
DATE OF REPORT: May 12, 2016

BRIEF STATEMENT OF ISSUE AND STATUS: A reporter from New Hampshire Public Radio (NHPR) contacted the White River Junction VA Medical Center (WRJ VAMC) on May 10, 2016. The purpose of the call was to notify the Public Affairs Officer (PAO) that they were initiating a Freedom of Information Act (FOIA) request in relation to a specific portion of the Office of Inspector General (OIG) report titled “Administrative Summary of Investigation Regarding Wait Times – Vermont” which was released April 5, 2016. The OIG had previously conducted an investigation regarding allegations of wait time manipulation at WRJ VAMC from June through December 2014.

ACTIONS, PROGRESS, AND RESOLUTION DATE:

An issue brief on the topic was originally done on April 6, 2016 and was closed as of April 12, 2016.

The exact information being requested is not known at this time. However, the NHPR reporter has told the WRJ VAMC PAO that he is interested in learning more about the allegations outlined in the OIG’s report on page 17, paragraph 1:

The aforementioned allegation reads as follows: “On May 5, 2014, a VA social worker from a Vet Center contacted the VAMC WRJ director to report that, in 2012, a veteran died of sleep apnea before VA care could be provided due to prolonged wait times at the VA facility. VAMC WRJ initiated a review and a determination was made that there was no significant delay by VA that appeared to have had an effect on the patient’s death.”

The facility previously re-reviewed the specific case mentioned above; there is no basis on which the OIG’s findings would be challenged.

This issue brief is closed.

CONTACT FOR FURTHER INFORMATION: Al Montoya, Interim Medical Center Director, 802/291-6206.