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BEFORE THE

COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

OCTOBER 29, 2009

Mr. Chairman, Members of the Committee:

Thank you for the opportunity to testify today and to discuss the Occupational Safety and Health Administration's (OSHA's) partnership with the States that have chosen to operate OSHA-approved plans, with particular attention to the Nevada OSHA program. When Congress enacted the Occupational Safety and Health Act of 1970 it created an opportunity for Federal-State partnerships to promote safety and health. Section 18 of the law allows states to develop and enforce occupational safety and health standards in the context of an OSHA-approved State Plan. Twenty-seven (27) States and territories have sought and obtained Plan approval--21 States and Puerto Rico have complete programs covering both the private sector and State and local governments; four States and the Virgin Islands have programs limited in coverage to public sector employees. Currently, the State Plans deliver the OSHA program to 40% of the nation's workplaces, with Federal OSHA responsible for the other 60%. Most of the State Plans were approved in the 1970's, although just last month OSHA approved a new Public Employee-Only State Plan in Illinois. In this testimony, I will provide a brief overview of the State Plan

program, and then discuss the Nevada program, and OSHA's recent investigation of it, in more depth.

State Plan standards and enforcement must be “at least as effective” as Federal OSHA in providing safe and healthful employment to workers in the state. In addition, the State Plans operate under authority of State law--not delegated Federal authority. Thus, in order to operate a State Plan, a State must enact a State equivalent of the OSH Act and must use State administrative and regulatory procedures to adopt its own standards, regulations, and operating procedures, all of which it must update within six months of any change in the Federal program.

In order to assure the States’ continuing commitment to their OSHA programs while allowing them the flexibility to improve those programs, the OSH Act requires the States to provide at least 50% of the funding for state OSHA plans, with Federal OSHA allowed to fund no more than 50% of their costs. In recent years, however, appropriations for State Plans have not kept pace with either inflation or even increases in funding for Federal enforcement. In fact, there has been no significant increase in OSHA State Plan grants for the past seven years, even though overall OSHA funding has gone up by more than 20% during that period. This has forced most States to contribute additional funding to their State Plans that is not matched by Federal OSHA.

In FY 2009, for example, Federal contributions to State Plans totaled $92,593,000. State contributions totaled $184,370,820, almost two thirds of the full $276,963,820 cost of running the plans. Even with this investment, many states have seen erosion in the inflation-adjusted resources committed to their OSHA plans. As a result some states have even had to leave compliance officer positions vacant. For FY 2010 the President's Budget has requested nearly a 15% increase for State Plan funding. This is intended to help restore state funding to a more appropriate level. In addition, during FY 2009, separate grants under the American Recovery and Reinvestment Act (ARRA) were offered for activity associated with ARRA work. Seven states matched more than $1,500,000 from this funding source.

Unfortunately, the FY 2010 potential funding increase for the states comes at a time of serious fiscal crisis in State governments. The six states that fund only 50% of their State Plans and have the greatest need for increased resources are unlikely to be able to match a funding increase. Those states that contribute additional funds can be expected to match at least some of the increase but may do so by decreasing their 100% funding.

There are a number of advantages to State Plans. They add resources to the Federal program directed at workplace safety and health which would not otherwise be available; they must cover their own state and local government employees, who are not covered by Federal OSHA; they are familiar with the mix of industries and work establishments in their jurisdiction; and they have the flexibility to deal with workplace hazards that are sometimes not addressed by Federal OSHA. The states conduct more inspections and are

able to reach proportionately more workplaces than Federal OSHA. The states have also used innovative approaches in both enforcement and standards-setting to protect their workforce.

For example, Washington, Oregon, Vermont, and other states use workers compensation data to target the most hazardous workplaces within their borders. A number of states have established standards for hazards that Federal OSHA does not regulate. California recently issued a heat stress standard, a standard to protect workers from airborne diseases and a standard to protect workers against "popcorn lung," a disease associated with exposure to the flavoring chemical diacetyl. Virginia has issued a unique standard requiring that machinery used in workplaces be operated in accordance with the manufacturer's instructions. For almost 20 years, California has had a law requiring all employers to establish effective injury and illness prevention programs. Other states, including Hawaii, Nevada, Oregon, and Washington, require similar programs or safety and health committees. A number of states also have "red tag" provisions that allow them to immediately shut down machinery or processes when they find hazards that could cause death or serious physical harm, a provision not available to Federal OSHA.

As valuable as the state efforts are, however, Federal OSHA has an important role to play in assuring that State OSHA Plans are at least as effective as the Federal program. Currently, when OSHA develops a new program or initiative to protect workers, the states are sometimes encouraged, and other times required, to adopt parallel state efforts. For example, Federal OSHA recently inaugurated a National Emphasis Program (NEP) to

inspect the accuracy of the injury and illness reporting requirements in order to prevent under-reporting. Although we did not require the state plan states to adopt this initiative, we have told the states that we believe that is essential that they do so because accurate reporting is critical to an effective enforcement program. We will re-evaluate whether we need to make this a requirement in the near future, depending on how many states choose not to participate. I reminded the State Plan states, when Federal OSHA announces a National Emphasis Program, American workers and employers expect it to be a truly *National* emphasis program. We plan in the future, to make all Federal OSHA NEPs and other similar initiatives mandatory rather than discretionary changes to the states' programs.

We also recognize that Federal OSHA needs to maintain effective oversight of State Plans to ensure that all workers in America are protected. Over the years, OSHA's monitoring has changed from a system of measuring the states against Federal performance on various indicators to a system that measures state performance against the state's own goals. In OSHA's early years, before computers, OSHA's evaluations were on-site and intensive. OSHA reviewed state enforcement case files, accompanied inspectors to observe their work, and gathered data manually. In the mid-1980s OSHA discontinued routine accompanied visits and sample case file reviews, except as needed to research issues. In return, the states all joined OSHA's computerized management information system, entering data on each inspection and other activity in the same manner as an office of Federal OSHA. Information on both state and Federal individual inspections is available on OSHA's website. OSHA then moved to a monitoring system

that relied more on direct statistical comparisons of state performance to Federal on many indicators.

In the mid-1990s oversight was again reduced in response to complaints from the states that they had been running their programs for many years and did not need such extensive oversight, and that they were contributing considerably more money to the program than Federal OSHA. The result is a goal-based system whereby each state develops its own five-year Strategic Plan and Annual Performance Plan. Each state must develop a Strategic Plan that will include the goal of reducing workplace injuries, illnesses and fatalities. Federal OSHA reviews each state's performance in relation to the goals established in its Strategic Plan in an annual Federal Annual Monitoring and Evaluation (FAME) report. In addition, OSHA performs investigations of a particular State Plan activity if it receives a Complaint About State Program Administration (CASPA) or otherwise becomes aware of a problem.

Nevada has operated a State Plan since 1974. Final approval of the Plan, which attests to its structural and operational effectiveness, was granted by Federal OSHA in April 2000. Nevada's program contains provisions similar to those of Federal OSHA governing such issues as the conduct of inspections, citation procedures, handling of imminent dangers, anti-discrimination procedures, and other worker protections.

During the 18-month period ending this past June, Nevada experienced 25 workplace fatalities. All 25 of the worker deaths were investigated by Nevada OSHA. During that

period Federal OSHA also received several CASPAs, regarding a confined space accident at the Orleans Hotel that resulted in two additional fatalities. The *Las Vegas Sun* published a series of articles that sharply criticized Nevada OSHA's handling of these fatalities. As a result of these events, Federal OSHA became aware of the problems that Nevada OSHA was facing and offered our assistance. At first the state was reluctant to accept OSHA's assistance in its enforcement effort, rejecting the Agency's initial overtures but then inviting Federal inspectors onsite only to tell them after a few weeks that they were no longer needed and developing citations without our input. However, more recently, under new leadership, Nevada OSHA is working closely with Federal OSHA to improve its program.

As a result of these events, I commissioned a Federal OSHA task force to conduct a special study of the Nevada State Plan. The review took several weeks and evaluated twenty-three of Nevada OSHA's fatality inspection case files. Five more cases that involved penalties to employers of more than $15,000 were also examined. All of the cases examined occurred between January 1, 2008, and June 1, 2009. The new leadership at Nevada OSHA cooperated fully throughout the process, sharing all available information.

The report on this study was released last week and, as I will describe, the results of that study have convinced me that significant changes must be made in how Federal OSHA conducts oversight over the state plan programs.

Federal OSHA identified a number of serious concerns about the Nevada Plan. For example, even though the files examined were primarily cases involving the deaths of workers, only one repeat and one willful violation were cited during the time period covered by the investigation and the single willful citation was reclassified. It appeared that Nevada OSHA avoided classifying violations as willful because the state lacked the management and legal counsel support necessary to uphold a willful classification. The repeat citation was issued to an employer that had committed multiple repeat violations of trenching operations within 12 months; yet, no willful violations (which involve intentional and knowing violations of the law) were issued in this case.

There were a number of cases which clearly supported the classification of repeat violations but they were not cited as repeat. In the Orleans Hotel case that was the subject of several CASPAs, Nevada OSHA had issued serious, rather than repeat or willful violations, even though the owner of the hotel where the violations occurred had previously been cited for substantially similar conditions at other properties.

Federal OSHA found that in seventeen percent of the fatality cases reviewed, hazards that were identified during inspections were not addressed in citations. In almost one-half of the fatality cases reviewed the state failed to notify families of deceased workers that it was investigating the death of a loved one. Thus, family members, who can often provide pertinent information, were never provided the opportunity to discuss the circumstances of the incident with Nevada inspectors.

Nevada OSHA did not always assure that hazards found during inspections were abated by the employer. The state plan lacked procedures to identify cases requiring follow-up inspections, to track abatements, and to ensure that employers carried out abatement. In three cases inadequate abatement documentation received by the state was accepted as proof that hazards had been corrected.

Our investigators also found that Nevada OSHA inspectors were not properly trained about the hazards of construction work, a particular concern because of the high level of construction activity and construction-related fatalities in that state in recent years. Few hazards were identified in the construction industry, despite the fact that the majority of the worker fatalities had occurred in that industry. Furthermore, in ninety-one percent of the fatality cases we reviewed, information from employer injury and illness logs was not obtained by inspectors. Without this information it is difficult for a supervisor to determine whether the inspector should have expanded the focus of the inspection beyond the circumstances of the accident to evaluate other hazards that may have been present in the workplace.

In order to go where the problems are, state plans, like Federal OSHA, use injury and illness rates to target problem workplaces and avoid inspecting workplaces where there are less likely to be violations. Nevada, however, conducted a very high number of in-compliance inspections resulting in few serious violations. For example, for safety inspections, Nevada's average of programmed inspections with serious violations was 26% compared with 79% for Federal OSHA. In other words, Nevada inspectors were

either failing to target inspections properly, failing to identify serious violations, or failing to classify those violations appropriately.

This is not an exhaustive list of the deficiencies that we discovered. I have provided the committee with a copy of the report so that you can read the complete findings.

The study report includes a number of recommendations for improvements. OSHA recommended that Nevada conduct an internal review of its citation policies and practices. The state was told to document willful violations more completely so that it can issue willful citations and sustain them in the review process. OSHA also recommended that the state work with legal counsel to train its inspectors to develop legally sufficient cases.

OSHA advised the state to ensure that all hazards identified during inspections are addressed with the employer through a citation, notification of violation, or some other method. Case files should be reviewed more thoroughly by supervisors, including review of photographs, to find hazards not initially identified.

OSHA strongly recommended that Nevada OSHA comply with existing state procedures and new legislation to contact families of victims soon after initiation of an inspection. OSHA recommended that the state ensure adequate abatement of all hazards found during complaint inspections as well as review its abatement verification policies to ensure that all necessary documentation required for abatement verification is included in

the case files. OSHA also recommended that the state provide its staff with additional training on construction hazards. The complete list of our recommendations is included in the report. Nevada OSHA will provide us with a Plan of Action that will lay out a schedule for addressing the recommendations.

I also want to take a moment to clarify that the problems we identified at Nevada OSHA were systemic problems in the management of the agency and that we are not casting any blame on the efforts of the dedicated inspectors and other staff of Nevada OSHA who are devoting their lives to ensuring that workers are provided with a safe workplace.

As a result of the deficiencies identified in Nevada OSHA's program and as a result of this Administration's goal to move from reaction to prevention, I have notified the State Plans that we will be announcing a number of enhancements and changes in order to strengthen the oversight, monitoring and evaluation of state programs. In order to improve oversight immediately, I sent interim guidance to each of OSHA's ten Regional Administrators in August reminding them of the wide range of monitoring tools currently available to them and encouraging more extensive investigation of potential problems as part of our monitoring procedures for all State Plans. For example, analysis of data on State performance in a particular program area, for example inspections, need not be limited to one measure, such as the number of inspections, but should include any other relevant information, such as information on the effectiveness of the state's overall training program for its compliance staff. We asked our regional evaluators to maintain more frequent direct communication with the states they oversee and to keep abreast of

state legislative developments, major incidents, and local initiatives. At least two of the four quarterly meetings between Federal OSHA representatives and State Plan administrators per year will now be conducted in person.

I have also announced that we will be conducting more special studies in response to information or data noted through routine monitoring, significant events, changes in a State Plan, media reports or CASPAs. CASPAs can be filed with OSHA regional offices by anyone who believes there are inadequacies in a State Program. The complaint may be submitted orally or in writing and the complainant's name may be kept confidential. OSHA investigates all such complaints. If the complaint is found to be valid, Federal OSHA will require corrective action by the state.

CASPAs will be taken much more seriously in this Administration, with the investigation determining not just whether the State followed its own policies but also whether the State's policies and procedures are at least as effective as those of Federal OSHA. Finally, when OSHA's monitors find that the outcome in a specific inspection or discrimination investigation is flawed, the State will be asked to take action to correct the outcome whenever possible, as well as to make procedural changes to prevent recurrence.

In addition, to ensure that deficiencies similar to those found in Nevada do not exist in any of the other State Plans I have announced that OSHA will conduct Baseline Special Evaluation Studies for every state that administers its own program. These studies will

also assist Federal OSHA in considering permanent changes in its monitoring system by identifying the most effective monitoring techniques.

These baseline studies will provide a better performance assessment for the FY 2009 FAME reports. The FAME reports are prepared by our Regional Offices on a fiscal year basis and issued the following spring. The problems we found in the Nevada program, which should have been revealed earlier during monitoring, made us realize that the current FAME reports are not adequate and need to be enhanced to be more comprehensive and address all significant issues. The baseline studies that the Regions will be conducting will be included in the FY 2009 "Enhanced" FAME reports.

We intend for these baseline studies to lead to better program performance and consistency throughout all State Plans. Using the results of these studies, federal OSHA will commence an overall review of our current oversight policies. These studies will give us a better idea of how best to permanently revise our current monitoring procedures. We will involve the states in the development of the revised monitoring procedures or changes in performance measures by working closely with the Occupational Safety and Health State Plan Association (OSHSPA). OSHSPA was founded in the late 1970s and represents the 27 states and U.S. territories that run their own occupational safety and health programs. The Association serves as the link between the State Plans and Federal OSHA. It has been an important mechanism for resolving controversies and negotiating policy consensus. OSHA is emphasizing to our state partners that we are not trying to change the nature of the relationship between

Federal and State OSHA but that we do need to speak with one voice and we need to assure American workers that they will receive adequate protection regardless of the state in which they work.

Overall the Federal-State partnership established by the OSH Act has successfully protected American workers. There have been times, however, when a state has failed to protect one or more segments of its workforce and Federal OSHA has had to apply corrective measures. During 1991-92 after a devastating fire at a chicken processing plant in North Carolina that resulted in 25 deaths, OSHA re-examined its relationship with North Carolina's OSHA program. Federal OSHA reasserted concurrent enforcement authority in the state by responding to all complaints of workplace hazards and referrals from other agencies. A staff comprised of OSHA inspectors and monitors worked closely with the state to institute improvements in its enforcement program until primary responsibility for enforcement was returned to North Carolina in March 1995. By then the state had made significant modifications to its program, including increases in funding and staffing. Similar action by Federal OSHA would be possible in Nevada, through suspension of its final approval status and reassertion of concurrent Federal jurisdiction. Beyond that, withdrawal of a State Plan's approval, which is a long and complex process, is the ultimate sanction when major and pervasive deficiencies are present and the state is not making an appropriate effort to correct them. I want to emphasize, however, that because of the cooperative attitude of the new leadership of Nevada OSHA, which has shown concern for the problems we have pointed out and has

worked cooperatively with OSHA to identify deficiencies, we do not expect either of these actions will be necessary.

However, if Nevada or any other state where problems are identified fails to make the necessary improvements in a timely manner, OSHA will persist in monitoring and recommending changes. Failure to provide protection at least as effective as the Federal program could result in reconsideration of a state's final approval status and the reinstitution of concurrent Federal enforcement jurisdiction. Ultimately, it might result in action to withdraw approval of the Plan.

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Mr. Chairman, over the years this Committee has played a key role in holding OSHA's feet to the fire when it comes to issues such as refinery explosions, combustible dust, and other dangers. I appreciate your work now in shining a spotlight on what has been an obvious gap in the protection of a portion of our workforce. I look forward to working with you to remedy this problem. In order to safeguard the nation's workers we need as much information and insight as possible from a variety of sources. You have served the workforce in Nevada and this country well by providing a forum for OSHA and others to point out areas for improvement. Thank you again for this opportunity to discuss the OSHA State Plan Program and our study of the Nevada State Plan. I look forward to your questions.