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November 20, 2002

The Special Counsel

The President
The White House
Washington, DC 20500

Re: OSC File No. DI-00-0935

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting a report provided to me pursuant to 5 U.S.C. §§ 1213(c) and (d) by the Honorable Gordon R. England, Secretary of the Navy. The report sets forth the findings and conclusions of the Secretary upon investigation of disclosures of information allegedly evidencing a substantial and specific danger to public health or safety arising out of actions by officials at the Department of the Navy, Naval Submarine Base, Trident Refit Facility (TRF) in Kingsbay, Georgia.

The whistleblower, Paul Huesser, crane operator, consented to the release of his name. Mr. Huesser declined to provide comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1).

These allegations were transmitted to the Secretary of the Navy on September 28, 2001. The Secretary of the Navy referred the matter to the Naval Inspector General, who, in turn, referred it to the Commander-in-Chief, Atlantic Fleet for action. The Commander-in-Chief, Atlantic Fleet tasked the matter to the Deputy Commander for Engineering Readiness, Submarine Squadron 20, who conducted an on-site investigation. Secretary England sent a report to this office on March 29, 2002.

On May 29, 2002, OSC informed the Naval Inspector General of several deficiencies in the agency's report. Among the deficiencies identified by OSC was the agency's failure to include in the report the names of witnesses interviewed during the investigation. The agency sent this office a supplemental report on July 12, 2002, that corrected the deficiencies but still failed to provide witness names. On June 27, 2002, the Honorable Alberto J. Mora, Navy General Counsel, agreed to provide OSC with a "For Official Use Only" version of the original and supplemental reports incorporating the names of witnesses for OSC's internal use and for dissemination to the whistleblower, the President, and the Congressional oversight committees. However, he did not consent to release of this version of the report into OSC's

The President

Page 2

public file pursuant to 5 U.S.C. § 1219. He explained that, instead, the Navy would provide OSC with a second version of the report, edited to exclude the names of witnesses, specifically for that purpose. The agency submitted both versions of the original and supplemental reports to this office on August 16, 2002.

We have carefully examined the original disclosures and reviewed the agency report. Pursuant to 5 U.S.C. § 1213(e)(2), I have determined that, in most respects, the agency report contains all of the information required by statute and the agency's findings appear reasonable. However, for the reasons discussed below, I find that the agency's position that OSC should withhold the names of material witnesses from the version of the agency report released into our public file appears unreasonable and is not in compliance with the statute.

The whistleblower's disclosures, the agency's response and my findings are discussed more fully in the balance of this letter.

The Whistleblower's Disclosures

Paul Huesser has worked as a crane operator for 21 years. He was employed at TRF for approximately nine years. In May 2001, he transferred to Strategic Weapons Facilities, Atlantic, also located at the Kingsbay Naval Submarine Base. He alleged that, on multiple occasions, supervisors in the Crane Operation and Repair Departments of TRF jeopardized employee safety by ordering crane operators to operate malfunctioning cranes, under threat of disciplinary action. He also alleged that management routinely neglected to remove from the work area cranes that were under repair or to adequately mark such cranes as "out of order," as mandated by Navy safety guidelines.

The Department of the Navy's Report

Mr. Huesser's allegations were investigated by the Deputy Commander for Engineering Readiness, Submarine Squadron 20. During the initial investigation, the agency interviewed Mr. Huesser, five crane operators currently working at TRF, four TRF management officials (including one who is now retired), two TRF supervisors, two TRF engineers, and two contractor employees. At OSC's request, the OIG conducted a follow-up investigation, at which time they interviewed 10 of the remaining 11 TRF crane operators. The supplemental report explains that the OIG did not interview the 11th crane operator, who was recently hired by TRF, because he does not have direct knowledge of the incidents investigated.

Allegation 1. Mr. Huesser alleged that the majority of portal cranes in operation at TRF are unsafe to operate due to chronic mechanical and electrical defects. Among the most serious defects afflicting the cranes are control boards that regularly blow fuses and circuit breakers that repeatedly shut down. Mr. Huesser contended that management's usual response

when this type of problem arises is to merely replace the fuse or reset the breaker and then order the crane operator back to work. However, Mr. Huesser alleged that, rather than solving the underlying problem, this approach often results in a repeat scenario.

According to the agency report, the crane operators and management officials acknowledged that, prior to 2000, the four portal cranes at TRF (labeled K-1 through K-4) exhibited chronic or repetitive electrical deficiencies. However, they maintained that the majority of repetitive deficiencies did not affect the safe operation of the cranes.

The investigators also sought the opinion of the Navy Crane Center (NCC). After reviewing the cranes' maintenance and inspection records from the relevant time period, NCC determined that, even though the number of circuit breaker trips experienced by the TRF cranes was relatively high for portal cranes, neither the type nor the pattern of electrical deficiencies reported created an unsafe condition.

The report states that, in February 2000, TRF hired a new chief crane engineer who has extensive work experience in crane design and electrical engineering. He successfully conducted root-cause analysis to minimize the number of circuit breaker trips. The investigators concluded that, presently, only one of the four portal cranes, crane K-1, and none of the dry dock bridge cranes at TRF exhibit failure that could be termed "repetitive" or "chronic." According to the report, TRF is planning to replace the electrical control systems on three cranes, including K-1, in upcoming fiscal years. Installation funding for K-1 is currently budgeted for FY 03. Pending overhaul of K-1's control system, TRF promulgated written procedures for handling trips, which were approved by the NCC.

At OSC's request, the investigators obtained further details about the present condition of crane K-1 and management's enforcement of the written safety procedures during operation of this crane. In the supplemental report, the agency stated that TRF has trained each operator on the K-1 written procedures and these written procedures are posted in the cab of the crane. Both the TRF Head Crane Engineer and the first-line supervisor expressed their belief, based on their interaction with the crane operators, that the operators are in fact complying with the written procedures for crane K-1. Therefore, the agency's conclusion that this allegation is unsubstantiated appears reasonable.

Allegation 2. Mr. Huesser alleged that, due to frequent circuit breaker trips, the portal cranes often swing suspended loads uncontrollably and occasionally drop the load. He explained that, because the cranes at TRF often lift dangerous weapons, such as torpedoes and other explosives, the potential harm that could result from a load accidentally striking another object or falling to the ground is extensive.

The crane operators and management officials acknowledged that there have been instances when a loss of power interrupted a crane's rotation and caused the load to swing in a pendulum-like motion. However, NCC personnel stated that the risk created by an electrical failure during crane rotation is low, and none of the witnesses could recall an accident occurring as a result of a power failure during rotation. According to the witnesses, in 1995, one of the portal cranes exhibited an intermittent problem resulting in loads lowering independently of operator control; however, this problem was repaired and has not since reoccurred. Since 1995, the witnesses could not recall a single incident when a crane dropped a load. Therefore, the agency concluded that the allegation is unsubstantiated. Based on the information contained in the report, this conclusion appears reasonable.

Allegation 3. Mr. Huesser alleged that supervisors frequently dismiss crane operators' safety concerns and, due to time constraints, order the operators to continue operating malfunctioning cranes, under the threat of disciplinary action. Mr. Huesser contended that, in doing so, management disregards paragraph 10.2.2 of Navy Facility (NAVFAC) Publication, P-307 (September 2000) authorizing crane operators to refuse to operate a crane when there are safety concerns.

According to the agency report, two of the crane operators asserted that, in the past, they had been frequently pressured to operate malfunctioning cranes. A third operator agreed that crane operators had been pressured, but on an infrequent basis. The report states that these three operators were unable to provide specific examples of any intimidating or coercive supervisory conduct, but they instead believed the coercion to be implied. The remaining two operators stated that they had never been pressured to operate a malfunctioning crane. The three operators who alleged coercion identified one supervisor in particular as having a "coercive manner"; however, this supervisor is no longer employed at TRF. During the follow-up investigation, the investigators questioned the other 10 crane operators regarding this allegation. According to the supplemental report, none of these crane operators recollected a single incident when a supervisor responded in a coercive, threatening, or hostile manner to a crane operator's refusal to operate a crane he perceived as being unsafe.

The report suggests that any coercion on the part of management may have arisen, in part, due to the incompetence of the TRF engineering staff prior to the arrival of the new chief engineer in 2000. The report states that, in the past, crane engineers may have informed management and crane operators that cranes were functioning properly, when in fact they were not. This situation may have created friction between the crane operators, who recognized that the cranes were not operating properly, and management, who relied upon the engineers' assessment of the cranes. However, all crane operators interviewed expressed the opinion that they currently have a positive working environment, due primarily to changes in management. Because the crane operators were unable to provide specific information concerning past

incidents of coercive behavior by management, the agency's conclusion that this allegation is unsubstantiated appears reasonable.

Allegation 4. Mr. Huesser alleged that he was inappropriately disciplined on October 21, 1999, for causing a crane with apparent mechanical deficiencies to be shutdown for three hours while inspections were performed.

The agency investigated this incident. However, because Mr. Huesser has filed a union grievance, and arbitration of this grievance is currently pending, the agency refrained from rendering a determination on this allegation. The agency's decision not to render a determination on this issue at this time appears reasonable.

Allegation 5. Mr. Huesser alleged that, approximately one month after the incident when a crane he was operating was shut down for three hours to be inspected, the Command asked the crane's manufacturer to send its own engineers to inspect the crane. These engineers found several defects, which they subsequently repaired. Mr. Huesser asserted that management's failure to take his concerns seriously, and to summon the manufacturer sooner, placed employees at risk during the intervening month when the malfunctioning crane was in operation.

Management officials stated that, when the crane's manufacturer P & H inspected the crane during the week of December 7, 1999, the P & H engineers informed them that the crane had not been dangerous to operate during the preceding six weeks. After reviewing the crane's maintenance records, NCC agreed with this assessment. The records indicate that the crane had been experiencing rough bridge control and a delay in the operation of the main hoist, and NCC explained that, while inconvenient for the operators, neither of these mechanical problems creates an unsafe condition. The report states that TRF permanently resolved the rough bridge control problem in May 2000. Thus, the report concludes that this allegation is unsubstantiated. This conclusion appears reasonable.

Allegation 6. Mr. Huesser alleged that, on multiple occasions, TRF management ordered crane operators to operate cranes in high wind conditions and that operation of cranes under such conditions created a danger to public safety.

The agency report notes that prior to August 1999, TRF standard operating procedures (SOPs) required crane operators to suspend operations and notify an upper-level supervisor when sustained wind speed reached 30 mph. The supervisor was then required to visit the work site in order to determine whether the lift could be made safely. One crane operator recalled that, prior to August 1999, he was told by his first-line supervisor on a number of occasions during high wind conditions to continue operations without waiting for an upper-level supervisor to visit the work site. A second operator recalled this occurring once or twice prior

to August 1999, most likely in 1998. The remaining three operators and the management officials interviewed had no recollection of this type of incident occurring. The supplemental report states that five of the additional 10 crane operators who were interviewed during the follow-up investigation provided further information about incidents prior to August 1999, when this supervisor failed to properly respond to reports of adverse weather conditions.

According to the agency report, the supervisor in question was separated from civil service in December 2001, "for matters unrelated to this investigation." The report also states that, in August 1999, TRF issued SOP 342.006, Adverse Operating Procedures, which provides that lifts made in high wind conditions (greater than 30 mph) require not only the approval, but also the presence of an upper-level supervisor. None of the operators or management officials interviewed recalled any violation of the current SOP. Because the supervisor in question has been separated from civil service and the crane operators have not reported any violations of the current SOP, the agency does not plan to take any additional corrective action at this time.

Based on the foregoing, the supplemental report concludes that the agency has "no objection to a characterization of the allegation that indicates it is substantiated for the period before August 1999, but not substantiated thereafter." The agency's characterization of the findings appears reasonable.

Allegation 7. Mr. Huesser alleged that in November 1999, management endangered the safety of crane operator Art Smith by ordering him to continue operating a crane even though water was dripping onto the crane's electrical control panel.

One of the crane operators interviewed stated that, approximately four years ago, his first-line supervisor directed him to continue operating portal crane K-4 after the supervisor had been notified of water dripping onto the electrical controls through a light fixture during heavy rains. A second operator corroborated the incident, stating that he overheard the conversation between the supervisor and the K-4 crane operator. Management personnel claimed to have no knowledge of this incident prior to this investigation.

The report found this allegation to be substantiated. However, because the supervisor responsible for the incident was separated from civil service in December 2001, no action was taken by the agency. Because this appears to have been an isolated incident and the supervisor involved has left civil service, the agency's decision not to take further action appears reasonable.

Allegation 8. Mr. Huesser alleged that many of the electrical and mechanical problems experienced by the TRF cranes can be attributed to the age of the equipment. He stated that many of the electrical control systems are too worn out to be repaired, and,

The President

Page 7

therefore, should be replaced. Mr. Huesser alleged that management's failure to replace this equipment creates a danger to public safety.

According to the report, the crane operators and management officials interviewed agreed that the cranes' electrical control systems need to be updated. TRF has already developed a plan to replace the systems in upcoming years. In FY 01, TRF funded development of the technical specifications for replacement of the electrical control systems on K-1, K-2, and K-3. NCC is in the process of developing the acquisition plan. Funding has been provided for the design work, and installation funding for K-1 is budgeted for FY 03. In the meantime, NCC has determined that these cranes are safe to operate despite the obsolescence of the electrical control systems.

The agency's plan for updating the cranes' electrical control systems appears reasonable. Although the agency has not yet developed a plan to replace the electrical control system for K-4, the continued operation of this crane does not appear to pose a safety risk based on the information contained in the report.

Allegation 9. Mr. Huesser alleged that supervisors at TRF neglect to follow many of the safety procedures set forth in NAVFAC P-307. Specifically, Mr. Huesser alleged that management routinely fails to comply with paragraph 2.3, which sets forth specific precautions that should be taken to ensure that an idle crane does not create a safety hazard in the work area. These precautions include moving the crane away from the work area, placing "out of order" signs on and near the crane, and positioning rail stops around the crane in order to prevent collisions with other cranes operating in the vicinity.

To illustrate the serious nature of the consequences that could result from management's failure to adequately mark idle cranes, Mr. Huesser alleged that management's failure to follow these procedures has already resulted in at least one serious accident. Mr. Huesser recounted that, approximately one year ago, the brake system on one of the cranes was being repaired. The panel covering the brakes had been removed and was resting unsecured on the crane. Because the idle crane had not been removed from the dry dock and rail stops had not been placed around it, a crane that was operating in the vicinity accidentally bumped into it. The repair team had also neglected to place cautionary tape and warning signs around the crane; consequently, an employee happened to be walking alongside the idle crane when this occurred. Tragically, the brake panel fell from the crane onto the employee's head, rendering him permanently impaired.

According to the report, on May 24, 2000, an operating crane accidentally collided with an idle crane, causing an unsecured brake guard to fall 75 feet, striking and seriously injuring a TRF employee walking alongside the idle crane. The accident investigators concluded that the primary cause of the accident was the crane team's failure to maintain

The President

Page 8

communication and proper signals. However, it was also discovered that an "out of commission" warning sign was either not used or prematurely removed from the idle crane, even though the brake panel had not yet been reinstalled.

The crane operators and management officials acknowledged that, before May 24, 2000, compliance with required safety precautions, particularly "out of commission" signs during maintenance, was inconsistent. They indicated this was due, in part, to disagreement over when a crane is considered to be in maintenance status. In the aftermath of the May 24, 2000 accident, TRF conducted extensive training on this topic, and all interviewees concurred that the correct procedures are now routinely followed.

The report concluded that, for the time period prior to May 24, 2000, the allegation that TRF failed to routinely comply with NAVFAC P-307 paragraph 2.3 requiring that "out of order" signs be posted on or near idle cranes is substantiated. The report further concluded that, after the May 24, 2000 accident, appropriate corrective measures were taken and, as a result, compliance with this requirement is now routine. The agency's findings and conclusions regarding this allegation appear reasonable.

Conclusion

As discussed above, I have determined, pursuant to 5 U.S.C. § 1213(e)(2), that the findings of the agency head, as stated in the agency report, appear to be reasonable. I have also determined, however, that the agency's position that OSC release into our public file a redacted version of the agency report that excludes the names of witnesses does not appear reasonable.

The agency's position that the names of witnesses should be withheld from OSC's public file was articulated by the Honorable Alberto J. Mora, Navy General Counsel, in letters dated June 27, 2002, and August 16, 2002. As the primary rationale for withholding the names, he invoked heightened security concerns in the wake of the terrorist attacks of September 11, 2001. He also argued that a passage from the Conference Report on the Civil Service Reform Act of 1978 suggests that I have discretion to redact the names of witnesses from agency reports that are released into OSC's public file, and that sufficient reason exists for me to exercise that discretion in the instant matter.

I agree with General Counsel Mora that the Special Counsel has the discretion to redact witness names in appropriate circumstances. In fact, OSC has redacted the names and addresses of witnesses in previous cases, to protect personal privacy, where there was no statutory interest in the disclosure of the information.

The Special Counsel

The President

Page 9

In this case, however, there is a strong statutory interest in the disclosure of the names of the crane operators because their testimony was crucial to the investigation of the whistleblower's disclosures. It seems clear that the purpose of the public file that 5 U.S.C. § 1219 requires is to provide the public with information concerning the disclosure and investigation process of 5 U.S.C. § 1213. That purpose would be frustrated if the names of key witnesses were redacted; without those names, members of the public who review the report would lack important information they would need to judge the validity of the agency's investigation of the whistleblower's disclosures.

It may well be that Congress intended the Special Counsel to occasionally exercise his or her discretion to redact witness names even in matters, like the present one, where there is a strong statutory interest in their disclosure. Assuming for the purposes of argument that such discretion exists, I think that it has to be narrowly construed. In this case, I am reluctant to approve redacting of the witness names because the countervailing interest asserted (national security) is an interest that Congress has already specifically addressed in 5 U.S.C. § 1219(b). That section does not apply here because disclosure of the names of the crane operators is not "prohibited by law or by Executive order requiring that information be kept secret in the interest of national defense or the conduct of foreign affairs." Additionally, the agency has failed to provide any information evidencing any real national security interest that would suggest the information be kept from the public. Absent such a proffer, I see no reason to depart from the statutory guidelines. Thus, I find that the agency's position that OSC must redact the witness names in the instant matter is unreasonable and not in compliance with statute.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of the report to the Chairmen of the Senate and House Committees on Armed Services. We have also filed a redacted copy of the report in our public file and closed the matter.

Respectfully,



Elaine Kaplan

Enclosures