



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

November 28, 2022

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-22-000099

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the U.S. Department of Veterans Affairs (VA) in response to the Special Counsel's referral of disclosures of wrongdoing at the VA Connecticut Healthcare System, West Haven Campus (West Haven VA), West Haven, Connecticut. The whistleblower [REDACTED], a HVAC Technician who consented to the release of his name, alleged that VA employees engaged in conduct that constitutes a violation of law, rule, or regulation and a substantial and specific danger to public safety. I have reviewed the disclosure, agency report, and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), have determined the report contains the information required by statute and the findings appear reasonable. The following is a summary of those findings.¹

On November 13, 2020, a steam explosion at the West Haven VA killed two employees conducting maintenance on the boiler system. In response, the Occupational Safety and Health Administration (OSHA) issued a "Notice of Unsafe or Unhealthful Working Conditions" to the facility, finding serious, willful, and repeat violations² of occupational safety and health standards for the control of hazardous energy. The West Haven VA was required to abate the OSHA violations by June 29, 2021. [REDACTED] disclosed that West Haven VA leadership failed to abate the OSHA citations or ensure the facility was free from recognized hazards that have and are likely to cause death or serious harm.

The agency substantiated [REDACTED] allegations. The agency found that West Haven VA employees do not follow or document required lock-out/tag-out (LOTO) procedures to control hazardous energy from the main branch steam line and facility steam

¹ The whistleblower's allegations were referred to Secretary of Veterans Affairs Denis McDonough for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The VA Office of the Medical Inspector conducted the investigation, and Secretary McDonough reviewed and signed the report.

² OSHA had previously cited the West Haven VA for violations of these standards in 2015.

³ 29 C.F.R. § 1910.147 and 29 C.F.R. Part 1960.

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stations, nor do they receive adequate training on those procedures. The agency also found that West Haven supervisors at multiple levels, including the Safety Office, failed to monitor and enforce compliance with LOTO procedures.

In addition, employees are not consistently performing periodic inspections or preventative maintenance of energy control procedures for steam stations and other equipment at the facility. The agency found that some safety systems had failed or were inoperative. The agency concluded that these violations of OSHA and VA policy created an environment that may result in serious harm or fatality.

In response, the agency issued 18 recommendations for corrective action to the West Haven VA and Veterans Integrated Services Network 1 (VISN1). The agency recommended the facility immediately address inoperative safety systems and identified steam leaks, and that VISN1 provide support funding to meet the immediate repair needs and ensure work is prioritized to mitigate identified risks as soon as possible. In addition, the agency recommended the facility ensure the Safety Office leads oversight for compliance with LOTO procedures, conducts and documents education on LOTO and other safety procedures, as required by VHA Directive 1810(1), and takes appropriate administrative actions to address leaderships failure to follow policy.

I thank the whistleblower for bringing these significant safety concerns to our attention. In his comments, [REDACTED] noted that he is pleased the agency investigated and substantiated his allegations—but expressed serious concern that the safety hazards at the West Haven VA still have not been remediated. I too am distressed by the continued failure to ensure the facility is safe for employees and veterans. It is unacceptable that life-threatening safety hazards remain in place at the West Haven VA despite numerous calls for the agency to correct them. I intend to follow up with the agency in 60 days on the status of the recommendations to ensure that they are fully implemented.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and whistleblower comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

A handwritten signature in black ink, appearing to read "Henry J. Kerner", with a stylized flourish at the end.

Henry J. Kerner
Special Counsel

Enclosures