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Analysis of Disclosures, Agency Investigation and Report, and Whistleblower Comments

OSC File Nos. DI-11-2518 and DI-11-1625 (Jackson VAMC, Jackson, Mississippi)

I. OSC File No. DI-11-2518: Failures within the Sterile Processing Department

The whistleblower, Gloria Kelley, who consented to the release of her name, was a Chief Intern in the Sterile Processing Department (SPD) at the G.V. (Sonny) Montgomery VA Medical Center (Jackson Medical Center or VAMC) from May 2009 to May 2011. Ms. Kelly alleged that 1) SPD employees regularly failed to properly don required Personal Protective Equipment (PPE) while cleaning and sterilizing reusable medical equipment, and 2) SPD management neglected to properly train employees and interfered with investigators conducting on-site reviews within SPD.

Ms. Kelley's allegations were referred on July 1, 2011, to the Honorable Eric K. Shinseki, Secretary of Veterans Affairs, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki delegated responsibility for conducting an investigation to the Veterans Health Administration. On November 17, 2011, Secretary Shinseki submitted the agency's report to this office. Ms. Kelley provided comments on the report pursuant to 5 U.S.C. § 1213(e)(1). As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and Ms. Kelley's comments to you.

Ms. Kelley explained that SPD employees are responsible for decontaminating, cleaning, and sterilizing reusable medical equipment (RME) after it is used. At the Jackson VAMC, RME consists of instruments such as scalpels, forceps, craniotomy sets, and vascular instruments. According to Ms. Kelley, the SPD decontamination area is staffed daily by approximately eight Medical Supply Technicians. Ms. Kelley made disclosures regarding several categories of wrongdoing within SPD, as outlined below.

A. *Failure to Properly Don Personal Protective Equipment*

SPD work areas are intended to be sterile and employees are expected to wear PPE while working in SPD in order to limit patient, employee, and visitor exposure to infectious microorganisms. Pursuant to VA Handbook 7176, *Supply, Processing, and Distribution (SPD) Operational Requirements* (August 16, 2002), Para. 4.304, individuals working in the decontamination area must also utilize specific attire, including face shields, or goggles and a surgical mask in lieu of a face shield, and long cuffed rubber or vinyl decontamination gloves. Para. 4.304 specifically notes that this attire must not be stored in the

decontamination area, must be put on prior to entering the decontamination area and removed before leaving, and that no one is permitted in the decontamination area without proper attire. VA Handbook 7176 also restricts accessories by limiting jewelry to wedding rings and post earrings.

During Ms. Kelley's two-year employment at the Jackson VAMC, she regularly observed her colleagues in the SPD decontamination area, either while she was training in the area or through observation windows between the decontamination area and the prep and sterilization areas. During that period, Medical Supply Technicians in the decontamination area failed on a near-daily basis to wear the required face coverings and gloves outlined in VA Handbook 7176. Employees also frequently donned their PPE after entering the decontamination area, and retrieved outer garments from within the decontamination area and then wore them throughout the facility. Ms. Kelley also observed employees wearing hoop earrings and watches in the decontamination area, and bringing in cell phones. Ms. Kelley claims she brought these violations to the attention of Jackson VAMC management when she first noticed the lapses, but no action was taken to counsel employees on proper attire or to remedy the lack of proper attire in the decontamination area. Ms. Kelley further alleged that the only time she observed proper attire being worn in the decontamination area was during inspections of SPD by the Veterans Integrated Service Network 16 (VISN) and VA Headquarters personnel, including during a July 29, 2010 visit, as discussed below.

According to the agency's report, an unannounced visit to SPD was conducted on August 24, 2011. During that visit, the agency was unable to substantiate Ms. Kelley's allegation that hoop earrings or similar jewelry was being worn in SPD. However, the agency determined that regardless of whether employees wore them, there was no risk to patients if items such as earrings, watches, or cell phones were brought into the decontamination area. Specifically, the report noted that the decontamination area is separated by a wall from the preparation area, where cleaned RME is sterilized and packaged, and therefore contamination from dirty instruments cannot affect the instruments in the preparation area. The report also asserted that the rationale for restricting accessories in the decontamination room is to protect technicians and their property, not individuals outside SPD.

During the August 24, 2011 site visit, investigators discovered one SPD employee in the decontamination area without the required face covering or gloves, and both of the two employees working in the area were wearing their protective gowns improperly. According to the report, the employees indicated that it was the way they were taught to wear the gowns. Upon questioning, it was discovered that the Assistant Chief of SPD also did not know how to properly don the protective gown. Thus, the report substantiated Ms. Kelley's allegation that employees failed to wear the required PPE, but determined that the failure did not pose a risk to patients. As a result of the findings, an on-the-spot, in-service training was conducted, as well as a documented in-service training led by the Assistant Chief of SPD. SPD leadership also counseled employees in writing regarding the proper use of PPE.

The agency also did not substantiate the allegation that SPD employees frequently don PPE after entering the decontamination area and retrieve from within the decontamination room outergarments that are worn throughout the facility. The report noted that the decontamination area has an anteroom for personnel to dress in and that the anteroom contained all required PPE and hooks with lab coats for employees to wear over their scrubs after removing PPE. The report asserted again that even if the investigators could substantiate these allegations, they would not pose a threat to patient safety.

Investigators discussed with management the allegation that employees only wore proper PPE during VISN and VA inspections, and management assured the investigators that it was common practice to reinforce the correct wearing of PPE at all times. The investigators also received a copy of Ms. Kelley's e-mail to management notifying them of her concerns, and evidence that the e-mail was forwarded by the Associate Director for Patient Care Services to the Assistant Chief of SPD for further action. The report asserted that this led to multiple in-service trainings regarding the proper use of PPE.

In her comments in response to the report, Ms. Kelley noted that the separation wall between the preparation and decontamination areas does not prevent technicians from leaving the decontamination area with contaminants on their person or property. She frequently observed employees answer calls on their cell phones in the decontamination area using the same gloves they were wearing to reprocess RME, and staff routinely brought books and candy into the area. Ms. Kelley explained that proper PPE is needed to prevent germs and contaminants from being spread into the hospital, and that this is specifically stated in the SPD Training Manual. Ms. Kelley further explained that although there is an anteroom in the decontamination area, as described by the agency, there is also an unrestricted, unsecured entrance into the decontamination area. According to Ms. Kelley, this entrance, which leads from the distribution area to a series of smaller rooms and directly into the decontamination area, is routinely used by SPD staff to enter the decontamination area, bypassing the anteroom where PPE is stored. Decontamination staff maintains a rack of PPE inside this entrance, allowing them to bypass the anteroom completely. Further, even when employees left through the anteroom, they wore the same gowns throughout the hospital to pick up equipment.

Ms. Kelley also described the use of a sliding window located in the separation wall between the decontamination and preparation areas. The window allows technicians in the preparation area to return instruments that are found to still be soiled after decontamination back to the decontamination area for reprocessing. Ms. Kelley noted that she observed technicians in the decontamination area hand the re-cleaned RME back through the window to the preparation area using the same gloves they wore to clean the instrument, which she believes compromises the sterilization process and evidences a failure to fully reprocess the instrument. She also explained that the window was often improperly left open to allow air flow through the decontamination area, and that because technicians frequently, and incorrectly, cleaned instruments above the water- and sink-line, splashes and sprays could easily carry through the window and into the preparation area.

Finally, Ms. Kelley restated the allegation that she brought these concerns to the attention of management, but was repeatedly told by the Acting Chief of SPD that the "Front Office" was aware of the situation but refused to take action. She reiterated that in her observation, SPD employees only donned full PPE when an inspection, assessment, or review was occurring, and if correct wearing of PPE was regularly enforced by management, as the agency's report states, there would be no problem with compliance, contrary to the report's findings.

B. *Interference by Management in Investigations*

Ms. Kelley also alleged that Jackson VAMC staff misrepresented to investigators the types and numbers of RME being processed by SPD. Specifically, Ms. Kelley stated that on July 29, 2010, Susan Scott-Williams, SPD Program Manager, and Chad Butler, Quality Assurance Specialist, entered the office of Martha Harris, Lead SPD Technician, while Ms. Kelley was speaking with Ms. Harris. Ms. Kelley stated that Ms. Scott-Williams announced that she and Ms. Myrtle Tate, VISN Inspector, were on the premises to verify that SPD had manufacturers' instructions for all of the RME being used and reprocessed at Jackson VAMC. Ms. Scott-Williams asked Ms. Kelley if SPD's "binder" had information for all of the RME. Ms. Kelley alleged that upon reviewing the binder with Ms. Scott-Williams, she discovered that it was not complete and stated so to Ms. Scott-Williams. Ms. Scott-Williams then asked the same question of Carla Acosta, Assistant Chief of SPD, who stated that the binder was complete.

According to Ms. Kelley, Ms. Tate asked her if she had another document containing the full list of RME, and Ms. Kelley stated that she did and left to print the list and e-mail it to Ms. Scott-Williams and Ms. Tate. However, Ms. Kelley alleged that by the time she returned with the full list, Ms. Scott-Williams and Ms. Tate were in a closed office with Dr. Dorothy Taylor, Associate Director for Patient Services. Ms. Acosta told Ms. Kelley not to enter the office. She alleged that several minutes later, Dr. Taylor met her in the hallway, took the list, and told Ms. Kelley that Ms. Scott-Williams and Ms. Tate did not need it.

Ms. Kelley disclosed that on July 30, 2010, Dr. Taylor created an alternate list of RME for Ms. Scott-Williams and Ms. Tate. Ms. Kelley stated that the list was incomplete and missing approximately 23 pieces of RME that should have been included, such as laryngoscopes, esophagoscopes, and anoscopes. She alleged that Dr. Taylor improperly withheld the full list of RME from Ms. Scott-Williams and Ms. Tate in order to conceal those instruments that were not being processed in accordance with manufacturers' instructions.

Upon investigating, the agency was unable to substantiate this allegation. Rather, the agency found that the list of RME provided by Dr. Taylor to Ms. Scott-Williams and Ms. Tate was complete. The report noted that investigators compared the list to the two lists of RME provided by Ms. Kelley, and determined that all three lists reflected the same equipment, except for one small intestine video scope that was not included. Thus, the agency determined that the list Dr. Taylor provided did reflect a full list of RME being used in the hospital and processed by SPD.

Ms. Kelley also alleged that VAMC management interfered with prior investigations of the Jackson VAMC SPD. Specifically, Ms. Kelley alleged that following an October 2012 site visit related to OSC File No. DI-09-3272, discussed below, she was questioned in a closed-door session by Dr. Taylor as to what transpired during her interview in connection with the investigation. She was directed by Dr. Taylor to draft a memorandum reflecting the content of her interview and to inform VAMC Director Linda Watson of the details. Finally, employees were assigned to "shadow" investigators and report back to management on what they observed.

In its report, the agency stated that investigators questioned Dr. Taylor about these allegations, and she denied asking anyone to document their conversations with investigators. She also denied asking Ms. Kelley to discuss her interview. Rather, Dr. Taylor asserted that Ms. Kelley came to her office voluntarily to inform her that Ms. Watson had directed her to write down the details of her interview. Dr. Taylor also denied directing Ms. Kelley to inform Ms. Watson of her interview and to draft a memorandum. The report notes that Ms. Kelley was unable to provide a copy of such a memo. The report also found that it is common practice for VA facilities to assign local employees to follow investigators and take notes. The report states that this is an encouraged management technique to allow for immediate corrective action to be taken.

In her comments, Ms. Kelley noted that Dr. Taylor sent her request for a written interview summary via e-mail, but that she deleted the e-mail. The message was also sent to Joan Simon, Acting SPD Chief, Martha Harris, Lead SPD Technician, and the SPD Supervisor. Thus, Ms. Kelley believes that this e-mail is retrievable and shows that Dr. Taylor did, in fact, request a written summary, regardless of whether it was ever drafted. Ms. Kelley also reiterated her version of what transpired with Dr. Taylor, and stated that Dr. Taylor's version of the events is inaccurate. Additionally, Ms. Kelley identified a script distributed to employees by management in advance of the October 2009 site visit. The script provides "correct" answers related to endoscopes, including answers on who trained an employee to clean the scopes and how the scopes are cleaned.

C. *Failure to Properly Train SPD Employees*

Ms. Kelley also explained that all Medical Supply Technicians must be trained how to process each piece of RME individually, because each category of instrument is distinct and requires particular skills to be properly processed. Additionally, each category of RME, e.g., laryngoscopes, may have several of the same instruments, each produced by a different company and requiring specific training to process. Ms. Kelley disclosed that the Medical Supply Technicians are not all trained, as required, in proper techniques for processing each piece of RME. She alleged that by altering the full list of RME, Dr. Taylor was concealing from inspectors the fact that the staff was improperly trained and continuing to process RME for which they had not received training.

The agency did not substantiate this allegation in its report of investigation. The report explained that investigators reviewed SPD's Standard Operating Procedures binder and Competencies document and found that in-service trainings were conducted for each piece of equipment. The binders also reflect that Competencies were signed for each technician who attended the in-service trainings. The investigators also found that training records showed all new employees completed Level I SPD training as required by VA Handbook 7176.

In her comments, Ms. Kelley explained that the in-service training sessions reflected in the SPD binders do not provide a factual indication that the trainings occurred. Rather, Ms. Kelley asserted that during staff meetings Ms. Simon would circulate multiple sign-in sheets containing a blank general purpose training record. She would instruct the employees to sign the sheets as they were passed around, and after the meetings, would fill in various training course titles, indicating that training had occurred when it had not. Ms. Kelley also stated that copies of SPD standard operating procedures were passed out during staff meetings along with a sign-in sheet indicating that training on the procedures had taken place, even though no such training had occurred.

Finally, Ms. Kelley explained that Level I SPD training is an automated course consisting of 10 modules. Test takers must pass an end-of-module test with a score of 80% or better in order to move on to the next module. Employees at Jackson VAMC, including the Acting Chief, were experiencing difficulty completing the modules independently. She alleged that they instead decided to work as a group to obtain the answers and then use those answers to individually complete the modules. Thus, according to Ms. Kelley, although SPD records show that all technicians completed the required Level I SPD training, it is not indicative of their knowledge or mastery of the content.

D. *Follow-up Actions in OSC File No. DI-09-3272*

As described in our referral letter to Secretary Shinseki, dated July 1, 2011, OSC previously referred for investigation allegations of improper sanitization and sterilization of RME in the Jackson VAMC SPD. See OSC File No. DI-09-3272. In its reports in response to that investigation, the agency indicated that it planned to hire "an experienced Chief and Assistant Chief of SPD…." In her disclosure in OSC File No. DI-11-2518, Ms. Kelley alleged that the problems occurring in SPD continued even after the agency's initial investigation, despite the agency's assurances to OSC that experienced staff would be hired.

In the agency's report in this matter, OSC File No. DI-11-2518, the agency found that problems within SPD were not continuing, and again noted that a new Chief of SPD, Assistant Chief of SPD, and 13 new staff had been hired. The report found only three instances since October 2010 in which instruments had to be returned to SPD by the Operating Room. All three instances involved orthopedic sets, which according to the report are inherently problematic to clean because small bone fragments can become lodged in hard-to-find places on the equipment, such as drill bits. The fragments then become dislodged during the sterilization process and fall to the bottom of the equipment tray, where

they are hard to find. The report found that these incidents do not indicate a routine failure when the number of sets processed each day is taken into account, and that such incidents are related to the design of the equipment and occur in all medical facilities.

Ms. Kelley refuted the report's findings. For example, she pointed out that instead of hiring experienced staff to fill the new SPD positions, the Jackson VAMC detailed an inexperienced Nurse Manager to the SPD Chief role and selected a receptionist who was previously working in the Director's office to take over as Assistant SPD Chief, although qualified and experienced applicants were available. Further, Ms. Kelley stated that the former Acting SPD Chief was detailed into the position of SPD Nurse Educator, which she alleged was a "nonexistent" role.

Ms. Kelley also explained that the manufacturers' instructions for use provide detailed steps for reprocessing medical devices, including diagrams and illustrations. She noted, therefore, that employees who encountered "hard-to-find" areas on devices, such as orthopedic sets, lack training and experience. Ms. Kelley also stated that the drill bits described in the report are not hard to find; rather, they are component parts of a power drill. Surgical Technicians removed debris during and after procedures, and then removed the drill bit from the drill prior to sending it to be reprocessed. Paying close attention to areas such as crevices, seams, joints, triggers, and connectors for tissue or bone fragments is key to the cleaning process, and that inspection for cleanliness after cleaning and decontamination did not occur in SPD due to training deficiencies.

II. OSC File No. DI-11-1625: Improper Jackson VAMC Press Release

The whistleblower in this matter, who wished to remain anonymous, alleged that Jackson VAMC employees violated 18 U.S.C. § 1001[1] and 18 U.S.C. § 1505[2] by issuing false information to the public, congressional staff, and veterans. Specifically, the whistleblower stated that on October 21, 2010, Jackson VAMC management became aware of an OSC press release summarizing the report of the Veterans Health Administration (VHA) investigation in OSC File No. DI-09-3272, discussed above. In its report in OSC File No. DI-09-3272, the VA substantiated the allegation that "there are occasions when staff violate policy by failing to ensure that RME are properly cleaned and sterilized." The report noted that hygiene and management issues within SPD at the Jackson VAMC were a long-standing issue. Although the Jackson VAMC follows its own standard operating procedures for cleaning and sterilizing equipment, and had taken steps to improve SPD's reprocessing of

[1] Pursuant to 18 U.S.C. § 1001, individuals are prohibited, in any matter within the jurisdiction of the executive, legislative, or judicial branches of the United States Government, from knowingly and willfully making any materially false, fictitious, or fraudulent statements or representations or making or using any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry.
[2] Pursuant to 18 U.S.C. § 1505, individuals are prohibited from corruptly obstructing or impeding the due and proper exercise of the power of inquiry under which any inquiry or investigation is being had by either House, or any committee of either House or any joint committee of the Congress.

RME, there were "still incidents of dirty, rust-stained instruments being sent to the clinics and operating room."

The whistleblower explained that, following OSC's release of the report in OSC File No. DI-09-3272, the Jackson VAMC Public Affairs Office received an inquiry from an Associated Press (AP) reporter. When the AP inquiry was received, an Infectious Control Committee meeting was about to begin, including VAMC Director Linda Watson, Chief of Staff Kent Kirchner, and Chief of Quality Management Ava Abney. The AP inquiry was discussed during the meeting, and Public Affairs staff were directed to draft a response. The whistleblower noted that members of management appeared to have a copy of the report during the meeting, but Public Affairs staff were not provided with or offered a copy. Public Affairs staff were directed to emphasize that no violations occurred, that the report focused only on a short period of time between 2001 and 2006 in the podiatry laboratory, and that the only RME implicated were nail nippers. Pursuant to these directions, Public Affairs staff drafted a press release for media, Congress, and Jackson VAMC employees.

The whistleblower alleged that the press release, which was drafted without the benefit of the agency's report, contains several apparently false statements. For example, the press release states that the report "concluded that the Jackson VA Medical Center was compliant with all VA regulations, rules, and procedures." This is an inaccurate statement of the VHA's findings. As previously noted, the report stated several times that the Jackson VAMC was in violation of VA policies pertaining to the cleaning and sterilization of RME. Moreover, the press release goes on to state that the report "focused on podiatry from 2001 to 2006 and on the use of nippers (nail clippers)." This is also false; the report included over four pages of summary on each of the laboratories and units listed above, and neither the investigation nor the findings in the report included only nail nippers. Instead, the report explicitly noted that staff sometimes receive "*instruments that have been sterilized that have dried blood or other debris on them…*" (emphasis added) and noted that both the Ear, Nose, and Throat Unit and the Operating Room-Post Anesthesia Care Unit, in addition to the Podiatry Clinic, had issues with receiving properly sterilized instruments.

The press release also states that improperly cleaned equipment was removed by staff when it was identified, and that such equipment was not used and at no time was any veteran exposed to infectious material. This assertion is also incorrect. As stated above, the report concedes the possibility that patients in the Podiatry Clinic may have been exposed to blood borne pathogens due to improperly cleaned RME.

After issuing the press release, Jackson VAMC Public Affairs personnel were notified that staff from the U.S. Senate Veterans Affairs Committee and the VA Congressional Relations Office would be visiting on November 9, 2010, to tour the facility and gather information on SPD and the cleaning of RME. The whistleblower alleged that during this meeting with the congressional staff, Jackson VAMC management reiterated the same points that were made in the press release. The whistleblower alleged that these statements were materially false, both in the press release and in the meetings with the congressional staffers. Following the visit, congressional interest in the VHA's findings continued. Minority staff

from the U.S. House of Representatives, Committee on Veterans Affairs, Subcommittees on Health and Oversight and Investigation, requested a meeting with Dr. Robert Petzel, VA Undersecretary for Health, during the week of December 13, 2010, in preparation for an oversight hearing on RME sterilization processes in VA facilities. While planning the meeting, e-mails indicated that Dr. Phil Roe, the Ranking Member of the Committee on Veterans Affairs at the time, would possibly attend.

The whistleblower also alleged that similar factually inaccurate statements were issued by the Jackson VAMC in a letter to veterans and in an e-mail to Jackson VAMC employees, both dated October 22, 2010, and signed by Ms. Watson, VAMC Director. In the letter and e-mail, Ms. Watson stated that the VA review concluded that the Jackson VAMC was compliant with all regulations, rules, and procedures regarding sterilization of RME.

In its November 15, 2011 report in response to the instant allegations, the agency explained that on December 21, 2009, the Administrative Investigation Board (AIB), convened to address the allegations in OSC File No. DI-09-3272 sent a report of investigation to the Jackson VAMC. That report focused more heavily on the Podiatry Clinic than on other areas within the Jackson VAMC and highlighted the period from 2001 to 2006. That report also found no apparent violations of VHA or Medical Center regulations, directives, or policies. The AIB confirmed to investigators that this version of the underlying report was the first of two versions, and that the second version contained substantial changes, including a finding that, at times, SPD staff violate policy by failing to ensure that RME are properly cleaned and sterilized. The AIB also stated to investigators that the existence of this second version, which was the version submitted to OSC, was not known to Jackson VAMC management until June 2011. The report in this matter concludes that the initial finding in the underlying matter - that no violations occurred - was changed at the VA Central Office level, but Jackson VAMC management was not notified of the change until receipt of OSC's May 12, 2011 referral letter in the instant matter.

Based upon the foregoing, the agency found that the Jackson VAMC's October 21, 2011 press release was drafted using the first, incorrect version of the agency's underlying report. The agency found that at the time of the press release, the AIB noted that OSC's press release mentioned specific instruments that were not listed in either the first or second versions of the reports. This, coupled with the fact that OSC's press release was markedly different from the conclusions in the first version of the underlying report, led the AIB to believe that OSC's press release was based on incorrect information. Thus, when asked to respond to the press release, the Jackson VAMC responded with the only information available, which was in the original version of the underlying report.

The agency's report in this matter also notes that VAMC management felt "tremendous pressure" to respond immediately to OSC's press release, and that this pressure contributed to management's failure to first contact VA Headquarters to ascertain a possible reason why OSC's press release was so drastically different from the information management had received. Thus, the report found that the reason for the inaccuracies in the agency's press release, e-mail, and letter, as well as misrepresentations to congressional staff,

was that management never received the final version of the agency report in the underlying matter, and failed to contact headquarters prior to drafting a response to OSC. Because the false information was reportedly due to a mistake, there was no intent on the part of the agency to deceive Congress or the public. As a result, the agency found that there was no evidence of criminal violations or other misconduct on the part of Jackson VAMC employees.

The whistleblower provided comments in this matter calling into question the VAMC's explanations. The whistleblower specifically noted that the Public Affairs Office at the Jackson VAMC was not provided a copy of either version of the agency's underlying report prior to drafting the press release. The whistleblower also indicated several instances where the press release and subsequent documents contradict findings included even in the incorrect version of the agency's report. For example, while the press release focused on podiatry at the Jackson VAMC, it is notable that the first version of the report still addresses, on multiple occasions, dirty instruments being delivered to the Ear, Nose, and Throat Clinic, operating rooms, and Orthopedics.

III. The Special Counsel's Findings

Overall, I find Ms. Kelley's response to OSC File No. DI-11-2518 compelling. The agency's explanations are not credible. The agency has substantiated the allegation that SPD employees do not always wear proper PPE and that employees, and even the Acting Chief, do not know the proper way to wear required PPE, yet it has also determined that it was common practice for management to regularly reinforce the proper wearing of PPE at all times. Furthermore, the agency's assertion that employees used the anteroom of the decontamination area to don and remove PPE at all times is presented without reference to the alternative entrance to the area described by Ms. Kelley. The report also fails to directly address the concern that germs can transfer to employees' clothing and accessories and be carried throughout the hospital.

It is also troubling that the VA did not interview Ms. Kelley.[3] Had Ms. Kelley been interviewed, she may have had the opportunity to directly rebut the statements made by Dr. Taylor and other witnesses regarding employee interference in the conduct of investigations, the manner and extent of employee training, and the failure to hire experienced SPD staff.[4] Additionally, Ms. Kelley could have provided an alternative viewpoint on the agency's contention that finding bone fragments in RME after reprocessing

[3] On September 13, 2011, OSC became aware that Ms. Kelley was not interviewed. We addressed our concerns about the lack of a full interview in a phone call to the agency on September 29, 2012. On October 3, 2011, we received an e-mail response from Walter Hall, Deputy Assistant General Counsel, indicating that at the time of the investigation, the agency felt that its initial telephone call with Ms. Kelley was sufficient and no additional interview was required. While OSC stated its objection to this assertion the same day, no additional interview was offered by the agency.

[4] It has recently come to my attention that Dr. Taylor was arrested on May 24, 2012, on charges of prescription fraud involving hydrocodone.

is a common problem. The agency offered no information to support its assertion that this problem is common and occurs in all medical facilities. Thus, I find credible Ms. Kelley's belief that a lack of proper training at all employee levels contributes to the recurring problems within SPD at the Jackson VAMC.

In addition, it has recently come to my attention that as of March 2012, the agency permanently rescinded VA Handbook and Directive 7176. It is my understanding that while the agency is in the process of drafting replacement guidance for the rescinded documents, employees are being advised to follow nationally recognized standards and other Veterans Health Administration Directives. While I hope that SPD employees have been fully and properly trained on the guidances and Directives now in effect, I note with concern that neither of the reports we received in these matters indicates that a comprehensive plan was in place to replace VA Handbook 7176 to ensure the safety of SPD employees and patients. Based on the foregoing, I have continuing and significant concerns regarding the safety of RME processes by SPD at Jackson VAMC.

Similarly, while I do not dispute the VA's conclusion in OSC File No. DI-11-1625 that agency officials did not willfully mislead the public and Congress in this matter, I remain deeply troubled with the outcome of this investigation. The fact that the Jackson VAMC was never notified of a later version of the underlying report in OSC File No. DI-09-3272, particularly as it contained substantially altered findings and conclusions, shows a serious lack of communication within the agency. Furthermore, it casts doubt upon the agency's assurances to OSC that Jackson VAMC management could continue its effort to improve SPD through compliance with regulations and agency directives, as was specifically stated on page 4 of the agency's underlying report. At the time the agency issued that report, the Jackson VAMC was still under the misapprehension that it had not been in violation of any of the provisions identified therein. Thus, it seems unlikely that management could identify and fully address potential violations, especially as we received the subsequent disclosure (discussed above) that SPD concerns were ongoing.

Furthermore, I am disturbed that the agency did not fully address Jackson VAMC management's failure at every level to verify the information released to patients, employees, the public, and Congress. The agency admits that no one considered the significant differences between OSC's press release and the agency's version of the underlying report to warrant additional follow-up prior to the drafting of the press release or other correspondence. Rather, in its report in this matter, the agency appears to condone and excuse this failure in a situation calling for a swift response. However, according to the report, no action was taken once the failure was discovered. Thus, not only does it appear that the staff involved avoided disciplinary action, but also the incorrect information that was disseminated has not been corrected or rescinded, or replaced with correct information.

In conclusion, I believe that these two matters, as well as prior matter OSC File No. DI-09-3272, indicate a pattern of poor management and failed oversight at the Jackson VAMC. As such, I find the agency's reports in OSC File Nos. DI-11-2518 and DI-11-1625 not reasonable. These matters document ongoing concerns regarding the cleaning and

sterilization of RME within SPD and the failure by the agency at the local and headquarters levels to properly communicate the outcome of an investigation into those concerns. As a result, I believe that the care provided to veterans has been compromised and the public trust damaged. Steps should be taken by the agency to swiftly repair the systems at the Jackson VAMC.