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The Special Counsel

September 10, 2015

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

Re: OSC File No. DI-12-3232

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 South Texas VA Health Care System, Audie L. Murphy Memorial VA Medical Center (Medical Center), in San Antonio, Texas, made to the 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, a maintenance mechanic at the facility, alleged that management violated procedures governing the safe handling of asbestos-containing materials and failed to provide medical surveillance for employees exposed to asbestos, endangering their health and safety. The whistleblower consented to the release of his name for the purpose of investigation of the allegations. Because the report contains information regarding his personal medical condition, he subsequently requested anonymity.

The investigation found violations of laws, rules, or regulations, and evidence of a substantial and specific danger to the health and safety of the maintenance & operations (M&O) employees. The VA's Medical Inspector, who conducted the investigation, concluded that the findings evidence mismanagement. The Medical Center failed to take appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos, failed to inform employees of the location and quantity of asbestos containing materials in the area, and failed to provide a medical surveillance program for all employees exposed to asbestos at a level greater than the permissible exposure limit. The investigation could not substantiate[1] that VA managers at the Medical Center knowingly ordered employees to perform maintenance tasks that disturbed asbestos containing materials without providing appropriate precautions or personal protective equipment, or that VA managers potentially exposed all Medical Center employees, patients, and visitors to

[1] According to the report, the Medical Inspector *substantiated* allegations when the facts and findings supported the alleged events or actions took place. The Medical Inspector *did not substantiate* allegations when the facts showed the allegations were unfounded. The Medical Inspector *could not substantiate* allegations when there was no conclusive evidence to either sustain or refute the allegation.

unsafe conditions. At OSC's request, and based on the whistleblower's comments, the VA conducted a follow-up site visit to investigate additional concerns and ensure that all the original recommended corrective actions were completed. The supplemental report confirmed that all corrective actions have been completed, and also made six new recommendations, which the facility agreed to implement. I have determined that the agency report contains all of the information required by statute, and that the VA's findings appear reasonable.

The whistleblower's allegations were referred to then-Secretary Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Shinseki submitted the agency's report on July 10, 2013, based on an investigation conducted by the VA's Office of the Medical Inspector. The VA submitted a supplemental report dated May 30, 2014, and a second supplemental report dated May 22, 2015. The whistleblower provided comments on the original report on June 25, 2014, but declined to comment on the supplemental reports. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports to you.[2]

I. The Whistleblower's Disclosures

The whistleblower alleged that VA management officials:

- Failed to take appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos;
- Knowingly ordered employees to perform maintenance tasks without appropriate precautions or personal protective equipment, which disturbed asbestos containing materials;
- Failed to inform employees in adjacent areas of the location and quantity of asbestos containing material present in the area;
- Failed to provide a medical surveillance program for all employees exposed at or above a permissible exposure limit; and
- Potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

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[2] The Office of Special Counsel (OSC) is authorized by law to determine whether a disclosure should be referred to the involved agency for investigation or review, and a report. OSC may refer allegations of 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 or safety. 5 U.S.C. § 1213(a) and (b). Disclosures must include information that aids OSC in making its determination. Disclosures must include information sufficient for OSC to determine whether referral is warranted. OSC does not have the authority to investigate disclosures and therefore, does not conduct its own investigations. 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). 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 comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The whistleblower has worked as a maintenance mechanic at the Medical Center since approximately 1990, and prior to that as a janitor since 1974. He alleged that despite their knowledge of asbestos containing materials, including in ceiling tiles and interstitial spaces, supervisors directed employees to perform tasks in the contaminated spaces without precautions or personal protective equipment. On October 25, 2012, the Department of Labor, Occupational Safety and Health Administration (OSHA) issued a report confirming employee exposure to airborne concentrations of asbestos at levels that constitute unsafe and unhealthful working conditions. OSHA's report identified numerous violations of OSHA regulations, categorized as "Serious," and set deadlines for abatement.

As of the date of OSC's referral, the whistleblower reported that the agency had not taken sufficient action to protect employees from the hazards known to exist at the Medical Center. Such actions include posting signage, notifying employees of the potential for exposure, and providing a medical surveillance program for all employees who were exposed at or above a permissible exposure limit. The OSHA report specifically cites annual incidents from 2008 through 2012, and between June 11 and June 15, 2012. OSHA found that in each of the years between 2008 and 2012, engineering service employees, including HVAC workers, plumbers and pipefitters, carpenters, and maintenance workers, were exposed to airborne asbestos fibers. During the June 2012 incident, the whistleblower and other employees were directed to remove cove base, brackets, carpeting, and/or floor tiles that contained asbestos, or that disturbed asbestos during removal. They were not notified of asbestos hazards or offered personal protective equipment. After the whistleblower complained to his general foreman and to the chief of safety, and after the work was completed, the room was sealed and marked as containing asbestos. Employees left tools in the room and were not permitted to return for two months.

The whistleblower reported that on a daily basis, he and other Maintenance Division employees, as well as plumbers, pipefitters, and air conditioning mechanics, were directed to perform activities that disturbed areas known to be contaminated with asbestos containing materials. He was regularly asked to remove ceiling tiles, work in interstitial spaces, and drill into drywall. He and other employees were directed to dispose of construction debris in regular trash dumpsters. None of the employees was offered personal protective equipment. Although asbestos abatement was ongoing at the Medical Center, the whistleblower reported that signage was posted only in the areas in which abatement was occurring. He believed that all Medical Center employees, patients, and visitors were potentially exposed to unsafe concentrations of asbestos.

The whistleblower reported that as of December 2012, similar incidents occurred, including during the week of December 3–7, 2012. During that week, the whistleblower entered into the men's changing room on the surgical ward and found a maintenance mechanic cutting into the drywall to make repairs. The drywall in this area of the Medical Center is known to be contaminated with asbestos, particularly in the joint compound. When the whistleblower questioned the mechanic, he replied that he was acting on his supervisor's directions.

On November 30, 2012, the whistleblower and another employee observed contractors on site and were told by a coworker that the contractors were sampling for asbestos in the pump room. The whistleblower alerted members of the collective bargaining unit and his supervisor. The whistleblower learned that the contractors, without using personal protective equipment or wet methods to limit dust, were engaged in cutting samples from the pipe insulation in the pump room. In addition, there were four employees working in the pump room who were not notified of the sampling. The whistleblower reported that the contractors were peeling off portions of pipe insulation and placing them in plastic bags. The whistleblower asserted that the pump room area is known to be contaminated with asbestos containing material but was not identified by signs. The employees working in the area were not notified either before or after the potential exposure. The safety officer and the assistant chief of engineering were notified and took no action other than observing that the contractor was "just taking samples." No employees were offered medical surveillance or evaluation, according to the whistleblower.

II. The Agency's Report

As more fully discussed below, the investigation confirmed that the Medical Center failed to take appropriate precautions to protect employees performing maintenance from exposure to unsafe concentrations of asbestos.

As background, the report explained that if an employee is involved in work that will result in the disturbance of asbestos containing materials, he or she must be enrolled in a medical surveillance program and be provided the appropriate personal protective equipment, including a filtration mask graded for use in areas containing asbestos. This mask is a full face piece particulate cartridge 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 whose duties could lead to exposure are to be enrolled in an asbestos medical surveillance program upon hire, or when current duties involve asbestos exposure. Annual exams are required for the duration of the employment. A termination exam is conducted when asbestos exposure ceases. The report states that in the Veterans Health Administration, it is also common practice to continue providing periodic exams to employees with a history of asbestos exposure after their exposure ceases due to the latency of asbestos-related diseases.

Employees who could be exposed to asbestos because of the nature of their work are required to receive annual training. The investigation determined that other than two trainings in May and December 2012, no annual asbestos-awareness training had been provided to staff.

The Medical Inspector further found that in 2005, an "apparent medical surveillance program" identified the whistleblower as having an abnormality on a chest radiograph suggesting asbestos exposure. However, the Medical Center failed to properly respond to these findings and remove him from further potential asbestos exposure. Subsequent to 2005, the Medical Center failed to correctly interpret the whistleblower's chest radiographs. Taken

in 2007, 2009, 2010, and 2011, the radiographs were all interpreted as normal. According to the report, 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 investigation also found that the Medical Center did not have in place a formal method to ensure that all three copies of the main Medical Center building's blueprints used within the M&O department are updated to reflect all abatements. Moreover, the Medical Center failed to accurately identify all areas with asbestos containing materials prior to the start of assigned work and did not communicate to all employees involved. The Medical Inspector also found that the Medical Center failed to perform personal air monitoring for any staff involved in the June 2012 incident described above, as required by OSHA. The Medical Center also failed to ensure that staff was provided appropriate personal protective equipment, specifically respiratory protection, for the duties assigned.

The investigation determined that the Medical Center is not compliant with portions of 29 CFR Section 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.* The Medical Inspector also substantiated that other employees may have been exposed to asbestos containing materials during their employment at the Medical Center.

The Medical Inspector substantiated the allegation that VA managers failed to inform employees in adjacent areas of the location and quantity of asbestos containing materials present in the area. The investigation confirmed that the Medical Center failed to notify employees in an adjacent area that sampling for asbestos concentration was planned, or to offer employees the opportunity to leave the area while sampling occurred. Nor were staff made aware that the planned sampling was expected to be a negative exposure procedure, requiring no additional precautions. The investigation could not determine whether or not the contracting officer representative was present when the interactions between contractors and staff occurred in the pump room, in the November 2012 incident.

The investigation substantiated the allegation that VA managers failed to provide a medical surveillance program for all employees exposed to asbestos at or above the permissible exposure limit. The Medical Center conducted no personal exposure monitoring on persons not on the asbestos abatement team; therefore, there is no data to determine whether exposure occurred above the limit or not. This information is necessary to determine the need for medical surveillance. As such, the Medical Center is in violation of 29 CFR Section 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. Only employees assigned to the asbestos abatement team have been assessed for exposure to asbestos greater than the limit. No medical surveillance was conducted, since no data were collected to determine whether it was warranted. The Medical Inspector could not substantiate the allegation that VA managers potentially exposed all Medical Center employees, patients, and visitors to unsafe concentrations of asbestos.

The Medical Inspector could not substantiate the allegation that VA managers at the Medical Center knowingly ordered employees to perform maintenance tasks that disturbed asbestos containing materials without providing appropriate precautions or personal protective equipment. Notwithstanding that finding, the report notes that 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 asbestos containing materials prior to instructing staff to begin work in that area. Staff who were interviewed in the investigation 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*. Following the investigative 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 asbestos abatement team began conducting negative exposure assessments on its projects.[3]

The Medical Inspector made 15 recommendations to the Medical Center, which were accepted. Following the investigative 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 asbestos containing materials and those that have been abated. These drawings have also been posted on bulletin boards in the M&O section. Information sheets about the dangers of asbestos exposure, permissible exposure limits, monitoring, OSHA standards, and additional resources were also posted. The specific recommendations were as follows:

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 asbestos containing material (ACM) before starting 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.

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[3] A negative exposure assessment is one that seeks to confirm that the exposure was under the permissible exposure limits.

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 Section 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. Implement a formal process for M&O supervisory staff to verify whether an area is known to contain ACM before the start of any wok 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. 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 007-13-09, *Asbestos Management Program.*

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 contracting officer's representative (COR) about the importance of accompanying contractors while material sampling is occurring.

15. Perform personal exposure monitoring on all current M&O staff who could be exposed to asbestos, as required by 29 CFR Section 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.

In a supplemental report dated May 30, 2014, the Medical Center reported on the status of the implementation of the recommendations, reporting that the Medical Center

successfully completed 12 of the 15 recommendations. With respect to recommendation 3, the supplemental report stated that all M&O employees were provided color-coded blueprints of the Medical Center, indicating which areas still contain ACM, which areas have been abated of ACM, and which areas possibly contain ACM. All M&O staff received training about the color-coded blueprints. A comprehensive survey assessing the presence of ACM in all areas of the Medical Center has been completed. The survey results will be transferred to an electronic document and made available for all M&O staff to access and review. That action is ongoing.

With respect to recommendation 5, the supplemental report stated that the Medical Center performed personal air monitoring and negative exposure assessments for most tradespersons who potentially could be exposed to ACM while performing their duties. The Medical Center still needs to perform negative exposure assessments for Environmental Management Service staff who perform tasks that could expose them to ACM.

For recommendation 14, the supplemental report indicated that the Medical Center performed personal exposure monitoring on all trades except EMS staff; monitoring of this last group is now in progress. Asbestos monitoring data are relayed to employees verbally and posted at the worksite. The Medical Center is developing a process for documenting employees' receipt of their asbestos monitoring data, and ensuring these data are included in the employee's file in Occupational Health. The Medical Center is also developing a process for proper communication between Safety Service, the AAT supervisor, and Occupational Health, to ensure these data are reviewed and appropriate actions taken as indicated. This process is ongoing.

The May 22, 2015 supplemental report confirmed that the three remaining actions from the original report have been satisfactorily completed. Based on the additional investigation, the VA made six new recommendations regarding asbestos at the Medical Center. These include to: formalize the whistleblower's informal agreement regarding non-asbestos related work; reinforce recommendation 1 from the original report to remove the whistleblower from any duties that could potentially lead to additional asbestos exposure; determine whether areas now clear contained asbestos at the time the whistleblower worked in them; make staff aware of the process for requesting respirator masks as well as the additional evaluation that must be completed prior to issuance; and develop a standard written notice to ensure that employees in affected areas are notified prior to the start of any job that will involve disturbing asbestos containing materials.

III. The Whistleblower's Comments

The whistleblower provided extensive comments on the original report, which generated OSC's request for additional information and the VA's subsequent re-investigation. His comments raised concerns regarding his work assignments and the continued potential for asbestos exposure, in addition to deficits in the personal protective equipment provided to employees and the notice to employees when work is to be performed

in areas that may contain asbestos. His concerns were addressed in the subsequent recommendations for corrective actions detailed in the May 22, 2015 supplemental report.

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I have reviewed the original disclosure, the agency's reports, and the whistleblower's comments, which led to a supplemental investigation and additional corrective actions. I have determined that the reports meet all statutory requirements and that the findings of the agency head appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency report 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 and the whistleblower's comments in OSC's public file, which is available online at www.osc.gov.[4] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[4] The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA 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 report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report 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 as an accommodation.