VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

March 27, 2018
15-04678-114

ACRONYMS

A-E	Architect-Engineer
COR	Contracting Officer's Representative
CSO	Construction Safety Officer
FAR	Federal Acquisition Regulation
OIG	Office of Inspector General
OSHA	Occupational Safety Health Administration
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration

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Executive Summary

Why the OIG Did This Review

On June 26, 2014, the Jack C. Montgomery VA Medical Center (VAMC), Muskogee, Oklahoma, awarded a construction contract valued at $8.7 million for the installation of a Full Facility Standby Generator System that would allow the facility to be fully operational in the event of a power outage.

In July 2015, the Office of Inspector General (OIG) received an allegation that VA officials did not comply with contract requirements and did not follow Occupational Safety and Health Administration (OSHA) safety requirements, creating an imminent danger. The complainant also alleged that the contracting officer's representative (COR) directed a VAMC employee to move excavated soil using VA equipment, instead of the contractor.

What the OIG Found

The OIG substantiated the allegation that VA officials at the Jack C. Montgomery VAMC contributed to hazardous construction conditions during the installation of a Full Facility Standby Generator System. Specifically, according to the COR, he allowed the contractor, BCI Construction USA, Inc. (BCI Construction), to begin excavation without an approved excavation and shoring design plan.

The OIG found the COR did not comply with contract requirements for approving an excavation and shoring design plan before allowing BCI Construction to begin excavation at the site. The COR never provided a reason as to why he allowed work to start without an approved excavation and shoring design plan. In addition, upon receipt of the excavation and shoring design plan, the COR accepted it even though the plan included calculation errors. The COR also did not perform a proper assessment of the hillside as a disposal location for the excavated soil. According to the COR, a geotechnical report of the excavation site, but not the disposal location, was completed and the report did not raise any concerns. While the geotechnical investigation was not required, had a geotechnical investigation been performed, some of the issues with the parking lot and hillside disposal location could have been identified and appropriate action could have been taken.

The Chief, Engineering Service, did not ensure the COR had the necessary experience to provide adequate contract oversight of the excavation portion of the Full Facility Standby Generator contract. The COR's previous work experience primarily involved responsibilities as an electrician and, according to the COR, he had never overseen an excavation project. The COR's decisions throughout the project demonstrated his inexperience managing an excavation, as evidenced in part by the COR's decision to allow excavation to occur without a required excavation and shoring design plan. The COR's lack of experience contributed to his failure to comply with contract requirements.

VA terminated the contract on March 7, 2017, after paying nearly $5 million. According to the contracting officer, the contract was terminated because of the instability at the hillside disposal location. The costs to repair the hillside and parking lot, as well as to redesign, remove, and reconstruct the shoring wall would add about $17.5 million. The total expected costs of $22.5 million would far exceed the $8.7 million original value of the contract. In addition, BCI Construction has up to one year from contract termination to submit documentation to the contracting officer for compensation due to the termination. BCI Construction has stated there will be additional costs associated with the contract termination; however, as of October 2017, the contractor had not provided any estimates of the costs. Because the focus of this review was to determine whether VA officials contributed to the hazardous conditions, no attempt was made to determine BCI Construction's or the Architect-Engineer contractor's culpability regarding the identified issues.

The OIG also substantiated the allegation that VA officials provided inadequate assurance of contractor compliance with OSHA safety requirements at the excavation site. Specifically, the safety inspections at the excavation site were ineffective as they were not performed weekly, as required by Veterans Health Administration (VHA) construction safety policy, and when safety inspections were performed, they were routinely done on the same days of the week. Also, according to the contracting officer, she was not always notified about safety-related issues that occurred during the construction.

The construction safety officer did not follow VHA construction safety policy on the frequency of safety inspections, which he attributed to work not being conducted at the excavation site, the contract being suspended, or his being on leave. This prevented VA from ensuring continued contractor compliance with safety requirements. Also, by routinely performing inspections on the same two days of the week, the construction safety officer did not effectively implement the periodic safety inspection requirement. This gave contractor personnel the ability to alter their behaviors to comply with safety requirements. Further, the contracting officer and the COR or project engineer did not delegate safety responsibilities in accordance with VHA construction safety policy. This led to confusion about reporting safety violations and did not ensure identified violations at the excavation site were reported. As a result, the contracting officer was not notified of safety violations and was unable to make a determination as to whether or not administrative actions were necessary to ensure a safe environment was maintained at the excavation site.

The OIG did not substantiate the allegation that VA staff or equipment was used to move the excavated soil.

What the OIG Recommended

The OIG made five recommendations. The OIG recommended the Medical Center Director, Eastern Oklahoma VA Health Care System:

1. Ensure CORs comply with the duties assigned in the Delegation of Authority Memo;
2. Ensure the Chief, Engineering Service, assigns a COR who has experience commensurate with delegated responsibilities;

3. Ensure VA personnel follow established VHA policies for safety inspections;
4. Clarify the implementation of safety inspections requirements; and
5. Ensure the assignment of a safety officer.

Management Comments

The Medical Center Director, Eastern Oklahoma VA Health Care System, concurred with all of the recommendations. The Medical Center Director's planned corrective actions are acceptable. The OIG considers Recommendation 4 closed based on actions reported and documentation provided by the Medical Center Director. The OIG will monitor the Medical Center's progress and follow-up on the implementation of Recommendations 1, 2, 3 and 5 until the proposed actions are completed.

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INTRODUCTION

Objective

The OIG conducted this review to determine the merits of allegations that VA officials at the Jack C. Montgomery VA Medical Center (VAMC) created hazardous construction conditions during the installation of a Full Facility Standby Generator System.

The complainant alleged that the contracting officer, the contracting officer's representative (COR), the facility safety manager, and the Chief, Engineering Service, (VA officials) did not comply with contract requirements for the installation of a Full Facility Standby Generator System and did not follow Occupational Safety and Health Administration (OSHA) safety requirements, creating an imminent danger. The complainant also alleged that the COR directed a VAMC employee to move the excavated soil using VA equipment, instead of the contractor.

Full Facility Standby Generator

On June 26, 2014, VA awarded BCI Construction USA, Inc. (BCI Construction) a contract valued at $8.7 million for the installation of a Full Facility Standby Generator System. The contract was awarded based on a Veterans Integrated Service Network goal to ensure facilities in the Gulf States, including Oklahoma, are prepared for natural disasters. The Full Facility Standby Generator System would allow the VAMC in Muskogee, Oklahoma, to be fully operational in the event of a power outage. In addition to the installation of the Full Facility Standby Generator System, the contract required the contractor to construct a new building to house the generator system. In order to prepare the site for the construction of the new building, the contractor was required to excavate.

Responsible Program Office

The Veterans Health Administration (VHA) Procurement and Logistics Office supports VHA in purchasing health care products and services. The Procurement and Logistics Office provides procurement services through its major organizational components, which include Service Area Offices. Service Area Offices are subdivided into Network Contracting Offices. Each Network Contracting Office provides local, regional, and national procurement support to the medical centers in its region. When the OIG review began, the VAMC was part of Service Area Office Central and Network Contracting Office 16, but it transitioned to Service Area Office West and Network Contracting Office 19 during the course of our review.

RESULTS AND RECOMMENDATIONS

Finding 1 VA Officials at the Jack C. Montgomery VA Medical Center Contributed to Hazardous Construction Conditions

We substantiated the allegation that VA officials at the Jack C. Montgomery VAMC contributed to hazardous construction conditions during the installation of a Full Facility Standby Generator System. This occurred because the:

- COR did not obtain and approve a required excavation and shoring design plan, which increased the risk of excavation failure.
- COR did not properly assess the stability of the hillside to determine whether that was an appropriate location for the disposal of excavated soil.
- Chief, Engineering Service, did not ensure that a COR with the experience commensurate with their responsibilities was selected to provide adequate contract oversight of the excavation portion of the Full Facility Standby Generator contract.

According to the COR, on January 20, 2015, without VA approval of an excavation and shoring design plan, the COR allowed BCI Construction to start excavation. In June 2015, according to a VA civil engineer, a parking lot and hillside collapsed. On March 7, 2017, VA terminated the contract for the convenience of the government. As of August 2017, VA officials estimated the cost to repair the hillside and parking lot, as well as to redesign, remove, and reconstruct the shoring wall, will add at least $17.5 million to the nearly $5 million in costs already incurred. In addition to the approximately $22.5 million in paid and anticipated costs, VA will likely incur additional costs as a result of the contract termination.

What Happened

The COR allowed BCI Construction to proceed with excavation without an approved excavation and shoring design plan,[1] which increased the risk of excavation failure. In addition, although the contract gave the COR authority to dispose of soil to designated areas on VAMC property, the COR's failure to properly assess the stability of the hillside as a disposal location for the project contributed to the hillside collapse.

[1] The Full Facility Standby Generator contract required BCI Construction to create an excavation and shoring design plan. BCI Construction's excavation and shoring design plan was required to be reviewed by VA before excavation could begin.

According to OSHA, excavation is among the most hazardous construction operations, with cave-ins posing a great risk that could result in fatalities.[2] In addition, OSHA's trenching and excavation safety publication states that waiting until after work has started to correct mistakes in shoring or sloping slows down operations, adds to the cost, and increases the possibility of excavation failure. Therefore, excavated material must be properly sloped or supported for construction and safety purposes. Excavation projects could include protection systems such as benching, sloping and shoring, as shown in Appendix A.[3]

Excavation Timeline

According to the COR, on January 20, 2015, without VA approval of a required excavation and shoring design plan, BCI Construction started excavation using the benching method. Allowing BCI Construction to begin excavation without an approved excavation and shoring design plan created hazardous conditions and resulted in project delays, as shown below.

- According to the construction safety officer (CSO), VA stopped excavation in February 2015 after the CSO became aware there was no design plan.
- On March 17, 2015, the Architect-Engineer (A-E) contractor[4] recommended approving BCI Construction's excavation and shoring design plan and VA accepted it. According to the COR, on March 25, 2015, BCI Construction resumed work using the approved shoring method.
- VA stopped excavation in April 2015 and required additional reviews of the shoring design plan before BCI Construction could proceed. After VA hired a third-party engineer to review the approved shoring design plan, the contracting officer was informed that BCI Construction failed to provide a satisfactory shoring design.
- According to the COR, after BCI Construction submitted a satisfactory shoring design plan, BCI Construction resumed excavation in January 2016 and completed excavation, and the shoring wall, in February 2016.

[2] United States Department of Labor 2226-10R-2015, *OSHA Trenching and Excavation Safety Publication* (2015).
[3] The type of protection system used depends on soil classification, depth of cut, water content of soil, weather and climate, and other operations in the vicinity. Benching forms one or a series of horizontal levels or steps, usually with vertical or near-vertical surfaces between levels. Sloping forms sides of an excavation that are inclined away from the excavation, and the angle of incline varies depending on conditions. Shoring is a structure such as a metal hydraulic, mechanical, or timber shoring system that supports the sides of an excavation.
[4] The A-E contractor responsibilities included checking the contractor's shop drawings and detail drawings for conformity with the contract documents and recommending approval, disapproval, or other suitable disposition to VA.

Hillside Collapse

The contract gave the COR authority to dispose of satisfactory soil to designated areas on VAMC property. However, the COR's decision to dispose of excavated soil over a hillside, while well-intentioned, contributed to the collapse of the hillside. Figure 1 shows the location of the excavation site and hillside disposal location. According to the COR, he directed BCI Construction to dispose of excavated soil over a nearby hillside, providing the following explanation for his decision:

> *Prior to the contractor beginning excavation there was a discussion about the third week of January 2015 about utilizing the spoils from the excavation of the generator construction site.*
>
> *Engineering employees were in the process at the time of clearing the underbrush on the hillside below parking lots 10 & 12. There was a group of engineering employees, including myself, that walked along the west edge of parking lots 10 and 12. It was identified in the walk there was significant erosion in two areas along the fence line of the parking lots. I felt that there would be a benefit to take the spoils and place them in one of the eroded areas, which was to [sic] at the north end of the parking lots and west of parking lot 12. At the time vehicles were parking in the area and the location would have minimal impact on parking spaces. With the amount of material being moved I envisioned an added benefit of possibly some additional parking in the future. I also considered at the time that perhaps this would be a good stockpile for dirt if needed back on the project for fill. There was a geotechnical report that was completed for the Generator project area and the report did not raise any concerns. It has also been a practice in the past years for fill to be placed on the west side of the campus.*

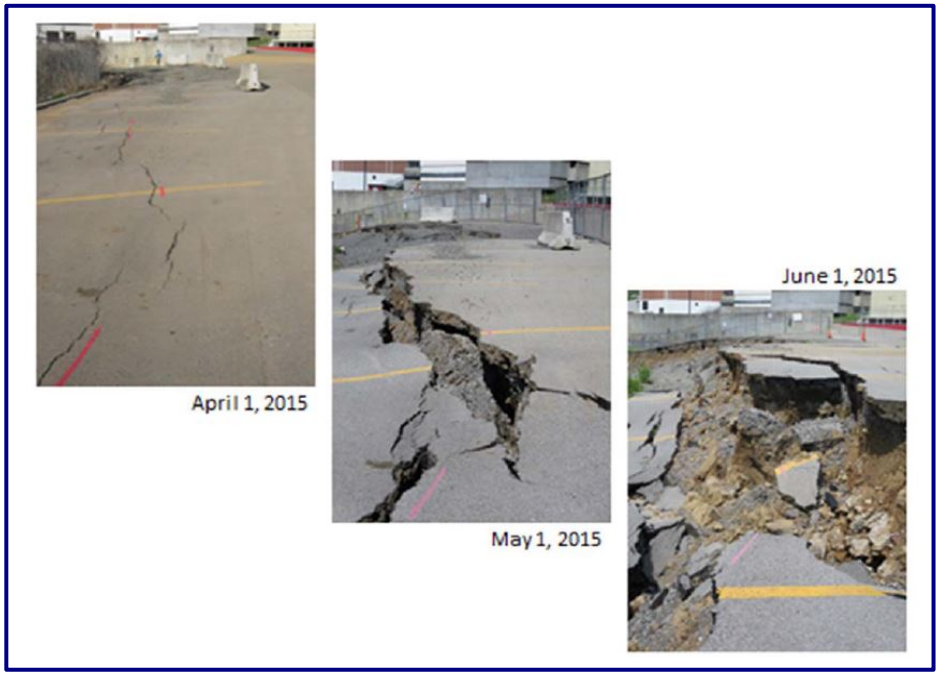
Figure 1. Excavation and Disposal Location

Source: Photograph provided to OIG by VAMC employee on March 1, 2016

According to the COR, dump trucks moved excavated soil from the excavation site, across the adjacent parking lot, to the hillside for disposal. He further stated that dump trucks made approximately 49 to 59 trips and moved about 20,000 to 24,000 pounds of soil, per trip. The OIG team estimated the trucks moved about 1 million pounds[5] of excavated soil across the parking lot during an approximate two-week period.[6] After the excavated soil was moved across the parking lot, fractures in the pavement and deterioration at the crest of the hill began to occur, and continued to the point of collapse. Figure 2 shows the deterioration of the parking lot.

[5] According to the COR, each load was at least 20,000 pounds.
20,000 pounds per load x 49 trips = 980,000 pounds.
[6] The excavated soil was moved across the parking lot during a one-week period in January 2015, and an approximate one-week period in March and April 2015.

Figure 2. Deterioration of Parking Lot



Source: VAMC employee; Parking Lot Condition; Muskogee, OK; April 1, 2015, May 1, 2015, and June 1, 2015

According to a VA civil engineer on the Construction Safety Committee, he had concerns about the soil disposal and the vibrations from dump truck movements. This VA civil engineer believed that vibrations from the continual dump truck and excavator traffic contributed to the hillside collapse. The VA civil engineer obtained an opinion from a private professional engineer regarding conditions at the parking lot and hillside. The private professional engineer disclosed the following observational opinion in a letter dated April 3, 2015.

> *Based on my visual observations only, it appears that the slope instability is due to the recent construction activities at the project site. Contributing factors may include (but may not be limited to) placement of uncontrolled fill material, composition of the uncontrolled fill material, steep slope of the uncontrolled fill material, lack of benching into the existing slope, and apparent loading at the crest of the slope due to construction equipment.*

By June 2015, the hillside collapsed, according to the VA civil engineer.

Why This Occurred

The COR did not comply with contract requirements for obtaining an excavation and shoring design plan. In addition, the COR did not properly assess the hillside as a disposal location to determine whether the location was appropriate for disposal of excavated soil, contributing to the hillside collapse. Also, the Chief, Engineering Service, did not ensure that a COR with the experience commensurate with their responsibilities was selected to provide adequate contract oversight of the excavation portion of the Full Facility Standby Generator contract. Lastly, unusually high precipitation may have also contributed to the hillside collapse.

Excavation and Shoring Design Plans

The COR allowed BCI Construction to begin excavation without an excavation and shoring design plan, as required by the Full Facility Standby Generator contract. The contract required submittals, including an excavation and shoring design plan, to be reviewed by the A-E contractor for compliance with the contract, and action thereon would be taken by the COR on behalf of the contracting officer. The COR's responsibilities included the rejection of unsatisfactory services and ensuring contractor compliance with technical requirements of the contract.

VA awarded an A-E contract, which tasked that contractor with providing VA specifications and drawings for how to proceed with the construction of a building to house the Full Facility Standby Generator. In drawings dated June 28, 2013, the A-E contractor informed VA that the construction contractor would be responsible for the excavation and shoring design plans, specifically stating:

> *…locations of potential temporary retaining structures to facilitate the proposed sequence of construction shown in the plans are for information purposes only and have not been designed and detailed. Actual limits of temporary retaining structures shall be determined by the contractor. Do not begin installation until approval of the design calculations and drawings by the engineer is received.*

According to the COR, he allowed BCI Construction to begin excavation work in January 2015 without an approved excavation and shoring design plan as required by the Full Facility Standby Generator contract. The COR did not provide a reason why he allowed BCI Construction to begin excavation without an approved plan. The COR did not obtain BCI Construction's required excavation and shoring design plan until March 2015. Once the A-E contractor recommended approving the required plan, the COR accepted the plan and allowed BCI Construction to continue excavation. However, the plan for the shoring wall included calculation errors requiring BCI Construction to halt excavation work. The COR should have been able to identify the calculation errors because he served as the technical expert on the contract. Through the COR's delegation letter, he was tasked with assuring

compliance with technical requirements, furnishing technical guidance, and taking actions such as rejecting unsatisfactory services or supplies.

Had the COR complied with the contract terms to obtain an excavation and shoring design plan prior to excavation, and rejected unsatisfactory design plans, the risks of unsafe conditions and project delays that eventually occurred would have been mitigated.

Hillside Disposal Location Not Properly Assessed for Stability

The COR did not properly assess the stability of the hillside for use as a disposal location for the project. According to a United States Army Corps of Engineers, Engineering Branch Chief, a proper assessment of the hillside as the disposal location may have identified vulnerabilities and provided recommendations to mitigate potential problems.

While a geotechnical investigation of the parking lot and the hillside disposal location was not required, it would have been prudent for the COR to have both the parking lot and the hillside evaluated for stability before using the area to dispose of excavated soil.

Before the Full Facility Standby Generator contract was awarded, a 2013 geotechnical investigation of the excavation site was performed to evaluate the subsurface conditions at the site and provide recommendations about the Full Facility Standby Generator project. The 2013 report evaluated the subsurface conditions at the excavation site and recommended the work area for the concrete slab to be proof rolled with a loaded, tandem-axle dump truck weighing at least 25 tons to locate any areas that are soft or unstable. The report also provided specific information for soil conditions and the potential impact of rainfall. However, the 2013 geotechnical investigation did not evaluate the subsurface conditions of the parking lot and hillside used for the disposal of the excavated soil.

According to a United States Army Corps of Engineers, Engineering Branch Chief, a geotechnical investigation would have likely detected instability of the parking lot and hillside area. He further stated that the movement of excavated soil over the hillside was a contributing factor to the hillside collapse. In addition, past practices of dumping soil, debris, and rubble that included large concrete pieces and broken plumbing pieces was an obvious clue that an additional assessment should have been conducted at the hillside disposal location. While the geotechnical investigation was not required, had a geotechnical investigation been performed, some of the issues with the parking lot and hillside disposal location could have been identified and appropriate action could have been taken.

COR Experience Not Commensurate With Responsibilities

The Chief, Engineering Service, did not ensure that a COR with the experience commensurate with their responsibilities was selected to provide adequate contract oversight of the excavation portion of the Full Facility Standby Generator contract. The Chief, Engineering Service, is expected to render engineering decisions based on extensive knowledge of engineering and construction principles and is responsible for selecting staff and providing oversight of their projects. According to the Federal Acquisition Regulation (FAR), the contracting officer is allowed to designate a COR.[7] The COR should be qualified by training and experience commensurate with the responsibilities to be delegated in accordance with agency procedures.[8] The COR's duties for the Full Facility Standby Generator contract, as delegated by the contracting officer, included rejecting unsatisfactory services and assurance of contractor compliance with the technical requirements of the contract. Even though the FAR states that the contracting officer could designate a COR, the Chief, Engineering Service, nominated the COR for the Full Facility Standby Generator contract. According to the contracting officer, she relied upon the Chief, Engineering Service's nomination and verified that the nominated COR was a certified COR.

According to the COR's training records, he had received Federal Acquisition Institute COR Level II certification on August 21, 2013.[9] In addition, the COR received an OSHA 30-hour Construction Safety certification, which included excavation related training, on September 2, 2011. However, according to the COR, he had never overseen an excavation project. His previous work experience primarily involved responsibilities as an electrician. From April 1983 until April 2010, his experience included working as an electrician and an electrical contractor. In May 2010, he was hired by VAMC Muskogee as an engineering technician. On June 24, 2014, he was assigned as the COR on this project. The Oklahoma's Construction Industry Board License Verification website showed the COR was licensed as an electrical journeyman until the license expired on September 30, 2008. The COR was licensed as a mechanical apprentice until his license expired on November 8, 1997.

The COR's decisions throughout the project demonstrated his inexperience managing an excavation. For example, according to the COR, he allowed excavation to occur without a required excavation and shoring design plan. In addition, the COR accepted an excavation and shoring design plan that contained calculation errors, and allowed disposal of excavated soil in an area

[7] FAR Subpart 1.602-2(d), *Responsibilities* (May 29, 2014).
[8] FAR Subpart 1.602-2(d)(3).
[9] The Federal Acquisition Institute COR Level II is one of three COR certification levels. A Level II certification requires that a COR have one year of previous COR experience, and 40 hours of training.

with demolition and construction debris, which should have signaled to the COR that an additional assessment should have been conducted. Therefore, it was imperative that the Chief, Engineering Service, select a COR with the appropriate level of experience necessary to oversee the excavation portion of the Full Facility Standby Generator contract.

High Precipitation

Unusually high precipitation may have also contributed to the hillside collapse. National Weather Service historical data showed that Muskogee's average rainfall between April and June was about 14.5 inches, and the area received about 22.7 inches of rainfall during the three-month period from April to June 2015. Therefore, in 2015 Muskogee received about an additional eight inches more than the average rainfall during the same period.

Table 1: Muskogee, Oklahoma, Rainfall

Month	Average Rainfall *(in inches)*	2015 Rainfall *(in inches)*
April	3.97	4.25
May	6.08	13.14
June	4.46	5.29
Total	**14.51**	**22.68**

Source: VA OIG compilation of National Weather Service data

Contract Termination and Costs To Mitigate Damages

According to a February 1, 2017 Memorandum of Record from the United States Army Corps of Engineers, VA requested assistance to review the Full Facility Standby Generator and hillside stabilization projects. After meeting with VA officials, the United States Army Corps of Engineers informed VA that the risk of continuing movement and eventual failure of the shoring wall was unacceptably high and recommended remediation be made as soon as possible. On February 2, 2017, VA suspended the Full Facility Standby Generator contract with BCI Construction. On March 7, 2017, VA terminated the contract for the convenience of the government. According to the contracting officer, contract termination occurred because of the inability to complete the project due to instability of the hillside disposal location.

As of August 2017, VA had spent nearly $5 million. VA's costs to repair the hillside and parking lot, as well as to redesign, remove, and reconstruct the shoring wall, would add about $17.5 million to the costs already incurred. In addition to the approximately $22.5 million in paid and anticipated costs, which would far exceed the original $8.7 million awarded for the Full Facility Standby Generator contract, VA will likely incur additional costs as a result of the termination of the contract.

The FAR allows contractors up to one year from the date of contract termination to submit documentation to the contracting officer for compensation.[10] Therefore, BCI Construction had until March 7, 2018, unless an extension was granted, to submit documentation requesting compensation for the Full Facility Standby Generator contract termination. As of October 2017, BCI Construction had not provided estimates of the additional costs to the contracting officer. However, BCI Construction informed the contracting officer that there would be additional costs associated with contract termination.

The $22.5 million that VA has spent and anticipates spending could have been put to better use to fund other initiatives. Instead, VA will need to fix mistakes that occurred due to the COR not following contract requirements; the COR failing to properly assess the hillside as a disposal location; and the Chief, Engineering Service, not appointing a COR with the proper experience.

Recommendations

1. The OIG recommended the Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, ensure contracting officer's representatives comply with duties assigned in the Delegation of Authority Memo.
2. The OIG recommended the Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, ensure that on future contracts, the Chief, Engineering Service, assign contracting officer's representatives who have experience commensurate with delegated responsibilities in accordance with the Federal Acquisition Regulation.

Management Comments

The Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, concurred with the recommendations. To address Recommendation 1, the Director reported that CORs will be reviewed quarterly by the Chief of Logistics to ensure compliance with the duties stated in the Delegation of Authority Memo. The review will be shared with the Administration Executive Board, which reports to the Executive Governing Board for executive oversight.

To address Recommendation 2, the Director reported that the Chief, Engineering Service, will receive written assurance from the COR nominee that they are qualified for the project. The assurance will be monitored by the Chief, Engineering Service, who will consult with the Veterans Integrated Service Network capital asset management, as needed, for assistance in reviewing qualifications or technical assistance.

[10] FAR Subpart 52.249-2(e), *Termination for Convenience of the Government (Fixed-Price)* (April 2, 2012).

OIG Response The Medical Center Director's corrective actions are responsive to the recommendations. The OIG will monitor the implementation of planned actions and will close the recommendations when sufficient evidence demonstrating progress in addressing the recommendations is received.

Finding 2 VA Provided Inadequate Assurance of Contractor Compliance with Safety Requirements

The OIG substantiated the allegation that VA officials provided inadequate assurance of contractor compliance with OSHA safety requirements at the excavation site. Specifically, safety inspections at the excavation site were ineffective and the contracting officer was not always notified of identified safety violations. This occurred because the CSO did not follow VHA construction safety policy on the frequency of safety inspections and did not effectively implement safety inspection requirements. Further, the contracting officer and COR or project engineer did not delegate safety responsibilities. This could have ensured the contracting officer was notified of identified safety violations at the excavation site. As a result, the contracting officer was prevented from making a determination as to whether or not administrative actions were necessary to ensure a safe environment at the excavation site.

Ineffective Safety Inspections

The CSO did not conduct safety inspections on a weekly basis as required by VHA construction safety policy. In addition, when safety inspections were performed they were routinely done on the same days of the week. Not conducting safety inspections as frequently as required by VHA construction safety policy, and routinely conducting inspections on the same days of the week, hampered efforts to ensure contractor compliance with safety requirements at the excavation site.

According to VHA construction safety policy, the Multi-Disciplinary Team is responsible for ensuring the Construction Safety Program includes periodic construction site hazard surveillance activities[11] with appropriate membership, scope, and frequency for each project, as determined by the CSO and the pre-construction risk assessment.[12] Weekly surveillance activities are required with reports or checklists submitted to the CSO. Any identified hazardous conditions must be communicated either orally or in written format to the contracting officer, who must take prompt corrective measures.

Safety inspection records indicated that weekly inspections were performed over a total of 48 weeks. However, safety inspections should have been performed during each of the 107 weeks between the excavation starting on January 20, 2015, and when VA suspended the contract on February 2, 2017. Safety inspections were not performed during 59 of the 107 weeks (55 percent). During the 59 weeks, there were extended periods of time when no safety inspections were performed.

[11] The team determined the "hazard surveillance activity" the CSO performed was a "safety inspection." The OIG uses the term "safety inspection" throughout the report.
[12] VHA Directive 2011-036, *Safety and Health During Construction* (September 22, 2011).

These extended periods include:

- 7 weeks from July 19, 2015 to August 30, 2015
- 12 weeks from November 1, 2015 to January 17, 2016
- 7 weeks from May 15, 2016 to June 26, 2016
- 9 weeks from August 7, 2016 to October 2, 2016
- 16 weeks from October 16, 2016 to January 29, 2017

Safety inspection records also indicated that during the period January 2015 to October 2016, the CSO conducted 83 safety inspections. Of the 83 inspections, the majority were conducted on the same two days of the week. Specifically, 75 of the 83 inspections (90 percent) were conducted on Wednesday or Friday. The table below lists the number of inspections that occurred on each day of the week, the number of OSHA violations identified, and other issues identified during the inspections.

Table 2. Days of Safety Inspections and Number of Violations Identified

Day of Inspection	Number of Inspections	Number of OSHA Violations	Number of Other Issues
Monday	0	0	0
Tuesday	7	10	1
Wednesday	**39**	**23**	**1**
Thursday	1	1	0
Friday	**36**	**15**	**2**
Total	83	49	4

Source: VA OIG compilation of safety reports obtained from CSO; April 2017

The CSO identified 49 OSHA violations and four other issues during the 83 inspections of the excavation site. Some inspections identified as many as five violations. The OSHA violations included employees not being protected from cave-ins by a shoring wall, garbage and other waste not being disposed of on a regular basis, and loose materials not being secured in windy conditions. The other issues included portable toilets not being cleaned and not adequately restricting access to hazardous equipment and supplies. The CSO stated that he did not provide the results of the safety inspections to the contracting officer.

OSHA Safety Issues Not Communicated

According to the contracting officer, she was not notified of other safety-related issues that occurred during the construction project. VHA construction safety policy states that all staff are responsible for identifying hazardous conditions that must be communicated to the contracting officer (or

other personnel responsible through delegation of authority by the contracting officer), who must take prompt corrective measures.[13]

Safety violations were not reported to the contracting officer, as required by VHA construction safety policy. For example, according to the CSO, he did not notify the contracting officer of the safety violations cited in the weekly inspection reports. In addition, according to a member of the Construction Safety Committee, the committee member met with the VAMC Director; Chief, Engineering Service; and the Executive Assistant to the Associate Director on April 2, 2015, to discuss safety concerns during excavation. During this meeting, an information letter was presented that discussed safety-related issues with the excavation and included photographs of individuals in violation of OSHA safety requirements for personal protective equipment. However, according to the contracting officer, the information from the meeting, including the information letter, was not provided to her by anyone who attended the meeting.

The OIG team obtained additional photographs, not included in the information letter, from VAMC employees that showed OSHA safety violations. According to the CSO, he was only aware of one of the photographed safety violations. Although there is no requirement for the CSO to be on site at all times, there is an expectation that known safety violations be reported to the contracting officer for corrective action in compliance with VHA construction safety policy.[14]

Figure 3 illustrates an example of individuals at the excavation site without required personal protective equipment.[15] This is an example of a safety violation that was identified by a VA employee and not reported.

[13] VHA Directive 2011-036, *Safety and Health During Construction* (September 22, 2011).
[14] *Ibid.*
[15] 29 CFR § 1926 prescribes safety requirements for personal protective equipment for construction, such as hard hats and vests, as well as protection from falling by the use of guardrail systems or personal fall arrest systems.

Figure 3. Lack of Personal Protective Equipment, Protection from Falling Debris, and Fall Arrest System

Source: VAMC employee; Excavation Site, Muskogee, OK; March 31, 2015

In accordance with the FAR, the contracting officer is required to notify the contractor of any condition that poses a serious or imminent danger to the health or safety of the public or government personnel. This notice shall be deemed sufficient notice of noncompliance and that corrective action is required. Further, if the contractor fails to promptly take corrective actions, the contracting officer may issue an order stopping all or part of the work until satisfactory corrective action has been taken.[16] According to the contracting officer, she relied on the COR and CSO for information regarding safety violations for the Full Facility Standby Generator project. She stated that she had not been provided any information regarding safety violations for this project until April 29, 2015. On April 29, 2015, she received an email from the COR stating that BCI Construction's noncompliance with FAR created a safety hazard and caused interruption to the government's day-to-day operations.[17] This email discussed excavation safety but did not include any information related to individuals without personal protective equipment, as required by OSHA.

Failure to notify the contracting officer of safety violations hindered the contracting officer from taking immediate and appropriate corrective action, as necessary, to ensure a safe environment at the excavation site.

[16] FAR Subpart 52.236-13, *Accident Prevention* (November 1991).
[17] FAR Subpart 52.236-9, *Protection of Existing Vegetation, Structures, Equipment, Utilities, and Improvements* (April 1984); and FAR Subpart 52.236-13.

Why This Occurred

Inadequate assurance of contractor compliance with OSHA safety requirements occurred because safety inspections were not performed with the frequency required by VHA construction safety policy. Further, the CSO did not effectively implement safety inspection requirements, and the contracting officer and COR or project engineer did not comply with VHA construction safety policy for delegating safety responsibilities.

Safety Inspections Did Not Follow VHA Policy

According to the CSO, he attributed the gaps in the weekly safety inspections to no work being performed at the excavation site, the contract being suspended, or that he was on leave. However, safety inspections were performed while no work was being conducted. Specifically, during the 96 weeks work was not being performed at the site, the OIG team found 66 safety inspections were conducted. During these 66 safety inspections, 46 of the 49 OSHA violations (94 percent) at the site were identified.

For example, after construction was stopped on April 2, 2015, and prior to work resuming on January 20, 2016, a safety inspection was performed on May 22, 2015, that identified three OSHA violations and a noncompliance with best practices. Another example was after the shoring wall was completed on February 25, 2016, and prior to suspension on February 2, 2017, a safety inspection was performed on October 11, 2016, that identified two OSHA violations and a noncompliance with best practices. In addition, the OSHA violations that occurred while work was not being performed included sidewalks, pavements, and structures being undermined and not properly supported. Even if the CSO was on leave, there should have been another VA official assigned the task of performing the safety inspection to ensure compliance with VHA construction safety policy. Had the safety inspections been continued, they could have helped to ensure continued contractor compliance with safety requirements.

Ineffective Implementation of Safety Inspection Policy

VHA construction safety policy requires periodic safety inspections. While the CSO followed this VHA construction safety policy requirement,[18] his implementation of the safety inspection requirement was ineffective because the CSO routinely performed safety inspections on the same two days of the week, Wednesday and Friday. By conducting safety inspections on the same two days each week, he created a pattern that allowed contractor personnel to anticipate when safety inspections would occur, removing the element of surprise and giving them the ability to alter their behaviors. Had the CSO conducted safety inspections in a less discernable pattern, the CSO could have better ensured that the contractor was maintaining compliance with safety requirements throughout the week.

[18] VHA Directive 2011-036, *Safety and Health During Construction* (September 22, 2011).

Delegation of Safety Responsibilities Not Clearly Defined

The contracting officer and COR or project engineer did not delegate safety responsibilities. This could have ensured the contracting officer was notified of identified safety violations at the excavation site. According to VHA construction safety policy, the contracting officer and COR or project engineer has the responsibility to designate, through a letter of delegation, the COR, CSO, chief engineer, or safety program manager to serve as the safety officer for VHA contracts.[19]

The contracting officer and COR or project engineer did not designate a safety officer for the Full Facility Standby Generator project, as required by VHA construction safety policy.[20] In addition, the COR's delegation letter specifically stated the COR was not delegated safety responsibilities. The lack of a safety officer designation led to confusion over who was responsible for reporting safety violations to the contracting officer. For example, the CSO stated that he normally would have reported violations to the contracting officer but instead reported safety violations to the COR because the contracting officer was not on site. Consequently, the contracting officer was not promptly notified of identified safety violations that occurred during the performance of this contract.

Contracting Officer Prevented From Taking Action

The CSO did not follow VHA construction safety policy to perform weekly safety inspections nor did he effectively implement safety inspections of the construction site. In addition, the contracting officer was not always notified of identified safety violations that occurred at the excavation site. As a result, the contracting officer was prevented from making a determination as to whether or not administrative actions were needed to ensure a safe environment at the excavation site.

Recommendations

3. The OIG recommended the Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, ensure personnel follow established Veterans Health Administration policies on safety inspections.
4. The OIG recommended the Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, clarify the implementation of the safety inspections in Veterans Health Administration Directive 7715, *Safety and Health During Construction*, April 6, 2017, to ensure the safety inspections are not performed routinely or in a discernable pattern.
5. The OIG recommended the Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, ensure the

[19] VHA Directive 2011-036, *Safety and Health During Construction* (September 22, 2011).
[20] *Ibid.*

assignment of a safety officer in accordance with Veterans Health Administration Directive 7715, *Safety and Health During Construction*, April 6, 2017.

Management Comments

The Medical Center Director, Eastern Oklahoma Department of Veterans Affairs Health Care System, concurred with the recommendations. To address Recommendations 3 and 4, the Director reported that the Medical Center Memorandum for construction projects and contractor safety was amended to specify VHA policy for personnel actions on safety inspections and construction projects. In addition, the Director reported the Construction Safety Sub-Committee conducts random, periodic inspections, at a minimum of once per week to ensure compliance with safety elements.

To address Recommendation 5, the Director stated he will verify a CSO is designated for each construction project. The written designation will be monitored by the Chief of Safety Emergency Management Program Service and reported through the Environment of Care Committee. He also reported the Chief of Safety Emergency Program Management Service now directly reports to the Associate Director and this realignment was made to remove potential conflicts of interest. The past practice was for this role to report to the Chief of Engineering.

OIG Response

The Medical Center Director's corrective actions are responsive to the recommendations. The OIG will monitor the implementation of planned actions and will close Recommendations 3 and 5 when sufficient evidence demonstrating progress in addressing the recommendations is received. The OIG considers Recommendation 4 closed based on the actions reported and the documentation provided.

Finding 3 VA Employees Did Not Misuse VA Equipment at the Excavation Site

The OIG did not substantiate the allegation that VA employees used VA equipment to remove soil from the excavation site. The complainant alleged the COR directed a VAMC Muskogee employee to move the soil to the back of the campus using VA equipment and staff. According to VA officials, the contractor used contractor-owned equipment to remove the soil from the excavation site.

Appendix A Background

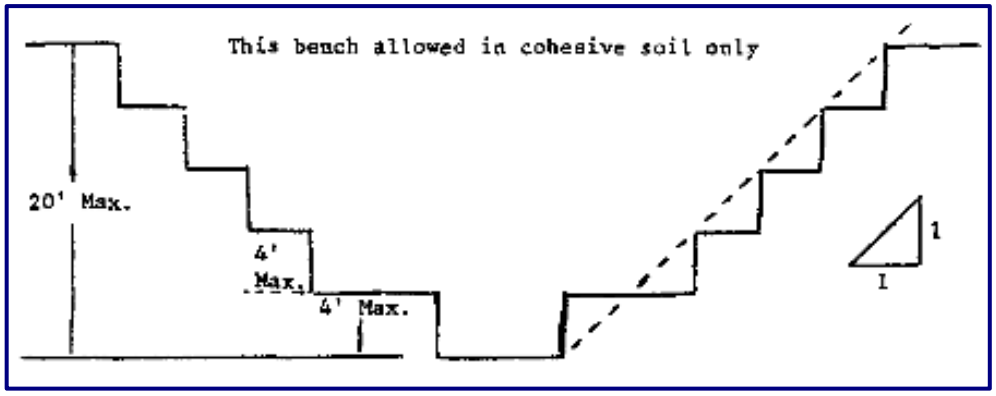
Architect-Engineer Contract

On June 25, 2012, Network Contracting Office 16 awarded Spur Design LLC the A-E contract for about $851,000. The contract stipulates that the firm would develop the construction contract documents, including construction drawings, specifications, and a detailed cost estimate.

BCI Construction Contract

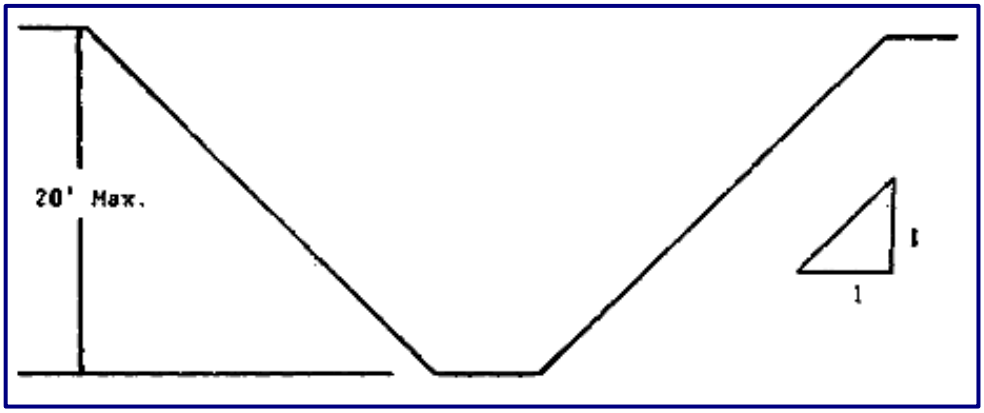
VA awarded BCI Construction an $8.7 million contract, which required BCI Construction to excavate and construct a new building for the Full Facility Standby Generator. The following figures provide examples of options of protection methods used during excavation.

Figure 1. Example of Benching



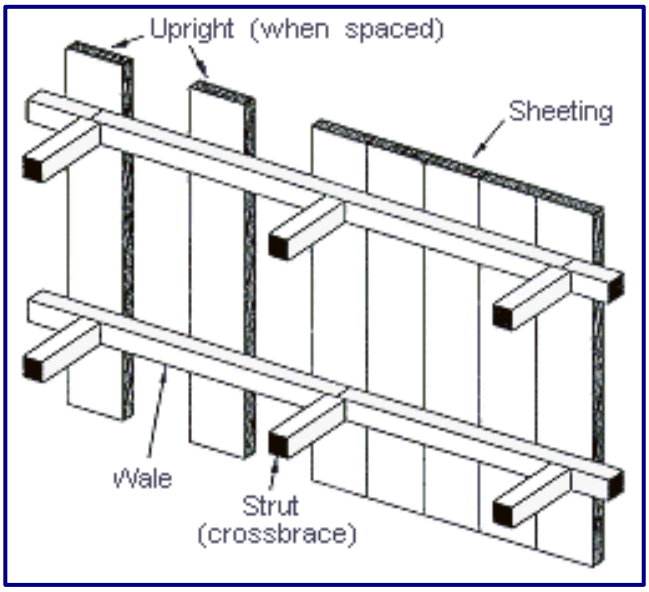
Source: OSHA Regulations (Standards - 29 CFR) website; April 27, 2017

Figure 2. Example of Sloping



Source: OSHA Regulations (Standards - 29 CFR) website; April 27, 2017

Figure 3. Example of Shoring



Source: OSHA Regulations (Standards -29 CFR) website; April 27, 2017

Appendix B Scope and Methodology

Scope

The OIG team conducted its review work from September 2015 through December 2017. The review focused on determining the merits of the allegations regarding hazardous conditions created by the contracting officer, the COR, the facility safety manager and the Chief, Engineering Service, during the installation of a Full Facility Standby Generator System at the Jack C. Montgomery VAMC in Muskogee, Oklahoma. The team did not attempt to determine BCI Construction's or the A-E contractor's culpability for the issues that occurred during the Full Facility Standby Generator project.

Methodology

To perform our review, the OIG team conducted a site visit at the VAMC on September 21, 2015. The team also reviewed contract documentation, applicable laws, VA and VHA directives, and handbooks relevant for determining compliance with acquisition requirements. In addition, the team conducted interviews with Network Contracting Office 16 contracting officials, the contracting officer, the COR, the CSO, and other engineering staff involved with the contract. The team also conducted an interview with a representative from the United States Army Corps of Engineers to obtain information regarding its involvement with the Full Facility Standby Generator and hillside stabilization projects.

Fraud Assessment

To assess the potential for fraud, the OIG team reviewed relevant contract documentation and held discussions with contract officials to assess the accuracy of gathered evidence. The team also coordinated with OIG's Office of Investigations and confirmed there were no ongoing investigations regarding the Full Facility Standby Generator contract at VAMC Muskogee, Oklahoma. The team found no indications of potential fraud.

Data Reliability

The OIG team obtained safety inspection reports dated between January 27, 2015 and October 11, 2016, that were generated from safety-reports.com software. The team obtained and reviewed information about the software from the system user and performed an analysis to identify any errors. This was done by comparing the reported OSHA violations or noncompliance with best practices in the safety inspection reports with a detailed observation report that also lists the total number of OSHA violations and noncompliance with best practices for calendar years 2015 and 2016. Based on this review of the reports, the team determined the system data were reliable for the purposes of the review.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix C Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Actual costs paid to mitigate damages and cost of contract paid to date	$5,060,496[21]	$0
1, 3	Approximate costs expected to be paid to permanently repair damages	$17,479,974[22]	$0
	Total	$22,540,470	$0

[21] To calculate this amount, the team reviewed and compiled actual costs paid from contract and agreement documents for the issues identified in the report that include unused supplies or materials that were paid for under the Full Facility Standby Generator contract and storage ($3,358,752.19), additional services for outside assistance and supplies for the Full Facility Standby Generator contract ($2,300), and services and supplies to temporarily or permanently fix the problems with the excavation and hillside ($1,699,444), totaling $5,060,496.19.

[22] To calculate this amount the team reviewed and compiled cost estimate information created for VA.

Appendix D Management Comments

Department of Veterans Affairs Memorandum

Date: February 26, 2018

From: Health Care System Director, Eastern Oklahoma VA HCS (00/623)

Subj: Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center

To: Assistant Inspector General for Audits and Evaluations (52)

Thru: Network Director, VA Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. The status update is on the attached tracking template including supporting documents where appropriate.

3. If there are questions, please contact Martha Hardesty, RN, Performance Improvement Specialist for OIG at 918-577-3473, or the VISN 19 Quality management Specialist, at 303-202-8165.

(Original signed by)

Mark E. Morgan, MHA, FACHE

Ralph T. Gigliotti, FACHE

Attachment

For accessibility, the format of the original memo has been modified to fit in this document.

Attachment

EASTERN OKLAHOMA VA HEALTH CARE SYSTEM

Draft Report Reponses

OIG Draft Report: Review of Alleged Hazardous Construction Conditions at the Jack C. Montgomery VA Medical Center

Date of Draft Report: January 19, 2018

Recommendation 1. We recommended the Medical Center Director, Eastern Oklahoma VA Health Care System ensure Contracting Officer's Representatives (COR) comply with duties assigned in the Delegation of Authority Memo.

VHA Comments: Concur.

The Contracting Officer's Representatives (COR) will be reviewed quarterly by the Chief of Logistics to ensure compliance with duties as stated in the Delegation of Authority Memo. This review will be shared by the Chief of Logistics to the Administration Executive Board. This Administration Executive Board reports to the Executive Governing board for executive oversight.

Status: In Progress **Target Completion Date:** March 1, 2018

Recommendation 2. We recommended the Medical Center Director, Eastern Oklahoma VA Health Care System ensure that on future contracts the Chief, Engineering Service assign Contracting Officer's Representatives who have experience commensurate with delegated responsibilities in accordance with the Federal Acquisition Regulation.

VHA Comments: Concur.

Prior to assignment of the Contracting Officer Representatives, the Chief of Engineering will ascertain, in writing, the nominee's assurance that they are qualified for the project. This assurance for qualified Contracting Officer Representative practices will be monitored by the Chief of Engineering, who will consult with the VISN Capital Asset Management as needed for assistance in reviewing qualifications and/or technical assistance.

Status: Complete **Target Completion Date:** January 26, 2018

Recommendation 3. We recommended the Medical Center Director, Eastern Oklahoma VA Health Care System ensure VA personnel follow established Veterans Health Administration policies on safety inspections.

VHA Comments: Concur.

Medical Center Memorandum 01S-03, Construction Projects and Contractor Safety, has been amended to specify VHA policy for personnel actions on safety inspections for construction projects. The Construction Safety Sub-Committee is composed of representatives from the following program areas: Infection Control, Patient Safety, Occupational Safety and Health, VA Police, Engineering, Engineering (Project Management), Green Environmental Management System (GEMS), Local Union Representative, Contracting, Emergency Planning, and Employee Occupational Health. Each of these members have current certificates of construction safety training on file in the facility Eastern Oklahoma Healthcare Safety Office and as of 2/8/2018 staff have 100% (11 employees completed education / 11 employees requiring education) compliance in education/training.

Status: Complete **Target Completion Date:** February 13, 2018

Recommendation 4. We recommended the Medical Center Director, Eastern Oklahoma VA Health Care System clarify the implementation of the safety inspections in Veterans Health Administration Directive 7715, *Safety and Health During Construction*, April 6, 2017, to ensure the safety inspections are not performed routinely or in a discernable pattern.

VHA Comments: Concur.

Medical Center Memorandum 01S-03, Construction Projects and Contractor Safety, has been amended to specify VHA policy for personnel actions on safety inspections for construction projects. The Construction Safety Sub-Committee conducts random, periodic inspections, at a minimum of once per week to ensure compliance with safety elements. Safety rounds are being documented by the Chief of Safety Emergency Management Program Service (SEMPS) and reported through the Construction Safety Sub-Committee. These findings are reported up to the Environment of Care Committee (EOC). The Environment of Care Committee reports to the Administrative Executive Board for executive oversight. The Chief of SEMPS now directly reports to the Associate Director. The position was realigned to remove potential conflicts of interest. The past practice was for this role to report to the Chief of Engineering.

Status: Complete **Target Completion Date:** February 13, 2018

(Note: One MS Word document inserted as an attachment – available through the VA OIG Information Officer.)

Recommendation 5. We recommended the Medical Center Director, Eastern Oklahoma VA Health Care System ensure the assignment of a safety officer in accordance with Veterans Health Administration Directive 7715, *Safety and Health During Construction*, April 6, 2017.

VHA Comments: Concur.

The Medical Center Director will verify the Construction Safety Officer is designated for each construction project. Written designation will be monitored through by the Chief of Safety Emergency Management Program Service (SEMPS) and reported through Environment of Care Committee (EOC). The Chief of SEMPS now directly reports to the Associate Director. The position was realigned to remove potential conflicts of interest. The past practice was for this role to report to the Chief of Engineering.

Status: Complete **Target Completion Date:** January 26, 2018

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

Appendix E OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Judith Sterne, Director Roland Baltimore Christopher Bowers Melissa Colyn Angela Espinosa Sarah Florino David Kolberg Thomas Pasquini

Appendix F Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeal

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: James Inhofe, James Lankford
U.S. House of Representatives: Jim Bridenstine, Tom Cole, Frank Lucas, Markwayne Mullin, Steve Russell

This report is available on the OIG website at www.va.gov/oig.