U.S. Department of Labor

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Memorandum For: Charles N. Jeffress, Assistant Secretary

From: Michael G. Connors, Chairman, Whistleblower Taskforce

Subject: Proposed Recommendations for the Whistleblower Taskforce

The purpose of this memorandum is to provide information and recommendations from the Whistleblower Taskforce. This Taskforce was formed at the direction of Acting Assistant Secretary Gregory Watchman, by his memo of September 10, 1997. For the convenience of the readers, the attachments to this memorandum are divided into the following:

I. Executive Summary

II. Detailed Findings and Recommendations

III. Appendixes

Attachments

I. EXECUTIVE SUMMARY

A. CHARTER AND BACKGROUND

In September 1997, Acting Assistant Secretary Greg·Watchman of the Occupational Safety and Health Administration (OSHA) directed the· creation of-a Whistleblower Taskforce. This Taskforce was to review all pertinent issues related to this program and to make recommendations to the Assistant Secretary for improving the program. His instructions focused on the following areas:

1. Evaluate the effectiveness of the Whistleblower program in terms of issues raised by the Office of the Inspector General (OIG), the U.S. General Accounting Office (GAO), National Advisory Committee on Safety and Health (NACOSH), and other stakeholders;

2. Solicit stakeholder input; and

3. Make recommendations to improve the effectiveness of our whistleblower programs, including administrative and legislative changes, as well as recommendations regarding training, resources and outreach.

The Taskforce is headed by Michael G. Connors, Regional Administrator, Region V, and Thomas Buckley, Office of Investigative Assistance (OIA). Three Regional Supervisory Investigators (John Spear, ARA, Region X, Jerry Foster, Region VI, and Arthur Johannes, Region IV), a Regional OSHA Counsel (SOL) (Stephen Dubnoff, Region II), a:pJational Solicitor (Daniel Mick, Associate Solicitor for Regional Litigation), the Director of the Office of Reinvention (Robert Kulick), two State Plan State representatives (Sherrill Benjamin, Minnesota, and James Brogan, Michigan), and a staff person/facilitator (Pamela H. Foster, Region V) complete the Taskforce.

This Taskforce has met monthly since October 1997, sponsored a "Best Practices" meeting of investigators from the regions, met With stakeholders, performed research and survey tasks and as a result of these activities is recommending various policy, legislative and program modifications and other actions which are designed to begin the process of improving the effectiveness of the program. A Program Plan has been developed to outline the time frames and actions recommended. This plan, updated to contain the Taskforce recommendations, is attached as Appendix A.

Creation of this Taskforce was stimulated by an audit of OSHA's Section 11 (c) Program conducted by the Office of the Inspector General. Following the report of this audit in March 1997, various stakeholders and the General Accounting Office also raised concerns regarding OSHA's performance of its responsibilities for the Section 11 (c) Program as well as the other whistleblower statutes currently enforced by OSHA.

B. OIG REPORT AND RECOMMENDED RESPONSE

OIG's report contained three chapters, each containing an issue. The issues and our recommended responses are as follows.

OIG Chapter I Issue: "Workers, particularly with small companies, are vulnerable to reprisals by their employers for consulting about unsafe/unhealthy work conditions." OIG provided no specific recommendations regarding this issue.

OSHA Response: OSHA agrees with the OIG analysis of pending legislation and has taken a position against the provisions which would require an employee to first complain to their employer about safety and health problems before making a complaint to OSHA.

The Taskforce found from its own information and that of stakeholders that employee/employer knowledge of whistle blower rights was severely lacking, To address this problem several actions are recommended. These actions include issuing a Grant to publicize the whistleblower protections in OSHA's jurisdiction; publicizing the whistleblower protections through public service announcements; preparing briefing packages for presentations; providing Internet information; adding whistleblower information to the new OSHA poster; publishing a brochure in several major client languages; and providing training to the CSHO's and investigators on several related topics.

OIG Chapter II Issue: "OSHA's operating practices and SOL coordination present obstacles to gaining all appropriate relief for complainants with merit cases." .

OSHA Response: The Taskforce recommends that OSHA continue its policy of seeking voluntary . settlements in order to conserve OSHA and SOL resources and to provide timely complainant relief. Such settlements will continue to be accepted by OSHA only if the complainant agrees to the settlement or if the settlement offer is 100% of the remedy due. Along with this recommendation is one for the establishment of a small group to work on solutions to the "chilling effect" present in workplaces when satisfactory settlements are not publicized and the employee does not return to work.

It is recommended that Regional Administrators make agreements with their Regional Solicitors which outline the procedures for early joint review of troublesome settlement cases, potential litigation cases and the utilization of set aside resources; to litigate merit cases. Joint efforts to accurately document and track SOL resource utilization for whistleblower cases are recommended so these resource utilization decisions may be made as well as to assure more timely action on referred.

A revision of the Investigators Manual is recommended to document Taskforce decisions on improvements needed in the investigative process and to ensure uniformity in case handling. A small group of investigators and supervisors could effectively perform this revision. Full

documentation of damages due an employee, common definitions and criteria for settlements, a revised Final Investigative Report (FIR) for all cases, and specifying case file documentation requirements for litigation cases are among the topics to be covered in this revision. A recommendation for. the establishment of a "peer" review of sanitized case files as well as 11 case audit function in the Office of Investigative Assistance would assist in assuring the consistency desired. Training is recommended regarding the manual revisions in general, as well as specifically on the compilation of damages. The OlG's point on the documentation issue is well taken and should be appropriately addressed by this revision. Direction to the Regional Administrators and investigative supervisors will be required and mechanisms instituted to insure the Nationwide consistency necessary for an effective program.

Research by the Taskforce concluded that punitive damages may be ordered by the Courts or the Secretary only in cases with particularly egregious conduct by. an employer. It is recommended that while it is possible to use the potential for punitive damages as a bargaining ,tool in settlements, the limited awards (thus far two) and the egregious requirements for seeking them do not justify the consideration of punitive damages in the great majority of cases. SOL will continue to keep current on the damage issues as they unfold in the courts.

QIG Chapter III Issue: "OSHA's automated case management system is ineffective for reporting and for managing llCc) cases."

OSHA Response: OSHA agrees with the OIG's findings regarding the whistleblower IMIS system. The Taskforce determined that the system is indeed misused, underutilized, and is fraught with data errors as a result. Action has been taken to implement short-term remedies for these problems. A Taskforce member worked with OMDS to develop output reports that are more user-friendly to produce and more useful in the operations of the investigations program and to display program results in a format more useful to our stakeholders. In addition, recommendations are being made to improve the data entry portion of the system, which will make the system easier to use and therefore, more likely to be used correctly. Training will be conducted shortly to train the whistleblower supervisors in the new data system and reports.

Additionally, the Taskforce is recommending performance measures which can be tracked utilizing the short-term remedies to the IMIS problem. These measures are: Case Backlog, Timeliness, Merit Rate, Settlements, 11(c) Appeals, SOL Processing, and Hearings Processing Time. The Timeliness measure can be utilized to track the whistleblower measure of the Strategic Plan. If these measures are approved and meet the additional needs of our stakeholders, direction to the Regional Administrators and the whistleblower supervisors will be essential to ensure that all data is uniformly entered into the system.

C. OTHER ISSUESIFINDINGS 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 operation, and training funding. The RSI's and Program Managers must meet regularly to insure consistency throughout the country.

Approved changes in policies and procedures 'Which result from the work of this Taskforce will require the same executive level attention and monitoring as is accorded the other OSHA programs. This includes the coordination and relationship with the "Office of the Solicitor in revising current agreements with OSHA or creating new ones to assure that a fair share of the Solicitor's OSHA resources are devoted to the needs of the whistleblower programs.

Significant information gathering was performed by the Taskforce with regard to operations of the whistleblower program at the State Plan level. It was found that most of the concerns and issues found at the Federal level are also true in the States. Foremost in the needs of the States is effective, timely, consistent and continuing communication between the Federal and State levels.

Taskforce recommendations regarding the potential legislative changes to the 11(c) program have already been prepared and forwarded to the Policy Office for appropriate action. Significantly, the changes proposed would include adjudication before an administrative law judge, extension of the filing time to 180 days, enumeration of reinedibfl1lld a requirement for employers to post a notice in the workplace.

Several other recommendations deserve mention in this summary. First is the recommendation for the development of a comprehensive training ,plan for the investigators, similar to that in existence for the CSHOs. Also included is the recommendation that specific training on the whistleblower program be provided to new as well as experienced CSHOs.

A severe morale problem has developed among the investigators since the journey level of the CSHOs was raised to the GS-12 level, while their positions remain at the GS-11 journey level. The' Taskforce found that the investigators consider themselves the lowest level of professionals in the Agency. The Taskforce recommends that a new ,review be made of the classification of the investigator position. The Taskforce recommends that the journey leyel of the investigator position be at GS-12 in a career ladder progression.

II. DETAILED FINDINGS AND RECOMMENDATIONS

A. CHARTER AND BACKGROUND

OSHA currently enforces 11 whistleblower protections. Four of these, under the Occupational Safety and Health Act (OSH Act), the Surface Transportation Assistance Act (STAA), the Asbestos Hazard Emergency Response Act (AHERA) and the International Safe Container Act (ISCA), have long been an OSHA responsibility. In February 1997, OSHA inherited from the Wage and Hour Division of the Employment Standards Administration authority to investigate and resolve complaints of on-the-job discrimination against workers who call attention to violations of seven additional federal laws. These laws are the Clean Air Act (CAA), Energy Reorganization Act (ERA), Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), Safe Drinking Water Act (SDWA), Solid Waste Disposal Act (SWDA), Toxic Substances Control Act (TSCA), and the Federal Water Pollution Control Act (FWPCA).

In FY 1997, 2732 whistleblower cases were filed under the OSH Act, commonly called Section 11(e) cases. Additionally, 333 cases under STAA, also called Section 405 cases, were closed. Throughout the country there are 54 staff investigators who are responsible for investigating complainant allegations and resolving the cases. In the National Office, advice and guidance is provided to the investigators and their supervisors by the three staff of the Office of Investigative Assistance. Eight regions have a program which is supervised by staff in the Regional Office, although the investigators may have work locations other than the Regional Office. Two regions have assigned investigators to the Area Office for supervision and have a coordinative function assigned to the Regional Office.

A report was issued by the Office of the Inspector General (OIG) on March 31, 1997. This report covered an audit of the OSHA Section 11(c) program's performance and operational effectiveness for the period FY 1995. This audit was critical of some of OSHA's policies and procedures regarding Section 11(c) investigations. Publication of the audit report also prompted input from OSHA's stakeholders, most notably from the National Advisory Council on, Safety and Health (NACOSH).

To respond fully to the concerns raised by OIG and stakeholders, action was taken by OSHA to establish a Whistleblower Taskforce in September 1997, at the direction of Acting Assistant Secretary Greg Watchman. This Taskforce held their first meeting in October 1997 and met monthly through March 1998. As previously indicated, the Taskforce has National and Regional staff from OSHA and SOL, two State Plan State representatives and the Director of the Office of Reinvention.

In its Program Plan (Appendix A) the Taskforce further defined the scope of its activities to review the procedures for processing whistleblower complaints under the eleven whistleblower

statutes within OSHA's jurisdiction and the systems for measuring what is viewed as an effective whistleblower program. This will include:

* Defining issues which adversely/impact on the effectiveness of OSHA's whistleblower program;

* Evaluating issues raised by OIG, NACOSH, GAO and other stakeholders;

* Recommending topics for legislative fixes;

* Providing the Assistant Secretary with recommendation for improving the program, to include resources, training and outreach considerations;

* Providing uniform operating procedures in areas where policy inconsistency is noted; and

* Defining measurements for program success and improvements to include: \

1. Defining what measures are to be used to evaluate the program;

2. Recommending changes to the existing systems;

3. Moving the program toward a "desired state" of computer usage;

4. Simplifying access to the computer process and reports; and

5. Developing reports for management, stakeholders, etc. which include % factors.

In the first year, the issues will be defined by the Taskforce, recommendations will be provided and implemented where it is possible to address the matter quickly to get consistency without new policies, and time lines will be planned for the future changes. It is anticipated that after presentation of the recommendations, the Taskforce as a group will disband and that the remainder of the Program Plan will be carried out by staff of the Office of Investigative Assistance and other groups or teams assembled to perform specific tasks.

Activities of the Taskforce which have been concluded thus far other than its working meetings and individual projects include several meetings with a NACOSH subgroup, holding a field investigators "Best Practices Group," detailing a member to the National Office to work directly with OMDS on IMIS programming remedies, various member meetings With counterparts and other organizational components to discuss and begin implementing recommendations, establishing a training task group and a meeting with OIG representatives.

B. OIG REPORT AND OSHA RESPONSES

The final OIG Report No. 05-97-107·10-105 was issued on March 31, 1997. Prior to issuance of the final report, OIG sought and received comments from OSHA regarding portions of the report findings and recommendations.

As previously indicated, OIG's report contained three chapters, each containing an issue. These issues and the Taskforce's recommended responses and actions are as follows.

Chapter I Issue: "Workers, particularly with small companies, are vulnerable to reprisals by their employers for complaining about unsafe/unhealthy work conditions.

In the discussion regarding small employers, the OIG report discussed several proposed pieces of legislation which would alter employee requirements when making a complaint regarding safety and health in the workplace. One would require notification to the employer prior to filing a complaint to OSHA and the second would require that a complaint be in writing with an indication of employer notification and a lack of response to correction of the hazard.

OIG found that workers who complain about workplace safety/health hazards are frequently the targets of reprisals by their employers. Particularly vulnerable were workers who brought complaints to the employers rather than to OSHA, and workers with small firms. Statistics gathered by OIG indicated that termination was the most prevalent form of reprisal against complainants. Additionally, they found that slightly over half of the complainants notified their employer of the hazard first and approximately one-forth contacted OSHA first. Of those who contacted their employer first, nearly 82% felt that they were terminated because of the complaint. In contrast, only about one-half of those who complained to OSHA first felt their termination was related to the complaint. The OIG statistics for smaller companies showed that approximately half of the complaints were made first to the employer, the complainants in this group suffered a 95% termination rate as a result. When the complaint was first made to OSHA in about one-third of the cases, the termination rate was 67%. When cases were settled, the cases reflected approximately the same trends and outcomes. Statistics also showed that smaller employers, those under 30 employees, after OSHA intervention, were more likely to settle the complaint with benefits accruing to the . complainant than were larger employers. The above is an indication that a complaint made first to the employer increases the rate of termination of the complainant rather significantly and that the termination rate is increased in small employers. Also, it suggests that OSHA intervention to settle the case in smaller firms generally resulted in some benefits to the complainant.

This analysis suggests that workers who first report safety/health hazards to employers, rather than OSHA, are more vulnerable to employer reprisals. OSHA agrees with the OIG analysis of the complaint statistics and the potential impact of the pending proposed legislation and has taken a position against the provisions which require an employee to first complain to their employers' before making a complaint to OSHA.

Related to the OIG issue, NACOSH wanted the Agency to see how the regulatory, enforcement and other OSHA initiatives can be utilized to ensure that workers can freely exercise their statutory rights without fear of employer retaliation. A portion of this concern was about company incentive programs. The Taskforce did not deal with the issue of incentive programs, which while not against any OSHA policy, need to be reviewed in a case by case manner and not as a general issue. In its examination of the more general NACOSH recommendation in light of the OIG findings, the Taskforce felt that two avenues needed to be examined.

The first is the issue of getting the message to the public about the protections available under the Acts within OSHA's jurisdiction. It has become more evident that employee/employer knowledge of whistle blower rights is severely lacking.

Excellent progress has already been made to address this lack of knowledge. With the support of the Office of Information and Consumer Affairs, the Office of Investigative Assistance will begin work on several initiatives. Plans are underway to produce a brochure for dissemination which would explain the whistleblower protections available through OSHA. It is intended that this brochure would also discuss the remedies available to resolve a complaint, including monetary remedies. This document will be available in several languages after gratis assistance offered by the Voice of America to translate the text. Information on an Internet Web Page is being explored.

The current OSHA poster is lacking information regarding whistleblower rights. It is now planned that the upcoming revision of the poster will contain whistleblower rights information. Briefing packages will be prepared for presentations. A plan to develop public service announcements is underway. In addition, action will be taken to announce a Grant to publicize whistleblower protections in OSHA's jurisdiction.

Several times during the last six months, members of the Taskforce have met with various stakeholders, such as NACOSH and the Government Accountability Project. It is recommended that the Office of Investigative Assistance establish a plan to periodically meet with stakeholders to discuss emerging issues and the status of the activities detailed in the Whistleblower Program Plan.

Complementary to these actions, the revised Program Plan describes several actions that should be taken within OSHA. It is recommended that a small group be formed to develop a comprehensive training outline for the Investigators to include a revision of the current, courses. It is also recommended that some of the CSHO oriented courses would be beneficial to provide the investigators with some basic knowledge of safety and health. Exploration of again obtaining training at the Federal Law Enforcement Training Center (FLETC) or some other intensive investigative training may be appropriate. Additionally, the Taskforce and the Best Practices group agreed on a recommendation that the CSHOs need training in the whistleblower program and its relationship to main stream safety and health issues. Training is also needed on how to

transmit this information to employees and employers during inspection and outreach activities. CSHOs also should be instructed to observe the atmosphere/animus at the work site and document it as well as the fact that the whistleblower programs were discussed. A small group should develop training segments to be included in the basic courses for CSHOs as well as a package that could be inserted in more advance courses for a period of time until the whistleblower program becomes a more integral part of the normal CSHO information dissemination activities.

A second issue is much more difficult to address. This is the problem of dealing with the chilling effect on employees who are witnesses to discriminatory acts against fellow employees who have filed safety and health complaints. After witnessing an adverse impact on a fellow employee, many employees will be very hesitant to file a safety or health complaint.·

If an employee remains in the workplace after the resolution of a retaliatory or discriminatory action, it was felt by the Taskforce that this employee would make sure that others knew of the resolution. However, in a great majority of the situations, the employee cannot, or does not wish to return to their former workplace. In this situation, all that the fellow employees are aware of is that the former employee tiled a safety or health complaint and now they are gone. They most likely will conclude that but for the filing of the complaint, the former employee would still be working and therefore they should be cautious in exercising their right to file a complaint.

These employees will probably never know that the former employee is now employed elsewhere and received a settlement for some; if not all of the monetary relief due to them. The Taskforce· recommends that in these situations the settlement agreement address a constructive effort to address this chilling effect, such as posting the settlement agreement or an equivalent notice. Since most settlements are voluntary and the employers do not wish to admit a violation, the requirement for a settlement notice being posted in the workplace could be an impediment to a settlement and could result in the employee not obtaining any relief. Other efforts to address the chilling effect, such as company training, news releases, community workshops, etc., may be available and should be explored by a task group. The task group, which will be recommended later in this report to update and revise the Investigators Manual, could be used for this purpose, or another task group appointed specifically for this purpose.

Chapter II Issue: "Operating Practices and SOL Coordination Present Obstacles to Gaining All Appropriate Relief for Complainants with Merit Cases."

In its report, OIG came to the conclusion that the U.S. District Court is rarely presented 11(c) discrimination cases by the DOL Solicitor's Office. They also cited factors which they believed contributed to this lack of cases. These factors included:

- OSHA settles merit cases, without SOL involvement, perhaps at less than "all appropriate relief' as provided for in the Act;

- Case file information is incomplete to verify attempts at recovering lost wages; - Cases were not promptly acted upon by the SOL; and

- Many predetermined settlements do not include conclusive evidence of an 11 (c) violation and many referred cases were returned to OSHA because the SOL believed the cases lacked merit.

All of these factors were explored by the Taskforce. In its discussion of the meaning of "all appropriate relief," the OIG report relied heavily on a report in the Boston College Law Review of March 1995 which stated: " ...in Reich v. Cambridgeport Air Systems, Inc., the United States Court of Appeals for the First Circuity held that the authority of a district court under section 11(c) of the OSHA {sic} to order "all appropriate relief' in a retaliatory discharge action embraced both compensatory and punitive damages." The further OIG discussion of this case and their recommendation cited lack of file documentation on damages and the seeking of punitive damages as the evidence that "all appropriate relief' was not obtained.

With regard to less than complete case file documentation, OSHA can agree that not all case files' are adequately documented, especially in the complete documentation of compensatory damages. The Taskforce recommends that to remedy this deficiency, and to promote uniformity, the Investigators Manual be revised. These revisions would implement the Taskforce decisions on the improvements. needed in the investigative process and to ensure uniformity in case handling. topics included in this revision would be, among others, full documentation of damages due an employee, common definitions and criteria for settlements, a revised Fin~ Investigative Report (FIR) for all cases, FOIA disc1osables, specifications on the use of the phone and fax procedure in investigations, customer advocacy issues, and specifications on case file documentation requirements for litigation of cases. More specifics regarding most of these topics will be provided later in this report. Training of the investigators regarding these revisions will be necessary and should be included in the comprehensive training plan which is recommended.

OIG's recommendation regarding using the seeking of punitive damages as a settlement leveraging tool was researched by the SOL representatives on the Taskforce. There is very little legislative history, only two in OSHA, in which punitive damages were awarded by the court for OSHA whistleblower violations. One of these cases was the Cambridgeport decision referred to above. The SOL research found that there is nothing definitive in the law, regulation or court cases, due to a lack of general and OSHA specific legal history, regarding the awarding of and amounts of punitive damages. Terms such as wanton, reckless, malice, callous and reckless indifference appear to be appropriate descriptors for the award of punitive damages. Retaliation actions are intentional and can be the basis for punitive damages, based on the extent of the retaliation. Negligence is not the basis for the award of punitive damages.

On the basis of this research, the Taskforce recommends that OSHA continue its policy of seeking -voluntary settlements in order to conserve OSHA and SOL resources and to provide timely complainant relief. Such settlements comprise 'over 95% of all remedies received by employees under Section 11 (c). Quick settlements are generally' expected by complainants, lessen the time the employee is out of work, and generally minimize the amount that an employer would have to pay. Such settlements will continue to be accepted by OSHA only if the complainant agrees to the settlement or if the settlement offer is 100% of the remedy due. The Taskforce additionally recommends the institution of settlement requirements to be adhered to by the investigators. These requirements are specifically listed later in this report and should be incorporated into the Investigators Manual revision.

It is recommended that while it is possible to use the potential for punitive damages as a bargaining tool in settlements, with proper investigator training and if caution is exercised, the limited awards thus far and the egregious requirements for seeking them do not justify the consideration of punitive damages in the great majority of cases. SOL has indicated that they will continue to keep current on the damage issues as they unfold in the courts.

It is recommended by the Taskforce that OSHA could seek pursuing the award of punitive damages in cases where we can show: (1) proof of the elements of constructive discharge; (2) where the retaliation is as much directed at the other employees in the workplace as well as at the impacted employee (this includes retaliation done in a public manner, many blacklisting situations, etc.); (3) there really is no motive; where records and evidence were created after the fact or shortly before the discharge in order to create a false record; witnesses for the employer were prepared; fraudulent concealment occurs, etc.; and (4) the employee is threatened by other employees on the behest of the employer.

In its review the Taskforce concluded that the OIG point "-case file information is incomplete to verify attempts at recovering lost wages" is well-taken and the recommendation that in "all" settled cases, the appropriate relief at that juncture of the process and the relief obtained must be documented in the file. This documentation requirement is recommended for inclusion in the revised Investigators Manual. Additionally, it is recommended that a memorandum be issued to the Regional Administrators which would require that the documentation requirements be implemented immediately.

One contributing factor to the lack of full documentation regarding remedies available can be tracked to the Agency's use of short-cuts to reduce the time investigators spend on report writing. Not all cases were being completed within the statutory guidelines. In an effort to improve this performance, several short-cuts were instituted. Investigators had been advised that they did not have to complete a detailed Final Investigative Report on settled cases, since a remedy was provided to the complainant and it was not anticipated that the full report of the case would ever be needed again. As indicated in the Program Plan, a revised and more automated version of the FIR is being piloted in Region VI.

Direction to the Regional Administrators investigative supervisors will be required and mechanisms instituted to insure the Nationwide consistency necessary for an effective program. Several mechanisms are recommended for insuring this consistency and are included in the revised Program Plan. One mechanism recommended is the development of a review or audit program of cases by the Office of Investigative Assistance; currently development is scheduled to begin in June and implementation in September 1998. Investigators participating in the Best Practices Group conducted at the request of the Taskforce, proposed the initiation of a peer review team to review a sampling of other investigators' cases (without identifiers) to evaluate and measure quality. The standards for review would be set by the peer review team, based on the Investigators Manual guidance and other quality factors. This team is recommended to be comprised of representative investigators and their supervisors. It must be noted that this recommendation in particular, but among others, should be reviewed for Labor Management implications and appropriate action taken.

Although not a measure of consistency, the Taskforce considered the use of customer questionnaires to help determine the effectiveness of the program. This project is still being considered, as is a similar one for the compliance programs. One of the State Plan Taskforce members volunteered to perform a customer survey in his state. As of this time, the survey period has not yet ended.

OIG was not incorrect when they found that "Cases were not promptly acted upon by SOL." However, the Taskforce is not in complete agreement with the findings. SOL Taskforce members have indicated that approximately 40% of all legal work done by regional SOL staff is devoted to OSHA activities. Agreements have been developed at the regional level between OSHA and SOL regarding legal action priorities and case referrals. Whistleblower activity has not, up to this time, been a high priority for the use of SOL resources. In addition, the length of time required for a whistleblower case to come to trial, combined with the normally small amount of the monetary dispute do not, according to SOL, make these cases priority cases for the Courts.

As a partial remedy the Taskforce recommends that the Regional Administrators make agreements with their Regional Solicitors which outline the procedures for early joint review of troublesome settlement cases, potential litigation cases, and the utilization of set aside resources to litigate merit cases. Similar agreements are already in existence with relationship to the handling of OSHA compliance cases. Attached as Appendix B is a sample "Pipeline" Proposal for Solicitor's Involvement that was developed by the Taskforce and could be used as a model for the regional agreements. The Taskforce believes that support by the 'Assistant Secretary for such agreements would be a guide to the Regional Administrators in their use of Regional SOL resources.

A contributing factor to perhaps untimely action on cases referred to SOL appears to be the lack of a common understanding of the necessary evidence needed in a case referred or recommended

for litigation. A discussion of the evidence necessary is recommended for inclusion in the revised Investigators Manual.

SOL Taskforce members provided the following evidence needs as. essential. The file must contain sufficient evidence to establish the four elements of the Secretary's prima facie case. In addition, evidence to rebut the employer's stated reason(s) for the adverse action against the employee must be present.

It is extremely important that corroborative evidence be submitted with the case file. Disinterested witnesses are really crucial when there is a he(she) said/they said scenario. All persons who played a part in the proceeding should be interviewed and all documents referred to by either party should be obtained and in the file. These would include personnel files, unemployment files, a full accounting of the entire pay package of the complainant including health benefits, pension contributions, seniority rights, etc. Further, all efforts on the part of the complainant to minimize his(her) losses should be in the file. Evidence 'or findings of intangibles such as "not able to sleep," "gone into therapy" or other "facts" should be specifica1lydescribed and not simply called "emotional distress." When litigation is being considered, it is strongly recommended that face-to-face interviews be conducted. Such face-to-face interviews assist the investigator and subsequently the courts in assessing the credibility of the complainant.

If after the above is submitted, a case is returned to OSHA without litigation, it is recommended that SOL inform OSHA of the reasons why the case is being returned. Assessing the reasons why and Where in the process a case was rejected will allow constructive feedback to be provided to the investigators regarding how to improve future efforts.

Later in this report is a discussion of improvements needed in the whistleblower IMIS system to adequately track case progress. Included in that discussion is the establishment of a report that will identify whistleblower cases referred to SOL and track their progress.

SOL has a time tracking system called the SOLAR system. Data entered into the SOLAR system involving whistleblower legal activities needs to be more uniform nationwide. The Taskforce recommends that SOL and OSHA review the SOLAR data to assure that the data requested meet their mutual needs. It is additionally recommended that at that time, SOL be requested to provide guidance to Regional SOL offices to assure that the SOLAR manual is followed and the appropriate data input . to assist in obtaining this uniformity. Recurring information from the SOLAR system regarding resource utilization will be available for OSHA to use in decision making and case tracking.

The last OIG discussion in Chapter II of their report concerned the "predetermined" settlements. Based on evidence contained in the files reviewed, OIG concluded that approximately half of the case settlements were made without obtaining conclusive evidence, through a full investigation, to support the four elements of a merit case. In addition, in approximately one half of these cases, evidence to support all four elements of a prima facie allegation was not present. The overall

conclusion of the OIG was that OSHA "may be under serving its customers by using predetermination settlements and settling complaints too soon." OIG felt that more SOL involvement and litigation would improve the settlement outcomes.

OSHA,. in its response to the draft report, stated that we did not believe that more SOL involvement would improve the outcomes. Additionally, OSHA indicated that lack of resources was a problem which had been exacerbated when jurisdiction for seven additional whistleblower statutes was assumed from the Employment Standards Administration's Wage and Hour Division without additional resources. These statutes require completed investigations within 30 days as opposed to the 90 days for the 11 (c) cases.

This difference in investigation completion deadlines and other inconsistencies between the eleven statutes administered by OSHA has prompted the potential need for legislative changes. The changes recommended by the Taskforce have already been forwarded to the Directorate of Policy. These recommendations are contained in Appendix C.

In its final conclusion, OIG understood that settlement operations could not be abandoned but could be improved to "replace the 11 (c) office level compromise and settlement operations currently practiced." They also again cited utilization of the Cambridgeport decision discussed above.

The Taskforce concluded that a settlement process is essential to obtaining a prompt remedy for an employee. The prompt settlement of a 'case serves to keep down the time an employee is out of work and without an income. It also serves to keep down the costs to the employer. It provides savings to OSHA in the efficient utilization of our limited resources. We have agreed that a recommendation is necessary which requires full documentation with conclusive evidence of a violation on any case which is anticipated to go to litigation. However, to expend time and resources to obtain the recommended "conclusive" evidence for a case which all parties agree to voluntarily settle is not in the best interests of OSHA or the parties involved.

It is recommended that to address the issue of perhaps premature settlements, that standards be adopted for settlements. Our Best Practices Group presented a strong case for, and the Taskforce adopted, a "one" settlement recommendation. The term "predetermination settlement" will no longer be used and all settlements will have a common definition and must meet the following requirements: The common definition is: A settlement is an agreement made after an allegation of a prima facie case is presented but before findings are issued.

Requirements for all settlements will be that:

1. The file must contain allegation of all elements of prima facie case.

2. The file must list appropriate relief at that juncture of the process and relief obtained.

3. The settlement agreement must contain all of the "Core elements of a Settlement Agreement."

The following were determined to be the "Core Elements of a Settlement Agreement":

* It must be in writing.

* The employer must agree to comply with the OSHAct.

* It must address alleged retaliation.

* It must specify relief obtained.

* Documentation of the above must be in the case file.

* It must address a constructive effort to address the chilling effect such as the posting of the agreement or an equivalent notice.

Exceptions to the above "core" elements are not to create a barrier to getting a quick settlement and some remedy for the complainant. Exceptions to the policy are allowable if approved in a pre-settlement discussion with the Regional Supervisory Investigator (RSI) or other supervisor, as appropriate.

A settlement policy containing the above needs to be developed and officially codified in. the very near future, prior to the completion of the revisions to the Investigators Manual. It is recommended that a memorandum be promptly issued to the Regional Administrators stating the above recommended policy and requiring implementation

The OIG recommendations in Chapter II of their report 'should be met when the Taskforce recommendations are implemented. These OIG recommendations were that OSHA:

"-consult with SOL to reevaluate and agree upon criteria for determining which cases should be negotiated and settled outside the judicial domain, or referred for litigation;
-require that documentation be maintained in case files specifically identifying "all appropriate relief' due to the complainant;
-ensure that punitive as well as compensatory damages are considered when evaluating complainants' entitlement to "all appropriate relief;" and
-confer with SOL on a means to accelerate action taken on merit cases."

Chapter III Issue: "OSHA's automated case management system is ineffective for reporting and for managing 11 (c) cases."

They found that it was ineffective because:

"- the IMIS is not consistently relied on ,for federal and state-plan states' 11(c) program reports;

- the IMIS does not provide program and case management capabilities to the 11 (c) field offices; and

- OSHA's output-oriented report may not convey to interested parties information about how well OSHA enforces the provisions of Section 11 (c).

Consequently, the system does not meet all the requirements necessary for effective program management and oversight."

OSHA agrees with the OIG's findings regarding the whistleblower IMIS system. The Taskforce determined that the system is indeed misused, underutilized, and is fraught with data errors as a result. The Taskforce recommends short-term and long-term remedies for these problems, In the short-term, one of the Taskforce members ~as already worked with OMDS to develop a number of output reports that are more user-friendly to produce and more useful to managers and supervisors in the day-to-day operations of the investigation's program and to display program results in a format more useful to our stakeholders. The reports, which now must be run on the local micro computers, will also be converted to micro-to-host reports, which will allow the national office and others to run the reports in a manner similar to the current enforcement IMIS. In addition, recommendations are being made to improve the data entry portion of the system, which will, again, make the system easier to use, and therefore, more likely to be used correctly. As an aid to insure correct usage, a written "desired state" plan of computer usage for investigators and their supervisors should be developed and implemented.

In addition to the computer program short-term remedies, well-defined and consistent data entry will also resolve many of the over or under reporting of various types of data. Administratively closed or "screened" cases where there is a lack of a prima facie allegation, lack of OSHA jurisdiction, untimeliness, or non-responsiveness of the complainant have been entered into the IMIS system by some regions and not by others. The Taskforce recommendation is that such cases not be entered into the IMIS system. Case file documentation and complainant correspondence should allow an uninformed person to find adequate reasons for the screening out of a potential case.

Cases with multiple complainants and multiple respondents are also entered inconsistently. A Taskforce recommendation is that multiple complainants will be entered separately unless three conditions of case similarity are met and that multiple respondents are to be entered separately.

If a case is returned for additional investigation on appeal, the Taskforce recommends that the results of the additional investigation be entered as an Appeals determination, not a second regional determination. Additionally, the current screening process renders the concept of a "No Full Field Investigation" obsolete and therefore the Taskforce recommends that the term no longer be used.

An IMIS Recommendations paper is attached at Appendix D, which provides full details of the short-term recommendations.

Training for the RSIs and other supervisors will be required to implement the short-term recommendations. Prior to the training there is programming which must be done by OMDS. Priority concerns are now being addressed to assure that the system is implemented in the near future.

Funds are not currently available to completely revise the whistleblower IMIS system. Long-term remedies will be partially implemented during the conversion/upgrading of the whistleblower system into the Oracle system along with the rest of OSHA's data to assure Year 2000 compliance. An IMIS users group will be used to assist in the conversion/upgrading. The users group recommended composition is to include state; union, RSI staff, as well as the Taskforce member, John Spear, who developed the short-term remedies.

In their report, OIG discussed the use of the IMIS in tracking performance measures. The Taskforce recommends adopting seven performance measures to be used both internally and externally to gauge the success of the program statistically using the short-term remedies to the IMIS problems. It may be appropriate to solicit stakeholder input prior to finalization of these measures. It should be pointed out that the true measure of the success of an investigative effort can only be made by reviewing case files. A successful investigation is one that reveals the truth of the situation in a timely manner and correctly applies the law to result in appropriate compensation to employees whose rights were violated and no compensation to employees whose rights were not violated. Therefore, in addition to the seven measures listed below, it is recommended that discrimination case files be routinely audited by an independent and knowledgeable evaluator, as suggested earlier in this report.

The seven measures are:

* Case Backlog

* Timeliness

* Merit Rate

* Settlements

* 11c Appeals

* SOL Processing

* Hearings Processing Time

Case Backlog. The case backlog is defined as the percentage of total caseload that has required more than the time frames established in the various whistleblower laws. For OSHA

discrimination cases, that is 90 days; for STAA cases, it is 60 days; and for the EPA and ERA whistleblower cases it is 30 days. This measure highlights how well the program is doing at meeting the statutory requirements (although the Courts have ruled that it is not absolutely; mandatory, and there are frequently sound reasons why the time requirements are not met). It is calculated by dividing all cases closed or which are remaining open during a given time period into the number of those same cases which took (or are taking) longer than the 90/60/30 days to complete. The OSHA five, year goal is to complete 75% of the cases within the time frames (25% backlog).

Timeliness. Timeliness is defined as the average length of the investigations expressed in days. This measure provides an indication of how efficiently the investigations are being completed. It is calculated by summing the total difference in time between the date the complaint was filed and the date the complainant was provided the written determination of the Regional Administrator and dividing by the total investigations completed.

Merit Rate. The merit rate is defined as the percentage of completed cases with a finding or settlement in favor of the complainant. This measure should be used primarily to compare program results among the various components of the organization, such as among regions or among the various whistleblower statutes or between time, periods. Because OSHA has no control over who files discrimination complaints (many are frivolous), minor deviations from the norm should not be of concern. However, unusually high or low deviations, especially over time, should be considered candidates for further attention 'to determine the reasons.

Settlements. The settlement rate is defined as the percentage of cases settled by OSHA. Upon finding that an allegation of a prima facie case has been presented, the next phase of the enforcement process is to attempt resolution of the case through settlement. Such resolution is highly beneficial to all parties in that it conserves precious time and resources in investigation and litigation. It is calculated by dividing the number of cases settled by the total number of cases for a given time period.

11(c) Appeals. 11 (c) appeals are measured in three ways. First is the percentage of dismissed cases that are appealed by complainants to the National Office Appeals Committee. A relatively low rate of appeals is an indication that the investigators are conducting thorough investigations and effectively communicating the negative results to the complainants. Second is the percentage of appeals that are sustained upon review by the Appeals Committee. The percentage of sustained appeals may be ' expected to be very low. A higher rate is an indication that the investigations are not thorough or well documented. The third is the average time in days that it takes the Appeals Committee to complete its review and issue a decision.

SOL Processing. SOL processing is measured in five sub-categories. Due to the limited numbers of cases that are actually litigated in U.S. District Court, only the raw numbers are tracked. The subcategories are: (1) the number of cases settled before litigation; (2) the number

of cases settled during litigation; (3) the number of cases litigated and won; (4) the number of cases litigated and lost and the average days the cases took to be litigated; and (5) the number of cases rejected for litigation by SOL and the average days taken for such a review.

Hearings Processing Time. Finally, although the Administrative Law Judge hearings processing time is an effort beyond OSHA's control, we are measuring the average time it takes for cases to go through the process from OSHA's determination, to the ALJ' s recommended decision and from the ALJ decision to the Administrative Review Board's final decision.

Taken together these seven measures give a good overall view of OSHA's performance at determining claims, resolving those claims, and length of time taken at the various stages of the cases.

In addition to the "Success Measures" mentioned previously, five additional output reports and two "utility" programs have been developed as a part of the short-term remedies to assist supervisors and managers.

Pending Discrimination Cases Report. This report lists all the cases currently pending at the various stages of investigation and post-investigation processing. It is expected to be used primarily by the supervisor to track the current status of his or her caseload. It lists each case by name and , number, the investigator assigned, the date the complaint was filed and the current length in days that each case has been pending. The report may be easily run by individual investigator or for all investigators within a region.

Length of Investigations Report. This report, which may be run by individual investigator or case type, lists all the cases which have been completed during a given time period, the number of days the investigation took to complete, and identifies those cases that took longer than the statutory time frame. It is also expected to be ,used by the supervisor to track the efforts of individual investigators and to identify problem areas. It also displays each case by name and number, the investigator assigned, the date the complaint was filed, the date the determination was issued, the case type, and the final disposition of the case.

Case Listing Report. This report may be run by individual investigator and case type. It lists every case in the system by number, case type, name, date filed, disposition level, disposition date, and the disposition of the case at each level. It is a convenient way of displaying the complete history of each case in the system for a given time period, which is very helpful for identifying any errors in the database or for reviewing the totality of the program's effort in its "raw data" form.

Discrimination Case Activity Report. This report, which may also be run for individual investigators or the whole group, is a convenient summary of investigative activity for a given time period. It is patterned after the old manually produced "monthly report" that has been commonly used in the past. It lists the number of cases filed by case type, the number completed,

the number of cases open pending investigation, and the number of those open cases which are overage or backlogged. It also lists the results of the completed cases by disposition, Le., withdrawn, dismissed, merit finding, or settled. Finally, it lists by name those cases which are pending investigation, the number of days' pending and identifies those cases which are overage. It is expected to be used by supervisors and higher level managers to track progress of the work.

Discrimination Investigations Data Report. This report displays a significant amount of summary data regarding the region's discrimination investigations effort, all on a single page. By case type it lists the number of cases received, cases completed, percent completed timely, average days to complete, number of open cases, average days that open cases have been pending, and the percentage of open cases overage. It then lists the number and percentage of cases which were withdrawn, dismissed, meritorious, and settled for each case type. And finally, it lists the numbers and percentages of cases which were completed and deemed meritorious displayed according to the type of allegation the complainants filed, i.e., formal complaint, complaint filed with another agency, refusal to work, complaint to management, testifying in a proceeding, or other safety and health activities. This report will help managers and supervisors gain an accurate overall view of the investigative effort and results and the kinds of cases involved.

Error Check Utility. This program should be run at regular intervals to help maintain the accuracy of the database. It checks the data used to produce all the above reports to ensure that all required data is present and in the proper format and sequence.

Next Number Utility. This handy program allows the data entry person to determine which local case number was last used so that he or she can assign the next number in the progression.

Implementation of the short term IMIS remedies and use of the above measures and reports should meet the OIG recommendations as well as improving the management of the program. Long term remedies are a necessity.

If the Taskforce recommendations are approved and meet the additional needs of the stakeholders, direction to the Regional Administrators and the whistleblower supervisors will be essential to ensure that all data is uniformly entered into the system. Direction is also required to insure that the management tools are utilized .. This could be accomplished by including whistleblower indicators in discussions and reports concerning compliance indicators.

C. OTHER ISSUES/FINDINGS AND RECOMMENDATIONS

* Management Support and Oversight

The results of the work of the Taskforce and the issues discussed in the OIG report have clearly demonstrated that 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 within the Agency, at the State level, with stakeholders, and with the customers.

Approved changes in policies and procedures which result from the work of this Taskforce will require the same executive level attention and monitoring as is accorded the other OSHA programs. This includes the coordination and relationship with the Office of the Solicitor in revising current agreements with OSHA or creating new ones to assure that a fair share of the Solicitor's OSHA, resources are devoted to the needs of the whistleblower programs.

Management support for the whistleblower program in the field is not consistent. The Taskforce consciously chose not to go into this issue in depth. Regions I and V have a different organizational structure for their whistleblower staff than the other regions. Investigators in Regions I and V are supervised in the area office, where they are physically assigned. In offices which have been Redesigned, the investigators are generally assigned to a team and their work integrated into the work of the team. The degree of integration varies from office to office. Region-wide coordination of the program is handled through a Program Manager assigned to the Regional Office. Investigators in the other regions are supervised by a supervisory Investigator, who is normally located in a Regional Office.

Arguments can be made in support of either organizational system. This issue may be appropriate to revisit, after the implementation of the recommended uniform policies and data entry have been allowed to function for a sufficient period of time. However, one structure may not be appropriate for all regions and it can be anticipated that some differences will remain due to the varying areas of coverage and the number of investigators.

* State Programs

Several members of the Taskforce represented State Plan States. It was determined that it would be in the best interests of the program to survey the states. Such a survey was performed and produced results which revealed concerns, problems and issues similar to those found in the Federal program. The most consistent recommendation from that group, which is seconded by the Taskforce, is that there is a need for improved/effective communications between the Federal OSHA and the States' whistle blower programs. Better coordination between the Directorate of Compliance Programs and the Office of Federal and State Operations is important in coordinating the efforts of the State Plan States and ensuring that they are kept up to date regarding case law and possible policy changes. It is important that this coordination and communication extend to the Regional Offices and State Plan Area Offices so that their monitoring 'and review functions are consistently performed with the most current information and policy guidance.

Additionally, recommendations were made concerning improvements and training in the IMIS system; rewriting/redefining/reestablishing Federal policies and procedures to form a model for the States; inclusion in activities at the Federal level that may impact the States' program;

improved and effective basic and advance training; and the establishment ofa Federal-State network in the whistleblower program. The Taskforce recommends that the State recommendations be seriously considered and implemented to the extent possible. More detailed infonnation may be found in Appendix E.

* Legislation

As mentioned earlier, Taskforce recommendations regarding the potential legislative changes to the II(c) program have already been prepared and forwarded to the Policy Office for appropriate action. Significantly, the changes proposed would include adjudication before an administrative law judge, extension of the filing time to 180 days, enumeration of remedies, and a requirement for employers to post a notice in the workplace.

* Resources

Recognition must be given at the highest levels of the organization that this program is very labor and time intensive. 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 operation (including LAN access), Solicitor availability, and training funding. The RSIs and Program Managers must meet regularly to insure consistency throughout the country.

The Taskforce believes that the emphasis 'in the whistleblower program should be on producing quality investigations. Correction of the concerns raised in the OIG report concerning case file , documentation, settlements, IMIS utilization, program measurement, and SOL coordination all have resource implications. Currently utilized short-cuts in the investigative process and case file documentation will no longer be appropriate. A"dded to this are the complications caused by the assumption of the seven statutes from the Wage and Hour Division in February 1997. These seven statutes have a requirement to complete the investigation and issue findings within 30 days of the filing of the complaint. An analysis of the impact of these new statutes was conducted by a Taskforce member in Region VI. This analysis indicated that the number of 11 (c) and ST AA cases which now cannot be completed within their longer statutory deadlines is increasing as the emphasis is shifting to completion of the cases with the 30 day deadline first. The study also indicates that these new statutes involve complex investigations which cannot be completed within the 30 day time frames. No additional ceiling slots were allotted to the whistleblower program when the seven new statutes were assumed. It was concluded by the Taskforce that additional resources will be needed in order for OSHA to be able to conduct thorough investigations, within statutory timeframes. A request was put into the FY 1999 budget request by the Office of Investigative Assistance.

The development and implementation of a comprehensive training plan for the investigators, similar to that in existence for the CSHOs is essential. Also included is the recommendation that specific training on the whistleblower program be provided to new as well as experienced

CSHOs. Since it was discovered recently that a significant number of staff were not aware of OSHA's newer responsibilities for the Energy and other whistleblower programs, this need for training is highlighted. Although remedial action to remedy this Hick of knowledge was taken by the issuance of a memorandum, the training need remains.

A severe morale problem has developed among the investigators since the journey level of the CSHOs was raised to the GS-12 level, while their positions remain at the GS-ll journey level. The Taskforce found that the investigators consider themselves the lowest level of professionals in the Agency. The Taskforce recommends that resources be made available or perform a new review of the classification of the investigator position. The Taskforce recommends that the journey level of the investigator position be at OS-12 in a career ladder progression.