U.S. Department of Labor

Office of Inspector General—Office of Audit

REPORT TO THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

OSHA'S VOLUNTARY PROTECTION PROGRAMS REQUIRE BETTER INFORMATION TO IDENTIFY PARTICIPANTS WITH CONTRACT-WORKER FATALITIES AND CATASTROPHES

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U.S. Department of Labor
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BRIEFLY…

September 11, 2017

OSHA'S VOLUNTARY PROTECTION PROGRAMS REQUIRE BETTER INFORMATION TO IDENTIFY PARTICIPANTS WITH CONTRACT-WORKER FATALITIES AND CATASTROPHES

WHY OIG CONDUCTED THE AUDIT

The Occupational Safety and Health Administration's (OSHA) Voluntary Protection Programs (VPP) create cooperative relationships with businesses and their workers that establish effective safety and health management systems to help prevent work-related fatalities, injuries, and illnesses. These systems also protect others working under contract (contract-workers) at the VPP participant's worksite. The Office of Inspector General (OIG) received a hotline complaint alleging that regional program officials did not take appropriate follow-up actions in response to a VPP contract-worker fatality. OSHA policy requires VPP program officials to notify the national office of fatalities and catastrophes, place the VPP participant on inactive status, review enforcement inspection reports and citations, and determine if the participant should be allowed to remain in VPP or be terminated. Between July 1, 2013, and September 30, 2016, OSHA received reports that 23 of 1,410 VPP participants experienced a worker or contract-worker fatality or catastrophe.

WHAT OIG DID

We conducted an audit to determine the following:

> Did OSHA appropriately follow up on worker and contract-worker fatalities and catastrophes experienced by VPP participants?

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to: https://www.oig.dol.gov/public/reports/oa/2017/02-17-202-10-105.pdf

WHAT OIG FOUND

Between July 1, 2013, and September 30, 2016, OSHA's VPP staff appropriately followed up on 23 participants that reported a worker or contract-worker fatality or catastrophe to determine if they should remain in VPP or be terminated. However, OSHA did not have assurance that VPP staff followed up on all VPP contract-worker fatalities and catastrophes because the program officials relied on participants, workers, and contract-workers to disclose VPP affiliation when reporting fatalities and severe injuries to OSHA. Under OSHA recordkeeping requirements, all employers must report work-related fatalities and severe injuries to OSHA. If the employer does not disclose their VPP affiliation, VPP staff may use the participant name and address to identify worker fatalities and catastrophes from lists of OSHA inspections and employer fatality and severe injury reports. However, VPP staff did not have adequate contractor information to identify VPP contract-worker fatalities and catastrophes.

VPP staff lacked adequate contractor information for several reasons. VPP program officials obtained basic contractor information (name and industry) from reports submitted manually by most VPP participants. However, program officials did not ensure the information was complete and distributed to staff. Additionally, VPP policy did not require approximately 12 percent of participants to include contractor information in their manual reports. As a result, there is the potential some VPP contract-worker fatalities or catastrophes went undetected and some participants remained in VPP when OSHA should have terminated them.

Finally, we concluded the hotline complaint did not have merit. Regional program officials acted appropriately. In this case, VPP follow–up actions were not required since the contract worker who died was not working at a covered VPP worksite.

WHAT OIG RECOMMENDED

We recommended the Acting Assistant Secretary for Occupational Safety and Health: 1) establish a system to collect and disseminate VPP contractor information; 2) establish controls to ensure the information is complete; and 3) expand collection of contractor information to all VPP participants. The Acting Assistant Secretary agreed to improve processes to address the recommendations.

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Office of Inspector General
Washington, D.C. 20210

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INSPECTOR GENERAL'S REPORT

Loren Sweatt
Acting Assistant Secretary
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The Occupational Safety and Health Administration's (OSHA) Voluntary Protection Programs (VPP) create cooperative relationships with businesses and their workers to establish effective safety and health management systems that help prevent worker and contract-worker fatalities, injuries, and illnesses. In February 2014, the Office of Inspector General (OIG) received a hotline complaint alleging a contract-worker fatality occurred at a VPP worksite and regional program officials did not take appropriate follow up actions in response to the fatality. OSHA policy requires VPP program officials to notify the national office of fatalities and catastrophes, place the VPP participant on inactive status, review enforcement inspection reports and citations, and determine whether to terminate or keep the participant in VPP.

Between July 1, 2013, and September 30, 2016, OSHA received reports that 23 VPP participants experienced a worker or contract-worker fatality or catastrophe. As of September 30, 2016, there were 1,410 VPP participants. The OIG conducted a performance audit of VPP to answer the following question:

> Did OSHA appropriately follow up on worker and contract-worker fatalities and catastrophes experienced by VPP participants?

RESULTS IN BRIEF

After receiving reports of worker or contract-worker fatalities or catastrophes, OSHA appropriately conducted follow up on 23 VPP participants to determine whether to keep participants in VPP or to terminate them from the program. However, OSHA did not have assurance that it received reports of all VPP contract-worker fatalities and catastrophes, because it did not have adequate information systems. Instead, OSHA relied on participants, workers, and contract-workers to report VPP fatalities and

catastrophes.[1] Regulations require all employers to report work-related fatalities and severe injuries to OSHA; however, contractors that report may not reveal their affiliation with a VPP participant. In such cases, OSHA did not have adequate information systems to enable staff to identify VPP contract-worker fatalities and catastrophes from its lists of inspections and employer fatality and severe injury reports.

OSHA's information systems were not adequate for several reasons. First, OSHA received manual reports with basic information (name and industry) on contractors from most VPP participants. However, OSHA did not enter the information into a system or otherwise distribute it so agency staff could identify contract-worker fatalities and catastrophes. Additionally, OSHA did not validate the contractor information so that staff could rely on it to identify VPP contract workers from lists of employer-reported fatalities and severe injuries. Finally, OSHA did not require approximately 12 percent of VPP participants to provide basic contractor information in their manual reports. As a result, there is a risk that OSHA will not detect some accidents involving VPP contract-workers, and these VPP participants remain in the program when OSHA should have terminated them.

Regarding the hotline complaint, we found that regional program officials acted appropriately in deciding not to take VPP follow-up actions. The contract-worker who died on the job did not work at a covered VPP worksite.

BACKGROUND

OSHA established VPP to recognize and promote effective worksite-based safety and health management systems. In VPP, management, labor, and OSHA establish cooperative relationships at workplaces that are implementing or have implemented comprehensive safety and health management systems. These safety and health management systems help prevent work-related fatalities, injuries, and illnesses. They also protect the participant's employees (workers) and other company employees who are working under contract with the participant at VPP worksites (contract-workers).

To ensure participants comply with VPP requirements, OSHA conducts periodic onsite certification visits. During these visits, staff evaluate the participant's safety and health program, review the manual report on the participant's annual self-evaluation of their safety and health programs, follow up on OSHA inspections, and perform other oversight activities. When a worker or contract-worker fatality or catastrophe occurs at a VPP worksite, OSHA's area office conducts an enforcement inspection to determine the cause, whether a violation of safety and health standards occurred, and if the violation contributed to the incident. In addition, VPP policy[2] requires the OSHA Regional Office to notify OSHA's national office of the incident and place the participant on inactive VPP

[1] A catastrophe is a work-related accident or illness where three or more workers are hospitalized.
[2] *VPP Policy Memorandum #7: Further Improvements to the Voluntary Protection Programs (VPP),* dated May 29, 2013

status. After the OSHA area office completes the inspection, the regional office reviews the investigation report and citations issued, and either recommends the participant be allowed to remain in VPP or be terminated from the program. The OSHA regional office sends its recommendation to the OSHA national office for review and the Assistant Secretary issues a final decision.

RESULTS

After receiving reports of worker or contract-worker fatalities or catastrophes, OSHA appropriately followed up on 23 VPP participants to determine whether to keep them or terminate them from the program. However, there is the risk that some accidents involving VPP contract-worker fatalities and catastrophes went undetected, and that OSHA kept some VPP participants in the program when the agency should have terminated them. This occurred because OSHA did not maintain adequate systems to identify contract-worker fatalities and catastrophes from lists of its inspections and employer fatality and severe injury reports. Instead, OSHA relied on participants, workers, and contract-workers to identify VPP fatalities and catastrophes.

Between June 1, 2013, and September 30, 2016, 23 VPP participants notified OSHA of worker or contract-worker fatalities or catastrophes. However, OSHA did not have adequate systems to ensure it received notification of all VPP-related accidents. This occurred because OSHA received manual reports with basic contractor information (name and industry) from most VPP participants, but failed to: (1) enter the data into a system or otherwise distribute it to staff; (2) ensure its reliability; or (3) require approximately 12 percent of VPP participants to provide it in their reports.

Federal internal control standards require recording and communicating relevant, reliable information to all those who need it to carry out their responsibilities.[3] However, OSHA did not have information systems to accumulate and communicate contractor information to staff who could identify VPP contract-workers from lists of OSHA inspections and employer fatality and severe injury reports. As a result, OSHA may not have known about some VPP contract-worker fatalities and catastrophes, and therefore could not have followed up to determine the VPP participants' continuing eligibility for the program.

OSHA LACKED COMPLETE INFORMATION ON CONTRACTORS USED BY VPP PARTICIPANTS

OSHA lacked an adequate system to provide staff with the necessary information to monitor lists of its inspections and employer fatality and severe injury reports

[3] *Standards for Internal Controls in Federal Government*, GAO/AIMD-00-21.3.1, dated November 1999

for contract-worker accidents at VPP worksites. Specifically, OSHA's system was inadequate because contractor information was not:

- entered in a monitoring system and disseminated to staff;
- validated for approximately 15 percent of sampled participants; or
- required from approximately 12 percent of VPP participants nationwide.

OSHA DID NOT ENTER CONTRACTOR INFORMATION INTO A MONITORING SYSTEM OR DISSEMINATE IT TO STAFF

Most VPP participants provided basic contractor information as part of their annual self-assessment reports to OSHA VPP program officials, but OSHA did not enter this information into a monitoring system nor otherwise share it with area office staff. Without this information, staff could not monitor lists of OSHA inspections and employer fatality and severe injury reports for potential VPP contract-worker fatalities and catastrophes. Lack of information sharing and communication issues reflected significant internal control weaknesses, leaving OSHA almost completely reliant on participants, workers, and contract-workers to identify and report contract-worker fatalities and catastrophes as VPP-related incidents. As a result, OSHA did not have assurance that it received reports of all VPP contract-worker fatalities and catastrophes, and appropriately followed up with VPP participants.

Office of Management and Budget (OMB) Circular A-123 states management is responsible for developing and maintaining effective internal controls and communicating information to relevant personnel at all levels within an organization.[4] OSHA's failure to disseminate contractor information to area office staff represented a breakdown in this key internal control area.

Our review of the VPP data system, interviews with key VPP personnel in Region III (Philadelphia), and review of a comprehensive self-audit performed by OSHA Region VI (Dallas) found the following:

- The VPP data system maintained searchable information on every participant, including the street address, city, state, associated company, corporation, union, and contact persons. However, for VPP contractors, the data system did not even include the basic information (name and industry) OSHA collects from VPP participants via their annual self-assessment reports.

- VPP staff in Region III indicated VPP contractor information was not readily available. The staff stated OSHA had no central database with contractor information that appropriate VPP personnel could access. In addition, staff said that the regional office maintained VPP participants'

[4] OMB Circular A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004

annual self-assessment reports with the contractor information. Area office staff could only request the information on a case-by-case basis.

- OSHA's comprehensive self-audit[5] of Region VI found similar communication issues where area office staff may not have known that a worksite was a VPP participant. Therefore, staff did not routinely notify VPP regional office officials when area offices conducted inspections at VPP worksites.

If area office staff had access to a data system where OSHA collected and maintained contractor information, they could monitor lists of OSHA inspections and employer fatality and severe injury reports for contract-worker fatalities and catastrophes. OSHA policy requires thorough investigations of all fatalities and catastrophes in order to determine the cause, whether a safety and health violation occurred, and if the violation contributed to the fatality or catastrophe.[6] Federal regulations require employers to report work-related fatalities and severe injuries to OSHA.[7] Data from both OSHA inspections and employer fatality and severe injury reports include the employer name and event location. OSHA staff could compare this information with the VPP contractor name and participant address to identify unreported VPP contract-worker fatalities or catastrophes.

CONTRACTOR INFORMATION WAS NOT RELIABLE FOR 15 PERCENT OF SAMPLED PARTICIPANTS

For 11 of 75 sampled participants (15 percent) in Region III (Philadelphia), OSHA collected incomplete or unreliable information on contractors from the participants' annual self-assessment reports. VPP policy requires participants to submit information for each contractor whose employees worked 1,000 hours or more during any calendar quarter for the participant. The information provided by 11 sampled participants was not complete or reliable. OSHA was unaware of this because its policy for reviewing the annual self-assessments did not include steps to validate contractor information. As a result, OSHA Region III lacked sufficient information to identify any contract-worker fatalities or catastrophes that may have occurred at the 11 sampled participants.

OMB Circular A-123 on internal controls states that information should be relevant, reliable, and timely.[8] However, OSHA did not establish sufficient controls to ensure the information VPP participants reported was reliable. The reliability of reported contractor information is critical because it is the only time the participant is required to provide OSHA with the name and industry of its contractors. After reviewing participant annual self-assessments and OSHA reports of its onsite certification visits, we found the following deficiencies.

[5] Per OSHA's Management Accountability Program (OSHA Instruction EAA 01-00-004, September 15, 2010) comprehensive audits include the review of all major program areas in a region, including VPP.
[6] *OSHA Field Operations Manual (FOM),* dated October 1, 2015
[7] Code of Federal Regulations, Title 29, Part 1904.39
[8] OMB Circular A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004

- Eight participants did not submit complete contractor information, six did not provide the name of the contractor, and two did not provide the industry code. For example, one participant reported that 1,478 contract-workers worked more than 2 million hours, but the participant did not provide any identifying information on the contractors. In response to the OIG audit, OSHA Region III obtained a list of 97 contractors that worked for the VPP participant and directed the participant to provide the required contractor information in all future self-assessment reports.

- Three participants' annual self-assessment reports contained information on the number of contract-workers that varied significantly from the number of contract-workers observed by OSHA staff during certification site visits. OSHA conducts periodic certification site visits (every 1 to 5 years) to determine whether to keep the participant in VPP or terminate them from the program. During these visits, OSHA staff document the number of contract-workers observed. To ensure contractor information is reliable, OSHA should follow up if there are significant differences between the number of contract-workers on site and the number on the participant's annual self-assessment report.

OSHA DID NOT REQUIRE APPROXIMATELY 12 PERCENT OF VPP PARTICIPANTS NATIONWIDE TO REPORT CONTRACTOR INFORMATION

Approximately 12 percent of participants did not provide any contractor information because OSHA's VPP policy did not require them to include it in their annual self-assessment reports. OSHA staff did not have access to the necessary contractor information for these participants. Therefore, staff could not identify a VPP contract-worker fatality or catastrophe, and ensure OSHA took appropriate follow-up actions to determine if the participant should remain in VPP or be terminated. Internal control standards required management to ensure there were adequate means of obtaining information from external stakeholders, such as VPP participants, that may have had a significant impact on the agency achieving its goals.[9] Because VPP policy did not require the participants to provide the information, OSHA did not have sufficient information for monitoring participants.

OSHA policy[10] had two different requirements for submission of contractor information in the participants' annual self-assessment, depending on the type of VPP participant. OSHA required one type of participant (site-based non-construction) to submit limited information for contract-workers (i.e., contractor name and industry code). Site-based, non-construction participants comprised approximately 88 percent of VPP participants nationwide. The remaining 12 percent of participants were in two other groups —

[9] *Standards for Internal Controls in Federal Government*, GAO/AIMD-00-21.3.1, dated November 1999
[10] *VPP Policy Memorandum #4: Further Improvements to the Voluntary Protection Programs (VPP)*, dated February 2, 2011

site-based construction and mobile workforce. OSHA did not require participants in these groups to submit any contractor information. Site-based construction and mobile workforce participants included companies in industries such as support activities for oil and gas operations, building construction, heavy and civil engineering construction, specialty trade contractors, remediation services, automotive repair and maintenance, and commercial machinery repair and maintenance.

For 2015, the Bureau of Labor Statistics (BLS) reported 682 contract-workers died on the job and identified the industries in which the contract-workers were employed when they died.[11] According to BLS, 213 of the 682 contract-workers who died on the job worked for companies in the same industries as the VPP site-based construction and mobile workforce participants. Because OSHA did not collect contractor information for these two groups, it could not identify whether any of the fatalities reported by BLS involved VPP participants.

OIG RECOMMENDATIONS

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

1. Establish a system to collect and disseminate VPP contractor information to OSHA staff that monitor lists of its inspections and employer fatality and severe injury reports.

2. Establish controls to ensure VPP participants report complete and reliable contractor information on their annual self-assessment reports.

3. Collect contractor information from site-based construction and mobile workforce VPP participants.

In her response, the Acting Assistant Secretary acknowledged OSHA's current procedures can be strengthened and discussed plans to improve both processes and technology to address the issues discussed in the report. Management's response to our draft report is included in its entirety in Appendix B.

[11] BLS report, *Fatal occupational injuries incurred by contracted workers, 2011-2015*, http://www.bls.gov/iif/oshwc/cfoi/contractor.xlsx

We appreciate the cooperation and courtesies that OSHA personnel extended to the Office of Inspector General 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

Appendices

APPENDIX A

OBJECTIVE, SCOPE, METHODOLOGY, AND CRITERIA

OBJECTIVE

Did OSHA appropriately follow up on worker and contract-worker fatalities and catastrophes experienced by VPP participants?

SCOPE

Our audit scope covered 23 participants under federal OSHA jurisdiction that experienced a worker or contract-worker fatality or catastrophe between June 1, 2013, and September 30, 2016, and the follow-up actions taken by OSHA through June 1, 2017. As of September 30, 2016, there were 1,410 VPP participants under federal OSHA jurisdiction. Our audit scope also included 507 sampled participants in VPP as of April 30, 2014, and 212 contract-workers. Using publicly available OSHA data, we searched for fatalities, catastrophic injuries or illnesses at VPP worksites for the sampled participants and contract-workers that may not have been reported to OSHA as VPP-related. We conducted fieldwork at OSHA Region III in Philadelphia, PA, where we interviewed regional program officials and staff, and reviewed documentation for 75 of the 507 sampled VPP participants and their contract-workers.

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

METHODOLOGY

We reviewed OSHA's policies and procedures to gain an understanding of internal controls considered significant to the audit objective, and confirmed our understanding through interviews and document reviews. We considered the internal control elements of control environment, control activities, information and communication, and monitoring during our planning and substantive audit phases and evaluated relevant controls. We obtained an understanding of processes to follow up on worker fatalities and catastrophes experienced by VPP participants. We reviewed VPP manual and policy memoranda for applicable requirements. We interviewed OSHA officials from the OSHA National Office (Directorate of Cooperative and State Programs) and Region III, and Compliance Assistance Specialists within Region III. We documented and tested key processes for following up on worker fatalities and catastrophes for the sampled participants.

We selected a random sample of 75 VPP participants in Region III that included 212 contractor-workers. For each sampled participant, we reviewed their Fiscal Year 2013 self-evaluation, OSHA's report of the most recent onsite reevaluation, and other documentation of OSHA's monitoring. From the self-evaluations, we compiled identifying information for the 212 contract-workers. We used a random sampling approach to select the 75 participants using an 80 percent confidence level and +/- 9 percent sampling precision.

The OSHA Directorate of Cooperative and State Programs established four optional inspection codes to improve the notification and tracking of VPP sites where enforcement activities are ongoing. Using these new codes, we identified fatalities and catastrophes reported to OSHA from June 1, 2013, through September 30, 2016. We used online OSHA resources to research whether the agency placed participants on inactive status pending its completion of enforcement, and the status of the inspection. We followed up with OSHA on the participant's VPP status as of June 1, 2017, and documentation of Policy Memorandum #7 processes that had been completed.

CRITERIA

- Federal Register Vol. 74, No. 6, Friday, January 9, 2009, Notices, pages 927-952
- *Occupational Safety and Health Act of 1970*
- OMB Circular A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004
- OSHA Directive CSP 03-01-003 – *Voluntary Protection Program (VPP): Policies and Procedures Manual* - April 18, 2009, and the seven policy memoranda
- *Standards for Internal Controls in Federal Government*, GAO/AIMD-00-21.3.1, dated November 1999

APPENDIX B

OSHA'S RESPONSE

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

Reply to the attention of:

AUG 31 2017

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

FROM: LOREN SWEATT
Deputy Assistant Secretary

SUBJECT: Response to OIG's Report No. 02-17-202-10-105, "OSHA's Voluntary Protection Programs Require Better Information to Identify Participants with Contract-Worker Fatalities and Catastrophes"

This memorandum is in response to the Office of the Inspector General (OIG) draft Audit Report No. 02-17-202-10-105, "OSHA's Voluntary Protection Programs Require Better Information to Identify Participants with Contract-Worker Fatalities and Catastrophes" (the Report). The Occupational Safety and Health Administration (OSHA) appreciates this opportunity to provide comments on the audit findings and recommendations outlined in the report.

OSHA is pleased that the OIG did not find merit in the hotline complaint alleging improper agency response to a contract-worker fatality occurring in the Philadelphia area, within OSHA's Region III. In addition, OSHA is pleased that the OIG did not identify any instances of failure to follow Voluntary Protection Programs (VPP) policies and procedures for responding to contract-worker fatalities at VPP facilities nationwide.

However, OSHA recognizes that the current procedures can be strengthened, and is committed to implementing enhanced processes and technology improvements to better enable the agency to identify and track enforcement activities, including contract-worker fatalities, at VPP sites. These improvements will result in a more systematic and comprehensive approach to determining whether a participant should be allowed to remain in VPP following enforcement activity.

Recommendation 1: Establish a system to collect and disseminate VPP contractor information to OSHA staff that monitor lists of its inspections, employer fatality, and severe injury reports.

Response: OSHA is currently enhancing the capabilities of the VPP Automated Data System (VADS), the agency's data management system for tracking and monitoring program information related to VPP participants. In the interim, OSHA is confident that current internal procedures address many of the issues raised in this report. Some examples are described below:

- Collecting and reviewing contractor information for accuracy in advance of the VPP on-site evaluation, and verifying during the on-site work.
- Establishing requirements for notification and communication of worker fatalities and catastrophes occurring at VPP sites (OSHA Policy Memorandum #7).
- Reviewing annual VPP participant self-assessments and verifying accuracy of the information during the reapproval process.

Recommendation 2: Establish controls to ensure VPP participants report complete and reliable contractor information on their annual self-assessment reports.

Response: OSHA requires VPP participants to self-report their contractor information on an annual basis. OSHA anticipates that system improvements to the VADS system will allow for better tracking of contractor data. However, creating and implementing a system that strives for real-time data regarding contractors at VPP sites would require time, resources, and technology at a cost that would exceed the benefits to overall worker safety and health at OSHA's VPP sites. As stated above in the response to Recommendation 1, OSHA has internal procedures to ensure accuracy, and reliability of contractor data.

Recommendation 3: Collect contractor information from site-based construction, and mobile workforce VPP participants.

Response: In accordance with Appendix C of the VPP Policy and Procedures Manual, during the annual self-assessment period, all VPP participants are required to provide information regarding contractors, including site-based construction, and mobile workforce participants. OSHA anticipates the enhanced VADS system will allow improved tracking of all contractor information, including site-based construction, and mobile workforce VPP participants.

APPENDIX C

ACKNOWLEDGEMENTS

Key contributors to this report were Mark Schwartz, Rebecca Bowen, Cardelia Yan, Sean Ally, Miguel Hughes, and Mary Lou Casazza.

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