



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

June 23, 2015

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

Re: OSC File No. DI-13-3174

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) investigative reports, based on disclosures of wrongdoing at the VA Pittsburgh Healthcare System (Pittsburgh VA), Pittsburgh, Pennsylvania, made to the U.S. Office of Special Counsel (OSC). OSC has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

The whistleblower, John Lesjak, a heating, ventilation, and air conditioning (HVAC) inspector/mechanic, alleged that Pittsburgh VA management neglected the maintenance of critical infrastructure; failed to properly address unsafe conditions that posed health and safety hazards to patients and staff; and failed to adequately manage construction projects performed by contractors, allowing construction to interfere with patient care. Mr. Lesjak consented to the release of his name.

The investigation, while confirming several factual allegations, did not substantiate that Pittsburgh VA management engaged in wrongdoing, or that their actions or inaction created a substantial and specific danger to the health and safety of employees and patients. Nevertheless, the Office of the Medical Inspector (OMI) made several recommendations for corrective actions and improvements in facility maintenance, construction, and remediation. Based on my review of the original disclosure and the agency's reports, I have determined that the reports contain all of the information required by statute and that the findings appear to be reasonable. However, it should be noted that some of the corrective actions that Pittsburgh VA and OMI agreed are necessary have yet to be made, one of which is not slated for commencement until late in fiscal year 2017.

On July 25, 2013, OSC referred Mr. Lesjak's allegations to then-Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. §§ 1213(c) and (d). Secretary Shinseki tasked then-Under Secretary for Health Robert A. Petzel with the investigation in this matter, who in turn directed the OMI to conduct the investigation. OSC received the VA's investigative report in December 2013. In response to OSC's request, the agency provided a supplemental report in March 2015. Mr. Lesjak declined to provide comments on

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the agency reports. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the agency reports to you.¹

I. The Whistleblower's Disclosures

Eradication Procedures Following Outbreak of Legionnaires' Disease

Mr. Lesjak explained that in November 2012, following an outbreak of Legionnaires' disease at the Pittsburgh VA, the Centers for Disease Control (CDC) conducted an investigation at the facility and determined that the potable water system contained a high concentration of *Legionella*, the bacteria that cause Legionnaires' disease. The CDC made several short- and long-term recommendations for eradication and prevention. In late November, Pittsburgh VA managers assembled a group of Facilities Management Service (FMS) employees, including Mr. Lesjak, to conduct heat-and-flush and hyperchlorination procedures on all water pipes and fixtures throughout the facility, as recommended by the CDC. Mr. Lesjak asserted that the procedures implemented were improper, inadequate, and exposed employees and patients to health and safety hazards.

Specifically, Mr. Lesjak stated that the employees were not trained for the heat-and-flush and hyperchlorination procedures, nor were they informed of the potential risks or provided personal protective equipment. Further, due to limitations of the Pittsburgh VA water system, they were unable to attain a water temperature of 160 degrees as recommended by the CDC. For the hyperchlorination procedure, bleach was injected into the water system and flushed from the hundreds of fixtures throughout the facility. Mr. Lesjak noted that the basement room where employees poured the bleach into the water tanks did not provide sufficient ventilation. He further asserted that employees improperly used chlorine test strips to test the chlorine levels and prematurely removed signs prohibiting water use from facility fixtures.

Construction Interference with Medical Procedures and Patient Care

Mr. Lesjak alleged that Pittsburgh VA management failed to provide proper oversight of contractors or coordinate construction activities with medical staff to ensure that patient care was not adversely affected. He explained that the main hospital building had extensive construction projects in progress above, below, and adjacent to the operating rooms where

¹ The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the whistleblower's comments under 5 U.S.C. § 1213(e)(1).

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liver and kidney transplants and heart surgeries are performed. He suggested that surgical procedures be transferred to the University of Pittsburgh Medical Center while the major phase of construction was conducted. Nevertheless, management insisted that surgeries continue during construction. Mr. Lesjak described an incident in May 2013, in which a contractor severed an electrical conduit, causing a power outage in several areas of the hospital for approximately two hours. Lighting and air conditioning were abruptly cut off in two operating rooms during a liver transplant and a heart surgery. Mr. Lesjak noted that the lights, air conditioning units, and extension cords brought into the operating rooms during these surgeries were not sterile. He further contended that management did not alter the construction schedule or take other steps to prevent similar incidents from occurring during the remainder of the construction.

Mr. Lesjak observed other instances of shoddy construction work and poor management of construction activities. In one instance, asbestos abatement contractors left water running in a decontamination shower, causing water to drip down into the kitchen where patient food is prepared. In other instances, Mr. Lesjak observed practices that were not compliant with VA's infection control risk assessment standards.

Failure to Maintain Systems, Correct Unsafe Conditions, and Conduct Required Inspections

Mr. Lesjak explained that a sewage storage tank in the basement of the main hospital building was not properly covered and frequently overflowed, causing raw sewage to accumulate on the floor. The sewage tank is located in the same room as the water storage tank and air handler intake, and is adjacent to the radiation therapy clinic. After staff and patients complained about the odor, management added an exhaust fan and covered the pit; however, these actions did not correct the problems. Mr. Lesjak also reported that a leaking sewage pipe in the mechanical room of the air conditioning shop had not been repaired.

Further, in May 2013, Mr. Lesjak and three other mechanics were tasked to design, engineer, and install the HVAC system for the Quality and Patient Safety office suite. Mr. Lesjak contended that this project should have been performed by experienced contract professionals rather than in-house mechanics. He further noted that work orders for preventive maintenance were delayed while he and the other mechanics worked to complete this project.

Mr. Lesjak also reported that in May 2013, the industrial hygienist discovered that there was no record of an inspection for asbestos in the crawlspace below the main hospital building, as required by Occupational Safety and Health Administration (OSHA) regulations, VA Directives, and other laws. Subsequent testing confirmed the presence of asbestos-containing materials above the regulatory limit in the soil of the crawl space, and abatement procedures were initiated. Mr. Lesjak explained that he spent a substantial amount of time in the crawl space for maintenance work. Pittsburgh VA notified him of the test results and potential exposure in June 2013. He and approximately 40 other employees underwent

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physical examinations and are participating in long-term medical surveillance by the VA to monitor their health for symptoms of asbestosis.

Improper Installation of Underground Water Storage Tanks

Mr. Lesjak disclosed that Pittsburgh VA contracted with Addvetco, Inc., to install two 150,000-gallon underground water storage tanks in order to bring the facility into compliance with applicable standards for water storage capacity. However, Mr. Lesjak alleged that the installation was faulty, and the tanks would have to be removed, properly sealed, and re-installed. He reported, however, that the tanks had not been removed, were inoperable, and no steps had been taken to correct the problem. In the meantime, Addvetco had been awarded and begun work on several additional contracts at Pittsburgh VA.

II. The Agency's Reports

The investigation did not substantiate the allegation that management instructed employees to conduct *Legionella* remediation procedures improperly that posed a safety hazard to staff and patients. OMI found that in response to the CDC's findings and recommendations, Pittsburgh VA shut down the potable water system and began water conservation efforts. The facility activated the Incident Command System (ICS), composed of critical staff, to oversee the matter. OMI found that although the emergency management program manager was a member of the ICS team, the safety manager was not included. The Pittsburgh VA also established a call center and held town hall meetings to respond to questions.

According to the report, the CDC recommended superheating and flushing the water system "and/or" hyperchlorination and flushing. When FMS staff were unable to achieve the CDC's recommended water temperature of 160-170 degrees, Pittsburgh VA leadership and engineering experts opted to initiate hyperchlorination procedures. Engineering supervisors met with the water consulting firm Tetra Tech, Inc., which recommended that the facility follow the hyperchlorination protocols in the OSHA Technical Manual on Legionnaires' disease. Tetra Tech further advised that the safest chlorine delivery method was to add household bleach to the water storage tanks, and recommended using pool and spa test strips to measure the chlorine levels. Tetra Tech assigned three field analysis specialists to be on-site to support VA staff during the process and to confirm and record all data. OMI found that the process implemented by the Pittsburgh VA followed the guidance provided by Tetra Tech.

The report explains that managers met with the employees who volunteered to assist with the procedures and provided an overview of the hyperchlorination process and instructions on the tasks to be performed. OMI confirmed through interviews with employees that most were familiar with *Legionella* prevention and remediation practices, and few expressed concerns about risks. All employees interviewed stated that they were provided an explanation of the tasks and an opportunity to ask questions at the briefing.

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The investigation revealed that although employees receive annual fit-testing and instructions for the use of personal protective equipment, a safety manager was not present during the briefing to provide guidance on safety risks associated with the remediation process. OMI consulted with the VA National Infectious Diseases Service (NIDS) regarding employees' risk of exposure to *Legionella* during the remediation process. NIDS found no reports of Legionnaires' disease in employees conducting remediation in building water systems. NIDS also reviewed numerous sources, including CDC guidelines and the OSHA Technical Manual on Legionnaires' disease, and found no specific guidance on employee protection during *Legionella* remediation procedures for potable water systems.

OMI found that the staff plumber who added the bleach to the water storage tanks wore gloves and a face shield and was held in place at the top of the tanks with a harness. The water level in the tanks had been reduced. The report explains that chlorine vapors are heavier than air, so any fumes would collect in the lower areas of the tank, and the chlorine would be immediately diluted on contact with the water. There was one report of a water splash to an employee's eye after the hyperchlorination process, with no reported sequelae. There were no other reports of eye or nose irritation. OMI found that, except for the few individuals who poured the household bleach and wore gloves and face shields, employees engaged in the flushing process reported no exposure to full-strength bleach.

The report explains that after the chlorinated water was flushed through the water system and adequate chlorine concentration levels were confirmed, the water outlets were turned off and "Do-Not-Use" signs were placed on fixtures throughout the facility for 24 hours, during which time potable water use was discontinued. After 24 hours, distal water samples were re-tested, the chlorinated water was flushed from the system, and EMS staff removed the signs. The water restrictions initially imposed were lifted on November 30, 2012.

The report notes that Pittsburgh VA took additional remedial actions, including adding a chlorine drip in the main system and installation of point-of-use filters and inline filtration products. The facility currently uses inline chlorine analyzers that automatically send high and low chlorine alerts to staff and generate automatic work orders to maintain the proper chlorine levels. The VA's supplemental report confirmed that approximately 2% of nearly 6,000 water samples taken since the 2013 outbreak tested positive for *Legionella*, and only 0.75% had been positive for the species most likely to cause pneumonia. Each time a positive sample was identified, Infection Prevention ordered appropriate remediation.

Although OMI found that the *Legionella* remediation process that Pittsburgh VA implemented was not improper or unsafe, OMI concluded that the safety manager is a valuable resource for evaluating safety risks to employees. OMI therefore recommended that the safety manager be included on the ICS team for any event where employees may have concerns about safety, personal risk, and the need for personal protective equipment. The supplemental report confirmed that, as of November 2014, the safety manager is a member of the ICS team.

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The investigation did not substantiate that management failed to properly supervise and coordinate construction activities to prevent disruption to patient care. OMI confirmed that a loss of power in two operating rooms occurred during a liver transplant and a vascular surgery on May 2, 2013, when a contractor accidentally cut a power conduit. Although normal lighting remained on, emergency power, high-intensity lighting, and air conditioning were interrupted. Ventilators converted to battery power, although anesthesiologists hand-ventilated the patients for approximately twenty seconds. Battery-operated lamps, monitors, and suction units from nearby rooms were wiped with disinfectant and brought into the operating rooms. The nurse manager reported that personnel followed the contingency plans and ensured patient safety. She suggested that battery back-up for the high-intensity lighting would be beneficial. The report states that there were no surgical site infections reported for either patient. The vascular patient was discharged two days later. The liver transplant patient had a complicated post-transplant course and died more than two months later. The facility's review found no evidence that the power outage influenced the patient's outcome. The report notes that the contractor addressed the incident with its employees and provided additional training.

OMI reviewed the facility's Infection Control Construction Permits, Safety Hazard Analysis, Surgical Service Contingency Plan, and weekly safety reports, finding the necessary documentation in place. Further, OMI reviewed the facility's analysis of the incident and planned corrective actions. OMI found that FMS instituted an interim procedure for on-site electricians to support the operating rooms during emergency procedures. FMS also initiated design, contracting, and engineering plans for an electrical upgrade project to provide emergency power redundancy for the operating rooms and reduce the risk of future interruptions. The anticipated completion date for the project was initially July 2014; however, the supplemental report reflects that the project is still in progress.

Further, OMI did not substantiate that water left running by contractors in an asbestos decontamination shower caused a water leak in the kitchen. The report confirmed that the source of water discovered in the kitchen was a slow leak on a new hose bib, or faucet, which was installed to connect a hose to supply water to the renovation project. No running water was found in the decontamination area, which was located approximately 150 feet from the leak source. The contractor cleaned the area, replaced ceiling tiles, and fixed the leaking hose bib. OMI found that no food was affected, and there was no harm or threat to employee or patient safety.

The report further states that OMI did not substantiate that managers neglected the maintenance of various systems and failed to address ongoing problems with an open sewage tank. OMI found that the storm and sanitary drain pit in the basement mechanical room was covered with metal plating and there was little odor at the time of inspection. Documentation reflected that an overflow and flooding of the mechanical room and nearby radiation therapy suite occurred in December 2010 following heavy rainfall. Employees could not recall more than one or two incidents of flooding in the past four years, and none recalled sewage collecting on the floor of the radiation therapy suite. Staff reported an occasional odor every few months, which maintenance staff suggested might coincide with quarterly cleaning.

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There were no reports of patient complaints. The report explains that following the 2010 flooding, Pittsburgh VA took remedial steps to protect the radiation equipment, began cleaning the pit on a quarterly basis, and installed a backflow prevention system in the drains of the radiation therapy suite. As a long-term solution, Pittsburgh VA initiated a project to relocate the storm and sanitary drain pit. With respect to the leaking sewage pipe in the air conditioning shop, OMI found that the necessary parts for the repair were on order.

Although OMI did not substantiate wrongdoing, OMI recommended that Pittsburgh VA reexamine the drain pit relocation project to determine whether it could be prioritized; address the occasional odor emanating from the pit; and confirm the status of the sewage pipe repair. The supplemental report confirmed that FMS had installed a new water and air prohibitive hatch on the drain pit and taken steps to improve the cleaning of the area. It also confirmed that the leaking sewage pipe was repaired. However, the supplemental report states that the project to relocate the drain pit would not commence until completion of other projects in the fourth quarter of fiscal year 2017.

Further, the report confirmed that the HVAC installation project was completed in-house and employees earned overtime while working on the project. OMI found no evidence that work orders or preventative maintenance were delayed due to the project, nor was there evidence to suggest that the project should have been contracted out rather than performed in-house.

With respect to the underground water storage tanks, OMI confirmed that there were construction delays and workmanship issues, which resulted in the contractor's inability to complete the project in accordance with contract specifications. The investigation further substantiated that the tanks were inoperable and the project had not been completed because the coating applied to the tanks was deficient and needed to be replaced with proper coating that met the contract specifications. Completion of the project was expected in December 2013. The report further explains that VA contracts are awarded regionally through the Acquisition and Logistics Program, and that awarding additional contracts to Addvetco during the pendency of the water tank project was consistent with Federal Acquisition Regulation guidance. OMI found that Pittsburgh VA contracting staff had not made entries in the electronic Contractor Performance Assessment Reports System (CPARS) for contractor performance. Thus, OMI recommended that the facility develop a plan to make timely use of the CPARS.

The supplemental report confirmed that the water storage tank installation project was complete. Further, FMS had awarded a new contract to modify the design of the tanks to comply with the new VA Legionella directive. In addition, training on the use of CPARS is complete.

Finally, OMI did not substantiate that management failed to conduct required inspections for asbestos, which resulted in exposing the whistleblower and other employees to unsafe asbestos levels. OMI found that Pittsburgh VA had complied with OSHA, VA and other applicable requirements for conducting surveys for asbestos-containing building

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materials. The investigation revealed that the facility had conducted asbestos abatement of the crawl space in 1989 and the early 1990s. Crawl space soil and air samples taken in 2001 and 2003 were negative for asbestos, and a 2006 survey by a contracted asbestos building inspector did not identify issues in the crawl space. OMI confirmed that in April 2013, soil samples of the crawl space tested positive for asbestos. Employees identified as having worked in the crawl space, including Mr. Lesjak, were notified of the findings, offered a medical evaluation, and have been provided ongoing medical surveillance.

OMI recommended that Pittsburgh VA continue to follow VA's directive governing the Asbestos Management Program and continue medical surveillance of the employees identified as working in the crawl space. According to the supplemental report, Pittsburgh VA established and distributed a revised policy on asbestos management and is continuing the medical surveillance of the affected employees.

III. The Special Counsel's Findings

I have reviewed the original disclosure and the agency's reports. Based on that review, I have determined that the reports contain all of the information required by statute and that the findings of the agency head appear reasonable. This investigation resulted in improvements at the Pittsburgh VA. Of remaining concern is the length of time required to complete the electrical upgrade project for the operating rooms, and to commence the storm and sanitary drain pit relocation project, now slated for late fiscal year 2017. I encourage the VA to review and prioritize these important projects.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports in OSC's public file, which is available online at www.osc.gov.² This matter is now closed.

Respectfully,



Carolyn N. Lerner

Enclosures

² The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.