U.S. Department of Labor

Office of Inspector General—Office of Audit

**REPORT TO THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION**

# OSHA NEEDS TO CONTINUE TO STRENGTHEN ITS WHISTLEBLOWER PROTECTION PROGRAMS

**Date Issued:** September 30, 2015
**Report Number:** 02-15-202-10-105

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

# BRIEFLY…

**September 30, 2015**

## OSHA NEEDS TO CONTINUE TO STRENGTHEN ITS WHISTLEBLOWER PROTECTION PROGRAMS

## WHY OIG CONDUCTED THE AUDIT

The Office of Inspector General (OIG) conducted this audit to see what improvements have been made to the Whistleblower Programs since our 2010 report and the Government Accountability Office's (GAO) March 2014 report. In 2010, OIG found approximately 80 percent of OSHA's whistleblower investigations for three statutes did not meet one or more of the eight elements from its Whistleblower Investigations Manual that were essential to the investigative process. Furthermore, GAO's March 2014 report concluded OSHA interagency collaborative mechanisms could be strengthened.

## WHAT OIG DID

OIG conducted a performance audit to determine the following:

> Did OSHA improve the administration of its Whistleblower Programs?

## 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/2015/02-15-202-10-105.pdf.

## WHAT OIG FOUND

OSHA has improved administration of its Whistleblower Programs. However, opportunities exist for OSHA to further strengthen the Whistleblower Programs to ensure complainants are protected as intended under the various Whistleblower Protection statutes.

We found OSHA did not consistently ensure complaint reviews under the Whistleblower Programs were complete, sufficient, and timely. Specifically, 18 percent of whistleblower reviews did not meet 1 or more of the 7 essential elements specified by the OSHA Whistleblower Manual. Moreover, OSHA did not ensure the manual and training reflected the most recent program updates and changing priorities, and 72 percent of investigations were not performed within statutory timeframes. In addition, OSHA did not adequately and timely communicate the violations alleged by whistleblowers internally to OSHA's enforcement units or externally to other federal agencies with jurisdiction to investigate the allegations.

## WHAT OIG RECOMMENDED

We made seven recommendations to the Assistant Secretary for Occupational Safety and Health to strengthen controls over whistleblower complaint reviews and improve communication internally with OSHA's enforcement units and externally with other federal agencies.

OSHA agreed with the recommendations and agreed more work can be done to continue to strengthen the whistleblower program. OSHA provided comments on a number of findings and did not fully concur with our estimate of incomplete investigations. However, nothing in its response changed our report.

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**U.S. Department of Labor**

Office of Inspector General
Washington, D.C. 20210

September 30, 2015

## INSPECTOR GENERAL'S REPORT

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The Occupational Safety and Health Administration's (OSHA) Whistleblower Protection Programs (Whistleblower Programs) enforce 22 whistleblower statutes. These statutes prohibit employers from retaliating against their employees for exercising their rights to report violations of various workplace safety, consumer product, environmental, financial reform, and securities laws. OSHA investigates complaints of discriminatory actions taken against employees who "blow the whistle" under any of these statutes.

The Office of Inspector General (OIG) conducted this audit to see what improvements have been made to the Whistleblower Programs since our 2010 report and the Government Accountability Office's (GAO) March 2014 report. In 2010, OIG issued a report titled, *Complainants Did Not Always Receive Appropriate Investigations under the Whistleblower Protection Program* (Report Number 02-10-202-10-105). In that report, OIG found approximately 80 percent of applicable investigations for three statutes did not meet one or more of the eight elements from the Whistleblower Investigations Manual (manual) that were essential to the investigative process. Furthermore, GAO's March 2014 report titled, *Whistleblower Protection Program: Opportunities Exist for OSHA and DOT (Department of Transportation) to Strengthen Collaborative Mechanisms* (GAO-14-286), concluded OSHA interagency collaborative mechanisms could be strengthened.

We conducted this audit to determine the following:

Did OSHA improve the administration of its Whistleblower Programs?

## RESULTS IN BRIEF

**OSHA has improved administration of its Whistleblower Programs. However, opportunities exist for OSHA to further strengthen the Whistleblower Programs to ensure complainants are protected as intended under the various Whistleblower Protection statutes. We found 18 percent of whistleblower reviews did not meet 1**

**or more of the 7 essential elements for conducting a complaint review specified by the manual. Moreover, OSHA did not ensure its manual and training reflected the most recent program updates and changing priorities, and 72 percent of investigations were not performed within statutory timeframes. In addition, OSHA did not adequately and timely communicate the violations alleged by whistleblowers internally to OSHA's enforcement units or externally to other federal agencies with jurisdiction to investigate the allegations.**

## BACKGROUND

OSHA was established after the passage of the Occupational Safety and Health (OSH) Act of 1970. It was created to ensure safe and healthy conditions for working men and women. Section 11(c) of that act prohibits anyone from discharging or discriminating against any private sector employee because that employee filed a complaint related to the act. Section 11(c) also allows these employees to file a complaint with the Secretary of Labor alleging such discrimination.

OSHA was initially responsible for investigating whistleblower allegations under only the OSH Act. Between 1983 and 2010, OSHA was assigned whistleblower provisions under 16 additional statutes. After the OIG 2010 report, Congress made OSHA responsible for investigating whistleblower complaints under the following additional statutes:

- Affordable Care Act;
- The Consumer Financial Protection Act of 2010;
- Seaman's Protection Act;
- Food Safety Modernization Act; and
- Moving Ahead for Progress in the 21st Century Act.

Currently, OSHA is responsible for investigating discrimination complaints under 22 statutes, the basic provisions of which are administered by 9 different federal agencies.

Since our last audit, OSHA stated it has made strengthening the Whistleblower Programs a top priority. The agency said it has successfully reinvigorated the programs by elevating them to a stand-alone Directorate, increasing staff, restructuring regional Whistleblower Programs, and enhancing training.

## RESULTS

OSHA has improved the administration of its Whistleblower Programs. The number of whistleblower reviews by investigators that did not meet the essential elements dropped from approximately 80 percent in 2009, to 18 percent during the period covered by this audit (October 1, 2012 through March 31, 2014). However, opportunities exist for OSHA to further strengthen the administration of its Whistleblower Programs to ensure reviews of whistleblower complaints are complete, adequate, and meet statutory timeframes.

Furthermore, OSHA needs to strengthen communication with federal agencies with jurisdiction to investigate whistleblowers' alleged violations of safety, consumer product, environmental, financial reform, and securities laws to determine if violations of these laws occurred.

## OPPORTUNITIES EXIST FOR OSHA TO FURTHER STRENGTHEN THE ADMINISTRATION OF ITS WHISTLEBLOWER PROGRAMS EVEN AFTER IMPROVEMENTS WERE MADE

OSHA did not ensure complaint reviews under the Whistleblower Programs were complete, sufficient, and timely. Specifically, 18 percent of sampled whistleblower reviews did not meet 1 or more of 7 essential elements detailed in the manual. Furthermore, training and guidance provided to investigators were not sufficient, and 72 percent of sampled investigations were not performed within statutory timeframes.

### OSHA WHISTLEBLOWER COMPLAINT REVIEWS WERE NOT COMPLETE

Eighteen percent of sampled whistleblower complaint reviews were not complete, as one or more of the essential elements for conducting a whistleblower review were not performed. This occurred because OSHA National Office did not perform reviews of the Whistleblower Programs or implement performance measures to ensure reviews were completed according to policy. We estimated at least 957 complainants (with a 95 percent confidence level) may not have received complete reviews.

The manual 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 manual and confirmation from OSHA officials, we identified seven essential elements for reviewing a whistleblower complaint. These essential elements are steps required for: 1) gaining information from 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 the complainant about the decision of the case and rights to appeal.

We reviewed 132 randomly sampled complaints. Of these, 24 (18 percent) had not met at least 1 of the essential elements for conducting a whistleblower review. Although this was an improvement from the 80 percent non-compliance rate noted in OIG's 2010 report, we estimate at least 957 complainants may not have received complete reviews. Table 1 shows the results of the seven essential elements for reviewing a whistleblower complaint.

**Table 1: Results of the Seven Essential Elements for Reviewing a Whistleblower Complaint** (See Exhibit for a detailed description of the exceptions)

| Element | Exceptions[1] | Applicable Cases | Error Rate |
|---|---|---|---|
| **Elements Pertaining to Contacting Key Individuals (Elements 1-3)** | | | |
| 1. Contact with Complainant | 11 | 132 | 8% |
| 2. Contact with Respondent | 7 | 60 | 12% |
| 3. Identify and Contact Witnesses | 7 | 33 | 21% |
| *Complaints with at Least One External Communication Exception* | **14** | **132** | **11%** |
| **All Other Elements (Elements 4-7)** | | | |
| 4. Prima Facie Elements Addressed | 7 | 98 | 7% |
| 5. Supervisory Review[2] | 12 | 130 | 9% |
| 6. Notification of Final Decision | 1 | 130 | 1% |
| 7. Notification of Appeal Rights | 4 | 89 | 4% |
| *Complaints with at Least One Other Element Exception* | **19** | **132** | **14%** |
| **Complaints with at least one error** | **24** | **132** | **18%** |

Fourteen of the 24 sampled reviews contained exceptions for at least one element pertaining to external communication that is necessary to gather facts and evidence. In these instances, investigators did not: a) contact the complainant when additional information was needed; b) allow the complainant the required time for providing evidence; or c) contact witnesses identified by the complainant. The manual stresses the importance of communicating with all relevant parties to obtain essential information needed to make a determination.

In addition, OIG received and analyzed 12 hotline complaints from whistleblowers about how OSHA handled their cases. For seven of these complaints, the complainants alleged investigators were either difficult to speak with, did not deliver all necessary documents to the complainant, or the investigator rushed the investigation. Our analysis of the complaints revealed a predominant theme of insufficient communication and customer service, which was consistent with our audit results.

OMB Circular A-123 states, “monitoring the effectiveness of internal control should occur in the normal course of business.” The 10 Regional Administrators have overall responsibility for whistleblower investigations, while the Directorate of Evaluation and Analysis, through its Management Accountability Program, assesses the efficiency and effectiveness of regional activities, including the Whistleblower Programs.

[1] There were 24 cases that had at least one exception. Some cases had more than one exception. Therefore, the number of complaints with at least one exception will be less than the total number of exceptions. Exceptions were only noted based on OSHA’s level of effort on the complaint until final disposition.

[2] In 12 of 130 applicable investigations (9 percent), there was no evidence that required supervisory reviews occurred to ensure technical accuracy, thoroughness, and completeness. For seven of these cases, it was the supervisory investigator that conducted the investigation, where a third-party review of the work was not performed.

OSHA's Management Accountability Program requires the Directorate of Evaluation and Analysis to conduct comprehensive, on-site, self-reviews of regional office activities at least once every four years. However, interviews with the Directorate of Evaluation and Analysis staff revealed only two regional comprehensive reports included a review of the Whistleblower Programs since 2011. When conducting these reviews, OSHA officials interviewed Regional officials to determine whether whistleblower procedures were being followed, but did not assess whether complainant reviews were complete. In addition, OSHA developed and disseminated a draft checklist to assist supervisors in determining if investigators completed steps and collected documentation to support determinations. However, the tool was not used by the regional staff during the period covered by our audit because they did not believe it was required. OSHA officials stated on June 1, 2015, the tool was reissued to clarify that it should be used when conducting case file reviews when performing reviews of Whistleblower Programs.

Moreover, OSHA did not implement performance measures or indicators for the Whistleblower Programs as it had agreed to in response to recommendations from the prior OIG report. In that report, the OIG reported 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* define the minimum level of quality acceptable for internal control in government. These standards state, "activities need to be established to monitor performance measures and indicators…Internal control monitoring should assess the quality of performance over time."

In its FY 2013 Operating Plan, OSHA established two qualitative, informational measures for the percentage of whistleblower cases completed in compliance with technical requirements and substantive requirements. However, the measures were not implemented. Therefore, the quality of the investigations remains uncertain as investigators skipped key investigative steps.

## OSHA WHISTLEBLOWER GUIDANCE AND TRAINING WERE NOT SUFFICIENT

OSHA did not ensure the whistleblower manual and training reflected the most recent program updates and changing priorities. This created inconsistencies in how regions conducted investigations and may have impacted the quality of those investigations.

### *OSHA DID NOT PROVIDE INVESTIGATORS A CURRENT MANUAL OR PROCEDURES*

OSHA updated its WPP Manual in September 2011.[3] Since then, OSHA updated some practices and priorities, but did ensure the manual kept pace with current whistleblower

[3] Chapter 6 - Remedies and Settlements, was added to the manual in April 2015, after the audit period, and did not change any of the reported audit results.

investigative practices. Specifically, OSHA did not include specific requirements for five statutes, procedures for certain cases to be opened and dismissed simultaneously, and policy to simplify investigative approaches.

Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*, Section C, Control Activities, states, "control activities include policies, procedures and mechanisms in place to help ensure that agency objectives are met."

The manual did not outline the specific requirements for the five most recent statutes. Each statute provides specific procedures for investigating complaints that are often unique to the statute. Some are more complex in nature than others. The manual did not address the level of investigations needed for all statutes. Specifically, OSHA had no official directive to provide guidance on 5 of the 22 whistleblower statutes[4] that it has been tasked to enforce. These statutes represented 9 percent of the 1,928 non-OSH Act-related cases closed by investigators during the audit period.

Moreover, our review of sampled Whistleblower cases revealed four occurrences in which investigators followed established practices that contradicted guidance provided in the manual and guidance memoranda. An investigator, upon receipt of a case, may recommend either closing and/or rejecting a case that appears to be without merit; however, the complainant has the right to refuse this recommendation and proceed with a full investigation. If the complainant chose to proceed with the investigation, OSHA's practice was to simultaneously docket (open) and dismiss the investigation – treating both phases of the investigation as one step. However, OSHA's guidance, in these circumstances, made it clear that docketing and dismissal processes were two distinct investigative steps, requiring the investigator to notify the various parties of their rights and responsibilities for each step. OSHA's practice, in these circumstances, may serve as a valuable tool to avoid pursuing claims that appear frivolous, but it should be made clear to investigators through policy, guidance, and training when and how certain investigative processes can be separated, combined, or omitted. By doing so, OSHA will ensure greater consistency and quality among regions.

OSHA officials stated stakeholders increasingly pressured the agency to reduce the backlog of whistleblower investigations. To simplify the investigation process, since 2011 OSHA issued the policies listed below; however, the policies did not contain guidance on when and how to use the simplified investigation approach.

1. Policy memorandum, "Revised Whistleblower Disposition Procedures", issued April 18, 2012, which reduced the need for the Reports of Investigations and Secretary's Findings for settlements and withdrawals; and,

[4] The five statutes are: 1) Affordable Care Act (ACA); (2) The 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).

2. Directive CPL 02-03-004, "Section 11(c), AHERA, and ISCA Appeals Program", issued September 12, 2012, which overhauled the appeal procedures for these 3 statutes.

### *OSHA COULD IMPROVE TRAINING TO INVESTIGATORS*

Standardized training for investigators did not sufficiently focus on investigator training needs and priorities. In addition, OSHA conducted a survey in which managers were "uniform in agreement that investigators need more training to perform their jobs more effectively." Currently, whistleblower investigators must take two courses: (1) OSHA 1420, Basic Whistleblower Investigation; and (2) OSHA 1460, Advanced Whistleblower Investigations. However, when interviewed, some whistleblower investigators stated the current curriculum is not sufficient. During fieldwork interviews, investigators stated settlement, negotiation/mediation, and interviewing skills are critical to job performance and training in these areas would be helpful. This was consistent with the OSHA survey that reported the Basic Whistleblower course was either inadequate to prepare them as investigators or in some cases too basic, while the Advanced Whistleblower course was too rushed and should be expanded to review all statutes in depth as some statutes are more complex.

The absence of an official training directive for Whistleblower Programs combined with the complex statutes, policies, and procedures creates an environment in which guidance is lacking, changing, and often contradictory. OSHA stated it expects to complete its development of four new courses that focus on these specific areas: 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.

## OSHA DID NOT PERFORM WHISTLEBLOWER INVESTIGATIONS WITHIN STATUTORY TIMEFRAMES

OSHA did not consistently conduct investigations within the statutory timeframes. Between October 1, 2012, and March 3, 2014, OSHA received 9,151 complaints, of which 4,475 were classified as investigations. For the 4,475 investigations, OSHA would have to make a determination within the 30, 60, or 90-day timeframe specified by the applicable statute. However, OSHA's data showed 3,206 (72 percent) exceeded statutory timeframes by an average of 163 days. These investigations took an average of 238 days to complete, which was an increase from the 150 days reported by the OIG in 2010. Table 2 shows full investigations exceeding statutory timeframes.

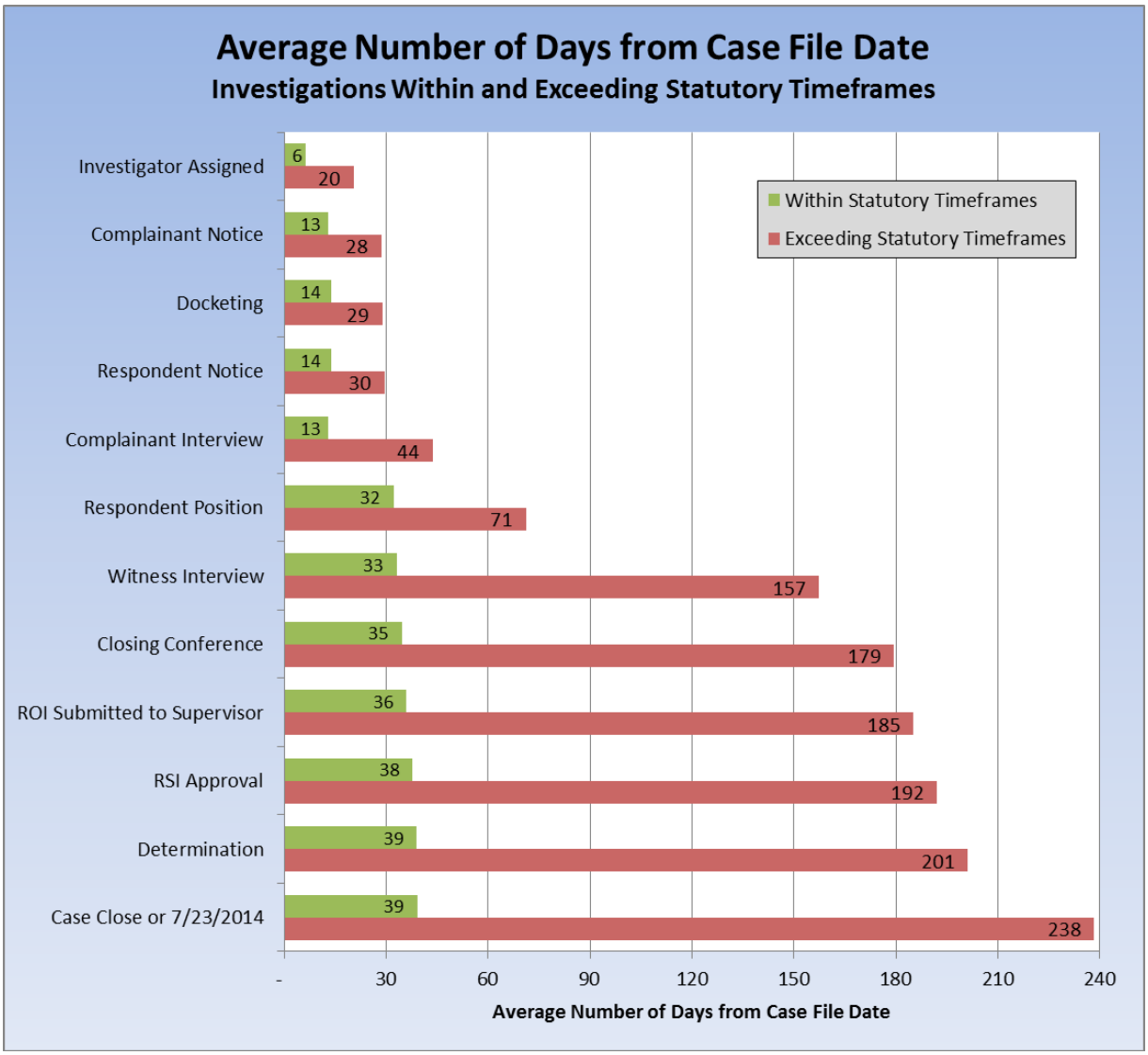
**Table 2: Full Investigations Exceeding Statutory Timeframes**

| Statute Timeframes | Within Statutory Timeframes | Exceeding Statutory Timeframes | Total Investigations | Average Days Exceeding Statutory Timeframes |
|---|---|---|---|---|
| 30 Days | 21 | 153 | 174 | 212 |
| 60 Days | 402 | 1,345 | 1,747 | 180 |
| 90 Days | 846 | 1,708 | 2,554 | 146 |
| Total | 1,269 | 3,206 | 4,475 | 163 |

Of the 3,206 investigations, 1,116 were still pending a determination as of July 23, 2014, an average of 307 days from when the complaint was filed, which was 3 to 10 times more than the time allotted for the investigation. Cases were exceeding statutory timeframes and taking longer to complete. Therefore, if a case was found to have merit, complainants who lost employment because of a complaint filed against an employer would have experienced longer periods of lost wages and unemployment while they waited for OSHA to make a determination.

An analysis of the investigations identified reasons for OSHA's inability to perform investigations within statutory timeframes. Specifically, delays in assigning complaints to the investigators and time taken to contact complainants hinder the ability to perform investigations within statutory timeframes. OSHA officials stated, as a standard practice, investigators were to contact complainants within 5 days after the complaint was filed. However, investigations that exceeded statutory timeframes averaged 20 days for assigning a complaint to an investigator. Other than contacting complainants, OSHA did not establish standards for completing investigative steps. Chart 1 shows the average number of days that investigative activities took from the day the complaint was filed.

**Chart 1: Average Number of Days to Complete Investigation Steps from Case File Date**




Investigations were not completed within statutory timeframes because OSHA did not establish goals to complete investigations within the 30, 60, or 90-day timeframes established by statutes. For FY 2016, OSHA established the goal of completing investigations within 360 days. OSHA officials believe the timeframes are not legal requirements and it does not have to establish goals to meet them. They also stated when investigations were brought before the courts, OSHA was not penalized for not making a determination within the timeframe.

## OSHA NEEDS TO STRENGTHEN COMMUNICATION WITH OTHER FEDERAL AGENCIES

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

agencies. While OSHA investigates whistleblower retaliation complaints for 22 statutes covering 9 federal agencies, it has enforcement responsibilities over employer violations of only 1 statute – the OSH Act. Collaboration is critical when meaningful results that the federal government seeks to achieve require the coordinated efforts of more than one federal agency. Whistleblower referrals served as one method in which federal agencies became aware of the alleged violations. Just as GAO reported in March 2014, OIG concluded OSHA interagency collaborative mechanisms could be strengthened.

During fieldwork interviews, DOT officials confirmed OSHA's system contained alleged DOT-related violations not received by DOT. In addition, review of DOT and Securities Exchange Commission (SEC) referrals provided to us revealed 23 percent of the alleged violations were not reported to the agency with jurisdiction to investigate such matters. In some instances, OSHA did not communicate the allegations because either the complainant resolved the whistleblower violation or the complainant expressed concerns with OSHA contacting the partner agency. However, OSHA should establish agreements with each partner agency on how to handle these cases to ensure all associated allegations are reviewed.

Furthermore, OSHA did not report alleged violations to other agencies in a timely manner. DOT officials stated untimely notification from OSHA hindered its ability to investigate the alleged associated violations. Review of referrals provided by DOT showed 60 complaints (32 percent) were not received in a timely manner. OSHA took an average of 197 days to report the alleged violations to DOT. There was one complaint that was filed on May 2010, but was not received by DOT until January 2013, approximately 960 days later.

Internally, OSHA's process to refer Whistleblower complaints was informal. OSHA officials stated staff responsible for enforcement activities generally received the initial claim so they would be aware of any alleged violations. However, OSHA could not provide reasonable assurance OSH Act allegations were reviewed by staff responsible for enforcement activities. During the review of the sampled regional complaints received, there were 31 OSH Act-related investigations, 10 of which did not have evidence of intra-agency notification.

This failure of notification occurred because OSHA did not establish a formal process and did not develop working relationships with agencies tasked with enforcement duties. The manual states investigations "may be disclosed to other federal agencies…if OSHA deems such disclosure to be compatible with the purpose for which the records were collected." By using the word "*may*," OSHA leaves it up to the individual investigator about whether or not to contact other federal agencies – an informal process. In addition, although OSHA is responsible for 22 different whistleblower statutes, it has established 10 Memoranda of Understanding with other federal agencies, resulting in coverage for less than half the statutes. These memoranda discuss the information to be provided, but do not specify when and how the information will be provided. With more complete and timely communication between OSHA and other federal agencies, the agencies and complainants would have greater assurance

that allegations of workplace safety, consumer product, environmental, financial reform, and securities laws were properly investigated.

## OIG RECOMMENDATIONS

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

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;

2. Develop and monitor specific performance measures or indicators to ensure Whistleblower Programs are working as intended;

3. Provide complete and unified guidance to ensure appropriate methods are used to close investigations;

4. Issue an updated manual and implement controls to ensure the manual will continue to be updated in a timely manner to reflect current policies, procedures, and statutes;

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;

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

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 violations.

## MANAGEMENT'S RESPONSE

The Assistant Secretary for Occupational Safety and Health agreed with all of the recommendations, and that more work can be done to continue to strengthen the whistleblower program. However, OSHA believes a number of the findings in the draft report are inaccurate or unsupported, and that the number of complaints having at least one error was overestimated. The comments provided by OSHA in response to the report were submitted during the audit and considered when preparing the report. Audit results were based on evidence obtained from OSHA and complaint cases.

Regarding areas of disagreement, OSHA stated OIG took exception to complaints where OSHA issued one comprehensive letter instead of issuing separate docketing/notification and Secretary's Findings letters. As stated in the report, there were four occurrences in our sample in which investigators followed established practices that contradicted guidance provided in the manual and memoranda. OSHA's practice, in these circumstances, may serve as a valuable tool to avoid pursuing claims that appear frivolous, but it should be made clear to investigators through policy, guidance, and training when and how certain investigative processes can be separated, combined, or omitted. Review of the case evidence revealed when OSHA combined the docket/dismiss procedures or did not demonstrate a third party review, complaints did not obtain a complete review. Examples included: 1) a complaint labeled as untimely, even though it was filed on time with another department; 2) prima facie elements were established, and additional work was performed, but OSHA claimed the docket/dismiss was used; and 3) a complainant that had to appeal to an Administrative Law Judge and ultimately obtain a settlement.

Moreover, OSHA disagreed with the processes OIG used to determine if OSHA adequately and timely shared relevant whistleblower complaints with its safety and health enforcement program or other federal agencies. However, OSHA did not provide evidence to support its claim. We used documentary and testimonial evidence provided by OSHA and DOT officials to reach our conclusions.

Management's response to our draft report is included in its entirety in Appendix B.

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 C.

Elliot P. Lewis
Assistant Inspector General
for Audit

# Exhibit

**Exhibit**

## Results Of Case File Testing

| ELEMENT / DESCRIPTION OF EXCEPTION | | COUNT |
|---|---|---|
| **1 – CONTACT WITH COMPLAINANT** | | |
| | Docket/dismiss procedures did not comply with manual's notification requirement | 4 |
| | Requisite certified return/receipt letter, requesting a response within 10 days not sent | 3 |
| | Docket notification letter not sent to complainant | 2 |
| | Investigator contacted respondent prior to obtaining concurrence from complainant that the case would proceed; subsequently the complainant withdrew | 1 |
| | Investigator did not follow up with complainant when additional facts were identified | 1 |
| | **Sub-total** | **11** |
| **2 – CONTACT WITH RESPONDENT** | | |
| | Docket/dismiss procedures did not comply with manual's notification requirement | 4 |
| | Docket notification letter not sent to respondent | 2 |
| | Investigator contacted respondent prior to obtaining concurrence from complainant that the case would proceed; subsequently the complainant withdrew | 1 |
| | **Sub-total** | **7** |
| **3 – IDENTIFY AND CONTACT WITNESSES** | | |
| | An interview was not attempted with witness(es) identified by the complainant | 4 |
| | Complainant was not sent the requisite certified return/receipt letter requesting a response within 10 days, and resulted in the complainant being denied due process rights in disclosing witnesses | 1 |
| | Case dismissed as untimely, even though equitable tolling provision (acceptable reasons for late filing) applied – causing an environment where complainant was denied due process rights in disclosing witness(es) to investigator | 1 |
| | Investigator contacted respondent prior to obtaining concurrence from complainant that the case would proceed; subsequently, complainant withdrew and was denied due process rights in disclosing witness(es) to investigator | 1 |
| | **Sub-total** | **7** |
| **4 – PRIMA FACIE ELEMENTS ADDRESSED** | | |
| | Complainant was not sent the requisite certified return/receipt letter, requesting a response within 10 days – causing an environment where complainant was denied due process rights of having all applicable, prima facie elements investigated | 4 |
| | Applicable, prima facie elements were not addressed during the investigation | 1 |
| | Case dismissed as untimely even though equitable tolling provision (acceptable reasons for late filing) applied – causing an environment where complainant was denied due process rights of having all applicable, prima facie elements investigated | 1 |
| | Investigator contacted respondent prior to obtaining concurrence from complainant that the case would continue; subsequently, the complainant withdrew and was denied due process rights of having, all applicable, prima facie elements investigated. | 1 |
| | **Sub-total** | **7** |
| **5 – SUPERVISORY REVIEW** | | |
| | Supervisor was the investigator and investigative results were not reviewed | 7 |
| | Investigative results were not reviewed | 5 |
| | **Sub-total** | **12** |
| **6 – NOTIFICATION OF FINAL DECISION** | | |
| | Notification of the investigation's final decision was not documented | **1** |
| **7 – NOTIFICATION OF APPEAL RIGHTS** | | |
| | The complainant withdrew, but there was no evidence that the investigator informed the complainant that their appeal rights would be relinquished | 3 |
| | The complaint was administratively closed, but there was no evidence that the investigator informed the complainant that their appeal rights would be relinquished | 1 |
| | **Sub-total** | **4** |
| **TOTAL** | | **49** |

# Appendices

## Appendix A

## Objectives, Scope, Methodology, and Criteria

### Objective

The objective of the audit was to determine the following:

Did OSHA improve the administration of its Whistleblower Programs?

### Scope

The audit covered 9,151 whistleblower complaints received between October 1, 2012, and March 31, 2014. Fieldwork was conducted at OSHA headquarters in Washington, DC, and three statistically selected regional offices: New York, Atlanta, and Dallas that were responsible for 4,116 (45 percent) of whistleblower complaints received. We tested a stratified statistical sample of 132 whistleblower complaints from four groups: OSHA, DOT, SEC, and other federal agencies. We reviewed laws, policies, procedures, documents, reports, referrals, OSHA management information system data, and OIG hotline complaints. We also interviewed national and regional OSHA officials and staff, and SEC and DOT officials.

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.

### Methodology

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.

*Sampling*

For testing of OSHA's complaint review process, we determined an overall universe of 9,151 whistleblower complaints filed with OSHA between October 1, 2012, and March 31, 2014. Since the audit objective required that we assess the completeness of the whistleblower complaint review process, the sampling universe included only closed complaints. From the 9,151 complaints, we determined that as of July 23, 2014, the date of receipt of OSHA's data, there were 8,035 complaint reviews completed – 4,676 complaints were administratively closed and 3,359 were fully investigated. From these complaints, we used a stratified, two-stage cluster random sampling plan for sample selection. OSHA's 10 regions were stratified into 3 different strata according to their

share of closed complaints and 3 regions were randomly selected, 1 from each strata. From the sampled regions, we selected a statistical sample of 132 closed complaints.

For review of the communication with other federal agencies, we used a non-statistical sample selection from OSHA Directorate of Enforcement, DOT, and SEC during the planning phase to assess the level of communication as the three agencies represented 90 percent of the total whistleblower complaints reported during FY 2011-FY2013. We compared complaints recorded in OSHA's database with complaints recorded by DOT and SEC. We determined there were 966 complaints related to DOT and SEC statutes. A comparison of OSHA enforcement-recorded complaints was not performed because OSHA did not maintain records of internal referrals.

To test the complainant review process for compliance with OSHA's policies and procedures, we identified seven elements from the manual as essential, and determined if each of the elements were performed during the complaint review. Officials from the Directorate of Whistleblower Protection Programs concurred these seven elements were essential. We also tested one attribute related to inter-agency communication of violations. Documents reviewed as part of the analysis included official correspondence, investigative reports, phone/contact logs, investigator notes, memos-to-file, complainant statements, witness statements, employer position statements, screening/intake forms, and questionnaires.

To test for coordination with other federal agencies, we reviewed the manual to determine the requirements. We interviewed OSHA Directorate of Enforcement, DOT and SEC officials to assess the working relationship with the OSHA Directorate of Whistleblower Protection Programs. We compared OSHA data with DOT and SEC data.

To gain an understanding of OSHA's internal controls over the Whistleblower Programs, we reviewed the manual and interviewed OSHA personnel at the national and regional levels.

**Criteria**

- Office of Management and Budget Circular A-123, Management's Responsibility for Internal Control

- The Occupational Safety and Health Act of 1970, Section 11 (c)

- 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

## Appendix B

## Management Response to Draft Report

**U.S. Department of Labor**

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

SEP 28 2015

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

FROM: DAVID MICHAELS, PhD, MPH

SUBJECT: Response to OIG's Draft Report No. 02-15-202-10-105, "OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs"

This memorandum is in response to your September 8, 2015, transmittal of the Office of the Inspector General (OIG) Audit Report No. 02-15-202-10-105, "OSHA Needs to Continue to Strengthen Its Whistleblower Protection Programs." OSHA appreciates this opportunity to provide comments on the findings and recommendations in your draft report.

Strengthening the Whistleblower Protection Program continues to be one of OSHA's top priorities, and OSHA appreciates the OIG's recognition that significant improvements have been made since the OIG's last audit in 2010. In particular, the OIG's conclusion that OSHA has reduced its error rate from four out of every five cases in 2010 (80%), to less than one in five cases in the current audit (18%), represents a dramatic improvement in complaint investigations that has resulted from OSHA's sustained effort and significant organizational reforms in the intervening five years.

As noted in the draft report, OSHA has reinvigorated the whistleblower program since 2010. Some of the changes OSHA made include elevating the program to a stand-alone Directorate, increasing staff, restructuring regional whistleblower programs, and enhancing whistleblower training. Additionally, OSHA has streamlined its paperwork procedures, issued new guidance to investigative staff, published numerous procedural regulations, strengthened our collaborative relationships with our partner agencies, developed new customer service and outreach tools, and much more. Despite growing caseloads and limited resources with which to handle them, OSHA's internal improvement efforts have helped gradually reduce investigative lapse times and backlogs of pending investigations while enhancing the quality of investigations.

The OIG draft report identifies several areas for further improvement, and OSHA agrees that more work can be done and is committed to continuing to strengthen the whistleblower program. We do, however, believe that a number of the findings in the draft report are inaccurate or unsupported. Responses to each of the recommendations, including those concerns, are detailed below.

*1. Complete and Sufficient Complaint Reviews*

As noted, the OIG's conclusion that 18% of whistleblower reviews were partially incomplete is a significant improvement over the OIG's 2010 findings, which showed an estimated 80% non-compliance rate. Of course, OSHA strives for a zero percent incomplete rate, and we appreciate the OIG's suggestions for continued improvement. However, OSHA's review of each complaint identified by the OIG as having at least one error makes clear that the OIG overestimated the rate of incomplete investigations. In some cases there seems to be confusion in how the OIG has interpreted OSHA's policies, procedures, and practices resulting in cases being misidentified as deficient. For example:

- **OSHA's Docket/Dismiss Procedures**: The OIG identified exceptions in several complaints where OSHA issued one comprehensive letter instead of both a docketing/notification letter and a Secretary's Findings letter. This long standing practice, however, is consistent with the "docket and dismiss" procedure outlined in the Whistleblower Investigations Manual (WIM)[1], and should not be considered an incomplete complaint review. The "docket and dismiss" procedure occurs in instances[2] where OSHA must terminate a case because it was not timely filed, does not fall within OSHA's jurisdiction, or lacks a prima facie allegation of whistleblower retaliation. In these cases, OSHA sends one letter (Secretary's Findings) to the parties indicating both that the case has been docketed, and then dismissed with appeal rights. In cases where an investigation actually takes place, but is later dismissed, OSHA will send two separate letters – a docketing/notification letter and a later dismissal letter (Secretary's Findings with appeal rights). The OIG expected that even when the "docket and dismiss" procedure was appropriate, investigators should still send the parties both letters. OSHA does not believe that sending both letters in "docket and dismiss" cases is required by the WIM and sending separate letters would add unnecessary burden and delay to an already resource-constrained program.

- **Supervisory Review**: In addition, the draft report concludes that about 9% of the sampled cases were incomplete because OSHA did not document supervisory review of the investigation. In more than half of these cases, however, "investigation" refers to a complaint that was closed at the initial screening phase by the supervisor, and OSHA does not believe that the WIM requires separate supervisory review of a supervisor's decision to administratively close or docket-and-dismiss a complaint after personally screening it[3]. Each of the cases that the draft report identifies as incomplete on this basis was either administratively closed or "docketed and dismissed" without an investigation.

[1] WIM states for OSHA, AHERA, and ISCA cases: "…if the complainant refuses to accept this determination [administrative closure], the case must be docketed and dismissed with appeal rights." Also, for all other cases, the WIM states "Complaints filed under these statutes must be docketed and a written determination issued, unless the complainant, having received an explanation of the situation, withdraws the complaint."

[2] Nineteen statutes require OSHA to docket all complaints. The three remaining statutes (section 11(c) of the OSH Act, the Asbestos Hazard Emergency Response Act, and the International Safe Container Act) allow for an administrative closure without docketing provided OSHA obtains the complainant's consent, otherwise they too must be docketed and dismissed.

Although the WIM states that, for administrative closure cases, "the investigator must draft a letter to the complainant explaining the reason(s) the complaint is not going to be investigated and send it to the supervisor for concurrence," the WIM does *not* require a third-party review if the supervisor is the screener of the complaint. Rather, the WIM and long-standing agency practice give the supervisor the authority to decide whether or not a complaint contains the basic elements necessary to conduct an investigation. It is more appropriate and effective for the agency to use its auditing and monitoring processes to periodically review the handling of docket and dismiss cases.

***2. Whistleblower Guidance and Training***

The draft report concludes that OSHA's whistleblower guidance is insufficient because the WIM has not been fully updated since 2011.

As OSHA explained to the OIG during its review, the WIM is not an exclusive source of policies and procedures, and full rewrites of the WIM are not the only means for OSHA to communicate updated information to whistleblower program staff. As fully updating the WIM is a lengthy process, OSHA makes periodic partial updates of the WIM – the most recent of which was completed in April 2015 – to reflect updates in program, policies, and procedures. OSHA also publishes new policies and procedures through other means, such as OSHA's procedural and interpretive regulations under each whistleblower statute, and policy guidance memos.[4] OSHA also has distributed desk aids that provide a quick reference on a variety of topics. These materials collectively ensure that investigators are fully updated on new investigative practices and procedures.

The OIG draft report incorrectly states that "OSHA had no official directive to provide guidance on 5 of the 22 whistleblower statutes that it has been tasked to enforce." In fact, OSHA has published interim final rules in the *Federal Register* that articulate the procedures for handling complaints under four of these five statutes,[5] and an initial rulemaking publication for the fifth statute (the Moving Ahead for Progress in the 21st Century Act (MAP-21)) is scheduled for later this year. And, although no final rule has been published to establish procedures specific to MAP-21, OSHA has published guidance instructing its staff to follow the investigative procedures for the Consumer Product Safety Improvement Act (CPSIA), which has similar requirements.[6] Hence, at no time was staff left without specific guidance on how to investigate

[4] OSHA's regulations, directives, and memoranda are publicly available at http://www.whistleblowers.gov/regulations_page.html.

[5] *See* Interim Final Rule, Procedures for Handling Retaliation Complaints Under the Employee Protection Provision of the Consumer Financial Protection Act of 2010, 79 Fed. Reg. 18,630 (Apr. 3, 2014); Interim Final Rule, Procedures for Handling Retaliation Complaints under Section 402 of the FDA Food Safety Modernization Act, 79 Fed. Reg. 8,619 (Feb. 13, 2014); Interim Final Rule, Procedures for Handling Retaliation Complaints Under Section 1558 of the Affordable Care Act, 78 Fed. Reg. 13,222 (Feb. 27, 2013); Interim Final Rule, Procedures for Handling Retaliation Complaints under the Employee Protection Provision of the Seaman's Protection Act, as amended, 78 Fed. Reg. 8,390 (Feb. 6, 2013).

[6] OSHA made its notification that the procedures regarding the CPSIA are controlling until MAP-21 is published was made publicly available at http://www.whistleblowers.gov/regulations_page.html.

all statutes administered by OSHA. OSHA will continue to provide supplementary training opportunities, including topic-specific webinars, as priorities dictate and resources allow.[7]

Finally, OSHA has taken significant steps towards completing a comprehensive training curriculum and overhauling and expanding its internal training offerings for whistleblower investigative staff. OSHA staff has dedicated significant time to designing improved training courses, and OSHA created a new position in 2015 for a full-time instructor who is a whistleblower subject matter expert.

***3. Timeliness of OSHA Whistleblower Investigations***

The draft report notes that OSHA is not always able to meet statutory timeframes for completing whistleblower investigations. Although OSHA agrees that it should continue to improve the timeliness of investigations, OSHA notes that the OIG's discussion omits two important considerations. First, the timeframe of the OIG audit coincided with a spike in newly-filed whistleblower claims to a historic peak, due in part to congressional enactment of new statutes and amendments to an existing statute. OSHA nevertheless was able to reduce both its backlog of pending cases and the average time taken to issue a merit determination every year since 2012.

In addition, OSHA recently implemented an Alternative Dispute Resolution (ADR) process for whistleblower cases that OSHA believes will continue to reduce investigation times and improve outcomes for complainants. The ADR process was piloted in two regions, which resulted in a significant increase in the settlement rate for both regions as well as providing significant savings in time and costs. In light of the positive results obtained during the pilot period, the program was expanded in August 2015 to provide all regions with the opportunity to implement an ADR program.

***4. Communication with Other Federal Agencies***

The draft report concludes that OSHA should strengthen its referral procedures to ensure that relevant enforcement agencies are advised of the underlying workplace safety violations alleged in whistleblower complaints. Although OSHA agrees that strong collaboration with federal agency partners is critical, OSHA disagrees with the processes used by the OIG to determine whether the agency adequately and timely shared relevant whistleblower complaints with its safety and health enforcement program or other federal agencies.

- **Internal referrals to the enforcement program:** Although some Section 11(c) cases were not referred to OSHA's safety/health enforcement team, OSHA policy states that the decision to make an 11(c) referral depends on the investigative team's assessment of the hazards alleged in the complaint.

[7] Regarding the OIG's observation that "the manual did not outline the specific requirements for the five most recent statutes," OSHA has determined that statute-specific chapters published in the WIM are duplicative of the procedural regulations already established under the Code of Federal Regulations (CFR). In fact, OSHA plans to remove all statute-specific chapters from the WIM.

- **Referrals to Other Federal Agencies:** The OIG relied on inaccurate data to determine the timeliness measurements and the frequency with which OSHA failed to share copies of complaints in accordance with our policies and procedures. The OIG based its analysis on the other agencies' databases, rather than the inter-agency correspondence in OSHA's case files. Also, OSHA is allowed to use its discretion in deciding which complaints to refer to partner agencies. In some cases that the OIG identified as failing to share complaints, the complainant requested that the complaint not be referred, fearing further retaliation or potential negative impact to on-going settlement negotiations between the parties. In other cases, the complaint was withdrawn by the complainant prior to docketing it for investigation. As a result, there was no need to refer the case.

**RECOMMENDATIONS**

**Recommendation 1: Monitor the Whistleblower Programs to routinely assess the efficiency and effectiveness of the program, and finalize and implement the draft checklist to assist in determining if investigators completed steps and collected documentation to support determinations.**

**OSHA Response:** OSHA agrees with the recommendation and will continue to monitor the Whistleblower Program to routinely assess the efficiency and effectiveness of the program.

OSHA currently monitors its Whistleblower Protection Program through several mechanisms, including monitoring of statistical performance metrics, the Management Accountability Program, and the Section 11(c), AHERA, and ISCA Appeals Program. Additionally, OSHA issued the first Quality Review Tool (referenced in the OIG's report as the draft checklist) in June 2014 to all ten regions. In June 2015, OSHA reissued it to the field to clarify that it is to be used when conducting reviews on whistleblower case files during focused audits of regional whistleblower programs, and may also be used during routine investigative oversight reviews.

**Recommendation 2: Develop and monitor specific performance measures or indicators to ensure Whistleblower Programs are working as intended.**

**OSHA Response:** OSHA has substantially improved its performance monitoring and agrees to continue its efforts to satisfy this recommendation. OSHA has already added two performance measures to the Department's 2014-2018 Strategic Plan, which measure the timeliness of the screening and investigative processes. OSHA has also established a group of core whistleblower performance measures for monitoring investigation timeliness and outcome trends, and routinely disseminates a package of statistical management reports to regional programs on a quarterly basis to provide up-to-date statistics on the program's performance.

**Recommendation 3: Provide complete and unified guidance to ensure appropriate methods are used to close investigations.**

**OSHA Response:** OSHA agrees to continue clarifying our procedures for closing complaints and investigations. OSHA has made progress in this area and will continue to improve upon these enhancements to ensure greater compliance with prescribed instructions and consistency among the regions.

**Recommendation 4: Issue an updated manual 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:** OSHA will continue to update the WIM on a periodic basis to incorporate changes to policies, procedures, and applicable law, and will establish controls to ensure that WIM updates proceed as planned. In addition, OSHA will continue to employ additional means to disseminate policy to keep staff apprised of changes to policies, procedures, and case law. Vehicles for sharing this information include policy memoranda, procedural regulations, and desk aids which can be issued on a timelier basis than manual updates.

**Recommendation 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.**

**OSHA Response:** OSHA agrees with this recommendation.

**Recommendation 6: Develop and implement a process to ensure that reasonable balance is applied between the quality and timeliness to complete investigations within statutory timeframes.**

**OSHA Response:** 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.[8]

Regarding resource issues, OSHA notes that although the agency has added more than 35 FTE to the whistleblower program since 2009, the number of new complaints filed with the agency has steadily increased by 58% from 1,934 in 2005 to 3,060 in FY 2014. Consequently, 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.[9]

**Recommendation 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 violations.**

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[8] *See, e.g., Roadway Express, Inc. v. Dole*, 929 F.2d 1060, 1066 (5th Cir. 1991).

[9] OSHA notes that a January 2012 OIG report ("Federally Operated Whistleblower Protection Program Cost", Report No. 22-12-014-10-105) found that reducing whistleblower investigative caseloads to 6-8 cases per investigator would require resources for 49-58 additional investigators, assuming that OSHA would continue to receive the same number of new cases that it received in FY 2011. Since that time, staff has grown slowly, while the number of new investigations has increased substantially. Consequently, whistleblower investigators currently carry an average of 23 pending investigations.

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**OSHA Response:** OSHA has made measurable progress in establishing collaborative working relationships with its partner agencies and will continue to coordinate with partner agencies to ensure that complaints filed with OSHA are timely provided to partner agencies.

**Appendix C**

## Acknowledgements

Key contributors to this report were Mark Schwartz, Rebecca Bowen, Renata Hobbs, Reza Noorani, Sheila Lay, and Mary Lou Casazza

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