U.S. Department of Labor Occupational Safety and Health Administration

OSHA's Whistleblower Protection Program Review

Findings and Recommendations

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Executive Summary

In April 2010, Assistant Secretary David Michaels and Deputy Assistant Secretary Richard Fairfax of the Occupational Safety and Health Administration (OSHA) created a whistleblower program review team ("the team"). The team was directed to conduct a "top to bottom" review of the whistleblower program and to make recommendations to the Assistant Secretary for improving the program.

Summary of the Report and Recommendations

Overall, the team found significant deficiencies and challenges facing OSHA's whistleblower protection program. The team believes that the program is staffed with many hard working and dedicated employees making every effort to successfully accomplish the mission with limited resources. The team believes that the agency needs to take expedient action to correct systemic problems identified in this report. If the agency makes widespread reforms to the whistleblower program, the team believes it will result in a credible, consistent and effective program. A centralized model was considered, but after careful evaluation was dismissed as inappropriate in order to achieve the needed program improvements as outlined in the report. Further discussion of this issue is included in the findings section of the report on page 3.

Field Organizational Structure

1. If leadership elects to continue the structural model utilized by Regions I, II, III, VI, and VII, we recommend:

    a. Ensure that flexiplace agreements are formalized, to include routine work in the Area Office, with the Area Office providing necessary administrative support.
    b. The RSI will need to be adept at managing remotely located employees.
    c. Staff meetings should be frequent with annual in-person meetings.
    d. A formal mentoring process should be developed. The mentoring process should include the assignment of the trainee to an experienced investigator and frequent face-to-face meetings with the RSI.

2. If leadership elects to continue the structural model utilized by Regions IV and V, we recommend:

    a. Ensure that all managers and supervisors are fully trained to grasp the complexities of the program.
    b. Ensure that audits are conducted of all Area Offices.
    c. Ensure that a coordinator position (Program Manager) is established and provided with the tools and resources to effectively coordinate the program.
    d. Ensure that direct lines of communication are established so that investigators have easy access to technical guidance.

e. Regional staff meetings should be frequent with annual in-person meetings.
f. A formal mentoring process should be developed that includes trainee assignment to an experienced investigator.
g. Ensure that where ADs and AADs are first-line supervisors of investigators, that they have the same level of training and expertise as an RSI.

3. If leadership elects to continue the structural model utilized by Regions VIII, IX, and X:

   a. Ensure that travel costs are budgeted and available to accomplish a reasonable percentage of on-site investigations.
   b. Utilize the most time efficient means of travel.
   c. Ensure that AO staff is trained to handle general queries and complaints.
   d. Ensure that a WB staff member is available as a duty officer to answer AO and customer queries.
   e. Integrate enforcement and whistleblower functions by assigning joint outreach and operational activities.
   f. Utilize investigators to conduct training of CSHOs on whistleblower policy and procedures.
   g. Ensure that all managers and supervisors are fully trained to grasp the complexities of the program.
   h. Ensure that audits are conducted of the regionally-based whistleblower program.
   i. A formal mentoring process should be developed that includes trainee assignments to an experienced investigator.

Field Staffing and Workload

4. Adopt the team's two staffing models to determine field staffing levels.

Equipment

5. Establish mandatory equipment and IT software lists for all investigators.

6. Utilize the team's minimum equipment/software list.

Budget

7. Create a specific line item budget for the whistleblower program on all organizational levels within OSHA. The budget should designate specific funds for personnel, training, equipment, etc.

OWPP

8. Consider fundamental changes in the mission and function of Office of the Whistleblower Protection Program (OWPP) and how OWPP is structured, managed, staffed, and funded.

9. Remove OWPP from Directorate of Enforcement Programs (DEP) and place OWPP in its own office reporting to the Assistant Secretary's office. Alternatively, the whistleblower

program could be its own Directorate. In any case, we believe it should report directly to the Assistant Secretary's office.

10. Institute confidence-building measures to improve the level of communication and collegiality between the OWPP and the field.

11. Provide adequate staffing to meet OWPP's new or revised mission and functions.

Policy/Procedures

12. Complete the revision of the whistleblower investigators manual.

13. Issue interim guidance on the new statutes that are not covered in the revised manual.

14. Incorporate the interim guidance on the statutes as soon as possible into the manual.

15. Update the manual as frequently as needed to ensure changes to policy and procedures are kept current.

Investigations Process

16. Revise and expand the guidance on administratively closing (screen-out) cases.

17. Until an IMIS update occurs, establish a standard method of documenting, tracking and retaining administratively closed complaints.

18. Capture administratively closed case time on the activity and hours form (OSHA 31s).

19. Ensure that supervisors review and approve all screen-outs.

20. Develop and provide training to personnel assigned to receive/screen whistleblower complaints.

21. Examine screen-outs during every audit.

22. Revise policy to emphasize the agency's desire for early resolution.

23. Allow for regional flexibility on the methodology used to investigate a case.

24. Following the implementation of the updated manual, study its impact on field operations.

25. Develop a training course on the collection and testing of evidence including the proper application of legal requirements contained in the statutes.

26. Develop and deliver a mandatory training course on settlement negotiations.

27. Develop and implement a national mediation/alternative dispute program.

28. Develop and provide a training course for those designated to participate in the mediation/alternative dispute program.

29. Ensure that settlements are analyzed for fair and equitable restitution and annotated in the case file.

30. Ensure that IMIS instructions clarify how to properly record settled cases.

31. Ensure that regions properly utilize the recommended settlement templates.

32. Ensure that regions follow the policy on approving settlement agreements.

33. Ensure that cases are properly reviewed and approved by supervisors.

34. Reconsider the proposed policy allowing supervisors/team leaders to sign final determination letters. Require mid-level managers to sign final determination letters.

Appeals Process

35. Direct OWPP to reduce the appeals backlog by performing a specific number of appeal reviews every month.

36. Return all Region IV, V, and VI appeals for their processing or, in the alternative, detail regional staff to process appeals.

37. Require OWPP and those regions with a pilot program to report on the progress of their appeal reviews on a monthly basis.

38. Identify the best procedures of each appeals program to develop a single written policy, whether administered by the National Office, regional level or a combination thereof.

39. Establish an appeal processing deadline of 60 calendar days.

40. Limit the number of reviewing officials to as few as possible; we recommend no more than two employees.

41. Utilize employees that have whistleblower expertise to review appeals.

42. Utilize a formalized template to document the analysis and conclusion of the review.

43. Ensure there is an independent reviewer and deciding official.

44. Determine the OWPP staffing needs for their appeals processing responsibility.

Performance Measures

In order to effectively measure performance, we suggest the following measures be considered:

45. Activity and hours form (OSHA 31): Ensure that investigators, CSHOs conducting investigations as a collateral duty, and any other program supervisor complete the case activity and hours form (OSHA 31).

46. Lapse Time: Measure lapse time in a manner similar to enforcement such as:

    a. complaint receipt to interview
    b. complainant interview to investigation
    c. investigation completed date
    d. investigation approval date
    e. findings issuance date

47. Merit Findings: Measure findings issued separate from settlements.

48. Settlement Rate: Include quality measurements such as:

    a. percentage of settlements that contain the core elements of a settlement
    b. percentage of OSHA settlement agreements versus party settlements
    c. percentage of settlements for enhanced settlements (Notice to Employees, Training, etc.)
    d. percentage of cases referred for litigation – OSHA Action 11(c)/STAA

49. Appeals: Include outcome and timeliness.

    a. percentage of remand
    b. percentage upheld
    c. timeliness of appeal decision

Whistleblower IMIS

50. Make modifications to whistleblower IMIS system such as:

    a. capture administratively dismissed cases (screen-outs) and referrals to other agencies.
    b. improve the reports system
    c. allow for deferral case time suspension
    d. identify multiple statutes
    e. separate merit findings from settlements
    f. provide for data error reports

51. Roll out the whistleblower OIS in the earliest timeframe possible.

52. Update the whistleblower IMIS manual and post the manual on the OWPP intranet page.

53. Develop a new IMIS course.

54. Mandate all field staff attend the new whistleblower IMIS course.

55. Break out settled cases from merit cases in the IMIS system.

56. Include administratively closed cases (screened out) in the IMIS system.

57. Ensure that regions enter all data in a timely and consistent manner including post investigation closure.

58. Ensure that settled cases are not entered as withdrawals.

Freedom of Information Requests/Non-Public Disclosure

59. Develop a comprehensive FOIA/Privacy Act guidance manual for the processing of a FOIA request, and non-public disclosure. The manual should include an example of a redacted case file and specific guidance on the more difficult issues such as confidential business information.

60. Develop and implement training for field staff to properly apply the FOIA/Privacy Act requirements.

61. Revise the non-public disclosure request to actually require a request.

62. Evaluate the impact of the non-public disclosure policy on staffing and resources.

63. Consider a moratorium on the non-regulatory disclosures until the impact on the field is studied.

State Plan Monitoring

64. Conduct comprehensive reviews of the state whistleblower programs immediately in states where comprehensive reviews have not been recently conducted.

65. Clarify the policy conflict on dually-filed complaints.

Management Accountability Program

66. Expand and update the suggested audit questions for the whistleblower program.

67. Incorporate the suggested audit topics into the Management Accountability Program Directive.

68. Ensure that subject matter experts are utilized as participants selected to represent DEA on the National Office attended audits.

Training

69. Review and update the 2006 competency model.

70. Develop and implement a whistleblower training directive.

71. Revise and develop new whistleblower courses to include; managing and supervising the whistleblower program, legal aspects, interviewing techniques, statute specific investigation course, investigative writing, settlements/mediations course, Freedom of Information Act and Non-Public Disclosure, evidence gathering and handling, and Web IMIS.

72. Move all training responsibility to DTE and adequately staff for development and delivery.

External Stakeholders

73. Create a Fact Sheet or Quick Card on the OSHA whistleblower settlement process covering those prohibited or repugnant clauses that the agency discourages from being placed in a settlement.

74. Hold panel discussions with groups like GAP, VCR and TELG, as well as known respondent's attorney groups to bolster investigator training.

75. Partner with and obtain training from the various enforcement agencies to acquire a general understanding of the enforcement principles under a specific statute.

76. Develop a pro se handbook to provide whistleblowers a guide on how to maneuver through the whistleblower investigation process.

77. Explore the possibility of documentation sharing between OSHA and the complainant and respondent, through an online system where they can gain access to the vetted documents through a secure password protected web site. The website would be available 24/7.

78. Create an alliance between OSHA and the American Bar Association and other interested whistleblower advocacy groups.

79. Utilize corporate or company wide settlement agreements and publicize significant whistleblower actions.

80. Posting whistleblower actions on the public web page, similar to enforcement actions.

81. If information is available that supports allegations that employees are being

retaliated against for reporting injuries, then OSHA should conduct a full recordkeeping audit.

1 Project Overview

In April 2010, Assistant Secretary David Michaels and Deputy Assistant Secretary Richard Fairfax of the Occupational Safety and Health Administration (OSHA) directed the creation of a Whistleblower Program Review Team. This Program Review Team was directed to conduct a "top to bottom" review of the Whistleblower Program and to make recommendations to the Assistant Secretary for improving the program.

The Program Review Team (hereinafter "the team") is comprised of Rita Lucero, ARA/PPS Region VIII, David Mahlum, ARA/FSO, Region X, and James Wulff, ARA/EP, Region IX. Ms. Lucero was a Whistleblower Program Investigator and Regional Supervisory Investigator prior to becoming ARA. Mr. Mahlum and Mr. Wulff have management responsibilities of the Whistleblower Program in their respective regions.

The team was augmented by on-site "ad hoc" team members: Michael Shanker, Investigations Specialist, OWPP; Michael Mabee, RSI, Region I; John Schreck, RSI, Region II; Sherrill Benjamin, Program Manager, Region V; Anthony Incristi, RSI, Region VI; and Joshua Paul, RSI, Region IX.

1.1 Objectives

To identify any weaknesses and inefficiencies in the program and provide recommendations for improving OSHA's Whistleblower Program.

1.2 Approach

The team met in May 2010 in Denver, Colorado, for a planning meeting. Subsequently, the team conducted on-site evaluations at the Office of the Whistleblower Protection Program (OWPP), Region I, Region II, Region V, Region VI, and Region IX. The team also met telephonically with Region VII management officials.

The team reviewed various external reports and comments, including previous General Accounting Office (GAO) program studies, and the Office of the Inspector General's (OIG) audit reports. Additionally the team reviewed program policy/procedures, program data, case files, budgeting, training records, staffing levels and performance standards.

The team conducted a survey of all internal program managers, supervisors, and investigators to gather opinions on issues related to the Whistleblower Program.

Additionally, the team interviewed both management and non-management officials at the OSHA National Office and regional offices that were visited.

The team met with external stakeholders to solicit their views on programmatic weaknesses and recommendations on improving OSHA's Whistleblower Program.

The team conducted on-site program reviews of five (5) regions. We selected the regions based upon organizational structure, size of the region and, the regions that were not recently visited by the GAO and OIG audits, except for Region V. The focus of our on-site review included adherence and deviations from policy/procedures, process inefficiencies, best practices and general management of the regional program.

1.3 Scope

The team conducted a comprehensive review of OSHA's Whistleblower Program which included organizational structure, staffing, equipment, budget, policy/procedures, performance measures, on-site reviews, National Office functions/responsibilities, training, investigation processes, including screening, investigations, settlements, approval process and appeals. Other areas of evaluation included Management Accountability Program, State Plan Monitoring, Non-Public Disclosure, and Freedom of Information Act processing.

2 Findings

2.1 Field Organizational Structure

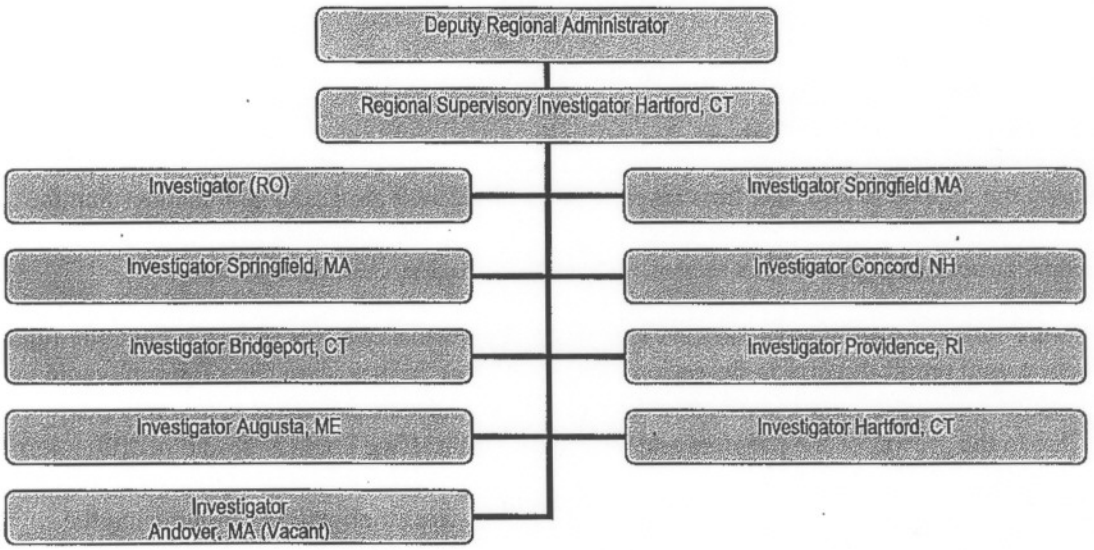
OSHA allows the regions to structure their respective whistleblower programs in a manner that the Regional Administrator deems appropriate. As a result, OSHA currently has several different organizational structures in place. This section outlines each region's current structure.

Proposals were made by various stakeholders to centralize the whistleblower program whereby field management would report directly to the national office because in their view the program would be more consistent. The review team considered this option, but rejected this model for numerous reasons. Due to the growth of the program and the increase in staffing levels it would be difficult to centrally manage such a large number of people located throughout the country. Other factors that are not conducive to central management include; case file management, effectively monitoring the whistleblower programs of the numerous state plans which is traditionally a regional function, supervision of employees from a distance, budgeting, individual development, administrative support including information technology issues, equipment procurement, workspace allocation, among others. The concerns raised by external stakeholders regarding centralized management of the program were primarily about consistency of the program. These concerns can be overcome with clear policies and procedures, comprehensive training policy and development, and with a strong audit program in place.

The team has evaluated each region's structural strengths and weaknesses and has provided recommendations to alleviate identified weaknesses.

Field Organizational Structure: (as of August 24, 2010)

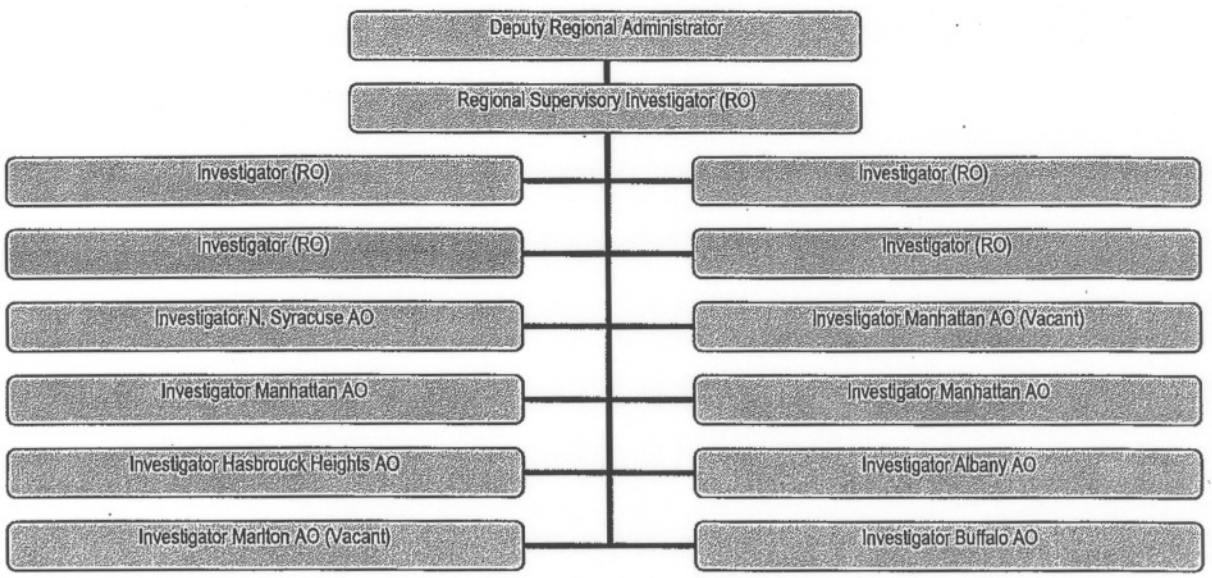
Region 1



From 1982 through 2005, Region I utilized a program manager with investigators reporting to an Area Director. With the retirement of the Program Manager in 2005, Region I announced a temporary promotion utilizing the RSI model. However, in 2007, Region I reverted to the Area Director model, opting to have investigators on a 120-day detail as Program Manager. In May 2010, Region I reverted back to the RSI model, hiring a permanent RSI who reports to the DRA.

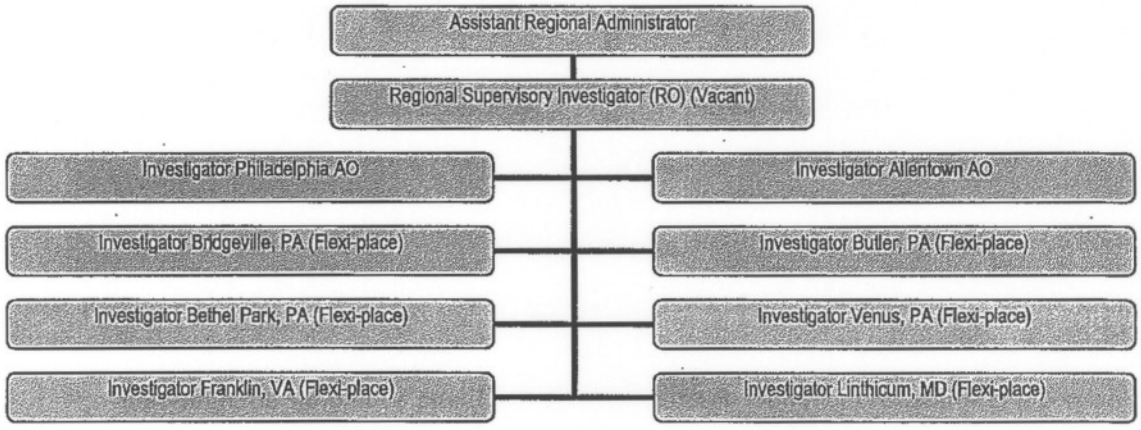
All investigators are physically assigned to the Regional Office, but most are working on informal flexi-place agreements and receive support from the Area Offices located in their flexi-place area.

Region II



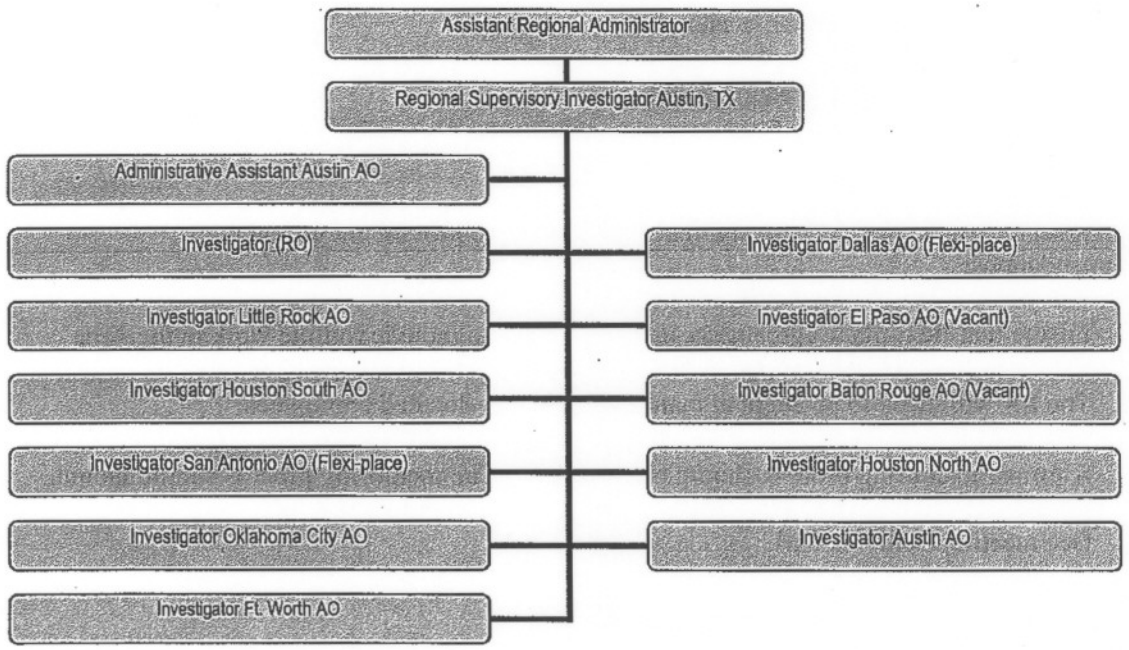
Historically, Region II has utilized the RSI model, reporting to the Regional Administrator. This model was utilized until May 2010 when a new RSI was hired, who now reports to the Deputy Regional Administrator. All investigators report to an RSI located in the Regional Office with 8 positions assigned to work out of Area Offices.

Region III

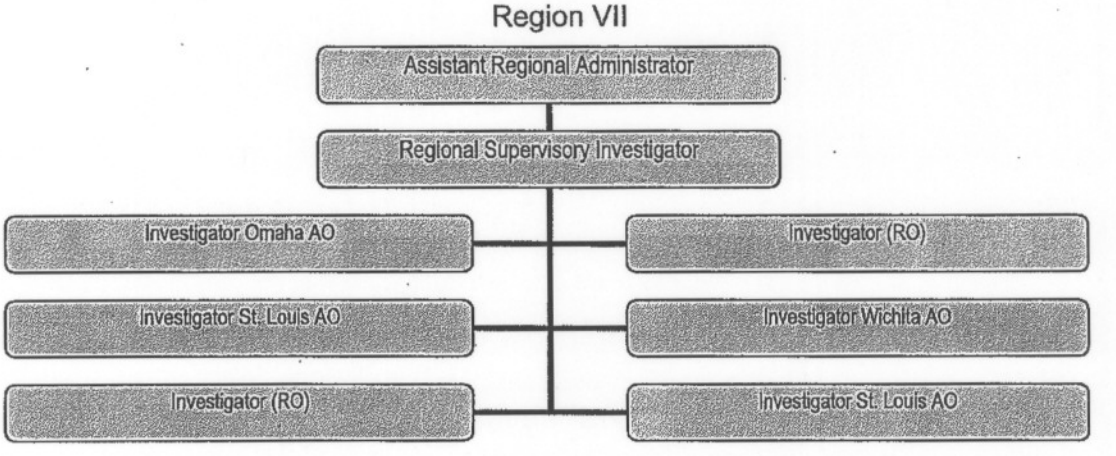


As Region III was not visited, we did not conduct an analysis of the Region III structural model. However, this model is similar to the model used in Regions I, II, VI, and VII and the strengths and weaknesses in Region III are expected to be similar.

Region VI



Historically, Region VI has utilized the RSI model with the investigators reporting to the RSI but geographically assigned to Area Offices. Most investigators are assigned workspace in the Area Office but two of the investigators are on flexi-place arrangements.



As Region VII was not visited, we did not conduct an analysis of the Region VII structural model. However, this model is similar to the model used in Region I, II, III and VI and the strengths and weaknesses are expected to be similar to those regions.

Region I, II, III, VI, and VII model strengths:

- The investigators are located geographically so that on-site investigations are the norm and travel expenditures are minimized.
- Enforcement staffs have some opportunity to interact with whistleblower staff.
- Office costs are minimized by utilizing flexi-place arrangements.

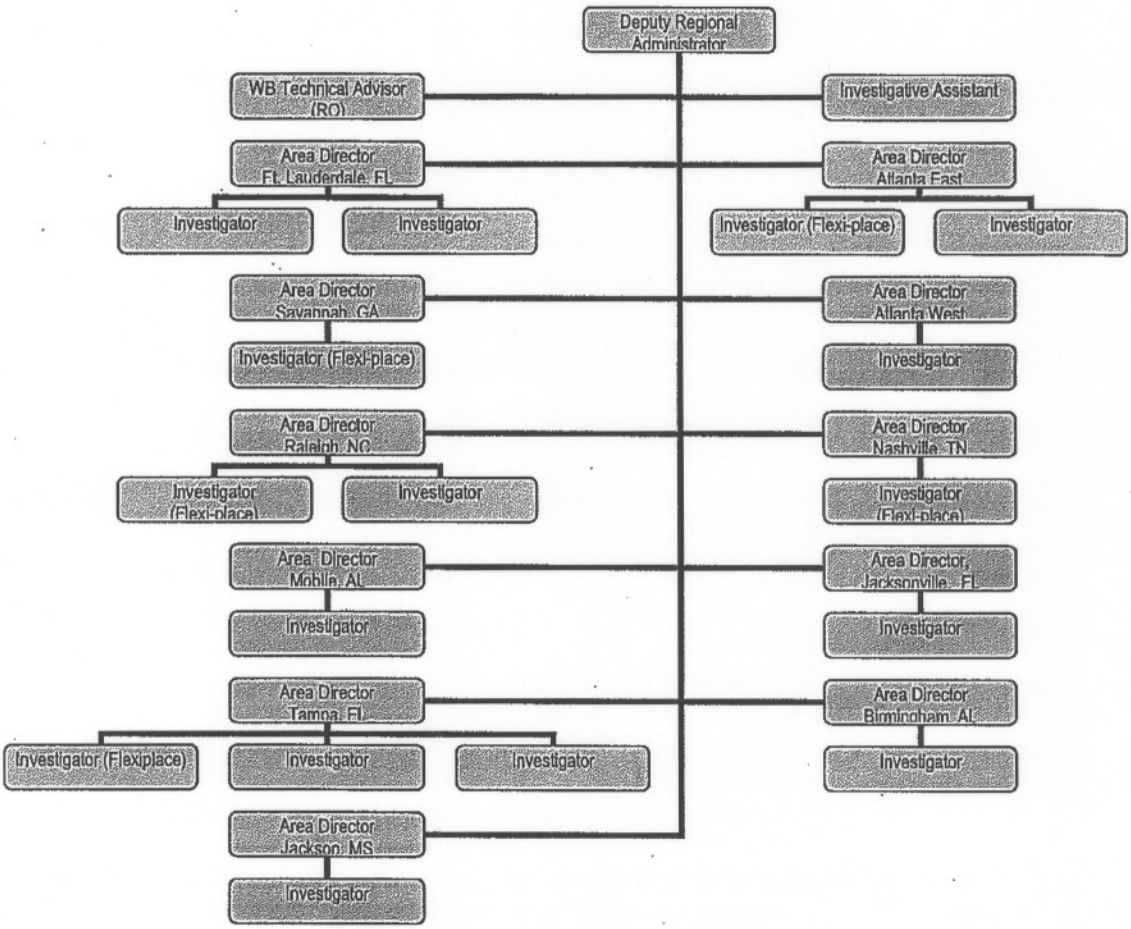
Region I, II, III, VI, and VII model weaknesses:

- Daily communication between staff and supervision is limited to e-mail and phone.
- Lack of formal flexi-place agreements.
- Limited opportunities for formal training and mentoring.
- Lack of access to administrative support.

If OSHA senior leadership elects to continue this model, we provide the following recommendations:

- Ensure that flexi-place agreements are formalized, to include routine work in the Area Office, with the Area Office providing necessary administrative support.
- The RSI will need to be adept at managing remotely-located employees.
- Staff meetings should be frequent with annual in-person meetings.
- A formal mentoring process should be developed. The mentoring process should include the assignment of the trainee to an experienced investigator and include frequent face-to-face meetings with the RSI.

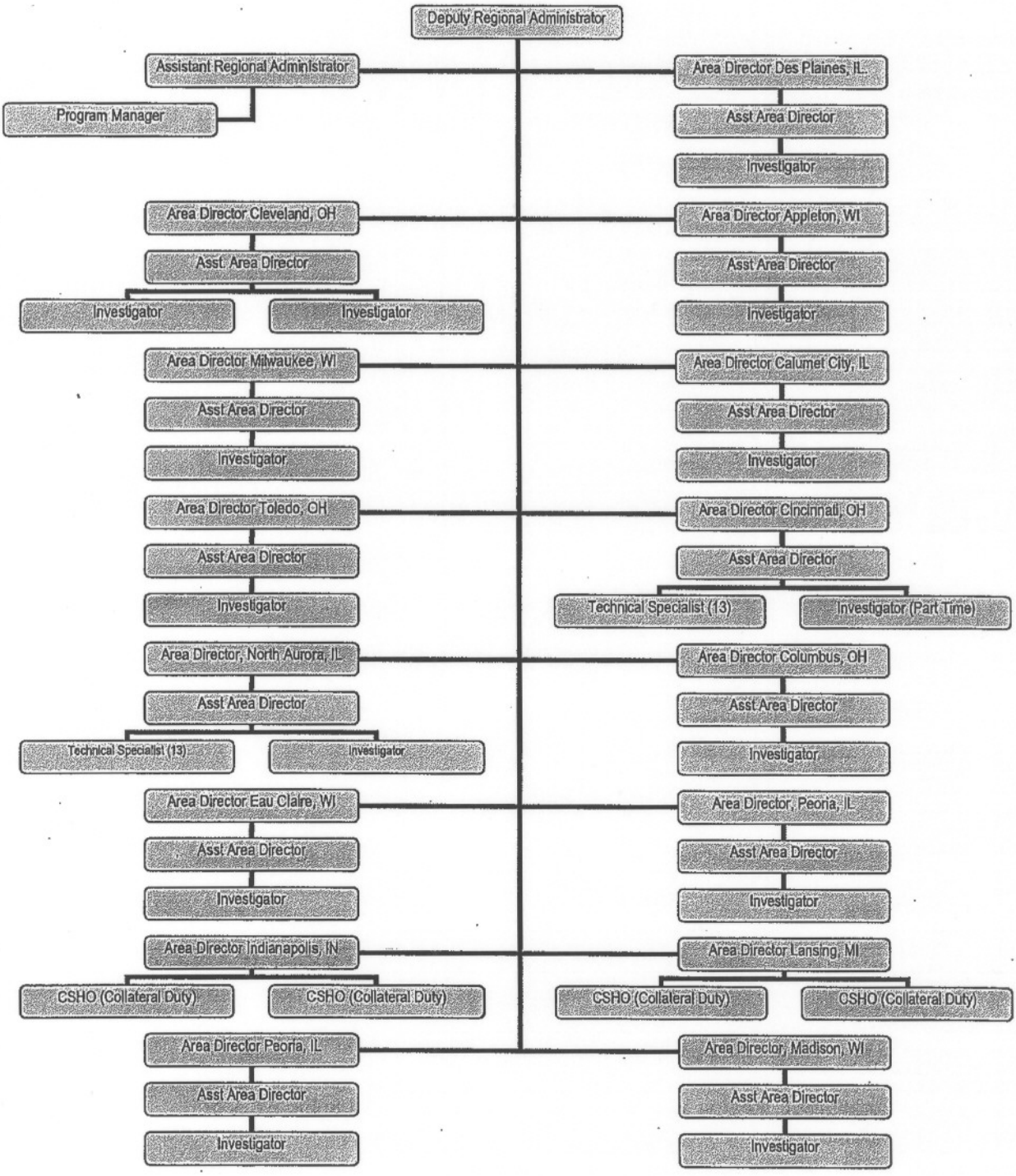
Region IV



As the team did not visit Region IV, we did not conduct an analysis of the Region IV structural model. However, this model is similar to the model used in Region V and the strengths and weaknesses in Region V will likely be similar to Region IV. The subtle differences between Regions IV and V are as follows:

- Region IV assigns the supervision of investigators to the Area Director. Region V assigns the supervision to Assistant Area Directors, except in State Plan offices where there is no AAD.
- Region IV does not assign investigations as a collateral duty to CSHOs. Region V has four CSHOs assigned to conduct investigations as a collateral duty.
- Region IV has a temporarily detailed "technical advisor" and an investigative assistant assigned to the ARA of Compliance. Region V has a program manager assigned to the ARA of Enforcement Programs.

Region V



For many years, Region V has operated under a Program Manager/Area Director model with the investigators assigned to the Area Offices and under the supervision of an Assistant Area Director. Additionally, in two State Plan Area Offices, CSHOs are assigned investigations as a collateral duty.

Recently, Region V has promoted two investigators to GS13 investigator positions as "technical specialists" to assist with various duties including reviewing other investigators' work, mentoring and training, and investigating complex cases.

Region V model strengths:

- Assigning other staff collateral duties has the potential flexibility to cover areas where complaint intake is low.

Region IV and V model strengths:

- The investigators are located geographically so that on-site investigations are the norm and travel expenditures are minimized.
- Field staff has some interaction with WB staff.

Region V model weaknesses:

- Assigning such complex work to CSHOs as a collateral duty. This can lead to inadequate investigations due to lack of formal whistleblower training.

Region IV and V model weaknesses

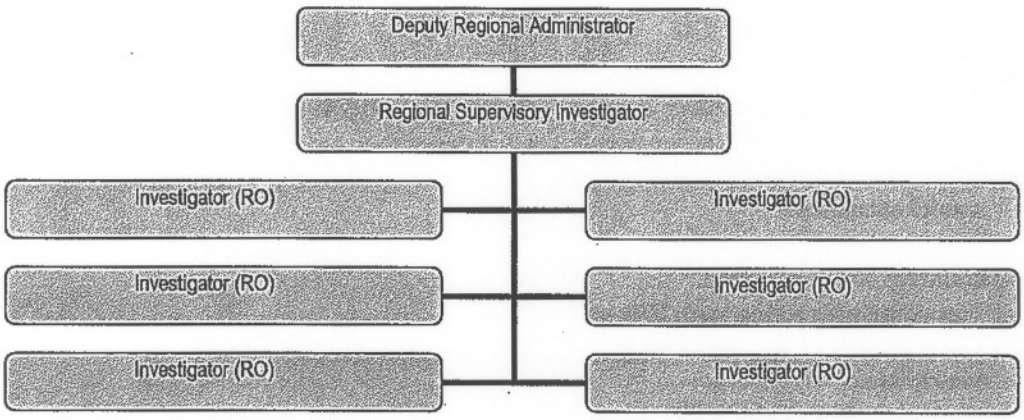
- Management will need to be kept current on the vast array of technical and legal issues facing both enforcement and whistleblower programs.
- Daily communication is limited to e-mail and phone.
- Limited opportunities to formal training and mentoring.
- Lack of access to administrative support.
- Competing interests between enforcement and whistleblower activities leave ADs/AADs spread too thin, thus limiting their ability to administer both programs.

This organizational structure has the potentials for greater operational challenges than other models. In the ARA/RSI model, the management team coordinates the day-to-day operations of only the whistleblower program. In this model, the management/supervisory team manage the day-to-day operations of both the safety and health enforcement and whistleblower programs. Simultaneously providing the attention and expertise to both complex high priority programs can be more of a challenge.

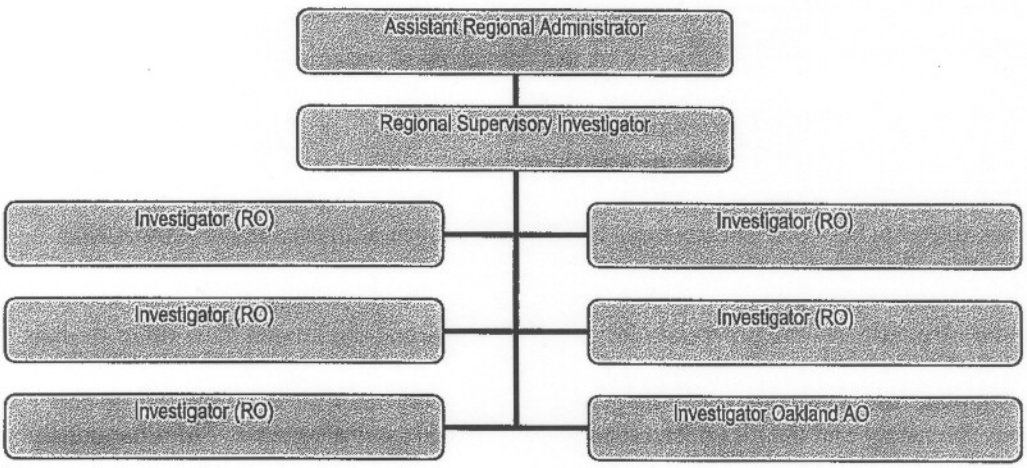
If OSHA senior leadership elects to continue this model, we provide the following recommendations:

- Ensure that all managers and supervisors are fully trained to grasp the complexities of the program.
- Ensure that audits are conducted of all Area Offices.
- Ensure that a coordinator position (Program Manager) is established and provided with the tools and resources to effectively coordinate the program.
- Ensure that direct lines of communication are established so that investigators have easy access to technical guidance.
- Regional staff meetings should be frequent with annual in-person meetings.
- A formal mentoring process should be developed where new investigators are assigned to an experienced investigator.
- Ensure that where ADs and AADs are first-line supervisors of investigators that they have the same level of training and expertise as an RSI.

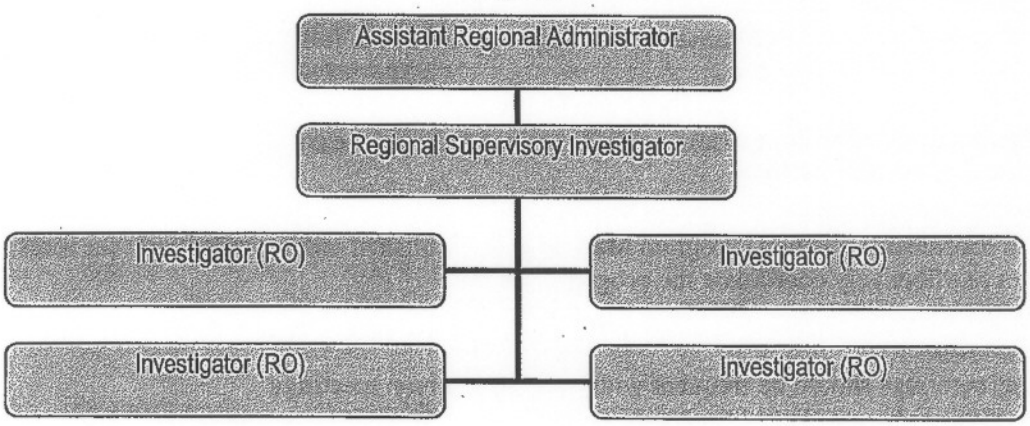
Region VIII



Region IX



Region X



Historically, Regions VIII, IX and X have utilized the RSI model with the investigators reporting to a RSI and are assigned to the Regional Office with the following differences:

Region VIII: One of the investigators is on a formal flexi-place agreement.
Region IX: One of the investigators is assigned workspace in an Area Office.

Region VIII, IX, and X model strengths:

- Investigators are centrally located so that supervision, communication, mentoring and training are easily facilitated.
- Easy access to equipment and administrative support.
- Facilitates networking and peer support among the investigators.

Region VIII, IX, and X weaknesses:

- Centralizing operations requires more travel time and costs, which can lead to fewer on-site investigations.
- It is more difficult to support walk-in customers when investigators are not assigned to Area Offices.
- Potential lack of integration between whistleblower and enforcement functions.

If OSHA senior leadership elects to continue this model, we provide the following recommendations:

- Ensure that travel costs are budgeted and available to accomplish a reasonable percentage of on-site investigations.
- Utilize the most time efficient means of travel.
- Ensure that AO staff is trained to handle general queries and complaints.
- Ensure that a WB staff member is available as a duty officer to answer AO and customer queries.
- Integrate enforcement and whistleblower functions by assigning joint outreach and operational activities.
- Utilize investigators to conduct training of CSHOs on whistleblower policy and procedures.
- Ensure that all managers and supervisors are fully trained to grasp the complexities of the program.
- Ensure that audits are conducted of the regionally-based whistleblower program.
- A formal mentoring process should be developed that includes trainee assignment to an experienced investigator.

2.2 Field Staffing

Historically, OSHA has no effective mechanism to adequately measure workload in order to determine proper staffing. In our survey, 81% of management and 93% of non-management believe that the field is understaffed. A statistical analysis was conducted that validated the belief that the whistleblower program is understaffed. Subsequently, the team developed two staffing models that can be used by senior leadership as a road map to properly staff the field.

In determining the proper staffing of the field, the team took into account that policy dictates it is the agency's goal to consistently conduct, where appropriate, full field investigations, in-depth legal analysis and the issuance of credible and defendable Secretary's Findings.

Based on national data from FY 2005-2010, the statistical analysis captured the following data points:

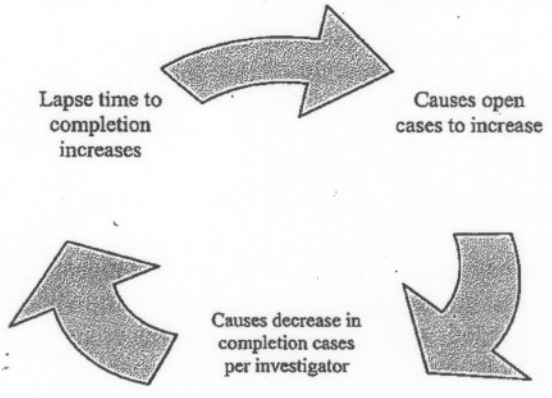
- Number of investigator positions for each region for each fiscal year.
- The number of cases completed, received and opened in each fiscal year to formulate a national and region-by-region case completion, received and open case rate per investigator.
- The number and percentage of cases by statute for each fiscal year, both nationally and by region.

The data revealed three *inter-related* driving points which we used to develop the two models for adequate staffing.

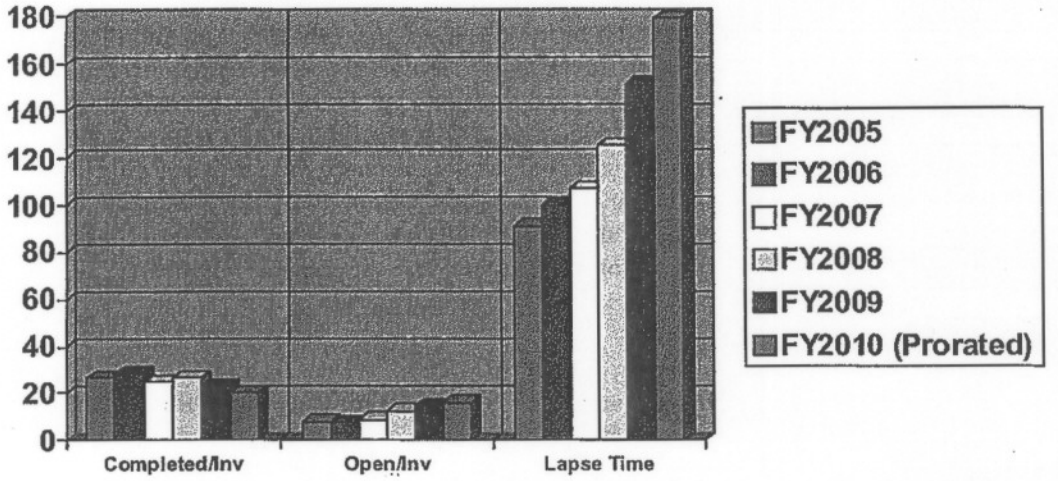
- As case lapse times rise, open case rates rise, and completion rates drop.
- An expectation of investigators completing more than 25 cases per year. An exception to this expectation must be where a region experiences a higher percentage of complex cases (non-11(c)/STAA) than the national average. When this occurs the region should lower their expectation to an average of 20 completed cases per year.
- Assigning more than 8 open cases per investigator at any given time will directly affect lapse times and completion rates.

This downward productivity cycle is the result of the average lapse time to complete a case rising gradually from 91 days per case in FY2005 to 107 days per case in FY2007. We believe this is a result of an increase in percentage of complex cases being investigated. Beginning in FY2008, the average case file lapse time increased at a much higher rate and has continued to climb at an even higher rate through FY2010. With increasing lapse times, there is a dramatic increase in open case load. Furthermore, the dramatic increase in open case load has caused a 25.7% decrease in the case completion rate from FY2005 to FY 2010. This brings us back full cycle to further increases in lapse time. The diagram below illustrates the productivity cycle.

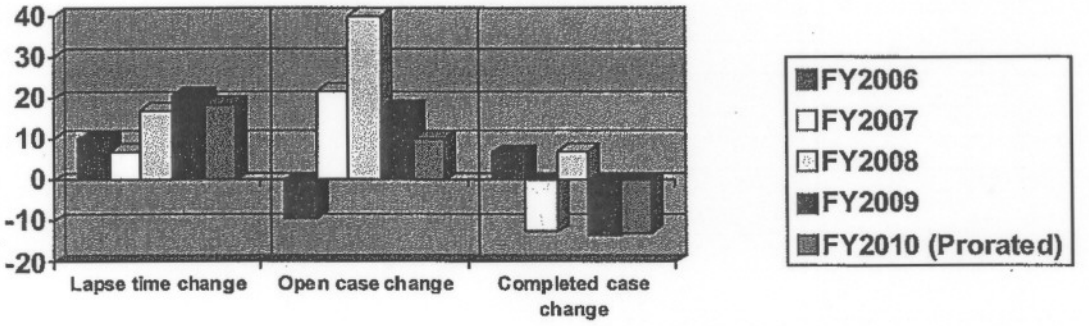
National Case Productivity Cycle



National Case Completed Productivity Measures



National
Productivity Measure Changes by Percentages



We developed two staffing models to take into account the variations in types and complexity of cases received:

Staffing model 1 is based on the expectation of completing 25 cases per investigator per year. The calculation is derived from the average of the cases that the region received between FY2007 through FY2010. That average number is then divided by 25. To take into account the backlog of open cases, we applied an adjustment factor. This adjustment factor is calculated by taking the average number of open investigations per investigator, divided by 8, which is the desired number of open cases per investigator at any given time. We then divided this number by three to create a three-year allowance to decrease the backlog without creating over staffing.

Staffing model 2 uses the same formula as model 1 with one exception. The exception is that we reduce the expectation of completing 25 cases per investigator per year to 20 cases per investigator per year. The reason for this model is to take into account the longer period of time it normally takes to complete

a complex case investigation. This formula is applied to the regions that have a higher percentage of complex cases than the national average.

In addition to applying the staffing models, we also are recommending the addition of two or three positions depending on the regional data. The first position is a technical specialist position to be utilized for complex investigations, complaint screening, investigator mentoring and training, outreach, state plan monitoring and CASPA investigations. The second position is an investigations assistant position to process non-public disclosures, IMIS data entry, docketing, FOIA and other duties related to the investigation process. We are expecting investigators will need to primarily and substantially concentrate on investigations to achieve and maintain a case completion rate of 25 completed cases per investigator as expected in our model. The other duties outlined above have had a material impact on the completion rate and must be accounted for with our high assumption of completion rates.

Regional Staffing Analysis

The team analyzed the data described above during FY2005-FY2010 for Regions I through X and then applied the appropriate staffing model that correlates to that region. This analysis is summarized for each region below.

Region I

Using model 1, we calculate that Region I would need six investigators. This would be a decrease of three investigators from current staffing. The reason for the decrease is a significantly lower completion rate over the four-year measurement period than the expected completion rate of 25 per investigator.

In addition, we recommend that Region I be allotted one technical investigator and one investigative assistant. We maintain the current RSI position. This addition would have the net effect of the loss of one FTE.

Model 2 does not apply because Region I experiences a slightly higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region I has had a high of 81.3% 11(c)/STAA cases in FY2008 and a low of 72.3% in FY2009. During FY2010, through August 31, 2010, Region I has an 11(c)/STAA rate of 79.4%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region II

Using model 1, we calculate that Region II would need 10 investigators. This would be a decrease of two investigators from current staffing. The reason for the decrease is a lower completion rate over the four-year measurement period than the expected completion rate per investigator. In addition, we recommend that Region II be allotted an additional supervisory investigator, one technical investigator and one investigative assistant. This addition would have the net effect of an increase of one FTE.

Using model 2, we calculate that Region II would need 12 investigators. This maintains the same investigatory staff as currently allowed. In addition, we recommend that Region II be allotted two supervisory investigators, one technical investigator and one investigative assistant. This staffing model would have the net affect of an increase of three FTE.

Model 2 applies to Region II because they experience a lower than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region II has had a high of 69.8% 11(c)/STAA cases in FY2008

and a low of 60% in FY2009. During FY2010, through August 31, 2010, Region II has an 11(c)/STAA rate of 67.6%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region III

Using model 1, we calculate that Region III would need eight investigators. This would be an increase of one investigator from current staffing. In addition, we recommend that Region III be allotted one technical investigator and one investigative assistant. We maintain the current RSI position. This addition would have the net effect of an increase of three FTE.

Model 2 does not apply because Region III experiences a slightly higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region III has had a high of 81.5% 11(c)/STAA cases in FY2008 and a low of 69.4% in FY2010, with a 3 year average of 75.7%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region IV

Using model 1, we calculate that Region IV would need 20 investigators. This would be an increase of four investigators from current staffing. In addition, we recommend that Region IV be allotted a program manager, two technical investigators and one investigative assistant. This addition would have the net affect of an increase of seven FTE.

Model 2 does not apply because Region IV experiences a slightly higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region IV has had a low of 79.8% 11(c)/STAA cases in FY 2009 and a high of 81.8% in FY 2010, with a 3 year average of 80.8%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region V

Using model 1, we calculate that Region V would need 21 investigators. This would be an increase of 3.5 investigators from current staffing. In addition, we recommend that Region V be allotted two technical investigators and one investigative assistant. We maintain the current PM position. This addition would have the net effect of an increase of 6.5 FTE.

Model 2 does not apply because Region V experiences a slightly higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region V has had a low of 83.8% 11(c)/STAA cases in FY 2009 and a high of 85.6% in FY 2010, with a three-year average of 84.7%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region VI

Using model 1, we calculate that Region VI would need eight investigators. This would be a decrease of three investigators from current staffing. The reason for the decrease is a lower completion rate over the four-year measurement period than the expected completion rate of 25 per investigator. In addition, we recommend that Region VI be allotted one technical investigator position. This addition would have the net effect of a decrease of two FTE.

Using model 2, we calculate that Region VI would need 10 investigators. This would be a decrease of one investigator. Under model 2, we recommend that Region VI be allotted two supervisory

investigators and one technical investigator. This staffing model would have the net effect of an increase of one FTE.

Model 2 applies to Region VI because they experience a lower than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region VI has had a low of 64.2% 11(c)/STAA cases in FY2008 and a high of 68.6% in FY2010 with a three-year average of 66.8%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region VII

Using model 1, we calculate that Region VII would need six investigators. This would maintain the current staffing level. In addition, we recommend that Region VII be allotted one technical investigator and one investigative assistant. We maintain the current RSI position. This addition would have the net effect of an increase of two FTE.

Model 2 does not apply because Region VII experiences a slightly higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region VII has had a high of 88% 11(c)/STAA cases in FY 2008 and a low of 73.3% in FY 2010, with a three-year average of 81.2%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region VIII

Using model 1, we calculate that Region VIII would need six investigators. This would maintain the current staffing level. In addition, we recommend that Region VIII be allotted one technical investigator and one investigative assistant. We maintain the current RSI position. This addition would have the net effect of an increase of two FTE.

Model 2 does not apply because Region VIII experiences a higher than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region VIII has had a high of 85.5% 11(c)/STAA cases in FY 2008 and a low of 78% in FY 2010, with a three-year average of 81.5%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region IX

Using model 1, we calculate that Region IX would need five investigators. This would be a decrease of one investigator from current staffing. The reason for the decrease is a lower completion rate over the four-year measurement period than the expected completion rate of 25 per investigator. In addition, we recommend that Region IX be allotted one technical investigator and one investigative assistant. This addition would have the net effect of an increase of one FTE.

Using model 2, we calculate that Region IX would need six investigators. This would maintain the current staffing level. Under model 2, we recommend that Region IX be allotted one technical investigator and one investigative assistant. We maintain the current RSI position. This staffing model would have the net affect of an increase of two FTE.

Model 2 applies to Region IX because they experience a lower than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region IX has had a high of 45.9% 11(c)/STAA cases in FY2008 and a low of 30.9% in FY2009 with a three-year average of 39.6%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Region X

Using model 1, we calculate that Region X would need four investigators. This would maintain the current staffing levels. In addition, we recommend that Region X be allotted one technical investigator position and one investigative assistant position. This addition would have the net effect of an increase of two FTE.

Using model 2, we calculate that Region X would need five investigators. This would be a net increase of one investigator position. Under model 2, we recommend that Region X be allotted one technical investigator position and one investigative assistant position. We maintain the current RSI position. This staffing model would have the net effect of an increase of three FTE.

Model 2 applies to Region X because they experience a lower than average rate of 11(c) and STAA cases. Over the last three fiscal years, Region X has had a high of 67.1% 11(c)/STAA cases in FY2008 and a low of 52.9% in FY2010 with a three-year average of 59.2%. Nationally, OSHA has a current 11(c)/STAA rate of 75.2%.

Recommendations:

- Region I (Utilizing model 1): One RSI, one technical investigator, six investigators and one investigative assistant.
- Region II (Utilizing model 2): Two RSIs, one technical investigator, 12 investigators, and one investigative assistant.
- Region III (Utilizing model 1): One RSI, one technical investigator, eight investigators and one investigative assistant.
- Region IV (Utilizing model 1): One PM, two technical investigators, 20 investigators and one investigative assistant.
- Region V (Utilizing model 1): One PM, two technical investigators, 21 investigators and one investigative assistant.
- Region VI (Utilizing model 2): Two RSIs, one technical investigator, 10 investigators and one investigative assistant.
- Region VII (Utilizing model 1): One RSI, one technical investigator, six investigators and one investigative assistant.
- Region VIII (Utilizing model 1): One RSI, one technical investigator, six investigators and one investigative assistant.
- Region IX (Utilizing model 2): One RSI, one technical investigator, six investigators and one investigative assistant.
- Region X (Utilizing model 2): One RSI, one technical investigator, five investigators and one investigative assistant.

2.3 Workload Analysis

The team conducted a workload data analysis to provide both national and regional case received, open and completion rates, including annual rates on case results such as merit, dismissal and withdrawal rates. This data may be used by leadership to better understand how workload factors have an impact on productivity and results.

National investigation data and case load measurements: FY2005-FY2010

The team's analysis of six years of case data shows a slight decline in cases received per investigator, a significant decline in cases completed per investigator, and a significant increase in open cases per investigator.

Received Cases

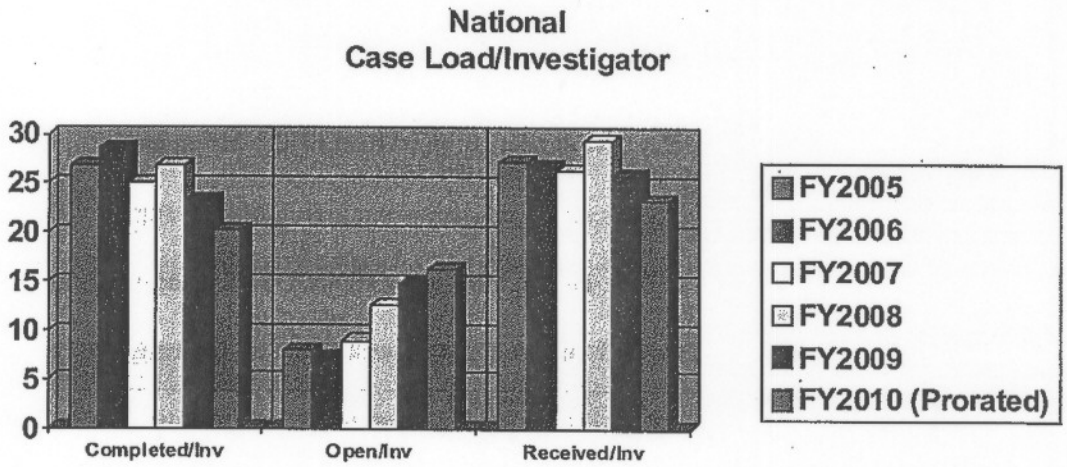
Nationwide, the total number of cases received has increased by 288 or 13%. However, the case received rate per investigator has declined from 27.2 received cases per investigator in FY2005 to 23.3 cases per investigator in FY2010, a decrease of 3.9 cases or 14.3%. **The decline of cases received per investigator is solely related to the hiring of 25 additional investigators during FY2009-2010.** The team cannot forecast the effect that the addition of the ACA and Dodd Frank Acts (or other possible future statutes) will have on the number of cases received.

Open Cases

Nationwide, the open case rate has risen from eight cases per investigator from FY2005 to 16.3 cases per investigator in FY 2010, an increase of 104%. The agency should note with possible alarm that irrespective of the hiring of 25 new investigators during late FY2009, the open case rate increased by 1.5 cases per investigator during FY 2010.

Case Completion

Nationwide, the total number of completed cases rose slightly from 1902 completed cases in FY2005 to 1939 cases completed in FY2009. The national case completion rate declined from 26.8 completed cases per investigator in FY2005 to 20.2 completed cases per investigator in FY2010, a decrease of 24.6%.



Merit Rate

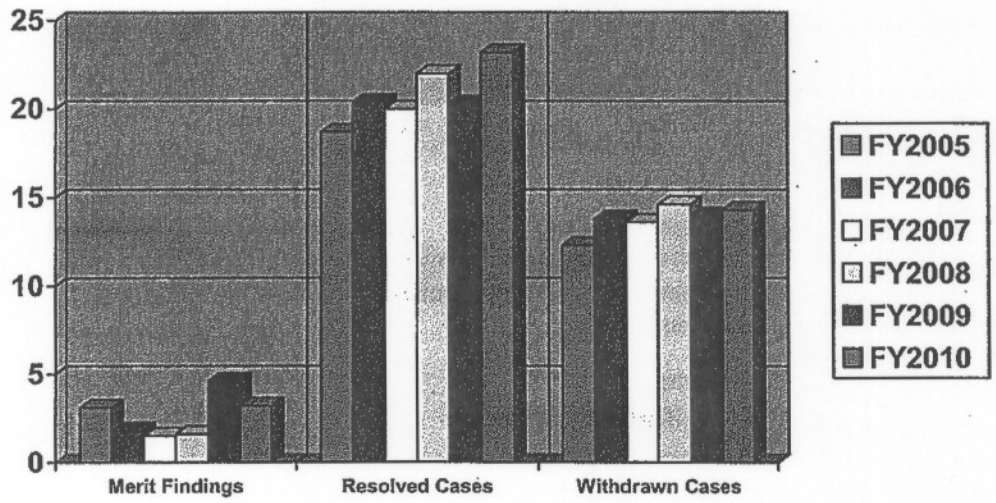
The merit rate has increased from 20.9% in FY2005 to 25.4% in FY2010, an increase of 21.5%. OSHA settled well more than 9 out of 10 merit cases. OSHA's lowest percentage of settled merit cases was 87.1% in FY2009 and the highest percentage was 95.3% in FY2008.

Most of the external criticism regarding merit rates is the inclusion of resolved cases as merit cases. We agree that we should not count resolved cases as merit but create a new category in IMIS. However, resolving cases for the parties should not be discounted as a negative statistic or factor. Resolving cases

to the satisfaction of both parties that does not violate a core principle should be highly desired by the agency.

If you review only total cases where OSHA issues findings, then merit findings range from a low of 1.5% in FY2007 to a high of 4.6% in FY2009. OSHA's merit finding rate has more than doubled (1.5-3.2) from FY2005-FY2010. Resolved cases (settled) have also increased over the last six years, from a low of 18.7% of total cases in FY2005 to 23.2% of total cases in FY2010, a 19.4% increase. Finally, withdrawn cases have also increased over the last six years, from a low of 12.3% of total cases to 14.3% of total cases in FY2010, an increase of 14%.

National Case Disposition by Percentages



Region I investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region I has experienced case received, open case and case completion rates consistently well below the national average.

Received Cases

The case received rate has risen from 13.9 received cases per investigator in FY2005 to 15.3 cases per investigator in FY2010, an increase of 9.2%. The received case rate is currently 34.3% below the national average of 23.3 cases per investigator.

Open Cases

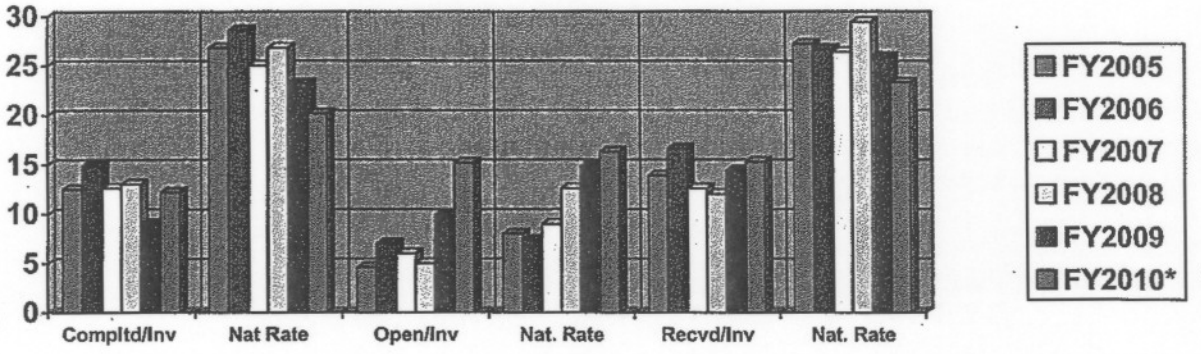
The open case rate has risen from 4.6 cases per investigator from FY2005 to 15.2 cases per investigator in FY 2010, an increase of 330%. However, the open case rate remains 6.7% below the national average of 16.3 cases per investigator.

Case Completion

The case completion rate has slightly decreased from 12.5 completed cases per investigator in FY2005 to 12.2 completed cases per investigator in FY2010, a decrease of 2.5% compared to a nationwide decrease of 24.6%. Over the last six years, Region I's completion rate per investigator is about 50% less

than the national completion rate.

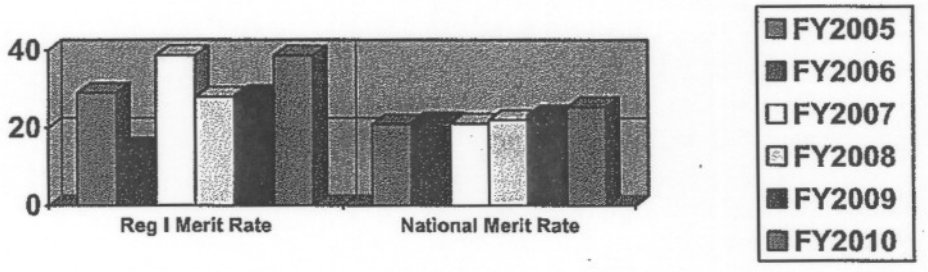
Region I
Case Load/Investigator



Merit Rate

Region I has a merit rate that has varied over the last six years, from a low of 15.0% in FY2006 to a high of 38.6% in FY2010, currently 52% above the national average. Over the last four years, the Region I merit rate has consistently been well above the national average.

Region I
Merit Rate



Region II investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region II has a received and a case completion rate that are generally below the national average, and open case rates that are consistently well above the national average.

Received Cases

The case received rate has risen from 13.9 received cases per investigator in FY2005 to 15.3 cases per investigator in FY2010, an increase of 9.2%. The received case rate is currently 34.3% below the national average of 23.3 cases per investigator.

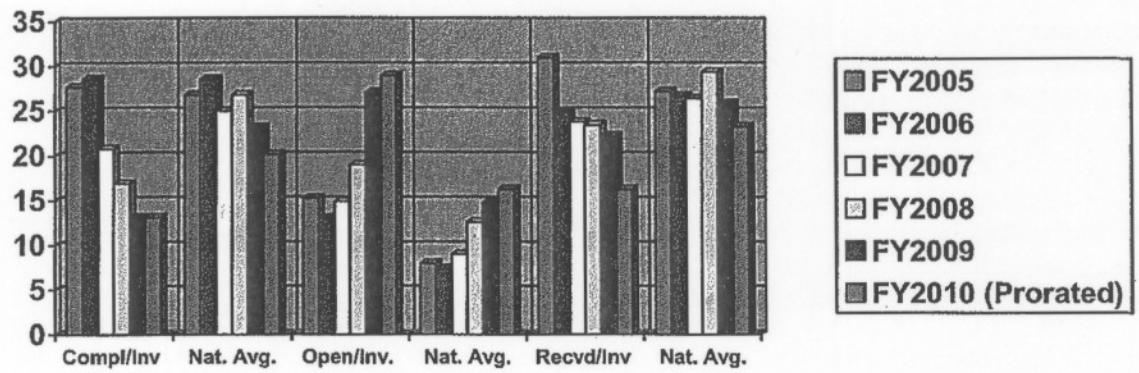
Open Cases

The open case rate has risen from 15.3 cases per investigator from FY2005 to 29 cases per investigator in FY 2010, an increase of 92.1%. The open case rate has consistently been well above the national average over the last six years and currently remains 78% above the national average of 16.3 cases per investigator.

Case Completion

The case completion rate has decreased significantly from 27.7 completed cases per investigator in FY2005 to 13.1 completed cases per investigator in FY2010, a decrease of 52.7% compared to a nationwide decrease of 24.6%.

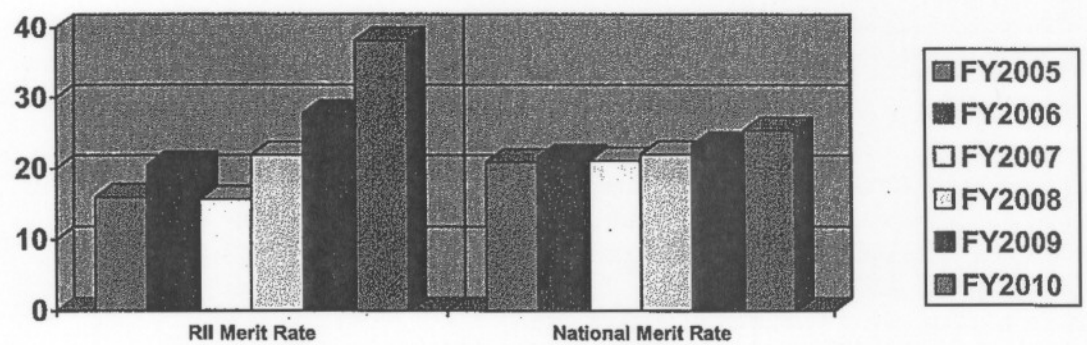
Region II
Case Load/Investigator



Merit Rate

Region II has maintained a merit rate that varies over the last 6 years, from a low of 15.7% in FY2007 to a high of 38.6% in FY2010. Over the last two years the Region II merit rate has consistently been well above the national average, currently 52% above the national average.

Region II
Merit Rate



Region III investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region III has a received and case completion rate generally above the national average, and open case rate consistently below the national average.

Received Cases

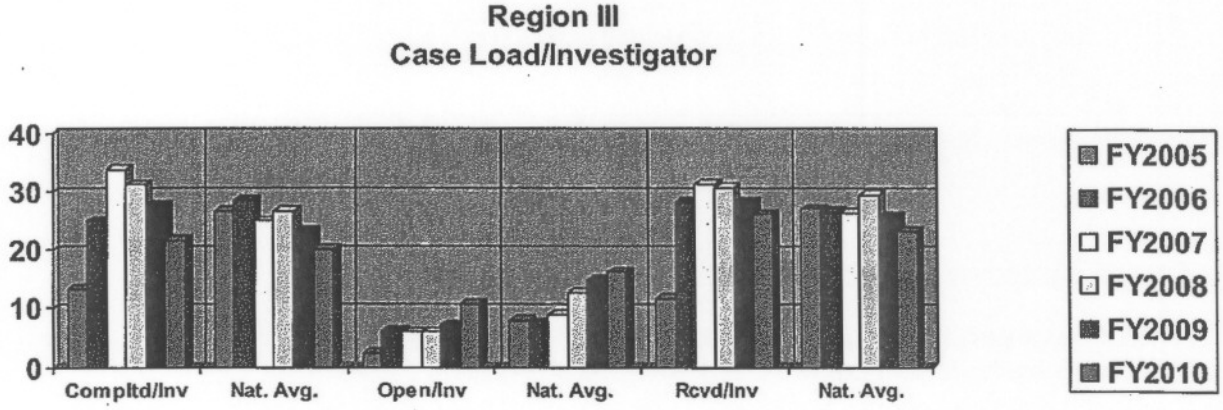
The case received rate has declined from 28.2 received cases per investigator in FY2006 to 26.2 cases per investigator in FY2010, a decrease of 7.1%. The received case rate is currently 11.1% above the national average of 23.3 cases per investigator.

Open Cases

The open case rate has risen from 6.2 cases per investigator in FY2006 to 7.2 open cases per investigator in FY2009, a 13.9% increase. Even with the addition of one new investigator the open case rate has continued to rise to 10.7 open cases per investigator, however, that rate is 34.4% below the national average of 16.3 cases per investigator.

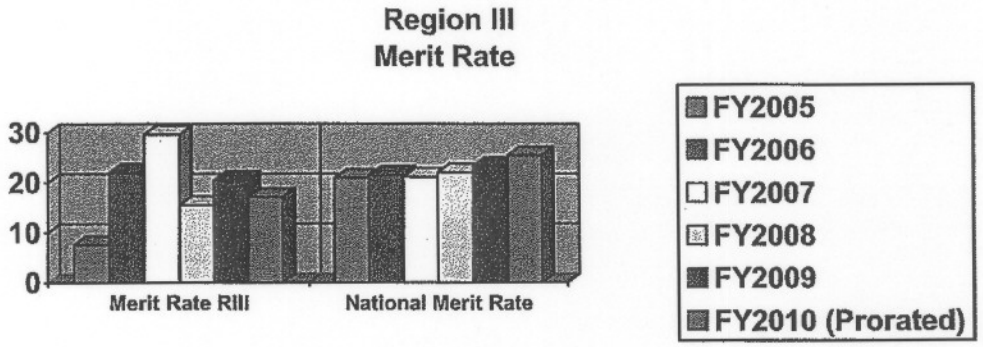
Case Completion

Over the last four years, Region III has completed cases at a higher rate than the national average. However, the case completion rate has continually decreased over the last four years from a high rate of 33.8 completed cases per investigator in FY2007 to 21.8 completed cases per investigator in FY2010, a decrease of 35.5% compared to a nationwide decrease of 19.2% over the same period of time.



Merit Rate

Region III experienced a merit rate that fluctuated from a low of 7.6% in FY2005 to a high of 29.6% in FY2007. The FY2010 merit rate is currently at 17.1%, which is 32.7% below the national average. The merit rate was below the national average during three of the six years and at or above the national rate the other three years.



Region IV investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region IV has experienced case received, open and case completion rates consistently above the national average.

Received Cases

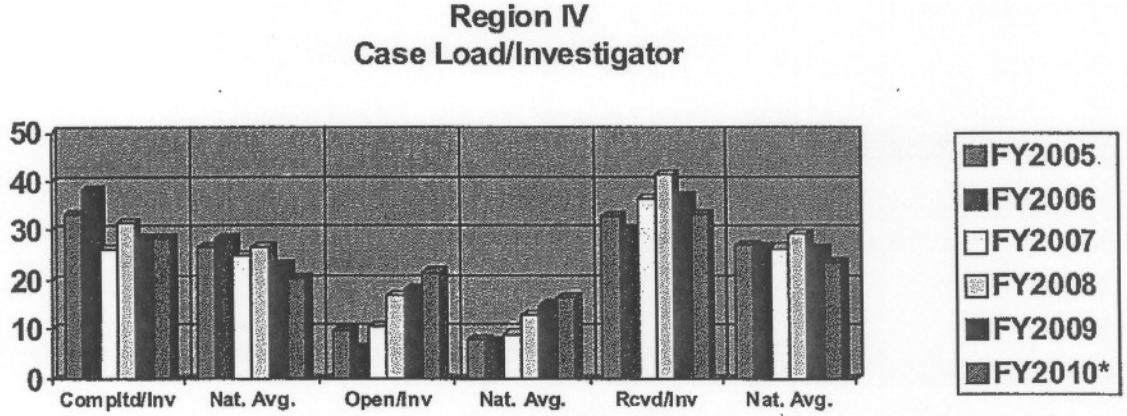
The case received rate has increased from 32.7 received cases per investigator in FY2005 to 33.3 in FY2010, an increase of 1.8%. However, the received case rate is currently 30% higher than the national average of 23.3 cases per investigator.

Open Cases

The open case rate has risen from 9.8 cases per investigator in FY2005 to 21.5 open cases per investigator in FY2010, a 119.4% increase. Even with the addition of four new investigator positions in FY2010, the open case rate has continued to rise by 3.4 open cases per investigator from FY2009 to FY2010 and is currently 24.2% above the national average of 16.3 cases per investigator.

Case Completion

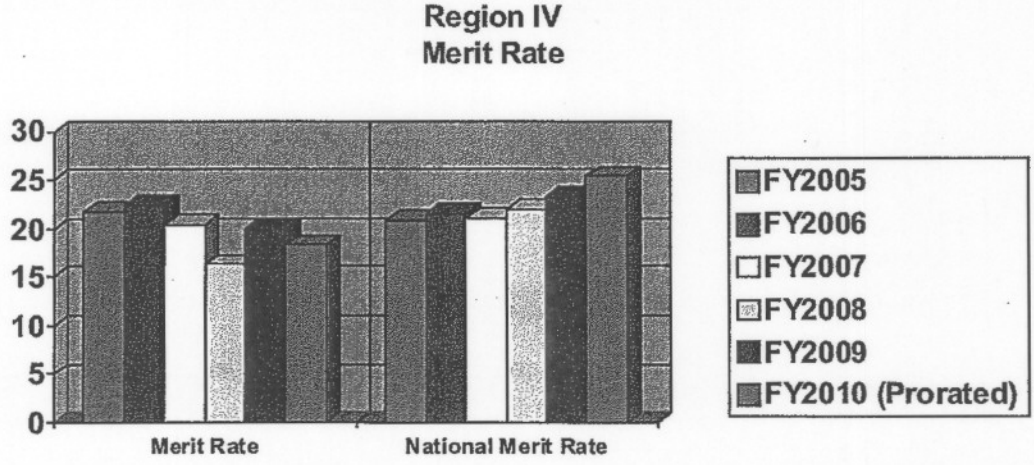
The case completion rate has decreased over the last six years from a high rate of 33.4 completed cases per investigator in FY2005 to 28.6 completed cases per investigator in FY2010, the same decrease in completion rate, 14.4%, as the national decline in case completion rate during the same period.



Merit Rate

The Region IV merit rate has decreased in four of the last six years and has generally been on a

downward trend during the last six years. The FY2005 merit rate was 21.7% and the FY2010 merit rate is currently at 18.3%, which is 28% below the national average. The merit rate was below the national average during the last four years after being above the national average in FY2005 and FY2006.



Region V investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region V has experienced case received and case completion rates generally above the national average, and open case rates consistently below the national average.

Received Cases

The case received rate has declined from 36 received cases per investigator in FY2005 to 27 cases per investigator in FY2010, a decrease of 25%. The received case rate is currently 13.7% above the national average of 23.3 cases per investigator.

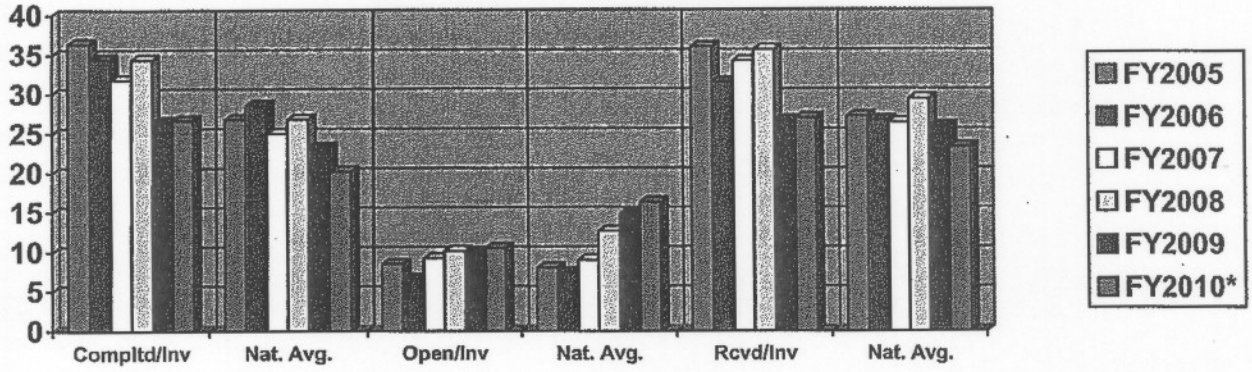
Open Cases

The open case rate has risen from 8.5 cases per investigator in FY2005 to 10.5 open cases per investigator in FY2010, a 19% increase. Even with the addition of 2.5 new investigators the open case rate has continued to rise by 1.3 cases per investigator. However, the open case rate is 5.8 cases per investigator, which is 35.6% below the national average in FY2010.

Case Completion

The case completion rate has decreased over the last six years from a high rate of 36.4 completed cases per investigator in FY2005 to 26.7 completed cases per investigator in FY2010, a decrease in completion rate of 26.6% as compared to a 14.4% decrease nationally.

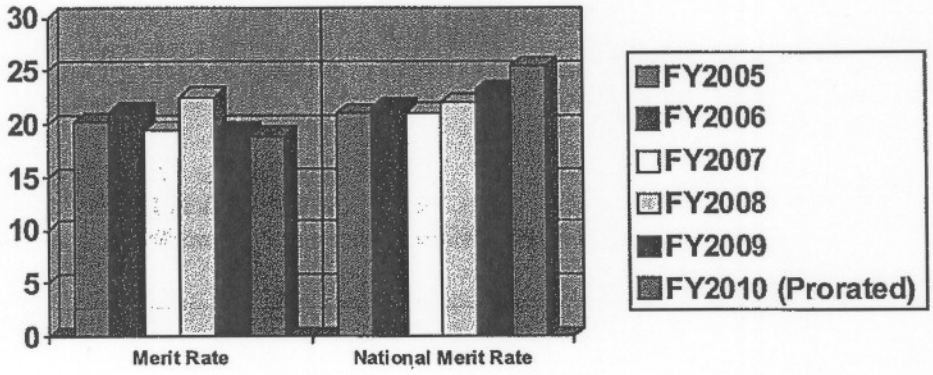
Region V
Case Load/Investigator



Merit Rate

The Region V merit rate has fluctuated over the last six years from a high of 22.5% in FY2008 to a low of 18.9% in FY2010 but has generally been on a downward trend. The merit rate was below the national average during five of the last six years and is currently 26.6% below the national average.

Region V
Merit Rate



Region VI investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region VI has experienced case received, open case and case completion rates generally below the national average.

Received Cases

The case received rate has declined from 25 received cases per investigator in FY2005 to 20.5 cases per investigator in FY2010, a decrease of 18%. Nationally the case received rate has declined from 27.2 cases per investigator to 23.3 cases per investigator, a decline of 14.3%. The received case rate is

currently 12% below the national average of 23.3 cases per investigator.

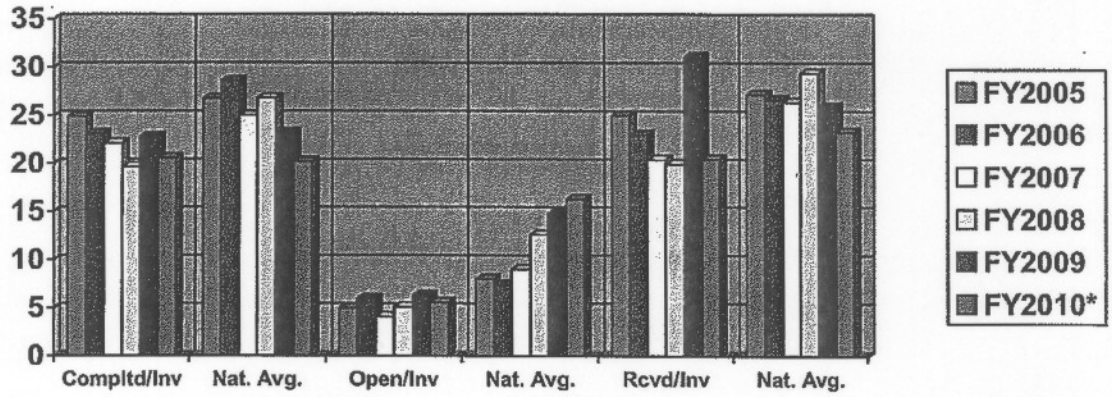
Open Cases

The open case rate has stayed fairly consistent over the last six years at a very low rate compared to the national average. The open case rate is currently 5.6 cases per investigator, 65.5% below the national rate. This is the only Region that is staffed at a level of 8 open cases or less per investigator which is the team's staffing target goal for open cases.

Case Completion

The case completion rate per investigator has declined five of the past six years. The case completion rate has decreased from 24.9 completed cases per investigator in FY2005 to 20.6 completed cases per investigator in FY2010, a decrease of 17.3% compared to a nationwide decrease of 24.6%.

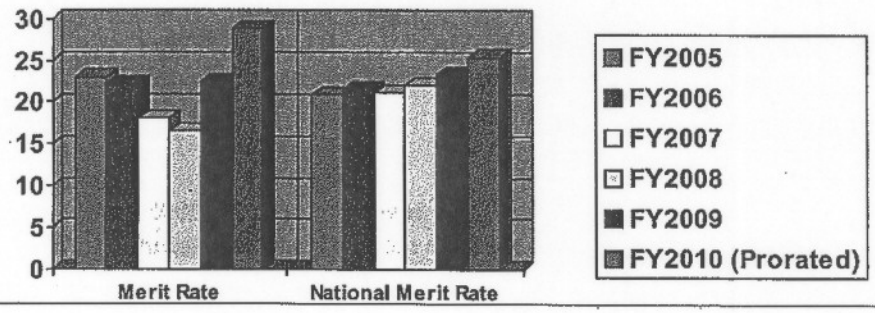
Region VI
Case Load/Investigator



Merit Rate

Region VI has had a varied merit rate over the last six years, from a low of 18.1% in FY2007 to a high of 28.8% in FY2010. Over the last three years the Region VI merit rate has continually increased and is currently 11.8% above the national average.

Region VI
Merit Rate



Region VII investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region VII has experienced case received and case completion rates generally above the national average, and open case rates consistently below the national average.

Received Cases

The case received rate has increased from 22 received cases per investigator in FY2005 to 26.9 cases per investigator in FY2010, an increase of 18.2%. Nationally the case received rate has declined from 27.2 cases per investigator to 23.3 cases per investigator, a decline of 14.3% cases per investigator. The received case rate is currently 13.4% above the national average rate of 23.3 cases per investigator.

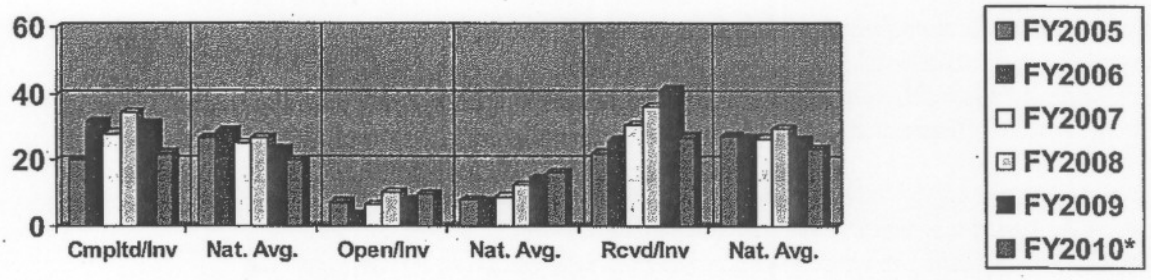
Open Cases

The open case rate has risen from 7.2 cases per investigator in FY2005 to 9.7 open cases per investigator in FY2010, a 25.8% increase. Even with the addition of three new investigators, the open case rate continued to rise by 1.9 cases per investigator although the open case rate is 40.5% below the national average of 16.3 open cases per investigator in FY2010.

Case Completion

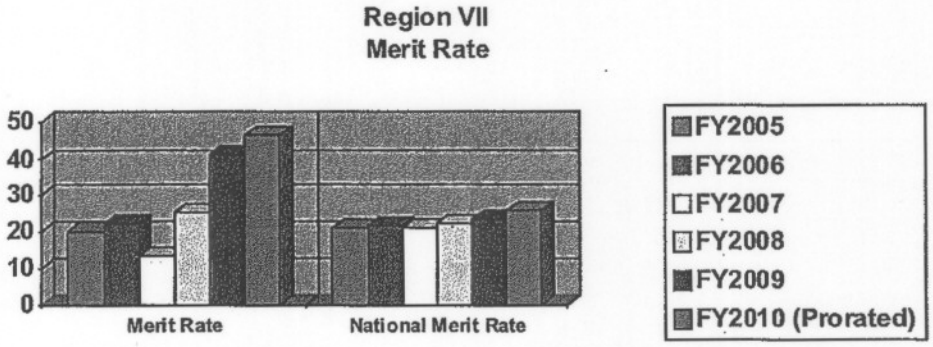
Over the last six years, Region VII has completed cases at a higher rate than the national average for four out of the six years. The case completion rate has increased over the last six years from a case completion rate of 20 completed cases per investigator in FY2005 to 22 completed cases per investigator in FY2010, a 9.1% increase as compared to a 14.4% decrease nationally over the same period of time. (This decline is solely related to the hiring of additional investigators during FY2010.)

Region VII
Case Load/Investigator



Merit Rate

The Region VII merit rate has dramatically increased over the last three years from a six year low of 13.4% in FY2007 to a high of 46.3% in FY2010. The dramatic increase appears to be primarily from a significant increase in settlements. The Region VII settlement increase should be studied as there may be some settlement methods that could be used at other regions with low merit rates. The merit rate is currently 45.1% above the national average.



Region VIII investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region VIII had experienced case received, open case, and case completion rates consistently above the national average until the doubling of their investigative staff in FY2010.

Received Cases

Over five of the last six years, Region VIII has received cases at a rate higher than the national average per investigator. The case received rate declined from 35.3 cases per investigator in FY2005 to 19.6 cases per investigator in FY2010, a decline of 44.5%. Nationally the case received rate has declined from 27.2 cases per investigator to 23.3 cases per investigator, a decline of 14.3% cases per investigator. (This decline is solely related to the hiring of additional investigators during FY2010.)

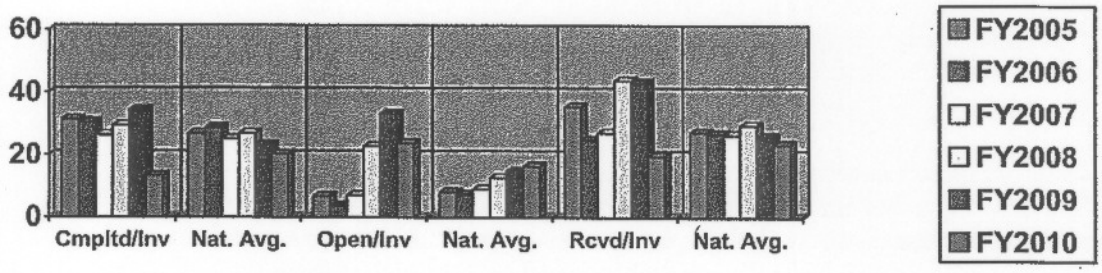
Open Cases

The open case rate has risen from 3.7 per investigator in FY2005 to 23.7 open cases per investigator in FY2010, a 641% increase. Even with the addition of three new investigators the open case rate still continues to be above the national average in FY 2010. The open case rate is currently at 23.7 per investigator, 31% higher than the national average of 16.3 per investigator.

Case Completion

Over the last six years, Region VIII has completed cases at a higher rate than the national average for five out of six years. The case completion rate decreased from 31.3 completed cases per investigator in FY2005 to 13.3 completed cases per investigator in FY2010, a decrease of 57.5% as compared to a nationwide decrease of 14.4% over the same period of time. However, this dramatic decrease can be attributed to the hiring of three new investigators in FY2010. The case completion rate per investigator should increase as the new investigators are trained.

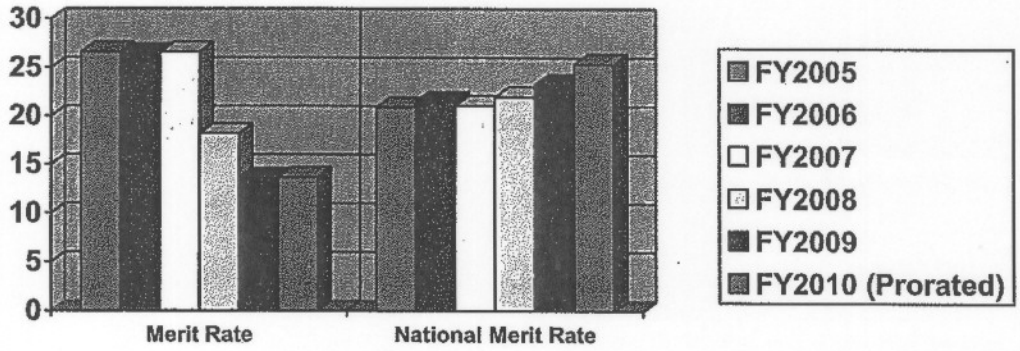
Region VIII
Case Load/Investigator



Merit Rate

Region VIII accomplished a merit rate increase from 26.4% to 26.6% during FY2005 through FY2007. However, the merit rates for FY2008 through FY2010 have dramatically declined. Overall the merit rate has declined from 26.7% in FY2005 to 13.7% in FY2010, which is 46.1% below the current national merit rate of 25.4%.

Region VIII
Merit Rate



Region IX investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region IX has experienced case received and case completion rates generally below the national average and open case rates consistently above the national average.

Received Cases

The case received rate has declined from 25.3 received cases per investigator in FY2005 to 17.4 cases per investigator in FY2010, a decrease of 31.2%. Nationally the case received rate has declined from 27.2 cases per investigator to 23.3 cases per investigator, a decline of 14.3%. The received case rate is currently 25.3% below the national average.

Open Cases

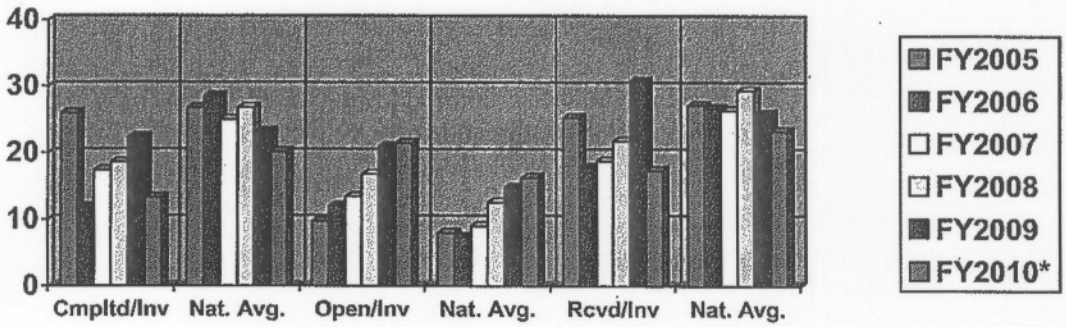
The open case rate has risen from 9.7 cases per investigator in FY2005 to 21.5 cases per investigator in

FY 2010, an increase of 121.6%. The open case rate has consistently been above the national average and currently remains 24.2% above the national.

Case Completion

The case completion rate has decreased from 26 completed cases per investigator in FY2005 to 13.3 completed cases per investigator in FY2010, a decrease of 48.8% compared to a nationwide decrease of 24.6%. When the two new investigators are fully functioning, the completion rate should dramatically increase.

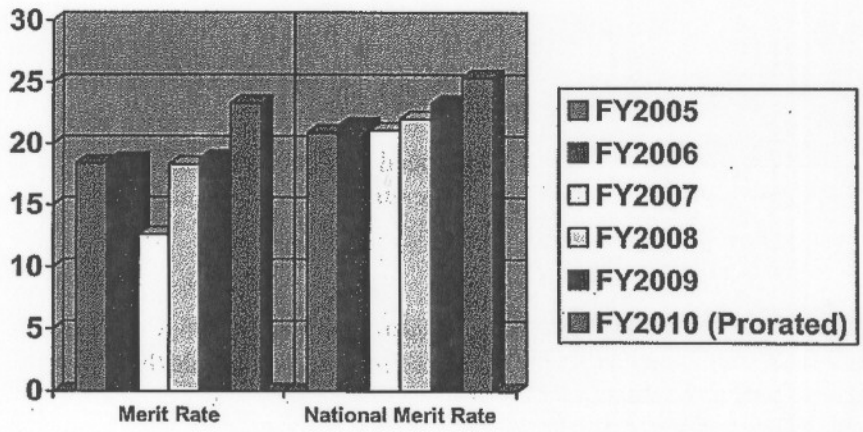
Region IX
Case Load/Investigator



Merit Rate

Region IX has maintained a merit rate that varies over the last six years, from a low of 12.6% in FY2007 to a high of 23.3% in FY2010. Region IX's merit rate has consistently been below the national average; currently their merit rate is 8.3% below the national average.

Region IX
Merit Rate



Region X investigation data and case load measurements: FY2005-FY2010

In reviewing six years of investigation data, Region X has experienced case received and case completion rates generally below the national average, and open case rates generally above the national average.

Received Cases

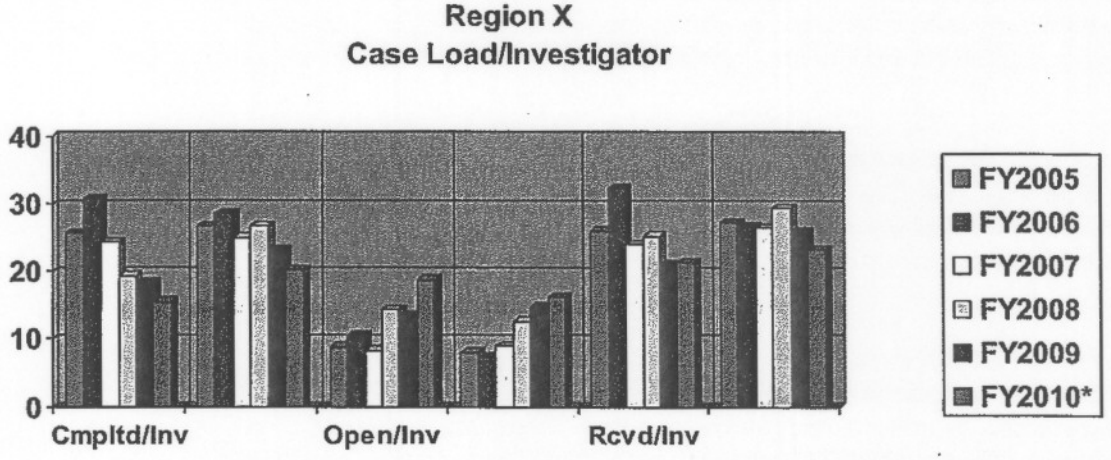
The case received rate has declined from 26 received cases per investigator in FY2005 to 21.3 cases per investigator in FY2010, a decrease of 18.1%. Nationally the case received rate has declined from 27.2 cases per investigator to 23.3 cases per investigator, a decline of 14.3%. The received case rate is currently 8.6% below the national average.

Open Cases

The open case rate has risen from 8.8 cases per investigator in FY2005 to 18.8 cases per investigator in FY2010, an increase of 53.2%. The open case rate is currently 14.4% above the national average of 16.3 cases per investigator.

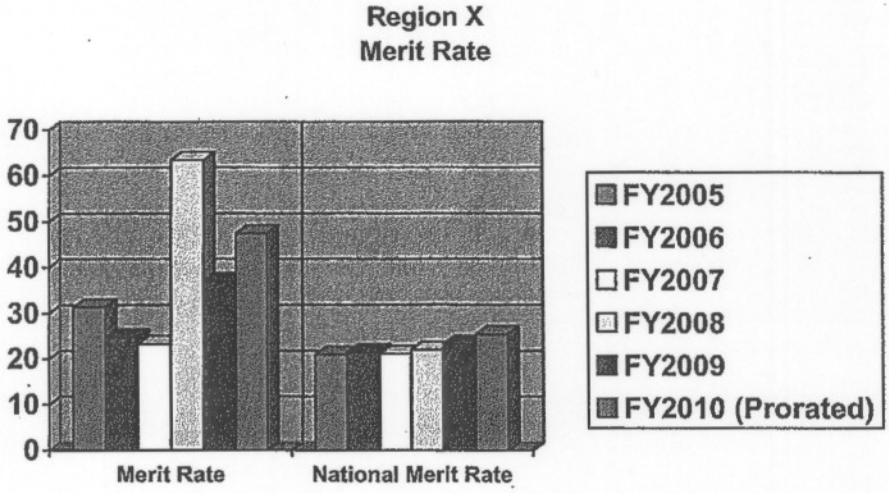
Case Completion

The case completion rate has decreased from 25.6 completed cases per investigator in FY2005 to 15.5 completed cases per investigator in FY2010, a decrease of 39.5% compared to a nationwide decrease of 24.6%. When the new investigator is fully functioning, the completion rate should increase.



Merit Rate

Region X has maintained a merit rate that is consistently above the national average for the last six years, and is currently 46.4% above the national average.



2.4 Equipment

The team researched the current status of equipment available to OSHA's whistleblower investigators and concluded that the types and amount of equipment available varied from investigator to investigator and from region to region, with some investigators being better equipped to perform their jobs than others. In some cases, investigators took it upon themselves to purchase laptops, digital recorders and other equipment to perform their jobs due to lack of funds and/or funding priority. Furthermore, the team determined that there is no set equipment list for investigators like the equipment list for compliance officers.

OSHA's equipment challenges were highlighted in the January 2009 GAO Report (GAO-09-106 Whistleblower Protection Program), and have been a topic of discussion by outside stakeholders and by the investigators interviewed and surveyed during this program review. Consistently, the review team heard from investigators that they were not fully equipped to do their jobs effectively and that they felt their equipment needs were given second priority to the equipment needs of the enforcement compliance staff.

There is little debate that properly equipped investigators will perform more effective, thorough and efficient investigations.

Recommendation:

Establish mandatory equipment and IT software list for all investigators. At a minimum the following items should be on the equipment/software list and issued to all investigators.

- Laptop with CD burner
- Portable printer
- Digital recorder equipped with accessories for both desk and cell phone connection
- Telephone headset
- Cell phone
- Thumb drive

- Case file/computer carrying case
- Full Adobe Acrobat/Redax software or equivalent
- Citrix account
- Audio redaction software
- Access to Westlaw
- Access to a scanner

In addition, issuing the following tools will assist investigators during their investigations:

- Pulse Pen
- Electronic signature pad or device for taking statements in lieu of portable printer

2.5 Budget

OSHA does not have a dedicated budget for the whistleblower program on the national, regional, and area office levels, with few exceptions. Currently, funding for whistleblower operations, training and equipment is integrated into the enforcement programs budget.

The practical implications of not separating the whistleblower program budget are as follows:

- Not budgeting for whistleblower staff or FTE affects staffing levels. FTE who should be dedicated to the whistleblower program can be easily shifted to fill other positions, shortchanging the total staff available to conduct investigations.
- In some regions, the lack of specific funding can lead to compromises with respect to travel funds available to conduct on-site investigations.
- Lack of dedicated whistleblower funds may lead to shifting of funds away from needed whistleblower investigator training.
- Without a line item budget for equipment, investigators will more than likely continue to be inadequately equipped.

The perceived implications of not separating the whistleblower program budget are as follows:

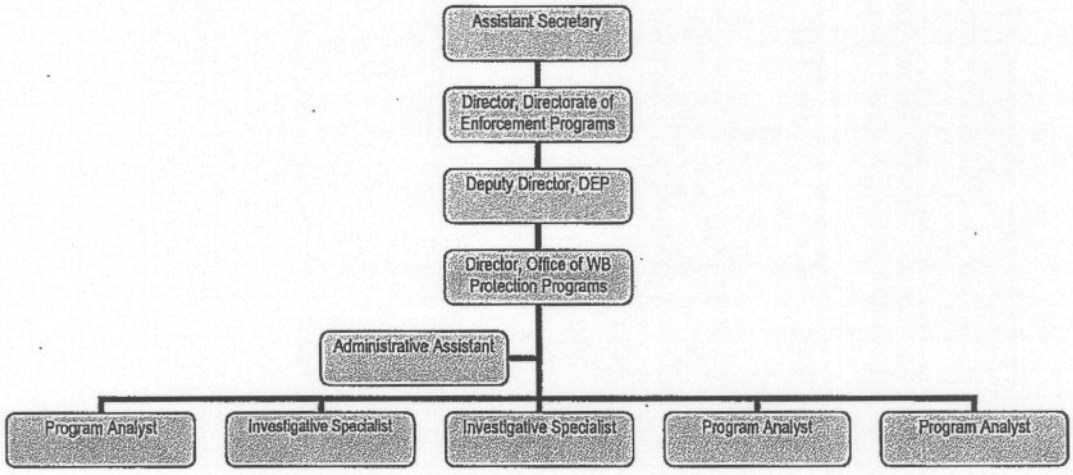
- The whistleblower program is not a priority.
- Whistleblower investigator morale is affected when decisions are made that funds are not available for whistleblower investigations, training or equipment because the funds are needed for enforcement operations.

Recommendation:

Create a specific line item budget for the whistleblower program on all organizational levels within OSHA. The budget would designate specific funds for personnel, training, equipment, etc.

2.6 National Office Review

The National Office whistleblower program is currently structured as follows:



Overall OWPP responsibilities per the Whistleblower Investigations Manual:

- Developing policies and procedures for the Whistleblower Protection Program.
- Processing appeals that are to be presented to the Appeals Committee under Section 11(c) of the Occupational Safety & Health Act (Section 11(c)), the Asbestos Hazard Emergency Response Act (AHERA), and the International Safe Container Act (ISCA).
- Reviewing case files and presenting cases to the Appeals Committee.
- Preparing memoranda summarizing the cases and recommending final determinations to the Director of the Directorate of Enforcement Programs.
- Constituting the majority of the Appeals Committee.
- Developing and presenting formal training for Federal and State field staff.
- Organizing national conferences.
- Providing technical assistance and legal interpretations to field investigative staff.
- Maintaining a law library of legal cases and decisions pertinent to whistleblower investigations.
- Sharing significant legal developments with field staff.
- Maintaining a statistical database on whistleblower investigations.
- Assisting in commenting on legislation on whistleblower matters.
- Maintaining Whistleblower Protection Program Web pages on the OSHA Intranet and Internet websites.
- Acting as liaison between the Whistleblower Protection Program and other government agencies.
- Supporting regional audits of case files to ensure national consistency.
- Assisting in the investigation of complex cases, as requested by the RA, or providing technical assistance in the investigation of such cases.
- Providing statistical information on whistleblower complaints to the public, both by informal request and by publishing statistics on the Web.

The Office of Whistleblower Protection Programs (OWPP) has the functional responsibility to coordinate whistleblower operations and work with all of the regions to ensure a strong, consistent, credible nationwide whistleblower program.

However, in practice, OWPP is not adequately performing in this leadership role. Some reasons to explain the lack of adequate performance are the following:

- OWPP's leadership role has been hindered by being structurally located in a Directorate whose primary mission is considerably different than the mission of the whistleblower program.
- OWPP is not wholly staffed with personnel with field experience and the technical expertise necessary to provide guidance and direction to the field.
- The whistleblower program has been less effective by the breakdown of collegiality between headquarters and the field.
- OWPP does not have enough personnel to handle the duties listed in their mission and functions statement. Leadership will need to decide the number of FTE assigned to OWPP based on their revised mission and functions statement and the level of expertise of assigned personnel.
- OWPP is ineffective working under DEP. This belief is held strongly by field staff. The team surveyed management and found that only 20% believe that OWPP should remain within DEP. The team also surveyed non-management, and only 9% believe OWPP should remain in DEP.

As a result, OWPP is not able to effectively lead the whistleblower program, maintain consistency, provide guidance to the field, provide a clear and consistent message to the public and stem external stakeholder criticism, so that workers blowing the whistle have a voice in the workplace.

Recommendations:

- Consider fundamental changes in the mission and function of OWPP and how OWPP is structured, managed, staffed, and funded.
- Remove OWPP from DEP and place OWPP in its own office reporting to the Assistant Secretary's office. Alternatively, the whistleblower program could be its own Directorate. In any case, we believe it should report directly to the Assistant Secretary's office.
- Institute confidence building measures to improve the level of communication and collegiality between the OWPP and the field.
- Provide adequate staffing to meet OWPP's new or revised mission and functions.
- OWPP have its own budget or at least line items for personnel, training, equipment, services, among others.

2.7 Survey

The review team developed and sent out two surveys to gather information and solicit views on the whistleblower program. One survey was sent to OSHA managers, including: Regional Administrators, Deputy Regional Administrators, Assistant Regional Administrators, National Office Directors, Area Directors, Regional Supervisory Investigators and Program Managers. The other survey was sent to non-managers including: investigators, OWPP staff, technical experts, and CSHOs assigned to perform whistleblower investigations. The questions in the two surveys are nearly identical except questions related to reorganizing the program, auditing and questions related to when and where interviews take place. For each question an option for additional comments was provided.

The information that the review team sought from the survey fell into general categories. These general categories included: position held in OSHA, duty station location, percentage of time focused on the WPP, level of knowledge and experience, organizational structure, budgeting, staffing, resources, training, policies and procedures, audits, investigation process (i.e., screening, interviews, full field investigations, file reviews), best practices, alternative dispute resolution, appeals process, state plan monitoring, dually filed complaints, CASPAs, program challenges and recommendations for program improvement.

The survey was sent to 58 OSHA managers, of which 33 responded (57% participation rate). The survey was sent to 92 non-managers, of which 79 responded (86% participation rate).

The condensed survey results are available in appendix A, with the complete results and comments available to the Assistant Secretary's office in an electronic format. A general summary of the views of each group is discussed below.

Throughout the manager survey, the general sentiment is that the program is not being administered effectively, lacks resources and needs reform. Of the managers surveyed 65% believe the WPP is stressed, while 29% believe it is broken.

The managers are clear in their view that they must have the flexibility to manage and administer the whistleblower program to fit their unique organizational and operational situations.

Throughout the non-manager survey it is quite clear that the perception on the part of the whistleblower staff is that the whistleblower program is not a priority, that in virtually every area from staffing levels, training, access to funds, equipment and support the whistleblower program comes second to safety and health enforcement programs.

Furthermore, the general non-management view is that mid-level OSHA management is ill-equipped to deal with the complexities of the program because they lack training and experience in the program, even though they are responsible to review investigation files and make critical decisions on the whistleblower program.

The survey results and comments indicated that there is a severe morale problem within the ranks of the whistleblower field staff. Investigators commented on feeling like the "step child" of the organization. They feel undervalued and overworked and that they don't receive adequate support, training and equipment to do their job.

Investigators state that case load and case complexity have risen, and as a result they are having difficulty managing their case loads and completing quality investigations. Investigators feel there is only so much they can do when the agency is so severely short-handed. Investigators feel demoralized because they can't keep up the pace and feel that they are not addressing the complaint as thoroughly as possible.

Regarding equipment, the view is that investigators are not provided with essential equipment to do their jobs. Some investigators commented that they lack laptops, digital recorders, cell phones, portable printers, jump drives, Citrix access, among other equipment. Out of frustration, some investigators have resorted to purchasing their own equipment and supplies to perform their jobs. Some investigators commented that they don't even have work stations.

Percentage of time focused on the WPP: about half of all managers spend 20% or less of their time on whistleblower issues; non-managers spend the majority of their time focusing on the WPP.

With respect to the experience of OSHA staff, managers tend to have worked with whistleblower issues for a greater number of years than investigators. According to the survey, just over 46% of non-managers have less than three years' experience working on whistleblower issues.

According to the survey, 78% of managers feel their level of knowledge is good to excellent; however,

22% of managers stated that they have very little knowledge of the whistleblower program. 98% of non-managers feel their level of knowledge is good to excellent.

On the subject of training, managers are uniform in agreement that investigators need more training to perform their jobs more effectively. According to the survey, 88% of all investigators surveyed have taken the 1420 course, but there were several mixed comments that this training was either inadequate to prepare them as investigators or in some cases too basic to be of any use. With respect to the 1460 course, 70% attended the 1460 course. The main comments state the course is too rushed and should be expanded to review all statutes in depth. In general, investigators want more training on a more frequent basis. Some of the courses mentioned that need to be developed to better prepare them to do their jobs include a comprehensive interviewing course, legal concept courses, writing courses, and settlement negotiations and mediation courses.

On the subject of the Investigations Manual, the overall sentiment is that the manual needs to be revised and followed consistently throughout the country. There were comments that investigators are directed to follow policies that are not part of the manual because the manual is not fully implemented in their region; however, in a number of cases that is because the manual is outdated or because regions implement their own whistleblower policies. As was mentioned previously, managers want the flexibility to manage the program to meet their needs and that is why there are a number of regional policies. For example, non-managers commented that their regions have whistleblower program policies on appeals, case tracking, screening, and FOIA, among others.

On the effectiveness of the organizational structure, comments from managers were mixed. Managers agree or strongly agree in 67% of the responses that their current organizational structure is designed for effective management of their regional WPP. This percentage falls in line with the sentiment that about two-thirds of managers believe having a RSI is most effective, while one-third believe utilizing area directors with a regional program manager or technical expert available for assistance is most effective.

However, about 50% of non-managers feel their organizational structures are effective and about 40% disagree or strongly disagree that their current organizational structure is effective. Non-managers commented that their current organizational structure is designed to support the compliance side of OSHA which is not necessarily effective for whistleblower operations. Several commented that they were dissatisfied with having to report to Area Directors claiming insufficient knowledge of the whistleblower program. Many feel that the direct and active involvement of a competent and knowledgeable whistleblower supervisor is the key to a successful operation. When surveyed on their current structure, 51% work under the RSI model and the rest work under an area director model. When surveyed on what they feel is the ideal structure most investigators feel the RSI model works best, but some commented that the structure should be where the National Office supervises the RSIs. Only 1.4% of non-managers surveyed believe the Area Director model is effective.

Where OWPP would be most effective: 45% of managers believe that OWPP should be its own OSHA Directorate, 35% believe the whistleblower program should be pulled out of OSHA altogether, the remaining 19% believe that OWPP should remain under DEP. For non-managers, 44% believe that OWPP should be its own OSHA Directorate, 47% believe the whistleblower program should be pulled out of OSHA altogether, and the remaining 8% feel that OWPP should remain under DEP.

Auditing: 47% of managers believe the National Office should conduct audits, 37% believe this is a regional function, while the rest believe it should either be a combination of the two or entirely outside the agency. For non-managers, 61% feel this should be a National Office function, while 27% feel it

should be a regional function. Regarding the frequency of audits, 87% of the managers surveyed say audits of their whistleblower programs take place at frequencies between once every year to every four years. The remaining 13% stated they never perform internal whistleblower program audits.

Interviewing complainants in person makes a more effective investigation: 40% of managers and non-managers agree, while 60% disagree. Most that commented agree that in-person interviews are preferable, but that travel, cost, time and other factors may not make it practical for every investigation. Likewise, managers and non-managers tend to agree that on-site investigations are important, but circumstances may dictate the need to handle the investigation in another manner.

The majority of investigators in the field take formal complainant, respondent and witness statements, but with decreasing frequency.

Both managers and non-managers agree that in general investigative files are adequately reviewed by a supervisor prior to merit or non-merit decisions; however, 10% of managers and 15% of non-managers disagreed or strongly disagreed with that statement.

Both managers and non-managers overwhelmingly agree that a mediation/alternative dispute resolution program can be an effective tool to resolve whistleblower complaints.

Both managers and non-managers agree that the current National Office appeals process is ineffective. Comments focused mainly on the backlog and length of time to get a response from the National Office. Suggested changes include hiring more OWPP staff to clear the backlog or give the task to the regions. Another comment is that legislation be enacted to give complainants a private right of action.

With respect to state plan monitoring activities, the majority of those surveyed spent 0% to 20% of their time on state plan issues, but a minority answered that they spent 60% to 100% of their time on state plan issues. Comments from management were that state plan whistleblower programs have not been monitored routinely and as a result there are questions whether the state programs have similar problems as the federal whistleblower program. The point was also raised that there is not enough staff to do effective state plan whistleblower monitoring. Other state plan related activities like dually filed complaints and CASPAs are handled by the regions. Comments from managers and non-managers on those activities indicated that they are time consuming and a drain on resources.

The survey asked what challenges there are in administering the whistleblower program and there were similar responses from both managers and non-managers. Comments from this question included elevating the program's status within the organization, lack of resources, lack of funds, more staff, more training, inconsistencies in the program, balancing the need for quality investigations against the pressures of an ever-increasing caseload, etc.

When asked where the agency should focus its attention to improve the program, those surveyed identified the following critical areas that need attention: restoring OWPP to a leadership role through reorganization if necessary; provide more resources, staff, and training; reduce case load; develop and enforce consistent policies; make IMIS improvements; and rebrand the whistleblower program to garner it more respect both inside and outside OSHA.

2.8 Policy/Procedure

The agency has not revised the Whistleblower Investigations Manual (DIS 0-0.9) since August 23, 2003.

Since that time, the agency has relied upon memoranda, informal communication such as e-mail and/or scheduled conference calls from OWPP to provide policy change to the field. Since 2003, unsuccessful attempts have been made to revise the Whistleblower Investigations Manual. Consequently, the field lacks up to date guidance, especially on new statutes that creates inconsistent results from region to region. The agency is currently vetting a revised manual which, when approved, should provide the field the direction they need to conduct investigations in a consistent manner. The manual is one of many tools needed to effectively manage the program. As the agency does with enforcement, we need to ensure that this policy manual is updated on a frequent basis to maintain current guidance. In the interim, all direction provided to the field is vetted as any other policy change and then incorporated as necessary into a change to the manual.

Although the team is not taking part in the vetting process, the team and the field are concerned that the recently adopted non-public disclosure policy that is currently being vetted and has been incorporated into newly revised regulations will substantially add to the field's workload, and can result in inconsistent application of non-public release of information. Formal guidance and training will have to be provided to personnel to ensure consistent release of information. The current and revised manual does not provide clear guidance on this issue. Field staff will need to be trained and provided formal guidance on the application of this policy.

Recommendations:

- Complete the revision of the whistleblower investigators manual.
- Issue interim guidance on the new statutes that are not covered in the revised manual.
- Incorporate the interim guidance on the statutes as soon as possible into the manual.
- Update the manual frequently to ensure changes to policy and procedures are current.

2.9 Investigations Process

The team conducted an on-site evaluation of five regions. The purpose of these on-site reviews was to gather information on inefficient processes, consistency, and adherence to policy. Additionally, the team sought out best practices in order to share with other regions. Case file reviews were limited in scope and were focused on finding general inconsistencies. Our intent was not to conduct lengthy case file audits.

Complaint Receipt

Each region visited took complaints in accordance with current policy. Complaints are taken both orally and in writing, depending on the requirement of the specific statute.

OSHA policy allows each region the flexibility to determine the most suitable complaint receipt process. Consequently, each region has a unique complaint receipt process based on their organizational structure. For example, in Region II a majority of the complaints are received at the area office level utilizing an OSHA 87 or equivalent form. The complaint form is then submitted to the Regional Supervisory Investigator for screening, pending assignment to an investigator. In Region I, IV, V, and IX, the telephone calls are referred from the area office to an investigator for intake and screening. We found no discrepancies in any of the reviewed complaint receipt processes.

As is proposed in the draft manual and current interim final regulations, the policy of taking complaints

for all statutes both orally and/or in writing will impact the complaint receipt processes for those regions that utilize non-whistleblower staff for oral complaint intake. Specifically, the regions will have to ensure that all non-whistleblower staff members are trained to identify whistleblower complaints for all nineteen statutes. To avoid the challenge of having non-whistleblower staff take complaints, the regions may decide to shift the primary responsibility of complaint receipt to the whistleblower staff, which will add additional duties to an already stressed staff.

Complaint Intake (Screening)

Three of the 19 statutes allow for the "screen out" of complaints. These statutes are Section 11(c), ISCA and AHERA. In 2009, the GAO evaluated OSHA's screening and docketing procedures and concluded that OSHA does not consistently screen and docket complaints utilizing standard methods from region to region. The team confirmed GAO's assessment that there are regional variations in this process.

Screening Data Collection and Retention

In the absence of a standardized system to collect "screened out" cases, the regions have created individual methods in capturing and maintaining data. For example, one region utilizes the Outlook Calendar system, another region created a Microsoft Access database, another created a Microsoft Excel spreadsheet, and still others a manual collection/retention system.

These multiple systems create inconsistencies in the collection and retention of data. Without a standardized system to collect and retain screening data, it is difficult to ascertain how many attempts to file complaints are screened out and whether it was appropriate. Additionally, we have no method of capturing the time spent on screen outs. the team believes the time spent to be considerable, averaging approximately 1 to 1.5 hours per screen out.

Recommendations:

- Revise and expand the guidance on administratively closing (screen-out) cases.
- Until an IMIS update occurs, establish a standard method of documenting, tracking and retaining administratively closed complaints.
- Capture administratively closed case time on the activity and hours form (OSHA 31s).

Training (over and under screening, consistency)

The team reviewed screened out cases at all visited regions and found instances of both over screening and under screening. Factors for this inconsistency include inadequate training, lack of management oversight, and heavy caseloads.

Recommendations:

- Ensure that supervisors review and approve all screen outs.
- Develop and provide training to personnel assigned to receive/screen whistleblower complaints on proper screening and documentation methods.
- Audit screen outs on every audit.

Investigation methodology

The team evaluated how each region investigates a whistleblower complaint and found variations in the investigation process. Variations observed in the process included:

- Method of respondent notification
- Timing of settlement discussions
- Method of interviews
- Methods of document gathering

For the most part, the variations in investigation methodology had no impact on case outcome, with one important exception. Regions that approach parties for settlement discussions early and often appear to have greater success in early resolution than the regions that do not emphasize early resolution.

Recommendations:

- Revise policy to emphasize the agency's desire for early resolution.
- Allow for regional flexibility on the methodology used to investigate a case.
- Following the implementation of the updated manual, study its impact on field operations.

Evidence Testing and Analysis

The team identified other factors that cause inconsistencies in the outcomes of investigations. There were instances where evidence was not tested or inadequately tested. We also found instances where the evidence was incorrectly analyzed. The common causes of these inconsistencies did not relate to process; rather the causes were inadequate training, lack of management oversight, heavy caseloads and misapplication of vague policies.

Recommendation:

- Develop a training course on the collection and testing of evidence, including the proper application of legal requirements contained in the statutes.

Settlement/Mediation

OSHA received criticism from the GAO, OIG and from external stakeholders that settlement procedures may have deprived complainants of proper restitution. The parties also claim that OSHA's settlement data is not reliable, believe that OSHA should train their investigators in settlement negotiations techniques, and that settlement negotiations begin as early in the investigation process as possible.

Current OSHA settlement policy as contained in the whistleblower investigation manual states:

> "The Secretary favors voluntary resolution of disputes, and investigators are encouraged to actively assist the parties in reaching an agreement, where possible. It is OSHA's policy to seek settlement of all cases determined to be meritorious prior to referring the case for litigation. Furthermore, at any point prior to the completion of the investigation, OSHA will make every effort to accommodate an early resolution of complaints in which both parties seek it."

To address the concerns expressed by the GAO, OIG and external stakeholders, the team analyzed settlement practices in the visited regions. Although this is not an exhaustive study, the team found the following inconsistencies:

- In the limited settlements that we reviewed, we found instances where the analysis of fair and equitable restitution was not annotated in the case file.
- The IMIS instructions do not clarify how to properly record settled cases in the system.
- Those regions that emphasize early settlement provided investigators with training on settlement techniques while others did not.
- Some regions properly utilize the recommended settlement templates while others did not.
- Some regions ensure that repugnant clauses are excluded in approved settlements while others did not.
- There are different styles and skills needed to be a successful negotiator and/or mediator. Currently, OSHA does not have a training class in settlement negotiations or mediations. The course #1420 - the Basic Whistleblower Course – 11(c) provides minimal training on settlement negotiations.

Additionally, OSHA does not have a formal mediation/alternative dispute program. Other agencies such as Office of the Administrative Law Judges (OALJ), the OSH state grantee in Oregon and the Equal Employment Opportunity Commission (EEOC) have adopted formal mediation/alternative dispute programs. This type of program has been viewed in the field as a program that can add value to the settlement process. To begin the national dialogue on a uniform mediation/alternative dispute program, Regions II, IX and X drafted proposed regional programs for consideration as a national program. The team has received these proposals. See Appendix B for the draft proposals.

Recommendations:

- Develop and deliver a mandatory training course on settlement negotiations.
- Develop and implement a national mediation/alternative dispute program.
- Develop and provide a training course for those designated to participate in the mediation/alternative dispute program.
- Ensure that settlements are analyzed for fair and equitable restitution and annotated in the case file.
- Ensure that IMIS instructions clarify how to properly record settled cases.
- Ensure that regions properly utilize the recommended settlement templates.
- Ensure that regions follow the policy on approving settlement agreements.

Case File Review/Approval Process

The current manual states in part, "The RA is authorized to issue determinations and approve settlement of complaints filed under the various whistleblower statutes. This authority may be re-delegated, but no lower than the Assistant Regional Administrator or Area Director level. The proposed draft manual suggested a change to, "the authority may be re-delegated, but no lower than the supervisor (or team leader)."

The team found instances where the final investigative report was not approved and signed by supervision. Additionally, determination letters are frequently signed by supervisors. GAO and some

external stakeholders have criticized the agency for the lack of oversight and accountability.

Recommendation:

- Ensure that cases are properly reviewed and approved by supervisors.
- Reconsider the proposed policy allowing supervisors/team leaders to sign final determination letters. Require mid-level managers to sign final determination letter.

2.10 Appeal Process

There is no statutory requirement for the acceptance of an appeal under Section 11(c), Asbestos Hazard Emergency Response Act (AHERA), and the International Safe Container Act (ISCA). However, OSHA has provided an "administrative" appeal process for aggrieved Complainants and this appeal process has been administered by OWPP. This process allows for a "second look" at a determination where the complainant is not satisfied. Currently OWPP is ineffective in administering this process, resulting in lengthy delays in appeal decisions.

In an effort to combat the lengthy delays, the National Office agreed to allow Regions IV, V and VI to pilot "Regional Appeals" programs. The Regions formulated their appeals program utilizing the ADM 8-0.2, OSHA Policy Issuances, ADM-8-0.3, OSHA Directive Systems and the rules of procedures specified in 29 CFR 1903.12. The policies are located in appendix C.

The other problem in the appeals program is the large backlog of pending appeals at OWPP. As of August 2010 there were 246 backlogged appeals. The regional breakdown of appeals is listed in the following table:

Pending Appeals Table

Region	Pending appeals
I	31
II	28
III	21
IV	33
V	65
VI	25
VII	9
VIII	16
IX	11
X	7

The team has concerns about the lack of effort being made to decrease and/or eliminate the backlog. The team's other concern is that permitting four separate appeals programs will lead to inconsistencies and further external criticism.

Recommendations:

- Direct OWPP to reduce the appeals backlog by performing a specific number of appeal reviews

every month.

- Return all Region IV, V, and VI appeals for their processing or, alternatively, provide staff on detail to process appeals.
- Require OWPP and those regions with a pilot program to report on the progress of their appeal reviews on a quarterly basis.
- Identify the best procedures of each appeals program to develop a single written policy, whether administered by the National Office, regional level or a combination thereof.
- Establish an appeal processing deadline of 60 calendar days.
- Limit the number of reviewing officials to as few as possible; we recommend no more than two employees.
- Utilize employees who have whistleblower expertise to conduct appeals.
- Utilize a formalized template to document the analysis and conclusion of the review.
- Ensure there is an independent reviewer and deciding official.
- Determine the OWPP staffing needs for their appeals processing responsibility.

2.10 Performance Measures

Historically, OSHA has used only two performance indicators for the whistleblower program; completed cases and case lapse time, that is, the time between the date of receiving the complaint and the issuance of findings (or other appropriate means of closure, such as withdrawal). These measures are not enough to provide management an effective performance measurement system in order to measure the quantity or the quality of the work or to determine future staffing needs.

To give some perspective to the lack of performance indicators, the agency has numerous indicators for the enforcement program that are analyzed and provided by the National Office on a monthly basis to the regions. By utilizing a large number of indicators, the agency is able to identify outliers and other potential areas of concern in a timely fashion. To overcome the lack of national whistleblower indicators, most regions have developed weekly whistleblower indicators reports.

Recommendation:

In order to effectively measure performance, we suggest the following measures be considered:

- Activity and hours form (OSHA 31): Ensure that investigators, CSHOs conducting investigations as a collateral duty, and any other program supervisor complete the case activity and hours form (OSHA 31).

- Lapse Time: Measure lapse time in a manner similar to enforcement such as:
  - complaint receipt to interview
  - complainant interview to investigation
  - investigation completed date
  - investigation approval date
  - findings issuance date

- Merit Findings: Measure findings issued separate from settlements.

- Settlement Rate: Include quality measurements such as:
  - percentage of settlements that contain the core elements of a settlement

- percentage of OSHA settlement agreements versus party settlements
- percentage of settlements for enhanced settlements (Notice to Employees, Training, etc.)
- percentage of cases referred for litigation – OSHA Action 11(c)/STAA

- Appeals: Include outcome and timeliness.
  - percentage of remand
  - percentage upheld
  - timeliness of appeal decision

2.12 Whistleblower IMIS

The current Whistleblower Information Management System (WB IMIS) allows the agency to collect key information on case handling and disposition; however, there are shortfalls that need to be fixed. The decision to leave this program out of the current OIS rollout will have to be remedied by short-term fixes until the whistleblower OIS system is implemented.

Agency decisions on how to input cases has caused some controversy with external stakeholders. For example, external stakeholders believe classifying a settled case as a merit case is not accurate, because OSHA has not come to a finding but has only resolved the issue to the satisfaction of the parties. An updated Web IMIS system will allow the agency to report this data separately.

WB IMIS Shortfalls:

- Unable to capture administratively dismissed cases (screened out) and referrals to other agencies.
- Reports are difficult to understand or use. The user is unable to roll whistleblower data into report worksheets such as Excel or Access.
- Can not capture deferred investigations.
- Reports don't indentify multiple statute filings
- System reports all merit findings and settlements in one indicator
- System has no ability to identify data errors or provide missing data reports similar to the enforcement reject report.

Recommendations:

- Make modifications to whistleblower IMIS system as indicated in the section above.
- Roll out the whistleblower OIS in the earliest timeframe possible
- Update the whistleblower IMIS manual and post the manual on the OWPP intranet page.
- Develop a new IMIS course.
- Mandate all field staff attend the new whistleblower IMIS course.
- Break out settled cases from merit cases in the IMIS system.
- Include administratively closed cases (screened out) in the IMIS system.
- Ensure timely and consistent data entry, including post investigation closure
- Ensure that settled cases are not entered as withdrawals
-

2.13 Freedom of Information Act Requests/Non-Public Disclosure

Requests for investigative files and other information regarding whistleblower activities are received at a high percentage nationwide, particularly under certain statutes such as SOX. Additionally, the agency is in the process of adopting a revised policy on the disclosure of information in all investigations entitled "non-public disclosure." The large number of FOIA requests and the revised non-public disclosure requirements place a tremendous workload on field staff.

Most field staff members are not formally trained in the proper application of FOIA exemptions or the Privacy Act, both of which come into play in the non-public disclosure policy. The guidance in the draft whistleblower investigations manual on non-public disclosure is not sufficiently detailed, merely directing that documents are "redacted, if necessary, in accordance with the Privacy Act and other applicable confidentiality laws."

Essentially, in most Regions, we are now asking our staff to conduct a task they are not formally trained to accomplish. Furthermore, the agency has no guidance manual on the application of the Privacy Act or FOIA to an investigative work file. The absence of a manual causes inconsistencies in the redaction and release of materials.

Another problem is that the agency lacks the necessary equipment and software to effectively and efficiently accomplish this task. For example, interviews are frequently captured with the use of a digital recorder. Specialized software is needed in order to redact and share these interviews. As a consequence, frequently the interviews are either not shared or the interview is transcribed at great time or cost. We have included recommendations for equipment in that section of the report to deal with this issue.

Recommendations:

- Develop a comprehensive FOIA/Privacy Act guidance manual for the processing of a FOIA request, and non-public disclosure. The manual should include an example of a redacted case file and specific guidance on the more difficult issues such as confidential business information.
- Develop and implement training for field staff to properly apply the FOIA/Privacy Act requirements.
- Revise the non-public disclosure request to actually require a request.
- Evaluate the impact of the non-public disclosure policy on staffing and resources.
- Consider a moratorium on the non-regulatory disclosures until the impact is studied in the field.

2.14 State Plan Monitoring

Until recently, OSHA did little monitoring of a states' administration of their OSH whistleblower program. With the increased emphasis on monitoring the performance of state OSH programs, it should be common practice to include state OSH whistleblower programs in the annual monitoring plan. Although state performance was not included in the scope of this assignment we believe that many of the issues needing improvement in OSHA's whistleblower program may apply to the states' programs. These issues include:

- IMIS data entry: It appears that not all states are entering case data into the IMIS system or not entering data in a timely fashion.
- The number of personnel assigned to conduct investigations and their training should be reviewed.

- Annual monitoring should include the review of a sampling of whistleblower case files.
- Ensure that state policies and procedures are consistent with OSHA policy and procedures.
- A review should include equipment provided to state personnel who conduct investigations.

Complaints Against State Plan Administration (CASPA)

There appears to be an increasing number of CASPAs relating to state whistleblower investigations. CASPAs add to the workload of federal whistleblower investigators when they are tasked to investigate the validity of the complaint and recommend corrective action. This workload is not being captured in the current staffing plans. Secondly, an increase in CASPA activity may indicate systemic problems with the state whistleblower program(s).

On May 17, 2010, Assistant Secretary Michaels issued a policy memorandum that specified the handling of whistleblower CASPAs. The memorandum has not been posted on the OWPP intranet page, which is where field WB staff looks for guidance and direction. A/S Michael's memorandum on whistleblower CASPAs states the following:

Discrimination CASPAs. If a CASPA addresses a discrimination complaint or the State's discrimination program, the Region should involve its 11(c) discrimination staff in the investigation.

Case-specific inspection or discrimination CASPAs. If the Region finds that the outcome in a specific State inspection or discrimination investigation is not appropriate (i.e., does not follow State policies and procedures, is not at least as effective as OSHA's policies and procedures, or the final State action is less effective than if investigated Federally), the Region should require the State to take action to correct the outcome whenever possible, as well as make procedural changes to prevent recurrence. When it is not feasible to reopen an inspection case, alternative means to address the hazard(s) should be explored, e.g., an advisory letter to the employer. **It should always be possible to reopen a discrimination case.**

The direction contained in the memorandum has not been fully incorporated into the draft investigations manual. Specifically, Chapter 7, paragraph V.E.7 requires OSHA to reinvestigate a state whistleblower complaint when OSHA does not agree with the state's determination. This is contrary to A/S Michaels' policy memo in which he requires the state "take action to correct the outcome whenever possible, as well as make procedural changes to prevent recurrence. **It should always be possible to reopen a discrimination case.**" The team believes that the memorandum and draft manual provide conflicting policy guidance and should be clarified.

Recommendations:

- Conduct comprehensive reviews of the state whistleblower programs immediately in states where comprehensive reviews have not been recently conducted.
- Clarify the policy conflict on dually-filed complaints.

2.15 Management Accountability Program

OSHA has been criticized by the GAO and IG for the lack of an effective oversight program. As a result of these criticisms, on September 15, 2010, OSHA issued a new Management Accountability Program Directive (EAA 01-00-004).

The directive contains no guidance on audit questions. The Directorate of Evaluation and Analysis (DEA) provides audit questions on the intranet site that regions are expected to utilize for critical audit topics. These audit questions have not been updated for the whistleblower program in many years. Furthermore, DEA lists approximately 1 ½ pages of questions for auditing the whistleblower program in comparison to the over 15 pages of suggested audit topics and questions for the auditing of the enforcement program.

The whistleblower program is identified as a critical audit topic and is required to receive a comprehensive on-site audit at least every four years. DEA is now required to participate in all Regional Office and selected Area Office audits. The agency would be better served to have DEA coordinate and oversee this activity, but utilize subject matter experts in the National Office to participate in field audits.

In conjunction with OWPP, DEA should coordinate the update and expansion of the suggested audits questions to be more in line with current policy and requirements.

Recommendations:

- Expand and update the suggested audit questions for the whistleblower program.
- Incorporate the suggested audit topics into the Management Accountability Program Directive.
- Ensure that subject matter experts are utilized as participants selected to represent DEA on the National Office attended audits.

2.16 Training

Training is critical to ensure that whistleblower management and non-management staff is prepared to properly manage and operate a credible and consistent whistleblower program. Therefore, the agency must develop and implement a training directive for the whistleblower program, revise and develop new training courses, and establish infrastructure to deliver this training. The lack of training was emphasized by GAO as an agency shortfall, which is important because 46% of the current whistleblower investigative staff has less than three years of experience. Furthermore, many managers responsible for this program lack the necessary training to effectively manage the program.

OSHA does not have a training directive specific to the whistleblower program, unlike the training directive established for compliance personnel. The goal of this directive is to "assist CSHOs and their supervisors with direction, guidance, and training options that directly contribute to the CSHO's ability to represent OSHA with a high degree of professional expertise." It is imperative that the whistleblower staff have a comparable training directive.

In March 2006, a competency model was developed to identify the core skills, knowledge and ability needed to professionally investigate whistleblower complaints. OWPP used this model in order to develop new and revised courses with the assistance of OSHA Training Institute (OTI). The competency based model was utilized to revise and develop the two basic courses. The group also developed a list of statute-specific and skill-specific courses such as a course for supervisors, legal aspects, interviewing techniques, investigating complaints under the Sarbanes-Oxley Act, investigative writing, negotiating settlement agreements, Freedom of Information Act, and handling of evidence specific to the whistleblower program. These statute and skill specific courses were never developed.

The Directorate of Training and Education (DTE) is responsible for OSHA's training. To that end, the staffing, development and delivery of training for the whistleblower program would be better placed under DTE. The reason that DTE should have primary responsibility for the whistleblower training program is that they have the infrastructure and training expertise to create new courses and to deliver a credible and sustained training program. Furthermore, OWPP is currently over tasked with programmatic issues to effectively develop and deliver training.

Recommendations:

- Review and update the 2006 competency model
- Develop and implement a whistleblower training directive.
- Revise and develop new whistleblower courses to include; managing and supervising the whistleblower program, legal aspects, interviewing techniques, statute specific investigation course, investigative writing, settlements/mediations course, Freedom of Information Act and Non-Public Disclosure, evidence gathering and handling, and web IMIS.
- Move all training responsibility to DTE and adequately staff for development and delivery.

2.17 External and Internal Reviews

Since 1988, the whistleblower program has been reviewed by the GAO on three occasions (1988, 2009, and 2010) and by the DOL-IG on four occasions (1989, 1997, 2001 and 2010). Additionally, in 1998 OSHA assembled a task force to review pertinent whistleblower issues and provide recommendation for improvement. The OSHA task force made numerous recommendations to improve the program. The one internal review is located in appendix D. The seven external reports are listed in the References section and can be accessed by visiting the GAO and OIG websites.

Regarding the 1988 GAO report and the 1989 IG report, the findings and recommendations primarily dealt with the lack of an effective management information system and that complaints were not investigated within statutory timeframes.

In the 2001 IG report, the IG made recommendations to improve training and management practices and reiterated the agency's need to investigate complaints within statutory timeframes.

The 2009 and 2010 GAO reports again recommended continued improvements to the management information system, and added new findings on ineffective management controls, ineffective training and the lack of equipment.

Finally, the 2010 OIG report criticized OSHA for not always ensuring that complainants received appropriate investigations and recommended fixes on management oversight, case load, and performance measures.

In 1998, OSHA assembled a task force that conducted what we would characterize as a "top-to-bottom" review of the existing whistleblower program. This task force made numerous recommendations to improve the program. The executive summary statement captured below provides a summary of the task force's findings and recommendations:

> *"The Whistleblower Program has not received adequate management support and oversight. Effective functioning of this program can only enhance operations throughout the Agency. High level attention to and positive publicity about the program needs to*

occur with the Agency, at the State level, with stakeholders and with the customers. Resources need to be provided to allow the quality completion of the investigative process within the statutory limitations. These resources include staff, equipment, IMIS programming and operations, and training funding. The RSIs and Program Managers must meet regularly to insure consistency throughout the country."

Recommendation:

After countless reviews by both external and internal groups, and the identification of numerous programmatic problems and improvements, the agency needs to take a systemic approach to repair the whistleblower program. A piecemeal approach has been tried in the past and has been proven ineffective.

2.18 External Stakeholders

The team was tasked by DAS Fairfax to speak with outside stakeholders and solicit their views on OSHA's administration of the whistleblower program. As a result, the team met either in person or via telephonic conference call with the following interested parties:

- Richard Renner, Legal Director, National Whistleblowers Center
- Tom Devine, Legal Director, Government Accountability Project
- David J. Marshall, Partner and Alison B, Asarnow, Associate, Katz, Marshall & Banks, LLP Attorneys at Law
- Cyrus Mehri, David Welch and Ellen Eardley, Voices for Corporate Responsibility
- Jason Zuckerman and R. Scott Oswald, The Employment Law Group
- Peg Seminario, Director of Safety and Health, AFL-CIO; John Rupp, UAW; Steve Mitchell, UAW; Jim Frederick, USW; Nancy Lessin, USW; Eric Frumin, CTW and SEIU; Steve Fowee, IAM; Matt Clark, BCTGM; Larry Willis, TTD

The team attempted to meet with Richard D. Miller, Senior Labor Policy Advisor, House Education & Labor Committee, Workforce Protections Subcommittee, U.S. House of Representatives and Jeff Ruch, Executive Director, Public Employees for Environmental Responsibilities but was unsuccessful.

At the conclusion of the meetings, it was clear that the outside stakeholder groups had general areas of concern about how OSHA administers the whistleblower program. The following captures their general concerns:

- Questioned OSHA leadership's overall commitment to the program
- Expressed concerns about the level of investigator training
- Believe there is a lack of field expertise on statutes and the application of the laws
- Is not transparent and is reluctant to share information
- Inconsistently administers the program
- Inconsistently applies whistleblower policies
- Lacks resources for the program
- Investigators are overworked
- Should stress early resolution of complaints
- Investigators are inadequately equipped
- Reluctant to share respondent's position statements with complainants

- Lacks independent audits of the program
- Does not interview all complainants during investigations
- Does not respect the roles of attorneys during investigations

Although these outside stakeholders have valid concerns, it is clear they generally believe that during investigations, OSHA should be advocates for whistleblowers, which is in conflict with our investigation duty and responsibility to be neutral fact finders.

Below is a summary of the mission of each outside stakeholder organization followed by the comments, opinions and views they shared with the review team on the state of the whistleblower program.

The National Whistleblowers Center (NWC)

According to the NWC website, the mission of the NWC is an advocacy organization with a 20-year history of protecting the right of individuals to speak out about wrongdoing in the workplace without fear of retaliation. Since 1988, NWC has supported whistleblowers in the courts and before Congress, achieving victories for environmental protection, nuclear safety, government ethics and corporate accountability. NWC also sponsors several educational and assistance programs, including an online resource center on whistleblower rights, a speakers' bureau of national experts and former whistleblowers, and a national attorney referral service run by the NWC's sister group the National Whistleblower Legal Defense and Education Fund (NWLDEF). The NWC is a non-partisan, non-profit organization based in Washington, D.C.

On August 31, 2010, the team held a conference call with Richard Renner, NWC Legal Director to solicit his views about the whistleblower program. Mr. Renner had a number of comments about how OSHA administers the whistleblower program and made the following points:

- It is very important that DOL persuade the public and advocate to protect employees
- The whistleblower program as a whole is not working
- OSHA does not consistently allow the complainant to rebut the respondent's defense. Investigators tend to credit the respondent's credibility over that of the complainant
- There are workload pressures on the whistleblower staff
- Believes that the program should not be managed regionally. It should be managed by the National Office
- The whistleblower program has resource issues
- There is an overall attitude throughout the country (mostly east of the Mississippi) that investigators need not work with the complainant's attorney
- Some investigators are hostile to the complainant's claim
- Investigators are not testing the evidence
- There is an institutional problem throughout OSHA that the whistleblower program is a "step child" and is not as important as other enforcement areas
- Questions whether investigators adequately conduct appropriate interviews
- Investigators don't consistently review evidence
- The overall investigation process needs to improve, including the level of attention and detail of the investigation
- Consistency and quality is lacking
- Investigators don't consistently and adequately document interviews
- Investigators should meet privately with witnesses

- There is a training problem, lack of experience, which affects the overall level of quality
- Believes that settlements are advantageous and the earlier the better
- When implementing mediation, need experience and credibility on both sides
- In current settlements, the employers are testing limits, have anti-gag limits
- The Department must enforce settlements

In addition, on March 4, 2010 during the "OSHA Listens" meeting, Mr. Renner submitted comments for the record that focus on a number of issues, namely his belief in the benefits of consolidating regional operations into a single National Office, the need for changes to the investigations manual, how to train investigators and in applying new developments in whistleblower law. Mr. Renner's main points include the following:

- OSHA can best address the GAO's concerns (from Report 09-106) by reorganizing regional operations into a new National Office
- Having a single National Office to review investigators' reports is the only way to assure a consistent standard for evaluating investigations and outcomes
- A National Office will also provide an added layer of separation between adjudicators and local employers
- Investigators should be issued laptops and portable printers so that they can obtain an accurate written record of a witness' first statement about a complaint
- The adoption of policies that call on investigators to get recorded statements from employer's decision makers as early as possible during the investigation
- OSHA needs to respect the roles of attorneys during an investigation. Investigators need to go through counsel when a complainant is represented by an attorney
- OSHA would improve the quality of its final reports if it would submit proposed findings to the parties for comment and rebuttal. This might encourage the parties to enter into a settlement of the claim
- The depth of investigation and analysis must become deeper as employers become more sophisticated
- OSHA needs to review its interim rules, address public comments and make its rules final
- Permitting witnesses to meet privately with OSHA investigators
- Service of OSHA determinations on counsel of record
- Imposing undue limitations on discovery
- Encouraging e-discovery. DOL should require parties to provide responses in searchable electronic forms when a party has the responsive information in such forms. Some respondents' counsels have been converting documents to PDF forms which frustrates the purpose of electronic discovery
- DOL should have a role in enforcing whistleblower protection statutes. DOL should consider intervening on behalf of complainants especially when dealing with pro se complainants

Government Accountability Project

According to the Government Accountability Project (GAP) website, GAP's mission is to promote corporate and government accountability by protecting whistleblowers, advancing occupational free speech, and empowering citizen activists. GAP is a non-profit 501(c)(3) organization with an operating budget of around $2.5 million. Founded in 1977, GAP is the nation's leading whistleblower protection and advocacy organization. Located in Washington, D.C., GAP is a

nonpartisan, public interest group. In addition to focusing on whistleblower support GAP leads campaigns to enact whistleblower protection laws both domestically and internationally. GAP also conducts an accredited legal clinic for law students, and offers an internship program year-round.

On September 15, 2010, the team met with Thomas Devine, GAP Legal Director who was accompanied by David Marshall, Partner and Alison B, Asarnow, Associate, with the law firm Katz, Marshall & Banks to solicit their views about the whistleblower program. Both Mr. Devine and Mr. Marshall discussed a number of issues about how OSHA administers the whistleblower program. Mr. Devine and GAP have published a number of papers on the subject of whistleblower protection and those views are included below.

Mr. Devine stated:

- That the strong point of the OSHA whistleblower program is the credibility, legitimacy and expertise of the National Office. OWPP is unique in how much respect and credibility they garner from law firms and groups like GAP for their good faith efforts
- Frustrations with the program include; lack of expertise by field investigators, some great, some not
- GAP believes there is a severe training deficiency
- Interpretations are drastically inconsistent due to lack of training and regional inconsistency. "The law doesn't mean the same thing in some parts of the country."
- There are long delays in processing cases for no apparent reason. For example, appeals sent to the National Office with the National Office having no authority to decide findings so the cases are remanded back to the region. This process takes time
- GAP wants the National Office to reverse regional decisions, feels this would make a big difference in resolving cases
- There is a need for intensive commitment to training. GAP offered to volunteer their time to training. For example, panel discussions where they could offer their specialized expertise.
- Unemployed people may not utilize OSHA's kick out procedures because they can't afford to hire a law firm
- Would like OSHA to set up a policy for companies to provide documents. If they don't cooperate, OSHA should make decision based on the information that they have
- There is lack of resources in the program, i.e. no laptops
- The OSHA whistleblower program lacks independent audits, creates a legitimacy asterisk
- OSHA should shift the emphasis and try to settle cases up front; GAP is in favor of early resolution. Start with settlement, instead of ending with it
- OSHA should stop calling a settlement as merit, maybe it can be a resolved case
- GAP finds it depressing that there is a regional appeals program, makes the appellate process into a grievance process and it becomes more of changing their minds
- With the current method OSHA uses to conduct internal audits there is an inherent conflict of interest. Therefore, it would not have legitimacy
- GAP feels auditing should go to a private auditing firm or at the department level or run through the National Office

GAP provided written comments to OSHA on March 30, 2010, on the adequacy and future of OSHA's whistleblower program which are summarized below:

- There is "anti-leadership" with respect to the whistleblower program

- There is a "vacuum of credible data" in the whistleblower program
- OSHA should make it a priority to seek "constructive resolution" and make mediation common practice for all investigations
- Merit rates vary drastically from region to region
- OWPP only has the authority to issue advisory remands and the pilot program to regionalize appeals is wrong
- There are "inconsistent translations of law" from region to region
- The processing time for investigations varies greatly from region to region, but in many cases the processing time is too long
- Due process procedures are inconsistent from region to region. For example, sharing the employer's response, permitting company lawyers to be present during interviews, and how claims of confidentiality are handled
- There lacks a serious commitment by OSHA management to provide adequate training to all investigators
- Complaints from whistleblowers on the lack of civility by some investigators
- The whistleblower program must have organizational independence
- Need for consistent regional policies
- OSHA must embrace full transparency for agency operations
- OSHA needs to establish inter-agency agreements with agencies with subject matter expertise

Katz, Marshall & Banks, LLP

According to the Katz, Marshall & Banks, LLP (KMB) website, KMB is a boutique civil rights, whistleblower and employment law firm based in Washington, D.C. The founders of KMB have established themselves as among the best employment lawyers nationally and in the Washington, D.C. area. Martindale-Hubbell has awarded the firm an "AV Preeminent" rating, its most prestigious peer review distinction. KMB serve as faculty members for the prestigious American Law Institute – American Bar Association ("ALI-ABA") and Georgetown CLE, and are regularly published in national legal publications on employment law, whistleblower and civil rights issues. The firm's lawyers are nationally recognized for their expertise in numerous practice areas including; nuclear and other whistleblower claims and Sarbanes-Oxley whistleblower claims.

During the review team meeting, Mr. Marshall commented on the OSHA program as follows:

- The strength of OSHA is that the complainant has the opportunity to file complaint easily and it is not expensive or resource intensive. This helps complaint get resolution and gets the company's attention
- The weaknesses of the program include the quality of the investigations vary
- There is variation of view of legal standards
- Difference in what is considered an adequate investigation
- The principal of extraterritoriality for SOX is not applied uniformly by whistleblower investigators
- Contributing factor not applied consistently, investigators apply burden shifting standard that is incorrect
- Investigators life is hurried resulting in difficulty in proving issues
- Some investigators incorrectly believe that the complainant's counsel has to wait until the OSHA investigation is over before we can interview witnesses

- The training process could be improved; we could put together panels, would be beneficial and free of charge
- Methodology and consistency issues; the complainant should have the right to see respondent's position statement
- The N.O. is clear that employees have right to speak alone with OSHA without company lawyers. Some investigators will allow this. There should be guidelines for witnesses to be contacted off-site and not have company lawyers present
- Discussed a specific case where none of the complainant witnesses were interviewed in a STAA case
- Investigators sometimes delay the investigation waiting for case to be kicked out.
- Believes hiring investigators with legal training helps with the investigative process

Voices for Corporate Responsibility

According to the Voices for Corporate Responsibility (VCR) website, VCR's mission is to help corporate employees, including professionals, to stand up against officer and director decision-making that is motivated by their own personal greed and short-term interests; to encourage corporate employees, including professionals, to participate in regulatory and legislative reform that protects their right to address conduct that adversely impacts the corporation, shareholders and consumers; to prompt corporate employees, including professionals, to recognize wrongdoing in their own place of employment, and to take action; and to enable corporate employees, including professionals, who have lost their jobs or have been injured as a result of wrongful conduct, to network with one another in order to make themselves whole. Voices for Corporate Responsibility is a project for professionals who want their corporations to behave with integrity for the long-term benefit of the company, shareholders, consumers, and the community.

On September 16, 2010, the team met with Cyrus Mehri, David Welch and Ellen Eardley from VCR to solicit their views about the whistleblower program. All shared their opinions about the state of the OSHA whistleblower program. In addition VCR regularly publishes newsletters and reports on the subject of whistleblower protection which is incorporated into this summary.

Mr. Welch, an OSHA SOX whistleblower, said that:

- Disappointed with the whistleblower investigative process
- Complainant was never interviewed
- Complainant did not share respondent's position.
- All materials were not considered before a decision was made
- Findings not sent certified mail
- Merit findings rate is astoundingly low, particularly for SOX where only 1.4% of SOX cases are merit
- Definitely believes in early resolution
- OSHA shouldn't allow pro se complainant to settle case themselves without OSHA involvement
- The National Office should be able to reverse a decision not just remand it
- Enhanced training for investigators
- Re-open closed SOX investigations to ensure they meet procedural and substantive legal standards

The Employment Law Group

According to The Employment Law Group (TELG) website, TELG serves people in Washington, D.C., Virginia and Maryland who have been victims of discrimination, harassment, or other violations of their civil rights. Founded in 1997, TELG law firm is a litigation boutique concentrating on the representation of employees, whistleblowers, and immigrants. TELG champions the rights of those who suffer discrimination, injustice, inequality, and retaliation in the workplace.

On September 16, 2010, the team met with Jason Zuckerman and R. Scott Oswald from TELG to solicit their views about the whistleblower program. Zuckerman and Scott shared their opinions about the state of the OSHA whistleblower program. TELG frequently publishes writings on the subject of whistleblower protection and those opinions are included below.

- Whistleblower investigators need to be trained and held accountable for their work
- There is a level of hostility by some investigators
- In some whistleblower investigations, decisions are made before the complainant or witness interviews take place. When interviews do take place, there are no probing questions
- Within the whistleblower program and during investigations there is a lack of transparency within OSHA
- Investigators are not fully testing the evidence
- OSHA is not affording witnesses and employees the opportunity to speak with OSHA without the presence of management. This step would help keep interviews confidential
- OSHA needs to form a greater partnership with the complainant's attorneys
- OSHA should emphasize early resolution of whistleblower complaints
- Believe in mediation. Mediation should be mandatory
- OSHA should create a national mediation office
- OSHA creates roadblocks to access of information obtained during the investigation
- General attitude by whistleblower investigators is how can they get the case off their desk
- Investigators need training on conflict resolution
- During the course of an investigation, if there is additional claims of adverse action, OSHA must amend the complaint and notify the respondent of the amendment
- Under all the new statutes the burden of proof was changed from motivating to contributing, we find that investigators are either not trained on the difference, have not applied the difference or refuse to accept the difference
- OSHA should provide investigators with annual legal training

AFL-CIO

On September 28, 2010, the team held a conference call with several officials of organized labor groups to solicit their views about the whistleblower program. The individuals included: Peg Seminario, AFL-CIO; John Rupp, UAW; Steve Mitchell, UAW; Jim Frederick, USW; Nancy Lessin, USW; Eric Frumin, CTW and SEIU; Steve Fowee, IAM; Matt Clark, BCTGM; Larry Willis, TTD. The views expressed by the group are as follows:

- From the unions' perspective, the OSHA whistleblower program is the "step child" of the agency. The OSH Act has strong clauses with respect to worker safety and health but is weak with respect to 11(c) discrimination
- As the program has been decentralized, it has lost prominence, lacks priority, and has limited

direction to operate effectively

- The whistleblower program currently is not effectively protecting workers
- The unions have seen an alarming increase in the number of personnel actions against employees that are reporting injuries. OSHA should be applying section 11(c) to protect workers when these adverse actions from written warnings to suspensions to discharge occur. In addition, OSHA should be citing employers under 1904.36 for recordkeeping violations when problems resulting from reporting injuries occur
- If information is available that supports that employees are being retaliated against for reporting injuries, then OSHA should conduct a full recordkeeping audit
- One union commented that before they file a whistleblower complaint, they ensure that they have a prima facie case and have all the elements, but when OSHA hears management's objections, the argument gets thrown out the window. They have filed more than 20 whistleblower complaints with OSHA and not one was found merit
- The dual motive argument in the manual is a joke. If something can be dredged up from the past it is used against the employee
- The appeals program is ineffective and a rubber stamp
- If employees with strong representation have difficulty maneuvering through the OSHA system, imagine the problems employees that are not represented have
- Understand the bar is high and there is a large caseload, but there need to be policies and direction
- Expressed frustration that after GAO report on the whistleblower program nothing changes
- The agency should ramp up the visibility of the program to get the message to the employers
- OSHA should be proactive when they become aware of discriminatory practices by sending out cease and desist letters to companies. Companies tend to listen to OSHA when these letters are issued
- OSHA should place priority on safety whistleblower statutes, not non-safety whistleblower statutes
- The unions agree that people are reluctant to come forward and file complaints. They are afraid to lose their jobs
- OSHA should publicize what kinds of discrimination practices it is seeing. An annual report can be published for the public
- Recommend the agency create an Ombudsman office as a point of contact for complainants and for use by OSHA to track trends and results
- The tools OSHA has under 11(c) are few and the burdens are high
- See serious problems with the OSHA appeals process. It is meaningless and doesn't work. It also varies from region to region. Want appeals through Washington instead of the regions
- To enhance attractiveness of the program, need to provide better training and promotional opportunities to whistleblower investigators

Recommendations:

- Create a Fact Sheet or Quick Card on the OSHA whistleblower settlement process covering those prohibited or repugnant clauses that the agency discourages to be placed in a settlement
- Hold panel discussions with groups like GAP, VCR and TELG, as well as known respondents' attorney groups to bolster investigator training
- Partner with and obtain training from the various enforcement agencies to acquire a general understanding of the enforcement principles under a specific statute
- Develop a *pro se* handbook to provide whistleblowers a guide on how to maneuver through the whistleblower investigation process

- Explore the possibility of documentation sharing between OSHA and the complainant and respondent, through an online system where they can gain access to the vetted documents through a secure password protected website. The website would be available 24/7
- Create an alliance between OSHA and the American Bar Association and other interested whistleblower advocacy groups
- Utilize corporate or company wide settlement agreements and publicize significant whistleblower actions
- Post whistleblower actions on the public web page, similar to enforcement actions
- If information is available that supports that employees are being retaliated against for reporting injuries, then OSHA should conduct a full recordkeeping audit

2.19 Implementation:

This report highlights a significant number of issues that need to be resolved in order to move the program in the right direction. The recommendations outlined in this report will require the agency to devote a considerable amount of time and resources to the program. Therefore, the team recommends the following implementation plan:

- Announce a GS 14/15 on a detail assignment (NTE 2 years) to implement the recommendations in this report
- The selected individual should work directly for the Assistant Secretary's office
- A field "SES Champion" should be assigned to assist the selected individual with Regional support and implementation
- The selected individual should develop and implement a tracking and reporting schedule
- The following are issues that may need workgroups
    - Consistent Policy and Application
    - Training
    - Performance Measures
    - Auditing Measures (topics)
    - State Plan Monitoring
- Within 3-5 years, conduct a full assessment of the program

References

OSHA Directives:

- Whistleblower Investigations Manual: DIS 0-0.9 (August 22, 2003)
- Initial Training Program for OSHA Compliance Personnel: TED 01-00-018 (August 6, 2008)

GAO Reports:

- Whistleblower Protection: Sustained Management Attention Needed to Address Long-standing Program Weaknesses, GAO-10-722 (August 2010)
- Whistleblower Protection Program: Better Data and Improved Oversight Would Help Ensure Program Quality and Consistency, GAO-09-106 (January 2009)
- Whistleblowers: Management of the Program to Protect Trucking Company Employees Against Reprisal, GGD-88-123 (September 1988)

DOL-IG Reports:

- Complainants Did Not Always Receive Appropriate Investigations Under the Whistleblower Protection Program, Report No. 02-10-202-10-105 (September 2010)
- Evaluation of OSHA's ERA and EPA Whistleblower Investigations, Report No. 2E-10-105-0001 (March 2001)
- OSHA's 11(c) Discrimination Investigations, Report No. 05-97-107-10-105 (March 1997)
- Survey of OSHA's Section 11(c)/405 Discrimination Complaint Investigation Program, Report No. 05-88-083-10-105 (February 1989)