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Analysis of Disclosures, Agency Investigation and Report, and Whistleblower Comments

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Summary

Albert Hurley, Licensed Master Electrician, disclosed to the Office of Special Counsel (OSC) a potential health hazard at the U.S. Department of Health and Human Services (HHS), National Institutes of Health (NIH), National Institute of Allergy and Infectious Diseases (NIAID), Rocky Mountain Laboratories, Hamilton, Montana. Specifically, he alleged that a door to a high containment laboratory cannot close properly due to a chronic airflow problem, leaving employees in the building at risk of exposure to dangerous microorganisms.

The HHS Office of Inspector General (OIG) investigated Mr. Hurley's allegations. The investigation substantiated Mr. Hurley's allegation that the door in Building 25, Suite D did not function properly for an extended period of time; however, the OIG found that NIAID repaired the door after the Centers for Disease Control and Prevention (CDC) performed an inspection and issued a citation. The agency concluded that, prior to being repaired, the malfunctioning door did not pose a substantial and specific danger to public health, but may have presented a potential risk to security.

The Whistleblower's Disclosures

Mr. Hurley, who has consented to the release of his name, has worked as an electrician for 20 years. He has worked for the NIH Rocky Mountain Laboratory for 11 years.

Mr. Hurley alleged that an airflow problem at the Biohazard Level 3* laboratory in Building 25 posed a danger to public health. He advised that scientists in this lab conduct research on several contagious, dangerous diseases, including tuberculosis and mad cow disease. According to Mr. Hurley, the doors to this lab did not close properly, thereby posing a risk that employees working elsewhere in the building could become infected. Mr. Hurley asserted that the lab doors did not close properly because of an airflow problem in the lab. He advised that he checked the lab's airflow log book, and the entries showed that the airflow measurements deviated significantly from standard requirements. Mr. Hurley also stated that the scientists working in the lab repeatedly expressed concern to him that the doors did not close properly.

* The CDC categorizes various diseases into Biohazard Levels (BLs) 1 through 4, with "BL 1" signifying minimal risk, and "BL 4" signifying extreme risk.

According to Mr. Hurley, management officials were aware of the problem, but they had not taken adequate steps to correct it. He stated that the individuals responsible for adjusting airflow in the lab, Clyde Truex and Kevin Mora, attempted to remedy the situation, but, at the time of his disclosure, they had been unsuccessful. Mr. Hurley noted that Mr. Truex and Mr. Mora are not licensed HVAC technicians. He strongly suggested that the agency procure the services of a licensed HVAC technician to assess the situation and resolve problem.

Department of Health and Human Services Investigation and Report

The HHS OIG investigated Mr. Hurley's allegations. According to the agency report, the investigators interviewed Mr. Hurley, other NIAID employees, Office of Research Facility (ORF) employees, and representatives from the CDC – Select Agent Program.

According to the agency report, Dr. Nancy Palme Hoe, Biosafety Officer, informed investigators that the malfunctioning door in Building 25, Suite D, could not close properly because too much negative airflow rushed into the laboratory. She also expressed the opinion that the malfunctioning door did not create a health hazard because the negative airflow prevented the escape of airborne contaminants from the laboratory suite.

Gregory Raymond, Senior Research Assistant, testified that the door to Suite D has not worked properly since Building 25 first opened. He advised that he made numerous requests to maintenance, yet they never succeeded in repairing the door. In order to address the problem, he instituted a new standard operating procedure that required employees to manually close the door behind them to ensure that it was closed properly and securely. Mr. Raymond opined that the malfunctioning door did not create a danger to public health. He explained that Bovine Spongiform Encephalopathy (BSE), commonly known as Mad Cow Disease, is stored in Suite D, but BSE is not airborne and is only transmitted by being ingested. Nevertheless, Mr. Raymond did express concern that the malfunctioning door posed a security risk.

The report states that, on January 11, 2006, Brian Satterfield, CDC Inspector, conducted an on-site inspection. Mr. Satterfield found that the door to Suite D was not self-closing, and he issued NIAID a citation, finding the laboratory to be in violation of Biosafety in Microbiological and Biomedical Laboratories (BMBL), page 33, section (D), subsection (1). This provision requires BL3 laboratories to maintain two self-closing doors between the laboratory itself and outside areas and corridors. Dr. Richard Henkel, CDC Occupational Health and Safety Manager, explained that the CDC's primary concern was that the malfunctioning door posed a potential security risk that an unauthorized individual could access the secured laboratory suite.

The CDC citation notice granted NIAID 14 calendar days to correct the deficiency. According to the agency report, the door was subsequently repaired to the satisfaction of the CDC, and the CDC closed out its inspection. Randy Williamson, Maintenance Unit Supervisor, ORF, stated that Clyde Truex, Air Conditioning Mechanic, and Kevin Mora, Facility Containment Specialist, examined the door and determined that the TSI controller was not functioning properly. He advised that the TSI controller is a sensor that is supposed to control the differential air pressure in the laboratory suite. Mr. Williams stated that Mr. Truex and

Mr. Mora replaced the door's TSI controller, and the door now closes securely. All of the witnesses expressed satisfaction with the current working condition of the door.

The agency report concludes that the malfunctioning door did not pose a substantial danger to public health. The investigators noted that the research scientists working with the pathogens utilized biosafety cabinets, which provided an extra measure of protection from contamination. They also found that the negative airflow in the suite prevented contaminants from escaping the laboratory suite. The report further states that, although the CDC inspectors found that the malfunctioning door created a security vulnerability, there was no evidence that a security breach had actually occurred. Lastly, the report states that any security risk that may have existed has now been eliminated because the door has been repaired and now functions properly.

The Whistleblower's Comments

Mr. Hurley commented on the agency report. He asserted that the agency report misquotes him and takes several of the statements he made out of context. He complained of widespread cronyism and favoritism at Rocky Mountain Laboratories.

Conclusion

Based on the representations made in the agency report and Mr. Hurley's comments, I have determined that the agency report contains all of the information required by statute and findings of the agency head appear to be reasonable.