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REPORT TO THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

REGION IX WHISTLEBLOWER PROTECTION PROGRAM COMPLAINTS WERE NOT COMPLETE OR TIMELY

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U.S. Department of Labor
Office of Inspector General
Audit

BRIEFLY...

REGION IX WHISTLEBLOWER PROTECTION PROGRAM COMPLAINTS WERE NOT COMPLETE OR TIMELY

November 23, 2020

WHY OIG CONDUCTED THE AUDIT

On July 6, 2018, then Secretary of Labor Alexander Acosta received a referral from the U.S. Office of Special Counsel (OSC) that described allegations against the Occupational Safety and Health Administration's (OSHA) Whistleblower Protection Program (WPP).

WPP investigates complaints of employer retaliation when employees report violations of law by their employers. The Whistleblower in OSC's referral was an investigator for OSHA from 2010–2015, who alleged OSHA's Region IX had breakdowns processing the complaints it received, which in turn resulted in widespread failure to protect complainants.

This report is in response to Secretary Acosta's request to review OSC's referral.

WHAT OIG DID

OSC determined there was substantial likelihood the Whistleblower's allegations disclosed violations of law, rule, or regulation, and gross mismanagement. OSC also raised overarching concerns about ongoing WPP issues raised in previous GAO and OIG audits.

To address OSC's concerns, we answered the 5 questions it posed and conducted additional work to answer the following question:

> *Did the whistleblower's disclosures reveal violations of law, rule, or regulation, and gross mismanagement?*

To answer all of these questions, we: 1) tested a sample of whistleblower complaints from October 1, 2010, through September 30, 2018; 2) conducted interviews in Region IX to determine if OSHA provided investigators with appropriate operational resources; and 3) reviewed 15 WPP cases and 77 allegations provided by the Whistleblower.

We also followed up on recommendations from prior audits to determine if OSHA had successfully implemented corrective actions.

WHAT OIG FOUND

We found no evidence of misconduct, nor evidence of any other issue that would rise to the level of "violations of law, rule, or regulation and gross mismanagement." However, we did find problems with the completeness and timeliness of investigations into whistleblower complaints, as 96 percent of those sampled did not meet all essential elements and 88 percent of cases exceeded statutory timeframes for investigations by an average of 634 days.

These results were worse than the results we reported in 2010 and 2015 audits, and could be attributed partly to average caseload counts in Region IX that were approximately double the average caseloads nationwide. Both Region IX and OSHA's Directorate of Whistleblower Protection Programs took steps to address the backlog created by the caseload, but in FY 2018 the average caseload in Region IX was still 57 percent higher than the national average.

WHAT OIG RECOMMENDED

We made recommendations to OSHA regarding case management, monitoring, and development of guidance. OSHA agreed with the report recommendations and stated strengthening WPP continues to be one of OSHA's top priorities.

READ THE FULL REPORT

http://www.oig.dol.gov/public/reports/oa/2021/02-21-001-10-105.pdf

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INSPECTOR GENERAL'S REPORT

Loren E. Sweatt
Principal Deputy Assistant Secretary
for Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

On July 6, 2018, then Secretary of Labor Alexander Acosta received a referral from the U.S. Office of Special Counsel (OSC). In that referral, OSC described allegations made against the U.S. Department of Labor's (DOL) Whistleblower Protection Program (WPP) in the Occupational Safety and Health Administration's (OSHA) Region IX. This report is in response to Secretary Acosta's request for the Office of Inspector General (OIG) to review OSC's referral.

WPP enforces 23 statutes[1] that protect employees from retaliation when they report violations of law by their employer. As part of this enforcement function, WPP investigates any complaints of employer retaliation. If WPP finds merit to a complaint, the employee (complainant) may be entitled to benefits or remedies.

The Whistleblower in OSC's referral was an investigator for OSHA from 2010-2015. The Whistleblower provided disclosures to OSC that alleged OSHA's Region IX had breakdowns processing the WPP complaints it received, which the Whistleblower claimed resulted in widespread failure to protect complainants. OSC determined there was a substantial likelihood the information provided by the Whistleblower disclosed a violation of law, rule, or regulation, and gross

[1] See Exhibit 1 for a list of the 23 statutes, including 1 that was added to OSHA's responsibilities after the date of the OSC's referral. Enacted on July 1, 2019, the Taxpayer First Act, 26 U.S.C. § 7623(d) protects employees from retaliation for reporting underpayment of taxes, potential violations of internal revenue laws, or potential violations of any provision of federal law relating to tax fraud to their employers or to the federal government, or engaging in other protected activities.

mismanagement. OSC's referral also raised overarching concerns regarding WPP because it stated previous GAO and OIG audits identified significant deficiencies with WPP's complaint investigations, and information from other OSC witnesses indicated the issues were ongoing. OSC's referral had 5 questions that needed to be answered and reported to the President and Congress, per statutory requirements.

OIG conducted an audit to answer OSC's 5 questions, and given OSC's overarching concerns, to answer the following question:

> Did the Whistleblower's disclosures reveal violations of law, rule, or regulation, and gross mismanagement?

To answer OSC's 5 questions[2] and the overarching question, we: 1) tested samples taken from 901 total whistleblower complaints from October 1, 2010, through September 30, 2018, to determine if Region IX appropriately investigated alleged retaliation; and 2) interviewed Region IX current and former investigators and managers,[3] and reviewed documentation to determine if OSHA provided investigators with appropriate operational resources.

As evidence to support the Whistleblower's disclosures to OSC, the Whistleblower provided us with 5 general allegations against WPP and a list of 15 WPP cases[4] with 72 specific allegations of wrongdoing related to the cases.[5] We reviewed the 15 cases to determine the merit of the Whistleblower's allegations and if OSHA appropriately investigated the alleged retaliation. To supplement this work, we followed up on recommendations from prior audit reports to determine if OSHA had successfully implemented corrective actions to improve management of WPP. See Appendix A for the scope, methodology, and criteria used for the audit.

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[2] See Appendix B for the 5 OSC questions and applicable results.

[3] Current investigators and managers were onboard with OSHA as of April 23, 2019. Former investigators and managers were those who worked in Region IX WPP between FY 2011 and FY 2018.

[4] Of the 15 cases provided by the Whistleblower with specific allegations of wrongdoing, 7 cases were part of Region IX's 901 total whistleblower complaints from October 1, 2010, through September 30, 2018. Another 7 cases were Region IX whistleblower complaints that were opened prior to October 1, 2010. The last case was from Region V.

[5] See Appendix D for the Whistleblower's 5 general allegations, summary of the 72 specific allegations, and applicable results.

Based on the results of our work, we found no evidence of misconduct, nor evidence of any other issue that would rise to the level of "violations of law, rule, or regulation and gross mismanagement." However, we did find problems with the completeness and timeliness of investigations into whistleblower complaints, as 96 percent of those sampled did not meet all essential elements and 88 percent of cases exceeded statutory timeframes for investigations by an average of 634 days. This was worse than the results we reported in 2010 and 2015 audits,[6] and could be attributed partly to average caseload counts in Region IX that were approximately double the average caseloads nationwide.

RESULTS

In 2010, OIG reported on the completeness of OSHA's whistleblower retaliation investigations, finding that an estimated 80 percent of investigations did not meet 1 or more essential elements.[7] In 2015, OIG reported OSHA's administration of the program had improved, as only 18 percent of sampled whistleblower complaint investigations were not complete.[8] With a 62 percent reduction in error rates, these 2 reports showed that OSHA significantly improved nationwide WPP management in the 5-years between reports. However, this audit, focused primarily on Region IX,[9] showed only a 4 percent reduction in error rates over time. For the completeness of sampled complaint investigations, 98 percent of investigations closed by May 2015 and 94 percent of investigations closed afterward did not meet 1 or more essential elements.

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[6] In the 2010 report, *Complainants Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program* (Report Number 02-10-202-10-105, September 30, 2010), OIG reported 80 percent of sampled investigations did not meet essential elements. In the 2015 report, *OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs* (Report Number 02-15-202-10-105, September 30, 2015), OIG reported 18 percent of sampled investigations did not meet essential elements.

[7] *Complainants Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program* (Report Number 02-10-202-10-105, September 30, 2010) reported results based on 172 sampled complaint investigations under 3 statutes: Section 11(c) of the Occupational Safety and Health Act of 1970 (OSH Act), Sarbanes-Oxley Act (SOX), and Surface Transportation Assistance Act (STAA). The sampled investigations were from 4 randomly selected regions: Philadelphia, Atlanta, Chicago and Denver, and OSHA made an initial determination on the complaint during the 12-month period ending October 31, 2009.

[8] *OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs* (Report Number 02-15-202-10-105, September 30, 2015) reported results were based on 132 randomly sampled inspections from the 3 sampled regions of New York, Atlanta, and Dallas. The sampled investigations were opened by October 1, 2012, and closed by March 31, 2014.

[9] Out of 75 sampled investigations, 74 were from Region IX and 1 was from Region V.

For Region IX, the completeness and timeliness of investigations could have been negatively impacted by an average caseload that was approximately double the nationwide average. Because Region IX had a small number of staff, any personnel changes could have a significant impact on caseloads. Both Region IX and OSHA's Directorate of Whistleblower Protection Programs (DWPP) took steps to address the backlog created by the caseload. Still, in FY 2018, the average caseload for the region was 57 percent higher than the national average.

THE WHISTLEBLOWER'S DISCLOSURES DID NOT REVEAL VIOLATIONS OF LAW, RULE, OR REGULATION, AND EVIDENCE OF GROSS MISMANAGEMENT

While we found problems with WPP in Region IX, we did not find evidence of misconduct, nor evidence of any other issue that would rise to the level of "violations of law, rule, or regulation and gross mismanagement." The term "gross mismanagement" is defined as follows.

> Management action or inaction which creates a substantial risk of significant adverse impact upon the agency's ability to accomplish its mission.

Gross mismanagement is more than *de minimis* wrongdoing or negligence and not all mismanagement qualifies. A disclosure of gross mismanagement must be so serious that it rises above a mere difference of opinion.

RESPONSE TO OSC'S REFERRAL

OSC's referral stated OSC had determined there was a substantial likelihood that the Whistleblower disclosed a "…violation of law, rule, or regulation and gross mismanagement." However, our audit did not find evidence to support the OSC's determination. For more information on the responses to OSC's referral, see Appendix B.

Pursuant to OSC's referral, OIG was asked to determine the following:

1. Whether investigations met all essential elements outlined in the Whistleblower Investigation Manual (WIM);

2. Whether investigators received appropriate resources, training, and legal assistance;

3. Whether—and, if so, how—the WIM had been updated since 2015;

4. Whether respondents (i.e., employers accused of retaliation) received more favorable treatment—including more access to information, more access to investigator and leadership time, and greater credibility in case determinations—than the complainants (i.e., employee whistleblowers); and

5. Whether investigators were pressured to close cases without investigating.

In responding to the questions in the OSC's referral, we found 96 percent of sampled investigations did not meet all essential elements outlined in the WIM (question 1). However, we did not find any evidence of misconduct by OSHA staff or managers related to those investigations. We also did not find any evidence that respondents received more favorable treatment than the complainants did; or that investigators were pressured to close cases without investigating (questions 4 and 5).

With regard to gross mismanagement, there was insufficient information to determine if not meeting all essential elements would have had a significant adverse impact on OSHA mission. For impact, we considered if meeting the essential elements would have resulted in a change to OSHA's determination for the sampled investigations. For example, if the investigator did not interview the witnesses, then we had no information on what evidence the witnesses could have provided. In making its determination, OSHA would have had to consider any validated information from the witnesses along with other evidence obtained during the investigation.

Another of OSC's questions was to determine whether investigators received appropriate resources (question 2). When asked about resources, Region IX staff and managers both identified the need for more investigators. However, we found OSHA did not have sufficient information to determine the appropriate number of investigators. Region IX received a proportionate amount of whistleblower investigators based on the region's share of new complaints. Because Region IX had a small number of staff, any personnel changes could have a significant impact on caseloads and increase the backlog in the region. Region IX's need for additional investigators did not rise to the level of gross mismanagement because the region received a proportionate amount of nationwide investigators.

RESPONSES TO THE WHISTLEBLOWER'S ALLEGATIONS

The Whistleblower provided OIG with 5 general allegations and 72 specific allegations for 15 cases (see Exhibit 2). However, our analysis of the Whistleblower's allegations did not reveal evidence of violations of law, rule, or regulation, and gross mismanagement. For more information on the responses to the Whistleblower's allegations, see Appendix D.

The Whistleblower provided 5 general allegations about OSHA's management of WPP, as follows:[10]

1. OSHA did not perform a quality review of the "corrupt practices" occurring within OSHA Region IX.

2. OSHA staff had conflicts of interest and improper influences that affected the integrity of the review.

3. OSHA management used the review results to target and drive out of federal service Region IX investigators who were also attorneys.

4. OSHA failed to investigate the reports of wrongdoing by Region IX management.

5. OSHA's mismanagement of WPP caused a substantial and specific danger to public health and safety.

Of the Whistleblower's 5 general allegations, 3 were not substantiated and 2 could not be substantiated because the Whistleblower did not provide evidence to support the allegations and declined to be interviewed by OIG.

In the fourth allegation, the Whistleblower alleged that OSHA failed to properly investigate reports of wrongdoing and a culture of corruption, but did not explain what reports had not been investigated and what was meant by "culture of corruption."

In the last allegation, the Whistleblower alleged OSHA's corporate mismanagement of WPP caused a substantial and specific danger to public health and safety, but did not explain what was meant by corporate mismanagement and what action or inaction caused a substantial and specific

[10] The first 3 allegations refer to the OSHA internal review conducted as a result of the Whistleblower's complaints to the Secretary of Labor, dated May 12, 2014.

danger to public health and safety. WPP is only responsible for investigating the complainant's allegations of retaliation, and not the underlying allegations related to an employer's violations of public health and safety laws and regulations.

For the 72 allegations from the 15 cases, each allegation and case was unique, with different sets of circumstances. Of the 72 allegations, 47 were not substantiated based on OSHA records and interviews, 24 could not be substantiated due to lack of information or records, and 1 had some merit. The allegation with some merit related to the complainant's appeal to DOL's Office of Administrative Law Judges (ALJ). However, we did not find evidence of misconduct, nor any pattern of evidence of any other issue that would rise to the level of "violations of law, rule, or regulation, and gross mismanagement."

OSHA'S REGION IX WHISTLEBLOWER COMPLAINTS WERE NOT INVESTIGATED COMPLETELY OR TIMELY

Region IX had problems with the completeness and timeliness of whistleblower complaint investigations – worse than the results reported by OIG in 2010 and 2015.

WHISTLEBLOWER INVESTIGATIONS MANUAL REQUIREMENTS

OIG reviewed 75 cases[11] to determine if their investigations met the essential elements of the WIM. The WIM sets forth policy, procedures, and other information on how to handle whistleblower complaints under the statutes delegated to OSHA. Based on our review of the WIM, we identified 8 essential elements for investigating a whistleblower complaint. These 8 essential elements were required for:

- Gaining information from the complainants, respondents, and relevant witnesses to determine the violations;
- Making a determination as to whether the *prima facie* elements were satisfied;

[11] The 75 cases are made up of 30 cases randomly selected from those cases opened and closed between October 2010 and April 2015; 30 cases randomly selected from those cases opened and closed between May 2015 and September 2018; and the 15 cases identified by the Whistleblower.

- Supervising work performed to ensure investigations were thorough; and

- Communicating pertinent information to all parties about the initiation and decision of the case, as well as the right to appeal.

Overall, we found 72 of 75 cases contained errors in 1 or more of the essential elements. See Table 1 for the number of errors by each essential element and Appendix C for details on each essential element.[12]

[12] Appendix C provides details of the errors found based on the review questions used to determine if OSHA met each essential element. There were up to 4 review questions per element with some questions more critical than others. For example, "Contact the Complainant" had 4 questions, as follows:

(1) Did the investigator obtain detailed information about the complainant's allegation(s)?
(2) Did the complainant have the opportunity to rebut the respondent's statements and evidence?
(3) Did the investigator obtain support documents from the complainant?
(4) Did the investigator maintain contact with the complainant throughout the investigation?

For these 4 questions, the first is the most critical. As noted in the WIM Chapter 3, Part IV-B, the investigator must contact the complainant as soon as possible, even if the investigator's caseload may delay the actual field investigation. Out of 37 errors for contacting the complainant, only 2 errors were because the investigator failed to obtain detailed information about the complainant's allegation.

In order to get a full understanding of the errors that OIG found, it is necessary to review the details in the tables contained in Appendix C.

Table 1 – Essential Elements, Total Number of Errors, and Total Number of Cases with at Least 1 Error	
Essential Element	Cases with Errors
1. Contact The Complainant	37
2. Contact The Respondent	16
3. Identify and Contact Witnesses	40
4. Address *Prima Facie* Elements	20
5. Conduct Supervisory Review	54
6. Notify Parties of Final Decision	0
7. Notify Parties of Appeal Rights	2
8. Coordinate with Other Agencies	16
Total Number of Errors	185
Number of Cases with at least 1 Error	72

Source: Testing results for 75 sampled complaint investigations

Table 1 presents results that were worse than results reported in the 2010 and 2015 OIG reports. In total, we found 96 percent of sampled investigations contained at least 1 error.[13]

In the 2010 report, OIG estimated that 80 percent of applicable investigations under 3 statutes did not meet 1 or more essential elements.[14] In the 2015 report, OIG stated that while OSHA's administration of the program had improved, opportunities still existed for OSHA to improve its monitoring of WPP. OIG reported 18 percent of sampled whistleblower complaint investigations were not complete, as 1 or more of the essential elements for conducting a whistleblower investigation were not performed. The report stated OSHA National Office did not

[13] Results for the 2010 and 2015 OIG reports are provided for information purposes, to provide the reader context. The data is not statistically comparable to the current audit results because of differences in scope and sampling methodology.

[14] *Complainants Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program*, (Report Number 02-10-202-10-105, September 30, 2010) sampled investigations under 3 statutes: Section 11(c) of the Occupational Safety & Health Act (OSH Act), Sarbanes-Oxley Act (SOX), and Surface Transportation Assistance Act (STAA)

include WPP when performing the required comprehensive, on-site, self-reviews of regional office activities. The report also stated OSHA did not implement performance measures to ensure investigations were completed according to policy.

In this current audit, we found no evidence that OSHA treated either the complainant or respondent more favorably.[15] This conclusion was based on the tone of the correspondence with the parties and the reasonableness of extensions provided. There was also no evidence that OSHA pressured investigators to close out the sampled complaints without an investigation.

We provided OSHA the errors we identified.

- For 59 percent of the errors, OSHA agreed with OIG that the essential elements were not met.

- For another 26 percent, OSHA stated the essential element in question was not necessary because the case ended in a settlement, withdrawal, or dismissal due to lack of cooperation. However, OIG disagreed because the investigations were open for an average of 613 days without meeting the essential element in question. The essential elements in question were basic fact-finding steps to: (1) contact the complainant; (2) contact the respondent; (3) identify and contact witnesses; and (4) address *prima facie* elements. OIG concluded that OSHA did not provide due diligence because the investigators did not complete the basic fact-finding part of the investigations, even though the cases were open for an average of 20 months.

- The remaining 15 percent of errors were mostly unique situations and had no discernable trends. OSHA maintained that steps taken during the investigations were sufficient, but OIG disagreed based on applicable criteria in the WIM and evidence in the investigative records. For example, OSHA stated that it could not interview witnesses in Thailand due to technical difficulties. OIG disagreed since investigative records showed the complainant was in Thailand, but the witnesses were elsewhere and OSHA did not attempt to contact the witnesses.

[15] There was 1 instance of a breakdown in communications between OSHA and a complainant, which may have affected the quality of the complaint investigation (Case Number 5 of the 15 provided by the Whistleblower).

As previously noted, investigations into 96 percent of sampled complaints were not complete. The investigator may not have pursued all appropriate investigative leads pertinent to the investigation, with respect to the complainant's and the respondent's positions. The investigator also may have not attempted to gather all pertinent data and materials from all available sources. The supervisor may not have reviewed the investigative file to ensure technical accuracy, thoroughness, and completeness of OSHA's investigation, correct application of law, and merits of the case. Moreover, OSHA may not have had sufficient evidence to render an objective conclusion about the merit of the complaint.

DAYS TO INVESTIGATE

For the 75 sampled cases, 66 of 75 (88 percent) exceeded statutory timeframes (30, 60, or 90 days)[16] by an average of 634 days. If a complaint was found to have merit, the complainant who lost employment because of retaliation would have experienced longer periods of lost wages and unemployment while they waited for OSHA to make a determination. Investigations were not completed within statutory timeframes because investigators had caseloads that were higher than the national average caseload. In addition, OSHA did not establish goals to complete investigations within the 30, 60, or 90-day timeframes established by statutes.

In the 2015 report,[17] OIG concluded OSHA did not consistently conduct investigations within the statutory timeframes. OIG's conclusion was based on nationwide OSHA investigation data from October 1, 2012, to March 3, 2014, which showed 72 percent of investigations exceeded statutory timeframes by an average of 163 days.

In response to our 2015 report, OSHA officials stated that they believed the timeframes were not legal requirements and OSHA did not have to establish goals to meet them. They also stated that when investigations were brought before the courts; OSHA was not penalized for making a determination outside the timeframe. Because the timeframes were statutory requirements, OIG recommended to OSHA:

[16] Each whistleblower retaliation statute contains timeframes (30, 60, or 90-days) for OSHA to make a determination on the complaint.

[17] *OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs*, (Report Number 02-15-202-10-105, September 30, 2015)

> Develop and implement a process to ensure reasonable balance is applied between the quality and timeliness to complete investigations within statutory timeframes.

As of July 2020, OSHA had not implemented corrective action to address the recommendation.

Table 2 presents the number of days in excess of statutory timeframes to complete investigations for sampled investigations closed before and after OIG issued its 2015 report.

Table 2 – Number of Days in Excess of Statutory Timeframes to Complete Investigations

Description	Sampled Investigations Closed by September 30, 2015	Sampled Investigations Closed after September 30, 2015	All Sampled Investigations
Number and percentage of sampled cases in excess of statutory timeframes	38 of 42 (90%)	28 of 33 (85%)	66 of 75 (88%)
Average number of days in excess of statutory timeframes to complete investigations	597	683	634

Source: Testing results for 75 sampled complaint investigations

As shown in the table above, the results for all sampled investigations was 634 days in excess of statutory timeframes. The current results were worse than those reported in the 2015 OIG report (163 days).[18]

[18] Results for this audit's sampled investigations and the 2015 OIG report are provided for information purposes, to provide the reader context. The data is not statistically comparable because of differences in scope and sampling methodology. The 2015 report used a scope of 17 months. The current audit had a scope of 8 years (from FY 2011 through FY 2018). Within the current audit's scope, OSHA closed 38 sampled investigations in a 17-month period. For those 38 sampled investigations, 29 investigations (76 percent) exceeded statutory timeframes by an average of 221 days.

We compared results for cases closed before and after the issuance of the 2015 OIG report (September 30, 2015) to see if there was any evidence of OSHA's efforts to address the open recommendation. We noted a 5 percent decrease in the number of cases that exceeded statutory timeframes, but an increase in the average number of days in excess of timeframes. This means that more investigations were completed timely, but the backlogged cases were taking longer. Therefore, we found no evidence that OSHA successfully improved the overall timeliness of investigations.

We also noted the 15 investigations that were judgmentally selected had worse results for timeliness. We found 93 percent of the investigations exceeded statutory timeframes by an average of 833 days. The reason these 15 investigations had worse results for timeliness than other sampled investigations may be attributed in part to ineffective communications and lack of consensus building.

For several of the 15 investigations, there were differences of opinion primarily between the investigator (who was the Whistleblower) and supervisor, and sometimes including regional managers and the Regional Solicitor of Labor (RSOL). The differences of opinion were about the thoroughness and completeness of the investigation, and conclusions based on the evidence. Many of the Whistleblower's allegations on the 15 cases were actually differences of opinion.

OSHA HAS NOT SUCCESSFULLY IMPLEMENTED EFFECTIVE CORRECTIVE ACTIONS TO ENSURE A REASONABLE BALANCE BETWEEN QUALITY AND TIMELINESS

OIG issued 4 reports on WPP between October 1, 2010, and September 30, 2018.[19] These 4 reports had 13 recommendations, of which 12 have been implemented (see Exhibit 3). However, the following recommendation from the 2015 report remains open:

> Develop and implement a process to ensure reasonable balance is applied between the quality and timeliness to complete investigations within statutory timeframes.

[19] In addition to the 2010 and 2015 OIG reports mentioned earlier, OIG issued the following: 1) *Federally Operated Whistleblower Protection Program Cost* (Report No. 22-12-014-10-105, January 20, 2012), which had no report recommendations; and 2) *Whistleblower Protection Program Complaint* (Report No. 02-11-202-10-105, March 31, 2011), which had 1 recommendation.

In response to the 2015 draft report, OSHA stated:

> OSHA will continue to develop policies and procedures to ensure that reasonable balance is applied between quality and timeliness, in order to increase the number of investigations completed within statutory timeframes. OSHA notes that many factors can impact the length of an investigation, and OSHA's investigations frequently continue beyond those timeframes both because of resource constraints and because the timeframes do not realistically reflect the complexities of the investigative process. In certain cases the statutory timeframe passes even before OSHA can complete the basic steps necessary to *start* an investigation. Judicial decisions make clear that OSHA's jurisdiction to complete an investigation is not affected if the investigation extends beyond the timeframe in the statute.[20]
>
> Regarding resource issues…OSHA still lacks the resources that it needs to process and investigate whistleblower complaints with the expediency that we would like, while also maintaining the quality and thoroughness that is appropriate.[21]

During the 2015 report resolution process, OSHA stated that regions were sharing their strategies and pilot programs to address their backlogs and streamline the investigative process. OSHA also stated it was exploring an electronic case management system to help investigators and managers manage their caseloads better.

In interviews with OIG for this audit, staff stated that efforts, such as pilot programs, focusing on older cases, and streamlining the writing process, have helped to ensure reasonable balance between quality and timeliness. However, staff stated that training and hiring would assist with the reasonable balance. Despite OSHA's efforts, finding that reasonable balance between quality and timeliness remains a struggle.

[20] In its response, OSHA referred to *Roadway Express, Inc. v. Dole,* 929 F.2d 1060, 1066 (5th Cir. 1991) as an example.

[21] When it responded to the 2015 draft report, OSHA stated that whistleblower investigators then carried an average of 23 pending investigations. However, as of FY 2018, average caseloads have increased to 31 per investigator.

EFFORTS BY REGION IX AND DWPP WERE NOT SUFFICIENT TO ADDRESS THE REGION'S HIGHER THAN AVERAGE CASELOADS

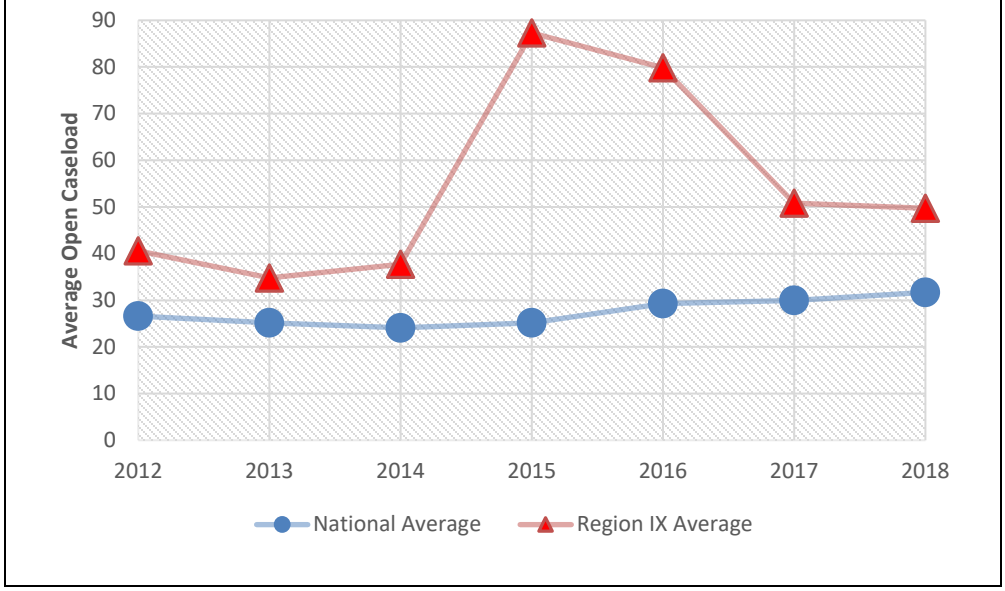
OIG and GAO audits have reported problems with the volume of whistleblower investigators' caseloads and the resulting backlog in completing investigations.[22] Since 2010, OSHA has undertaken initiatives to reduce the backlog of cases. However, the average caseloads in Region IX remain higher than the national average.

The completeness and timeliness of investigations could be attributed partly to Region IX's average caseload, which was approximately double the nationwide average. Because Region IX had a small number of staff, any change in personnel could have a significant impact on caseloads. The following chart presents the average caseload per investigator for Region IX as compared to the national average.

[22] OIG Reports: *Complainants Did Not Always Receive Appropriate Investigations Under The Whistleblower Protection Program* (Report Number: 02-10-202-10-105; issued September 30, 2010); *OSHA Needs To Continue To Strengthen Its Whistleblower Protection Programs* (Report Number: 02-15-202-10-105, issued September 30, 2015)

GAO Report: *Whistleblower Protections: Sustained Management Attention Needed to Address Long-standing Program Weaknesses* (Report Number: GAO-10-722, issued August 17, 2010)

Chart 1 – Average Open Caseload Per Investigator



Source: OSHA data on caseloads

During FY 2015, the number of onboard investigators in Region IX dropped from 6 to 3, while the average caseload spiked at 87 complaints per investigator. One investigator, the Whistleblower, separated from OSHA in May 2015, and another 2 separated in August 2015 leaving the region short-handed. Another reason for the spike was personnel actions. One investigator was placed on a performance improvement plan in January 2015 and that investigator's caseload was reduced to 15 complaints while the other investigators were allocated the rest of the investigator's caseload.

Both Region IX and DWPP took steps to reduce the backlog resulting from the high caseload, as follows:

- DWPP initiated the Alternative Dispute Resolution (ADR) program nationwide in FY 2015.[23] The ADR program can assist the complainants and respondents to resolve their whistleblower complaints with the assistance of a neutral, confidential OSHA representative who has subject-matter expertise in whistleblower investigations. While the parties are attempting complaint resolution

[23] ADR program was piloted in Region IX in FY 2013.

through the ADR program, the whistleblower complaint investigation is suspended.

- In August 2016, Region IX initiated a pilot program for Expedited Case Processing. The pilot allowed the complainants under 19 statutes[24] the option of requesting OSHA terminate its investigation and issue Secretary's Findings so they can more quickly pursue their claims in whistleblower retaliation cases adjudicated by the ALJ.

- In October 2016, OSHA convened a team of staff from the regions, DWPP, and others to determine what OSHA knew about Wells Fargo whistleblower cases and how cases could be open so long. The team initially focused on Region IX. When the team noted the high caseloads in Region IX, 45 backlogged cases were reassigned to staff in other regions.

Although Region IX's average caseloads improved after FY 2015, the average caseload in FY 2018 for the region was 57 percent higher than the national average.

OIG'S RECOMMENDATIONS

We recommend the Principal Deputy Assistant Secretary for Occupational Safety and Health:

1. Explore solutions to improve case management, including tracking completion of the essential elements and alerting the investigator and supervisor when there are periods of inactivity on an investigation.

2. Develop and implement a system to track and monitor the work performed by FTEs to better allocate personnel costs by program and ensure resources are used as intended.

3. Continue efforts to find solutions to developing a reasonable balance between the quality and timeliness of investigations.

[24] As of FY 2020, OSHA had 20 statutes that could be appealed to the ALJ. Region IX's pilot included 19 statutes because the pilot ended before the Taxpayer First Act was enacted on July 1, 2019.

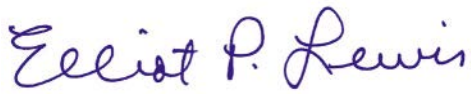
4. Ensure OSHA issues an updated WIM by the end of FY 2021 and complete desk guides for all applicable statutes.

SUMMARY OF OSHA'S RESPONSE

OSHA concurred with each of the report's 4 recommendations. OSHA recognizes the ongoing challenge the agency faces, across regions, in completing whistleblower complaint investigations in a timely manner. The agency is actively working on improving operations to promote a heightened balance between the dual goals of timeliness and completeness of investigations.

OSHA's written response to our draft report is included in its entirely in Appendix E.

We appreciate the cooperation and courtesies OSHA extended us during this audit.



Elliot P. Lewis
Assistant Inspector General for Audit

EXHIBIT 1: WHISTLEBLOWER RETALIATION STATUTES

Year	Name	Statute
1970	Section 11(c) of the Occupational Safety and Health Act (OSH Act)	29 U.S.C. § 660(c)
1972	Federal Water Pollution Control Act (FWPCA)	33 U.S.C. § 1367
1974	Energy Reorganization Act (ERA)	42 U.S.C. § 5851
1974	Safe Drinking Water Act (SDWA)	42 U.S.C. § 300j-9(i)
1976	Solid Waste Disposal Act (SWDA)	42 U.S.C. § 6971
1976	Toxic Substances Control Act (TSCA)	15 U.S.C. § 2622
1977	Clean Air Act (CAA)	42 U.S.C. § 7622
1977	International Safe Container Act (ISCA)	46 U.S.C. § 80507
1980	Comprehensive Environmental Response, Compensation and Liability Act (CERCLA)	42 U.S.C. § 9610
1982	Surface Transportation Assistance Act (STAA)	49 U.S.C. § 31105
1986	Asbestos Hazard Emergency Response Act (AHERA)	15 U.S.C. § 2651
2000	Wendell H. Ford Aviation Investment and Reform Act for the 21st Century (AIR21)	49 U.S.C. § 42121
2002	Pipeline Safety Improvement Act (PSIA)	49 U.S.C. § 60129
2002	Sarbanes-Oxley Act (SOX)	18 U.S.C. § 1514A
2007	Federal Railroad Safety Act (FRSA)	49 U.S.C. § 20109
2007	National Transit Systems Security Act (NTSSA)	6 U.S.C. § 1142
2008	Consumer Product Safety Improvement Act (CPSIA)	15 U.S.C. § 2087
2010	Affordable Care Act (ACA)	29 U.S.C. § 218c
2010	Consumer Financial Protection Act (CFPA)	12 U.S.C. § 5567
2010	Seaman's Protection Act (SPA)	46 U.S.C. § 2114
2011	FDA Food Safety Modernization Act (FSMA)	21 U.S.C. § 399d
2012	Moving Ahead for Progress in the 21st Century Act (MAP-21)	49 U.S.C. § 30171
2019	Taxpayer First Act (TFA)	26 U.S.C. § 7623(d)

EXHIBIT 2: WHISTLEBLOWER ALLEGATIONS

In analyzing the Whistleblower's allegations, we used the following definitions:

- **Some Merit.** The facts and findings showed the alleged events or actions probably took place.
- **Not Substantiated.** The facts and findings showed the allegations were unfounded.
- **Could not be Substantiated.** The available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action did or did not take place.

WHISTLEBLOWER'S GENERAL ALLEGATIONS

Allegation	OIG Conclusion
1. OSHA did not perform a quality review of the "corrupt practices occurring within OSHA Region IX."	Not substantiated – OIG reviewed OSHA's internal management review and found no issue with the quality.
2. OSHA staff had conflicts of interest and improper influences that affected the integrity of the review.	Not substantiated – OIG interviewed the staff participating in the review and found no evidence of conflicts of interest or improper influences.
3. OSHA management used the review results to target and drive out of federal service Region IX investigators who were also attorneys.	Not substantiated – OIG reviewed personnel files and found 4 staff left federal service after the review report. Two staff left voluntarily after positive performance reviews. Two staff were terminated or retired in lieu of, but had performance or conduct issues prior to the issuance of OSHA's review report.
4. OSHA failed to investigate the reports of wrongdoing by Region IX management.	Could not be substantiated – The Whistleblower did not explain what "reports of wrongdoing" had not been investigated.

Allegation	OIG Conclusion
5. OSHA's mismanagement of WPP caused a substantial and specific danger to public health and safety.	Could not be substantiated – The Whistleblower did not provide any evidence linking OSHA's investigation of whistleblower retaliation to "…substantial and specific danger to public safety" and the Whistleblower declined to be interviewed.

WHISTLEBLOWER'S ALLEGATIONS FOR 15 CASES

Allegation	OIG Conclusion
1. Complainant allegedly was not offered the opportunity to refute all the respondent claims.	Could not be substantiated – The complainant did not provide information on what claims were not addressed.
2. Complainant alleged that OSHA did not further investigate the respondent's claims using documents in the complainant's possession and information maintained by state agencies.	Could not be substantiated – The complainant did not provide information on what claims were not investigated.
3. Complainant alleged the respondent fabricated evidence that it provided to OSHA to show the complainant received the respondent policies and procedures.	Not substantiated – The complainant did not prove the respondent fabricated evidence. Also, the complainant's evidence did not show the complainant did not receive the policies and procedures.
4. Complainant described alleged retaliation subsequent to reporting safety and health concerns to management and to OSHA.	Not substantiated – The alleged retaliation was already covered in OSHA's WPP investigation. OSHA determined the complaint to be non-merit.
5. Complainant described the security incident that resulted in termination.	Not substantiated – The complainant's account of the security incident was the same as shown in OSHA's investigation.

Allegation	OIG Conclusion
6. Whistleblower alleged the RSOL attorney stated in a meeting that they did not want to approve the Due Process letter because they did not want to argue a case involving drug testing in court.	Could not be substantiated because the meeting with RSOL was not memorialized in OSHA's records
7. Whistleblower alleged Regional Supervisory Investigator (RSI) rewrote the Report of Investigation (ROI) and misrepresented it as coming from the investigator	Not substantiated – There is no evidence the report was misrepresentative. The report was an internal OSHA document and there was evidence in the casefile that the RWI and RSI disagreed on the report's recommendation.
8. Whistleblower alleged that RSI omitted evidence from the rewritten ROI.	Not substantiated – The rewritten ROI included information on timeliness, coverage, elements, defense, and recommended disposition as required by the WIM. The report was also clear that the reason the case was determined as non-merit was RSOL's analysis of the case, which it referenced and included as an exhibit.
9. Whistleblower alleged the RA failed to investigate report of possible wrongdoing.	Could not be substantiated – The Whistleblower did not explain what reports were not investigated.
10. Whistleblower and complainant alleged the RSI delayed review of the ROI, drawing repeated complaints from the complainant.	Not substantiated – The WIM does not provide a deadline for the RSI's review. There was no evidence that the RSI purposefully delayed review of the casefile, or that the complainant repeatedly complained about delays.
11. Whistleblower alleged the RSI extended the investigation far beyond what was required, but did not explain further.	Could not be substantiated – The Whistleblower did not explain how the investigation was extended beyond requirements.
12. Whistleblower and complainant alleged the RSI summarily dismissed the complaint when the complainant complained about the delays.	Not substantiated – There was no evidence in the WPP casefile to support the allegation. The dismissal was based on a comprehensive review by the Assistant Regional Administrator (ARA).

Allegation	OIG Conclusion
13. Whistleblower and complainant alleged the RSI "low-balled" damages in the final ROI.	Could not be substantiated – The Whistleblower and complainant did not explain what was meant by "low balled."
14. Whistleblower alleged the RSI attempted to coerce settlement on the respondent's terms, but did not explain further.	Could not be substantiated – The Whistleblower did not explain what was meant by coercion.
15. Whistleblower alleged the RSI wrote the final ROI without the Regional Whistleblower Investigator's (RWI) participation or knowledge.	Not substantiated – The RSI used segments of the ROI drafted by the RWI, and made changes based on the RSI's own review of the casefile and recommendations by the ARA.
16. Whistleblower and complainant alleged the ALJ dismissed the case on improper grounds.	Some merit – The Administrative Review Board (ARB) partially reversed the ALJ's dismissal due to the error.
17. Whistleblower and complainant alleged the ALJ coerced agreement to a minimal settlement by the complainant and protected the respondent from inferences of wrongdoing.	Could not be substantiated – There was no information about the ALJ's involvement in the settlement.
18. Complainant alleged Region IX denied the complainant's request for a copy of the final ROI, but did not explain further.	Could not be substantiated – There was a lack of information about the complainant's request and the region's response to the request.
19. Complainant alleged the ALJ, respondent attorneys, and RSOL collaborated to throw up roadblocks to pursuing his case, but did not explain further.	Could not be substantiated – The complainant did not explain what the "roadblocks" were.
20. Whistleblower alleged the case was initially assigned to an industrial hygienist who had little training in investigations.	Not substantiated – The initial RWI had approximately 7 years of experience as a whistleblower investigator and had completed OSHA's 2 mandatory training classes for whistleblower investigators prior to being assigned the case.
21. Whistleblower alleged RSI reversed the merit decision after speaking with respondent's attorney.	Could not be substantiated – There was no record of the alleged meeting between the RSI and respondent's attorney.

Allegation	OIG Conclusion
22. Whistleblower alleged the RSI 1) dismissed the idea of a "hostile work environment" and 2) dismissed the complaint based on faulty analysis of what constitutes contributing factor.	Not substantiated – 1) In reviewing the adverse actions against the complainant, the actions did not form a pattern of ongoing and persistent harassment. 2) The preponderance of evidence does not support contributing factor, especially since the same manager counselled the complainant and then gave a positive performance review 3 weeks later.
23. Whistleblower alleged the case was assigned to an investigator with no training in Toxic Substances Control Act (TSCA) cases. Whistleblower stated the Complainant reported serious violations of TSCA that the company was improperly disposing of toxic waste from a construction site.	Not substantiated – No evidence that TSCA would be applicable for the case. The investigator completed OSHA's mandatory training.
24. Whistleblower alleged OSHA collaborated with the National Park Service to conceal the service's wrongdoing.	Could not be substantiated – The Whistleblower did not provide information about the alleged "collaboration." The respondent was a sub-contractor of the National Park Service.
25. Complainant alleged that OSHA did not amend the OSH Act Section 11(c) complaint to include violation of SPA.	Could not be substantiated – The records were inconclusive. In an interview with OIG, the complainant stated that at the OSH Act Section 11(c) closing conference, they requested OSHA amend the complaint to include SPA. However, the closing conference discussions were not in OSHA's records. Also, the complainant did not mention SPA in his appeal to OSHA DWPP of the OSH Act Section 11(c) investigation.
26. Complainant alleged OSHA refused to talk with them, discuss evidence with them, and OSHA told them not to call.	Not substantiated – In an interview, the complainant stated that OSHA was available for discussion up until the complaint investigation was closed. However, the complainant's own behavior resulted in OSHA taking steps to funnel calls and emails through managers rather than staff.

Allegation	OIG Conclusion
27. Complainant alleged OSHA did not interview witnesses recommended by the complainant.	Not substantiated – The complainant identified 1 witness who was key to the dispute whether the termination was retaliatory. While the witness was not formally interviewed, OSHA's investigative notes indicated that the witness did not hear what the complainant alleged.
28. Complainant alleged that OSHA collaborated with National Park Service and OSHA withdrew 2 of the occupational safety citations it had issued based on the complainant's disclosures.	Not substantiated – There was nothing in the investigative file to indicate OSHA collaborated with National Park Service. Safety citations were handled by a separate unit in OSHA and the withdrawal of the citations appeared to be in accordance with the applicable procedures.
29. Whistleblower alleged Hawaii Occupational Safety and Health (HIOSH) lacked authority to investigate complaints involving STAA and AIR21. The Whistleblower stated the RWI tried to stop HIOSH's investigation and federal program managers did not try to restrain HIOSH.	Not substantiated – HIOSH investigated the complaint under Hawaii state law.
30. Whistleblower alleged the RWI had insufficient training and knowledge about the WPP.	Not substantiated – While new to the WPP, the RWI was not an inexperienced investigator. Also, the RWI received mandatory training in a timely manner.
31. Whistleblower alleged the RSI made repeated demands for further investigation and redrafting the ROI.	Not substantiated – OSHA managers and the RWI did not agree on the investigative analysis and recommendation, so it was returned to the RWI for further investigation. This was handled according to WIM requirements.
32. Whistleblower alleged OSHA did not notify SEC of the complaint.	Not substantiated – The investigative file shows OSHA notified the SEC about a week after the complaint was filed. OSHA's notice to SEC included a copy of the complaint.

Allegation	OIG Conclusion
33. Whistleblower alleged that OSHA delayed in making the merit finding for more than 3 years.	Could not be substantiated – The pace of the investigation could not be determined. Although the investigation was open for over 3 years, there was no evidence to suggest OSHA intentionally delayed the investigation, nor was there evidence to suggest OSHA caused additional economic hardship for the complainant.
34. Whistleblower alleged that OSHA denied the complainant full recovery of damages by accepting without question the respondent representations that it had independent grounds to fire the complainant.	Not substantiated – OSHA did not accept the respondent's evidence without question.
35. Complainant alleged that OSHA delayed the merit finding, which would have been important to the complainant's arbitration.	Not substantiated – There was nothing in the investigative file to show a merit determination would have been made before arbitration. The file shows that 15 months after arbitration, OSHA was continuing to resolve questions about the complaint.
36. Complainant alleged they had to collect the evidence from former clients to refute the respondent SOP. The complainant stated the Technical Investigator said at one point that the Technical Investigator did not believe the case had merit. The complainant stated they contacted former clients and found the respondent's statements were false.	Not substantiated – The complainant started collecting the client witness statements prior to filing their whistleblower retaliation complaint and used the statements for purposes other than responding to the respondent's statement of position.
37. Complainant alleged he was not given a chance to respond to the conclusion that the respondent would have fired him based on the after-acquired evidence.	Not substantiated – The complainant was able to address the after-acquired evidence. Prior to issuing the Secretary's Findings, OSHA was not required to discuss the impact of after-acquired evidence on damages for a merit case.

Allegation	OIG Conclusion
38. Complainant alleged that OSHA limited damages based on some trumped-up allegation by the respondent after it had made false statements under oath. The complainant provided multiple documents to OSHA showing discrepancies in statements made by the respondent.	Not substantiated – OSHA was required to consider the after-acquired evidence from the respondent. In the ROI, the Technical Investigator discussed the discrepancies in evidence received from the complainant and the respondent. In conclusion, the ROI considered the respondent's written policy trumped the complainant's position about local practice that were not in compliance.
39. Whistleblower alleged the RSI attempted to compromise the recommendation by secretly, but unsuccessfully, "reinterviewing" witnesses to get them to change their testimony.	Not substantiated – The RSI performed some reinvestigation based on information provided by the respondent during the due process letter meeting. Based on the new information, the RSI determined the case would be dismissed. OSHA's national office and RSOL agreed with the dismissal.
40. Whistleblower alleged RSI and ARA met secretly with company officials to craft a rationale for dismissing the complaint.	Could not be substantiated – There was no evidence that the RSI and ARA met secretly with the respondent officials or exceeded their authority in dismissing the case.
41. Whistleblower alleged the RSI's rationale lacked any legal merit, which didn't prevent the RSI from dismissing the complaint. The Whistleblower did not provide further information on how the rationale "lacked legal merit."	Not substantiated – OSHA followed WIM requirements in dismissing the complaint. The respondent followed progressive discipline policies and there was no disparate treatment.
42. Whistleblower alleged the ALJ continued to slow-walk his review until the complainant was near financial exhaustion.	Not substantiated – There was a total of 193 days between the appeal and settlement. In addition, ALJ tracking data showed case activity each month except December 2014.
43. Whistleblower alleged the ALJ imposed a minimum settlement to satisfy the company.	Could not be substantiated – Neither the Whistleblower nor the complainant were available for interview, and the terms of the settlement were sealed.

Allegation	OIG Conclusion
44. The RSI continuously rejected RWIs investigative findings and instructed RWI to go beyond the requirements for a credible investigation to succeed and justice to be administered.	Could not be substantiated – The complainant did not provide information on what the RWI was instructed to do that was beyond the requirements for a credible investigation. There was no evidence in the investigative file to demonstrate the RSI continuously rejected the RWI's investigative findings.
45. At one point, the RSI sat on the case for more than a year and did nothing with it, then handed it back to the assigned RWI with more demands above and beyond what was required.	Could not be substantiated – The complainant did not provide information on the "demands above and beyond what was required."
46. OSHA Region IX management grossly mismanaged the complaint and abused their authority repeatedly at a tremendous cost to the complainant and compromised the safety of aviation by allowing the respondent to continue without accountability.	Could not be substantiated – The complainant did not provide information on how OSHA Region IX management grossly mismanaged the complaint, abused their authority repeatedly at a tremendous cost, or compromised the safety of aviation.
47. The RSI further abused his authority by giving the respondent more than 10 days for "relevant rebuttal" per protocol and described in the Due Process letter with merit finding.	Not substantiated – The respondent contacted OSHA within 10 days and requested an extension. The request and extension was according to WIM requirements.
48. The RSI colluded with respondent's attorney during the RWI's absence, reinvestigated the complaint, tampered with the witnesses, and altered documents within the case file that the RWI had completed. OSHA management secretly met with the respondent's attorneys to discuss the dismissal of the compliant behind RSI's, complainant's, and complainant attorney's back.	Could not be substantiated – The complainant did not provide additional information on how the RSI colluded with the respondent's attorney and tampered with witnesses. The investigative file showed the RSI worked within OSHA requirements for due process in conducting additional interviews and editing the ROI.
49. The RSI dismissed the case based on non-relevant rebuttal.	Not substantiated – The RSI dismissed the case based on a number of things, including transcripts of several of the complainant's calls and certain portions of the arbitrator's position.

Allegation	OIG Conclusion
50. The dismissal letter issued by the RSI was not legal because it was missing required signatures.	Not substantiated – A copy of the signed Secretary's Findings, which recommended dismissal, was included in the investigative file.
51. The Whistleblower alleged DOL's RSOL refused to represent the complainant, as required by law.	Not substantiated – RSOL was not required by law to represent the complainant. While RSOL may assume the role of prosecuting party, it may withdraw as the prosecuting party in the exercise of prosecutorial discretion per 29 CFR § 1978.108(a)(2).
52. Whistleblower alleged the RSI and RSOL improperly released the complainant's personal information. Further information about the allegation was not available because the Whistleblower and complainant were not interviewed.	Not substantiated – The personal information in question was the complainant's address. It is routine to provide the complainant's address to the respondent and respondent's attorney during litigation to serve the party.
53. Whistleblower alleged mismanagement and possibly misconduct by the DOL ALJ's office which failed to timely resolve the complainant's case. Further information about the allegation was not available because the Whistleblower and complainant were not interviewed.	Not substantiated – The ALJ decided to dismiss the case on: 1) the complainant not being able to represent themselves consistent with Supreme Court authority and with the due process rights of the respondent; and 2) the complainant refusing the appointment of a guardian ad litem, as required in the applicable rules.
54. Whistleblower alleged evidence from the first RWI's investigation strongly supported a merit finding. To support this claim, the Whistleblower provided a draft ROI.	Not substantiated – The draft ROI did not strongly support a merit finding because the draft was incomplete and did not meet WIM requirements for objectivity in discussing the respondent and the complainant evidence. Whereas, the final ROI evaluated both the complainant's claims and the respondent's response, incorporated RSOL's analysis, and recommended the complaint be dismissed.

Allegation	OIG Conclusion
55. Whistleblower alleged the RSI and ARA ordered the case dismissed on the grounds the complainant was insubordinate, a completely inappropriate legal standard in all whistleblower statutes.	Not substantiated – There was no evidence in the investigative file to demonstrate the RSI and ARA ordered the case dismissed. Rather, the documentation showed that RSOL reviewed the case and concluded it was not appropriate for litigation.
56. Whistleblower alleged that the RSI's report selectively reported or misrepresented evidence for the adverse action. The RWI's report included at least 4 adverse actions, but the RSI's report included only 2 adverse actions.	Could not be substantiated – The Whistleblower did not provide information on how not reporting one complainant's demotion and the opposition to unemployment benefits would affect OSHA's determination of merit/non-merit.
57. Whistleblower alleged the RSI's report selectively reported or misrepresented evidence for the nexus. The Whistleblower discussed differences in how the RWI's and RSI's reports analyzed the nexus between the protected activities and adverse actions.	Could not be substantiated – The investigative details were the same for both the RWI and the RSI reports, but their conclusions differed. Both were logical and reasoned opinions looking at the facts as a whole. However, neither report addressed whether there was any disparate treatment of the complainants under the respondent's discipline policy.
58. Whistleblower alleged the RSI and ARA ordered the case dismissed, reasoning that other employees didn't want to work with the complainant after the incident. The Whistleblower stated that the reasoning was a completely inappropriate legal standard in all whistleblower statutes.	Not substantiated – The rationale provided in the Whistleblower's allegation was not the same as the basis for dismissing the case per the signed Secretary's Findings. Also, the basis per the Secretary's Findings complies with WIM requirements.
59. Whistleblower alleged that RSI wanted to exclude evidence. When the RWI refused to rewrite the merit findings to exclude evidence, the RSI rewrote it himself.	Not substantiated – The ROI drafted by the RWI and the one completed by the RSI discussed the Chronology of Relevant Events. However, the ROI completed by the RSI was more comprehensive and therefore did not exclude evidence supporting merit, but rather included additional evidence relevant to the investigation.

Allegation	OIG Conclusion
60. Complainant disputed facts from the Secretary's Findings, alleging: 1) they had a valid prescription for OxyContin; 2) they were not conducting business on respondent property, but were a patient; and 3) they were not treated the same as a co-worker (MedTox screen).	Not substantiated – The complainant did not show how the information that was disputed would have connected the complainant's termination to their protected activity.
61. Whistleblower alleged that the investigation was severely hampered by OSHA unwillingness to issue subpoenas for documents and witness interviews.	Not substantiated – The Whistleblower stated the RWI conducted an "extended investigation" and obtained additional documentation to reach a conclusion. Therefore, the use of subpoenas was not necessary.
62. Whistleblower alleged RSOL would not pursue cases against the respondent, which was a federal agency.	Not substantiated – RSOL provided evidence that RSOL has tried cases against the respondent in the past.
63. Whistleblower alleged that when the RWI made a merit recommendation, the ARA closed the case authoring a Secretary's Findings, which the Whistleblower states the RWI was authorized to produce.	Could not be substantiated – The RWI's alleged merit recommendation was not in OSHA's records and the Whistleblower, who was also the RWI, declined to be interviewed by OIG.
64. Whistleblower alleged that the ARA authored a Secretary's Findings, which adopted tortured logic that concealed the evidence supporting the merit finding.	Could not be substantiated – The RWI's alleged merit recommendation was not in OSHA's records and the Whistleblower, who was also the RWI, declined to be interviewed by OIG.
65. Whistleblower alleged that the RSI delayed assigning an investigator to the cases until after the 6-month statutory period allowed for an investigation.	Not substantiated – The date the first RWI was assigned was 29 days from the date the complaint was filed.
66. Whistleblower alleged that OSHA assigned the investigations to a new, untrained investigator.	Not substantiated – The 2 RWIs who worked on the investigation had adequate training and experience to conduct the investigation or had access to supervisory assistance to help them perform their work.

Allegation	OIG Conclusion
67. Whistleblower alleged that OSHA improperly extended the time for the respondent to respond to the complaint.	Not substantiated – The Whistleblower was incorrect on the applicable WIM requirements. The respondent had the opportunity to respond to the notice of complaint, but the respondent was not required to respond to the complaint until the respondent was put on notice with the "10-day letter."
68. Whistleblower alleged that OSHA closed cases without an investigation and without interviewing the complainant.	Not substantiated – The complainant elected to file action in district court and included allegations of whistleblower retaliation. Even though OSHA had not yet interviewed the complainant, it was proper to dismiss the investigation because OSHA no longer had jurisdiction.
69. Whistleblower alleged that the RSI delayed assigning an investigator to the cases until after the 6-month statutory period allowed for an investigation.	Not substantiated – The date the first RWI was assigned was 29 days from the date the complaint was filed.
70. Whistleblower alleged that OSHA assigned the investigations to a new, untrained investigator.	Not substantiated – The 2 RWIs who worked on the investigation had adequate training and experience to conduct the investigation or had access to supervisory assistance to help them perform their work.
71. Whistleblower alleged that OSHA improperly extended the time for the respondent to respond to the complaint.	Not substantiated – The Whistleblower was incorrect on the applicable WIM requirements. The respondent has the opportunity to respond to the notice of complaint, but the respondent was not required to respond to the complaint until the respondent was put on notice with the "10-day letter."
72. Whistleblower alleged that OSHA closed cases without an investigation and without interviewing the complainant.	Not substantiated – The complainant elected to file action in district court and included allegations of whistleblower retaliation. Even though OSHA had not yet interviewed the complainant, it was proper to dismiss the investigation because OSHA no longer had jurisdiction.

Note: The Whistleblower made the same 4 allegations in 2 separate whistleblower retaliation investigations. The allegations are listed as numbers 65 to 68, and also as numbers 69 to 72.

EXHIBIT 3: PRIOR OIG AUDITS AND RECOMMENDATIONS

Complainants Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program (report number 02-10-202-10-105, September 30, 2010)

No.	Recommendation	Corrective Action Taken
1	Implement controls to ensure all investigations are adequately reviewed by supervisors, and all supervisors are adequately trained in both the legal and highly technical issues unique to whistleblower investigations and statutes.	On September 20, 2011, OSHA published its new WIM that included controls for supervisory review and for providing training (formal and field) for investigators.
2	Implement controls to oversee and monitor caseloads in the regions to ensure adequate caseload management so that all complainants receive quality investigations in a timely manner.	The supervisor must assign the case for investigation. Ordinarily, the case will be assigned to an investigator, taking into consideration such factors as the investigator's current caseload, work schedule, geographic location, and statutory timeframes. However, in cases involving complex or unusual circumstances, the supervisor may conduct the investigation or assign a team of investigators.
3	Implement controls to oversee and monitor investigations so that investigations are conducted in accordance with OSHA policies and procedures and are consistent across all regions.	On September 20, 2011, OSHA published its new WIM that included controls to oversee and monitor investigations.
4	Develop and monitor specific performance measures or indicators to ensure the whistleblower program is working as intended.	In FY 2016, OSHA established the following performance goals: 1) Whistleblower investigations completed; 2) Average age of pending whistleblower investigations; and 3) Average days to complete new complaint screening process.

No.	Recommendation	Corrective Action Taken
5	Issue an updated WIM incorporating the recommendations contained in this report, and implement controls to ensure the WIM will continue to be up-dated in a timely manner to reflect current policies, procedures, and statutes.	In a memorandum dated December 4, 2015, OSHA stated it "is devoted to revising the [WIM] on an ongoing basis to keep guidance as current as possible." On January 28, 2016, OSHA updated the WIM.

Whistleblower Protection Program Complaint (report number 02-11-202-10-105, March 31, 2011)

No.	Recommendation	Corrective Action Taken
1	Implement controls to require that supervisors review all complaints for coverage and the presence of a *prima facie* allegation prior to beginning an investigation.	OSHA published a new WIM that included instructions requiring as a part of the intake process, the supervisor will verify that applicable coverage requirements have been met and that the *prima facie* elements of the allegation have been properly identified.

Federally Operated Whistleblower Protection Program Cost (report number 22-12-014-10-105, issued January 20, 2012)

There were no recommendations in this report.

OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs (report number 02-15-202-10-105, September 30, 2015)

No.	Recommendation	Corrective Action Taken
1	Monitor the Whistleblower Programs to routinely assess their efficiency and effectiveness, and finalize and implement the draft checklist to assist in determining if investigators completed steps and collected documentation to support determinations.	On September 15, 2010, OSHA issued a directive establishing a Management Accountability Program. OSHA stated it will continue to monitor WPP through several mechanisms, including quarterly monitoring of statistical performance metrics and the Management Accountability Program.

No.	Recommendation	Corrective Action Taken
2	Develop and monitor specific performance measures or indicators to ensure Whistleblower Programs are working as intended.	In FY 2016, OSHA established the following performance goals: 1) Whistleblower investigations completed; 2) Average age of pending whistleblower investigations; and 3) Average days to complete new complaint screening process.
3	Provide complete and unified guidance to ensure appropriate methods are used to close investigations.	In a memorandum dated January 12, 2017, OSHA transmitted to its regional administrators and whistleblower program managers the updated policy for docket and dismiss procedures. The memorandum stated that it "serves to address the appropriate procedures for closing complaints that are not subject to a full field investigation because the complaint is either docketed and dismissed or administratively closed."
4	Issue an updated WIM and implement controls to ensure the WIM will continue to be updated in a timely manner to reflect current policies, procedures, and statutes.	In a memorandum dated December 4, 2015, OSHA stated it "is devoted to revising the [WIM] on an ongoing basis to keep guidance as current as possible," and on January 28, 2016, OSHA Update the WIM.
5	Develop and provide a comprehensive training curriculum to investigators to ensure they have the proper skills, knowledge, and understanding of program requirements and goals.	On October 8, 2015, OSHA issued a directive titled "Mandatory Training Program for OSHA Whistleblower Investigators," which focused on the following: 1) Complaint Resolution and Settlement Negotiations; 2) Interviewing Techniques for Whistleblower Investigators; 3) Report Writing for Whistleblower Investigators; and 4) Legal concepts for Whistleblower Investigators.
6	Develop and implement a process to ensure reasonable balance is applied between the quality and timeliness to complete investigations within statutory timeframes.	The recommendation has been resolved, but not closed.

No.	Recommendation	Corrective Action Taken
7	Develop and implement a formal process and working relationships with other agencies to ensure information is shared in a timely manner to assist in the enforcement of the various statutes and correction of violation.	In a memorandum dated November 17, 2016, OSHA provided guidance to the field on Updated Guidelines on Sharing Complaints and Findings with Partner Agencies. According to OSHA, the guidance "requires timely sharing of complaints and findings and documenting the correspondence in the case file."

APPENDIX A: SCOPE, METHODOLOGY, & CRITERIA

SCOPE

OSHA Region IX opened and closed 901 whistleblower retaliation investigations between FY 2011 and FY 2018. OIG's fieldwork focused on how Region IX administered its WPP and investigated complaints. OIG also followed up on allegations of mismanagement for 1 case in OSHA's Region V. OIG reviewed a random sample of 60 whistleblower complaints from 2 groups: 30 from the period the Whistleblower was working in Region IX (between October 2010 and April 2015), and 30 from the period after the Whistleblower left Region IX (between May 2015 and September 2018).

We also reviewed 15 whistleblower investigations where the Whistleblower made 72 specific allegations that OSHA, ALJ or RSOL mismanaged the investigations. Of the 15 cases, 7 cases were part of Region IX's 901 total whistleblower complaints from October 1, 2010, through September 30, 2018. Another 7 cases were Region IX whistleblower complaints that were opened prior to October 1, 2010. The last case was from Region V.

We interviewed 13 current (as of April 23, 2019) national and regional OSHA officials, 6 current OSHA regional office staff, 3 current RSOL staff, 5 former staff from OSHA Region IX, 1 former national office official, and 2 whistleblower complainants. Former investigators and managers were those who worked in Region IX WPP between FY 2011 and FY 2018.

The Whistleblower "respectfully declined" OIG's invitation for an interview. The Whistleblower provided contact information for 13 complainants, of which 12 were eligible for interview. The last complainant was not eligible for interview at the request of the U.S. Attorney's Office for the Northern District of California. OIG offered to interview the 12 complainants who were eligible for interview. However, only 2 were actually interviewed. Six complainants did not respond to OIG's multiple attempts to set up interviews. Four complainants were not interviewed after they placed conditions on their participation that OIG was unable to honor. The conditions included demands for answers on the scope and objective of this audit, which OIG was unable to answer pre-interview.

OIG conducted fieldwork at OSHA headquarters in Washington, DC, and Region IX in San Francisco, CA.

METHODOLOGY

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. In addition, an OIG attorney and criminal investigator reviewed all evidence for potential violations of law or gross mismanagement.

OIG reviewed applicable laws, policies, procedures, documents, reports, OSHA's management information system data, and WPP regional and national statistics. To gain an understanding of OSHA's internal controls over the Whistleblower Programs, we reviewed the WIM and interviewed OSHA personnel at the national and regional levels. We assessed the reliability of OSHA management information system data by: (1) performing tests for completeness, accuracy, and consistency of the required data elements; and (2) reviewing existing information about the data. We determined the data was sufficiently reliable for purposes of this report.

For this audit, we evaluated 3 samples of complaint investigations, as follows:

- Random sample of 30 complaint investigations that were selected from a stratum of 341 investigations opened and closed between October 2010 and April 2015, which was while the Whistleblower worked in Region IX.

- Random sample of 30 complaint investigations that were selected from a stratum of 518 investigations opened and closed between May 2015 and September 2018, which was after the Whistleblower separated from Region IX.

- Judgmental sample of 15 complaint investigations that were identified by the Whistleblower. The sample included complaint investigations opened between May 2009 and November 2016, and closed between November 2010 and February 2017.

Results for the samples were not statistically projectable.

CRITERIA

OSHA Instruction, DIS 0-0.9, *Whistleblower Investigations Manual,* effective date August 22, 2003

OSHA Instruction, CPL 02-02-003, *Whistleblower Investigations Manual,* effective date September 20, 2011

OSHA Instruction, CPL 02-03-005, *Whistleblower Investigations Manual,* effective date April 21, 2015

OSHA Instruction, CPL 02-03-007, *Whistleblower Investigations Manual,* effective date January 28, 2016

OSHA Directive TED-01-00-020, *OSHA's Mandatory Training Program for OSHA Whistleblower Investigators*, effective October 8, 2015

OSHA Directive Number CPL 02-03-004, *Section 11(c), AHERA, and ISCA Appeals Program*, effective September 12, 2012

OSHA Directive Number CPL-02-00-160, *OSHA's Field Operations Manual (FOM)*, effective August 2, 2016

OSHA Directive Number CPL-03-008, *Alternative Dispute Resolution (ADR) Processes for Whistleblower Protection Programs,* effective February 4, 2019

OSHA Region IX Directive Number CPL 02-03-01, *Regional Whistleblower Protection Program Expedited Case Processing Pilot*, effective August 1, 2016

24 OSHA guidance documents issued between FY 2011- 2018

23 whistleblower statutes (see Exhibit 1)

APPENDIX B: RESPONSE TO THE OSC'S REFERRAL

Pursuant to OSC's referral, OIG was asked to determine the following:

1. Whether investigations met all essential elements outlined in the WIM

2. Whether investigators received appropriate resources, training, and legal assistance

3. Whether—and, if so, how—the WIM had been updated since 2015

4. Whether respondents (i.e., employers accused of retaliation) received more favorable treatment—including more access to information, more access to investigator and leadership time, and greater credibility in case determinations—than the complainants (i.e., employee whistleblowers)

5. Whether investigators were pressured to close cases without investigating

DID INVESTIGATIONS MEET ALL ESSENTIAL ELEMENTS OUTLINED IN THE WIM?

OSHA Region IX did not meet all essential elements outlined in the WIM for sampled whistleblower investigations. OSHA's current database was not an effective tool to ensure the essential elements were completed by investigators. Moreover, the database did not flag periods of inactivity on an investigation to prompt the investigator to proceed with the next element and maintain contact with the complainant and respondent. Effective use of a tracking system that includes case management features could help ensure all essential elements are addressed.

Another reason that Region IX investigations did not meet all essential elements was that the casefiles did not contain evidence that supervisors checked whether the investigators completed the essential steps before reaching their findings. Under the WIM, the supervisor was required to review the investigative file to

ensure technical accuracy, thoroughness of the investigation, applicability of law, completeness of the report, and merits of the case.[25]

The WIM set forth policy, procedures, and other information on how to handle whistleblower complaints under the statutes delegated to OSHA. Based on our review of the WIM, we identified 8 essential elements for investigating a whistleblower retaliation complaint. These essential elements are steps required for:

1. Gaining information from the complainants, respondents, and relevant witnesses to determine the violations;

2. Making a determination as to whether the *prima facie* elements are satisfied;

3. Supervising work performed to ensure investigations were thorough; and

4. Communicating pertinent information to all parties about the initiation and decision of the case, as well as the right to appeal.

We reviewed 75 cases (60 cases randomly selected and 15 judgmentally selected by the Whistleblower). Of the 75 cases, we found 72 cases contained errors in 1 or more of the essential elements tested. Table 1 on page 9 shows the number of cases with errors for each essential element tested.

In reviewing the cases, we considered the number of days the case was open and the reason the case was closed. For example, a case that was withdrawn early in the process would not require the identification and contact of witnesses. However, if the case was withdrawn after 100 days, OSHA would have been expected to provide due diligence in progressing the case by identifying and contacting witnesses. This process affected both the number of exceptions and the applicable case.

In its 2010 report, OIG estimated that 80 percent of applicable investigations under OSH Act Section 11(c), SOX, and STAA did not meet 1 or more essential elements. In the 2015 report, OIG stated that while OSHA's administration of the program had improved, opportunities still existed for OSHA to improve its monitoring of WPP. OIG reported 18 percent of sampled whistleblower complaint investigations were not complete, as 1 or more of the essential elements for conducting a whistleblower investigation were not performed. The report stated OSHA National Office did not perform Management Accountability Program

[25] 2003 WIM Chapter 4, Part IV-A

reviews of WPP or implement performance measures to ensure investigations were completed according to policy.

DID INVESTIGATORS RECEIVE APPROPRIATE RESOURCES, TRAINING, AND LEGAL ASSISTANCE?

Investigators received mandatory WPP training[26] and appropriate access to legal assistance. However, OSHA did not have sufficient information to determine if investigators received appropriate resources. Detailed results are presented separately below for resources, whistleblower investigator training, and legal assistance.

A. Resources

OSHA records and interviews confirmed that the investigators had laptops, internet access, EDGAR[27] corporate search database, recorders, and supervisor and RSOL assistance to help in completing the investigations. In interviews, the staff collectively felt that they needed additional resources to do the investigations. The additional resources suggested included additional investigators, search databases, and support staff. However, OSHA did not have sufficient information to determine if OSHA provided Region IX investigators with appropriate resources.

To make a determination, OSHA would need information on the actual use of resources and the appropriate caseload level for investigators.

- OSHA did not have timesheets to allocate personnel costs by work performed. Regions were allocated WPP FTEs and hired WPP staff. However, there was no information on whether the staff worked on WPP activities or had been assigned work in other OSHA program.

- While OSHA had information on caseload levels for investigators (Chart 1 on page 15), there was no current information as to what would be the <u>appropriate</u> caseload level. One OSHA employee stated based on personal experience, an investigator could handle

[26] This audit did not evaluate the quality of training received by investigators.

[27] EDGAR is the Electronic Data Gathering, Analysis, and Retrieval system used at the SEC for submissions by companies and others who are required by law to file information with the SEC.

> up to 20 cases efficiently. Another employee stated a reasonable caseload would be 6-8 cases based on a 2009 study.[28] Both the national (27.4) and Region IX (54.4) average caseloads were well above the levels mentioned by staff (20 cases and 6-8 cases).

If OSHA does not provide appropriate resources, this could create a generalized or inherent pressure to close out WPP cases. Staff may cut corners and make errors in an effort to close out more cases. Standards for internal control in the federal government, paragraph 5.08, states that management is responsible for evaluating pressure on personnel and can adjust excessive pressures using tools such as rebalancing workloads or increasing resources. Paragraph 5.07 states:

> Pressure can appear in an entity because of goals established by management to meet objectives or cyclical demands of various processes performed by the entity, such as year-end financial statement preparation. Excessive pressure can result in personnel "cutting corners" to meet the established goals.

The following discusses: 1) Caseloads per Investigator; 2) Personnel Costs and FTEs; 3) Program Inputs (New Complaints) and Outputs (Investigations Completed); and 4) Regional Goals.

1. Caseloads per Investigator

The 2010 OIG report stated:

> Higher caseloads cause both timeliness and quality of investigations to suffer...regions with higher caseloads averaged at least twice the amount of open investigations and took at least twice as long to complete investigations.

As shown in Table 3 below, the average open caseload per investigator for Region IX was higher than the national average from FY 2012 through FY 2018.

[28] The staff did not provide the study report. In 2012, OIG provided an estimate to congressional requestors on the additional FTEs and costs needed to reduce caseloads to 6, 7, or 8 per investigator. OSHA would need between 49 and 53 new investigators, and increased funding of between $6.5 and $7 million. The estimate was based on several assumptions, such as case levels remaining the same as FY 2011; no additional whistleblower statutes being added to OSHA's jurisdiction; and all investigators, including new hires, being able to complete the same average number of cases. See *Federally Operated Whistleblower Protection Program Cost*, report number 22-12-014-10-105, issued January 20, 2012.

Table 3: Average Open Caseload Per Investigator		
Fiscal Year	National Average	Region IX Average
2012	26.6	40.6
2013	25.2	34.8
2014	24.1	37.7
2015	25.2	87.3
2016	29.3	79.8
2017	30.0	50.8
2018	31.7	49.7
Average	27.4	54.4

Source: OSHA data on caseloads

Table 3 also demonstrates that the national average was generally trending upward throughout the period, while the Region IX average spiked in 2015 and 2016. That spike coincided with the period that OSHA was taking disciplinary actions leading up to the separation of 2 investigators with performance or conduct-related issues.

2. Personnel Costs and FTEs

For FYs 2012 through 2018, OSHA Region IX spent an average of $509,573 for WPP personnel costs and had an average of 4 investigators. Region IX's personnel costs and number of investigators constituted approximately 5 percent of the national personnel costs and number of investigators. Table 4 shows National and Region IX WPP personnel costs and investigator FTE levels for FYs 2012 through 2018.

Table 4: National and Region IX – Personnel Costs and Investigator FTE Levels						
Fiscal Year	Personnel Costs			Investigator FTEs		
	National	Region IX	Percent	National	Region IX	Percent
2012	$9,979,551	$353,240	4%	95	5	5%
2013	9,243,959	581,364	6%	96	6	6%
2014	9,974,311	650,027	7%	100	6	6%
2015	11,133,689	608,133	5%	96	3	3%
2016	11,517,048	407,707	4%	84	4	5%
2017	11,278,163	503,633	4%	77	4	5%
2018	11,182,364	462,906	4%	76	3	4%
Avg.	$10,615,584	$509,573	5%	89	4	5%

Source: OSHA WPP personnel costs and investigator FTEs

3. Program Inputs (New Complaints) and Outputs (Investigations Completed)

For FYs 2012 through 2018, OSHA Region IX received an average of 144 new complaints and completed 145 investigations per fiscal year. The number of new complaints received by Region IX, as well as those investigations completed by Region IX, constituted about 5 percent of national numbers. Table 5 shows National and Region IX WPP new complaints and completed investigations for FYs 2012 through 2018.

Table 5: National and Region IX – New Complaints and Completed Investigations						
Fiscal Year	New Complaints			Completed Investigations		
	National	Region IX	Percent	National	Region IX	Percent
2012	2,783	129	5%	2,898	99	3%
2013	2,972	118	4%	3,087	112	4%
2014	3,112	154	5%	3,159	137	4%
2015	3,327	151	5%	3,279	116	4%
2016	3,369	170	5%	3,315	100	3%
2017	3,318	163	5%	3,352	290	9%
2018	3,014	130	4%	2,922	152	5%
Avg.	3,145	144	5%	3,128	145	5%

Source: OSHA data on cases received and completed

4. Regional Goals for Completed Cases

In interviews with current and former OSHA staff, OIG asked 2 questions about goals and pressures to close out investigations.

1) Did your supervisor or regional management ever discuss regional goals related to the whistleblower programs? If so, was there anything in the regional goals that could be interpreted as pressure to close out cases?

2) Was there ever anything in your performance plan that could be interpreted as pressure on you to close out cases?

During the interviews, 8 staff stated they were aware of regional goals for closing out cases. The staff acknowledged that managers told them that the failure to achieve goals would not affect their (the investigators) performance evaluations. However, staff stated they felt pressured to close out cases because of the goals and the existing backlog of cases in the region. Staff also stated that one RSI posted weekly case closing statistics on the office window to motivate staff. According to staff, the region was allocated a portion of the national goal based on the number of FTE investigators. However, the goal was not adjusted when there was a vacancy in the region.

B. Whistleblower Investigator Training

For the review of training, OIG considered that OSHA did not have a training directive for whistleblower investigators prior to October 8, 2015. OSHA issued Directive TED-01-00-020, *OSHA's Mandatory Training Program for OSHA Whistleblower Investigators Directive*, effective October 8, 2015, in part to address recommendations from the 2010 OIG report that OSHA provide comprehensive training to investigators and a 2010 internal OSHA report that stated OSHA did not have a training directive specific to WPP.

OIG reviewed training records for 12 investigators who conducted 95 percent of Region IX cases during the period of our audit. Of the 12 investigators, 8 were hired prior to the 2015 training directive, and the other 4 were hired after the training directive was issued. The following summarizes the results for: 1) the period before the training directive (October 1, 2010, through October 7, 2015); and 2) the period under the training directive (October 8, 2015, through September 30, 2018).

1. Before the training directive

Prior to OSHA's issuance of the training directive dated October 8, 2015, there was no written policy requiring investigators to attend formal training. However, OSHA had 2 whistleblower investigator training courses that were not mandatory.

- Course #1420: Whistleblower Investigation Fundamentals
- Course #1460: Basic Whistleblower Investigations - Federal Statutes

For the 8 investigators hired prior to the 2015 training directive, 5 took course #1420 and 5 took course #1460. Although no training was mandatory, only 1 investigator did not take either course.

2. Under the training directive

The training directive (dated October 8, 2015) describes a 3-year approach to mandatory training for OSHA Whistleblower Investigation personnel. During the first year, the investigator is required to complete a whistleblower investigation fundamentals course. During years 2 and 3, the investigator is required to complete 4 additional technical courses. However, OSHA had 1 of the technical courses (#1630: Written Communication and Report Writing for Whistleblower Investigators) still in development during this audit. [29]

[29] Course #1630 was developed in FY 2019. The first class was scheduled for May 2020 and then postponed due to COVID-19.

Based on the directive, the following were the mandatory training courses for OSHA whistleblower investigators from October 8, 2015, through September 30, 2018.

- Course #1420 Whistleblower Investigation Fundamentals Course
- Course #1610: Interviewing Techniques for Whistleblower Investigators
- Course #2710: Legal Concepts for Whistleblower Investigators
- Course #2720: Whistleblower Complaint Resolution and Settlement Negotiations

OIG reviewed the training records for the mandatory training of 5 investigators who were onboard as of October 8, 2015, and 4 investigators who were hired after October 8, 2015. All investigators completed the mandatory courses that they were required to complete. However, some investigators were not required to complete the mandatory courses if they had over 3-years of experience prior to October 8, 2015, or if they left WPP in their first 3 years. Table 6 provides detail on the completion of the mandatory courses by the 9 investigators. The table identifies the course number, the number of investigators who completed the training, and the number not required to complete the training.

Table 6: Completion of Mandatory Courses

Course	Completed	Not Required
#1420	8	1
#1610	5	4
#2710	4	5
#2720	4	5

Source: OSHA training records

The training directive also required an individual development plan that "is a dynamic plan that helps the Whistleblower Investigator achieve organizational and career goals by documenting progress." The directive also required the plans to be updated annually. However, Region IX did not have any individual development plans submitted for FYs 2016-2018.

C. Legal Assistance

For the period of FYs 2011-18, there were no agreements in place between OSHA's WPP program and the RSOL office. OIG interviewed 3 attorneys in RSOL, and 12 whistleblower investigators and supervisors in the WPP program about legal assistance. All interviewees indicated that when the cases needed to be reviewed, RSOL offices were available for review. Investigators and managers stated there was not an issue with access to RSOL. Some managers required staff to go through them, while others allowed their staff to go directly to RSOL. However, 2 managers mentioned that there were times where there were delays in RSOL's response. Overall, staff stated that if there was a difference of opinion between OSHA and RSOL, RSOL was willing to discuss the issue.

HOW HAS THE WIM BEEN UPDATED SINCE 2015?

The WIM was updated on April 21, 2015, to revise Chapter 6, "Remedies and Settlement Agreements."[30] On January 28, 2016, OSHA reissued the 2015 WIM with annotated references to OSHA relevant memoranda and other guidance documents. The 2016 version of the WIM revised Chapter 1, "Preliminary Matters," to move its Non-Public Disclosure discussion into a newly-added Chapter 23, and update Chapter 3, "Conduct of the Investigation," to provide clarification on the investigative standard for whistleblower investigations.[31] The essential elements were more or less the same in these 2 updates to the WIM as in previous versions.

However, the changes in the 2015 and 2016 WIM were not sufficient to address gaps in OSHA's policy and procedures for specific statutes. The 2015 OIG report noted that the 2011 version of the WIM did not outline the specific requirements for 5 recent statutes, as follows: 1) Affordable Care Act (ACA); 2) Consumer Financial Protection Act of 2010 (CFPA); 3) Seaman's Protection Act (SPA); 4) Food Safety Modernization Act (FSMA); and 5) Moving Ahead for Progress in the 21st Century Act (MAP-21).

According to DWPP, a revised WIM, with Desk Aids to replace the statute specific chapters, was expected to be completed by the end of 2020 and made

[30] OSHA Instruction, CPL 02-03-005, Whistleblower Investigations Manual, effective date April 21, 2015

[31] OSHA Instruction, CPL 02-03-007, Whistleblower Investigations Manual, effective date January 28, 2016

available to the public. OSHA has issued 11 desk aids, which included 4 of the 5 statutes listed above. A desk aid for ACA has not yet been issued.

DID THE RESPONDENTS RECEIVE MORE FAVORABLE TREATMENT THAN THE COMPLAINANTS?

We found no evidence that recipients received more favorable treatment than the complainants. Based on case file documents, the complainants were provided with the respondents' statements of position and were offered the opportunity to refute the respondents' evidence. OSHA managers in the Regional Office and National Office responded to concerns from both respondents and complainants.

We found no indication that OSHA determinations were based on anything other than the evidence obtained during the investigation. In interviews, OSHA staff stated the respondents and complainants were provided equal access to their time. In 1 case, OSHA stopped communicating with a complainant after the case was closed because the complainant had made threats of violence to OSHA staff.[32]

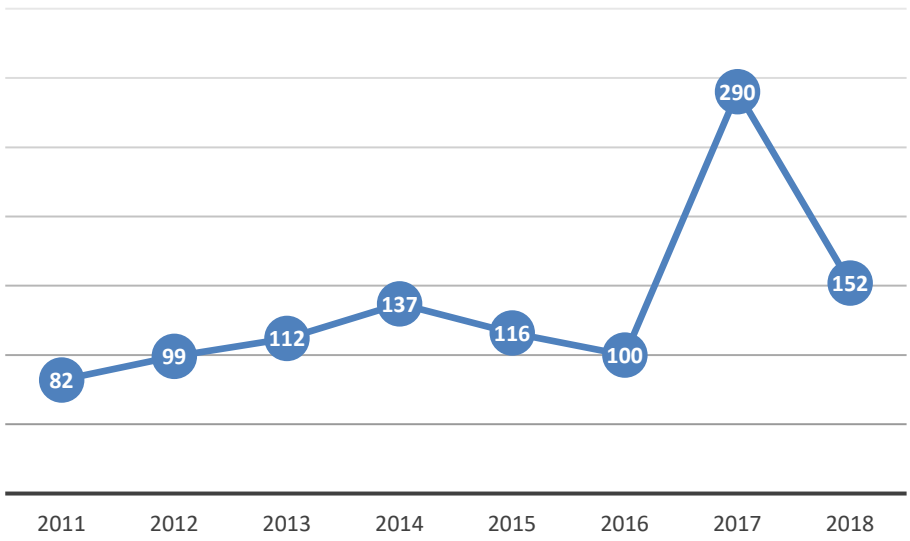
WERE INVESTIGATORS PRESSURED TO CLOSE CASES WITHOUT INVESTIGATING?

We found no evidence that OSHA pressured investigators to close cases without investigating, but there was a perceived pressure to close out cases quickly. In the staff interviews, we were told that management never instructed staff to close a case early. The Whistleblower identified 2 cases where the Whistleblower was allegedly told to close without an investigation. In both cases, OSHA did not ensure the cases were progressing over time. However, OSHA took appropriate action to dismiss the cases after the complainants had filed complaints in district court that included allegations of whistleblower retaliation. Once a complaint is filed in district court, further investigation would not be appropriate because OSHA no longer has jurisdiction.

While we found no direct pressure to close cases, there was a perceived pressure to close out cases because of caseloads and OSHA's strategic goal to close cases. Even with the perceived pressure, cases were not being closed at a higher rate. Chart 2 shows the Region IX cases closed by year.

[32] Case Number 5 of 15 provided by the Whistleblower. The complainant in this case was 1 of 2 who were interviewed by OIG.

Chart 2: Region IX Cases Closed by Year



Source: OSHA data on cases completed in Region IX

The number of cases closed did not fluctuate significantly between 2011 and 2016. It was not until FY 2017 when there was a peak in closures of 190 percent of the prior year. This was 2 years after the Whistleblower had separated from OSHA and after OSHA implemented a process for addressing the backlog.

APPENDIX C: REVIEW OF ESSENTIAL ELEMENTS

Based on our review of the WIM, we identified 8 essential elements for investigating a whistleblower complaint.[33] These essential elements are steps required for: 1) gaining information from the complainants, respondents, and relevant witnesses to determine the violations; 2) making a determination as to whether the *prima facie* elements are satisfied; 3) supervising work performed to ensure investigations were thorough; and 4) communicating pertinent information about the decision of the case and rights to appeal.

In total, we tested OSHA's whistleblower investigations for the following:

1. Contact the Complainant
2. Contact the Respondent
3. Identify and Contact Witnesses
4. Address *Prima Facie* Elements
5. Conduct Supervisory Review
6. Notify Parties of Final Decision
7. Notify Parties of Appeal Rights
8. Communicate with Applicable Compliance Agency

OIG reviewed records for 75 whistleblower investigations to test if OSHA's investigation met the essential elements, and OSHA communicated with applicable compliance agencies about the complaint. Overall, we found 72 of 75 cases contained errors in 1 or more of the tested areas.

CONTACT THE COMPLAINANT

The WIM required that the assigned investigator contact the complainant as soon as possible after receipt of the case assignment. The WIM also required the investigator to contact the complainant after obtaining the respondent's statement of position in order to resolve any discrepancies or test the respondent's proffered non-retaliatory reason for the alleged retaliation.

To assess whether the investigator appropriately contacted the complainants, we looked at the following (see Table 10):

[33] Of the 8 elements, 7 were the same elements identified by OIG and confirmed by OSHA. See audit report number 02-15-202-10-105, dated September 30, 2015. Based on the findings in that report, we included as the eighth essential element whether investigators provided timely communication of whistleblower complaints to the applicable enforcement agency.

Table 10: Contact the Complainant		
Review Question	Number of Errors	Percent with Errors
Did the investigator obtain detailed information about the complainant's allegation(s)?	2 of 73	3%
Did the complainant have the opportunity to rebut the respondent's statements and evidence?	13 of 42	31%
Did the investigator obtain support documents from the complainant?	5 of 32	16%
Did the investigator maintain contact with the complainant throughout the investigation?	35 of 66	53%
Total Cases with at least 1 Error[34]	37 of 74	50%

Source: Testing results for 75 sampled cases. This element was not applicable for 1 case.

For 50 percent of sampled investigations, OSHA did not maintain appropriate contact with the complainants.

OSHA did not maintain contact with the complainant throughout the investigation for 53 percent of sampled investigations. For example, 1 complaint was filed in 2014 and the complainant had to contact OSHA in 2016 for a status update. In another case, OSHA closed an investigation in June 2014 for lack of cooperation by the complainant, but the complainant had died in December 2013.

Based on Table 10, OSHA was not consistent in collecting the complainant's rebuttal and support documents. While obtaining the rebuttal was not always applicable due to withdrawals, settlements and lack of cooperation, OSHA investigators did not collect the complainant's rebuttal and supporting documents 13 out of 42 times when it was required.

[34] For this table through Table 14, this number is the number of cases that had at least 1 exception. Some cases had more than 1 exception. Therefore, the number of complaints with at least 1 exception will be less than the total number of exceptions.

CONTACT THE RESPONDENT

The WIM required investigators to make contact with respondents to get their side of what happened throughout the investigation. To assess whether the investigator appropriately contacted respondents, we looked at the following (see Table 11):

Table 11 – Contact the Respondent

Review Question	Number of Errors	Percent with Errors
Did the investigator obtain the respondent's statement of position?	9 of 57	16%
Did the investigator obtain support evidence for the respondent's statement of position?	7 of 48	15%
Total Cases with at least 1 Error	16 of 57	28%

Source: Testing results for 75 sampled cases. This element was not applicable for 18 cases.

As shown in Table 11, OSHA did not obtain the Statement of Position (SOP) from the respondent 9 times and did not obtain support for the SOP 7 times. For example, OSHA closed 1 sampled case 1,274 days after it was filed in 2014, but did not obtain the SOP from the respondent. The case file records show that OSHA requested the SOP on February 6, 2014. However, OSHA did not follow up with the respondent to obtain the SOP or take any other action against the respondent. The WIM required the investigator to inform the respondent of possible consequences of failing to provide the requested information in a timely manner. It also stated that OSHA could draw an adverse inference against the respondent based on its refusal to cooperate with specific investigative requests.

IDENTIFY AND CONTACT WITNESSES

The WIM stated that the investigator was responsible for interviewing the complainants and witnesses, obtaining statements, and obtaining supporting documentary evidence. To assess whether the investigator identified and contacted witnesses, we looked at the following (see Table 12):

Table 12 – Identify and Contact Witnesses		
Review Question	Number of Errors	Percent with Errors
Did the investigator identify witnesses?	33 of 60	55%
Were the identified witnesses contacted and interviewed?	7 of 25	28%
Total Cases with at least 1 Error	40 of 60	67%

Source: Testing results for 75 sampled cases. This element was not applicable for 15 cases.

Review of the case files revealed that OSHA investigators did not identify witnesses regularly. In the 60 cases where obtaining witnesses were appropriate, OSHA did not identify witnesses 33 times. There were 25 times that witnesses were identified. For the cases where OSHA identified witnesses, OSHA did not interview witnesses from 7 of the cases. For example, 1 case was open for 216 days and 6 witnesses were identified, but no witnesses were interviewed. Generally, Region IX staff did not identify and contact witnesses as required.

ADDRESS *PRIMA FACIE* ELEMENTS

The whistleblower statutes allow employees to report various activities that include safety concerns, financial violations, and injuries. The WIM stated:

> [A]s soon as possible upon receipt of the potential complaint, the available information should be reviewed for appropriate coverage requirements, timeliness of filing, and the presence of a *prima facie* allegation.

The *prima facie* elements were: 1) Protected Activity; 2) Employer Knowledge; 3) Adverse Action; and 4) Nexus.[35]

Either by statute or by regulation, all of the administrative statutes also contain "gatekeeping" provisions, which provide that the investigation must be discontinued or the complaint dismissed if no *prima facie* allegation is made. To

[35] A close temporal proximity exists between the protected activity and adverse action, as when the complainant was laid off shortly after the respondent learned that the complainant had called OSHA.

assess whether the investigator collected evidence to support the *prima facie* elements, we looked at the following (see Table 13):

Table 13: Address *Prima Facie* Elements

Review Question	Number of Errors	Percent with Errors
Did OSHA identify the protected activity the employee engaged in?	2 of 74	3%
Did OSHA identify whether employer had knowledge of the protected activity?	3 of 63	5%
Did OSHA identify the negative outcome the employer allegedly caused?	2 of 74	3%
Was there a causal link between the protected activity and the adverse action?	18 of 53	34%
Total Cases with at least 1 Error	20 of 74	27%

Source: Testing results for 75 sampled cases. This element was not applicable for 1 case.

As shown in Table 13, OSHA did not always establish the *prima facie* elements needed to support investigating the complaint. For a 2014 case, OSHA closed the case after 633 days. The first record of communication was not until 2016. OSHA did not maintain documentation of any of the *prima facie* elements to verify that an investigation was warranted. Eventually, the complainant requested to withdraw the case on August 11, 2016.

CONDUCT SUPERVISORY REVIEW

Per the WIM, supervisors were responsible for:

> [Reviewing] investigative reports for comprehensiveness and technical accuracy and revising draft Secretary's Findings and presenting them for signature by the RA or his or her designee.

The WIM also stated:

> [An] ROI must be signed by the investigator and reviewed and approved in writing by the supervisor.

We reviewed the file to confirm whether case logs were completed detailing the steps taken to investigate the case. In addition, we looked at whether the supervisor approved the case in writing. To assess whether the cases were adequately reviewed by supervisors, we looked at the following (see Table 14):

Table 14: Conduct Supervisory Review

Review Questions	Number of Errors	Percent with Errors
Did the investigator complete the log?[36]	39 of 71	55%
Was the reviewer of the ROI someone other than the preparer?	28 of 75	37%
Total Cases with at least 1 Error	54 of 75	72%

Source: Testing results for 75 sampled cases.

As demonstrated in Table 14, OSHA investigators did not maintain the case log 39 times. Therefore, the supervisor would not be able to ascertain whether the investigator took comprehensive steps to reach their findings. For example, 1 case had a limited number of entries on the log for the 1,212 days the case was open. The case was closed due to lack of cooperation by the complainant. However, the log was not comprehensive enough to know whether the investigator acted with due diligence in attempting to contact the complainant.

In addition, supervisors did not approve 28 case files in writing as required by the WIM. For 1 sampled case, OSHA closed the case after 1,109 days. The case was ultimately closed for lack of cooperation. However, there was no report of investigation or any other written document that contained the supervisor's approval to close out the case.

[36] OSHA stated that errors for missing or inadequate Telephone/Activity Logs were not equivalent to errors related to no supervisory review. The WIM required the supervisory review to be comprehensive and the log was a required part of investigative records. We included the case log in the review because the supervisor would not be able to ascertain whether the investigator took comprehensive steps to reach their findings without a completed case log.

NOTIFY PARTIES OF FINAL DECISION

The WIM stated, "All findings and preliminary orders must be sent to the parties." To assess whether the parties were notified of the final decision, we looked at the following (see Table 15):

Table 15: Notify Parties of Final Decision

Review Question	Number of Errors	Percent with Errors
Did the investigator notify parties of the final decision?	0 of 74	0%
Total Cases with at least 1 Error	0 of 74	0%

Source: Testing results for 75 sampled cases. This element was not applicable for 1 case.

We did not find any instances where the parties were not notified of OSHA's final decision.

NOTIFY PARTIES OF APPEAL RIGHTS

The WIM required that the investigator inform the complainant of their right to appeal under the appropriate statute. If the complainant elects to withdraw the complaint, the WIM requires that the investigator notify the complainant that they will not have the right to appeal. To assess whether the parties were notified of their appeal rights, we looked at the following (see Table 16):

Table 16: Notify Parties of Appeal Rights

Review Question	Number of Errors	Percent with Errors
Did the investigator notify the complainant about their appeal rights?	2 of 57	5%
Total Number of Cases with at least 1 Error	2 of 57	5%

Source: Testing results for 75 sampled cases. This element was not applicable for 18 cases.

In 2 sampled cases, OSHA did not demonstrate that it informed the parties about their appeal rights. For 1 case, the complainant was notified that OSHA dismissed their case as non-merit, but were not notified they had the right of appeal.

For the other case, the complaint was withdrawn, but the complainant was not notified that they were forfeiting their right to appeal or object. OSHA closed the case due to a withdrawal request. The WIM required the investigator inform the complainant that by entering a withdrawal on a case, he or she is forfeiting all rights to appeal or object, and the case will not be reopened. However, there was no record of OSHA notifying the complainant that a withdrawal would cause the complainant to give up the appeal rights.

COMMUNICATE WITH APPLICABLE COMPLIANCE AGENCY

OIG also examined whether OSHA was timely in its contact and communication with Region IX enforcement staff and other federal agencies with concurrent jurisdiction to investigate the complainant's allegations. In the September 30, 2015, audit report, OIG recommended the following:

> Develop and implement a formal process and working relationships with other agencies to ensure information is shared in a timely manner to assist in the enforcement of the various statutes and correction of violations.

To assess whether OSHA implemented the recommendation, we looked at the following (see Table 17):

Table 17: Communicate with Applicable Compliance Agency

Review Question	Number of Errors	Percent with Errors
Did OSHA coordinate with the appropriate enforcement agency?	16 of 73	22%
Total Cases with at least 1 Error	16 of 73	22%

Source: Testing results for 75 sampled cases. This element was not applicable for 2 cases.

Review of the case files showed that OSHA did not coordinate with the appropriate enforcement agency 16 times. We looked for e-mails, letters, or any other documentation that would show contact with the other agency and did not see any such documentation in these 16 case files. It should be noted that 9 of the cases without notification were closed before May 2015. This was prior to OIG's recommendation.

APPENDIX D: RESPONSE TO THE WHISTLEBLOWER'S ALLEGATIONS

The Whistleblower provided 5 general allegations about OSHA's management of WPP. The allegations were: [37]

1. OSHA did not perform a quality review of the "corrupt practices occurring within OSHA Region IX."

2. OSHA staff had conflicts of interest and improper influences that affected the integrity of the review.

3. OSHA management used the review results to target and drive out of federal service Region IX investigators who were also attorneys.

4. OSHA failed to investigate the reports of wrongdoing by Region IX management.

5. OSHA's mismanagement of WPP caused a substantial and specific danger to public health and safety.

The Whistleblower provided OIG with 72 specific allegations for the 15 cases (see Exhibit 2). In analyzing the Whistleblower's allegations, we used the following definitions:

- **Some Merit.** The facts and findings showed the alleged events or actions probably took place.

- **Not Substantiated.** The facts and findings showed the allegations were unfounded.

- **Could not be Substantiated.** The available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action did or did not take place.

[37] The first 3 allegations refer to the OSHA internal review conducted as a result of the Whistleblower's complaints to the Secretary of Labor, dated May 12, 2014.

WHISTLEBLOWER'S GENERAL ALLEGATIONS

1. Allegation that OSHA did not perform a quality review of the "corrupt practices occurring within OSHA Region IX"

The Whistleblower stated the review into "corrupt practices" was to address allegations from a letter to the Secretary of Labor, dated May 18, 2014, that disclosed waste of government funds, gross mismanagement, abuse of authority, and violation of 18 U.S. Code § 1001 (falsification of government documents). The Whistleblower stated the allegations specifically detailed 7 cases of corrupt practices occurring within OSHA Region IX and failure of the national OSHA office to implement corrective actions regarding violations of law, rule, or regulation.

OIG Analysis/Conclusion – The allegation was not substantiated because there was no evidence to suggest "corrupt practices" were occurring within Region IX. OIG reviewed the work performed in OSHA's 2014 review and interviewed the staff who performed the review. OIG did not find any material issues with the quality of OSHA's review. Furthermore, in analyzing the Whistleblower's allegations for this audit, OIG found no evidence to suggest "corrupt practices" occurred.

In 2014, OSHA performed a management review of Region IX. In the scope, the review team stated it addressed 8 allegations from the Whistleblower. OSHA concluded that there were no corrupt management practices, or violations of the whistleblower law and policy. However, the investigation did identify weaknesses in case file organization/completeness, case review/approval processes, program management, RSI training, RSI mentoring, and culture change. For each area of weakness, OSHA made recommendations for improvements. Program weaknesses were also noted in OIG's 2015 report. OIG made 7 recommendations and, to date, OSHA has implemented corrective actions on 6 of them (see Exhibit 3).

2. Allegation that OSHA staff had conflicts of interest and improper influences that affected the integrity of the review

The Whistleblower alleged that a member of the review team had a long-term relationship with Region IX, and thus substantial conflicts of interest. The Whistleblower also stated the belief that a Senior Policy Advisor to the Secretary of Labor and the OSHA Chief of Staff improperly influenced the review.

OIG Analysis/Conclusion – The allegation was not substantiated because no conflicts of interest or improper influences were identified.

OSHA assigned 2 individuals to perform the review—1 from the National Office who had experience performing this type of management review and 1 from Region VIII who had extensive experience with WPP. The individuals knew each other professionally, but not personally, before the review. The individuals also knew some of the management and staff of Region IX professionally, but there was no evidence that their professional relationships had any improper influence on the review results.

The individuals were provided with the Whistleblower's 2014 complaint and were tasked with designing and conducting the review. The individuals worked independently during the review, 1 interviewed staff to discuss the allegations while the other reviewed sampled cases. The individuals worked together on the report. In separate interviews with OIG, the individuals who performed the review stated they were not subjected to improper influence and no one changed the contents of their report.

3. *Allegation that OSHA management used the review results to target and drive out of federal service Region IX investigators who were also attorneys*

The Whistleblower alleged OSHA used the review process as a vehicle for attacking the Whistleblower and other OSHA Region IX investigators who were also attorneys. The Whistleblower stated all OSHA Region IX investigators who were also attorneys were targeted and driven out of federal service.

OIG Analysis/Conclusion – The allegation was not substantiated because 2 separated investigators had positive ratings on their last rating of record and 2 separated investigators had performance or conduct related issues that predated the issuance of the OSHA review team report.

The OSHA review team submitted the final report to OSHA management on February 27, 2015. During the next 2 years, 4 investigators separated from OSHA and did not transfer to another federal agency. Of the 4 separated investigators, 2 received ratings of "Effective" or "Highly Effective" in their last rating of record and voluntarily separated from OSHA. The remaining 2 separated investigators are discussed below.

- One investigator was notified in January, May, and July 2014 that the investigator was failing on "Case Management," which was the third element in the standards. The investigator's rating period for FY 2014 was extended to enable performance improvement. The investigator was provided specific assignments and deadlines, had a reduced caseload, and regularly met with their supervisor. On January 28, 2015, the investigator was formally placed on a

> Performance Improvement Plan. The investigator was rated as "Unsatisfactory" for FY 2015 with a detailed explanation of how the investigator's work on 10 assigned cases was not according to standards. On January 22, 2016, the individual retired in lieu of removal.

- One investigator received "Minimally Satisfactory" on the investigator's last rating of record for FY 2014. The removal of the investigator was proposed on February 17, 2015, and the investigator was terminated on May 6, 2015, for unauthorized release of government information, violation of standards of ethical conduct, unauthorized use of transit subsidy funds and transit GO card, misuse of government issued travel card, and lack of candor. The investigator was provided with specific examples dating back to 2013.

Both investigators were notified of their rights to file an appeal with the Merit Systems Protection Board or an equal employment opportunity complaint with the DOL's Civil Rights Center.

4. Allegation that OSHA failed to investigate the reports of wrongdoing by Region IX management

In the allegation, the Whistleblower referred to a letter to the Assistant Inspector General for Audit, dated November 3, 2014, which cited the letter to the Secretary of Labor, dated May 18, 2014. The Whistleblower stated:

> [There was] clear and convincing evidence the national office of the Whistleblower Protection Program was engaged in promoting and/or suborning policies and practices that violated laws and policies with the intent to conceal wrongdoing by OSHA managers, including evidence of the falsification of investigations, the wrongful dismissal of whistleblower complaints, and systematic retaliation against employees and whistleblowers who raised questions about the conduct of investigations.

The Whistleblower stated the OSHA Region IX investigators were disciplined for questioning OSHA practices of denying whistleblowers access to critical information during the investigations. The Whistleblower also stated that OSHA Region IX illegally placed employees under surveillance, and created and maintained a chilled environment for reporting violations of law and policy within the region.

OIG Analysis/Conclusion – The allegation could not be substantiated because the Whistleblower did not explain what "reports of wrongdoing" had not been investigated. As mentioned above under allegation 1, OSHA's 2014 internal review addressed all the allegations from the Whistleblower's May 18, 2014, letter to the Secretary of Labor.

In an email to OIG, the Whistleblower also mentioned Region IX management illegally placing employees under surveillance. However, the Whistleblower declined OIG's interview offer and did not provide any evidence to support this allegation.

In interviews with 27 current/former OSHA staff and current RSOL staff, OIG asked about misconduct and surveillance. The following provides the questions and summarizes the interview responses.

Misconduct. As part of the interviews, OIG asked:

> Are you aware of any misconduct by yourself, any other current/former OSHA personnel, or RSOL personnel in the handling of OSHA whistleblower complaints? This could include, but not be limited to: coercing statements from the complainants, respondents, or witnesses; falsifying reports; suppressing, fabricating, or mishandling evidence; inappropriate relationships with the complainants or respondents; giving unfair preference to respondents; coercing settlement agreements; or the unauthorized disclosure of investigative or case related materials?

Regional staff stated that the only misconduct they were aware of concerned the Whistleblower's allegations regarding case mismanagement and the investigator's (who was also the Whistleblower) misconduct of sharing internal documents with a complainant that led to the investigator's removal. In the interviews with OIG, 3 employees stated they learned of the Whistleblower's allegations either directly from the Whistleblower or the Whistleblower's YouTube video. Also in the interviews, 7 employees who were mostly regional managers stated they were aware of the investigator's misconduct. Both matters had previously been investigated by OSHA during the management review and in the decision to terminate the investigators' employment.

Surveillance. As part of the interviews, OIG asked:

> Are you aware of any type of surveillance program on Whistleblower staff, such as the interception, monitoring, or recording of work phone calls, the monitoring of work e-mails, or physical surveillance of employees outside of work?

Other than the allegations shared with them by the Whistleblower, no one in Region IX was aware of any illegal surveillance of employees by management. The allegation of illegal surveillance was investigated by OSHA in its management review.

Regarding work e-mails, some staff stated they were aware that managers could gain access to e-mails from their federal accounts through headquarters and that it would not violate privacy rights. Between October 1, 2010, and March 31, 2019, DOL's Office of the Chief Information Officer processed 103 requests for work emails of current or separated employees from 8 regions and OSHA's national office. These requests were for business reasons, such as to respond to Freedom of Information Act (FOIA) requests, equal employment opportunity complaints, and record retention such as records subject to litigation holds. Region IX made 8 requests for work emails. According to OSHA's records, the emails were requested just prior to or after the employees had separated from OSHA. Therefore, the emails could not have been used for surveillance of employees by management.

5. Allegation that OSHA's mismanagement of WPP caused a substantial and specific danger to public health and safety

The Whistleblower referred to an emailed report, dated June 20, 2012, to the Regional Administrator (RA) of OSHA Region IX and the Director of WPP. The Whistleblower stated:

> [The report detailed] the wrongful dismissal of four whistleblower complaints which alleged substantial and specific dangers to public health and safety.

The Whistleblower stated the report specifically detailed federal employee gross mismanagement, abuse of authority, the falsification of documents, and collaborations with company defendants to dismiss otherwise merit complaints.

OIG Analysis/Conclusion – The allegation could not be substantiated because the Whistleblower did not provide any evidence linking OSHA's investigation of whistleblower retaliation to "substantial and specific danger to public safety" and the Whistleblower declined to be interviewed.

While OSHA investigates whistleblower retaliation complaints for 23 statutes, it has enforcement responsibilities over employer safety and health violations for 1 statute – the OSH Act. For the other 22 statutes, 11 different federal agencies are responsible for investigating employer violations of various airline, commercial motor carrier, consumer product, environmental, financial reform,

food safety, health insurance reform, motor vehicle safety, nuclear, pipeline, public transportation agency, railroad, maritime, and securities laws.

The 2015 OIG Report stated

> OSHA did not adequately and timely communicate whistleblower reported alleged employer violations internally to OSHA's enforcement units or externally to other federal agencies.

The report noted that OSHA used an informal process for referring WPP complaints to OSHA's enforcement units. However, for 10 of 31 OSH Act related investigations there was no evidence of the internal notification. The 2015 OIG report also stated for the U.S. Department of Transportation (DOT) and Securities and Exchange Commission (SEC):

> [Twenty-three] percent of the alleged violations were not reported to the agency with jurisdiction to investigate such matters.

With more complete and timely communication between OSHA and other federal agencies, the agencies and the complainants would have greater assurance that employer violations would be properly investigated. The report recommended OSHA formalize the referral process. On October 3, 2017, OSHA issued guidance addressing coordination with federal partner agencies.

The results from our current audit are shown on Table 18 below. We found coordination with the appropriate enforcement agency was an issue in 16 of 75 cases. More exceptions occurred in cases closed by May 2015, than in cases closed afterward. Table 18 shows the breakout for the cases closed by May 2015 and afterward.

Table 18 – Errors for Coordination with Other Agencies, Cases Closed By and After May 2015

Description	Cases Closed By May 2015	Cases Closed After May 2015
Number of Sampled Cases	41	34
Number of Errors	10	6
Error Rate	24 percent	18 percent

Source: Testing results for 75 sampled investigations

Referrals from WPP were one way federal agencies became aware of alleged safety and health violations. Another way was when the complainant contacted the federal agency to self-report the employer's alleged violations of federal laws or regulations.

For our judgmental sample of 15 cases, OSHA's whistleblower investigative records showed for 6 of 15 cases the complainant's protected activities included self-reports that the respondent allegedly violated safety and health laws or regulations enforced by OSHA's safety and health enforcement staff, the Federal Aviation Administration (FAA), or Nuclear Regulatory Commission (NRC).

WHISTLEBLOWER'S SPECIFIC ALLEGATIONS FOR 15 CASES

The Whistleblower provided OIG with 72 specific allegations for the 15 cases (see Exhibit 2).[38] These allegations fell into 9 categories with 7 categories applicable to OSHA's investigation and 2 categories related to RSOL and ALJ, as follows:

1. **Diligence.** OSHA staff may not have been diligent in following WIM requirements for testing evidence, following leads, notifying federal agencies, etc.

2. **Fairness.** OSHA may not have been fair to the complainant while performing the investigation (i.e., not obtaining the complainant's rebuttal).

3. **Reporting.** OSHA may have omitted key evidence from reports or made findings without legal basis.

4. **Delay.** OSHA's investigation may have been unnecessarily delayed or prolonged.

5. **ALJ.** The Whistleblower's concerns related to ALJ's involvement in appeals.

6. **Roles.** OSHA staff may have acted outside their assigned roles or areas of responsibility.

[38] The first case was from Region V, but was 1 of 15 cases identified by the Whistleblower.

7. **Training.** RWI may not have been properly trained to conduct the investigation.

8. **Collusion**. OSHA may have colluded with the respondent or other party, and acted inappropriately.

9. **RSOL**. The Whistleblower's concerns related to RSOL's involvement in OSHA's investigations and making determinations.

As shown in Table 19, 47 allegations were not substantiated based on OSHA records and interviews, 24 allegations could not be substantiated due to lack of information or records, and 1 allegation had some merit. The table shows the number of allegations by the 9 categories and the number of allegations that were not substantiated, could not be substantiated, or had some merit.

Table 19: Number of Allegations by Category and OIG Conclusion

Allegation Category	Total Number	Not Substantiated	Could not be Substantiated	Some merit
1. Diligence	15	11	4	0
2. Fairness	12	7	5	0
3. Reporting	11	8	3	0
4. Delays	10	6	4	0
5. ALJ	6	2	3	1
6. Roles	6	5	1	0
7. Training	5	5	0	0
8. Collusion	4	1	3	0
9. RSOL	3	2	1	0
Totals	72	47	24	1

Source: Testing results for 72 allegations from the Whistleblower

Allegations that were not substantiated. Based on OSHA records and interviews conducted by OIG, 47 of 72 allegations (65 percent) were not substantiated. Records and interviews showed that the Whistleblower lacked a clear understanding of the evidence related to the allegation, applicable WIM requirements, and the roles and responsibilities of OSHA staff, RSOL, and the

ALJ. For example, the Whistleblower alleged 5 times that the RWIs were not properly trained before being assigned an investigation. The 5 allegations were not substantiated because the RWIs had adequate training and experience to conduct the investigation, or had access to supervisory assistance to help them perform their work (see Exhibit 2, Numbers 20, 23, 30, 66, and 70).

Allegations that could not be substantiated. Of 72 allegations, 24 (33 percent) could not be substantiated because the Whistleblower did not provide sufficient information about the allegation, declined to be interviewed, and OSHA's records did not contain evidence of the alleged events occurring as the Whistleblower alleged. For example, the Whistleblower alleged RSOL made comments at a meeting to discuss the merits of 1 case (see Exhibit 2, Number 6). The allegation could not be substantiated because the investigator (who was the Whistleblower) did not memorialize the meeting with RSOL in OSHA's records.

Allegation with some merit. Table 20 below summarizes the specific allegation and comments related to the 1 of 72 allegations (1 percent) with some merit. The allegation with some merit related to the complainant's appeal to the ALJ. For this allegation, there was no evidence of misconduct.

Table 20 – Specific Allegation with Some Merit

Specific Allegation	Comments
ALJ erred in dismissing case (Exhibit 2, Number 16)	The complainant appealed the ALJ dismissal to the ARB, which agreed the ALJ made an error. The ARB remanded to the ALJ and the case was settled. Therefore, the error was corrected through the complainant's appeal to ARB.

Source: Case Number 3 out of 15 cases provided by the Whistleblower

With regard to the 72 allegations, there was no evidence that OSHA provided treatment that is more favorable to either the complainant or respondent. This conclusion was based on the tone of the correspondence with the parties and the reasonableness of extensions provided. OSHA was consistent in tone and when requested, gave extensions to both the complainants and respondents. In addition, 15 of 15 OSHA whistleblower staff and managers stated in interviews that they provided equal access to both the complainants and respondents. However, there was 1 instance of a breakdown in communications between OSHA and a complainant that may have affected the quality of the complaint investigation (Case Number 5 out of 15 cases provided by the Whistleblower).

APPENDIX E: OSHA'S RESPONSE TO THE REPORT

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

September 18, 2020

MEMORANDUM FOR: ELLIOT P. LEWIS
Assistant Inspector General for Audit

FROM: LOREN E. SWEATT
Principal Deputy Assistant Secretary

SUBJECT: Response to the Office of the Inspector General's Draft Audit Report No. 02-21-001-10-105, *Region IX Whistleblower Protection Program Complaints Were Not Complete or Timely*

This memorandum is in response to your September 3, 2020, transmittal of the Office of the Inspector General's (OIG) Draft Audit Report No. 02-21-001-10-105, *Region IX Whistleblower Protection Program Complaints Were Not Complete or Timely*. The Occupational Safety and Health Administration (OSHA) appreciates this opportunity to provide comments on the findings and recommendations in the draft report.

Strengthening the Whistleblower Protection Program (WPP) continues to be one of OSHA's top priorities. I appreciate the OIG's confirmation that the agency did not engage in misconduct or violations of law, rule, regulation, or gross mismanagement in the operations of the WPP in Region IX. I also recognize the ongoing challenge the agency faces, across regions, in completing whistleblower complaint investigations in a timely manner. The agency is actively working on improving operations to promote a heightened balance between the dual goals of timeliness and completeness of investigations. The upcoming revisions to the Whistleblower Investigations Manual (WIM), along with other strategies, some of which are outlined in this memorandum, will help OSHA achieve this reasonable balance.

OSHA concurs with each of the four recommendations presented in the OIG's report. The following responses set forth OSHA's planned actions regarding these recommendations.

OIG Recommendation 1: Explore solutions to improve case management, including tracking completion of the essential elements and alerting the investigator and supervisor when there are periods of inactivity on an investigation.

OSHA Response: OSHA agrees with this recommendation and is actively working to establish this balance. The agency has been focused on creating a more equitable case management and workload distribution system across regions as well as ensuring that all essential elements in a whistleblower investigation are completed. To this end, in January 2020, OSHA began a process of reassigning cases across regional boundaries to establish a more reasonable workload balance throughout the regions. This project includes assessing regional caseload and reassigning cases from regions with heavy caseloads to regions with lesser caseloads. This process will continue until a reasonable balance exists across all regions.

In addition, the agency developed and distributed a "Whistleblower Investigation Checklist" to be used in all investigations to ensure that all essential elements are properly addressed, resulting in a quality investigation. This checklist was distributed to the regions in February 2020.

Finally, OSHA whistleblower managers are working closely with their investigators and using available management tools, such as database reports, to monitor the progress of investigations in order to reduce the periods of inactivity during investigations. This will ensure investigative activity will remain dynamic throughout the entire investigative process and ensure professional development of investigators, especially those new to the agency. In addition, OSHA's Directorate of Whistleblower Protection Programs (DWPP) plans to develop and transition to a new whistleblower module in the Occupational Safety and Health Information System that will function as both a database and a case management system.

OIG Recommendation 2: Develop and implement a system to track and monitor the work performed by FTEs to better allocate personnel costs by program and ensure resources are used as intended.

OSHA Response: OSHA agrees with this recommendation and is using new tools to work toward appropriate allocation of personnel and cost. The agency will continue to use its database reports to track and monitor performance by individual FTE and will use this information to better allocate resources for its WPP. The agency currently uses the "Performance Measures and Key Indicators Report (Dashboard)" to track individual FTE performance. Moving forward, the National Office will use this report in its analyses for allocating personnel costs and other essential resources to maximize effective utilization.

OIG Recommendation 3: Continue efforts to find solutions to developing a reasonable balance between timeliness and completeness of investigations.

OSHA Response: OSHA agrees with this recommendation and, as the report notes, is working to find these solutions. The agency continues to look for ways to improve its overall balance between the timely response to complaints and the completeness of investigations. One strategy includes the overhauled and streamlined WIM that promotes this reasonable balance, without compromising investigative quality. Another strategy, as mentioned in the report, involves the reassignment of cases from regions with higher caseloads per investigator to regions with lower caseloads per investigator. This will improve case file lapse time and completion rates. In addition, as indicated above, OSHA developed an investigative checklist that field managers are using to ensure essential elements of an investigation are followed, which will assist in obtaining more complete and thorough investigations. Finally, DWPP continues to encourage the development and implementation of regional pilot programs to explore increased investigative and procedural efficiencies.

OIG Recommendation 4: Ensure OSHA issues an updated WIM by the end of FY 2020 and completes desk guides for all applicable statutes.

OSHA Response: OSHA agrees with this recommendation and the agency is close to completing the revised WIM. The process included a comprehensive review by a field workgroup, followed by a National Office team of subject matter experts in DWPP and the Office of the Solicitor. Hundreds of comments were submitted by the field offices, requiring extensive review and discussion. The agency's goal is to implement the revised WIM in FY 2021.

In addition, OSHA has completed desk aids for 12 statutes. OSHA anticipates publishing the Pipeline Safety Improvement Act and Consumer Product Safety Improvement Act desk aids very soon. OSHA is also currently developing an additional four desk aids, which will cover the Energy Reorganization Act, the Environmental Protection Agency (six statutes), the Taxpayer First Act, and the Affordable Care Act. The agency plans to have these final desk aids completed by the end of FY 2021.

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