My Rebuttal Response Comments, Dated May 27th, 2015

RE: OSC File No. DI-14-1588

I am a previous employee employed by the Veteran Affairs Hospital in Ann Arbor. I came from a private sector hospital with numerous years of experience in the Sterile Processing area also an experienced Surgical Tech of 15 years. I pursued a career at the VA hoping to help the Veterans that has done so much for our country. I had set many goals and preparation to make a difference in their care, but I was never given that chance you see I was terminated five days before my year probation was up. I have two Associates degrees one in Surgical Tech and a Bachelors in Management/Business Administration. I brought all of my knowledge and experience and landed the job that I thought I would retire from doing what I love and have the passion for (Helping People) especially those that have been acknowledged by our country.

I would like to start my response by making a statement. I would like to thank all of you for this opportunity to address "truthful and factual". The truth is that all of the Investigative team members involved with the investigation "ALL" work for the VA. The fact that this sets an "immediate" stage for "Impartiality" against this Whistle-blower or the next whistle-blower, and even previous Whistle-blowers against any VA especially the one in Ann Arbor. Basically the VA Policing and Investigating with their employers to write up a Judgment finding against them is NEVER going to happen. There will always be a cover up for the truth as long as the same people are at the top. Furthermore, NO current employees that are personally interviewed are going to want their "name" in any report of "Wrong Doing", thus meaning, that employees will not be "Truthful" in the questioning of Practices and policies. Because of their fear of Reprisal is an "instant" safeguard for any employee I know from first hand because I was afraid to report what was happening to me because I was trying to make it to the year probationary period and avoid reprisal, and the lost of my job and it happened anyway. For Employees to refuse truthful testimony and to provide as little information as possible, this is what's called "Unethical". This also what's wrong with the VA system as a whole? When a Government Agency is policing their agency, this will only lead to a disastrous outcome for the Agency. Throughout my rebuttal to the individual allegations themselves you will see that another profound revelation and that will be that this investigation Team "never" once mention they conducted and forensics into their investigation efforts even though I told them where all the work orders was kept and that there was no standard training of the department not IAHCSMM in place. There was no standard training for me as a Supervisor of policies on what I could or could not do. Furthermore When I told them of the signing off of the competencies of each employee by Management they didn't even check. This was nothing I heard about I actual was given a directive to do this, and when I question the fact, being a previous Educator of Sterile Processing I was told this is how it had been done for years by Robin McLeod and her then Assistant Chief Mary Lenmorie. I have never signed off on

an employee competency unless I watched them perform the task that is a (R.O.T.C) process. But I followed the directive that I was given by my Chief Robin McLeod. The Investigative team all have VA computer Access, and had the proper resources to obtain the information and lacked any experience necessary to be called "Detectives" or "Investigators". In fact it is not like the VA is getting a WB complaint filed against them on a regular basis to keep them Experience in doing such an investigation. I feel this report undermines my Faithful, Truthful, and Dedication that I had set forth in doing my job. They might as well have called me a liar and I find that additionally painful as a WB. Had this investigation team had the experience "necessary" and wasn't employed with the VA, the efforts and outcome s would have been 100% different. I know for a fact that President Obama and Congress have no clue of the things that is really going on in this place. As I stated earlier I came from a private sector and even with them there is cover up but not like this. Had I known the set-up I was willing to address to Congress, was that the VA is protected because they police and investigate their own. I was not protected but railroaded, had I thought that to pursue the WB would be such a fruitless outcome and nothing would come out of it but lies I would have done like the majority and not speak up. But I did it for the Veterans.

According to Allegation #1.

The Staff not wearing the proper PPE's, when I was there I can only go by what I saw for myself nothing that anyone told me or that I assumed. The staff did not wear face mask they only wore face shields. As a previous Educator of Sterile Processing I know that the chemicals and aerosols can cause issues and is a safe hazard. Upon my return from level 2 training which is also listed in the IAHCSMM book and according to OHSA"You must wear a face mask along with the face shield unless the face shield came down to your upper chest". They did not have that particular shield I tried several times to order it but they continued to send the one that came to the chin. I informed My Chief at that time Robin McLeod of what was mentioned at the training and she replied "That is a hit I will just have to take because I am not making them wear those mask". It was not until after I was terminated and Sharon Ales was the New Chief and she had hired a new staff member who complained because she was not comfortable working without a face mask because where she came from, a different hospital, it was required and she felt safer if she had to touch her face with the gloves on she would be touching the mask. This is the only reason the investigators saw the people with the face mask on and all of the staff do not wear them only certain ones. When the investigators came back in June, 2013 I was there and saw for myself how the staff entered and left the decontamination area including Management because I questioned it to Management and to the staff. It was only the day the investigators came that I saw a difference. I started there in the department on May 7, 2013 so up and till the investigation the people walked into Decontam without PPE'S, and when they were in there they discarded their PPE's inside of the area and walked out with just Scrubs on. This is why when the investigators were in the Decontamination area and

the Lead Tech took off her PPE'S in front of them and made her statement before she left, she did this because this was a normal reaction they practiced and she did not feel she had done anything wrong. The only reason Robin McLeod and Stacey Breedveld made a big issue about it was because the investigators were there and did not want them to assume this was the everyday practice. Honestly I really don't know if Stacey knew about this practice but I do know that Robin McLeod and her Assistant Chief Mary Lenmorie did because that is how they took me into Decontam without PPE's just our scrubs and a warm up jacket, that is why I question them at the very beginning when I was hired and they replied "We come through here all the time like this" They actually thought if it was nothing (no soiled instruments) were in Decon it would not matter. Okay this is your "Managements knowledge the people you chose as leader of this department". Where is the knowledge of OSHA or Infection control, or even IAHCSMM? So when the first whistle blower reported this was happening I witness it for myself it was true. I do not like the fact that the investigators insinuating that I am a liar.

Allegation # 2

Staff not performing the Sterilization process correct. What I said is that when the instruments came into the Decontamination area all trays were separated and put into multiple trays which could cause confusion or have trays missing instruments, when the tray was retrieved in the assembly area if they were not use to this. Some of the employees was not use to this and the people you talk to have of them I hired and I know that was not the practice they were accustom to. They came from private sector hospitals that I know do not follow this practice. So for them to tell you they were used to this they lied to you and I can name the Hospital's they came from, Henry Ford Main, Botsford Hospital, Oakwood River View, and Detroit Medical Center. Detroit Medical Center tried to start this but it already had problems there so it really confused them. As for the loading of the Sterilizer, they would put the wrap items on the first shelf of the sterilizer carrier then the peel packs on the second shelf and the metal pans on the bottom. I tried to explain and show them the correct way. I went a step forward to make sure I was giving them the correct information I e-mailed the Educator of IAHCSMM, Patti Koncur to assure myself of the correct practice and she responded and told me I was absolutely correct, peel pack goes on first shelf, wrap items goes on second shelf and metals goes on the last shelf. The wrap items did not go on the first shelf because of the moisture and condensation could drip down onto the peels packs and render them contaminated. There was a "SOP" written for this process that was completely wrong and it was signed off by "The Chief Robin McLeod", so who wrote the SOP? Again I say where is the Sterile Processing knowledge? I also ask Don Dalebout from Getinge did these washer require that you separate all the instruments for cleaning he responded "No as powerful as these washer are as long as they were loaded correctly , meaning instruments on stringers open wide and standing up but not touching the spin arms of the washer". At all the seminars I have attended for SPS they have always stated that the less you touch instruments in the

Decontam area the safer the environment would be. They would refer to "what area of SPS has the most injuries, the answer is always Decontam. There is a tray called the flexible Bronch, it is in a really large container, this is the item I was referring to that was not being properly processed with sterilization. This tray requires a 72 in. x 54 in. wrap the staff was using a 54in. x 54 in. which was entirely too small and did not cover the complete tray, using the proper aseptic techniques to prevent contamination. These techniques include wrapping the instruments in a manner that avoids tenting and gapping and using too mall of a drape. I tried to tell them that anywhere in the United States of Sterile Processing this tray would not be considered Sterile. The reply that I got from the staff is that they did not know how to wrap with the large drape. I instantly called Kimberly Clark where we purchased our drape from and called my friend Michelle Harwthe who is a sales rep for Kimberly Clark. She explain to me that she had such a hard time with Robin McLeod trying to do In-services but when she introduce the "one step" drape to the VA staff at Ann Arbor she did an in-service on how to wrap trays , how the fold should be and where the flap or tail should be. Everyone wrapped differently besides a few one was Avant Hall whom I had trained at Detroit Medical Center at Receiving Hospital; he had come from a private sector hospital. When this tray was wrapped the wrap only ended half across the tray and not to the end of the complete tray and they would put a dusk cover sealed on it but the drape was not sterile because it did not completely complete the wrapping process. Also the items that were sent to the clinics and floors were not covered the people who picked it up carried it in their arms under their arms or however they could transport it. The proper way to transport these items was to be place in a sealed dusk cover bag to prevent contamination from being transported through the hallways. This refers back to the training process and the knowledge of what you are doing and or the rational of why.

Allegation # 3

Instruments needed for Emergent procedures or situations were unavailable. When I made this statement this is what it detailed; There is a Lead tech in the assembly area that they interviewed named Thomas Scanlon who's job title means that he has proven the ability to be competent in all areas of the Sterile Processing. He also has proven the ability to prioritize and make decisions when needed he directs the work flow but also be a team player and help out with the processing of trays , putting loads in the sterilizer if needed, and working in the Decontamination area or even helping with peel packaging of items when needed. This is what a Lead tech represents not just delegating, but also being part of the team. On several occasion Tom has allowed trays to sit in the assembly/prep area because they were not on the needs list. The needs list is generated by the OR (Operating Room), for cases for the next day. The Sheet arrives in the prep area about 10:00 a.m. in the morning giving the day shift ample time to prepare for the next day's

cases. It is the Lead Techs job to look at the list and also check the cases that were scheduled for the existing day so he could get a clear understanding of what needs to be done. Meaning if they are asking for a Neuro tray and no Neuro cases was done that day this means all of the trays should be on the neuro rack already sterilized, just one example. So with this in mind as the Lead you basically should know all the instruments the OR has, how many they have, and also what trays are used together for a case. So when I mention that there were trays not available when a Veteran came in for an Emergency procedure I was speaking about Neuro trays that were all used on a particular day they had a total of 4 Neuro trays at that time , they did 4 Neuro cases that day. As the Lead tech that has been placed in this role because he has proven his ability to lead should have thought to at least process two of the trays even though they were not on the needs list and would have just been a precautions. He decided not to process the trays so all four were in the prep area. On my way home I received a call from Shamahl Burgess the afternoon lead tech that the OR needed a Neuro set and that all of them were sitting in the prep area unassembled. He stated to me that the OR wanted him to send them the whole tray so it could flash (IUSS) and this was definitely out of the question, according to AORN this should kept at a minimum no more than 3%. I asked him to give me the phone number of the person that was calling and I called them on my cell phone. Because of my experience with instruments as a Sterile Processing Educator and I was a previous Surgical Tech I felt I may be able to trouble shoot and find a way to get them what they needed in a hurry. When I called the OR I asked them what kind of case they were attempting to do and she said Burr-holes/ Craniotomy. I also asked her what instruments did they already have and she expressed that they really only needed a Woodson Elevator, I apologized for the overlook and assured them I would have them something to be able to do the case. I knew That I had recently ordered some Woodson elevators because while doing the QA's (Quality Assurance sheets that comes back from the OR) I notice Woodson elevators missing from trays so I had ordered some to make the trays complete. I called Shamahl back and told him to look in the drawer and get a Woodson elevator and send it to them. This was a delay for the case. The next time a tray was unavailable it was the ReSite tray that it use in conjunction with the Cataract tray, I believe at the time they only had one maybe two, however many they had they or it was sitting in the prep once again unassembled because Tom did not see it on the needs list and did not feel the need to get it process so again I received another phone call from Shamahl Burgess. This time Shamahl expressed to me that the OR had stated that the tray had been down in SPS since 10:30 a.m. that morning and it should have been turned around because it was known that it was one of a kind tray. So in this instance the afternoon shift processed the tray and got it sterilized the OR had to change the time of the case until the tray was ready. This is when these trays were put on the "Hot List". The Hot list was nothing that required an "SOP" because it was a function in Censitrac. The staff was in-serviced on this feature. I called Censitrac and spoke with Shane who helped me to develop and bring out the features of the systems that could help us with our process. I started the "Hot List" to assure that

trays that were one of a kind and trays that were two of a kind would be processed even if they were not on the needs list. That's why I could not understand was why when the instrument trays came out of the Decontamination area they were not scanned into the prep area. Meaning if you were in the OR and you were looking for a tray it may be just sitting in the prep area but in Censitrac would say it was in the washer, this made no sense not to use that function. The "Hot List" was something you turned on and off. If the OR purchase more trays and they were able to do surgeries without having to turn around the trays you could turn it off. If they continued to have one of a kind tray you would leave it on and only Management or the Leads should have control of this function. When the "Hot List" was start it started with Cardio/Thorasic services. A list was provided by the team leader of the service, the SPS's staff was in-serviced and the list of instruments was places in a cover sheet input in the Decontamination Area and the Prep area along with being entered in the computer on the "HOT LIST". Anything on the hot list once scanned in Decontam would notify the staff in the prep/assembly area that there was a "hot item" in decontam. Once it was scanned into the washer it notified the prep/ assembly staff again the tray was in the washer. This message "pop up on the computer screen every time the tray was scanned, that's why I do not know why they did not have the function of scanning the tray off the conveyor to alert that the tray was now in the prep area. The only people who were not aware of this function would have been the people I hired before I was terminated and that would have been Lydia Kaiser and Edward McClenney, because I was not there when they started but I did hire them. Again this is what I mean about training. If you want to know about instruments and delay of cases ask Dr. Josh Miller.

Allegation # 4

The SPS Management team routinely signed off on competencies, without conducting appropriate reviews. I was directed by my Chief Robin Mcleod to sign off on competencies for the staff members in the SPS Department for task I had never seen them perform. When I was told to do this, "Robin informed me that she and Mary has done this for years". As a previous Educator I did not feel comfortable doing this I have always practiced the R.O.T.C practice that involved return demonstration and for the staff member to be able to verbalized what they were doing and why before I would sign off on them. This was not the case at the VA in Ann Arbor as I looked through the files as I was signing off on them this had been done for numerous years and I know Neither Robin McLeod or Mary Lemorie watch them perform them because they had already told me in my interview that that had no knowledge of instruments or SPS Mary was "GIP" and Robin Stated everything she know came from reading the books and the Level I and Level II training but the hired her because she was a RN(Registered Nurse). The Assistant Director came to the department after my termination asking question about the Process and education and Robin had all Files Sent to the off- site warehouse. I sent Don Fisher this information via e-mail prior to them going for the investigation, because I knew they

would not find the files there, but had they checked like I said they would have seen my signature for 2013 competencies, where we both signed and dated. Like I said at the beginning of my statement how could someone employed by the VA actually investigate the VA, It should been an independent investigator. Also I started working in May 2013 how was I able to sign off on 2013 competencies? The staff was informed this year to have their competencies signed off by May 15, 2015 who watched them perform the task? The new staff may have not known that their competencies were being signed but the old staff did they knew they did not sign off on them.

Allegation # 5

How the employees lack the appropriate training to perform their job duties and all areas. Level I and Level II training was find but it was more book knowledge what these people learned in their program if they attended a program. There are no standard training for the department for example how to process a tray. There are no standards that showed you what you should do to begin to process a tray step by step. If it was there would standardization in the area. I watched as the task were performed and I watch people dumping instruments out of the tray that had just come from Decontam they should have learned in their program that dumping instruments may it be in decon or prep can damage the instruments.. People were not drying out the trays assuming the steam from the sterilizer would dry it. They were not putting like instruments together assuring you have all that is needed for the tray. There was no standardization at all no one had been properly trained on how to assemble a tray unless they had come from a private sector hospital that had an Educator that actually showed you the steps where you would first:

1. Dry the tray completely including the casket, the wire basket and the lid.
2. Check the rubber around the lid to make sure it was intake so that the steam would not leak during sterilization.
3. Put the filter in the lid and make sure it was secure.
4. Put your soak sheet / tray liner in the tray along with your integrator this way you know you did not forget it. Because if your integrator was not in the tray the tray is assumed contaminated.
5. Have arrows ready to be inserted at the end of the tray. A tray without the physical indicator is a unsterile tray.

This was the type of training I was talking about. Knowing that the removal of the arrows in decon would prevent the drains in the cart washer from clogging up and causing the case carts not to be properly cleaned. This is information that is not in the VA training but it is departmental training that everyone needs to go through. Each Hospital uses different equipment and some people have not been introduce to all equipment like the Sterrad Machine you had people who came from dental clinics like Trina Corcione who really was not too familiar with her instrumentations but they let her work on Midnights a shift

where there's no Lead or Management so she depends on her co-workers who either does the tray for her under her name in Censitrac or if she is by herself she just leaves it. How over whelming would that be for you to not knowing your instruments, and having to depend on others to your work or being alone and not have a clue. But this is how it was when I got there and she had only been there going on two years. Where I came from Midnights was your strongest shift because whatever didn't get down from the first and second shift, especially specialty sets, had to get done by midnights to assure all of the patients had what they needed for their cases. We had 180 cases a day and processed at least 500-790 trays a day and our Lead tech were able to function in all areas, meaning if you had a Lead in the Prep area and the Lead in Decon was off he/she should be able to go into Decon and delegate or help push the instruments out and vice versa. Ask your Lead in the Prep area Tom to demonstrate to you and function in Decon he cannot. And recently when there were dirty instruments sent up to the OR and the Doctor's threaten to take their Cases to U of M Hospital ask them who was working in Decon Tom. This is How Robin Came back to SPS and They resigned Sharon, It wasn't that Robin knew SPS better than Sharon It was because Robin Kept Janise Jones the Lead in Decon in that area because she knew she was a very detail person who cared about what was sent to the Veterans because she was a Veteran herself, but Robin never acknowledge the fact nor did upper Management they just sent someone away that had 25 years in the VA, talking about control. This lady had just got there she dependent on her leads to be honest and knowledgeable. How did she know that Tom could not perform in Decon or really process trays how was he a Lead according to the lead job description? There was a scope that was sent down to SPS on a Friday and on Monday it was not processed and the Anaesthesia department was really upset. So I know that they have had issues and are still having them. When I was there doing the QA's the mistakes that were being made, I counted every sheet from every case unlike the previous practice of what they were doing when I was hire. There is no way that the OR said they have not been having instruments missing nor wrong I was an Educator for 8 years and there was always a mistake because people are human. I also know that there is no one doing the QA's to report the error rate so how can you really validate if there was an error or not. I do know this the two months that I was in charge of the department the error rate went 7.8 % to 0.68 % check it out for yourself. With all of the call-ins that is very often leaves the areas short staffed and over worked.

Allegation # 6

This should have read, the SPS department was rarely cleaned, leading to an accumulation of dust and dirt in the soiled/clean sterile areas. Also malfunctioning of the equipment all of the time. Let's start with the cleaning, I know they hire disable Veterans for Housekeeping but are they trained on how to clean each area? Some areas they may just have to dust or take out the garbage but with you SPS area it is more detailed. Your SPS area should be cleaned just like your Operating Rooms. You would not miss a day

mopping the OR so why would you miss a day mopping Decontam. I have witness where the tables were moved in Decon but the floors were not mopped. When I came back from Leadership training they told us that all SPS department should have a cleaning schedule that was a hard copy with housekeeping. So when I came back from training I e-mailed Roger Lane and asked him did we have a cleaning schedule, this was not my first time emailing him about the cleaning of the department. He sent a e-mail to Robin Mcleod as if he was upset that I had asked about this and thought that the Lead Janise Jones from Decon had ask me to e-mail him. The reason I ask if the people are trained within an area is because I called one day and there was a large soiled spot in the prep area at the first table/computer on the left side when you walked in the prep area. It was totally discussing this was supposed to be a clean sterile area where the instruments were assembled I gave them the area and description of the soiled area and they assured me it would be taken care of. I was about to go home so when I came in the next day the spot was still there, so I called again. The housekeeping person told me they had mopped the area and the spot was gone. I tried to tell him I was looking at the spot and it had not been touch so the supervisor sent the person over, the man had mopped at the front door when you first enter SPS by the Offices he did not know where the prep area was. How is that on training? There were dust bunnies behind all doors leading into the area where supplies and instruments were kept. The ante-room where the staff gets dress to go into Decontam is hardly ever cleaned and the Decon area is supposed to get stone bleached mopped at least once a week where I came from the Decontam had a terminal cleaning every night. You have to remember it is not like the OR was spraying their instruments so that they did not come down to Decontam soiled. The point of cleaning starts at the point of use. This means there is a step the OR should be doing before the instruments are sent to the Decon area. Were they trained? As a Surgical Tech you must clean your instrument in between use so they should never come down bloody and highly soiled this should be mandatory. But they do not require them to do this. First of all it would extend the life span on the instruments so they would not have to ordered as often, saving money and provide a faster turnaround time on trays. Now lest talk about the equipment that consistently breaks down. This was part of my whistle-blower and it was mentioned on the phone interview but I did not see any details written about it. To have a department functioning correctly you have to have equipment that is not breaking down every other day. If this happens you need to have a skilled person that would get it fix and up and running right away. Well this is not how it works at the VA in Ann Arbor. I went to the extent to tell the investigators where the work orders were kept, in the Assistant Chief Office in the file cabinet to the right in the top drawer on your right hand side is the folder labelled "work orders" so that they could see on their own how often equipment does not work. Obviously they did not checked for them because if they had they would have seen that the cart washer for the same issue was in there at least 4-5 times for the same part. The ETO sterilizers # 5&6 were not working when I got hired and guess what they were not working when I got Terminated the same problem and same part when I walk into the

door was the same Problem when I left. When you call the Bio- med guy Jack Markston, who only worked from 6-2:30, if it was close to 2:00 he would not even answer the phone or wait and call back and say he was about to leave and to call Jerry, an out sourced contracted person. Sometimes when I called he would just come and look at the item and say no I can't fix that you will have to call Jerry an outside contracted person who worked on the equipment. When I have ever had a problem in the private sector and the Bio-med person was gone home we would call the company to trouble shoot the problem. No one ever told me that you could not do that at the VA. Once the lead tech called Getinge about the washer because the door was stuck open and reading a code that we both did not recognized and I assume Janise the lead tech in Decon told Jerry she called and he got mad and ask me did I authorize her to call the company I told him no, but when we called him he told us that he could not come until the next day so she called the company. Robin McLeod came over to the department and said that Janise was not supposed to call the company now the Nursing department had to pay for tech support, I knew this was a lie Jerry had informed her that Janise called and this is how she would fabricate the truth. She must have really thought I had no knowledge of how things work when calling the company for assistance. I don't think he cared to much for Janise because she would call him out on items that he and Jack was supposed to have fixed in her area that would only work while they were standing there and when they left it would stop working again. They had a water spray arm in Decontam to use just in case the cart washer broke down. When the sprayer stopped working it was tagged with the message"Don't use waiting for parts", I know this message was there about three months and neither of the two ever ordered the part. There were times that the scrubber that worked with the ETO sterilizer that would help the gases from the ETO be released into the atmosphere, was to be checked every Monday, this particular equipment had to be filled to a certain level to assure that the ETO sterilizers would be functional. There were many times that Jack Markston would just sign his name and never filled the equipment. This was obvious because the ETO sterilizer would abort meaning any instruments in the sterilizer when it aborted would have to be reprocessed. I could go on about the situation with the equipment and the cleaning but it would take a outside investigation to prove all the facts I had made available. The work orders are not only hard copies they are also in the computer. So for all of the allegations being declared "NOT substantiated is hard to swallow when there is evidence that was not even reviewed correctly or truthful.

I firmly believe that during this "entire investigation team did not follow through on the facts that were presented by me who actually witness everything. The Investigation team made "very little" if any, real efforts to uncover data as they described in their report. when the data was "right at their own finger tips", then to say that everything I as the whistle blower was found to be "Not Substantiated on all allegations is very surprising and untruthful. The real important data was "right there on the computer and on hard copied. I Strongly feel that NO MATTER WHAT, this WB says or suggest, to find and discover the

truth of my complaints will never get the due attention and effort that is needed for justice as long as the people employed by the VA is the investigative team. This report was a clear attempt to destroy the credibility of the Whistle-blower, when in reality the facts were, and still are "obtainable".

Attention to:
President Obama and Congressman Jeff Miller of the VA Oversight Committee, and VA Secretary McDonald, and other members of Congress.

I find that the Whistleblowing Policy and Procedures is "highly" Unethical at best. Allowing for the Agency in question to have their "own people / employees" investigate Whistleblowing Complaints "undermines" the Impartiality and due attention each case deserves, and the Whistle-blower should have. I'm quite sure the U.S. Supreme Court would agree with this conflict of Impartiality being conducted with this set-up, (allowing Federal Agencies to "investigate" themselves). I went to the VA for a Purpose to give back to those who have sacrificed their lives for me and others. There are Veterans that work in the Sterile Processing department that are being treated so unfair and cruel, it really bothered me to watch this type of treatment go on and is still going on. I believe all people should be treated with respect and dignity, this is not happening and I do not understand how one person who that put as a leader that had no knowledge of the area or what it detailed but was an RN (Registered Nurse) continue to be allowed to do the things she has done without an investigation on her (Robin McLeod) and get away with it. Where are the constitutional rights have they fallen at waist side or is there still justice for people like the Veterans and myself who really care and was not there just for a pay check?

If I could make a suggestion that I think would help all of the VA hospitals:
A team of caring, experience individuals which for now I will call the "Task Force" go and spend time at each and every VA and standardized it and make sure that everyone is well trained for the position they hold and they are competent of what/why there are doing this. I've been in the medical field along time working on both sides The OR and the Sterile Processing area and it was really scary the issues I encounter while I work there for that short length of time. I feel had I been able to be there longer than what I was I could have increased the knowledge in both areas and really made a difference, it was already beginning.

I would like to end this with thanks to all the people involved for their efforts, even those employees that find it a "Must", to deny the facts because of fear of Reprisal and or finding out they really are not really competent in their job. No One wants to put their name of "wrong doings found", especially if you want to remain employed with them

(VA). I just hope that you really evaluate the suggestion I made maybe it could help to make a difference on the VA's Future.

Thanks in Advance,
Shelia C. Griffin
5-27-2015