Description of document:	Closing documents for several Department of Energy (DOE) Inspector General (OIG) investigations, 2012-2013
Requested date:	02-October-2014
Released date:	11-December-2015
Posted date:	11-January-2016
Source of document:	Department of Energy FOIA Requester Service Center 1000 Independence Avenue, SW Mail Stop MA-90 Washington, DC 20585 Fax: (202) 586-0575 Online DOE Headquarters FOIA Request Form

National Nuclear Security Administration

Department of Energy
National Nuclear Security Administration
Office of the General Counsel
P. O. Box 5400
Albuquerque, NM 87185

DEC 11 2015

CERTIFIED MAIL –RETURN RECEIPT REQUESTED

This letter is the final response to your October 2, 2014 Freedom of Information Act (FOIA) request for a copy of the report of investigation (ROI), the closing memo, closing letter, referral memo, referral letter, final report, or closing report for each of the following closed DOE Office of Inspector General investigations:

1. 12-0250-C
2. 12-0275-C
3. 12-0279-C
4. 13-0023-C
5. 13-0055-C
6. 13-0065-C
7. 13-0068-C
8. 13-0106-C
9. 13-0107-C
10. 13-0123-C
11. 13-0124-C
12. 13-0140-C
13. 13-0153-C
14. 13-0259-C
15. 13-0285-C
16. 13-0296-C
17. 13-0310-C
18. 13-0373-C
19. 14-0038-C
20. 14-0059-C
21. 14-0061-C
22. 14-0062-C
23. 14-0201-C
24. 14-0203-C
25. 12-0111-I
26. 13-0363-C
27. 13-0380-C

28. 13-0407-C
29. 06-0153-I
30. 09-0044-I
31. 13-0038-I
32. 13-0366-C
33. 13-0077-C
34. 13-0101-C
35. 13-0274-C
36. 12-0024-I
37. 05-0487-C
38. 07-0015-I
39. 13-0397-C
40. 12-0202-C
41. 11-0018-I
42. 13-0405-C
43. 13-0193-C
44. 13-0198-C
45. 05-0480-C

Your request was initially sent to the Department of Energy Headquarters Office (DOE/HQ)/Office of Inspector General (OIG). DOE/OIG searched and located three documents (Document 2a, Document 3, and Document 33a) that contained National Nuclear Security Administration (NNSA) equities. The documents were transferred to this office and were received on June 8, 2015.

We contacted the NNSA Production Office-Pantex (NPO-Pantex) about Document 33a and Document 2a. Document 33a has been reviewed and is being provided to you with deletions made pursuant to 5 USC § 552 (b)(6) and (b)(7)(f) (Exemptions 6 and 7(f) of the FOIA).

We contacted the Sandia Field Office (SFO), which has oversight responsibility for Sandia National Laboratory (SNL), about Document 3 and Document 2a. Document 3 has been reviewed and is being provided to you with deletions made pursuant to 5 USC § 552 (b)(6) (Exemption 6 of the FOIA).

NPO and SFO have reviewed Document 2a and determined it to be fully releasable and it is being provided to you in its entirety.

The purpose of Exemption 6 is to protect individuals from the injury and embarrassment that can result from the unnecessary disclosure of personal information. To determine whether disclosure would constitute a clearly unwarranted invasion of personal privacy, the public interest in disclosure, if any, must be balanced against the privacy interests that would be invaded by disclosure of the information. In this case, the names of contractor employees have been withheld. Release of this information pertaining to those contractor employees will cause inevitable harassment and unwarranted invasion of personal privacy for those individuals. In addition, release of this information would not shed light on the operations of the federal government. Since its release will not reveal anything of

significance to the public, the interest in protecting against the invasion of privacy that would result to the individuals in question far outweighs the public interest in such disclosure.

Pursuant to Exemption (7)(f), the portions of this document withheld are about protection and security measures used to protect Federal buildings and personnel. Exemption (7)(f) of the FOIA protects law enforcement information that could reasonably be expected to endanger the life or physical safety of any individual. The ordinary meaning of law enforcement includes not just the investigation and prosecution of offenses already committed but also proactive steps designed to maintain security. The disclosure of information pertaining to the security measures of Federal buildings could enable anyone, including terrorists, to more easily plan operations that would target these facilities. Without question, uncontrolled release or access to this information by an unauthorized person could endanger the life or physical safety of security police officers and employees as well as the general public.

Pursuant to 10 CFR § 1004.7(b) (2), I am the individual responsible for the withholding of the information mentioned above pursuant to Exemption 6 and 7(f) of the FOIA.

Pursuant to 10 CFR § 1004.8, you may appeal withholding of information in writing, within 30 calendar days after receipt of this letter, to the Director, Office of Hearings and Appeals, Department of Energy, L'Enfant Building, 1000 Independence Avenue, SW, Washington, DC 20585, or you may also submit your appeal by email to OHA.filings@hq.doe.gov, including the phrase "Freedom of Information Appeal" in the subject line. The written appeal, including envelope, must clearly indicate that a Freedom of Information Act appeal is being made, and the appeal must contain all other elements required by 10 CFR § 1004.8. Judicial review will thereafter be available to you in the District of Columbia or in the district where: (1) you reside, (2) you have your principal place of business, or (3) the Department's records are situated.

There are no charges to you for processing your FOIA request.

If you have questions, please contact Melanie Anderson by e-mail at Melanie.Anderson@nnsa.doe.gov or write to the address at the top of the first page. Please reference Control Number FOIA 15-00222-SL.

Sincerely,

Jane R. Summerson,
Authorizing and Denying Official

Enclosure

Document Number 2a

Department of Energy
National Nuclear Security Administration
Washington, DC 20585

October 17, 2013

MEMORANDUM FOR: Michael S. Milner
Assistant Inspector General for Investigations
Office of Inspector General

From: Dean Childs
Director, Internal Affairs
National Nuclear Security Administration

Subject: Response to Allegation of Questionable Practices by Sandia National Laboratories Surveillance Organization Staff
(Case 12RS100/2013-00886) – 12-0275-C

The National Nuclear Security Administration received the subject Management Referral from your office. The specific allegations were stated as follows:

> "Staff is being directed by management to exaggerate the completion status and downplay the deficiencies at the B61/B83 tester being developed for their [Weapons Evaluation test Laboratory] WETL facility in Amarillo, TX. The magnitude of the cost overruns is being hidden by directing staff to mischarge other projects.
>
> The surveillance staff has been directed to ignore anomalies detected during performance, reliability and safety testing of nuclear weapon systems in an effort to improve metrics reported to NNSA.
>
> Testing of safety critical components at WETL has degraded their safety performance. However, the Surveillance Organization is not reporting the degradation and is allowing the components to be installed in nuclear weapons and returned to stockpile resulting in an increased risk of a nuclear accident."

The issues were referred to Sandia Field Office for Review and Action. Attached is a report from the Sandia National Laboratory Ethics and Business Conduct Office capturing the results of their review of these allegations. Upon receipt of the report, the NNSA Internal Affairs Office obtained clarifying information on selected aspects of the findings in the report which were not clearly addressed. The following clarifications/additional information are provided based on that follow-up:

1) *Responsibility for Reporting Completion Status* – The review team clarified that it is a Sandia managers' responsibility to report on "completion status" and other aspects of performance against the established milestones. Therefore, the initial allegation that "Staff is being directed by management to exaggerate the completion status…" is not consistent

with current practices and, at a minimum, would be a misstatement on the part of the complainant.

2) *Clarification on "Substantiated" Allegation* – The team clarified that, while the report states that the allegation that "management was directing staff to exaggerate the completion status…" is substantiated, this was not, in fact, validated. As noted in the third paragraph of the report, the review did not find that management was directing the employees to exaggerate the status, although "management" was aware of factors that would lead to milestone delays. As noted in clarification number one above, management, not staff, is responsible for reporting milestone statuses. Therefore, there would not be a circumstance in which management was directing staff to do so, and the team found no evidence of such. However, the review team did substantiate that the status was not reported in an appropriate manner and that the reporting manager was aware of issues with completion status. As such, NNSA would consider the noted allegation "Partially Substantiated."

3) *Clarification on Inappropriate Reporting of Milestone Status* – In follow-up discussions with the review team, the Internal Affairs Office confirmed that the review team did not identify any evidence of intentional misrepresentation on the part of the manager responsible for reporting the completion status. To clarify, based on that managers' belief that the milestone in question would be deleted, the status was not updated to reflect a yellow or red status. It was only later when it was confirmed that the milestone would not be deleted that a potential reporting issue/impact was identified. The responsible manager did provide accompanying narrative with the milestone reporting which highlighted his understanding of issues potentially impacting milestone completion. The key issues were the color coding of the related milestone and the chosen way of handling the milestone which he believed would be deleted (but ultimately was not). As noted in the report, Sandia is looking into this situation and will put in place more clear guidelines on how to handle reporting in unusual circumstances such as this.

4) Allegation of Hidden Cost Overruns – The review team interviewed managers and staff and reviewed cost reports, and identified no evidence of inappropriate charging.

5) Allegation of Staff Being Directed to Ignore Anomalies – The review team interviewed the quality engineer responsible for tracking the tester qualification process, to include anomalies. No major concerns were identified. The quality engineer did note however that after full discussion by, and approval of, the Product Realization Team (PRT), the sequence and level of qualification processes and/or anomalies may be modified. Any such modifications are documented; however, some individuals may not agree with the PRT approved approach.

6) Allegation of Degradation of Safety Performance – The review team was unable to substantiate this allegation and found no evidence of unsafe components being returned to the stockpile due to testing of those components. However, staff interviewed did note an

incident from a few years ago when a decision was made to test certain components in a "cold environment." A component was damaged, which ultimately helped identify a potential testing risk. As a result, changes were made to avoid repeating that issue when testing at cold temperatures. While no unsafe components were returned to the stockpile as a result of that incident, it is possible misunderstanding of that incident was the source of the allegation.

Based on the clarifications above and information provided in the initial report from Sandia, I find that the allegations have been adequately reviewed and that the conclusions were reasonable. As a result, NNSA considers this management referral closed pending any additional request from the Office of Inspector General. Should you have any additional questions, please let me know.

Attachment

cc:
Jesse Hewitt, Sandia Field Office Audit Coordination Officer

Document Number 3

[illegible]
Sandia Field Office
[illegible]
Albuquerque, [illegible]

JUN 18 2013

MEMORANDUM FOR: Jardean L. Childs, Director, Office of Internal Controls, HQ/GTN, NA-MB-1.1

FROM: Geoffrey L. Beausoleil, Manager

SUBJECT: Allegation of Questionable Practices by Sandia National Laboratories Surveillance Organization Staff (Case No. 12RS100/2013)

On April 2, 2013, the Sandia Field Office (SFO) received a management referral concerning an allegation dated August 1, 2012. SFO referred this matter to the Sandia Corporation (Sandia) Audit, Ethics and Business Conduct organization (which includes Investigations). Additionally, an SFO subject matter expert shadowed the investigation. It was determined that one of the allegations was substantiated. The SFO concurs with the path forward as recommended in the attached letter containing the results of Sandia's investigation.

If you have questions, please contact Jesse Hewitt of my staff at (505) 845-5826.

Document Transmitted Contains [illegible] Information

13-500-515367

Sandia National Laboratories
Operated for the U.S. Department of Energy by
Sandia Corporation
P.O. Box 5800

(b)(6)
Director, Independent Audit, Ethics and Business Conduct

Albuquerque, NM 87185-1460
Phone: (505) 844-9336
Fax: (505) 844-9728
email: jkplumm@sandia.gov

June 6, 2013

Geoffrey Beausoleil, Manager
National Nuclear Security Administration
Sandia Field Office
P.O. Box 5400, MS-0184
Albuquerque, NM 87185-5400

Subject: Allegation of Questionable Practices by Sandia National Laboratories Surveillance Organization Staff (Case No. I12RS100/2013-00886)

Dear Mr. Beausoleil:

This letter is to inform you of the results of Sandia's investigation of Case No. I12RS100/2013-00886 regarding the B61/B83 tester development activity at the WETL facility in Amarillo, Texas. As requested, the Sandia Ethics and Business Conduct Office thoroughly investigated all allegations contained in the IG management referral and Jeffrey Petraglia shadowed the investigation. The following allegations are not substantiated: staff were directed to mischarge other projects and thus hiding the magnitude of cost overruns; staff were directed to ignore anomalies detected during performance, reliability and safety testing in an effort to improve metrics reported to NNSA; and testing of safety critical components at WETL has degraded their safety performance and the Surveillance Organization was not reporting the degradation and allowing the components to be installed in nuclear weapons and returned to stockpile resulting in an increased risk of a nuclear accident.

The allegation that management was directing staff to exaggerate the completion status and downplay the deficiencies at the B61/B83 tester being developed for the WETL facility is substantiated.

Information gathered during the investigation indicated that while staff may not have been directed by management to exaggerate the status, management was well aware of factors that would lead to a delay in meeting an established Level 2 (L2) milestone (4139). Surveillance managers said that they had two competing L2 milestones. One milestone (4291) had two grading criteria with deliverables due at the end of FY12 3rd Quarter, and another milestone (4139) had three grading criteria, including the same two deliverables as 4291 due at the end of FY12 3rd Quarter. The third deliverable was due at the end of FY12 4th Quarter. Because of the

"double" milestone deliverable listing and their belief that 4139 would be deleted, management continued to report milestone status for both milestones as green or "on track" to NNSA, via quarterly scorecards.

The investigation found that Sandia began asking NNSA to modify/delete 4139 in November 2011. The milestone was never deleted and Sandia management continued to report status to NNSA, anticipating the milestone would be deleted. In the 3rd quarter scorecard, management reported several technical risks that, if realized, would impact schedule, cost, and delivery to commitments. Despite input from management and staff that the third deliverable of milestone 4139 was not on track to be completed at the end of FY12, management continued to report to NNSA that progress on that milestone was on target for delivery (green).

It was not until the 4th Quarter that surveillance management realized 4139 would not be deleted and, therefore, assigned the status as "red" (incomplete). During the investigation, employees stated that it was well known by management and staff early in 2012 (Feb/Mar) that they would not meet the 4th Quarter deliverable – an indication that the 3rd Quarter status (at a minimum) should have been yellow, i.e., "some issues or delays exist".

It is worth mentioning that on September 7, 2012, the surveillance Senior Manager commissioned a study on the milestone process "focused on discovering why Sandia has experienced difficulty identifying and communicating issues on L2 milestone projects using the PLATR/scorecard process." The study focused on the B61/B83 testbed upgrade project because it was thought to be "exemplary of more generalized conditions that contributed to its FY12 red status."

Sandia intends to follow our normal internal process on substantiated allegations. The process includes the involvement of Human Resources and line management to develop corrective action(s). We will share results with Jesse and Lloyd. Please don't hesitate to contact me if you have questions, or need further information.

Sincerely,

Copy to (electronic distribution via email only):
MS-1460 (b)(6)
MS-1460
MS-1460
MS-0184 DeSerisy, Lloyd, SFO
MS-0184 Hewitt, Jesse, SFO

Exceptional Service In The National Interest

Document Number 33a

Department of Energy
National Nuclear Security Administration
Washington, DC 20585

March 3, 2013

MEMORANDUM FOR: Michael S. Milner
Assistant Inspector General for Investigations
Office of Inspector General

From: Dean Childs
Director, Internal Affairs
National Nuclear Security Administration

Subject: Response to Allegation of Abuse of Authority and Hostile Work Environment at the Pantex Plant (Case # I12RS024 I 2012-00207)

12-0204-C

The National Nuclear Security Administration received the subject Management Referral from your office concerning alleged abuse of authority and hostile work environment at the Pantex Plant. The issues were referred to the National Nuclear Security Administration Production Office (NPO). Based on their review, they have determined that only the allegation regarding "multiple medical restriction violations" was substantiated. I have reviewed the information provided in the NPO response, and I find that the allegations have been adequately reviewed and that the conclusions were reasonable. In addition, NPO has identified specific corrective actions to address the process improvement opportunities they identified. As a result, NNSA considers this management referral closed pending any additional request from the Office of Inspector General. I have attached the original response from the NPO Manager for your convenience.

Should you have any additional questions and/or need follow-up information, please let me know.

Attachment

cc:
Tom Vereb, Assistant Manager for Business and Contract Management NPO
Janice Brashears, Deputy AM for Business and Contract Management NPO

NOTE: This memorandum and the information contained herein, is the property of the National Nuclear Security Administration and are for OFFICIAL USE ONLY. The original and any copies of this document must be appropriately controlled and maintained. Disclosure to unauthorized persons without prior written approval is strictly prohibited and may subject the disclosing party to liability. Unauthorized persons may include, but are not limited to, individuals referenced in the memorandum, contractors, and individuals outside the Department of Energy. Public disclosure is determined by the Freedom of Information Act (Title 5, U.S.C., Section 552) and the Privacy Act (Title 5, U.S.C., Section 552a).

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U.S. Department of Energy
NNSA Production Office
Post Office Box 2050
Oak Ridge, Tennessee 37831-8009

November 29, 2012

MEMORANDUM FOR: DEAN CHILDS
DIRECTOR
INTERNAL AFFAIRS, NNSA

FROM: STEVEN C. ERHART
MANAGER
NNSA PRODUCTION OFFICE

SUBJECT: Response to Allegation of Abuse of Authority and Hostile Work Environment at the Pantex Plant; Case File I12RS024 / 2012-00207

Reference: Alleged Abuse of Authority and Hostile Work Environment at the Pantex Plant; Case File I12RS024/2012-00207, Dated January 25, 2012

Supplemental Information: Abuse of Authority and Hostile Work Environment at the Pantex Plant (OIG File No. I12RS024), Dated March 2, 2012

In response to the referenced document, the National Nuclear Security Administration Production Office (NPO) Pantex requested B&W Pantex Internal Audit personnel conduct an investigation and provide this office with a report. While most of the allegations were not substantiated, the report particularly highlighted that they did not identify any retaliating practices or substantiate the existence of a hostile work environment that contributed to (b)(6) suicide as referenced in the March 2, 2012 memorandum from the Office of the Inspector General. However, the investigation determined that the allegation of "multiple medical restriction violations" was substantiated, and also identified several business processes and management practices which could be improved.

To address these issues, B&W Pantex has developed a comprehensive action plan to implement the needed improvements. These actions are anticipated to be completed by the first quarter of FY13. B&W Pantex has also developed a Safety Culture Plan that will be deployed during the remainder of CY2012 and throughout CY2013 with the objective of positively reinforcing safety behaviors that are consistent with the Institute of Nuclear Power Operators (INPO) Principles for a Strong Nuclear Safety Culture. They will also provide training for management personnel on a Safety Conscious Work Environment (SCWE) to establish an environment where employees are encouraged to raise concerns without fear of reprisal or retaliation.

The NPO has reviewed the investigation report, along with the proposed corrective actions, and has confidence that the comprehensive action plan developed by B&W Pantex will adequately address the identified issues and prevent recurrence in the immediate and distant future.

Should questions arise, please contact Ms. Becky Tracy at (806) 477-3135, or Ms. Dawn M. Jones at (806) 477-3129.

Attachments:

See page two for cc list.

cc w/attachments:
T. Vereb, NPO-50-Y12
B. Tracy, NPO-50-PX
J. Brashears, NPO-50-Y12
D. Jones, NPO-50-PX

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B&W technical services
Pantex, LLC
A VPP Star Site
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• phone 806.477.3000 • www.pantex.com

NOV 26 2012

Mr. Steven C. Erhart
Manager
U.S. Department of Energy
NNSA Production Office
P.O. Box 2050
Oak Ridge, TN 37831-8009

Subject: Request for Management Response to B&W Pantex Internal Audit Report No. IA-12-10, Alleged Abuse of Authority and Hostile Work Environment, Dated August 9, 2012

Dear Mr. Erhart:

NNSA Production Office Pantex (NPO Pantex) was notified by the Office of Inspector General (OIG) of allegations related to abuse of authority and a hostile work environment at the Pantex Plant. NPO Pantex requested that the B&W Pantex Internal Audit Department investigate these allegations. The results of this investigation were summarized and distributed on June 5, 2012, and are enclosed.

The complaint alleged that "Retaliatory practices and a hostile work environment may have led to the suicide of Mr. XX, former Pantex inspector."

Additional allegations to the OIG included

- Supervisor misconduct and retaliatory practices
- Less than adequate managerial responsibilities
- Violation of the B&W Pantex/MTC Contract and the American Disabilities Act
- Disregard for employee safety
- Multiple medical restriction violations
- Constant shuffling of MTC employees in Applied Technology
- Less than adequate training
- Inadequate internal inquiry
- Hostile work environment

The investigation concluded that, "We were unable to identify any retaliatory practices or substantiate the existence of a hostile work environment that contributed to Mr. XX's suicide."

The investigation was not able to substantiate the allegations listed above with the exception of the allegation of "Multiple medical restriction violations", where the investigation concluded that

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~~Department of Energy review required before public release. Name/Org: Stan Stambaugh, Aechyt, PTX~~
~~Date: 11-26-2012~~
~~Guidance (if applicable): N/A~~

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Building 12-121 was an incompatible work environment due to medical restrictions and that management did not provide adequate accommodations for Mr. XX.

As a result of this investigation, several business processes and management practices were identified that could be improved. B&W Pantex has developed a comprehensive action plan to address the needed improvements. Specific actions being taken are identified below with the date of each action's actual or anticipated implementation.

- Supervisors performing MTC work, page 9. Complete. Communication from Division Manager, (b)(6) to all Department Managers in 2011 followed with an e-mail from all (b)(7)(f) Department Managers on September 26, 2012.

- Dual Verification, page 14. Complete. E-mail communications from Department Manager to Section Managers dated October 12, 2011, October 14, 2011, and November 17, 2011, as well as up-to-date Dual Validation training records for (b)(7)(f) Manufacturing as of September 26, 2012.

- Lack of Accommodation, page 17. Complete. Process changed to require the supervisor to discuss medical restrictions and requiring signature by both supervisor and employee. Example dated April 2, 2012. Reminder e-mail sent from (b)(7)(f) Manufacturing Department Manager to Supervisors on Wednesday, September 26, 2012.

- Inadequate Training on (b)(7)(f) Waste Disposal, page 19. Open. Training Manual needs to be updated to include mentoring program prior to new technicians arriving. Anticipated completion date is FY13 Q1. Labeling Waste Can training provided on August 20, 2012, during a stand-up meeting.

- Schedule Pressures/Inadequacies, page 21. Complete. (b)(7)(f) Manufacturing execute work using a comprehensive integrated production schedule that has been in place since 2010. (b)(7)(f) Manufacturing discusses work planning each morning during the department meeting.

In addition, B&W Pantex has developed a Safety Culture Plan that will be deployed during the remainder of CY2012 and throughout CY2013 with the objective of positively reinforcing safety behaviors that are consistent with the Institute of Nuclear Power Operators (INPO) Principles for a Strong Nuclear Safety Culture. B&W Pantex will also provide training for management personnel on a Safety Conscious Work Environment (SCWE) to establish an environment where employees are encouraged to raise concerns without fear of reprisal or retaliation.

Please contact me at (806) 477-6200 with any questions or comments you may have regarding this report or the information above.

Respectfully,

John D. Woolery
General Manager

Enclosure: As stated

cc: K. Waltzer, NPO PX
T. Vereb, NPO Y-12
B. Tracy, NPO PX, 12-36A
D. Jones, NPO PX, 12-36A
R. Johnson, B&W Pantex, 12-69A
W. Call, B&W Pantex, 12-15A

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• phone 806-477-3000 • www.pantex.com

JUN 05 2012

Mr. Mark Padilla
Assistant Manager
Contract Administration & Business Management
U.S. Department of Energy
National Nuclear Security Administration
Pantex Site Office
P.O. Box 30030
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Mr. Gary Wisdom
Assistant Manager
Safeguard and Security
U.S. Department of Energy
National Nuclear Security Administration
Pantex Site Office
P.O. Box 30030
Amarillo, TX 79120-0030

Subj: Investigative Report - Alleged Abuse of Authority and Hostile Work Environment, IA-12-10

Dear Mr. Padilla and Mr. Wisdom:

B&W Pantex Internal Audit Department (IA) was notified by the Pantex Site Office (PXSO) of Office of Inspector General (OIG) allegations related to abuse of authority and a hostile work environment at the Pantex Plant. PXSO requested that the B&W Pantex IA Department investigate these allegations. The results of our investigation are summarized in the enclosed report.

Please contact me at extension 5928 with any questions or comments you may have regarding this report.

Respectfully,

Wanda Call

Wanda Call, CPA, CFE, CFSA, CBM, FCPA
B&W Pantex Internal Audit Manager

Enclosure: As stated

cc:
J. Woolery, B&W Pantex, 12-69A
R. Johnson, B&W Pantex, 12-69A

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Investigative Report

ALLEGED ABUSE OF AUTHORITY
AND
HOSTILE WORK ENVIRONMENT

No. IA-12-10

Conducted by

INTERNAL AUDIT

~~*Contains Information which may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552); Exemption Number(s): 5, Privileged Information. Approval by the Department of Energy prior to public release is required. Reviewed by: R. A. Barr, B&W Pantex CO, Date: May 30, 2012, Guidance (If Applicable): N/A*~~

B&W Pantex

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Table of Contents

Investigative Report – Alleged Abuse of Authority and Hostile Work Environment

Executive Summary

Background

On January 25, 2012, the Office of Inspector General (OIG) notified the Pantex Site Office (PXSO) of allegations related to abuse of authority and a hostile work environment at the Pantex Plant. On February 1, 2012, PXSO requested that the B&W Pantex Internal Audit Department (IA) investigate these allegations (File No. I12R5024/2012-00207). Additional allegations were received on March 19, 2012, regarding the release of information pertaining to the inquiry into a Pantex employee's suicide and the absence of subsequent corrective actions. In many cases, the allegations pertain to events surrounding the suicide of this employee subsequently referred to as Mr. XX.

Purpose and Results

The complaint submitted with the OIG alleges that retaliatory practices and a hostile work environment may have contributed to the suicide of Mr. XX, a former Pantex inspector. Additional allegations are included below:

- Supervisory misconduct and retaliatory practices
- Less than adequate managerial responsibilities
- Violations of B&W Pantex/MTC Contract and the American Disabilities Act
- Disregard for employee safety
- Multiple medical restriction violations
- Constant shuffling of MTC employees in Applied Technology
- Less than adequate training
- Inadequate internal inquiry
- Hostile work environment

The purpose of the investigation was to determine the validity of these allegations.

In the performance of our investigation, we found some merit to the following:

- Insufficient personnel health evaluations,
- Supervisors conducting MTC work inconsistent with the MTC agreement,
- Lack of utilization of job-task analysis,
- Incompatible work areas,
- Inadequate accommodations provided for certain employees with medical restrictions,
- Supervisor and technician complacency,
- Medical restriction violations, and
- Incomplete qualification process.

Conclusion

Ultimately, we cannot conclude that retaliatory acts were taken against Mr. XX or that a hostile work environment caused him to commit suicide. However, based on our review, Internal Audit can substantiate some of the other allegations as stated above.

Investigation

1. Introduction

Mr. XX worked as a lathe operator in the (b)(7)(f) Division (formerly "Applied Technology") for approximately twelve years, machining (b)(7)(f) prior to his last back surgery in 2010. He had three other back surgeries while employed at Pantex and two knee surgeries. His doctor informed him that full recovery from the last back surgery would be very slow – up to two years.

After Mr. XX's suicide on September 1, 2011, Human Reliability Program (HRP) officials conducted an investigation into his suicide since he was certified in the HRP at the time of his death. The purpose of the investigation was to provide known facts, analysis, and conclusions related to the death within the context of the HRP.

As part of the HRP investigation, an inquiry was conducted into allegations that work pressures directly or indirectly contributed to Mr. XX's decision to commit suicide. In addition, Employee Concerns and EEO conducted a review and limited investigation into similar issues raised by a Pantex employee.

Scope & methodology

IA conducted an investigation of the previously-specified allegations from February 1, 2012 through May 9, 2012.

The following methodologies were used to perform the investigation:

- Conducted over 45 interviews of (b)(7)(f) management, engineers, engineering technicians, special mechanic inspectors and other individuals pertinent to the investigation;
- Reviewed Forms PX-4457, *Applied Technology Division Record of Stand-Up Meeting* (generated daily), from July 2008 through August 2011.
- Reviewed Forms PX-2844, *Inventory of Container at Waste Accumulation Site*, from July 2008 through August 2011.
- Reviewed Forms PX-4343, *Pre-Job/Post-Job Briefing Building 12-121* for June 2010 through April 5, 2012.
- Reviewed Forms PX-3257, *Daily Machine Tool Checklist"* from December 2010 through March 2012.
- Reviewed medical entries and HRP information pertinent to this investigation.

- Compiled data, analyzed results, concluded significance of issues identified, and briefed management on the results of the investigation.
- Reviewed the medical records of Mr. XX and Employee #1.

Criteria

Written procedures and processes considered and/or tested during the investigation included, but were not necessarily limited to those defined in:

- 10 CFR 712, *Human Reliability Program;*
- *Articles of Agreement Between B&W Pantex, LLC and the Metal Trades Council of Amarillo, Texas & Vicinity, AFL-CIO;*
- HA-PHA-941319, Revision 1;
- *Building 12-121* (b)(7)(f) *Machining Operations Process Hazard Analysis;*
- MNL-293131, *Occupational Medicine Manual;*
- MNL-352166, *Human Reliability Program Manual;*
- F6-5000, *General Safety Requirements for the* (b)(7)(f) *Division;*
- F7-5121, *Building 12-121 Specific Safety Requirements;*
- P7-0104, *Cutter and N-C Program Handling Requirements;*
- P7-0350, *Operating Instruction for the Accurate/Dostomatic Precision 5-Axis Mill and Bourn and Koch 4-Axis Mill Machine;*
- P7-0351, *Operating Procedures for the Babcock and Wilcox Saw;*
- P7-0352, *Operating Instructions for the Bourn and Koch Lathes;* and
- Applicable work instructions located in the Business Requirements and Instruction Network.

2. Results

Introduction

This section of the report will be organized under the following headings, correlating with each allegation:

- Supervisory misconduct and retaliatory practices
- Less than adequate managerial responsibilities
- Violations of B&W Pantex/MTC Contract and the American Disabilities Act
- Disregard for employee safety
- Multiple medical restriction violations
- Constant shuffling of MTC employees
- Less than adequate training
- Inadequate internal inquiry
- Hostile work environment

Supervisory misconduct and retaliatory practices

Preface

The OIG letter provides the following examples:

- Verbal abuse documented on psychology interviews and during one-on-one meetings with Metal Trades Council (MTC) employees.
- No union representatives present during one-on-one meetings with MTC employees,
- Human Reliability Program (HRP) statutes are being pulled and/or reinstated without proper work instructions being followed.
- Fit for Duty evaluations are not being completed.
- Technicians are being threatened to keep all concerns and issues within Zone 12-121.
- MTC employees are being forced into work areas and positions without their consent or without being properly trained.

Verbal abuse

Eleven employees acknowledged or expressed their concerns about specific supervisors' managerial styles, citing problems with supervisors' interpersonal skills, derogatory comments, difficult personalities and assignment of less-than-desirable work. One individual stated that the managers liked to tease employees, and some employees were offended.

MTC employees also expressed concerns about comments made during a standup meeting. Management told employees that their overtime would be performed on Saturday rather than during the week since personnel

got more done on the weekends than during the week. The technicians interpreted this statement to mean that they were being punished.

Two employees left the department in November of 2010. While neither employee stated that they left due to supervisor conflicts, both acknowledged problems with supervisors. One of the employees took a lower paying position within the Plant, stating that he wanted a career change.

We cannot validate the allegation of verbal abuse. No employee reported supervisors raising their voices or using vulgarity. One employee stated that supervisors never crossed the line. However, interviews suggest that some supervisors may have behaved unprofessionally.

Lack of union representation

In the *Inquiry Report on the Workplace Conditions Prior to [Mr. XX's] Suicide*, it was reported that Mr. XX, in a meeting with a manager with no union representation present, was told sarcastically, "We won't do anything to hurt your poor little back." The allegation stated above implies that Mr. XX was refused the option to have representation.

We could not substantiate this allegation. MTC employees in Building 12-121 had access to union representation with a union steward working in Building 12-121. In addition, according to our interviews, Mr. XX requested the meeting.

Inappropriate removal from the HRP

According to HRP officials, two employees were removed from the HRP due to Mr. XX's suicide. One employee lived with Mr. XX and reportedly was his fiancée. The other was a friend who worked with Mr. XX the last three weeks of Mr. XX's life. This employee helped clean the room after the suicide. After discussions with HRP officials, we determined that these actions were typical in these circumstances and were instigated by HRP officials, not Building 12-121 management.

As stated in the Human Reliability Program Manual (p. 23) and 10 CFR 712, an individual may be removed from HRP due to "an inability to deal with stress, or the appearance of being under unusual stress." Per HRP officials, these are the guidelines HRP officials used to remove these individuals from the HRP after the death of Mr. XX. One employee was temporarily removed from the HRP for three months and the other has been awaiting reinstatement since September 2011. His reinstatement is imminent according to the HRP certifying official. These individuals were monitored during this period by the Plant's Designated Psychologist, who is licensed in the state of Texas.

Based upon data obtained from the HRP certifying official from July 2008 forward, the average time for reinstatement is 7.41 months. HRP officials reported that this time is affected by the designated psychologist's follow-up and the recertification process when an individual's annual certification lapses during the temporary removal period.

We found no evidence that HRP procedures or regulations were violated or that any individual was removed from the HRP inappropriately. Consequently, we cannot substantiate the allegation of inappropriate removals from the HRP.

Lack of Fit-For-Duty evaluations

The Occupational Medicine Manual (MNL-293131) states:

> Medical evaluates individuals after a job offer is accepted, but before performance of job duties, as well as present personnel before job transfers. This comprehensive evaluation determines an individual's health status and fitness for duty, to assure that assigned duties may be performed in a safe, reliable manner and consistent with applicable ADA requirements.
>
> If a job transfer results in occupational risk changes, a clinician reviews the person's medical record to determine evaluations necessary to assure the ability to safely perform the new job tasks.

On June 23, 2011, Mr. XX returned to Medical to have his restrictions evaluated per his department manager's instruction. Medical opted to perform a consultation since Mr. XX's annual physical was conducted in January 2011, the month he returned from surgery. Medical did not perform a comprehensive evaluation prior to July 5, 2011, the date that Mr. XX transferred to Building 12-121 to train as an inspector in the density and gauging bays. A comprehensive evaluation, conducted prior to his job transfer, would have determined whether the newly-assigned duties were compatible with Mr. XX's restrictions.

During the consultation, the nurse practitioner recorded Mr. XX's concerns with "heavy lifting, repetitive reaching, and standing long periods," all routine job duties of the inspector position. The nurse practitioner indicated that Mr. XX wanted to ensure that his restrictions remained in place in order to protect his health. Medical issued a Return-to-Work form, advising the supervisor of his responsibilities to ensure that work assignments were consistent with the restrictions. Mr. XX's permanent medical restrictions were included on this form (see Table 1, p. 15).

Based on our interviews and review of medical records, we determined that management did not request nor did Medical conduct a Fitness-For-Duty evaluation of Mr. XX prior to his reassignment to Building 12-121. One control to ensure that this evaluation is conducted is contained in the PX-100-11, *Personnel Hire/Transfer Data* form. This form is submitted to Human Resources when an employee changes departments, changes title, or is awarded a new position through the job-bid process. Medical must complete the form prior to the job transfer and will characterize the person's ability to meet the physical requirements for the position as:

- Fit for duty without restriction.
- Fit for duty but has restriction(s).
- Unfit for duty.

No PX-100-11 is required for a supervisor change; hence none was submitted in this case since Mr. XX's transfer only involved a change in location and supervisors.

We confirm the allegation that a fitness-for-duty evaluation was not performed on Mr. XX prior to his transfer to Building 12-121 as an inspector as required by the Occupational Medicine Manual. Furthermore, we did not identify any additional actions taken to address Mr. XX's concerns.

Threatening of technicians

Most individuals we interviewed thought that management wanted them to keep issues internal; however, they felt that if necessary, they could go outside the organization for resolution.

Furthermore, the former (b)(7)(f) division manager stated that she had interviewed an employee to ascertain why he had decided to contact the general manager in order to resolve a problem. At that time, she expressed her desire for him to report his concerns up through the management chain to allow management a chance to correct the problem.

We were unable to confirm the allegation that technicians were threatened.

Unauthorized employee moves and lack of training

Article 7 of the MTC Agreement, "Management of the Business," states:

> The right to manage the Plant and to direct the working forces and operations of the Plant is exclusively vested in, and retained by, the Company, understanding that the Company, when exercising this right, will not use it in conflict with any of the terms and provisions of this Agreement.

Based on our interviews and review of PeopleSoft data, we confirm the allegation that some employees were moved to new positions without their consent; however, management has the right to direct work and operations.

Employee training is addressed in the section, "Less than adequate training."

Supervisors performing MTC work

The MTC Agreement, Article 3, "Supervisors Working" states:

> Supervisory employees will not be permitted to perform work on any bargaining unit job except in the following types of situations: (1) in emergencies; (2) in experimental work which requires special techniques and knowledge, and bargaining unit employees are not qualified to do the experiment; (3) in the instruction of employees; (4) in the performance of necessary work when production difficulties are encountered on the job. Production difficulties mean those difficulties requiring supervisory assistance to determine the cause.

In July of 2008, the Applied Technology division manager issued a cease and desist letter, instructing supervisors to stop performing MTC work (see Appendix A). However, based upon interviews of

management and union personnel, supervisors reportedly move materials and package parts contrary to the MTC Agreement. In support of these statements, we obtained an A/N can[1] label, recently completed by a supervisor, corroborating the allegation that managerial personnel perform MTC-assigned work. One manager reported that supervisors assisted MTC employees in order to get the work done more expeditiously.

Conclusion

We were unable to identify any retaliatory actions taken by management. Per the MTC Agreement, management retains the right to direct work, giving management the authority to reallocate personnel at their discretion.

We cannot substantiate the allegations of supervisor misconduct and retaliatory practices with exception of supervisors performing MTC work. In addition, we concluded that a fitness-for-duty evaluation of Mr. XX was not performed prior to his transfer to Building 12-121 in July 2011 as required by the Occupational Medicine Manual.

Less than adequate managerial responsibilities

Preface

The OIG letter provides the following examples:

- Technicians are being forced to operate equipment that is not safe or in proper working order.
- Budget issues are used as an excuse to reassign MTC employees.
- HRP medical assessments and/or psychological evaluations may not be performed if a job task analysis/description has not been provided as stated in Document MNL-293131, p. 83, Note 2.

Unsafe equipment operations

We cannot confirm the allegation that technicians were forced to operate equipment that was unsafe or not in proper working order. While we did identify instances where machinery was not functioning properly, we cannot substantiate that personnel were "forced" to continue operations. Work Instruction 02.01.01.05.05, *Initiating Stop Work Authority for Personnel Safety*, states, "Employees have the right to 'pause' work in order to get clarification on an issue. . . . Continuation of the work may start once the employee's concerns have been addressed. If not satisfied, the employee may then formally stop work. . . ." This policy is an integrated part of the Pantex safety culture.

Please also refer to the section, "Disregard for employee safety" for further discussion.

[1] A can (b)(7)(f) weighing approximately 32 lbs. empty.

Reassignment of MTC employees

Management has stated that Mr. XX was moved to Building 12-121 due to budget issues. We concluded that this was a true statement. At the end of FY 2011, the Non-Density Determination System project (ND[3]) was over budget for Department 840 and would have been over budget for the whole project at June 2011's spend-rate.

We confirm the allegation, but fail to confirm the underlying accusation that there was an inappropriate reason for the move. (Please see "Constant shuffling of MTC employees" for more information.)

Lack of job task analysis/descriptions

The Occupational Medicine Manual, Section 2.8, "Medical Human Reliability Program Protocols," states:

> The SOMD[3] or designate (examining psychologist, physician, or nurse practitioner) is responsible for the medical assessment of HRP candidates and HRP-certified individuals, including:
>
> - Medical evaluations
> - Psychological/psychiatric evaluations
> - Evaluation of any other relevant information to determine an individual's overall medical qualification for assigned HRP duties.
>
> Human Resources (HR) provides job descriptions for HRP-designated positions for use in medical evaluations.
>
> Note 2: HRP medical assessments and/or psychological evaluations may not be performed if a job task analysis/description has not been provided.

Per our discussions with Medical officials, job descriptions reviews, performed concurrently with medical assessments or psychological evaluations, are typical protocol. The job description, used in place of the job-task analysis, defines ". . . the requirements of a position and identifies the knowledge, skills, and abilities necessary to effectively perform the duties of the position" (10 CFR 712.3). A review of Mr. XX's medical file revealed a job-task-analysis section containing his 2008 job description.

The nurse practitioner, who saw Mr. XX on June 23, 2011, indicated that she did not review the job description/job-task analysis during the consultation. However, based on the consultation, she determined that Mr. XX could not meet the physical requirements of his job. Consequently, she issued a Return-to-Work form to Mr. XX, listing the same restrictions as before, to be provided to his management.

We confirm the allegation that a medical assessment (i.e., consultation) was performed without a job-task analysis/description. In addition, since no comprehensive medical evaluation was conducted prior to Mr. XX's transfer to Building 12-121 on July 5, 2011, no job-task analysis was performed based upon his restrictions.

[3]Site Occupational Medical Director

Conclusion

We confirm the allegation that the job-task analysis was not reviewed in conjunction with a comprehensive medical evaluation prior to Mr. XX's transfer to Building 12-121 in July 2011.

Violations of B&W Pantex/MTC Contract and the American Disabilities Act (ADA)

Preface

The OIG letter provides the following examples:

- Medical limitations were ignored for MTC employees (see "Multiple medical restrictions violations").
- Placement of employees with permanent medical limitations and restrictions were not followed (see "Multiple medical restrictions violations").

The MTC Agreement states:

> Both parties to this agreement will work cooperatively to retain in employment a worker with medical limitations incurred on or off the job. It will be the policy of the Company to make reasonable accommodation for the worker who has medical limitations. Affected employees will be consulted regarding reasonable accommodations. Any accommodation made will assure that the work can be performed safely. In the event a person is permanently disqualified from his/her present job classification, the Company and the Council will work together in an effort to place the employee in another position for which he/she is qualified.

Furthermore, the Americans with Disability Act of 1990 states:

> Sec. 12112. Discrimination
> (a) General rule. No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment. (See Appendix B for additional ADA text.)

Work Instruction 02.01.01.01.18, "Fitness-for-Duty Assessments," states that a condition is permanent if it is expected to last more than six months.

Mr. XX returned to work in July 2008 after having back surgery. Medical assigned permanent restrictions, *limiting Mr. XX's lifting, pushing, and pulling to 25 lbs. (see Table 1 on p. 15). In order to accommodate him,* management assigned a helper as he continued his work as a lathe operator in Building 12-121.

In November 2010, Mr. XX underwent another back surgery. He returned to work in January 2011. The Company placed him in Building (b)(7)(f) assigning him to the ND[3] project. An interview with his supervisor in

Building (b)(7)(f) confirmed that the placement of Mr. XX in this area was due to his medical restrictions. He was adamant that Mr. XX's medical restrictions be adhered to and stated that he worked with another employee while located in Building 11-50.

In March 2011, Mr. XX received his HRP recertification. At that time, his supervisor did not recommend his return to Building 12-121. In June 2011, Mr. XX was given the option of moving to Buildings 12-17, 12-31 or 12-121. Management later decided that the only viable option would be inspection work in Building 12-121 due to his medical restrictions and rescinded the other offers. Per the department manager, he discussed the change with Mr. XX, and Mr. XX reportedly agreed to return to Building 12-121.

Conclusion

We did not identify any discrimination or adverse employment actions taken against Mr. XX. In addition, we determined that Mr. XX was consulted regarding reasonable accommodations based on our interviews with his supervisor and fiancée.

Disregard for Employee Safety

Preface

The OIG letter provides the following example:

Inaccurate vacuum pressure on two saws which managerial officials refused to shut down. MTC employees were compelled to report the incident to the Plant Manager because the immediate supervisor, Section Manager, Department Manager and Division Manager ignored employee concerns.

The following is a discussion of recent events occurring in Building 12-121. Based upon our interviews, these events caused the engineering technicians concern and from their perspective, evidenced management's disregard for safety. However, as we discuss further, these occurrences may not necessarily have put the employee at risk, especially in retrospect. In many cases, these incidents may highlight management's lack of communication and initial unresponsiveness.

Inaccurate Vacuum Pressure

In September and October of 2011, technicians encountered inaccurate vacuum pressure readings on two saws which managerial officials reportedly failed to shut down until MTC representatives attempted to raise the issue with upper management. The technicians reportedly argued with supervision about whether to shut down the machines.

On one saw, the gauge indicated a much higher reading than it should have without a part on the fixture. On the other saw, the light indicating adequate vacuum pressure malfunctioned. The technicians were concerned that without a functioning gauge and light, they would not be aware of an unacceptable decrease in vacuum pressure during machining operations. The level of vacuum pressure is important because it holds the (b)(7)(f)

part in place during machining operations. First-line supervision felt confident that if the vacuum pressure fell below the minimum level, the machine safety system would shut off the saw.

In October, when the department manager was notified of the issue, he interviewed various supervisors and technicians to gain a better understanding. He discovered that the supervisors and engineers had evaluated the situation the day before and concluded that it was safe to continue operations. However, the technicians did not agree and tagged out the machines.

The department manager called a meeting with technicians, supervisors, and engineers in attendance. In the meeting, all agreed upon establishing a maximum vacuum pressure reading without a part present. If the pressure exceeded the maximum level, the technician would suspend operations and notify the supervisor. The department manager also directed that the faulty vacuum gauge be replaced and the vacuum lines evaluated. (b)(7)(f) machining operations were authorized for the other saw until it could be repaired.

Conduit

An issue concerning the separated conduit from the turret head of the lathe was noted by the technician on February 10, 2011. In 2009, Electrical Safety personnel inspected the conduit and determined that there were no safety concerns because there were no 'exposed conductors, no arc-producing terminals or terminations in the connecting j-boxes.' A work order was submitted on May 4, 2011 to repair the problem. During a walk-through of Building 12-121 in February 2012, IA personnel questioned Maintenance about the separated conduit and were told that a work order had been submitted to repair the problem. We contacted Electrical Safety to determine if there was a hazard. Electrical Safety concluded that safety had not been compromised by the separation of the sleeve. Shortly after our walk down, the lathe was shut down until repairs were made.

Mill in Bay 9

On April 27, 2012, an engineering technician was performing (b)(7)(f) machining operations on an (b)(7)(f) component using a mill when the technician heard a noise and hit the emergency stop. Earlier that morning, the technician, assisted by another technician, received an error message regarding the lack of coolant while attempting to machine the second feature on a part. He contacted his supervisor, and they decided to replace the tool.

The supervisor told the technicians to go to lunch, and he would have another technician replace the tool while they were gone. When the technicians returned, the supervisor instructed them to perform the required dry cycle without the tool installed and while the (b)(7)(f) part was still attached to the fixture reportedly in an attempt to salvage the part.

Building safety requirements contained in F7-5121 state, "When a process is set up using an approved part program, the machine is to be 'dry cycled' prior to processing (b)(7)(f) to check for proper function and the absence of interference between stationary and moving parts." The operating instruction for the mill (P7-0350) states that if an error message is encountered and subsequently corrected, the technician should perform a dry run to make sure that the problem is repaired for current operation.

At the beginning of the shift, an engineering technician runs a dry cycle with the tool installed. Management stated that in this case, the technicians were in compliance with the requirements as written because the dry cycle did not specify whether the tool was installed in either procedure. Their interpretation allowed for the removal of the tool prior to the dry cycle.

The technician ran the dry cycle without the tool installed while the part was still attached to the fixture. He again ran the dry cycle to the second step of the two-tool operation. After installing the tool, he commenced (b)(7)(f) machining operations. While machining, the technician heard a "chirp sound." At that point, he killed the feed and hit the emergency stop to suspend operations.

Dual verification

The PX-4343, *Pre-Job/Post-Job Briefing Building 12-121*, documents the supervisory review for all machining processes in Building 12-121. We reviewed approximately 300 documents from 2008 to present for validation of dual signatures. We noted 24 exceptions (8%), indicating a failure to adequately document the dual verification. In these cases, we were unable to determine whether the dual verification was actually performed due to the lack of documentation.

Conclusion

We conclude that these events give some credence to the allegations. In many cases, what may appear to the technician as a disregard for safety really may be a lack of communication on the part of the supervisor. The supervisor may direct the technician to continue work when he has already determined through his own experience or discussions with subject matter experts that the issue is not safety related.

In other instances, it appears that there was a lack of adherence to procedure that did not impact safety. Complex and redundant safety features are engineered into the machine software, the facility, and particularly (b)(7)(f) ensuring safe (b)(7)(f) operations at Pantex. These safety features compensate for errors in judgment and equipment failures.

Multiple medical restriction violations

Preface

The OIG letter provides the following examples:

- MTC employees are being allowed to work in areas that do not encompass their work restrictions. Examples include MTC employees working with full arm casts and exceeding push/pull/lift limitations set forth by medical staff.
- MTC employees' permanent restrictions are not being adhered to by managerial officials.
- MTC employees were not further accommodated when assigned assistance personnel were on leave.

Table 1: Mr. XX's Restrictions

Restriction	Effective Dates
Lift, push, pull up to 25 lbs.	Permanent from July 1, 2008
May Walk or Stand as Tolerated	Permanent from July 1, 2008
May Bend, Stoop, or Squat as Tolerated	Permanent from July 1, 2008

Table 2: Employee #1's Restrictions

Restriction	Effective Dates
No use of left arm	July 5 – July 25, 2011
Lift, push, pull up to 10 lbs.	July 26 – August 9, 2011
Lift, push, pull up to 20 lbs.	August 10 – August 23, 2011

Table 3: Engineering Technician II Functional Requirements

Function Requirements	
Lifting or Carrying up to 40 lbs.	Reaching Above Shoulder Level
Walking 2 hours/Day	Standing 2 hours/Day
Straight Pulling or Pushing 1 hour/Day	

Incompatible work areas

When Mr. XX returned from back surgery in July 2008, Medical assigned permanent restrictions due to his doctor's orders (see Table 1). He continued to work as a lathe operator in Building 12-121 even though his restrictions were not compatible with the functional requirements of the job (see Table 3). Immediately after his return, another technician was assigned to assist Mr. XX. Based upon our review of daily work assignments found on the Form PX-4457, *Daily Stand-Up Meeting*, through the month of October 2008, he usually had another technician assigned to his bay; however, after the middle of November 2008, he consistently worked alone.

A lathe operator's duties entail performing manual tasks such as:

- Moving product stored in A/N cans in and out of bays,
- Removing product weighing a few pounds to approximately 30 pounds out of A/N cans,
- Placing/removing parts on or from the lathe with arms extended,
- Bagging scrap pieces and waste, placing them in A/N cans located on pallets,
- Moving the pallets to Bay 10 for weighing, and
- Picking up A/N cans filled with waste and placing them on the scale.

All these functions require some physical effort and Mr. XX's unassisted performance of them may have exceeded his restrictions. Moreover, Building 12-121 consists of bays with hydraulic-assisted (b)(7)(f) doors weighing around 4,000 lbs. In the past, the hydraulic assist did not work on some of the doors, and technicians typically did not use the assist because it was slower than manual operation (see Appendix C for results of blast door hydraulic-assist testing).

In July 2011, Mr. XX returned to Building 12-121 after spending time (b)(7)(f) recovering from his last back surgery in November. At this time, he was frequently assigned to work in Bays 6, 8, and 13. A review of the

work orders for Building 12-121 showed that the hydraulic assist on the outer (b)(7)(f) door of Bay 13 was not functioning during the time Mr. XX was assigned to work there (see Appendix C). On April 9, 2012, Safety conducted a push/pull test on this door using an IMADA PSH Push/Pull Scale. The results indicated that a stationary-to-moving pull required 25 lbs. of force and a stationary-to-moving push required 22 lbs. of force.

At the same time that Mr. XX returned to Building 12-121 in July 2011, Employee #1 returned from elbow surgery, bearing a full-arm cast on his left arm. He also had restrictions, initially preventing the use of his arm (see Table 2 on p. 15). Management has stated that Employee #1 was assigned to assist Mr. XX when he returned to Building 12-121 July 5, 2011. A review of work assignments during the period of time from July 5th – August 23rd indicates that for ten days, Employee #1 was assigned to work exclusively with Mr. XX in Bays 6, 8, or 13 or to work alone, leaving him or Mr. XX without adequate assistance (see Appendix D, "Employee #1's Work Assignments").

During this time period, the production manager indicated that the department had a personnel shortage, making it difficult to keep up with production demands as well as accommodating employees recovering from surgery. Compounding the problem was the institution of the graveyard shift in July 2011, reducing the number of personnel working days.

Due to the inoperable (b)(7)(f) doors, required heavy lifting and other manual labor, coupled with the lack of personnel available to provide assistance, we have concluded that Building 12-121 was an incompatible work area for Mr. XX and Employee #1 due to their medical restrictions.

Lack of adherence to permanent medical restrictions

IA reviewed the Forms PX-2844, *Inventory of Container at Waste Accumulation Site*, from July 2008 through September 2010 (see Appendix E). This analysis indicated that 129 times, Mr. XX recorded weights on the forms that when added to the weight of the A/N cans, exceeded his weight restrictions. He potentially lifted these cans, filled with scrap materials ranging from 32 to 88 lbs. Supervisors and engineering technicians reported seeing Mr. XX performing these duties as well as others without assistance prior to his last surgery in November 2010.

After November 2010, we did not identify any instances where Mr. XX completed a PX-2844. A supervisor reported that he found Mr. XX alone in a bay and cautioned him against violating his restrictions. Other personnel reported that Mr. XX continued to open the (b)(7)(f) doors, lift cans and move pallets. We were unable to corroborate these statements with direct evidence.

We conclude that from 2008 - 2010, management did not adhere to Mr. XX's medical restrictions. When he returned in July, 2011, it appears that management attempted to accommodate Mr. XX. However, IA noted seven instances where Mr. XX was assigned to work with Employee #1, who also had medical restrictions.

Lack of accommodations

Mr. XX had permanent medical restrictions as stated above. As he did not meet the functional requirements for his position (see Table 3 on p. 15), IA reviewed the work assignments to determine if there was someone

there to accommodate him. From July 2008 (date of permanent restrictions) until his last date of employment in August 2011, Mr. XX had 420 assignments in Bldg. 12-121 in different bays and work areas. An analysis of the daily stand-up meeting assignments forms (FX-4157) from this time period indicates that 60% of the time he was working alone (see Appendix D, "Mr. XX's Work Assignments").

We conclude that management did not provide appropriate accommodations for Mr. XX. While employees are ultimately responsible for protecting their health and abiding by their restrictions, management also is required to assign job duties that are consistent with their medical restrictions and to ensure that accommodations are effective.

Conclusion

We substantiate the allegations of management's disregard for medical restriction violations as discussed above.

Constant shuffling of MTC employees

Preface

The OIG letter provides the following examples:

- Since June/July 2011 (approximate) seven MTC employees were reassigned or had their employment terminated.
- One of the MTC employees was removed from Zone 12-121 after 15 years of excellent performance.

On October 27, 2011, management issued a memo stating that it was "necessary to make re-alignments to support the current production and surveillance workload" (see Appendix F).

Per management, one MTC employee asked to be moved. Three MTC employees were moved to support subassembly operations, and one was to support component disposition according to the memo. Another MTC employee had been removed from the HRP due to his close relationship with Mr. XX. The final MTC employee included in the group of seven retired in lieu of termination. He bypassed a safety control while machining (b)(7)(f)

Management adamantly denies the use of job assignments as a method of discipline. The former division manager stated, "Discipline is handled in conjunction with the Human Resources Department, using the constructive discipline process."

According to Article 7 of the MTC Articles of Agreement, management has the right to direct the "working forces." However, some of these changes were cause for concern for many of the MTC employees we interviewed.

Conclusion

We conclude that while employees were reassigned or forced to retire, management acted within their authority.

Less than adequate training

Preface

The OIG letter provides the following examples:

- Signing off on qualification sheets when the MTC employee has not received training from a qualified trainer.
- New hires being trained and placed on graveyard shifts while still on probation in violation of the MTC contract.
- Pieces of (b)(7)(f) being placed in the wrong waste containers due to inadequate training of new hires.

Unqualified trainer

Currently, in order to obtain qualifications on a piece of machining equipment in Building 12-121, the engineering technician must:

- Be knowledgeable of building and general safety-related requirements,
- Be familiar with machine operations,
- Perform work on mock items with trainer,
- Successfully complete 64 hours of machining mock/wax parts,
- Successfully complete a written exam, and
- Demonstrate proficiency in the operation of the equipment.

During our investigation, we interviewed the supervisor tasked with providing training to the new technicians. According to his interview, this supervisor has extensive machining experience, working as a machinist at Pantex for 13 years and teaching at a technical college and local high school for 19 years. However, by his own admission, he has never machined (b)(7)(f)

Several newly-qualified technicians reported that they had only received training from this supervisor prior to being certified. They also reported that the training was adequate and that they were ready to machine (b)(7)(f)

Based on his credentials, we conclude that the trainer is qualified to provide training on machine operations and general procedures. Additionally, training from a qualified technician with experience machining (b)(7)(f) might be beneficial.

MTC agreement violations

In the summer of 2011, an MTC employee approached management about implementing a night shift to help relieve the stress on the department. Four newly-qualified and two unqualified employees were placed on the graveyard shift starting June 20, 2011. These employees were still probationary employees until they had met the 18-week requirement. During interviews, technicians and supervisors raised concerns about these technicians machining (b)(7)(f) without the availability of experienced personnel to guide them if problems were encountered. One technician received his qualification just eight days prior to being placed on the graveyard shift. Although there were few senior qualified technicians available, one of the two supervisors manning the shift had over 25 years of experience working with (b)(7)(f) machining operations at Pantex. We were not aware of any incidents occurring during the time the shift was in operation.

Article 14, Section C of the MTC agreement states that newly hired Engineering Technicians for Manufacturing and Applied Technology Divisions will remain probationary employees until they receive their HRP certification and work in the job for which they were hired for eighteen (18) weeks. A probationary employee may exercise no seniority rights until he/she has completed the probationary period.

We did not identify anything in the MTC contract to support the allegation that placing probationary employees on the graveyard shift is a violation of the MTC contract.

Inadequate training on (b)(7)(f) waste disposal

One employee stated in his interview that he mistakenly labeled a waste container with the wrong hazard classification. He was unsure of which label to apply so he used the highest classification. Waste Operations caught the mistake and notified his supervisor. Following this notification, his supervisor informed him of his mistake and identified the correct label. During the interview, he stated that he was still unsure of the correct labeling/packaging process.

This technician successfully completed the computer-based training (b)(7)(f) n October 2010. One of the course's enabling objectives included onsite marking and labeling requirements for explosives. The course asked the student to interpret (b)(7)(f) labels. However, no instructions were given on how to identify the appropriate hazard classifications for the materials he/she may encounter. We concluded that this particular training was to be administered through his qualification training and required reading list.

The training class (b)(7)(f) refers the student to the Manufacturing Resource Planning Database (MRP) for guidance; however, (b)(7)(f) machinists do not use the MRP system. Further review of the technician's training revealed no additional training on the procedure providing (b)(7)(f) labeling guidance (b)(7)(f)

We confirm the allegation that an A/N can, containing explosives waste, was mislabeled due to inadequate training.

Conclusion

As a result of our review, we determined that engineering technician training may be improved. While the operator training appears to be appropriate for machine operations, it may be enhanced by the inclusion of a mentoring program on (b)(7)(f) machining instruction.

Although new technicians receive their qualifications to machine (b)(7)(f) they do not have any experience machining (b)(7)(f) While the current training prepares machinists for machine operations and working with mock/wax parts, additional formal training/mentoring from an experienced (b)(7)(f) machinist/trainer would enhance personnel competency in machining (b)(7)(f) The process is different from machining mock and wax. The tolerances, (b)(7)(f) composition, tooling, introduction of coolant and new procedures make the process more complex. This training/mentoring should be administered prior to the receipt of final qualification.

Retaliatory practices and a hostile work environment contributed to Mr. XX's suicide

Preface

The OIG letter provides the following:

- Multiple factors have contributed to a hostile work environment within Zone 12-121 at the Pantex Plant. Specifically, Metal Trades Council (MTC employees are expected to adhere to "Zero Tolerance" rules and Zone 12-121 managerial personnel are not held to the same standards. MTC employees are also reassigned or have their employment terminated for upsetting the Department or Section Managers (see "Supervisory misconduct and retaliatory practices").
- An inquiry into these concerns was performed by Babcock & Wilcox Pantex (B&W Pantex) during the period September through November 1, 2011, but no corrective action has been taken to date. Further, not all MTC employees were interviewed during the internal inquiry.
- The wrong people had their bars pulled during this inquiry...and some employees have still not been reinstated. As an example, one individual who worked for B&W Pantex for 36 years had his employment terminated while working for Zone 12-121 (see "Constant shuffling of MTC employees"). Another individual who worked for B&W Pantex for 26 years recently committed suicide while working in Zone 12-121 (see "Background," p. 1). Prior employees of Zone 12-121 have also 'bid-out' due to problems with managerial officials (see Supervisory misconduct and retaliatory practices").

Hostile work environment

In order to determine if hostility in the workplace existed in Building 12-121, we interviewed 37 exempt and MTC employees working in or having responsibility over the area. We were unable to substantiate the allegation of a hostile work environment; however, based upon our interviews, we identified common factors that contributed to union and non-union employees' dissatisfaction:

Supervisors' lack of interpersonal skills and experience/knowledge of the work being performed in Building 12-121 – Eleven MTC and managerial/exempt personnel indicated that some managers lacked interpersonal skills. Managerial officials teased and ridiculed their subordinates at times. Others stated that certain managerial officials lacked the technical background to direct the work of the (b)(7)(f) machinists/ inspectors.

Conflicts between management and union members – Thirteen MTC and managerial/exempt personnel indicated that there are often conflicts between management and union members. There appears to be a lack of trust between both groups. Management related concerns that union members look for ways to slow down production. Union members stated that management puts production over safety.

Conflicts and lack of coordination within management – Eight MTC and managerial/exempt personnel indicated that there were often conflicts within management about the schedule. Often first-line supervisors would direct work, only to be overridden. Priorities were set by authorized management and then changed by other management officials with differing agendas.

Schedule pressures/inadequacies – Eight MTC and managerial/exempt personnel indicated that the schedule was unrealistic; unachievable; did not account for equipment failures, set-up time, facility capacities, and other downtime; was not integrated with Manufacturing; and was not well-communicated to other managerial officials and engineering technicians. Add to this the fact that overtime must be approved and is controlled; therefore, in some cases, overtime may not be used to "catch up."

Supervisor pressures - Management did not indicate that pressure was placed on employees; however, six MTC employees reported that pressure was placed on them to obtain qualifications and perform work. It is anticipated that management will communicate priorities to employees; however, the methods utilized are important, especially considering the nature of the work these employees perform.

Facility/equipment problems – Eleven MTC and managerial/exempt personnel reported facility/equipment failures, making it difficult to meet schedules. They reported difficulties in getting Maintenance to respond to their concerns in a timely manner. Management would typically place a high priority on work orders. If there was not a timely response, they would bring the issues up in the Integrated Plan of the Day where production issues are highlighted.

In addition, maintenance personnel reported problems with rust in the water used in machining operations. While filtration systems keep most of the rust from affecting the product, the rust plays its toll on switches and instrumentation. Water pressure, computer breakdowns and equipment failures all affect the ability to perform work.

Lack of corrective actions

There were three investigations performed relating to the suicide of Mr. XX. We have included the conclusions from each one below:

1. The Suicide Investigation Report stated that its purpose was to provide known facts, analysis, and conclusions related to the death of Mr. XX. The scope of the report was limited to an analysis of Mr. XX's suicide within the context of the HRP program. The report concluded, "The underlying reason why [Mr. XX] committed suicide is unknown."

2. The "Inquiry Report on the Workplace Conditions Prior to [Mr. XX's] Suicide," included in the Suicide Investigation Report, concluded that there were no indications that Mr. XX 's restrictions, whether ignored or observed, were a factor in his suicide.

3. Employee Concerns and EEO conducted a review and limited investigation into four major issues involving the (b)(7)(f) Division:

   (1) employees are pressured or forced to work outside the boundaries of their medical restrictions; (2) there is an unsafe work environment (particularly with the group managed (b)(6) (3) employees do not feel free to raise safety concerns; (4) there is retaliation for raising safety concerns.

   Employee Concerns and EEO found no evidence to support the allegations.

We were unable to substantiate the allegations regarding the inquiry. Since all three investigations identified no findings, no corrective actions were taken.

With regard to interviews conducted during the internal inquiry, twelve technicians, (b)(6) and six managers were interviewed. These interviews were sufficient to accomplish the objectives, which were to supplement the facts, analyses and conclusions of the HRP suicide investigation.

Misuse of the HRP

The allegation that "the wrong people had their bars pulled during this inquiry" implies that the HRP was used punitively. The purpose of this program is to "... ensure that individuals who occupy positions that involve access to certain materials, nuclear explosive devices, facilities, and programs meet the highest standards of reliability and physical and mental suitability."[3] The program is not designed to be used as a human resource tool. We found no evidence of misuse of the HRP; therefore, we cannot substantiate this allegation.

Conclusion

We were unable to identify any retaliatory practices or substantiate the existence of a hostile work *environment that contributed to Mr. XX's suicide.*

[3] Glenn S. Podonsky, "Human Reliability Program," memo, June 22, 2010

Appendix A – Division manager letter

Excerpts from letter dated July 9, 2008 from AT division manager to AT managers

It is my expectation that non-qualified *individuals* cease and desist in performing any machining type work that normally and historically is *performed* by the "Engineer Technician-Machinist" *classification*. There will be no exceptions and therefore any and all "Engineering Technician-Machinist" work that is required to be performed must and will be *performed* only by qualified *Engineer Technician-Machinists* in accordance with the existing MTC contract. It is further expected that this requirement be complied with immediately and *also* clearly and concisely communicated to each of your non-exempt/exempt employees.

Appendix B – The Americans with Disabilities Act of 1990

Excerpts from the ADA

Sec. 12102. Definition of disability

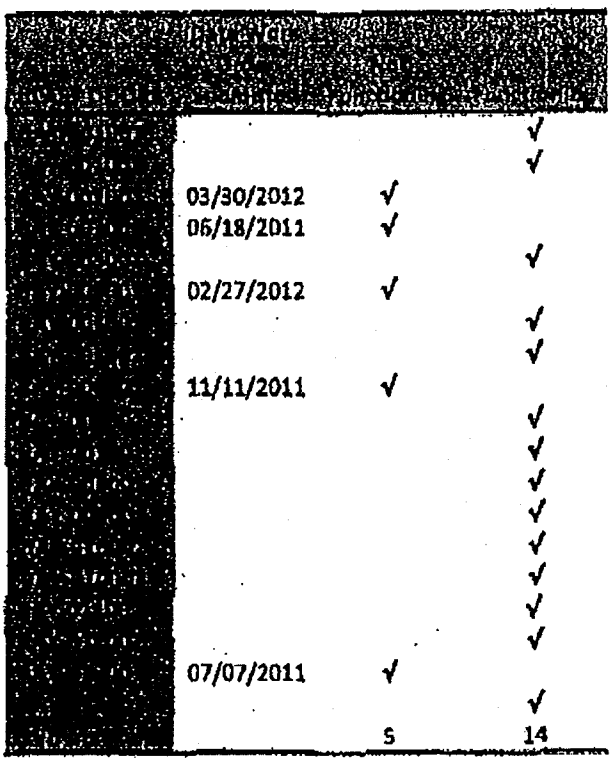
(1) Disability. The term "disability" means, with respect to an individual
(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;
(B) a record of such an impairment; or
(C) being regarded as having such an impairment (as described in paragraph (3)).
(2) Major Life Activities
(A) In general. For purposes of paragraph (1), major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
(3) Regarded as having such an impairment. For purposes of paragraph (1)(C):
(A) An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.
(B) Paragraph (1)(C) shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.

Sec. 12111. Definitions

Qualified individual. The term "qualified individual" means an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.
Reasonable accommodation. The term "reasonable accommodation" may include (A) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and (B) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.
Accommodations and services. Nothing in this chapter shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept.

Appendix C – Results of 12-121 hydraulic-assist test

Test conducted on April 4, 2012



		√
		√
03/30/2012	√	
06/18/2011	√	
		√
02/27/2012	√	
		√
		√
11/11/2011	√	
		√
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		√
		√
		√
		√
		√
07/07/2011	√	
		√
	5	14

Note: Management recently informed IA that all the doors have been repaired.

Appendix D – Summary of work assignments

Summary of Applied Technology Division Record of Stand-Up Meetings (PX-4457)

Mr. XX's Work Assignments
With/Without Assistance
July 2008 – August 2011

Work Assignment	Employee #1	No Assistance	Other Employees	Grand Total
2008		13	28	41
Bay 7		2	26	28
Bay 11		1		1
(b)(7)(f) Lathe		10	2	12
2009		139	47	186
Bay 3			1	1
Bay 7		132	25	157
Bay 7-3		4	2	6
Bay 7-11			1	1
Bay 9			1	1
Bay 11		3	10	13
Lathe			6	6
(b)(7)(f) Lathe-Bay 3			1	1
2010		92	56	148
Bay 3			1	1
Bay 7		45	52	97
Bay 11		2	3	5
Middle Lathe		10		10
(b)(7)(f) North Lathe		34		34
None		1		1

2011	7		28	35
Bay 5			2	2
Bay 6	1		1	2
Bay 6-8-13	2		1	3
Bay 6-8-13-Rm 145	2		4	6
Bay 8-Rm 145	1			1
Bay 11			2	2
Bay 13	1		1	2
Rm 145			2	2
None			15	15
Grand Total	7	244	159	410

Employee #1	2%
No Assistance	60%
Other Employees	38%
Total	100%

Employee #1's Work Assignments
With/Without Assistance
July 5th – August 23rd

Work Assignment	Mr. XX	No Assistance	Other Employees	Grand Total
2011				
Bay 13	1		1	2
Bay 6	1	1		2
Bay 6-13			1	1
Bay 6-8-13	2			2
Bay 6-8-13-Rm 145	2			2
Bay 8			3	3
Bay 8-13			3	3
Bay 8-Rm 145	1	2		3
Rm 145			1	1
None			17	17
Grand Total	7	3	26	36

Mr. XX	19%
No Assistance	8%
Other Employees	73%
Total	100%

Appendix E – Weights lifted by Mr. XX

Summary of PX-2844s - Inventory of container at waste accumulation site

Month/Year	Number of Cans	Monthly Average Weight (lbs)/Can*
SEP08	4	62
OCT08	2	68
NOV08	6	62
DEC08	4	48
FEB09	1	56
APR09	1	64
MAY09	1	65
JUN09	13	67
AUG09	7	68
SEP09	11	66
OCT09	12	65
NOV09	6	71
DEC09	2	60
JAN10	7	69
FEB10	2	65
MAR10	11	61
APR10	18	61
MAY10	6	60
JUN10	10	55
JUL10	2	69
AUG10	1	32
SEP10	2	47
Grand Total	129	63

*Includes A/N can weight of approximately 32.2 lbs. plus contents

Note: Weights varied from 32 – 88 lbs.

Appendix F – Department 840 realignments

Excerpts from department manager letter sent October 27, 2011

It is necessary to make re-alignments within Department 840 to support the current production and surveillance workload. Effective October 31, 2011 the following changes will be implemented:

1) (b)(7)(f) Pressing Section: We implemented two shifts in the pressing area to support production needs for the end of fiscal year 2010. We have hired nine new Engineering Technicians and sometime during this year when the new technicians become qualified we will return to two shifts. For now, we will return to one shift and [Manager #1] will be the day shift Production Section Manager (PSM) with the following technicians reporting to him: [Technician #1], [Technician #2], [Technician #3], and [Technician #4].

2) [Employee #1] has an extensive amount of experience in several areas of our operations. As a result, [Employee #1] will continue to report to [Department Manager] and will serve as a rotating PSM for our department. [Employee #1] will also help mentor the new supervisors in the areas of quality, inspections, and procedures.

3) (b)(7)(f) Machining & Inspection: [Technician #5] will be assigned to 12-121 to be trained as an inspector and lathe operator. [Technician#6] has been assigned to 12-121 to be trained as an inspector.

4) (b)(7)(f) Subassembly Operations: Building 12-32 has been modified and will be authorized to support additional workload in the (b)(7)(f) subassembly area. To support the expansion of these operations as well as the facility startup [Manager #2] will remain the PSM with the following technicians reporting to him: [Technician #7], [Technician #8], [Technician #9], [Technician #10], and [Technician #11].

5) Inert Machining: The current production schedule indicates an increase in component disposition activities. [Technician #12] will be assigned to Building (b)(7)(f) to support component disposition. [Technician #12] will report to [Manager #3]. As production demands fluctuate it may be necessary to cross train the Engineering Technicians and rotate within our various operations.

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