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NEVADA'S WORKPLACE HEALTH AND SAFETY ENFORCEMENT PROGRAM: OSHA'S FINDINGS AND RECOMMENDATIONS

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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C O N T E N T S

NEVADA'S WORKPLACE HEALTH AND SAFETY ENFORCEMENT PROGRAM: OSHA'S FINDINGS AND RECOMMENDATIONS

Thursday, October 29, 2009
U.S. House of Representatives
Committee on Education and Labor
Washington, DC

The committee met, pursuant to call, at 10:01 a.m., in room 2175, Rayburn House Office Building, Hon. George Miller [chairman of the committee] presiding.

Present: Representatives Miller, Kucinich, Wu, Altmire, Hare, Sablan, Titus, Chu, Kline, Petri, McKeon, McMorris Rogers, and Roe.

Also present: Representative Berkley.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Calemine, General Counsel; Lynn Dondis, Labor Counsel, Subcommittee on Workforce Protections; Patrick Findlay, Investigative Counsel; Richard Miller, Senior Labor Policy Advisor; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Rachel Racusen, Communications Director; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Erin Sullivan, Investigative Associate; Michael Zola, Chief Investigative Counsel, Oversight; Mark Zuckerman, Staff Director; Kirk Boyle, Minority General Counsel; Casey Buboltz, Minority Coalitions and Member Services Coordinator; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Richard Hoar, Minority Professional Staff Member; Barrett Karr, Minority Staff Director; Alexa Marrero, Minority Communications Director; Jim Paretti, Minority Workforce Policy Counsel; Susan Ross, Minority Director of Education and Human Services Policy; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel; and Loren Sweatt, Minority Professional Staff Member.

Chairman MILLER [presiding]. The committee on Education and Labor meets this morning to examine a federal Occupational Safety and Health Administration review of the Nevada health and safety program.

The committee first heard testimony regarding problems with Nevada's OSHA program at a June 2008 hearing on construction safety. During an 18-month period between 2006 and 2008, 12 construction workers died on the Las Vegas strip.

At the hearing, witnesses said that it was routine for Nevada OSHA officials to reduce or eliminate tough sanctions behind closed doors.

The Nevada workplace health and safety was also the focus of a year-long investigation by the Las Vegas Sun in 2007 and 2008. The paper reported that productivity was frequently put ahead of safety as contractors pursued completion bonuses.

These growing health and safety issues sparked labor disputes. Workers staged a walkout in June of 2008, demanding safety improvements, after concerns grew over eight deaths at two construction sites in Las Vegas.

Safety trends in Nevada had been pointing in the wrong direction. Between 2003 and 2007, Nevada's construction illnesses and injury rate went up by more than 20 percent while the national construction injury and illness rate fell by 11 percent.

As safety became an issue, so did enforcement. Two complaints alleging backroom deals between Nevada OSHA and politically connected firms were lodged by those involved in a 2008 tragedy that killed two workers and nearly took the life of another at the Orleans Hotel and Casino.

The mother of one worker that was killed at the Orleans Hotel joins us today. She will recount the reckless disregard of worker safety by Boyd Gaming and the agreement with Nevada OSHA that resulted in Boyd escaping willful violations even though they had been cited for substantially similar violations at its other properties in Nevada over the previous 3 years.

The lead Nevada OSHA inspector who recommended willful violations against the Orleans took an extraordinary step of filing a complaint with federal OSHA officials after the deal was made. He resigned his position shortly thereafter.

The committee was advised that he was counseled that assisting in a complaint against the state could result in an adverse personnel action.

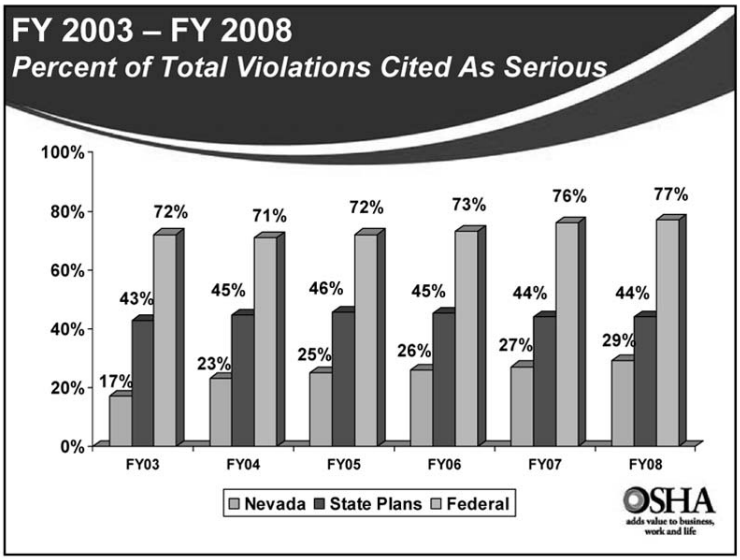
The inspector pointed to extensive irregularities in the Boyd Gaming deal and said that the deal could only be a result of OSHA protecting the contractors from bad publicity and wrongful death lawsuits by the workers' families.

This and many other allegations of misconduct eventually led to a special review of the Nevada state plan by the new administration.

The review shows that Nevada's OSHA program failed to cite employers for clear hazards, didn't properly train inspectors, didn't follow up to ensure that dangerous conditions were fixed, failed to include worker representatives in inspections, and failed to notify families of deceased workers of investigations or give them the chance to speak to investigators.

It is also troubling how infrequently Nevada inspectors found serious violations and took little meaningful enforcement action.

As this chart shows, last year only 29 percent of Nevada's citations were classified as serious. Compare that to 44 percent in—for other state plans and 77 percent for federal OSHA.



It is clear that there is something terribly wrong with the Nevada's OSHA program. But Nevada's problems may also reflect a larger problem with the oversight of the 27 states and territories that operate their own plans.

Federal OSHA must ensure that the state operates its own plan in a manner that is at least as effective as the federal program. No flags were raised during previous reviews of Nevada's plans under the Bush administration.

In fact, Bush OSHA officials called Nevada's health and safety program "very good overall." These thumbs-up were occurring at the same time that fatalities and injuries were skyrocketing.

Federal officials were clearly asleep at the switch. With rosy proclamations from the Bush administration, there was no push for Nevada to better protect its workers.

This was at least until the new acting assistant secretary for OSHA, under the leadership of a new administration, ordered a comprehensive review of the state plan. He will join us today to explore the agency's conclusions and recommendations.

I am also pleased that Nevada's OSHA's new director will join us today, and I look forward to hearing from him about Nevada's plans for turning this program around.

While Nevada promises to improve the program are an important first step, they must be strictly monitored by federal officials. Basic oversight of state plans is not only important in Nevada, but it is vital to the 57 million American workers whose health and safety protections are enforced by 27 state plans.

While some states are running innovative programs, it is clear that additional reviews of state plans is warranted.

Excluding California because they have higher penalties, the average serious penalty assessed by state plans is only 65 percent of the federal OSHA average. This disparity suggests that some states may not be as effective as federal OSHA.

Indeed, one witness today will offer his perspective that Nevada may not be the only state with problems meriting closer scrutiny.

OSHA's announcement of additional state reviews is important to ensure that every worker has sufficient health and safety protection while on the job.

Before we get to the witnesses, we will first hear from our distinguished guest from the State of Nevada, Senator Reid—I don't know if—has the senator arrived yet? Not yet, okay—who has been a stalwart in the fight for health and safety of the American workers, ensuring that those who have been harmed on the job receive just compensation.

And we look forward to his testimony as soon as he shows up.

In the meantime, while he is—we understand that he is on his way—I would like to now recognize the senior Republican member of our committee, Mr. Kline, for an opening statement.

[The statement of Mr. Miller follows:]

Prepared Statement of Hon. George Miller, Chairman, Committee on Education and Labor

The Education and Labor Committee meets this morning to examine a federal Occupational Safety Health Administration review of the Nevada health and safety program.

The committee first heard testimony regarding problems with Nevada's OSHA program at a June 2008 hearing on construction safety. During an 18-month period between 2006 and 2008, 12 construction workers died on the Las Vegas strip. At the hearing, witnesses said that it was routine for Nevada OSHA officials to reduce or eliminate tough sanctions behind closed doors.

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These growing health and safety issues sparked labor disputes. Workers staged a walkout in June 2008 demanding safety improvements after concerns grew over eight deaths at two construction sites in Las Vegas.

Safety trends in Nevada had been pointing in the wrong direction: between 2003 and 2007, Nevada's construction illness and injury rate went up by more than twenty percent while the national construction injury and illness rate fell by 11 percent.

As safety became an issue, so did enforcement.

Two complaints alleging backroom deals between Nevada OSHA and politically connected firms were lodged by those involved in a 2008 tragedy that killed two workers and nearly took the life of another at the Orleans Hotel and Casino.

The mother of one worker who was killed at the Orleans Hotel joins us today. She will recount the reckless disregard of workers safety by Boyd Gaming and the agreement with Nevada OSHA that resulted in Boyd escaping willful violations even though they had been cited for substantially similar violations at its other properties in Nevada over the previous three years.

The lead Nevada OSHA inspector who recommended willful violations against the Orleans took the extraordinary step of filing a complaint with federal OSHA officials after a deal was made. He resigned his position shortly thereafter. He was counseled that assisting in a complaint against the state could result in an adverse personnel action.

The inspector pointed to "extensive irregularities" in the Boyd Gaming deal and said that the deal could only be the result of OSHA protecting the contractor from bad publicity and a wrongful death lawsuit by the workers' families.

This and many other allegations of misconduct eventually led to a special review of the Nevada state plan by the new administration.

The review shows that Nevada's OSHA program failed to cite employers for clear hazards, didn't properly train inspectors, didn't follow up to ensure that dangerous conditions were fixed, failed to include worker representatives in inspections, and even failed to notify families of deceased workers of investigations or give them the chance to speak to investigators.

It is also troubling how infrequently Nevada inspectors found serious violations and took little meaningful enforcement action. As this chart shows, last year only

29 percent of Nevada's citations were classified as "serious." Compare that to 44 percent for other state plans and 77 percent for federal OSHA.

It is clear that there is something terribly wrong with the Nevada's OSHA program.

But, Nevada's problems may also reflect a larger problem with the oversight of the 27 states and territories that operate their own plans. Federal OSHA must ensure that a state operates its own plan in a manner that is "at least as effective" as the federal program.

No flags were raised during previous reviews of Nevada's plan under the Bush administration. In fact Bush OSHA officials called Nevada's health and safety program "very good overall." These thumbs-up were occurring at the same time that fatalities and injuries were skyrocketing. Federal officials were clearly asleep at the switch.

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Basic oversight of state plans is not only important in Nevada, but it is vital to the 57 million American workers whose health and safety protections are enforced by a state plan. While some states are running innovative programs, it is clear that additional reviews of state plans are warranted.

Excluding California because they have higher penalties, the average serious penalty assessed by state plans is only 65 percent of the federal OSHA average. This disparity suggests that some state plans may not be as effective as federal OSHA,

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OSHA's announcement of additional state reviews is important to ensure that every worker has sufficient health and safety protection while on the job.

Before we get to these witnesses, we will first hear from a distinguished guest from the State of Nevada. Senate Majority Leader Harry Reid has been a stalwart in the fight for the health and safety of American workers and ensuring that those who have been harmed on the job receive just compensation.

Thank you for joining us today. I look forward your testimony and the testimony of all our witnesses today. I now yield to Ranking Member Kline for his opening statement.

Mr. KLINE. Thank you, Mr. Chairman. Good morning to everybody.

Worker safety and health are among the most fundamental concerns of every employer in this country. No worker wants to risk illness or injury on the job, and no employer wants that risk either.

Recognizing that different states have different workplace needs, the Federal Occupational Safety and Health Act allows states to create their own state-run safety and health programs, subject to federal OSHA's approval and monitoring.

Currently, 22 states and jurisdictions, including my home state of Minnesota, operate complete state plans that cover both public and private sector workers. Several other states have plans that cover only public sector workers, leaving federal OSHA to inspect the private sector in those states.

State workplace safety plans can be extremely effective. According to the Occupational Safety and Health State Plan Association, state plans are able to inspect more workplaces more effectively than the federal government, are considered more flexible than federal OSHA, and can foster safety innovation that is not always available at the federal level.

Unfortunately, not every state plan is reaching its full potential to enhance protections for workers, and one state plan in particular has been found to fall far short, putting the lives of workers at risk.

We will hear this morning from OSHA about its recent review of the Nevada state plan. I know concerns about workplace safety are being taken very seriously by that state's leaders, and I welcome OSHA's efforts to identify weaknesses in Nevada's safety program so that necessary steps can be taken to protect workers.

I would like to read briefly from a statement submitted by Nevada's governor, Jim Gibbons: "I affirm my strong commitment to worker safety in Nevada and believe that our worker safety can best be ensured by a plan that is developed and managed at the state level, adhering to and exceeding federal standards, rather than one designed and operated from Washington."

Governor Gibbons has put his finger squarely on our challenge. In evaluating state OSHA systems, our goal must be to preserve the flexibility and responsiveness of state plans, which in many instances actually exceed federal safety requirements, while ensuring adequate oversight for these plans that are not effectively protecting workers.

Mr. Chairman, I would request unanimous consent to have Governor Gibbons' full statement inserted in the record, along with a statement from Nevada Senator John Ensign.

Chairman MILLER. Without objection, so ordered.

[The information follows:]

Prepared Statement of Hon. Jim Gibbons, Governor, State of Nevada

Thank you Chairman Miller, Ranking Member Kline, Congresswoman Titus and distinguished Committee members for allowing me this opportunity to submit this statement for the record.

An effective and efficient worker safety program is of paramount importance to me, as it should be for all Nevadans, and I welcome the opportunity to engage in this healthy dialogue on how Nevada's state plan can be updated to ensure it remains as effective as the federal plan.

I would first like to commend Nevada Occupational Safety and Health Administration (Nevada OSHA) for their commitment and hard work throughout the review process from the Department of Labor's Occupational Safety and Health Administration (OSHA). It is my understanding that both agencies worked very well together and showed an immediate desire to solve the underlying problems which will ultimately protect Nevadans from further instances.

As you know, the State of Nevada is among twenty-seven states and territories that have elected to operate its own worker safety program. As a former Member of Congress, I recognize the importance of federal oversight in critical areas like worker safety, but also believe this is an opportunity to reaffirm the importance of developing and ensuring the proper operation of state agencies that can more adeptly meet the needs of Nevadans.

The Nevada budget, like most state budgets, is more strained than it has been in decades, which has highlighted the importance of robust state-federal partnerships. Unlike many programs where state expenditures are met with robust cost-sharing by the federal government, OSHA has slipped behind in federal support levels, presenting a set of fiscal challenges. While federal funding commitments are intended to split the cost of state-run plans evenly, this number has crept up over the years. Today, Nevada is tasked with funding over 78% of the state-run OSHA program.

Despite this funding disparity, however, the State of Nevada remains committed to continuing its state-run program with conscientious adherence to recent federal recommendations and a commitment to our continued partnership with federal OSHA to ensure that Nevada's safety standards exceed that of federal standards.

I affirm my strong commitment to worker safety in Nevada and believe that our workers' safety can best be ensured by a plan that is developed and managed at

the state level, adhering to and exceeding federal standards, rather than one designed and operated from Washington.

I appreciate the House Education and Labor Committee taking the time to ensure that Nevadans are kept safe in the workplace, and for allowing me to submit this testimony for the record. I look forward to an ongoing dialogue and our future shared success as Nevada OSHA works with its federal partners at OSHA to address the report's recommendations.

Prepared Statement of Hon. John Ensign, U.S. Senator From the State of Nevada

I would like to thank Chairman Miller, Ranking Member Kline, and the members of the House Education and Labor Committee for holding this hearing and allowing me the opportunity to submit this statement for the record.

Ensuring the safety of Nevada's workforce is of vital importance. As this committee is already aware, there were 25 workplace fatalities on Las Vegas Strip construction projects between January 2008 and June 2009. I appreciate the efforts that have been made by this committee, as well as the federal and state entities, to improve worksite safety.

In response to these tragic workplace fatalities, the Department of Labor's Occupational Safety and Health Administration (OSHA) recently conducted a comprehensive evaluation of Nevada OSHA's policies and procedures, as well as case files related to the construction fatalities, to determine whether there were systemic issues with Nevada OSHA's oversight. The report findings contained a number of concerns on the part of the federal investigators. Nevada OSHA has stated that it will undertake a review of its policies and procedures to address the findings in the report.

As you are aware, Nevada is one of 27 states that opted to develop and operate its own job safety and health programs under a federally approved state plan. The safety of Nevada workers is the first, last, and only concern of my state's OSHA program. I believe that, going forward, the recommendations and reviews by the federal OSHA officials should be incorporated into the Nevada OSHA program. I am also pleased to hear that Nevada OSHA was cooperative throughout the review process and staff was available to discuss cases, policies, and procedures.

Again, I appreciate the Committee's taking the time to address such a critical issue for my state and states across the country. I look forward to the opportunity to continue this dialogue and to ensure that both federal OSHA and Nevada OSHA follow through on this report's critical recommendations for ensuring workplace safety.

Mr. KLINE. Workplace safety is not a partisan endeavor, and I hope we approach this issue with the recognition that a safe workplace is good for business.

With that in mind, our efforts to promote workplace safety should focus on enhancing what works, fostering collaboration and emphasizing prevention to avoid the types of tragic accidents we will hear about today.

I want to thank our witnesses and especially the family members of those whose lives were lost on the job. I thank you for sharing your stories so that we can take steps to prevent other families from suffering the way you have.

With that, I know members are going to wish to be heard, and I would yield back.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Senior Republican Member, Committee on Education and Labor

Thank you Chairman Miller, and good morning.

Worker safety and health are among the most fundamental concerns of every employer in this country. No worker wants to risk illness or injury on the job—and no employer wants that risk either.

Recognizing that different states have different workplace needs, the federal Occupational Safety and Health Act allows states to create their own state-run safety

and health programs, subject to federal OSHA's approval and monitoring. Currently 22 states and jurisdictions—including my home state of Minnesota—operate complete state plans that cover both public and private-sector workers. Several other states have plans that cover only public sector workers, leaving federal OSHA to inspect the private sector in those states.

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I'd like to read briefly from a statement submitted by Nevada's governor, Jim Gibbons:

"I affirm my strong commitment to worker safety in Nevada and believe that our workers' safety can best be ensured by a plan that is developed and managed at the state level, adhering to and exceeding federal standards, rather than one designed and operated from Washington."

Governor Gibbons has put his finger squarely on our challenge. In evaluating state OSHA systems, our goal must be to preserve the flexibility and responsiveness of state plans—which, in many instances, actually exceed federal safety requirements—while ensuring adequate oversight for those plans that are not effectively protecting workers.

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I want to thank our witnesses, and especially the family members of those whose lives were lost on the job. I thank you for sharing your story so that we can take steps to prevent other families from suffering the way you have.

With that, I know other Members wish to be heard and we have a full slate of witnesses, so I will yield back the balance of my time.

Chairman MILLER. Thank you.

I would like to yield 2 minutes to Ms. Woolsey. We are going to recognize the subcommittee chairs. But Ms. Woolsey is not here, so she has yielded her time to Ms. Titus.

Ms. Titus is recognized for 2 minutes.

Ms. TITUS. Thank you, Mr. Chairman.

Chairman MILLER. Your microphone.

Ms. TITUS. Excuse me.

My home state of Nevada is one of 22 U.S. states that operate their own OSHA administration program. These state programs are required by law to be at least as effective as comparable federal standards.

But apparently, according to the recent report, we know that that has not been the case in Nevada. The rules in Nevada may be comparable to federal standards, but what is clear from the federal OSHA special review of Nevada's OSHA enforcement program is that Nevada OSHA has not been enforcing these standards as well as should be the case.

Perceived undue political influence has been part of the problem, and that must be addressed as well as staffing and training.

Between 2003 and 2007, the construction illness and injury rate nationally declined by 11.4 percent, but it increased by 21.4 percent in Nevada. During an 18-month period between 2006 and 2008, 12 workers were killed on the Las Vegas strip in construction accidents.

Yet as the chairman pointed out, Nevada is well behind the curve in vigorous targeting and enforcement of the most serious safety violations. For example, in 2008, only 29 percent of Nevada's violations were cited as serious. This compares to 77 percent of the federal OSHA violations that were cited as serious the same time period.

And from January of 2008 through June of this year, Nevada OSHA cited only one violation as willful. Nevada workers need to know that the state and federal OSHA programs will enforce the laws and keep our workers safe.

So I thank the chairman for holding this committee, and I thank the majority leader, Senator Reid, for his leadership in this area within the state.

I yield back.

Chairman MILLER. Thank the gentlewoman.

Pursuant to Committee Rule 7(c), all members may submit an opening statement in writing which will be made part of the permanent record.

Ms. McMorris, did you want to make a statement, or do you want to wait until after Mr. Reid, or whatever you——

Mrs. MCMORRIS RODGERS. I can wait until after.

Chairman MILLER. Whatever you are comfortable with.

Mrs. MCMORRIS RODGERS. Well, can I go ahead?

Chairman MILLER. Yes, go ahead.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman. I thank you for yielding.

I join my colleagues in thanking the witnesses for being here today to share their personal stories and professional expertise about the Nevada state OSHA plan.

I also want to extend my sincere condolences to those who have lost family members in workplace accidents in Nevada and across the nation. We appreciate your efforts to prevent others from suffering as you have.

Workplace safety is a shared responsibility and one that must be taken very seriously. Employers work every day to prevent illness and injury among their workers. To do that, they rely on and are held accountable to Occupational Safety and Health guidelines implemented at the state level, the federal level or both.

As we will hear today, federal OSHA has identified a number of deficiencies in Nevada's state plan. It must be corrected immediately. And I am pleased that state officials are dedicating resources to improving their program.

I believe effective state plans have the potential to significantly enhance workplace safety. State plans must meet federal standards at a minimum, but they can also exceed federal standards as well as allow more flexibility to address individual workplace needs.

My home state of Washington is a state plan state. The state plan has had many successes through various partnerships between business and labor. For example, the Washington Industrial

Safety and Health Act requires the creation of an advisory board consisting of both employers and employees.

This advisory board is responsible for commenting on all policies, regulations and guidelines that affect workplace health and safety.

The state plan recognizes the safety and health assessment and research for prevention program that encourages a collaborative approach to developing and testing innovative policies.

Moreover, a safety and health grant program administered by WISHA provides funding for safety projects supported by both employers and employees.

While I recognize this is just one state, it illustrates why efforts to respond to weaknesses in the Nevada system should not disregard a model that has worked well in other states. In fact, more than two dozen states are fully or partially responsible for their worker safety through state OSHA plans.

These plans have benefits that include increased inspections, enhanced flexibility and greater access to innovative strategies for making job sites safer.

I look forward to hearing from our witnesses about what steps can be taken to immediately correct weaknesses in the Nevada plan and to engage in a broader dialogue about the role state plans can play in making our workplaces safer.

Thank you very much, Mr. Chairman, and I yield back.

Chairman MILLER. Thank you.

It is my honor to recognize the majority leader of the United States Senate, Harry Reid. Thank you for coming over to testify.

Mr. Reid, before he was in the Senate, was my colleague in—our colleague in the House of Representatives and is no stranger to this issue of workplace health and safety, both from a personal point of view but also from a public policy point of view, where he has been unrelenting in his efforts to create a safer and healthier workplace for workers.

And we look forward to your testimony. Thank you for joining the committee. And, Senator Reid, proceed in the manner in which you are most comfortable.

STATEMENT OF HON. HARRY REID, SENIOR SENATOR OF THE STATE OF NEVADA, U.S. SENATE MAJORITY LEADER

SENATOR REID. Chairman Miller, thank you very much. It is good to be back in the House, where I had pleasurable several terms and want to acknowledge of all the kind things you did for me while I was adjusting here. You were one of the senior members, and you had been here for a couple more years than me—and you were always very kind and thoughtful, and I appreciate that very much.

Thank you, Member Kline. Thank you very much for being here, and members of the committee, especially my friends Dina Titus—and Shelley Berkley who are here.

Few, if any, states have felt the full force of this recession as intensely as Nevada. Foreclosures in the state lead the nation and have for some time, and unemployment there is at an all-time high.

Because of this, much of the attention in recent weeks and months has understandably been devoted to job security. But that is only half the story. We must also pay attention to safety and security on the job.

That is why I am very happy that the United States Department of Labor's Occupational Safety and Health Administration has reviewed, and will continue to review, troublesome violations and other concerns in Nevada's workplaces.

And it is why I am happy to be here today to do what I can to give information that will make this committee determine what the future should be.

The famous Las Vegas Strip has recently seen $32 billion in building booms up and down the strip. At one job site, City Center, I counted one day 28 cranes on just the one job site.

But something else was going up along with the hotels and casinos, and that is the unnecessary deaths of construction workers. Twelve working men and women died in just 18 months.

Those tragedies represent just under half of all of the workplace deaths in Nevada during that period. Elsewhere in the state, 13 other workers died equally tragic and equally preventable deaths.

The men and women who have made Las Vegas into the fast-growing city it is today, who have made the Las Vegas Strip the entertainment capital of the world, are professionals who are both capable in their respective trades and cognizant of the dangers they face. They deserve better than Nevada OSHA's indifference to their health and safety.

When a construction worker's day includes climbing on iron structures hundreds of feet into the air under intense heat and high winds, or a maintenance worker having to climb down into a manhole, his or her job is hard enough.

That worker should not also have to worry about whether the state agencies whose sole purpose is ensuring his or her safety is doing their job also. But that is exactly what I am worried about.

As you know, Nevada is one of 27 states and territories that operate its own health and safety enforcement program. Unfortunately, though, Nevada's OSHA failed too many times to enforce workplace safety.

In some cases, it simply failed to act; in others, it acted improperly or poorly. Its carelessness created an environment that allowed dangerous conditions to persist and put Nevadans' lives at risk.

The Federal OSHA review found many patterns of this kind of negligence. A citation for a willful violation carries significantly higher penalties to punish employers who flout the law and endanger employees.

Regrettably, willful violations will happen.

But Nevada's workplace safety program discouraged these citations, issuing only one willful violation in the 18-month period that was reviewed.

The program also failed to cite glaring repeat violations which would have flagged persistent problems and led to proper remedies that could have saved lives.

For example, two men were killed at the Orleans Hotel and Casino and a third was severely injured after they were directed to enter a poorly ventilated grease pit filled with toxic fumes.

It wasn't the first time the property owners had been found responsible for similar conditions and hazards. But Nevada OSHA did not act, terrible mistakes were repeated, and Travis Koehler and Richard Luzier died.

I met earlier today with Travis' mother, Debi. She will testify before you later today. She has with her a picture of her boy.

Over a 6-year period, Nevada OSHA also consistently failed to find and cite serious violations. Federal OSHA classified more than three out of every four violations as serious ones, and state plans did so for nearly half of theirs. But Nevada OSHA reported less than one-third of their breaches as serious.

Finally, the state agency failed to notify a victim's family that it was investigating their loved one's death in almost half of fatalities in Nevada workplaces during the time that OSHA had the review. This record is simply, Mr. Chairman, unacceptable and not defensible.

Each one of these deaths is tragic. And while accidents happen, each one could have been prevented. It is not unreasonable to demand that the agency dedicated to worker safety doesn't look the other way.

Federal OSHA and this committee are correct to hold the state agency accountable for its violations of the law and the public trust.

I will continue to support your efforts on the federal level by directing my staff to remain in contact with the director of Nevada OSHA. As my office did for Debi Koehler-Fergen, who you will hear from later, I will also continue to support any Nevadan who issues a complaint about the state program.

I will continue to work with my colleagues in the Senate and those here in the House to ensure federal OSHA gets the funding it needs to ensure Americans work in safe places. And I will not hesitate to call for further action if Nevada OSHA fails to act on this report's recommendations.

As our economy recovers, it is not enough merely to ensure Nevadans, and all Americans, can have a good job to go to every morning, which not everyone has today. But we must also make sure that they can safely come home from that job every night.

Thank you very much, Mr. Chairman.

[The statement of Senator Reid follows:]

Prepared Statement of Hon. Harry Reid, Majority Leader, U.S. Senate

Chairman Miller, Ranking Member Kline, distinguished members of the House Education and Labor Committee: Thank you for asking me to speak with you this morning.

Few states have felt the full force of this recession as intensely as Nevada. Foreclosures in the state lead the nation, and unemployment there is at an all-time high.

As a result, much of the attention in recent weeks and months has understandably been devoted to job security. But that is only half the story; we must also pay attention to safety and security on the job.

That is why I am pleased that the U.S. Department of Labor's Occupational Safety and Health Administration has reviewed—and will continue to review—troublesome violations and other concerns in Nevada's workplaces. And it is why I am pleased that your Committee is building upon that investigation with today's hearing.

The Las Vegas Strip recently saw a $32 billion building boom. But something else was going up along with the hotels and casinos—the unnecessary deaths of construction workers. Twelve of them died in just 18 months.

Those tragedies represent just under half of all of the workplace deaths in Las Vegas during that period. Elsewhere in the city, 13 other workers died equally tragic and equally preventable deaths.

The men and women who have made Las Vegas into the fast-growing city it is today—and who have made the Las Vegas Strip the entertainment hub of the

world—are professionals who are both capable in their respective trades and cognizant of the dangers they face. They deserve better than Nevada OSHA's indifference to their health and safety.

When a construction worker's day includes climbing an iron structure several hundred feet into the air under intense heat and high winds—or a maintenance worker must climb down into a manhole—his or her job is hard enough. That worker should not also have to worry about whether the state agency whose sole purpose is ensuring his or her safety is doing its job, too.

But that is exactly what we are worried about. As you know, Nevada is one of 27 states and territories that operate its own health and safety enforcement program. Unfortunately, Nevada OSHA failed too many times to enforce workplace safety. In some cases, it simply failed to act; in others, it acted improperly or poorly. Its carelessness created an environment that allowed dangerous conditions to persist, and put Nevadans' lives at risk.

The Federal OSHA review found many patterns of this kind of negligence. A citation for a "willful violation" carries significantly higher penalties to punish employers who flout the law and endanger employees. Regrettably, they happen. But Nevada's workplace safety program discouraged these citations, issuing only one willful violation in the 18-month period that was reviewed.

The program also failed to cite glaring repeat violations, which would have flagged persistent problems and led to proper remedies that could have saved lives. For example, two men were killed at the Orleans Hotel and Casino, and a third was severely injured, after they were directed to enter a poorly ventilated grease pit filled with toxic fumes. It was not the first time the property's owners had been found responsible for similar conditions and hazards.

But Nevada OSHA did not act, terrible mistakes were repeated, and Travis Koehler and Richard Luzier died. Travis' mother, Debi Koehler-Fergen, will testify before you later today.

Over a six-year period, Nevada OSHA also consistently failed to report serious violations, doing so at a much lower rate than they likely occurred. Federal OSHA classified more than three out of every four violations as serious ones, and state plans did so for nearly half of theirs. But Nevada OSHA reported less than one-third of their breaches as serious.

Finally, the state agency failed to notify a victim's family that it was investigating their loved one's death in almost half of the fatalities at Nevada workplaces during the time of the OSHA review.

This record is unacceptable and indefensible. Each one of these deaths is tragic, and while accidents happen, each one could have been prevented. It is not unreasonable to demand that the agency dedicated to worker safety doesn't look the other way.

Federal OSHA and this Committee are right to hold the state agency accountable for its violations of the law and the public trust.

I will continue to support your efforts on the federal level by directing my staff to remain in contact with the director of Nevada OSHA. As my office did for Debi Koehler-Fergen, I will also continue to support any Nevadan who issues a complaint about the state program.

I will continue to work with my colleagues in the Senate, and those here in the House, to ensure Federal OSHA gets the funding it needs to ensure American workers' safety. And I will not hesitate to call for further action if Nevada OSHA fails to act on this report's recommendations.

As our economy recovers, it is not enough merely to ensure Nevadans, and all Americans, can have a good job to go to every morning. We must also make sure they can safely come home from that job every night.

Chairman MILLER. Thank you very much. Thank you very much, Leader Reid, and thank you for taking your time to come over here. I thank you for extending the offer of your resources of your office to help us as we continue to pursue this matter.

Clearly, Nevada OSHA has to be fixed. It has to have additional resources. But as we will hear later today, there are other state agencies that raise serious questions.

And I think we also look favorably upon the offer of Congresswoman McMorris Rodgers that we look to other state agencies that

are succeeding to see what those models that might be adopted to help those states secure that safe workplace.

I know you have a very busy schedule, and we had an arrangement. I would say if there is a member of the committee that has a burning question, we will give you an opportunity to ask that of Senator Reid, but if not, we will let him return to the business at the Senate, which has confounded me my entire career here.

But you somehow seem to have mastered it. Thank you so very much.

I also want to recognize that we have been joined by Congresswoman Shelley Berkley of Nevada, who has been following and working with our staff on these investigations throughout our time doing this.

I would like to now call the next panel up to the witness table, if I might. And I will introduce them as they are taking their seat.

Mr. Jordan Barab is the acting assistant secretary for Occupational Health and Safety Administration. He formerly served as senior labor policy advisor on this committee, worked as a health and safety specialist for the U.S. Chemical Safety Board, and served as special assistant to the OSHA administrator.

Prior to his government service, he was director of health and safety at the American Federation of State, County, and Municipal Employees.

Mr. Donald Jayne is the administrator of the division of industrial relations, Department Business and Industry for the State of Nevada. His division handles health and safety regulation, workers compensation and training.

He has served as general manager of the State Industrial Insurance System in Carson City, and most recently is the principal of Jayne & Associates. Mr. Jayne is accompanied by Mr. Stephen Coffield, who is the chief administrative officer to the Nevada OSHA. Mr. Coffield will be available to answer questions directly or to assist Mr. Jayne in answering questions.

Ms. Deborah Koehler-Fergen is a resident of Las Vegas. She is the mother of Travis Koehler, who died in a preventable confined space accident at the Orleans Hotel in February 2008. She filed a complaint with the federal OSHA about Nevada's OSHA decision to downgrade the citation against Boyd Gaming.

As the mother of a worker killed on the job, she has made it her mission to raise awareness of the need for better workplace safety, and we thank her for traveling across the country to be with us here today.

Dr. Frank Mirer is a professor of environmental occupational health at the Urban Public Health Program at Hunter College at the City University of New York, and previously served as director of the UAW health and safety department.

He served as chair of the Michigan Health and Safety Advisory Committee to Michigan OSHA and worked extensively on enforcement policies and issues related to the Michigan plan.

Welcome to the committee. Thank you all for taking your time to be with us today and to lend us your expertise and your experience.

Some of you know, but some of you are new to testifying, in front of you are little consoles there. When you begin to speak, a green light will go on. You will have 5 minutes for your remarks.

At 4 minutes an orange light will come on that suggests you might want to consider wrapping up your remarks. But we want you to finish your remarks in a coherent and a manner in which you are comfortable. And then a red light will go on which suggests that you should wrap up.

And we will go through the entire panel, and then we will open it up for questions from the chair and the members of the committee.

So with that, Jordan, we will begin with you. Welcome to the committee. We need to put on a microphone.

STATEMENT OF JORDAN BARAB, ACTING ASSISTANT SECRETARY, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR

Mr. BARAB. Thank you, Mr. Chairman, Ranking Member Kline and members of the committee.

Thank you for the opportunity to testify on the Occupational Safety and Health Administration's state plan program and recent investigation of the Nevada state plan.

Section 18 of the Occupational Safety and Health Act allows states to operate and enforce their own safety and health programs. Currently 25 states and two territories have state plans that deliver the OSHA program to 40 percent of the nation's workplaces.

State plan standards and enforcement must be "at least as effective" as federal OSHA. In addition, the state plans operate under authority of state law, not delegated federal authority. States must also provide at least 50 percent of the funding for state OSHA plans.

There are a number of advantages to state plans. They add resources to the federal program which would not otherwise be available. They cover state and local government employees who are not covered by federal OSHA. And they have the flexibility to deal with workplace hazards that are sometimes not addressed by federal OSHA.

For example, California recently issued standards for heat stress, airborne diseases and popcorn lung, a disease associated with exposure to the flavoring chemical diacetyl.

As valuable as the state efforts are, however, federal OSHA is required to maintain effective oversight of state plans to ensure that all workers in America are protected.

Nevada has operated a state plan since 1974. A high number of well-publicized construction-related fatalities on the Las Vegas Strip in 2007 and 2008 raised a number of serious questions about the operation of Nevada's OSHA program.

As a result of these fatalities and a number of complaints filed against the state plan, I commissioned a federal OSHA task force to conduct a thorough evaluation of the Nevada state plan.

The review took several weeks and evaluated 23 of Nevada OSHA's fatalities that occurred between January 2008 and June

2009. Nevada OSHA fully cooperated with our investigation, providing all the records that we needed.

For this study, federal OSHA identified a number of serious concerns about the Nevada plan. Even though the files examined were primarily cases involving the death of workers, only one willful citation was issued and later reduced. Willful violations are those the employer intentionally and knowingly commits, and they carry the highest penalties.

Hazards identified during inspections were not addressed in citations. In almost one-half of the fatality cases reviewed the state failed to notify families of deceased workers that it was investigating the death of a loved one.

Nevada OSHA did not have procedures to assure that hazards found during inspections were abated by the employer. Inspectors were not properly trained about the hazards of construction work, despite the high level of construction activity and construction-related fatalities in the state.

In 91 percent of the fatality cases reviewed, information from employer injury and illness logs was not obtained by inspectors. This by no means is an exhaustive list of the deficiencies we discovered. I have provided the committee with a copy of the report so you can read the complete findings.

[The information follows:]

U.S. DEPARTMENT OF LABOR—OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Review of the Nevada Occupational Safety and Health Program

EXECUTIVE SUMMARY

From January 1, 2008, through June 1, 2009, Nevada experienced 25 workplace fatalities which were investigated by the Nevada Occupational Safety and Health Administration (Nevada OSHA). In addition, the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) received two complaints (formally known as Complaint About State Program Administration [CASPA])[1] regarding a fatality investigation at The Orleans Hotel and Casino, Las Vegas, Nevada, and a complaint inspection at the Luxor Hotel and Casino, Las Vegas, Nevada. To address rising concerns, Federal OSHA conducted this special study to review critical elements of the Nevada OSHA program. This report summarizes the study findings where there are recommendations for improvements.

Section 18 of the Occupational Safety and Health Act of 1970 encourages states to develop and operate their own job safety and health programs. Federal OSHA approves and monitors State plans and provides up to 50 percent of an approved plan's operating costs. Nevada is one of 27 states and American territories approved to operate its own safety and health enforcement program. Among other things, states that develop these plans must adopt standards and conduct inspections to enforce those standards.[2]

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[1] Anyone finding inadequacies or other problems in the administration of a state's program may file a Complaint About State Program Administration (CASPA) with the appropriate OSHA Regional Administrator. OSHA investigates all such complaints, and where complaints are found to be valid, requires appropriate corrective action on the part of the state. The identities of individuals who file CASPAs are kept confidential.

[2] Federal OSHA approves and monitors state plans and provides up to 50 percent of an approved plan's operating costs. To obtain federal approval, states must meet a number of criteria:

- Set job safety and health standards that are "at least as effective as" comparable federal standards.
- Conduct inspections to enforce its standards.
- Cover public (state and local government) employees.
- Operate occupational safety and health training and education programs.
- Provide free on-site consultation to help employers identify and correct workplace hazards.

Such states also have the option to promulgate standards covering hazards not addressed by federal standards.

STUDY METHODOLOGY

This study concentrated on identifying areas needing improvement. A review of the Nevada OSHA workplace safety and health program was conducted from July 22, 2009 to August 6, 2009. Twenty-three (23) fatality inspection case files were evaluated. In addition, eight cases with current penalties in excess of $15,000 were identified and five of the eight were evaluated. (The initial criterion was to look at additional cases with final penalties in excess of $45,000, but there were no such cases, so the penalty threshold for the additional cases was reduced to $15,000.) All cases occurred from January 1, 2008, through June 1, 2009.

In addition to reviewing the above cited case files, the study team focused on reviewing data gathered from all Nevada OSHA inspections conducted from January 1, 2008—June 1, 2009, including general statistical information, complaint processing, and inspection targeting. Nevada data as contained in the Integrated Management Information System (IMIS), OSHA's database system used by the State to administer its program and by the State and OSHA to monitor the program, was examined. Compliance with legislative requirements regarding contact with families of fatality victims, training, and personnel retention was assessed.

Throughout the entire process, Nevada OSHA was cooperative, shared information and ensured staff was available to discuss cases, policies, and procedures. Also, Nevada OSHA staff members were eager to work with the evaluation team.

FINDINGS

Highlights of the study findings are as follows:

• Only one willful violation was issued during the period reviewed, however, the violation was reclassified during settlement. Willful violations carry significantly higher penalties. (See IV-4, VI-2)

• Willful violations were discouraged because of the lack of management and legal counsel support. (Willful violations are those the employer intentionally and knowingly commits or a violation that the employer commits with plain indifference to the law and carry the highest penalties allowed under the law). Violations that should have been further evaluated as potential willful violations were identified during the study. In one case, there were multiple repeat violations for trenching violations within a 12-month span of time, however no indication willful violations were considered. (See I-5, II-1)

• Clearly supportable repeat violations were not cited. In the Orleans Hotel and Casino case (the subject of one of the two Complaints About State Plan Administration State Programs [CASPA]) Nevada OSHA issued serious rather than willful or repeat citations even though the owner/operator of this hotel had been previously cited for substantially similar conditions/hazards at other properties. (See II-7)

• In 17 percent of the fatality cases reviewed, hazards that were identified during inspections were not addressed in citations, a notice of violation or a letter to the employer. (See I-10)

• Union representatives were not notified of inspections and provided an opportunity to participate in opening conferences, closing conferences and informal conferences. (See I-6, I-7)

• During inspections, Nevada OSHA investigators issued Notice of Violations instead of citations for alleged other—than-serious violations. Had these Notice of Violations been reviewed by a supervisor, they may have been characterized as serious. (See I-11)

• In the Luxor Hotel Case (the subject of the second CASPA), the Nevada OSHA investigator did not speak with employees to determine exposure to the alleged hazard. Therefore, the inspector was unable to determine that employees were exposed to a hazard. Additionally, worker representatives (unions) were not present and were not interviewed during this inspection. Their statements may have revealed recent worker exposures and thus confirmed the violation.

• In almost half of the fatality cases reviewed, the state failed to notify the families of deceased workers that it was investigating the death of their loved one. Thus, these family members were never given an opportunity to talk with investigators about the circumstances of the fatality. Family members may provide information pertinent to the case. (See I-3, VIII-1)

• Nevada OSHA did not assure that hazards were abated (corrected) by the employer after they were identified. Nevada OSHA lacked procedures to identify cases requiring follow-up inspections, to track abatements, and to ensure that companies were abating hazards that were cited during inspections. Employers are required to submit abatement information for all violations cited unless the violation was corrected on site (Abatement verification). Abatement is the correction of the safety or health hazard/violation that led to an OSHA citation. Interviews with Agency super-

visors and investigators indicated that there was no clear policy conveyed indicating what employers were required to submit for abatement. Additionally, case file reviews indicated that in three cases, inadequate abatement documentation was received by Nevada OSHA and accepted as adequate. (See IV-5, V-4, VI-6)

• Nevada OSHA investigators were not properly trained on the hazards in construction work. There was limited hazard recognition demonstrated, with few hazards identified in the construction industry where the majority of fatalities has occurred. In addition, it was determined that some long time employees have not taken some of the basic courses that investigators should take. (See IV-6, X-1)

• This report reviewed IMIS data for the 2,117 programmed or planned inspections conducted by the state and found the percent of programmed inspections with serious violations to be extremely low. (Planned or programmed inspections of worksites are those that have been scheduled based upon objective or neutral selection criteria. The worksites are selected according to state scheduling plans for safety and health or special emphasis programs.) Overall, Nevada has experienced a high number of in-compliance programmed inspections—that is, inspections that do not result in hazards identified or citations being issued. The high rate of in-compliance inspections and low percentage of "serious" violations clearly show that the Nevada OSHA Inspection Targeting System is not targeting locations where serious hazards are occurring and a need for an improved targeting system and/or additional construction hazard recognition training for investigators. (For safety violations, Nevada's average of programmed inspections with serious violations was 26% compared with 79% for Federal OSHA) (IV-1, VII-4)

• Case files were not organized in a uniform manner to reduce the possibility of important case documentation being lost or misplaced. (See I-1, VI-1)

• No documentation showed that Nevada OSHA informed workers of their legal protection against discrimination for making a complaint about workplace hazards. Workers were also not informed of their right to talk with the OSHA inspector without fear of retaliation. (See II-3)

• In 91% of the fatality case files reviewed, information from injury and illness logs was not obtained from employers. Without this information, it is difficult for a supervisor to determine whether the inspection should have been expanded. (See I-9)

• Nevada OSHA is not maintaining all of its enforcement data in the IMIS and not using it to run reports. The information is therefore not available to assist the state to track and evaluate the results of its enforcement efforts and better prepare investigators for conducting inspections. (See III-1, III-2, III-3, VI-3)

• Nevada OSHA agreed to conduct 2900 inspections as part of its budgeting process, which translates to 95 to 115 inspections per year per investigator, far too many per investigator to do a thorough job. The Nevada legislature utilizes this information to determine if the program is meeting its goals. (See IV-2, VII-5)

• Nevada OSHA groups violations based on the location of the standards being cited in the code of state regulations rather than by the individual hazardous conditions. (See IV-3, VI-5)

• Employee contact information was not obtained for employees interviewed and exposed to hazards. (See I-8, V-3, VI-4)

KEY RECOMMENDATIONS

This study resulted in a number of recommendations for improvement. Highlights of these recommendations are listed below.

Nevada OSHA should:

• Conduct an internal review of their willful citation policies and practices. Then take corrective action to fully document willful violations, so such citations can be issued and successfully sustained or affirmed. (See IV-4, VI-2)

• Work with legal counsel to develop training to improve the development of legally sufficient cases and increase the pursuit of willful violations. The training should be specific to Nevada OSHA and should address what is required by the State Review Board to sustain a willful violation. With this training, the Nevada OSHA cases containing willful violations should be legally sufficient and sustainable by the Review Board. (See I-5, II-1)

• Review its procedures and consider evaluating potentially repeat violations with the assistance of legal counsel. (See II-7)

• Ensure that hazards identified during complaint inspections are addressed with the employer through citation, notification of violation or some other method. Case files must be reviewed more thoroughly, including review of photographs for hazards not identified or addressed by the investigators. (See I-10, V-5)

• Review all available IMIS data reports and track the most frequently cited standards to determine what additional training on such things as hazard recognition and case file documentation is necessary to increase the breadth of standards cited and the classification of such violations. Special emphasis should be placed on construction hazards in an effort to improve hazard recognition which will result in employees being removed from hazard. This should be done for the agency as a whole as well as for each individual compliance officer. (See I-10)

• Adhere to current Nevada OSHA procedures and ensure that union representatives are notified of inspections and provided an opportunity to participate in opening conferences, closing conferences and informal conferences. Union representatives should be informed that they must request copies of citations, or no copy will be sent to them. (See I-6, I-7)

• Review the policy and practice of issuing Notice of Violations on-site during inspections, with an emphasis on ensuring complete and accurate documentation, classification of hazards, and confirmation of abatements. (See I-11,V-4)

• Comply with Nevada OSHA's established procedures, and the new Nevada Senate Bill 288, requirement to contact families of victims soon after the initiation of the investigation and provide the families with timely and accurate information at all stages of the investigation. (See I-3, VIII-1)

• Ensure that adequate abatement is obtained for all complaint items found valid, regardless of being handled via an inquiry or an inspection. Review the abatement verification policy with all supervisors and investigators to ensure the supporting information and documentation required for abatement verification are present in the case files. (See IV-5, V-4, VI-6, X-1, X-2)

• Provide additional training to involved staff as well as each investigator with special emphasis on construction hazards. (See IV-6)

• Target high hazard industries for inspections. Perform an evaluation of the effectiveness of active targeting programs. Once the evaluation is complete make any necessary changes to more effectively target high hazard industries and facilities. (See IV-1, VII-4)

• Provide clear guidance to all enforcement personnel on the organization of case files. Correspondence should not be filed throughout the investigative file but in one specific location in the file. This approach will help ensure all necessary correspondence is sent to employers, employees and family members of victims. The files should also be contained in file folders which will help ensure that all correspondence and investigation materials are maintained in the file. (See I-1, VI-1)

• Follow established complaint procedures to ensure all complainants are provided information about their rights and asked to provide their name, address and phone number. Discrimination rights must be communicated to the complainants when they call and file a complaint even if they do not allege discrimination at the time of the call. (See II-3)

• Reconcile the differences in procedure between Nevada and OSHA. Particular attention should be paid to obtaining injury and illness log information during inspections. Once those differences have been reconciled, employees must be trained on current policy and be provided copies of current policy documents. (See I-9)

• Ensure that the IMIS system is kept up-to-date, is accurate, and is used by Nevada OSHA to run reports that will assist with management oversight of enforcement efforts and CSHOs in preparing for inspections. (See III-1, III-2, III-3, VI-3)

• Work with the Nevada legislature to utilize more outcome measures to evaluate the effectiveness of the program. Educate the legislature on the importance of quality inspections versus a large quantity of inspections. (See IV-2, VII-5)

• Review its current citation grouping policies and procedures and issue citations in accordance with its Nevada Operations Manual (NOM). (See IV-3, VI-5)

• Obtain employee contact information for all employees interviewed and exposed to hazards. This information will provide accessibility to witnesses for contested cases and it will also ensure information is maintained in the event a discrimination complaint is filed. (See I-8, V-3, VI-4)

SUMMARY OF THE STATE'S RESPONSE

OSHA Region IX provided a draft of this report to the Administrator of the Department of Business and Industry, Division of Industrial Relations, Occupational Safety and Health Administration (Nevada OSHA). The Administrator provided written comments which are reproduced in their entirety in Appendix B.

Nevada OSHA is under new leadership with a new Chief Administrative Officer and an Administrator of the Nevada Division of Industrial Relations/Nevada State Plan Designee. Although the Administrator pointed out differences in the nature of the monitoring completed during the review conducted in July and August and pre-

vious years, his response committed the Nevada OSHA management team to resolving "both the real and perceived problems with Nevada's OSHA program."

The Nevada OSHA leadership and staff are committed to resolving the deficiencies identified in this report. While this report focuses on areas in need of improvement, it provides an independent review of critical elements of the Nevada OSHA program that will aid management in developing and implementing action plans. Nevada OSHA is developing action plans and making programmatic changes that will allow the state to implement the recommendations outlined in this report. The goal of Nevada OSHA is to revitalize the staff, mend fences with Federal OSHA, restore public confidence in the agency and perform thorough, legally sufficient inspections that will be sustained throughout the review process. Nevada OSHA is committed to enhancing its operations so that it is better prepared to address the worker safety and health concerns in the State of Nevada.

[The complete report may be accessed at the following Internet address:]

http://www.osha.gov/dcsp/final-nevada-report.pdf

Mr. BARAB. I also want to take a moment to clarify that the problems we identified at Nevada OSHA were systemic problems in the management of the agency. We are not casting blame on the efforts of the dedicated staff who are devoting their lives to ensuring safe workplaces for Nevada workers.

The report also includes a number of recommendations for improvement. For example, Nevada OSHA should work with counsel to train inspectors to develop legally sufficient cases, review case files more thoroughly to find hazards not initially identified, contact families of victims soon after the initiation of an inspection, ensure adequate abatement of all hazards found during complaint inspections, and provide staff with additional training on construction hazards.

As a result of the deficiencies identified in Nevada OSHA's program and as a result of the administration's goal to move from reaction to prevention, I have notified the state plans that we will be implementing a number of changes to strengthen the oversight, monitoring and evaluation of state programs.

I sent interim guidance to OSHA's 10 regional administrators in August, encouraging more extensive investigation of potential problems.

I also told the regional evaluators to maintain more frequent direct contact with the states they oversee and to keep abreast of state legislative developments, major incidents and local initiatives.

In addition, to ensure that similar deficiencies do not exist in any of the other state plans, federal OSHA will conduct evaluations similar to what we conducted in Nevada for every state that administers its own program.

These evaluations will assist federal OSHA in improving its monitoring system and lead to better program performance and consistency throughout all state plans.

We will involve states in the development of the revised monitoring procedures. OSHA is emphasizing to our state partners that we are not trying to change the nature of the relationship between federal and state OSHA, but we do need to speak with one voice

and assure American workers that they will receive adequate protection, regardless of the state in which they work.

However, if Nevada or any other state where problems are identified fails to make the necessary improvements in a timely manner, OSHA could reassert concurrent federal jurisdiction. Beyond that, withdrawal of a state plan would be the appropriate sanction when major and pervasive deficiencies are present and the state does not correct them.

Mr. Chairman, I appreciate your work today in shining a spotlight on what has been an obvious gap in the protection of our workforce. Thank you again for this opportunity to discuss the OSHA state plan program and our study of the Nevada state plan.

I look forward to your questions.

[The statement of Mr. Barab follows:]

Prepared Statement of Hon. Jordan Barab, Acting Assistant Secretary for Occupational Safety and Health, U.S. Department of Labor

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

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

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

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

Unfortunately, the FY 2010 potential funding increase for the states comes at a time of serious fiscal crisis in State governments. The six states that fund only 50% of their State Plans and have the greatest need for increased resources are unlikely

to be able to match a funding increase. Those states that contribute additional funds can be expected to match at least some of the increase but may do so by decreasing their 100% funding.

There are a number of advantages to State Plans. They add resources to the Federal program directed at workplace safety and health which would not otherwise be available; they must cover their own state and local government employees, who are not covered by Federal OSHA; they are familiar with the mix of industries and work establishments in their jurisdiction; and they have the flexibility to deal with workplace hazards that are sometimes not addressed by Federal OSHA. The states conduct more inspections and are able to reach proportionately more workplaces than Federal OSHA. The states have also used innovative approaches in both enforcement and standards-setting to protect their workforce.

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

As valuable as the state efforts are, however, Federal OSHA has an important role to play in assuring that State OSHA Plans are at least as effective as the Federal program. Currently, when OSHA develops a new program or initiative to protect workers, the states are sometimes encouraged, and other times required, to adopt parallel state efforts. For example, Federal OSHA recently inaugurated a National Emphasis Program (NEP) to inspect the accuracy of the injury and illness reporting requirements in order to prevent under-reporting. Although we did not require the state plan states to adopt this initiative, we have told the states that we believe that is essential that they do so because accurate reporting is critical to an effective enforcement program. We will re-evaluate whether we need to make this a requirement in the near future, depending on how many states choose not to participate. I reminded the State Plan states, when Federal OSHA announces a National Emphasis Program, American workers and employers expect it to be a truly National emphasis program. We plan in the future, to make all Federal OSHA NEPs and other similar initiatives mandatory rather than discretionary changes to the states' programs.

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

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

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

During the 18-month period ending this past June, Nevada experienced 25 workplace fatalities. All 25 of the worker deaths were investigated by Nevada OSHA. During that period Federal OSHA also received several CASPAs, regarding a confined space accident at the Orleans Hotel that resulted in two additional fatalities. The Las Vegas Sun published a series of articles that sharply criticized Nevada OSHA's handling of these fatalities. As a result of these events, Federal OSHA became aware of the problems that Nevada OSHA was facing and offered our assistance. At first the state was reluctant to accept OSHA's assistance in its enforcement effort, rejecting the Agency's initial overtures but then inviting Federal inspectors onsite only to tell them after a few weeks that they were no longer needed and developing citations without our input. However, more recently, under new leadership, Nevada OSHA is working closely with Federal OSHA to improve its program.

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

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

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

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

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

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

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

In order to go where the problems are, state plans, like Federal OSHA, use injury and illness rates to target problem workplaces and avoid inspecting workplaces where there are less likely to be violations. Nevada, however, conducted a very high

number of in-compliance inspections resulting in few serious violations. For example, for safety inspections, Nevada's average of programmed inspections with serious violations was 26% compared with 79% for Federal OSHA. In other words, Nevada inspectors were either failing to target inspections properly, failing to identify serious violations, or failing to classify those violations appropriately.

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

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

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

OSHA strongly recommended that Nevada OSHA comply with existing state procedures and new legislation to contact families of victims soon after initiation of an inspection. OSHA recommended that the state ensure adequate abatement of all hazards found during complaint inspections as well as review its abatement verification policies to ensure that all necessary documentation required for abatement verification is included in the case files. OSHA also recommended that the state provide its staff with additional training on construction hazards. The complete list of our recommendations is included in the report. Nevada OSHA will provide us with a Plan of Action that will lay out a schedule for addressing the recommendations.

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

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

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

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

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

changes in its monitoring system by identifying the most effective monitoring techniques.

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

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

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

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

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

Chairman MILLER. Thank you.
Mr. Jayne, welcome.

STATEMENT OF DONALD E. JAYNE, ADMINISTRATOR, DIVISION OF INDUSTRIAL RELATIONS, STATE OF NEVADA DEPARTMENT OF BUSINESS AND INDUSTRY; ACCOMPANIED BY STEVE COFFIELD, CHIEF ADMINISTRATIVE OFFICER, NEVADA OSHA

Mr. JAYNE. Thank you. Good morning, Chairman Miller, Ranking Member Kline, Congresswoman Titus, Congresswoman Berkley and distinguished committee members. I appreciate the opportunity to speak with you today about Nevada's Occupational Safety and Health Program.

My name is Donald Jayne. I am the administrator for Nevada's Division of Insurance. I was appointed to that post in March of 2009. I have with me today the newly appointed chief administrative officer for Nevada OSHA, Mr. Stephen Coffield, to my left.

We are pleased to be here today to answer your questions about the federal OSHA's review of the Nevada Occupational Safety and Health Program. This report is a product of a special study by federal OSHA and it is first, as I understand, in a series of special reports as outlined by Jordan.

When I was asked if I would agree to have Nevada be the first of the state plans to be evaluated, I said yes. My reason was simple. I wanted to know what was and what was not working.

Now I know. I know that Nevada OSHA needs work, quite a bit of work. But I am here to tell you that Nevada OSHA is not a wreck. The program should not be junked. It needs to be repaired and it needs to be properly maintained.

In moving forward, we should not forget the people who work for Nevada OSHA. Like employees of federal OSHA and other state plans, our employees are committed to enforcing occupational safety and health standards.

In many ways, OSHA is similar to the highway patrol. We are the cops. We are the enforcement officers. We enforce the laws and we investigate tragic accidents. We don't blame cops for tragic accidents, and we should not blame OSHA enforcement officers either.

We should keep in mind that the primary responsibility for occupational safety and health rests with employers. If an employer fails in its responsibility, we, like the highway patrol, should issue a citation that carries an appropriate fine.

But I am not here today to talk about fines. I am here today to talk about Nevada OSHA's response to the federal OSHA study. After reviewing the report and considering the testimony that preceded me, you may wonder how I can be so sure that Nevada OSHA can be salvaged.

My answer is simple. I have confidence in Mr. Coffield and the enforcement professionals that we have in Nevada to do their job with the proper leadership that we have talked about. We have got dedicated employees who are dedicated to reducing work-related accidents, illness and fatalities. Therefore, as part of Nevada's new leadership, I know that OSHA will improve.

Thus, my opening comments and my answers to your questions may be more positive than you expect. I believe that the issuance of the federal OSHA report marks the beginning of a new relationship based on a shared goals—reducing injuries, illnesses and fatalities in the workplace.

I am here today to tell you that federal OSHA and the state plans can work together to achieve this goal. We must work together because even one work-related death is too many. The impact on family, loved ones, friends and fellow employees is too great.

In Nevada, we have shared the pain of work-related fatalities all too often. Therefore, at this time, I want to offer my public condolences to all those who have lost someone in a work-related accident. As I said, even one work-related death is too many.

Federal OSHA and the state plans must do more to eliminate fatalities. For its part, Nevada has a history of doing more. In 1991, we developed a law requiring each employer with more than 10 employees to establish and carry out a written safety program.

And in 1995, Nevada OSHA was authorized to adopt standards and procedures for safe operation of cranes.

More recently, Nevada responded to work-related fatalities by requiring mandatory OSHA 10 and OSHA 30 training for employees and supervisors engaged in the construction industry.

Nevada also passed S.B. 288 requiring consultation with members of a deceased's family.

Today I am here to state on the record that Nevada OSHA is going to address the issues raised in the federal OSHA report. However, budgetary constraints may have adverse impacts on our ability to address the issues quickly.

Thus, while we are committed to change, we must be mindful of our financial limitations. Historically, Nevada has stepped up to the plate financially. At present, the State of Nevada contributes three-quarters of the operational cost for Nevada OSHA.

But Nevada is not alone. Over the years, the ratio of federal contributions have slipped, with the state plans picking up an increasing share of the costs.

Therefore, as federal OSHA increases its oversight of state plans, we are compelled to ask you for an equitable and consistent formula to fund state programs. If you want state plans to succeed, we must address the funding formula.

In my remaining time, I would like to take this opportunity to address a couple of the issues from the federal OSHA report. At the onset, I want to touch the willful and repeat violations.

Here I can tell you that we are already addressing the perception that willful violations that are discouraged. They are not. In conjunction with this effort, we are forging a new and effective working relationship with our enforcement personnel and attorneys.

These actions, along with others, will ensure that the employers who willfully or repeatedly violate OSHA standards are issued appropriate citations.

Overall, it is my intention to enhance and strengthen the enforcement policies and practices. Accordingly, Nevada will develop an action plan addressing the findings and recommendations in the federal OSHA report.

Next, I would like to say just a few words about training. We do not take this issue lightly. Like other plans, we rely on the OSHA Training Institute, and we—that will not change. We will continue to send our enforcement officers, even though it is an extremely cost deficient approach.

In the effort of time, I will move to a summary and simply assure the committee that we are here today to accept the recommendations, to work towards correcting the recommendations, and to be visible and answer the questions that the committee may have.

Thank you for your time.

[The statement of Mr. Jayne follows:]

Prepared Statement of Donald E. Jayne, Administrator, Division of Industrial Relations, Department of Business & Industry, State of Nevada

Good Morning. Thank you Chairman Miller, Ranking Member Kline, Congresswoman Titus and distinguished Committee members for this opportunity to speak with you today about Nevada's Occupational Safety and Health Program.

My name is Donald Jayne. I am the Administrator of Nevada's Division of Industrial Relations and the state plan designee for Nevada's Occupational Safety and Health Program. I have with me the newly appointed Chief Administrative Officer for Nevada OSHA, Stephen Coffield.

We are pleased to be here today to answer your questions about Federal OSHA's Review of the Nevada Occupational Safety and Health Program ("Federal OSHA Report"). The report is the product of a special study by Federal OSHA—the first in what I understand will be a series of special studies of state plans.

When I was asked if I would agree to have Nevada OSHA be the first of the state plans to be evaluated by a special study, I said "yes." My reason was simple: I wanted to know what was, and what was not, working.

Now I know. I know Nevada OSHA needs work. Quite a bit of work. But, I am here to tell you Nevada OSHA is not a wreck. The program should not be junked; it just needs to be repaired and properly maintained. In moving forward, we should not forget about the people who work for Nevada OSHA. Like employees of Federal OSHA and other state plan states, our employees are committed to enforcing occupational safety and health standards.

In many ways, Nevada OSHA is similar to the highway patrol, we are the cops, the enforcement officers who enforce the laws and investigate tragic accidents. We don't blame cops for tragic accidents and we should not blame OSHA enforcement officers either. We should keep in mind that the primary responsibility for occupational safety and health rests on employers. If an employer fails in its responsibility, we—like the highway patrol—will issue a citation carrying an appropriate fine.

But I am not here today to talk about fines. I am here to discuss Nevada OSHA's response to Federal OSHA's Report. Now, after reviewing the report and considering the testimony preceding me you may wonder how I can be so sure Nevada OSHA can be salvaged. My answer is simple: I have confidence in Mr. Coffield and the Nevada OSHA employees who have dedicated themselves to reducing work-related accidents, illness and fatalities. Therefore, as part of Nevada's new leadership, I know Nevada OSHA will improve.

Thus, my opening comments—and my answers to your questions—may be more positive than you might expect.

I believe the issuance of Federal OSHA's Report marks the beginning of a new relationship based on a shared goal—reducing injuries, illnesses and fatalities. I am here today to tell you that Federal OSHA and the state plans can work together to achieve this goal.

We must work together because even one work-related death is too many. The impact on family, loved-ones, friends and fellow employees is too great. In Nevada, we have shared the pain of work-related fatalities all too often. Therefore, at this time, I want to offer my public condolences to all those who have lost someone to a work-related accident.

As I said, even one work-related death is too many. Federal OSHA and the state plans must do more to eliminate fatalities.

For its part, Nevada has a history of doing more. In 1991, we adopted a law requiring each employer with more than 10 employees to establish and carry out a written safety program; and, in 1995, Nevada OSHA was authorized to adopt standards and procedures for the safe operation of cranes. More recently, Nevada responded to work-related fatalities by requiring mandatory OSHA 10 & 30 hour training for employees and supervisors engaged in construction work. Nevada also requires consultation with members of the deceased's family.

Today, I am here to state on the record that Nevada OSHA is going to address the issues raised in Federal OSHA's Report. However, budgetary constraints may have an adverse impact on our ability to address the issues quickly. Thus, while we are committed to change we are mindful of our financial limitations.

Historically, Nevada has stepped up to the plate financially. At present, the State of Nevada contributes over three quarters of the operational cost for Nevada OSHA. But, Nevada is not alone. Over the years, the ratio of federal contribution has slipped, with the state plans picking up an increasing share of the costs.

Therefore, as Federal OSHA increases its oversight of state plans, we are compelled to ask you implement an equitable and consistent formula to fund state plan programs. The current formula is antiquated and inadequate. If you want state plans to succeed, you must address the funding formula.

In my remaining time I would like to take this opportunity to address a couple issues raised in the Federal OSHA Report.

At the onset, I want to touch on "willful" and "repeat" violations. Here, I can tell you we are already addressing the perception that willful violations are discouraged; they are not. In conjunction with this effort, we are forging a new and effective working relationship between our enforcement personnel and our attorneys.

These actions, along with others, will ensure that employers who willfully or repeatedly violate OSHA standards are issued appropriate citations.

Overall, it is my intention to enhance and strengthen all our enforcement policies and practices. Accordingly, Nevada will develop an action plan addressing all the findings and recommendations in Federal OSHA's Report.

Next, I want to say a few words about training. We do not take this issue lightly. Like other state plans we rely on training from the OSHA Training Institute (OTI). That will not change; we will continue to send our inspectors to OTI. We will also continue to schedule on-site training because we think it is extremely cost effective. In addition, we will take steps to ensure our enforcement personnel understand and apply their training, particularly in the area of hazard recognition.

In closing, Nevada OSHA welcomes the advent of uniform, meaningful and effective Federal OSHA oversight. Therefore, I say to you today, let us all work together in a positive and constructive manner to achieve our common goals. Nevada will take the lead in addressing issues raised in the Federal OSHA Report but we need your support and assistance.

Thank you for your time and attention.

Chairman MILLER. Ms. Debi Koehler-Fergen. Welcome to the committee, Ms. Fergen, and we thank you for being here. We, I think on behalf of every member of the committee, we extend our condolences to your family.

But I also want to recognize you taking up this battle to change these circumstances after your son became a victim of a very badly managed program, if not more.

So thank you for being here, and we look forward to your testimony.

STATEMENT OF MS. DEBI KOEHLER–FERGEN

Ms. KOEHLER-FERGEN. Chairman Miller and distinguished members of the committee, my name is Debi Koehler-Fergen, and I would like to thank you for inviting me to testify here today. I do so in the memory of my son, Travis Wayne Koehler—I am sorry. I give God the glory for answering my prayers to be heard.

Travis and Richard Luzier lost their live and David Snow was severely injured at the Orleans Hotel, as been stated, on February 2nd, 2007. The federal review of the Nevada state agency accurately reflects the fact that Nevada OSHA utterly failed, not only my son, but also Richard and the other workers killed or injured.

I view the federal report on Nevada OSHA's investigative practices as vindication of my allegations in the CASPAI filed that showed clearly supportable evidence for willful or repeat violations that were not cited by Nevada OSHA even though the owner-operator of this hotel had been previously cited for substantially similar conditions and hazards at other properties.

It was clear to lead investigator John Olaechea that Boyd management and the supervisors knew of the dangerous conditions that existed concerning confined spaces, yet Nevada OSHA management would not support willful/repeat citations and essentially let the gaming company get away with, in my opinion, murder.

My son trusted his employer. He never would have dreamt that he would be called upon to intentionally be put in a deadly situation. He is a Carnegie Hero Award recipient for his actions that day. And while proud of him, it is of little consolation for our family. He is desperately missed by me, his dad Pops, his brothers Bobby and Brandon, other family and friends.

I found it especially troubling to read in the federal report that Nevada investigative personnel are completely lacking in many areas of training for the jobs that they are entrusted with.

The federal report states that two employees have conducted fatality investigations in 2009 without the benefit of accident investigation training. How can an agency entrusted to protect Nevada's workforce lack in so many areas of training themselves?

There is also a desperate need for family member victims to be heard and included in the investigation process and to be treated with dignity. But sadly, that is not what happened to me personally.

I felt misled by Steve Coffield, then acting CAO of Nevada OSHA in Las Vegas, who said I would be happy with the outcome of the case. I am not sure how reduced citations would make me happy.

I am also dismayed to find out from the federal report that the case was delayed because Nevada felt the need for further investigation, yet I was told it was due to a scheduling issue between all parties.

As a mother whose son had suddenly been ripped from her arms due to a completely preventable incident, it wasalso very distressing for me to stand in the back lobby of the OSHA offices when Mr. Coffield gave us the investigative report and endure sideways glances of other employees coming to work, watching me cry when told of the reduced findings. No invitation to his office or other private area to ask questions, not even an offer to sit or a drink of water.

It was a humiliating and disrespectful experience. And still, I have no answers why those willful citations were not given.

Unless someone can prove to me otherwise, and I welcome the effort, I will always believe there was corruption in the Orleans case. Powerful companies such as the gaming industry use their political connections to influence such things as the outcome of an investigation, as I believe Boyd Gaming did.

Nevada OSHA cannot continue to buckle under these political pressures and needs to stand up and send the clear message that the game is over and give the citations and fines that prove it.

And federal OSHA needs to hold them responsible for making the changes set out in the review report.

I am very pleased with the outcome of this federal review of the Nevada OSHA office and practices. They did a thorough job of looking for the truth and finding areas that need improvement.

I applaud everyone involved for their dedication to make not only the Nevada state office a more efficient agency, but for trying to

ensure that hard-working people can go home to their families at the end of the day.

In closing, due to the enormity of the task ahead for Nevada OSHA, I am skeptical that they will be able to implement the changes in a timely manner and with the urgency it must in resolving these deficiencies.

While I want very much to believe they are willing to address all of the issues and make a more effective agency, I personally have a wait-and-see attitude.

I would like to, for the record, give a copy of the Workplace Tragedy Family Bill of Rights to Mr. Jayne, if I can.

[The information follows:]

Workplace Tragedy Family Bill of Rights

The following Bill of Rights for family member victims of workplace fatalities and serious injuries would provide fundamental privileges to the loved ones left behind by workplace incidents.

1. A federal liaison office must be established to provide family members with information about the accident investigation(s) process, role of other state or federal agencies, workers' compensation and other matters related to their loved one's death.

2. Family members must have full "party status" in legal proceedings involving OSHA, MSHA, or whatever state or federal agency is conducting the workplace-fatality investigation.

3. Family members must have the right to designate a representative to act on their behalf in all matters related to the investigation and any follow-up legal actions related to the investigation.

4. Family members must be notified of all meetings, phone calls, hearings or other communications involving the accident investigation team and the employer, and be given the opportunity to participate in these events.

5. Family members must have the opportunity to recommend names of individuals to be interviewed by the accident investigation team and to submit questions to the investigators for response by the interviewees. Family members should be given access to all transcripts of interviews, affidavits, or written statements made by witnesses and others interviewed for the investigation.

6. Family members must have the right to be kept routinely [no less than once every 14 days] informed by federal and state officials (e.g., OSHA, OSHA State-Plans, MSHA) on the progress of the incident investigation, including an estimate of when the investigation will be completed.

7. Family members must have the right to conduct an independent investigation of the work-related fatality or serious injury, including the right to visit the scene of the accident before it is released by the investigation team back to the employer's control.

8. OSHA and MSHA must assure that all physical evidence related to the accident investigation is preserved and secured in a tamper-resistant environment. Family members should have the right to view all physical evidence.

9. Family members should have access to all documents gathered and produced as part of the accident investigation, including records prepared by first responders, and state and federal officials. Information mentioning the deceased family-member's name and condition should not be redacted from documents provided to family members. All fees related to the production of documents should be waived for family members.

10. Family members must be compensated for the time and expenses incurred because of a work-related fatality or serious injury. In cases where the deceased or seriously injured worker has no spouse or dependent children, a parent of the worker should be compensated for funeral cost, travel and medical expenses, and lost wages.

Ms. KOEHLER-FERGEN. I urge federal OSHA and Department of Labor not to let Nevada OSHA slide back into complacency.

Thank you very much.

[The statement of Ms. Koehler-Fergen follows:]

Prepared Statement of Debi Koehler-Fergen

My name is Debi Koehler-Fergen; I reside in Las Vegas, NV and am the mother of Travis Wayne Koehler, who along with Richard Luzier, was killed and Dave Snow was seriously injured at the Orleans Hotel in Las Vegas on February 2, 2007.

The Federal OSHA review of the Nevada State plan agency confirms that NV OSHA utterly failed not only my son and Richard, but also all workers in the state of Nevada. I filed a CASPA because NV OSHA inexplicably downgraded penalties for Boyd Gaming that the investigator recommended as willful and repeat. The Federal report vindicates the allegations in my CASPA because it clearly shows supportable evidence for those recommended penalties. The Federal report is a grave indictment of the problems in the State plan agency, showing it in significant and woeful disrepair. My son trusted his employers and never would have dreamt that on that fateful day he would be called upon to intentionally be put in a deadly situation. And how many people feel that they can trust OSHA to keep their employers from doing them harm? Far too many I'm afraid.

I found it especially troubling to read that NV OSHA investigative personnel are completely lacking in many areas of training for the jobs they are entrusted with. The Federal Review report states that "Two employees have conducted fatality investigations in 2009 without the benefit of Accident Investigation Training". One employee who had not received basic training for Initial Compliance was hired in 1993! How can an agency entrusted to protect Nevada's workforce by ensuring they are properly trained lack in many different areas of training themselves? They write citations to companies for non-compliance for various violations and yet they themselves are also in non-compliance.

NV OSHA is not living up to its enforcement plan that it be at least as effective as Federal OSHA. They are allowing powerful companies to use their political connections to influence such things as the outcome of investigations, as I believe Boyd Gaming did. If NV OSHA continues to buckle to those political pressures and if they fail, within an agreed upon time frame, to fully and completely reform itself according to what has been set out in the Federal Review then Federal OSHA needs to exercise its responsibilities as set forth in Section 18F of the OSHA Act, step in and exert its authority over the State Plan, even if it means taking away Nevada's certification.

Federal OSHA did a thorough job of looking for the truth and finding the areas that need improvement. I applaud everyone involved for their dedication to make not only the Nevada State office a more effective agency but for helping to ensure that hard working people can go home to their families at the end of the day. I see the enormity of the task ahead for NV OSHA to remedy these serious and troubling problems. I am skeptical whether they will implement the changes in a timely manner and with the degree of urgency that it should, therefore, I have a wait-and-see attitude but urge Federal OSHA and Department of Labor not to let NV OSHA slide back into complacency. Life is too precious to allow that to happen again.

Congressman Miller and distinguished Members of the Committee: My name is Debi Koehler-Fergen; I reside in Las Vegas, NV and I would like to thank you for inviting me to testify here today for the hearing entitled: "Nevada's Workplace Health and Safety Enforcement Program: OSHA's Finding and Recommendations". I do so in the memory of my son, Travis Wayne Koehler. When he was killed February 2, 2007 one of my first prayers was to please allow this one mother's voice be heard and I give glory to God for hearing my prayer.

It has been my contention for years that NV OSHA made intentional missteps and were unduly influenced in how they handled the Orleans Hotel case that caused the deaths of my son Travis Koehler and Richard Luzier and severely injured David Snow. On that terrible day, Richard was directed by his supervisors to go into a permit required confined space, without any training or knowledge of the consequences, to correct a problem in the grease trap/lift station. Gasses were released after he cut a pipe and when he fell into trouble the same supervisors sent Travis, also untrained and unaware of the consequences, to go help Richard. At his heels Dave Snow was told to go help; he was also untrained and unaware of the consequences. According to the Coroner's report the level of hydrogen sulfide fumes were at such extreme levels that it would have rendered them unconscious within seconds. Did the supervisors even take the time to consider the innumerable OSHA rules and state laws they were violating? They obviously had time to think about it but their decision shows me they didn't care. Following are examples of these supervisors' personal failures and the failures of Boyd Gaming Management:

- Failed to contact the contracted outside company who always did this type of work—the supervisors' reason for not having their department personnel trained.

• Failed to follow state law and notify the Clark County Fire Dept. Heavy Rescue Squad of their plans. Instead they were 30 miles away conducting training and those poor souls had to stay down in that manhole until CCFD got back into town, set up their rescue equipment and remove their lifeless bodies from their death chamber.

• Failed to heed their own managers to get the men trained and keep them away from all confined spaces. Boyd management showed a culture for not caring about safety issues.

• Failed to heed the concerns of a couple of the men who loudly expressed their opinion that this was too dangerous and they needed to wait for the outside company.

• Failed to utilize the safety equipment that was on site, gathering dust in a storage area.

• Failed to equip the men with any more specific safety gear other than gloves. According to the OSHA investigation report, the Orleans had a contractual agreement with the outside pump company which prevented them from letting their engineering employees use respirators!

• Failed to supply air to the area to clear out the fumes and stinking gasses that everyone knew was present in the area.

• Failed to perform an air sampling of the pit to make sure it was free of gasses.

It is not difficult to conclude from these points that Orleans management demonstrated their plain indifference for the employees and set in motion a tragedy that took the lives of two young men and permanently hurt a third. It is was clear to John Olaechea, lead investigator on the Orleans Hotel case, that Boyd management and the supervisors KNEW of the dangerous conditions that existed concerning confined spaces, yet NV OSHA obviously chose to turn a blind eye to the obvious and not support the citations recommended by Mr. Olaechea and essentially let the gaming company get away with—in my opinion—murder.

I believe the Federal review of the Nevada State plan accurately reflects the fact that NV OSHA utterly failed not only my son and Richard, but the other workers who died and all workers in the state of Nevada. I view the findings on NV OSHA's investigative practices as vindication for my allegations, expressed in the CASPA I filed, that shows clearly supportable evidence for willful or repeat violations that were not cited by NV OSHA. The Federal Review report is a grave indictment of the problems in the State plan agency. It shows the State agency in significant and woeful disrepair that needs urgent attention. People go to work every day with the misguided notion that they are being protected by their employer and an agency whose job it is to keep them safe. I know my son trusted his employers. He would never have dreamt that on that fateful day he would be called upon to intentionally be put in a deadly situation. He is a Carnegie Award Hero for his actions, but I'm sure he did not believe following the directions of those he trusted would result in his death. And how many people feel that they can trust OSHA to keep their employers from doing them harm? Far too many I'm afraid.

The citations that were clearly warranted by Mr. Olaechea, and documented in an internal memo (taken from the OSHA investigation report) that made his case, according to OSHA's own definitions, for three willful neglect and three repeat serious citations among others. As supported and stated in this review report, NV OSHA issued serious rather than willful or repeat citations even though the owner/operator of this hotel had been previously cited for substantially similar conditions and hazards at other properties. I might point out that while the citations were irresponsibly downgraded to serious; the penalties assessed were $23,000 each which is far above the normal penalty fine for a serious violation. According to Boyd Gaming online financial reports, the quarter ending September 2007 the total fines of $185,000 equals one third (⅓) of one day's NET profit. To say these were significant fines and some of the largest assessed in the state is laughable considering what the gaming company earns. OSHA, as a whole, needs to understand that when they downgrade or withdraw citations and penalties, it just adds to our family's overwhelming grief over the death of our loved one and it feels like there is no justice for anyone—except for the offending company.

Personally it was clear to me, and many others, that NV OSHA was trying to cover the fact that they knew they should have cited them for willful and repeat since while they downgraded the citations they penalized them more on the level of repeat. To further point out that NV OSHA missed the mark on our investigation and ignored obvious reasons to cite Boyd Gaming with willful or repeat, consider the following points that the Boyd Gaming EHS Manager stated in our OSHA report:

• He knew of the notice of violation at the California Hotel for confined spaces.

• He knew that confined spaces were very dangerous hazards and that they were common to all Boyd properties (not only in Las Vegas but across the country).
• He also knew there were no safety programs or training at the Coast properties.
• He discussed all this with corporate officials above him and he knew all of this in mid 2005.
• He attempted to do audits on safety issues but upper management canceled the internal audits.

It is clear that Boyd Gaming upper management was aware of the safety issues at their properties, yet did nothing to address the hazard of confined spaces by making sure their employees were well-trained. It is clear that since the Nevada state agency was in such disarray they completely and utterly missed an opportunity to not only do the right thing and give justice to these young men, but also to have sent a very loud, clear message across the Las Vegas valley to the other companies—especially construction—that may have prevented at least some of the deaths that occurred in the months following my son's death.

While the findings of the Federal review team do not entirely surprise me, I found it especially troubling to read that investigative personnel are completely lacking in many areas of training for the jobs they are entrusted with. The Federal review report states "Two employees have conducted fatality investigations in 2009 without the benefit of Accident Investigation Training". OSHA employees who should have had basic training for Initial Compliance, for example, had not received this training—and one was hired as far back as 1993! How can an agency entrusted to protect Nevada's workforce by ensuring they are properly trained lack in many different areas of training themselves? They write citations to companies for non-compliance in getting their employees trained and yet they themselves are also in non-compliance.

Because I wanted to stay informed about the progress of our report and the findings, I had several conversations with Mr. Olaechea and he told me that he didn't know why this case was being handled in such an unusual way. He said he didn't understand why it was taking so long and also told me he had several conversations with Steve Coffield, acting CAO of NV OSHA in Las Vegas, stressing the importance of keeping those violations as willful and repeat. He felt what happened in this incident was so egregious that the company and supervisors should be criminally prosecuted. He said he was adamant about that and indicated that Mr. Coffield assured him nothing would change. I also contacted Mr. Coffield by phone expressing concern for the six month deadline and he told me not to worry, the case was still intact and indicated to me that I would be very pleased with the outcome. He knew I wanted justice for my son and the only way was to find them willfully negligent. As pointed out in the Federal Review report NV asserted that because of the need for "further investigation" the "need to reinvestigate was a primary reason final settlement was somewhat delayed". It was disturbing to read this because Mr. Coffield told me the reason for the delay was that it was just difficult to get everyone together at the same time for a meeting, that it was a scheduling issue. I would have appreciated being told the truth, first of all, and it would also have helped me better accept the delay at that time.

Mr. Coffield assured me that I could come to their office and pick up a copy of the report once it was completed and would answer any questions. Of course, due to what I assert were undue influences Boyd Gaming walked away with a sweetheart deal thanks to NV OSHA. I would like to ask if anyone seriously believes that I would be pleased with reduced citations that did not hold the company and individuals that killed my son and Richard accountable for their deaths. To reduce those citations was to say that their lives meant nothing. Adding insult to injury when we arrived to pick up the report I was told to come in the back lobby area and he would be right down (reporters were expected to be coming to the front door and going to their office). Instead of inviting us to his office he stood by the back elevator explaining why they reduced the citations while employees were walking past us watching me cry as I was understandably upset. At no time did he offer me a chair or to go to a private room while I digested what was going on around me. He did not show me common courtesy and was the most unprofessional encounter I have ever had.

Personally, I believe that at some point Mr. Coffield may have planned to give the willful and repeat citations, but some highly unusual maneuverings took place that caused him to back down. I am referring to the very unusual involvement of Mendy Elliott, who worked for the NV governor and Roger Bremnar, of the Department of Business and Industry, who inserted themselves into the Closing Conference, invited by whom I don't know. Someone had to have contacted Mr. Bremnar's office asking for their help. To me that says they believed this case to be bigger than just an accident with a couple of fatalities. In an unsolicited letter

she wrote to me, Ms. Elliott expressed her feelings about my filing the CASPA and stated that she and Roger Bremnar were involved in the closing conference and that the settlement discussions that followed were appropriate. I understand that Mr. Bremnar made the final decision to downgrade the citations yet no one has ever communicated with me why. I would still like to know that. Ms. Elliott further stated that she and Roger have "concluded that NV OSHA acted in the best interest of the Nevada workers". I'm sorry but the "significant monetary penalties" against Boyd Gaming were nothing more than pocket change to the owner and certainly nothing to make them pay attention to any future fines. And my request of Ms. Elliott for full disclosure of the settlement discussions was ignored.

While the Federal Review report states that Boyd Gaming is not a part of the SHARP (Safety & Health Achievement Recognition Program), there is a legally-signed document supporting their inclusion into SCATS (Safety Consultation & Training Section) to prepare them for the program in the NV OSHA investigative report. In light of the glaring issues within NV OSHA as well as the history of Boyd Gaming safety issues, I would encourage them to be on top of unannounced inspections of Boyd Gaming properties.

One important reason why I believe Nevada needs a strong, competent OSHA is due to the transient nature of the construction market in Las Vegas where people come from all over North America to work on construction projects, as well as in the hotels and casinos. Employers must be made to keep up with a workforce that could change on a weekly basis.

I believe that within the Nevada State agency there must be 100% openness in all their dealings with regards to the families. No more private meetings, no more making decisions without being prepared for full disclosure on all aspects of the case. Even to why they reduce or withdraw a citation. Corruption can be tolerated NO MORE!! OSHA should be an apolitical office and treat every case the same regardless of the company, corporation or gaming giant they are dealing with.

In my opinion, the only way to get the attention of employers across the Las Vegas valley, especially that of the gaming industry who believe they answer to their own power, and uses its political connections to influence such things as the outcome of an investigation, as I believe Boyd Gaming did, is for Nevada OSHA to take a strong stand and give citations and fines that will send a message that they mean business. If the gaming industry continues to exert its influence by using the political system in the State of Nevada, and NV OSHA continues to buckle to them, then Federal OSHA needs to step in, take over and put a stop to it!

In closing, I am very pleased with the outcome of this review of the NV OSHA office and practices. I feel they did a thorough job of looking for the truth and finding the areas that need improvement. I applaud everyone involved for their dedication to make not only the Nevada State office a more efficient and positive agency, but also for helping to ensure that hard working people can go home to their families at the end of the day.

I see the enormity of the task ahead for NV OSHA to remedy these serious and troubling problems and I am concerned if they will be able to implement the changes in a timely manner and will the NV agency actually be able to resolve the deficiencies that have been identified with the degree of urgency that it needs to. I cannot say that I am satisfied with all the responses made by the State OSHA office. Many of them said nothing really or didn't address the allegations as thoroughly as they should have. While I want very much to believe they want to address all of these issues and make a more effective agency I personally have a wait-and-see attitude.

I urge Federal OSHA and Department of Labor not to let NV OSHA slide back into complacency.

Chairman MILLER. Thank you.
Dr. Mirer?

STATEMENT OF FRANKLIN E. MIRER, PROFESSOR OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH, CITY UNIVERSITY OF NEW YORK

Mr. MIRER. I am Frank Mirer. I am a professor now, but I spent 30 years with the United Auto Workers Union. My academic project is trying to generalize that experience.

And I have to say the most intense experience with state plans was the night we worked in—I think it was 2000—way into the night to settle the Ford Rouge power plant investigation and million-dollar penalty, and management agreed to take on an issue that is through the whole company, which reinvigorated health and safety in the company and derived benefit far beyond the borders of Michigan. And there is a lesson there as to what happens after a tragedy.

We are here looking at inspection, citation, employer contest, abatement—where the rubber meets the road in health and safety. And let's face it. We are here because of the courageous actions of some families in Nevada to bring this before us.

But the problems depicted in the OSHA report—slow investigation, modest penalty, employer contest or threatened contest, reduced penalty, family and employees not involved in investigation, settlement and uncertain abatement—unfortunately, those are characteristics of a lot of things that happen in the safety and health world now, not just in Nevada, not just in state plans, but elsewhere. And that is what we have to talk about correcting.

There are a lot of statistics in my testimony, but statistics don't put guards on machines or conduct confined-space entry programs. We have to talk about what is really going to level the playing field between state and local—state and federal upward, and take advantage of the innovations in both directions.

Now, state plans were historically a compromise back in 1970. Some of us felt that giving back enforcement to agencies that we were replacing federal with—state with federal to level the playing field between the states. But the essence of the interaction is equalizing upward.

Since that argument, two things have emerged, I think, that change the terrain. One is the notion of multi-plant, multi-state agreements to abate hazards, which are disadvantaged in the state program system.

And the other is the coverage of public employees which exists in state plan states and not elsewhere, and this is a large segment of our population.

And so those have to—those two issues have to be addressed in trying to abate these problems.

Now, there are a lot of statistics about the differences between state and federal enforcement, and what they boil down to is two questions. Why do states appear to classify violations as lower gravity, lower penalty, than federal OSHA? And on the other hand, why does federal OSHA appear to be less productive in terms of investigations and total citations?

And we have to understand the reason why that is happening. This should not be a trade between productivity and quality. And we should be equalizing everything upward and taking advantage of of both experiences to improve protections across the country.

In my testimony, there is some more detailed analysis of the differences in the statistical measures between Nevada and state plans and OSHA in general. We need to have a system that recognizes statistical abnormalities, things that are operating outside the system and responding to them.

But ultimately, the oversight of these programs depends on individual case reviews. That is why we are here, because of individual case reviews. Individual case reviews tell a story that people can use, whereas numbers are numbers and can be interpreted in a lot of different ways.

At the end of my testimony I cite an example which may be a way forward, the explosion in Corbin, Kentucky taken up by the Chemical Safety Board. There is an example of both a lost opportunity, protections not extended across the country, from a tragic accident.

And it also depicts the power of a complete case review looking for failures in regulation, failures in enforcement, failures in state program, in this case, activity. But I submit that it has to be applied to—applied in the federal system equally as well to move forward.

Thanks very much.

[The statement of Mr. Mirer follows:]

Prepared Statement of Franklin E. Mirer, Ph.D., CIH, Professor, Environmental and Occupational Health Sciences, Urban Public Health Program, Hunter College, City University of New York

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

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

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

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

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

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

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

My testimony will address four matters: the importance of enforcement in the system of safety and health protections; the history and rationale for state plan enforcement; the faults revealed by the OSHA review of the Nevada plan; general

issues with enforcement, whether state or federal; and, issues to consider going forward.

Importance of enforcement in the system of safety and health protections

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

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

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

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

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

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

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

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

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

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

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

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

erendum directing that the state plan be restored was supported by the majority of California voters.

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

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

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

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

Since the 1970's, two other issues emerged, one a disadvantage of state enforcement, the other an advantage. Regarding enforcement, state plans would be unable to reach beyond their borders to coordinate enforcement to influence management which had facilities in other states. Corporate-wide settlement agreements and partnerships both would have to implemented and monitored separately in each state jurisdiction. The example below, the explosion at CTA Acoustics in Corbin, KY in 2003 illustrates the opportunities which may be lost by not expanding beyond state borders.

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

Enforcement statistics reveal important areas for improvement for both state plans and for OSHA.

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

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

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

The obvious questions for quality improvement are:

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

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

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

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

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

Performance measures for Nevada Appear Outside the System

The most striking deviation by Nevada was the absence of willful citations in 2008, noted by the OSHA report. The proportion of willful violations for state plans combined was also about ¼ that for federal OSHA (N = 0, S= 0.3%, F = 1.3%). The fraction of higher gravity, combining willful, repeated and failure to abate was lower (N = 2%, S= 5%, F = 9%) These were less than half the proportion for states combined and less than ¼ the proportion for federal OSHA. The fraction of serious violations was also lower (N = 29%, S= 44%, F = 76%) In addition, violations per inspection were lower than state plans combined and than federal (N = 2.4, S= 3.3, F = 3.2). Serious violations per CSHO were ½ that for states combined and about ⅓ that for federal (N = 21.5, S = 42.9, F = 60.0). The number of higher gravity citations (WRF) per CSHO was about ½ that for state plans combined and less than ½ that for federal. (N = 1.3, S= 2.5, F = 3.1).

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

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

Workers at CTA Acoustics in Corbin, KY, a supplier to the auto industry and therefore of interest to the UAW, suffered a dust explosion on February 20, 2003 that killed seven workers and injured 37 others. The facility was non-union. The United States Chemical Safety Board (CSB) reported "Investigators found that CTA had been aware that combustible dust in the plant could explode, but did not communicate this hazard to workers or modify operating procedures or the design of the plant. CTA company memoranda and safety committee meeting minutes from 1992 through 1995 showed a concern about creating explosive dust hazards when cleaning the production line. Further concerns were raised in 1997." *http://www.csb.gov/newsroom/detail.aspx?nid=119* The facility had been inspected by Kentucky OSHA in December, 2002 in response to a complaint (subject of complaint not known), but no citation was issued for the combustible dust hazard. OSHA's records show that Kentucky OSHA issued citations for 7 serious violations (mostly of electrical standards) on August 5 of 2003, which were settled on August 25, 2003, for a total of $49,000. The abatement agreement, beyond penalty, is not known. *http://www.osha.gov/pls/imis/establishment.inspection—detail?id=305910440*

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

Recommendations

1. Federal OSHA needs to enhance its oversight and monitoring of state plans to ensure that they are performing as required by the OSHAct, with standards and enforcement programs that are at least as effective as federal OSHA's protection

2. OSHA oversight should increase emphasis on case file review, in relation to other statistical methods. State plans should be required to identify significant cases, while OSHA oversight should sample cases likely to be problematic. A narrative of the incident with successes and failures would advance both the target agency, agencies in other states, federal enforcement, congress and the general public.

3. Post citation processes should be especially scrutinized: describe the impact of informal conference, negotiations after employer contest, the nature of an abatement agreement if negotiated, and a sample of formal hearings.

4. Parallel inspections or accompanied inspections by OSHA oversight personnel are important. For injury control (safety) standards, it is sometimes necessary to see what's happening on the floor to understand whether appropriate hazard identification and abatement took place.

6. For each state plan and federal OSHA, OSHA should collect data and publish data to compare training, longevity, pay rates of CSHO's.

6. Enforcement data collected should stratify results by construction, general industry, public sector.

7. Penalty data should distinguish penalties assessed from final penalties. For penalty data, OSHA should provide the median as well as the average amounts. The average is very likely skewed by a few high penalty cases, but most employers will see the median.

8. OSHA needs a way to intervene and improve state plan performance short of revoking the state plan. Revoking a state plan means depriving state and local employees of health and safety protection. Legislation may be needed to facilitate mechanisms for federal intervention, such as concurrent jurisdiction, where state plans are found to be deficient.

9. Finally, and maybe most important. Our nation can't expect to get the significant reductions in fatalities, injuries and illnesses by tinkering with the inspection and enforcement program within the current framework. Fundamental change is needed—this change includes increased employee participation in all phases of health and safety, plus standards that reflect the science of the 21st century, plus coverage of all American workers, plus reliable protection of workplace whistleblowers.

TABLE 1: COMPARISON OF ENFORCEMENT DATA BETWEEN NEVADA OSHA, ALL STATE PLANS COMBINED, AND FEDERAL OSHA.

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

Source: OSHA IMIS, accessed 2009-10-22.

STATE PLAN COMPLIANCE SAFETY AND HEALTH OFFICERS PER COVERED EMPLOYEES

State	State Gov Employees	Local Gov Employees	Total Public Sector Employment	Private Sector Employees	Total Employees Covered	Allocated CSHOs FY 2009	1,000 Covered Employees per CSHO	# CSHOs per 100,000 Covered Employees
Alaska	25,700	42,200	67,900	224,900	292,800	12	24.4	4.1
Arizona	90,900	300,100	391,000	2,115,000	2,506,000	25	100.2	1.0

STATE PLAN COMPLIANCE SAFETY AND HEALTH OFFICERS PER COVERED EMPLOYEES—Continued

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

CASPAs by State (Within Region)

	FY 00	FY 00 Open	FY 01	FY 01 Open	FY 02	FY 02 Open	FY 03	FY 03 Open	FY 04	FY 04 Open	FY 05	FY 05 Open	FY 06	FY 06 Open	FY 07	FY 07 Open	FY 08	FY 08 Open	FY 09	FY 09 Open	FY 10 To Date	FY 10 Open	TOTALS BY STATE	TOTAL OPEN CASPAs	
REGION 1																									
Connecticut	0		0		0		0		0		0		0		0		0		0				0	0	**REGION 1**
Vermont	0		0		0		0		0		0		0		0		0		0				0	0	
REGION 2																									
New Jersey	0		0		0		0		0		0		0		0		0		0				0	0	
New York	10		5		0		0		0		0		1		0		1		0				17	0	**REGION 2**
Puerto Rico	0		0		0		0		0		0		0		0		0		0				0	0	
Virgin Islands	1		0		0		0		0		0		0		0		0		0				1	0	
REGION 3																									
Maryland	2		1		0		0		0		1		1		2		0		0				7	0	**REGION 3**
Virginia	1		0		1		0		2		2		2		0		0		2				10	0	
REGION 4																									
Kentucky	1		4		0		2		0		1		1		3		1		1	1			14	1	
Tennessee	3		1		1		3		0		0		1		1		1		1	1			12	1	**REGION 4**
North Carolina	0		0		2		3		0		0		1		5		1		2	1			14	1	
South Carolina	0		0		3		1		1		0		1		1		0		1				8	0	
REGION 5																									
Indiana	6		3		6		4		2		2		2		4		0		3				32	0	
Illinois	na		na		na		na		na		na		na		na		na		na				0	0	**REGION 5**
Michigan	5		1		4		2		4		3		1		1		4		1				26	0	
Minnesota	0		0		0		1		3		2		0		2		2		2				12	0	
REGION 6																									**REGION 6**
New Mexico	2		0		0		0		0		0		0		0		1		0				3	0	
REGION 7																									**REGION 7**
Iowa	0		1		4		2		2		0		0		2		0		2				13	0	
REGION 8																									**REGION 8**
Utah	0		2		0		1		0		6		1		2		0		2	2			14	2	
Wyoming	0		0		3		0		0		0		0		0		0		0				3	0	
REGION 9																									
Arizona	3		3		0		1		2		5		0		0		0		3	1			17	1	
California	12		3		3		7		3		0		1		4		3		5	3			41	3	**REGION 9**
Hawaii	1		2		0		2		1		3		0		3		2		1				15	0	
Nevada	3		1		5		1		0		1		1		5		0		1				18	0	
REGION 10																									
Alaska	3		1		0		0		1		0		0		1		1		3	3			10	3	
Oregon	5		5		0		1		1		4		1		3	1	2		0				22	1	**REGION 10**
Washington	2		13		2		2		2		2		1		2		1		4	1			31	1	
																							0	0	
TOTALS BY YEAR	60	0	46	0	34	0	33	0	24	0	32	0	16	0	41	1	20	0	34	13	0	0	**340**	14	
	FY 00		**FY 01**		**FY 02**		**FY 03**		**FY 04**		**FY 05**		**FY 06**		**FY 07**		**FY 08**		**FY 09**		**FY 10**				

Chairman MILLER. Thank you.

Thank you all very much for your testimony.

Let me just say at the outset, Ms. Fergen, I think one of the things that has upset this committee time and again on both sides of the aisle is when families are cut out of the process, whether it is in mining accidents or construction accidents or other issues where there has been a loss of life or very serious injury.

And part of our ongoing effort here is to make sure that, in fact, families are part of that process. The idea that they have to be bystanders, that they have nothing to contribute, when in fact, we know in a number of accidents families contribute very important evidence, because they talk to their spouse or to their father or their brother going to work, and they talk about what is wrong with the work site.

In mining, very often that takes place. And yet nobody solicits their opinions, their knowledge, their understanding, as if they are completely irrelevant to these investigations.

And that simply has to change. It has to change at the federal level, has to change at the state level, and we are continuing to pursue that. It should sound easy but for some reason it is not quite as easy to do as it should sound, but it is very important to members on both sides of this aisle.

We have been through this too many times, and we have had too many witnesses such as yourself that have suffered a loss and have basically been told just to stand over there and behave, and you will learn the results when everybody else does.

And I know there are variations on that theme, but it all sort of ends up in that place. So I just want to thank you and assure you that that is an ongoing effort on our part.

At the end of your statement, you made a plea that this isn't going to work out unless federal OSHA is more deeply involved monitoring how the review is dealt with.

Mr. Barab, what is the assurance we have that there is going to be this involvement, speaking specifically now about Nevada?

Mr. BARAB. Yes, we have asked the state, or we have told the state, that we want a detailed corrective action plan from them to describe how they are going to address all of the recommendations we made.

We have given them 30 days from the time we submitted the report, to November 20th, to give us that detailed action plan. From that point on, we have given them a year—we will give them a year to address all of the recommendations that we have made, and we plan to very carefully monitor their progress in addressing these recommendations. We will be on the ground there frequently——

Chairman MILLER. What do you——

Mr. BARAB [continuing]. To monitor that.

Chairman MILLER. You will be on the ground—will you have federal OSHA officials there, or an office, or what are you doing?

Mr. BARAB. We are planning on—we do not currently have an office in Nevada, but we are planning on setting one up there. But in the meantime, we will have people there temporarily at least.

Chairman MILLER. And what is the time frame for——

Mr. BARAB. I am not——

Chairman MILLER [continuing]. Having an office?

Mr. BARAB [continuing]. Sure yet. We are kind of negotiating now with a—we are trying to find a location. We are talking to the GSA. You know, it is the federal government. We are not quite sure what the time line is, but we have made it a priority and we are moving forward on it.

Chairman MILLER. Well, yes. I think that is important. Senator Reid testified to, you know, what has taken place in Nevada and the nation—the world has watched this.

What has happened on the—with development, not—residential, commercial and the rest of that, and the—it is clear that Nevada will go through another cycle.

And I think it is important that the resources be there.

Mr. Jayne, one of the things that concerns me in this is if I read it right, and I certainly stand to be corrected, but Senator Reid talked about the $32 billion of activity on the strip, and it is really quite amazing, and people who have been there to see it—the combination of not only entertainment facilities and gaming facilities and residential, but it is really quite massive—that has taken place.

But you don't see much increase in the personnel resources, the staff dedicated to this process, when you really had thousands of workers at the same time. People have marveled in the news.National magazines have commented on the number of cranes in the sky and what is taking place, and yet it looks to me like this was fairly flat during that period of time.

Mr. JAYNE. Just for the record, Don Jayne.

I share your same observations. One of the things that I looked at when I came on board was to take a look back at past budget cycles. And for many years, the total allocation has been relatively flat.

You know, we have had some growth over the years that Nevada has experienced and we funded it up. But the last few budget cycles we have been relatively flat as far as the number of individuals.

Now, the unfortunate reality of the current economy is that is—let's, you know, back things back down as far as the number of jobs, and quite a significant number of jobs in the construction industry have been lost in Nevada.

But I do believe that there will be a rebound to that cycle and that they will come again where Nevada will begin to boom with a building move.

One of the things that caught us in the last cycle was during that boom time virtually 50 percent of our experienced staff was taken away by the private sector and other governmental entities.

And that compounds one of the problems that we are still working through today, that virtually 50 percent of our staff is approaching 1 year of seniority, and—I am sorry, 25 percent of our staff, and another 25 percent of our staff has less than 3 years' of experience as we aggressively train through.

So we are going to have to dedicate resources in Nevada towards improving the pay structure. There has been a subcommittee created already by the Nevada legislature that I will start working

with immediately, have made contact with the chairman of that committee.

And we are talking to schedule our first meeting in the early part of the year to continue to monitor this process on a state level as well as working with our federal partners.

Chairman MILLER. This is sort of the cow is out of the barn here, but you know, I know—I think all of us experience that when cities and counties engage large developments, fees are assessed for roads, for highways, for all of these things that are going to have to support that development.

And when you are going to add, you know, thousands on a really—on a very rapid scale, you are going to add thousands of jobs, it would seem to me somebody should have said, you know, "What do we do about it here?"

I recognize the federal deficiencies in funding OSHA. We haven't been a great partner there. But in terms of that effort, it has to look different than just the run-of-the-mill development that is taking place, because it is so outstanding in the magnitude of the development that was collapsed in this period of time.

And I just think the state has got to think about—these are extraordinary circumstances, and especially if there is—you know, that raises competition for your employees.

You have to think about how you put the resources in so that, in fact, trained inspectors will be in place and can properly monitor these jobs, because the—what this report tells is that that simply wasn't happening on the level that was necessary, given the work sites and the number of employers and employees involved here.

So I just would hope that some consideration would be given to that.

Mr. Kline?

Mr. JAYNE. I understand and agree.

Mr. KLINE. Thank you, Mr. Chairman.

And, Ms. Koehler-Fergen, I want to identify myself with the remarks of Chairman Miller. We all extend our condolences to you and to your family and to all those who have suffered and died.

And I think we understand—we can't fully appreciate, because we are not in your shoes, but—the frustration that you and families have felt, as Chairman Miller said, in being cut out too often in these discussions and in—when these terrible tragedies occur.

Mr. Barab, how long does—is this process going to take, not in Nevada but your sort of review, this wall-to-wall review of these state plans? Can you give us some sense of what you are looking at here?

Mr. BARAB. Yes, we have told our regional administrators to basically start immediately on these reviews. The normal time frame for these reviews—the time frame we have given them—we are targeting—is the end of April next year.

Given the number of the reviews that are going on, we are hoping to get it done by then. At very least, however, the first part of next year we will have these finished, and they will be published, and they will be public.

Mr. KLINE. You are going to do all of them, or is there some—there is not a priority here? There is 27 of these that you are going out to do simultaneously?

Mr. BARAB. Yes, we are going to do all of them at the same time. I mean, each region has responsibility for a certain number of state plans under its authority. Some of them have more than others.

We will be sharing staff between regions if that is necessary in order to get all of these done.

Mr. KLINE. Okay. And what happens if they come up short? What are your courses of action here?

Mr. BARAB. We will basically follow the same pattern that we followed with Nevada. We will deliver to them our findings and recommendations. We will ask them to offer an action plan and we will give them a deadline for addressing all the recommendations we have given them.

Mr. KLINE. And if they come up short, do you establish a federal OSHA office in the state?

Mr. BARAB. We already have federal OSHA offices in a good number of the states where we have state plans, so it will depend on the state and on the situation.

What we will do is we will certainly, you know, focus on getting an assurance from them that they will address these problems. There are further steps we can take if any state basically refuses to or is unable to address the recommendations.

Mr. KLINE. And the further step being federal OSHA takes over, or how does that work?

Mr. BARAB. Yes, it depends on the status of the state. Most of the states have what we call final status. We have given them basically full control of their state programs, although obviously we are still required to oversee those programs.

It is kind of a complicated process, but ultimately the main weapon we have is to reassert federal jurisdiction over the state enforcement.

In other words, we would go in there and essentially—for a while, until they have managed to correct the situation, to assert federal jurisdiction. In other words, we would be running the state program.

Now, that is easier said than done if the state with final status can actually refuse to allow us in, in which case we would have to begin the process of essentially removing that state program, taking away their ability to run the state program.

That is a fair—we have never had to do that. It is a fairly long and arduous process. We are hoping not to do that, not to have to do that.

Mr. KLINE. Okay. While this is going on, while you are reviewing the state programs, and potentially establishing offices and so forth, there are some half the states that don't have these state plans, where you are it.

Do you see a draw-down on the—are you going to be able to maintain your level of effort there and make sure we are not having these horrible accidents in the states——

Mr. BARAB. Yes, we are confident——

Mr. KLINE [continuing]. Where there isn't a state plan?

Mr. BARAB [continuing]. We have the resources to do that, between the resources we have now and, as you may also be aware, the president's fiscal 2010 budget has requested about a 10 percent increase for OSHA, which will include about—somewhere over 100

new compliance officers, and some of these will also be—or at least some of those resources will certainly be dedicated to state plan oversight.

Mr. KLINE. Okay, thank you. I am just about to run out of time. You are going to conduct these reviews and, by the way, I think it is a very fine idea. I mean, clearly we need to know what is going on and we don't want to see a repeat of what happened in Nevada.

In this plan is there a process to continue to review, to continue the oversight? How do you see that playing out?

Mr. BARAB. Yes, absolutely. Once we have completed all the reviews, we are going to be looking at the findings that we have had.

We are then going to look at our current state plan monitoring procedures and make any changes in those monitoring procedures that need to be made, and we are fairly sure we are going to need to make some fairly major changes in those current monitoring procedures.

They obviously have not succeeded in identifying a lot of the problems that, for example, we just identified in Nevada.

Mr. KLINE. Okay. I think we will probably want to take a look at that.

Thank you, Mr. Chairman. I yield back.

Chairman MILLER. Thank you.

Congresswoman Titus?

Ms. TITUS. Thank you, Mr. Chairman.

Thank all of you for your testimony, especially Ms. Koehler-Fergen, for your advocacy on behalf of your son and on behalf of all workers who rely on OSHA to enforce these worker safety laws.

I am pleased that federal OSHA has helped the Nevada program identify ways to improve oversight and enforcement and that Mr. Jayne has brought a new administration and is committed to making those improvements.

And as I have heard some of the problems, I realize that a lack of training—we can fix that. A lack of resources—that can be addressed by the legislature or in the different budgets.

But none of these improvements will matter if outside pressure continues to be inappropriately applied. So we need to explore not only what are the needed internal program changes but how we minimize the perception or reality of undue political influence and establish a more standardized, transparent process moving forward.

Now, the perception of Nevada OSHA is that the process has been capricious, it has not been inclusive, it has not been fair, and it has not been aggressive enough in ensuring worker safety. Furthermore, the perception is this process has been driven by undue political influence.

So I would ask you, Mr. Jayne, what you are planning to do to remove the perception that Nevada OSHA is making decisions based on bad politics, not good policy, especially given that many of the faces in the program are the same.

And then I would ask you, Mr. Barab—I appreciate the changes that you are making internally and the oversight that you are doing—especially appreciate having an office in the district in southern Nevada.

But is there not anything we can do legislatively to give you some more teeth to your recommendations short of having to take over the whole program, whether it might be sanctions or whatever?

So those would be my two questions.

Mr. JAYNE. For the record, Don Jayne.

Thank you, Congresswoman Titus. I am aware, too, of some of the allegations and the concerns that there may or may not have been some undue political influence. I have not been able to find anything that would lead me to any definitive conclusions there other than the observations that were made.

Certainly, the advice of the technical staff, the safety staff, the professionals is what I need to abide by when they make recommendations to me.

The administrator of our division of industrial insurance should have the authority to make those decisions within the agency. I do believe that authority rests there and the decisions are ultimately made there.

I guess the observation I could make would be that at least the leadership from business and industry in Nevada, through the administrator, through the chief administrative officer, has all been changed.

I can, again, on the record—and that really is something that I can merely say—is that I would not bow to undue political influences, but I understand what you are saying as far as the perception.

When I work with the subcommittee in Nevada to review the procedures, I will make sure we address that to see if there is any appropriate way to try to insulate some of that.

Certainly, we are in a chain with a reporting chain, and I stand fairly strong from my position, but I understand the concerns, and we will bring it with that committee as well as the subcommittee.

Mr. BARAB. Let me address your question to me. As I mentioned, right now our only major option if we do not have a cooperative state program is essentially to revoke that state program, which is an extremely burdensome process requiring notice and comment, rule-making, hearings possibly, and possibly also going on to the courts for final decisions.

Now, the administration does not have a position on legislative improvements or legislative changes. We haven't discussed this thoroughly yet. We certainly have heard a number of suggestions that would basically lead toward making it a lot easier for OSHA to assert concurrent jurisdiction, even if the state were unwilling to allow us in.

So I think those kind of suggestions to kind of come part of the way toward engaging with the state without having to go, again, through the hearings, notice and comment, and that type of thing, are some of the things that have been suggested.

Chairman MILLER. Thank you.

Mr. Roe?

Mr. ROE. Thank you.

Chairman MILLER. Thank you. Okay, Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

And I would also associate myself with the chairman and ranking member's comments, Ms. Fergen, for you and your family, and I see the picture of your son. I have two sons, and you are right to advocate for he and other young people who work in the construction industry, so my condolences to you and your family.

My father worked in a factory and I think probably had better—died at 61 years of age. And I think if there had been better regulations about the environment he worked in, he would have had a longer life. I believe that.

I also know that in my dealings in my medical practice we have had some OSHA views—examinations, I should say, that their time would have been better spent somewhere else, as to the color of a bag that something was in, or—just ridiculous things that make business harder to do. And I can sit down and talk to you for an hour about that.

That is not what this is. This is a very serious issue and should be addressed. And I think unacceptable, quite frankly.

Mr. Secretary, I missed the number. How many people had died within a year's time in construction?

Mr. BARAB. It depends on the time period you are talking about. When the articles had been written in the Las Vegas Sun there were, I think, about nine, within a very short time period, fatalities on the strip itself.

The time period covered by our report covered 25 fatalities within about a 16-or 18-month period.

Mr. ROE. Didn't that wave a red flag at somebody? I mean, that seems to be an enormous number of people.

Mr. BARAB. Well, luckily, it originally—I think it raised the red flag with a reporter, Alexandra Berzon, with the Las Vegas Sun. She managed to raise it to the public's consciousness.

The problem you find with workplace fatalities is most of them happen one at a time, so there may be an article—a small article in the paper one month, and another one the next month. Nobody really notices.

Mr. ROE. But please—not to interrupt, but I don't have much time, but I know in the practice of medicine we report things to a central area, and when you—it looks to me like Nevada OSHA would have been where you reported.

That should have been not a red flag, that should have been a marching band telling you——

Mr. BARAB. We agree.

Mr. ROE [continuing]. That there was a problem.

Mr. BARAB. We agree. And that was one of the findings of the report.

Mr. ROE. And was it a problem with leadership, or resources, or what? I mean, how could that go on?

Mr. BARAB. Well, I think we identified a number of problems with the Nevada state plan, but I would have to say the problem was also with federal OSHA. We were not performing the oversight that we are required to do.

And that is one of the things we are looking at very carefully, is the kind of oversight we need to provide for these states.

Mr. ROE. I certainly don't want to make it impossible to carry on business; I mean, and believe me, a lot of the OSHA rules make it harder to carry on business.

But it should be reasonable rules, I think, and that was certainly reasonable to have protection where your son went. I mean, that was a—anybody with common sense would have known that.

I also think that—and, Dr. Mirer, your comments on productivity and quality were right on, I think. You want to make it where you can work in a safe environment, provide a quality work environment, and remain productive so your business can be competitive. I think you were right on the money there.

My question for the secretary—the state plans are required to be at least as effective as federal OSHA, correct? And can you tell us what benchmarks federal OSHA uses to quantify that?

Mr. BARAB. Well, that is the essence of the issue here. There are a number of benchmarks that we could be using.

We can compare, for example, the—some of the statistics that went up there before—how many inspections they do, how they cite what the level of fines are, what the seriousness of the citation is, obviously injury and illness, fatality rates in the state.

There are a number of different factors we can use to measure that. We have not been using enough of those, really, to oversee the states and to ensure that they are at least as effective.

And that is one of the things that we are going to be doing as we go through and review all the state plan performance. We are going to be looking at those measures again and trying to decide which best ones to use to ensure that the states are at least as effective as the federal plan.

Mr. ROE. See, I think it is—I think that somebody dropped the ball, because it took a citizen to step up, really a newspaper to step up, and identify the problem when the agency in charge of the problem apparently didn't identify the problem. Am I correct?

Mr. BARAB. You are correct, absolutely.

Mr. ROE. I think just one last question. Was it a resource problem or a leadership problem? I still didn't get the answer to that.

Mr. BARAB. We didn't really identify any of the problems as real resource problems. They really were procedure and performance problems that we identified.

Mr. ROE. So you had enough money to do it.

Mr. BARAB. Yes. Nevada OSHA actually provides quite a bit more money. They over match. They are one of the states that actually provides greater that 50 percent.

So again, it was really more the procedures that they followed and the performance that we identified as the key problems.

Mr. ROE. So it was leadership.

Mr. BARAB. Yes.

Mr. ROE. Okay.

I yield back my time, Mr. Chairman.

Chairman MILLER. Thank you.

Congresswoman Chu?

Ms. CHU. Thank you, Mr. Chair.

My questions are for Mr. Barab.

In Nevada, worker safety has been put in danger because of lax enforcement, the reduced or withdrawn citations for fatality cases

after contractors objected. These cases were highlighted in the Las Vegas Sun and now California's problems are showing up in the Los Angeles Times.

[The information follows:]

[From the Los Angeles Times, October 21, 2009]

Worker Safety Appeals Board Rulings Raise Question

The board often reduces or dismisses penalties against companies that Cal-OSHA has fined

By JESSICA GARRISON

Rosa Frias was working the evening shift at Bimbo Bakeries in South San Francisco when she reached into her bread-making machine to remove a hunk of dried dough.

She screamed as her left hand, and then her lower arm, were sucked into the gears of the Winkler stringline proofer. That night, the limb had to be amputated above the elbow.

The incident drew a $21,750 fine from the California Division of Occupational Safety and Health. But Bimbo paid nothing. It appealed to the Cal-OSHA Appeals Board, which dismissed the case on a technicality: The inspector had retired and Cal-OSHA could not prove that he had had permission to enter the factory.

Since that 2003 accident, five more employees in Bimbo's California plants have lost fingers or parts of fingers in accidents in which inspectors found similar safety violations. In two of those accidents, the appeals board reduced the fines by thousands of dollars.

"That is mind-boggling," said Linda Delp, director of UCLA's Labor Occupational Safety and Health program.

It is not, however, unusual for companies to fare well on appeals. A Times review found that the board has repeatedly reduced or dismissed penalties levied by Cal-OSHA over the last few years, even in situations in which workers have died or been seriously injured. The board's actions have done more than save companies money. They have undermined Cal-OSHA's efforts to prevent future accidents, according to labor advocates, inspectors and state documents.

Earlier this year, 47 inspectors and district managers at Cal-OSHA, about a quarter of the staff, signed a letter to the board complaining that Cal-OSHA's "deterrent effect has been significantly undermined as employers learn they can 'game the system.'"

"It sends a message that all an employer has to do is appeal," said Jeremy Smith of the California Labor Federation, a group that lobbies on behalf of unions. "Penalties will get whittled down, and the employer can write that off as the cost of doing business."

Candice Traeger, the chairwoman of the appeals board, acknowledged that during her tenure thousands of cases had been settled, often for cents on the dollar.

It is not because the board favors employers, she said: Rather, the board had to clear a backlog of 2,500 cases, a goal it accomplished earlier this year.

The backlog, which had drawn a federal complaint, was bad for workers, she said, because companies did not have to fix problems while their cases languished.

"Eliminating the backlog * * * was what gave us the flexibility [to] do what we are doing now, which is make and create a better appeals process," said Traeger, a former Teamster union steward and executive at UPS who was appointed in 2004 by Gov. Arnold Schwarzenegger.

In May, however, the state Senate Committee on Labor and Industrial Relations took Traeger's board to task over the way it had whittled down its caseload.

Drawing in part from testimony at a Senate oversight hearing, the committee issued a report that cited "drastic" penalty reductions for employers and a flawed hearing process. According to the report, the board scheduled multiple cases to be heard simultaneously by the same judges, often far from where witnesses lived.

"Many argue that this practice is resulting in fines and penalties for real workplace hazards being withdrawn, downgraded and severely reduced in coerced settlements," the report said.

Traeger countered that many cases have been settled because Cal-OSHA inspectors have not properly issued citations or documented the problems—not her board's fault.

"Honestly, nobody likes us," Traeger said. "I tend to think that means we're doing something right. We're balanced, we're in the middle. We make a determination on what's right under each case."

In California, imposing safety fines on an employer can be an elaborate process. First, a Cal-OSHA inspector cites violations, which can be appealed to an administrative law judge appointed by the appeals board. Then the three-member board can either accept the judge's decision or change it. Its decisions, in turn, can be appealed in state court. (Any fines collected go to the state, not the employees.)

The current board is made up of industry representative Traeger, public representative Robert Pacheco and labor representative Art Carter. Carter was appointed in March after the labor seat had been vacant for two years.

There is no simple way to assess all 18,000-plus appeals the board has handled since 2005 because the dockets are not readily accessible. But one measure of the board's record is to look at cases in which the panel has stepped in to review its own judges' decisions. These "Decisions after Reconsideration" are the board's way of setting precedent for its judges to follow.

The Times reviewed all 55 decisions the board has issued under Traeger, finding that in about half of them, the panel reduced or dismissed the employer's fine—often by thousands of dollars. It also changed the gravity of some findings—reducing them from "serious" to "general," which could have implications for a company's insurance costs and competitiveness.

In 11 of them, the board changed rulings in employers' favor even before an appeal was filed. Some examples:

• When a worker died in Barstow in 2001 after a hopper with 13 tons of liquid asphalt fell on him, Cal-OSHA fined the company $18,000 for not securing the load—a penalty upheld by a judge. But the appeals board in 2007 dismissed the case, ruling that Cal-OSHA needed also to show that the design of the equipment was unsafe.

• A judge upheld a citation against a general contractor after a subcontractor's worker was injured in an accident involving a pressurized pipe. But the board in 2007 dismissed the citation against the contractor even though there had been no appeal, saying the contractor could not be aware of a subcontractor's "every activity."

• In a 2006 case, a worker's arm and fingers were injured when a rock conveyor moved unexpectedly at a quarry. A fine of $12,600 was issued. The appeals board stepped in to say that such fines can be reduced, at the board's discretion, for reasons that include financial hardship to an employer.

That decision drew a stinging dissent from the then-labor representative on the panel, Marcy Saunders. "A decision that allows a multimillion-dollar employer to be rewarded for committing a violation which results in the fracturing of a worker's [limb] and * * * potentially allows all 'financially distressed' employers to avoid responsibility for safety violations is, at best, irresponsible and, at worst, shameful."

The appeals board also has let stand judges' decisions to dismiss cases on narrow technical grounds.

Kevin Scott Noah, 42, was installing rebar on the Golden Gate Bridge when he fell 50 feet to his death in August 2002.

A Cal-OSHA investigator concluded that the contractor had not provided employees with scaffolds and issued three "serious" citations and a $26,000 fine, records show.

The contractor appealed on the grounds that Cal-OSHA had issued the citations to "Shimmick Obayashi," the name listed on the company's business cards. The company's full name was "the Shimmick Construction Company Inc./Obayashi Corp."

An administrative law judge tossed the case out, writing that Cal-OSHA had failed to determine the company's legal name.

Although the board let the decision stand, Traeger said, the panel since has begun allowing incorrect names to be amended on citations.

That is little comfort to Noah's mother, Sandra Noah, who said that her son had three boys who had to grow up without a father. "I just don't feel it's right," Noah said.

Dozens of times in the last two years, the board and its judges have summarily reduced a $5,000 fine that is levied on employers for not reporting workplace accidents within eight hours as required, according to the Senate report.

Traeger told The Times that flexibility is necessary to ensure that injuries get reported, and employers who report late should not be treated the same as those who try to hide accidents.

But Paul Koretz, a Los Angeles city councilman who wrote the reporting law when he was in the Assembly, said, "This is not what was intended. They are obviously trying to get around this legislation."

Labor advocates say the Bimbo case crystallizes their concerns about a process that they consider stacked against regulators and employees.

After Frias was injured, an inspector found that the machine that had mangled her hand lacked a required guard. But by the time Bimbo's appeal was heard, in 2007, that inspector had retired and was unavailable.

Cal-OSHA lawyers insisted that the inspector had permission to enter the factory: His report said plant managers were cooperative. What's more, Bimbo did not offer any evidence that it refused entry. In addition, Frias' foreman testified that it was standard procedure for employees to put their hands into machines.

Even so, the judge dismissed the case, so Bimbo was not required to fix the problems.

Over the next three years, six more employees lost fingers or parts of fingers, and Cal-OSHA filed citations against Bimbo in five of the accidents.

Cindy Marquez's case at the Montebello plant was eerily similar to Frias': She too reached into a machine without the proper guards, records show. The judge ruled that Cal-OSHA had not offered enough proof that an unguarded blade should be a serious violation. The fine was reduced from $22,500 to $5,000. Cal-OSHA has appealed.

A representative of a public relations company retained by Bimbo issued a statement that said, in part, "the use of the appellate process provided under the law did not delay our efforts to correct safety issues that arose at our plants."

Union officials at the plants confirmed that the company eventually learned from the accidents and has since spent millions of dollars improving safety.

After The Times began asking about the Bimbo cases, Cal-OSHA inspected several of the company's facilities earlier this month.

"Bimbo has a significant way to go to achieve acceptable workplace safety levels," said Division Chief Len Welsh through a spokesman.

Traeger, meanwhile, said the board intends to review the judge's decision in the Frias case.

Six years after her accident, Frias' workers' compensation attorney says she is too distraught to talk about it. The attorney, Donald Galine, was incredulous when told of the subsequent injuries at Bimbo plants.

"Five injuries after Rosa?" he said. "Had the state done what they are supposed to, maybe Rosa would not have been saved—but maybe others would have."

GRAPHIC: ONE BAKERY'S WORKPLACE ACCIDENTS

Cal-OSHA found a series of violations involving employee injuries at Bimbo Bakery's California plants. Violations cited since July 2003 and the resulting fines:

Date	Injury	Original fine	Reduced to	By
July '03	Amputation	$21,750	$0	Appeals board
Oct. '04	Amputation	22,500	5,000	Appeals board
Nov. '04	Fractured hand	980	Not reduced	
July '05	Amputation	20,750	8,250	Appeals board
Sept. '05	Amputation	5,400	0	Cal-OSHA*
March '06	Amputation	375	0	Cal-OSHA*
Sept. '06	Amputation	1,800	1,200	Cal-OSHA*

Note: The list includes injury accidents involving violations of Health and Safety Code sections that require guards on machines to protect workers from sharp blades and lockout mechanisms to prevent machines from starting accidentally.

*Cal-OSHA can reduce or dismiss penalties it has levied.

Sources: U.S. Occupational Safety and Health Administration, Cal-OSHA
Graphics reporting by JESSICA GARRISON

Ms. CHU. In California, the worker safety appeals board has repeatedly reduced or dismissed penalties against companies that Cal/OSHA has fined. There was one company, Bimbo Bakery in

San Francisco, where Rosa Freeyez reached into a bread-making machine and her arm was sucked in and had to be amputated.

The incident drew a $21,750 fine but the bakery paid nothing after they appealed to the worker safety appeals board. And now it turns out that over the last few years the vast majority of cases have been dismissed or settled for a few cents on the dollar or penalties have been drastically reduced just because companies protested.

Also, the hearing process is very, very flawed, with the board scheduling multiple cases to be heard simultaneously by the same judges, often far from where the witnesses live.

So, what I want to know is, what has broken down in terms of federal OSHA's oversight over the state plan system.

Mr. BARAB. That is a good question, and that is one of the things we will be looking at as we go and look at California and the other states. Review boards are certainly within OSHA's purview of oversight.

It is a little bit more complicated because we require each state to have an independent review board, but that means independent of the state OSHA, so you are actually—you can't go to the state OSHA and ask them to correct problems with the review board. You would have to go up to the governor's office to ask them to do that, because they are an independent agency.

As we go in and look at, for example, the problems that you identified in California, we are going to need to find out whether the problems are actually with, for example, poor documentation of cases by the OSHA inspectors, some of which we found in Nevada, or whether they were arbitrary decisions made by the review board or, perhaps, decisions made by the review board that are based on regulations or laws that we would consider to be not as effective as the similar regulations or laws in the federal government, in which case we could go in and require them to modify those regulations or laws.

We would also look at the procedures that article identified, for example, as you mentioned, where the board would schedule a number of different hearings at the same time. That sounds like a problem with their procedures and certainly something that we would want to address.

Ms. CHU. So you think it can be done through regulation? Or does Congress need to change some laws?

Mr. BARAB. I don't think this is a matter of Congress changing the laws. I think, again, this comes back to oversight over the state programs, which includes oversight over the review boards, to make sure that they are functioning properly as they are intended to function.

Ms. CHU. Mr. Barab, the L.A. Times article also mentions that it is nearly impossible to track the appeals board cases because the dockets are not readily accessible.

I know that the Obama administration takes transparency and accountability very seriously. Can you tell me if there can be new regulations or guidelines to make sure that the state-administered plans are more open and transparent?

Mr. BARAB. Yes, I think that is one of the things we are going to be addressing. Obviously, it is hard to monitor any kind of agen-

cy or any kind of program if you don't have the basic data to monitor it with.

And whereas we could probably get that data, I think it is also important that citizens also have that data, as well, to access, so that will be one of the areas we will be addressing.

Ms. CHU. California has, of course, a state OSHA plan just like Nevada, and nationwide there are 340 complaints about state plans in general. In Nevada there were 18 complaints and California had 41 complaints.

How do you monitor these complaints?

Mr. BARAB. When someone files a complaint against a state program, it goes to the regional administrators. We have 10 regions around the country. California is part of region nine. And that region is responsible for responding to that complaint.

We found as part of the process—we haven't just been looking at OSHA—we have also been looking at ourselves, and we, quite frankly, are not satisfied either with the way we have been responding in some cases, to the complaints against state programs.

We have asked our regional administrators to look at their procedures to make sure that these complaints are handled on a much more timely basis than they have been in some cases, and we will be collecting data on where these have been filed and really following up on them in a—in much greater detail than we have before.

Ms. CHU. Well, in the future, I would like to follow up with you on the California situation and see what your findings——

Mr. BARAB. Sure.

Ms. CHU [continuing]. Have brought forth, but also I would be very concerned if there isn't any action before there are even worse injuries taking place.

Mr. BARAB. Yes. We would be glad to work with you on that. And California has been, especially in terms of standards, innovative standards, as I mentioned, an outstanding program. They have really come up with some very good ideas and—inspirational to not only the federal government but also other state plan states.

Ms. CHU. Thank you.

I yield back.

Chairman MILLER. Thank you.

Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman.

First of all, I echo every single thing that Congresswoman Chu just said about California. Imagine, we are a model for the country and we are—the things that California is not living up to these days. Shame, shame on all of us.

Ms. Koehler-Fergen, when I read about your son's accident and his death and the destruction of that—what could have been prevented—preventable accident, I guess we should say—it became very clear to me as the chair of the Workforce Protection Subcommittee here on this committee—wonderful committee we are sitting on—there is a pattern.

This had been happening. I had been reading about it all over the country, but particularly in Nevada.

And so I ask you, Mr. Jayne and Mr. Coffield, if he is responding, where were you guys? You didn't see the pattern? You didn't know

people were getting injured and killed and maimed, what were you doing about it?

Mr. JAYNE. For the record, Don Jayne.

We do have Mr. Coffield here, and I will let him respond to that question. I don't like to punt, but I wasn't in position then. I, too, was reading the newspapers, and I, too, would have, you know, had observations about the cluster of activity down there.

Ms. WOOLSEY. Yes.

Mr. JAYNE. But unfortunately, I can merely respond to the future to say that, you know, hopefully, with new leadership, you know, we would respond to those situations quicker.

But I will yield to Mr. Coffield on that.

Mr. COFFIELD. Congresswoman Woolsey, I am Steve Coffield from Nevada OSHA. City Center was the driving force behind our fatality spike, and we actually began meeting with the contractors and the labor organizations back in the 2004 or 2005 time frame.

When we saw the complexity, the size and the number of structures that were going to be coming out of the ground on a mere 65-some acres of land, everybody was very concerned about it.

And as construction start date arrived or started getting closer, the contractors started hiring our staff. And so we very rapidly our experience level dropped and our staffing level had not been increased.

Ms. WOOLSEY. Well, excuse me. If they had hired your staff, they should have known what they were supposed to be doing on the ground. I mean, they should have had the expertise there.

I would like to just go over and ask Assistant Secretary Barab a question or two.

First of all, I would like to say that now that we have Acting Secretary Barab—you are so wonderful. Thank you, Jordan, for being here. And with our new Secretary of labor, Hilda Solis, we know we are going to do something about all of this.

And we also know that Congress has to support OSHA and that we have to go with the president's and pass the president's increase in OSHA's budget. We know that. We must make it happen. And certainly, this committee will work very hard for that.

I also have legislation, H.R. 2067, called the Protecting America's Workers Act, which Chairman Miller has signed with me, that will put some real increases in penalties and will strengthen enforcement and bring OSHA into the 21st century. So, Jordan, we are working on that, believe me.

Would you tell me, now that you are in your position and the new secretary—how would this Nevada OSHA situation have been handled differently in 2004 or with their new structure could it have been handled differently?

Mr. BARAB. Well, we would have hoped, I guess, that each of the individual cases as they began to occur, certainly as they identified these fatalities and the spike in fatalities, would have been handled, I guess, on a more serious basis, that we would have had penalties commensurate with the severity of the incidents. In other words, that we would have willful citations when they were deserved, that we would have repeat citations when they were deserved, and high enough fines to deter that kind of behavior from other companies.

I think that is one of the benefits of the OSHA penalty system. And the benefits of being able to issue willful citations, for example, is not just does it send a message specifically to the company, but it sends a message to the entire community that OSHA is taking this kind of cutting corners on safety extremely seriously and will not tolerate it.

And I think that is the message that did not go out there.

Ms. WOOLSEY. Thank you.

Mr. Chairman, thank you.

Chairman MILLER. Thank you. I look forward to working with the subcommittee chair on this matter.

Mr. Jayne, you said you are going to address "the perception that willful violations were discouraged. They are not," like in the present. Looking back, were they discouraged?

Mr. JAYNE. For the record, again, Don Jayne.

I am going to make some comments and ask Mr. Coffield to fill in as well, because he lived, you know, through that era during that time.

Certainly, in my interaction with staff and working with the folks that conducted the special study, there was a perception among staff that the aggressive pursuit of willful violations was something that was difficult to obtain, that the evidentiary level was high, and that general counsel and staff and leadership staff, you know, wanted to challenge the willfuls and make sure, if you will, the perfect case existed.

In my world, there is probably never going to be a perfect case.

Chairman MILLER. Well, that is more than a perception, that's a fact.

Mr. JAYNE. The perception among staff as far as whether or not—that is what I was addressing there.

Chairman MILLER. Well, if you get seven out of eight, people die and you don't end up with a serious violation, a willful violation. That is a fact.

Mr. JAYNE. Well, what I wanted to say was that, you know, we have addressed staff since we have—since I have been there, since Mr. Coffield is on board, and we have told staff that that is not a issue that we want to have, that if we had——

Chairman MILLER. But, Secretary Barab——

Mr. JAYNE [continuing]. That we would pursue those.

Chairman MILLER [continuing]. The findings—the finding of the review is that willful violations were discouraged because of a lack of management and legal counsel support. So, I mean, this is almost a setup.

You have such bad record-keeping, you have such bad training, and you have such bad—you have such a lack of resources or skilled people, apparently, here that can do this that you end up seven out of eight, nothing happens. Essentially, nothing happens for the death of a worker.

I mean, that is not a perception. There is something very wrong there. You know, there is something very wrong with that. It just doesn't pass the smell test.

I mean, an agency is in shambles, and the fact that the agency is in shambles is used to suggest that we can't proceed to prosecute

willful or repeat violations or serious violations against a responsible party.

That is not a perception. If you think that is a perception, we are going to have problems with the review of what is going on in Nevada OSHA.

Mr. Coffield, so this was just legal people challenging and saying, "Well, we just can't bring that case, we don't have the evidence, we don't have the experience, we don't have the talent, we don't have the record-keeping?"

Mr. COFFIELD. Basically, the technical staff and myself at the time would recommend willfuls, and when they went up the chain they would not get supported.

Chairman MILLER. So people who were further and further away from the process overturned it.

Mr. COFFIELD. People that didn't know a thing about the process.

Chairman MILLER. Who didn't know a thing about the process, and then this is checked off as this is a bureaucratic problem, this is some kind of mix of bad training, bad record-keeping, and so the inspectors who are out on the front line—as this works its way up—as I read the review, these things get rolled over.

Mr. Jayne, you said you are like the highway patrol. I don't know about the Nevada highway patrol, but no one is seven out of eight in front of the—going to get their tickets written down, and if they are going 150 miles an hour, they are not going to get them written down—maybe if they are going, you know, 67 over 65 miles an hour.

But there is something very wrong here, something very wrong here. It simply doesn't add up to the families of these victims, to people observing it, to the oversight. There is something very wrong, and we cannot start out that somehow this was just a perception within—with the inspectors.

As I see it, these inspectors are out there busting their ass trying to provide for the real enforcement because the enforcement is supposed to have some deterrent effect on continuing an unsafe workplace, and they do it, and over and over and over again they are overridden.

What is the message to the employer? What is the message to the contracting company? What is the message to the investors? What is the message to the bank? What is the message to the owner of that facility? That the only thing that matters is that I get my completion bonus, we get it done on time, and the bank gets their money, and this is just collateral damage?

No. These are lives of workers. So I appreciate you said you are going to be more optimistic, or you are going to be more positive, or whatever it is in your testimony. I am worried that you may not have a grasp of the situation.

Go back and look at the numbers of people who lost their life, who lost their life in similar circumstances. I am not even getting to the Boyd case yet, where it is frighteningly similar circumstances and repeat behavior.

And they have become exempt from some kind of inspection for the next 18 months or 2 years, whatever it is in the report, as if they are—you know, they are the exemplary employer and they care more about the safety of their employees than others, so we

are going to not going to inspect them, we are going to put them in a program designed for small business?

That is great P.R. for their enterprise. It is just really bad worker safety process and protections.

So you know, I appreciate you all being here. We are not done with this in this committee, because something is very, very wrong here, very wrong. And it costs good, solid people their lives and costs a lot of misery and sorrow in their families.

And we cannot just say, "Well, seven out of eight cases just—that is just the way it was." And we just check off the bureaucratic boxes and we give the report to the family and say, "Well, you know, if we were better trained, if we had better record-keeping, maybe your husband, or your brother, your spouse—whatever—would be alive." That just won't work here. It just won't work.

I appreciate you being here, but I just got to tell you that this cannot be where we leave this. I know we are very short on time, but I don't want to respond without giving you an opportunity, even if you want to reserve the right to put something in writing—however you want to do it.

Mr. KLINE. That is fine.

Chairman MILLER. Thank you very much. We are in the middle of a vote and we have several votes behind this. A number of our members wanted to be here. We were interrupted because of other activities in the House.

So I don't want to hold you until after the votes, but we will be following up with each and every one of you. Thank you so very much for taking the time.

I have my own bureaucracy. Without objection, members will have 14 days to submit additional materials and questions for the hearing record. And with that, the committee will stand adjourned.

And again, my thanks to the witnesses.

[Additional submissions from Mr. Miller follow:]

FY 2008 State Plan Enforcement Activity

	Region I		Region II				Region III		State Plan	Federal
	CT*	VT	NJ*	NY*	PR	VI*	MD	VA	Total	OSHA
Total Inspections	**217**	**358**	**1,659**	**1,695**	**1,345**	**89**	**1,455**	**3,468**	**57,327**	**38,591**
Safety	141	249	1,286	1,134	1,012	44	1,231	2,708	45,010	33,074
% Safety	*65%*	*70%*	*78%*	*67%*	*75%*	*49%*	*85%*	*78%*	*79%*	*86%*
Health	76	109	373	561	333	45	224	760	12,317	5,517
% Health	*35%*	*30%*	*22%*	*33%*	*25%*	*51%*	*15%*	*22%*	*21%*	*14%*
Construction	34	180	89	455	631	1	922	2,317	26,179	23,157
% Construction	*16%*	*50%*	*5%*	*27%*	*47%*	*1%*	*63%*	*67%*	*46%*	*60%*
Programmed	148	174	730	555	607	49	1,042	2,617	34,980	23,023
% Programmed	*68%*	*49%*	*44%*	*33%*	*45%*	*55%*	*72%*	*75%*	*61%*	*60%*
Complaint	52	102	253	379	382	21	129	375	9,290	6,697
% Complaint	*24%*	*28%*	*15%*	*22%*	*28%*	*24%*	*9%*	*11%*	*16%*	*17%*
Accident	-	2	16	29	25	-	128	57	3,666	1,008
Total Violations	**703**	**543**	**3,154**	**4,267**	**1,707**	**388**	**5,567**	**6,361**	**122,288**	**87,687**
Serious	198	337	2,625	2,426	993	235	2,571	4,000	53,286	67,052
% Serious	*28%*	*62%*	*83%*	*57%*	*58%*	*61%*	*46%*	*63%*	*44%*	*76%*
Willful	-	1	-	21	2	-	1	19	185	509
Repeat	-	3	4	12	31	2	99	173	2,374	2,817
Failure to Abate	-	-	-	68	6	71	21	39	509	170
Other than Serious	505	199	525	1,740	675	80	2,875	2,130	65,864	17,131
% Other	*72%*	*37%*	*17%*	*41%*	*40%*	*21%*	*52%*	*33%*	*54%*	*20%*
Avg # Violations/	4.3	2.1	3.9	6.8	2.8	6.7	4.6	2.9	3.3	3.2
Total Penalties	**$24,523**	**$268,796**	**$ 1,000**	**$ 25,722**	**$ 1,819,082**	**$ 42,000**	**$ 2,430,799**	**$ 4,996,141**	**$ 70,248,913**	**$ 103,350,367**
Avg Penalty / Serious Violation	$123.90	$ 566.50	$ 0.40	$ -	$ 1,154.70	$ 51.10	$ 729.30	$ 542.30	$ 924.50	$ 973.60
Contested Cases										
% Insp w/ Contested Violations	0.0%	0.0%	0.0%	0.0%	13.7%	2.0%	0.0%	6.6%	13.7%	7.0%

FY 2008 State Plan Enforcement Activity

	Region IV				Region V			State Plan	Federal
	KY	NC	SC	TN	IN	MI	MN	Total	OSHA
Total Inspections	**1,311**	**5,121**	**1,547**	**2,573**	**1,677**	**5,062**	**2,490**	**57,327**	**38,591**
Safety	1,054	3,447	1,306	1,942	1,445	4,240	1,981	45,010	33,074
% Safety	*80%*	*67%*	*84%*	*75%*	*86%*	*84%*	*80%*	*79%*	*86%*
Health	257	1,674	241	631	232	822	509	12,317	5,517
% Health	*20%*	*33%*	*16%*	*25%*	*14%*	*16%*	*20%*	*21%*	*14%*
Construction	715	2,421	1,052	837	1,054	3,100	994	26,179	23,157
% Construction	*55%*	*47%*	*68%*	*33%*	*63%*	*61%*	*40%*	*46%*	*60%*
Programmed	591	3,519	1,109	1,903	1,106	4,094	2,117	34,980	23,023
% Programmed	*45%*	*69%*	*72%*	*74%*	*66%*	*81%*	*85%*	*61%*	*60%*
Complaint	235	769	173	375	405	616	256	9,290	6,697
% Complaint	*18%*	*15%*	*11%*	*15%*	*24%*	*12%*	*10%*	*16%*	*17%*
Accident	30	123	49	48	51	36	23	3,666	1,008
Total Violations	**1,845**	**13,843**	**2,697**	**5,147**	**1,890**	**16,274**	**4,062**	**122,288**	**87,687**
Serious	1,124	5,316	2,037	2,769	1,145	6,236	3,055	53,286	67,052
% Serious	*61%*	*38%*	*76%*	*54%*	*61%*	*38%*	*75%*	*44%*	*76%*
Willful	7	7	1	-	15	8	15	185	509
Repeat	51	310	2	29	9	593	21	2,374	2,817
Failure to Abate	11	4	15	14	-	68	43	509	170
Other than Serious	652	8,206	642	2,335	721	9,369	928	65,864	17,131
% Other	*35%*	*59%*	*24%*	*45%*	*38%*	*58%*	*23%*	*54%*	*20%*
Avg # Violations/	2.6	3.9	2.9	2.6	3	4.5	2.5	3.3	3.2
Total Penalties	**$ 2,745,131**	**$ 3,554,090**	**$ 711,077**	**$ 2,068,824**	**$ 1,507,656**	**$ 3,952,193**	**$ 2,777,794**	**$ 70,248,913**	**$ 103,350,367**
Avg Penalty / Serious Violation	$ 1,675.60	$ 518.50	$ 336.60	$ 643.20	$ 951.20	$ 474.10	$ 657.60	$ 924.50	$ 973.60
Contested Cases									
% Insp w/ Contested Violations	16.0%	2.1%	2.7%	1.2%	5.5%	6.7%	24.3%	13.7%	7.0%

FY 2008 State Plan Enforcement Activity

	Region VI	Region VII	Region VIII		State Plan	Federal
	NM	IA	UT	WY	Total	OSHA
Total Inspections	**603**	**1,002**	**566**	**473**	**57,327**	**38,591**
Safety	480	839	483	420	45,010	33,074
% Safety	*80%*	*84%*	*85%*	*89%*	*79%*	*86%*
Health	123	163	83	53	12,317	5,517
% Health	*20%*	*16%*	*15%*	*11%*	*21%*	*14%*
Construction	258	631	337	290	26,179	23,157
% Construction	*43%*	*63%*	*60%*	*61%*	*46%*	*60%*
Programmed	377	601	327	420	34,980	23,023
% Programmed	*63%*	*60%*	*58%*	*89%*	*61%*	*60%*
Complaint	7	126	108	35	9,290	6,697
% Complaint	*1%*	*13%*	*19%*	*7%*	*16%*	*17%*
Accident	14	29	113	10	3,666	1,008
Total Violations	**889**	**1,801**	**871**	**1,924**	**122,288**	**87,687**
Serious	597	1,076	630	1,150	53,286	67,052
% Serious	*67%*	*60%*	*72%*	*60%*	*44%*	*76%*
Willful	3	20	-	4	185	509
Repeat	15	35	22	70	2,374	2,817
Failure to Abate	2	6	4	6	509	170
Other than Serious	272	664	215	641	65,864	17,131
% Other	*31%*	*37%*	*25%*	*33%*	*54%*	*20%*
Avg # Violations/	3.4	3	2.2	4.5	3.3	3.2
Total Penalties	**$ 789,605**	**$ 2,612,789**	**$ 733,875**	**$ 815,673**	**$ 70,248,913**	**$ 103,350,367**
Avg Penalty / Serious Violation	$ 850.90	$ 1,008.00	$ 986.10	$ 469.40	$ 924.50	$ 973.60
Contested Cases						
% Insp w/ Contested Violations	29.4%	6.4%	1.2%	0.0%	13.7%	7.0%

FY 2008 State Plan Enforcement Activity

	Region IX				Region X		State Plan Total	Federal OSHA
	AZ	CA	HI	NV	AK	OR	WA		
Total Inspections	**1,424**	**9,149**	**477**	**2,532**	**254**	**5,257**	**5,523**	57,327	**38,591**
Safety	1,000	7,366	335	1,858	187	4,311	4,511	45,010	33,074
% Safety	*70%*	*81%*	*70%*	*73%*	*74%*	*82%*	*82%*	*79%*	*86%*
Health	424	1,783	142	674	67	946	1,012	12,317	5,517
% Health	*30%*	*19%*	*30%*	*27%*	*26%*	*18%*	*18%*	*21%*	*14%*
Construction	885	2,672	273	1,615	131	1,775	2,510	26,179	23,157
% Construction	*62%*	*29%*	*57%*	*64%*	*52%*	*34%*	*45%*	*46%*	*60%*
Programmed	932	3,060	323	1,194	120	3,791	3,474	34,980	23,023
% Programmed	*65%*	*33%*	*68%*	*47%*	*47%*	*72%*	*63%*	*61%*	*60%*
Complaint	287	2,561	56	533	55	756	244	9,290	6,697
% Complaint	*20%*	*28%*	*12%*	*21%*	*22%*	*14%*	*4%*	*16%*	*17%*
Accident	38	2,474	8	86	3	223	51	3,666	1,008
Total Violations	**2,975**	**19,567**	**568**	**3,039**	**749**	**10,485**	**10,972**	**122,288**	**87,687**
Serious	713	4,024	297	883	200	4,271	4,378	53,286	67,052
% Serious	*24%*	*21%*	*52%*	*29%*	*27%*	*41%*	*40%*	*44%*	*76%*
Willful	21	14	-	-	2	4	20	185	509
Repeat	11	77	7	34	29	233	502	2,374	2,817
Failure to Abate	20	7	-	20	-	36	48	509	170
Other than Serious	2,208	15,445	264	2,102	518	5,941	6,012	65,864	17,131
% Other	*74%*	*79%*	*46%*	*69%*	*69%*	*57%*	*55%*	*54%*	*20%*
Avg # Violations/	3.8	3.3	2.5	2.4	3.8	2.7	2.9	3.3	3.2
Total Penalties	**$1,287,563**	**$28,745,234**	**$275,075**	**$1,286,186**	**$328,359**	**$2,370,792**	**$4,078,934**	**$ 70,248,913**	**$ 103,350,367**
Avg Penalty / Serious Violation	$ 1,148.10	$ 5,325.50	$ 856.50	$ 1,103.40	$ 885.80	$ 348.00	$ 636.50	$ 924.50	$ 973.60
Contested Cases									
% Insp w/ Contested Violations	8.4%	40.2%	5.6%	8.4%	4.2%	14.3%	19.1%	13.7%	7.0%

OCCUPATIONAL SAFETY & HEALTH STATE PLAN ASSOCIATION,
November 10, 2009.

Hon. GEORGE MILLER, *Chairman;* Hon. JOHN KLINE, *Ranking Member,*
Committee on Education and Labor, U.S. House of Representatives, 2181 Rayburn House Office Building, Washington, DC 20515.

DEAR CONGRESSMAN MILLER AND CONGRESSMAN KLINE: The Occupational Safety and Health State Plan Association (OSHSPA) hereby submits written testimony pertaining to the U.S. House of Representatives' Education and Labor Committee hearing of October 29, 2009 held to examine the federal Occupational Safety and Health Administration's (OSHA) review of Nevada's workplace health and safety State Plan Program. We respectfully request that you "offer-up" this cover letter and our testimony to be entered into the hearing record.

OSHSPA represents the 27 states and territories that have chosen to enforce occupational health and safety laws within their jurisdictions. Our organization and our individual member States have historically worked very closely with federal OSHA to address common issues and common goals related to the safety and health of America's workers. We view our relationship with OSHA as a cooperative effort and believe that we provide unique contributions toward the attainment of our common goals.

We further believe that the operational issues identified in Nevada are not indicative of the situation in other State Plan States. We believe that the majority of State Plan monitors in OSHA regional offices have done an excellent job of working with the States. We welcome the upcoming evaluations as an opportunity to improve our programs and to provide federal OSHA with insights to improving its own enforcement and monitoring programs.

The hearing on October 29th highlighted several areas which do have a significant impact on the ability of State Plan States to ensure that our programs are at least as effective as that of federal OSHA. These areas are summarized here and are discussed in more detail in the attached testimony.

Equitable Funding—A process must be established to accurately and fairly address the budgetary requirements of State Plan Programs. The total OSHA budget in FY 2009 was $515 million dollars. The total amount allocated to State Plan programs was $93 million. In addition to matching those funds, State Plans had to contribute an additional $91.8 million in overmatching funds in an effort to maintain effective programs. Congress should fully fund 50% of the costs of State Plan Programs.

Effective Partnership—Maximum effectiveness and efficiency of both federal OSHA and State Plan States will only be achieved if we work collaboratively to address key enforcement issues. Conversely, if federal OSHA seeks to impose a "one size fits all" approach in every jurisdiction, it invalidates one of the primary intents of allowing State Plans. States invest a great deal of time and resources to ensure their programs focus on the industries and demographics of their specific state. State Plans are not contractual services, but rather grants with required matching funds and significant overmatching state funds. Congress should encourage a true Federal/State partnership between OSHA and State Plan Programs in the areas of strategic planning, policy and standards development, and legislative initiatives.

Monitoring Criteria—Congress should encourage OSHA to work cooperatively with State Plan States to review current monitoring guidelines, make improvements where needed, and establish benchmarks for both State Plan Programs and federal OSHA. The benchmarks should include staffing levels, federal/state funding levels, training, equipment, quality control, internal auditing and outcome measures.

State Responsibility—In enacting the Occupational Safety and Health Act of 1970, Congress declared its purpose "* * * to assure every working man and woman in the Nation safe and healthful working conditions * * * by encouraging the States to assume the fullest responsibility for the administration and enforcement of their occupational safety and health laws * * * ." States cannot assume full responsibility for their enforcement programs unless they have full authority to manage their enforcement programs. Congress and OSHA should resist reactionary requests to adopt legislation that would make it easier for OSHA to assert concurrent jurisdiction in State Plans.

We hope that you will consider our comments as an attempt to improve the safety and health environment in every American workplace. There should be no question that we are totally dedicated to achieving this goal. In that regard, we would be happy to participate in any future hearings by your committee on this topic. If you would like more information about our programs or have any questions regarding our position on these matters, please contact me at 919-807-2863 or kevin.beauregard@labor.nc.gov .

Sincerely,

KEVIN BEAUREGARD, CSP, CPM,
Chair, Occupational Safety and Health State Plan Association.

Prepared Statement of the Occupational Safety and Health State Plan Association (OSHSPA)

When OSHA was established, Congress specifically encouraged states to develop their own safety and health plan programs, to provide enforcement and compliance assistance activities in their states. Section 18 of the Occupational Safety and Health Act (OSH Act) authorizes states to administer a state-operated program for occupational safety and health, provided the programs are "at least as effective" as

federal OSHA. Congress envisioned a comprehensive national program that would provide safety and health protection in all U.S. States and Territories. Prior to the creation of OSHA, many states had already been operating programs to protect their workers.

Today, the 27 states and territories that operate a State Plan Program for workplace safety and health work together through the Occupational Safety and Health State Plan Association (OSHSPA) to address common issues and facilitate communications between the States and federal OSHA. State programs have made major contributions in the area of occupational safety and health and have helped drive injuries, illnesses and fatalities to all time low levels. It makes sense for State Plan Programs and OSHA to work together to develop strategies for making jobsites safer and to share methods that will work on both a national and state level.

OSHSPA does not view occupational safety and health as a partisan issue. The OSH Act was established "to assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the states in their efforts to assure safe and healthful working conditions; by providing research, information, education and training in the field of occupational safety and health; and for other purposes."

In order to meet the original intent of the OSH Act, OSHSPA firmly believes that a "balanced approach" within OSHA and State Plan Programs is required. We believe the most effective approach includes strong, coordinated programs that address enforcement, education and outreach, and consultation. The lack of commitment to any of these three elements will eventually lead to an ineffective OSHA program.

State Plan Programs and OSHA share common goals regarding occupational safety and health. Over the years we have formed many positive relationships and have achieved many successes through cooperation between OSHSPA members and OSHA staff as we worked side-by-side on numerous projects and in response to nationwide catastrophic events. Those successes prove that OSHA has many positive attributes and talents to share with State Plans and, likewise that State Plans have many positive attributes and talents to share with OSHA.

One of the many benefits of State Plan Programs is the flexibility afforded states to address hazards that are unique or more prevalent in particular states, or are not already being addressed by OSHA. In many instances, State Plans have passed more stringent standards or additional standards that do not exist on the federal level, while OSHA labors through the standard adoption process that frequently takes not only years but decades. These include State regulations such as, but not limited to: cranes and derricks , communication towers, confined space in construction, ergonomics, heat stress, reverse signal operations, residential fall protection, tree trimming, workplace violence, comprehensive safety and health programs, safety and health committees and lower chemical permissible exposure limits (PELS).

State Plan Programs have also developed innovative inspection targeting systems directly linked to Workers' Compensation databases, and special emphasis inspection programs covering such hazards as residential construction, logging, food processing, construction work zone safety, waste water treatment plants, and overhead high voltage lines. Many states sponsor annual State Safety and Health Conferences which bring training, networking and outreach to thousands of employees and employers, and spread the word about the positive benefits of providing safe and healthful workplaces. OSHSPA publishes annually the Grassroots Workplace Protection report which highlights many of these unique and innovative state initiatives (see: *http://www.osha.gov/dcsp/osp/oshspa/annualreport.html)*

OSHSPA RESPONSE TO ORAL AND WRITTEN TESTIMONY AT OCTOBER 29TH HEARING

We would like to expand on some of the comments that Acting Assistant Secretary Barab made at the October 29th hearing.

OSHSPA applauds the joint efforts of OSHA and the Nevada State Plan to work together to identify and address legitimate issues and concerns raised in the special evaluation of the Nevada program. OSHSPA also very much welcomes the testimony of Acting Assistant Secretary Barab in support of Congressional and Administration efforts to address the current inadequate levels of funding for State Plan Programs (see below discussion). We appreciate Mr. Barab's recognition of the value and benefits that State Plan Programs provide to working men and women around the country. OSHSPA looks forward to working closely with Mr. Barab and the eventual permanent Assistant Secretary to work through the many challenges that confront OSHA nationally and State Plan Programs locally.

Funding of State Plans

Employers and employees in all states should be provided with comparable levels of occupational safety and health protections. While Congress envisioned that the

partnership between federal OSHA and the State Plans would include federal funding of 50 percent of the costs, the federal portion for State Programs has diminished significantly over the years. Although State Plans operate in 27 States and Territories and account for approximately 60 percent of all enforcement activity, State Plans received only 18 percent of the total OSHA Budget in FY2009.

State Plans cover approximately 40 percent of private sector workers nationwide and more than 10 million public sector workers. The total OSHA budget in FY 2009 was $515 million. The total amount allocated to State Plan enforcement programs was $93 million. In addition to matching those funds, states contributed an additional $91.8 million in overmatching funds in an effort to maintain effective programs. However, due to the current nationwide economic situation, many states will likely have to decrease their overmatch contributions in the coming year. The overall current funding level of State Plan Programs is approximately 66.5% state funding and 33.5% federal funding.

OSHA has announced that it will be adding 130 new inspectors in FY 2010 in addition to those positions added in FY2009. Meanwhile, many states have been eliminating positions, holding positions vacant and furloughing employees due to the lack of federal funding. In addition, some states have been unable to send compliance officers to training at the OSHA Training Institute (OTI) due to budget constraints and OTI has often been unable to provide training for states that request it due to insufficient space in, and frequency of, classes. The retention of trained personnel in some states is undoubtedly affected in many cases by insufficient budgets. Data presented by federal OSHA as recently as last summer show that Nevada OSHA's base grant for enforcement is "underfunded" by almost $1.1 million. Additionally, the same data indicated that eleven other State Plans are collectively "underfunded" by more than $13 million.

There may be a time in the not so distant future when some states may opt out of having a state-administered program, simply due to the ever increasing burden of providing well beyond 50% of the program funding. If this comes to pass, the federal government will need to allocate 100% of the funding to provide equivalent enforcement. To prevent this from occurring and based on the original intent of Congress, the long term goal should be to fully fund 50% of State Plan Programs.

Although the number of employers and employees covered by State Plan Programs continues to increase in most states, the net resources to address workplace hazards in the State Plan Programs have declined due to inflation and lack of funding from Congress. The potential impacts, if this trend continues, are reduced enforcement and outreach capabilities and smaller reductions in injuries, illnesses and fatalities.

A process must be established to accurately and fairly address the budgetary requirements of State Plan Programs. Insufficient federal funding poses the most serious threat to the overall effectiveness of both State Plans and federal OSHA. If the intent of Congress is to ensure OSHA program effectiveness, this issue must be adequately addressed. OSHSPA urges Congress to establish a process to accurately and fairly address the budgetary requirements of State Plan Programs.

Congress Should Encourage a True Federal/State Partnership in Occupational Safety and Health

Past and current OSHA administrations have all espoused the benefits of State Plan Programs and OSHA being "partners." OSHSPA is fully supportive of a credible and meaningful partnership with federal OSHA and we encourage Congress to support such partnership to make it a reality. Our State Plan Programs are not merely an extension of federal OSHA; we represent distinct and separate government entities operating under duly elected governors or other officials and in addition to the protocols provided by Congress and federal OSHA, also operate under state constitutions and legislative process. State Plans are not just more "OSHA offices" and are not intended to be identical to federal OSHA, but rather to operate in such a manner as to provide worker protection at least as effectively as OSHA. Words such as "transparency," "partnership," "one-OSHA" and "one-voice" have been circulating for years, in regard to the desired relationship between State Plans and OSHA. Since we all share the common goal of improving nationwide occupational safety and health conditions, this would appear to make perfect sense. However, in reality there has often been an unequal "partnership" between OSHA and State Plans, especially when it comes to policy development, funding, and program implementation.

Similar to OSHA, each State Plan Program is staffed with dedicated occupational safety and health professionals with years of combined experience. Although OSHSPA members' contributions could be an integral part of the OSHA strategic planning process, our members are quite often excluded from providing critical

input. Often State Plans are not brought into the discussion of important policies and plans to implement those policies that directly affect our programs until all the critical decisions have been made. The same can be said for OSHA's development of its regulatory agenda and legislative initiatives. For example, if, as noted in Mr. Barab's testimony, States are to be mandated to implement new or continuing National Emphasis Programs, States need to be genuinely involved in identifying what kind of programs are needed and how they will be implemented. State Plan Programs are not looking for preferential or special treatment, but feel strongly that OSHA should work harder at establishing a true "partnership" with State Plan Programs and be more cognizant of the effect that policy decisions have on State Plan Programs.

State Plan Monitoring Background

All members of OSHSPA are subject to regular federal OSHA monitoring activities as a condition of maintaining a State Plan Program and all States acknowledge responsibility for maintaining programs at least as effective as OSHA. There are different sized State Plan Programs throughout the United States with varying capabilities. Likewise, there are different sized federal area offices with varying capabilities in federal OSHA jurisdictions. Properly conducted, audits and program monitoring can be helpful for all federal and State programs in identifying both program strengths and weaknesses.

In addition to regular monitoring activities on a local, regional and national level, there is also a rigorous State Plan approval process in place for any State or Territory that desires to have a state-run OSHA program. The approval process includes many minimum requirements and obligations that must be met to ensure that the eventual program is "at least as effective as OSHA." Prior to achieving final State Plan approval, States must also meet mandatory benchmark staffing levels for safety and health enforcement officers. Interestingly, although States are held to minimum staffing levels, there are no such staffing benchmarks applied to federal jurisdictions. As a result, many federal jurisdiction OSHA states have far fewer enforcement officers and enforcement activities than those found in a comparably sized State Plan jurisdiction. Although the State Plans expect and accept that OSHA will conduct oversight and monitoring activities, the criteria and expectations applied need to be universal for both state and federal operations.

State Plan Monitoring Concerns

The members of OSHSPA have concerns regarding some of the testimony at the October 29th hearing pertaining to OSHA's stated intent to increase monitoring of State Plan Programs. Acting Assistant Secretary of OSHA Jordan Barab indicated in a recent OSHA press statement and again during the hearing that "as a result of the deficiencies identified in Nevada OSHA's program and this administration's goal to move from reaction to prevention, we will strengthen the oversight, monitoring and evaluation of all state programs." As noted above, State Plan Programs are not opposed to OSHA monitoring their programs, and even welcome constructive review and analysis of state operations. However, the statement itself appears contradictory in that the announced increased oversight, monitoring and evaluation activity all appear to be "reactionary" in response to the Nevada findings, as opposed to preventative in nature and design.

We feel that this statement and other similar statements indicate that some within OSHA and perhaps elsewhere have a preconceived notion that there are significant deficiencies in all State Plan Programs. OSHA appears to be drawing from one State Plan Program's difficulties the broad generalization that there must be problems in all State Plan Programs and therefore a need for intensive on-site monitoring activities.

Regular auditing and monitoring based on understood and well-defined criteria and measures of all Occupational Safety and Health Programs, including federal OSHA, would be helpful to better ensure overall quality of our national program. As OSHA has announced that they will be conducting additional monitoring activities of all State Plan Programs for quality control, it would seem prudent that they would also be planning to conduct similar monitoring activities of their own offices. All federal Area Offices should be given the same in-depth evaluation that is planned for all State Plan Programs over the next six to nine months. Acting Assistant Secretary Barab indicated in his testimony that OSHA would make the results of their increased State Plan Program monitoring publicly available. Likewise, OSHA should make all audits of their national, regional and area offices publicly available. If the goal of OSHA and Congress is to better ensure equivalent workplace safety and health protection for all employers and employees nationwide, then

should not OSHA be held to the same quality, performance and staffing levels to which State Plan Programs are being held?

Prior to conducting more comprehensive State Plan monitoring activities, OSHA and the States should establish well-defined performance measures and goals for both States and OSHA. Among other items, these benchmarks should include staffing levels, federal/state funding levels, training, equipment, quality control, internal auditing and outcome measure performance for both State Plans and federal OSHA. Following the establishment of those benchmarks, there should be regular audits of both State Plan Programs and OSHA national, regional and area offices against those benchmarks. As Acting Assistant Secretary Jordan Barab indicated in his testimony, State Plans should be included and involved in the establishment of these benchmarks and the monitoring process.

Acting Assistant Secretary Barab also stated during his testimony that, although the current OSHA administration has not taken a position on potential legislative changes regarding measures against State Plans, he has heard of suggestions that would make it easier for OSHA to assert concurrent jurisdiction in State Plans. According to Acting Assistant Secretary Barab, this measure could be utilized whenever OSHA believed a State had not addressed OSHA's concerns satisfactorily in regards to the "at least as effective" requirement. This could allow OSHA to proceed with assuming concurrent jurisdiction without having to go through the established process of notification via federal register, hearings and the appeal process currently afforded State Plan Programs that have been granted final approval status. The mere fact that OSHA, and perhaps Congress, are entertaining these suggestions is very disconcerting, as it would appear to disallow a State Plan Program the opportunity to sufficiently respond to perceived deficiencies. We believe it is far too premature to even consider such an approach.

For instance, the "at least as effective as OSHA" status is a constantly moving target which compares mandated activity trends and policies within federal OSHA with each State Plan. Currently, the monitoring activities center on mandated activities and indicators such as, but not limited to: percent serious rate of violations cited, contestment rates, penalties assessed and penalties retained. Some of these items individually interpreted can lead to conclusions that are not factually based. For instance, OSHA's own policy decisions can affect the percent serious rate, but not anyone's program effectiveness. For example, OSHA has adopted a focused construction inspection policy that excludes issuing non-serious violations for items abated during the inspection. Individual State Plans may be more effective than OSHA by not adopting this policy and by continuing to cite all hazardous conditions noted. As a result, those inspections that qualify for focused inspections on a federal level could have a 100% serious rate, when in reality the percentage of serious hazards identified is much lower (as OSHA does not issue citations for those non-serious hazards abated during their focused inspection, it would affect the rate).

Likewise, grouping or combining violations noted on an inspection can have a significant impact on the percent serious rate, even when all items are cited. While each of these mandated measures may be worth reviewing, the overall effectiveness of a program should be focused on activities associated with quality of staff, program performance and outcome measures associated with the impact of the program on overall occupational safety and health.

Closing Remarks

Together State Plan Programs and OSHA can successfully improve workplace conditions and continue to drive down occurrences of injuries, illnesses and fatalities. We should always be working toward program improvement with the single goal of having a positive impact on nationwide occupational safety and health. However, establishing an "us" and "them" relationship between OSHA and State Plan Programs, which appears to be the direction we are moving, will do little to enhance nationwide workplace safety and health.

OSHA, State Plan Programs and Congress need to join forces to best ensure workplace injuries, illnesses and fatalities continue to decline nationwide. There should be a true partnership between OSHA and State Plan Programs to ensure all employers and employees are afforded equivalent workplace protections nationwide. Efforts should be made to ensure State Plan partners are included in the OSHA strategic planning and policy development process. OSHA should work to complete national regulations in a timely manner. OSHA and State Plan Programs should be held equally accountable regarding performance, and matching federal funding should be provided to State Plans as Congress originally intended. These measures together will do more to enhance nationwide occupational safety and health than any other measures being considered at this time. Thank you for the opportunity to provide written testimony.

[Letter, dated August 31, 2007, from John Olaechea follows:]

August 31, 2007

Bob Scolio
USDOL/OSHA
230 N. First Avenue
Suite 202
Phoenix, AZ 85003

RE: Formal filing of a CASPA

Dear Mr. Scolio:

I am a State of Nevada CSHO writing to inform the regional office of Federal OSHA of problems I have observed in the implementation of the State of Nevada OSHA program.

On February 2, 2007, two men died and a third was hospitalized in critical condition after entering a sewer lift station (while in the presence of three supervisors) for a grease trap at the Orleans Hotel and Casino in Las Vegas. This property is one of many run by Boyd Gaming Corporation. I investigated this accident and proposed (to OSHA management) willful and repeat citations for violations of the confined space and hazard communication standards. These were proposed based on Boyd management's clear knowledge of the hazard, knowledge of employee exposure to the hazard (and lack of training), and knowledge of the OSHA standard. In addition to this information (obtained through a sworn deposition, internal documents, and other interviews), Boyd had previously been cited at other properties for the same exact standards within the past year.

After months of internal meetings and discussions, I was finally given the clearance to hold a closing conference and issue willful and repeat citations. However, **after** the closing, and **before** the issuance of citations, the Chief Administrative Officer of OSHA privately negotiated a settlement which involved changing all willful and repeat citations to serious citations.

It was critical for Boyd that these classifications be changed as it would then make any lawsuits from the families of the victims virtually impossible given the strong worker compensation laws in the State of Nevada.

What is baffling, is why OSHA chose to reclassify the citations. No reasonable explanation has been given to me. In three years with OSHA, I have not personally investigated anything that is a better match for the classification of repeat or willful.

I have attached a report including the narrative and the citations issued by OSHA. The narrative and citation worksheets clearly make the case for willful and repeat citations,

especially with regard to confined spaces. This is not the whole case file (it can be requested during your investigation and includes depositions).

Here is a list and brief explanation of some irregularities with the handling of this case:

1. Federal standards and the Nevada Revised Statutes both call for a 6 month limitation on the issuance of citations following a violation.

Citations were issued on 8/21/07, six months and 19 days after the accident occurred. I waited for weeks at a time while management waited to decide the next move. I sent numerous e-mails (available upon request) toward the end of the six month period urging the closing of the case. My closing conferences were canceled and rescheduled for me by management. When I asked about the six month limit, I was told that an agreement had been made with Boyd that would allow OSHA to go past 6 months. I never saw such an agreement in writing though I was told it existed. I believe that passing the 6 months (waiver or not) weakened OSHA's position in the event that the case would have had to proceed with a review board hearing or other litigation. There was no reason for this investigation to go past 6 months.

2. Citations were negotiated before issuance.

Citations are never negotiated **before** they are issued. Every employer has the right to an informal conference or a contest **after** the issuance of citations. The Nevada Operations Manual makes this very clear.

3. The definitions of willful and repeat were met exactly, yet violations were classified as serious.

Per the Nevada Operations Manual, a willful citation should be issued for an intentional violation or plain indifference. Per the NOM, the following cases (individually) can be made to show plain indifference:

a. A higher management official was aware of an OSHA standard or law applicable to the company's business but made little or no effort to communicate the requirement to lower level supervisors and employees.

b. A company official was aware of a continuing compliance problem but made little or no effort to avoid violations.

c. An employer representative was not aware of any legal requirement, but was aware that a condition or practice was hazardous to the safety or health of employees and made little or no effort to determine the extent of the problem or to take the corrective action. Knowledge of a hazard may be gained from such means as insurance company reports, safety committee or other internal reports,

the occurrence of illnesses or injuries, media coverage, or, in some cases, complaints of employees or their representatives.

A case could easily be made for any of these three definitions from the information gathered during the inspection. Please note that during a formal, sworn deposition, the corporate EHS manager for Boyd stated:

a. He knew about a citation (same standard) issued at another Boyd property just six months before the accident.
b. He knew that confined spaces were very dangerous hazards and that they were common to all Boyd casino-hotels across the country.
c. He knew that the Orleans (where the accident occurred) and other "Coast" properties did not have confined space programs or training.
d. He knew all of this (except for the citation –issued later) by mid 2005 and discussed it with corporate officials above him.
e. NOTHING was done to address the hazard of confined spaces.

Whether the corporate manager or his superiors failed to act, it is clear that Boyd Corporate had knowledge and failed to act. This is the exact definition of willful (by indifference) under the NOM.

Additionally, if memos and testimony of three corporate representatives are accurate, then the definition of criminal willful could be met by the supervisors present during the accident.

Even if an argument could be made against willful classification, these confined space violations certainly meet the definition of repeat (citations of the confined space standard were issued at many of their properties over a one year period).

4. There was no reason for reducing the classifications.

Boyd has offered nothing in return for this favor. An "Agreement to Cooperate" was reached during the settlement, however, it is a bare bones document with no measurable goals. I have reviewed this document and there seems to be no concessions from Boyd. In fact, it appears to be a good deal for the company. The agreement includes reduced or limited enforcement inspections. It involves inclusion in the SHARPS program typically reserved for companies with a good compliance histories and progressive, ahead of the curve safety programs. And it calls for massive expenditure of State resources normally reserved for small businesses to help Boyd progress toward meeting the minimums. What has Boyd offered? It seems that they have only offered to achieve compliance. Compliance must be achieved after the issuance of citations so there was no need to reduce the citations (pre-issuance) in exchange for the "Agreement to Cooperate."

Just two weeks prior to the negotiations, Boyd was issued yet another citation within the confined space standard at the Gold Coast Hotel and Casino (inspection #311017024). This was the second confined space standard citation issued to Gold Coast in six months.

The first one (inspection #310428982 – issued 3/15/07) was issued for a violation of the exact same standards cited at the Orleans. Further, an inspection at Bill's Gamblin' Hall and Saloon – formerly operated by Boyd as the Barbary Coast – was cited for a violation of the confined space standard in inspection #310431036 on 4/12/07. It is clear that Boyd has not thoroughly addressed the confined space standard at all their properties since the accident.

These reclassifications were made by the Chief Administrative Officer, Steve Coffield (an appointee), and State officials above him. During your investigation I urge you to speak to management within the chain of command below the CAO. I can't speak for anyone else, but I don't know of anyone in the office that agreed with these actions.

5. According to the Nevada Operations Manual, a serious citation of more than $7000 can not be issued. Eight serious citations were issued at $23,000 each.

6. The CAO dropped OSHA 300 Log and accident investigation (not conducted by Boyd) citations without cause. These documents were requested throughout the investigation and not provide for 6 months.

The goal of OSHA should be to uniformly enforce laws and protect employees without infringing upon the rights of the employer. Issuing willful and repeat citations would have accomplished such a goal. OSHA is not tasked with ensuring that employers do not face large lawsuits and bad press after the issuance of citations. That is the only reason that I can find for the extensive irregularities during the Orleans inspection.

Lastly, I would like to make the point that I am not a trouble maker. I have worked for Nevada OSHA for 3 years and always received well above standard evaluations. I have worked in government, mostly inspections and enforcement, for over 10 years. I have never made any complaints to an outside agency. I have never felt it was warranted. In this case, however, it is. What happened here is wrong. The information I have gathered tells me it was wrong, the OSHA standards tell me it was wrong, the gravity of the situation tells me it was wrong, the Nevada Operations Manual tells me it was wrong, but, most of all, my gut tells me it was wrong.

By the time you receive this I will have resigned from the State of Nevada. I can be reached by phone (702-224-4794), by e-mail (johnfolaechea@yahoo.com), or by mail (1019 Crestwood Hills Drive, Vandalia, OH 45377). Please consider these important issues and let me know if I can be of any assistance to you in your investigation.

Sincerely,

John Olaechea

[Questions for the record and their responses follow:]

[VIA EMAIL],
November 6, 2009.

Hon. JORDAN BARAB, *Acting Assistant Secretary,*
Occupational Safety and Health Administration, U.S. Department of Labor, Washington, DC.

DEAR ASSISTANT SECRETARY BARAB: Thank you for testifying at the Committee's hearing on "Nevada's Workplace Health and Safety Enforcement Program: OSHA's Findings and Recommendations," held on Thursday, October 29, 2009.

I had additional questions for which I would like written responses from you for the hearing record.

1. While some state plans have enforcement and abatement strategies which are more effective than OSHA's, it is also troubling that the average dollar amount for penalties issued by state plans for serious violations in the private sector are only about 65% of federal OSHA's, if you exclude California which has a $25,000 maximum penalty compared with $7,000 in federal OSHA. State plans lag federal OSHA in the percentage of higher gravity violations, such as serious or willful with only 46% of the violations; whereas about 80% of OSHAs violations are for higher gravity violations.

a. Why do state plans, on average, tend to fall so far behind federal OSHA's effectiveness in finding and citing higher gravity violations? Is this a function of targeting? Or are there other explanations?

b. Why are state plans assessing penalties, on average, at 65% of the rate of federal OSHA for serious violations in private facilities?

2. Some states receive as little as 20% of their funding from federal OSHA. What should be done to better equalize funding, and should there be a minimum amount provided by OSHA to a state plan? If so, what should that floor be?

a. There were 340 CASPA filed since 2000. How many were deemed valid or otherwise meritorious by OSHA? How many had no merit?

b. Does OSHA plan to assess the adequacy of federal OSHA's reviews of previously filed CASPAs?

c. Is your office routinely notified of a CASPA or an investigation regarding a CASPA? Or does this information generally held by the Regional Administrators office without headquarters involvement?

Please send your written response to the Committee on Education and Labor staff by COB on Monday, November 16, 2009—the date on which the hearing record will close. If you have any questions, please contact the Committee. Once again, we greatly appreciated your testimony at this hearing.

Sincerely,

GEORGE MILLER, *Chairman.*

Responses to Questions for the Record From Mr. Barab

Question: While some state plans have enforcement and abatement strategies which are more effective than OSHA's, it is also troubling that the average dollar amount for penalties issued by state plans for serious violations in the private sector are only about 65% of federal OSHA's, if you exclude California which has a $25,000 maximum penalty compared with $7,000 in federal OSHA. State plans lag federal OSHA in the percentage of higher gravity violations, such as serious or willful with only 46% of the violations; whereas about 80% of OSHA's violations are for higher gravity violations.

Why do state plans, on average, tend to fall so far behind federal OSHA's effectiveness in finding and citing higher gravity violations? Is this a function of targeting? Or are there other explanations?

State Plans conduct nearly twice as many inspections and cite nearly twice as many violations as Federal OSHA (59,723 v. 38,847 and 129,075 v. 87,923 in FY09 [preliminary data]), although they find on average about the same number of violations per inspection. State Plans have a proportionately higher number of inspectors than OSHA and many of the State plans are in smaller States with less heavy industry. The fewer violations cited as serious, willful, or repeat may be the result of differences in targeting, with State Plans inspecting a greater number of less hazardous and smaller establishments than Federal OSHA. A lower percentage of serious, willful, and repeat citations may also be attributed to differences in violation classification, or problems with hazard recognition, different priorities in settlement of cases, or different State enforcement philosophies, including citing all other-than-serious violations even if immediately abated. We intend to take a closer look at

these issues as part of the baseline State Plan special evaluation studies I described in my testimony, the reports of which should be issued sometime next spring.

Question: Why are state plans assessing penalties, on average, at 65% of the rate of federal OSHA for serious violations in private facilities?

State Plans have their own penalty calculation and penalty reduction policies and procedures that may differ from Federal OSHA's though they must still be "at least as effective." Several of the States have penalty reduction policies similar to Federal OSHA's previous Quick-Fix, which permits penalty reductions in certain circumstances as an incentive for employers to immediately abate hazards, agree not to contest, and to quickly eliminate hazards that could lead to employee injury, illness, or death. All State Plans have statutory penalty authority equivalent to the OSH Act and their policies and procedures related to penalties must be submitted and reviewed by OSHA. The baseline studies we will be conducting will help us determine through case file reviews how differences in policy are affecting penalty levels and whether such differences are meaningful and appropriate. In addition, OSHA recently re-issued a revised Field Operations Manual. States must revise their procedures and adopt an equivalent Manual and identify for OSHA any differences in their procedures. OSHA will be paying close attention to the differences in State procedures during our review of State submissions.

Question: Some States receive as little as 20% of their funding from federal OSHA. What should be done to better equalize funding, and should there be a minimum amount provided by OSHA to a state plan? If so, what should that floor be?

Though the Act authorizes OSHA to award matching grants to States of up to 50% of their operational costs, OSHA's State Plan funding levels are set as part of the agency's annual appropriation and not by money that individual states have available to match Federal funding. Currently, 21 of the 27 approved State Plans contribute additional State funds over and above that amount which OSHA has available to offer them for State Plans. The other six States provide the exact 50% match to the Federal funds made available to them.

In the beginning of the program, OSHA was able to provide full 50% Federal funding for each State at its requested level at plan approval. Over the years, many States obtained additional State funding to expand their programs, but matching OSHA grant funding increases did not keep pace with those State increases. State contributions in excess of the required 50% match demonstrated the States' commitment to their OSHA programs. In FY 2010, the Administration requested an increase of nearly $14 million to help address this funding disparity.

It is not realistic to equalize Federal funding among the States without either a redistribution of current Federal grant funds among the States or the Congressional approval of a very significant increase in Federal grant funding to match the current State contributions. It is difficult to see how either option is a practical alternative. The fifty percent funding goal established by the Act is a reasonable standard as it assures that States that choose to operate such OSHA-approved State Plans have a level of commitment to the program at least equal to that of the Federal government. Additional State contributions above the required 50% match, which may vary from year to year depending on State economic conditions, demonstrate their commitment to occupational safety and health and allow opportunities for flexibility and innovation.

Question: There were 340 CASPAs filed since 2000. How many were deemed valid or otherwise meritorious? How many had no merit?

OSHA has automated data available back to 2004. Of the 167 CASPAs filed and investigated by OSHA's Regional Offices from FY 2004 through FY 2009, 94 or 56% resulted in a finding that State corrective action was needed on one or more complaint items. CASPAs often contain multiple complaint items. They also may deal with specific inspections or investigations and reflect the unique concerns of the affected complainant. They are sometimes filed long after the event in question. Since enforcement action must occur within 6 months of the first identification of a violation, it is often impossible to effect a remedy for the specific case. In such situations, corrective action can take the form of required changes in State policy, or requiring that the State take steps to prevent a recurrence.

Question: Does OSHA plan to assess the adequacy of federal OSHA's review of previously filed CASPAs?

As I indicated in my testimony before the Committee, we will be undertaking increased oversight of the State plans beginning with a baseline special evaluation of each State Plan, the reports of which should be issued sometime next spring. The Special Studies will focus on the State Plans' performance during FY 2009 and the Regions will review any CASPAs investigated last fiscal year as part of that effort.

I will also be issuing new guidance to our Regions on responding to CASPAs, both setting timeframes for response (60-90 days) and requiring coordination with the National Office on complaints that raise concerns about significant or systemic State performance issues.

Question: Is your office routinely notified of a CASPA or an investigation regarding a CASPA? Or is this information generally held by Regional Administrator's office without headquarters involvement?

Regions are responsible for investigating CASPAs and are asked to provide copies of their final actions to the National Office. Though OSHA has a computerized database for tracking CASPAs, the agency has found its overall utility limited in helping to track CASPAs. We anticipate that deployment of the agency's new data system, the OSHA Information System (OIS), will provide much greater capability for tracking CASPAs. Also, the new guidance that we will issue on CASPAs will require closer adherence to these requirements and will also require submission and coordination of responses on CASPAs that raise significant issues, receive public attention, or otherwise are of concern to the Regional Administrator. I will look to our Regional Administrators to assure that CASPAs are fully and appropriately investigated and that the States take appropriate follow-up action.

[VIA EMAIL],
November 6, 2009.

Mr. DONALD JAYNE, *Administrator,*
Division of Industrial Relations, Department of Business and Industry, State of Nevada, Carson City, NV.

DEAR MR. JAYNE: Thank you for testifying at the Committee's hearing on "Nevada's Workplace Health and Safety Enforcement Program: OSHA's Findings and Recommendations," held on Thursday, October 29, 2009.

I had additional questions for which I would like written responses from you for the hearing record.

1. What explains the fact that Nevada OSHA issued only 28% of its violations as "serious" for private sector facilities in 2008 compared with federal OSHA which cited approximately 76% of its violations as serious in that same time frame?

2. In terms of future performance, will Nevada OSHA's be setting a goal for percentage of violations cited as serious? If so, what is that goal?

3. The OSHA recent review found that Nevada OSHA is not targeting enough of the higher hazard facilities in your state.

• What specifically are you going to do to improve targeting so that Nevada is at least as effective as federal OSHA in targeting higher hazard facilities?

4. Please explain why Nevada OSHA's funding formula has a comparatively small share (20%) of federal funding. Based on OSHA data, Nevada's state OSHA program receives the second smallest amount of federal funding of all state plan states—after Washington state which only receives 17% federal funding.

• If the formula were modified so that Nevada received added funds, would Nevada OSHA increase its budget, or keep its budget flat and simply reduce the share of state appropriated funds?

5. Did the Nevada exclusive state workers' compensation fund ever provide resources to Nevada OSHA, and did its subsequent privatization reduce funding that had previously gone to Nevada OSHA?

Please send your written response to the Committee on Education and Labor staff by COB on Monday, November 16, 2009—the date on which the hearing record will close. If you have any questions, please contact the Committee. Once again, we greatly appreciated your testimony at this hearing.

Sincerely,

GEORGE MILLER, *Chairman.*

Responses to Questions for the Record From Mr. Jayne

DEAR CHAIRMAN MILLER: I appreciate the opportunity to address the questions raised in your November 6, 2009 correspondence. The following responses are submitted by Nevada OSHA for inclusion in the hearing record.

1. What explains the fact that Nevada OSHA issued only 28% of its violations as "serious" for private sector facilities in 2008 compared with federal OSHA, which cited approximately 76% of its violations as serious in that same time frame?

Response: There are several reasons why Nevada OSHA's serious rate was low in comparison to federal OSHA results. First, the special study revealed that NV

OSHA was over-grouping citations. This had not been cited as a problem during previous fed OSHA audits performed by Region IX. As a result, NV OSHA has discontinued this practice, which was inadvertent but impacted the percentage of serious violations results.

Second, as acknowledged, Nevada OSHA's staff experience level is developing, but is not where we want it to be. With additional OTI training, NV OSHA enforcement staff will gain expertise and improve as experience is gained. In addition, Nevada OSHA is restructuring and creating a Training and Standardization function which will be responsible for improving the hazard recognition of our staff members.

Third, the two major population centers in Nevada (Reno-Washoe County and Las Vegas-Clark County) have received a significant number of inspections by the 41 Nevada CSHO's.

Despite individual observations to the contrary, we believe our inspections are having a positive impact. We believe with additional training our impact on employers with high incidence rates will also improve.

Finally, this question and the one that follows (No. 2) imply that State Plan Programs are not "at least as effective as" federal OSHA unless they "match" federal OSHA inspection statistics. Nevada, like other members of the Occupational Safety and Health State Plan Association (OSHSPA) favor another approach. As noted in the written testimony submitted by OSHSPA on 11/10/09:

[T]he 'at least as effective as [federal] OSHA' status is a constantly moving target. * * * Currently, the monitoring activities center on mandated activities and indicators such as, but not limited to: percent serious rate of violations cited, contestment rates, penalties assessed and penalties retained. Some of these items individually interpreted can lead to conclusions that are not factually based.

Likewise, grouping or combining violations noted on an inspection can have a significant impact on the percent serious rate, even when all items are cited. While each of these mandated measures may be worth reviewing, the overall effectiveness of a program should be focused on activities associated with quality staff, program performance and outcome measures associated with the impact of the program on overall occupational safety and health.

Thus, while Nevada is concerned about the low percentage of "serious" citations issued in 2008, it is also wary of offering explanations which could be interpreted as a pledge to simply "match" federal OSHA inspection statistics without regard of the impact on occupational safety and health.

2. In terms of future performance, will Nevada OSHA's be setting a goal for percentage of violations cited serious? If so, what is that goal?

Response: NV OSHA believes the steps outlined in Question 1 will significantly increase our state-wide serious rate, and improvement should be reflected almost immediately due to the way we are now grouping citations. In the short term (next 24 months), our primary focus will be on CSHO training, hazard recognition, citation classification, and legal sufficiency. Once we believe the CSHO's skills are at a journeyman's level, we will expect a high serious rate. A range of 60% to 80% will be targeted. However, as indicated above, our targeting of a range of 60% to 80% should not be interpreted as a pledge by Nevada to "match" federal OSHA "serious" citation statistics without regard of the impact on occupational safety and health.

3. The recent OSHA review found Nevada OSHA is not targeting enough of the higher hazard facilities in your state.

What specifically are you going to do to improve targeting so that Nevada is at least as effective as federal OSHA in targeting higher hazard facilities:

Response: First, we are in contact with OSHA officials to learn the process of developing targeting lists in high hazard facilities, measuring our success as we inspect, and then fine tuning the lists when our inspection efforts are not productive. Second, we are currently updating our targeting lists and our local emphasis program lists and expect to have that process completed by January 1, 2010. Third, we are attempting to gain access to real-time workers compensation claim information so that we can focus on the companies that are having the highest WC claims.

4. Please explain why Nevada OSHA's funding formula has a comparatively small share (20%) of federal funding. Based on OSHA data, Nevada's state OSHA program receives the second smallest amount of federal funding of all state plan states—after Washington state which only receives 17% federal funding.

If the formula were modified so that Nevada received added funds, would Nevada OSHA increase its budget, or keep its budget flat and simply reduce the share of state appropriated funds?

Response: It is NV OSHA's understanding that the federal funding formula was developed in the late 1980's and has not been significantly modified since. With the dramatic growth that Nevada experienced in the last twenty years, significant resources were needed for Nevada to develop and secure final state plan approval and

to maintain the Nevada OSHA state program. Final approval for Nevada to be a state plan state was obtained in April of 2000.

As federal funding has been essentially flat during this time period, the State of Nevada has dramatically increased their financial commitment to NV OSHA. As Nevada OSHA needed more funding and matching funds were not available from Federal OSHA, Nevada's agency budgets were developed and submitted for review and approved in accordance with Nevada budgetary procedures. This process involves both Executive Branch and Legislative Branch review and approval to authorize the NV OSHA budget requests.

Any additional funding received would be subject to the existing statutory oversight provided by Nevada's executive and legislative branches. However, I would be advocating increasing the overall budget to address NV OSHA's need for additional resources rather than "simply reduce the share of state appropriated funds".

5. Did the Nevada exclusive state workers' compensation fund ever provide resources to Nevada OSHA, and did its subsequent privatization reduce funding that had previously gone to Nevada OSHA?

Response: We have not been able to find any specific allocation of resources from the State Industrial Insurance System (SIIS), the exclusive state fund, that were provided to Nevada OSHA. The subsequent privatization of SIIS did not reduce funding to NV OSHA, as the assessment formula is applied to all workers' compensation insurers in Nevada. However, as one of the largest workers' compensation carriers in Nevada, the succeeding entity, Employers Insurance Group, pays one of the highest assessments for OSHA and SCATS funding requirements.

As evidenced by Nevada's willingness to step up and fund NV OSHA activities and to work with Federal OSHA to correct deficiencies outlined in the special report, we value the State Plan Program approach. We look forward to working with our federal counterparts in a revitalized partnership in which both entities strive to improve operational efficiencies incorporating both reasonable and effective federal oversight.

Nevada, individually, and as a member of OSHSPA, stands ready join forces with federal OSHA. As I have stated many times, Nevada's State Plan and Federal OSHA share the same goals regarding occupational safety and health: to assure safe and healthful work conditions for Nevada's working men and women. If you need additional information please let me know.

[Whereupon, at 11:29 a.m., the committee was adjourned.]