THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
July 10, 2013

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-12-3232

Dear Ms. Lerner:

I am responding to your letter regarding alleged violations at the Department of Veterans Affairs (VA) South Texas VA Health Care System, Audie L. Murphy Memorial VA Hospital in San Antonio, Texas. These allegations were made by whistleblower (B)(6) [redacted] a maintenance mechanic at the facility, who charged that management had violated procedures governing the safe handling of asbestos-containing materials and failed to provide medical surveillance for employees exposed to asbestos, thereby endangering their health and safety. You asked me to determine whether the alleged misconduct constituted gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety.

I asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under 5 U.S.C. § 1213(d). He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI did substantiate 3 of the 5 allegations made by the whistleblower, but could not substantiate the other 2, and made 16 recommendations for the facility. Findings from OMI's investigation are contained in the enclosed Final Report, which I am submitting for your review.

VA notes that the Veterans Health Administration (VHA) is conducting a system-wide review of asbestos management practices and abatement requirements at its VA medical centers. Based on the results, VHA will identify fiscal year 2014 funds to conduct additional risk assessments, develop more robust operations and maintenance plans, and conduct asbestos containing material abatement activities. In addition, to enhance compliance with not only VHA policy but also Occupational Safety and Health Administration and Environmental Protection Agency regulations, VHA will increase oversight using audits and random site inspections.

Sincerely,

Eric K. Shinseki

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

Report to the
Office of Special Counsel
OSC File Number DI-12-3232

Department of Veterans Affairs
Audie L. Murphy Memorial VA Hospital
San Antonio, Texas

Veterans Health Administration
Washington, DC
Report Date: June 11, 2013
OMI TRIM # 2013-D-510

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

Summary of Allegations

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by (B)(6) [redacted] (hereafter, the whistleblower) at the Audie L. Murphy Memorial Veterans Affairs (VA) Hospital in San Antonio, Texas (hereafter, the Medical Center). The whistleblower, a maintenance mechanic in the Engineering Service's Maintenance and Operations Section (M&O), alleged that the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety in regard to management of asbestos exposure issues. OMI conducted a site visit to the Medical Center on April 23–25, 2013.

The whistleblower alleged that managers at the Medical Center have:

1. Failed to take the appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos;

2. Knowingly ordered employees to perform maintenance tasks that disturbed asbestos containing materials (ACM) without providing appropriate precautions or personal protective equipment (PPE);

3. Failed to inform employees in the adjacent areas of locations and quantity of ACM present in the area;

4. Failed to provide a medical surveillance program for all employees exposed to asbestos at or above permissible exposure limits; and

5. Potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

Conclusions

OMI substantiated the allegation that the Medical Center failed to take appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos.

- In 2005, the whistleblower was identified by an apparent medical surveillance program as having an abnormality on chest radiograph suggesting asbestos exposure. However, the Medical Center failed to properly respond to these findings and to remove him from further potential asbestos exposure.

- The Medical Center failed to correctly interpret the whistleblower's chest radiographs subsequent to 2005. These radiographs taken in 2007, 2009, 2010,

and 2011 were all interpreted as normal. The Medical Center thus missed opportunities in each of these years to respond to the whistleblower's asbestos-related condition and remove him from duties that involved potential asbestos exposure.

- The Medical Center does not have in place a formal method to ensure all three copies of the main hospital building's blueprints used within the M&O are simultaneously updated to reflect all abatements.

- The Medical Center failed to accurately identify all areas with ACM prior to the start of assigned work and did not communicate to all employees involved.

- The Medical Center failed to perform personal air monitoring for any staff involved in the room B700 incident in June 2012, as required by the Occupational Safety and Health Administration (OSHA).

- The Medical Center failed to ensure that staff was provided appropriate PPE (respiratory protection) for the duties assigned.

- The Medical Center is not compliant with portions of 29 Code of Federal Regulations (CFR) § 1910.1001, *Asbestos*; Veterans Health Administration (VHA) Directive 2010-036, *Asbestos Management Plan*; and the Medical Center's Policy Memorandum 007-13-09, *Asbestos Management Plan*, which requires that engineering staff receive annual asbestos awareness training.

- Other employees may have been exposed to ACM during their employment at the Medical Center.

OMI could not substantiate the allegation that VA managers at the Medical Center knowingly ordered employees to perform maintenance tasks that disturbed ACM without providing appropriate precautions or PPE.

- However, supervisory staff are responsible for ensuring the work environment is safe and would be expected to know or be able to obtain information to verify whether an area contains ACM prior to instructing staff to begin work in that area.

- Staff interviewed were not familiar with the process for reporting suspected asbestos exposures to immediate supervisors, the asbestos abatement team (AAT) supervisor, and the Safety Service, as described in Medical Center Policy Memorandum 007-13-9, *Asbestos Management Program*.

OMI substantiated the allegation that VA managers failed to inform employees in adjacent areas of the location and quantity of ACM present in the area.

- The Medical Center failed to notify employees in an adjacent area that sampling for asbestos concentration was planned, or offer employees the opportunity to leave the area while sampling occurred.

- The Medical Center failed to ensure staff were aware the planned sampling was expected to be a negative exposure procedure, requiring no additional precautions.

- It is not clear whether the Contracting Officer Representative (COR) was present when the interactions between contractors and staff occurred in the pump room.

OMI substantiated the allegation that VA managers failed to provide a medical surveillance program for all employees exposed to asbestos at or above permissible exposure limit (PEL). The Medical Center conducted no personal exposure monitoring on persons not on the AAT; therefore, they have no data to determine whether exposure had occurred above the PEL or not. This information is necessary to determine the need for medical surveillance.

- The Medical Center is not compliant with portions of 29 CFR § 1910.1001(d), which requires personal exposure monitoring be conducted to assess the risk and occurrence of exposure for employees whose duties could lead to asbestos exposure. Persons not assigned to the AAT have not been assessed for exposure to asbestos greater than the PEL.

- The Medical Center did not provide medical surveillance since no data were collected to determine whether staff other than the AAT warranted medical surveillance.

OMI could not substantiate the allegation that VA managers potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

Recommendations

The Medical Center should:

1. Remove the whistleblower from any duties that could potentially lead to additional asbestos exposure.

2. Provide the whistleblower with or assist him with obtaining an appropriate occupational health evaluation per his desire.

3. Develop a process for updating all three facility blueprints simultaneously as abatements are completed and documented by the AAT supervisor. Consider converting the blueprints to an electronic document, if possible, to obviate this problem.

4. Implement a formalized process for M&O staff to verify whether an area is known to contain ACM before the start of any work that involves its disruption. This process should include verification by supervisory and non-supervisory staff prior to the initiation of assigned work, providing training about this process, monitoring compliance and addressing non-compliance as indicated.

5. Perform personal air monitoring when appropriate to assess the risk and occurrence of exposure to ACM.

6. Perform job hazard assessments on all M&O work done in areas with known or presumed ACM.

7. Ensure all M&O personnel are provided the proper PPE (respiratory protection) in accordance with OSHA standards.

8. Provide annual asbestos-awareness training as required by 29 CFR § 1910.1001, *Asbestos*; VHA Directive 2010-036, *Asbestos Management Plan*; and the Medical Center's Policy Memorandum 007-13-09, *Asbestos Management Plan.*

9. Perform a retrospective review with all M&O staff for evidence of asbestos exposure; this review should include evaluating the medical records of current and former employees.

10. Provide training about the process for reporting suspected asbestos exposures to the immediate supervisor, the AAT supervisor, and the Safety Service, as described in Medical Center Policy Memorandum 007-13-9, *Asbestos Management Program.*

11. Notify other employees in the area where potential ACM will be disturbed for sample collection prior to the sampling process, and offer them an opportunity to leave the area during that process.

12. Provide staff training about negative exposure procedures, including what qualifies as such a procedure and how that determination is made.

13. Provide training to the COR about the importance of accompanying contractors while material sampling is occurring.

14. Perform personal exposure monitoring on all current M&O staff who could be exposed to asbestos, as required by 29 CFR § 1910.1001, and notify monitored persons of the results on an individual basis.

15. Provide medical surveillance for all staff with exposure levels greater than the PEL.

Summary Statement

OMI's investigation and review of its findings did find violation or apparent violation of statutory laws, rules or regulations, as set forth in 29 CFR § 1910.1001. OMI's investigation and review of its findings revealed evidence of a substantial and specific danger to the health and safety of the M&O employees. OMI believes that the findings above evidence mismanagement.

I. Introduction

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by (B)(6) [redacted] (hereafter, the whistleblower) at the Audie L. Murphy Memorial Veterans Affairs (VA) Hospital in San Antonio, Texas (hereafter, the Medical Center). The whistleblower alleged that the Medical Center may have violated laws, rules, or regulations, engaged in gross mismanagement and an abuse of authority, and created a substantial and specific danger to public health and safety in regard to management of asbestos exposure issues. OMI conducted a site visit to the Medical Center on April 23–25, 2013.

II. Facility Profile

The Medical Center is comprised of 487 beds and provides comprehensive health care with acute medical, surgical, mental health, physical medicine and rehabilitation, geriatric, and primary care services. The Medical Center provides quaternary services including bone marrow transplantation, open-heart surgery, magnetic resonance imaging, and positron emission tomography also includes a Spinal Cord Injury Center, a Community Living Center, a Domiciliary, and a Substance Abuse Residential Rehabilitation Treatment Program. As a Level II Research facility, the Medical Center has more than 600 projects that include aging, cardiac surgery, cancer, and diabetes. The facility has one of three National Institutes of Health sponsored clinical research centers in VA. In addition, the Geriatric Research, Education & Clinical Center is a "Center of Excellence." The Medical Center houses the Veterans Evidence-Based Research Dissemination Implementation Center (VERDICT). VERDICT is one of seven Research Enhancement Award Programs funded by VA's Health Services Research and Development Service. The Medical Center employs more than 3,400 staff, and provides health care services for 80,000 unique Veterans who made over 1,271,000 outpatient visits in fiscal year (FY) 2012. The Medical Center is affiliated with the University of Texas Health Science Center at San Antonio.

The main hospital building was originally constructed in 1974, using construction materials that contained asbestos, and underwent major construction projects in 1982, 1983, and 1989 to renovate and add to the existing structure. Efforts are ongoing to abate asbestos containing materials (ACM) that remain in some areas of the Medical Center.

The Medical Center's Engineering Service is organizationally aligned under the Assistant Director. It is comprised of the following sections: Office of the Chief, Maintenance and Operations Section (M&O), Transportation Department, Biomedical Section, and Design and Construction.[1] The whistleblower works in M&O as a maintenance mechanic.

[1] The M&O Section includes, among others, carpenters, maintenance mechanics, plumbers, pipefitters, electricians, painters, and heating and air conditioner specialists.

III. Allegations

VA managers at the Medical Center:

1. Have failed to take the appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos;

2. Have knowingly ordered employees to perform maintenance tasks that disturbed ACM without providing appropriate precautions or personal protective equipment (PPE);

3. Have failed to inform employees in the adjacent areas of locations and quantity of ACM present in the area;

4. Have failed to provide a medical surveillance program for all employees exposed to asbestos at or above permissible exposure limits; and

5. Have potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

IV. Conduct of Investigation

An OMI team consisting of (B)(6) the Medical Inspector; (B)(6) Special Assistant to the Medical Inspector; (B)(6) (B)(6) Clinical Program Manager; and (B)(6) Office of Occupational Safety, Health and the Green Environmental Management System Program (10NA8), conducted the site visit. OMI reviewed relevant policies, procedures, reports, memorandums, and other documents, a complete list of which is in Attachment A. OMI visited room B700, the pump room, and an active construction project site, and held entrance and exit briefings with the Medical Center leadership.

The whistleblower, accompanied by (B)(6) an American Federation of Government Employees Local 3511 representative, was interviewed during the site visit. OMI also interviewed the following individuals: (B)(6) and (B)(6) painters; (B)(6) and (B)(6) electricians; (B)(6) and (B)(6) carpenters; (B)(6) maintenance mechanic; (B)(6) and (B)(6) engineering employees; (B)(6) Occupational Health physician; (B)(6) reproduction assistant; (B)(6) industrial hygienist; (B)(6) foreman; (B)(6) and (B)(6) air conditioning equipment mechanics; (B)(6) maintenance technician; (B)(6) housekeeping aide; (B)(6) general foreman; (B)(6) safety officer; (B)(6) asbestos abatement team (AAT) supervisor; (B)(6) Chief, Safety Service; (B)(6) Chief, Engineering Service, and (B)(6) Assistant Chief Engineer.

The Office of General Counsel reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI ***substantiated*** allegations when the facts and findings supported the alleged events or actions took place. OMI ***did not substantiate*** allegations when the facts showed the allegations were unfounded. OMI ***could not substantiate*** allegations when there was no conclusive evidence to either sustain or refute the allegation.

V. Findings, Conclusions, and Recommendations

Allegation 1

VA managers at the Medical Center have failed to take the appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos.

Findings

Asbestos is the name given to a group of six minerals that occur naturally as a bundle of fibrous crystals. Asbestos is resistant to heat and corrosion, does not conduct electricity, and when added to many products increase its tensile strength. Asbestos has been used in building products, such as floor and ceiling tiles, cement adhesives for flooring, spackling materials, and insulation of pipes and empty spaces. As a result of health concerns associated with asbestos exposure, the use of ACM for construction was banned in 1979. New production of asbestos was stopped but the remaining stock was permitted to be used. Many buildings constructed up until 1986 were built using ACM.[2]

The mere presence of asbestos in materials is not dangerous until the integrity of the material is disturbed, or the ACM becomes friable.[3] Once ACM is disturbed, the fibers can become airborne and inhaled by those exposed to it. When inhaled, fibers of asbestos tend to accumulate in the lower lobes of the lungs and visceral pleura. There are four main asbestos related diseases associated with inhalation of asbestos fibers: mesothelioma, asbestos related lung cancer, asbestosis, and non-malignant pleural plaque.[4,5] Pleural plaques are the most common manifestation of asbestos-related disease. These plaques are discrete fibrous or partially calcified thickened areas which

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[2] "Asbestos," United States Department of Labor, Occupational Safety and Health Administration (OSHA) http://www.osha.gov/SLTC/asbestos/.

[3] Friable asbestos-containing material: defined by the Environmental Protection Agency (EPA) as ACM with an asbestos content of greater than 1%, that, when dry, can be crumbled, pulverized, or reduced to powder by hand pressure. (http://www.epa.gov/region4/air/asbestos/asbmatl.htm).

[4] Mesothelioma: a rare cancer that affects the covering of the lung or lining of the pleural and abdominal cavities, often associated with exposure to asbestos ("Mesothelioma" National Institute for Health Medline Plus. http://www.nlm.nih.gov/medlineplus/mesothelioma.html).

[5] Asbestosis: a diffuse progressive pulmonary fibrosis of the lungs of varying severity, progressing to bilateral fibrosis, honeycombing of the lungs on radiological view with symptoms including rales and wheezing. (http://www.nlm.nih.gov/medlineplus/ency/article/000118.htm).

can be seen on chest radiographs of individuals exposed to asbestos.[6] Asbestos related diseases are not curable, and require monitoring to facilitate early diagnosis of any respiratory complications and treatment of associated symptoms.

According to the Occupational Safety and Health Administration (OSHA), "there is no safe level of asbestos exposure for any type of asbestos fiber."[7] However, in an effort to minimize the hazards of exposure, OSHA established workplace-permissible exposure limits (PEL) for asbestos in workplace air that is averaged over an 8-hour shift of a 40-hour work week.[8] *See generally* 29 CFR § 1910.1001(d).

OSHA regulations state that it is the duty "of employers and building and facility owners" to "determine the presence, location, and quantity of ACM and/or [presumed ACM] at the work site" - 29 CFR §§ 1910.1001(j)(3)(i).

The current PEL for the workplace is 0.1 fibers per cubic centimeter (f/cc) of air. OSHA requires that employers provide personal exposure monitoring to assess the risk and occurrence of exposure, hazard awareness training for employees whose duties could lead to asbestos exposure. The "Exposure Monitoring" section of OSHA regulations states that "[d]eterminations of employee exposure shall be made from breathing zone air samples that are representative of the 8-hour [time weighted average] and 30-minute short-term exposures of each employee." 29 CFR § 1910.1001 (d)(1)(i).

If an employee is involved in work that will result in the disturbance of ACM, he or she must be enrolled in a medical surveillance program and provided the appropriate personal protective equipment (PPE), including a filtration mask graded for use in areas containing asbestos. This respiratory protection is a full face-piece particulate cartridge fitted with a filter to protect against inhalation of airborne asbestos fibers, and must be fit-tested to ensure an adequate seal of the mask to the employee's face. Employees with exposure as defined above are enrolled in an asbestos medical surveillance program upon hire or when current duties involve asbestos exposure as previously defined. Annual exams are required for the duration of the employment. A termination exam is conducted when asbestos exposure ceases. Appropriate medical oversight includes health and work practices counseling, communication with the safety department if employee knowledge deficits are noted, and referrals for further evaluation if evidence of disease occurs. In the Veterans Health Administration (VHA) it is also common practice to continue to provide periodic exams to employees with a history of exposure to asbestos after their exposure ceases due to the latency of asbestos-related diseases.[9]

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[6] "Pleural Plaque," www. http://radiopaedia.org/articles/pleural-plaque.
[7] Asbestos. http://www.osha.gov/SLTC/asbestos/.
[8] OSHA website http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=9995.

[9] VHA Employee Health Guidebook http://vaww.ceosh.med.va.gov/01HP/02HP_Guidebooks/03_Collections/04HP_OccupationalHealth/COH2009/2009_COH.htm.

Employees who could potentially be exposed to asbestos because of the nature of their work, including those who perform housekeeping duties, are required to receive asbestos-awareness training annually. Employees who perform housekeeping operations in an area that contains or potentially contains ACM also must receive asbestos-awareness training at least once per year, per 29 CFR §1910.1001(j)(7)(ii). VHA Directive 2010-036, *Asbestos Management Plan*, requires "annual awareness training for VHA custodial and facility maintenance staff and supervisors. New employees must receive this training within 60 days of assignment." The Medical Center conducted asbestos-awareness training on May 24, 2012, and a 16-hour asbestos-awareness refresher training in December 2012. According to those interviewed, no prior annual asbestos-awareness training had been provided to staff.

If work is planned in an area believed or determined to be positive for ACM, measures must be taken to abate the area prior to the start of this work. Abatement involves the use of specific standardized procedures to control fiber release from ACM by encapsulation and encasement of the area, and removal of the material in a manner that minimizes exposure. The Medical Center has an in-house, four-person AAT responsible for abatement if ACM is known or discovered to be present in an area where work that might disturb the ACM is scheduled. Abatement for major construction projects is performed by the contractor responsible for the project. Members of the Medical Center's in-house AAT are all licensed by the State of Texas, and certified by the EPA. Since the main hospital building is known to contain ACM, the AAT supervisor is frequently contacted to assess and verify whether a particular area contains ACM. This informal process is utilized mostly by the frontline engineering staff that are completing work orders. If it is determined that the area contains ACM, the AAT will perform the abatement before the assigned work is initiated. The AAT supervisor keeps a log of completed abatements, and updates the building blueprints to reflect these abatements. Three sets of blueprints for the main hospital building indicate where ACM may be present and areas that have been abated. The AAT supervisor maintains one set of these blueprints in his office and updates them as abatements are completed. The other two sets are kept in various places within M&O and are updated on a quarterly basis by the AAT supervisor. The Medical Center has plans for a contractor to survey the entire building and identify all areas with ACM.

The whistleblower has worked at the Medical Center since 1974, with the exception of an 8-year leave of absence for additional education. He has worked as a maintenance mechanic continuously since 1989, performing various jobs throughout the Medical Center that could potentially expose him to ACM. In 2005, he had a chest radiograph taken at the Medical Center apparently as part of a medical surveillance program.[10] This study revealed that he had linear pleural thickening (a pleural plaque) in the right

[10] Although details are few, this program apparently enrolled about 24 employees who were followed until about 2009 when 20 were removed from the program. The only remaining employees in the medical surveillance program from 2009 forward are the members of the AAT.

lung, the presence of which raised the question of asbestos exposure. The whistleblower received four additional radiographs between 2007 and 2011, all of which were done at the Medical Center, and read as "normal" without any reference to the presence of a pleural plaque as noted on the 2005 radiograph. Current Medical Center review of these chest radiographs for OMI reveals that they all contain evidence of the same linear pleural thickening from 2005.

After the OMI site visit, the whistleblower provided OMI with two of his personal documents. One from the Department of Labor (DOL), dated December 18, 2009, stating that he has an asbestos plaque, and a second document, apparently part of a DOL claim, stating that after two medical evaluations (one by a pulmonologist) performed at the request of the DOL, "the evidence at hand is consistent with asbestos plaque related to exposure during federal employment at the Audie Murphy VA Hospital." The whistleblower is currently receiving care from a non-VA provider. The whistleblower also had pulmonary function testing at the Medical Center several times between 2005 and 2011. This along with the repeat chest radiographs would seem to indicate he was in some sort of surveillance program, although no one at the Medical Center currently seems to be aware of this. Because he complained of shortness of breath, the pulmonary function testing he had in 2011 was more extensive than previously; the results show that he has lung changes that may be suggestive of restrictive lung disease.

The whistleblower was involved in an event in June 2012, in which he alleges exposure to ACM in room B700 of the Medical Center. He states he was instructed by his foreman to assist with the work being performed to re-purpose the room, and the work in progress included removal of flooring and baseboards and patching holes in the wall. In order to remove the flooring, a grinder was used to break up the cement mastic, generating airborne dust. The whistleblower observed the work being done and became concerned that this room contained ACM. He mentioned this to his immediate supervisor who was in the work area that day. The supervisor informed him that he did not think ACM was present and that the whistleblower should proceed with his assignment. During that workday, the whistleblower assisted with removal of materials from the area. No personal air monitoring was conducted for the whistleblower or any other staff working in the room at the time. The following day, the whistleblower refused to work in the space because he believed the area contained ACM and was concerned that no steps had been taken to protect the employees working there. The AAT supervisor was on leave that day, so the whistleblower left a voice message for him, requesting an assessment of room B700 for the presence of ACM upon his return the following Monday. On Monday, the whistleblower arrived at room B700 and found that it had been sealed off and bore a sign directing staff not to enter. He later learned that the room contained ACM. He told OMI that no action was taken by management once it had been determined the area did contain ACM. The whistleblower and other staff involved reported they were not wearing the required respiratory protection, had not been fit-tested for the full face mask required when disturbing ACM, and had not been issued such a mask. They also stated that no personal exposure monitoring was

conducted while they were working in this room, so their level of exposure is unknown. With the exception of the AAT supervisor, no staff interviewed by OMI reported receiving any previous personal exposure monitoring. Other staff involved in the exposure in room B700 also reported additional instances in which work was stopped because the presence of ACM was confirmed after the work had been started. They also reported that no follow-up actions were taken by management.

The room B700 event of June 2012 occurred during an OSHA site inspection and was addressed in OSHA's "Notice of Unsafe or Unhealthful Working Conditions" issued on October 24, 2012. This OSHA notice identified nine "Serious" violations that the Medical Center was required to address. Most staff interviewed stated that since the OSHA citations, there is no apparent procedural change in the manner in which ACM is confirmed prior to the start of work. OMI was informed during the site visit that OSHA had accepted the Medical Center's Certification of Corrective Action Worksheet and closed the October 2012 case.

Following the site visit, OMI spoke to another employee of the Medical Center's M&O who retired in 2003 after 25 years of service. He said that he has been diagnosed with an asbestos-related disease and is receiving product liability compensation from the class action lawsuit against asbestos manufactures. He is forwarding his documents to OMI. No documents had been received by the time this report was submitted for approval.

Conclusions

OMI substantiated the allegation that the Medical Center failed to take appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos.

- In 2005, the whistleblower was identified by an apparent medical surveillance program as having an abnormality on chest radiograph suggesting asbestos exposure. However, the Medical Center failed to properly respond to these findings and to remove him from further potential asbestos exposure.

- The Medical Center failed to correctly interpret the whistleblower's chest radiographs subsequent to 2005. These radiographs taken in 2007, 2009, 2010, and 2011 were all interpreted as normal. The Medical Center thus missed opportunities in each of these years to respond to the whistleblower's asbestos-related condition and remove him from duties that involved potential asbestos exposure.

- The Medical Center does not have in place a formal method to ensure all three copies of the main hospital building blueprints used within the M&O are simultaneously updated to reflect all abatements.

- The Medical Center failed to accurately identify all areas with ACM prior to the start of assigned work and did not communicate to all employees involved.

- The Medical Center failed to perform personal air monitoring for any staff working involved in the room B700 incident in June 2012 as required by OSHA.

- The Medical Center failed to ensure that staff were provided appropriate PPE (respiratory protection) for the duties assigned.

- The Medical Center is not compliant with portions of 29 CFR § 1910.1001, "Asbestos;" VHA Directive 2010-036, *Asbestos Management Plan*; and the Medical Center's Policy Memorandum 007-13-09, *Asbestos Management Plan*, which requires that engineering staff receive annual asbestos awareness training.

- Other employees may have been exposed to ACM during their employment at the Medical Center.

Recommendations

The Medical Center should:

1. Remove the whistleblower from any duties that could potentially lead to additional asbestos exposure.

2. Provide the whistleblower with or assist him with obtaining an appropriate occupational health evaluation per his desire.

3. Develop a process for updating all three facility blueprints simultaneously as abatements are completed and documented by the AAT supervisor. Consider converting the blueprints to an electronic document, if possible, to obviate this problem.

4. Implement a formalized process for M&O staff to verify whether an area is known to contain ACM before the start of any work that involves its disruption. This process should include verification by supervisory and non-supervisory staff prior to the initiation of assigned work, providing training about this process, monitoring compliance and addressing non-compliance as indicated.

5. Perform personal air monitoring when appropriate to assess the risk and occurrence of exposure to ACM.

6. Perform job hazard assessments on all M&O work done in areas with known or presumed ACM.

7. Ensure all M&O personnel are provided the proper PPE (respiratory protection) in accordance with OSHA standards.

8. Provide annual asbestos-awareness training as required by 29 CFR § 1910.1001, "Asbestos;" VHA Directive 2010-036, *Asbestos Management Plan*; and the Medical Center's Policy Memorandum 007-13-09, *Asbestos Management Plan.*

9. Perform a retrospective review with all M&O staff for evidence of asbestos exposure; this review should include evaluating the medical records of current and former employees.

Following the OMI site visit, the Medical Center initiated a retrospective review of employees who may have been exposed to asbestos. All engineering staff were provided color-coded drawings of the facility showing areas that possibly contain ACM and those that have been abated. These drawings have also been posted on the M&O bulletin boards. Information sheets about the dangers of asbestos exposure, PEL, exposure monitoring, OSHA standards for asbestos exposure, and additional resources have also been posted.

Allegation 2

VA managers at the Medical Center have knowingly ordered employees to perform maintenance tasks that disturbed ACM without providing appropriate precautions or PPE.

Findings

The whistleblower stated that he was instructed by his foreman to assist with the work being performed to re-purpose room B700, which included removal of flooring and baseboards and patching holes in the wall. In order to remove the flooring, a grinder was used to break up the cement mastic, generating airborne dust. The whistleblower observed the work being done and became concerned that this room contained ACM. He voiced these concerns to his immediate supervisor, who was in the work area that day. The supervisor informed him that he did not think ACM was present and that the whistleblower should proceed with his assignment. Other staff interviewed described additional instances when they inquired about the presence of ACM prior to starting a job, were informed the area contained no ACM, only to be stopped while working in the area, because it was later confirmed that ACM was present. Although supervisors are expected to know which areas contain ACM prior to allowing work to commence, there is no evidence the supervisors knowingly ordered employees to perform work that would disturb ACM without appropriate precautions and protective equipment.

When asked about reporting suspected exposures, none of the staff was able to articulate the process of notifying the immediate supervisor, the AAT supervisor and the

Safety Service, as described in the Medical Center Policy Memorandum 007-13-09, *Asbestos Program Management.*

Conclusions

OMI could not substantiate the allegation that VA managers at the Medical Center knowingly ordered employees to perform maintenance tasks that disturbed ACM without providing appropriate precautions or PPE.

- However, supervisory staff are responsible for ensuring the work environment is safe and would be expected to know or be able to obtain information to verify whether an area contains ACM prior to instructing staff to begin work in that area.

- Staff interviewed were not familiar with the process for reporting suspected asbestos exposures to immediate supervisors, the AAT supervisor, and the Safety Service, as described in Medical Center Policy Memorandum 007-13-9, *Asbestos Management Program.*

Recommendations

The Medical Center should:

10. Implement a formal process for M&O supervisory staff to verify whether an area is known to contain ACM before the start of any work involving the disruption of that area. This process should include verification by supervisory and non-supervisory staff prior to the initiation of assigned work, providing training about this process, monitoring compliance and addressing non-compliance as indicated.[11]

11. Provide training about the process for reporting suspected asbestos exposures to the immediate supervisor, the AAT supervisor, and the Safety Service, as described in Medical Center Policy Memorandum 007-13-9, *Asbestos Management Program.*

Allegation 3

VA managers failed to inform employees in the adjacent areas of locations and quantity of ACM present in the area.

[11] This recommendation applies to this situation but is a repeat of Recommendation #4 above. It was not repeated in the Executive Summary at the beginning of this report.

Findings

The Medical Center's pump room is a large room, approximately 50 feet by 50 feet with about a 20 foot ceiling, containing numerous pipes, some as large as 3 feet in diameter, to transport water and steam to all areas of the Medical Center. Many of the pipes are wrapped in a thermal insulation, some containing ACM, and are so labeled.

The M&O employees interviewed described contractors entering the pump room unaccompanied by a Contracting Officer Representative (COR). The contractors cut into the insulation material of a pipe to obtain samples while the staff members were in an adjacent area of the room. The M&O employees interviewed felt they did not receive adequate information addressing their inquiries of why the contractors were in the pump room. As they were aware that some pipes were wrapped in ACM insulation and labeled with "asbestos" stickers, they voiced their concerns about the dust particles being generated, and contacted the VA Police Service who escorted the contractors out of the area. At no time prior to the sampling were staff informed that contractors would be taking samples for asbestos concentration measurement, told that the sampling was expected to be a negative exposure procedure, or offered the opportunity to leave the area while the sampling was taking place.[12] The M&O staff believed they had been exposed as a result of this sampling.

During the OMI site visit, the Medical Center received a "Notice of Unsafe or Unhealthy Working Conditions" from OSHA about the pump room incident; this notice is considered to be a violation of a "Serious" nature, requiring prompt action (Attachment B).

Additional information from the Medical Center indicated the contractors were given access to the pump room to obtain samples from pipe insulation. While Medical Center leadership stated that contractors were accompanied by the COR, it is unclear where the COR was during the interaction that led to the removal of the contractors from the pump room. The Medical Center's Safety Officer stated this sampling was expected to be a negative exposure event, so no additional precautions were necessary. It is not clear how this determination was made, or why this information was not conveyed to staff in the pump room at the time. OSHA later downgraded this violation to a "Non-Serious" status.

Conclusions

OMI substantiated the allegation that VA managers failed to inform employees in adjacent areas of the location and quantity of ACM present in the area.

[12] Negative exposure procedure: determination that exposure during an operation is expected to be consistently below the PELs. 29 CFR § 1926.1101(b).

- The Medical Center failed to notify employees in an adjacent area that sampling for asbestos concentration was planned, or offer employees the opportunity to leave the area while sampling occurred.

- The Medical Center failed to ensure staff were aware the planned sampling was expected to be a negative exposure procedure, requiring no additional precautions.

- It is not clear whether the COR was present when the interactions between contractors and staff occurred in the pump room.

Recommendations

The Medical Center should:

12. Notify employees in the area where potential ACM will be disturbed for sample collection prior to the sampling process, and offer them an opportunity to leave the area during that process;

13. Provide staff training about negative exposure procedures, including what qualifies as such a procedure and how that determination is made;

14. Provide training to the COR about the importance of accompanying contractors while material sampling is occurring.

Following the OMI site visit, the Medical Center collaborated with VA's Center for Engineering and Occupational Safety and Health for assistance in creating a negative exposure assessment process. Shortly thereafter, the AAT began conducting negative exposure assessments on its projects.

Allegation 4

VA managers failed to provide a medical surveillance program for all employees exposed to asbestos at or above permissible exposure limits.

Findings

The Medical Center is responsible for ensuring employees are not exposed to concentrations of asbestos in excess of the PEL, 0.1 f/cc of air. In order for exposure levels to be determined, personal exposure monitoring must be conducted. OSHA requires that employers provide this monitoring to assess the risk for employees whose duties could lead to asbestos exposure. See 29 CFR § 1910.1001(d)(1)(i) ("determinations of employee exposure shall be made from breathing zone air samples that are representative of the 8-hour time weighted average and 30-minute short-term exposures of each employee.") If work will occur in an area known to contain ACM or

potentially contains ACM, personal air monitoring should be conducted to determine whether the exposure is greater than the PEL. Personal air monitoring is the accepted standard for determining exposure to levels of asbestos greater than the PEL. If this is the case, the employee should receive medical surveillance.

Per OSHA requirements, medical surveillance is clinically focused and includes medical and work histories, physical assessment, and biological testing used for monitoring and analysis. See 29 CFR § 1910.1001.app.I. Medical surveillance includes initial and annual medical history, chest radiograph, pulmonary function testing, and any other warranted tests.

With the exception of the members of the AAT, all staff interviewed reported personal exposure monitoring had not been conducted for them, even though there appears to be at least two confirmed cases of asbestos-related diseases among staff, one being a current employee and the other a retiree (see pages 3 and 4 above). Currently, only members of the AAT are included in the Medical Center's asbestos exposure medical surveillance program. Since there was no exposure monitoring done, the Medical Center has no data to confirm whether exposure occurred above the permissible level.

Conclusions

The OMI substantiated the allegation that VA managers failed to provide a medical surveillance program for all employees exposed to asbestos at or above PEL. The Medical Center conducted no personal exposure monitoring on persons not on the AAT; therefore, they have no data to determine whether exposure had occurred above the PEL. This information is necessary to determine the need for medical surveillance.

- The Medical Center is not compliant with portions of 29 CFR § 1910.1001(d) which requires personal exposure monitoring be conducted to assess the risk and occurrence of exposure for employees whose duties could lead to asbestos exposure.[13] Persons not assigned to the AAT have not been assessed for exposure to asbestos greater than the PEL.

- The Medical Center did not provide medical surveillance since no data were collected to determine whether staff other than the AAT warranted medical surveillance.

Recommendations

The Medical Center should:

[13]Asbestos. http://www.osha.gov/SLTC/asbestos/

15. Perform personal exposure monitoring on all current M&O staff who could be exposed to asbestos, as required by 29 CFR § 1910.1001, and notify monitored persons of the results on an individual basis;

16. Provide medical surveillance for all staff with exposure levels greater than the PEL.

Allegation 5

VA managers potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

Findings

Medical Center employees, patients, and visitors are not allowed in areas where ACM might be disturbed as these areas are restricted, only M&O staff are allowed in these areas. To ensure that asbestos levels remain safe, air monitoring is conducted in areas where ACM will be disturbed because of required work. Per the AAT supervisor, where the planned work will disturb an area known to contain asbestos material, air samples for asbestos concentration are obtained prior to and at the completion of the work. If the presence of ACM is confirmed after work has begun, air samples are only collected after the work is completed.

The lack of consistent ongoing monitoring of at risk areas leads to a lack of data on asbestos levels; however, there is no evidence to support the allegation that all staff, patients, and visitors were potentially exposed to unsafe concentrations of asbestos.

Conclusion

- OMI could not substantiate the allegation that VA managers potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

Recommendation

None

OMI would like to acknowledge and thank the Office of Occupational Safety, Health and the Green Environmental Management System Program (10NA8) and the Office of the Chief Consultant for Occupational Health (10P3D) for their assistance with the site visit and preparation of this report.

Attachment A

Documents Reviewed by the OMI

1. The Code of Federal Regulations 1910, Chapter 20, Subpart Z, Standard #1910.1001 entitled "Asbestos"
2. Veterans Health Administration Directive 2010-036, *Asbestos Management Plan,*
3. Medical Center's Policy Memorandum 007-13-09, *Asbestos Management Plan.*
4. Notice of Unsafe or Unhealthy Working Conditions, Inspection Number 413042
5. Medical Center's Certificate of Corrective Action Worksheet
6. Informal Settlement Agreement Between the Medical Center and OSHA
7. Various electronic and paper communications between the Medical Center and OSHA
8. Engineering staff asbestos awareness training records
9. Annual Workplace Evaluations
10. Project Air Samples Log

Attachment B
Notice from the Department of Labor

U.S. Department of Labor
Occupational Safety and Health Administration

Inspection Number: 799721
Inspection Date(s): 12/20/2012 - 12/20/2012
Issuance Date: 04/19/2013

Notice of Unsafe and Unhealthful Working Conditions

Company Name: Department of Veterans Affairs
Inspection Site: Audie L. Murphy Hospital, 7400 Merton Minton, San Antonio, TX 78229

Notice 1 Item 1 Type of Violation: **Serious**

29 CFR 1910.1001(k)(1): The employer did not maintain all surfaces as free as practicable of ACM waste and/or debris and accompanying dust:

On or about November 30, 2012, employee(s) entering the M003 pump room were potentially exposed to asbestos containing material and presumed asbestos containing material from the deteriorated pipe wrap material and removed insulation left in piles under existing piping in area with piping identified as asbestos containing material.

ABATEMENT DOCUMENTATION REQUIRED FOR THIS ITEM

Date by which Violation must be Abated: 04/29/2013

Kelly C. Knighton, CSP
Area Director