ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Medical Center in Montgomery, Alabama
June 12, 2017

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated an investigation pursuant to information sent by the United States Attorney's Office for the Middle District of Alabama. The U.S. Attorney for the Middle District of Alabama had received a congressional inquiry, dated July 14, 2014, from a U.S. congresswoman representing Alabama's 2nd District. The letter alleged that unidentified personnel at the Central Alabama Veterans Health Care System (CAVHCS) had: falsified medical records, allowed personnel to suppress information regarding the manipulation of patient scheduling, failed to reimburse area hospitals for outsourced medical care, and neglected to review more than 900 patient x-rays. The letter also alleged that substandard care administered by CAVHCS medical staff contributed to the wrongful death of 12 unnamed veterans. The claims alleging that unidentified CAVHCS personnel had falsified medical records and that information regarding manipulation of patient scheduling was suppressed were investigated separately.[1]

The VA OIG Office of Investigations (OI) did not examine the claim that CAVHCS neglected to review more than 900 patient x-rays as this matter fell under the purview of the Office of Healthcare Inspections (OHI). An OIG report[2] dated July 29, 2015 stated that VA OIG did not evaluate a variety of Radiology Service and imaging consult-related concerns as those issues were under review by the Veterans Health Administration. As well, OI did not examine the claim that CAVHCS failed to reimburse area hospitals for outsourced medical care because the same OHI report addressed Non-VA Care Coordination (NVCC) services.

2. Description of the Conduct of the Investigation

Our work was coordinated and limited in scope so as not to duplicate the independent investigation conducted by the U.S. Attorney for the Middle District of Alabama. OI's main role in this investigation was to have the necessary medical records made available to the U.S. Attorney's Office for the Middle District of Alabama. All protected health information was obtained pursuant to a U.S. District Court order.

- **Interviews Conducted:** VA OIG did not conduct any interviews regarding this investigation.

- **Records Reviewed:** VA OIG reviewed medical records for 10 veterans.

[1] VA OIG Administrative Summary, Report 14-02890-112 and VA OIG Administrative Summary, Report 14-02890-95

[2] *Healthcare Inspection: Deficient Consult Management, Contractor, and Administrative Practices at Central Alabama VA Health Care System, Montgomery, Alabama*, Report No. 14-04530-452

3. Summary of the Evidence Obtained From the Investigation

- Following the Senate Committee on Veterans' Affairs hearings in 2014, the U.S. Attorney for the Middle District of Alabama directed his office to conduct an independent investigation into the alleged suspicious deaths at CAVHCS. In addition, the U.S. Attorney's Office for the Middle District of Alabama opened an investigation on matters related to the provision of health care at CAVHCS.

- The U.S. Attorney's Office for the Middle District of Alabama acquired its own medical expert who reviewed pertinent medical records and subsequently rendered a finding that was provided to the U.S. Attorney for the Middle District of Alabama. The results of this review were not provided to, or shared with, VA OIG.

- OHI conducted an independent review of the care received by 10 of the 12 veterans alleged to have received substandard care that contributed to their deaths. Two of the cases were not reviewed because tort claims had already been filed for them. The quality-of-care incidents identified in the remaining 10 cases were alleged to have occurred in 2010 and 2011 in the Emergency Department, Medical Service, and Surgical Service, including the Anesthesia Service. OHI's review determined that CAVHCS took appropriate actions in 9 of the 10 cases. OHI requested that the CAVHCS Director initiate a clinical review of the 10th case, which was done. [The facility's clinical review determined that the care provided in the 10th case was appropriate for the diagnosis, presenting signs and symptoms, and test performed, and that the discharge was appropriate. OHI accepted this determination.] OHI also noted that CAVHCS took a number of systemic actions to improve the intensive care unit and other areas of the hospital.[3]

- On March 1, 2016, the U.S. Attorney for the Middle District of Alabama signed a memo declining this matter for criminal prosecution. The declination memo stated that its medical expert did not report finding anything to indicate that CAVHCS had acted with "wanton and reckless disregard for human life."

4. Conclusion

The investigation revealed that following the Senate Committee on Veterans' Affairs hearings in 2014, the U.S. Attorney for the Middle District of Alabama had his office conduct an independent investigation into the alleged suspicious deaths at CAVHCS.

OI's main role in this investigation was to provide the necessary medical records to the U.S. Attorney's Office for the Middle District of Alabama for review. All protected health information was obtained pursuant to a U.S. District Court order. The U.S. Attorney's Office

[3] This was an OHI assist and as such, no report was published. Due to statutory protections against disclosure of quality assurance documents, OHI was limited in describing the exact nature of the reviews performed. See 38 United States Code §5705.

for the Middle District of Alabama acquired its own medical expert who reviewed all pertinent medical records and subsequently rendered a finding that was provided to the U.S. Attorney's Office for the Middle District of Alabama but not to VA OIG.

OHI conducted a review of the care provided to 10 of the 12 veterans and determined that the care was appropriate.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on December 8, 2016.

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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.