Administrative Closure
Suspicious Death, Alleged Premature Discharge, and Quality of Care Issues
VA Southern Nevada Healthcare System (660/00)
Las Vegas, Nevada
MCI# 2013-03662-HI-0356

On April 4, 2013, the VA Office of Inspector General's (OIG's) Hotline Division received a letter from the (b)(3):5 U.S.C. App 3 (IG Act);(b)(6); (complainant) of a deceased veteran patient questioning the patient's death within 12 hours of his discharge from the Mike O'Callaghan Federal Hospital (MOFH), a Department of Defense hospital closely affiliated with the VA Southern Nevada Healthcare System (facility). The complainant reported that the family had major concerns about the patient's hospital care, stating that a general surgeon and a registered nurse[1] who reviewed the patient's medical records both questioned various aspects of the patient's care. The letter contained the following enclosures/information: (1) autopsy report, (2) miscellaneous laboratory report, (3) inpatient records, (4) excerpts from charts, (5) sister's letter to MOFH Commander on March 12, 2012, (6) facility Director's[2] response to the sister's letter on April 20, 2012, (7) sister's letter to the facility Director on May 16, 2012, (8) sister's follow-up contact with the facility on August 12, 2012 (referenced in the letter but no hard copy was provided), and (9) medical doctor discharge orders.

Background: The facility's new hospital became operational in January 2013. Prior to this date, the VA had only outpatient clinics in the Las Vegas area. Veterans requiring inpatient care were either admitted at MOFH through a sharing agreement or were fee-based at a community hospital. VA patients admitted at MOFH were cared for jointly by VA and MOFH staff. The patient was under the care of a VA attending surgeon.

The patient was in his early 70s and had a history of rectal cancer. In August 2010, he was admitted at MOFH for a low anterior resection with a loop ileostomy procedure and was hospitalized for 23 days. On September 15, the patient was discharged home, and within 12 hours of discharge was found dead in his bed. On September 17, an independent autopsy was performed and the cause of death was reported as "a colorectal surgery complicated by peritonitis with abscess formation and defect of large bowel."

On December 13, 2010, the facility initiated a protected peer review due to the patient's death within 30 days of a surgical procedure. (b)(3):38 U.S.C. 5705

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[1] It was unclear if these reviewers were hired by the family.
[2] This refers to the facility's former Director who retired in April 2013.

(b)(3):38 U.S.C. 5705 At a meeting on May 26, 2011, the facility's Peer Review Committee agreed with the reviewer, and no further action was taken.

In a March 12, 2012 letter to the MOFH Commander, the patient's sister questioned the untimely death of her brother, listed several concerns about his hospital care, and attached a copy of the autopsy report, and record review summaries from the general surgeon and nurse. The letter and attachments were forwarded to the facility Director. On April 20, the Director responded stating that the facility would perform a comprehensive review of the patient's medical records. The complainant reported several unsuccessful attempts by the sister to contact facility leaders to inquire about the status of the review, review findings, and any actions taken.

Office of Healthcare Inspections Hotline Workgroup Reviews: On April 16, 2013, we requested that the facility review the case and provide all relevant documents. On June 7, the facility provided us a copy of the 2011 protected peer review, copies of the patient's non-VA medical records, the patient's discharge summary, and the former facility Director's letter to the patient's sister.

On June 18, we referred the complainant's letter to Veterans Integrated Service Network (VISN) 22 for response. On July 30, the facility's new Director responded through the VISN that the allegations had already been reviewed and addressed, that a protected peer review had been conducted, and that the reviewer did not identify any quality of care or other issues. The Director mentioned the documents sent to us on June 7.

We reviewed the facility's response through the VISN and determined that it was inadequate. We noted that, at the time of the 2011 peer review, the reviewer did not have access to the independently performed 2010 autopsy results. On October 22, we accepted the case for further review.

OIG Follow-Up Review: We evaluated all the documents and information from the complainant. We also reviewed the patient's medical records in detail. On October 25, we conferred with the facility's Chief of Staff (COS), the quality manager, and the patient safety specialist. The facility did not have a copy of the autopsy report and did not learn of the family's concerns about the patient's hospital care until receipt of the sister's March 2012 letter with attached documents. Therefore, the initial peer review did not incorporate the results of the autopsy. We discussed the autopsy findings, questions raised by the patient's sister, and issues identified by OIG reviewers.

The COS agreed to send the case back to the initial surgeon reviewer for a comprehensive review and to address the concerns identified by the family and issues from the autopsy report. In addition, the COS agreed to have a pulmonologist conduct a

(b)(3):38 U.S.C. 5705

protected peer review to address specific concerns and questions related to the patient's pulmonary care.

On December 17, 2013, we reviewed the completed protected peer reviews. (b)(3);38 U.S.C. 5705 (b)(3);38 U.S.C. 5705 (b)(3);38 U.S.C. 5705

Summary:

We determined that the facility has taken measures to address the issues identified by the complainant. After prompting by OIG, the facility completed comprehensive protected peer reviews in accordance with VHA guidelines[4] (b)(3);38 U.S.C. 5705 (b)(3);38 U.S.C. 5705. The facility is in the process of conducting non-protected surgical and nursing reviews. Once these reviews are completed, the COS will (b)(3);38 U.S.C. 5705.

We have no recommendations; therefore, this case is administratively closed.

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[4] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.