OFFICE OF INSPECTOR GENERAL
City of Albuquerque

Melissa Santistevan
Inspector General

P.O. Box 1293, Suite 5025
Albuquerque, New Mexico 87103
Telephone: (505) 768-3150
Fax: (505) 768-3158

Report of Investigation

FILE NO: 22-0162-C

SUBJECT MATTER: Alleged nonfeasance and misrepresentation of fact related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic and abuse of authority and undue influence, by a City Official, resulting in circumvention of City policies and the possibility of conflict of interest between a City Official and the vendor.

STATUS: Final

INVESTIGATOR: M. Santistevan

DocuSigned by:
Melissa R. Santistevan
383279FCC7574DA...

MELISSA SANTISTEVAN
INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL

June 2, 2023
Date of Completion

See Disclaimer
EDMUND E. PEREA, ESQ ACCOUNTABILITY IN GOVERNMENT OVERSIGHT COMMITTEE CHAIRPERSON

July 13, 2023
Date of Issuance

DISTRIBUTION:

Honorable Mayor
President City Council
Chief Administrative Officer
City Councilors
Director Council Services
City Attorney
Department Director
Members, Accountability and Government Oversight Committee
File

TABLE OF CONTENTS

EXECUTIVE SUMMARY

According to City Ordinance §2-17-2, the Inspector General's goals are to (1) Conduct investigations in an efficient, impartial, equitable, and objective manner; (2) Prevent and detect fraud, waste, and abuse in city activities including all city contracts and partnerships; (3) Deter criminal activity through independence in fact and appearance, investigation and interdiction; and (4) Propose ways to increase the city's legal, fiscal and ethical accountability to insure that tax payers' dollars are spent in a manner consistent with the highest standards of local governments.

On September 2, 2022, the Office of Inspector General (OIG) initiated an investigation into the alleged nonfeasance and misrepresentation of facts related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic and abuse of authority and undue influence, by a City Official, resulting in circumvention of City policies and the possibility of a conflict of interest between a City Official and the vendor. This investigation was predicated on the OIG's 22-0116-C Report of Investigation where it was revealed that the City's Transit Department (TD) obtained and utilized four (4) 55-gallon barrels of "bleach/sanitizer" for use on City buses. These barrels were transported by City employees to the Yale Transit facility prior to obtaining proper placards or a safety data sheet (SDS). Investigation 22-0116-C also disclosed a potential abuse of authority and undue influence by a City Official resulting in the circumvention of City policies, and a potential conflict of interest between a City Official and the vendor. The OIG determined that the allegations contained elements of potential fraud, waste, or abuse and that it was appropriate for the OIG to conduct a fact-finding investigation. The purpose of the investigation was to substantiate or not substantiate, through the collection of sufficient evidence, the allegations of nonfeasance and misrepresentation of fact related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic and abuse of authority and undue influence by a City Official resulting in circumvention of City policies and the possibility of a conflict of interest between a City Official and the vendor.

During our investigation, the OIG identified a subsequent matter regarding compliance with Article 17.

As a result of the investigation, the OIG was able to obtain evidence consistent with concluding the allegation of nonfeasance as a result of the City not acquiring the proper documentation for the chemical before obtaining and transporting the chemical occurred. The evidence obtained was consistent with concluding nonfeasance on behalf of the City for not performing due diligence on the vendor or the chemical prior to acquisition or use occurred. The OIG was able to obtain evidence consistent with concluding the alleged misrepresentation of facts occurred as there had been no quality control testing on the efficacy of the chemical by the vendor to support the SDS provided to the City subsequent to the City acquiring the chemical. Additionally, the evidence obtained was consistent with concluding an abuse of authority and undue influence, resulting in the circumvention of City policies. The OIG investigation was inconclusive with regard to Allegation 3 pertaining to a possible conflict of interest between the City Official (A1) and the vendor (VD). The OIG was able to obtain evidence related to the subsequent matter consistent with concluding non-compliance with §2-17-12 (B).

ABBREVIATIONS

A1: City Official
CITY: City of Albuquerque
E1: Transit Employee
E2: Transit Employee
E3: Transit Employee
E4: Transit Employee
FD1: Former Director
FM1: Former Manager
M1: Transit Manager
MSDS: Material Safety Data Sheet
OIG: Office of Inspector General
SDS: Safety Data Sheet
TD: Transit Department
VD: Vendor
V1: Vendor Representative
V2: Vendor Representative

INTRODUCTION

The mission of the Office of Inspector General (OIG) is to promote a culture of integrity, accountability, and transparency throughout the City of Albuquerque in order to safeguard and preserve public trust.

Complaint

Alleged nonfeasance[1] and misrepresentation of facts related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic and abuse of authority and undue influence by a City Official resulting in circumvention of City policies, and the possibility of a conflict of interest between a City Official and the vendor.

Background

Report of Investigation 22-0116-C, dated September 16, 2022, was published in October 2022. This investigation addressed multiple allegations, however, one (1) specific allegation of possible fraud through changing the labels on sanitizer to meet material safety data sheet (MSDS) requirements predicated a spin-off investigation by the OIG. Based on the OIG investigation, the OIG was able to substantiate that a safety data sheet (SDS) was provided only after the pick-up and transport of an unknown chemical back to the Yale Transit facility.

[1] Merriam-Webster defines nonfeasance as the failure or omission to do something that should be done or especially something that one is under a duty or obligation to do.

Additional information obtained during Investigation 22-0116-C revealed possible nonfeasance and misrepresentation of facts related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic and revealed abuse of authority and undue influence resulting in the circumvention of City policies. Additionally, the possibility of a conflict of interest between a City Official and the vendor was raised.

Since July 2021, the Transit Department has experienced turnover in leadership and has encountered staffing issues. The former Transit Director (FD1) retired in January 2022 and FM1 terminated employment with the City in November 2021. The Transit Department has had two interim Directors since January 2022, with a new Director being selected in August 2022. The OIG reached out to the former director (FD1), a retired employee, and provided the opportunity for an interview, but FD1 declined. The OIG did not reach out to the former TD manager (FM1) as the reasons for termination of employment were unknown.

SCOPE AND METHODOLOGY

Scope: Transactions, correspondence, inventory logs, and service logs of the TD between January 1, 2020 and June 30, 2020 related to the chemicals used to sanitize City buses.

The methodology consisted of:

Assess complaint allegations
Prepare an investigation work plan
Review Purchasing policy
Review the Code of conduct
Review Ethical conduct for Purchasing
Obtain and review purchases coded to Transit supplies from January 1, 2020 to June 30, 2020
Review the Transit schedule of pandemic supply purchases
Research employee information for those identified
Site visit at Yale Transit facility
Send out Notice of Investigations
Send out Notice of extension for investigation
Send out Notice of Interviews
Develop interview questions for witnesses
Develop interview questions for Subject
Conduct interviews
Conduct informal interview during Yale Visit
Contact Legal Department to identify pending litigation that would prohibit OIG from investigating
Contact Risk Management to identify pending litigation that would prohibit OIG from investigating
Write report
Obtain AGO approval
Publish Report to OIG web

This report was developed based on information from interviews, inspections, observations, and the OIG's review of selected documentation and records.

INVESTIGATION

Allegation 1: Alleged nonfeasance and misrepresentation of fact related to the use of unverified chemicals to sanitize City buses during the COVID-19 Pandemic.

Authority: Article 17: Inspector General Ordinance

Article 7: Whistleblower Policy

301. Code of Conduct

Evidence: Emails between FD1, FM1, M1, E1, and E2 where A1 was carbon copied in certain emails.

An email containing an SDS[2] for the alleged chemical was received after the initial pick up and transport of the chemical.

Interview statements of those interviewed regarding their involvement in picking up the chemicals without a placard or an SDS.

Interview statements made by those interviewed regarding the chemical from VD for sanitizing City buses.

Comparison of the SDSs for Miox Corporation dated 22 July 2015 and the vendor, dated 1/22/2020.

Vendor SDS V1-04292020.

Interview statements made by V2 regarding quality control testing and the shelf life of the chemical.

Internet research on the shelf life and storage of Sodium Hypochlorite.

Email containing a contract proposal for Sodium Hypochlorite Oxidant Solution from V1 to FD1, carbon copying A1 and V2.

Emails from City employees expressing concern about the vendor and cost.

Transit Department timesheets for temporary employees.

Transit invoices for chemical disposal services.

[2] An SDS is a "Safety Data Sheet" and it includes information about the chemical inside a container, including the chemicals properties, any hazard it may pose, any protective measures which can be used to mitigate the hazards, and safety precautions for the safe storing, handling, and transportation of the chemical.

Photographs of a barrel containing unidentifiable chemicals at Yale Transit facility.

Spreadsheet of Transit COVID-19 purchases.

Analytical Report from ACTenviro.

Interviews: During the OIG interview with E1, E1 stated that in Spring 2020, FM1 directed E1, when E3 was not in the office, to take two (2) empty 55-gallon drums to a personal residence located near Paseo and Wyoming and pick up a barrel containing disinfectant. E1 emailed E3 to advise E3 that FM1 was going to contact E3 about the material. E1 stated that E3 was not happy about the situation. E1 asked for the SDS but it was not provided at that time. FM1 stated that this was a directive from FD1 because this was a family friend of someone high up in the City. E1 stated that E1 felt that it was "weird/strange" to go to a personal residence for materials and not be provided an SDS for chemicals. As the chemical was provided on demand, E1 stated that the individual provided E1 with a 55-gallon drum that was about half full and the second barrel at a later date. E1 stated that there was no paperwork provided with the material, which was also unusual. E1 picked up the material and transported it back to the Yale Transit facility. E1 stated that there was no placard indicating whether the materials were hazardous during transport to the facility. E1 stated that FM1 provided an SDS after the material was brought to the Yale Transit facility. E1 stated that the SDS label looked like it was printed off the internet.

E1 stated that while at the private residence, E1 worked with an individual, later identified as V1. V1 stated that V1 made a machine that could make a bleach mixture, using salt, water, and electrodes. E1 stated that V1 was very smart. E1 stated that without the SDS or a specification sheet, E1 did not know what the material was. When asked if the material smelled like bleach, E1 said E1 didn't know what bleach smelled like.

About two weeks later, E1 was asked by FM1 to take two (2) empty 55-gallon drums to the same address. E1 followed the directive by FM1. A week later, E1 was asked a third time to pick up the 55-gallon drums for the police department. E1 did not feel comfortable with this situation from the beginning but only refused to go the third time. E1 believes that FM1 found another employee to go pick up the drums. E1 stated that E1 did not know who picked up the materials.

On August 26, 2022, E1 stated that there was one (1) 55-gallon barrel of this material still located at the Yale Transit facility.

An OIG interview with E2 revealed that E2 was aware that a co-worker was asked to pick up bleach from somebody's house. E2 did not know if the employee expressed discomfort with management. E2 did not know of anyone changing the SDS label on the sanitizer. E2 stated that SDS labels were put on spray bottles of chemicals from a drum in question. E2 stated that E2 put the labels that were provided by FM1 on the bottles.

During the OIG interview, E3 stated that he was told by FM1 to go pick up some sanitizer. E3 asked for the SDS sheet but was told that they did not have one. E3 refused to pick up the sanitizer without an SDS sheet. E3 contends that FM1 waited until E3 was not at the facility and then directed E1 to go pick up the sanitizer. FM1 stated that this was a directive by FD1 because the person providing the sanitizer was a relative of a high-ranking City official. E3 and E1 had email correspondence regarding the matter and FM1 and FD1 stated they would get the SDS. E3 stated that there were two (2) 55-gallon drums located in the Transit Parts facility that had no markings. E3 asked E1 where the SDS was for the material and E1 stated that FM1 directed E1 to pick up the materials and that no SDS or specification sheet was provided. E3 stated that E1 was not provided a hazardous material placard required to transport such materials. E3 inquired about the SDS or specification sheet with FM1 and FM1 left and returned with a printed SDS for Johnson and Johnson sanitizer. E3 stated that the item was not a Johnson and Johnson product.

The OIG interview with M1 revealed that M1 did not know about sanitizer being purchased without an SDS sheet being provided. M1 stated that M1 maintained a spreadsheet of items purchased using COVID pandemic-sourced funding. M1 was not aware of any donations of disinfectant, "Bleach", during the pandemic. M1 stated that accepting donations for operational use is not normal practice.

V1 was contacted via telephone on January 3, 2023, and again on January 9, 2023. V1 stated that VD launched its business operation in 2019. V1 is the CEO of VD. V1 stated that the product, which was not a primary business product of VD, was manufactured in Placitas, NM, or in Albuquerque, NM. V1 referred the OIG to V2, the CTO of VD, and provided V2's contact information, stating that V2 handled the transactions with the City of Albuquerque.

On January 9, 2023, and again on January 12, 2023, the OIG conducted telephone interviews with V2. During those interviews, V2 stated that VD provided the City with three (3) to four (4) barrels of a chemical referred to as "Dilute Hypochlorite Solution". When asked why VD only provided three (3) to four (4) barrels to the City, V2 stated that it was not a market VD was going after. V2 stated that the chemical would be used as a "10:1 household bleach and could be used in accordance with EPA guidelines for viruses." V2 provided a statement that quality control on the efficacy of the chemical poured into the City provided barrels was not performed by the vendor but that the Miox Zuni 2.0 machine had been previously tested by Miox, Corporation. V2 stated that V2 could provide a document reflecting quality control completed on the Miox Zuni 2.0 machine. V2 stated that the general shelf life of the Sodium Hypochlorite Oxidant solution provided is one year if it is stored correctly. V2 stated that the Center for Disease Control provides active chemistry calculations that are used to determine shelf life. V2 stated that the City provided empty 55-gallon barrels to VD for V2 to fill with the Sodium Hypochlorite Oxidant solution for the City's use. V2 stated that V2 believed the City employees emptied and washed the 55-gallon barrels but that the oxidant solution would sanitize the barrels if they hadn't been cleaned. V2 stated that the 55-gallon barrels were not completely full with the Sodium Hypochlorite Oxidant solution when they were provided to the City.

V2 did not recall whom V2 contacted in the City. When asked if V2 knew anyone in the City, V2 replied "maybe". OIG then inquired about whether V2 specifically knew A1 and V2's response was "maybe". V2 then recalled that FD1 was the City contact.

V2 stated that VD billed the City but that VD no longer has the invoice because VD subsequently automated its accounting system and no longer has the "older" records. V2 stated that the chemical was **not** donated to the City. V2 then stated that V2 did not look for an invoice. V2 stated that VD did not receive any payments from the City and that V2 wrote off the invoice as bad debt. When asked for supporting documentation for the write-off, V2 stated again that those records no longer exist because of VD's change to an automated accounting system.

Analysis: The provisions of ROA 1994, Chapter 2, Article 17 (Inspector General Ordinance) and ROA 1994, Chapter 3, Article 7 (Whistleblower Ordinance) were considered during the OIG's analysis of the applicability of the definitions of nonfeasance and improper governmental actions.

The Inspector General Ordinance provides the OIG the authority to prevent and detect fraud, waste, and abuse through investigations of theft or other disappearance of cash, check, or property, misfeasance or nonfeasance, defalcation, and improper governmental actions as defined in the Whistleblower Ordinance and non-compliance with federal and state law, city ordinances and city regulations of which they are aware.

The Inspector General Ordinance does not currently define misfeasance or nonfeasance, therefore, the OIG referred to Merriam-Webster for its definition of these terms. Misfeasance is defined as the performance of a lawful action in an illegal or improper manner. Nonfeasance is defined as the failure or omission to do something that should be done, especially something one is under a duty or obligation to do.

The OIG reviewed and considered the application of the definition of improper governmental action contained in the Whistleblower Ordinance, which is cited by the Inspector General Ordinance. ROA 1994, Section 3-7-3 defines "improper governmental action" as:

> [a]ny action by a city employee, an appointed member of a board, commission, or committee, or an elected official of the city that is undertaken in the performance of such person's duties with the city in violation of a federal, state or local government law or rule, an abuse of authority, of substantial and specific danger to the public health or safety, or a gross waste of public funds that is in violation of city policy or rules. The action need not be within the scope of the employee's, elected official's or board, commission, or committee member's official duties to be subject to a claim of improper governmental action. Improper governmental action does not include city personnel actions, including but not limited to employee grievances, complaints, appointments, promotions, transfers, assignments, reassignments, reinstatements, restorations, reemployments, performance evaluations, reductions in pay, dismissals, suspensions, demotions, reprimands,

> violations of collective bargaining agreements or the merit system ordinance, §§ 3-1-1 et seq. ROA 1994.

The OIG reviewed and considered the following sections of the City's Code of Conduct found within Section 301 of the City's Personnel Rules and Regulations[3] for analysis of nonfeasance and misrepresentation of fact.

Section 301.1 is titled "Duty to the Public" and states:

> The City of Albuquerque is a public service institution. In carrying out their assigned duties and responsibilities, employees must always remember their first obligation is to the general public's safety and well-being. This obligation must be carried out within the framework of federal, state, and local laws.
>
> Employees shall serve the public with respect, concern, courtesy, and responsiveness, recognizing service to the public is the reason for their employment. Telephone calls, correspondence or other communications should be answered promptly or referred to appropriate individuals for timely action.
>
> It is recognized it is not always possible to fulfill all of the requests of the general public, however, employees are required to handle all requests and inquiries courteously, fairly, impartially, efficiently and effectively.

Section 301.3 is titled "Standards of Conduct" and states: "Employees shall in all instances maintain their conduct at the highest personal and professional standards in order to promote public confidence and trust in the City and public institutions and in a manner that merits the respect and cooperation of coworkers and the community."

Section 301.8 is titled "Safety" and states: "Employees are responsible for performing assigned duties in the safest possible manner, using all available safety measures and devices to prevent injury to themselves, coworkers or the general public and to report unsafe equipment, materials, or conditions to their supervisor and the Risk Management Division."

Section 301.9 is titled "False Statements/Fraud" and states:

> No employee shall willfully make any false statement, certificate, mark, rating or report in regard to any test, certification, appointment or investigation, or in any manner commit any fraud, conceal any wrongdoing or knowingly withhold information about wrongdoing in connection with employment with the City or in connection with the work-related conduct of any City employee.

[3] Full version is available at https://codelibrary.amlegal.com/codes/albuquerque/latest/albuquerque_nm_person/0-0-0-1363.

The OIG's investigation found that the above-cited City personnel rules and regulations are applicable to these facts and circumstances and shall be used to determine whether the allegations can be substantiated.

The OIG reviewed emails between FD1, FM1, M1, A1, E1, E2, and the vendor. These emails revealed who had knowledge of the acquisition of the chemicals. These emails aided the OIG in establishing that FD1, FM1, and A1 held positions that afforded the opportunity to assert undue influence over these transactions. Additionally, the OIG noted that our request for FD1's emails yielded no information as the emails had been eliminated prior to receipt by the OIG.

Upon further inquiry with a representative of the Department of Technology and Innovation (DTI), the OIG was informed that FD1 "probably deleted emails prior to leaving". Outside the Inspection of Public Records Act, DTI does not have a separate retention policy in place to prevent anyone from deleting emails.

The OIG reviewed an email chain from FM1 directing E2 to take empty barrels and pick up a chemical, identified as "bleach" to an address identified as a personal residence. This email chain reflects that FD1 was carbon copied or forwarded the email chain and is indicative that both FD1 and FM1 should have known this was a personal residence and not a company address and should have prompted additional questions related to the vendor.

The OIG obtained and reviewed emails between FM1, E1, E2, and V2 where FD1 was carbon copied in one email. The OIG does not have direct evidence that those carbon copied on the email read the email. These emails contained concerns raised by E1 and E2 to FM1 about not having the proper documentation necessary for transportation and materials handling on the product picked up from the personal residence and the subsequent email receipt of the SDS sheet for the product from V2 to FM1 and forwarded to E1, E2, and FD1.

The OIG discovered an email from M1 to FD1 stating "I can't find anything about this company online. Besides their web page that is non-specific in its referrals, I can't find any reviews by anyone about this product. – Could be a scam. Mailing address is a house. Contacts on form (sic) don't have anything to do with contacts on the website." This email reveals that certain employees were attempting to perform due diligence regarding the acquisition of the chemicals but that FD1 disregarded the concerns raised.

The OIG relied on interview statements by witnesses as evidence and indication of their involvement in the acquisition of the chemicals, and that the chemicals were picked up and transported to the Yale Transit facility without a placard or an SDS sheet.

The OIG relied on interview statements made by those interviewed regarding the use of the chemical for sanitizing City buses as evidence that the chemical was utilized by the Transit Department.

The OIG inspected and compared the SDS sheets for Sodium Hypochlorite Oxidant Solution, obtained from the Miox Corporation website, dated July 22, 2015, and for VD, dated 1/22/2020, reflecting changes in the name of the company, address, telephone number, and issue date.

VD SDS sheet V1-04292020 indicates that the chemical can be used for Microbe Control on surfaces to inactivate microbials (e.g. mold, mildew, bacteria, and viruses), however, there is no mention of what viruses can be rendered inert or to what efficacy.

The OIG relied on interview statements made by V2 who was identified as the Chief Technical Officer (CTO) of VD. V2 acknowledged the business nature of the transactions between the City and VD. V2's statement that quality control testing, on the efficacy of the chemical provided to the City, was not performed by the vendor, instead, the Miox Zuni 2.0 machine had been previously tested by Miox Corporation. This statement is indicative that VD did not validate the information on the quality purported in the VD SDS sheet provided to the City after delivery. V2 did not provide the OIG with the document reflecting the quality control testing completed on the Miox Zuni 2.0 machine used in the production of the Sodium Hypochlorite Oxidant solution provided to the City.

The OIG researched and reviewed articles from the Centers for Disease Control and Preventions, US Environmental Protection Agency, NIH, Western University Canada, Center for Research on Ingredient Safety, and the National Collaborating Centre for Environmental Health as a means to support V2's statement that the general shelf life of the Sodium Hypochlorite Oxidant solution provided is one year if it is stored correctly. Through these articles, the OIG found that the shelf-life can be up to twenty-three (23) months depending on how it is stored.

The OIG obtained an email from V1 to FD1, carbon copying A1 and V2 along with two other VD employees stating that VD would be "charging to recover our costs and to increase capacity" containing a contract proposal for 55-gallon barrels at a cost of $1,100 each. The email stated that if the City agreed with the terms to sign and return the agreement to V1. V1 would then send a payment link to the City. The contract proposal was signed by V1 but not signed by a City representative. The email was forwarded to M1 for a requisition. The OIG requested a copy of any contracts with VD and was advised that the City did not have a signed contract on file with VD. M1 provided an email to OIG confirming TD had picked up the VD product but that TD did not have a record that payment was made.

The OIG reviewed purchase card expenditures made by TD for amounts approximating $1,100 to $6,000 between March 1, 2020 and June 30, 2020 but without the payment link, it was difficult to ascertain if these payments were processed on behalf of or to VD. The OIG reviewed the PeopleSoft vendor files for the City for payments to VD, V1, and V2 and was unable to locate a vendor file under these names. The OIG was unable to validate, through an inspection of invoices, V2's statement that VD billed the City for the Sodium Hypochlorite Oxidant Solution.

The OIG reviewed the City's Emergency Support Function (ESF) #16 for Volunteer & Donations Management and found that the guidelines had not been followed for VD's product. Additionally, the OIG was unable to validate that the VD product was a donation as documentation and records for the donation could not be provided as requested in an email from E3 to E1 and FM1, carbon copying E2.

The OIG reviewed expense reimbursement payments for A1, FD1, FM1, M1, E1, E2, and E3 for the period of investigation and found no evidence of reimbursement for sanitizing chemicals.

The OIG requested and reviewed all emergency purchase approval forms for the period of investigation and found no evidence to support an approved transaction between the City and VD, V1, or V2.

The OIG discovered emails where City employees raised concerns about VD not having a historical profile and VD's cost of the product as the City had a local vendor on a contract to supply drums of bleach at a cost of $310.50 which was a significant saving compared to VD's cost of $1,100.

The OIG reviewed a list provided by TD of temporary employees for March and April 2020 indicating that twenty-seven (27) individuals were hired as a Cleaning/Servicer and one (1) individual was hired as a custodian. One (1) of the Cleaning/Servicers was assigned to the Yale Transit Facility while the other individuals were assigned to the Daytona Facility. Some of the TD timesheets reviewed for temporary employees from March 1, 2020 through June 30, 2020 indicated "COVID 19" on them. An email received from TD states: "There are timesheets for the staff that cleaned buses. There is an Excel sheet listing the temps. Their durations are varied. We were asking temp agencies to send us as many people as they had. Individuals would show up, see the work needing to do and often leave immediately or within a short amount of time."

The OIG reviewed TD invoices for chemical disposal services, but was unable to locate any reference to the disposal of the VD's Sodium Hypochlorite Solution, which implied the chemical was used or that any remaining barrels may still be at the Yale Transit facility.

Based on the statement provided by E1 that one (1) barrel of the chemical was still located at the Yale Transit facility, the OIG requested that E1 secure the material and take it out of circulation. According to E1, while attempting to secure the material, E1 discovered that there were no more drums of this material remaining at the Yale Transit facility at which point E1 contacted the OIG to provide an update.

In September 2022, the OIG toured the Yale Transit facility and observed various barrels throughout the Yale Transit facility. The OIG made note of numerous barrels of chemicals in use that contained labels on the barrels identifying specifications and safety data. While observing the inventory and fuel island, the OIG took photographs of one (1) unmarked semi-transparent white barrel containing unidentifiable chemicals. Upon inquiry, the OIG was told the barrel had been there since the beginning of the pandemic and it had never been picked up for disposal because

the contents were not identifiable. The barrel has been sitting outside as it could not be disposed of using the City's disposal vendors because the unknown chemical does not have the appropriate markings or paperwork for safe disposal. The barrel in question originally contained another identifiable compound, though the labels were removed when the barrel was emptied and it was filled with another unidentified chemical. The OIG inspected and observed the contents of the barrel noting no odor. With the assistance of E4, the OIG was able to obtain a cloth soaked in the contents as evidence. The contents have not been tested due to the length of time the contents were exposed to weather elements. The chemical provided by VD only had a shelf life of one (1) year and the OIG made its observation on September 7, 2023, more than two and a half (2 ½) years later. According to statements made during interviews, the chemical had been outside in the elements since the Spring of 2020.

On March 3, 2023, the OIG conducted a follow-up for corrective action on the originating complaint and discovered the barrel with unidentified chemicals was still located at the Yale Transit Facility. The OIG inquired as to why the barrel had not been properly disposed of and was advised that it had not been made clear that proper disposal was necessary. The OIG requested that proper testing and disposal occur in accordance with standards. The TD hired ACTenviro to properly dispose of the contents of the unidentified barrels. The barrels were picked up by ACTenviro on April 19, 2023.

The Analytical Report by Pace Analytical for ACTenviro dated April 27, 2023 indicated ACTenvrio took custody of nine (9) containers on April 19, 2023. The report references a sample Chain of Custody but the attachment did not contain the typical information contained in a chain of custody form. There was no indication of a description of each barrel. There was no tracking of the barrels through the testing process. The report results do not show the results of testing for each barrel separately, making it impossible to determine which barrel the detected contents were associated with. The results revealed the detection of Barium in excess of the reported detection limit. Additionally, the results indicated the presence of Toluene-d8, 4-Bromofluorobenzene, 1,2-Dichloroethane-d4, and Terphenyl. The results did not indicate sodium chloride or sodium hypochlorite, the key ingredients as stated on the SDS sheet provided by VD. The results of the ACTenviro, dated April 27, 2023 cannot be used to support the conclusion once contained a Sodium Hypochlorite Solution.

The OIG reviewed a spreadsheet provided by the TD of COVID-19 purchases revealing bus sanitizer, bleach, and disinfectant purchased from other vendors but not from VD. The OIG selected related purchases and validated them through invoices paid by the City.

Finding regarding Allegation 1: The evidence obtained was consistent with concluding the allegation of nonfeasance relating to the City not acquiring the proper documentation for the chemical before obtaining and transporting the chemical was substantiated. The evidence obtained was consistent with concluding the allegation of nonfeasance on behalf of the City for not performing due diligence on the vendor or the chemical prior to acquisition and use was substantiated. The evidence obtained was consistent with concluding the allegation of

misrepresentation of fact was substantiated because there had been no quality control testing on the efficacy of the chemical, by the vendor, to support the SDS sheet provided to the City subsequent to the City acquiring the chemical.

Recommendations: The Transit Director and City Officials should determine the disciplinary action, if any, that should be taken against employees who may have engaged in nonfeasance by not performing due diligence.

The City's Procurement Division should host ethics and purchasing training for TD to reiterate the importance of City policies and adherence to those policies. All TD employees should be required to attend and sign a document reflecting their attendance.

The City's Risk Management Department should host training for TD on the proper materials handling protocols. All TD employees taking part in the procurement, management, and transporting of supplies and inventory should be required to attend and sign in reflecting their attendance.

The City's Legal Department should review whether there is a legal remedy available to the City against the VD for any misrepresentation.

Management's response: Management is unable to provide a complete response to Allegation 1 in Report 22-0162-C. As a threshold mater, the OIG ordinance does not permit the OIG to conduct investigations based solely on allegations of "nonfeasance," a vague and undefined term. Permitting investigations based solely on the OIG's perception of nonfeasance would open the door for politically based and investigations based on subjective factors, when issues related to such allegations are better left to Department Directors. The OIG is authorized to conduct investigations into waste, fraud or abuse. Allegations that city employees failed to acquire proper documentation before transporting a chemical do not rise to the level of waste, fraud or abuse, and the OIG in its summary does not claim that it does. Likewise, allegations that city employees failed to engage in an undefined level of "due diligence" prior to the use of the chemical do not appear to rise to the level of waste, fraud or abuse.

In addition, Report 22-0116-C alleged that chemical safety data sheets were not provided prior to the department handling the chemicals in question. Report 22-0116-C has been finalized and released with an appropriate management response. It seems report 22-0162-C is duplicating, in part, the finding from 22-0116-C.

The description provided is also insufficient for Management to formulate a response. Directors should be given the opportunity to review the entire report so that they can understand the context and address any factual inaccuracies. Moreover, Principles and Standards for Offices of Inspector General state that investigative report language should be clear and concise and should be intelligible to informed professionals. The summary provided by the OIG does not meet that standard. The allegation is vague, the narrative is incoherent and lacks appropriate citation for the chemical verification process that the Inspector General (IG) is alleging to be violated. We cannot tell, from the description provided, who is alleged to have mispresented a fact and what fact was misrepresented. Management cannot respond to an allegation regarding "misrepresentation of

facts" when we do not know what has been misrepresented and by whom. Moreover, there is no dollar value associated with this finding as the product was donated to the transit department during the pandemic.

Allegation 2: Alleged abuse of authority and undue influence, by a City Official, resulting in circumvention of City policies, regulations, and federal laws.

Authority: Article 17: Inspector General

Article 7: Whistleblower Policy

City of Albuquerque Code of Conduct

City's Emergency Support Function (ESF) #16 for Volunteer & Donations Management

Evidence: Emails between FM1, FD1, V1, and V2, where A1 was carbon copied.

An email containing a contract proposal for Sodium Hypochlorite Oxidant Solution from V1 to FD1, carbon copying A1 and V2.

Lack of evidence for donations from TD

Interviews: During the OIG interview with E3, E3 stated that FM1 directed E3 to pick up sanitizer from a private residence in March 2020. E3 asked for the related paperwork and FM1 advised E3 there was no paperwork and that this was a directive from FD1 who purportedly stated the vendor was a relative of a City Official.

The OIG sent a notification of investigation to A1 on May 30, 2023, which was declined on June 2, 2023. The OIG also sent an email to A1 on June 1, 2023, requesting the signed notification of investigation be returned to the OIG and advising A1 that the OIG would like to provide the opportunity for A1 to relay any information A1 may have regarding the matter and to request an interview. This email was never acknowledged by A1.

Analysis: The Inspector General Ordinance §2-17-1 to §2-17-12 and Whistleblower Ordinance §3-7-3 were considered during the OIG's analysis of the applicability of the definition of improper governmental actions.

The Inspector General Ordinance provides the Office of Inspector General the authority to prevent and deter fraud, waste, and abuse through investigations of theft or other disappearance of cash, check, or property, misfeasance or nonfeasance, defalcation, improper governmental actions as defined in the Whistleblower Ordinance, and non-compliance with federal and state law, city ordinances and city regulations of which they are aware.

The OIG reviewed and considered the application of the definition of improper governmental action in the Whistleblower Ordinance as cited in the Inspector General Ordinance. Section 3-7-3 of the Whistleblower Ordinance defines "improper governmental action" as:

> any action by a city employee, an appointed member of a board, commission, or committee, or an elected official of the city that is undertaken in the performance of such person's duties with the city in violation of a federal, state or local government law or rule, an abuse of authority, of substantial and specific danger to the public health or safety, or a gross waste of public funds that is in violation of city policy or rules. The action need not be within the scope of the employee's, elected official's or board, commission, or committee member's official duties to be subject to a claim of improper governmental action. Improper governmental action does not include city personnel actions, including but not limited to employee grievances, complaints, appointments, promotions, transfers, assignments, reassignments, reinstatements, restorations, reemployments, performance evaluations, reductions in pay, dismissals, suspensions, demotions, reprimands, violations of collective bargaining agreements or the merit system ordinance, §§ 3-1-1 et seq. ROA 1994.

The OIG reviewed and considered the following sections of the City's Code of Conduct found within Section 301 of the City's Personnel Rules and Regulations for analysis of improper governmental action.

Section 301.1 is titled "Duty to the Public" and states in part: "The City of Albuquerque is a public service institution. In carrying out their assigned duties and responsibilities, employees must always remember their first obligation is to the general public's safety and well-being. This obligation must be carried out within the framework of federal, state, and local laws."

Section 301.3 is titled "Standards of Conduct" and states in part: "Employees shall in all instances maintain their conduct at the highest personal and professional standards in order to promote public confidence and trust in the City and public institutions and in a manner that merits the respect and cooperation of coworkers and the community."

Section 301.17 is titled "Supervision of Employees" and states: "Employees with supervisory duties or responsibilities shall, in all instances, ensure that all supervisory actions comply with the provisions of the Merit System Ordinance, Labor-Management Relations Ordinance, Personnel Rules and regulations, applicable legislation, and relevant judicial/administrative decisions."

The OIG's investigation found the above-cited City rules and regulations are applicable to these facts and circumstances and shall be used to determine whether the allegations can be substantiated.

Neither the Inspector General Ordinance nor the Whistleblower Ordinance defines abuse of authority or undue influence, therefore, the OIG researched these terms and found the following definitions.

Black's Law Dictionary defines undue influence as "The improper use of power or trust in a way that deprives a person of free will and substitutes another's objective; the exercise of enough control over another person that a questioned act by this person would not have otherwise been performed, the person's free agency having been overmastered."

Merriam-Webster defines undue influence as "improper influence that deprives a person of freedom of choice or substitutes another's choice or desire for the person's own."

Oxford Dictionary defines undue influence as "influence by which a person is induced to act otherwise than by their own free will or without adequate attention to the consequences."

Black's Law Dictionary does not provide a definition of abuse of authority but does provide definitions for the following terms:

Abuse is defined as "A departure from legal or reasonable use; misuse."
Authority is defined as "The official right or permission to act, esp. to act legally on another's behalf; esp., the power of one person to affect another's legal relations by acts done in accordance with the other's manifestations of assent; the power delegated by a principal to an agent the authority to sign the contract."

Abuse of Power is defined as "The misuse or improper exercise of one's authority; esp., the exercise of a statutorily or otherwise duly conferred authority in a way that is tortious, unlawful, or outside its proper scope."

The OIG will apply these definitions for the purpose of this investigation.

The OIG obtained and reviewed emails between FM1, FD1, V1, and V2, where A1 was carbon copied indicating that A1 should have been aware of the dealings between the City and VD. Given that such transactions do not typically involve assistance or input from A1, the inclusion and mention of A1 in these transactions could suggest undue influence, whether intentional or not.

The OIG reviewed an email from FD1 to E3 that contained an instruction to ensure the bleach is picked up as directed in response to an email where E3 appeared the question the integrity of the transaction. The email chains were forwarded from FM1 to FD1.

The OIG reviewed an email from V1 to FD1, carbon copying A1, V2, and two other VD employees stating VD would be "charging to recover our costs and to increase capacity." The email contained a contract proposal for 55-gallon barrels at a cost of $1,100 each. The email stated the City should

sign and return the agreement if the City agreed to the terms. The OIG was unable to locate a signed contract with VD.

The OIG reviewed the City's Emergency Support Function (ESF) #16 for Volunteer & Donations Management and found that the guidelines had not been followed for VD's product. Additionally, the OIG was unable to validate the VD product was a donation as documentation and records for the donation could not be provided. This is despite E3's recommendation the guidelines be followed and such documents and records would be generated.

To establish the basis for undue influence, the OIG considered whether City employees were susceptible to the influence of FM1, FD1, and A1. Whether FM1, FD1, and A1 had the opportunity to exert influence and if any of their involvement with the transaction was an exertion of improper influence that resulted in a violation of City policies.

The OIG was unable to establish a reason for which A1 would have been included in the emails. The evidence supports the conclusion that A1 knew or should have known of these transactions.

Finding regarding Allegation 2*:* The evidence obtained was consistent with concluding A1's involvement in these transactions gives the appearance of undue influence and may have contributed to the circumvention of City policy and potential abuse of authority by FD1 and FM1.

Recommendation: The appropriate City Officials should review the actions of A1, FD1, and FM1 in accordance with the Merit system and determine what action, if any, should be taken against A1, FD1, and FM1 if those actions resulted in violations of City policies.

Management's response: Management is unable to provide a complete response to Allegation 2 in Report 22-0162-C. Directors should be given the opportunity to review the entire report so that they can understand the context and address any factual inaccuracies. Moreover, Principles and Standards for Offices of Inspector General state that investigative report language should be clear and concise and should be intelligible to informed professionals. Here, the description provided for Allegation 2 provides no information that would enable Management to formulate a response. We cannot respond to a city officials involvement if we do not know who was involved and the activity that they were involved in. Indeed, it appears that the IG was unable to come to a conclusion. The IG suggests that the "appearance" of undue influence "may be" present and that there "may" have been a "potential" abuse of authority.

Allegation 3: Possible conflict of interest between a City Official and the vendor.

Authority: City Charter, Article XII

Article 3 Conflict of Interest

Evidence: A familial link was established through social media between the vendor and A1.

Research shows that A1 and V1 resided on the same street.

Research shows that an immediate family member of A1 was employed at the same company as V1 and V2.

Research shows that an immediate family member of A1 has a business that is aligned with the business of VD, operated by V1 and V2.

Research shows that an immediate family member of A1 is linked through social media to VD and V2.

Emails between FM1, FD1, V1, and V2, where A1 was carbon copied.

Conflict of interest forms on file with the City Clerk reflected that there was no disclosure form on file for A1 regarding this VD.

Absence of a direct financial link between A1 and VD.

Absence of vendor data or payments directly to VD in PeopleSoft.

Interviews: During the OIG interview with E3, E3 stated that FM1 directed E3 to pick up sanitizer from a private party in March 2020. E3 asked for the related paperwork and FM1 advised E3 there was no paperwork and that this was a directive from FD1 who stated that the vendor was a relative of a City Official.

An interview with V2 revealed V2 did not recall whom V2 contacted in the City. When asked if V2 knew anyone in the City, V2 replied "maybe". OIG then inquired about whether V2 specifically knew A1 and V2's response was "maybe".

Analysis: The OIG reviewed and considered the definitions applicable and the implications of the City Charter, Article XII as it relates to this investigation.

Article XII of the City Charter is the City's Code of Ethics and defines an *Official* as:

> the Mayor, all members of the Council, all members of boards, commissions, and committees; all directors and the equivalent thereof for each department, division, or section; assistant, associate or deputy department, division or section directors and the equivalent thereof; the Director of Council Services; the Chief Administrative Officer; Deputy or Assistant Chief Administrative Officers and the equivalent thereof; and all other city employees appointed directly by the Council, Mayor of Chief Administrative Officer.

The Code of Ethics defines *immediate family* or *immediate family members* as a "spouse, children, step-children, parents, grandparents, grandchildren, siblings, first cousins, nieces, nephews, uncles, and aunts."

The Code of Ethics defines *direct interest, private interest,* or *private financial interest* as:

> (1) a partnership, limited liability partnership, limited liability company, corporation, or any other for-profit entity in which an official owns an interest of 10% interest or more; or (2) a corporation, partnership, limited liability partnership, or limited liability company in which the official is an officer, director, or agent. Direct interest, Private interest, or Private Financial Interest does not mean an interest in stock owned indirectly through a mutual fund, retirement plan, or another similar commingled investment vehicle the individual investments of which the official does not control or manage.

The Code of Ethics defines *indirect interest* or *indirect private financial interest* as:

> any interest in which legal title is held by another as trustee or another representative, but the equitable or beneficial interest is held by the official or the official's immediate family. Indirect interest shall include a pecuniary or competitive advantage that exists or could foreseeably accrue as a result of the act or inaction of the official.

Section 4(a)(2) of the Code of Ethics states: "Vote or otherwise participate in the negotiation or the making of any contract with any business or entity in which the official has a direct or indirect private financial interest;"

The OIG also reviewed the ethics presentation provided to City employees by the Human Resources Department upon hire, noting additional guidance and examples are provided to assist employees in their understanding of Article XII.

Based on the OIG's reading of Article XII, the OIG was able to establish that A1 qualifies as an *Official* and that V1 qualifies as an *immediate family member.* The OIG found no evidence that a *direct interest, private interest* or *private financial interest* existed between A1 and VD. The OIG was unable to ascertain whether an indirect interest, via a pecuniary or competitive advantage, existed or could foreseeably accrue as a result of A1's action. The OIG was unable to establish if there was a disclosure of affairs of the City without proper authorization in order to advance the private financial or other private interest of A1 or VD.

The Conflict of Interest Ordinance, ROA 1994, §§ 3-3-1 to -13, defines Employee to include "every appointed classified or unclassified officer or employee of the city who receives compensation in the form of a salary or who is eligible to receive per diem and mileage. The term employee shall not include elected officials of the City." ROA 1994, § 3-3-2.

Section 3-3-2 defines a financial interest as: "Any interest which shall yield, directly or indirectly, any monetary or other material benefit to a city employee or to the city employee's spouse or minor children."

The OIG could not find a definition of "other material benefit" in the City Ordinances making it difficult to ascertain if a financial interest exists.

Section 3-3-3 states that:

> Employees must in all instances maintain their conduct at the highest standards. No employee shall continue in his or her city employment with pay when he or she engages in activities which are found to more than likely lead to the diminishing of the integrity, efficiency, or discipline of the city service.

The OIG's review of the Conflict of Interest Ordinance's definition of "financial interest" reveals there may not be a financial conflict of interest as no evidence was obtained to reflect that A1 had or has a financial interest in VD. The OIG could not establish a financial interest by A1, the employee's spouse, or minor children. The OIG was unable to obtain evidence of any financial exchange between the City and VD.

Black's Law Dictionary defines conflict of interest as **1.** A real or seeming incompatibility between one's private interests and one's public or fiduciary duties. **2.** A real or seeming incompatibility between the interests of two of a lawyer's clients, such that the lawyer is disqualified from representing both clients if the dual representation adversely affects either client or if the clients do not consent.

The OIG's research revealed that there is a familial link between A1 and V2. V2's response to whether V2 knew anyone in the City or if V2 knew A1 was intentionally vague to obfuscate the nature of the relationship and potentially protect A1.

The OIG's research revealed that A1 and V1 resided on the same street and were neighbors.

The OIG's research revealed that an immediate family member of A1 was previously employed at the same company as V1 and V2.

The OIG's research indicates that an immediate family member of A1 has a business that is aligned with that of VD which is operated by V1 and V2.

The OIG's research reveals that an immediate family member of A1 is linked through social media to VD and V2.

The OIG obtained and reviewed emails between FM1, FD1, V1, and V2, where A1 was carbon copied indicating that A1 was aware or should have been aware of the dealings between the City

and VD. Given that such transactions do not typically involve assistance or input from A1, the inclusion and mention of A1 in these transactions could be suggestive of a possible undue influence, whether intentional or not.

The OIG obtained and reviewed all conflict of interest forms for A1, FD1, and FM1, on file with the City Clerk. The OIG's review of those documents showed no disclosure form on file for A1 regarding VD. Additionally, no forms for conflict of interest were on file for FD1 and FM1.

Finding regarding Allegation 3: The OIG's investigation was inconclusive with regard to the possible conflict of interest between A1 and VD due to the conflicting language in the City of Albuquerque Charter, Articles, Ordinances, and other rules and regulations.

Subsequent Matter: Alleged violation of § 2-17-12 (b) Inspector General Ordinance.

Authority: Article 17 Inspector General Ordinance states "All city officials, employees, and contractors shall provide the Inspector General full and unrestricted access to all city offices, employees, records, information, data, reports, plans, projections, mattes, contracts, memoranda, correspondence, electronic data, property, equipment and facilities, and any other materials within their custody. At the Inspector General's request, an official employee or contractor shall prepare reports and provide interviews. If an official, employee, vendor, or contractor fails to produce the requested information, the Inspector General shall notify the Board and make a written request to the Chief Administrative Officer for his assistance in causing a search to be made and germane exhibits to be taken from any book, paper or record excepting personal property. The Chief Administrative Officer shall require the officials, employees, vendors, or contractors to produce the requested information.

Evidence: Declined DocuSign envelope and email

Analysis: The OIG sent a notification of investigation to A1 on May 30, 2023, which was declined on June 2, 2023. The OIG also sent an email to A1 on June 1, 2023, requesting the signed notification of investigation be returned to the OIG and advising A1 that the OIG would like to provide the opportunity for A1 to relay any information A1 may have regarding the matter and to request an interview. This email was never acknowledged by A1.

Subsequent Matter Finding: The evidence obtained was consistent with concluding that A1's declination of the Notice of Investigation and their unresponsiveness to the request for an interview is in violation of §2-17-12 (b).

Recommendation: The Mayor should review the finding and take appropriate action regarding any violations in accordance with City Ordinances, and if necessary, refer to the Ethics Board for their review.

Management Response: The OIG has not provided enough information for Management to formulate a response. Unless the OIG provides the complete report, or identifies which City employee declined to be interviewed, it is impossible to meaningfully respond and provide rationale, if any, why the person did not respond and declined.

GENERAL OBSERVATIONS AND RECOMMENDATIONS

Observation 1: AI 1-5 Records Management addresses City records which could include emails depending on their content but does not contain a mechanism to prevent the deletion of employee emails.

Recommendation: The City Clerk and DTI should implement a mechanism to prevent the deletion of emails used to conduct public business by employees. The City should consider a redundant backup to retain emails for a select period of time. Additionally, training on AI 1-5 should be provided to all current City employees and continually provided to new employees as a part of the new hire orientation.

Management Response: The City has an effective process and system for email retention. Guidance and training is provided to employees. The inability to retrieve individual emails related to a very specific subject is not necessarily a reason to find fault with the system or processes. City employees read and manage thousands of emails annually. The Department of Technology and Innovation has appropriate systems backup procedures that are tested and reviewed periodically.

Observation 2: The evidence of this investigation reveals a potential health and safety liability to the City for the use of an unverified chemical.

Recommendation: City Officials, Legal Counsel, and Risk Management should conduct a review of any implications for the City as the result of the use of the unverified chemical.

Management Response: The City and its contractors use many products to support operations. Independent verification of the effectiveness of every product and chemical cannot be performed. Several entities donated products during the pandemic and none of these products was independently verified. Media coverage during the pandemic reported on many consumer products initially thought to be effective but later determined to not be effective. Additionally, media stoked fears about the coronavirus transmission from hard surfaces like gas pump handles and countertops. There were not effective processes, procedures or products identified for use against the corona virus until well into the pandemic.

Observation 3: Although this investigation could not substantiate that the chemical was a donation, the OIG noted that if the donation had been substantiated as indicated in emails, the Emergency Support Function (ESF) # 16 was not followed.

Recommendation: The City should determine why the Emergency Support Function (ESF) # 16 was not followed and provide City-wide training on the proper protocols for Volunteer & Donations Management.

Management Response: The inability of the IG to substantiate this cleaning product as a donation is perplexing. Commenting on the observation is difficult outside the context of the entire report, however, Emergency Support Function 16 does not absolutely require all donations to be tracked by the Office of Emergency Management.

AGO Disclaimer: A vote by the Committee failed to approve this report as two members felt that additional time was necessary to review the report.