



U.S. OFFICE OF SPECIAL COUNSEL

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April 20, 2010

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

Re: OSC File No. DI-09-1308

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), the Office of Special Counsel (OSC) is forwarding to you agency reports concerning disclosures from Jerry Woodward, a former employee at the Department of Veterans Affairs (VA), VA Gulf Coast Veterans Health Care System, Biloxi VA Medical Center (Medical Center), Biloxi, Mississippi. Mr. Woodward, who consented to the release of his name, alleged that VA employees failed to inspect hundreds of pieces of medical equipment used on patients and attempted to conceal the lack of inspections.

Mr. Woodward's allegations were referred on April 22, 2009, to the Honorable Gen. Eric K Shinseki, Secretary of Veterans Affairs, for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki submitted his report on October 26, 2009. Pursuant to an OSC request for additional information, a supplemental report was provided by the VA on December 14, 2009. The investigation was conducted by a team of VA Biomedical Engineers (review team).

The agency's reports substantiated Mr. Woodward's allegations. The review team found that the medical equipment inventory contained many inaccuracies and not all medical equipment was inspected prior to use on patients. According to the agency's reports, the Biomedical Engineering staff possessed "limited knowledge of the maintenance processes required to run an effective medical equipment maintenance program." In addition, the Biomedical Engineering staff lacked supervision. The agency provided a detailed explanation of the maintenance documentation and inspections of 10 items specifically mentioned in the OSC referral. Deficiencies were identified for all of these items except two defibrillators, which could not be located. A supervisor was suspended for ordering subordinates to mislabel equipment to hide the fact that it had not been inspected. The two subordinates who mislabeled the equipment received reprimands.

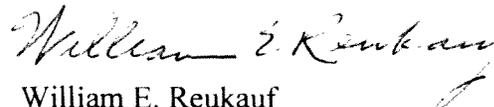
The agency is taking corrective actions to remedy the deficiencies. It is conducting a full inventory of its medical equipment at the Medical Center with a target completion date of June 30, 2010. Life support equipment has already been identified and inspected, and has received preventive maintenance. A Biomedical Engineer has been temporarily detailed to the Medical Center to help address the deficiencies, and the agency is in the process of hiring a full-time Biomedical Engineer for the Medical Center.

Mr. Woodward submitted comments on the agency's reports. He recounted Medical Center employees' inadequacies in performing maintenance and inspections of equipment. He also included a copy of the letter he sent to the Joint Commission about the inspection and maintenance problems, a chronological recollection of his observations during employment at the Medical Center, relevant policies, and printouts of hundreds of open work orders at the Medical Center.

We have reviewed the original disclosures, the agency's reports, and the whistleblower's comments. Based on that review, OSC has determined that the agency's reports contain all of the information required by statute and their findings appear to be reasonable.

As required by law, 5 U.S.C. § 1213(e)(3), we have sent copies of the reports and Mr. Woodward's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. OSC has also filed a redacted copy of the agency reports and whistleblower's comments in our public file and closed the matter.¹ OSC's public file is now available online at www.osc.gov.

Respectfully,



William E. Reukauf
Associate Special Counsel

Enclosures

¹ The VA provided OSC with a revised supplemental report, which substituted duty titles for the names of employees who engaged in wrongdoing. The VA cited the Freedom of Information Act (FOIA) (5 U.S.C. § 552) as the basis for these revisions to the report produced in response to 5 U.S.C. § 1213. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b).