

Review of the Nevada Occupational Safety and Health Program

October 20, 2009



U. S. Department of Labor
Occupational Safety and Health Administration
Region IX
San Francisco, California



**U.S. Department of Labor
Occupational Safety and Health Administration**

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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

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 supervisors 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 previous 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.



**U.S. Department of Labor
Occupational Safety and Health Administration**

Review of the Nevada Occupational Safety and Health Program

I. Fatality Case File Reviews

During the period January 1, 2008 through June 1, 2009, Nevada experienced 25 fatalities which were investigated by Nevada OSHA. Twenty-three (23) of the 25 fatality files were reviewed as part of this evaluation. In addition to the case file reviews, the evaluation process included interviews with employees, supervisors, one district manager and legal counsel. The interviews supported the evaluation team's case file review findings.

Findings

Eight (8) of the 23 (35%) files were found to be in-compliance, with no citations issued. The files were closed as in-compliance files for reasons such as no hazards identified or proposed violations which were not approved by management.

Case files were not organized in a uniform manner and by a means which would reduce the possibility of important case file documentation being lost or misplaced. One (1) of the 23 (4%) of the fatality files reviewed was placed in a case file with all documentation pronged and securely fastened to the file. The remaining 22 files were either clipped together with a large binder clip or held together with a rubber band and then placed into an accordion file folder. There were some sections of the case files in the binder clip or rubber band that were stapled together. All correspondence in the file was intermingled with the investigative portion of the case file.

Two (2) of the 23 (9%) case files contained a diary sheet that provided a chronological listing of case file activity. All files contained a Case File Cover Sheet that provided a summary of initial violations, citation and penalty modifications based on settlement, and written notes regarding when amended citations and debt collection letters were sent to employers. No notes regarding abatement verification or other important events were included on these sheets. Page II-1 of 93 of the Nevada Operations Manual (NOM) states, "The OSHA Case file Cover Sheet is designed to provide a ready record and summary of all actions relating to a case. The cover sheet will be used to document

important events related to the case, especially those not found elsewhere in the case file, including the use as a telephone log for penalty collection and abatement verification.”

Thirteen (13) of the 23 (56%) case files contained no notification to the family that Nevada OSHA was investigating the death of their loved one. In cases where Nevada OSHA did send the initial letter, no additional letters were sent with citation(s), informal settlement agreements or case closure information. Management and employee interviews indicated that when letters were sent to family members from the Reno office, those letters were signed by the district manager. In Henderson, the letters were signed by the Safety and Health Representative (SHR), Industrial Hygienist (IH), Supervisor or the District Manager. There was no clear guidance on who should be signing the letters that were mailed to the families of victims. Page I-30 of 93 in the Nevada NOM states, “Family members of employees involved in fatal occupational accidents or illnesses shall be contacted at an early point in the investigation, given the opportunity to discuss the circumstances of the accident or illness, and provided timely and accurate information at all stages of the investigation.” Page I-29 of 93 of the Nevada NOM states, “Guidance on conducting fatality and catastrophe inspections is found in OSHA Instruction CPL 2.113.” OSHA Instruction, CPL 02-00-113 (formerly CPL 2.113), Fatality Inspection Procedures, states, “Family members of employees involved in fatal occupational accidents or illnesses shall be contacted at an early point in the investigation and given an opportunity to discuss the circumstances of the accident or illness.” CPL 02-00-113 also states, “If the family member(s) do not respond to the information letter, no further contacts need be attempted.” There is currently no tracking system in place in Nevada to ensure that the letters are mailed to the families of the victims.

Investigators were instructed to enter into the IMIS, OSHA forms 36, Fatality/Catastrophe Report and OSHA-170, Accident Investigation Summary after initiating the fatality investigation. It was noted that 23 of the 23 (100%) case files reviewed included the OSHA 36 and 170 forms.

Thirteen (13) of the 23 (56%) case files did not include IMMLANG (code designed to allow the Agency to track fatalities among Hispanic and immigrant workers) documentation. Of the thirteen (13) files missing IMMLANG documentation, six (6) workers’ primary language was Spanish, five (5) workers’ primary language was English and two (2) workers’ primary language could not be determined. The original memorandum implementing the IMMLANG procedures states, “State Plan States will be asked to follow the same procedure.” The December 16, 2003 Federal OSHA memorandum from Davis Layne, Interim Procedure for Fatality and Catastrophe Investigations (IMMLANG) encourages State Plan States to utilize the new IMMLANG procedures. Nevada OSHA did not adopt the IMMLANG requirement however; management and employee interviews indicated that the IMMLANG coding was required for fatality investigations.

Fatality investigations are assigned by the Supervisors or the District Manager. Through employee interviews it was ascertained that each SHR/IH and Supervisor handles cases differently. Some investigators have discussions with their Supervisor before submitting the case for review. Other investigators write up the file, submit it to the Supervisor

receive the file back with Post-it notes with suggested changes. No discussions are documented in the case file.

During interviews with the Nevada investigators, it was determined that they are discouraged from pursuing willful violations by management and legal counsel. Interviews documented that during the evaluation period any proposed willful violation was reviewed by the Chief Administrative Officer and legal counsel, and those were usually reclassified. Through IMIS reviews the team determined that only one willful violation was approved in Nevada in FY 2007 and one in FY 2008.

Four (4) inspections out of the 23 reviewed were identified as having union representation. Two (2) of the four (4) inspections did not have union representation at the opening; three (3) of the four (4) inspections did not have union representation at the closing conference; and three (3) of the four (4) inspections did not have union representation at the informal conference. No documentation in the files indicated that the union representatives were notified of these activities or afforded the opportunity to participate.

Interactions with union representatives varied; some interviewees indicated that they spoke with union representatives; others would simply mark the file as a union facility and annotate the local's number. Page I – 20 of 93 of the NOM states “The SHR/IH will determine as soon as possible after arrival whether the employees at the worksite to be inspected are represented and, if so, will ensure that employee representatives are afforded the opportunity to participate in all phases of the workplace inspection.” Page I -27 and 28 of 93 of the NOM states, “At the conclusion of an inspection, the SHR/IH will conduct a closing conference with the employer and the employee representatives, jointly or separately, as circumstances dictate. The closing conference may be conducted on site or by telephone as deemed appropriate by the SHR/IH.” Investigator interviews also found that copies of citations are not mailed to union representatives unless they requested the information. Page III-4 of 93 of the NOM states, “Citations will be mailed to employee representatives and any employee upon request.”

Eighteen (18) of the 23 (78%) files did not include contact information such as home addresses and/or phone numbers of exposed workers. Interviews with Nevada OSHA investigators and supervisors revealed that worker contact information is entered only on the OSHA 1A, Narrative Report to assist administrative personnel with Freedom of Information Act Requests. The contact information included on the OSHA 1A, Narrative Report many times only included the worker's name and phone number, but no home address.

All files contained written interview statements signed by the worker in accordance with the NOM. The written statements did not include the NOM-required ending language for interview statements. Page I-26 of 93 states, “The statements will end with wording such as: ‘I have read the above, and it is true to the best of my knowledge.’ The statement will also include the following: ‘I request that my statement be held confidential to the extent allowed by law.’ The individual, however, may waive confidentiality. The individual will sign and date the statement and the SHR/IH will then sign it as a witness.”

None of the 23 files contained documentation indicating that workers were informed of their discrimination rights when being interviewed. The Inspection Checklist (1) does contain a statement under Walk around Procedures that states, "Private interviews may be held with employees (Explain NRS 618.445 Discrimination)." Investigator interviews indicate that they provided discrimination rights information to workers being interviewed, but they include no documentation in the interview statement or file to indicate that discrimination rights were discussed with the worker.

Twenty-one (21) of 23 fatality case files did not contain copies of OSHA's Form 300, Log of Work-Related Injuries and Illnesses (OSHA 300) or indicate that the information had been entered into the IMIS system. Although copies of the OSHA 300 Logs were missing from case files, investigators coded in the optional information box indicating that OSHA 300 Logs had been reviewed. During interviews investigators indicated that they only look at the logs if the logs have not been reviewed in the last two or three years, on comprehensive inspections, fatality inspections and complaint inspections where injuries have occurred. The July 1, 2004 version of the NOM states on Page I – 23 of 93, "As appropriate, the SHR/IH will review the injury and illness records to the extent necessary to determine compliance and identify trends. Other OSHA programs and records will be reviewed at the SHR/IH's professional discretion as necessary." The NOM conflicts with guidance in OSHA Instruction, CPL 02-0.131, Recordkeeping Policies and Procedures Manual, which Nevada adopted on January 1, 2002. Section II.A. of the directive states, "All CSHOs (Compliance Safety and Health Officers) on all inspections must review and record the establishment's injury and illness records for the three prior calendar years."

In two (2) of the 23 (9%) case files, the OSHA 300 logs contained deficiencies in Column F (Description of injury or illness, parts of body affected, and object/substance that directly injured or made person ill). The files contained no documentation that the deficiencies were discussed with the employer, and no citations were issued.

Four (4) of the 23 (17%) case files included documented hazards that were not addressed as citations, Notices of Violation (NOVs) or hazard alert letters. Nine (9) hazards were identified but not addressed. One multi-employer case contained documentation that the general contractor could have been issued a citation as the creating employer, yet no citation was issued. Some of the hazards identified included no personal protective equipment, no fail-safe for connectors when pressurized, no ground-fault circuit interrupters at wet locations, skylights not guarded, and ladder used to access roof not secured.

Nine (9) fatality cases included informal conferences. The SHR/IHs attended four (4) of the nine (9) conferences or 44%. Interviews with the SHR/IHs revealed that they are expected to be in the field, but on major cases or cases with significant issues management will invite the SHR/IH to attend. During informal conferences, 6 of 61 (10%) violations were withdrawn. All but two case files included the reasons for withdrawal.

Nevada OSHA implemented a procedure in 1980 which allowed compliance officers to issue a Notice of Violations (NOV) in lieu of citations for certain other-than-serious violations to expedite inspections and concentrate resources on serious violations NOV's were implemented. NOV's are issued on-site with no monetary penalties if the employer agrees to abate the violation and not file a notice of contest. Notice of Violations (NOV) are presented to the employer and signed on site during the inspection. Investigator interviews showed that the employers have been complaining that the NOV's issued are misleading and misrepresented by Nevada OSHA. Employers are unclear about whether NOV's are citations because they appear on the Internet as other than serious violations.

Conclusions and Recommendations

Conclusion I-1: Case files were not organized in a uniform manner and by a means which would reduce the possibility of important case file documentation being lost or misplaced.

Recommendation I-1: Provide clear guidance to all enforcement personnel on the organization of case files. It is recommended that correspondence not be filed throughout the investigative file but in one specific location in the file. This 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.

Conclusion I-2: The OSHA Case File Cover Sheets did not provide a ready record and summary of all actions relating to a case.

Recommendation I-2: The Case File Cover Sheet must be used in accordance with the NOM or a Diary Sheet should be added to ensure that all communications are documented in the case file.

Conclusion I-3: Families of victims are not always contacted when a fatality investigation is initiated and no additional communication is initiated by Nevada OSHA once the investigation has begun.

Recommendation I-3A: In accordance with the NOM, and the new Nevada Senate Bill 288, "families of victims should be contacted soon after the initiation of the investigation and provided timely and accurate information at all stages of the investigation."

Recommendation I-3B: We suggest communication with families when the investigation is initiated, when citations are issued, when informal settlement agreements are signed, when the case is contested and when the case is closed. We also suggest a clear policy be developed indicating who should sign the initial correspondence to the family and any additional correspondence. Additionally, a tracking system should be developed and implemented to help ensure that required correspondence is sent to families of victims.

Conclusion I-4: The IMMLANG policy is not consistently followed.

Recommendation I-4: Review the current IMMLANG policy and make a determination regarding whether Nevada OSHA will adopt the policy. Once the decision has been made, ensure that all management and employees are informed of the policy and that the policy is consistently followed.

Conclusion I-5: Willful violations are discouraged because of lack of management and legal counsel support.

Recommendation I-5: 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 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.

Conclusion I-6: Union representation is not always present for opening, closing and informal conferences.

Recommendation I-6: Nevada OSHA must follow its current procedures and ensure that union representatives are provided the opportunity to participate in opening conferences, closing conferences and informal conferences.

Conclusion I-7: Copies of citations are only mailed to union representatives when they request the information.

Recommendation I-7: Ensure that all union representatives are informed that they must request copies of citations or no copy will be sent to them.

Conclusion I-8: Files do not contain employee contact information such as home phone numbers and mailing addresses.

Recommendation I-8: Worker contact information must be obtained for all workers interviewed and exposed to hazards. This information will provide accessibility to witnesses for contested cases and ensure that information is maintained in the event that a discrimination complaint is filed.

Conclusion I-9: OSHA 300 information is not obtained for the previous three years and entered into the IMIS system as required by OSHA Instruction CPL 02-0.131.

Recommendation I-9: Nevada OSHA must reconcile those differences between the NOM and OSHA Instruction CPL 02-0.131. Once those differences have been reconciled, employees must be trained on current policy and be provided copies of current policy documents.

Conclusion I-10: All hazards identified were not addressed as citations, notices of violations or hazard alert letters.

Recommendation I-10: All hazards identified during inspections must be addressed. Case files must be reviewed more thoroughly including review of photographs for hazards not identified or addressed by the investigators.

Conclusion I-11: The NOV policy is confusing to employers.

Recommendation I-11: Nevada OSHA must review its NOV policy, and if the policy is continued, make modifications necessary to eliminate confusion for employers and clarify the difference between NOVs and Other-Than-Serious violations. Once the policy has been reviewed and changes are made regarding the policy, compliance officers must receive training on how to convey this information to employers.

II. Complaints About State Program Administration (CASPs)

This evaluation included a review of Nevada OSHA responses and implementation of corrective actions for CASPs received between January 2007 and April 2009. The CASPs relate to 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.

The review consisted of the Federal OSHA information, Nevada OSHA information, and affected case files. This review focused on the CASPA allegations, Federal OSHA findings, Nevada OSHA's response, and changes Nevada OSHA implemented based on the Federal OSHA recommendations. All CASPA letters and responses were found to be timely.

The Orleans Hotel and Casino

CASPA Allegation: Nevada OSHA issued untimely citations; citations were not issued within the six-month statute of limitations.

Region IX Recommendation: Nevada OSHA should review its current procedures regarding Closing Conferences and consider holding such conferences earlier in the process to provide more immediate feedback regarding inspection findings and to assure prompt hazard abatement. The State should also consider revising its procedures to more clearly describe its actual practice and submit the revision to Federal OSHA for review as a State plan change.

Nevada OSHA's CASPA Response: "Nevada OSHA closing conferences are held in a timely manner, usually within 24 days of the opening conference, and we feel this is adequate. Hazards noticed during a walkaround inspection are imparted to the employer/employee representatives at the time of the inspection and discussed with the employer and covered at the closing conference."

Findings

The Orleans case citation was in fact issued beyond the six-month statute of limitations and in the initial CASPA investigation it was determined that this was not a violation of the law since both parties agreed to go beyond the six-month statute of limitations and this verbal agreement was a binding legal agreement reached between the parties. Since that time, all citations have been issued within the six-month statute of limitations.

One case citation was issued close to the expiration of the six-month limitations period, but all other case citations were issued well before the six-month statute of limitations period expired. Closing conferences are held well before the six-month deadline. The average lapse time (time between opening conference and citation issuance) for fatality case files initiated between January 1, 2008 and June 1, 2009 was 55 days. Investigator interviews indicated that they convey hazards to the employer before exiting the facility and then a more formal closing conference (usually in the Nevada OSHA offices) is held once the citations are written and reviewed by the Supervisor. Union workers are usually not contacted by Nevada OSHA to afford them the opportunity to participate in closing conferences.

CASPA Allegation: Nevada OSHA issued citations classified as “serious” (rather than “willful” or “repeat”) although Boyd Gaming Corporation, owner and operator of the Orleans Hotel, had been previously cited for substantially similar conditions/hazards at other properties.

Region IX Recommendation: Nevada OSHA should review its procedures and consider evaluating potentially willful violations with the assistance of counsel before issuance and before any repeat citation when appropriate. Courts have unanimously held that a willful violation of the OSH Act constitutes “an act done voluntarily with either an intentional disregard of, or plain indifference to, the OSH Act’s requirements.” *Bianchi Trison Corp v. Chao*, 409 F.3d 196, 208 (3d Cir. 2005). Under the accepted definition of willful, “actual malice is not required.” *Kaspar Wire Works, Inc., v. Secretary of Labor*, 268 F.2d 1123, 1127 (D.C. Cir. 2001). A repeat violation is established when the employer was previously cited for a violation of the same regulation or condition, or one that is substantially similar in terms of the hazard to which workers were exposed, and the prior citation has become final before the occurrence of the alleged repeated violation. *See Potlatch Corp.*, 7 BNA OSHC 1061, 1063, 1979 CCH OSHD ¶ 23,294 (No. 16183, 1979); *Manganas Painting Co. v. Secretary*, 273 F.3d 1131 (D.C. Cir. 2001)

Nevada OSHA’s CASPA Response: “As stated in your letter, Nevada OSHA conferred with its legal counsel, however, what your investigator did not ascertain was that legal counsel was involved within the first 3 weeks of the investigation and subsequently throughout the investigation. When counsel found that certain evidentiary statements from the initial investigation conflicted, he personally extended the time for evidence gathering. He re-interviewed some witnesses and took three depositions which were not obtained in the first investigation. This need to reinvestigate was a primary reason final settlement was somewhat delayed. Therefore, legal counsel was involved at the early part of the investigation.”

Region IX Recommendation: Nevada OSHA should consider revisiting its procedures to ensure that senior professional staff who are familiar with the investigation and conversant with technical compliance issues are available to participate in the resolution of significant and complex cases whenever possible. In the present case, for example, Nevada could have made the permanent Chief Administrative Officer (CAO) available for a brief period in order to assist in the resolution of this high profile, double-fatality accident case.

Nevada OSHA's CASPA Response: "The acting Nevada OSHA CAO, a part of the final settlement "team" at the Division of Industrial Relations (DIR) was, in fact, a Safety Supervisor for Nevada OSHA. He has had extensive OSHA training and experience."

Findings

Integrated Management Information System (IMIS) reports were analyzed regarding willful violations issued and sustained during FY 2007 and FY 2008. Two willful violations were proposed in FY 2007 and one was sustained. Only one (1) willful violation was issued in FY 2008, however, it was reclassified during settlement. Interviews with supervisors and SHR/IHs lead the team to believe that willful violations are discouraged and not supported. One company has been issued repeat violations for 1926.652(a)(1) four (4) times between 3/4/2008 and 1/27/2009. They have been issued two (2) repeat violations for 1926.651(c)(2) during the same timeframe and were not evaluated for willful violations.

CASPA Allegation: Nevada OSHA negotiated a settlement with Boyd Gaming Corporation before any citations were issued.

Findings

Since the Orleans case no additional cases were identified where pre-citation settlement conferences were held.

CASPA Allegation: The settlement agreement signed by Nevada affords Boyd Gaming Corporation the benefit of inclusion into Nevada's Safety and Health Achievement Recognition Program (SHARP) along with limited enforcement inspections; SHARP is typically reserved for small employers who operate an exemplary safety and health management program.

Region IX Recommendation: Nevada OSHA should carefully review documents or agreements in all future settlements to remove any potential ambiguity. The State should continue to ensure that consultation services to Boyd do not adversely affect the provision of consultative services to small employers. Nevada should consider the appropriateness of the use of Consultation services as a tool in future settlement agreements.

Nevada OSHA's CASPA Response: "Boyd requested help from the Safety Consultation and Training Section (SCATS) and is currently receiving training and program advice as well as inspection services. As stated earlier, Boyd has hired a safety consultant and spent over two million dollars in improvements and training to improve the safety and health culture in their nine properties.

"As you know, the hotel/casino industry is included with construction and manufacturing as part of our Nevada OSHA Strategic Plan.

"We are in the process of reviewing the Nevada OSHA Operations Manual (NOM) in those areas mentioned in your investigative report; however, changes to our NOM will not be proposed until such time as we receive your revised FIRM and have compared the two documents to ensure consistency."

Findings

Boyd Gaming currently does not have any facilities in the SHARP program. They have hired corporate and site safety personnel. The first annual review of the settlement agreement has been completed. Notes regarding the first annual review were written but were not included in the case file. Nevada OSHA is in the process of reviewing CPL 02-00-148 Field Operations Manual and will be revising its NOM.

Luxor Hotel and Casino

CASPA Allegation: The complainant was not sent a letter: (a) describing the investigative findings and why they did not result in a violation, (b) advising the complainant that a request for further investigation can be made if the findings of the investigation are disputed, or (c) informing the complainant of his rights for an informal review under Nevada Revised Statute, NRS 618.435.

Region IX Recommendation: None. As per the Nevada Operations Manual, "After an investigation of a complaint by inspection, by letter or phone/fax, the District Manager/Supervisor will send a letter to the complainant within 30 days." However, the Operations Manual also states, "A letter to the complainant is not required for anonymous employee complaints or when the address of the complainant is unknown." Since Nevada OSHA received an anonymous **Notice of Safety or Health Hazards**, Federal OSHA finds that Nevada OSHA responded to the complaint in accordance with their policies and procedures. No recommendation is warranted.

Findings

Interviews revealed that Nevada OSHA employees ask complainants for their name and phone number if they want to leave it. They do not always ask for the address. This differs by investigator. One thing that does not differ by investigator – they do not inform complainants of their discrimination rights unless the complainant alleges some type of discrimination. If the complainant alleges some type of discrimination, then they

will discuss discrimination rights with the complainant. The lack of discrimination right discussion could be a deterrent to complainants regarding leaving their name and might also endanger their discrimination rights because they could not prove that they called OSHA and filed the complaint. Pages I-6 and I-7 of 93 of the NOM states, “b) explain the complaint process and how complaints are investigated. d) Inform the complainant about confidentiality, and e) explain the complainant’s discrimination rights under the law.”

This CASPA dealt with notification of complainants. A review of IMIS information found that letters were only mailed to complainants who filed a formal complaint. Fifty-five percent (55%) of the complaint inspections initiated between January 1, 2008 and June 1, 2009 were anonymous complaints. Page I-12 of 93 of the NOM states, “Special Investigation to the Complaint. After an investigation of a complaint by inspection, by a letter or phone/fax, the District Manger/Supervisor will send a letter to the complainant within 30 days.” “The complainant will also be informed of his or her right for an informal review under NRS 618.435.” “A letter to the complainant is not required for anonymous employee complaints or when the address of the complainant is unknown.” This guidance appears to have a direct correlation to the number of anonymous complaints and information requested by SHR/IHs taking complaints.

Nevada OSHA adopted OSHA Instruction CPL 02-00-140, Complaint Policies and Procedures, identically on September 1, 2006. The complaint directive states that as appropriate, OSHA will describe the complaint process to the caller and if appropriate, the concepts of an “inquiry” and “inspection” as well as the relative advantages of each. If the caller is a current employee or representative of the employees, OSHA will explain the distinction between a formal complaint and a non-formal complaint and the rights and protections that accompany filing a formal complaint. The rights and protections include a) the right to request an on-site inspection b) notification in writing if an inspection is deemed unnecessary because there were no reasonable grounds to believe that a violation or danger exists and c) the right to obtain review of a decision not to inspect by submitting a review for request in writing.

OSHA Instruction CPL 02-00-140, Complaint Policies and Procedures, also states that if appropriate, OSHA should inform the complainant of their rights to confidentiality in accordance with Section 8(f)(1) of the Act, for private sector employees, and ask whether the complainant wishes to exercise this right. When confidentiality is requested, the identity of the complainant is protected regardless of the formality of the complaint. OSHA is to explain Section 11(c) rights to private sector employees.

CASPA Allegation: Nevada OSHA did not conduct an adequate investigation – When the complainant called Nevada OSHA to find out about his complaint, he was informed by the safety specialist who conducted the inspection that no employees would talk to him about the catwalks during his investigation and there was nothing he could do because nobody would come forward.

Region IX Recommendation: The Nevada Operations Manual indicates that past employee exposure may serve as a basis for a violation, but only if it had occurred within

the previous six months. The case file indicates that union officials were not present and interviewed during the course of the inspection; statements by these officials may have revealed recent worker exposures.

Potential worker exposures must also be addressed. Due to the fact that fluorescent lighting, emergency lighting and the HVAC system are located above the catwalk and would have to be maintained, there is reason to expect potential exposure. The case file does not reveal that Nevada OSHA received the employer's assurance that employees would not be allowed to access the catwalk.

Although the Nevada Operations Manual only requires photos to be included in a case file when used to document a violation, Federal OSHA recommends that Nevada OSHA consider including photos to also document potential hazards.

A review of the case file revealed that notes in the case file mention there was also a missing handrail on the 28th floor but no further description is given.

Federal OSHA finds that Nevada OSHA did not conduct the inspection in accordance with its policies and procedures. We understand you have scheduled a new inspection at this hotel and casino. Please send us the results of that inspection so that we can close out this file.

Nevada OSHA's CASPA Response: (Nevada conducted a follow-up inspection and provided a copy of the State's case file to the Region.)

Findings

A review of the second inspection case file related to the Luxor CASPA showed that two sets of workers were interviewed together. Workers should be interviewed privately. The NOM Page I-25 of 93 states, "NRS 618.325 authorizes the SHR/IH to question any employee privately during regular working hours in the course of an OSHA inspection."

Union stewards were involved in the follow-up inspection. It was documented in the narrative of the file that the employer assured Nevada OSHA that the necessary steps would be taken to ensure employee protection prior to any employee working in the area to change a light bulb or work on any part of the HVAC system or plumbing, perform any paint work or perform carpentry work.

Interview statements in the Luxor file, fatality files or settlement files did not contain language required by the NOM. Page I-26 of 93 of the NOM states, "The statements will end with wording such as: 'I have read the above, and it is true to the best of my knowledge.' The statement will also include the following: 'I request that my statement be held confidential to the extent allowed by law.' The individual, however, may waive confidentiality. The individual will sign and date the statement and the SHR/IH will then sign it as a witness." Employee statements were signed by the employees but not always witnessed by the SHR/IH.

Conclusions and Recommendations

Conclusion II-1: See Conclusion I-5.

Recommendation II-1: See Recommendation I-5.

Conclusion II-2: Notes of the first annual review of the Orleans settlement agreement were written but not included in the case file.

Recommendation II-2: All notes and case file documentation must be included in the files and not kept on individual computers. This will ensure that files are effectively evaluated for abatement, debt collection, contest and any other actions being taken on the file.

Conclusion II-3: Through employee interviews it was determined that Nevada OSHA employees do not inform complainants of their discrimination rights unless the complainant alleges some type of discrimination and they do not always ask for the complainant's address.

Recommendation II-3: Nevada OSHA must follow established complaint procedures to ensure that 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 don't allege discrimination at the time of the call.

Conclusion II-4: During a review of IMIS information, it was found that letters were only mailed to complainants who filed a formal complaint.

Recommendation II-4: The process outlined in the NOM and OSHA Instruction CPL 02-00-140 must be followed with regard to letters sent the complainant.

Conclusion II-5: The second inspection case file for Luxor showed that two sets of employees were interviewed together. Nevada regulations authorize the SHR/IH to question any employee privately during regular working hours in the course of an OSHA inspection.

Recommendation II-5: Ensure that interviews are conducted privately and that they cover the required information discussed in the current NOM.

Conclusion II-6: Interview statements in the Luxor file, fatality files or settlement files did not contain language required by the NOM.

Recommendation II-6: Ensure that interview statements are taken, and documented, in accordance with the NOM.

Recommendation II-7: 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.

Conclusion II-7: Nevada OSHA should review its procedures and consider evaluating potentially repeat violations with the assistance of legal counsel.

III. Integrated Management Information System

A thorough review of the management of the Integrated Management Information System (IMIS) in Henderson and Reno, as well as the reports available through IMIS, was conducted to determine the effectiveness of Nevada OSHA's information management programs.

IMIS Management

Findings

All transmissions to the host computer (e.g., End-of-Day [EOD] and Start-of-Day [SOD]) are conducted on a daily basis. In addition, system backups are performed daily. It was noted and verified during interviews that the monthly backup was performed daily rather than conducting daily, weekly and monthly backups individually. This is done because the IMIS has been experiencing technical difficulties due to the age of the hardware, and thus, the Systems Administrators are performing monthly "dumps" where the entire system structure (e.g., databases, system files, etc.) is being backed up every single day. This was found to be an effective way of securing data in case of system and/or electrical failure.

With regard to the maintenance of data forms, it was noted that both offices have a significant number of draft/incomplete records. Excluding OSHA-1B citation worksheets created within the past six months (which is the statute of limitations for issuing citations) and which may remain in draft until citations are issued, the Henderson office had 100 draft forms that should have been finalized in order for these forms and their data to be transmitted to the host computer in Washington, D.C. In the Reno office, there were 3,505 draft forms that should have been finalized, including over 2,300 OSHA-1 Inspection Records. Most of these inspection records were found on the Internet and Intranet, indicating that although the forms were found in draft format in the Reno IMIS database, the forms had been finalized, submitted and accepted at the host computer but somehow were reclassified as draft at the Reno location. Many of these forms have not been accessed since 2004. With this large number of old Inspection records in draft it would make it impossible to look at the draft forms and determine if there were inspection records that need to be finalized. Possible causes for the old draft forms could have been a system crash where an old backup tape may have been used to reload the database where these forms were still in draft format. The following table outlines the form types and numbers found in draft format in both systems:

Form Type	Henderson IMIS	Reno IMIS	Total
OSHA-1 - Inspection Record	18	2,332	2,350
OSHA-1B – Citation Worksheet <i>(beyond the six-month statute of limitations from the report run date)</i>	51	1,071	1,122
OSHA-170 – Accident Investigation Summary Report	0	4	4
OSHA-36 – Accident/Event Report	1	2	3
OSHA-7 – Complaint Report	2	3	5
OSHA-90 – Referral Report	0	6	6
OSHA-31 – Program Activity	28	87	115
Totals	100	3,505	3,605

With regard to the handling of forms rejected by the host computer in Washington, D.C., the Reno system had six recently rejected forms while Henderson did not have any. Those forms rejected at the Reno location were being handled expeditiously and no deficiencies were noted in the handling of the rejected forms by the Nevada OSHA program.

IMIS Management Reports

Findings

A review of the local management reports menu system was made to determine if the Nevada OSHA management team has a system for review of the most widely used management reports. The time period used for these reports is January 1, 1980 (beginning of the database system) through June 1, 2009 (the last date for this special study time frame) with the exception of the Area Office Complaint Log - Auditing Report, which ran from January 1, 2008 through June 1, 2009, the time frame range for this special study. This time frame was selected because the IMIS system is a historical tracking program and many items left behind for multiple years may have a serious effect on the overall performance and reliability of the information management system. A historical Complaint Audit Log report is lengthier than the one reviewed; however, this time frame was used to obtain a “snapshot” of the agency’s handling of complaint responses.

It was noted that most reports are not being used effectively nor are they set up in the system for automatic generation and distribution. In discussions with management, it became clear that they are not familiar with most of the management reports available in the system to effectively monitor and control the flow of agency operations. This has also been evidenced by the individual review of these reports where significant deficiencies were noted and are explained below:

Complaint - Employer Response Due Report – This report lists all complaint inquiries where the employer’s response to OSHA’s request to investigate the complaint allegations has not been received. This report is available for use by management to contact the employer and remind them that their abatement response is past due or to

schedule the complaint for an inspection due to the lack of response. The Reno office's report lists four cases past due – three over five years old and one case more than 13 years old. The Henderson office's report lists 74 cases past due – 10 of these cases have been past due since 1996, and 14 since 1997.

Complaint – OSHA-7 for Signature – This report lists all complaint inquiries where the employee's requested signature has not been received. This report is available for use by management to contact the employee and remind them that their signed complaint form is past due, or maintain the "non-formal" classification due to the lack of the employee's signature and process the complaint as an inquiry. The Reno office's report did not show any past due cases while the Henderson office's report shows four cases past due with one case being over three months past due. An inspection was conducted for this complaint but the complaint was not properly linked to the inspection record.

Unsatisfied Activity Report – This report lists all complaint, referral and accident/event records that have been selected for an inspection yet no inspection has been initiated. In the Reno system, six complaints and five referrals were listed, all within the past two weeks of the report run date, which is within normal range. In the Henderson system, 11 complaints and eight referrals were listed, all within the past 20 days of the report run date, also within the normal range.

Citations Pending Report – This report lists all open inspections where the citations have not been issued. This report is available for use by management to track the six-month statute of limitations for issuing citations. In the Reno system, 33 cases were listed with an opening conference date beyond 180 days with no citations issued. In fact, these cases show the number of days open, ranging from 318 days to 3,853 days. An additional 12 cases were listed without an opening conference date, thus making it impossible to determine the six-month statute of limitations date for the issuance of citations. In the Henderson system, 11 cases are listed with an opening conference date beyond 180 days and no citations issued. These cases show the number of days open, ranging from 364 days to 2,876 days. An additional five cases were listed without an opening conference date.

Violation Abatement Report – This report lists all cases with abatement past due for specific violations and is available for use by management to contact the employer and remind them of their past due abatement, or schedule a follow-up inspection because of the lack of the employer's abatement response. The Reno office's report listed 73 cases showing past due abatement, with 28 cases ranging from less than one month to nine months past due and 45 cases ranging from one year to up to nine years past due. Two cases over seven years past due had willful violations issued and yet the report shows the violations as unabated (Inspection # 304597719 and #305058943). In the Henderson office's report, 34 cases showing past due abatement; 24 of these cases were less than one month old. The remaining cases ranged from one month to up to nine years past due.

Open Inspection Report – This report lists all open inspections for each office. For internal audit purposes, this report can be reviewed to determine if case file management is being handled properly. The review will identify all cases that have all abatements

completed and all penalties paid, so the cases can be effectively closed on the IMIS system. In the Reno office's report, 107 cases were found to have all abatements completed. A case audit report was run for each case, and 31 of the 107 cases, or 29%, were found to have both completed abatements and penalties paid. These cases should have been closed. Of the 31 cases, 13 should have been closed in 2009. The remaining 18 cases should have been closed between 2001 and 2008.

In the Henderson office's report, a total of 169 cases were found to have abatements completed. After running individual case audit reports for each case, it was noted that only two (2) cases were found to have abatements completed and penalties paid and thus were ready for closure.

Forty (40) cases on the Henderson report were shown to have abatements completed although the citations were still in draft format. After further review of this observation several cases were found to have entries for notices of contest and Petitions to Modify Abatements (PMAs) issued while the citations remained in draft.

During the interview process, it was found that the Henderson office's practice is to keep all OSHA-1Bs in draft format until the final order is reached, which means that they remain in draft even after the citations are issued. The rationale given to the evaluator was that the citations need to remain in draft until the final outcome of the inspection is concluded, including formal and informal settlement agreements. The Reno office does not follow this practice, which indicates that there is inconsistency in the data entry and the handling of the management systems between the two offices.

Another observation made during this review was that many violations were found where the abatement dates preceded the actual citation issuance date. This usually causes a system reject unless the Nevada IMIS has been modified to allow for this entry to bypass host-level validation checks. The Henderson office lists eight violation records where the abatement date was earlier than the citation issuance date while the Reno office lists 381 violations records with the abatement date earlier than the citation issuance date.

Area Office Complaint Log – Auditing Report – This report lists all complaints for a specific period of time and is available for use to ensure that complainants are notified of the results of the inquiry or inspection. Two separate reports were generated in each office, one for complaint inquiries and one for complaint inspections.

Complaint Inquiry Reports - In the Reno office, 15 complaint inquiries were listed with all complainants coded as anonymous, meaning that the complainant's name and address are unknown or not entered into the IMIS database. Of these 15 cases, six had a letter sent to the complainant with the results of the inquiry, which indicates that the office staff is not entering the complainant's identifying information in the OSHA-7, Complaint Report, into IMIS. Also identified were three complaint inquiries still open, dating back to December 2008 and January 2009, with no action taken by the office staff.

In the Henderson office, 338 complaints were handled by inquiry. In addition, 222 (66%) of these complaints did not contain the complainant's name and address, 41 cases having

name and phone number only and 24 cases having name only in the IMIS database. In 25 cases, the complainant's name and address were found in the OSHA-7; yet, the office did not inform the complainant of the results of the inquiry. Furthermore, it was noted in 12 cases that the Letter H (Inspection Results) was issued instead of the more appropriate Letter G (Employer's Response to Complainant). In another case, the employer did not respond to the complaint; yet, the complaint was closed anyway with no comments in IMIS indicating why the complaint was closed without the employer's response.

Complaint Inspection Reports - In the Reno office, 140 complaint inspections were listed with 138 (98.5%) noted as anonymous. Of the 140 cases listed, only 21 complaint records were noted as having a Letter H (Inspection Results) sent to the complainant. Of the 21 cases, 19 did not have the complainant's name and address in the OSHA-7 record, indicating that the Reno staff members were not entering the complainant's identifying information into IMIS, even when the information is obtained.

In the Henderson office, 541 complaint inspections were listed with 295 (55%) noted as anonymous, 91 cases having name and phone only and 30 cases having name only. Of the 541 cases listed, 69 cases with the complainant's name and address in IMIS did not have the Letter H (Inspection Results) recorded in the IMIS database. Page I-11 of 93 of the NOM states, "After an investigation of a complaint by inspection, by a letter or phone/fax, the District Manager/Supervisor will send a letter to the complainant within 30 days. A total of 55 cases were noted with the Letter H in the IMIS database. Interviews indicated letters are only sent to complainants who file a formal complaint.

A random review of case files revealed that some complaints had no complainant contact information entered into the IMIS system. These files did not contain documentation as to why the office did not attempt to obtain the complainant contact information. Cases that contained the name and phone number had no documentation of any further attempts by the agency to obtain the additional mailing information for the complainant. The files contained no information showing that complainants requested to remain anonymous. Investigator interviews revealed that several investigators were attempting to obtain mailing information while other investigators indicated they were instructed not to obtain this information. It was also determined that Nevada OSHA does not provide complainants with their discrimination rights unless they allege some type of discrimination while filing the complaint. Neither case file reviews nor interviews indicated that agency personnel explain to complainants that by providing contact information, Nevada OSHA would be able to contact them and provide feedback on the results of the investigation. For all complaints other than formal complaints Nevada OSHA relies on complainants to contact them versus Nevada OSHA contacting the complainants.

Debt Collection Report – This report lists all cases with outstanding penalties that require action by the office. This report is available for use by management and/or administrative staff to pursue the collection of penalties and refer cases to the Administrative Services Unit (ASU) for collection when local collection attempts fail. In the Reno office, 68 cases were listed with past due penalties. Of these 68 cases, 66 did not have a Penalty Due Date, which is crucial in the pursuit of debt collection. Without a

penalty due date in the IMIS, it is extremely difficult to track, pursue and refer outstanding penalty cases to ASU. An additional five cases with the penalty due dates in the IMIS were noted where no action was taken since 2007 and 2008.

In the Henderson office, 13 cases were listed with six (6) of those cases missing the penalty due date in the IMIS. Of the remaining seven (7) cases, one (1) was up-to-date and under a repayment plan, and six (6) cases appear had no action taken, some dating back to 1998 and 2001.

Conclusions and Recommendations

Conclusion III-1: Nevada OSHA offices have a significant number of draft and incomplete records on the IMIS system.

Recommendation III-1: Nevada OSHA must perform a review and cleanup of the IMIS database records to ensure that all draft forms are finalized and transmitted to the host computer as expeditiously as possible, except for OSHA-1Bs less than six months old, because they may still be modified before the citations are issued. A system must be developed to ensure that periodic reviews of draft and rejected IMIS forms are conducted to maintain a viable information system.

Conclusion III-2: The majority of IMIS management reports are not being used effectively nor are they set up in the system for automatic generation and distribution.

Recommendation III-2: Nevada OSHA must establish a comprehensive system for the proper handling of the IMIS management reports system. An automated report setup program will assist the agency in ensuring that the most widely used reports are automatically generated, reviewed and acted upon on a periodic basis (either weekly, bi-weekly or monthly) based on the importance of the specific report and its volume of cases to be reviewed and monitored.

Conclusion III-3: The IMIS system is not kept up-to-date and contains information which does not allow for effective internal evaluation of the Nevada OSHA program.

Recommendation III-3: Nevada OSHA must ensure that the IMIS system is kept up-to-date and is accurate. Nevada OSHA needs extensive IMIS training to include: review of OSHA Instruction ADM 1-1.31 IMIS Enforcement Data Processing Manual, data entry (all forms), pre- and post-citation processing, handling of incomplete (draft) and rejected forms and IMIS Management reports processing to effectively improve and maintain an effective IMIS Maintenance and Management Reports structure.

IV. General Inspection Statistics

A statistical review of the Nevada OSHA Program was conducted using the IMIS Micro-to-Host Inspection #8 and Enforcement #8 reports and a comparison was made against several monitoring measures from the State Activities Mandated Measures (SAMM) Report and the State Interim Report (SIR). During the evaluation period of this study (January 1, 2008 through June 1, 2009), the Nevada OSHA Program conducted 3,917 inspections: 1,193 in the Reno office and 2,724 in the Henderson/Las Vegas office.

General Statistical Review

Findings

Of the 3,917 inspections conducted by the State of Nevada, 2,965 (76%) were safety-related while 952 (24%) were health-related. Total programmed inspections were 2,117 (54%) while total unprogrammed inspections were 1,800 (46%).

The 1,800 unprogrammed inspections were comprised of the following: 89 accident³ investigations, 678 complaint inspections, 647 referral inspections, 55 follow-up inspections and 331 unprogrammed related inspections. No monitoring or variance inspections were conducted during this period.

When breaking out the inspections by industry, a significant number were construction-related with 2,569 (66%) inspections. The remaining inspections were conducted at manufacturing facilities (186) or “other” categories, such as hotel and service industries (1,161) and maritime (1). The Nevada State Plan applies to all public and private sector employers in the State, with the exception of private sector maritime as stated in 29 CFR 1952.295.

A total of 3,840 inspections were conducted at private sector establishments, and 77 inspections were conducted at public sector agencies.

Programmed Inspections

Findings

Of the 2,117 programmed inspections, 2,033 were coded as programmed [planned] while only 84 were coded as programmed-related. Nevada Operations Manual, Page I-3 of 93 states: “Programmed Related. Inspections of employers at multi-employer worksites whose activities were not included in the programmed assignment; such as, a low injury rate employer at a worksite where programmed inspections are being conducted for all high injury rate employers. All high hazard employers at the worksite should normally be included in the programmed inspections.” This issue was raised with the program coordinator, who indicated that he was unaware of this trend and could not determine if all 2,033 were planned and/or high hazard rate employers but considered the low number

³ Nevada OSHA enters an OSHA 36 form and codes inspections as accidents if the accidents result in a fatality(ies), or hospitalization of any number of employees with injuries/illnesses that are not fatal. Federal OSHA enters an OSHA 36 form and codes inspections as accidents only if the accidents result in a fatality(ies) or in the hospitalization of 3 or more employees.

of programmed-related inspections questionable. He indicated the need for Nevada OSHA to look into this practice and if needed, conduct proper data entry training to comply with NOM instructions.

Of the 3,917 inspections conducted during this evaluation period 2,072 inspections (52%) resulted in citations. Forty-three percent (43%) resulted in the issuance of serious violations, while 55% of the inspections resulted in the issuance of “other-than-serious” violations. This result clearly indicates that the Nevada OSHA program is in need of revamping its inspection process, especially its inspection targeting system, to refocus resources toward the most highly hazardous workplaces. This change will result in an increase of not-in-compliance (NIC) inspections with serious violations. As of the end of FY 2008, Nevada OSHA’s performance was calculated at 20.75% NIC inspections with S/W/R violations for programmed safety inspections which is less than half of the national (Federal and State data) average of 58.9% NIC inspections with S/W/R violations. For health programmed inspections, Nevada OSHA’s performance was calculated at 32.94% NIC inspections with S/W/R violations, significantly lower than the national (Federal and State data) average of 51.4% NIC inspections with S/W/R violations. These calculations are contained on the State Activity Mandated Measures (SAMM) Report, Measure #8. The State Interim Report (SIR) shows the Nevada OSHA program with a lower than federal average of Programmed Inspections with Serious Violations: SIR #C-3 shows the Safety Inspection Indicator at 26.3% for the Nevada OSHA vs. Federal OSHA at 79.6%; for the Health Inspection Indicator, Nevada OSHA has 28.5% NIC Inspections with Serious violations vs. 69.3% for Federal OSHA.

Nevada OSHA is mandated by its legislature to conduct 2900 inspections per year. This number is outlined in its budget document each year. This is 95 to 115 inspections per investigator per year, far too many per investigator to do a thorough job. The focus on simply getting a high number of inspections may lead to cutting corners. Nevada OSHA should work with the Nevada legislature to begin utilizing outcome measures instead of pure numbers of inspections. Emphasis should be placed on reducing fatalities, injuries and illnesses.

Violations per Inspection

Findings

When reviewing the actual number of violations cited, Nevada OSHA issued a total 4,829 violations with 1,274 cited as serious (26.4%), 50 cited as repeat (1%), 47 cited as failure to abate (1%) while 3,458 violations were cited as “other-than-serious” (71.6%). Case file reviews and employee interviews revealed that Nevada OSHA has been in the practice of grouping serious violations that should have been cited individually. Nevada OSHA groups violations based on the location of the standard in the code of state regulations rather than by the individual hazardous conditions. Issuing citations based on individual hazardous conditions more effectively removes workers from hazards. Based on information contained in SAMM Measure #9 for FY 2008, Nevada OSHA issued 0.84 serious/willful/repeat/unclassified violations per inspection compared to the 3-year national average (Federal and State data) of 2.1 violations per inspection. Page II-11 of

93 of the NOM states, “Grouping Related Violations – The following situations normally call for grouping: When the SHR/IH believes violations classified either as serious or other-than-serious are so closely related as to constitute a single hazardous condition.”

Willful Violations

Findings

Only one willful violation was cited by Nevada OSHA during the evaluation period. The last four willful violations cited by Nevada OSHA and final resulting outcomes were:

- Inspection # 302709993 – Willful cited for 1926.501(b)(1) – Fall Protection – Unprotected sides and edges – on May 14, 1999. This citation was upheld with a penalty reduction from \$28,000 to \$7,767.56 on July 21, 2008 by a formal settlement agreement (Review Board).
- Inspection # 309412567 – Willful cited for 1910.132(a) – Personal Protective Equipment – on May 15, 2006. This citation was upheld with a penalty reduction from \$49,000 to \$19,600 on June 29, 2006 by a formal settlement agreement (Review Board).
- Inspection # 310576632 – Willful cited for 1926.501(b)(11) – Fall Protection – Steep roofs – on March 1, 2007. This citation was upheld with a penalty reduction from \$49,000 to \$41,000 on March 28, 2007 by an informal settlement agreement (ISA).
- Inspection # 311830400 – Willful cited for 1926.501(b)(1) – Fall Protection – Unprotected sides and edges – on June 20, 2008. This citation was reclassified to a “Repeat” violation with a penalty reduction from \$70,000 to \$15,000 on July 17, 2008 by an Informal Settlement Agreement.

Follow-Up Inspection Statistics

Findings

The 55 follow-up inspections resulted in the issuance of 47 failure-to-abate (FTA) citations. This translates to an average of 0.85 FTA violations per follow-up inspection.

The “Candidates for Follow-up Inspections” Management Report is not being used by the Nevada management team. The Violation Abatement Report, which shows a significant number of past due abatements, in many cases with abatements past due for years, is also not being used in these offices.

Most Frequently Cited Standards

Findings

A detailed review was conducted of the most frequently cited standards by Nevada OSHA. The top 20 standards cited indicate additional hazard recognition training, both formal and on-the-job, is necessary for the compliance staff. The top standard cited was 1910.1200(e) – Hazard Communication –Written Program with 91 serious, 152 “other” and one repeat violation. This indicates that only 37.3% of these violations were cited as serious.

The second most frequently cited standard was 1910.303(b) – Electrical – Examination, installation, and use of equipment with 65 serious, and 173 “other” violations. This indicates that only 27.3% of these violations were cited as serious. This data indicates deficiencies in the breadth of the citations cited by Nevada OSHA as well as the proper classification of violations. Additional training is needed in recognition of hazards identified and standards cited as well as the classification of these citations. Construction fatalities represented 61% of the fatalities in Nevada during this evaluation period and 66% of the inspections conducted were in the construction industry.

Only 10% of the top 20 most frequently cited standards are related to the construction standards. Below is a table listing the Top 20 Most Frequently Cited Standards.

Nevada OSHA Top 20 Most Frequently Cited Standards January 1, 2008 through June 1, 2009

	Standard	Serious	Other	Repeat	Total	% Serious
1	1910.1200(e) Hazard Communication - Written Program	91	152	1	244	37.3%
2	1910.303(b) Electrical - Examination, installation, and use of equipment	65	173	0	238	27.3%
3	1910.305(g) Electrical - Flexible cords and cables	69	150	0	219	31.5%
4	618.376(1) Employer to provide employee with rights and responsibilities to promote safety in workplace; regulations - document or video tape	0	201	1	202	0.0%
5	1910.305(b) Electrical - Cabinets, boxes, and fittings	64	110	1	175	36.6%
6	1926.501(b) Fall Protection - Unprotected sides and edges	136	30	5	171	79.5%
7	618.540(1) Requirements of written safety program	0	163	1	164	0.0%
8	1904.32(a) Recordkeeping - Annual Summary - Basic Requirement	0	156	1	157	0.0%
9	1910.1200(h) Hazard Communication - Training	73	57	1	131	55.7%
10	1910.303(g) Electrical - 600 Volts, nominal, or less. This paragraph applies to electric equipment operating at 600 volts, nominal, or less to ground	39	88	0	127	30.7%
	1910.132(d) Personal Protection Equipment - Hazard assessment and equipment selection	36	79	2	117	30.8%

	Standard		Serious	Other	Repeat	Total	% Serious
11							
12	1926.405(g)	Electrical - Flexible cords and cables	17	93	2	112	15.2%
13	1910.37(b)	Egress - Lighting and marking must be adequate and appropriate	8	12	0	20	40.0%
14	618.383(1)	An employer shall establish a written safety program and carry out the requirements of the program within 90 days after it is established.	0	107	2	109	0.0%
15	1910.134(c)	Respiratory Protection Program	51	57	0	108	47.2%
16	1910.1200(g)	Hazard Communication - MSDS	34	72	0	106	32.1%
17	1904.29(b)	Recordkeeping - Forms - Implementation	0	104	1	105	0.0%
18	1910.157(c)	Fire Extinguishers - General Requirements	0	103	0	103	0.0%
19	618.540(2)	Requirements of written safety program - an employer with more than 25 employees who is required to establish a safety committee	0	87	1	88	0.0%
20	1910.178(l)	Powered Industrial Trucks - Operator Training	53	35	0	88	60.2%
		Totals	736	2029	19	2784	26.4%

Complainant's Notification of Inspection Results

Findings

With regard to SAMM #3 – Complainant's Notified Timely of the results of the Inspection, Nevada OSHA's timely response was calculated at 100% with a reference point of 100% at the end of FY 2008. Although one would tend to believe that Nevada OSHA is appropriately and timely responding to complainants with the results of the inspections, the SAMM indicator only includes OSHA-7 Complaint Records where the letter "H" was actually entered into the IMIS. If the Letter "H" was not entered into the IMIS, then these records are not included in the algorithm, making it impossible to evaluate the State's compliance with this very important requirement. There were 120 complaint inspections with no "H" letter entered into the IMIS system.

Conclusions and Recommendations

Conclusion IV-1: Fifty-two percent (52%) of all inspections resulted in citations. Of those 52%, over half of those cases (55%) resulted in only other-than-serious violations.

Recommendation IV-1: Nevada OSHA must evaluate its targeting system and make modifications to ensure that its limited resources are inspecting locations where serious hazards are present. Nevada OSHA must also ensure that violations are being classified in accordance with the NOM.

Conclusion IV-2: The focus on simply getting a large number of inspections may lead to cutting corners to meet the requirement.

Suggestion IV-2: Nevada OSHA should work with the Nevada legislature to begin tracking outcome measures instead of just pure numbers of inspections. Emphasis should be placed on reducing fatalities, injuries and illnesses.

Conclusion IV-3: Nevada OSHA groups its violations based on the location of the standards being cited in the code of state regulations rather than by the individual hazardous conditions.

Recommendation IV-3: Nevada OSHA must review its current citation grouping policies and procedures and issue citations in accordance with its NOM.

Conclusion IV-4: Only one willful violation was cited by Nevada OSHA during the evaluation period.

Recommendation IV-4: Nevada OSHA must conduct an internal review of its willful citation policy and take corrective action in order to be able to fully document and support willful violations so that they can be issued and successfully sustained/affirmed.

Conclusion IV-5: IMIS Reports are not utilized to identify cases requiring follow-up inspections to track abatement and to ensure abatement verification.

Recommendation IV-5: Nevada OSHA must begin using the “Candidates for Follow-up Inspections Report” and the “Violation Abatement Report” to identify and assign establishments that require follow-up inspections.

Conclusion IV-6: The list of most frequently cited standards shows limited hazard recognition with few hazards identified in the construction industry, which is where the majority of fatalities are occurring.

Recommendation IV-6: Nevada OSHA must review all available IMIS data reports and track the most frequently cited standards to determine what additional training, hazard recognition and case file documentation are necessary to increase the breadth of standards cited and the classification of such citations. Special emphasis should be placed on construction hazards in an effort to improve hazard recognition, which will result in workers being removed from hazards. This should be done for the agency as a whole as well as for each individual SHR/IH.

V. Complaint Processing

As a result of inconsistencies found during the review of the IMIS reports regarding complaint processing and the issues raised in the Luxor CASPA, it was determined that a review of complaint files, both complaint inquiries (without inspections) and complaint inspections, was warranted. A total of 21 complaint files (10 complaint inquiries; 11 complaint inspections) was reviewed as part of this study.

Findings

The review revealed that no diary sheets or similar daily chronological logs were found in any of the 21 case files reviewed.

There was no indication that the complainant was informed, in writing and/or recorded in IMIS, of the results of the inquiry/inspection (in cases where the complainant's name and address were on file and/or in the IMIS database) in 15 out of 21 cases (C-1, C-3, C-6, C-7, C-10, I-1, I-2, I-3, I-4, I-5, I-6, I-7, I-8, I-9, I-10). This was confirmed by CSHO interviews and discussions with administrative personnel. Nevada OSHA only sends letters for formal complaints, which conflicts with guidance in the NOM.

The incorrect response letter was sometimes used – Nevada OSHA sent letter H (Inspection Results) instead of letter G (Employer's Satisfactory Response) for complaint inquiries in 3 cases (C-2, C-8, C-9).

Discrimination rights are not provided to complainants when they file a complaint unless they allege some type of discrimination when filing the complaint. This was ascertained during interviews with investigators and supervisors.

It was noted that most complaints did not have the complainant's identifying information in the IMIS, even though in some cases in the Reno office the response letters G (Employer's Response to Complainant) or H (Inspection Results) were entered into the IMIS, indicating that the information is simply not entered into the system.

A total of 353 complaint inquiries was listed for both offices, with 302 cases or 86% not containing the complainant's complete contact information.

A total of 681 complaint inspections was listed for both offices, with 554 cases or 81% not containing the complainant's complete contact information.

The above three findings relate back to the Luxor CASPA in that Nevada OSHA did not notify the complainant of the findings of the inspection, and did not request additional information beyond the complainant's name and telephone number. Additional detailed information on these statistics can be found in the IMIS Management Reports section of this Special Study.

Inadequate abatement reports received and accepted as adequate:

- Case C-1 – The office requested the Failure Mode and Effects Analyst (FMEA) Report. They did not receive the requested report, and the company submitted documentation indicating additional security assessments/analyses for workplace violence. Nevada OSHA accepted the abatement letter as adequate.
- Case C-2 – Employer responded that safety and health and harassment training was provided but did not include any records to support this claim. Nevada accepted this response as adequate abatement.

- Case C-8 – Complainant alleged no safety and health training regarding hazards present and chemicals used at the water treatment facility. The company’s response indicated that training was provided and documented, yet no records to support this claim were submitted. Nevada OSHA accepted the company’s incomplete response and classified it as “satisfactory”.

Missed citations on complaint items:

- Case I-10 – Complainant stated that “*the project is six stories and the manlift is frequently shut down due to winds*”. Item was found ‘valid’ during the inspection, yet citations were not issued nor did any documentation provide an explanation as to why no citations were issued.
- Case I-10 – Complainant stated that “*the internal stairways contain scaffolding and are only partially handrailed*”. Item was found valid during the inspection yet no citation was issued. Inspection narrative states that “*the crossing point of the supported scaffold crossbraces in stairwell number 5 was at 52 inches. This exceeds the maximum height requirement of 48 inches and is in violation*”. A citation should have been issued for 1926.451(g)(4)(xv).
- Case I-10 – Complainant stated that there are floor openings in the stairwell and on all of the other floors. Two separate instances where citations were not issued:
 - Inspection narrative states “*On the sixth floor of stairwell number 5, floor is open behind the scaffold and employees could be exposed to a fall of approximately 60 feet*”. Citation should have been issued for 1926.501(b)(4)(i).
 - Inspection narrative states “*Additionally, employees working on the third floor were exposed to tools and other materials falling through the floor penetrations*”. Citation should have been issued for 1926.501(b)(4)(iii).

Cases where complainant disputed the employer’s response, yet no inspection ensued and there was no acknowledgement of the disputed findings:

- Case C-2 – Complainant disputed the employer’s response on May 9, 2008. Complainant’s letter stated “*I sincerely do not see your organization as being one able to protect my rights under OSHA concerning this issue. We have a lot of laws but without implementation they are nothing. Education that is inadequate leaved us with an illiterate society that’s costs everyone.*” Nevada OSHA did not respond to the complainant’s rebuttal, did not conduct an inspection as required by OSHA Instruction CPL 02-00-140, Complaint Policies and Procedures⁴, nor did it document in the case file why no action was taken on this rebuttal. This was a formal signed complaint.
- Case C-8 – Complainant disputed the employer’s response on April 12, 2009. Complainant’s letter indicated that they did not want to be like the unfortunate individuals who perished due to the ignorance of the employer. They also asked that Nevada OSHA write back and convince them that they were wrong. Nevada OSHA did not respond to the complainant nor conduct an inspection. No further documentation was found in the file as to why no further contact was made with

⁴ Nevada OSHA adopted this directive identically on September 1, 2006.

the complainant. This was a formal signed complaint, yet the IMIS entry was marked as non-formal.

Cases where complaint was classified improperly:

- Case C-6 – Classified as Safety-Other, yet allegations included injuries such as severe trauma to neck, head, jaw, elbow, forearm, upper and lower back, hip, knee, and organs.
- Case C-7 – Classified as Safety-Other, yet complainant alleged animal bites.
- Case C-8 – Classified as Health-Other, yet allegations included no safety and health training on hazardous chemicals.
- Case C-9 – Classified as Safety-Other, yet allegations included overcrowding at emergency room, workers concerned about workplace violence (drunk and belligerent patrons).
- Case C-10 – Classified as Safety-Other, yet allegations included possible back injury, muscle strains and sprains by pushing/pulling laundry carts weighing up to 400 pounds through thick (heavy) carpet.
- Case I-6 – Classified as Health-Other, yet allegations included exposure to excessive gas emissions from buses (CO). Area was 2,500 to 2,000 sq. ft. subject to infiltrates from exhausts of the buses; workers did not wear respiratory protection.

Other findings:

- Case C-4 – The OSHA 7 had an annotation in the optional information field that this complaint was a duplicate of another complaint. A review of the IMIS system showed that the initial complaint was linked to an inspection (#312274897) but the OSHA 1, Inspection Record, was not linked to the C-4 complaint. All complaints should be noted as related activity on the OSHA 1.
- Case C-7 – Complaint received on January 15, 2009. No acknowledgement letter F was sent to complainant; only Employer Letter D (Nonformal Complaint Notification to Employer) was sent to the employer on January 16, 2009 with a response due date of January 29, 2009. An unsatisfactory response was received on January 30, 2009, but the IMIS system was updated as “1-Satisfactory” indicating that a satisfactory response was received. The employer requested and received an extension to February 18, 2009 to submit final abatement. On February 28, 2009, a fax transmittal form was received from the employer with the company’s safety handbook. This information submitted for abatement was considered satisfactory and the complaint was closed, however, the complainant was never informed of the last employer submission or of their rights to rebut.
- Case I-5 – Grouped violations were issued for two different hazardous conditions: 22(a)(2) – wet floors: and 22(b)(1) – aisles not clear.
- Case I-6 – Complaint allegation included exposure to carbon monoxide emissions due to exhaust from buses in a 2,500 square foot area. The inspection was initiated on April 23, 2008 and while on site the walkaround was completed. The investigator returned on April 25, 2008 in the afternoon to conduct screening for air contaminants. No overexposures were found. There is no reason documented

in the file as to why the investigator did not take screening samples on the first day of the inspection (4/23/08).

- Case I-7 – The OSHA 7, Notice of Alleged Safety and Health Hazards, and IMIS system showed the name of the complainant as unknown but the Ironworkers #416 was listed as the union representative and a telephone number was included. There was no documentation in the case file indicating why no additional contact information (name and address) was obtained or if the union representative wanted to remain anonymous.
- Case I-9 – Two separate and unrelated items were initially issued separately but grouped together as part of the Informal Settlement Agreement. Citation 1, Item 1 – General Duty Clause – Auto lift training, inspection points, daily inspections and Citation 1, Item 2 – 1910.101(b) – Compressed gas cylinder was not properly supported to prevent it from being knocked over. There was no documentation in the file to indicate why these two unrelated items were grouped together during the IFC.

Conclusions and Recommendations

Conclusion V-1: No diary sheets or similar daily/chronological logs were found in any of the 21 case files reviewed.

Recommendation V-1: See Recommendation I-2.

Conclusion V-2: No indication was found that the complainant was informed, in writing and/or recorded in IMIS, of the results of the inquiry/inspection.

Recommendation V-2: Nevada OSHA must ensure that all complainants are responded to in accordance with the Complaint Policies and Procedures directive, OSHA Instruction CPL 02-00-140. Complainant responses must be consistent with complaint handling procedures. All complaint inquiries must be responded to using IMIS Letter G – Employer Response to Complainant, and complaint inspections must be responded to using IMIS Letter H – Formal Complaint Inspection Results.

Conclusion V-3: The majority of complaints did not have the complainant's contact information in the IMIS.

Recommendation V-3: Nevada OSHA must make every attempt to acquire, document and enter into IMIS complainants' identification, including name, address and phone number, unless complainant explicitly requests to remain anonymous. All requests to remain anonymous must be documented in the case file.

Conclusion V-4: Inadequate abatement was received and accepted as adequate.

Recommendation V-4: Nevada OSHA must ensure that adequate abatement is obtained for all complaint items found valid, regardless of whether they are being handled via an inquiry or an inspection.

Conclusion V-5: As per the information in the case files, complaint items were found to be valid, but no citations were issued to address the hazards.

Recommendation V-5: Nevada OSHA must ensure that hazards identified during complaint inspections are addressed with the employer through citation, notification of violation or some other method.

Conclusion V-6: There were cases in which the complainant disputed the employer's response, yet no inspection took place and there was no acknowledgement of the disputed findings.

Recommendation V-6: All disputed complaints must be handled in accordance with OSHA Instruction CPL 02-00-140, including the complainant's right to request an inspection and/or the agency's responsibility to respond whether an inspection will or will not be conducted and the reasons why.

Conclusion V-7: There were cases in which the complaint was classified improperly.

Recommendation V-7: Nevada OSHA must ensure that complaint allegations are properly evaluated and classified and that such classification will ensure proper handling of the complaint items, either via an inquiry or an inspection.

VI. Specific Cases

The initial criterion for the specific case reviews was current penalties in excess of \$45,000. In preparation for the review an IMIS report was generated to identify those cases that fit the criterion between January 1, 2008 and June 1, 2009. The report identified no applicable cases for that time frame. The criterion was then modified to include penalties between \$15,000 and \$45,000. The new search identified eight (8) cases which would be analyzed – seven (7) from the Henderson office and one (1) from the Reno office. The eight (8) cases included four (4) planned inspections, two (2) referrals, one (1) complaint and one (1) nonfatal accident investigation. Two (2) of the eight (8) cases had initial penalties that exceeded \$45,000 but settlement agreements reduced the penalties below the initial review level. Five (5) of the eight (8) cases were selected for review.

Findings

Case files were not organized in a uniform manner and by a means which would reduce the possibility of important case file documentation being lost or misplaced. Files were either clipped together with a large binder clip or held together with a rubber band and then placed into an accordion file folder. There were sections of the case file in the binder clip or rubber band that were stapled together. All correspondence in the file was intermingled with the investigative portion of the case file.

No willful violations were proposed in any of the files reviewed. Interviews with investigators and supervisors indicated that willful violations were discouraged. The interview with legal counsel indicated that the only legal training investigators received is the OSHA Training Institute's (OTI) legal aspects course. No local legal training has been provided to assist with the development of willful violations that could be sustained by the Review Board.

Two (2) of 127 (2%) violations were withdrawn during informal settlement conferences. The citations for one case were initially issued as four repeat violations and 6 serious violations, but during the informal conference 3 of the repeat violations were reclassified to serious violations. The IMIS system does not reflect the reclassification. This is a Henderson office case and that office leaves violations in draft until after informal and formal settlement agreements are reached and then amended citations are issued. If all informal conference violation reclassifications are updated in this fashion, the IMIS data used for monitoring will be incorrect because it will not accurately reflect how many violations are reclassified during informal conferences.

Informal conferences were held in seven (7) of the eight (8) cases. All seven employers who attended informal conferences received penalty reductions. The average penalty reduction obtained during informal conferences was 36%. Most notes for penalty reduction indicated penalty reduction was given for actions taken by the employer to abate the violations.

No investigators were present during the informal conferences. Usually only the District Manager represented Nevada OSHA at these conferences.

The OSHA 1Bs, Citation Worksheets, were not completed in accordance with OSHA Directive, ADM 1-1.31, IMIS Enforcement Data Processing Manual. Deficiencies included but were not limited to: no contact information for workers interviewed; no contact information for workers exposed to hazards; duration and frequency listed as "as needed" on the majority of the violations; missing equipment identifiers such as manufacturer, model number and serial number; and employer knowledge listed as "with due diligence."

Violations that should have been further evaluated for potential willful violations were identified. One company (#311638829) was cited for lockout/tagout for outside contractor violations and industrial truck training and inspection violations. With regard to lockout/tagout for outside contractors, the company's lockout/tagout program specifically stated who was responsible and that they would ensure compliance. However, there was no further investigation conducted to determine why the company wasn't following its own program with regard to lockout/tagout for outside contractors and evaluate this for a potential willful violation. The company's powered industrial truck training written program discusses required training and who is responsible for ensuring that training is accomplished, but no additional research was conducted to determine why the company wasn't following their own program. The company's powered industrial truck training program covered inspections and how those were to be accomplished but no additional research was conducted to determine why the company

wasn't following their own program. Another company (#312278211) was cited for a 1910.212(a)(1) violation, and their history shows that they received a 1910.212(a)(1) violation in 2004, but no additional research was conducted to further investigate this hazard. They also received a citation for 1910.242(b) in 2001, with no documentation in the file that any additional research was conducted related to this hazard. A third company's (#312276934) case file included notes that indicated that the owner knew that the ladder wasn't secured and employees were told to "just get it done! The benching is not important. I don't want excuses." This was not evaluated for a willful violation; instead, it was issued as another repeat violation. This company has been issued multiple repeat violations of the trenching standards during a 12-month period, yet no willful violations were pursued or issued. The information listed above does not in itself indicate that the violations were willful, but it does provide evidence that additional research should have been conducted.

Photographic evidence contained in the file is very clear; it shows worker exposure and many times contains an arrow with descriptive information pointing to the exact area of exposure.

Grouping issues were identified in these files as well as in the fatality files and complaint inspection files that were reviewed. Some instances include grouping of: (the lockout/tagout device being affixed; sharing the respective lockout/tagout programs; and training in safety related work practices); (lack of guarding on drill press; machines not anchored to floor; grinder with no work rest; grinder tongue guards missing); (equipment not used in accordance with listing and labeling; receptacles for fixed cords; flexible cords used in lieu of fixed wiring). Usually all electrical violations were grouped together regardless of hazard. Interviews with supervisors and investigators indicated that violations were grouped if they were in the same subpart of the state code of regulations, regardless of the hazard.

When violations are grouped the entire 1B for item 1a of the grouped citation is completed. For subsequent 1B items (i.e. 1b, 1c, 1d, etc.), information such as hazard description, equipment, location, injury/illness, measurements, and employer knowledge is not included.

All violations that weren't corrected on site state on the citation, "ABATEMENT DOCUMENTATION REQUIRED". Some files contained the abatement verification form and others included the abatement verification form with additional documentation. Interviews with supervisors and investigators indicated that there was no clear policy conveyed indicating what employers were required to submit for abatement. Supervisors review abatement and it is unclear what is required for abatement. There is no consistency in abatement documentation in the files. Nevada OSHA adopted OSHA Instruction CPL 02-00-114 Abatement Verification Regulation, 29 CFR 1903.19 Enforcement Policies and Procedures on November 27, 1998. This guidance document was not followed when reviewing and accepting abatement submitted by employers.

Conclusions and Recommendations

Conclusion VI-1: Case files did not contain diary sheets and were held together with a binder clip or rubber band, with correspondence that was intermingled throughout the investigation file.

Recommendation VI-1: See recommendation I-1.

Conclusion VI-2: Only one willful violation was proposed for any of the files reviewed. Interviews with investigators and supervisors indicated that willful violations were discouraged.

Recommendation VI-2: See Recommendation I - 5.

Conclusion VI-3: The Henderson Office leaves violations in draft in the IMIS until after informal and formal settlement agreements are reached and then amended citations are issued. If all informal conference violation reclassifications are updated in this fashion the IMIS data used for monitoring will be incorrect because it will not accurately reflect how many violations are reclassified during informal conferences.

Recommendation VI-3: Change the policy of leaving violations in draft to ensure that all citation history is maintained. Once this is in place, then a thorough evaluation of the informal settlement practices and procedures should take place and changes implemented if deficiencies are identified.

Conclusion VI-4: Deficiencies were noted on the OSHA 1B supporting documentation including: no contact information for workers interviewed and exposed to hazards; duration and frequency listed as “as needed” on the majority of the violations; missing equipment identifiers such as manufacturer, model number and serial number; and employer knowledge listed as “with due diligence.”

Recommendation VI-4: Nevada OSHA must ensure that OSHA 1Bs are fully documented. Provide additional training to investigators on case file documentation and the importance of having each OSHA 1B fully documented. This training should also fully explain the legal process in Nevada, which will help them develop a more legally sufficient case.

Conclusion VI-5: Excessive and inappropriate grouping issues were identified in these files, as well as the fatality files and complaint inspection files that were reviewed. Interviews with supervisors and investigators indicated that violations were grouped if they were in the same subpart regardless of hazard, contrary to guidance in the NOM.

Recommendation VI-5: See Recommendation IV-3.

Conclusion VI-6: Some files contained the abatement verification form and others included the abatement verification form with additional documentation. Interviews with

supervisors and investigators indicated that there was no clear policy conveyed indicating what abatement information employers were required to submit.

Recommendation VI-6: The abatement verification policy must be reviewed with all supervisors and investigators to ensure the supporting information and documentation required for abatement verification is present in the case files.

VII. Programmed Inspection Targeting System

The Nevada OSHA Program currently has a number of General Industry-specific and Local Emphasis Programs (LEPs) for its inspection targeting system. According to the information obtained during this evaluation, Nevada OSHA's Programmed Inspection Targeting System includes the following industries:

General Industry Lists:

1. Fabricated Metal Products
2. Non-Metallic Mineral Product Manufacturing
3. Wood Product Manufacturing
4. Printing and Related Support Activities
5. Miscellaneous Manufacturing
6. Couriers and Messengers
7. Air Transportation
8. Transit and Ground Passenger Transportation
9. Nursing and Residential Care Facilities
10. Building Material and Garden Equipment Supplies Dealers
11. Merchant Wholesalers, Non-durable Goods
12. Merchant Wholesalers, Durable Goods

Local Emphasis Programs:

1. Casinos and Hotels
2. Auto Body Shops
3. Medical Laboratories

Findings

Due to resource constraints, Nevada OSHA is only targeting the first five general industry target areas. There are written, detailed instructions (similar to those in an LEP) in place for the emphasis programs for Construction, General Industry, and Hotels and Casinos. These instructions include: prioritization of industries in general industry based on their Days Away Restricted or Transferred (DART) rate, selection of establishment and creation of inspection registers using the state's employer directory database, and randomization steps using a third-party random table form. For the construction program, the Nevada OSHA program uses the McGraw Hill Dodge reports for ongoing construction projects, develops a high-priority construction list for targeting purposes and inspects all facilities listed, as resources permit.

A detailed review and comparison between the program coordinator’s records and the IMIS database showed several discrepancies on the selection and use of LEP codes and General Industry targeted areas’ codes, as follows:

Local Emphasis Programs

Findings

Program Coordinator’s records show three LEPs: Hotels and Casinos, Automotive Repair and Analytical Laboratories, while the IMIS shows a total of six LEP codes (Analytical Laboratories[ALAB], Asbestos Removal[ASBESTOS], Automotive Repair – Health [AUTOREP], Hotels and Casinos[CASINO], Electrical Utilities[ELUT], and Process Safety Management-PWV-INSP[PSMPQV]).

The program coordinator indicated that the Asbestos Removal LEP relates to an internal annual inspection audit of licensed asbestos remediation employers required by Nevada Revised Statute 618.830⁵; the Electrical Utilities LEP was developed before his tenure at the Department and he is unaware of its status. He was also unaware of the existence of the Process Safety Management (PSM) LEP.

All LEP codes are being entered into the IMIS system, whether the LEP is active or not. Below is a table showing the number of inspections coded under these six LEPs⁶:

LEP	Henderson/Vegas	Reno	Total
ALAB	0	13	13
ASBESTOS^	51	65	116
AUTOREP	9	38	47
CASINO	326	28	354
ELUT*	5	7	12
PSMPQV*	16	8	24
Totals	407	159	566

**Inactive LEPs*

^State-specific initiative

Of even more concern is that the Nevada OSHA is not effectively updating the IMIS system to accurately reflect LEP inspections and inspections that impact their strategic program. The IMIS system reflects a discrepancy in the number of actual inspections conducted for the CASINO LEP. Some inspections are coded as LEP, some are coded as

⁵ **NRS 618.830 – Control of Asbestos - Inspection of projects.** *The Division or a person authorized by the Division shall inspect annually at least one project for the control of asbestos conducted by each contractor licensed pursuant to [NRS 618.795](#). The contractor shall, upon request of the Division or a person authorized by the Division, allow the inspection of all property, activities and facilities at the project and all related documents and records.* These are OSHA inspections conducted by Nevada OSHA Industrial Hygienists and include the evaluation of all identifiable safety and health hazards (e.g., 1910 and 1926).

⁶ LEP notices are submitted to the Regional Office via the ATS process in response to the State’s alternative approach to the federal Site Specific Targeting (SST) Program.

Strategic Plan and others are coded as both. Following is a table outlining the number of inspections for each IMIS code:

	Henderson/Vegas	Reno
CASINO - LEP	326	28
CASINO/HOTEL Strategic Code	356	17

It is difficult, perhaps even impossible, to determine the actual total number of inspections conducted under this initiative due to the duality of coding in the IMIS and the lack of consistency in data entry. The program coordinator was unaware of the existence of these two codes but indicated that only the Strategic Code should be used since this has a direct relationship to the State’s Strategic Plan. Under Federal OSHA policy, if both the LEP code and Strategic Plan code apply, both codes should be entered.

General Industry

Findings

The IMIS database lists a number of targeted general industry codes that are inconsistent with the General Industry targeted list noted on page 34. In the IMIS, the following general industry codes exist and are being used:

1. MFG 2011-2391
2. MFG 2392-2952
3. MFG 2992-3462
4. MFG 3463-3677
5. MFG 3678-3999

In contrast, no coding exists for the general industry codes listed below:

1. Fabricated Metal Products
2. Non-Metallic Mineral Product Manufacturing
3. Wood Product Manufacturing
4. Printing and Related Support Activities
5. Miscellaneous Manufacturing

The program coordinator was unaware of the existence of these IMIS codes and even of their meaning. He was also unaware of the non-existence of the appropriate codes for the active targeted general industries noted above.

Construction

Findings

There is a “CONSTRUCTION” code for inspections in the construction industry under the Strategic code system. The majority of construction inspections are noted as in-

compliance due to the fact that Nevada OSHA creates OSHA-1's for all employers at a multi-employer worksite, regardless of whether they have workers exposed to a hazard. Federal OSHA normally enters a multi-employer worksite and conducts an opening conference with the general contractor. The compliance officers then begin the walkaround and initiate inspections with subcontractors on the jobsite who are performing work and have workers exposed to hazards. Normally, Federal OSHA does not conduct an opening conference and create an OSHA 1 for every contractor on the jobsite. All jobsites are not the same and this is handled on a case-by-case basis.

The high in-compliance rate for programmed construction inspections indicates that construction targeting is not focusing on locations where serious hazards are occurring and/or investigators need additional hazard recognition training for construction. A review of construction IMIS data shows that Nevada OSHA has experienced a 47% in-compliance rate for programmed construction inspections between October 1, 2008 and June 1, 2009.

During discussions with management, the evaluation team was informed that approximately 10 years ago the Division estimated for budget purposes that they would conduct 2,900 safety and health inspections, approximately 95 to 115 inspections per investigator. During the last 10 years the number has not increased or decreased. The Nevada legislature uses the 2,900 inspections to determine if Nevada OSHA is meeting its goals. No outcome measures such as reduced injuries, illnesses or deaths are used by the legislature to evaluate the effectiveness of the Nevada program. Even with the large number of inspections conducted, the Days Away Restricted or Transferred (DART) rate for Nevada remains unchanged.

Other Findings

Most OSHA-1 programmed inspection records are being coded in the IMIS as "programmed [planned]". Of the 2,117 programmed inspections, 2,033 were programmed [planned] while only 84 were programmed-related. The Nevada Operations Manual (NOM), Page I-3 of 93 states: "Programmed Related. Inspections of employers at multi-employer worksites whose activities were not included in the programmed assignment; such as a low injury rate employer at a worksite where programmed inspections are being conducted for all high injury rate employers. All high hazard employers at the worksite should normally be included in the programmed inspections." This trend was discussed with the program coordinator, who indicated that he was unaware of this trend and could not determine if all 2,033 were planned and/or high hazard rate employers, but considered the low number of programmed-related inspections questionable. He indicated the need for Nevada OSHA to look into this practice and if needed, conduct proper data entry training to comply with NOM instructions.

Overall, Nevada has experienced a high number of in-compliance programmed inspections. Between October 1, 2008 and June 1, 2009, 46% of Nevada's programmed inspections were in-compliance. In addition to the high rate of in-compliance inspections among programmed inspections, the percent of programmed inspections with serious

violations was found to be extremely low. According to IMIS reports, the percent of programmed inspections with serious violations was noted at 33% with the percent of programmed inspections with only other-than-serious violations was calculated at 66%. The high rate of “other” violations vs. “serious” violations indicates that the Nevada OSHA Inspection Targeting System is not targeting locations where serious hazards are present. The goal of targeting establishments under the Programmed Inspection Policy is to identify the high-hazard industries.

Conclusions and Recommendations

Conclusion VII-1: The IMIS LEP codes do not match current LEP practices and LEP and Strategic Initiative codes are not always updated appropriately.

Recommendation VII-1: Nevada OSHA must update its IMIS coding database to list only those local emphasis and strategic initiative codes that are currently active. This will prevent inconsistencies and discrepancies in the tracking, monitoring and evaluation of these programs. Nevada OSHA must decide if one or both codes will be used by the state and provide appropriate IMIS training to secure adherence to this data entry policy.

Conclusion VII-2: IMIS coding is not available for all General Industry targeting systems.

Recommendation VII – 2: Work with the Office of Management and Data Systems (OMDS) to ensure that targeting codes are available and ready for use.

Conclusion VII-3: Nevada OSHA is entering OSHA 1s for every construction employer on multi-employer worksites which directly impacts the in-compliance rate experienced for the construction industry.

Recommendation VII-3: Discuss current Federal OSHA policy with Region IX and make any necessary changes to multi-employer worksite policies and IMIS data entry requirements.

Conclusion VII-4: The low percentage of serious violations and the high percentage of in-compliance inspections for programmed inspections indicate a need for an improved targeting system.

Recommendation VII-4: Perform an evaluation of the effectiveness of active LEPs and targeting programs. Once the evaluation is complete, make any necessary changes to more effectively target high hazard industries and facilities. One tool that could be used to assist with the evaluation of targeting programs is Appendix A of OSHA Instruction CPL 04-00-001, Procedures for Approval of Local Emphasis Programs (LEPs).

Conclusion VII-5: Nevada OSHA has agreed to conduct 2,900 inspections per year as part of its budgeting process and this information is used by the legislature to determine if the program is meeting their goals. This translates to 95 to 115 inspections per year per investigator.

Suggestion VII-5: 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.

Conclusion VII-6: Nevada OSHA is not properly coding programmed-related inspections in the IMIS system.

Recommendation VII-6: Nevada OSHA must properly and accurately classify its programmed inspections based on NOM instructions on Page I-3 of 93. Programmed [Planned] inspections should only be used for the “initial” establishment and any high hazard employers at the worksite, while Programmed-Related inspections should be used for all other low-hazard establishments found at that multi-employer worksite.

VIII. Communication with Family Members of Deceased Employees

On March 16, 2009 Nevada Senate Bill 288 was introduced by Senator Margaret A. Carlton and Assemblyman Marcus Conklin. This bill requires Nevada OSHA and the Occupational Review Board to contact families of fatality victims at specific times during OSHA inspections. The bill was approved by the Assembly Commerce and Labor Committee on May 13, 2009 and was signed into law by the Governor on May 26, 2009. The law became effective October 1, 2009.

Section 12.5 of the bill requires the Division of Industrial Relations of the Department of Business and Industry to enter into a discussion with immediate family members of each deceased employee within a reasonable time after citations are issued. During this discussion they are required to provide the family with: (a) information regarding the citation and abatement process, (b) information regarding the means by which the family may obtain a copy of the final incident report and abatement decision of the Division and c) any other information the Division deems relevant and necessary to inform the family of the outcome of the inspection by the Division.

Section 47 of the bill requires the Division to provide to the Occupational Safety and Health Review Board the information on how to contact the immediate family of each deceased employee, in the event the employer contests the citations or proposed penalties.

Section 57 of the bill revises provisions relating to formal fact-finding hearings held by the Occupational Safety and Health Review Board after a fatal accident to require the Board to notify the immediate family of each deceased employee of certain procedural information.

Findings

Sections 12.5 and 47 of Bill 288 contain new responsibilities for the Division of Industrial Relations of the Department of Business and Industry regarding contact with

family members of employees who were killed on the job. The Program Manager explained that once the bill is approved it will be assigned a Nevada Revised Statute (NRS) number and they expect to receive the NRS number by the end of the year. He also indicated that he would probably have to complete his NOM revision prior to receiving the NRS number and his current plan is to incorporate this change into their NOM revision.

During the fatality case file reviews we found that some files contained fatality letters for family members and others did not. In Las Vegas some letters were signed by the District Manager or Supervisor and others were signed by the compliance officer. In Reno, the District Manager indicated that he signs all family fatality letters, however, he did indicate that they had been remiss in sending letters to family members and he has instituted a new policy for tracking these cases to ensure the letters are sent.

Conclusions and Recommendations

Conclusion VIII-1: Sections 12.5 and 47 of Bill 288 contain new responsibilities for the Division of Industrial Relations of the Department of Business and Industry regarding contact with family members of employees who were killed on the job.

Recommendation VIII-1: A policy must be developed and incorporated into the NOM which outlines the procedures to be followed in order to comply with Nevada OSHA's new responsibilities. Because this amends the underlying state plan legislation, the state plan must submit a state plan change in accordance with 29 CFR 1953.4(d)(2).

Suggestion VIII-1: In addition, a tracking system should be developed to ensure that all necessary communications with family members are accomplished. In the development of the process to meet the requirements of Section 47 of the bill, include a step for confirming that contact information for the family is still accurate. Nevada OSHA should also look into developing a form to be completed which will ensure that the information provided to the Occupational Safety and Health Review Board will be consistent. Nevada OSHA should consider how it will handle multiple family members. For example: A deceased son/daughter of a father and mother who are divorced or a brother/sister with multiple siblings. Will they be providing letters to all family members or just one? How will they decide whom to communicate with? Will they be providing contact information to the Board for all family members or just for one?

Due to the sensitive nature of this issue, it is also suggested that a uniform method of letter completion and signature be developed to ensure that all letters are uniform and signed by the appropriate official.

IX. Nevada OSHA's 10/30 Hour Courses

On February 9, 2009 Assembly Bill 148 was introduced by the Nevada Commerce and Labor Committee. The bill was passed on May 18, 2009 by the Assembly, on May 28, 2009 by the Senate and signed by the Governor on June 3, 2009. Sections 1 -12, 15 and

16 become effective on January 1, 2010; sections 13 and 14 become effective on January 1, 2011. This legislation requires that supervisory employees and all other construction workers working on a construction site complete a 30-hour and a 10-hour safety and health course, respectively, no later than 15 calendar days after being hired.

Section 8 of the bill requires the Division of Industrial Relations of the Department of Business and Industry to adopt regulations approving courses which may be used to fulfill the requirements of Section 10 and to establish a registry to track approved providers of courses. Section 8.5 requires providers of approved courses to display at the place where they are conducting training the card which shows that they were authorized by the U.S. Department of Labor, Occupational Safety and Health Administration, to provide training.

Section 10 requires supervisory employees and all other construction workers working on a construction site to complete a 30-hour and a 10-hour safety and health course, respectively.

Section 11 requires employers to suspend or terminate construction personnel who fail to provide proof of obtaining the required training no later than 15 calendar days after being hired.

Section 12 provides for administrative fines for employers who fail to suspend or terminate construction workers and supervisors who cannot provide proof of obtaining the required training within 15 calendar days after being hired.

Section 15 allows employees to satisfy the requirements of Section 10 of the bill by completing an alternative course offered by their employer, provided that the employee takes an approved course before January 1, 2011. The employer must keep records of the employees who took the training as well as training records and make them available to the Division.

The bill requires a regulatory response from Nevada OSHA. As part of the regulatory process, Nevada OSHA held a workshop to solicit comments on the proposed standard in Las Vegas where interested parties in Carson City were linked via video conference. Notice of the workshop was posted 15 days prior to the workshop.

Several representatives from Nevada OSHA attended the workshops. Those present in Las Vegas were: the Acting Chief Administrative Officer; Henderson office District Manager; Henderson office Safety Supervisor; Safety Consultation and Training Section [SCATS] Training Supervisor; and Division Counsel. The Nevada OSHA representatives attending via video conference in Carson City were: the Administrator for the Division of Industrial Relations and the Labor Commissioner. Senator Warren Hardy from the Nevada State Legislature was also seated in the audience in Las Vegas and commented during the hearing on the intent of the Legislature.

The Labor Commissioner stated that because the training was required as a condition of employment by the state, employees were responsible for the cost of the training. He

also stated that employers were not required to pay wages for the time employees spent attending these classes.

The Acting CAO asked for comments on the bill, section by section. The majority of those who gave verbal testimony at the workshop spoke to the following concerns: who was covered by the standard; authenticity of the cards and training; would cards be accepted as employees move from job to job or would they expire once an employee left an employer; whether copies of cards were acceptable; whether existing holders of cards could be grandfathered in permanently and if not, how would an expiration date be determined since the cards did not have one; to what degree would employers be required to verify authenticity of the cards and training; whether safety talks given over a period of days, weeks or months, would be considered as acceptable training if they covered the required topics in the required time when considered in total; would the general contractor be responsible for its subcontractors; would Mine Safety and Health Administration (MSHA) training be accepted as equivalent; how would employers verify the authenticity of the continuing education classes of 5 and 15 hours; what constituted acceptable online training; how would the three strikes provision be interpreted for companies which have been in business for many years; and objection to the exclusion of the Nevada Department of Transportation (NDOT) from the provisions of the law.

At the close of the workshop, the Acting CAO stated that written comments would be accepted for the record which would remain open for 10 more days until August 9, 2009. After the record closed, the agency would draft regulations and submit them to the Legislative Council Bureau (LCB) for review. Once the draft was approved, a notice of a final hearing would be issued at least 30 days prior to the hearing. Testimony would be taken and a final regulation would be issued for the LCB's review. Once the LCB approved the final regulation the standard would become law. The Acting CAO stated that he anticipated the process to take approximately 60 days.

Findings

The Labor Commissioner has interpreted the law to mean that workers pay for their own training and that employers are not required to pay their wages while they attend the training. This interpretation puts the burden on workers and not employers.

SCATS is anticipating that 70,000 workers will need to be trained to meet the requirements of the new legislation. Workers can visit www.nv1030.org to register to attend free training offered by SCATS. The free training slots are limited in number. If an individual is currently employed, they are asked to enter their employer's name and the size of the company. Enrollment is limited to 5 workers for small employers (250 workers or less). If an employer has more than 250 workers, the workers will not be allowed to register for free training. Classes are offered in Las Vegas and less frequently in other parts of the state in English. Classes in Spanish are offered monthly in different locations throughout the state. There are only two 30-hour courses (one in English and one in Spanish) offered between August 7, 2009 and December 31, 2009.

The SCATS Training Supervisor (STS) stated that as much as possible Nevada planned to use the existing structure of the OSHA 10/30 courses given by trainers authorized by the OTI and the OTI Ed Centers. He stated that since it was an unfunded legislative mandate that the state did not have the resources or the time to pursue developing a state-only program. He stated that he had been in very close contact with OTI. The STS felt that the existing requirements that OTI had developed adequately addressed the Nevada legislation, including the 5/15 continuing education unit (CEU) provision which he stated had been inserted at the last minute, without consulting Nevada OSHA and which had not been a part of the main discussion of the bill. During the “workshop” the STS stated that the 5/15 CEU courses would have to meet the requirements of the OSHA 10/30 and that they would only be valid if they were taken within five (5) years of the original full length course. If they were given before the expiration of the card they could be used to extend the life of the card indefinitely. OTI and the STS agreed that neither the 10/30 cards nor special cards would be issued for the 5/15 CEU training. Instead, the employer would be expected to keep sufficient documentation to prove that the content offered in CEU courses met the requirements of the standard.

Nevada is not planning to issue cards for the alternative training; rather the employer is expected to keep documentation that such alternative training has occurred and that it was adequate.

Even though the Labor Commissioner interprets the law to mean that employers are not expected to pay their workers’ wages while they are obtaining the required training, employers could be required to pay for the training under certain conditions. The U.S. Department of Labor’s Wage and Hour Division has issued a letter of interpretation indicating that time spent in training programs need not be counted as hours of work if all of the four regulatory criteria are met. A summary of the criteria is as follows: (a) Attendance is outside the employee’s regular working hours; (b) Attendance must be voluntary; (c) Training must not be directly related to the employee’s job; and (d) The employee performs no productive work during attendance.

Conclusions and Recommendations

Conclusion IX-1: Assembly Bill 148 contains new requirements for Nevada OSHA.

Recommendation IX-1: Because this new law amends the underlying state plan legislation, the state plan must submit a state plan change in accordance with 29 CFR 1953.4(d)(2).

Conclusion IX-2: Regulations are currently under development to address this new legislation.

Recommendation IX-2: Work closely with OTI and Region IX to ensure that the regulations under development do not conflict with Federal OSHA Outreach 10- and 30-hour courses.

Conclusion IX-3: The new legislation is silent regarding who is required to pay for the required worker training.

Recommendation IX-3: Nevada OSHA needs to contact the U.S. Department of Labor’s Wage and Hour Division to ascertain and get clarification regarding the conditions under which employers must pay wages to employees during training.

X. Personnel and Training

Training records for Nevada OSHA personnel were evaluated to determine the extent of safety and health training received. In addition to reviewing training records, employees were interviewed and case files were reviewed. Nevada OSHA tracks individual investigator training through the use of an Excel spreadsheet. Nevada OSHA utilizes the OSHA Training Institute (OTI) by sending employees to training in Arlington Heights, IL and they also bring OTI courses to Nevada. They have a standing agreement with Arizona OSHA that they will reserve approximately 10 slots for training and, in turn, Nevada will do the same. This allows both states to offer more training to their employees. Formal OTI training is supplemented by Safety Consultation and Training Section (SCATS) training, OSHA webinars and other independent courses. SCATS offers a wide variety of training. The classes are approximately 3 hours in length and cover topics such as but not limited to: Introduction to OSHA; Written Workplace Safety Program; Hazard Communication Awareness; Confined Space Awareness; Machine Safeguarding and many others.

Findings

The training spreadsheets identified training for 31 Henderson office employees and 16 Reno office employees. Below is a table outlining required initial training and the number of employees in each office who have not received the required training.

Course Number and Title	Henderson Office	Reno Office
#1000 – Initial Compliance	6	4
#1050 – Introduction to Safety Standards for Safety or #1250 Introduction to Health Standards for IH or #2000 Construction Standards	7	1
#1310 Investigative Interviewing Techniques	31	16
#1410 Inspection Techniques and Legal Aspects	9	5
#2450 Evaluation of Safety and Health Management Systems	31	15

#1230 Accident Investigation	10	4
Cross Over Courses		
Safety	7	1
Health	7	2
#8200 Incident Command System I-200	Unknown	Unknown
Four Additional Technical Courses during Initial 3 years	10	5

#1000 – *Initial Compliance*: Of the six individuals in the Henderson office who have not received the initial compliance course, three were hired in 1995 and three were hired between March and June of 2009. The three individuals hired in 2009 are scheduled to attend the initial compliance course in August 2009. Of the four individuals in Reno who have not received the initial compliance course, one was hired in 1993, one was hired in 1999, one was hired in 2001 and one was hired in 2009.

#1050 – *Introduction to Safety Standards for Safety* or #1250 *Introduction to Health Standards for IH* or #2000 *Construction Standards*: In Henderson four safety compliance officers have not received #1050 or #2000 and three health compliance officers have not received #1250. In Reno one safety compliance officer has not received #1050 or #2000. Henderson safety compliance personnel were scheduled for #1050 in September 2009 and three are scheduled for the #2000 course in January 2010. The three health compliance officers who have not received the #1250 course have worked for Nevada OSHA since 1989 and 1995. The Reno safety compliance officer is scheduled to take #1050 in September 2009 and #2000 in January 2010.

#1310 – *Investigative Interviewing Techniques*: No compliance officers in Nevada have taken this course or are scheduled to take this course. The Bureau of Alcohol, Tobacco and Firearms (BATF) offers an interviewing techniques class and Nevada OSHA is working with them to offer the class locally. They hope to offer the class by December 31, 2009.

#1410 – *Inspection Techniques and Legal Aspects*: In Henderson, nine compliance officers have not received this training. Five of the nine compliance officers were scheduled to take this course in August 2009. In Reno, five compliance officers have not taken this course. Three of the five were scheduled to take the course in August 2009.

#2450 – *Evaluation of Safety and Health Management Systems*: No employees in the Henderson office have received this training. One employee from the Reno office received the training in 1995. No employees from either office are currently scheduled to attend this training.

#1230 – *Accident Investigation* or #1020 *Basic Accident Investigation*: In Henderson, ten compliance officers have not received the #1230 course or the #1020 Basic Accident

Investigation course. The ten compliance officers have worked for Nevada OSHA for varying lengths of time: one since 1995; six since 2008 and three since 2009. In Reno, four compliance officers have not received the #1230 course or the #1020 Basic Accident Investigation course. The four compliance officers have been hired within the past two years.

Safety Crossover Courses: Seven employees in the Henderson office have not received crossover training. Three employees were scheduled to take #2000 *Construction Standards* in July 2009 and three are scheduled to take #2000 in January 2010. One employee in the Reno office has not received crossover training; however, they are scheduled to take #2000 in January 2010.

Health Crossover Courses: Seven employees in the Henderson office have not received crossover training. No compliance officers are currently scheduled for crossover training. The seven employees have worked for Nevada OSHA for varying lengths of time. Five were hired between 1995 and 2006. Two employees in the Reno office have not received crossover training and neither is scheduled for crossover training at this time. These two employees have worked for Nevada OSHA for different lengths of time. One employee was hired in 1981 and the other employee was hired in 2001.

Four Additional Technical Courses During the Initial 3 Years: Ten Henderson employees and five in Reno have not completed their additional technical training. Thirteen of those employees have been hired since 2008 and are currently scheduled for some additional technical training.

Two employees have conducted fatality investigations in 2009 without the benefit of Accident Investigation training.

Nevada is one of the few states that has an emergency response team. Training records of Incident Command System training (OSHA #8200 *Incident Command System ICS-200*) or Federal Emergency Management Agency (FEMA) ICS-100 and ICS-200) were incomplete and did not identify all ICS training and what level of training was complete.

Offsite classes are scheduled roughly two (2) to three (3) times per year. When Arizona and Nevada schedule classes they each usually reserve approximately 10 seats in the class for the other state. The offsite classes taken between 2007 and 2008 consisted of the safety courses listed below:

- Accident Investigation
- Machine Guarding
- Cranes in Construction
- Excavation and Trenching
- Scaffolding
- Fall Arrest Systems

Conclusions and Recommendations

Conclusion X-1: Records indicate that Nevada OSHA is currently not in compliance with OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel.

Recommendation X-1: Nevada OSHA must follow OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel, dated November 3, 2008, adopted by the state on January 3, 2009.

Conclusion X-2: Employees are assigned fatality investigations prior to completing the Accident Investigation course.

Suggestion X-2: The State should not send investigators to conduct fatality/accident investigations until they have completed the accident investigation course.

Conclusion X-3: Nevada OSHA maintains an emergency response team; however, training records for emergency response training are incomplete.

Recommendation X-3: Emergency response training records must be maintained to ensure that all response team members receive the required training.

XI. Retention of Staff

Retention of staff has been a major concern for Nevada OSHA and it believes that this is due to low salaries. We were provided copies of class specifications and pay tables for Nevada Industrial Relations employees. In addition, we obtained from Bureau of Labor Statistics (BLS) Occupation Employment Statistics for the Las Vegas – Paradise, NV metropolitan area. The three safety professions BLS identified can be found in the table below. The Average Mean Salary for State employees nationwide in the Occupational Health and Safety Specialist occupation code is \$57,440.

Occupation Code	Occupation Title	Employment (1)	Wage Estimates			
			Median Hourly	Mean Hourly	Mean Annual (2)	Mean RSE (3)
17-2111	Health and Safety Engineers, Except Mining Safety Engineers and Inspectors	170	\$35.23	\$35.54	\$73,930	5.50%
29-9011	Occupational Health and Safety Specialists	300	\$31.61	\$32.16	\$66,880	2.70%
29-9012	Occupational Health and Safety Technicians	50	\$27.10	\$27.15	\$56,460	2.80%

[About May 2008 National, State, Metropolitan, and Nonmetropolitan Area Occupational Employment and Wage Estimates](#)

(1) Estimates for detailed occupations do not sum to the totals because the totals include occupations not shown separately. Estimates do not include self-employed workers.

(2) Annual wages have been calculated by multiplying the hourly mean wage by a “year-round, full-time” hours figure of 2,080 hours; for those occupations where there is not an hourly mean wage published, the annual wage has been directly calculated from the reported survey data.

(3) The relative standard error (RSE) is a measure of the reliability of a survey statistic. The smaller the relative standard error, the more precise the estimate.

Additional research was conducted on the Internet regarding safety professional average salaries in Nevada and salaries of safety professionals in other Nevada State Agencies. This information is included in the table below.

Organization	Occupation Title	Average Salary
NV Industrial Relations	Safety Specialist 3/Step 10	\$67,692
NV Public Utilities Commission	Safety Specialist 3/Step 10	\$66,023
NV Industrial Relations	Safety Specialist 2/Step 1	\$40,110
NV Department of Corrections	Safety Specialist 2/Step ?	\$48,530
NV Industrial Relations	Safety Specialist 1/Step 1	\$36,915
Internet Advertisement	Construction Project Officer with 7 – 10 yrs experience for NV project	\$45,000
Internet Advertisement	Construction Safety Manger 3 – 5 years experience for NV project	\$70,000
Board of Certified Safety Professionals	Average Salary for Nevada Safety Manager	\$56,000

In the table below we also compared the salary progression of a Federal CSHO to a Nevada investigator.

Grade and Step	Federal OSHA	Grade and Step	Nevada OSHA
5-1	\$30,772	30-1	\$36,915
7-1	\$38,117	32-1	\$40,110
9-1	\$46,625	35-1	\$41,906
11-1	\$56,411	35-2	\$47,606
12-1	\$67,613	35-3	\$49,694
12-2	\$69,867	35-4	\$51,865
12-3	\$72,120	35-5	\$54,204
12-4	\$74,373	35-6	\$56,626
12-4	\$74,373	35-7	\$59,194
12-5	\$76,627	35-8	\$61,950
12-5	\$76,627	35-9	\$64,707
12-6	\$78,880	35-10	\$67,692

Findings

Through interviews and discussions it was found that employees have previously left the employ of Nevada OSHA to take jobs with construction firms in the area. Employees who left Nevada OSHA employment had approximately 3 years of experience and their

salary was approximately \$41,906. Those employees left Nevada OSHA employment for safety positions with construction firms with salaries of approximately \$80,000.

Safety professionals working for other Nevada state agencies appear to have salaries close to salaries at Nevada OSHA. We were unable to substantiate a difference in safety specialist salaries between different state departments. A search of the Nevada Salary database for 2008 was conducted using the word safety as a search tool. Safety Specialist positions in the Nevada state government were found in three departments and those were Industrial Relations, Public Utilities Commissions and the Department of Corrections.

Throughout the evaluation, employees and supervisors identified areas where policies and procedures were not communicated and followed within Nevada OSHA. Areas were identified where training was insufficient, policies were not followed or communicated, and the pursuit of willful violations was discouraged.

Conclusions and Recommendations

Conclusion XI-1: Employees with 3 years of safety and health experience have left the employment of Nevada OSHA for higher paying safety positions.

Suggestion XI-1: Evaluate all safety positions in Nevada State Government and work to reclassify positions to higher paying safety classifications.

Conclusion XI-2: Lack of clear guidance and support could be leading to low employee morale.

Suggestion XI-2: Explore ways to identify whether employee morale is leading to the desire to leave employment with Nevada OSHA.

Review of the Nevada Occupational Safety and Health Program
APPENDIX A
Conclusions and Recommendations

I. Fatality Case File Reviews

Conclusion I-1: Case files were not organized in a uniform manner and by a means which would reduce the possibility of important case file documentation being lost or misplaced.

Recommendation I-1: Provide clear guidance to all enforcement personnel on the organization of case files. It is recommended that correspondence not be filed throughout the investigative file but in one specific location in the file. This 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.

Conclusion I-2: The OSHA Case File Cover Sheets did not provide a ready record and summary of all actions relating to a case.

Recommendation I-2: The Case File Cover Sheet must be used in accordance with the Nevada Operations Manual (NOM) or a Diary Sheet should be added to ensure that all communications are documented in the case file.

Conclusion I-3: Families of victims are not always contacted when a fatality investigation is initiated and no additional communication is initiated by Nevada OSHA once the investigation has begun.

Recommendation I-3A: In accordance with the NOM, and the new Nevada Senate Bill 288, “families of victims should be contacted soon after the initiation of the investigation and provided timely and accurate information at all stages of the investigation.”

Recommendation I-3B: We suggest communication with families when the investigation is initiated, when citations are issued, when informal settlement agreements are signed, when the case is contested and when the case is closed. We also suggest a clear policy be developed indicating who should sign the initial correspondence to the family and any additional correspondence. Additionally, a tracking system should be developed and implemented to help ensure that required correspondence is sent to families of victims.

Conclusion I-4: The IMMLANG policy (code to track fatalities among Hispanic and immigrant workers) is not consistently followed.

Recommendation I-4: Review the current IMMLANG policy and make a determination regarding whether Nevada OSHA will adopt the policy. Once the decision has been made, ensure that all management and employees are informed of the policy and that the policy is consistently followed.

Conclusion I-5: Willful violations are discouraged because of lack of management and legal counsel support.

Recommendation I-5: 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 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.

Conclusion I-6: Union representation is not always present for opening, closing and informal conferences.

Recommendation I-6: Nevada OSHA must follow its current procedures and ensure that union representatives are provided the opportunity to participate in opening conferences, closing conferences and informal conferences.

Conclusion I-7: Copies of citations are only mailed to union representatives when they request the information.

Recommendation I-7: Ensure that all union representatives are informed that they must request copies of citations or no copy will be sent to them.

Conclusion I-8: Files do not contain employee contact information such as home phone numbers and mailing addresses.

Recommendation I-8: Worker contact information must be obtained for all workers interviewed and exposed to hazards. This information will provide accessibility to witnesses for contested cases and ensure that information is maintained in the event that a discrimination complaint is filed.

Conclusion I-9: OSHA 300 information is not obtained for the previous three years and entered into the IMIS system as required by OSHA Instruction CPL 02-0.131.

Recommendation I-9: Nevada OSHA must reconcile those differences between the NOM and OSHA Instruction CPL 02-0.131. Once those differences have been reconciled, employees must be trained on current policy and be provided copies of current policy documents.

Conclusion I-10: All hazards identified were not addressed as citations, notices of violations or hazard alert letters.

Recommendation I-10: All hazards identified during inspections must be addressed. Case files must be reviewed more thoroughly including review of photographs for hazards not identified or addressed by the investigators.

Conclusion I-11: The Notice of Violation (NOV) policy is confusing to employers.

Recommendation I-11: Nevada OSHA must review its NOV policy, and if the policy is continued, make modifications necessary to eliminate confusion for employers and clarify the difference between NOVs and Other-Than-Serious violations. Once the policy has been reviewed and changes are made regarding the policy, compliance officers must receive training on how to convey this information to employers.

II. Complaints About State Program Administration (CASPs)

Conclusion II-1: See Conclusion I-5.

Recommendation II-1: See Recommendation I-5.

Conclusion II-2: Notes of the first annual review of the Orleans settlement agreement were written but not included in the case file.

Recommendation II-2: All notes and case file documentation must be included in the files and not kept on individual computers. This will ensure that files are effectively evaluated for abatement, debt collection, contest and any other actions being taken on the file.

Conclusion II-3: Through employee interviews it was determined that Nevada OSHA employees do not inform complainants of their discrimination rights unless the complainant alleges some type of discrimination and they do not always ask for the complainant's address.

Recommendation II-3: Nevada OSHA must follow established complaint procedures to ensure that 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 don't allege discrimination at the time of the call.

Conclusion II-4: During a review of IMIS information, it was found that letters were only mailed to complainants who filed a formal complaint.

Recommendation II-4: The process outlined in the NOM and OSHA Instruction CPL 02-00-140 must be followed with regard to letters sent the complainant.

Conclusion II-5: The second inspection case file for Luxor showed that two sets of employees were interviewed together. Nevada regulations authorize the SHR/IH to question any employee privately during regular working hours in the course of an OSHA inspection.

Recommendation II-5: Ensure that interviews are conducted privately and that they cover the required information discussed in the current NOM.

Conclusion II-6: Interview statements in the Luxor file, fatality files or settlement files did not contain language required by the NOM.

Recommendation II-6: Ensure that interview statements are taken, and documented, in accordance with the NOM.

Recommendation II-7: 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.

Conclusion II-7: Nevada OSHA should review its procedures and consider evaluating potentially repeat violations with the assistance of legal counsel.

III. Integrated Management Information System

Conclusion III-1: Nevada OSHA offices have a significant number of draft and incomplete records on the IMIS system.

Recommendation III-1: Nevada OSHA must perform a review and cleanup of the IMIS database records to ensure that all draft forms are finalized and transmitted to the host computer as expeditiously as possible, except for OSHA-1Bs less than six months old, because they may still be modified before the citations are issued. A system must be developed to ensure that periodic reviews of draft and rejected IMIS forms are conducted to maintain a viable information system.

Conclusion III-2: The majority of IMIS management reports are not being used effectively nor are they set up in the system for automatic generation and distribution.

Recommendation III-2: Nevada OSHA must establish a comprehensive system for the proper handling of the IMIS management reports system. An automated report setup program will assist the agency in ensuring that the most widely used reports are automatically generated, reviewed and acted upon on a periodic basis (either weekly, bi-weekly or monthly) based on the importance of the specific report and its volume of cases to be reviewed and monitored.

Conclusion III-3: The IMIS system is not kept up-to-date and contains information which does not allow for effective internal evaluation of the Nevada OSHA program.

Recommendation III-3: Nevada OSHA must ensure that the IMIS system is kept up-to-date and is accurate. Nevada OSHA needs extensive IMIS training to include: review of OSHA Instruction ADM 1-1.31 IMIS Enforcement Data Processing Manual, data entry (all forms), pre- and post-citation processing, handling of incomplete (draft) and rejected forms and IMIS Management reports processing to effectively improve and maintain an effective IMIS Maintenance and Management Reports structure.

IV. General Inspection Statistics

Conclusion IV-1: Fifty-two percent (52%) of all inspections resulted in citations. Of those 52%, over half of those cases (55%) resulted in only other-than-serious violations.

Recommendation IV-1: Nevada OSHA must evaluate its targeting system and make modifications to ensure that its limited resources are inspecting locations where serious hazards are present. Nevada OSHA must also ensure that violations are being classified in accordance with the NOM.

Conclusion IV-2: The focus on simply getting a large number of inspections may lead to cutting corners to meet the requirement.

Suggestion IV-2: Nevada OSHA should work with the Nevada legislature to begin tracking outcome measures instead of just pure numbers of inspections. Emphasis should be placed on reducing fatalities, injuries and illnesses.

Conclusion IV-3: Nevada OSHA groups its violations based on the location of the standards being cited in the code of state regulations rather than by the individual hazardous conditions.

Recommendation IV-3: Nevada OSHA must review its current citation grouping policies and procedures and issue citations in accordance with its NOM.

Conclusion IV-4: Only one willful violation was cited by Nevada OSHA during the evaluation period.

Recommendation IV-4: Nevada OSHA must conduct an internal review of its willful citation policy and take corrective action in order to be able to fully document and support willful violations so that they can be issued and successfully sustained/affirmed.

Conclusion IV-5: IMIS Reports are not utilized to identify cases requiring follow-up inspections to track abatement and to ensure abatement verification.

Recommendation IV-5: Nevada OSHA must begin using the “Candidates for Follow-up Inspections Report” and the “Violation Abatement Report” to identify and assign establishments that require follow-up inspections.

Conclusion IV-6: The list of most frequently cited standards shows limited hazard recognition with few hazards identified in the construction industry, which is where the majority of fatalities are occurring.

Recommendation IV-6: Nevada OSHA must review all available IMIS data reports and track the most frequently cited standards to determine what additional training, hazard recognition and case file documentation are necessary to increase the breadth of standards cited and the classification of such citations. Special emphasis should be placed on construction hazards in an effort to improve hazard recognition, which will result in

workers being removed from hazards. This should be done for the agency as a whole as well as for each individual SHR/IH.

V. Complaint Processing

Conclusion V-1: No diary sheets or similar daily/chronological logs were found in any of the 21 case files reviewed.

Recommendation V-1: See Recommendation I-2.

Conclusion V-2: No indication was found that the complainant was informed, in writing and/or recorded in IMIS, of the results of the inquiry/inspection.

Recommendation V-2: Nevada OSHA must ensure that all complainants are responded to in accordance with the Complaint Policies and Procedures directive, OSHA Instruction CPL 02-00-140. Complainant responses must be consistent with complaint handling procedures. All complaint inquiries must be responded to using IMIS Letter G – Employer Response to Complainant, and complaint inspections must be responded to using IMIS Letter H – Formal Complaint Inspection Results.

Conclusion V-3: The majority of complaints did not have the complainant's contact information in the IMIS.

Recommendation V-3: Nevada OSHA must make every attempt to acquire, document and enter into IMIS complainants' identification, including name, address and phone number, unless complainant explicitly requests to remain anonymous. All requests to remain anonymous must be documented in the case file.

Conclusion V-4: Inadequate abatement was received and accepted as adequate.

Recommendation V-4: Nevada OSHA must ensure that adequate abatement is obtained for all complaint items found valid, regardless of whether they are being handled via an inquiry or an inspection.

Conclusion V-5: As per the information in the case files, complaint items were found to be valid, but no citations were issued to address the hazards.

Recommendation V-5: Nevada OSHA must ensure that hazards identified during complaint inspections are addressed with the employer through citation, notification of violation or some other method.

Conclusion V-6: There were cases in which the complainant disputed the employer's response, yet no inspection took place and there was no acknowledgement of the disputed findings.

Recommendation V-6: All disputed complaints must be handled in accordance with OSHA Instruction CPL 02-00-140, including the complainant's right to request an

inspection and/or the agency's responsibility to respond whether an inspection will or will not be conducted and the reasons why.

Conclusion V-7: There were cases in which the complaint was classified improperly.

Recommendation V-7: Nevada OSHA must ensure that complaint allegations are properly evaluated and classified and that such classification will ensure proper handling of the complaint items, either via an inquiry or an inspection.

VI. Specific Cases

Conclusion VI-1: Case files did not contain diary sheets and were held together with a binder clip or rubber band, with correspondence that was intermingled throughout the investigation file.

Recommendation VI-1: See recommendation I-1.

Conclusion VI-2: Only one willful violation was proposed for any of the files reviewed. Interviews with investigators and supervisors indicated that willful violations were discouraged.

Recommendation VI-2: See Recommendation I – 5.

Conclusion VI-3: The Henderson Office leaves violations in draft in the IMIS until after informal and formal settlement agreements are reached and then amended citations are issued. If all informal conference violation reclassifications are updated in this fashion the IMIS data used for monitoring will be incorrect because it will not accurately reflect how many violations are reclassified during informal conferences.

Recommendation VI-3: Change the policy of leaving violations in draft to ensure that all citation history is maintained. Once this is in place, then a thorough evaluation of the informal settlement practices and procedures should take place and changes implemented if deficiencies are identified.

Conclusion VI-4: Deficiencies were noted on the OSHA 1B supporting documentation including: no contact information for workers interviewed and exposed to hazards; duration and frequency listed as "as needed" on the majority of the violations; missing equipment identifiers such as manufacturer, model number and serial number; and employer knowledge listed as "with due diligence."

Recommendation VI-4: Nevada OSHA must ensure that OSHA 1Bs are fully documented. Provide additional training to investigators on case file documentation and the importance of having each OSHA 1B fully documented. This training should also fully explain the legal process in Nevada, which will help them develop a more legally sufficient case.

Conclusion VI-5: Excessive and inappropriate grouping issues were identified in these files, as well as the fatality files and complaint inspection files that were reviewed. Interviews with supervisors and investigators indicated that violations were grouped if they were in the same subpart regardless of hazard, contrary to guidance in the NOM.

Recommendation VI-5: See Recommendation IV-3.

Conclusion VI-6: Some files contained the abatement verification form and others included the abatement verification form with additional documentation. Interviews with supervisors and investigators indicated that there was no clear policy conveyed indicating what abatement information employers were required to submit.

Recommendation VI-6: The abatement verification policy must be reviewed with all supervisors and investigators to ensure the supporting information and documentation required for abatement verification is present in the case files.

VII. Programmed Inspection Targeting System

Conclusion VII-1: The IMIS LEP codes do not match current LEP practices and LEP and Strategic Initiative codes are not always updated appropriately.

Recommendation VII-1: Nevada OSHA must update its IMIS coding database to list only those local emphasis and strategic initiative codes that are currently active. This will prevent inconsistencies and discrepancies in the tracking, monitoring and evaluation of these programs. Nevada OSHA must decide if one or both codes will be used by the state and provide appropriate IMIS training to secure adherence to this data entry policy.

Conclusion VII-2: IMIS coding is not available for all General Industry targeting systems.

Recommendation VII – 2: Work with the Office of Management and Data Systems (OMDS) to ensure that targeting codes are available and ready for use.

Conclusion VII-3: Nevada OSHA is entering OSHA 1s for every construction employer on multi-employer worksites which directly impacts the in-compliance rate experienced for the construction industry.

Recommendation VII-3: Discuss current Federal OSHA policy with Region IX and make any necessary changes to multi-employer worksite policies and IMIS data entry requirements.

Conclusion VII-4: The low percentage of serious violations and the high percentage of in-compliance inspections for programmed inspections indicate a need for an improved targeting system.

Recommendation VII-4: Perform an evaluation of the effectiveness of active LEPs and targeting programs. Once the evaluation is complete, make any necessary changes to

more effectively target high hazard industries and facilities. One tool that could be used to assist with the evaluation of targeting programs is Appendix A of OSHA Instruction CPL 04-00-001, Procedures for Approval of Local Emphasis Programs (LEPs).

Conclusion VII-5: Nevada OSHA has agreed to conduct 2,900 inspections per year as part of its budgeting process and this information is used by the legislature to determine if the program is meeting their goals. This translates to 95 to 115 inspections per year per investigator.

Suggestion VII-5: 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.

Conclusion VII-6: Nevada OSHA is not properly coding programmed-related inspections in the IMIS system.

Recommendation VII-6: Nevada OSHA must properly and accurately classify its programmed inspections based on NOM instructions on Page I-3 of 93. Programmed [Planned] inspections should only be used for the “initial” establishment and any high hazard employers at the worksite, while Programmed-Related inspections should be used for all other low-hazard establishments found at that multi-employer worksite.

VIII. Communication with Family Members of Deceased Employees

Conclusion VIII-1: Sections 12.5 and 47 of Bill 288 contain new responsibilities for the Division of Industrial Relations of the Department of Business and Industry regarding contact with family members of employees who were killed on the job.

Recommendation VIII-1: A policy must be developed and incorporated into the NOM which outlines the procedures to be followed in order to comply with Nevada OSHA’s new responsibilities. Because this amends the underlying state plan legislation, the state plan must submit a state plan change in accordance with 29 CFR 1953.4(d)(2).

Suggestion VIII-1: In addition, a tracking system should be developed to ensure that all necessary communications with family members are accomplished. In the development of the process to meet the requirements of Section 47 of the bill, include a step for confirming that contact information for the family is still accurate. Nevada OSHA should also look into developing a form to be completed which will ensure that the information provided to the Occupational Safety and Health Review Board will be consistent. Nevada OSHA should consider how it will handle multiple family members. For example: A deceased son/daughter of a father and mother who are divorced or a brother/sister with multiple siblings. Will they be providing letters to all family members or just one? How will they decide whom to communicate with? Will they be providing contact information to the Board for all family members or just for one?

Due to the sensitive nature of this issue, it is also suggested that a uniform method of letter completion and signature be developed to ensure that all letters are uniform and signed by the appropriate official.

IX. Nevada OSHA's 10/30 Hour Courses

Conclusion IX-1: Assembly Bill 148 contains new requirements for Nevada OSHA.

Recommendation IX-1: Because this new law amends the underlying state plan legislation, the state plan must submit a state plan change in accordance with 29 CFR 1953.4(d)(2).

Conclusion IX-2: Regulations are currently under development to address this new legislation.

Recommendation IX-2: Work closely with OTI and Region IX to ensure that the regulations under development do not conflict with Federal OSHA Outreach 10- and 30-hour courses.

Conclusion IX-3: The new legislation is silent regarding who is required to pay for the required worker training.

Recommendation IX-3: Nevada OSHA needs to contact the U.S. Department of Labor's Wage and Hour Division to ascertain and get clarification regarding the conditions under which employers must pay wages to employees during training.

X. Personnel and Training

Conclusion X-1: Records indicate that Nevada OSHA is currently not in compliance with OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel.

Recommendation X-1: Nevada OSHA must follow OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel, dated November 3, 2008, adopted by the state on January 3, 2009.

Conclusion X-2: Employees are assigned fatality investigations prior to completing the Accident Investigation course.

Suggestion X-2: The State should not send investigators to conduct fatality/accident investigations until they have completed the accident investigation course.

Conclusion X-3: Nevada OSHA maintains an emergency response team; however, training records for emergency response training are incomplete.

Recommendation X-3: Emergency response training records must be maintained to ensure that all response team members receive the required training.

XI. Retention of Staff

Conclusion XI-1: Employees with 3 years of safety and health experience have left the employment of Nevada OSHA for higher paying safety positions.

Suggestion XI-1: Evaluate all safety positions in Nevada State Government and work to reclassify positions to higher paying safety classifications.

Conclusion XI-2: Lack of clear guidance and support could be leading to low employee morale.

Suggestion XI-2: Explore ways to identify whether employee morale is leading to the desire to leave employment with Nevada OSHA.

APPENDIX B

**Comments from the Nevada Department of Business and Industry, Division of
Industrial Relations, Occupational Safety and Health Administration**

STATE OF NEVADA

JIM GIBBONS
Governor

DONALD E. JAYNE, CPCU
Administrator



DIANNE CORNWALL
Director

STEVE COFFIELD
Chief Administrative Officer

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

October 14, 2009

Executive Summary
State Plan Monitoring and Evaluation
Federal OSHA Special Study of Nevada OSHA
July 2009

From July 15-30, 2009, Federal OSHA conducted a baseline Special Study of the Nevada OSHA program to determine how well Nevada OSHA complies with federal and state policies and procedures related to the State Plan State process. A team of four experienced state plan monitors from around the country performed this evaluation. It should be noted that Federal OSHA has indicated their intentions to revise their State Plan monitoring and evaluation process. The Nevada Special Study was the first effort by Federal OSHA to implement their new process. It is our understanding that Federal OSHA plans to conduct a baseline review in each State Plan State during the next 12 - 18 months.

The July 2009 Nevada Special Study focused on identifying areas needing improvement and as such was different from the State Plan monitoring process that had been performed by Federal OSHA Region IX during the past 10 years. Region IX's official determination on the performance and effectiveness of State Plans has been the annual Federal Annual Monitoring Evaluation (FAME) Reports.

During past quarterly meetings with Region IX, two or three Region IX staff members met with the Nevada OSHA staff and reviewed inspection performance statistics. Nevada OSHA was usually given positive feedback during the quarterly reviews by Region IX and in their annual FAME reports. There would also occasionally be areas where the Region IX monitors thought that Nevada OSHA fell short. When that happened, the issue was thoroughly discussed, recommendations made, and Nevada OSHA did its best to implement the recommendations.

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On the other hand, many of Region IX's comments were quite favorable. For example, in the most recent issued FAME report (for federal fiscal year 2007), Federal OSHA Region IX stated that Nevada's enforcement and consultation programs continued to be very good overall and that the State continues essential program activities mandated by the Occupational Safety and Health Act. In the same report, Region IX also stated that employer surveys returned continued to reflect a high satisfaction rating during this evaluation period and that Nevada contributed \$4,408,121 of its \$5,540,521 budget (80%). Region IX also stated that Nevada is to be commended for its efforts in trying to improve safety and health in the State as evidenced by its budgetary participation.

During the July 2009 baseline Special Study, a totally different approach was taken. A four person team of experts from around the country performed the evaluation. Fatality and other inspection report case files were obtained and extensively reviewed by the evaluators. Two Complaint Against State Plan Administration (CASPA) files were also extensively evaluated, even though the CASPAs had already been evaluated during the original investigation by Region IX. Enforcement staff training was also evaluated and training records were reviewed. The Nevada OSHA Training Coordinator was questioned extensively about staff training, training funding, etc. In addition to the administrative evaluation process, our staff members were privately interviewed. Most of the interviews lasted from one to one and one half hours. The Nevada OSHA employees interviewed included one District Manager, five enforcement supervisors, and a large number of enforcement staff members.

The Special Study report generated by the Federal OSHA evaluation team was written in a manner that concentrated on identified exceptions to normal OSHA operations. This approach does not provide positive feedback or recognition of efforts made by the Nevada OSHA staff. The Special Study approach does not offer an overall assessment of the fundamental OSHA process in Nevada indicating that it was functioning, while in need of improvement.

Nevada OSHA is under new leadership with Steve Coffield serving as the recently appointed Chief Administrative Officer of Nevada OSHA and Don Jayne as the Administrator of the Nevada Division of Industrial Relations and Nevada State Plan Designee. This management team is committed to resolving both real and perceived problems with Nevada's OSHA program.

On September 17, 2009, Don Jayne, Steve Coffield and Resty Malicdem were briefed by Federal OSHA on the "draft" findings of the Special Study. The Federal OSHA members in attendance were Steve Witt, Director, DCSP, OSHA National Office; Ken Atha, OSHA Region IX Regional Administrator; and Bonita Winingham, Des Moines, Iowa Area Director and Team Leader. During this meeting Director Witt confirmed that the Special Study approach is being considered for use by Federal OSHA in state plan monitoring and evaluation and may be used in lieu of the FAME reports. The Special Studies will create a baseline for future State Plan Monitoring and Evaluation efforts which will be more extensive than in the recent past.

The Nevada OSHA leadership and staff are committed to resolving the deficiencies identified in this report. While the Special Study process focuses on areas in need of improvement; it provides an independent review of critical elements of the Nevada OSHA program which will aid management in developing and implementing corrective action plans. Nevada OSHA action plans will create a training and standardization unit to manage the training and improve the competency of our enforcement staff. We are also expanding the Program Coordinator function, which will enable the individuals assigned to these positions to deal with the State Plan State issues, budgeting, regulatory development issues, etc. We are also reviewing our legal services support. Our goal is to revitalize the staff, mend fences with our partners, restore public confidence in the agency, and to perform thorough, legally sufficient inspections that will stand the scrutiny of the review process. Nevada OSHA is committed to enhancing its operations so that we are better prepared to address the worker safety and health concerns in the State of Nevada.

Nevada OSHA would also like to take the opportunity to thank the Federal OSHA team that performed this evaluation. The team members were professional, informative and easy to work with. We look forward to continuing to work with them to resolve the identified issues that are beyond our ability or resources to correct.

Nevada Response to OSHA Evaluation

The baseline Special Study report is 66 pages in length and has a unique format in that it repeats itself throughout the document. The purpose of this memo is to attempt to capture the essence of their findings, which have been broken down by type (Operational; Training; Administrative) with a short Nevada OSHA response following each finding addressed.

Operational

(1) 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 are 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)

Nevada OSHA Comment:

The findings regarding willful violations are partially an issue of perception. Nevada OSHA has issued 13 willful violations from calendar years 2000 through 2009 (9-25-09).

2000: 0	2005: 0
2001: 5	2006: 1
2002: 2	2007: 1
2003: 2	2008: 0
2004: 2	2009: 0

Willful violations are difficult to prosecute and require a high burden of proof to be sustained at the Nevada OSHA Review Board. Nevada OSHA had decided to proceed cautiously, with advice from legal counsel, when deciding if a willful violation would be issued and wanted to make certain that a viable case had been developed. Nevada OSHA Management does not discourage willful violations, but it does require the appropriate level of proof necessary to sustain the willful violation. It is understandable that our staff perceives management or legal counsel discourages willful violations, because the burden of proof is so high. Nevada OSHA will re-evaluate its stance regarding willful violations. OSHA inspection staff will receive training on the revised policy. Nevada OSHA will work with legal counsel to identify training needs for both enforcement staff and legal counsel in preparing cases containing willful violations in order to be sustained upon review.

(2) 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)

Nevada OSHA Comment:

The circumstances surrounding the Orleans Hotel and Casino case have been extensively reviewed in the past. Willful violations and repeat violations were proposed in the closing conference but were negotiated to serious violations in the settlement conference. As an agreement to cooperate was negotiated with the employer, including the original penalties and a significant commitment by the employer to improve their safety and health management system, Nevada OSHA has no additional comments.

(3) In 17% (4 of 23) 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)

Nevada OSHA Comment:

Since the evaluation, we have confirmed with the inspection staff their understanding that during a fatality investigation, management does not want hazards unrelated to the actual fatality to be addressed. This belief does not correctly reflect Nevada OSHA policy. We expect all recognized serious hazards observed during a fatality investigation or any other type of inspection to be addressed. This would include information observed upon review of photographs, if a prima facie case can be established. This will be clarified to management and re-enforced with the inspection staff.

(4) 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)

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.

Nevada OSHA Comment:

The finding regarding the employee interview process is an incorrect statement. The two Nevada OSHA inspectors on site (one supervisor, and one safety specialist) interviewed a number of hotel employees that might have had an opportunity to access the hazard.

However, none of the employees interviewed could recall ever having changed the light in question. The finding regarding the union representatives not being present is correct. The inspectors did not contact the union staff to accompany them on the inspection, and they should have. This deficiency will be addressed through policy reminders and re-training.

(5) Abatement of hazards was not properly documented. OSHA staff interviews showed there was confusion about the correct procedures to follow.

Nevada OSHA Comment:

Nevada OSHA management made the decision to centralize the administration of citations, penalties and abatement into a single staff member. Nevada OSHA's decision to centralize this process has not been previously identified as an item of concern for Federal OSHA. The Administrative Assistant that processes all citations also tracks abatement for each case file. We will verify the documentation required by Federal OSHA policy and ensure abatement is more completely documented in future case files.

(6) 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 Comment:

Nevada OSHA will fully implement the fatality CPL and Nevada Senate Bill 288 regarding notifying family members. Implementation will result in a total of three letters being sent to the family members of the decedent. The District Manager (DM) and Chief Administrative Officer (CAO) will issue and sign letters at the beginning of the investigation. The DM's letter will also include an enclosure that describes for the family how the investigation process works, etc. At the conclusion of the investigation, the DM will send an additional letter to the family, outlining the findings of the investigation and containing a copy of the investigative report and proposed citations. In addition, the DM's will offer to enter into a discussion with the family member(s) when citations are proposed, as outlined in Senate Bill (SB) 288.

(7) The OSHA Integrated Management Information System (IMIS) data base showed that out of 2,117 programmed, planned inspections, Nevada experienced a high number of in-compliance inspections. The high rate of in-compliance inspections and low percentage of “serious” violations (for safety violations, Nevada’s average of programmed inspections with serious violations was 26% compared with 79% for Federal OSHA) 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. (IV-1, VII-4)

Nevada OSHA Comment:

Nevada OSHA will perform an evaluation of the effectiveness of active targeting programs. Once the evaluation is complete Nevada OSHA will make any necessary changes to more effectively target high hazard industries and facilities. Plans are being finalized to reorganize the Program Coordinator function which will result in ongoing monitoring of the results of our programmed inspection targeting system.

In addition, our training and standardization plans will improve the knowledge and hazard recognition skills of our inspectors, which will increase our serious violation rate.

(8) 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) In addition, OSHA 300 Injury and Illness data was not entered into IMIS.

Nevada OSHA Comment:

Nevada OSHA is adopting the new Field Operations Manual and will ensure it is reconciled with OSHA Instruction CPL 02-0.131 on review of OSHA 300 Injury and Illness Logs. Our enforcement staff will be trained on this policy.

Regarding the finding that OSHA 300 Injury and Illness data is not entered into the IMIS system. Nevada OSHA has not entered this data into the IMIS for at least the last 15 years, and this apparent deficiency was not previously identified by Region IX as a finding. However, we will begin doing so once IMIS training for our inspection staff can be coordinated with Region IX.

(9) 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-12)

Nevada OSHA Comment:

Nevada OSHA frequently issues "Notices of Violations", (NOVs), instead of other than serious violations, which according to the inspectors interviewed has been perceived as

misleading by employer representatives. Notices of Violation are "other than serious" violations. They were developed many years ago to provide immediate notification that a violation had been observed by Nevada OSHA and to speed the process for employers that had no serious violations, especially in the outlying areas of the State. We will clarify NOV procedures with the staff.

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

Nevada OSHA Comment:

Nevada established the goal of 2900 inspections per year in conjunction with Nevada's legislative budgetary oversight. While the primary focus was on the number of inspections, quality should not be compromised. Emphasis should be on reducing fatalities, injuries and illnesses. During the 2009 Nevada Legislative session, Nevada OSHA committed to review all performance standards to develop additional measurable, quality based performance indicators. Some components to be measured may include numbers of hazards abated, serious violation rate, and targeting establishments with high Bureau of Labor Statistics injury and illness rates.

(11) 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)

Nevada OSHA Comment:

Nevada OSHA is not following grouping procedures as outlined in the Nevada Operations Manual. Nevada OSHA was basically over grouping citations, which lessens the monetary penalty and the deterrent value of an inspection. A review of the correct use of the grouping policy will be accomplished and the staff trained to address this issue.

(12) Retention of staff. Employees with as little as 3 years of experience have left Nevada OSHA for higher paying positions

- (a) Work to obtain higher salaries for OSHA enforcement staff.
- (b) Lack of clear guidance and support could be leading to low employee morale.

Nevada OSHA Comment:

Nevada OSHA is acutely aware of the retention issues affecting our staff. We intend to address this issue with a multi faceted approach. First, we will work on improving staff

morale. Second, we must also be more supportive of staff through additional communications when inspection outcomes are over turned. Third, the new training and standardization process developed by staff and management should improve staff self confidence. Finally, as the economy improves, we will continue to pursue an increase in salary to bring our staff members up to par with safety and health professionals in the private sector and local governments.

Training

(1) 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 have 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)

Nevada OSHA Comment:

Nevada OSHA has suffered from significant staff turnover in the past five years. The turnover issue has been evaluated and discussed in the past and continues to be a topic of concern. The new inspection staff members have received as much training at the OSHA Training Institute as our budget would allow. They have also attended all or most of the training classes offered by the Safety Consultation and Training Section. In addition, first line supervisors and more experienced inspectors provide field training. Training resources will continue to be sought and our staff will receive as much training as we can obtain.

(2) Nevada OSHA is not maintaining all of its enforcement data in the IMIS and not using it to run reports that would better 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 Comment:

The existing Nevada OSHA staff has not received IMIS/NCR training. We are essentially self-taught. We will work with Region IX on setting up supervisory computers to be programmed to generate commonly used management reports. We will also seek additional IMIS/NCR hands on training from Federal OSHA Region IX.

(3) The IMMLANG policy (code to track fatalities among Hispanic and immigrant workers) is not consistently followed.

Nevada OSHA Comment:

The inspection staff was instructed to complete the immigrant language policy since its inception, however we did not realize that it needed to be "adopted". Nevada OSHA will adopt this policy. We will re-train staff on this requirement.

(4) Records indicate that Nevada OSHA is currently not in compliance with OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel. Nevada OSHA must follow OSHA Instruction TED 01-00-018, Initial Training Program for OSHA Compliance Personnel, dated November 3, 2008, adopted by the state on January 3, 2009.

Nevada OSHA Comment:

Nevada OSHA, as previously discussed, has had retention issues during the past 5 years due to retirements, low salaries, low morale, etc. However, the agency will continue to ensure that every dollar of our allocated training funds is efficiently used. We will seek higher training budget authority during the next Legislative session so that training deficiencies can be corrected.

Administrative

(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)

Nevada OSHA Comment:

Nevada inspectors verbally inform workers of their legal protection against discrimination, as well as, their rights and responsibilities. However, this was not documented in the interview notes. Agency forms used to record comments and interviews will be changed so that the appropriate language is incorporated, providing written confirmation, regarding whistleblower protections.

(2) 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)

Nevada OSHA Comment:

We will adopt the Federal OSHA model for assembly of case files.

(3) Employee contact information was not obtained for employees interviewed and exposed to hazards. (See I-8, V-3, VI-4) Thus case files frequently did not have the home address and the phone number of exposed employees.

Nevada OSHA Comment:

Nevada OSHA policy regarding interview techniques will be reviewed, clarified and reiterated to the inspection staff. The address and phone numbers of exposed employees will either be obtained or a note will be written stating that the employee refused to provide the information.

(4) Nevada OSHA must perform a review and clean up of the IMIS database records to ensure all draft forms are finalized and transmitted to the host computer.

Nevada OSHA Comment:

Region IX has committed to obtain persons with IMIS/NCR expertise to help clean up our data base and also provide training to staff on the IMIS/NCR advanced procedures.

(5) The OSHA Case File Cover Sheets did not provide a ready record and summary of all actions relating to a case. The Case File Cover Sheet must be used in accordance with the NOM or a Diary Sheet should be added to ensure that all communications are documented in the case file.

Nevada OSHA Comment: Nevada OSHA will implement the case file diary as we move forward with implementing the new Field Operational Manual.