NATIONAL GRIEVANCE
NG-11/06/2020

7H/00395555

Date: November 6, 2020

To: Michael Picerno
Acting Executive Director
Office of Labor-Management Relations
U.S. Department of Veterans Affairs
michael.picerno@va.gov
Sent via electronic mail only

From: Sarah Hasan, Staff Counsel, National Veterans Affairs Council (#53) ("NVAC"), American Federation of Government Employees, AFL-CIO ("AFGE")

RE: **National Grievance against the Department of Veterans Affairs for failure to investigate and report to OSHA COVID-19 employee deaths and hospitalizations**

STATEMENT OF THE CHARGE

Pursuant to the provisions of Article 43, Section 11 of the Master Agreement Between the Department of Veterans Affairs and the American Federation of Government Employees (2011) ("MCBA"), American Federation of Government Employees/National Veterans Affairs Council ("NVAC" or "the Union") is filing this National Grievance against you and all other associated officials and/or individuals acting as agents on behalf of the Department of Veterans Affairs ("Department") for failure to investigate and report to Occupational Safety and Health Administration ("OSHA") those employees who have either died from or been hospitalized due to COVID-19. The Department has also unilaterally changed its policy with respect to VHA Directive 7701 by refusing to initiate a Board of Inquiry ("BOI") to investigate workplace fatalities and hospitalizations unless requested by a facility. To date, the Department has failed to remedy these violations, and as such, continues to violate the Master Agreement and federal law.

Specifically, the Department violated Articles 2, 3, 17, 29, 30, 41, 47 and 49 of the MCBA; 29 C.F.R. § 1904; 20 C.F.R. Part 10; 5 U.S.C. § 7116(a); VHA Directive 7701; and any and all other relevant articles, laws regulations, and past practices not herein specified. The Union specifically reserves the right to supplement this grievance based upon the discovery of new evidence or information of which it is not presently aware, or otherwise, as necessary.

STATEMENT OF THE CASE

Background

Pursuant to VHA Directive 7701, Comprehensive Occupational Safety and Health Program, VISN 10 Network Director initiated a Board of Inquiry ("BOI") to investigate work-related fatalities and hospitalizations resulting from the COVID-19 pandemic. This BOI analyzed data from March 1, 2020 to April 21, 2020 across VISN 10, which it published in a report ("Report") on or about May 27, 2020. (*See* Attachment A, with 4 Exhibits).

According to this Report, the BOI found that 5 employee deaths and 14 hospitalizations were reported within VISN 10's Incident Command Team for this time period, but that the Employee's Compensation Operations and Management Portal ("ECOMP") captured approximately 287 positive employee cases of COVID-19. The Report also found that VISN 10 facilities did not have a defined policy or communication process for reporting COVID-19 positive employees to the Safety Office for reporting and record-keeping purposes. The Report failed to include an analysis of whether facilities in VISN-10 were compliant with OSHA and Office of Worker's Compensation Programs ("OWCP") regulations and standards concerning the reporting of employee deaths and hospitalizations or the timely investigations of the same.

In spite of the BOI recognizing a breakdown in reporting and recording positive employee COVID-19 cases, it concluded that BOIs will not be convened for COVID-19 unless requested. This is both contrary to the plain language in VHA Directive 7701 requiring a BOI to be convened for each hospitalization and fatality, as well as contrary to the OWCP and OSHA regulations that require timely reporting and recording of the same to each respective agency.

While the Report is limited to the BOI initiated in VISN 10, similar violations have been reported at VA facilities around the country. As of the date of this National Grievance, approximately 64 employee fatalities due to COVID-19 have been reported across the Department. The majority of these were not reported to OSHA within 8 hours, as required by OSHA regulations. The majority of these were not immediately reported to OWCP nor was a CA-6 form submitted within 10 days as required by OWCP regulations. As COVID-19 employee deaths and hospitalizations continue to grow, the Department continues to fail to adhere to these reporting requirements on an ongoing basis.

Furthermore, the unilateral modification to VHA Directive 7701 concerning automatic BOI investigations constituted a change affecting employees' conditions of employment that requires advance notification to the Union and an opportunity to bargain. The Department failed to provide the Union notice and an opportunity to bargain over these changes prior to implementation.

Violations

By failing to fulfill its obligations, the Department violated and continues to violate, the following:

- Article 2 of the MCBA: requiring the Department to comply with federal law and regulations;
- Article 3 of the MCBA: requiring the Department to maintain an effective, cooperative labor-management relationship with the Union;
- Article 17 of the MCBA: requiring the Department to afford employees a healthy and safe environment;
- Article 29 of the MCBA: requiring the Department to maintain an effective and comprehensive Occupational Health and Safety Program consistent with OSHA regulations, to conduct a comprehensive analysis of injuries and illnesses at its facilities, and to timely report occupational illnesses or injuries;
- Article 30 of the MCBA: requiring the Department to maintain a healthful working environment and provide employees with preventative health measures;
- Article 41 of the MCBA: requiring the Department to adhere to OWCP regulations to ensure employees are apprised of their rights, provided the proper forms, and to otherwise cooperate with the employee in reporting workplace injuries and deaths;
- Article 47 of the MCBA: requiring the Department notify and bargain with the NVAC President over proposed changes in personnel policies, practices, or working conditions affecting two or more local unions;
- Article 49 of the MCBA: requiring the Department bargain with the Union prior to making changes in conditions of employment;
- 29 C.F.R. § 1904: requiring that the Department keep a record of injuries and illnesses on an OSHA 300 log and to report fatalities within 8 hours;
- 20 C.F.R. Part 10: requiring the Department to immediately report deaths due to work-related injuries to OWCP and to complete and send a CA-6 form within 10 days to OWCP;
- VHA Directive 7701: requiring the Department to initiate a Board of Inquiry ("BOI") that investigates any work-related fatality or inpatient hospitalization of its employees;
- 5 U.S.C. § 7116(a)(1) and (a)(5): requiring the Department to consult and negotiate in good faith with the Union; and
- Any and all other relevant articles, laws, regulations, customs, and past practices not herein specified.

Remedies Requested

The Union asks that, to remedy the above situation, the Department agree to the following:

- Return to the *status quo ante*;
- Rescind the unilateral modification of VHA Directive 7701;

- Fully comply with its contractual obligations under Articles 2, 3, 17, 29, 30, 41, 47, and 49 of the MCBA, its regulatory obligations under 29 C.F.R. § 1904, 20 C.F.R. Part 10, and its statutory obligations under 5 U.S.C. § 7116(a)(1) and (a)(5);
- Distribute an electronic notice posting to all bargaining unit employees concerning the Agency's failure to satisfy bargaining obligations with the Union prior to implementing changes in conditions of employment;
- Agree to comply with any and all other relevant articles, laws, regulations, customs, and past practices not herein specified.
- Agree to any and all other appropriate remedies in this matter.

Time Frame and Contact

This is a National Grievance, and the time frame for resolution of this matter is not waived until the matter is resolved or settled. If you have any questions, please contact the undersigned at the AFGE Office of the General Counsel. The undersigned representative is designated to represent the Union in all matters related to the subject of this National Grievance.

Submitted by,

Sarah Hasan
Staff Counsel, National VA Council
AFGE, AFL-CIO
80 F Street, NW
Washington, DC 20001
Tel: 202-639-6424
Fax: 202-379-2928
hasans@afge.org

cc: Alma L. Lee, President, AFGE/NVAC
William Wetmore, Chairperson, Grievance and Arbitration Committee, AFGE/NVAC
Thomas Dargon, Acting Supervisory Attorney, AFGE/NVAC
Roy Ferguson, Director, Staff Operations, OLMR
Donald Stephens, OLMR
Thomas McGuire, OLMR

Department of Veterans Affairs

Memorandum

Date:

From: Network Director, Veterans Integrated Service Network 10 (10N10)

Subj: Administrative Investigation of Fatalities and Hospitalizations related to COVID-19 within VISN 10

To: Assistant Under Secretary for Health for Operations (10N)

CC: Acting Director, Office of Occupational Safety and Health (10NA5B)
Senior Industrial Hygiene Program Manager, Office of Occupational Safety and Health (10NA5B)
Union Presidents, Veterans Integrated Service Network 10 Facilities

1. As required by appointment memo dated April 20, 2020 the VISN 10 Board of Inquiry submits its report for review.

2. Questions can be referred to Mark Permelia, VISN 10 Captial Asset Manager, Carolyn Gutowski, VISN 10 Occupational Safety and Health Manager, John Elliott, VISN 10 Energy Engineer or Darren Mullins, VISN 10 Environmental Protection Specialist.

RimaAnn O. Nelson

Attachments
Exhibit 1
Exhibit 2
Exhibit 3
Exhibit 4

BACKGROUND

VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, requires that the Network Director initiate a Board of Inquiry (BOI) to investigate work-related fatalities and hospitalizations. This report establishes the outcomes of a BOI convened to investigate all occupationally acquired COVID-19 cases resulting in the hospitalization or death of VISN 10 employees occurring between approximately March 1, 2020 and April 21, 2020. This report includes all elements required in 29 CFR 1960.29.

Board Membership includes:

- Mark Permelia, VISN 10 Capital Asset Manager, BOI Chairperson
- Carolyn Gutowski, VISN 10 Occupational Safety & Health Manager
- John Elliott, VISN 10 Energy Manager
- Darren Mullins, VISN 10 Environmental Protection Specialist

Due to ongoing travel restrictions and social distancing guidelines related to the COVID-19 pandemic, this BOI was conducted virtually, thereby, limiting our ability to conduct direct observations and face-to-face interviews. Although we have attempted to ensure that the data and information used to formulate our conclusions is complete and accurate, informational divides created by our inability to conduct direct observation and interviews has limited our access to complete concise information. Therefore, this report should not be used as the sole resource for decision making. Furthermore, the number of hospitalization and fatality cases evaluated during this investigation represents a small sample size and may not be representative of a larger data set including future cases. Follow-up, investigations and data analysis is suggested if an accurate evaluation would merit additional results.

Despite the above-mentioned limitations the BOI has reviewed the available data and has made recommendations for improvement. Below is the information provided for your knowledge and awareness.

As of May 11, 2020, five (5) fatality and fourteen (14) hospitalization cases related to COVID-19 had been entered in the Employees' Compensation Operations & Management Portal (ECOMP) accident/incident reporting system.

In order to facilitate the BOI, information, not already available in the ECOMP system, information was solicited from each facility via suspense V10-20-48990. The suspense included the following data requests:

1. Completion of a checklist to gather task specific information for each ECOMP case. The checklist used in the solicitation is consistent with the OSHA Rapid Response Investigation tool.

2. Provide a procedural process to ensure that all COVID-19-19 related fatalities and hospitalizations involving employees are reported to the staff responsible for investigating the cases (e.g., OSHA Record Keeper) in an accurate and timely manner.

The BOI team compiled and evaluated the data captured in this investigation in order to determine issues/trends associated with COVID-19 and assist with future prevention at facilities across the network.

Overview

There were 5 deaths and 14 hospitalizations in our network for a total of 19 incidents to be investigated.

Strengths

Many communication tools are used at the VISN 10 facilities: daily huddles, town halls, daily emails, tools provided to Employee Health to assist with OSHA recordkeeping requirements.

OSHA Recordkeeping and Reporting Issues

The BOI utilized the data captured by the VISN 10 Incident Command Team for the purpose of meeting national reporting expectations as the basis for quantifying the number of employees determined to be COVID-19 positive. This data appears to be a summary of all cases of employees who are or were assumed to be COVID-19 positive, the data was not necessarily collected to meet OSHA recordkeeping purposes. This data was compared against the cases entered in the ECOMP system by each facility.

The BOI team found a significant disparity between the number of cases captured by the VISN 10 Incident Command team and the number cases entered into the ECOMP system. As of May 11, the BOI team found that there were 287 COVID-19 positive employee cases whereas only 19 cases were entered into the ECOMP system.

Of these 287 cases, each facility had to determine if these cases were work-related (occupationally acquired) based on OSHA guidelines. The facilities also had to determine if these cases resulted in the employee becoming hospitalized or if the employee became deceased due to COVID-19. Once the site makes these decisions all work-related cases must be entered into ECOMP.

The BOI team suspects that not all cases are adequately assessed and entered into ECOMP making it difficult to determine which cases were work-related and should be further evaluated.

The following challenges have impacted each site's ability to adequately identify and investigate cases where employees are believed were identified as being COVID-19 positive:

1. Determination of work-relatedness and if those cases resulted in a hospitalization or death.

2. Were the cases determined to be work-related placed into ECOMP.

The first challenge is determining if the cases involving hospitalizations and fatalities were work-related tends to be difficult to assess due to several factors:

1. Testing may not have been available

2. Testing may not have been accurate

3. Testing may not have been conducted if an employee was sent home to be self-quarantined

4. An employee may have called in sick and the supervisor may not have communicated with Employee Health or the Safety Office

5. An employee may have acquired COVID-19 through the community

6. It may be difficult to determine how the employee was exposed.

7. Limited ability to conduct contact tracing to determine source of exposure.

8. An employee may have been detailed to another job during the pandemic.

9. Initially, Employee Health was reluctant to provide information due to perceived privacy rules.

10. Not all illness cases in ECOMP are COVID-19, they could be pneumonia or something else.

The second challenge is that cases may not have been entered in ECOMP-for several reasons:

1. An employee may be in the hospital and not able to enter a case

2. An employee may not think of COVID-19 as an injury and not know to enter into ECOMP case for an illness.

3. An employee may not know how to use ECOMP.

As a result of the above-mentioned challenges, reporting of hospitalizations and fatalities has not been consistent resulting in a lag in reporting. This makes it difficult for the facility and the network to investigate incidents in a timely manner to meet OSHA recordkeeping and reporting requirements.

If a facility has not entered a non-recordable case in ECOMP, it is difficult for the VISN to know if a full investigation was conducted to determine work relatedness and recordability. This documentation must be available for OSHA review.

ANALYSIS OF OCCUPATIONAL EXPOSURES

Table 1.

Facility	COVID-19 Positive (as of 5/11/20)	Hospitalization	Fatalities
Ann Arbor	**45**	**3**	**1**
Battle Creek	**21**		
Chillicothe	**10**		
Cincinnati	**25**		

Cleveland	**33**	**1**	
Columbus	**7**		
Dayton	**21**	**1**	
Detroit	**32**	**8**	**1**
Indianapolis	**85**	**1**	**3**
Northern Indiana	**1**		
Saginaw	**7**		

As mentioned above, facilities utilized a checklist like the OSHA Rapid Response Investigation tool to investigate each hospitalization and fatality. The completed checklists along with a summary of responses are attached to this report.

Employees who were hospitalized or died were in various occupations (Medical records technician, Nurse, Social Worker, Echo Technician, Biomedical Specialist, Food Service Worker, Health Technician, MSA, Phlebotomist, Radiology Tech). Nurses were in the majority with 5/19 cases.

It should be noted that some employees were detailed to higher risk positions during the pandemic which may have increased their exposure potential. For example, 2 of the 19 employees were assigned to be Screeners. Although CDC guidance related to personal protective equipment has changed over time, it is important to note that at the time that many of these cases occurred the following conditions existed:

1. These two employees were provided with computer-based training, but it is uncertain if this training was specific to the new position.

2. According to the facility's checklist response, one of the Screeners who died was not wearing face protection while disinfecting temporal thermometers. This case occurred on 3/24/2020.

3. A second Screener who was hospitalized but did not die was wearing a surgical mask. This case occurred on 4/19/2020.

It should be noted that risk / personal protective equipment (PPE) assessments were provided by the facilities. However, many of these assessments may not be specific to all occupations and tasks performed during the pandemic which could lead to potential exposures. It is questionable if employees were made aware of the PPE requirements and were trained or retrained on each specific task when detailed to a different and

higher risk positions. It is believed that computer-based training may not be adequate in these high-risk circumstances, specifically where demonstrated competency cannot be assessed. It is important to note the following:

1. In 10 of the 19 cases, employees used surgical masks only.

2. In 6 of the 19 cases, employees did not use face protection.

3. In 10 of the 19 cases, employees worked with a COVID-19 positive co-worker

4. At most facilities, face-to-face training is only provided for employees fit tested for an N95.

FATALITY SPECIFIC DATA ANALYSIS

There was a total of five (5) COVID-19 related fatalities across the VISN with the following breakdown. See table 1 for detail.

There was no test data available for the five fatality cases at the time of this investigation. Therefore, we are unable to definitively determine if all cases were in fact COVID-19 related. Additional information relevant to the fatality cases includes:

1. 3 of the 5 employees had coworkers that were COVID-19 positive

2. 4 of the 5 employees had patient contact

3. 4 of the 5 Employees were not wearing N95 (but may not have been required based on CDC guidelines or facility risk assessment at time of exposure). It should be noted that CDC guidance has changed over time since the pandemic started.

4. Only 1 of the 5 employees wore an N95 and that employee only wore the respirator when patients were symptomatic

5. 1 of the 5 employees had worked in Cardiology before becoming deceased. Later, 3 other employees in the same work area tested positive for COVID-19. It is unclear what the process was to track and prevent exposure to other employees in their work area.

POLICY/ PROCESS

It was apparent that VISN 10 facilities did not have a defined policy or communication process for reporting COVID-19 positive employees to the Safety Office for reporting and recordkeeping purposes.

RECOMMENDATIONS

1. Ensure that risk and personal protective equipment assessments are specific to occupations and tasks that may have exposure potential. Provide personal protective equipment and training accordingly.

2. Ensure to evaluate risk assessments and ensure that these occupations have adequate engineering or administrative controls, personal protective equipment and/ or training in place.

3. Improve communication between Employee Health and Safety Office.

4. Refine the process to document and investigate future cases during emergent conditions.

5. Enter both recordable and non-recordable cases into ECOMP in order to document decisions made towards recordability and to create a permanent record. Ensure that all illnesses are properly investigated. Clearly state if an employee was hospitalized in the ECOMP system.

6. Ensure that an accurate means of tracking COVID-19 positive employees, hospitalizations and fatalities exists at the facility and share data with the Network 10 Environmental Health and Safety (EHS) staff.

7. Ensure that test results confirming that an employee was COVID-19 positive are communicated to the site's OSHA Recordkeeper to ensure that cases are recorded properly on the OSHA 300 log.

8. Ensure that if an employee has tested or is assumed to be COVID-19 positive, a full investigation is conducted locally in a timely manner, and measures are taken to prevent exposures to the employee's coworkers. Ensure that the investigation process includes an attempt to trace the source of the initial exposure.

9. Since the time of the suspense, facilities have developed a policy or process; however, due to limited time, these documents have not been reviewed by the BOI

10. Facilities should ensure that if employees are detailed to another position that they are retrained on the potential hazards within their new position.

11. Facilities should not rely solely on computer-based training. Training should include a means of assessing competency for PPE use.

GOING FORWARD

1. As the review was conducted virtually and under a time constraint, going forward, the BOI team would like to conduct interviews with Employee Health and Infection Control to further understand the process and assist with improving communications.

2. The VISN 10 EHS staff would like to review the facilities process/ policies and data and create templates for the facilities to use and hare information across the network to prevent employee exposures.

3. Technically, VHA Directive 7701 requires a BOI to be convened for each hospitalization and fatality. Since COVID-19, is an unusual infectious disease and hospitalizations may occur frequently, the BOI team recommends, the facilities report hospitalizations and fatalities related to COVID-19 daily via an Issue Brief, including ECOMP case number and thorough investigation. The BOI team will review the Issue Briefs as they occur. Further BOIs will not be convened for COVID-19 unless requested.

SUSPENSE V10-20-XXXXX

DUE DATE May 13, 2020

DUE TO Mark Permelia, Carolyn Gutowski, John Elliott, Darren Mullins and cc: VISN 10 Actions

RESPONSIBLE PERSON(S) Safety Office with information provided by Employee Health, Infectious Diseases/ Infection Prevention and Worker's Compensation

BACKGROUND

VISN 10 understands that COVID-19 is new and that we are all learning about this virus together. VISN 10 also understands that everyone has responded to this crisis with an all hands-on deck approach and with the veteran and employees at our center. COVID-19 is very unpredictable, and it is of the utmost importance that we gather as much information as possible in order to identify measures that can be implemented to protect our patients, visitors and staff. VISN 10 also recognizes that decisions are made sometimes with little information and as more information becomes available mitigation efforts are made to further protect veterans and employees. VISN 10 appreciates the efforts of all the facilities within our network.

Unfortunately, within our network there has been 5 employee fatalities and some employees who have been hospitalized due to COVID-19.

Facility	Cumulative # Positive	# of deceased from COVID
Ann Arbor	37	1
Battle Creek	9	0
Chillicothe	1	0
Cincinnati	15	0
Cleveland	22	0
Columbus	7	0
Dayton	17	0
Detroit	25	1
Indianapolis	74	3
Northern Indiana	1	0
Saginaw	3	0
VISN Totals as of 4/21/20	211	5

Facilities are required to investigate workplace injuries and illnesses within the medical center and determine recordability on their OSHA logs using OSHA criteria in 29 CFR 1904. This may be slightly different than the criteria used by Infectious Diseases/ Infection Control to determine if the illness is community acquired.

Facilities are required to report fatalities within 8 hours and hospitalizations within 24 hours in accordance with 29 CFR 1904.39

Each injury or illness must be recorded on the OSHA 300 Log and 301 incident report within 7 calendar days of receiving information that a recordable injury or illness has occurred. Since the new E-comp system is reliant upon the employee to enter a 301-incident report, if the 301-incident report is not entered into the E-comp system, facility safety staff may not be aware of the incident. This makes it difficult for the facility safety staff to properly record incidents. A checklist will be provided to assist facilities with investigations. Questions will be derived from OSHA and CDC checklists.

VHA Directive 7700 requires that VISN staff conduct an Accident Investigation Board to review fatalities and hospitalizations. VISN 10 Environmental Health and Safety team will be reviewing information provided to assist with prevention at facilities and across the network. Your cooperation will be appreciated.

ACTION

1) Define a process to establish how safety office will be notified immediately if there is a death or hospitalization due to COVID-19 so that staff can notify OSHA and record the injury w/ in required timeframes on the OSHA log. Including notification to the VISN 10 EHS staff. Submit your process to the VISN EHS Team.
2) Ensure that an OSHA 301 incident report has been entered into the E-comp system for employees who have been hospitalized or died from COVID—19 as soon as possible.
3) Ensure that the investigation is complete within 5 business days and submit ECN case numbers to VISN EHS Team. Once an E-comp case is entered, the facility

safety staff will determine OSHA recordability utilizing OSHA recordkeeping rules and the guidance documents in the reference section. Employee confidentiality is of extreme importance so the names of individuals should not be shared through the VISN Suspense process. Please only provide ECN Case numbers.

4) Edit Column F on OSHA 300 log, starting with the word COVID-19. Also, indicate in column F if the employee was hospitalized.
5) Utilize the excel checklist provided to perform investigations conducted for all employees who were hospitalized or died due to COVID—19. Questions have been obtained from the OSHA Rapid Response Investigation Questionnaire which sites would have to answer if OSHA opened an investigation based on the fatalities or hospitalizations. (To save the file: File, Save As, Excel Macro-Enabled Template (*xltm), Save)
6) Provide Respirator Risk Assessment and PPE assessment related to COVID-19.
7) Provide E-comp ECN and excel questionnaire to the VISN EHS staff within 8 hours for any <u>future</u> fatalities or within 24 hours for any hospitalizations that occur after the date of this suspense.

REFERENCES

1) OSHA guidance recording vs. reporting.

COVID-19
Recordable vs Non-I

OSHA Worker
Exposure Risk to CO

2)

Respiratory
Protection Risk Asse

3) Respirator Protection Risk Assessment Sample
4) https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
5) https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
6) Enforcement guidance

Enforcement Guidance Document

7) OSHA Fact Sheet-HIPPA

OSHA-factsheet-HIPAA-whistle.pdf

8) How we effectively communicate between Employee Health, Safety & Workers Compensation

HOW DO WE EFFECTIVELY COLLAE

9) March 2020 ORK-ECOMP Meeting

March 2020 ORK ECOMP Monthly Me

Send all responses to those in the DUE TO line. Please do not change the email subject line.

CONFIDENTIAL

VISN 10 COVID FATALITY/ HOPITALIZATION EVALUATION QUESTIONNAIRE

Complete one form for each individual employee.
All questions are pertaining to the deceased or hospitalized employee and their work environment at the time of potential workplace exposure.

	ECN:		
#	**QUESTION**	**RESPONSE**	**COMMENTS/ PERSONS INTERVIEWED**
1	Type of Case		
2	Employee's Service		
3	Employee's Department		
4	Employee's Supervisor		
5	Did the employee regularly perform direct patient care, for example, face to face contact with patients for the purpose of diagnosis, treatment and monitoring?		
6	Employee's position		
7	In the 14 days prior to becoming ill with COVID-19, what type of healthcare area did the employee work in? **(SELECT ALL THAT APPLY):**		
8	In the 14 days prior to becoming ill with COVID-19, on which unit types or other locations did the employee work? **(SELECT ALL THAT APPLY):**		
9	Please indicate number of days worked in each category in previous question.		
10	Was a respiratory protection risk assessment completed for employees at risk for exposure to COVID-19? If so, please attach. See attached sample reference document and CDC Strategies for N95 Respirators.		
11	Was a PPE risk assessment completed for employees at risk for exposure to COVID-19? If so, please attach. See attached reference document. CDC Strategies for Face Masks		
12	Were these risk assessments shared with the employees? If so, provide training records.		
13	Were these risk assessments implemented? Describe how in comments.		
14	What guidance did the facility utilize to protect employees against potential COVID-19 exposure? Describe in comments.		
15	Describe any engineering controls in place to prevent or minimize COVID-19 exposure (e.g., negative pressure isolation, Plexiglass counter shields, etc.).		
16	Describe any administrative controls in place to prevent or minimize COVID-19 exposure (e.g., social/physical distancing, temporary processes, etc.).		

VISN 10 COVID FATALITY/ HOPITALIZATION EVALUATION QUESTIONNAIRE

17	Describe any written work rules, policies and procedures related to the employee's COVID-19 exposure and protection.		
18	Has there been any change in workplace procedures, PPE selection/ use/ maintenance or training since the incident? If so, what are they?		
19	List all PPE available to the employee for COVID-19 exposure control.		
20	List the PPE actually used by the employee. Describr PPE and what activities/ procedures the employee used it for in comments.		
21	If PPE was not provided, were any alternative methods utilized? Please describe in comments.		
22	Were there any PPE shortages that affected the ability for the employee to protect him/her while working onsite? If so, please list PPE that was not available and dates of unavailability in comments.		
23	Was disposable PPE re-used? If so, what procedures were followed?		
24	Was outdated/ expired PPE utilized? If so, what procedures were followed?		
25	Was disposable PPE sanitized/ decontaminated? If so, what procedures were followed?		
26	Did other employees who worked directly or in proximity with the employee test positive? Provide ECN for these cases if available.		
28	No. of employees that work in the employee's department?		
29	Had the employee been fit-tested for an N-95 respirator?		
30	When was the employee last fit-tested? Provide date.		
31	Did the employee know what size N95 he/she was supposed to be wearing?		
32	Did the employee know where to get the correct size of N95 mask?		

VISN 10 COVID FATALITY/ HOPITALIZATION EVALUATION QUESTIONNAIRE

33	If the employee was not fit-tested for an N95, was he/she trained and provided a PAPR or another device? Please describe		
34	In the 14 days prior to becoming ill with COVID-19, did the employee have regular close contact with employees who later tested COVID-19 positive.		
35	In the 14 days prior to becoming ill with COVID-19, did the employee enter a patient's room while the patient was present?		
36	In the 14 days prior to becoming ill with COVID-19, did the employee have physical contact with any patient(s)?		
37	In the 14 days prior to becoming ill with COVID-19, did the employee enter the room of a patient (while the patient was present) with any of the following respiratory illnesses (**SELECT ALL THAT APPLY**):		
38	If yes, please indicate how often the employee used the following personal protective equipment upon entering their room:		
39	Gloves		
40	Gowns		
41	Surgical/ Procedure Mask		
42	N-95 Respirator		
43	Powered Air Purifying Respirator (PAPR)		
44	Face Shield or Goggles		
45	Other PPE (list)		
46	In the 14 days prior to becoming ill with COVID-19, did the employee work in area or task in which they had routine exposures to patients and staff? (e.g., screener, etc.)		
47	If yes, please indicate how often the employee used the following personal protective equipment upon entering their room:		
48	Gloves		
49	Gowns		
50	Surgical/ Procedure Mask		
51	N-95 Respirator		
52	Powered Air Purifying Respirator (PAPR)		
53	Face Shield or Goggles		

54	Other PPE (list)		
	Training Information		
55	Provide all training information for the employee regarding PPE use and maintenance. Provide TMS course numbers if applicable. Describe any non-CBT training records.		
56	Provide all additional COVID-19 related training records for the employee. Provide TMS course numbers if applicable. Describe any non-CBT training records.		

Department of Veterans Affairs

Memorandum

Date:

From: Network Director

Subj: Administrative Investigation of Fatalities and Hospitalizations related to COVID-19 within Veterans Integrated Service Network 10

To: Safety and Occupational Health Manager
Energy Manager
Green Environmental Management System Manager

1. You are hereby appointed to a Veterans Integrated Service Network (VISN) 10 Board of Inquiry Per Directive 7701 Comprehensive Occupational Safety and Health Program. Mark Permelia, VISN 10 Capital Assets Manager, has been appointed as Chairperson. This Board shall conduct a thorough investigation into the facts and circumstances regarding potential employee fatalities and hospitalizations to COVID-19 at VISN 10 VA Medical Centers. It is understood that facilities may not be aware of all hospitalizations at this time. It is my expectation that you investigate based on the information provided at the time of the inquiry.

2. In conducting this Board of Inquiry, due to the nature of the virus, investigating potential causes may not be an efficient use of your time, you are to evaluate if there are trends within the facilities, across the Network and potential opportunities for prevention. You are to obtain information by reviewing Occupational Safety and Health Administration (OSHA) Log and Injury reports, interviewing staff, reviewing information related to personal protective equipment and training, referencing policies and gathering relevant information.

3. Due to the Centers for Disease Control and Prevention (CDC) recommendations for social distancing it is not recommended to conduct onsite inspections at this time. If onsite inspections are needed request this through the VISN 10 Deputy Network Director.

4. The following personnel are detailed as staff to the investigation:

- Carolyn Gutowski, VISN 10 Safety and Occupational Health Manager,
- John Elliott, VISN 10 Energy Engineer and
- Darren Mullins, VISN 10 Green Environmental Management System Manager.

5. You may find it necessary to consult with others as needed, such as, VISN 10 Workers Compensation, VISN 10 Industrial Hygienist, VISN 10 Privacy Officer, Employee Health, Infectious Diseases/Infection Prevention, and facility safety staff who manage OSHA recordkeeping.

6. The Board must submit a descriptive report, including all elements required in 29 CFR 1960.29, to the VISN Director, the VA Medical Facility Directors of the facilities which have had a hospitalization or fatality, the applicable Facility Union representatives, and the Deputy Under Secretary for Health for Operations and Management within 30 calendar days and to the Designated Agency Safety and Health Official within 45 days from the date of receipt of this memo.

RimaAnn O. Nelson