Richmond City Council

The Voice of the People — Richmond, Virginia

Office of the Inspector General

June 25, 2021

Mr. Lincoln Saunders
Interim Chief Administrative Officer
City of Richmond

The Office of the Inspector General (OIG) has completed an investigation in the Department of Public Utilities (DPU). This report presents the results of the investigation.

Allegation:

The Office of Inspector General received a complaint alleging an employee from the Department of Public Utilities turned on the gas at a residence and did not perform the proper turn-on procedure.

Legal Requirements:

In accordance with the Code of Virginia, §15.2-2511.2, the Office of the Inspector General is required to investigate all allegations of fraud, waste, and abuse. Also, City Code section 2-231 requires the Office of the Inspector General to conduct investigations of alleged wrongdoing.

Findings:

The employee was identified as an Acting Gas and Water Service Technician Supervisor assigned to the Department of Utilities, Richmond Gas Works. The employee was assigned a residential gas service order and proceeded to the location to turn on the Gas. The employee turned on the Gas and five hours later the customer called complaining of a Gas leak.

A second Technician responded to the Gas leak and noticed the gas meter registering fast along with the odor of gas. The second Technician shut off the gas and began investigating the source of the leak. The Technician found a pipe in the rear of the exterior of the home not capped. The Technician removed the meter and plugged lines and cut the gas from the curb.

The investigator conferred with the Deputy Director of Public Utilities to request all documentation related to this Gas leak. The Deputy Director forwarded documents to the Investigator to include a document titled Memo of Conversation and a document

titled Performance Action Plan. These documents are dated December 18, and 19, 2019 respectively. The investigator was able to determine that these two documents were created on March 3, 2020, which is after the Investigator requested documentation from the Deputy Director.

Interviews:

The investigator interviewed the subject employee who confirmed he/she responded to a Service Order to turn on the gas at a Residence. They conducted the required "shut-in test" and other tests to install the service. The subject employee unlocked the meter, marked the spot, and proceeded to watch the meter for the required 5-10 minutes, at which time the meter read no registration. The subject employee left the location and continued his/her duties. Later in the evening, the Subject employee heard the report of a gas leak and the Residence which was previously visited by the subject employee. The subject employee returned to the residence and stated they did not notice any odor of gas although Fire Department fans were blowing at the front door.

The subject employee was questioned about the gas leak and stated possibly the resident came behind them and took something apart after the initial visit. During the subject's tenure with the Department of Public Utilities, the subject alleges that on other calls citizens/residents have tampered with gas lines causing a leak, but these incidents were never reported. The subject employee admitted to not checking the HVAC ductwork inside the attic nor checking the required piping for the shut-in test.

The subject said he/she received a Performance Action plan on February 27, 2020, prior to a meeting with the OIGs Office. The employee further stated they performed a ride along with a Utilities Field Specialist and completed the required review of the training manual with a supervisor.

The subject employee was shown the Performance Action Plan memo showing specific times and dates of the training and the names of the supervisors who were to conduct the review of the manual which is not the individual who the subject named as the person who reviewed the manual with the subject. The subject employee was asked about the inconsistencies of the Performance Action Plan the subject employee stated they did not read the memo they just signed it.

The subject employee stated that he/she had a meeting with two supervisors and an Operations Manager and it was explained at that time that a proper shut-in test was not completed.

The investigator interviewed the second technician who stated he/she responded to the gas leak and upon arrival, there was a smell of gas and the meter was moving fast. The second technician turned off the gas and investigated. The second technician stated that a pipe in the rear of the exterior of the home was not capped. The Technician removed the meter and plugged the line and cut off the gas from the curb. There was no evidence of any gas appliance at the residence all appliances were electric (2 electric

air handlers, electric hot water heater, and electric stove. The fire department assisted in airing out the residence.

The investigator spoke to the Operations Manager and asked if he/she was aware of the failed shut-in test. The Operations Manager advised that he/she was informed by the supervisors and he/she allowed them to come up with corrective action. The Operations Manager stated he/she was not involved in the creation of the Memo of Conversation or the Performance Action Plan. The Operations Manager stated he/she only saw those documents when it was sent to the Deputy Director and they did not look at the date that was on the documents.

The investigator interviewed the Utilities Field Supervisor who stated he/she is the Supervisor of the subject employee. The subject employee was dispatched to a residence to set up gas utilities. The subject employee arrived at the location to view the premises and establish gas. He/she performed the required 10 minute "shut-in" test completed the install and left the location. Five hours later a call was received via dispatch for the smell of gas. The subject employee along with several other supervisors, Technicians, and the fire department responded to the address. The first responding technician to the second call, turned off the meter to ensure safety at the residence. The supervisor determined the subject employee did not perform a proper shut-in test and subsequently, the Operations Manager received a letter in regards to a pending investigation of this incident. The Operations Manager read the letter to both the Superintendent and the Supervisor and agreed to place the subject employee on a Performance Action Plan, in addition to counseling and on the job training. This took place in mid-February 2020.

During the interview, the supervisor was asked several questions regarding a memo that was received by the Inspector General's Office. He/she stated the document dates were incorrect, however the Performance Action Plan, counseling session, and ride-along did take place. The ride along was not documented, the department is unable to show the nature of completion. The only way to show completion is when a technician becomes Operations Quality (OQ) qualified.

The supervisor stated the Operations Manager decided since becoming the Quality Control Supervisor the disciplinary action process was changed. Employee mistakes have now become "teachable moments', with additional training and performance action plans. Instead of more administrative actions such as suspensions and or reprimands.

The investigator interviewed the Utilities Field Superintendent in regards to this incident and the creation of the documents Memo of Conversation and Performance Action Plan. The Superintendent stated a Performance Action Plan and training was done to the subject employee. The Superintendent produced documents to support disciplinary action was taken. The Investigator made the Superintendent aware of inconsistencies within the documents and the Superintendent admitted the documents were created after the OIG inquiry. These documents were created by the Superintendent with the knowledge of the Utilities Field Supervisor. The Superintendent said he/she did it to get along with the Supervisor for which there is a tumultuous relationship.

The investigator contacted the Operations Manager who stated he/she was informed by the Supervisors that the subject employee did not perform a proper shut-in test. The Operations Manager further stated he/she allowed the supervisors to come up with corrective action. The Operations Manager stated he/she was not involved in the creation of the Memo of Conversation or the Performance Action Plan. The Operations Manager said he/she seen the documents only when it was sent to the Deputy Director but did not pay attention to the date on the document.

Conclusion:

Based on the findings, the OIG concludes that the allegation is substantiated against the Acting Gas and Water Service Technician Supervisor. The OIG also recommends that all individuals involved in the creation of the Memo of Conversation and the Performance Action Plan receive appropriate disciplinary action.

If you have any questions, please contact me at extension 1840.

Sincerely,

James Osuna,
Inspector General

cc: Alfred Scott, Interim Director Department of Public Utilities
Honorable Members of City Council