

U.S. Department of Labor

Office of Inspector General—Office of Audit

**OCCUPATIONAL SAFETY AND
HEALTH ADMINISTRATION**



COMPLAINANTS DID NOT ALWAYS RECEIVE APPROPRIATE INVESTIGATIONS UNDER THE WHISTLEBLOWER PROTECTION PROGRAM

Date Issued: September 30, 2010
Report Number: 02-10-202-10-105

BRIEFLY...

Highlights of Report Number 02-10-202-10-105, to the Assistant Secretary for Occupational Safety and Health.

WHY READ THE REPORT

The Occupational Safety and Health Administration (OSHA) created the Whistleblower Protection Program to enforce Section 11(c) of the Occupational Safety and Health (OSH) Act of 1970, which prohibits employers from retaliating against employees who exercise their rights under the OSH Act which include reporting safety or health violations to OSHA and participating in any proceeding related to an OSHA inspection. Since 1983, OSHA has been assigned whistleblower provisions under 16 additional statutes related to the trucking, nuclear power, pipeline, environmental, rail, consumer product safety, and securities industries. OSHA investigates complaints of discriminatory actions taken against employees who “blow the whistle” under the OSH Act or any of these additional whistleblower statutes.

WHY OIG CONDUCTED THE AUDIT

Over the past 20 years, we have issued three reports related to OSHA’s whistleblower program. Our findings ranged from incomplete case files to settlement procedures that may have deprived complainants of full and appropriate relief. In addition, GAO issued an audit report in January 2009 and found that OSHA lacked reliable data on investigations and its investigators lacked the resources, training and legal assistance required to perform investigations.

We conducted an audit of OSHA’s whistleblower program to answer the question: To what extent did OSHA ensure that complainants received appropriate investigations under the Whistleblower Protection Program?

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to:
<http://www.oig.dol.gov/public/reports/oa/2010/02-10-202-10-105.pdf>.

September 2010

COMPLAINANTS DID NOT ALWAYS RECEIVE APPROPRIATE INVESTIGATIONS UNDER THE WHISTLEBLOWER PROTECTION PROGRAM

WHAT OIG FOUND

During the audit period, 77 percent of the Whistleblower complaints under OSHA 11(c), Sarbanes-Oxley Act (SOX), and Surface Transportation Assistance Act (STAA) were either dismissed or withdrawn. Settlements which accounted for 21 percent were generally minimal, and the remaining 2 percent were found to have merit.

OSHA did not always ensure that complainants received appropriate investigations under the Whistleblower Protection Program. We estimate that 80 percent of applicable investigations under OSHA 11(c), SOX and STAA did not meet one or more of eight elements from the Whistleblower Investigations Manual that were essential to the investigative process. OSHA can improve investigations under the Whistleblower Protection Program if it (1) supervises investigations adequately, (2) manages regional investigators’ caseloads adequately, (3) oversees and monitors investigations for compliance with policies and procedures, (4) develops performance measures or indicators for the whistleblower program, and (5) provides adequate guidance to investigators. As a result of not providing complainants with thorough investigations, OSHA could not provide assurance that complainants were protected as intended under the various whistleblower protection statutes.

WHAT OIG RECOMMENDED

We recommended that the Assistant Secretary for Occupational Safety and Health implement controls to oversee and monitor investigations and caseloads, develop specific performance measures, update the Whistleblower Investigations Manual, and designate subject matter experts with technical competencies in specific whistleblower statutes.

In response to our draft report, the Assistant Secretary stated that he agreed with the recommendations. OSHA is in the process of performing a top-to-bottom review, including assessing whether to restructure the Office of the Whistleblower Protection Program. The Assistant Secretary stated the review will incorporate the valuable perspective and recommendations received from this audit report.

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U.S. Department of Labor

Office of Inspector General
Washington, D.C. 20210



September 30, 2010

Assistant Inspector General's Report

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The Occupational Safety and Health Administration (OSHA) created the Whistleblower Protection Program to enforce Section 11(c) of the Occupational Safety and Health (OSH) Act of 1970, which prohibits employers from retaliating against employees who exercise their rights under the OSH Act which include reporting safety or health violations to OSHA and participating in any proceeding related to an OSHA inspection. Since 1983, OSHA has been assigned whistleblower provisions under 16 additional statutes related to the trucking, nuclear power, pipeline, environmental, rail, consumer product safety, and securities industries. OSHA investigates complaints of discriminatory actions taken against employees who “blow the whistle” under the OSH Act or any of these additional whistleblower statutes.

We conducted an audit of OSHA’s whistleblower program to answer the following question:

To what extent did OSHA ensure that complainants received appropriate investigations under the Whistleblower Protection Program?

The audit covered OSHA practices, policies and procedures as of June 2010. The audit examined whistleblower investigations conducted under the OSHA 11(c), Sarbanes-Oxley Act (SOX) and Surface Transportation Assistance Act (STAA) statutes which received an initial determination from OSHA during the 12-month period ending October 31, 2009. These investigations accounted for 87 percent of OSHA’s caseload during our audit period. We conducted field work at OSHA headquarters in Washington, D.C. and at four regional offices.

To accomplish our objective, we obtained an understanding of applicable laws, regulations, and OSHA’s policies and procedures governing whistleblower investigations; conducted case file testing; interviewed OSHA personnel at the national and regional levels; and reviewed documents and reports related to the whistleblower

program. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audits to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provided a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS IN BRIEF

OSHA did not always ensure that complainants received appropriate investigations under the Whistleblower Protection Program. We estimate that 80 percent of applicable investigations under OSHA 11(c), SOX and STAA did not meet one or more of eight elements from the Whistleblower Investigations Manual that were essential to the investigative process. OSHA can improve investigations under the Whistleblower Protection Program if it (1) supervises investigations adequately, (2) manages regional investigators' caseloads adequately, (3) oversees and monitors investigations for compliance with policies and procedures, (4) develops performance measures or indicators for the whistleblower program, and (5) provides adequate guidance to investigators. As a result of not providing complainants with thorough investigations, OSHA could not provide assurance that complainants were protected as intended under the various whistleblower protection statutes.

Furthermore, OSHA's Whistleblower Investigations Manual had not been updated since 2003 and investigators did not have any written guidance on how to conduct investigations under the three new whistleblower statutes assigned to OSHA since the last update. Additionally, many investigators did not have access to subject matter experts for technical guidance on the 17 statutes they were responsible for enforcing.

We recommend the Assistant Secretary for Occupational Safety and Health implement controls to oversee and monitor investigations and caseloads, develop specific performance measures, update the Whistleblower Investigations Manual, and designate subject matter experts with technical competencies in specific whistleblower statutes.

In response to our draft report, the Assistant Secretary for Occupational Safety and Health stated that he agreed with the recommendations. OSHA is in the process of performing a top-to-bottom review of the program, including assessing whether to restructure the Office of the Whistleblower Protection Program. The objective is to identify any weaknesses and inefficiencies in the program and improve the way OSHA conducts this very important activity. The results of this comprehensive evaluation will include recommendations on programmatic changes to ensure that there is consistency and program delivery is greatly improved. The Assistant Secretary stated the review will incorporate the valuable perspective and recommendations received from this audit report.

The Assistant Secretary's response is included in its entirety as Appendix E.

RESULTS AND FINDING

Objective — To what extent did OSHA ensure that complainants received appropriate investigations under the Whistleblower Protection Program?

OSHA did not always ensure complainants received appropriate investigations and, therefore, cannot provide assurance that complainants were protected as intended under the various whistleblower protection statutes

Finding — OSHA did not always ensure that complainants received appropriate investigations under the Whistleblower Protection Program

OSHA did not always ensure that complainants received appropriate investigations under the Whistleblower Protection Program. We estimate that 80 percent¹ of applicable investigations under OSHA 11(c), SOX and STAA did not meet 1 or more of 8 elements from the Whistleblower Investigations Manual essential to the investigative process.

The OSHA Whistleblower Investigations Manual sets forth policy, procedures and other information relative to the handling of whistleblower complaints under the various statutes delegated to OSHA. We tested investigative case files against eight elements identified in Whistleblower Investigations Manual. These elements are essential to the investigative process to ensure that complainants receive appropriate investigations.

Results of Case File Testing

Element Tested	Exceptions	Error Rate
1) Conduct formal interview with complainant	33	23%
2) Document interview with complainant via signed statement or digital recording	19	22%
3) Obtain suggested witnesses from complainant	48	44%
4) Interview (or attempt to interview) all pertinent complainant witnesses	21	37%
5) Document complainant witness interviews via signed statement or digital recording	12	38%
6) Conduct face-to-face interviews or on-site investigative work	66	46%
7) Allow complainant an adequate opportunity to refute employer's defense or resolve discrepancies	40	38%
8) Conduct closing conference with complainant	14	15%

¹ This is the unbiased point estimate. Based on sample results, we are 90 percent confident that errors ranged between 72 percent and 87 percent. See Appendix B for Sample Methodology.

A brief description of each element, summary of audit results and description of the related policies and procedures follows. (See Exhibit 1 for the detailed projections related to each element.)

Elements 1 and 2 — Conduct formal interview with complainant and document interview via signed statement or digital recording — In 23 percent of applicable investigations, there was no evidence that the investigator conducted a formal interview with the complainant detailing the allegation. Furthermore, in 22 percent of applicable investigations, investigators did not obtain a signed statement or digital recording documenting the interview with the complainant². The Whistleblower Investigations Manual states that investigators will arrange to meet with a complainant as soon as possible to interview and obtain a signed statement detailing the complainant's allegations. Signed statements are highly desirable and useful for purposes of case review, subsequent changes in the complainant's status, possible later variations in testimony, and documentation for potential litigation. Complainants should never be instructed to submit a statement without engaging in the interview process.

Element 3 — Obtain suggested witnesses from complainant — In 44 percent of applicable investigations, the investigator did not identify any complainant witnesses and there was no evidence in the case file that the investigator attempted to elicit this information outside of a routine notification letter or questionnaire mailed to the complainant. This information is critical to successfully develop relevant and sufficient evidence in order to support the complainant's allegation and reach an appropriate determination of the case. The Whistleblower Investigations Manual states that the complainant's side of the investigation must be developed as thoroughly as possible and complainants should be encouraged to identify as many witnesses as possible, including a summary of specifically what each witness might be able to testify to in support of the complainant's allegations.

Element 4 — Interview (or attempt to interview) all pertinent complainant witnesses — In 37 percent of applicable investigations, there was no evidence that the investigator interviewed, or attempted to interview, all relevant witnesses identified by the complainant. The Whistleblower Investigations Manual states that investigators have a responsibility to fairly pursue all appropriate leads which develop during the course of an investigation. Contact must be made whenever possible with all relevant witnesses, and every attempt must be made to gather all pertinent data and materials from all available sources.

Element 5 — Document complainant witness interviews via signed statement or digital recording — In 38 percent of applicable investigations, there was no evidence that the investigator obtained or attempted to obtain signed statements from all complainant witnesses. The Whistleblower Investigations Manual states

² For the purposes of our audit, we considered digital recordings to be equivalent to signed statements when cases contained a digital recording but no signed statement.

that the investigator must attempt to obtain a signed statement from each relevant witness. In the event the investigator cannot obtain a signed statement, a memorandum setting forth all pertinent information obtained from the witness should be prepared.

Element 6 — Conduct face-to-face interviews or on-site investigative work — In 46 percent of applicable investigations, the investigator conducted the entire investigation by telephone or email and performed no face-to-face interviews or on-site investigative work. We found the emphasis placed on the importance of face-to-face interviews and on-site visits differed between the regions we visited, resulting in a range of 19 percent in Region V to 68 percent in Region III for this element. OSHA officials stated that due to case backlog and travel distances, it is not always feasible for investigators to conduct face-to-face interviews or on-site investigative work³. The Whistleblower Investigations Manual states that personal interviews and on-site collection of documentary evidence will be conducted when practical. In limited circumstances, testimony and evidence may be obtained by telephone, mail, or electronically.

Element 7 — Allow complainant an adequate opportunity to refute employer's defense or resolve discrepancies — In 38 percent of applicable investigations, there was no evidence that the investigator allowed the complainant an adequate opportunity to refute the employer's defense or resolve discrepancies during the investigation. The OSHA Whistleblower Manual states that the investigator will contact the complainant during the investigation to resolve any discrepancies or counter allegations resulting from the investigator's contact with the employer.

Element 8 — Conduct closing conference with complainant — In 15 percent of applicable investigations, there was no evidence that the investigator conducted a closing conference with the complainant. The Whistleblower Manual states that the investigator will conduct a closing conference with the complainant after completion of the investigation. A thorough, tactful closing conference is a valuable step to achieve a successful conclusion to an investigation. Assuring the complainant that his or her concerns have been fully explored and the investigative findings impartially evaluated will minimize the likelihood of appeals or objections, even though the complainant may not be totally satisfied or in agreement with the determination. The closing conference also allows the complainant another opportunity to offer new evidence or witnesses.

OSHA did not always ensure these essential elements were performed because it did not (1) supervise investigations adequately, (2) manage regional investigators' caseloads adequately, (3) oversee and monitor investigations for compliance with policies and procedures, (4) develop performance measures or indicators for the whistleblower program, and (5) provide adequate guidance to investigators.

³ If this element was eliminated from our overall projections, we estimate that 74 percent of investigations under OSHA 11(c), SOX and STAA did not meet one or more of the remaining 7 elements essential to the investigative process.

OSHA can improve the supervision of its investigations.

In 50 percent⁴ of investigations, there was no evidence that required supervisory reviews occurred. Specifically, 5 percent of the case files did not contain a Final Investigation Report (FIR). In addition, 47 percent of the remaining case files contained no indication of supervisory review on the FIR or via memorandum to the Regional Administrator. (See Exhibit 1 for detailed projections.)

The Whistleblower Investigations Manual states that the supervisor is responsible for providing guidance, assistance, supervision, and direction to investigators. The supervisor will review the completed investigative case file to ensure technical accuracy, thoroughness of the investigation, applicability of law, completeness of the report, and merits of the case. Supervisory concurrence with the investigator's analysis and recommendations will be documented on the FIR or documented via memorandum to the Regional Administrator.

Although OSHA had training requirements for its investigators, it did not have any requirements for its supervisors. None of the 39 supervisors in the 4 regions we visited had completed the 2 national OSHA Training Institute whistleblower investigation courses required for all investigators. Six supervisors had completed one of the courses, one supervisor was scheduled to take both courses in 2010, and another supervisor was scheduled to take one course. Two regions did provide 3 days of local training to investigators and supervisors annually. In addition to the lack of training, three of the six supervisors we interviewed stated they had little to no experience conducting whistleblower investigations.

Management in two regions stated that supervision was lacking during our audit period. In Region IV, an audit reported that a lack of day-to-day supervision of investigators and their casework resulted in a decline in the quality of the whistleblower program. The region responded by re-organizing the program by assigning investigators to local area offices where they would be supervised by area directors instead of dedicated Regional Supervisory Investigators. Interviews with investigators and area directors revealed that the area directors did not always have the time or the technical knowledge to handle the added responsibilities.

OSHA can improve its management of regional investigators' caseloads.

OSHA's national office did not adequately manage regional investigators' caseloads. As a result, average caseloads in the regions varied from 6 to 35 open investigations per investigator, with individual investigators' caseloads fluctuating from 3 to 66 investigations. In Fiscal Year (FY) 2009, OSHA took an average of 150 days to

⁴ This is the unbiased point estimate. Based on sample results, we are 90 percent confident that errors ranged between 38 percent and 62 percent. See Appendix B for Sample Methodology.

complete an investigation and completed only 41 percent within the statutory time frames⁵.

According to information obtained from OSHA, an investigator can handle between six to eight open investigations at a time. Higher caseloads cause both timeliness and quality of investigations to suffer. One investigator we interviewed indicated that the current investigative process was not adequately protecting whistleblowers because investigators were less likely to conduct thorough investigations due to the high caseloads and OSHA's lack of staff to conduct screenings and investigations.

A review of FY 2009 investigation data showed that regions with higher caseloads averaged at least twice the amount of open investigations and took at least twice as long to complete investigations. The four regions with the highest caseloads, which averaged 24 to 35 open investigations, averaged between 179 to 290 days to close an investigation. The four regions with the lowest caseloads, which averaged 6 to 12 open investigations, averaged between 89 to 109 days to close an investigation.

Instead of specifically budgeting full-time equivalents (FTE) to the whistleblower programs in the regions, OSHA provided its regional offices an annual FTE ceiling as part of the budgeting process. The regions determined how to allocate those FTEs between the whistleblower program and all the other OSHA activities they are responsible for, such as the compliance program.

In order to mitigate its increasing case backlog and more effectively complete investigations, OSHA requested and received funding to hire an additional 25 whistleblower investigators in 2010. OSHA's national office provided the regions a specific FTE allocation for these additional whistleblower investigators. According to information provided by OSHA management, the allocation was based on cases received. However, this allocation did little to address the excessive caseloads carried by certain regions. For example, Region VIII — which had the highest average caseload of 35 investigations per investigator — was allocated three FTEs while Region VI — which had the lowest average caseload of 6 investigations per investigator — was allocated four FTEs.

⁵ Depending on the statute involved, OSHA has statutory time frames between 30 and 90 days to complete its investigation and make its initial findings.

Regional Case Statistics and Additional FTE Allocation⁶				
Region	Average Caseload	Average Case Length	Avg. Cases Older Than 180 Days	Additional FTE Allocation
VIII 35		179	14	3
II 29		290	7	2
IX	25	264	14	2
IV 24		181	13	4
X	17	201	11	1
I 17		168	6	1
V 12		109	5	4
VII 12		89	5	3
III 9		100	4	1
VI 6		97	4	4
Total 25				

OSHA national office stated that the regions hired 19 of the 25 new whistleblower investigators; however, based on a comparison of Whistleblower Program Rosters maintained by OWPP from before and after the FY 2010 appropriation, the regions only added (or planned to add) 16 additional investigator FTEs from FY 2009 levels. Specifically, the regions hired 14 new investigators and had plans to hire 2 more investigators as of September 2010. We did not include 6 investigators who were hired to backfill previously existing positions from FY 2009 which had become vacant.

Because OSHA did not adequately manage regional investigators' caseloads, both timeliness and the quality of its investigations suffered. In addition, despite receiving funding to hire 25 additional whistleblower investigators to mitigate its case backlog, OSHA added or planned to add only 16 investigators.

OSHA can improve its oversight and monitoring of investigations for compliance with policies and procedures.

OSHA's audit process did not achieve national consistency in the whistleblower program because regions were responsible for conducting their own audits with insufficient national oversight. This created inconsistencies in how regions conducted investigations and may have impacted the quality of those investigations

⁶ Average Caseload and Average Cases Older Than 180 Days data are based on unaudited data provided by OSHA officials in support of OSHA's FTE allocation.

The OSHA Whistleblower Investigations Manual assigns responsibility to the Office of Whistleblower Protection Program (OWPP — identified in the manual as the Office of Investigative Assistance) for conducting regional audits of case files to ensure national consistency.

OWPP officials stated that they did not conduct regional audits due to lack of resources. Instead, they relied on OSHA's Management Accountability Program which requires each region to conduct comprehensive on-site audits of approximately one quarter of its area offices every year and regional office programs at least once every 4 years.

Although audits of the whistleblower program had been conducted in the four regions we visited, the methodologies used to conduct the audits and the areas reviewed were inconsistent between regions. The methodologies were not identified in the audit reports issued in two regions. The other two regions used self-audit checklists to conduct the audits. Depending on the region, the reports included coverage of between two to seven of the eight investigative elements targeted by our audit. Two regions audited themselves, the other two regions requested audits by supervisors from other regions or OWPP staff.

The lack of oversight over the regions resulted in unique regional practices which created inconsistencies in how regions conducted investigations and may have impacted the quality of those investigations. For example, one region issued withdrawals instead of dismissals when an investigator was unable to contact a complainant. This practice denies the complainant the opportunity to appeal OSHA's decision. In another example, we found regions were not consistent when investigators had difficulty locating a complainant to initiate or continue the investigation. Although the Whistleblower Investigations Manual states that investigators should mail a certified, return-receipt-requested letter to the complainant requesting contact within 10 days of receipt prior to dismissing a case, two regions allowed the complainant only 5 days to contact them. Although this practice lessens the amount of time it takes to complete some investigations, it increases OSHA's risk of wrongfully dismissing a complainant's case.

In addition to the weaknesses we identified in OSHA's audit process, a GAO report from January 2009 found that OSHA's audit guidance was unclear, audits lacked independence, and the audit process lacked accountability mechanisms for addressing problems found in audits.

OSHA should develop performance measures or indicators for the whistleblower program.

OSHA did not measure the performance of the whistleblower program and therefore had no way to determine if the program was working as intended. There were no formal management reports monitored at the national level, and reports used by regional

management varied in nature and focused more on timeliness than quality of investigations.

GAO's *Standards for Internal Control in the Federal Government* defines the minimum level of quality acceptable for internal control in government. These standards state that:

Activities need to be established to monitor performance measures and indicators. ... Internal control monitoring should assess the quality of performance over time.

OSHA's national office did not review any regular performance reports on the whistleblower program. OWPP ran some reports from OSHA's primary information system, the Integrated Management Information System (IMIS), for its own information. The OSHA Whistleblower Investigations Manual assigns overall responsibility for all whistleblower investigative activities to 10 Regional Administrators. Under OSHA's organizational structure, the Regional Administrators report to OSHA's Deputy Assistant Secretaries, not OWPP.

In each of the regions we visited, management used varying practices to monitor the program's performance, which tended to focus more on timeliness than quality. Region IV used a timeliness measure of completing investigations within 90 days and ran weekly IMIS reports to determine regional caseload and overall performance statistics. Regions V and VIII did not have any formal performance measures but ran semi-annual IMIS reports to compare their performance to other regions in areas such as timeliness, completed investigations and merit cases. Region V also ran weekly and monthly reports to monitor the area offices, and Region VIII ran a weekly report to monitor caseloads and the status of ongoing investigations. Region III did not have any formal performance measures and did not use any management reports to monitor the program's performance.

Establishment and monitoring of performance measures and indicators are an integral part of an entity's planning, implementing, reviewing and accountability for stewardship of government resources and achieving effective results. Until OSHA develops and monitors performance measures or indicators for the whistleblower program, it will not know if the program is successful or working as intended.

OSHA can improve the guidance provided to investigators.

Investigators were not provided adequate written guidance and access to subject matter experts.

OSHA last updated its Whistleblower Investigations Manual in August 2003. Since then, OSHA was assigned three new whistleblower statutes — Federal Railroad Safety Act, National Transit Systems Security Act, and Consumer Product Safety Improvement

Act⁷. Although a draft version of an updated manual was circulated to the regions for comment in 2007, an official update was never issued by OSHA. Some investigators in the regions were using the 2007 draft manual for statutes not covered by the official 2003 manual. Because of the lack of timely updating, investigators did not have written guidance on how to conduct investigations under these newer statutes.

In addition, while investigators were responsible for conducting investigations under all 17 statutes and most of them did not specialize in specific statutes, many did not have access to subject matter experts for technical guidance. (See Exhibit 2 for a complete list of the statutes under OSHA's jurisdiction.) For example, only 1 of the 4 regions, Region V, had a designated expert for investigations related to the SOX statute but no designated expert for the other 16 statutes. The remaining 3 regions had no designated experts for any of the 17 statutes. According to regional officials, some investigators had more knowledge about various statutes than others. Investigators indicated that there was a need for subject matter experts with the whistleblower program to deal effectively with specialized statutes. One area director stated that the training courses were not adequate, and that if certain investigators specialized in statutes it would be a tremendous help to the whistleblower program, particularly in reducing the length of time it takes to complete an investigation.

RECOMMENDATIONS

We recommend that the Assistant Secretary for Occupational Safety and Health:

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.
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.
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.
4. Develop and monitor specific performance measures or indicators to ensure the whistleblower program is working as intended.
5. Issue an updated Whistleblower Investigations Manual incorporating the recommendations contained in this report, and implement controls to ensure the manual will continue to be updated in a timely manner to reflect current policies, procedures, and statutes.

⁷ During fieldwork for this audit, OSHA was assigned two more statutes: Section 1558 of the Affordable Care Act and Section 1057 of the Dodd Frank Wall Street Reform and Consumer Protection Act. In addition, amendments were issued to SOX.

6. Designate subject matter experts — with technical and legal competencies in specific whistleblower statutes — whom investigators may contact for technical assistance.

We appreciate the cooperation and courtesies that OSHA personnel extended to the Office of Inspector General during this audit. OIG personnel who made major contributions to this report are listed in Appendix E.



Elliot P. Lewis
Assistant Inspector General
for Audit

Exhibits

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Exhibit 1**Results Of Case File Testing**

The following table shows the results and projections of our case file testing at a 90 percent confidence level with sample and universe sizes adjusted to include only those attributes/elements determined to be applicable:

Statistical Projections						
Attribute	Exceptions	Adjusted Sample	Adjusted Universe	Point Estimate	Lower Limit	Upper Limit
Overall compliance with eight essential elements	116	148	1471	80%	72%	87%
Eight Essential Elements						
1) Conduct formal interview with complainant	33	135	1,339	23%	14%	33%
2) Document interview with complainant via signed statement or digital recording	19	99	981	22%	13%	32%
3) Obtain suggested witnesses from complainant	48	127	1,253	44%	35%	52%
4) Interview (or attempt to interview) all pertinent complainant witnesses	21	51	541	37%	24%	50%
5) Document complainant witness interviews via signed statement or digital recording	12	38	417	38%	23%	53%
6) Conduct face-to-face interviews or on-site investigative work	66	129	1,289	46%	35%	56%
7) Allow complainant an adequate opportunity to refute employer's defense or resolve discrepancies	40	104	1,048	38%	28%	48%
8) Conduct closing conference with complainant	14	99	970	15%	8%	22%
Supervisory Attributes						
Case file contained a FIR	15	159	1,568	5%	1%	9%
Case file contained supervisory review on the FIR or a memorandum to the Regional Administrator	71	144	1,498	47%	36%	58%

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Exhibit 2**Whistleblower Protection Statutes**

The following table shows the 17 whistleblower statutes OSHA is responsible for enforcing:

Whistleblower Protection Statutes		
Cognizant Agency	Statute	Year⁸
DOL	Occupational Safety and Health Act	1970
EPA	Federal Water Pollution Control Act (FWPCA)	1972
EPA	Safe Drinking Water Act (SDWA)	1974
EPA	Solid Waste Disposal Act (SWDA)	1976
EPA	Toxic Substances Control Act (TSCA)	1976
EPA	Clean Air Act (CAA)	1977
DOT	International Safe Container Act (ISCA)	1977
DOE	Energy Reorganization Act (ERA)	1978
DOT	Federal Railroad Safety Act (FRSA)	1980
EPA	Comprehensive Environmental Response, Compensation and Liability Act (CERCLA)	1980
DOT	Surface Transportation Assistance Act (STAA)	1982
EPA	Asbestos Hazard Emergency Response Act (AHERA)	1986
FAA	Wendell H. Ford Aviation Investment and Reform Act for the 21st Century (AIR21)	2000
DOT	Pipeline Safety Improvements Act (PSIA)	2002
SEC	Sarbanes-Oxley Act (SOX)	2002
DOT	National Transit Systems Security Act (NTSSA)	2007
CPSC	Consumer Product Safety Improvement Act (CPSIA)	2008

⁸ These years represent the date the whistleblower protection provisions were added to the relevant statutes, and not necessarily the date of the original enactment of the statutes themselves, or the date OSHA was given responsibility for enforcement of the whistleblower provisions.

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Appendices

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Appendix A**Background**

OSHA created the Whistleblower Protection Program to enforce Section 11(c) of the OSH Act of 1970, which prohibits employers from retaliating against employees who exercise their rights under the OSH Act. These rights include reporting safety or health violations to OSHA and participating in any proceeding related to an OSHA inspection. Since 1983, OSHA has been assigned whistleblower provisions under 16 additional statutes related to the trucking, nuclear power, pipeline, environmental, rail, consumer product safety, and securities industries.

OSHA investigates complaints of discriminatory actions taken against employees who “blow the whistle” under the OSH Act or any of these additional whistleblower statutes. Depending on the statute involved, OSHA has statutory time frames between 30 and 90 days to complete its investigation and make its initial findings. The WPP operates under OSHA’s Directorate of Enforcement Programs (DEP) within a decentralized structure of regional and area offices. OSHA’s 10 regional administrators are responsible for administering the program in their regions. The whistleblower program’s national office, OWPP, is responsible for developing policies and procedures, providing training, and offering technical assistance and legal interpretations.

The whistleblower program shares resources with OSHA’s other enforcement programs under DEP, and distribution of those resources is determined by each of the 10 regional administrators. In FY 2010, OSHA was given funding to hire an additional 25 whistleblower investigators in order to mitigate its increasing case backlog and more effectively complete investigations. In FY 2009 OSHA took an average of 150 days to complete an investigation and completed only 41 percent within the statutory time frames.

During the audit period, 77 percent of the Whistleblower complaints under OSHA 11(c), SOX and STAA were either dismissed or withdrawn, settlements — which accounted for 21 percent — were generally minimal, and the remaining 2 percent were found to have merit.

Complaint Outcomes: OSHA 11(c), SOX & STAA cases		
Year Ending October 31, 2009		
Outcome	Cases	
Dismissed or Withdrawn	1,236	77%
Settled:		
Monetary Compensation	215	13%
Job Reinstatement	10	1%
Job Reinstatement & Monetary Compensation	31	2%
Non-Monetary	76	5%
Merit	34	2%
Total Cases	1,602	100%

A review of IMIS data on settlements showed that 13 percent of complainants received monetary compensation only, 3 percent returned to work, and 5 percent received no monetary compensation and no job reinstatement but may have had their records expunged. The average payment for OSHA 11(c) cases, which consisted of back wages and compensation, was \$4,800 and ranged from \$8 to \$129,150. The average payment on STAA cases, which consisted of back wages and compensation, was \$6,100 and ranged from \$100 to \$67,500. The average payment on SOX cases, which consisted of back wages, compensation, and punitive damages, was significantly higher at \$265,000 and ranged from \$14,000 to \$1.9 million.

Over the past 20 years, we have issued three reports related to OSHA's whistleblower program. Our audits and evaluations found that investigations were not being completed within statutory time frames, case files contained incomplete documentation, OSHA's policies and procedures did not cover eight of the statutes they were responsible for enforcing, management needed to place more emphasis on case monitoring and oversight, settlement procedures may have deprived complainants of full and appropriate relief, and OSHA's case management system was ineffective and not used for reporting and monitoring.

In addition, GAO issued an audit report in January 2009 and found that OSHA lacked reliable data on investigations and its investigators lacked the resources, training and legal assistance required to perform investigations. Although GAO recommended that OSHA take a number of steps to improve the accuracy of its data and enhance program oversight, OSHA failed to provide specific information on how it would implement those recommendations. The report also found that case processing times were affected by increasing case complexity and increasing caseloads.

Appendix B**Objective, Scope, Methodology, and Criteria**

Objective

The objective of the audit was to answer the following question:

To what extent did OSHA ensure that complainants received appropriate investigations under the Whistleblower Protection Program?

Scope

The audit covered OSHA practices, policies and procedures as of June 2010. The universe used in our audit consisted of 1,602 whistleblower investigations conducted under the OSHA 11(c), SOX and STAA statutes, which received an initial determination from OSHA during the 12-month period ending October 31, 2009. These investigations accounted for 87 percent of OSHA's caseload during our audit period. This audit was limited to the investigative process and therefore did not test OSHA's settlement processes, cases that were screened out, or the appropriateness of OSHA's determinations.

We conducted field work at OSHA headquarters in Washington, D.C. and at four statistically selected regional offices: Philadelphia (Region III), Atlanta (Region IV), Chicago (Region V) and Denver (Region VIII). For Regions IV and V, we judgmentally selected area offices for interviews⁹. OSHA has 10 regional offices in total.

We conducted case file testing on a statistical sample of 159 out of 1,568 dismissed, withdrawn and settled investigations. In addition, we conducted case file testing on 13 out of 34 investigations where OSHA issued a merit finding; these 13 investigations were 100 percent of the merit investigations in our audit period at the 4 regions selected. We obtained documents and reports related to the whistleblower program from the national and regional offices. We also interviewed national office staff, as well as investigators and supervisors in each of the regions where fieldwork was conducted.

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.

⁹ Regions III and VIII did not have an area office structure for the whistleblower program.

Methodology

To accomplish our objective, we obtained an understanding of OSHA's policies and procedures governing whistleblower investigations, and applicable laws and regulations. We also conducted case file testing, interviewed OSHA personnel at the national and regional levels, and reviewed documents and reports related to the whistleblower program.

Reliability Assessment

We assessed the reliability of OSHA's IMIS 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 the purposes of this report.

Sampling

We determined a universe of 1,568 dismissed, withdrawn, and settled whistleblower investigations conducted under the OSHA 11(c), SOX and STAA statutes which received an initial determination from OSHA during the 12-month period ending October 31, 2009. We used a stratified two-stage cluster random sampling plan for sample selection. OSHA's 10 regions were stratified into 2 different strata according to the number of investigations completed during our audit period and 4 regions were statistically selected. From the 4 regions, we selected a statistical sample of 159 dismissed, withdrawn and settled investigations for case file testing. In addition, we selected all 13 investigations where OSHA issued a merit finding for case file testing.

Our projections were based on the results of the case file testing for investigations that were dismissed, withdrawn or settled. We did not project the results of our testing of the merit investigations due to the small sample size (13) and universe size (34).

Analyses

To test investigations for compliance with OSHA's policies and procedures, we identified eight elements from the OSHA Whistleblower Manual as essential to the investigative process and determined if each of the elements was performed during the investigation. An official from OWPP concurred that these eight elements were essential to conducting investigations. We also tested case files against two attributes related to supervision of investigations. Documents reviewed as part of the case file testing included investigative reports, phone/contact logs, investigator notes, memos-to-file, complainant statements, witness statements, employer position statements, digital recordings, screening/intake forms, and questionnaires.

During case file testing, we may have determined that an investigative element was not applicable to a particular case. When this occurred, the lack of an investigative element

was not classified as an exception. For example, if a case was withdrawn at a very early stage, it may not have been appropriate to interview the complainant or witnesses.

To gain an understanding of OSHA's internal controls over the whistleblower program, we obtained and analyzed documents and reports related to the investigative process, training, staffing and caseloads, performance, and prior audits. We also interviewed OSHA personnel at the national and regional levels. At the national level we interviewed the OSHA Director of Enforcement Programs, the Director of OWPP, and the Deputy Director of Administrative Programs. At the regional level we interviewed investigators, supervisors, and regional management personnel.

Internal Control

In planning and performing our audit, we considered whether internal controls significant to the audit were properly designed and placed in operation. This included reviewing OSHA's policies and procedures related to conducting whistleblower investigations. We confirmed our understanding of these controls and procedures through interviews and case file review and analysis. We evaluated internal controls used by OSHA for reasonable assurance that investigations were conducted according to federal requirements and guidance. Our consideration of OSHA's internal controls for conducting investigations would not necessarily disclose all matters that might be significant deficiencies. Because of inherent limitations in internal controls, misstatements or noncompliance may nevertheless occur and not be detected.

Criteria

We used the following criteria to accomplish the audit objectives:

- The Occupational Safety and Health Act of 1970, Section 11 (c)
- Corporate and Criminal Fraud Accountability Act, Title VIII of the Sarbanes-Oxley Act of 2002 (SOX)
- Surface Transportation Assistance Act of 1982 (STAA)
- OSHA Directive Number: DIS 0-0.9, Whistleblower Investigations Manual, August 22, 2003
- OSHA Directive Number: EAA 01-00-003, Management Accountability Program, July 23, 2007
- Secretary's Order 5-2007 – Delegation of Authority and Assignment of Responsibility to the Assistant Secretary for Occupational Safety and Health
- 29 CFR Part 1977 - Discrimination Against Employees Exercising Rights under the Williams-Steiger Occupational Safety and Health Act
- 29 CFR Part 1978 - Rules for Implementing Section 405 of the Surface Transportation Assistance Act of 1982
- 29 CFR Part 1980 - Procedures for the Handling of Discrimination Complaints under Section 806 of the Corporate and Criminal Fraud Accountability Act of 2002
- GAO Standards for Internal Control in the Federal Government (GAO/AIMD-00-21.3.1), November 1999

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Appendix C

Acronyms and Abbreviations

CFR	Code of Federal Regulations
DEP	Directorate of Enforcement Programs
DOL	U.S. Department of Labor
FIR	Final Investigation Report
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
IMIS	Integrated Management Information System
OIG	Office of Inspector General
OSH	Occupational Safety and Health Act
OSHA	Occupational Safety and Health Administration
OWPP	Office of Whistleblower Protection Program
SOX	Sarbanes-Oxley Act
STAA	Surface Transportation Assistance Act

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OSHA Response to Draft Report

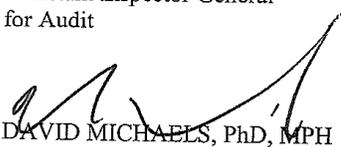
U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210



SEP 30 2010

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

FROM: 
DAVID MICHAELS, PhD, MPH

SUBJECT: Response to OIG's Draft Audit Report
No. 02-10-202-10-105
"Complainants Did Not Always Receive
Appropriate Investigations Under the
Whistleblower Protection Program"

This memorandum is in response to your September 20, 2010, transmittal of the Office of Inspector General (OIG) Draft Audit Report No. 02-10-202-10-105, "Complaints Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program." We appreciate this opportunity to respond to the findings and recommendations of the OIG. The timing of this report, following the recent Government Accountability Office (GAO) report on OSHA's Whistleblower Protection Program (GAO-10-722, *Whistleblower Protection: Sustained Management Attention Needed to Address Long-standing Program Weakness*), allows the Agency the opportunity to reiterate our commitment to continuously improve this program. Towards that end, the Agency would like to bring to the attention of the OIG the efforts it is taking to fully evaluate its whistleblower protection program, including assessing whether to restructure the Office of the Whistleblower Protection Program (OWPP). Specifically, the Agency is in the process of a top-to-bottom review of this program. This comprehensive review is being overseen by the Deputy Assistant Secretary and will cover policy, resources, equipment, organization and work processes. The objective is to identify any weaknesses and inefficiencies in the program and improve the way OSHA conducts this very important activity. Furthermore, the results of this comprehensive evaluation will include recommendations to the Assistant Secretary on programmatic changes to ensure that there is consistency and program delivery is greatly improved. Our assessment will incorporate the valuable perspective and recommendations we received from the GAO report and this review. The Agency agrees with many of the recommendations, but would like to update the OIG on some activities and policies with regard to whistleblower protections.

While the OIG is very critical of OSHA's internal controls with regard to its whistleblower protection program, it did not report on the Agency's most up-to-date policies and procedures. We believe adoption of these updated policies and procedures address the valid concerns raised in this report. OSHA released its revised Management Accountability Program (MAP) Instruction on September 15, 2010. This Instruction updates the MAP in accordance with OSHA's April, 2009 Statement of Executive Action in response to GAO findings from the GAO report entitled "*Whistleblower Protection Program Better Data and Improved Oversight Would Help Ensure Program Quality and Consistency*" (GAO-09-106), ensuring that whistleblower programs are always included as audit topics. In addition, the new Instruction establishes Agency policy and provides procedures and guidelines for conducting an audit component applicable to Agency programs and activities conducted by Regions and Area Offices. The MAP established by this Instruction is one component of OSHA's internal control system, as required by OMB Circular A-123.¹ The new Instruction revises OSHA's MAP by maintaining and updating audits that still have current relevance, improving communication of audit priorities and response to audit findings, clarifying and providing flexibility in the frequency, scope and methodology of field audits, and providing for greater, independent National Office participation in Regional and selected Area Office Audits.

Finally, while the OIG is critical of OSHA in terms of staffing this program, the explanation it provides is not comprehensive. OSHA is committed to filling all the whistleblower investigator positions as quickly as possible. The 25 new whistleblower investigator positions² were allocated—based on, not only the caseload carried by the regions, but also other factors such as the type and complexity of cases. The Agency fully allocated all 25 FTE positions to the regions and intends to fill all 25 positions, as directed by Congress. As the OIG is aware, the Department has been conducting unprecedented hiring over the last year and OSHA alone has filled over 200 regional FTE positions in FY 2010. The Agency is actively working with the appropriate OASAM Regional Office to fill the remaining whistleblower vacancies and will monitor recruitment activity accordingly.

RECOMMENDATIONS

OSHA appreciates the opportunity to comment on the report and provides the following responses to the recommendations.

¹ OMB Circular A-123 sets out the policy that management controls should be an integral part of the entire cycle of planning, budgeting, management, accounting, and auditing. Controls should support the effectiveness and integrity of every step of the process and provide continual feedback to management.

² In January 2010, the Agency received its FY 2010 budget including the 25 new whistleblower FTEs. This was the first time there was a resource increase for FTEs since the inception of the whistleblower program, despite the expansion and exponential growth of the program over the years.

Recommendation 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.

OSHA Response: The Agency agrees with this recommendation and is taking a number of steps to address this recommendation. The Whistleblower Investigations Manual, both in the current version and the draft now in clearance, delineates the responsibilities of supervisors, which includes “providing guidance, assistance, supervision, and direction to investigators during the conduct of investigations and settlement negotiations” and “reviewing investigative reports for comprehensiveness and technical accuracy and finalizing Secretary’s findings.” In addition, the Agency has committed that over the next 18 months Area Directors and other personnel who supervise whistleblower investigators who have not taken the mandatory training on whistleblower protection will receive such training. As noted above, the revised MAP requires that the whistleblower protection program be included in every audit. These audits will be used, in part, to ensure cases are adequately reviewed by supervisors. OSHA Regional Administrators will be informed of the findings from these audits and be expected to respond to any shortcomings in the supervisory reviews. Furthermore, the OWPP and regions will hold monthly conference calls to maintain up-to-date awareness of developments in case law and other timely issues. The Agency is reviewing how best to ensure participation on these calls.

Recommendation 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.

OSHA Response: The Agency agrees with this recommendation. The Agency is currently assessing methods for improving the balancing of caseloads, as part of its thorough evaluation of the whistleblower protection program. In addition, the evaluation will review how to ensure the timely and thorough investigation of every case.

Recommendation 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.

OSHA Response: The Agency’s evaluation of the whistleblower protection program will include an assessment on how to address regional oversight, including whether to restructure the OWPP to accomplish this goal. As noted above, the evaluation team reviewing the whistleblower protection program will be making recommendations to the Assistant Secretary on programmatic changes to assure that there is consistency across regions. Once the evaluation recommendations are implemented, the audit program and OWPP’s case file review will be used to monitor that OSHA’s regions are consistent in their approach to program management. In addition, as noted above, the new Instruction revises OSHA’s MAP by maintaining and updating audits that still have current relevance, improving communication of audit priorities and response to audit findings,

clarifying and providing flexibility in the frequency, scope and methodology of field audits, and providing for greater, independent National Office participation in Regional and selected Area Office Audits.

Recommendation 4: Develop and monitor specific performance measures or indicators to ensure the whistleblower program is working as intended.

OSHA Response: The Agency agrees with this recommendation. The Department is currently in the process of developing the Fiscal Year (FY) 2011 – 2016 Strategic Plan. The Department’s outcome goal to “ensure worker voice in the workplace” is directly supported by the Whistleblower Protection Program. To address this goal further, the Agency will look into developing related performance measures in its FY 2011 Operating Plan.

Recommendation 5: Issue an updated Whistleblower Investigations Manual incorporating the recommendations contained in this report, and implement controls to ensure the manual will continue to be updated in a timely manner to reflect current policies, procedures, and statutes.

OSHA Response: The Agency is currently revising its Whistleblower Investigations Manual. On August 30, 2010, the revised manual was sent to all OSHA Directorates and regions for clearance and comment. Responses are due back to the Office of the Whistleblower Protection Program by October 13, 2010. All comments will be thoroughly reviewed and appropriately implemented into the Manual as warranted. We will ensure that the recommendations in this report are assessed in the review process. In addition, the Agency has implemented procedures for real-time updating, either by revising or adding individual chapters.

Recommendation 6: Designate subject matter experts — with technical and legal competencies in specific whistleblower statutes — whom investigators may contact for technical assistance.

OSHA Response: The Agency agrees with this recommendation and has plans to develop a roster of subject matter experts in the field and will ensure it is made available to investigators to supplement the existing resources available through their supervisors and OWPP. The Agency is concurrently developing procedures to ensure that designated experts are providing consistent advice within and across regions, and have direct access to OWPP staff members when they themselves need assistance or advice.

Both the GAO and OIG reports have given the Agency the opportunity to clearly delineate the steps it is taking to continue to improve the whistleblower protection

program. While the OIG has laid forth some of the challenges the Agency faces in administering this programs, I am confident that the developed plan will prove successful. Given the complexity of the program, please feel free to contact the Director of Enforcement Programs, Thomas Galassi at 202-693-2100 if you have any further questions.

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Appendix E

Acknowledgements

Key contributors to this report were Mark Schwartz, Stephen Sovich, Cardelia Tsoi, Sean Ally, Steven Johnson, and Miguel Hughes.

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