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United States Senate
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May 20, 2025

Dr. David Walker
VISN 7 Network Director
3700 Crestwood Parkway, NW, Suite 500
Duluth, GA 30096-5585

Dear Dr. Walker,

In January 2022, the Carl Vinson VA Medical Center in Dublin, GA disclosed that 6,600 veterans who underwent surgical procedures at their facility may have been exposed to HIV and Hepatitis due to improper sterilization procedures.[1] The scale and impact of this disclosure was profound, and in response, the VA Office of Inspector General (OIG) conducted an investigation, publishing their findings in a report on March 6, 2024.[1]The report details systemic failures within the facility's sterile processing department from top to bottom as well as a failure on the part the Dublin VA's leadership to quickly address and remedy these serious and well-known patient safety concerns. Based on their investigation, the OIG provided nine recommendations, seven of which were directed at the Facility Director and two of which were directed at you as the VISN Director. As of September 1, the OIG has determined that one facility recommendation remains open.

Unfortunately, within several months of the publication of their March 2024 report, the OIG learned of another serious incident in which a reusable medical device deemed a nonconforming instrument (surgical instruments not safe for use due to pitting, staining, or tarnishing) was used during a patient procedure.[2] On March 6, 2025, the OIG published a second report. [2] Through their investigation, the OIG found at least 800 nonconforming surgical instruments being circulated for regular use in surgical procedures, potentially placing thousands more veterans at risk. Their investigation also revealed a clear continuation of previously identified sterile processing deficiencies that reflected failures at all levels of leadership within the department, facility, and VISN. Based on their investigation, the OIG provided five recommendations, three of which were directed at the Facility Director and two of which were directed at you as the VISN Director. All of these recommendations remain open at the time of this letter.

The severity of these egregious patient safety concerns is self-evident: no Georgia veteran should have to worry about contracting a bloodborne pathogen, such as HIV, when they undergo a surgical procedure at the Carl Vinson VA Medical Center. Yet despite the established existence of these risks and clear recommendations to address them, they continue to persist. VISN and facility leadership has now had over a year to remedy these issues but have failed to adequately address OIG recommendations and find solutions.

It is unacceptable to allow veterans to remain at risk and immediate action needs to be undertaken.

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As such, I ask that you provide a response outlining the steps you have taken to address and implement the following recommendations, particularly those that OIG notes remain open and unaddressed, from both the 2024 and 2025 OIG reports:

- The Carl Vinson VA Medical Center Director ensures applicable staff, such as Sterile Processing Services staff and end users of reusable medical devices, comply with procedures regarding the identification of and disposition of nonconforming surgical instruments. **(2025, open)**

- The Carl Vinson VA Medical Center Director confirms operating room staff completes training regarding the recognition of and procedures for nonconforming surgical instruments. (**2025, open**)

- The VA Southeast Network Director establishes a comprehensive strategy to review patients who may have been affected by the approximately 800 nonconforming surgical instruments to evaluate whether harm occurred, the need for patients to undergo testing or treatment, and the appropriateness of disclosures. **(2025, open**)

- The VA Southeast Network Director evaluates whether administrative action is warranted for employees regarding Sterile Processing Services deficiencies at the Carl Vinson VA Medical Center and takes action as appropriate. (**2025, open**)

- The VA Southeast Network Director provides consultation and oversight to the Carl Vinson VA Medical Center's Sterile Processing Services to ensure implementation of facility-level action plans and sustainability of identified outcomes. (**2025, open**)

- The Carl Vinson VA Medical Center Director ensures that the Sterile Processing Services chief conducts comprehensive staff competency assessments for the reprocessing of reusable medical equipment, and monitors for compliance.

- The Carl Vinson VA Medical Center Director ensures that the CensiTrac Instrument Tracking System is fully implemented, and that training is provided to the CensiTrac coordinator and Sterile Processing Services staff, and monitors for compliance. (**2024, open**)

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- The Carl Vinson VA Medical Center Director evaluates and ensures that Sterile Processing Services maintains a safe and clean environment in all areas where decontamination, sterilization, or clean and sterile storage of reusable medical equipment are performed, and monitors for compliance.

- The Carl Vinson VA Medical Center Director develops an action plan for remediation of the location and use of the training room adjacent to Sterile Processing Services' clean and sterile storage area, and monitors for compliance.

- The Carl Vinson VA Medical Center Director ensures that clinic areas, including radiology, have or share a designated soiled utility room as required by Veterans Health Administration policy, and monitors for compliance.

- The Carl Vinson VA Medical Center Director ensures that Sterile Processing Service standard operating procedures for reusable medical equipment are developed, updated consistent with manufacturer's instructions for use, disseminated, and available at the point of use, and monitors for compliance.

- The Veterans Integrated Service Network Director reviews the facility's Sterile Processing Service water management program and takes action as necessary to ensure compliance with Veterans Health Administration guidance, and monitors for compliance.

- The Carl Vinson VA Medical Center Director ensures that the facility Water Working Group submits critical water system test results to the Veterans Integrated Service Network Sterile Processing Services Management Board, as required, and monitors for compliance.

- The Veterans Integrated Service Network Director ensures all critical water system test results are reviewed by the Veterans Integrated Service Network Sterile Processing Services Management Board, corrective action is taken when appropriate, and all corrective actions are reported to the National Program Office for Sterile Processing, and monitors for compliance.

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Thank you for your attention to this important and urgent veteran safety issue.

Sincerely,

Jon Ossoff
United States Senator

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COMMITTEE ON RULES AND ADMINISTRATION

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