



U.S. OFFICE OF SPECIAL COUNSEL

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February 2, 2015

The Special Counsel

The President  
The White House  
Washington, D.C. 20510

Re: OSC File No. DI-14-2623

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Smithsonian Institution's report based on a disclosure of wrongdoing at the Center for Astrophysics (CfA), Fred Lawrence Whipple Observatory (FLWO), Amado, Arizona. The Office of Special Counsel (OSC) has reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

The whistleblower, former facility manager George Johnson, who consented to the release of his name, disclosed that agency management failed to take proper safety precautions in violation of agency policy and Occupational Safety and Health Administration (OSHA) regulations. Specifically, Mr. Johnson alleged that FLWO lacked a required safety coordinator and that management failed to provide necessary training to employees, maintain heavy equipment, and keep accident records.

**The agency substantiated the majority of the whistleblower's allegations. The investigation determined that FLWO lacked a permanent safety coordinator, did not provide complete or adequate fall protection and heavy equipment training, and did not maintain front-end loader maintenance and inspection records. The report did not confirm deficiencies in the training or certification of mobile crane operators, or that accident reports were not completed. In response, the agency hired a new safety coordinator in November 2014, provided all employees with fall protection training, instituted heavy equipment training, and required FWLO to follow all established maintenance procedures for heavy equipment. Based on my review, I have determined that the report meets all statutory requirements and that the findings appear to be reasonable.**

Mr. Johnson's allegations were referred to then-Secretary of the Smithsonian Institution G. Wayne Clough, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). Secretary Clough delegated the authority to review and sign the report to John K. Lapiana, the deputy under secretary for finance and administration. An investigative team consisting of staff from central safety, facilities, and human resources offices was tasked with investigating the matter. On December 2, 2014, Mr. Lapiana submitted the agency's report to OSC. Pursuant to 5 U.S.C. § 1213(e)(1), Mr. Johnson provided comments on the

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agency report on December 12, 2014. As required by 5 U.S.C. §1213 (e)(3), I am now transmitting the report to you.<sup>1</sup>

## **I. Mr. Johnson's Disclosures**

### FLWO Lacks a Required Safety Coordinator

Mr. Johnson worked at FLWO as the facilities manager from May 5, 2013, until May 3, 2014. He supervised a team that included an administrative assistant, four maintenance technicians, and a motor-pool supervisor. When Mr. Johnson began working at FLWO, the facility had a designated safety coordinator, Tom Welsh. In February 2014, Mr. Welsh retired from federal service. Mr. Johnson alleged that agency management, located in Cambridge, Massachusetts, denied Mr. Johnson's request to hire a new safety coordinator. In December 2013, Mr. Johnson emailed his direct supervisor Patricia Brennan, and Wystan Benbow, the manager of the FLWO's telescopes, to report Mr. Welsh's planned retirement. At this time, he also expressed the need to hire a new safety coordinator. According to Mr. Johnson, Ms. Brennan and Mr. Benbow rejected his request, due to cost concerns.

In response, Mr. Johnson reported that he divided the responsibilities of the safety coordinator among the remaining employees. Pursuant to agency policy, Smithsonian safety coordinators must receive extensive training on accident and incident investigations, environmental protection standards, hazardous materials management, and a broad variety of other topics. *See* SI-Safety Manual 6, Attachment 3. Mr. Johnson noted that the employees who assumed the duties of the former coordinator did not receive training in these areas.

FLWO is subject to Smithsonian Directive 419, and The Smithsonian Institution Safety Manual (the manual), published by Smithsonian Office of Safety, Health, and Environmental Management. Directive 419 states: "All applicable safety and health-related regulations, codes, policies, rules, procedures, and plans in effect at the institution must be followed."

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<sup>1</sup> The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

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The manual describes the classifications of employees and their responsibilities in maintaining a safe and healthful environment for staff, volunteers, and visitors. *See*: SI Safety Manual 1-1. Pursuant to the manual, the safety coordinator is a mandatory position and requires extensive training. *See* SI-Safety Manual 6. The safety coordinator is responsible for assisting supervisors in training, investigating accidents, and maintaining the facility's log of unsafe conditions. *See*, SI Safety Manual, 2-7, 2-8.

#### Failure to Provide Fall Protection, Heavy Equipment, and Crane Training

Mr. Johnson explained that in June 2013, he discovered that the facility had no fall protection training program. He determined that fifteen full-time employees worked in conditions that require fall protection training and that only one employee at FLWO, Emmitt Roache, had a current fall protection certification. Mr. Roache was credentialed to train other employees in fall protection, but never did so according to Mr. Johnson. Mr. Johnson directed Mr. Roach to provide this training. However, at the end of June 2013 Mr. Roach let his certification lapse and separated from federal service shortly thereafter. Mr. Johnson also learned that the safety coordinator never hired an outside vendor to provide this training. Mr. Johnson alleged as of May 2014, no fall protection training was conducted.

Smithsonian Institution policy mandates that employees working in areas where they may face fall hazards of four-feet or higher receive fall protection training. *See*: SI Safety Manual 10-1, 10-9. Fall protection training is also mandated by OSHA regulations. *See*: 29 CFR §1926.503(a)(1). In addition, FLWO's own safety directives require scientists, volunteers, and students to receive training and proper supervision if they work on motorized man-lifts or at elevation. *See*: Basic Safety Information and Training for FLWO Users. Pursuant to agency policy, the facility's safety coordinator is responsible for ensuring that all affected employees have fall training and the facility must retain a written record of the training. *See*: SI Safety Manual 10-1, 10-10.

In addition, Mr. Johnson explained that employees at FLWO regularly used front-end loaders and other heavy equipment for maintenance on the observatory facilities and Mt. Hopkins Road. Mr. Johnson described a December 2013 incident in which a front-end loader operator was removing snow on Mt. Hopkins Road when the engine stalled. Without power, the vehicle started to roll down a steep cliff and the operator, Robert Hyne, jumped from the loader before it crashed into a boulder.

The vehicle was equipped with an auxiliary safety system to facilitate emergency steering and breaking in the event of engine failure. In discussing the incident with Mr. Hyne, Mr. Johnson learned that Mr. Hyne was unaware of the auxiliary safety system. Mr. Johnson reviewed Mr. Hyne's training and found that he was not trained in the use of material handling equipment. Mr. Johnson alleged that none of the four operators who reported to the motor-pool supervisor had proper training in the use of the

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equipment. Further, no record of training was maintained. Mr. Johnson developed training proposals to address these issues but left the agency before he could implement them.

OSHA regulations state: “The employer shall permit only those employees qualified...by training or experience to operate equipment and machinery.” *See* 29 CFR § 1926.20(b)(4). OSHA regulations further require appropriate training for employees, noting: “Each agency shall provide appropriate safety and health training for employees including specialized job safety and health training appropriate to the work performed by the employee.” *See* 29 CFR §1960.59(a). In addition, the manual states each facility and organization director must ensure that “staff receive required and necessary training on the hazard controls...specific to their job tasks.” *See* SI Safety Manual 3-4.

Mr. Johnson also explained that FLWO employees use a mobile crane to perform maintenance on buildings and Mt. Hopkins Road. After the incident with Mr. Hyne, Mr. Johnson asked every member of his staff whether they had received specific training on any heavy equipment or the mobile crane. According to Mr. Johnson, no employees were trained on heavy equipment usage. Moreover, he asserted that they lacked OSHA certifications required to operate the mobile crane. OSHA regulations mandate extensive and specific training requirements for crane operators. *See* 29 CFR § 1926.1427 and 1926.1430. Operating a mobile crane without proper training also appears to contravene OSHA regulations prohibiting unqualified employees from operating equipment and machinery. *See* 29 CFR § 1926.20(b)(4).

#### Failure to Maintain Heavy Equipment and Report Accidents

Following the front-end loader incident, Mr. Johnson initiated a review of the vehicle’s maintenance and inspection records. He alleged these documents indicated that FLWO employees never performed a safety inspection or serviced the front-end loader in the eleven-year service history of the vehicle, in contravention of the manufacturer’s specifications. Mr. Johnson inspected the records of 71 other vehicles and determined that required safety inspections and manufacturer specified maintenance was not performed. In response to these issues, Mr. Johnson attempted to develop a planning and scheduling system to track vehicle maintenance and inspections, but staff refused to follow it. Mr. Johnson attempted to discipline these employees but left the agency before any actions were taken.

The failure to perform routine maintenance on FLWO vehicles appears to violate OSHA regulations intended to assure safe and healthful working conditions for federal employees. *See* 29 CFR § 1960. OSHA regulations require inspections of all vehicles operating on off-highway job sites at the beginning of each shift to ensure that component parts and systems are in safe operating condition. *See* 29 CFR § 1926.601(b)(14).

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In addition, Mr. Johnson was directed by CfA management to draft an OSHA-mandated annual safety and health report. This report contains a self-assessment of FLWO's safety management program, environmental incidents, and accidents on the site. Mr. Johnson reviewed the 2013 version of the document and discovered that three vehicle accidents were not reported. Mr. Johnson discussed these deficiencies with the motor-pool supervisor, Danny West, who informed him that employees intentionally concealed vehicle accidents to avoid administrative consequences and paperwork. Mr. Johnson then discovered a binder containing dozens of photos taken of vehicle accidents dating back to 2007 which were never reported in the Annual Safety and Health report. He informed Ms. Brennan about these accidents but was unaware if any corrective action was taken.

The Safety Manual requires that all incidents and near misses are reported to supervisors and safety coordinators. *See* SI Safety Manual 7-6. Employees are responsible for immediately notifying supervisors, who are responsible for completing incident reports and notifying the safety coordinator. Vehicle accidents are to be reported on a specific accident report form. Operators must complete this form and provide it to their supervisor. According to Mr. Johnson, these procedures are not followed at FLWO, and a large number of accidents documented by photo were not properly reported to agency management.

## **II. The Agency's Report**

The agency's report of investigation substantiated Mr. Johnson's allegations. The investigation confirmed that FLWO lacked a permanent safety coordinator and that FLWO lacked complete or adequate fall protection and heavy equipment training at the time of Mr. Johnson's allegations. The investigation further confirmed that front-end loader maintenance and inspection records were not properly maintained. The investigation did not confirm deficiencies in the training or certification of mobile crane operators, or that required motor accident reports had not been completed.

The investigation determined that following Mr. Welch's retirement, the recruitment of a permanent safety coordinator was delayed pending the completion of a staffing analysis for FLWO. In response to the staffing analysis, the agency posted a vacancy announcement for the new safety coordinator on November 24, 2014, and established an interim safety coordinator, who was trained in core competencies to serve in this capacity until the position is permanently filled.

The investigation further confirmed Mr. Johnson's allegations concerning fall protection training. It was determined that FLWO lacked a certified fall protection trainer, and it had no contract with an outside vendor to provide this training at the time of Mr. Johnson's disclosure. As a result, fall protection training was not offered. In response, the report explained FLWO contracted with a vendor to provide fall protection training, which all staff are now required to take. In addition, FLWO developed a

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comprehensive fall protection program to cover all facilities, including administrative offices and the visitor center. In the past, fall protection training was only required for employees who maintained the telescope infrastructure.

The investigation also reported that an unannounced OSHA inspection conducted on June 6, 2014 resulted in the issuance of a “serious” citation to FLWO for failing to maintain heavy equipment properly. In response to this citation and inquiries from investigators, FLWO confirmed the lack of recorded maintenance and appropriate training for the operation of the front loaders. FLWO subsequently conducted front loader operation training for staff on July 15, 2014. The training included education on operating and maintaining all front loaders. The report noted that FLWO will require similar training of new staff as needed. In addition, FLWO now requires that operation and maintenance manuals and drivers’ checklists be placed in waterproof sleeves in vehicle cabs, and that all drivers complete maintenance and operation checklists before using the vehicle.

With regard to Mr. Johnson’s allegations concerning mobile cranes, the investigation determined that only one staff member was permitted to operate the cranes, and that this individual was sufficiently trained. However, the investigation noted that better documentation should be maintained to reflect relevant crane training, and that in response, FLWO will henceforth document all crane training provided to, and by, staff.

The investigative team confirmed Mr. Johnson’s allegations that heavy equipment front-end loaders were not maintained in accordance with the operation and maintenance manuals. These maintenance issues were also identified in the unannounced OSHA inspection noted above. As part of the corrective action required by the citation issued to FLWO, the facility will now follow all maintenance procedures as set forth in the manufacturers’ manual for all front-end loaders, including periodic checklists. In addition, FLWO will require all front-end loader operators to use the operator’s checklist furnished by the manufacturer before each use of a front-end loader. Appropriate training on these requirements was provided on July 15, 2014.

In regards to Mr. Johnson’s allegations concerning accident reporting, the investigation did not find evidence indicating that employees intentionally concealed vehicle accidents to avoid administrative consequences. The team noted that employees properly documented both Smithsonian and non-Smithsonian accidents that occurred on the facilities grounds. Notwithstanding the fact that the investigation did not substantiate these allegations, the report noted that the FLWO safety coordinator and administrator will ensure all staff are aware of their responsibilities to report accidents.

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### **III. The Whistleblower's Comments**

Mr. Johnson disagreed with several statements and conclusions reached in the report. Specifically, he noted that during the onboarding process for his position, he was never apprised of the variety of safety deficiencies that existed at the facility. He further questioned the qualifications of the individuals from the agency who investigated these matters, and suggested that they should have interviewed additional staff at the facility. He also disputed the report's assertion that safety was a top priority for the agency, given the condition of the facilities when he worked there.

### **IV. The Special Counsel's Findings**

I have reviewed the original disclosure, the agency report, and Mr. Johnson's comments. While Mr. Johnson had concerns regarding aspects of the agency's report, it appears that the agency took immediate and appropriate measures to resolve the serious allegations that Mr. Johnson raised. For these reasons, I have determined that the findings of the agency head appear reasonable and the agency report meets all statutory requirements.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency report and Mr. Johnson's comments to the Chairman and Ranking Member of Senate Committee on Rules and Administration and the Chairman and Ranking Member of the Committee on House Administration. I have also filed copies of the agency report and whistleblower comments in our public file, which is available at [www.osc.gov](http://www.osc.gov). OSC has now closed this file.

Respectfully,



Carolyn N. Lerner

Enclosures