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The Special Counsel

July 10, 2015

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

Re: OSC File No. DI-14-4705

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veteran Affairs' (VA) report based on disclosures of wrongdoing at the Ann Arbor VA Medical Center (Medical Center), Ann Arbor, Michigan. The Office of Special Counsel (OSC) has reviewed the report and, in accordance with 5 U.S.C. §1213(e), provides the following summary of the allegations and our findings.

Shelia Griffin, the former assistant chief of the Sterile Processing Service (SPS), who consented to the release of her name, disclosed that employees at the Medical Center engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health. Specifically, Ms. Griffin disclosed that employees in the SPS consistently failed to follow proper procedures and as a result, patients and staff were at risk of infection from contaminated supplies and equipment.

The agency did not substantiate Ms. Griffin's allegations. The VA determined that employees wore proper protective equipment, correctly performed sterilization procedures, and had instruments ready for emergency procedures. The agency also determined that managers properly trained and evaluated employees. Finally, the report noted that the processing area was adequately cleaned. Notwithstanding these conclusions, the report made fourteen recommendations to ensure ongoing quality control, training, and safety. Based on my review, I have determined that the report meets all statutory requirements and that the findings appear to be reasonable.

Ms. Griffin's allegations were referred to Secretary Robert McDonald to conduct an investigation pursuant to 5 U.S.C. §1213 (c) and (d). Secretary McDonald asked the Interim Under Secretary for Health to refer the allegations to the Office of the Medical Inspector for investigation. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report, which he submitted on April 9, 2015. Pursuant to 5 § U.S.C. §1213(e)(1), Ms. Griffin provided comments on the agency report on June 2, 2015. As required by 5 U.S.C. §1213(e)(3), I am now transmitting the report and Ms. Griffin's comments to you.[1]

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of

I. Ms. Griffin's Disclosures

According to Ms. Griffin, SPS staff frequently failed to wear appropriate protective equipment (PPE) in the decontamination area, in violation of both OSHA and Veterans Health Administration regulations. *See* 29 C.F.R. 1910.132(a) and VHA Directive 2009-004 § 3. Ms. Griffin also alleged that SPS staff routinely did not wear face masks and used face shields that were too short when cleaning dirty equipment in the decontamination area. She attributed these deficiencies to a lack of training and a staff unfamiliar with standard operating procedures.

Ms. Griffin also asserted that staff did not perform sterilization procedures properly. She alleged that staff did not separate instruments when processing trays, loaded sterilizing machines incorrectly, and did not wrap sterilized instruments in a proper aseptic manner. These actions appeared to violate applicable Centers for Disease Control sterilization guidelines, which are cited in the above-referenced VHA policy. *See* Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.

The whistleblower also reported that SPS staff failed to appropriately process trays containing Medical Center Operating Room instruments. According to Ms. Griffin, she observed frequent instances in which SPS staff failed to clean unique instruments in a timely manner prior to the next surgery. Ms. Griffin reported observing dirty instruments sitting unsterilized in the decontamination room over the course of several SPS shifts. In addition, she described an emergency situation where she was called at home to return to the facility to assist with the sterilization of a needed instrument.

Ms. Griffin attributed these issues to a lack of training and lax supervision by managers. Ms. Griffin asserted that employees lacked the general overall competencies required to perform their duties. According to Ms. Griffin, it was routine practice in the SPS to fill out and approve staff competencies without conducting any review or evaluation of the employee. Ms. Griffin alleged that SPS managers simply rated employees and signed off on evaluations without conducting any quality assessment or appraisal. She also noted that the initial training employees received was insufficient preparation for work in the unit, and contravened the above referenced CDC guidelines.

Ms. Griffin also alleged that the SPS area was not cleaned thoroughly on a regular basis. She explained that during the year she worked in the unit, the floors in the

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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 of the aforementioned conditions exists, she is required to advise the appropriate agency 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). 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).

decontamination room were not cleaned regularly and trash cans in the preparation area were not routinely emptied. She noted that dust accumulated in significant quantities in the corners of the decontamination room and behind doors.

II. The Agency's Report

The agency did not substantiate the allegations concerning the failure to wear PPE. The report explained that investigators conducted two unannounced tours of the SPS and observed staff wearing appropriate PPE. The report indicated that staff wore appropriate masks and face shields when cleaning instruments, and did not observe any employees wearing PPE outside the decontamination area.

According to the report, staff separated instruments into numerous trays in an effort to ensure that they were cleaned completely. The report notes this is a more time consuming process, but it ultimately ensures that instruments are cleaned more thoroughly. In addition, the report stated that in the past, sterilization machines were not loaded properly, but after new standard operating procedures were implemented on September 30, 2014, this problem was eliminated. Investigators examined numerous wrapped trays in the sterile processing area and sterile storage area and found no evidence of improper wrapping. The investigation did not discover any incident reports from operating rooms regarding improperly wrapped items or trays. A review of surgical quality reports found no evidence of elevated infection rates in patients who underwent surgical procedures at the Medical Center.

With respect to allegations concerning the failure to sterilize instruments in a timely manner, investigators found no indication that any emergency surgery was delayed or that a patient needing emergency surgery had to be transferred to a different facility because needed equipment was not sterilized and ready to use. The report identified one orthopedic case where a unique instrument was unavailable because it was sent out for repair, not because it was unprocessed.

Investigators interviewed staff members and determined that with one exception attributable to an administrative oversight, no employee received an evaluation that was conducted without a proper review or assessment of the employee. In addition, the report determined that all SPS staff members completed multiple levels of training and certification in instrument sterilization techniques and processes, and that SPS management provides additional training to staff year round and conducts routine quality assurance evaluations of staff and systems.

In addition, inspectors examined the cleanliness of the SPS facilities during two unannounced tours. They determined that all areas of the SPS including corners of the rooms and vents were clean and dust free with properly maintained trash receptacles. Supervisory staff also indicated that cleaning staff were responsive to cleaning and trash removal requests.

The report made fourteen recommendations to ensure ongoing performance in the SPS. Among other things, it indicated that SPS managers should continuing ongoing

compliance monitoring efforts intended to ensure that the operation of the unit conforms to VHA policies and procedures. It further recommended that the unit should continue to provide appropriate training and appropriately report any incidents of noncompliance in the future.

III. Ms. Griffin's Comments

Ms. Griffin disagreed with the evidence, findings, and conclusions contained in the report. She asserted that agency investigators have an inherent conflict of interest in investigating their own agency. Ms. Griffin further contended that the employees who were interviewed were not truthful due to fear of reprisal. She questioned the substance and validity of the investigation, and suggested that if the investigators had reviewed the matter appropriately, her allegations would have been substantiated.

Specifically, Ms. Griffin indicated that the SPS department was given advanced notice of the investigation. Ms. Griffin noted that she believes staff still do not wear facemasks that properly cover their faces in the decontamination area. She also believes the sterilization trays are still not being wrapped properly, and despite the report's findings, she recalled emergency procedures that lacked needed sterilized instruments. Further, Ms. Griffin has ongoing concerns with the training and the practice of management approving staff competency evaluations without conducting an appropriate review. Lastly, Ms. Griffin still believes the facility is not being cleaned properly.

IV. The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and Ms. Griffin's comments. Notwithstanding Ms. Griffin's objections to the findings of the report, I am satisfied that the agency's investigation was sufficient. Based on the VA's report and recommendations contained within, the agency report meets all statutory requirements and the findings of the agency appear reasonable.

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

Respectfully,

Carolyn N. Lerner

Enclosures