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Office of Inspector General—Office of Audit

**REPORT TO THE OCCUPATIONAL
SAFETY AND HEALTH
ADMINISTRATION**



**OSHA NEEDS TO IMPROVE THE
GUIDANCE FOR ITS FATALITY AND
SEVERE INJURY REPORTING
PROGRAM TO BETTER PROTECT
WORKERS**

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BRIEFLY...

OSHA NEEDS TO IMPROVE THE GUIDANCE FOR ITS FATALITY AND SEVERE INJURY REPORTING PROGRAM TO BETTER PROTECT WORKERS

September 13, 2018

WHY OIG CONDUCTED THE AUDIT

In January 2015, OSHA made significant changes to employer reporting requirements for work-related fatalities and severe injuries. OSHA's revised regulations require employers to report all work-related fatalities and certain injuries, inpatient hospitalizations, amputations, and losses of an eye within specific timeframes; and encourage employers to investigate these types of incidents and abate the hazards identified to prevent future accidents.

From January 2015 through April 2017, employers reported 4,185 fatalities and 23,282 severe injuries to OSHA. However, OSHA's former Assistant Secretary estimated that perhaps 50 percent or more of severe injuries have gone unreported.

WHAT OIG DID

Given this concern, we conducted an audit to answer the following question:

Has OSHA effectively implemented its revised fatality and severe injury reporting program?

To answer this question, we tested a sample of incidents reported from January 1, 2015 to September 30, 2016, focusing on who should investigate and whether employers had abated hazards. We also assessed the adequacy of OSHA's procedures for identifying unreported injuries.

WHAT OIG FOUND

To implement its revised fatality and severe injury reporting program, OSHA upgraded its information systems to accommodate the new reporting requirements and informed stakeholders of these new requirements. However, we found OSHA did not know the total number of work-related fatalities and severe injuries, and had limited assurance employers abated hazards properly. As a result, OSHA lacked information needed to target compliance assistance and enforcement efforts effectively, and could not demonstrate employers have identified and eliminated serious hazards.

OSHA issued guidance, trained regional staff, and created websites to inform the public and stakeholders about the changes in the program. OSHA's implementation efforts resulted in employers performing 14,834 investigations and OSHA conducting 10,475 on-site inspections in response to employer-reported incidents.

However, OSHA did not have controls to ensure it had complete information on the number of work-related fatalities and severe injuries. Estimates show that employers do not report 50 percent or more of severe injuries. We attributed this to the lack of guidance and training on how to detect and prevent underreporting, and inconsistency in issuing citations for late reporting.

Lastly, OSHA had limited assurance employers abated hazards properly. We attributed this to unclear guidance and poorly documented case files.

WHAT OIG RECOMMENDED

We recommended OSHA: 1) develop guidance and train staff on identifying underreporting, 2) issue citations for all late reporters, 3) clarify guidance on documenting essential decisions, collecting evidence to demonstrate employers corrected all identified hazards, and monitoring employer-conducted investigations, and 4) conduct inspections on all Category 1 incidents. OSHA commented on a number of the results and recommendations, but nothing in its response changed our report.

<https://www.oig.dol.gov/public/reports/oa/2018/02-18-203-10-105.pdf>

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INSPECTOR GENERAL'S REPORT

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This report presents the results of our audit of the Occupational Safety and Health Administration's (OSHA) handling of its revised reporting regulations for work-related fatalities and severe injuries. In January 2015, OSHA made significant changes to employer reporting requirements for work-related fatalities and severe injuries. OSHA's revised regulations require employers to report all work-related fatalities, inpatient hospitalizations, amputations, and losses of an eye within specific timeframes; and encourage employers to investigate these types of incidents and abate the hazards identified to prevent future accidents.

From January 2015 through April 2017, employers reported 4,185 fatalities and 23,282 severe injuries to OSHA. We were concerned these numbers did not reflect the total number of work-related injuries because OSHA's former Assistant Secretary estimated that perhaps 50 percent or more of severe injuries have gone unreported. Complete information on severe injuries is needed for OSHA to effectively target its compliance assistance and enforcement efforts.

Given this concern, we conducted an audit to answer the following question:

Has OSHA effectively implemented its revised fatality and severe injury reporting program?

To answer this question, we tested a random sample of 50 fatalities and 100 severe injuries, focusing on who should investigate and whether employers abated hazards. We assessed the adequacy of OSHA's procedures for identifying unreported incidents. Additionally, together with OSHA, we surveyed

state-plan states¹ to obtain their perspectives of this program and information on methods they are using to determine the extent of underreporting.

OSHA implemented parts of its revised fatality and severe injury reporting program by upgrading its information systems to accommodate new reporting requirements and informing stakeholders of these new requirements. However, OSHA did not know the total number of work-related fatalities and severe injuries. The agency also had limited assurance employers properly abated hazards.

RESULTS

Every year, tens of thousands of men and women across the United States suffer severe injuries on the job, sometimes with permanent consequences to themselves and their families. In the past, OSHA lacked timely information about where and how those injuries were occurring, limiting how effectively OSHA could respond. Too often, OSHA would investigate a fatal injury only to find a history of serious injuries at the same workplace.

According to the former Assistant Secretary for Occupational Safety and Health, the revised injury reporting program was guided by the principle that when employers engage with OSHA after a worker suffers a severe injury – whether or not a workplace inspection is launched – they are more likely to take action to prevent future injuries. OSHA also stated the revised reporting requirements would improve access to information about workplace safety and health for employers, employees, researchers, and the public, and increase their ability to identify and abate serious hazards.

Operationally, this type of approach uses fewer OSHA resources than required for on-site inspections. In this way, OSHA said it could use resources more efficiently, and ultimately, better protect the safety and health of workers.

Our audit found OSHA implemented parts of its revised fatality and severe injury reporting program by upgrading its information systems to accommodate new reporting requirements and informing stakeholders of these new requirements. However, OSHA needs to take steps to prevent underreporting of fatalities and injuries, and ensure employers correct identified hazards. We came to this conclusion after considering the following:

¹ State Plans are OSHA-approved job safety and health programs operated by individual states rather than federal OSHA.

- OSHA had no assurance employers reported work-related in-patient hospitalizations, amputations, and losses of an eye. Estimates show employers do not report 50 percent or more of severe injuries. Moreover, OSHA did not consistently follow its policy to issue a citation when an employer failed to report work-related fatalities and severe injuries within the specified timeframes.
- For an estimated 87 percent of employer investigations, OSHA lacked justification for its decision to allow employers to perform an investigation, or closed investigations without sufficient evidence employers had abated the hazards that had caused the accident. Furthermore, OSHA did not monitor any employer investigations to ensure accuracy and completeness of the information reported.

We attributed the incomplete reporting of fatalities and severe injuries and limited assurance employers abated hazards properly to OSHA's lack of guidance and training on detecting and preventing underreporting, inconsistent use of citations as a deterrent, inadequate documentation supporting essential decisions, and lack of verification of actions taken by employers to abate hazards.

Without complete information on work-related fatalities and severe injuries, OSHA cannot effectively target its compliance assistance and enforcement efforts. Similarly, without adequate evidence that employers abated hazards properly, OSHA lacks assurance that employers have taken the necessary corrective actions to provide a safe workplace.

STEPS OSHA TOOK TO IMPLEMENT THE REVISED REPORTING REQUIREMENTS

To implement its revised regulations changing the reporting requirements for employers related to work-related fatalities and severe injuries, OSHA upgraded its information systems to accommodate new reporting requirements and provided training to its regional staff. The agency also took numerous steps to inform the public and other stakeholders about the new program, including the following actions:

- Issued guidance, "Revised Interim Enforcement Procedures for Reporting Requirements under 29 C.F.R. 1904.39"
- Created websites to inform the public and stakeholders about the revised reporting requirements

- Developed Frequently Asked Questions related to the revised requirements
- Sent postcards on the new rules to employers that had not previously been required to keep records
- Provided outreach on the new rule to their stakeholders around the country
- Disbursed publications, such as fact sheets, to provide updates to OSHA's Recordkeeping Rules, and wallet cards on OSHA Reporting Requirements for Employers

OSHA stated that educating employers through these outreach activities helps to prevent underreporting. However, OSHA officials stated that most area offices did not have staff or resources dedicated to outreach activities. Over the last two years, OSHA decreased or eliminated the Compliance Assistance Specialist positions tasked with tracking, conducting, and being the primary contact for outreach activities, resulting in fewer resources for educating employers.

RESULTS OF INITIAL IMPLEMENTATION

OSHA's prior regulations required employers to report all work-related fatalities and in-patient hospitalizations of three or more employees. Effective January 2015, the revised regulations still required employers to report all work-related fatalities within 8 hours of an incident but were amended to require employers to report all work-related, in-patient hospitalizations, as well as amputations and losses of an eye, within 24 hours.

OSHA's initial implementation efforts resulted in employers reporting 4,185 fatalities and 23,282 severe injuries from January 2015 through April 2017. Employers performed 14,834 investigations to evaluate the causes of the injuries. Furthermore, OSHA conducted 10,475 on-site inspections based on employer-reported fatalities and severe injuries.

ESTIMATES SHOW THAT 50 PERCENT OR MORE OF SEVERE INJURIES WERE NOT REPORTED

OSHA lacked complete information on the number of work-related fatalities and severe injuries. We found:

- challenges related to identifying underreporting,
- inconsistent practices for detecting and preventing underreporting, and
- citations not consistently used as a deterrent.

We attributed these findings to OSHA not issuing formal guidance and training for detecting and preventing underreporting of work-related fatalities and severe injuries. How to detect and prevent underreporting was left to the discretion of each OSHA regional and area office, resulting in inconsistent practices and effort.

OSHA did not have controls to ensure it had complete information on the number of work-related fatalities and severe injuries. Estimates show that employers did not report 50 percent or more of severe injuries. While we did not find similar studies regarding underreporting of fatalities, OSHA lacked controls to ensure complete reporting. Without complete information on work-related fatalities and severe injuries, OSHA cannot target its compliance assistance and enforcement efforts at industries with the most severe incidents.

OSHA IS CHALLENGED TO IDENTIFY UNDERREPORTING OF WORKPLACE INJURIES

OSHA management needs quality information to make informed decisions and evaluate the entity's performance in achieving key objectives and addressing risks. According to the U.S. Government Accountability Office's Standards for Internal Control in the Federal Government, data are processed into quality information that is defined as information that is appropriate, current, complete, and accurate. Estimates showed that underreporting is significant, but OSHA may not have the tools it needs, such as workers' compensation data, to detect underreporting.

*ESTIMATES SHOW THAT UNDERREPORTING OF
WORKPLACE INJURIES IS SIGNIFICANT*

Underreporting of workplace injuries has been well documented. While OSHA's severe injury reporting was new, a GAO audit report published in April 2016 found "DOL faces challenges gathering data on injury and illness rates for meat and poultry workers because of underreporting and inadequate data collection".² In addition, OSHA conducted a recordkeeping national emphasis program review from 2009 to 2012 to identify the extent and causes of unrecorded and incorrectly recorded occupational injuries and illnesses.³ OSHA found recordkeeping violations in close to half of all facilities inspected. Employee interviews identified workers' fear of reprisal and employer disciplinary programs as the most important causes of underreporting.

Findings from an analysis conducted by the Massachusetts Department of Public Health indicated that employers reported fewer than half of work-related amputations.⁴ The analysis found that by restricting cases to the most serious identified through workers' compensation data, employers only reported 38 of 120, or 32 percent, of the cases to OSHA. The analysis showed that using data to assess employer underreporting might assist OSHA in identifying outreach, compliance assistance, and enforcement priorities.

Moreover, according to an evaluation⁵ issued by the former Assistant Secretary of Occupational Safety and Health in 2016, employers failed to report perhaps 50 percent or more of severe injuries to OSHA.

Accordingly, OSHA risked not knowing about severe injuries that may have occurred at an estimated 23,000 employers as of April 2017. The evaluation based this conclusion on three factors:

- Comparison with injury claims provided by state workers' compensation programs identified unreported injuries.

² GAO, *Workplace Safety and Health: Additional Data Needed to Address Continued Hazards in the Meat and Poultry Industry*, GAO-16-337, April 25, 2016

³ Kathleen M. Fagan and Michael J. Hodgson, OSHA, *Under-recording of work-related injuries and illnesses: An OSHA priority*, *Journal of Safety Research*, December 9, 2016

⁴ Grattan K., L. K. Davis, M. Fiore, E. Pechter, J. Laing, *Employer Compliance with OSHA Requirement to Report Amputations, Updated Findings from a Massachusetts Study*. Council of State and Territorial Epidemiologists Annual Conference, June 6, 2017

⁵ David Michaels, PhD, MPH, Assistant Secretary of Labor for Occupational Safety and Health, *Year One of OSHA's Severe Injury Reporting Program: An Impact Evaluation*, issued March 17, 2016

- Employers chose not to report because they perceived the cost of not reporting to be low.
- Many small and mid-sized employers were unaware of the new requirements.

SOME STATES USE WORKERS' COMPENSATION DATA TO DETECT UNDERREPORTING

Workers' compensation data could help detect underreporting. However, OSHA officials stated workers' compensation data were not readily available in all states. Therefore, OSHA could not rely just on workers' compensation data to determine if employers were reporting severe injuries. We conducted a survey of the 26 state plan states to obtain their perspectives on this program and ask about methods they used to determine the extent of underreporting. Nine of the 26 state-plan states completed the survey. Of the nine states, three used their state workers' compensation data to help identify underreporting, while the other six states used the data for targeting and outreach, did not use the data, or had no access. From the three states that used their state workers' compensation data to identify underreporting, one indicated less than 25 percent of injuries were not reported and another state estimated approximately 50 percent were not reported. The remaining state did not provide an estimate. This state has partnered with a university to perform a study to compare hospital discharge and workers' compensation records to determine if employers are not reporting.

INCONSISTENT PRACTICES FOR DETECTING AND PREVENTING UNDERREPORTING

OSHA area office officials stated that detecting and preventing underreporting of work-related fatalities and severe injuries is a difficult challenge. Some OSHA officials stated OSHA's only option is to rely on what employers report.

Other OSHA officials stated they work with medical examiners' offices to ensure fatality cases are reported. These officials also stated they use the following practices to detect underreporting of severe injuries:

- Conducting onsite inspections
- Collecting and reviewing employer's previous injury and illness history
- Gathering and sharing information with local authorities and first responders

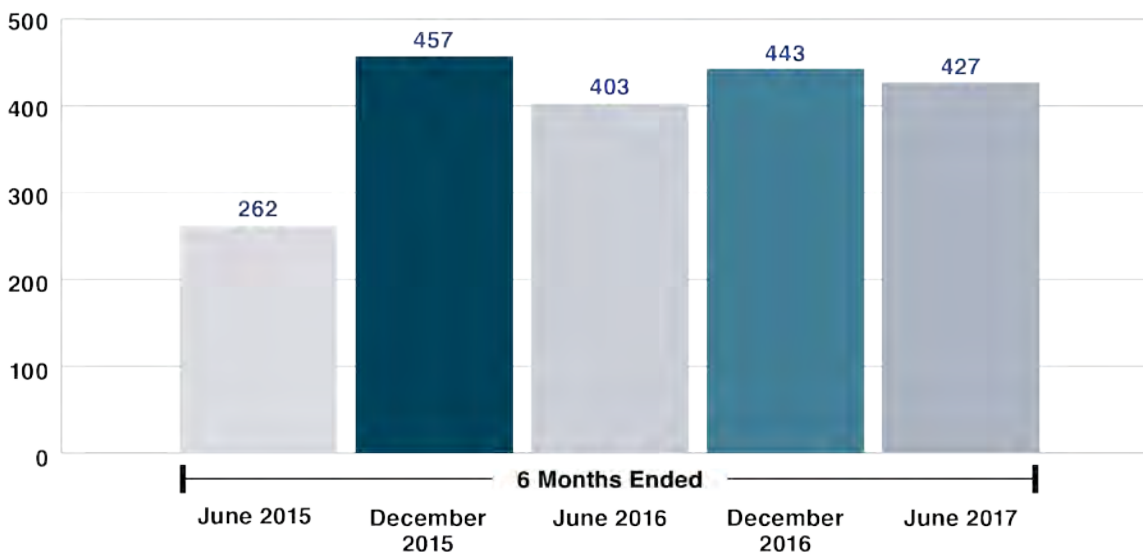
- Reviewing logs in which some employers are required to record serious occupational injuries and illnesses
- Maintaining an awareness of media reports
- Reviewing workers’ compensation data when available

CITATIONS NOT CONSISTENTLY USED AS A DETERRENT

To enforce compliance, OSHA issues citations for late reporting and failing to report fatalities and severe injuries. Employers are required to report all work-related fatalities within 8 hours of an incident, and in-patient hospitalizations, as well as amputations and losses of an eye within 24 hours.

OSHA issued 1,865 citations and imposed initial penalties totaling approximately \$5.2 million for late reporting from January 1, 2015 through April 30, 2017. During the period January 1, 2015 to June 30, 2017, OSHA issued an average of 398 citations every six months. For specific details, see Chart 1.

Chart 1: Citations Issued for Late Reporting or Failing to Report



OSHA’s memorandum, “Revised Interim Enforcement Procedures for Reporting Requirements under 29 C.F.R. 1904.39,” dated March 4, 2016, increased the unadjusted penalty for not reporting a severe injury from \$1,000 to \$5,000. The area director can increase the penalty to as much as \$7,000 to achieve the necessary deterrent effect. However, we found OSHA should have imposed a penalty in 17 of 21 sampled fatalities and severe injuries that were reported between 2 and 47 days after the incident. OSHA area office staff did not follow

OSHA guidance for issuing citations for late reporting and did not provide evidence to support their decisions for not issuing citations.

The receipt of employer reports within OSHA's required timeframes enables OSHA to inspect the site of the incident and interview personnel while their recollections are immediate, fresh, and untainted by other events, thus providing more timely and accurate information. Furthermore, reducing the reporting time increased the chances that the site of the incident would remain undisturbed.

OSHA HAD LIMITED ASSURANCE EMPLOYERS ABATED HAZARDS PROPERLY

Severe injuries may result in either an OSHA inspection or an employer investigation, as decided by the OSHA Area Director. For an employer investigation, the employer is expected to conduct its own investigation into the work-related incident, and share its findings and abatement verification with OSHA. For an estimated 87 percent of employer investigations,⁶ OSHA lacked justification for its decision to allow employers to perform investigations, or closed investigations without sufficient evidence the employer had abated the hazard(s). In addition, OSHA did not monitor investigations conducted by employers to ensure accuracy and completeness.

OSHA's guidance requires that all case files contain an activity diary sheet to provide a record and summary of all actions and decisions relating to a case. By not documenting the reason for choosing to rely on an employer investigation, OSHA made it difficult to determine the reasoning behind the area director's decisions.

Moreover, OSHA had no assurance hazards were corrected and employees may continue to be exposed to workplace hazards. Per OSHA officials, the lack of evidence showing that corrective actions were taken occurred because its guidance was unclear. OSHA officials stated the guidance states the employer "should" provide supporting documentation to verify the implementation of the corrective action taken instead of "shall," which may not be a requirement.

⁶ We are 95 percent confident OSHA did not document the justification for its decision to have employers conduct their own investigations and verify corrective actions reported by employers for 9,713 to 11,708 employer investigations.

OSHA LACKED JUSTIFICATIONS FOR ITS DECISIONS TO ALLOW EMPLOYERS TO PERFORM INVESTIGATIONS

OSHA's guidance requires that all case files contain an activity diary sheet. The activity diary sheet provides a record and summary of all actions and decisions relating to a case. For 100 randomly sampled reports of severe injuries, OSHA performed 37 inspections and requested 63 employers perform their own investigations to evaluate what went wrong and take actions to protect workers from suffering similar injuries by eliminating the hazards identified by the investigations.

In 50 of the 63 sampled severe injuries that OSHA requested employers to investigate, OSHA did not document its decision to allow employers to perform an investigation. An OSHA official stated that area directors look at the facts, circumstances, and conditions when making decisions. In addition, they use judgment and the decision-making is discretionary based on regional goals, priorities, and activities within the geographic area.

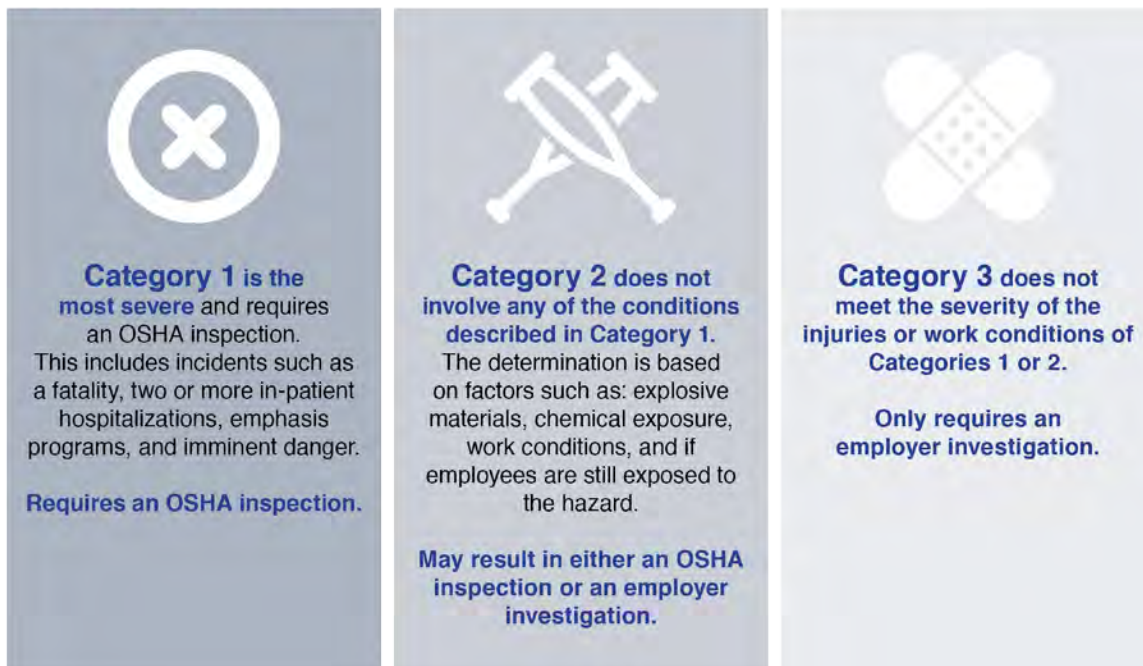
OSHA DID NOT PERFORM REQUIRED INSPECTIONS FOR 906 SEVERE INJURY CASES

An onsite inspection is required for the more severe injury cases. OSHA requires an area director or their designee to triage employer severe injury reports to determine if they require an OSHA inspection or an employer investigation.

Category 1 is the most severe and requires an OSHA inspection. This includes incidents such as a fatality, two or more in-patient hospitalizations, emphasis programs, and imminent danger. Category 2 are less severe injuries that may result in either an OSHA inspection or an employer investigation. Category 3 does not meet the severity of the injuries or work conditions of Categories 1 or 2,

and an employer investigation shall be conducted. Figure 1 shows OSHA’s triage process.

Figure 1. Triage Process



Of the 12,364⁷ investigations OSHA delegated to employers, our analysis found 906 Category 1 incidents that required an inspection by OSHA. Of the 906 that should have received an inspection, 858, or 95 percent, involved emphasis programs for preventing amputations that require an OSHA inspection. In our opinion, this occurred because OSHA did not stress the importance of conducting inspections on Category 1 injuries.

OSHA established the National Emphasis Program on Amputations with the intent of targeting workplaces with machinery and equipment that cause or are capable of causing amputations, while maximizing the Agency’s inspection resources. An OSHA inspection is required for emphasis program because of the severity and high rate of occurrence of the injuries. From January 1, 2015 to April 30, 2017, 6,203 amputations were reported to OSHA, which is an average of 7 amputations a day. According to a Former Deputy Assistant Secretary, most of the reported amputations involved fingers, but workers also lost hands, toes, feet, and other body parts. The national number is higher because this data does not include amputations in workplaces that are covered by state-plan states.

⁷ These investigations occurred during our sampling period from January 1, 2015 through September 30, 2016.

OSHA CLOSED INVESTIGATIONS WITHOUT SUFFICIENT EVIDENCE HAZARDS WERE ABATED

OSHA's guidance stated the employer should send abatement verification to the area director. The abatement verification should include a detailed description of the corrective action taken. In addition, the employer should provide supporting documentation to verify the implementation of the corrective action. For example, a copy of new/revised operating procedures/policies/work rules, copies of monitoring results, photographs, videos, or training records.

In our sample of 63 investigations conducted by employers, all employers provided detailed descriptions of corrective actions they planned to take to abate hazards. However, in 37 of the investigations, OSHA did not have evidence that the employers corrected the hazards. The corrective actions included staff training, third party inspection of materials handling equipment, sampling of airborne chemicals, and purchase of safety equipment. The following two examples illustrate cases where OSHA closed employer-conducted investigations without evidence that the hazards were corrected:

Example 1 – EMPLOYEE SUFFERED BROKEN ANKLES

Incident

An employee suffered two broken ankles while hoisting a scale using an overhead crane. The scale had just been painted and was being lifted from a floor platform to be moved to an adjacent nearby area for drying. The employee was raising the scale off the floor platform taking up the slack of the rigging, when the scale slid off the platform striking his feet. Both ankles were broken from the impact.

OSHA actions

In accordance with its guidance, OSHA sent a letter to the employer and provided in detail the need for the employer to immediately conduct its own internal investigation to determine the reasons for the occurrence of the work related incident, to identify the hazards related to the incident, and to implement corrective measures.

Employer actions

The employer identified the cause of the injuries was the weight of the scale which resulted from improper placement of the overhead crane. The employer's documented corrective actions indicated that by a certain date support piping would be placed on the automatic paint cart to prevent the load from shifting. The Human Resources/Safety Manager would insure that all painters and operators would be trained on possible hazards and sign off on the training forms.

OIG conclusion

OSHA did not verify the corrective actions were taken, and closed the case a day after they received the employer's corrective action plan. As a result, OSHA had no evidence that the corrective actions took place.

Example 2 - FINGER AMPUTATION

Incident

An employee working at a company involved in support activities for oil and gas operations found a piece of iron that was sticking out from the equipment. He reached up to move the iron when his finger was caught between the iron and the equipment. The resulting injury resulted in his finger needing to be amputated.

OSHA actions

In accordance with its guidance, OSHA sent a letter to the employer and provided in detail the need for the employer to immediately conduct its own internal investigation to determine the reasons for the occurrence of the work-related incident, to identify the hazards related to the incident, and to implement corrective measures.

Employer actions

The documented employer corrective action plan indicated the employer would by a certain date: 1) revise and recommunicate heavy equipment backing guidelines to work crews, and 2) create and communicate to employees methods for preparing equipment mobilization including “rigging down of removable items.”

OIG conclusion

OSHA did not wait to verify the corrective actions were taken, but immediately closed the case the same day they received the employer’s corrective action plan. As a result, OSHA had no evidence that the corrective actions took place.

Per OSHA officials, the lack of evidence showing that corrective actions were taken occurred because the guidance is unclear. OSHA officials stated the guidance states the employer “should” provide supporting documentation to verify the implementation of the corrective action taken instead of “shall,” which may not be a requirement. Without evidence that employers corrected the hazards, OSHA had no assurance hazards were corrected, and employees may have continued to be exposed to workplace hazards.

OSHA DID NOT MONITOR INVESTIGATIONS CONDUCTED BY EMPLOYERS TO ENSURE ACCURACY AND COMPLETENESS

OSHA's guidance advised area offices to conduct monitoring inspections of closed employer-conducted investigations based on a randomized selection of closed investigations. The monitoring inspection (limited to an inspection of the reported condition) was to ensure accuracy in reporting. OSHA recognized that a critical part of the employer-conducted investigations is an employer's willingness to conduct their own internal investigation to determine the reasons for the occurrence of a work-related incident, to identify related hazards, and to implement corrective measures. However, OSHA had not monitored any employer investigations. As a result, OSHA had limited assurance employers reported accurate information and implemented appropriate corrective actions to protect other employees from the same injuries.

OIG'S RECOMMENDATIONS

We recommend that the Acting Assistant Secretary for Occupational Safety and Health:

1. Develop formal guidance and train staff on how to detect and prevent underreporting of fatalities and severe injuries.
2. Consistently issue citations for late reporting.
3. Clarify OSHA's guidance related to:
 - a. documentation of essential decisions,
 - b. evidence required to demonstrate employers corrected all identified hazards, and
 - c. requirements for monitoring employer-conducted investigations.
4. Emphasize the necessity to conduct inspections on all Category 1 incidents.

SUMMARY OF OSHA'S RESPONSE

OSHA agreed that it can improve case file documentation to include essential decisions, and take necessary steps to implement the monitoring aspect of the program to ensure accuracy in reporting. OSHA partly agreed with the recommendations regarding issuing citations for late reporting and the necessity to conduct inspections for Category 1 incidents. OSHA agreed area directors need to justify these decisions and document them in the case file.

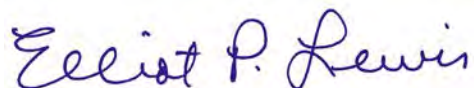
However, in response to the recommendation to develop formal guidance and train staff on how to detect and prevent underreporting of fatalities and severe injuries, OSHA stated it is not clear what additional measures it could take through formal guidance or training to prevent underreporting, absent statutory changes to allow the sharing of information or substantial additional resources devoted specifically to seeking out unreported injuries. We continue to believe OSHA needs to develop formal guidance and train staff to ensure consistency among its offices. As stated in this report, some officials stated OSHA's only option is to rely on injuries employers report, while other officials provided specific actions they used to detect underreporting.

Regarding the recommendation to clarify OSHA's guidance related to evidence of hazard abatement, OSHA stated that an employer is only under a legal obligation to report an event, not to conduct an investigation or submit proof of abatement. As indicated in our report, we made the recommendation to clarify the guidance because OSHA officials found it to be unclear. Because the guidance uses the term "should" instead of "shall," OSHA officials stated it is unclear whether they are required to obtain evidence of abatement from employers.

The guidance provides "internal guidance and procedures for the area offices to enforce the reporting requirements." It also states that the "Rapid Response Investigation is intended to identify any hazards, provide abatement assistance, and confirm abatement." (Underscoring added.) It further states that one of the "[k]ey components" of a Rapid Response Investigation is the employer's actions regarding its abatement verification. The guidance is consistent with OSHA's response to an OIG report titled *OSHA Could Do More to Ensure Employers Correct Hazards Identified During Inspections*, issued March, 31, 2017, in which it stated, "A crucial aspect of OSHA's mission is to ensure quality and lasting abatement."

OSHA's response to our draft report is included in its entirety in Appendix B.

We appreciate the cooperation and courtesies OSHA extended us during this audit. OIG personnel who made major contributions to this report are listed in Appendix C.



Elliot P. Lewis
Assistant Inspector General for Audit

APPENDIX A: SCOPE, METHODOLOGY, & CRITERIA

SCOPE

This audit covered 3,642 fatalities and 18,805 severe injuries employers reported to Federal OSHA from January 1, 2015 through September 30, 2016⁸, and did not include fatalities and severe injuries from states that administer their own safety and health programs.

Fieldwork was performed at OSHA's National Office in Washington, DC, regional offices in Region 7 (Kansas City), Region 6 (Dallas), and Region 1 (Boston), and area offices in Omaha, Kansas City, Fort Worth, Houston South, Springfield, and Braintree.

METHODOLOGY

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

To achieve our objective, we collected and summarized background information on OSHA's issues related to the audit objective. We examined OSHA's controls over the reporting of fatalities and severe injuries by reviewing applicable criteria and OSHA's response to our customized internal control questionnaires. We also interviewed key OSHA officials to obtain an understanding of OSHA's processes and procedures such as intake and recording of employer reported incidents; determining if OSHA or the employer should have investigated the incident; confirming hazards were abated; and identifying employers that had not reported incidents. In collaboration with OSHA, we surveyed state plan states to gain an understanding of their implementation of the fatality and severe injury reporting requirements.

⁸ To provide the most current data, we extracted fatalities and severe injuries from OSHA's website on April 2, 2018. From January 1, 2015 through April 29, 2017, employers reported 4,185 fatalities. From January 1, 2015 through April 30, 2017, employers reported 23,282 severe injuries.

We statistically selected employer reported fatality and severe injury incidents from the 10 regions to answer our audit objective and support our results and conclusions. We assessed the reliability of data for the 3,642 fatalities and 18,805 severe injuries in our audit that we received from OSHA on November 29, 2016 and November 8, 2016, respectively. We considered the completeness and reliability of the data received from OSHA as follows:

1. We tested the data for employer reported fatalities and severe injuries within our scope by ensuring the incident receipt date was from January 1, 2015 through September 30, 2016. Based on our testing, we concluded the data to be within the scope of our audit.
2. For the universe of employer reported fatalities and severe injuries, we compared the fatality and severe injury data OSHA provided to the data on OSHA’s webpage. OSHA could not provide reasonable assurance that the universe of severe injuries and fatalities was complete (see the Results section of this audit report titled, “Estimates Show that 50 Percent or More of Severe Injuries were Not Reported”).

We assessed the effectiveness of controls by interviewing National and regional officials; reviewing their responses to internal control questionnaires; reviewing OSHA guidance for enforcement procedures for reporting requirements under 29 CFR 1904.39, including OSHA’s Field Operations Manual; and reviewing Management Accountability Program reports issued by OSHA that addressed the reporting requirements.

For sample selection, we used a stratified two-stage random sampling plan to select regions (stage 1) and fatalities and severe injuries for review (stage 2). For stage 1, we grouped regions into 3 strata (small, medium, and large) based on their number of fatalities and severe injuries and selected one region from each stratum — Regions 1, 6, and 7. For stage 2, we used a 95 percent confidence level, and a 10 percent margin of error to select 50 sampled fatalities and 100 sampled severe injuries as follows:

Sample Selection


Region	Number of Sampled Fatalities	Number of Sampled Severe Injuries
1	5	13
6	34	62
7	11	25
Total	50	100

CRITERIA


- GAO Standards for Internal Control in the Federal Government, September 2014
- OSHA Directive Number: CPL 03-00-019, National Emphasis Program on Amputation, August 13, 2015
- OSHA Field Operations Manual
- OSHA Memorandum, Interim Enforcement Procedures for New Reporting Requirements under 29 C.F.R. 1904.39, December 24, 2014.
- OSHA Memorandum, Revised Interim Enforcement Procedures for Reporting Requirements under 29 C.F.R. 1904.39, March 4 2016.
- Title 29, Code of Federal Regulations, Section 1904.39, OSHA Recording and Reporting Occupational Injuries and Illness.

APPENDIX B: AGENCY'S RESPONSE TO THE REPORT

U.S. Department of Labor Occupational Safety and Health Administration
Washington, D.C. 20210

AUG 28 2018 

MEMORANDUM FOR: ELLIOT P. LEWIS
Assistant Inspector General for Audit

FROM: LOREN SWEATT 
Deputy Assistant Secretary

SUBJECT: Response to OIG's Draft Report No. 02-18-203-10-105, "OSHA Needs to Improve the Guidance for its Fatality and Severe Injury Program to Better Protect Workers"

Thank you for the opportunity to provide comment on the draft of the Office of Inspector General (OIG) Audit Report No. 02-18-203-10-105, "OSHA Needs to Improve the Guidance for its Fatality and Severe Injury Program to Better Protect Workers." OSHA appreciates the efforts OIG undertook to develop this report.

OSHA agrees that better case documentation can help to promote consistency in the issuance of citations, as well as the determination of whether to conduct an inspection or pursue a rapid response investigation. However, OSHA is concerned that the OIG's report suggests that the burden to ensure reporting of injuries and illnesses falls on the agency. The Occupational Safety and Health Act of 1970 clearly states that it is the employer's responsibility to "comply with occupational safety and health standards under this Act." (Section 5(a) (2)). The agency encourages employers to comply with illness and injury reporting requirements through a variety of enforcement, outreach, and compliance assistance tools. In reference to Recommendation #3b, there is no legal requirement for employers to provide documentation to show abatement of hazards, only to report the injury or fatality.

The agency appreciates the opportunity for continued improvements to our enforcement efforts. Please see the more detailed responses to the recommendations below.

RECOMMENDATIONS

Recommendation 1: Develop formal guidance and train staff on how to detect and prevent underreporting of fatalities and severe injuries.

OSHA's Response: OSHA's current policy for responding to unreported fatalities and severe injuries is clear and appropriate. Statutorily, the obligation to report certain work-related injuries belongs to the employer. To discourage underreporting, OSHA increased the unadjusted penalty for failing to report injuries involving an inpatient-hospitalization, amputation, or loss of an eye.

from \$1,000 to \$5,000 in March 2016. OSHA also has multiple mechanisms for learning about reportable injuries that employers fail to report. For example, workers may file a complaint with OSHA and include information about a reportable injury as part of their description of a potential hazard. In addition, when OSHA conducts an inspection, the Compliance Safety and Health Officer (CSHO) is required to review the employer's injury and illness records (see Field Operations Manual Chapter 3 Section VI – Review of Records). When OSHA learns about a reportable injury through these other avenues after the reporting timeframe has elapsed, a citation maybe issued for failing to report, if appropriate.

OSHA appreciates that the OIG's report acknowledges that the agency "may not have the tools it needs, such as workers compensation data, to detect underreporting" (p. 5). This is a critical point. OSHA does not have the authority to compel other entities that may have information about severe injuries—including workers compensation carriers, first responders, and hospitals—to provide that information to OSHA. In some cases, depending on state and local laws, particular area offices may have pre-existing partnerships that provide access to additional data on amputations or in-patient hospitalizations. However, it is not clear what additional measures OSHA could take through formal guidance or training to prevent underreporting absent statutory changes to allow the sharing of this information or substantial additional resources devoted specifically to seeking out unreported injuries.

Recommendation 2: Consistently issue citations for late reporting.

OSHA's Response: OSHA believes that the current policy regarding citation issuance is clear, and that affected field staff have received adequate training to determine when citation issuance is appropriate. Area Directors must be allowed some level of flexibility in making a determination whether to issue, based on the unique circumstances presented in each case. In some cases, OSHA may hear about an incident after the six-month statute of limitations has expired, in which case no citation could be issued. However, the agency recognizes that, where an Area Director determines that a citation is not appropriate despite an apparent failure to report, the case file should contain adequate documentation to support that decision. OSHA will remind staff of the need to improve case file documentation.

Recommendation 3: Clarify OSHA's guidance related to:

- a. documentation of essential decisions,
- b. evidence required to demonstrate employers corrected all hazards, and
- c. requirements for monitoring employer-conducted investigations.

OSHA's Response: OSHA concurs that the agency can improve case file documentation, to include essential decisions, such as whether to issue citations (see Recommendation #2), and when to deviate from the triage guidance (see Recommendation #4). OSHA also concurs that the monitoring aspect of this program has not been fully implemented, and will take the necessary steps to do so.

The revised reporting requirements under 29 CFR 1904.39 resulted in a significant increase in severe injury reports from employers. OSHA receives an average of approximately 1,000

reports each month, which diverts resources from programmed inspections. . . An employer is only under a legal obligation to report an event, not to conduct an investigation or submit proof of abatement. By encouraging them to do so voluntarily, OSHA is impacting workplaces it otherwise would not have the resources to reach. OSHA believes that the monitoring investigations, when implemented, will help to ensure that rapid response investigations are effective and that abatement has taken place. The agency will also provide additional guidance for field staff to help identify when an employer's abatement plan is sufficient to allow case closure.

Recommendation 4: Emphasize the necessity to conduct inspections on all Category 1 incidents.

OSHA's Response: On March 4, 2016, OSHA published the *Revised Interim Enforcement Procedures for Reporting Requirements Under 29 CFR 1904.39*, which outlines the criteria for conducting an inspection for Category 1 incidents. The guidance states: "After the Area Director (or his or her designee) determines that an employer report falls within Category 1, an onsite inspection shall be conducted in accordance with the procedures contained in the Field Operations Manual (FOM)." (Section VI.A.). Chapter 9 of the FOM provides those procedures. Specifically, Paragraph I.H.b. states: "The Area Director may determine not to inspect a facility if he/she has a substantial reason to believe that the condition complained of is being or has been abated." OSHA will remind Area Directors of the need to document their justification in the case file when deciding not to conduct an inspection for a Category 1 incident.

APPENDIX C: ACKNOWLEDGEMENTS

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