United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

September 9, 2021

The Honorable Denis R. McDonough
Secretary of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary McDonough,

We write to discuss oversight failures at Department of Veterans Affairs (VA) medical facilities. In particular, we are concerned with the failures at the Louis A. Johnson Veterans Affairs Medical Center in Clarksburg, West Virginia (Clarksburg), and the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas (Fayetteville) that resulted in significant harm and death of veterans in VA's care. In both instances, facility leadership created cultural conditions that fostered mismanagement and a lack of accountability resulting in tragic outcomes. The Department must work to prevent future similar incidents from occurring, and we request more information about how VA intends to accomplish this objective.

Below are examples from the corresponding VA Office of the Inspector General (OIG) reports relating to the Clarksburg and Fayetteville VA facilities. The reports detail specific failures at these facilities that contributed to a nursing assistant committing several murders at the Clarksburg facility and a doctor committing manslaughter and causing other patient harm by being impaired on the job in Fayetteville. The OIG recommendations were made to help VA provide top quality medical care to those who use their facilities. We are encouraged to learn VA concurs with all of the OIG recommendations and expect VA to consider how these recommendations could be implemented nationally to ensure nothing similar happens at other VA facilities.

Homicides in Clarksburg, West Virginia

The May 2021 OIG report, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia,* detailed how, starting in July 2017, VA employee Reta Mays was able to murder patients in her care and how her crimes went unnoticed at Clarksburg. The OIG illuminated consecutive and compounding oversight issues that allowed Ms. Mays to inject her victims with deadly amounts of insulin, causing them to die of hypoglycemic shock. Ultimately, she was convicted of killing seven patients and the attempted murder of another patient over the course of her employment on Ward 3A of the facility. The OIG concluded, "a combination of clinical and administrative failures at the facility created the conditions that allowed Ms. Mays to committee these criminal acts and for them to go undetected for so long." These failures began with her employment and continued through the period in which she killed patients in Clarksburg. It is of serious concern to us that these failures were not due to any single oversight mistake, but compounding oversight shortfalls that allowed patients to be harmed and killed.

It appears the earliest failure to adhere to a policy that could have prevented what happened on Ward 3A occurred during the hiring process. The OIG found Ms. Mays previously worked as a corrections officer, and received complaints of excessive force during that time, which should have been more thoroughly examined during her hiring process. The OIG illustrated how the Office of Personnel Management (OPM) flagged initial employment paperwork regarding past work history to contain "potentially actionable issue(s)… which may be disqualifying under suitability/security considerations." This designation by OPM required the VA adjudicator to conduct a more thorough investigation to determine the suitability of her employment, but the OIG found no documented evidence of this follow-up investigation. Instead, the adjudicator added Ms. Mays' file to the large amount of delinquent adjudication work at the facility, and later marked the case as favorably adjudicated. This created a circumstance in which Ms. Mays was never fully vetted prior to being hired and was not subject to further vetting that would have otherwise been required. What will VA do to address this serious lapse in procedures in workforce adjudication reviews? Has VA thoroughly vetted all work conducted by the previous adjudicator at the Clarksburg facility to ensure there are no other issues of concern? What steps is VA taking to review adjudication work at other facilities?

The OIG also found failures related to the mean in which Ms. Mays carried out the murders. Veterans Health Administration (VHA) policy requires the use of certain medications, including insulin, by staff and available stocks of medication rooms to be thoroughly documented at medical facilities. This did not occur in Clarksburg. The OIG found medication rooms were open to all nursing staff and medication carts were not properly secured. Furthermore, an abnormally large amount of D50, a primary medication used in treating hypoglycemic events, was used in Ward 3A. The OIG noted that this amount of D50 could have raised red flags if proper protocols were being followed. The OIG report indicates VA concurs with the OIG recommendation that the Clarksburg facility utilize the Veterans Health Information Systems and Technology Architecture Automatic Replenishment System. However it is difficult to imagine lax medication security is unique to Ward 3A of this facility. VA must utilize the Veterans Health Information Systems and Technology Architecture Automatic Replenishment System to track medication usage at all facilities, not just in Clarksburg. What is VA doing to ensure that proper medication tracking is being conducted across all VA medical facilities?

Another issue pointed out by the OIG was the lack of investigation into the hypoglycemic events on the ward. It is of serious concern that such an investigation occurred only once during the events detailed in the OIG's report. Of the hypoglycemic patients outlined in the OIG's investigation to Ms. Mays' actions, several were documented in nondiabetic patients, so a sudden and severe hypoglycemic event should have been cause for further concern. In addition, information that would have proved helpful for treatment was not sent to an endocrinologist, who could have helped provide guidance to medical staff and potentially identified the events as they occurred. The OIG report indicates VA concurs with OIG's recommendation to implement further oversight of patient outcomes across Veterans Integrated Service Network 5, but we expect this to be implemented across VA. What will VA do to ensure that undesirable patient outcome trends are being tracked and trends evaluated at all VA medical facilities?

Also of serious concern is that during the duration of Ms. Mays' employment, Clarksburg was regularly being accredited by The Joint Commission (TJC). Given this facility was not adhering to serious safety protocols, it is concerning that TJC did not uncover these problems. Have VA and TJC discussed these issues and whether the accrediting body probed deeply enough to uncover these problems? How can these shortcomings in TJC's review be mitigated by VA moving forward so that serious concerns are brought to light and addressed sooner?

It is clear the lack of adherence to VHA policies on Ward 3A were not unique to the unit as ten out of the fifteen recommendations by OIG were made to the entire medical facility. Although the circumstances in which the murders in this facility took place were unique, we expect the OIG's recommendations to be considered and applied at every facility to ensure that nothing like what occurred in Clarksburg ever happens to veterans in VA's care again.

Medical Malfeasance in Fayetteville, Arkansas

The June 2021 OIG report, *Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas,* detailed how Dr. Robert Morris Levy abused his position as Chief of Pathology and Laboratory (Path and Lab) Services at the Veterans Health Care System of the Ozarks to cover-up his alcohol abuse and his many ethical and medical errors. Some of these errors resulted in his manslaughter conviction in June of 2020. These failures were compounded by oversight failures, particularly in the area of quality management, and were further exacerbated by what the OIG described as "a culture in which staff did not report serious concerns…because of a perception that others had reported or they were concerned about reprisal." Simply put, the fail-safes put in place to protect patients from medical malpractice were not followed. As a result, many patients received inadequate care from VA facilities, which proved fatal in some cases, including when Dr. Levy misdiagnosed a patient based on their lab results, and then revised his diagnosis, forging the approval of another pathologist to concur. Both diagnoses were incorrect, and the patient died approximately a year later without having had access to treatment options a correct diagnosis would have afforded them.

A full review of Dr. Levy's work found that of approximately 34,000 diagnoses, nearly 3,000 were incorrect and 589 were major mistakes. During his tenure, Dr. Levy was regularly under the influence of alcohol while at work and violated VA procedures in order to cover his mistaken diagnoses and ethical misconduct. As the OIG notes, this situation was able to continue over the course of many years due to deficiencies in the quality management system at the facility, and because there was a culture at the facility that made staff feel unsafe to report issues or have reports acted on.

One of the concerns outlined in the OIG report is the way in which the facility conducted its peer review process for catching and correcting incorrect diagnoses. VA policy requires certain pathology findings to receive a second review by a different pathologist, but the Staff Pathologist who conducted these reviews worked directly under Dr. Levy at this facility. VA policy also requires a randomly selected 10 percent of pathology findings to be reviewed to identify possible errors. Inexplicably, these reviews were also conducted by the same Staff

Pathologist, removing the intended independent oversight. Having a subordinate of Dr. Levy conduct the peer review process created a clear conflict of interest.

The OIG also found Dr. Levy had been forging documents to affirm his own erroneous diagnoses. The OIG report indicates that VA concurs with OIG's recommendations for improving the peer review system. Please provide more information on what VA will do to ensure previous and future concurrences in pathology findings are independently validated in all VA facilities.

Another oversight failure was at the pathology quality management committee level within the Ozark facility. Dr. Levy was the Chairman of three different boards in charge of quality control, and we were alarmed to learn that one of these committees reported *zero* major discrepancies over the course of almost eight years. While we acknowledge the influence Dr. Levy had as Chairman, we also note that he was not alone on these committees. Recommendation 8 in the OIG report states that because other medical and administrative staff did not "adequately perform their duties" VA should "determine whether administrative action is warranted." Do you expect to complete this determination by the target date of October 2021, if not sooner?

According to the OIG's findings, formal complaints of Dr. Levy being impaired on the job arose as early as March 2014. Despite multiple red flags indicating alcohol abuse was affecting his performance, he was allowed to maintain his position due to miscommunications about VA's authority to test him for alcohol abuse. It was not until 2016 that Dr. Levy was tested for alcohol, and this test proved what many around him had long suspected, that he was under the influence while managing medical diagnostics with serious implications for veterans. VA concurred with OIG's recommendation to consider the implementation of a mandatory alcohol testing policy for VHA employees who "hold safety-sensitive positions" at VA facilities, with an expected completion date of March 2022. We request a preliminary briefing on this effort 30 days from the date of this letter, a full briefing on expectations and testing of employees once this policy is enacted, including how VA will define those who hold positions that would be affected by such a policy, and to be made aware of any major obstacles VA faces in development or implementation of such a policy.

Dr. Levy was allowed to return to all of his previous duties after attending an alcohol treatment program, and soon after began using a substance to become intoxicated but that couldn't be detected by routine testing. He showed signs of intoxication on the job once again, but was allowed to continue working because he passed his mandatory alcohol screenings. We would like to know why staff didn't conduct a more thorough test that could have detected this substance, and what VA will do in the future to ensure that other staff who have been disciplined for substance abuse cannot find other ways to avoid detection through conventional drug and alcohol testing.

For quality health care to be achieved consistently it requires efforts from every level of an organization. This includes senior leaders that are engaged, proactive, and promote a culture of safety and adherence to protocol. The OIG also made recommendations to improve the culture of the Ozark facility, which VA agreed to, however we have concerns that this issue is prevalent

throughout many facilities. It is our belief that if others had felt open to come forward sooner and have their concerns acted on, that the actions of Dr. Levy could have come to light years earlier.

What is VA doing to ensure that the cultural issues, particularly the fear of retaliation by subordinates for reporting the misconduct of their superiors, are being addressed at all other facilities? Please provide us with the status and timeline of VA's efforts to implement the High Reliability Organization framework at all of its facilities.

A culture of safety requires holistic accountability both in and of people in positions of power. At the Ozark facility, staff did come forward with concerns about Dr. Levy's conduct, and that these concerns were under-addressed by his supervisor. When employees speak out with concerns, they should have confidence that management will act and thoroughly investigate accusations of misconduct. How will VA act to ensure oversight and discipline of VA employees in positions of power are not bottlenecked to one person, as demonstrated at the Ozark facility? How is VA addressing this situation at the Ozark facility specifically?

Congress will continue to conduct thorough oversight and provide the Department legislative assistance in order to meet our shared goal of providing top quality care for our nation's veterans. Meeting this objective requires VA to follow procedure, promote accountability, and cultivate management that inspires faith in VA employees and those they serve. It is sacrosanct to VA's mission that veterans trust the medical treatment they receive is high-quality and the people treating them meet all relevant ethical and professional standards required by their field. VA must be proactive in identifying issues with staff as they arise, monitor the quality of care at all levels, and continue to advance a culture of safety at all facilities. We appreciate your prompt attention to these matters.

Sincerely,

Jon Tester
Chairman
Committee on Veterans' Affairs

Jerry Moran
Ranking Member
Committee on Veterans' Affairs

Joe Manchin III
United States Senator
Committee on Veterans' Affairs

John Boozman
United States Senator
Committee on Veterans' Affairs