U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

March 18, 2013

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-11-1625 and DI-11-2518

Dear Mr. President:

Enclosed please find two reports from the Department of Veterans Affairs (VA). These reports respond to whistleblower disclosures made by employees of the G.V. (Sonny) Montgomery VA Medical Center (Jackson Medical Center or VAMC) in Jackson, Mississippi. The VA was required to complete these reports after two whistleblowers alerted the Office of Special Counsel (OSC) to persistent problems with the cleaning and sterilizing of Reusable Medical Equipment, and the VA's failure to responsibly address these concerns. After reviewing the reports and the whistleblowers' subsequent comments, I find the conclusions in the VA reports unreasonable in both cases.[1]

In addition and of greater import, I find a troubling pattern of disclosures from these and other whistleblowers at the Jackson Medical Center. Over a period of three and a half years, a diverse group of five employees disclosed serious wrongdoing at this facility to OSC. Collectively, these disclosures raise questions about the ability of this facility to care for the veterans it serves. This letter references all five cases – two with accompanying reports, a previously closed case, and two cases recently referred to the VA for investigation.

Background

Since the fall of 2009, OSC has received five separate disclosures of wrongdoing from Jackson VAMC employees. These employees' allegations met the high "substantial likelihood"

[1] OSC is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

standard required by OSC for referral to the Secretary of Veterans Affairs, who is then required by law to conduct an investigation and report the findings back to OSC.

The first whistleblower came to OSC in 2009, alleging that Jackson Medical Center staff in the Sterile Processing Department (SPD) routinely failed to properly clean and sterilize Reusable Medical Equipment, such as scalpels, nail nippers and bone cutters. In August 2009, OSC referred these allegations for investigation to the VA.[2] The subsequent VA report to OSC substantiated many of the whistleblower's allegations, finding that improperly cleaned and sterilized instruments were distributed to clinics and operating rooms at the Jackson VAMC. For example, the report found that the Jackson Podiatry Clinic received instruments from the Sterile Processing Department that were blood- and rust-stained and contained dirt and particles. In its report, the agency represented that it was taking steps to ensure that the problems within the Sterile Processing Department would be resolved. The matter was closed and sent to you in October 2010.

In March 2011, a second whistleblower disclosed that Jackson VAMC employees were directed to issue public information mischaracterizing the findings in the 2009 case involving sterile medical equipment.[3] The whistleblower alleged that while the VA had determined that equipment was not sterilized properly in violation of agency policy, the Jackson VAMC nevertheless informed the public and Congress that no violations occurred. OSC referred these allegations for investigation in May 2011.

Shortly thereafter, a third whistleblower, Gloria Kelley, an SPD employee, alleged to OSC that incorrect procedures persisted in the Sterile Processing Department, placing the safety of employees and patients at risk.[4] OSC referred these allegations for investigation in July 2011.

A fourth whistleblower filed a disclosure with OSC in July 2012. Dr. Phyllis Hollenbeck raised numerous troubling allegations regarding patient safety, including:

- Narcotics are prescribed to veterans by nurse practitioners who are not legally permitted to do so;
- Physicians are pressured to prescribe narcotics to veterans they have not seen, without the ability to assess the patient's medical needs or develop a continuity of care plan;
- Chronic understaffing in the Primary Care Unit results in inadequate care for veterans and improper supervision of nurse practitioners;
- Veterans are routinely scheduled for appointment times when no primary care physician is on duty, leaving patients to arrive at unstaffed clinics, only to be turned away;
- Nurse practitioners operate in the facility without proper certification in violation of VA rules and state licensing requirements; and

[2] OSC File No. DI-09-3272, *available at* http://www.osc.gov/FY%202011%20A.html.
[3] OSC File No. DI-11-1625
[4] OSC File No. DI-11-2518

- Inadequate physician staffing levels result in numerous fraudulently completed Medicare Home Health Certifications for veterans.

Finally, a fifth whistleblower came to OSC in January 2013. Dr. Charles Sherwood disclosed that thousands of radiology images were unread or improperly read, resulting in missed diagnoses of serious, and in some cases fatal, illnesses. In brief, it was asserted that:

- A former radiologist at the Jackson VAMC regularly marked patients' radiology images as "read" when, in fact, he failed to properly review the images and at times failed to review them at all;
- These failures led to numerous missed diagnoses of serious, and in some cases, fatal illnesses;
- Management was aware of this neglect but did not require any corrective action; and
- The agency failed to notify the large number of patients who were potentially affected by this lapse in clinical care.

In the second and third cases referenced above – those being closed by OSC today – the VA's findings, whistleblowers' comments, and my determinations are explained more fully below and in the enclosed Analysis of Disclosures. I recently referred the final two cases referenced above to the Secretary of Veterans Affairs for investigation in separate correspondence. Based on the assessments of OSC staff, the whistleblowers' comments, and the ongoing pattern of disclosures from this facility, I am deeply concerned that these cases are representative of more pervasive challenges and threats to patient care at the Jackson Medical Center.

Summary of Findings in OSC File No. DI-11-1625, Inaccurate Statements to Congress and the Public

The whistleblower in this matter requested anonymity. The employee alleged that despite findings that "dirty, rust-stained instruments" were used in the care of veterans, Jackson VAMC employees falsely stated that no violations of VA policy had occurred.

The 2009 VA report in question confirmed that unsterilized equipment was used to treat patients in violation of agency policy. A May 5, 2010, letter from the Secretary of Veterans Affairs to OSC stated, "The investigation substantiated that employees violated VA policy by failing to ensure reusable medical instruments are properly cleaned and sterilized." The accompanying report stated that it "concurs" with the finding that "there are occasions when staff violate policy by failing to ensure that reusable medical equipment are properly cleaned and sterilized." The report confirmed that these were longstanding issues.

Notwithstanding these findings, Jackson VAMC management directed public affairs staff to state in a press release that no violations were found to have occurred. After this press release

was issued, similar statements purporting that no violations had occurred were issued by the Jackson VAMC to veterans, employees, and congressional staff.

In response to these disclosures, the VA determined that inaccurate information was in fact disseminated by Jackson VAMC employees. However, the VA report concluded that the false statements were not willfully made. Rather, the investigation found that VA headquarters did not provide Jackson VAMC management with a copy of the final version of the underlying report. Instead, local management was given a draft report. The draft report did not find that any violations had occurred, although it did note that improperly cleaned instruments were used in a number of units.

The VA now claims that the direction to provide inaccurate information was not intentional, because the order was based upon the draft report and Jackson management did not have the final version. The VA notes that Jackson management was not made aware of the final report, including its findings of violations of agency policy, until June 2011, over a year after it was issued, and only because the whistleblower came forward.

Accordingly, the VA concedes that its own negligence caused the dissemination of incorrect information by one of its facilities. It is unclear why the VA did not inform VAMC management of the findings for over a year. However, the VA's failure to inform VAMC of its findings caused VAMC management to misinform the public and Congress. The facility maintained and projected a false sense of confidence regarding the VA's review of its sterilization practices. Indeed, the first line in the VAMC press release following the report stated, "The report regarding the cleaning of Reusable Medical Equipment in podiatry concluded that the Jackson VA Medical Center was compliant with all VA regulations, rules and procedures." This, of course, was directly at odds with the VA's actual findings.

Unfortunately, rather than acknowledging this negligence, the VA finds that the inaccurate public statements by the facility were not intentional and did not violate federal statutes on false statements. There is no indication that any follow-up inquiries were made to determine why headquarters was delinquent in its dissemination of a critical finding. In fact, the VA simply concludes, "Because there was no evidence of wrongdoing regarding the false statement allegations, the Agency will take no action." I find this resolution unreasonable.

Summary of Findings in DI-11-2518, Failure to Adhere to Protocol for Maintaining a Sterile Environment

As discussed above, this is the second case from the Jackson Medical Center involving the facility's failure to properly oversee the Sterile Processing Department and minimize the risk of contamination in the facility. The whistleblower, Gloria Kelley, alleged that during her employment in the Sterile Processing Department she regularly observed her colleagues working without wearing required Personal Protective Equipment, such as face masks and disposable gloves. She further alleged that management did not provide sufficient training to employees and attempted to influence investigators conducting on-site inspections at the Jackson VAMC.

Ms. Kelley expressed concern that these actions could lead to the spread of contaminated materials within the hospital, and could be significantly detrimental to patients and staff.

As discussed further in our attached analysis, during its investigation of her allegations, the VA did not interview Ms. Kelley. Rather, Ms. Kelley was telephoned and only asked whether the allegations referred by OSC were accurately transmitted to the VA. Ms. Kelley was not asked to provide any other information to the agency and was told by the agency that no interview was necessary.[5]

The agency was unable to substantiate several of Ms. Kelley's allegations, including her assertion that employees in the Sterile Processing Department frequently wore prohibited jewelry and garments into the sterile area. The agency also failed to substantiate Ms. Kelley's allegation that these employees frequently moved between the sterile processing areas and the rest of the facility without removing or replacing their Personal Protective Equipment outer garments. The agency found that, even if these allegations were substantiated, such actions would not pose a threat to the safety of patients and other employees because the requirements were intended to protect only the employees in the sterile processing area. However, the agency found during its on-site investigation that employees did not know how to properly don Personal Protective Equipment gowns over their clothing. Investigators also observed one employee who was wearing neither the required gown nor gloves. The report stated that, as a result of this incident, trainings were conducted on the proper way to wear these garments and employees were counseled in writing.

In her comments, Ms. Kelley noted that if regular training and enforcement of these procedures had occurred, there should be no compliance issues such as those described by the report. Ms. Kelley also explained that while protective garments protect employees in the Sterile Processing Department, rules regarding wearing accessories and removal of outer-garments also eliminate possible contamination of public and patient areas.

The agency was also unable to substantiate Ms. Kelley's allegation that members of management interfered with the agency's investigations of the Sterile Processing Department in both this matter and in the first Jackson whistleblower case, which alleged inadequate cleaning of surgical equipment.[6] The agency found that a list of Reusable Medical Equipment, which

---

[5] OSC became aware that Ms. Kelley was not properly interviewed on September 13, 2011. We discussed our concerns regarding this issue with the agency shortly thereafter. On October 3, 2011, we were informed by the VA General Counsel's Office that the Acting Director of the National Program Office for Sterile Processing felt that the agency's conversation with Ms. Kelley was sufficient, and no additional interview was required. Specifically, the Acting Director indicated that no substantive interview of Ms. Kelley was necessary because the findings of the investigation addressed all of the allegations they had at that time. OSC took issue with this characterization of the telephone conversation, but there has been no follow-up by the VA.

[6] OSC File No. DI-09-3272

Ms. Kelley indicated was altered by management prior to being provided to investigators, was in fact a complete list. Further, the report noted that despite Ms. Kelley's concerns, it is common agency practice to assign an employee escort to investigators while they are on-site.

Ms. Kelley refuted the agency's findings in her comments. She indicated that she was aware of documentation supporting her allegations, however, because she was not fully interviewed by the agency's investigators, she had no opportunity to provide this information to the agency.

The agency failed to substantiate Ms. Kelley's allegation that Sterile Processing Department employees were not properly trained to process each piece of Reusable Medical Equipment at the Jackson VAMC. The agency found that each employee had received in-service training on each piece of this equipment and had completed required Level I training for the Sterile Processing Department. In response however, Ms. Kelley stated that management frequently distributed blank training slips during staff meetings and directed employees to sign them. The sheets would then be filled in after the meeting with various training course titles, without employees having actually completed the training. Ms. Kelley further noted that employees inappropriately worked together to complete this Level 1 training. Thus, the training documentation reviewed by the agency did not reflect the actual training and competency of the employees.

In addition to these allegations, Ms. Kelley's disclosure indicated that the agency failed to carry out certain corrective actions described in its report for the first whistleblower, who disclosed the unsterilized scalpels and other medical equipment.[7] In that report, the agency represented that it planned to hire new, experienced leaders for the Sterile Processing Department. In its report in Ms. Kelley's matter, the agency noted that problems with improperly cleaned Reusable Medical Equipment within the department were not ongoing at Jackson, and that new management was in place, along with 13 new staff members. The report found only three instances of improperly cleaned Reusable Medical Equipment since October 2010, all involving orthopedic sets, which the agency stated were difficult to clean. However, as discussed more fully in the analysis, Ms. Kelley asserted that the individuals hired to head the Sterile Processing Department at Jackson had little to no experience, despite the agency's assurances to the contrary. Further, she explained that the improperly cleaned and sterilized Reusable Medical Equipment was not difficult to handle, but rather that the failure to properly clean it evidenced poor training and inadequate experience.

Summary of Special Counsel's Findings

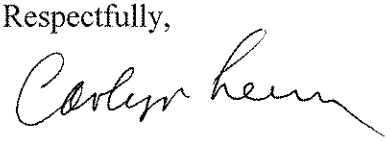
I find the agency's conclusions in OSC File Nos. DI-11-2518 and DI-11-1625 unreasonable. With regard to the problems with equipment reprocessing within the Sterile Processing Department, Ms. Kelley's comments are compelling and the agency reached its conclusion without interviewing her. It does not appear that the agency has taken significant

[7] OSC File No. DI-09-3272

steps in improving the quality of management, staff training, or work product within this Department since its findings regarding the first whistleblower's allegation more than two years ago. Further, while Jackson VAMC employees did not knowingly disseminate incorrect information, it is unreasonable and irresponsible for the VA to have failed to inform the facility about the initial findings on the use of improperly cleaned surgical and other medical equipment. It is troubling that the content and findings in the final report were not communicated to the employees who had engaged in the violations. In sum, these cases, and the two related disclosures from VAMC whistleblowers, indicate a pattern of poor management and failed oversight at the Jackson VAMC.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency's reports and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs.[8] I have also filed copies of the redacted reports and the whistleblowers' comments in our public file, which is now available online at www.osc.gov, and closed these matters.

Respectfully,



Carolyn N. Lerner

Enclosures

[8] As previously stated, the VA originally provided OSC with reports in both of these cases that omitted the names of the employees involved, and instead referred to these employees by title only. The agency did not provide a legal basis for the omission of the names in these matters. The agency subsequently provided addenda to the reports containing the employees' names and corresponding titles. The addenda are attached to the enclosed reports. The whistleblowers were given an opportunity to comment upon the addenda, but declined to do so. OSC objects to the omission of employee names from the public versions of the reports because the inclusion of the names of subject employees would best serve the public interest.