OFFICE OF INSPECTOR GENERAL

U.S. Department of Energy

INSPECTION REPORT

DOE-OIG-22-04

November 2021

ALLEGATIONS RELATED TO THE Y-12 NATIONAL SECURITY COMPLEX FIRE DEPARTMENT

Department of Energy
Washington, DC 20585

November 8, 2021

MEMORANDUM FOR ADMINISTRATOR, NATIONAL NUCLEAR SECURITY ADMINISTRATION

SUBJECT: Inspection Report on Allegations Related to the Y-12 National Security Complex Fire Department

The attached report discusses our review of allegations regarding the Y-12 National Security Complex Fire Department. This report contains three recommendations that, if fully implemented, should help ensure that the issues identified during this inspection are corrected. Management fully concurred with our recommendations.

We conducted this inspection from January 2020 through August 2021 in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*. We appreciated the cooperation and assistance received during this inspection.

Anthony Cruz
Assistant Inspector General
for Inspections, Intelligence Oversight,
and Special Projects
Office of Inspector General

cc: Deputy Secretary
Chief of Staff

Department of Energy
Office of Inspector General

Allegations Related to the Y-12 National Security Complex Fire Department
(DOE-OIG-22-04)

WHY THE OIG PERFORMED THIS REVIEW

The Office of Inspector General received an allegation and subsequent concerns regarding the Y-12 National Security Complex Fire Department (Fire Department). Complaints related to the work environment, disciplinary actions, beryllium training, security, structure-related training, escorting procedures, independence, response to complaints filed through Ethics and Employee Concerns, and confidentiality of medical information.

We initiated this inspection to determine the facts and circumstances regarding the allegations related to the Fire Department.

What Did the OIG Find?

Although we were unable to identify documentary evidence to substantiate that Fire Department management created a hostile work environment or fostered a fear of retaliation, our inspection revealed numerous concerns raised by Fire Department employees to Ethics and Employee Concerns dating back to 2015.

In addition, we substantiated the allegation that disciplinary actions and drug and alcohol testing in response to motor vehicle accidents were inconsistent. Of seven accidents reviewed, one individual did not receive disciplinary action, and in three accidents, individuals were not tested for drugs and alcohol.

Finally, we did not substantiate the allegations related to beryllium training, security of the Fire Department Alarm Room, structure-related training, escorting procedures in the Fire Department Alarm Room, Ethics and Employee Concerns complaint processing, and confidentiality of medical information.

What Is the Impact?

Addressing these concerns is vital to ensuring that Fire Department employees do not fear retaliation and harassment for reporting violations. In addition, a consistent response to motor vehicle accidents could eliminate concerns raised that Fire Department employees are being singled out, harassed, and retaliated against.

What Is the Path Forward?

To address the issues identified in this report, we have made three recommendations that, if fully implemented, should help ensure that issues identified during our inspection are corrected.

BACKGROUND

The Y-12 National Security Complex (Y-12) in Oak Ridge, Tennessee, is one of six production facilities in the National Nuclear Security Administration's (NNSA) Nuclear Security Enterprise. Y-12 specializes in processing and storing uranium and developing technologies associated with those activities. Since July 2014, Y-12 has been managed and operated by Consolidated Nuclear Security, LLC (CNS) under Contract No. DE-NA0001942. Y-12 spans 811 acres and employs more than 4,700 Federal and contractor staff, which includes approximately 90 employees of the Y-12 Fire Department (Fire Department).

In November 2019, the Office of Inspector General Hotline received a complaint regarding the Fire Department. Specifically, the complainant's allegations included a hostile work environment at the Fire Department, including retaliation for filing grievances or complaints, inconsistent application of disciplinary actions, inadequate security of the Fire Department Alarm Room (FDAR), insufficient structure-related training, and a lack of independent response to complaints filed through Ethics and Employee Concerns (E&EC). Due to the seriousness of these allegations, we interviewed an additional 22 current and previous Fire Department employees. Those interviews provided additional concerns related to beryllium training, escorting procedures in the FDAR, and the confidentiality of medical information.

We initiated this inspection to determine the facts and circumstances regarding the allegations related to the Fire Department.

CONCERNS RELATED TO FIRE DEPARTMENT WORK CLIMATE

Although we were unable to identify documentary evidence to substantiate that Fire Department management created a hostile work environment or fostered a fear of retaliation, our inspection revealed numerous concerns expressed during our interviews and raised by Fire Department employees to E&EC dating back to 2015. At the time of our interviews, 21 individuals were current Fire Department employees and 2 were previous employees. We found 15 interviewees expressed concerns with the work climate. Specifically, it was alleged that Fire Department management showed favoritism to some employees while harassing others, created a hostile work environment, threatened to fire anyone that did not do as they were told, and threatened to remove raises or retaliate against employees if complaints were filed. One individual we interviewed refused to discuss the work environment with us because of fear of retaliation. Additionally, we identified concerns related to harassment, retaliation, and hostile work environment that were raised to E&EC from March 2015 through January 2018.

After E&EC conducted its reviews, the E&EC Manager stated there was not enough evidence to substantiate the claims of harassment, retaliation, or a hostile work environment. Although E&EC officials were unable to substantiate these concerns, the E&EC Manager stated that the officials held discussions with Fire Department management on areas of improvement when these types of concerns were raised. Despite the discussions led by E&EC officials, allegations of harassment, retaliation, and a hostile work environment have persisted.

As a result, employees who fear retaliation and harassment for filing complaints are less likely to do so, creating an atmosphere that threatens the safety and security of personnel, as well as the protection of Department of Energy property. This could lead to a detrimental impact on Federal and contractor employees and the public's opinion of the Department. According to CNS procedure, *Ethics and Business Conduct*, managers and supervisors are responsible for promoting a work environment that encourages questions and concerns regarding business ethics to be raised without fear of retaliation.

RESPONSE TO VEHICLE ACCIDENTS WAS INCONSISTENT

We substantiated the allegation that disciplinary actions and drug and alcohol testing in response to motor vehicle accidents were inconsistent. Specifically, it was alleged that a Fire Department employee who was involved in a motor vehicle accident was not tested for drugs and alcohol and did not receive any disciplinary action, while two other Fire Department employees who had accidents were tested and disciplined. We confirmed that the one individual did not receive disciplinary action after a preventable vehicle accident and was not tested for drugs and alcohol. A Labor Relations official stated that individuals in accidents determined to be preventable should receive disciplinary action. In addition, an NNSA Production Office (NPO) safety and industrial hygiene official told us that drug and alcohol testing was required while two CNS officials stated that all operators received drug and alcohol testing. However, we found that there are no Department or contractor policies or procedures that require testing after an accident, and CNS had conflicting policies related to who was responsible for making the determination whether drug and alcohol testing was necessary. For the other two individuals noted above, both had preventable accidents and received disciplinary actions; however, for one of the accidents, the individual was not tested. We identified two additional preventable accidents that occurred during the scope of our review but were outside of the complaint. We determined that while both individuals received disciplinary actions, one of the two was not tested for drugs and alcohol.

We confirmed that disciplinary action was not administered in response to the accident identified in the allegation. CNS officials stated that disciplinary action was not issued because neither Labor Relations nor the Fire Department were provided the investigation report from Safety and Industrial Hygiene, which would have dispositioned the accident as preventable and prompted Labor Relations to follow up with the supervisor to advise them on discipline. We obtained a copy of the report but found no evidence that it was provided to Labor Relations or Fire Department management. Regardless, Labor Relations was notified about the accident once it occurred, and Fire Department management was aware of the accident because the Fire Chief was involved in the post-accident walkdown of the site to determine how it could have been prevented. However, there is no evidence that either Labor Relations or Fire Department management followed up with Safety and Industrial Hygiene regarding the report to determine whether appropriate disciplinary action needed to be taken. Considering the infrequent occurrence of accidents and the substantial damage to the vehicle, it would have been reasonable for the supervisor to follow up. CNS procedure, Y11–415, *Employee Discipline*, states that the supervisor is responsible for determining whether a disciplinary action is warranted and consulting with Labor Relations to verify the appropriate level of disciplinary action and consistency in application.

Of the seven accidents reviewed, three of the vehicle operators were not tested for drugs and alcohol while the other four were tested. CNS had conflicting policies related to who was responsible for determining whether drug and alcohol testing was necessary. CNS procedure, Y73–008, *Y-12 Motor Vehicle Safety Program,* states that Labor Relations determines if a post-incident drug test is necessary for Y-12 employees. The Labor Relations Manager stated that he was unaware the policy states this and noted that Labor Relations does not, nor do they have the authority to, direct an individual to complete drug and alcohol testing. CNS provided another procedure, Y11–411, *Drug Control Program-Illegal Drugs,* which states that the Designated Employer Representative is responsible for determining whether a test is required. The current Designated Employer Representative is the Drug and Alcohol Program Coordinator in Occupational Health and Safety. The Labor Relations Manager acknowledged there are conflicting policies that need to be addressed.

Consistency in drug and alcohol testing and disciplinary actions in response to motor vehicle accidents could eliminate concerns raised that Fire Department employees are being singled out, harassed, and retaliated against.

Incomplete Motor Vehicle Accident Documentation

During our review, we determined that vehicle accident documentation is not maintained in a manner that would provide a complete record of all accidents involving Fire Department employees. Based on our request for information for all accidents from July 2014 through August 2020, CNS provided a spreadsheet that identified four accidents involving Fire Department personnel. We determined there were three more accidents not included in the original spreadsheet. Specifically, we identified two accidents by reviewing disciplinary actions taken and another accident based on email reviews.

In addition, an NPO official stated that he did not maintain a database to track vehicle accidents. The CNS official in charge of inputting data into the SharePoint database that maintains the motor vehicle accident documentation stated that the responsibility to update and track those files has changed departments and individuals; therefore, he was unable to determine why all files were not included in SharePoint. As a result, the CNS SharePoint database did not provide accurate accountability for retrieving data involving Government-owned vehicles involved in motor vehicle accidents.

OTHER ALLEGATIONS

We did not substantiate the allegations related to beryllium training, security of the FDAR, structure-related training, escorting procedures in the FDAR, E&EC complaint processing, and confidentiality of medical information.

Material Exposure Training

We did not substantiate the allegation that a former Y-12 firefighter on the day shift did not complete beryllium training. Although Fire Department management confirmed the individual was on the day shift when beryllium work is typically performed, the individual was not enrolled

in the active worker program and, therefore, had not completed the training associated with that program. Fire Department management stated that although the individual did not conduct work that required the training, the individual maintained beryllium training requirements under another beryllium associated worker program.

Security of Fire Department Alarm Room

We did not substantiate the allegation that the security of the FDAR was compromised due to removing the lock. After discussions with the Y-12 Safeguards and Security Manager, we found no indications that the removal of the FDAR lock violated Department or contractor policy. The Manager told us that a safety concern raised by one of the Fire Department's rotating shift battalion chiefs instigated the lock removal. The Manager also indicated that the assigned operator on one of the shifts had returned to work following a medical condition and that the Battalion Chief was uncomfortable with the operator being alone behind a locked door at night. The Manager stated that security requirements were reviewed by Safeguards and Security, and it was determined that there was no requirement for the FDAR door to be locked.

The Y-12 Safeguards and Security Manager also confirmed that the FDAR is defined as a Control Area by CNS procedure, Y14–001, *Conduct of Operations*, and as such, it does not require a lock—only a clearly defined and marked boundary. Additionally, the Manager explained that a Control Area established under Y14–001 is not defined as a security area in Department Order 473.3A, *Protection Program Operations*; therefore, no risk assessment was required as a result of the lock removal. The NPO Fire Protection Program Manager confirmed that locking a Control Area is not a requirement. Although aware that the lock was removed, he did not perform a review or provide written approval since he determined it was not required.

Structure-Related Training

We did not substantiate the allegation that firefighters received insufficient training because training was based on residential-type structures (i.e., municipal) rather than structures in an industrial setting. An official with the Department's Office of Environment, Health, Safety and Security stated that due to variations in materials and locations, the intent behind DOE Standard 1066–2016, *Fire Protection*, is that each Department location conduct a Fire Hazard Analysis to identify on-site risks. The Office of Environment, Health, Safety and Security official noted that according to information in that analysis, each site was to create a Baseline Needs Assessment that identifies training and equipment needed for that location. The Office of Environment, Health, Safety and Security official also stated that because there were so many different variables, DOE Standard 1066–2016 was written to direct each site to create its own specific requirements in the Baseline Needs Assessment. The NPO Fire Protection Engineer who reviewed and recommended approval of Y-12's Baseline Needs Assessment stated that the Baseline Needs Assessment addressed the issue of no specific industrial standard for emergency responses. In fact, the assessment utilized the National Fire Protection Association 1710, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*, which

the DOE Standard 1066–2016 cites as one of the applicable standards for determining the minimum number (i.e., baseline) of trained firefighters necessary to begin interior structural firefighting.

We also reviewed nine internal NPO operational awareness assessment reports conducted from April 2016 through July 2020 and the Office of Enterprise Assessments *Targeted Review of the Fire Protection Program at the Y-12 National Security Complex and Pantex Plant* report issued in January 2016. None of the reports had findings or observations concerning inadequate or inappropriate site-specific training.

Escorting Procedures in Fire Department Alarm Room

We did not substantiate the allegation that the alarm room operator was incapable of providing the required attention to perform escort duties or that uncleared employees were being escorted without the proper escort agreements. According to CNS procedure, Y19–023, *Physical Protection Manual,* escorts may perform tasks beyond their escort duties if they maintain visual contact with personnel being escorted and remain in a position to observe their movements. Additionally, we reviewed emails from Safeguards, Security, and Emergency Services to the Fire Department for each escort agreement authorizing a one-to-one ratio for FDAR alarm room operators escorting individuals who do not have the appropriate security clearance. We also reviewed FDAR activity logs for the timeframe when alleged escorting issues occurred and determined there was no evidence that a violation of the one-on-one working method existed.

CNS Ethics and Employee Concerns Complaint Processing

We did not substantiate the allegations related to the independence of E&EC reviews and the lack of documentation provided to the complainant after E&EC closed the complaint. Specifically, some Fire Department employees feared filing concerns because they alleged that the previous Internal Audit, Ethics, and Employee Concerns Director (who left CNS in December 2017) was friends with the Fire Chief and any complaints would be provided to the Fire Chief. The E&EC Manager stated that the previous Director recused himself from all allegations related to the Fire Department as well as making CNS senior management aware of the conflict. We obtained both the conflict of interest form from 2016 and an email that the previous Director sent to various individuals within the company in 2013 disclosing the relationship. In our review of the complaint documentation, we did not identify the former Director's name to demonstrate personal involvement in the reviews nor did we identify any documentary evidence that communications between the Fire Chief and previous Director occurred. The Fire Chief confirmed that he was friends with the former Director but stated that the two never discussed any complaints.

Additionally, we did not substantiate the allegation that when an individual asked for documentation related to the closure of a complaint, E&EC did not provide the investigation's conclusion in writing. E&EC personnel stated that they spoke to the complainant to provide conclusions, but documentation was not provided. CNS procedure, E-PROC-3079, *Employee*

Concerns Program, states that E&EC can contact the individual who raised a concern to provide feedback on the review, results, and corrective action, as appropriate; however, it does not require that information be provided in written form.

Confidentiality of Medical Information

We did not substantiate the allegation that confidential medical information was being shared by Y-12 medical personnel with Fire Department management. A firefighter alleged that the certified trainer who conducts health risk assessments for firefighters reported the results to Fire Department management. The Division Chief in charge of health and wellness for the Fire Department stated that firefighters complete health risk assessments for two reasons: (1) as an annual requirement, or (2) in response to a firefighter failing to pass the annual Fit for Duty test, which is used to determine a firefighter's ability to perform essential job functions. The Division Chief and the certified trainer stated that when an employee completes the annual health risk assessment, only the certified trainer and the employee know the results. If an individual fails the annual Fit for Duty test, the individual is provided the option to utilize the CNS certified trainer during the workday to prepare for and retake the Fit for Duty test. A health risk assessment is completed monthly while participating in physical training sessions.

To determine what constitutes a violation of the *Health Insurance Portability and Accountability Act of 1996*, we received assistance from the Office of Inspector General's General Counsel, which was unable to find a direct violation due to the nature of the duty description for firefighters. Specifically, Title 29 Code of Federal Regulations 1630.14, *Medical Examinations and Inquiries Specifically Permitted*, states, "A covered entity may require a medical examination of an employee that is job-related and consistent with business necessity." United States Department of Health and Human Services Summary of the *Health Insurance Portability and Accountability Act of 1996* Privacy Rule states, "Covered entities may disclose protected health information to employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration."

RECOMMENDATIONS

We recommend that the Administrator, NNSA:

1. Conduct an independent assessment of the Fire Department's culture and the specific concerns raised in this report and develop and implement an action plan to support an environment where Fire Department personnel did not fear raising concerns to management.

We recommend that the Administrator, NNSA, work with CNS to:

2. Update roles and responsibilities outlined in procedures when responding to motor vehicle accidents to ensure a thorough and consistent process.

3. Establish a single location for storing motor vehicle accident documentation that allows the NPO and contractor to retrieve a complete set of information.

MANAGEMENT RESPONSE

Management concurred with all three recommendations and stated proposed actions will be completed no later than May 31, 2022. In addition, Management stated NNSA takes the reported concerns relating to the workplace culture seriously and is committed to fostering an environment free from the fear of retaliation.

Management comments are included in Appendix 3.

INSPECTOR COMMENTS

Management's comments and corrective actions are responsive to our recommendations.

OBJECTIVE

We initiated this inspection to determine the facts and circumstances regarding the allegations related to the Y-12 National Security Complex Fire Department (Fire Department).

SCOPE

The inspection was performed from January 2020 through August 2021. Our scope period was from July 2014, when Consolidated Nuclear Security, LLC (CNS) became the management and operating contractor, through August 2020. We conducted the inspection at the Y-12 National Security Complex in Oak Ridge, Tennessee. The inspection was conducted under Office of Inspector General project number S20DN008.

METHODOLOGY

To accomplish our inspection objective, we:

- Reviewed Federal and Department of Energy regulations and National Nuclear Security Administration and contractor policies and procedures;
- Held discussions with Department, National Nuclear Security Administration's National Production Office, and CNS personnel with subject matter expertise in the inspection areas;
- Reviewed training and certification requirements related to beryllium and compared those to the training records of a Fire Department firefighter;
- Reviewed prior Ethics and Employee Concerns complaints submitted to the Office of Inspector General Hotline, National Production Office, and CNS;
- Reviewed security requirements related to the Fire Department Alarm Room and the actions taken to remove the electronic door lock;
- Reviewed all escort agreements from 2015 through 2019 and associated communication related to the escorting of uncleared personnel in the Fire Department Alarm Room;
- Interviewed CNS personnel responsible for conducting the annual Health Risk Assessment and reviewed email communications related to the release of protected medical information; and
- Reviewed all motor vehicle accident reports and disciplinary actions taken against Fire Department personnel.

We conducted our inspection in accordance with the *Quality Standards for Inspection and Evaluation* (January 2012) as put forth by the Council of the Inspectors General on Integrity and Efficiency. We believe that the work performed provides a reasonable basis for our conclusions.

Management officials waived an exit conference on October 13, 2021.

Office of Inspector General

- Audit Report on *Followup Audit on Chronic Beryllium Disease Prevention Programs at Oak Ridge Sites* (OAI-L-16-15, September 2016). The report states that although we did not identify any material weaknesses with the Chronic Beryllium Disease Prevention Programs at Oak Ridge sites, we noted that implementation of some corrective actions from our previous reports were either initially ineffective or incomplete. Additionally, the Y-12 National Security Complex's beryllium information database had not been maintained and the website replacement for the database did not contain maps of all beryllium-associated facilities. While not required, these maps are important because they allow workers diagnosed with beryllium sensitivity, chronic beryllium disease, or those who wish to minimize the possibility of beryllium exposure, to know which areas to avoid. The maps could also potentially help minimize beryllium exposure for personnel responding to an emergency by alerting them to the need to wear personal protective equipment. Y-12 National Security Complex personnel told the auditors that it planned to add the rest of the beryllium-associated facilities maps to the website. The database was intended to provide a single repository of beryllium information to identify contaminated locations for management and workers. The report suggests that Y-12 National Security Complex consider updating and maintaining its beryllium information website to include maps of all unclassified beryllium-associated facilities. In addition, the report also suggests that Oak Ridge National Laboratory consider taking additional action to ensure beryllium-associated workers receive training as required by Title 10 Code of Federal Regulations 850, *Chronic Beryllium Disease Prevention Program*.

U.S. Government Accountability Office

- Audit Report on the *Department of Energy Whistleblower Protections Need Strengthening* (GAO-16-618, July 2016). The report finds that the Department has used a combination of independent reviews and contractor self-assessments to evaluate the openness of the environment for raising safety and other concerns. The independent reviews, which were methodically sound and consistently applied, reveal problems with the environment for raising concerns. In contrast, many self-assessments use flawed and inconsistent methodologies and overstate the openness of the environment. Therefore, the Department cannot judge the openness of its environment or ensure that appropriate action is taken in response to evaluation results. Factors that may have limited contractor employees from raising concerns and seeking whistleblower protections were finding the whistleblower program difficult to navigate and concerns about anonymity. In addition, the Department has infrequently used its authority to enforce policies that prohibit retaliation and has taken little action to hold contractors accountable for creating a chilled work environment. The Department's reluctance to hold contractors accountable may diminish contractor employee confidence in mechanisms for raising concerns and seeking whistleblower protection. Management concurred with five of the six recommendations including that the Department conduct independent assessments of the environment for raising concerns, expedite timeframes for clarifying regulations, and clarify policies to hold contractors accountable. Management nonconcurred with the recommendation to fully evaluate the extent to which the pilot has been implemented and whether the

provisions of the pilot will mitigate challenges associated with the Department's existing program but outlined steps it would take that are consistent with an aspect of the recommendation.

Department of Energy
Under Secretary for Nuclear Security
Administrator, National Nuclear Security Administration
Washington, DC 20585

October 5, 2021

MEMORANDUM FOR TERI L. DONALDSON
INSPECTOR GENERAL

FROM: JILL HRUBY

SUBJECT: Response to the Office of Inspector General Draft Report *Allegations Related to the Y-12 National Security Complex Fire Department* (S20DN008)

Thank you for the opportunity to review and comment on the subject draft report. NNSA appreciates the inspectors' independent review of the facts and circumstances around the reported allegations regarding the Fire Department at the Y-12 National Security Complex. While most of the allegations were not substantiated by the inspectors, NNSA takes the reported concerns relating to the workplace culture seriously and is committed to fostering an environment free of the fear of retaliation. NNSA will further review the specific concerns raised in this report and take any actions deemed necessary to ensure a workplace culture within the Y-12 Fire Department that is consistent with NNSA's values.

Detailed responses to each recommendation are included in the attached management decision. Our subject matter experts have also provided technical comments under separate cover for the inspectors' consideration to enhance the accuracy of the report. If you have any questions regarding this response, please contact Mr. Dean Childs, Director, Audits and Internal Affairs, at (301) 903-1341.

Attachment

Attachment

NATIONAL NUCLEAR SECURITY ADMINISTRATION
Management Decision

*Allegations Related to the Y-12 National Security Complex Fire Department (*S20DN008*)*

The Office of Inspector General (OIG) recommended that the National Nuclear Security Administration (NNSA):

Recommendation 1: Conduct an independent assessment of the Fire Department's culture and the specific concerns raised in this report, and develop and implement an action plan to support an environment where Fire Department personnel do not fear raising concerns to management.

Management Response: Concur. NNSA will work with the OIG to better understand the specific allegations and concerns raised regarding the Fire Department's culture. Using the specific allegations as a basis, NNSA will then conduct an independent assessment and based on the results of the assessment, work with the contractor to identify and implement actions deemed necessary to improve the Fire Department's culture. The estimated completion date for the assessment and corrective actions is May 31, 2022.

Recommendation 2: Work with Consolidated Nuclear Security, LLC (CNS) to update roles and responsibilities outlined in procedures when responding to motor vehicle accidents to ensure a thorough and consistent process.

Management Response: Concur. The NNSA Production Office (NPO) will work with CNS to update procedures to clarify roles and responsibilities when responding to motor vehicle accidents. The estimated completion date for this action is March 30, 2022.

Recommendation 3: Work with CNS to establish a single location for storing motor vehicle accident documentation that allows the NPO and contractor to retrieve a complete set of information.

Management Response: Concur. NPO will work with CNS to establish a single location for storing motor vehicle accident documentation that is retrievable by NPO and contractor personnel. The estimated completion date for this action is December 31, 2021.

FEEDBACK

The Office of Inspector General has a continuing interest in improving the usefulness of its products. We aim to make our reports as responsive as possible and ask you to consider sharing your thoughts with us.

Please send your comments, suggestions, and feedback to OIG.Reports@hq.doe.gov and include your name, contact information, and the report number. You may also mail comments to us:

Office of Inspector General (IG-12)
Department of Energy
Washington, DC 20585

If you want to discuss this report or your comments with a member of the Office of Inspector General staff, please contact our office at 202–586–1818. For media-related inquiries, please call 202–586–7406.