Department of Energy
Washington, DC 20585
June 1, 2004

MEMORANDUM FOR THE SECRETARY

FROM: Gregory H. Friedman
Inspector General

SUBJECT: INFORMATION: Investigation of Allegations Involving Occupational Medical Services and Tank Farm Vapor Exposures at the Hanford Site (OIG Case No. I04RL003)

INTRODUCTION

On February 24, 2004, you requested that the Office of Inspector General (OIG) conduct an investigation of activities associated with the provision of occupational medical services to U.S. Department of Energy and contractor employees at the Hanford Site. In response to your request, OIG Special Agents initiated an investigation into specific events and incidents involving alleged criminal misconduct. These allegations—which involved potential false claims, false statements, conspiracy and other related misconduct—included:

- Alteration and destruction of medical records at the Hanford Environmental Health Foundation (HEHF), the Department contractor that provides occupational medicine and industrial hygiene services to about 11,000 contractors and workers on the Hanford site;
- False injury reporting by Hanford contractors;
- Cover-up of ammonia vapor readings at the tank farms by employees of CH2M Hill Hanford Group, Incorporated (CH2M Hill), the Department contractor that manages the tank farms at Hanford; and,
- Other potential violations of law.

This letter report summarizes the results of our investigation. It also provides observations from our review as well as a discussion of a path forward.

OVERVIEW

During the course of the investigation, the OIG conducted extensive interviews of over 70 current and former Department Federal and contractor employees at Hanford, and obtained and analyzed volumes of documents. The OIG also retained the services of an independent medical and Occupational Safety and Health Administration (OSHA) regulations specialist to review medical files and safety records.

Based on the facts developed during the investigation, we provided a detailed briefing to the United States Attorney's Office for the Eastern District of Washington. The United States Attorney's Office declined to pursue criminal prosecution on this matter. Therefore, absent additional relevant and compelling information, we intend to close this case.

Inasmuch as this was a criminal investigation of specific alleged events and activities, we did not focus on general concerns with mismanagement, the technical aspects of tank vapor monitoring activities, whether medical services met professional standards, or the merit of individual worker's compensation claims. It was our understanding that these topics were included, either directly or indirectly, in other concurrent reviews involving the Hanford site. In this regard, during the course of our investigation, we furnished relevant information regarding potential administrative or operational irregularities at Hanford to other offices performing programmatic reviews of these subjects.

RESULTS OF INVESTIGATION

A summary of the investigative results follows:

1. *Alteration and destruction of medical records at HEHF*

It was alleged that HEHF personnel made inappropriate changes to patients' medical files. The changes allegedly resulted in the misrepresentation of the nature, cause, extent and/or severity of injuries or illnesses. Individuals believed that the changes were often prompted by pressure placed on HEHF physicians by contractor safety representatives. It was also alleged that HEHF recently shredded documents, presumably to destroy evidence of wrongdoing.

The facts developed during the investigation did not substantiate criminal misconduct with regard to the alteration and destruction allegations. Further, the independent medical and OSHA specialist retained by the OIG reported that: (1) HEHF medical files were detailed, well-organized, and consistent with standard medical practices; (2) changes and modifications to documents and/or entries in medical files appeared to be reasonable and proper; and, (3) no improper alteration, destruction, and/or manipulation of records was identified. The specialist conducted a review of a sample of files relating to worker injuries and illnesses at the Hanford Site, including patient medical files, contractor safety files, and related documentation. The sample was drawn from a universe of cases identified—primarily by OIG witnesses—as potentially having improper alterations, documents removed, or issues relating to recordability.

2. *False injury reporting by Hanford contractors*

It was alleged that there was an ongoing conspiracy between the Hanford site contractors' safety representatives and HEHF management to avoid creating and documenting recordable injuries. Witnesses provided examples in which contractors allegedly required injured workers who should have stayed home to report to work but perform no duties. The OIG also examined aspects of contractor input of data into a Department database that is used to collect and analyze reports of injuries, illnesses, and other accidents.

The facts developed during the investigation did not substantiate criminal misconduct with regard to injury or illness reporting. However, the investigation did verify a single instance where a former Hanford site subcontractor in 1999 encouraged an injured employee to report to work following a work-related injury, yet the subcontractor had the employee perform no duties for 5 days. The employee remained on restricted duty for another 24 days. The subcontractor did not conceal the nature or cause of the injury itself, and it was documented as "recordable." The subcontractor's actions were, nonetheless, troubling.

3. *Cover-up of ammonia vapor readings at the tank farms by employees of CH2M Hill*

The OIG pursued allegations that employees of CH2M Hill had taken steps to cover up excessively high vapor exposure readings at the tank farms. High exposure readings allegedly were either not documented or misrepresented. The OIG focused on the two specific vapor exposure incidents provided as examples by witnesses.

The facts developed during the investigation did not substantiate criminal misconduct relating to alleged cover-ups of vapor readings. With respect to the first incident, the OIG identified conflicting testimony among various witnesses. We were unable to reconcile the differences through other witnesses or available documentation, and no independent corroborating evidence was found to support either version of events with certainty. With respect to the second incident, two witnesses initially identified to the OIG as having valuable information did not provide such corroborating information.

4. *Other potential violations of the law*

The OIG also investigated several additional allegations that did not fall within the three categories described previously. These included allegations that: (1) HEHF artificially inflated results in an annual performance self-assessment report; (2) a Department supervisor improperly removed relevant information from a report that was critical of a contractor's occupational injury and illness reporting and recordkeeping program; (3) HEHF improperly maintained two sets of medical records; and, (4) there was a conspiracy to develop an intentionally vague "Record of Visit," a form that is used by HEHF to record assorted information about a patient's visit, in order to facilitate the underreporting of injuries and illnesses.

The facts developed during the investigation did not substantiate criminal misconduct with regard to these allegations. However, the OIG received conflicting testimony from various witnesses with respect to the annual self-assessment allegation, and we were unable to reconcile these differences through other witnesses or available documentation. No facts were developed to support the other allegations in this area.

OBSERVATIONS

Although criminal allegations were the focus of our investigation, we observed several worker health and safety protocols that need to be addressed by Federal managers at the Hanford site. Specifically, action is needed to ensure that:

1. *Industrial Hygiene Technicians (IHT) take vapor exposure readings in a timely manner following reported exposure incidents at the tank farms and document exposure readings in appropriate reports.*

   During an examination of the vapor exposure cover-up allegation, the OIG determined that an IHT failed to record vapor monitoring data on a "Direct Reading Instrument" (DRI) survey form, as required by the contractor's tank farm monitoring policies and procedures. The reading was recorded instead in a log book. Additionally, the vapor reading was not taken until approximately two hours after the exposure was reported.

2. *Site employees on work restriction are assigned meaningful duties.*

   The OIG identified a troubling instance where a former Hanford Site subcontractor in 1999 encouraged an injured worker to show up at the job site but perform no duties, rather than remain at home. Despite the placement of work restrictions on this employee, and documenting the injury as "recordable," the subcontractor's actions raise questions about its practices.

3. *Patient care is not inappropriately influenced by whether the care will make an injury or illness "recordable."*

   The OIG identified internal HEHF e-mails that some recipients interpreted as encouraging physicians to emphasize recordability of injuries over patient standard of care. The OIG received no confirmation that care was, in fact, improperly compromised. However, unclear communications such as these appear to have led to concerns over the provision of patient care.

4. *Work restrictions following injuries and illnesses are identified and applied in a timely manner.*

   The OIG identified a particular worker who was not given an immediate work restriction following a diagnosis for beryllium sensitivity, in accordance with standard medical practice.

Additionally, we found that the Department did not always utilize contractor self-assessments and internal quality assurance reviews when evaluating performance relative to the provision of contractor occupational medical services. Internal reviews, when coupled with effective contractor metrics, can provide useful performance information to responsible Federal program officials.

PATH FORWARD

As noted previously, we interviewed over 70 individuals with knowledge of relevant operations at the Hanford Site. During this process, it became clear that, despite major health and safety efforts by the Department of Energy, a significant number of individuals interviewed had unresolved concerns about the safety of the work at Hanford, the potential for health problems as a result of this work, and the quality of occupational health care provided to Hanford employees. Given the challenges at Hanford, where the acknowledged risks to the workforce are significant, some level of concern would be understandable even if the Department's occupational health program worked perfectly. However, the number, scope, and continuing nature of the employee and citizen concerns we heard during our investigation suggest that management needs to intensify its efforts to improve employee confidence in the occupational health and safety program at Hanford. One example of an action we believe would be beneficial is evaluating current mechanisms for receiving, analyzing and addressing employee complaints about occupational medical services. A more effective and robust program for dealing with employee concerns has the prospect of building employee and public confidence in worker safety at the Hanford site.