



U.S. OFFICE OF SPECIAL COUNSEL

1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

www.osc.gov

The Special Counsel

September 5, 2003

The President
The White House
Washington, DC 20500

Re: OSC File No. DI-01-0828

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting reports provided to this office pursuant to 5 U.S.C. § 1213(c) and (d) by the Honorable Anthony J. Principi, Secretary of Veterans Affairs. The reports set forth the findings and conclusions of the Secretary upon investigation of disclosures of information allegedly evidencing a gross waste of funds, an abuse of authority, and a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veterans Affairs (VA), Veterans Health Administration (VHA), Atlanta VA Medical Center (VAMC), Decatur, Georgia. The whistleblower identified multiple problems with air handler units at the VAMC which he alleged were contributing to the spread of bacteria and causing the circulation of stale air within the facility. He also alleged that a government contractor hired to perform work on heating and cooling systems had been paid for work that was not completed or was not correctly performed.

The whistleblower, Raymond Petted, an Air Conditioning Equipment Mechanic, consented to the release of his name. Mr. Petted's allegations were transmitted to the Secretary of Veterans Affairs for investigation on May 9, 2002. Secretary Principi referred the matter to VHA for an investigation. Secretary Principi sent an initial report to this office on September 10, 2002. In his response, the Secretary indicated that certain allegations of contract fraud made by Mr. Petted were under criminal investigation by the Office of the Inspector General, and, therefore, were not covered by the first report. These allegations were addressed in a second report provided by the agency to this office on June 23, 2003.

Pursuant to our general policy, we provided a copy of the agency's initial report to Mr. Petted for comments. 5 U.S.C. § 1213(e). He provided comments on this report pursuant to 5 U.S.C. § 1213(e)(1), which I am transmitting. However, we did not provide him with a copy of the second report which addressed his allegations related to Georgia Trane. Pursuant to 5 U.S.C. § 1213(f), if evidence of a criminal violation is obtained by the agency and referred to the Attorney General, the report shall not be transmitted to the whistleblower.

We have carefully examined the original disclosures, the agency's responses, and Mr. Petted's comments. Pursuant to 5 U.S.C. §1213 (e)(2), I have determined that the agency reports contain all of the information required by statute and the findings appear to be reasonable.

The Whistleblower's Disclosures

Mr. Petted has worked at the Atlanta VAMC for nineteen years and as a licensed air conditioning equipment mechanic for five years. He alleged that VAMC's air handlers were improperly configured and could endanger the health and safety of patients and staff. He also alleged that one of the air handlers was circulating stale air to patient rooms because the smoke dampers were not functioning properly. Mr. Petted alleged that the poor air circulation may pose a substantial and specific danger to public health.

Specifically, Mr. Petted alleged that air handler unit No. 13, located in the Ambulatory Care building, was installed incorrectly by Brian Keller, Facilities Supervisor, and had been operating in an unsafe condition for three years.¹ Mr. Petted stated that the drain for air handler unit No. 13 did not have a trap or seal, which are necessary to prevent a backflow of sewage air and water. He alleged that this drain configuration violates the manufacturer's specifications and heating, ventilation, and air conditioning (HVAC) codes. Mr. Petted reported that four other air handlers used to be similarly installed, but that the configuration of these units was corrected in anticipation of scheduled inspections.

According to Mr. Petted, when air handler unit No. 13 is functioning properly, the excess water from the air handler unit simply empties into the floor drain without risk of backflow. However, he stated that occasionally someone will leave an outside door open or close the outside dampers, causing the air handler to be improperly vented. He explained that improper ventilation creates a negative pressure vacuum that allows air or water from the sewage line to be sucked into the air handler unit. Although Mr. Petted stated that he has witnessed sewage gas and water being sucked into the air handlers on more than one occasion, the worst incident occurred on March 21, 2001, when air handler unit No. 11, then connected to the sewage line, filled with water and overflowed. He asserted that the air and water being sucked from the sewage line by air handler unit No. 11 was especially dangerous because this particular sewage line drains into the Microbiology Lab located on the floor below.

Mr. Petted stated that even though the air passes through a filter before being circulated by the air handler, the filter is unable to completely remove all of the dangerous microorganisms from the sewage air. Thus, he alleged that the incorrect manner in which air handler unit No. 13 is presently installed, and other air handlers, such as air handler unit No. 11, have been installed in the past, may be contributing to the spread of disease in the VAMC.

¹ He stated that the air handler was originally connected to a separate drain. After this drain backed up, however, Mr. Keller connected the unit to the floor drain, which leads to the sewage system.

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In addition, Mr. Petted alleged that air handler unit No. 2, located in the Nursing Home, is not adequately ventilated, and, thus, may also be contributing to the spread of disease. He alleged that this problem was first brought to his attention approximately two years ago when the Nursing Home Director approached him to inquire whether the air conditioning system might be partly responsible for an unusually high incidence of tuberculosis on the second and third floors of the Nursing Home. He explained that the fire dampers are supposed to be left open to allow fresh air to enter the patients' rooms, while exhausting stale air. Instead, because they remain closed, stale air circulates from room to room, increasing the likelihood that disease will spread among the patients. When Mr. Petted inquired as to why these dampers were closed, he learned that management's reason for keeping the dampers closed is that the electronic controls were vandalized four years ago; consequently, the dampers, which are designed to automatically close in the event of a fire, are unable to do so. Mr. Petted stated that, in order to protect patients from both the spread of disease and the threat of fire, the VAMC should repair the controls so the dampers can operate as designed.

Mr. Petted further alleged that, over the span of several years, the VAMC paid thousands of dollars to contractor Georgia Trane for work that was unsuccessfully completed or never completed at all, amounting to a gross waste of funds. Mr. Petted stated that he first discovered the extent of Georgia Trane's alleged incompetence in 1998 when David Mersch, former Chief Engineer of the Facilities Management Service, assigned him the task of monitoring the contractor's work. Mr. Petted stated that he closely monitored Georgia Trane's work for two years, from 1998 until 2000, and found that a significant portion of the equipment that Georgia Trane was paid to install and maintain either had never been installed or was installed incorrectly and/or was in poor condition. Mr. Petted documented his findings in a report concluding that Georgia Trane did not complete much of the work which they were paid to perform. In response to his findings, Mr. Mersch asked Georgia Trane to repair and correctly install the equipment. Mr. Petted reports that Georgia Trane was unsuccessful in doing so and, in fact, created new problems in the process. Consequently, Mr. Mersch hired a second contractor, Mallory and Evans, to complete the work Georgia Trane had already been paid to perform.

Mr. Petted reports that, in spite of Georgia Trane's incompetence, the VAMC continued to award the company contracts for installing and maintaining air conditioner equipment, until recently when the Facilities Management Service encountered a shortage of funds. Mr. Petted states that the VAMC employees primarily responsible for overseeing and monitoring Georgia Trane's work were Tim Kozak, former Assistant Chief Engineer,² and John Badger,³ former Lead Air Conditioner Mechanic. He alleges that he witnessed Mr. Kozak and Mr. Badger regularly approve invoices submitted by Georgia Trane, knowing that the work had not been successfully completed.

According to Mr. Petted, on May 16, 2000, Mr. Badger abused his authority by asking him to sign documents verifying that Georgia Trane had performed work setting up an electronic

² Mr. Kozak retired from the VAMC in 1999.

³ Mr. Badger retired from the VAMC in 2000.

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building control system, which Mr. Patted knew had not been completed. When Mr. Patted refused to sign, Mr. Badger responded, "You could be in big trouble!" Mr. Patted stated that, because Mr. Badger was responsible for overseeing Georgia Trane's work, he knew or should have known that the work had not been completed. Mr. Patted reported this incident to Mr. Sage, but Mr. Sage did not take any action in response.

The Department of Veterans Affairs First Investigation and Report

Mr. Patted's allegations were investigated by a team of VA employees, which included the Senior Operations Engineer, the Director of Occupational Health Program, a Chief Engineer from another VA Medical Center, and an Electronic Industrial Controls Mechanic. This group conducted interviews with several individuals and reviewed documents related to health and infection within the VAMC. They also re-interviewed six of the individuals on the list to clarify discrepancies, differences in interpretation, and conflicting statements.

The team substantiated Mr. Patted's allegation that air handler unit No. 13 was incorrectly configured. Specifically, the team found that the air handler unit was piped incorrectly without a trap or air gap as required by VA design criteria and the manufacturer's recommendation. The team also discovered that air handler unit No. 11 was also incorrectly configured and, after reporting these findings, the engineering staff began inspecting and modifying air handler unit drains that lacked traps and an air gap. The team reported this matter to VAMC management who took immediate steps to correct the problem.

The team was unable to substantiate Mr. Patted's allegation that improper installation of air handling units may be spreading disease throughout the facility. In order for such a backup of sewage material or gases to occur, the team concluded that multiple unusual circumstances would need to occur simultaneously, making the possibility of a backup remote. Although Mr. Patted reported that he had witnessed a backup of sewage material in air handler unit No. 11, the team was unable to locate any record of unclogging an air handler unit drain. The liquid in the air handler units at the time of the inspection was clear. Moreover, the team reviewed Infection Control Committee and Nursing Home Care Unit (NHCU) Quality Improvement Committee records which supported the determination because there was no incidence of disease consistent with the circulation of air contaminated by microorganisms from sewage. For these reasons, the team concluded that air handler unit No. 11 had not circulated harmful bacteria.

The team was unable to substantiate Mr. Patted's allegation that air handler unit No. 2 was not adequately ventilated because the fire dampers on the third floor were kept permanently closed. The report states that these dampers are part of the system which circulates air to administrative areas, corridors, and bathrooms, but not to patient rooms. Upon inspection, these dampers were open, although the report acknowledged documents showing these dampers had been closed previously. In any event, the team learned that this damper system is part of a smoke control system which has been rendered superfluous by the fire sprinkler system installed as part of a VA system-wide effort. As this project moves forward, most dampers are removed or fixed open, as the damper system has been deemed obsolete for fire/smoke control purposes.

The team was also unable to substantiate Mr. Petted's allegation that poor circulation may have contributed to several cases of tuberculosis. The team reviewed documents from 1997 through 2002. They also interviewed the Infection Control Practitioner/Manager and the NHCU Medical Director. The team concluded that there had been no cases of tuberculosis in the NHCU. Although there had been a case of tuberculosis identified in one hospital employee elsewhere in the facility, there was no evidence that it spread into or through the NHCU.

The Department of Veterans Affairs Second Investigation and Report

The agency failed to substantiate Mr. Petted's allegations of gross waste of funds and abuse of authority. The agency's second report described steps taken to investigate the criminal allegations made by Mr. Petted in connection with the Georgia Trane contracts, which included interviews of the Contracting Officer, Robelto Joshua, and the Contracting Officer Technical Representative, Mike Cox. Mr. Cox stated that VAMC initiated the solicitation to settle with Georgia Trane in October 1999. The report states that a settlement was entered into between VA and Georgia Trane during April 2001 whereby the VA released Georgia Trane of any further responsibility. Mr. Cox certified that Georgia Trane completed the work required of them on April 17, 2001.

The report also states that, on April 23, 2003, the Office of Inspector General presented Mr. Petted's allegations to the U. S. Attorney's Office, Public Corruption and Government Fraud Section, Northern District of Georgia, Atlanta, Georgia. That office declined prosecution. The Affirmative Litigation Division, on April 25, 2003, declined civil prosecution of Mr. Petted's allegations.

The Whistleblower's Comments

After review of the agency's initial report, Mr. Petted disagreed with the agency's determination that air handler unit No. 13 had been fixed. He acknowledged that the agency installed two traps which they claimed met the applicable standards, but stated that he did not believe this correction to be sufficient to prevent the vacuum effect. He reported that on January 13, 2003, Mr. Keller directed that cement be poured into the original air handler unit drain, making it impossible to restore the original and proper configuration.

Mr. Petted also disagreed with the agency's conclusion that sewage had not been sucked into air handler unit No. 11. Mr. Petted pointed out that his allegation that he was exposed to sewage material in air handler unit No. 11 was substantiated by a Hearing Representative for the Director, Officer of Workers' Compensation Programs.

Finally, Mr. Petted disputed the agency's conclusion that it could not affirmatively establish the configuration of the dampers over the past four years, as he had submitted several documents which indicated that the dampers had been closed for an extended period of time.

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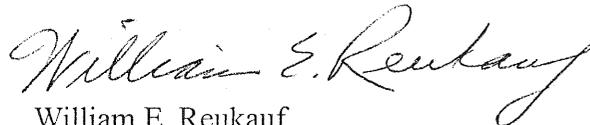
He also expressed concern that, unless the smoke dampers in the air handlers are able to open and close, the new fire suppression system will violate section 2.2(F) of the VA's Fire Protection Design Manual, which requires smoke dampers at air handlers. Although Mr. Petted acknowledged that the agency advised him compliance with this provision was not required, he believes that smoke dampers would enhance the safety systems for the nursing home.

Conclusion

Based on the representations made in the reports and as stated above, I have determined, pursuant to 5 U.S.C. § 1213(e)(2), that the agency's reports contained the information required by the statute and the findings appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of the reports and Mr. Petted's comments to the Chairmen of the Senate and House Committees on Veterans' Affairs. We have also filed a copy of the first report and Mr. Petted's comments in our public file and closed the matter. The second report contained information related to criminal allegations which were referred to the Attorney General and, pursuant to statute, has not been included in the public file.

Respectfully,



William E. Reukauf
Acting Special Counsel

Enclosures