OFFICE OF SPECIAL COUNSEL

RE: OSC FILE 15-5181

Whistleblower Rebuttal 5-31-2016

TO: Lynn Alexander, Attorney Disclosure Unit, U.S Office of Special Counsel

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The Veterans Administration Office of Inspector General fell short, inadequately investigated legitimate concerns and failed to appropriately address my allegations as a whistleblower. In fact, the OIG was deficient and unreasonable in failing to address specifically; the lengthy convoluted competencies, short staffing and whether improper or inadequate processing occurred and endangered the public health and safety. The OIG inspectors substantiated short staffing and acknowledged hiring more full time employee's (FTE) but fails to explain the consequences this had on improperly processing of Reusable Medical Devices (RME) relating to convoluted lengthy competencies that are impossible to follow step by step even in the best situations concerning contamination with bio-burden and infectious diseases in the lesser or in excess scenario before hiring and still current understaffing. The OIG inspectors failed to address minimum time processing of RME and maximum processing of RME, of which there is NEVER a maximum time limit depending on the RME and filthy infectious contamination. The staffing situation had been extremely short for quite some time and because 6-7 FTE's were hired does not address PAST practices.

The "surprise" inspections are never a surprise, as the front office is always aware when inspectors are on site. These surprise inspections have no validity if OIG inspectors didn't stay to witness the totality of processes occurring at that time and throughout any given day. One or two processes, does not a day make! The Sterile Processing staff has been well versed to take their time and do well in the presence of ANY inspections without consequences by the Chief and Assistant Chief. This is not the

norm. Quantity over quality is expected. I have witnessed this on a daily basis. The OIG inspectors implied that I was the only one "cutting corners" and that quantity over quality was never an issue enforced by management. This is an untruth. This is a complete and inadequate explanation as everyone did their best (with the exception of a few lazy employees without integrity) to process items correctly but constantly pressured by management to push the work through. With that said, filthy infectious and not so filthy RME were processed in the same fashion regardless. I am quite sure that contaminated Colonoscopes were reused endangering many patients without proper cleaning and sterilization especially when one (new) person is assigned to that rotation with one helper if lucky. The competencies for these scopes are so lengthy and convoluted that even an experienced person like me would have trouble on a good day. GOD forbid the bad (busy) days.

The OIG Administrative Investigation Board failed to adequately address; staff, changing sworn testimony under oath, weeks later for frivolous reasons, I suspect for reasons in favor of a corrupt management and promised perks again. These staff members who lied and changed testimony, which can be proven, should receive appropriate punishment as the damage has been done because of the false testimony changes. The VA management is so corrupt yet VA OIG stands by the corruption. When the new Secretary of the Department of Veterans Affairs took this office, he promised to change everything for the good and help the Veteran! What happened to this promise? A corrupt VA does not help the Veteran. One corrupted employee leads to more. This needs to stop. My truth is the real truth, I witnessed this.

Thank you once again for giving me the chance to respond to your report.

Respectfully,

Lena Denise Cruz