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The Special Counsel

May 31, 2000

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

Re: OSC File No. 99-1464

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting a report from the Honorable Togo D. West, Jr., Secretary, Department of Veterans Affairs (VA), sent to me pursuant to 5 U.S.C. §§ 1213(c) and (d). The report sets forth the findings and conclusions of the Secretary's review of disclosures of information allegedly evidencing a substantial and specific danger to public health and safety within the Department of Veterans Affairs (VA), Toledo Outpatient Clinic (Clinic), Toledo, Ohio.

The whistleblower, Patti Kessler-Franck, provided comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1), which I am also transmitting.

We have carefully examined the original disclosures and reviewed the agency's response and Ms. Kessler-Franck's comments. Pursuant to 5 U.S.C. § 1213(e)(2), I have determined that the findings in the agency's report appear reasonable and contain all of the information required by statute.

Ms. Kessler-Franck alleged that VA officials tolerated unsafe practices at the Clinic between December 1998, and April 1999. She reported that whirlpools were not properly cleaned, causing her and patients to suffer skin reactions, that officials at the Clinic permitted red hazardous waste bags to remain open until filled with waste containing bodily fluids, that Ms. Kessler-Franck was directed to provide an unclean disposable urinal to a patient, and that sponges used on patients receiving electrical stimulation were improperly stored.

The VA report partially substantiated Ms. Kessler-Franck's allegations, finding that although there was a lack of strict adherence to some procedures, there were no violations or apparent violations of law, rule, or regulation, and no danger to public health or safety. The report stated that irregularities in procedures were rectified, and that management officials from the VA Ann Arbor Healthcare System are conducting

periodic reviews of the work area. The specific findings of the report are discussed below.

First, with respect to the allegation that whirlpools were not properly cleaned, the report found that staff did not use a measuring cup to determine the exact proportion of disinfectant to water; consequently, there was a higher proportion of disinfectant used than recommended by the manufacturer. The Clinic has purchased the manufacturer's squirt pump top, a measuring cup, and a tablespoon, and this equipment is used routinely. The report found that there were no known patient injuries or rashes, no patients became worse, and no patients complained about the whirlpool.

With respect to the injuries Ms. Kessler-Franck allegedly sustained as a result of the disinfectant, the investigation was unable to substantiate the allegation that red spots on her forearm were sustained during her tour of duty. Ms. Kessler-Franck reported the "burns" on a Monday, stating that she had received the burns the previous Friday. According to the report, she sought no immediate medical attention, the chemicals involved do not cause a delayed reaction, and she worked at a second job over the weekend, where she was responsible for providing hydrotherapy treatments to nursing home residents.

Second, Ms. Kessler-Franck reported that red hazardous bags containing dressings covered with bodily fluids were left open until filled. The report found that one open red bag had been placed in a small wastebasket and reused several times, but that at no time was the bag left un-emptied until completely filled with dirty dressings. At a minimum, bags were disposed of at the end of the day. Upon Ms. Kessler-Franck's report of this situation to Ms. Leslie Westbury, Chief, Physical Therapy Section, Ms. Westbury instructed the Clinic staff in the proper disposal procedures for biohazardous waste, consistent with the Standard Precautions governing infection control practices for all VA healthcare facilities, and obtained a closed-lid, foot pedal-operated waste container for the Clinic.

Third, the report found no danger to public health or violation of law in connection with the use of an unclean urinal. The urinal in question, requested by Ms. Kessler-Franck for a patient, was not contaminated, but had collected dust and dirt from having been stored open in the staff bathroom for several months. The report found that Ms. Prasad, Ms. Kessler-Franck's supervisor, did not direct her to give the dirty urinal to the patient. Nor did the patient use the urinal; the patient walked to the patient bathroom. Since the allegations were made, several clean urinals have been provided to the Physical Therapy department, and staff has been instructed to store them in a cupboard in the hydrotherapy room.

Finally, Ms. Kessler-Franck expressed concern about the storage of electrode sponges in the Physical Therapy department staff bathroom. The sponges were used,

washed with disinfectant soap and water in the staff bathroom sink, and left to dry in a bowl on the sink. The report found that the bowl had been placed on the back of the toilet, perhaps by the cleaning crew, but that the staff did not intend to store the bowl in this location. As a result of Ms. Kessler-Franck's concerns, the bowl was moved to the hydrotherapy room and dry sponges are now stored in a drawer.

The report stated that on two subsequent visits to the Clinic by Ms. Westbury, she noted that the disposable urinals were kept on a shelf in a closed storage area in the hydrotherapy room, the electrode sponges were in the hydrotherapy room, and proper use of infection control procedures were maintained. Ms. Westbury and other management officials from the VA Ann Arbor Healthcare System will continue to monitor the Clinic for compliance with infection control policies. In addition, other staff making periodic visits to the Clinic have been asked to audit the area, and have been supplied with a survey sheet of items to check.

Ms. Kessler-Franck comments that the report represents proof that there were many things being done improperly at the Clinic. Nevertheless, she believes that the report operates to protect the employees who were less than efficient in their practices. She also believes that the involved employees were less than honest about their actions, and took deliberate steps to confiscate evidence of the improper and unsanitary practices at the Clinic. In support of her allegations, she has provided photographs of several of the areas of concern, which are included as a part of her comments. Finally, Ms. Kessler-Franck suggests that VA facilities be subject to inspection by unbiased entities outside of the control of the VA.

Based on the representations made in the report, I have determined, pursuant to section 1213(e)(2), that the findings in the agency's report appear reasonable and contain all of the information required by statute.

As required by section 1213(e)(3), I have sent a copy of the report and Ms. Kessler-Franck's comments to the Chairmen of the House and Senate Committees on Veterans' Affairs. We have also filed copies of the report and Ms. Kessler-Franck's comments in our public file and closed the matter.

Respectfully,



Elaine Kaplan

Enclosures