

**WRITTEN TESTIMONY OF  
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Workforce Protections Subcommittee  
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Madam Chair, and Members of the Subcommittee, I appreciate the opportunity to discuss the Office of Inspector General's (OIG) audit of the Enhanced Enforcement Program (EEP) administered by the Occupational Safety and Health Administration (OSHA). As you know, the OIG is an independent entity within the Department of Labor (DOL); therefore, the views expressed in my testimony are based on the findings and recommendations of my office's work and are not intended to reflect the Department's position.

**BACKGROUND**

Since OSHA's inception in 1971, its core mission has been "to promote the safety and health of America's working men and women..." With few exceptions, the OSH Act covers most private sector employers and their employees in the 50 states and all territories, either directly through Federal OSHA or through an OSHA-approved state program. OSHA's workforce comprises approximately 2,100 employees which include inspectors, whistleblower investigators, engineers, physicians, educators, standards writers, and other technical and support personnel. OSHA uses three basic strategies to help employers and employees reduce injuries, illnesses, and deaths on the job:

1. Enforcement.
2. Outreach, education, and compliance assistance.
3. Partnerships, Alliances, and other cooperative and voluntary programs.

Currently, OSHA covers 115 million workers at 7.2 million worksites. In FY 2008, OSHA's 1,000 inspectors conducted over 38,000 inspections of worksites to identify hazards and unsafe conditions that have significant impact on worker safety and health.

OSHA reported in its publication "All About OSHA" that annually:

- Almost 5,200 Americans die from workplace injuries in the private sector;
- As many as 50,000 employees die from illnesses in which workplace exposures were a contributing factor;
- Nearly 4.3 million people suffer non-fatal workplace injuries and illnesses; and

- The cost of occupational injuries and illnesses totals more than \$156 billion.

Because of its significant impact on the lives and well-being of American workers, it is essential that OSHA target its limited resources to inspect workplaces with the highest risk of hazardous conditions.

As you know Madam Chair, in 2003, OSHA augmented its enforcement program by establishing the Enhanced Enforcement Program for employers indifferent to their obligations under the Occupational Safety and Health Act of 1970, placing their employees at greater risk. The purpose of EEP is to identify these high-risk employers and target their worksites with increased enforcement attention. Employers are identified from all types of inspections where cited violations are: serious, high gravity, and related to fatalities; willful and/or repeat; or related to a failure-to-abate previously cited hazards. Once identified, EEP cases are supposed to receive additional enforcement efforts such as enhanced follow-up inspections, inspections of other workplaces of the employer, and more stringent settlement terms. EEP inspections represent a small percentage (1 percent) of total programmed inspections, but the targeted employers are deemed by OSHA to pose the highest risk to employee safety.

### **ENHANCED ENFORCEMENT PROGRAM**

Madam Chair, as requested by the Subcommittee, I will focus my testimony on our recent report that assessed (a) whether establishments were properly identified as EEP cases and inspections were conducted in accordance with OSHA's EEP Directives and (b) whether OSHA's January 2008 revised EEP Directive had an adverse impact on the EEP and its ability to protect the American worker. As part of our audit, we reviewed a total of 325 cases of which 282 were EEP qualifying cases. The 282 cases involved 196 employers and a total of 274 fatalities. In cases where we found a problem with effective implementation of EEP, we identified 45 employers who had a total of 58 subsequent fatalities.

#### **Were Establishments Properly Identified as EEP Cases and Were Inspections Conducted in Accordance with OSHA's EEP Directives?**

Our overall conclusion was that OSHA did not always properly identify and conduct EEP inspections. For 97 percent of EEP qualifying cases we sampled, OSHA did not comply with at least one of the following requirements: designating EEP cases; inspections of related worksites; enhanced follow-up inspections; or enhanced settlement provisions. In addition, OSHA did not have specific criteria for issuing National Office EEP Alerts on multi-state employers. These alerts are issued when OSHA believes it is necessary to notify regional and state administrators about employers with multiple worksites across regions and/or states. This shortcoming occurred because OSHA did not place appropriate emphasis on compliance; commit necessary resources; or provide clear policy guidance.

Full and proper application of EEP procedures may have deterred and abated hazards at the worksites of 45 employers where 58 subsequent fatalities occurred.

Following is a brief description of our specific findings.

*OSHA Did Not Properly Designate 53 Percent of Sampled EEP Qualifying Cases and 24 Employers had 33 Subsequent Fatalities*

OSHA management did not ensure indifferent employers were properly designated for the program. Specifically, OSHA did not properly identify 149 of 282 (53 percent) sampled EEP qualifying cases because area office staff did not understand EEP requirements or because of coding errors in OSHA's online data system (Integrated Management Information System, IMIS). As a result, the worksites were not subject to the full range of EEP actions. The EEP actions may have provided a deterrent and abatement to address violations at worksites where subsequent fatalities occurred.

*OSHA Generally Did Not Inspect Related Worksites for 80 Percent of Sampled EEP Qualifying Cases and 34 Employers had 47 Subsequent Fatalities at Other Worksites*

OSHA generally did not inspect related worksites even when company-wide safety and health issues indicated that workers at these sites were at risk for serious injuries or death. Specifically, OSHA did not properly consider related worksite inspections for 226 of 282, (80 percent), of sampled cases. Related worksite inspections were to be used to determine whether compliance problems in the EEP case were indications of a company-wide problem. OSHA either did not commit the necessary resources or lacked information on other worksites needed to perform the inspections. Inspections may have deterred and abated hazards at the worksites where the 47 subsequent fatalities occurred.

*OSHA Did Not Conduct Proper Follow Up on 52 Percent of Sampled EEP Qualifying Cases and 5 Subsequent Fatalities Occurred at the Same Worksite*

EEP requirements state that a follow-up inspection must be conducted to assess not only whether the cited violation(s) were abated but also whether the employer was committing similar violations. OSHA did not comply with requirements for follow-up inspections to ensure abatement and determine whether employers were committing similar violations. Specifically, OSHA did not conduct proper follow up for 146 of 282 (52 percent) sampled EEP qualifying inspections, or provide a compelling reason to not perform the follow-up inspections. Of the sampled employers with multiple EEP qualifying and/or fatality cases, 54 did not have proper EEP follow up, and 5 of the 54 employers had subsequent fatalities at the same worksite.

*OSHA Generally Did Not Utilize Enhanced Settlement Provisions Effectively for Sampled EEP Qualifying Cases and 45 Employers had 32 Subsequent Fatalities*

OSHA generally did not utilize enhanced settlement provisions to maximize the deterrent value of EEP actions and ensure future compliance with OSH Act. EEP criteria states that in some settlement agreements, particularly for egregious cases and for other significant enforcement actions, OSHA require employers to take steps to address systemic compliance problems or to provide OSHA with information to facilitate follow up inspections. However, we found enhanced settlement provisions were not included in 153 of 188 (81 percent) EEP qualifying cases with settlement agreements.

Employers with multiple EEP qualifying and/or fatality cases pose the greatest risk for workplace injuries or fatalities. Of these sampled employers, 60 had a total 108 settlement agreements, and enhanced provisions were not included in 89 agreements. For 45 of the 60 employers, none of their settlement agreements contained enhanced provisions, and the employers had 32 fatalities subsequent to the settlement agreement dates.

*OSHA Has No Specific Criteria for Issuing National Office EEP-Alert Memorandum on Employers with Worksites Across Regions and/or States*

OSHA criteria state that EEP-Alert Memoranda are issued when the National Office deemed it necessary to notify Regional Administrators and State Designees of the activity of a particular employer with many worksites across regions and/or states. However, the criterion was not specific on when to issue an EEP-Alert Memorandum and, nationally, OSHA has only issued memoranda on nine employers. Our sample contained 22 employers where multiple EEP qualifying and/or fatality cases occurred in more than one region (totaling 87 fatalities). OSHA issued EEP-Alert Memoranda on only 5 of those sampled employers and only after the majority of the fatalities had occurred.

**Does OSHA's January 2008 Revised EEP Directive Have an Adverse Impact on the EEP and Its Ability to Protect the American Worker?**

With the 2008 revised EEP directive, OSHA still did not focus EEP enforcement actions on qualifying employers with company-wide safety and health issues to protect workers from subsequent injuries or fatalities. Over the last five years, the purpose of EEP remained the same: to target employers who are indifferent to their OSH Act obligations. However, the revised directive incorporated a component of qualifying history (i.e., prior fatality and similar in-kind violations) which effectively reduced the number of EEP qualifying cases; delayed designation; and increased the risk that employers with multiple EEP qualifying and/or fatality cases may not be properly designated due to the lack of quality history data. Further OSHA continued to not properly designate and conduct EEP cases. As a result, fewer employers may be subjected to EEP enhanced enforcement actions and may incur more fatalities before designation occurs.

*Less EEP Qualifying Cases Means Fewer Employers Subject to EEP Activities and Greater Risk for Subsequent Fatalities*

Using the 2008 criteria, the number of EEP qualifying cases was reduced significantly. In 2008, OSHA designated 7 percent of all fatality cases for enhanced enforcement, whereas OSHA designated an average of 50 percent between 2003 and 2007. Analysis of 2008 fatalities revealed 260 cases would not have been designated under the 2008 criteria, but would have qualified under the original EEP criteria. Because the fatalities occurred in 2008, 260 employers would not be subject to EEP activities and their employees may be at risk for injury or death before company-wide safety and health issues are addressed through OSHA enforcement.

*Issues in Determining Employer History Delayed Designation and Increased Risk That Employers May Not Be Properly Designated*

To more specifically focus the program on recalcitrant employers, the revised directive incorporated a key component of qualifying history of OSHA violations (including history with the State Plans). History determination is a manual search process, which can be affected by final order status of prior inspections, differences in standards cited for state cases, and lack of quality data for history searches due to employer-related companies and name variations. Issues in determining employer history delayed designation and increased the risk that employers may not be properly designated.

- *Final Order Status of Prior Inspections*  
History searches were complicated by the status of prior cases. Similar in-kind violations cannot be determined until there is a final order of settlement, which takes on average 6 months from the contest date.
- *Differences in Standards Cited For State Cases*  
Another challenge of history searches is determining similar in-kind violations when using State inspection data. There were 26 states and territories which operate their own safety and health programs under an OSHA approved state plan. Although these state-plan states enter violations into OSHA's information system, the states' coding may be different from OSHA's. OSHA does not have a crosswalk between state and Federal codes to assist in determining similar in-kind history. Of the 26 state-plan states, 5 states use different coding for most, if not all, of their safety and health standards: California, Washington, Michigan, Hawaii, and Oregon. Another 17 states have a few unique codes because Federal equivalent codes do not exist. Four states use coding identical to Federal OSHA. Without a crosswalk between state and Federal codes, determining similar in-kind history may be impossible or very time consuming.
- *Lack of Quality Data*  
OSHA officials indicated that history searches are subject to errors due to the lack of quality information on the employer in IMIS. Employers could have several different names in IMIS due to spelling errors; abbreviations; punctuation; name variations; or different divisions, operating units or physical locale. History searches may also omit events of related companies such as parent and subsidiary, because the names are not linked in IMIS. OSHA officials stated that they plan to

address naming issues in the new OSHA Information System, which is currently under development with a roll-out date in the fall of 2010.

### *OSHA Continued to Not Properly Designate and Conduct EEP Cases*

Although the 2008 criteria resulted in significantly fewer eligible cases, OSHA continued having issues with designating and conducting EEP cases. Out of 708 fatality cases, OSHA designated 50 fatality cases as EEP, but failed to identify 32 cases and improperly designated 16 cases.

Furthermore, we noted similar problems in complying with the 2008 criteria as we did the 2003 criteria. We reviewed 11 EEP cases from 2008, of which 7 had no documentation that OSHA considered related worksite inspections; 4 did not have proper follow up; and 3 with settlement agreements did not include enhanced provisions.

### *Criteria Gaps May Mean Delayed EEP Designation and Additional Fatalities*

There are gaps in the 2008 criteria which may mean delays and additional fatalities before an employer is designated as an EEP case. The revised directive has six criteria for becoming an EEP case, of which three require prior history of another fatality or similar in-kind violations within three years to qualify for the program. However, the criteria leaves gaps where employers would not qualify for EEP without an additional fatality or non-fatality case.

- *Employer's History Included Fatality and Non-Fatality Cases*  
One gap occurred when the employer's history included both fatality and non-fatality cases. The non-fatality criterion does not consider prior fatalities as relevant history for EEP designation, unless the fatality cases have similar in-kind violations. This gap also applies in the inverse as the fatality criteria do not consider prior non-fatality cases unless the cases have similar in-kind violations.

From our limited sample of 2008 cases, we do not have any that illustrate this gap and the impact of additional fatalities before designation. Using cases prior to 2008 as an example, one employer Homrich Incorporated had a non-fatality case that had three serious, willful violations cited. Homrich Incorporated had a fatality which occurred 15 months prior, but did not have similar violations to the non-fatality case. If these cases occurred in 2008, then the prior fatality would not have been considered as relevant history for EEP designation. As such, Homrich Incorporated incurred an additional fatality 15 months later, and only then would have qualified for EEP under the 2008 criteria.

- *EEP Qualifying Case Occurred in a State That Did Not Adopt An EEP Plan*  
Another gap occurs when the employer's history includes Federal and state OSHA cases. When a case that meets EEP criteria for designation occurs at a state that has not adopted EEP, no enhanced enforcement actions would be taken until a subsequent fatality or serious case occurs under Federal jurisdiction. The

criterion is silent on how OSHA will address incidents that would qualify as an EEP case that occur in a state that has not adopted EEP.

### **OVERALL CONCLUSION**

Madam Chair, our overall conclusion is that OSHA has not placed the appropriate management emphasis and resources on this program to ensure indifferent employers were properly designated for this program and subject to EEP actions. It is essential that OSHA target its limited resources to inspect workplaces with the highest risk of hazardous conditions that have greater potential to cause injuries and fatalities. By analyzing inspection information, OSHA can identify worksites with known hazardous conditions to target under EEP. By effectively utilizing EEP activities, OSHA could reduce the risk of future injuries, illnesses, and fatalities.

While we cannot conclude that enhanced enforcement would prevent subsequent fatalities, full and proper application of EPP procedures may have deterred and abated workplace hazards at the worksites of 45 employers where 58 subsequent fatalities occurred.

### **RECOMMENDATIONS**

We recommend the Assistant Secretary for Occupational Safety and Health:

1. Form an EEP Task Force to make recommendations to improve program efficiency and effectiveness to include:
  - Targeting indifferent employers most likely to have unabated hazards and/or company-wide safety and health issues at multiple worksites.
  - Ensuring appropriate actions (i.e., follow-up and related worksite inspections) are taken on indifferent employers and related companies.
  - Centralizing data analysis to identify employers with multiple EEP qualifying and/or fatality cases that occur across Regions.
  - Identifying and sharing Regional and Area Offices' "best practices" to improve compliance with EEP requirements.
2. Revise EEP directive to address issues with prior qualifying history and designation, and to provide specific criteria when National Office EEP-Alert Memoranda are to be issued.
3. Provide formal training on EEP requirements including designation, consideration of related worksite inspections, enhanced enforcement follow up, and enhanced settlement provisions to ensure consistent application of EEP requirements.

4. Incorporate enhanced settlement provisions in OSHA's informal settlement template.
5. Establish controls for periodic reconciliation of the EEP log to OSHA's data system.
6. Develop and distribute a crosswalk to Federal OSHA citations for state standards that have a different coding than Federal OSHA standards.

Madam Chair, this concludes my statement. I would like to thank you for the opportunity to share the OIG's findings on this important issue. I am happy to respond to any questions that you or the other Subcommittee members may have.