered the wrong test and even had it been the correct test it was after D50 had been applied so it wouldn't have shown what it could have.

Next area—the failure of the hospitalists, the doctors, and the nurses to communicate effectively about patient care. To have a really high quality of care, you need to coordinate, you need to have coordination of efforts there. So as these events are occurring, they're not talking to one other about how can this happen, why is it on this ward, and why are they having such a rare event. It's particularly striking because in the spring of 2018 you had four unexplained hypoglycemic events within three weeks. That should have set off major alarm bells. Somebody should be asking a question and looking into it. They did not do so.

Next is patient safety. These events—an unexplained hypoglycemic event—is a patient safety event. It should have been reported to the patient safety department. None of them ever were. Why wasn't it reported? Because the patient safety manager never trained the staff about what kind of events should be reported. Again, that's a major failing of the medical center. You put in place systems to help prevent things like this and it just wasn't done.

Finally, the risk manager had tools at their disposal, including a mortality tracker, that could have shown any spikes in mortality at the medical center. During Ms. Mays's time there, there were nine different times when there were mortality spikes. Nobody bothered to check. Nobody picked it up.

Our report contains 15 recommendations, each of which VA has concurred with, to assess and address the issues that we identified in the report. One of these recommendations is for VA to take another look at the various patients that had quality of care issues outside of the

hypoglycemic events, so we are going to be monitoring this very closely. Our work is continuing, and we are going to assure VA fully implements all 15 of those recommendations.

Nothing will bring back the veterans who were lost. Hopefully, the sentencing today and our healthcare inspection report will bring solace to the families and hopefully ensure that nothing as tragic as this ever happens again. Thank you.

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