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VIA EMAIL TO: jyoung@osc.gov

January 26, 2016

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

Re: *Glenn Schwarz, OSC File No. Dl-15-4357*

Dear Ms. Lerner:

As you know, this firm represents Mr. Glenn Schwarz, GS-11, Maintenance Control Coordinator, Fleet Readiness Center – East (FRCE), Cherry Point, NC, in his whistleblower disclosure case, OSC File No. DI-15-4357. This letter is sent in response to OSC's letter dated January 8, 2016, received by this office on January 13, 2016 requesting Mr. Schwarz's comments on the Office of the Naval Inspector General's Report of Investigation (ROI) dated 15 December 2015, (NAVINSGEN 201502727) completed as a result of his disclosure case. *See* 5 U.S.C. § 1213(e)(l). This letter is sent on his behalf as the whistleblower and contains his timely comments and concerns on NAVINSGEN 201502727. [1]

While the ROI itself is generally sound and makes logical, rational conclusions and recommendations, and in fact substantiates Mr. Schwarz's years long concerns regarding the fuel situation at FRC-E, the Report does suffer from factual flaws that can best be organized into two categories: issues of technical inaccuracy in the report and issues of personnel accountability for the problems and for the resultant on-going, yet incomplete solutions. As set forth below, Mr. Schwarz requests that the Special Counsel take into consideration his comments below in making its findings and recommendations to the President and the appropriate congressional oversight committees of Congress. *See* 5 U.S.C. § 1213(e)(3). As set forth in the attached consent, Mr. Schwarz consents to the public release of these comments. (*See* Exhibit 1, "Consent Form").

OVERALL COMMENTS ON THE REPORT

Overall, the ROI takes a complicated issue of fuel and fuel safety and makes it understandable and shows the seriousness of the issues brought to light. However, due to both technical inaccuracies in the findings with respect to the various aircraft or equipment involved, and other misstatements or inaccuracies regarding personnel accountability and the timeline of events, it misses some of the elements of delay, stall tactics and technical misunderstanding that have plagued FRC-E in its fuels handling program for years and continues to date. While it is gratifying that someone outside of FRC-E acknowledges the serious financial and safety issues confronting the Command with respect to its fuel program, the report does not go far

[1] An extension of the deadline until this date was extended due to inclement weather.

enough to explain the years long delay in FRC-E fixing its own problems and the wholesale failure of both staff and FRC-E senior management to understand the problem and address it in a timely manner.[2]

Indeed even today, it appears the Navy wants to first blame past management performance problems for the issue and then give credit for fixing it to those same poor managers who come late to the problem with little knowledge, insight or technical experience, in order to justify crediting itself with cleaning up its own mess. In fact, the need for and implementation of the merry-go-round of Command-directed management changes at FRC-E existed independent of any issue of fuels accountability and, not surprisingly, continues to this day with more management reshuffling ongoing which continues to leave managers in positions in which they are ill qualified to hold.

Finally, in order to pat itself on the back for fixing a problem it ignored for years, the Navy credits individuals with no knowledge, skills or abilities for addressing a problem into which they were dragged kicking and screaming by Mr. Schwarz's ongoing allegations of waste and safety violations. These persons should not now be held out as some sort of heroes for doing a job they were hired to do years ago and which they simply lacked the ability or willpower to do, absent OSC and Navy OIG intervention.

ISSUES OF TECHNICAL ACCURACY

The investigators charged with investigating this OSC complaint and compiling this report are not aircraft technicians or experts by any means. However, any issues of technical insufficiency of the report are on account of not only non-technicians being placed in control of the investigation, but also the witnesses' lack of knowledge of the FRC-E mission and their own jobs. Thus, the technical errors are simply not solely the responsibility of the investigators: many of the errors of a factual or technical nature in the report stem from the management witnesses themselves who lack the knowledge, skills and abilities to understand what FRC-E does, who its clients are, what serious responsibilities exist, and how to fix the problems, some of which have easy solutions ignored for years.

While an exhaustive examination of the errors cannot be made here (the attachment contains more detail on all of the ones noted), certain technical issues appear to recur. For instance, discussion of F-35, service issues on various aircraft and the fuels question itself, or foreign aircraft serviced by FRC-E are misunderstood (*see e.g.,* Page 1 paragraph 4 -- Foreign Military (Italian AV-8) do deploy directly to the carriers for transportation back to receiving squadron; Page 9, paragraph 33 – FRC-E does not work on Air Force F-35's—FRC-E only works on the STOVL Model used by the USMC. However, the two operational squadrons were operating on Air Force bases which only supplied JP 8; Page 12 paragraph 42 - The 9 April 2014 Audit was on an AV-8 wing that was damaged due to over pressurization during leak checks, not a flap. This most likely was due to the fact the fuel hose pressure regulators had not being calibrated in years; Page 13, item 5 - JP-8 burns cleaner than JP-5, so this statement is inaccurate of false and is used as an excuse for lack of action taken by management; Page 13, item 7 – FRC-E and Station Fuels do not have the resources to store usable JP 8 fuels and that is one of the reasons fuel is being wasted at FRC-E. Storage Tanks would resolve the issue of storage for usable mixed fuels. There is not even a requirement to flush or clean existing

[2] For sake of completeness and clarity, attached as Exhibit 2 is a page by page, paragraph by paragraph compendium of noted errors both as to technical issues and personnel accountability. We ask that OSC take this attachment and its contents into account in its response to the Navy OIG Report, which is riddled with errors of both kinds.

storage tanks. They just simply have to be re-identified as "JP Fuel" instead of JP-5; and Page 28, Paragraph 131 - This statement shows that management is not aware of their clientele. FRC-E does have a contract to overhaul Italian AV-8s which deploy from FRC-E directly to the carrier for transport back to the squadron. This is not a huge number, but there is a need to be able to service the customers as contracted).

Overall, the report therefore, could contain glaring inaccuracies because management, either through neglect or intent, simply misstated or misunderstood the technical issues to the investigators and the investigators did not have the in depth knowledge needed to correct the misperception left by management. Either way, the report is deficient from a technical standpoint and should be corrected accordingly.

ISSUES OF PERSONAL ACCOUNTABILITY

Many of the whistleblower's issues with the ROI stem from "kudos" given to management officials for taking action now (or for those ongoing), when they have been advised of verbally and in writing, sat in meetings on, and corresponded with on these issues and still did nothing until this investigation caused red flags to be issued. Some of these individuals may indeed have been having performance problems in their assigned positions; however, from the standpoint of the artisans and other skilled technicians at FRC-E, those performance issues appear to be instead, a repeated pattern of deliberate refusal to understand the seriousness of the safety issues at stake and to take management or other action to alleviate the issues in a timely manner. The report is riddled with these individuals who now are getting credit for a problem they created, ignored or failed to manage before OIG intervention. Senior management keeps putting persons in jobs they have no business doing instead of making them accountable to perform.

Again, while an exhaustive examination of the personnel and management accountability issues and errors cannot be made here (the attachment contains more detail on all of the ones noted), certain recurring themes appear: persons taking credit for actions they had not taken, misleading statements regarding corrective actions or their origins, or misplaced kudos to those with demonstrably little or no understanding of the issues at hand. (*See e.g.,* Page 5, Paragraph 15 - The hoses had been mentioned in numerous meetings held over a two year period. Action had still not been taken on the testing or replacing of the hoses during this time period, until Mr. Schwarz made it very clear in a meeting that FRC-E would be held liable in the event of a mishap. The issue of the liability and danger to flight test Artisans had to be repeatedly and overly stressed to management officials in order for action to be taken. Over time, meetings had been circular with little or no results and were directed more towards the saving fuel in lieu of the safety of the fuel delivery practices and equipment; Page 5, Paragraphs 16 and 17 and footnote 9 - In order to eliminate the possibility of a mishap, replacing the hoses was the way to proceed in an efficient manner. Lives are at stake and hoses need to be in serviceable condition in order to be safe to use; the accounting of the fuel was and is poor at best, and is most likely inaccurate. No strict adherence to accounting policies for fuel was being followed. The Chemist was more than likely not provided all the proper accounting, resulting in significantly lower numbers quantifying wasted fuel. It should be noted that these incorrect practices have been going on for the past 8 to 11 years – something not investigated during this inquiry; after the audit requested by Mr. Schwarz, management was informed that the CCFD tests were not being performed as prescribed in the NATOPS Manual; Page 9, paragraph 33 - Mr. Schwarz provided management the information for affordable storage containers from Spokane Company and the fact that Naval Facilities would fund the purchase given the need for immediate fuel storage needs. Station Fuels continues to waste useable fuel for the continued lack of

storage tanks and misunderstanding; Page 9, Footnote 17 - during this reorganization by the CO, Mr. Stephen Barrow was given this position with absolutely no knowledge of fuel operations, NAVAIR 109 Manual or daily operating procedures of fuel and aircraft – he was not by any stretch a "good fit;" Page 11, Paragraph 40 - Management had full knowledge that code violations restricted the use of JP-5 and had not addressed them in a timely fashion, which resulted in unnecessary waste of usable fuel; Page 12, footnote 22 – this is a fabrication: the 31 August 2015 audit was a follow-up to the original audit Mr. Schwarz requested and was not the original Audit. Mr. Schwarz also had to request Quality Assurance perform the follow up several times. There were many critical corrections advised in the original Audit that had not been addressed. It was not the Production Planning Division Director who advised employees to disregard the NAVAIR 109; it was Mr. Ronnie Ache, Lead Supervisor for the Transportation Contractor LSG. Upon information and belief, he was fired due to his actions and non-actions in this matter; Mr. Steven Barrow administratively worked the fuel issues at hand; however, he did not know what needed to be corrected without the advice of Ms. Megan Goold and Mr. Schwarz as subject matter experts. Mr. Barrow was able to administratively push the resolutions through the proper channels; however, it was Mr. Schwarz and Ms. Goold who provided the information and resolutions to be approved for implementation; Mr. Barrow had no knowledge or experience in fuel operations or NAVAIR 109 Manual Requirements, and he relied on the subject matter experts for information. The IO's conclusion that Mr. Barrow was a major contributor is incorrect: Mr. Schwarz and Ms. Goold were the major contributors to the changes made regarding the fuel issues at hand; Page 12, Paragraph 43 - The new Production Planning Division Director, 6.3.1 was assigned to this position having very little or no experience or knowledge regarding aircraft and fuel operations and requirements. Apparently, Mr. Barrow came out of the ELP Program and was given a Deputy Director position under Leanna Radford in order to help with the fuel situation because it had been set aside by management; however, Mr. Schwarz and Ms. Goold both refused to let this fuel issue die. The issue is not just saving wasted fuel, but more important the health, safety and welfare of the employees, Marines and local public – something that repeatedly escaped Barrow' attention; Page 13. Paragraph 46 - The management changes were initiated because the knowledge of issues coming to light, and because management placed personnel into areas that they have little or no knowledge about and it was not productive. For instance, Mr. Barrow would not have been able to assist in the resolution of fuel issues if he did not have subject matter experts who provided the information and resolutions required. The subject matter experts were diligent and continued to address the fuel issues not letting the issues go by the wayside despite lack of concern and attention for public safety; Page 13, Paragraph 47 – and Page 17, Paragraph 62 - The fact that the maintenance on the fuel trucks was not being done properly and could result in a mishap was not on account of the Production Planning Division Director's personal knowledge. Instead, Mr. Schwarz (a GS-11) during a fuel meeting had to halt the meeting and explain that the facility has a major liability with the fuel trucks not being addressed, and he basically had to identify a potential mishap in detail in order for action to be taken. Mr. Barrow had no knowledge of the mishap liabilities. Instead, he was focusing on the savings of fuel in order to obtain Command recognition, not in preventing a mishap; Mr. Schwarz took the bull by the horns, identified the problems and persistently requested action from management. But, Mr. Barrow who is a functionary with little information is getting all the credit.

In fact, Schwarz was nominated by Flight Check Officer, Safety Officer and OpsO in early 2014 for the discovery of the fuel situation in November 2013; however, the award for resolution of life saving procedures was withheld due to ongoing reprisal for disclosure of the issues at hand and others; Page 14, Paragraph 48 - The notification of major concerns was a direct result of Mr. Schwarz's expression of concern of the liability of the facility in the previous fuel meetings. The TPOC and Production Planning Division Director had no clue as to the dangers present with the fuel trucks, hoses and gauges; Page 19, Paragraph 72 – FRC-E was very fortunate not to have a loss of life level mishap as a result of the lack of conformance to the NAVAIR 109. The statement of hoses being replaced or tested in one to three years is suspect; that short time frame cannot be credible if Transportation contractor and civilian employees had no knowledge of the requirements of the NAVAIR 109; Page 21, Paragraph 91 and Page 24, Paragraph 104 - Issues with fuel testing and equipment were identified late 2013 through early 2015; however, parts were not ordered until *November of 2015*. This shows that even life threatening issues are treated passively, with management holding meeting after meeting with no resolution. The lack of knowledge of NAVAIR Instructions is a real problem and excluding the employee who has the knowledge and identified the issues at hand from meetings and resolution does not further a safety agenda. A majority of the issues could have been addressed in a more efficient manner. FRC-E was very fortunate to have escaped from a life threatening mishap while having a passive attitude towards the issues. For instance, CCFD equipment was identified by Mr. Schwarz, reported to Mark Bastyr, and the equipment was ordered and put in place in less than 6 months; CCFD testing equipment by Mark Bastyr was a direct result of Mr. Schwarz identifying non-conformance issues found during his fact finding and review of the NAVAIR 109 Manual in November 2013. Mr. Schwarz notified Mr. Bastyr, his direct supervisor, immediately upon discovery; and Page 21, Paragraph 94 – Accountability is being ignored by the finding that lack of knowledge was the culprit and not misconduct. We acknowledge lack of knowledge by mid-level management is the key. But how could less than knowledgeable management be put in place when the Command & COMFRC allegedly select their Division Directors based on knowledge and experience and those charged with that responsibility have no idea what is required in order to first ensure health, safety and welfare of the employees of the facility, secondly to ensure reduced liability to the facility, and thirdly cost effective means of operation. The GS-13, 14 & 15's failed in their duties out of ignorance, but receive 6 figure salaries to ensure instructions, health, safety and welfare regulations are being followed. As of this date the same is happening: Upper management has to learn from the employees under their direction and do not take accountability on their own to learn their jobs).

The bottom line is that FRC-E management is in place (now and historically) with little technical knowhow of their positions and when lower level employees educate them, they are slow to act. There is no sense of urgency due to a lack of clear understanding about not only the waste implications of fuel contamination allegations, but also the safety issues with the fuel. They should not now be lauded for being pressured into acting by OSC and Navy intervention. The record clearly reflects a two year long battle to get this problem fixed. It was not fixed until outside pressure shed a light on it. That is not something to applaud, it is something to learn from and act upon so that it does not happen again.

CONCLUSION

Mr. Schwarz appreciates the opportunity to comment on the ROI and asks that the ongoing attacks at FRC-E on his professional reputation due to his report of these substantiated allegations and others be halted immediately.

Sincerely,

Cheri L. Cannon
Partner
Chairperson
Federal Labor and Employment Law Team

Encls: as stated

EXHIBIT 1

CONSENT FORM

EXHIBIT 2

RESPONSE TO OSC REPORT

Response to OSC Report
Dated December 15, 2015 Glenn Schwarz

Comments correspond with highlighted text in the OSC report.

Pg. 1/ Para. 4: Foreign Military (Italian AV-8) do deploy directly to the carriers for transportation back to receiving squadron.

Pg. 3/ Para.7: Mr. Schwarz requested a management directed audit via Mr. Mark Bastyr based on the fact finding he conducted after knowledge of an H-53 was identified with water contaminated fuel in November 2013.

Pg.4/ Para.1: Command Evaluator: Kyle Tutwiler, whom was requested not to be any part of Mr. Schwarz's Claims due to the inappropriate actions by Mr. Tutwiler in a previous investigation. See attached.

Pg. 5/Para: 15: The hoses had been mentioned in numerous meetings held over a two year period. Action had still not been taken on the testing or replacing of the hoses during this time period until Mr. Schwarz made it very clear in a meeting that FRCE would be held liable in the event of a mishap. The issue of the liability and danger to flight test Artisans had to be overly stressed to Management in order for action to be taken. Meetings over time had been directed more towards the saving of fuel issue in lieu of the safety of the fuel delivery practices and equipment.

Pg.5/Para: 16: In order to eliminate the possibility of a mishap, replacing the hoses was the way to proceed in an efficient manner. Lives are at stake and hoses need to be in serviceable condition in order to be safe to use.

Pg.5/ FN9: The accounting of the fuel was and is poor at best most likely inaccurate. No strict adherence to accounting policies for fuel were being followed. The Chemist was more than likely not provided all the proper accounting resulting in significantly lower numbers quantifying wasted fuel. It should be noted that these incorrect practices have been going on for the past 8 to 11 years.

Pg.5/ Para: 17: After the audit requested by Mr. Schwarz Management was informed that the CCFD test were not being performed as prescribed in the NATOPS Manual.

Pg. 6/ Para: 1: Were there any findings of 55 gallon drums being filled with useable fuel labeled as contaminated and disposed as hazardous waste instead of selling the fuel to Noble Oil?

Pg.7/Para: 2: When the H-53 was discovered with water in the fuel, the weather conditions increased the probability of water contaminated fuel to cause a mishap. Mr. Schwarz's responsibility as Maintenance Control Coordinator and his personal Aviation Experience and Devotion increased the safety of flight line Artisans, flight crews and the public.

Pg.8/Para: 30: Mr. Schwarz volunteered to assume the FMO duties on two separate occasions, via Mark Bastyr and Lee Burton. The 109 Manual states that the FMO position should have

no other duties or responsibilities associate with the position. Assigning the TPOC with FMO responsibilities is a major conflict of interest. Mr. Schwarz was designated as Quality Fuel Surveillance Manager by the Commanding Officer and was considered a subject matter expert by Mr. Stephen Barrow to resolve the fuel issues at hand.

Pg.8/Para: 32: The monthly test is for Flashpoint is conducted to ensure if the fuel trucks labeled JP-5 that the product meets the appropriate requirements.

Pg. 8/FN15: Mr. Schwarz volunteered to assume the FMO position on two separate occasions via Mark Bastyr and Lee Burton as he has knowledge of the NATOPS and local requirements regarding fuel as well as knowledge of actual procedures being performed on a daily basis. Mr. Schwarz was designated by the Commanding Officer to be Quality Fuel Surveillance Manager and was considered a subject matter expert by Management to resolve fuel issues at hand.

Pg. 9/Para. 33: FRCE does not work on Air Force F-35's; FRCE only works on the STOVL Model used by the USMC. However the two operational squadrons were operating on Air Force bases of which only supplied JP 8.

Planning and preparing for the F-35 was prior to receiving the first F-35 in June 2013, Mr. Schwarz was a major participant in the process with CNAF approval in order to get final authorizations for flight operations of the F-35.

Mr. Schwarz provided Management the information for affordable storage containers from Spokane Company and that Naval Facilities would fund the purchase given the need for immediate fuel storage needs. Station Fuels is also wasting useable fuel for the same lack of storage tanks.

Pg. 9/Para.35: The email was authored by Mr. Schwarz the day after Mr. Schwarz conducted the fact finding investigation regarding the water contamination of fuel. It should be noted that at time of this incident, Mr. Schwarz chose to act in the interest of the Facility as the Quality Assurance Department is responsible for investigations of this nature and had not observed any action being taken to prevent reoccurrence. Mr. Schwarz knew of the consequences if the issue was not addressed.

Pg. 9/FN17: During this reorganization by the CO, Mr. Barrow was given this position with absolutely no knowledge of fuel operations, NAVAIR 109 Manual or daily operating procedures of fuel and aircraft.

Pg. 11/Para.40: Management had full knowledge that code violations restricted the use of JP-5 and had not addressed them in a timely fashion, which resulted in unnecessary waste of usable fuel.

Pg.12/FN: The 31 August 2015 audit was a follow-up on the original audit I requested not the original Audit. I also had to request Quality Assurance to perform the follow up several times. There were many critical corrections advised in the original Audit that had not been addressed. It was not the Production Planning Division Director advising employees to disregard the NAVAIR 109; it was Mr. Ronnie Ache, Lead Supervisor for the Transportation Contractor LSG. It is my knowledge that he was fired due to his actions and non-actions.

Mr. Steven Barrow administratively worked the fuel issues at hand; however, would not have known what needed to be corrected without the advice of Ms. Megan Goold and myself as subject matter experts. Mr. Barrow was able to administratively push the resolutions through the proper channels; however, it was Mr. Schwarz and Ms. Goold who provided the information and resolutions to be approved for implementation.

Again, Mr. Barrow had no knowledge or experience of fuel operations or NAVAIR 109 Manual Requirements he relied on the subject matter experts for information. The IO's conclusion that Mr. Barrow was a major contributor is incorrect. Mr. Schwarz and Ms. Goold were the major contributors to the changes made regarding the fuel issues at hand.

Footnote 22: Is therefore a false statement as identified above.

Pg. 12/Para.42: The 9 April 2014 Audit was on an AV-8 wing that was damaged due to over pressurization during leak checks, not a flap. Probably due to the fact the fuel hose pressure regulators not being calibrated in years.

Pg.12/Para.43: The new Production Planning Division Director, 6.3.1 was assigned to this position having very little or no experience/knowledge regarding aircraft and fuel operations and requirements. Apparently Mr. Barrow came out of the ELP Program and was given a Deputy Director position under Leanna Radford in order to help with the Fuel situation because it had been set aside; however, Mr. Schwarz and Ms. Goold refused to let this fuel issue die. The fuel issue is not just saving wasted fuel, but more importantly was about the health, safety and welfare of the employees, Marines and local public.

Pg.13/Item5: JP-8 burners cleaner than JP-5, so I find this statement to be false and used as an excuse for lack of action taken by Management.

Pg. 13/Item6: Accounting of fuel is a simple task, require employees to document all fuel when defueling, fueling, and testing. Mr. Danny Beligotti has firsthand knowledge of this.

Pg.13/Item7: Initial Signage could have been installed months ago; there are a couple of test cell storage tanks that have large capacities that could be used now until full signage can be acquired. The F402 engine test cell has a 27,000 gal storage tank. Any fuel saved is a

benefit to the facility, Department of the Navy and the taxpayers. The facilities sign shop could produce the needed signage in order to accommodate this interim fix.

Pg13/Item7: As previously noted, FRCE and Station Fuels do not have the resources to store usable JP 8 fuels and that's one of the reasons fuel is being wasted at FRCE. Storage Tanks would resolve the issue of storage for usable mixed fuels. There is not even a requirement to flush or clean existing storage tanks. They just simply have to be re indentified as "JP Fuel" instead of JP-5.

Pg.13/Para: 45: Mr. Schwarz and Ms. Megan Goold were asked to review and comment on the drafting of this contract and the requirements needed to be compliant with the NAVAIR 109 Manual regarding testing procedures, maintenance and verification of fueling equipment.

Pg.13/Para.46: It should be noted that the management changes were initiated because the knowledge of issues coming to light, placing management personnel into areas that they have little or no knowledge about is not productive. Example: Mr. Barrow - he would not have been able to assist in the resolution of fuel issues, if he did not have subject matter experts who provided the information and resolutions required. The subject matter experts were diligent and continued to address the fuel issues not letting the issues go by the wayside.

Pg.13/Para.47: The issue that the maintenance on the fuel trucks was not being done properly and could result in a mishap, was not the Production Planning Division Director's personal knowledge. Instead, Mr. Schwarz (GS-11) during a fuel meeting prior had to halt the meeting and explain that the facility has a major liability at hand with the fuel trucks not being addressed, basically had to identify a potential mishap in detail in order for action to be taken. Mr. Barrow had no knowledge of the mishap liabilities. He was focusing on the savings of fuel in order to obtain recognition not preventing a mishap.

Mr. Schwarz took the bull by the horns, and found the problems and persistently requested action from Management of which Mr. Barrow is getting all the credit for doing. Mr. Schwarz was nominated by Flight Check Officer, Safety Officer and OpsO in early 2014 for the discovery of the fuel situation in November 2013; however, he never received it due to ongoing reprisal for raising that issue and others.

Pg.13/Para.47: If the employees were properly trained and followed the NAVAIR109 Instruction, this position would not be required, as well as the contractor supervisor being held accountable for the same responsibility.

Pg. 14/Para.48: The notification of major concerns was a direct result of Mr. Schwarz's expression of concern of the liability of the facility in the previous fuel meetings. The TPOC and

Production Planning Division Director had no clue as to the dangers present with the fuel trucks, hoses and gauges.

Pg.14/Para.52: The term should be Pressure Differential Log and Pressure Differential Graph.

Pg. 16/Para.59: As stated in comment for Pg. 8/FN15: Mr. Schwarz volunteered to assume the FMO position several times. NAVAIR 109 is clear that the FMO should be that employee's only responsibility. It is a **conflict of interest** having one employee hold TPOC and FMO.

Pg. 17/Para. 62: Mr. Schwarz (GS-11) during a fuel meeting prior had to halt the meeting and explain that the facility has a major liability at hand with the fuel trucks not being addressed, basically had to identify a potential mishap in detail in order for action to be taken. Mr. Barrow had no knowledge of the mishap probability, he was focusing on the savings of fuel as that could get him recognized not preventing a mishap. Finally the out of date and damaged fuel hoses were replaced. (All hoses were out of date, not just a some of the hoses.)

Pg.18/Para.69: The truck received from DRMO was in a usable condition and only required acceptance inspection. The $61,000.00 costs were inclusive of modifications that were not required to put the truck into service. Mr. Barrow was building the truck up with unnecessary items in order to make the impression that he was doing great things. Mr. Danny Beligotti could testify to this fact.

Pg.19/Para.72: FRC-E was very fortunate not to have a loss of life level mishap as a result of the lack of conformance to the NAVAIR 109. The statement of hoses being replaced or tested in one to three years is suspect; how can it be that short of a time frame if Transportation Contractor and Civilian employees had no knowledge of the requirements of the NAVAIR 109.

If a single out of date fuel hose were to burst and ignite a fire, this would be considered a single point of failure at the loss of life level.

Pg. 20/Para.75-76: There is no need to hire another employee to fill the position of FMO, when the facility already employees a candidate deemed a subject matter expert, held the Fuel Quality Surveillance Program Manager position who passed an AMMT inspection with no issues noted. A candidate with 24 years of Aircraft Knowledge, Experience and Knowledge of mandatory instructions. Mr. Schwarz would be the perfect candidate to continue his proactive approach to following instructions, and health, safety and welfare of the employees and surrounding public. Mr. Schwarz played a key role in identifying the non conformance items, proposing corrective measures, and remaining stead fast overseeing operations regarding fuel program issues.

Pg. 21/Para.84: Mr. Schwarz provided the Management Team with this information on several occasions during the fuel meetings.

Pg. 21/Para. 86: All fuel hoses were out of date. This took place as a result of Mr. Schwarz's emphasis on liability of the facility in the event of a mishap which was a high probability.

Pg. 21/Para.87: Mr. Schwarz along with Ms. Megan Goold assisted with the implementation of these logs.

Pg. 21/Para.91: Issues with fuel testing and equipment were identified late 2013 through early 2015; however, parts were not ordered until November of 2015. This goes to show that even life threatening issues are treated passively, with management holding meeting after meeting with no resolution. The lack of knowledge of NAVAIR Instructions is a real problem and excluding the employee whom has the knowledge and identified the issues at hand. Majority of the issues at hand could have been addressed in a more efficient manner. FRC-E was very fortunate to have escaped from a life threatening mishap while having a passive attitude towards the issues. *I.e.* CCFD equipment was identified by Mr. Schwarz, reported to Mark Bastyr, and the equipment was ordered and put in place in less than 6 months.

Pg.21/Para.93: This action item planned is a direct conflict of interest.

Pg. 21/Para.94: Accountability being smoothed over by saying lack of knowledge not misconduct. How could that be when the Command & COMFRC select their Division Directors based on knowledge and experience and those charged with that responsibility have no idea what is required in order to first ensure health , safety and welfare of the employees of the facility, secondly to ensure reduced liability to the facility, and thirdly cost effective means of operation. The GS-13, 14 & 15's failed in their duties out of ignorance and they are receiving 6 figure salaries in order to ensure instructions, health, safety and welfare are being followed. As of this date the same is happening. Upper management has to learn from the employees under their direction.

Pg. 24/Para. 104: CCFD testing equipment by Mark Bastyr was a direct result of Mr. Schwarz identifying non-conformance issues found during his fact finding and review of the NAVAIR 109 Manual in November 2013. Mr. Schwarz notified Mr. Bastyr immediately upon discovery. Mr. Bastyr was his direct Supervisor at the time of discovery.

Pg. 24/Para. 106-107: Mr. Schwarz has volunteered to coordinate manpower requirements with transportation which is outside his PD and corrected conformance issues at a loss of life level.

Pg.25/Para. 109,110 &115: The facility already employs a candidate deemed a subject matter expert, held the Fuel Quality Surveillance Program Manager position who passed an AMMT

inspection with no issues noted. A candidate with 24 years of Aircraft Knowledge, Experience and Knowledge of mandatory instructions. Mr. Schwarz would be the perfect candidate to continue his proactive approach to following instructions, and health, safety and welfare of the employees and surrounding public. Mr. Schwarz played a big role in defining the non conformance items, proposing corrective measures, and remaining stead fast vigilance concerning flight operations regarding fuel program.

Pg. 27/Para.126: This was not FRCE employees; it was the LSG contract employees and their management.

Pg. 28/Para. 128: The fire code issues were known and included the use of JP-5.

Pg. 28/Para. 129: We have a graphic arts shop that makes all the decals for the facility. It is not understood why they are unable/capable of producing the simple decals required. They could produce decals in stages, starting with decals for fuel trucks and the AV-8 Engine Test Cell which would be a significant start to saving fuel immediately. It appears that the Production Planning Division Director would prefer to wait up to another year to get decals for all the locations and continue to waste thousands of gallons of useable fuel in lieu of working with the graphic arts shop to product decals in stages, which would allow FRC-E to start saving wasted usable fuels now, not a year from now. FRCE Management has been aware of this instruction for over a year and a half, how long will this be allowed to continue at the FRC-E pace? To have a fully staffed graphic arts shop not utilized to expedite savings of the fuel and awarding a contract to an outside source is waste of not only the Agencies money, but Taxpayer money.

Pg. 28/Para.130: Ms. Goold has been very vigilant in making Management aware of the wasted useable fuels, but the accounting of fuel from original notification of Instruction not being followed by Mr. Schwarz in November 2013 to December 2014 has not been addressed or questioned, nor have the gallons of fuel wasted for years prior to notification to management in November 2013. The time frame was conveyed along with the testing, fuel trucks and waste of usable fuels by Mr. Schwarz in November 2013. (12,000 gallons x 2 = 24,000 gallons per year x 8 years = 192,000 gallons this is a very conservative estimate as accounting for fuel has not been a high priority at FRCE. If you times 192,000 gallons by 2 the number of gallons of fuel wasted over 8 years would be more accurate which would include the workloads being higher in previous years, which has not been mentioned with in this investigation.)

Pg. 28/Para. 131: This statement goes to show that Management is not aware of their clientele. FRCE does have a contract to overhaul Italian AV-8s which deploy from FRCE directly to the carrier for transport back to the squadron. This is not a huge number but we need to be able to service our customers as contracted.

FRCE continues to lack storage of JP-8 because Management has not followed the NAVAIR 109 Instruction due to lack of knowledge of the instruction. FRCE has treated fuels with a different flash point other than 140 as contaminated in lieu of using in GSE equipment and test cells. If the NAVAIR 109 Instruction was being followed there should be no need to request Station Fuels to store fuels for FRCE. A lack of responsibilities held by upper management has allowed thousands upon thousands of gallons of useable fuels to be wasted at the cost to the taxpayer.

Station Fuels should also pursue Naval Facilities for storage of JP-8 storage, as they are wasting usable fuels the same as FRCE.

The quote "Unless the propulsion guys say" is a Leanna Radford quote. This is what Mr. Schwarz was indicating in that we are wasting time waiting for local engineers to say we can do what the NAVAIR 109 Instruction dictates us to do.

Pg. 29/Para. 136: Again the delays were caused by Upper Management not acting on the issues due to lack of knowledge of the Instruction, allowing local engineering to determine if FRCE would be able to adhere to the NAVAIR 109 Instruction which is considered the written rule not to be deviated from. Local Engineering and Facilities Management should have knowledge of this Instruction in order to make sure that equipment being purchased, repaired or upgraded are compliant with the instruction requirement to use mixed fuels.

Again, it needs to be noted that the new "Production Planning Division Director" had absolutely no knowledge or experience with the NAVAIR 109 nor the local operating procedure when position was given to him directly out of the ELP Program. The "CCFD" was instrumental in taking the information provided by the subject matter experts to approval status. All the fact finding and investigative procedures were basically accomplished by Mr. Schwarz and Ms. Megan Goold. It should be noted once again, that issues regarding fuel testing, fueling/defueling procedures, maintenance of fueling/defueling equipment and wasting of useable fuels would not be being addressed if Mr. Schwarz had not gone above and beyond in order to investigate the water contamination in the H-53 back in November 2013.

Pg. 30/Para.143: Mr. Schwarz suggested implementing the use of mixed fuels in stages numerous times to Management i.e., labeling fuel trucks and AV-8 test cell tank first as it was the largest tank and would allow the most mixed fuel savings quickly. Realistically if suggestion was accepted by Management mixed fuels would have been being saved for just short of two years if not more.