



Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

Background

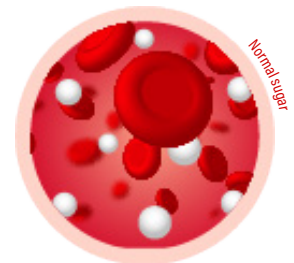
On July 14, 2020, Reta Mays, a former nursing assistant, pleaded guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder of patients at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.

Ms. Mays pleaded guilty to deliberately administering insulin to these patients in 2017 and 2018, resulting in profound hypoglycemia and death.

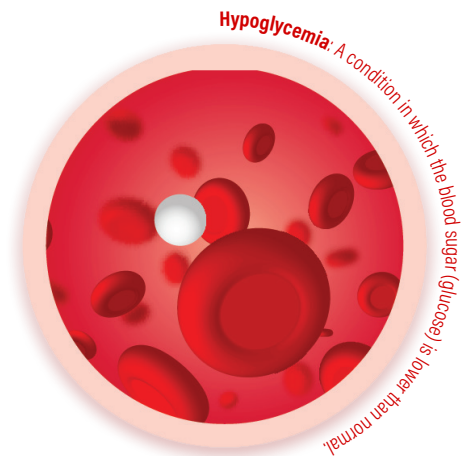
The VA Office of Inspector General conducted a healthcare inspection to assess the facility's environment, practices, and controls, and whether deficits could have contributed to these patients' deaths.

OIG Healthcare Inspection Report

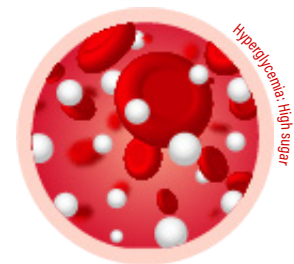
Veterans and their families entrust their lives to VHA medical providers and staff every day at the more than 1,200 VHA facilities. They expect and deserve the highest quality of care delivered in a safe and accountable healthcare setting. However, the OIG found that the facility did not consistently promote a culture that prioritized patient safety as expected of a high reliability organization. Consequently, a combination of clinical and administrative failures at the facility created the conditions that allowed Ms. Mays to commit these criminal acts and for them to go undetected for so long. Ultimately, the failure of leaders at multiple levels to ensure patient safety resulted in the tragic events described in the healthcare inspection report.



Normal sugar



Hypoglycemia: A condition in which the blood sugar (glucose) is lower than normal.



Hyperglycemia: High sugar

"I hope that the victims' families can find some measure of solace knowing that Reta Mays was caught and punished, and that steps are being taken to help ensure other families do not suffer the same loss. I would like to thank the US Attorney's Office, the FBI, and the West Virginia State Police for their strong partnership throughout this complex investigation."

VA Inspector General Michael J. Missal

Key Findings

The healthcare inspection resulted in six key findings detailed in the report.



Missteps in hiring and performance assessments.

Missteps were made in Ms. Mays's hiring and performance assessments. This included not completing checks that could have revealed previous allegations of excessive use of force while employed at a jail, as well as subsequently receiving fully successful performance ratings despite known problems with her patient care while with VA.



Unsecured medication rooms and carts.

Medication rooms and carts were not secured on the ward where Ms. Mays worked, giving her unauthorized access to the insulin used in these deaths. The pharmacy service also did not have a formal process to track medications that could have signaled the suspicious rise in hypoglycemic events.



Clinical evaluations of unexplained hypoglycemic events lacking.

Clinical evaluations of unexplained hypoglycemic events were lacking. The attending hospitalists did not fully understand or pursue diagnostic testing for seven of the eight victims included in Ms. Mays's plea deal, some of whom were not diabetic or not on diabetes medications.



Reporting and responding to the events was delayed.

Reporting and responding to the hypoglycemic events was delayed despite concerns being discussed internally. A cluster of hypoglycemic events occurred in late March and early April 2018, and in June. Some hospitalists did not understand the utility of diagnostic tests or did not conduct them promptly. Staff did not complete patient safety event reports for any of the victims in the report.



Deficient monitoring and oversight functions.

Key quality control and oversight functions were deficient. Some staff were unaware of what incidents to report and how to report them. Not properly communicating and reporting patient safety concerns hampers the evaluation and trending of adverse events and the robust review of patient deaths. The facility did not consistently promote a culture that prioritized patient safety.



Some action taken, but more needed.

Facility, Veterans Integrated Service Network (VISN), and VHA leaders took some corrective actions but much more needs to be done, including more effective mortality reviews, data analyses, and tracking and trending of adverse patient events.

VA concurred with 15 OIG recommendations.