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The Special Counsel

April 16, 2015

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

Re: OSC File No. DI-13-3728

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find an agency report based on disclosures made by an employee of the Department of Veterans Affairs (VA), Carl T. Hayden VA Medical Center (Phoenix VAMC), Sterile Processing Service (SPS), Phoenix, Arizona, alleging that employees engaged in conduct that constituted violations of law, rule, or regulation, and a substantial and specific danger to public health. The whistleblower, who is anonymous, alleged that Phoenix VAMC employees regularly failed to properly clean and sterilize reusable medical equipment (RME) and did not wear required protective equipment.

The VA did not substantiate the whistleblower's allegation that employees regularly failed to properly clean RME, and was unable to substantiate that employees in SPS failed to wear required protective equipment. However, the agency did make several recommendations to the facility regarding compliance with VA requirements and monitoring of the facility's quality program. I have determined that the report meets all statutory requirements and that the agency head's findings appear reasonable.

The whistleblower's allegations were referred to then-Secretary of Veterans Affairs Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). Secretary Shinseki delegated the authority to sign the VA's report of investigation to Chief of Staff Jose D. Riojas. On November 13, 2013, Mr. Riojas submitted the agency's report to OSC based on an investigation conducted by the VA Office of the Medical Inspector. The agency submitted a supplemental report to OSC on May 28, 2014. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblower was offered the opportunity to comment on the findings of the Secretary's office, but declined to do so. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and comments to you.[1]

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging violation 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 the aforementioned conditions exists, she is required to advise the appropriate agency

I. The Whistleblower's Disclosures

The whistleblower disclosed that Jerome Tandy, SPS day shift lead medical supply technician, regularly failed to follow correct procedures when cleaning RME, placing patients and staff at risk.[2] Mr. Tandy is not restricted to working in one area of SPS, and therefore can switch between positions in the decontamination and prep areas. The whistleblower alleged that Mr. Tandy frequently stated aloud that SPS processes are too slow and that he is not thorough when cleaning and sterilizing equipment. The whistleblower offered several examples of Mr. Tandy's shortcomings, including instances involving the improper cleaning and inspection of a drill bit, a fiberoptic scope, and suction tips. As a result of Mr. Tandy's actions, the whistleblower alleged that RME frequently comes through the cleaning and sterilization process containing bio-burden, such as tissue, blood, and bone.

The whistleblower further alleged that Mr. Tandy also regularly failed to wear proper personal protective equipment (PPE) while working in SPS, despite being repeatedly directed to do so. The whistleblower stated that Mr. Tandy wore scrubs while working in SPS but failed to remove those scrubs before leaving SPS. Thus, Mr. Tandy wore potentially contaminated clothing throughout the hospital, including into patient areas. The whistleblower alleged that Mr. Tandy also did not cover his beard as required and regularly used lip balm while in SPS.

II. The Agency Reports

The VA did not substantiate the whistleblower's allegation that Mr. Tandy failed to properly clean and sterilize RME on a regular basis. OMI investigators were unable to corroborate the whistleblower's claim that on one occasion, Mr. Tandy instructed another employee to improperly clean a drill bit. The investigation similarly could not corroborate that the improperly cleaned drill bit was placed on an instrument tray and sent to the operating room, as no record of the incident existed and no other employees could recall the incident. Similarly, the investigation could not corroborate the whistleblower's allegation that Mr. Tandy improperly placed a fiberoptic scope and attachments into an ultrasonic cleaner. The report notes that a similar incident was reported to leadership involving another lead SPS

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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).

[2] SPS procedures and policies were previously outlined in VHA Handbook 7176, *Supply, Processing, and Distribution (SPD) Operational Requirements* (August 16, 20012). VHA Handbook 7176 was rescinded in March 2012. At the time these allegations were referred, it had not been replaced. In the interim, SPS employees rely on a variety Veterans Health Administration (VHA) Directives and on nationally-recognized references for guidance on conduct and processes within SPS. Although VA currently lacks a single approach to the cleaning and processing of RME, VHA Directive 2009-031 (June 26, 2009), para. 2.b. notes that "[p]roper processing of RME is a key component to ensuring patient and staff safety, and therefore must be performed to exacting standards."

technician and, in that case, the employee was counseled and an in-service training was held for all SPS staff. Finally, the investigators were also unable to corroborate the allegation that Mr. Tandy improperly cleaned suction tips leading to contamination of already-cleaned instruments. The report notes that staff members did not recall this incident and there was no documentation of the event.[3]

The investigators did find three occasions in which bio-burden was discovered on previously cleaned RME, all occurring between October 2012 and August 2013. According to the report, no patients were harmed as a result of the improperly cleaned RME and in two of the instances the bio-burden was discovered prior to the use of the contaminated RME on the patients. In all three instances, the facility responded appropriately. The report also notes that these three incidents represented 0.004 percent of all RME processed during that time period.

According to the report, one SPS technician reported observing Mr. Tandy assisting with a backlog of RME while not wearing proper PPE. A second employee also reported that, on another occasion, she witnessed Mr. Tandy in the decontamination area without the required PPE. However, the investigators determined that the second employee's description of Mr. Tandy's attire did constitute acceptable PPE. The investigators did not find information indicating that Mr. Tandy regularly failed to wear PPE while working in SPS and no employees recalled any incidents in which Mr. Tandy failed to cover his beard and head. Several employees reported that Mr. Tandy did apply lip balm while in SPS, but only in the assembly and preparation areas, and not in the decontamination area.

The report notes that during OMI's visit, all staff were appropriately attired, and staff training on the use of PPE is conducted annually. The report also notes that scrubs worn in the decontamination and preparation areas are substantially the same, making it difficult to determine whether an employee changed scrubs before entering or leaving SPS. The investigation found that all SPS employees wore appropriate covering over their scrubs and were well-versed on required covering when leaving SPS. However, the agency recommended that the facility monitor PPE compliance in the decontamination area and address non-compliance as necessary. In its supplemental report, the agency confirmed that the facility had developed a sterile processing tracer tool to conduct biweekly tracers to assess compliance with PPE requirements. Between December and March 2014 the tracer assessed compliance at 100 percent.

Finally, according to the report, neither the SPS chief nor the assistant chief reported that they were notified of any of the three incidents alleged by the whistleblower. As the investigation was not able to substantiate those allegations, the report determined that

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[3] The report also notes that OSC provided 11 photographs relevant to the allegations, which were provided by the whistleblower. According to the report, witnesses were unable to corroborate that the photographs showed evidence of wrongdoing. The investigation independently reviewed whether it was appropriate for employees to take photographs within the facility, and found that such action is prohibited by a local medical center policy. As a result, the OMI recommended that the facility ensure that SPS employees are aware of the policy against electronic devices in SPS. Because OSC did not refer this allegation, we will not address it further.

management did not fail to take sufficient action to remedy Mr. Tandy's actions. The report notes that the facility has multiple levels of monitoring over SPS, including tracking issues related to SPS and investigating individual events. Thus, the agency recommended that the facility continue to monitor the delivery of standardized equipment as part of its quality assurance program. In its supplemental report, the agency confirmed that the facility reviewed its Immediate Use Steam Sterilization data from January 2013 to January 2014 to determine how many times flash sterilization was performed. Flash sterilization would be conducted on-site if an instrument was found to be contaminated. Five occurrences of flash sterilization occurred during the relevant time period, all prior to October 2013. The facility planned to continue to monitor this data.

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III. The Special Counsel's Findings

I have reviewed the original disclosure and the agency reports. I have determined that the reports meets all statutory requirements and that the findings of the agency head appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports in our public file, which is available online at www.osc.gov.[4] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[4] The VA provided OSC with reports containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA did not provide a legal basis for its redactions. However, OSC objects to the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as a basis for redactions to a report produced in response to 5 U.S.C. § 1213, 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). OSC also objects to redactions made pursuant to the Privacy Act of 1974 (Privacy Act) (5 U.S.C. §552a) on the basis that the application of the Privacy Act in this manner is overly broad. However, OSC has agreed to post the redacted version of the agency reports as an accommodation.