The VA Administrative Investigation Board (AIB) report to OSC fails to include key information regarding the development of the Jackson VA Medical Center's News Release and messages that were distributed to the media, Members of Congress, employees, veterans, and the general public. Leadership at the Jackson VA Medical Center did **NOT** provide a copy of either report (Attachment A or Attachment B) to the Public Affairs Officer. The Medical Center Director referred to a hardcopy of the report while the leadership team verbally provided the Public Affairs Officer with information to prepare the news release and similar messages to stakeholders.

The VA AIB Report supports the claims in the Jackson VA Medical Center's News Release (Attachment D) that the focus of the earlier report regarding cleaning reusable medical equipment was on "podiatry from 2001 to 2006." However, both the VA AIB Report and the Jackson VA Medical Center News Release overlook information in that earlier report (Attachment A) that is in complete disagreement. What follows are specific statements from the report (Attachment A) in disagreement with the initial response by the Jackson VA Medical Center and the recent conclusions by the VA Administrative Board.

- In February of this year (2009), ENT reported a lack of properly sterilized and peel pack instruments, a lack of properly sterilized instruments for an entire week, requiring them use disposable instruments and to scramble to get needed instruments from other sources. They estimated that 10 – 12 incidents over the last year. (Page 5, Attachment A)
- On August 13, 2009, in operating room Suite 2, a rigid metal lumen suction tube was found to have debris in it, causing contamination of the sterile field. . . . In addition, the instrument tray with the dirty tube was mislabeled "OR. Rigid Esophagoscopy Ridig Scope," it should have read "Adult Esophagoscopy Set." ENT has also received sterile OR instrument trays with the wrong expiration dates as well as missing instruments. (Page 5, Attachment A)
- The OR has issues with dirty instruments about once a month. (Page 6, Attachment A)
- The OR sometimes receives sterile instruments in packs with no expiration date, the incorrect expiration date, or broken wrappers. Incomplete instrument sets have also been an issued [sic] but this has improved. There were also and [sic] incidents where a glidenscope blade and a camera were melted during reprocessing. (Page 6, Attachment A)
- On occasions ophthalmology has received damaged equipment from SPD, and they cannot see the damage except under magnification. (Page 7, Attachment A)
- Orthopedics uses sterile instruments in the OR and does have concern about the processing of drill bits. (Page 7, Attachment A)
- Interviews with the podiatrists revealed at one point things had improved, but problems with blood, and rust-stained equipments has recurred. The investigative team removed five instruments from the podiatry cabinet and found two with what appeared to be dirt/particles on them; all five of the instruments were stained. (Page 8, Attachment A)

Finally, the VA AIB relies on faulty logic to rationalize its conclusions. The Jackson VAMC claims it relied on the prior report (Attachment A) which included information that supported that statement that "the VA Medical Center was compliant with all VA regulations, rules, and procedures." The actual report (Attachment B) included the following information "the review team found 'occasions when staff violate policy by failing to ensure that RME are properly cleaned and sterilized.'" Even if a person were to accept VA's premise about relying on wrong information, it would not somehow render all of the findings inconsequential or unimportant. Other findings in the same report (attachment A), which are outlined earlier in this statement, clearly identify dirty instruments at the Jackson VA Medical Center years after 2006.