SIX INVESTIGATION:
Corruption in the OSHA Whistleblower Protection Program

The OSHA Whistleblower Protection Program (Program) is failing its mission to protect qualified whistleblowers from retaliation and to protect the public from safety and health risks. The evidence of this failure is writ large in the statistics that OSHA gathers that report the results of Program investigations over the last decade. The failure begins by denying whistleblowers easy access to the Program. Recently, initial access has improved through the adoption of an online complaint system. This requires that whistleblowers navigate to and through the filing process, and trust that their complaints will be properly screened, which in too many cases they are not. Further, even when whistleblowers do manage to find the Program, an opaque labyrinth of programs and qualifications that must be satisfied before any investigation begins discourages the majority of complainants. The few that survive this often-bewildering process enter a nether world of curt treatment, drawn out investigations, coerced settlements, and unfathomable management that leave them without any real protection. It should come as no surprise that the vast majority of employees believe reporting safety and health issues is dangerous to their employment.

As direct regulation has decline over the last several decades, the burden of protecting workers and the public from known safety and health threats has shifted from regulatory agencies to those who are in the best position to identify these threats – the employees who have direct knowledge and understanding of what constitutes safety and health threats. Thus, the frustration of whistleblowers complaints substantially undermines the Program's mission to protect the public safety and health, which implicitly is the Program's greater mission. Safety and health threats rarely affect only employees. As technology has pushed systems to more complexity and involved more deadly chemicals and processes, it has greatly expanded the scope of threats far outside the traditional workplace. As initially designed and included in OSHA, the Program has not kept up with the evolution of such threats, nor has OSHA evolved its thinking about the Program and its purposes. When Congress expanded the Program to extend whistleblower protection to an every larger swath of the American economy, Congress also mandated the interconnection of the Program with other regulatory bodies, such as the EPA, the DOT, the NRC, and the FAA. These interconnections were intended as an early warning system that would facilitate identifying safety and health threats to both employees and the public. Thus, when the Program fails to acknowledge and protect whistleblowers it robs both whistleblowers and the public of this vital link in safety and health protection.

The failures of the Program derives from two sources: a dysfunction institutional design, and a pattern of cronyism and careerism that promotes as protects unqualified employees to management positions. Over time, this has generated a culture of corruption

that facilitate an assumption of authority by career bureaucrats who redefine the goals and methods of the Program according to their own interests. As a consequence, Program managers have created and sustained a pattern of obfuscation, concealment, and suppression to deflect attention away from mismanagement and abuse of authority by Program managers, with cronyism replacing competence as the standard for promotion, and careerism placing loyalty to the Agency above commitment to serve the purposes of the Program. The lack of accountability within OSHA and the Program has generated a belief among managers that they are authorized to substitute their preferences and prejudices for those provided by whistleblower statutes, rules, and regulations.

The culture of corruption that now dominates the Program has historical roots. Early opposition to OSHA led to a series of decisions that preserved the OSHA but also fundamentally undermined its mission. This crisis drove out those who came to OSHA with a regulatory mindset and replaced them with career bureaucrats willing to compromise the Agency's mission. In turn, this opened the door to the culture of corruption that followed. This culture of corruption might have passed with little notice but for repeated acts of Congress that modified the Program. Beginning in 2000, Congress expanded coverage for the Program and substantially strengthened its powers to protect whistleblowers. This new coverage extended whistleblower protection far beyond the relatively limited coverage provided by the original Act, and redefined the way whistleblower investigations were conducted. However, by that time OSHA-trained industrial hygienists, who had little knowledge or training in these new subject areas, populated key management positions in the Program. Largely unqualified to address these new Program requirements, these managers turned their attention to protecting their power by generating diversionary programs and arguments, and creating a chilled working environment within the Program that would conceal their lack of competence.

Further, the institutional design of OSHA allowed only for weak leadership and organizational control at the national Program level, and for the development of authoritarian and sometimes hostile management of the Program at the Regional level. This left management of the Program to the discretion of OSHA Regional Administrators (RAs), most if not all of whom were trained as industrial hygienists and promoted into management based on that training and experience. As OSHA transformed away from a program of inspection and toward a program loosely devoted to safety and health education, cronyism and careerism replaced professionalism as the primary motive for OSHA and Program management. This encouraged a more authoritarian management culture that was itself hostile to whistleblowers, and over time and by the design of the Program cronyism, careerism and an underlying hostility toward whistleblowers invaded local Program management and the investigatory process. Consequently, the Program lost connection to its larger mission of protecting whistleblowers and protecting the safety and health of the public.

The discussion that follows provides a more detailed account of the history of the Program, identifying specific factors that led to the culture of corruption that now surrounds it. It also includes a detailed discussion of six whistleblower investigations conducted between 2010 and 2015 that offer insights into how this culture of corruption

has generated substantial risks to the national public safety and health. Many of the risks to the public safety and health left by the failure of the Program to protect whistleblowers are relatively minor and discrete. However, many also represent not only substantial risks to the public, but in some cases potentially catastrophic risks, particular where the Program fails to protect whistleblowers in high-profile industries, such as air carriers, nuclear facilities, railroads, trucking, and industrial testing. In most cases, the legislation creating protection for whistleblowers in these industries were prompted by a catastrophe and a recognition of the key role that employees play in protecting the public. In telling the stories of these whistleblower investigations, the institutional failures of OSHA and its culture of corruption become apparent.

Contrary to representations made by OSHA senior management, these failures are not merely the result of a lack of funding or lack of Congressional support. Of course, adequate funding is essential to a functioning program. However, what is "adequate" depends on how the Program is managed. Further, public safety and health are not partisan issues: good government is in everyone's interest, and Congressional intentions for the Program appear clearly in the statutes adopted by Congress since 2000 that strengthened whistleblower protection. Rather, even as funding for the Program has increased, OSHA and Program managers have diverted funds away from investigations and into programs that actually compromise the Program's mission while promoting more management.

The Program - Background

The Whistleblower Protection Program has undergone three phases. The first phase began with its creation in 1970 and continued into the 1980s. The second phase began in the early 1980s with the extension of whistleblower protection through several environmental statutes and the Energy Reorganization Act (ERA), which covered the nuclear industry. The third, current phase began in 2000 with the extension of whistleblower protection to several major sectors, including the financial industry, and major revisions in the design of whistleblower investigations. While the Program underwent periodic revisions after 1982, OSHA's treatment of the Program changed very little. Throughout all three phases, industrial hygienists continued as the principal Program investigators and managers, Regional OSHA administrators continued to provide leadership and management for the program, and the Office of the Solicitor of Labor continued to play a key role in advising the Program about legal issues and procedures.

What did change during these three phases was the culture of OSHA and its management. As recounted in OSHA's own history of the Agency, the 1980s were a time of turmoil within OSHA as it came under political attacks for interfering with the unfettered management of business. Critics accused OSHA of being hostile to business management, and in response, OSHA adopted survival strategies that included becoming more of a safety and health mentor to businesses, and working closely with businesses to mitigate violations of safety and health regulations. Thereafter, OSHA reduced fines by

negotiating with companies, OSHA personnel were directed to minimize any invasive processes, including investigations of whistleblower complaints, and advocates for a more regulatory role for OSHA left to be replaced by middle and senior OSHA managers who supported the way that OSHA defined its work.

As with all public enterprises, agencies tend to develop organizational inertia over time: employees are promoted to management based on their loyalty and time in service, rather than their skills or training as managers; and as an agency's identity strengthens, it begins to self-promote its own agenda without regard to outside changes and political mandates. The process continues symbiotically, with managers promoted to still higher positions in agencies until they arrive, as Professor Peters famously said, at the level of their incompetence where they remain. Unfortunately, this practice corrupts the mission of an agency, first by creating a system of rewards that are disconnected from its mission, and second by creating an internal system of authority that focuses on self-preservation and covering up problems with competence. In that process, agency management becomes ever more authoritarian and intolerant of dissent, secrecy replaces openness, and junior managers and employees are coached to ignore rules and regulations where they conflict with corrupt management practices. Left alone, such agencies can become quite self-deluded as to what they are actually doing, which is substantially what happened to OSHA beginning in the 1980s.

The Program as created by the Act

The Whistleblower Protection Program was created in 1970 as part of the Occupational Safety and Health Act (29 *U.S. Code* §660 (c)). That Act envisioned a Program that would operate hand in glove with the larger OSHA program, which conducted on-site inspections of companies subject to OSHA's jurisdiction. In doing this, the Act gave primary administrative control over the Program to Regional OSHA Administrators who either managed it directly or delegated management to a junior administrator. Investigations were conducted under Section 11(c) of the Act, which then as now provides jurisdiction over complaints filed by employees who suffered some form of retaliation for reporting safety and/or health issues to their employers. Whistleblower investigations were commonly conducted by the industrial hygienists who populated the main OSHA inspection program and who commonly produced from an OSHA inspection that led to an employee filing a complaint.

The standards for determining whether a complaint had merit under 11(c) were high. Complainants had to provide evidence that they made a safety and/or health report, that their employer knew about the report, that they suffered some form of "adverse action", broadly defined, and that there was a palpable connection between their report and the adverse action. Proving these elements required a showing by "a preponderance of evidence" (more likely than not), and the whistleblower also carried the burden of showing that the safety and/or health report "motivated" the adverse action. Employers could defend against the complaint by making a similar showing by "a preponderance of evidence" that it would have taken the same adverse action absent the employee's report

of a safety and/or health concern. Because these complaints often followed an OSHA inspection, the investigation itself often began with considerable background knowledge of the situation. The Act thus envisioned that investigation would be relatively quick and completed within 90 days after a complaint had been filed. If the investigation concluded by finding that the complaint had merit, the case was given to a Solicitor from the Department of Labor working with the Program for further legal action. In turn, the Solicitor had considerable discretion as to how to proceed, and he/she could then order remedies for the whistleblower only for back pay, compensatory damages, and sometimes punitive damages, but could not order reinstatement for a whistleblower who had been fired.

The template created by the Act for the Program had several weaknesses. First, it relied on industrial hygienists as investigators and Regional Administrators for Program leadership. The concept of protecting whistleblowers was novel, even in that time, and it was counter intuitive that inspectors could be easily converted into investigators and that administrators would be enthusiastic about protecting employees who "ratted out" managers. Investigation were further hamstrung by the involvement of Department of Labor attorneys who were not necessarily well trained in whistleblower protection, and who often balked at taking cases to court where there was any chance they might lose. The negative effects of this arrangement can be seen in the absence of any whistleblower complaints brought against the United States Postal Service – the largest producer of whistleblower complainants – until 2013; more than 40 years after the Program went into effect.

The beginnings of institutional change

The management of the Program begin to change in the 1980s as Congress added new coverage for whistleblowers in several industries not covered under the original Act. This included adding protections for whistleblowers who reported violations of seven environmental statutes: the Federal Water Pollution Control Act (FWCA), added in 1972; the Safe Drinking Water Act (SDWA), added in 1974; the Toxic Substance Control Act (TSCA), added in 1976; the Solid Waste Disposal Act (SWDA), added in 1976; the Clean Air Act (CAA), added in 1977; the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), added in 1980; and the Asbestos Hazard Emergency Response Act (AHERA), added in 1986. Congress also added two other statutes that extended coverage to workers in the nuclear industry under the Energy Reorganization Act (ERA), added in 1974, and to pipeline workers under the Pipeline Safety Improvement Act (PSIA), added in 1979.

In addition to adding new coverage, these nine statutes began subtly to change the conduct of whistleblower investigations. For example, these new statutes extended the time for filing a complaint from 30 to 90 days, but reduced the time allowed for conducting an investigation from 90 to 30 days, reflecting the intent of Congress to open the door wider for whistleblowers under these statutes, but also to encourage "the expeditious handling of retaliation complaints." (29 *CFR* 24.100(b)) The 1970s had been

a time of intense organizing among nongovernment environmental organizations, and by recognizing the role of whistleblowers in environmental protection Congress imagined that investigations would be completed and reported to Agencies, such as the EPA, in a timely fashion, and these agencies could then take initiative to actively enforce environmental regulations. Even today, this interagency relationship between the Program and other regulatory agencies remains a key goal in whistleblower investigations.

Congress, however, retained the basic standards of "preponderance of evidence" used in 11(c) cases for these new statutes, but also substantially reduced the role of the Solicitor by authorizing whistleblowers to take their cases directly to federal court. Responding to criticisms that the Program only weakly protected whistleblowers, Congress also allowed for the reinstatement of employees wrongfully demoted or dismissed, and provided for the recovery of attorney's fees. Finally, in drafting a whistleblower protection clause in the ERA, Congress begin to lower the threshold for qualifying for protection by allowing that whistleblowers only need to show that their protected activity "contributed to", rather than motivated an employer's adverse action. Congress followed that by extending the time for filing a complaint under the 1982 Surface Transportation Assistance Act (STAA) from 90 to 180 days, and then allowed whistleblowers to "kick out" complaints to federal court if OSHA failed to complete an investigation within 210 days. In adding the "kick out" provision, Congress acknowledged STAA investigations were difficult for Program investigators to conduct and that the Program was finding it difficult to complete investigations within statutory time limits.

The changes imposed by Congress on the Program during the 1980s introduced new and complex issues for managing investigations. Care had to be taken in screening complaints to be certain that they were logged under all of the proper statutes, which required more analysis and knowledge of multiple statutes, and that the time for filing a complaint was properly considered. Then, once an investigation began, an investigator had a defined time in which to complete and report results. Most importantly, the shift in the causation standard from "motivating" to "contributing" factor meant that the bar for qualifying as whistleblower was substantially lower. This eliminated the need to investigate deeply any "dual motive" on the part of the employer, and in theory limited the time and effort an investigator would devote to this sometimes very tricky analysis.

In practice, what remained after these changes was that OSHA and the Solicitor, whether qualified or not, still occupied central roles in approving merit findings once an investigation had concluded. The complexity introduced by these changes required more training and leadership. However, OSHA made little effort made to adapt, leaving in place industrial hygienists and Regional administrators as the core personnel in the Program, and Solicitors, whether or not qualified or interested, as the key legal players in the investigative process. This created a mishmash of approaches and outcomes that varied according to the level of knowledge and interest of Regional administrators and Solicitors.

Fundamental change after 2000

Beginning in 2000, Congress again introduced substantial revisions to the Program. With the passage of The Wendell H. Ford Aviation Investment Act for the 21st Century (AIR-21) in 2000, Sarbanes-Oxley (SOX) and the Pipeline Safety Improvement Act in 2002, and the Federal Railroad Safety Act (FRSA) in 2007, coverage for whistleblowers was added to four important new industries. However, in these cases, Congress not only added new classes of whistleblowers, it substantially reformed how they would be treated. Among the changes introduced was a requirement that the Program issue an Order for Preliminary Reinstatement when an investigation found "reason to believe" that a violation of statute had occurred. (See, *Whistleblower Investigations Manual*, 5-7) Previously, the Program was required to order reinstatement only after issuing a final report that found a complaint had legal merit. In making this change, Congress was also saying that violations in these industries were of heighten concern, and that strongly protecting whistleblowers was the only way to secure early reporting of a potential violation.

The addition of "preliminary reinstatement" to the remedies for retaliation against this group of whistleblowers stirred a firestorm of opposition, particularly from the air carrier industry. Companies argued such orders violated their rights of due process, in part because they were to be effective immediately on receipt. In response, hearings were held in 2003 and the Program agreed to issue a "Due Process" letter to the companies before issuing an Order for preliminary reinstatement. However, this did not wholly resolve the controversy, and in practice Program managers and Solicitors balked at issuing them. After an initial burst of Orders for Preliminary Reinstatement, such Orders dropped off dramatically after 2004. In its place, Program managers often delayed investigation and/or manipulated them in an effort to force whistleblowers and companies to settle complaints so that the Program could avoid issue Orders.

Beginning in 2007, Congress added yet more whistleblower coverage to the Program, all of which followed the template of AIR-21in requiring Orders for preliminary reinstatement, adopting "contributing factor" as the rule for causation, extending to 180 days the time allowed for filling a complaint, allowing whistleblowers to "kick out" their complaints to federal court when OSHA failed to produce a timely result, allowing for punitive damages in most, but not all, cases, and in requiring that the Program complete investigations within 60 days. These new statutes included: the National Transit Systems Security Act (NTSSA), added in 2007; the Consumer Product Safety Improvement Act (CSPIA), added in 2008; the Seaman's Protection Act (SPA), the Affordable Care Act (ACA), and the Consumer Financial Protection Act (CFPA), all of which were added in 2010; the Food Safety Modernization Act (FSMA), added in 2011; and the Moving Ahead for Progress in the 21st Century Act (MAP-21), which was added in 2012.

In adding these statutes to the Program, Congress not only extended whistleblower protection into almost every corner of the American economy, it also indicated that the function of Program investigations was to provide expedited

investigations that would better protect whistleblower and be quickly resolved to allow the underlying safety or health issue to be addressed by the proper regulatory agency. But this intent rested on an assumption that the Program would follow the plan. With limited competence in the subject matter of these statutes, coupled with a history of collaborating with companies to minimize regulatory impacts, OSHA and Program managers shifted their attention to creating appearances and pleading for more funding, when had they followed Congressional intent neither would have been required.

The Program – The Development of a culture of corruption

From the beginning, the mission of the Program has been hostage to how OSHA Regional administrators and the Solicitors defined and managed it. When the Act placed management of the Program in the hands of OSHA Regional administrators, and coupled that with an ill-defined role for RSOLs, it invited the cultures of those agencies into the Program. This included moving from an objective mission to protect whistleblowers to a subjective mission to collaborate with companies, and adopting management values that were essentially hostile to whistleblowing and whistleblowers. This was made possible by the absence of strong and independent leadership within the Program that could have better protected the Program's mission and its management of investigations from adverse influences.

The mismatch between OSHA and the Program came into sharper focus as Congress reshaped the Program toward a more aggressive protection of whistleblowers in an increasingly large pool of employees. By 2000, the dysfunctionality within the Program began to breed a different and more sinister type of corruption as efforts by OSHA and Program managers turned to concealing the underlying mismanagement. In the late 2000, the Program hired an outside Director to provide the leadership that was lacking. However, this Director was never provided with the authority to make required changes, and instead fell victim to the internal politics of OSHA that were preoccupied with obfuscating rather than exploring these changes. After this Director and her senior assistant left in 2011, the Program never again secured stable leadership, suffering through four Directors in as many years, with long periods between when the office was occupied by an "acting Director".

The fatal flaw was and continues to be that the Act created a weak and disbursed Regional Program left to the whims and discretion of Regional administrators. In some cases, these Regional administrators have at least attempted to give the Program support. In other cases, Regional administrators have openly disregarded the Program, depriving it of basic necessities and essential administrative support. In at least one case, a Regional Administrator has actively sought to cover up corruption among his junior administrators who consistently attack whistleblowers and investigators who seek to support them.

The lack of Program leadership also contributes to the culture of corruption that has come to envelop the Program by denying any accountability for mismanagement by OSHA. When issues appear, senior Program and OSHA managers move quickly to stifle dissent and attack those who raise issues. When challenges arise from outside the Agency,

senior Program and OSHA managers move to frustrate and obfuscate investigations by closely guarding how investigations are conducted and keeping them strictly in-house. A steady drumbeat of "positive news" and cheerleading, the distribution of rewards to those who faithfully protect senior management, and the defaming of those who do not go along with the party line reinforce this reactive strategy.

This culture of corruption also extends to the treatment of whistleblowers who come to the Program seeking protection. Since 2006, the Program has produced merit findings in less than 2% of whistleblower investigations, and in the case of complaints filed under AIR-21 Region IX has issued only a single merit determination in 2006. In some cases, this has included actively attacking whistleblowers who object to the mismanagement of their investigations. In other cases, it involves creating faux legal excuses for dismissing complaints that clearly are merit, falsifying investigative reports, harassing witness that support the whistleblower, defaming the whistleblower, and attempting to coerce settlements with little regard to the whistleblower's rights to a "make whole remedy."

Most recently, the Programs disregard for the public purposes behind whistleblower protection has become institutionalized in the form of efforts to generate Alternative Dispute Resolution (ADR) program. In response to their inability to manage investigations effectively and in a timely manner, senior Program managers have chosen to promote "early settlements", "mediation" and unilateral settlements. In effect, these ADR programs side step the Program's mission of supporting whistleblowing by terminating investigations before the Program has to issue "findings". Arguably, whistleblowers have the right to resolve their complaints on their own terms, and some do. However, these ADR efforts do not respect those rights, but substitute the Program managers' efforts to create an appearance of Program efficiency for the whistleblower's judgment about when and how to resolve her/his complaint. This encourages Program managers to conceal vital information from whistleblowers, under the theory it might discourage them from settling, and/or misrepresenting the rights of the whistleblower, and/or threatening whistleblowers with adverse consequences if they do not settle. Further, such "early resolutions" excuse the Program from issuing public reports about investigations and communicating with other regulatory agencies and reporting potential violations of law and regulations.

The most troubling evidence of this culture of corruption appears in the way that OSHA and Program senior management has actively sought to suppress internal reports of wrongdoing. For example, in 2011 the entire group of investigators in Region IX brought a grievance to the Regional Administrator concerning mismanagement by the local Regional Senior Investigator (RSI). After a serious of meeting between the investigators and the RA over a period of eight months, no action was taken to address the complaint. Shortly thereafter, similar complaints followed from individual investigators, who immediately became targets of disciplinary hearings and hostile workplaces. When the DOL Civil Rights Center (CRC) requested an investigation, the RA assigned it to one of his subordinates, who made false reports to the CRC. When one of the investigators reported to the RA and the national Program Director that this same

RSI was violating law and policy by wrongly dismissing complaints based on personal animus, and then falsifying documents to conceal his wrongdoing, the RA conducted a sham investigation during which one of his senior subordinates lied about one of the cases. Thereafter, the RA told the National Program Director and the Assistant Secretary of Labor that worked with OSHA that the investigator's supervisor (the very supervisor about whom the investigator reported), "is preparing discipline against him". When a report was made to the Secretary of Labor in May 2014, asking for an investigation into the problems in Region IX, the National Program, and the Office of the Secretary, the Secretary's office tasked OSHA itself with conducting an investigation. Predictably, that investigation was also a sham. Tragically, the investigation also prompted Region IX management to retaliate against three investigators who supported the allegations of mismanagement, one of whom was accused of being "dangerous" and placed on indefinite administrative leave, another who schedule early retirement, and the third which has been targeted for termination. Sadly, a fourth investigator who witnessed these attacks shortly thereafter went on medical leave for four months and did not return. Thus, four of six investigator are no longer available to serve the Program due to management retaliation.

While this series of events occurred in Region IX, they clearly show that the National Program, OSHA, and even the Office of the Secretary of Labor would prefer to attack those who report wrongdoing, rather than take steps to address management problems.

Six Investigations

The discussion of six whistleblower investigations offered below offers specific examples of corruption in the Program has generated corruption in the protection of whistleblower and disregard public safety and health. The investigations represent a cross-section of cases that arose from complaints based on statutes adopted after the passage of the original Act. The investigations were conducted by a single investigation and over the period from Augusts 2010 to November 2014. All of the whistleblowers in these cases were terminated, and four of the cases involve the potential for the issuance of Orders for Preliminary Reinstatement. Many other cases could have been added to this list, including cases conducted by other investigators in other OSHA Regions. To the extent that they reflect unique conditions in Region IX, they also point to a lack of Program leadership and the character of OSHA organizations that permits an anarchy of management that allows senior OSHA administrators to act with impunity and disregard for the Program. However, they also reveal how lack of leadership in the Department of Labor, and particularly in the DOL's Office of the Solicitor, has led to a dysfunctional and ineffective Program.

Three investigations reported were investigated under the standards of AIR-21, one under the ERA, one under TSCA, and one under the FRSA. The AIR-21 and FRSA investigations and use a "contributing factor" standard to qualifying for merit, and a "clear and convincing evidence" test for company's claims its adverse action was not motivated by an employee's report of a safety and health issue. They also provide that an Order of Preliminary Reinstatement be issued when there is "reason to believe" that a violation of the statute has occurred. The investigation under ERA also requires a "contributing factor" standard and a "clear and convincing evidence" test, but it does not provide for preliminary reinstatement. Like investigations under 11(c) of the original Act, investigations under the TSCA use both the "motivating factor" standard and the "preponderance of evidence" test, and do not provide for preliminary reinstatement.

Copper Basin Railroad/Lawson/9-0370-11-007

This case was the second of two investigations involving the same company and the same employee. The first case, logged as *Copper Basin Railroad/Lawson/ 9-0370-10-030* and settled in 2011 (Ex. B-1-1), was resolved through an agreement to pay back wages and reinstate the employee. (Ex. B-1-2) By settling the case, the company avoided the Program issuing an Order for Reinstatement as required by FRSA, and it similarly relieved the Program of reporting a merit finding to the Federal Railroad Administration for possible further action. However, shortly after his reinstatement the employee called the investigator to report that he was again working under the supervision of the very manager against whom he had filed his complaint, and that this manager had created a hostile workplace on his reinstatement. A few weeks later, the employee called to report he had been terminated.

A second investigation into the employee's subsequent termination began in January 2011. That investigation found that the company manager had openly declared he would find a way to fire the employee and that the manager actively discouraged other employees from socializing with the reinstated employee. Shortly after creating this hostile work environment in violation of the settlement agreement, the manager ordered a random drug test, which is standard practice for railroad employees. However, before any results were available, the manager order the reinstated employee to take a second test, which the employee refused, based on his belief that he was entitled to the results of the first test. Ultimately, the results of the employee's drug test were negative, but the employee was nonetheless terminated for refusing the second test.

On October 17, 2011, the investigator completed his second investigation and drafted a Final Investigative Report (Ex. B-1-3) and Secretary's Findings (Ex. B-1-4) with a recommendation for merit and an Order of Reinstatement. These were submitted to the Region IX RSI, who agreed with the merit recommendation and forwarded a Due Process letter with its notice of a merit recommendation to the Regional Solicitor of Labor (RSOL). In January 2012, the investigator was called into a meeting with the RSI and the RSOL, which was highly unusual. In the meeting, the RSOL advised the investigator and RSI that he did not want to approve the Due Process letter because he

did not want to argue a case involving drug testing in court. This misrepresented the actual role of the RSOL because under FRSA the RSOL would never argue the legal merits of the case in court, but only defend the Order against a claim that it somehow burdened the company. The RSI never questioned the RSOL's reasoning, nor the RSOL's misrepresentation of his role. Rather, shortly thereafter the RSI ordered the investigator to change his merit recommendation and revise his investigative report to reflect non-merit. The investigator refused the order. In response, the RSI told the investigator, "I will draft the FIR here and keep your FIR as a draft in the file. However, in the future, I will be expecting you to redraft FIRs or ROIs as necessary." (Ex. B-1-5) However, when the RSI rewrote the investigator's report (Ex. B-1-6), he misrepresented it as reflecting the investigator's recommendation, and then issued Secretary's Findings based on his own rewritten report. (Ex. B-1-7)

Comparing documents

When compared against the investigator's report, the RSI rewritten version offers clear evidence that the RSI knowingly concealed probative evidence to enable his dismissal of the case. For example, after discussing the considerable evidence that the employee's termination was pre-textual, the RSI never discusses this issue in his analysis. Further, the RSI failed to discuss the company's lack of credibility that appeared during the investigation, then failed to acknowledge that FRSA requires that the company's claim the termination was justified be supported "clear and convincing" evidence. Finally, in producing his rewritten report, the RSI doctored the report to make it appear that the Report was drafted by the investigator and merely "approved by" by the RSI. This ensured that anyone reviewing the case would wrongly assume it reflected evidence developed during the investigation and the investigator's view of the evidence.

The dismissal in this case occurred in the context of the investigator raising questions about the RSI's management, which produced a long period of hostility and retaliation by RSI against the investigator. These circumstances were noted in the investigator's later report in June 2012 to the Regional Administrator (RA) and the National Director of the Program, asking that the case be reviewed for possible wrongdoing by the RSI. However, during the investigation conducted by the RA, the RA failed to conduct a credible investigation, relying on misrepresentations by his Assistant RA reporting that the case had been settled rather than dismissed. (Ex. B-1-9)

PG&E/Easley & Sanders/9-3290-10-041

This complaint was filed under the Energy Reorganization Act (ERA) in September 2010 by the Director of Security and the Assistant Director of Security at a nuclear plant in California. The investigation began in October 2012 and produced the following evidence: the plant Director had strong credentials as a well-respected member of the nuclear management community. He was an experienced nuclear safety officer, and had been a consultant to the Senate in drafting protocols for the decommissioning of

nuclear plants. He was hired for the stated purpose of assisting the company in the decommissioning of the plant, which required knowledge the federal nuclear safety that were enhanced following 9-11-2001. When he first arrived in 2002, he found numerous safety problems, including safety personal that were physically unable to perform their duties, widespread drug use, obsolete and broken security systems, unsafe and insecure storage of nuclear fuel rods, and a chilled environment for employees reporting safety and health problems. Accordingly, he recommended steps to correct these problems. However, once he began to act on the problems the local plant manager pushed back, engaging in a multi-year effort to discredit him and force him out of his job.

Beginning in 2005, the Director began to make reports to the NRC regarding his concerns about the poor state of safety at the plant, including a report that the company had lost track of nuclear fuel rods. Then, when the local plant manager began construction of a new security facility without consulting him, the only plant staff member with nuclear security experience, the Director objected, pointing out the deficiencies in the construction. Then, when he discovered that the construction did not follow NRC regulations, the Director issued two stop-work orders. This prompted a company audit that confirmed his concerns. However, it also prompted an order by the plant manager that he conceal from the NRC the state of security at plant or risk losing his job.

Shortly thereafter, the Director of Security was demoted and replaced by the plant's Assistant Director for Security who had been trained and worked closely with the Director. An auditor from the company's working nuclear facility concluded in December 2008 that this change in security leadership "had a significant impact on the [morale] of entire Security organization" and contributed to the degradation of safety performance" at the plant. In May 2009, the NRC issued three citations to the plant regarding fuel rods that went missing in 2006 missing fuel rods, and began an investigation into other security issues raised by the Director, with a middle-level security officer threatening the Director and Assistant Director if the problems were attributed to him. In October 2009, the NRC advised the company it would conduct an audit of plant in January 2010. Thereafter, the mid-level security officer tells the plant manager that the Director and Assistant Director stole $400 worth of tools from an employee organization a year earlier in October 2008. In December 2009, the company manager was advised that the NRC wants to confer with Director and Assistant Director during its January 2010 audit. Shortly thereafter, the plant manager launches an internal investigation of the allegations brought by the mid-level security officer. The NRC arrives and conducts its audit in January 2010, openly praising the Assistant Director for his candid reports on plant security. Shortly thereafter, the Director and the Assistant Director were terminated, based on the investigation of the allegations they stole $400 worth of tools more than a year earlier.

A nuclear industry employment group and the California Unemployment Appeals Board conducted two outside investigations of the Director and Assistant Director's termination. Both investigations found that the terminations were not supported by evidence. Thereafter, when the Director found new employment in the nuclear industry,

someone from the company reported to his new employer that the Director could not be trusted, causing the Director to lose the security clearance required for employment in the nuclear industry. Then, the company reportedly retaliated against the employment group that had secured the Director's reemployment by cancelling contracts with the employment group.

The investigation in this case took two troubling turns. In January 2011, the investigator shared information with the company attorney about the course of the investigation, as directed by the Investigations Manual, suggesting that evidence supporting a merit recommendation had emerged. In April 2011, that company attorney was replaced with a new company attorney who called the RSI complaining that the investigator was "threatening" the company by sharing evidence supporting a merit finding. Following that call, the RSI became increasingly hostile to the investigator and the investigation. When the investigator submitted his investigation report in October 2011 recommending merit (Ex. B-2-1), the RSI took the investigation away from the investigator and rewrote the investigative report to justify a dismissal of the complaint. (Ex. B-2-2), and a Secretary's Findings based on his altered report. (Ex. B-2-3)

Comparing documents

The Final Investigative Report produced by the investigator in October 2011 reported that a preponderance of evidence supported a *prima facie* case of retaliation. It based this conclusion on multiple reports to management by the Director and Assistant Director of security issue at the plant, and the demotion and subsequent termination of the Director and Assistant Director. These three elements were uncontested. The investigator's report then found a temporal nexus between these elements and the terminations, and found that there was not a preponderance of evidence the company would have taken these actions in the absence of the reports of security issues by the Director and Assistant Director. It noted that two independent reviews of theses terminations came to the same conclusion, and that an employee who had threatened to retaliate against the Assistant Director after he was charged with security violations was the one who created a pretext for the company's internal investigation into the missing tools. The report also noted that there was substantial evidence of long-term animus toward the Director by the plant manager, that the investigation into the missing tools had occurred in temporal proximity to the NRC audit, and that the Director and Assistant Director played central roles in that audit. It went on to note that company witnesses lacked credibility, because their misrepresentation of facts served their self-interest in avoiding accountability.

The report rewritten by the RSI lacked credibility because it selectively reported and misrepresented evidence that provided only a justification for dismissing the complaint. For example:

1) The rewritten report opines that the employee who alleged to that the Director and Assistant Director had stolen tools in October 2008 had delayed his report "because he

felt" they had "caused him to suffer a hostile work environment," and that "it appears" that the employee made the report "earlier" to another plant manager. (Ex. 2-B-2, p. 9) What the RSI does not acknowledge is that these were self-interested statements which lacked evidentiary support, and that this employee had earlier threatened to retaliate against the Assistant Director because he had disciplined the employee.

2) The rewritten reports relies substantially on a quote from an apology offered by the Assistant Director to the plant manager. However, the RSI's rewritten report attempts to characterize this as an admission of guilt regarding the missing tools, when in fact the apology is ambiguous about its subject, and never refers to the Director or the missing tools. (Ex. 2-B-1, p. 10; Ex. 2-B-2, p. 10) Further, the quote used by the RSI clearly indicates that the Assistant Director was referring to "[company] property and costs", not to employee property, and that whatever the issue it did not involve the Director.

3) The investigator's report and RSI's rewritten report diverge considerably in their analysis of the evidence. The rewritten report adopts the investigator's analysis for protected activity and employer knowledge, but thereafter adopts a radically different analysis regarding adverse action and nexus. For example, the investigator's report notes that the Director was demoted on September 3, 2008, which was an adverse action, and that he was terminated on January 22, 2010, a second adverse action. It also omits that the company opposed his application for unemployment benefits, a third adverse action, and the company subsequently terminated a contract with the company that reemployed the Director in the nuclear industry, a fourth adverse action. (Ex. 2-B-1, p. 16) In contrast, the RSI's rewritten report omits any reference to the Director's demotion, reporting only that he was terminated. It then misrepresent that the company "persuaded" the Director's subsequent employer to terminate him. (Ex. 2-B-2, p. 14) This conveniently narrows the rewritten report to consider only events that occurred well after the Director began to experience the hostile workplace that preceded his termination, and discounts the post-termination retaliation he suffered.

The differences between the investigative report and rewritten report become substantially larger in analyzing the element of nexus. The investigator's report has a broad focus on evidence that supports a finding that the Director's termination occurred in the context of a long history of animus by the plant manager toward the Director specifically related to his reporting safety issues, which first led to the Director's demotion and subsequently to his termination. (Ex. 2-B-1, p. 16) It notes that the Director's and Assistant Director's terminations occurred in close temporal proximity to an NRC audit of security at plant, which involved NRC consultations with the Director and Assistant Director who had been making reports critical of plant security. It also considers the company's post termination retaliation as further evidence of animus that confirms the pre-textual motive for terminating the two senior safety officers based on an allegation of stolen employee tools.

The rewritten version of the report includes an elaborate argument that the Director and Assistant Director were terminated based on the company's "actual or

reasonably mistaken belief" that they sole tools "and/or" cover up their theft. (Ex. 2-B-2, p. 14-15) However, the RSI offers no evidence for this conclusion, which substantially contradicts the findings of the two independent reviews and ignores that the company's own investigation that could not establish that the tools were ever stolen. It also ignores the extensive evidence of animus by the plant manager towards the Director, based on his reports of safety issues and the plant's checkered history with security management. Rather, the rewritten report attempts to defend its illogical and unsupported conclusions by alleging they are supported by "circumstantial evidence", which is constructed around surmise and inferences that no other investigation considered as credible.

The rewritten report not only misrepresented facts developed during the investigation, but also misrepresents its source. As with the earlier case, the RSI produced this rewritten report leaving the impression that the investigator rather than he authored the report. As with the earlier case, this concealed the underlying objections of the investigator about the report. Further, the rewritten report became the basis for the subsequent Secretary's Findings, which falsely reported the substance of the investigation. In the investigator's memo of June 2012, where he stated his concern about the dismissal of this complaint, he noted that the case was particularly important because it was filed by the two highest security officials at a nuclear plant, who had made repeated reports over a period of years about security deficiencies at the plant. (Ex. B-2-4) This memo did not produce a substantive review of this case, and the investigator was never asked to flesh out the details of his concern.

3 - ***FedEx/Forrand/9-3290-09-057***

A senior aircraft mechanic working with a major air carrier filed this complaint in May 2009 under AIR-21. However, the investigation was not assigned to the investigator until April 2011, after it had languished for two years with another investigator. (Ex. B-3-1) The complaint was based on an allegation that mechanic had been subjected to a hostile workplace after meeting with an FAA investigator regarding his report of violations of FAA regulations. When the RSI transferred the case, he urged to investigator to investigate the complaint because the RSI believe it to be a merit case. The first investigator was an industrial hygienist who had little training in investigations, and who had been involuntarily assigned to investigate complaints. On transferring the complaint to the investigator, Mr. Paul, the RSI, offered that he believed it to have merit and encouraged the investigator to find the necessary evidence to make that recommendation.

Investigating the complaint proved difficult because the company maintained an n extremely hostile environment for employee whistleblowing that discourage other employees participating in a Program investigation. After a long and unproductive effort to penetrate this atmosphere, the investigator was finally able to find a witness that supported the mechanic and provided evidence to support a merit recommendation. In May 2011, at the conclusion of the investigation, the investigator attempted to open settlement discussions with the company attorney who refused to discuss settlement. When the investigator reported this conversation to the RSI, the RSI offered to intervene

and talk to the attorney himself. Shortly thereafter, the investigator and RSI held a second conference with the company attorney. The attorney was aggressively hostile and rejected the RSI offer to negotiate a settlement, declaring that the company never settled OSHA cases. Visibly shaken, the RSI discontinued settlement efforts.

In September 2011, the investigator completed and submitted his Final Investigative Report to RSI. (Ex. B-3-2) Thereafter, the RSI appeared to take no action to review the report. However, in February 2012, the investigator received a call from the mechanic, who reported that the RSI had dismissed his complaint. When the investigator queried the RSI about this dismissal, he was told that it had been dismissed because the mechanic had received an award from the company praising his work. When the investigator challenged that result, the RSI told him that the award, which had been made regarding the mechanic's long service to the company, absolved the company of any claim of a hostile workplace. The mechanic found an attorney and appealed the dismissal to the Administrative Law Courts, and in September 2012, the Administrative Law Judge assigned to his case accepted his case for review, openly criticizing the RSI's actions in dismissing the complaint. (Ex. B-3-3)

Comparing documents

The RSI rewrote the investigator's Final Investigative Report that not only rewrote facts in the case but also distorted the standards for an investigation. (Ex. B-3-3) This included attempting to dismiss the idea of a hostile work environment by arguing only one of the many incidents that made up an almost continuous series acts was "timely". (Ex. B-3-4, p. 2) However, the Whistleblower Investigations Manual (Manual) provides that timeliness only apply to the time limit imposed by a statute for initiating a complaint, which is measured from the time of *the last incident of adverse action* to the filing of the complaint. It then explicitly states, "A complaint need only be filed within the statutory timeframe of **any act that is part of the hostile work environment, which may be ongoing"** [emphasis added]. (Manual p. 3-3)

The RSI then argued that the hostile environment had to be offset by positive performance reviews and awards by the company. That novel claim lacked the support of any law, rule, or guidance involving AIR-21 complaints, and ignored strong evidence of substantial animus toward the mechanic by local company managers. To support his conclusion, the RSI added to the Report's Chronology that on 2-28-2008, several months before he began to make health and safety reports, the mechanic received a very positive performance review. However, it does not indicate who authored this positive report.

The RSI then justifies dismissing the complaint in his discussion of nexus, where he argues "there is no evidence that the protected activity contributed to RP's decision to issue him the write-up on March 25, 2009". In arriving at that conclusion, the RSI relies on previous minor infractions by Mr. Forrand, his very positive performance reviews, and claims by a manager that he was disciplined for his behavior during a meeting. In addition to contradicting evidence that the mechanic had engaged in numerous acts of protected activity and the animus expressed toward him by local managers, this analysis

reflects a serious misreading what constitutes "contributing" to acts of retaliation. As the Manual observes, "A contributing factor is 'any factor, which alone or in combination with other factors, tends to affect in any way the outcome of the decision", citing *Marano v. Dep't of Juistice*, 2 F.3d 1137, 1140 (Fed. Cir. 1993).

The more interesting question in this investigation is why the RSI shifted from advocating for a merit recommendation to not only opposing a merit recommendation, but also concealing his dismissal of the complaint from the investigator. As with the earlier cases, when the RSI rewrote the investigative report he did so by representing the report as a joint project of the investigator and the RSI. This once again conceal the true nature of the investigation from any subsequent review, which acted to protect the RSI from accountability for his unilateral dismissal. The only intervening events in this case was RSI's telephone conference with the company attorney, and the hostile workplace he had created for the investigator. Curiously, the Secretary's Findings in this case, which are ordinarily produced at or near the time the Final Investigative Report is submitted and approved, were delayed until November 19, 2012, five months after my objection to his dismissal and more than 10 months after Mr. Paul rewrote the investigative report. (Ex. B-3-5)

4 – ***EM Labs P&K/Madry/9-0370-11-001***

Regional Manager filed this complaint under TSCA in October 2010 for the nation's largest industrial testing company. (Ex. 4-B-1) It followed an earlier companion complaint, which also was filed under TSCA in April 2010 by the company's national Director of Quality Assurance. (Ex. B-4-2) Both complaints alleged that the Manager and Director suffered retaliation for reporting that the company was producing false asbestos testing reports. The Manager worked directly under the Director and their cases shared many common features during their respective investigations.

The investigations into these two complaints found that the manager and director made their reports of false test reports in response to requests to investigate the testing process made by two auditors in December 2008 and February 2009. The auditors had made these requests based on laboratory inspections requested by the National Voluntary Laboratory Accreditation Program (NvLAP), which is part of the regulatory process created by TSCA in the 1980s. The auditors expressed concern that the high volume of reported tests indicated improper testing procedures, noting that the high volume of tests was inconsistent with known procedures used in asbestos testing. Their requests to investigate were made to the Regional Manager, who supervised individual testing facilities, and the Manager began his investigation by attending classes to become more familiar with the requirements for valid asbestos testing. (Ex. B-4-3) Once he acquired sufficient knowledge, the manager reported to the Director that he believed the testing process employed by the company was faulty and encouraged laboratory technicians to shortcut the testing process leading to false test reports. When the Director and manager reviewed test reports, they discovered duplicated test reports, indicating false tests were

being generated, and reported this repeatedly to company managers, beginning in June 2009.

The company formed in 2007 through a merger of two independent testing laboratories that had previously confined themselves to mold testing. However, demand for mold testing had steadily declined in the years preceding the merger, and the venture capital group that bought and merged the separate testing laboratories shifted to asbestos testing believing it could develop testing methods that were more efficient and profitable. To that end, the company initiated a "Lean" program and the use of a "speed pad", adapted from computer gaming, that allowed technicians to auto populate fields from one test sample to another. Using speed pads allowed technicians to complete 150 or more tests in an eight-hour shift, and in some cases to complete tests in 20 seconds or less. What concerned the auditor was that in his 50 years of experience with asbestos testing he found that no credible evidence that testing could be done in less than 6 minutes per sample.

As the auditor explained to the investigator, asbestos samples are multilayered and asbestos fibers were not uniformly distributed within each layer. The auditor also noted that the proper preparation of a sample required the technician to separate the layers, then prepare slides using samples from each layer and then examine each slide optically under a microscope. He then advised that asbestos fibers are not easily distinguished from other fibers and samples have to be examined multiple times before a technician can credibly say that it did or did not contain asbestos fibers. Thus, when the auditor observed technicians using a speed pad to examine and report on samples in less than a minute, the auditor found that this procedure inherently misrepresented the presence or absence of asbestos.

Following the report of their concerns to the company president, the director and manager began to experience an increasingly hostile workplace, which increased as the practice of using key pads in asbestos testing continued unabated. By February 2010, the pressure on Director increased and he was terminated in March 2010. With the removal of the director, the task of continuing to monitor asbestos testing fell to the manager, who also began to experience increased hostility by the company. The director's replacement was the company's "Lean Manager", who told the investigator she accepted the position reluctantly because it represented a conflict of interest with her Lean duties. When she assumed the position, she was unaware of the circumstances surround the director's removal and the hostile workplace created for the manager. She told the investigator once she began her duties as the Director of Quality Assurance she recognized that the manager was under extreme pressure. Four months after her appointment, she submitted her resignation, telling the investigator she had become increasingly uncomfortable with the company's treatment of the manager. She also advised the investigator that the company had falsified reports concerning the manager to make it appear that he was incompetent and mentally unstable. Shortly after her resignation, the company placed the manager on mandatory leave and ordered him to psychological evaluation and treatment.

There were suspicious incidents that punctuated the course of these investigations. At the time, the investigator was assigned to director's case, which was within weeks of

his appointment, he was told by the RSI to conduct an obligatory interview with the director then dismiss his complaint. The RSI told the investigator to dismiss the complaint, because director had not explicitly cited health and safety concerns in reporting false asbestos testing to the company. The investigator had only been with the Program three weeks, and was suspicious that he was given these orders even before an investigation had begun. The investigator later learned that the RSI had unsuccessfully attempted to settle the complaint and had little knowledge about the issues present in the complaint.

The investigation quickly demonstrated that both the director and manager had engaged in protected activity by making reports of false asbestos test to company managers, and that the adverse actions they suffered were in response to those reports. The only lingering issue was whether the company could show by a preponderance of evidence that they would have taken these adverse actions regardless of the protected activity. The company failed this test because the evidence produced by the company in support of its claim was found to have been falsified. The attorney for the company repeatedly attempted to subvert the investigation by pressuring and manipulating witnesses, and produced documents that were subsequently discredited by witnesses. Finding sufficient evidence to support a merit recommendation, the investigator submitted his Final Investigative Reports in July 2011 to the RSI. At that point, the two cases had collected more than 4000 pages of documents, many of them technical reports, reported 8 witness interviews, and analyzed complex issues involving coverage, adverse action, and nexus.

From July 2011 to December 2011, RSI avoided reviewing either report, drawing repeated complaints from both the director and the manager. In December 2011, the RSI again tried to settle the director's complaint but without engaging either the investigator or director in the settlement discussions. In exasperation, the director took the settlements discussions away from the RSI, after the RSI had attempted to coerce the director into a minimal settlement with threats of dismissing his complaint. In January 2012, the director called the investigator to report that his attorney-wife had settled the complaint with the company 20 times that proposed by the RSI. Unfortunately, the manager was not so fortunate, and his case continued to languish. In February 2012, the RSI attempted to persuade the investigator to dismiss the manager's case, and then took management of the case from the investigator when he refused to dismiss it.

During this period, the manager began to complaint to senior Program managers, including OSHA Director Dr. Michaels, about the RSI's mismanagement of his case. In May 2012, the RSI began a collaboration with his supervisor, an ARA appointed to work with the Program. Mr. Wulff performed a cursory review of the case, which at that point contained more than 2000 pages of documents, and sketched out a rationale to dismiss it. On the evening of June 14, 2012, after the RSI had left his office, the ARA sent an email to the RSI advising the RSI of his rational, but also directing that the RSI should take no action until the Regional Administrator reviewed the case. Several hours later, in the early morning hours of June 15, 2012, the manager sent an email to the RSI once again complaining about the RSI's mismanagement and opining that if the RSI did not support

the program he should find another job. Thereafter, the RSI immediately sent an email to the investigator ordering that the manager's complaint be dismissed, cutting and pasting the rational provided by the ARA to the order.

After considering the close temporal proximity between these events, the investigator authored a "concerns" email to the RA and the national Program director expressing his concern about RSI's apparent retaliation in dismissing the manager's complaint, along with his concerns about the three earlier complaints listed here. (Ex. B-4-4) The national Program subsequently reviewed the manager's complaint and reversed the RSI's dismissal, and Secretary's Findings issued in November 2012. (Ex. B-4-5) In follow up calls to the EPA and NvLAP in mid-2014, the investigator was informed that the Program never advised these agencies of the merit findings in these two cases, which notice the law requires. Without this notice, they were denied the opportunity to take corrective action and stop the falsification of asbestos tests, and evidence has now emerged that the falsification of asbestos test continued at least into August 2014. However, because of the investigator's June 2012 "concerns" report, Region IX begin a campaign of retaliation against him, subjecting the investigator to three progressively more hostile disciplinary hearings, putting the investigator under surveillance with regard to the investigator's outside non-work activities, and eventually issuing the investigator a Notice of Removal on February 14, 2014.

5 – ***Lockheed-Martin/Stookey/9-0370-11-005***

A flight services specialist filed this complaint in December 2010 under AIR-21. (Ex. B-5-1) The specialist worked for a major air carrier in a program that provided weather briefings to pilots, and the complaint alleged that the company had retaliated against the specialist for refusing to follow company call answering protocols that concealed the specialist's location from the requesting pilots. In January 2011, the complaint was assigned to the investigator, and the investigator opened his investigation by reviewing the complaint and the company's statement of position submitted in response to the complaint. The complaint stated a prima facie case of retaliation for whistleblowing, and the statement of position acknowledged that the company had terminated the specialist for repeatedly refusing to follow the company's call answering protocols. Thus, very early in the investigation it was already clear that the specialist qualified as a bona fide whistleblower and that the only questions left to investigate were whether AIR-21 provided coverage to the specialist and whether the specialist had a reasonable belief that the protocols presented a safety risk for pilots.

In April 2011, the investigator arranged to interview the specialist. The specialist pointed out that he had included a reference to FAA that required him to identify his location when responding to a call for a weather briefing and explained how concealing his location would potentially put a pilot at risk. The investigator began to formulate a plan to attempt a settlement of the complaint, but in June 2011, he was ordered to transfer the case to another investigator. After preparing a transfer memo, the investigator gave the files to the other investigator, assuming that the case would be quickly resolved.

However, that turned out not to be true, and when the investigation appeared to have stalled in early 2012, the investigator asked that the case be returned to him to complete.

One of the first items that the investigator addressed when the case was returned to his management was the issue of AIR-21 coverage. After considerable legal research, the investigator determined that the broad language of AIR-21 and the fact that the company was in the business of supplying parts and other services to air carriers, and that the provision of weather briefings implicitly involved air safety issues, the investigator concluded that there was coverage in this case under AIR-21. The investigator presented his research and reasoning to the RSI, who concurred. The investigator then contacted the company attorney in June 2012 in an attempt to encourage settlement discussion. The attorney vigorously objected to this effort and countered that notwithstanding legal authority AIR-21 did not cover the company or the specialist, and that the company protocols not did not create a flight safety risk.

When the investigator discussed this conversation with the RSI, the investigator was told to turn his attention to investigating whether the specialist's refusal to follow the company's protocols was based on a reasonable belief that they presented a safety risk. According to the guidance in the Manual, the reasonable belief issue should have been satisfied when the investigator confirmed that the protocols violated a FAA rule. However, the RSI argued that this additional investigation was necessary as a response to the company's claim that the protocols were not a danger. The investigator accepted the RSI's direction, but became suspicious that the RSI was extending the investigation beyond the scope of AIR-21, and delaying a resolution of the complaint without good cause.

The investigator continued an ongoing dialogue with the company attorney and with the specialist, agreeing to interview three company witnesses as well as four witness identified by the specialist. The company witness interviews were conducted in late 2012 and early 2013, and the interviews with the specialist's witnesses were conducted in May and June 2013. The interviews with the company's witnesses added little relevant information to the investigation. However, the interviews with the specialist's witnesses, several of whom were pilots and had extensive experience in providing weather briefings as employees of the National Weather Service, strengthen the merit features of the complaint. These witnesses universally agreed that the protocols did create a safety risk, reported that violating the protocols was common among the specialists, recounted the very chilled workplace that the company maintained against whistleblowers, confirmed that the specialist had been the most outspoken critic of the protocols, and testified that the specialist was a highly regard and competent colleague.

In July 2013, the investigator submitted a Report of Investigation with a merit recommendation to the acting RSI. This acting RSI had not previously been involved in the investigation and had little training in AIR-21 investigations. Nevertheless, the acting RSI rejected the Report and offered numerous critical comments, none of which related to AIR-21 investigation standards, and the Report was withheld from the investigator until January 2014. In the interim, an ARB case (*Cobb v. FedEx Corporate Services*, ARB Case No. 12-052, ALJ Case No. 2010-AIR-024 (2013)) emphatically disposed of

the coverage issue. After receiving the Report of July 2013 with critical comments, the investigator made revisions and resubmitted his Report in May 2014. That Report was accepted by the RSI, along with its merit recommendation, and the investigator proceeded to draft a Due Process letter, which itself was issued to the company in June 2014.

A number of disturbing events unfolded after the Due Process letter was issued. While the investigator was on leave, the RSI held a phone conversation with the company attorney and thereafter undertook to reinvestigate the complaint by re-interviewing three of the specialist's witnesses. These witnesses reported that the RSI cross-examined them in an apparent attempt to discredit their witness statement. When the investigator returned from leave, the RSI did not disclose these interviews, but cross-examined the investigator, implying that the investigator had conducted sham interviews with the company's witnesses. Shortly thereafter and without notice to the investigator, the specialist, or the specialist's attorney, the RSI held a telephone conference on July 31, 2014, with the company attorney and two Region IX administrators during which he apparently agreed to dismiss the complaint. Following that meeting, the RSI forwarded two documents to the specialist, neither of which were credible evidence for the investigation, claiming that he had received them from the company and that they justified dismissing the specialist's complaint. (Ex. B-5-2) Then on August 11, 2014, Mr. Paul called the investigator to tell him that the complaint would be dismissed, based on the two articles provided by the company and on the RSI's rejection of the statements of the three employee witnesses. (Ex. B-5-3) The investigator refused to withdraw his merit recommendation and asked the RSI to put his reasoning in writing, which he refused to do.

The RSI refused for several weeks to confirm that he was dismissing the complaint. The RSI also violated Program directives that a closing conference with the complainant be conducted before any formal action is taken dismissing a complaint. Finally, on October 2, 2014, the RSI's supervisor issued Secretary's Findings formally dismissing the complaint. (Ex. B-5-4)

Comparing documents

The Findings dismissing the complaint acknowledge that the specialist engaged in protected activity, that the company had knowledge of this protected activity, that the company took adverse action against the specialist based on that protected activity, and that other specialists believed the company's protocols presented a safety issue. Yet, remarkably the Findings then claim that these beliefs were unreasonable, based on publications issued after the specialist was terminated. This tortured logic is not only unsupported by Program law and policy, it obfuscates the reality that these specialists were experienced pilots and had extensive experience providing weather briefing to pilots in an earlier iteration of the program managed by the National Weather Service. It also has to ignore that these protocols violated FAA regulations in force at the time.

The Findings also attempts to dismiss the very clear nexus between the complainant's protected activity and his termination by making another tortured argument that "The majority of the questions [the complaint] was asked and the answers he provided during the September 17, 2010 interview [which became the basis for his termination] involved Respondent's transferring and terminating call policy. Therefore, there is no nexus between Complainant's engaging in protected activity and the investigation interview he was subjected to." In making this argument, the Findings thinly attempt to shift focus from the clear nexus between the specialist's protected activity and his termination, to an investigation interview, which itself was based on the specialist's protected activity. The Findings then conclude, "Even though Complainant did engage in protected activity when he questioned Respondent's call-answering policy on September 17, 2010, and he was terminated shortly afterwards that same day, there is clear and convincing evidence that Complainant would have still been terminated for repeatedly transferring and terminating calls against Respondent's policy even after Respondent engaged in progressive discipline in a failed attempt to correct Complainant's behavior." In fact, this conclusion clearly states the case for a merit determination, not a dismissal. The Findings also claim it was unclear whether the adverse action taken by the company had any chilling effect on other employees, disregarding the collective testimony of the specialists interviewed during the investigation, who reported that they feared retaliation if they openly opposed the company's call answering protocols.

The contradictions and misrepresentations in the Findings, combined with the efforts of the RSI to conceal his actions, argue that there was collusion between the RSI and the company to dismiss this complaint. Further, the ongoing mismanagement by the RSI and temporary RSI argue that the corruption of the Program in Region IX created an opportunity for mischief and the violation of Program law and policy.

6. – ***Hawaii Air Ambulance/Stone/9-2400-10-004***

A pilot working for an air ambulance company filed this complaint in July 2010. (Ex. B-6-1) Because the complaint alleged potential violations of safety issues involving air carriers and trucking, it was filed under both STAA and AIR-21. The complaint alleged that the pilot was terminated in retaliation for making a series of safety reports, including: reporting that company pilots were operating fuel trucks without required training and licensing, he was pressured by company managers to fly over hours, and that company managers pressured him to pilot a plane when he was fatigued. The pilot also alleged that his termination occurred in temporal proximity to reporting an in-flight incident with smoke in the cockpit of his plane and his open participation in an FAA investigation of the company. In responding to the complaint, the company did not dispute any of these reports. Rather, the company claimed that the pilot had been laid off because a merger with another air ambulance company left the company with too many pilots.

The pilot had first filed his complaint with the Hawaii Industrial Occupational and Safety and Health Department (HIOSH). However, as a state plan program HIOSH had authority to investigate only traditional 11c complaints and not complaints involving STAA and AIR-21. This limit on state plan investigation reflected that state investigators did not have training to conduct investigations beyond those involving traditional OSHA safety and health issues. Due to a lack of training with regard to the broad range of OSHA whistleblower statutes, HIOSH in this case simply assumed authority to investigate. After the investigator became aware of this improper assumption of authority, he made repeated unsuccessful attempts to advise HIOSH to withdraw from its investigation. Consequently, HIOSH continued its investigation and dismissed the complaint as lacking merit. This then led to an extended appeal process that continued through much of 2013 and early 2014, complicating and delaying the federal investigation. At no time did the managers of federal Program act to restrain HIOSH in its misguided investigation, even though it was widely known that HIOSH was operating contrary to the Program rules.

The federal Program investigation, which opened in September 2010, was assigned to a new and untrained investigator with little knowledge of the Program or the requirements of investigations under AIR-21, and little guidance on how to proceed. This was and continues to be a common management practice that significantly undermines the credibility of Program investigations. Notwithstanding the lack of training and management support, the investigation proceeded. Over the following 10 months, documents were gathered, seven interviews with witnesses were completed, and a legal analysis was conducted regarding coverage for the complaint under STAA and AIR-21. Once the interviews and documents were analyzed, coverage clarified, and damages were calculated, it was apparent that there was reason to believe the complaint had merit. (Ex. B-6-2) At that point, in July 2011 the investigator contacted the attorneys for the pilot and company and suggested they consider negotiating a settlement. Thereafter, the parties engaged in extended settlement discussions, which ended in December 2011. In May 2012, the investigator released a preliminary report on the investigation noting that the investigation was complete and "there is reasonable cause to believe" that the company has violated AIR-21. (Ex. B-6-3) Thereafter, the investigator prepared a draft Due Process letter, anticipating that the final investigative report and a merit recommendation would be issued. (Ex. B-6-4) However, that letter was never issued and the investigation continued for another two and a half years as the Region IX RSI made repeated demands for further investigation.

The first hint that Secretary's Findings with a merit recommendation and an Order for Preliminary Reinstatement would not be issued came in July 2012 when the RSI ordered the investigator to resolve legal issues beyond those required by the rules governing AIR-21 investigations. (Ex. B-6-5) At that point, the RSI ordered a reinvestigation of the issue of an alleged layoff of the pilot. This issue had been investigated and resolved during several witness interviews conducted in 2011, and a discussion of this issue included in the draft Due Process letter. The issue was reinvestigated and once again resolved, finding that the alleged layoff acted as a pretext

for the company to terminate the pilot. In June 2013, the investigator submitted a second Report of Investigation recommending a merit finding (Ex. B-6-6), and conducted a closing conference with the attorney's representing the pilot and the company. The investigator provided a review of the investigation to the attorneys (Ex. B-6-7) and encouraged them to restart their settlement discussions.

A review of the Report by the RSI did not come until March 2014, at which time the RSI ordered yet another redrafting of the Report, based on information regarding a HIOSH hearing. The information to be included in this new Report once again was peripheral to a determination in an AIR-21 case, and merely substantiated the testimony gathered through witness interviews in 2011. Exasperated with the repeated delays, the attorney for the pilot sent a letter to the RSI in July 2014 noting that the attorney had previously complained about the management of the case in November 2012, which appeared to violate the statute and rules governing AIR-21 investigations and asking that a new RSI be assigned to the case. (Ex. B-6-8) At the same time, the RSI ordered the investigator brief the case to Agency managers, which was highly unusual and further delayed completing the investigation, and demanded yet another revision of the Report. (Ex. B-6-9) The investigator subsequently submitted a third Report in August 2014, then a fourth revised Report in September 2014, with recommendations of merit. (Ex. B-6-10) As of the date of this Report, it is unclear whether the Program will ultimately issue Secretary's Findings and an Order of Preliminary Reinstatement, based on the investigators recommendation of merit.

The (mis)management of the investigation in this case raises several issue that apply more generally to Region IX and possibly to the Program itself. What the history of is investigation confirms is that even with a lack of initial investigator training and an absence of substantive management support, an investigation into a relatively complicated AIR-21can be completed with a merit recommendation within a year of the filing of the complaint. With proper training and support, and with proper management, the complaint could have been resolved, a merit recommendation approved, and Secretary's Findings with an Order of Preliminary Reinstatement issued within the time provided by AIR-21 and its Rules. The micromanagement of the investigation and unnecessary intrusion of solicitor has now delayed the resolution of the complaint for more than four years. This indefensible delay has complicated the investigation beyond the boundaries intended by Congress and burden both parties with the prospect of damages far beyond what would have been the case had the complaint been properly managed.

C. Observations and Conclusions

The cases reviewed above are representative of a large number of cases that have been mismanaged and wrongly dismissed in Region IX and elsewhere. These cases occur across the full range of investigations conducted by the Program. However, they tend to cluster around cases involving preliminary reinstatement, complex 11(c) cases, and environmental cases that invite intervention by the Solicitors. The mismanagement

reflected in these cases is rooted in the structure of the original Act that creates dysfunctional relationships within the program. However, some also comes from a lack of leadership that ensure adherence to the mission of the Program, some comes from a general antipathy toward whistleblowers and whistleblowing by Program managers, and some is generated by a culture of corruption that values loyalty over incompetent management and substitutes appearances for substantive performance. Structural problems can be reformed by Congressional action. However, the culture of corruption cannot be defeated without addressing the deeper problems of Program managers and management. This culture has developed over a long period that has created a web of relationships that compromise the Program's ability to adhere to best management practices and focus on the Program's mission. Curing this culture of corruption will requires vetting Program management practices and managers.

Structural reform

Whether or not intended, the original OSH Act created dysfunctional structural relationships between OSHA and the Program and within the Program itself. Consequently, OSHA's priorities and practices came to supersede, and in some cases replace, the mission of the Program. When Congress expanded and revised the Program to make it more inclusive and whistleblower friendly, it collided with this structural dysfunction and led OSHA to blunt Congressional intent where it lacked the competence to comply. Many of the basic problems in the Program, including the claim it lacked financial resources, are illusions produced by OSHA itself as part of its effort to redirect attention away from OSHA's management of the Program. For reasons discussed above, any structural reform of the Program cannot leave the Program within OSHA if it is to be effective. Rather, such reforms will only be realized if the Program is removed from OSHA and allowed to become freestanding and self-managed. Whether this can be done within the Department of Labor, or whether it requires that the Program be independent of the DOL itself, is an open question.

Secondly, any structural reform must not leave the Program hostage to Solicitors who have no loyalty to the Program's purpose. An effective Program requires a dedicated staff of solicitors, and as history shows the DOL's Office of Solicitor lacks the will to actively and constructively support the Program, and does not exercise good control over the Solicitors it assigns to the Program. Locating dedicated Solicitors within the Program would strengthen the Program in many ways. It would ensure a focus on whistleblower law and process, and provide a stronger working relationship within Program between solicitors, investigators and managers. It also would create meaningful feedback systems between these groups that would further enhance Program knowledge and efficiency, leading to more effectiveness outcomes.

The expansion of coverage for the Program by Congress is implicitly tied to effective relationships between the Program and the many of the regulatory agencies now associated with the Program, including the Securities and Exchange Commission, the Federal Aviation Administration, and the Nuclear Regulatory Agency. However, presently

these relationships are very shallow and do not promote the sharing of important information or the coordination of regulation with Program investigations. In addition, this loose relationship deprives both the Program and associated agencies of specialized knowledge relevant to meeting the goal of employee and public protections against identifiable safety and health threats. Efficiency and effectiveness argue that Program and associated agency effectiveness requires some reform of the structural relationships between the Program and agencies where expert knowledge, and particularly expert legal knowledge can be shared.

While appearing to be equitable, the notion that the Program can and should represent whistleblowers in court is misplaced. Asking the Program to undertake this task would create internal conflicts much as it has for the Solicitor of Labor. A better approach might be to create a specialized legal process within the Program that would include dedicated administrative law judges that work exclusively with whistleblower cases. It also might be useful to support the development of specialized attorneys dedicated to representing whistleblowers, similar to what has happened with SOX and STAA cases. This could provide whistleblowers with legal counsel throughout the investigative process and ensure that the Program's mission as well as whistleblower rights are more fully protected.

Improving Program leadership

Perhaps the most serious damage done to the Program by the Act has been in depriving the Program of empowered and independent leadership. Some reorganization of the Program has already occurred, and the creation of a Whistleblower Protection Directorate has been a positive, if incomplete, move in the right direction. However, there remains an absence of stable leadership, evidenced by the inability of the Program to secure a permanent, long-term Director. Rather, it appears that the structural reforms have allowed the Program to continue directly and indirectly by default with OSHA management. This has robbed the Program of independence at a when OSHA management continue to reflect a culture of corruption. Consequently, there has been no meaningful reform of Program training for investigators and RSIs to ensure reestablishing the mission of the Program. As recently as 2008 to 2010, the Program recruited outside leadership that attempted to institute reforms. However, those highly qualified leaders were isolated and eventually driven out of the Program, first by the DOL's Office of Solicitors and then by senior OSHA managers who resisted the calls for reform. Recruiting and retaining such highly qualified leaders requires ensuring that their voices are heard and their recommendations seriously considered which can only occurred where they are truly independent and empowered to make change. If this were to happen, it would reinforce the perception of their effectiveness as leaders among Program employees, and encourage employees to actively contribute their ideas and knowledge to Program improvements. Because of the compromised leadership within OSHA, Program leaders and senior managers should be recruited from outside of OSHA to prevent the continuation or migration of bad management practices into the Program.

Containing the culture of corruption

Inevitably, the Program requires continuity, which means that existing managers and employees that have been working within the culture of corruption in OSHA continue in their roles. However, much can be done to contain the effects of the OSHA culture of corruption through structural reforms that attack the problems of cronyism and careerism. A first step should be reaffirming the commitment to carry out the Program as envisioned by Congress, rather than following OSHA's current practice of circumventing Congressional intent. This should include training and a discussion of the history of the Program, which is presently unknown to most Program employees, to clarify how and why Congress mandated procedures for the conduct of investigations. A second step should be creating better intra-Program communications, which are almost non-existent now. Program goals and practices are learned through exchanges with other employees. Presently, these communications are limited, which limits knowledge and commitment to the mission of the Program. In addition, Program employees are not presently examined with regard to their knowledge of the Program. Rather, employees are subject to performance evaluations based on metrics and conformance to the expectations created by local OSHA-controlled managers. This needs to be replaced with evaluations based on overall Program knowledge and competency that broadly reflects the Program's mission. Additionally, Program managers need to be held to account for meeting the mission of the Program, rather than rewarded for loyalty to OSHA management.

Ultimately, the future functionality of the Program depends on the will of Congress to ensure that functionality. This requires examining actual practices and relationship within the Program, and connecting the dots back to dysfunctionalities that presently exist in the Program. What has and is happening is that the Program has been studied and debated for more than a decade, with recommendation but not reforms following from those studies and debates. Under these circumstances, it is hard to take seriously Congressional mandates and statements of purpose. Delay and failures to act have their price. As of this date, the Program is badly broken. Time is of the essence as the failures of the Program have and will result in preventable injuries and deaths in the workplace and in our communities. Only an honest, open, and thorough discussion can illuminate the way forward.

_____ _____

Dr. Darrell L. Whitman Date