

Testimony of OSHA Oversight of State Plan Enforcement

By

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Introduction

I am Franklin E. Mirer, Professor of Environmental and Occupational Health in the Urban Public Health Program, Hunter College, City University of New York.

However, most of my career was spent living in and representing workers in a state plan state, Michigan on behalf of the United Auto Workers. I served on the advisory committee to the Michigan Health Standards Commission, which votes standards for Michigan OSHA. I directed UAW staff who served on the actual standards commissions. By agreement with Michigan OSHA, I received and reviewed every citation issued in UAW represented facilities, and all notices of contest. By agreement with OSHA, I also received many citations notices of contest for UAW represented facilities in these jurisdiction. I have directed staff in numerous OSHA and state OSHA contests and settlement discussions. I personally was involved in negotiating and implementing the OSHA companywide settlement agreements on ergonomics in all three the auto companies. I also participated in the OSHA-Ford-Visteon partnership, which included a major state plan component.

My academic project is extracting from this experience the lessons for future policy in occupational safety and health.

This hearing offers a window into the world of inspection, citation, employer contest and abatement. This is where the rubber meets the road for occupational safety and health compliance. It also reminds us that in 20 states, 46 million private sector employees must rely on state agencies rather than federal OSHA for protection at work. And for state and local public employees, state laws in the states that chose to adopt them, administered by state agencies are the only means of protection. So our nation's health and safety outcomes depend on more than federal OSHA.

We are here because of a series of fatalities in a high profile location – Las Vegas, Nevada - received attention because of the efforts of courageous families and a moving series of newspaper reports. The fatalities were suffered by workers maintaining or building structures for a rich and visible industry. The product of oversight hearings should be a system for correcting situations which don't rise to the public eye.

The OSHA report, and the press reports, depict failures of enforcement and the enforcement process in the Nevada state plan. After a tragic injury, a slow investigation, a modest penalty, an employer contest or threatened contest, a reduced penalty, family and employees not involved in the investigation and settlement. And, uncertain abatement. Unfortunately, these are common faults in our safety and health system.

Federal OSHA can take this opportunity to improve its oversight of state plans. Hopefully, state plan administrators will take this opportunity to address improvements in their agencies. Congress should consider legislative needs where legislation is needed to improve Federal oversight.

My testimony will address four matters: the importance of enforcement in the system of safety and health protections; the history and rationale for state plan enforcement; the faults revealed by the OSHA review of the Nevada plan; general issues with enforcement, whether state or federal; and, issues to consider going forward.

Importance of enforcement in the system of safety and health protections.

Enforcement – inspections, citations, penalties and prosecutions are essential to safety and health protection. In our society, lack of consequences for violating a law signals that we – the citizens of the United States - don't care about that law, or the victims of its violations. In my experience, a violation with an inappropriate low penalty is undermines compliance more than no violation at all. This signal is equally an obstacle for workers, and for health and safety professionals employed by management, in getting hazards abated. Always, but especially in times of economic crisis, management wants to know what it has to do, not what it ought to do. The importance of enforcement of standards for workers may seem obvious. I know, from years of experience in labor management discussions, and implementation of joint health and safety programs, that it's important for management that wants to do the right thing.

Enforcement effectiveness is a combination of frequency of inspection, targeting of inspections on high exposure workplaces, degree of certainty of citation, gravity and penalty, and assuring abatement.

When it comes to job safety enforcement and coverage, it is clear that federal and state OSHA combined lack sufficient resources to protect workers. The combination of too few OSHA inspectors and low penalties makes the threat of an OSHA inspection hollow.

In FY 2008, at most 2,043 federal and state OSHA inspectors were responsible for enforcing the law at approximately eight million workplaces.

In FY 2008, the 799 federal OSHA inspectors conducted 38,652 inspections and the 1,244 inspectors in state OSHA agencies combined conducted 57,720 inspections. At current staffing and inspection levels, it would take federal OSHA 137 years to inspect each workplace under its jurisdiction just once.

The current level of federal and state OSHA inspectors provides one inspector for every 66,258 workers. This compares to a benchmark of one labor inspector for every 10,000 workers recommended by the International Labor Organization for industrialized countries.

Federal OSHA's ability to provide protection to workers has greatly diminished over the years. Since the passage of the OSHAct, the number of workplaces and number of workers under OSHA's jurisdiction has more than doubled, while at the same time the number of OSHA staff and OSHA inspectors has been reduced. In 1975, federal OSHA had a total of 2,405 staff (inspectors and all other OSHA staff) and 1,102 inspectors responsible for the safety and health of 67.8 million workers at more than 3.9 million establishments. At the peak of federal OSHA staffing in 1980, there were 2,951 total staff and 1,469 federal OSHA inspectors (including supervisors). In 2008, there were 2,147 federal OSHA staff responsible for the safety and health of more than 135.3 million workers at 8.9 million workplaces. The ratio of OSHA inspectors per one million workers was 14.9. The number of employees covered by federal OSHA inspections was 1.4 million in FY 2008. In 1992, federal OSHA could inspect workplaces under its jurisdiction once every 84 years, compared to once every 137 years at the present time.

In FY 2008, the average hours spent per inspection was 9.7 hours per safety inspection and 34.9 hours per health inspection.

Penalties for significant violations of the law are low. In FY 2008, serious violations of the OSHAct carried an average penalty of only \$921 (\$960 for federal OSHA, \$872 for state OSHA plans). A violation is considered "serious" if it poses a substantial probability of death or serious physical harm to workers.

Federal OSHA issued 497 willful violations in FY 2008. The average penalty for a willful violation in FY 2008 was \$41,658. The average penalty per repeat violation was \$4,077 in FY 2008. In the state plan states, in FY 2008, there were 182 willful violations issued, with an average penalty of \$28,943 and 2,367 repeat violations with an average penalty of \$2,021 per violation.

History of State Plans: State plans were a compromise in the passage of the OSHA Act in 1970. As safety and health protection evolved, the importance of differing issues compromised changed. Coverage of public employees has emerged as a major value of state plans.

Formation of state plans was among the central political and policy issues during the Congressional debate on the Occupational Safety and Health Act and the early days of OSHA. Controversies arose in several states over whether state jurisdiction was a good idea. State plans were approved for as many as 28 states. Eight states subsequently withdrew, reverting to federal enforcement. California at one point withdrew, reverting to federal enforcement, and then revived the plan after a referendum directing that the state plan be restored was supported by the majority of California voters.

The OSHA law was passed because of perceived shortcomings of the state based safety and health enforcement and standards system which preceded. This included weak enforcement by state agencies. Section 18 of the OSHA law should be viewed as a compromise reached in the 91st Congress.

Proponents of state plan enforcement argued that these state agencies were closer to the ground than federal OSHA would be. Proponents argued that laws parallel to the OSHA law adopted at the state level would be better than the old state laws and would permit the agencies to do a better job. The states would have to pay half the cost of enforcement, matched by the federal government, therefore expanding resources. States might promulgate more effective standards than OSHA, or innovate requirements such as safety and health programs.

Proponents of federal enforcement argued that a new attitude from the ground up in a new agency was needed. A federal system would level the playing field between states, so that auto workers (and management) in Tennessee could expect the same treatment as those in Ohio. Leveling the playing field would mean that management couldn't seek to locate facilities in states with weaker enforcement. Federal OSHA proponents also felt that business influence in a state, especially the influence of corporations or industries with major facilities in a state, would have more control over a localized agency than over the federal government.

The compromise agreed to by the Congress in enacting the OSHAct was the establishment of a federal system of protections and worker rights backed up by a common system of enforcement and penalties. States were permitted to participate as partners and exercise jurisdiction if they established state safety and health plans that provided for standards and enforcement that were at least as effective as the federal OSHA program. States were also required to cover public employees under their laws and to participate in national injury and illness reporting programs. Federal OSHA was given the responsibility to review and approve the state plans and to monitor them on an ongoing basis to ensure that they were performing as required by the law. As part of the partnership arrangements, the OSHAct provided for the federal government to provide up to 50 percent of the funding for the state plans.

Since the 1970's, two other issues emerged, one a disadvantage of state enforcement, the other an advantage. Regarding enforcement, state plans would be unable to reach beyond their borders to coordinate enforcement to influence management which had facilities in other states. Corporate-wide settlement agreements and partnerships both

would have to be implemented and monitored separately in each state jurisdiction. The example below, the explosion at CTA Acoustics in Corbin, KY in 2003 illustrates the opportunities which may be lost by not expanding beyond state borders.

On the other side, state plans were required to provide protection to state, county and municipal employees. These employees represent a large sector of the economy in which federal OSHA was forbidden to tread. Four federal enforcement states have instituted public employee-only state plans. In the remaining federal enforcement states, public employees are unprotected.

Enforcement Statistics Reveal Important Areas For Improvement for both State Plans and for OSHA.

Enforcement statistics are dry and complicated, but they are process measures for a safety and health agency which may measure quality as well. In terms of quality control, the output of a safety and health agency is hazards identified and hazards abated. Citations can be taken as enumerating the hazards identified. The gravity of the citation should be related to the gravity of the hazard. Lower proportions of higher gravity citations between jurisdictions may indicate deviating definitions of gravity, a different spectrum of workplaces observed, or deficiencies in investigative techniques.

The attached chart compares the Nevada State Plan, State Plans in total, and Federal OSHA enforcement. In my opinion, both state plans and OSHA are deficient.

In summary, compared to OSHA, state plans in general issue fewer citations classified as higher gravity, including serious, willful, failure to abate and repeated. Total penalties assessed are significantly lower for state plans than federal OSHA, despite a greater number of citations. Despite lower gravity and penalties, more citations are contested among state plans than federal. By contrast, state plans conduct more inspections, and issue more citations classified as "other than serious." State plans employ more numerous staff than OSHA, compared to the workforce covered. State CSOs conduct more inspections than their OSHA counterparts.

The obvious questions for quality improvement are:

Why do state plans appear to classify violations as lower gravity with lower penalty than federal OSHA?

Why does federal OSHA appear less productive in terms of inspections and total citations?

Personally, I see no trade off between gravity and productivity.

Explaining the differences in these statistics would be enhanced by generating the enforcement results for inspections in construction, general industry safety, general industry health, and public sector separately.

In addition, it will be very important for additional methods for assessing productivity to be applied. Health inspections, especially those involving air sampling, take longer than safety (injury control) inspections. Allowance should be made. A separate metric should be applied to construction inspections which typically count multiple contractors at the same site as multiple inspections.

Performance measures for Nevada Appear Outside the System

The most striking deviation by Nevada was the absence of willful citations in 2008, noted by the OSHA report. The proportion of willful violations for state plants combined was also about ¼ that for federal OSHA (N = 0, S= 0.3%, F = 1.3%). The fraction of higher gravity, combining willful, repeated and failure to abate was lower (N = 2%, S= 5%, F = 9%) These were less than half the proportion for states combined and less than ¼ the proportion for federal OSHA. The fraction of serious violations was also lower (N = 29%, S= 44%, F = 76%) In addition, violations per inspection were lower than state plans combined and than federal (N = 2.4, S= 3.3, F = 3.2). Serious violations per CSHO were ½ that for states combined and about 1/3 that for federal (N = 21.5, S = 42.9, F = 60.0). The number of higher gravity citations (WRF) per CSHO was about ½ that for state plans combined and less than ½ that for federal. (N = 1.3, S= 2.5, F = 3.1).

Examples of incidents needing case review are not limited to Nevada.

The following incident report illustrates the nature of the incidents which need review. In the CTA Acoustics explosion, the most important issues are the nature of abatement negotiated, and the opportunity taken or lost for generalizing the abatement of combustible dust hazards beyond the specific state agency.

Workers at CTA Acoustics in Corbin, KY, a supplier to the auto industry and therefore of interest to the UAW, suffered a dust explosion on February 20, 2003 that killed seven workers and injured 37 others. The facility was non-union. The United States Chemical Safety Board (CSB) reported "Investigators found that CTA had been aware that combustible dust in the plant could explode, but did not communicate this hazard to workers or modify operating procedures or the design of the plant. CTA company memoranda and safety committee meeting minutes from 1992 through 1995 showed a concern about creating explosive dust hazards when cleaning the production line. Further concerns were raised in 1997."

<http://www.csb.gov/newsroom/detail.aspx?nid=119> The facility had been inspected by Kentucky OSHA in December, 2002 in response to a complaint (subject of complaint not known), but no citation was issued for the combustible dust hazard. OSHA's records show that Kentucky OSHA issued citations for 7 serious violations (mostly of electrical standards) on August 5 of 2003, which were settled on August 25, 2003, for a total of \$49,000. The abatement agreement, beyond penalty, is not known.

http://www.osha.gov/pls/imis/establishment.inspection_detail?id=305910440

My reading of the CSB report suggests that willful violations could certainly have been issued and could have been sustained. Willful violations of an OSHA standard leading to the death of a worker may be subject to criminal prosecution, so the distinction between willful and serious violations carries consequences for lessons learned by the industrial community. This was an opportunity to progress to control of combustible dust pending completion or even the start of setting an OSHA standard.

Recommendations.

1. Federal OSHA needs to enhance its oversight and monitoring of state plans to ensure that they are performing as required by the OSHAct, with standards and enforcement programs that are at least as effective as federal OSHA's protection
2. OSHA oversight should increase emphasis on case file review, in relation to other statistical methods. State plans should be required to identify significant cases, while OSHA oversight should sample cases likely to be problematic. A narrative of the incident with successes and failures would advance both the target agency, agencies in other states, federal enforcement, congress and the general public.
3. Post citation processes should be especially scrutinized: describe the impact of informal conference, negotiations after employer contest, the nature of an abatement agreement if negotiated, and a sample of formal hearings.
4. Parallel inspections or accompanied inspections by OSHA oversight personnel are important. For injury control (safety) standards, it is sometimes necessary to see what's happening on the floor to understand whether appropriate hazard identification and abatement took place.
6. For each state plan and federal OSHA, OSHA should collect data and publish data to compare training, longevity, pay rates of CSHO's.
6. Enforcement data collected should stratify results by construction, general industry, public sector.
7. Penalty data should distinguish penalties assessed from final penalties. For penalty data, OSHA should provide the median as well as the average amounts. The average is very likely skewed by a few high penalty cases, but most employers will see the median.
8. OSHA needs a way to intervene and improve state plan performance short of revoking the state plan. Revoking a state plan means depriving state and local employees of health and safety protection. Legislation may be needed to facilitate mechanisms for federal intervention, such as concurrent jurisdiction, where state plans are found to be deficient.
9. Finally, and maybe most important. Our nation can't expect to get the significant reductions in fatalities, injuries and illnesses by tinkering with the inspection and enforcement program within the current framework. Fundamental change is needed –

this change includes increased employee participation in all phases of health and safety, plus standards that reflect the science of the 21st century, plus coverage of all American workers, plus reliable protection of workplace whistleblowers.

	NV	State Plan Total	Federal OSHA
Total Inspections	2,532	57,327	38,591
CHSO's	41	1,243.5	1,118
Inspections/CHSO	61.76	46.1	34.52
Safety	1,858	45,010	33,074
% Safety	73%	79%	86%
Health	674	12,317	5,517
% Health	27%	21%	14%
Construction	1,615	26,179	23,157
% Construction	64%	46%	60%
Programmed	1,194	34,980	23,023
% Programmed	47%	61%	60%
Complaint	533	9,290	6,697
% Complaint	21%	16%	17%
Accident	86	3,666	1,008
% Accident	3%	6%	3%
Total Violations	3,039	122,288	87,687
Serious	883	53,286	67,052
% Serious	29%	44%	76%
Willful	-	185	509
% Willful	0.0%	0.3%	1.3%
Repeat	34	2,374	2,817
Failure to Abate	20	509	170
% WRF	2%	5%	9%
Other than Serious	2,102	65,864	17,131
% Other	69%	54%	20%
Avg # Violations/ Initial Inspection	2.4	3.3	3.2
Violations per CSHO	74.1	98.3	78.4
Serious violations per CHSO	21.5	42.9	60.0
WRF violations per CHSO	1.3	2.5	3.1
Total Penalties	\$ 1,286,186	\$ 70,248,913	\$ 103,350,367
Avg Penalty / Serious Violation	\$ 1,103.40	\$ 924.50	\$ 973.60
Contested Cases			
% Insp w/ Contested	8.4%	13.7%	7.0%

Table 1: Comparison of enforcement data between Nevada OSHA, all state plans combined, and Federal OSHA. (source: OSHA IMIS, accessed 2009-10-22)

State	State Gov Employees	Local Gov Employees	Total Public Sector Employment	Private Sector Employees	Total Employees Covered	Allocated CSHOs FY 2009	1,000 Covered Employees per CSHO	# CSHOs per 100,000 Covered Employees
Arizona	90,900	300,100	391,000	2,115,000	2,506,000	25	100.2	1.0
New Mexico	61,100	109,200	170,300	645,200	815,500	10.5	77.7	1.3
Tennessee	97,200	287,600	384,800	2,312,900	2,697,700	39	69.2	1.4
California	494,200	1,791,800	2,286,000	12,292,900	14,578,900	224.5	64.9	1.5
Utah	66,900	116,400	183,300	1,040,300	1,223,600	19	64.4	1.6
South Carolina	102,100	217,300	319,400	1,535,400	1,854,800	29	64.0	1.6
Virginia	159,400	384,600	544,000	3,023,800	3,567,800	58	61.5	1.6
Michigan	176,900	430,900	607,800	3,408,000	4,015,800	67	59.9	1.7
Iowa	69,500	172,800	242,300	1,260,800	1,503,100	29	51.8	1.9
Minnesota	99,400	292,300	391,700	2,301,200	2,692,900	57	47.2	2.1
Maryland	113,600	254,300	367,900	2,089,600	2,457,500	53.5	45.9	2.2
Kentucky	97,600	187,400	285,000	1,512,200	1,797,200	41	43.8	2.3
Indiana	115,900	296,000	411,900	2,471,200	2,883,100	70	41.2	2.4
Connecticut	73,200	165,400	238,600	-	238,600	6.5	36.7	2.7
Wyoming	16,600	48,400	65,000	228,500	293,500	8	36.7	2.7
North Carolina	205,800	460,300	666,100	3,336,500	4,002,600	114	35.1	2.8
Hawaii	77,400	18,600	96,000	488,700	584,700	18	32.5	3.1
Vermont	18,400	32,300	50,700	247,000	297,700	9.5	31.3	3.2
New York	262,500	1,145,300	1,407,800	-	1,407,800	45	31.3	3.2
New Jersey	150,400	454,400	604,800	-	604,800	20	30.2	3.3
Nevada	39,300	109,200	148,500	1,075,700	1,224,200	41	29.9	3.3
Washington	152,200	325,500	477,700	2,382,600	2,860,300	114	25.1	4.0
Alaska	25,700	42,200	67,900	224,900	292,800	12	24.4	4.1
Puerto Rico	224,800	68,200	293,000	712,000	1,005,000	48	20.9	4.8
Oregon	78,500	198,000	276,500	1,389,900	1,666,400	80	20.8	4.8
State Plans	3,069,500	7,908,500	10,978,000	46,094,300	57,072,300	1,243.5	45.9	2.2
Federal OSHA	Federal Employees: 2,776,600			65,886,400	68,663,000	1,118	61.4	1.6

Table 2: Staffing levels for state plans and federal OSHA.