7-0296 LG

(b)(5)

Memorandum to the File
Case Closure

Suspicious Death
VA Connecticut Healthcare System
West Haven Connecticut

MCI Number: 2007-01041-HI-0293.

The Department of Veterans Affairs Office of Inspector General's Office of Healthcare Inspections conducted an inspection to determine the validity of allegations about a suspicious death in the medical emergency room (MER) at the VA Connecticut Healthcare System (the system), West Haven, CT.

On January 31, 2007, the Office of Inspector General's (OIG) Hotline Division received a report from a complainant, who wanted to remain anonymous, alleging that during the time the complainant was treated in the system's MER, an unnamed patient died. The complainant alleged that doctors and nurses in the MER attempted to conceal the death.

The complainant's medical record shows that a MER attending physician assessed the complainant at approximately 5:00 pm (b)(3):38 U.S.C. 5701,(The complainant's was suffering from (b)(3):38 U.S.C. 5701,(b)(3):5 U.S.C. App 3 (IG Act),(b)(6)

(b)(3):38 U.S.C. 5701,(b)(3):5 U.S.C. App 3 (IG Act),(b)(6)

Since no such bed was available at the time of admission, clinicians kept the complainant in the MER throughout the night of (b)(3):38 and into the next day.

The complainant's written statement to the OIG shows that at approximately 5:30 pm on (b)(3):5 U.S.C. the VA police brought a restrained patient in a wheel chair into the MER. According to the written complaint, the police removed an "almost empty" bottle of vodka from the second patient, and the patient was placed in a room next to the complainant. The complaint alleges that the second patient screamed and yelled all night "about his catheter and wanted [to] get out of his restraints." The complaint goes on to show that at approximately 3:00 am (b)(3):5 the complainant received pain medication (IV morphine) and fell asleep. When he awoke at approximately 5:00 am, the MER was "totally silent" and the complainant believed that something untoward

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happened to the second patient. He based this belief on conversation from MER employees he allegedly overheard.

The complainant discharged himself from the MER (b)(3):5 U.S.C. App 3 (IG Act) at approximately 5:45 pm. The medical record shows that he left because he was angry about being kept in the MER. The complainant said in a telephone interview with the inspector that he left because he felt threatened due to his suspicions that the second patient died, and MER employees and the VA police tried to cover it up.

We interviewed the complainant on February 21 by telephone. He could give no specific information (such as approximate age or ethnicity) about the patient of concern. We contacted the system's director. The gain and loss report for (b)(3):5 U.S.C. showed no deaths in the MER. Through a VA police report, the system identified a patient who VA police found nearly unconscious on the sidewalk outside the MER at approximately 5:15 (b)(3):5 U.S.C. App 3

VA police brought the patient into the MER in a wheel chair. According to this patient's medical record and the police report, the patient was found with a 2/3 empty bottle of vodka. The patient had a past medical history of (b)(3):38 U.S.C. 7332 chronic obstructive pulmonary disease, depression/anxiety, hepatitis B, and gastritis. At the time of his admission to the MER, the medical record shows that the patient had (b)(3):38 U.S.C. 73 (b)(6) had minimal gag reflex, and minimal response to deep pain stimuli. Clinicians started the patient on IV fluids, inserted a Foley catheter, and placed the patient in two point soft restraints. At 1:00 am on (b)(3):5 U.S.C. the medical record shows that the patient was awake, alert, without restraints, requested pajamas, and was (b)(6) The MD documented that over the previous few hours the patient "calmed down" and spoke coherently, and the patient's mental status was markedly improved compared to admission. The (b)(6) (b)(6) Clinicians removed the Foley catheter and planned to transfer the patient to the Psychiatric ER (PER). The patient was transferred to the PER at approximately 3:00 am (b)(3):5 U.S. and discharged to outpatient treatment at approximately 11:30 am the same day.

Conclusions

We did not substantiate that a patient died in the MER on (b)(3):5 U.S.C. App 3 We did not substantiate that an untoward patient event occurred in the MER during the above dates, or that there was a conspiracy to conceal an untoward patient event. We concluded that a patient fitting the general description of the patient described by the complainant was admitted to the MER on (b)(3):5 U.S.C. at 5:30 pm with (b)(3): (b)(3):38 U.S.C We concluded that this patient was stabilized medically and transferred to the PER in the early morning of (b)(3):5 U.S.C while the complainant may have been asleep. Further, we concluded that the patient was appropriately discharged from PER to (b)(3):38 U.S.C. 5701 (b)(3):5 U.S.

Further review of this case was not warranted, and we made no recommendations. The case can be closed without the issuance of a formal report.

Prepared by: _____ Date: March 5, 2007
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Approved by: _____ Date: March 7, 2007
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