FY 2011 FAME

STATE OF VERMONT
DEPARTMENT OF LABOR
VERMONT OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
23(G) PROGRAM
(VOSHA)

Federal Fiscal Year 2011

(October 1, 2010 to September 30, 2011)

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REGIONAL ADMINISTRATOR
OSHA REGION I

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I. EXECUTIVE SUMMARY

A. Summary of the Report

The purpose of this report is to assess the Vermont Occupational Safety and Health Administration's (VOSHA) activities for FY 2011. To this end, Region I evaluated the State's performance in the following areas:

- enforcement (complaints, fatalities, targeting and programmed inspections, citations and penalties, abatement, employee involvement , and informal conferences, etc.);
- standards and federal program changes adoption;
- discrimination program;
- voluntary compliance;
- public sector onsite consultation program; and
- State progress in achieving annual performance goals and objectives.

In addition to conducting an evaluation of the State's FY2011 performance in the areas listed above, Region I also conducted an assessment of the State's progress in addressing outstanding recommendations from the previous year's report—the FY 2010 Enhanced Federal Annual Monitoring Evaluation (EFAME) Follow-Up Report. The Region's review of the State's discrimination program this year was also extensive, as required in the Directorate of Cooperative and State Program's (DCSP's) FY 2011 Federal Annual Monitoring and Evaluation (FAME) Guidance, and is a special focus of this report.

Region I conducted its assessment of State Plan performance based on the following:

- a comprehensive review of 70 inspection case files closed in FY 2011 and 10 whistleblower case files opened from October 11, 2009 through September 30, 2011;
- a review of State Plan Enforcement data for FY 2011, including a comparison of State and Federal data;
- a review of the State Activity Mandated Measures (SAMM) Report and the Interim State Indicator Report (SIR);
- a review of voluntary compliance files for Voluntary Protection Program (VPP) sites and VOSHA's Alliance partners; and
- interviews with the VOSHA director; compliance chief; five compliance safety and health officers (CSHO); the program's two whistleblower investigators; and one whistleblower stakeholder.

In FY 2011, the Vermont State Plan had no Complaints About State Plan Administration (CASPAs); otherwise, these files would also have been reviewed. An analysis of the Integrated Management and Information System (IMIS) reports identified above (such as the SAMM, SIR and Enforcement statistics) and the Region's onsite case file review of inspection case files, indicate that all but one of the findings in the FY 2010 Enhanced FAME (EFAME) Follow-Up Report remain uncorrected. For example, issues persist with respect to violation classification and gravity assessments; inadequate documentation of abatement; evidence to support violations cited as serious; and sending letters to

fatality victims' next of kin. Section III of this report details the status of all of the findings cited in the FY 2010 Report. Any corrective actions the State has been taking to correct these findings have apparently not been effective.

The Region's case file review this year also identified new findings in addition to the persistence of those cited in the previous year's report. Chief among these are severe deficiencies with respect to fatality investigations, such as failure to follow fundamental fatality investigative procedures outlined in OSHA's Field Operations Manual (FOM), and failure to thoroughly document fatality incidents. These and other new findings, as well as the actions the Region is proposing to address these deficiencies, are discussed in more detail in Section IV of this report.

The Region's special study of the State's discrimination program also raised a number of serious concerns: the program's investigators do not have sufficient training and supervision, and the VOSHA managers who supervise the discrimination program have no training or experience in discrimination investigation. The whistleblower audit team found that in some cases, "no distinction was made between established fact and uncorroborated assertion," and that the investigators tended to "reach conclusions without examining each element of the prima facie case." These and other serious problems in the State's discrimination program are discussed further in Section IV of this report.

In FY 2011, VOSHA fell short of its goal of 400 inspections, conducting only 317.[1] According to the VOSHA managers, Tropical Storm Irene and the extended medical leave taken by the VOSHA director, which coincided with the storm's impact, made it difficult for VOSHA to efficiently conduct all aspects of its program. As discussed later in this report, however, Region I does not agree that these events significantly affected the State's ability to meet its inspection goals. The fact is that there was only one month remaining in the fiscal year when the storm hit, and VOSHA was already so far behind in its inspections that it would not have been possible for the State to make up the ground it needed to reach its goal, even if the storm (and the other circumstances cited by VOSHA management) had never occurred.

There is no question that the State encountered many obstacles in FY 2011, such as the loss of one CSHO to another state agency; extended medical leave taken by key administrative and management personnel; and significant weather events. However, the State must recognize that the key deficiencies cited in this report are due to failure by management and staff to follow OSHA's policies and procedures. Management also did not take the steps necessary to keep the program on track for meeting its inspection goals. It will take a major commitment to program improvement on the part of the Vermont Commissioner of Labor and strong Region I oversight to move the VOSHA program forward this year.

[1] VOSHA's SOAR states that the Plan conducted 342 inspections (237 safety and 105 health) in FY 2011. However. this data was derived from an Inspection Summary Report which was run later than the IMIS Inspection and Enforcement reports used in this report. Region I derived its data from IMIS reports which were run by OSHA's Office of State Programs (OSP) on November 8, 2011. Region I used these reports in accordance with the OSP's FY 2011 FAME Guidance.

B. Introduction of State Plan

Vermont State Plan Background

State Designee: **Anne M. Noonan, Commissioner of Labor**[2]
Vermont Department of Labor
5 Green Mountain Drive
Montpelier, Vermont 05601
Program Manager: **Robert McLeod**

Plan approved: **October 1, 1973**

Plan Certified **(completion of developmental steps)**: **March 4, 1977**

Final Approval/18(e) Determination: **Pending**

FY 2008-2012 Funding History						
	Federal Award	**State Match**	**100% State Funds**	**Total Funding**	**% of State Contribution**	**Unmatched / Deobligation/One-Time Only**
2012	$750,800	$750,800	$0	$1,501,600	50	0
2011	$750,800	$750,800	$0	$1,501,600	50	0
2010	$725,800	$725,800	$0	$1,451,600	50	$30,900
2009	$725,800	$725,800	$0	$1,451,600	50	0
2008	$713,100	$713,100	$12,700	$1,438,900	50	0

In July 2011, Vermont requested, and was granted, $25,000 in additional federal funds. The State of Vermont also matched this increase in federal funding. Therefore, Vermont's total funding (both state and federal) increased by $50,000 in FY2011, from $1,451,600 to $1,501,600. In FY2011, VOSHA used this additional funding to offset increased costs in personnel, fringe benefits, travel, equipment, and other areas that the plan had not anticipated when it prepared its FY2011 budget.

For example, VOSHA incurred unanticipated overtime costs due to an increase in its 11(c) whistleblower case load (to a total of 5 cases for the year). Another significant cost that the plan had not anticipated was the travel expense associated with sending one compliance safety and health officer (CSHO) to three process safety management (PSM) courses at the OSHA Training Institute (OTI) in Arlington Heights, IL. The plan also purchased electronic and industrial hygiene equipment with the additional funds.

[2] Appointed January 6, 2011; replaced Valerie Rickert.

Vermont 2011 Covered Workers		
Public Sector Employees	**Private Sector Employees**	**Total Employees Covered**
47,216	244,545	291,761

VOSHA Staffing (All positions funded 50% State/50% Federal)		
23(g) Grant Positions	**Allocated Full-Time Equivalents (FTE)**	**FTE On Board as of 9/30/2011**
Managers/Supervisors (Administrative)	0.85	0.85
First Line Supervisors (Program)	1.00	1.00
Safety Compliance Officers	6.00	5.00
Safety Compliance Staffing Benchmark	*9.00*	
Health Compliance Officers	4.00	4.00
Health Compliance Staffing Benchmark	*13.00*	
Public Sector Safety Consultants	0.45	0.45
Public Sector Health Consultants	0.25	0.25
Compliance Assistance Specialist	1.00	1.00
Clerical	1.00	1.00
Other *(all positions not counted elsewhere)*	0.06	0.06
Total 23(g) FTE	**14.61**	**13.61**

SIGNIFICANT PROGRAM HISTORY

VOSHA has been administered under the Vermont Department of Labor, Division of Workers' Compensation and Safety, since July 1, 2005. The Department of Labor is the enforcing agency for the program. The Commissioner has the authority to issue safety and health citations. The program is operated through the program's headquarters at 5 Green Mountain Drive, Montpelier, Vermont, as well as several field offices located throughout the state.

In FY2011, VOSHA's enforcement program was fully staffed for the first half of the fiscal year with six safety and four health CSHOs, and one compliance assistance specialist (CAS)/Voluntary Protection Program (VPP) coordinator. Midway through the fiscal year, however, one safety CSHO resigned from the program. In November 2011, another CSHO with a background in safety was hired to fill this vacancy.

VOSHA does not have sufficient funding to staff at its benchmark levels for compliance officers. Since Vermont currently does not have final approval status, it is not required to maintain its allocated staffing levels to meet its benchmarks.

VOSHA's public sector consultation program consists of two safety and health consultants who commit a fraction of their time to provide on-site consultation services to the public sector. The public sector staff is also utilized in support of the VOSHA Strategic Plan.

Vermont has adopted most Federal standards by reference. The state has two unique standards: one addressing permissible exposure limits (PELs) and one for electrical power generation, transmission and distribution. The PELs enforced by VOSHA are those issued by Federal OSHA in 1988 and subsequently overthrown in court. They are considerably stricter than OSHA's current PELs. Construction, manufacturing, transportation and warehousing, non-durable goods wholesalers, and healthcare and social assistance sectors are the state's high-hazard targeted industries.

Vermont's coverage of pubic employees is identical to that of private employees, including citation issuance and first instance sanctions. VOSHA also offers a number of voluntary and cooperative programs, including Green Mountain (GM) VPP and Project WorkSAFE (consultation), SHARP, and Project RoadSAFE (funded by the Federal Highway Safety Administration to inform employers about hazards associated with motor vehicles).

C. Monitoring Methodology

From January 23-27, 2012, Region I conducted an onsite review of 70 randomly selected inspection case files that were closed in FY 2011. This review was conducted at VOSHA headquarters at 5 Green Mountain Drive, Montpelier, Vermont. This case file review was comprehensive in scope, in that the Region addressed all aspects of the inspection process (i.e., hazard identification, penalties, abatement, etc.) in its review. The review included five fatality case files (four of which were opened in FY 2011 but not yet closed as of the date of the onsite review; and one that was opened in FY 2010 and closed in FY2011).

In conjunction with this case file review, Region I interviewed five out of 10 Vermont CSHOs and the VOSHA director and compliance chief. The focus of these interviews was on the changes in the State's program administration and other effects of OSHA's enhanced Federal monitoring of the VOSHA State Plan program. Region I also evaluated data from the State's Enforcement statistics, the FY 2011 SAMM and SIR Reports, and several IMIS reports run by the State for the purpose of evaluating program management.

The results of the case file review, interviews with VOSHA staff, and the data from the above referenced IMIS reports were used by Region I to evaluate the performance of the State Plan in conducting enforcement activities and addressing the findings of the FY 2010 EFAME Report. Federal OSHA also identified a number of new findings identifying performance deficiencies in Vermont's programs.

To evaluate the performance of VOSHA's 23(g) consultation program, Region I used data from the following IMIS reports run for FY 2011: the Mandated Activities Report for Consultation (MARC) and the Consultation Report.

Breakdown of Inspection Case Files Reviewed	
No. of Safety	48
No. of Health	22
Accident (fatalities)	5
Complaints	17
Referrals	11
Ownership	Local Gov't.(5); State Gov't. (2); Private Sector (63)
Union	6
Non-union	64

Region I whistleblower investigators conducted a special study of the VOSHA discrimination program on site on January 23-24, 2012. The team examined 10 of eleven cases recorded on the IMIS Case Listing from October 11, 2009 through September 30, 2011. The whistleblower audit team interviewed VOSHA managers, the State's two whistleblower investigators, and one stakeholder. More information on the whistleblower case study methodology is contained in Section IV of this report.

D. Findings and Recommendations

With regard to the State's enforcement activities, several of the key findings in this report target deficiencies that were identified, discussed and/or cited as findings in the previous two FAME reports (FY 2009 and FY 2010). For example, Region I continued to find that:

- VOSHA's percentage of Serious, Willful, and Repeat (S/W/R) violations was not comparable to Federal OSHA's;
- VOSHA did not properly assess the probability and severity of violations, tending to err on the side of lower probability and severity than warranted by the nature of the violation(s) cited;
- VOSHA misclassified violations (Serious Violations were classified as Other-than-Serious);
- some case files were closed without having adequate documentation of abatement;
- VOSHA did not contact fatality victim's next of kin in a timely manner;
- some case files did not contain field notes; and
- CSHOs who were cited in the FY 2009 EFAME Report as not having completed OSHA Training Institute (OTI) Course #1310—Investigative Interviewing Techniques, still have not completed this course. In addition, none of the program's CSHOs have completed the mandatory training track for compliance officers as required by OTI.

Other findings identified areas of concern that were not focused on during Federal OSHA's previous evaluations. For example, the Region found that some case files did not properly assess penalty reductions (based on history, size and good faith); case files did not contain documentation that air sampling and noise surveys were performed where appropriate; and no documentation of employee interviews was contained in some case files, although such interviews would likely have provided valuable factual information concerning hazardous conditions.

To address the recurring findings listed above, VOSHA reports that it has conducted internal training for all CSHOs on various chapters in OSHA's Field Operations Manual (FOM) that relate to these deficiencies. However, when interviewed about this training, CSHOs said that it was essentially a "waste of time," in that they were already familiar with the FOM and its requirements.

This report, however, indicates that VOSHA managers and staff do not understand and/or follow the FOM. As discussed in more detail in Section IV, the program's most significant deficiencies are due to managers' and CSHOs' inattention or failure to understand basic inspection and investigatory techniques.

For example, in one fatality case:

- The CSHO did not identify and interview all persons with firsthand knowledge of the incident;
- The CSHO did not thoroughly document how and why the incident occurred, describe or sketch the physical layout of the scene, or take measurements, etc.
- The CSHO overlooked violations that were documented by photos of the accident scene that were contained in the case file, and did not issue citations based on these violations.

Region I also found that in another fatality case, VOSHA did not follow basic investigatory techniques as outlined in the FOM and did not consider issuing citations. And in another, the program was months overdue in sending a next-of-kin letter to a victim whose family resides in Mexico, on the grounds that VOSHA had been unable to translate the letter into Spanish.

In light of these serious deficiencies, Region I will intensify its quarterly monitoring of the State Plan, and will randomly select a number of case files to review to ensure that the program is adhering to the FOM's inspection policies and procedures. Region I will also review all fatality case files before they are closed to ensure compliance with all FOM requirements. This enhanced monitoring will continue as long as the Region deems it necessary to ensure that the State meets OSHA's requirements for inspections and fatality investigations. Since OSHA places a high priority on communicating with families after a workplace fatality, Region I will also closely monitor VOSHA to ensure that all next of kin communication is conducted promptly and in accordance with the FOM.

Consistent with the Region's finding that many enforcement inspections were inadequate, the whistleblower program audit found that the State's whistleblower investigators failed to conduct a thorough analysis of "each element of the prima facie case." The whistleblower audit team identified several weaknesses in the VOSHA discrimination program, and made findings in the following areas:

screening complaints; investigation procedures; report writing; case file management; settlements; timeliness of completion; program management; outreach; public sector complaints; use of a VOSHA-created form; Freedom of Information Act (FOIA) requests; and failure to obtain Federal OSHA's concurrence with VOSHA's determinations.

The Region's chief concerns with the State's discrimination program are as follows:

- VOSHA failed to implement important recommendations from previous Federal OSHA audits. For example, files were not tabbed and organized according to the Whistleblower Investigations Manual, letters were not sent to the parties, case logs were not used in each case, Final Investigative Reports (FIRs) did not address each element of the prima facie case, and VOSHA failed to establish an appeals process.
- VOSHA also failed to notify complainants of their rights - the right to dual file, the right to file a Complaint About State Program Administration (CASPA), or the right to file an appeal of VOSHA's determination.
- In some cases, OSHA would not have reached the same determination as VOSHA. In other cases, the investigation and final report lacked the evidence and/or analysis necessary to determine whether OSHA would have reached the same conclusion.
- Vermont's investigators have not received sufficient training and supervision.
- Those personnel supervising the discrimination program have no training or experience in discrimination investigations.
- VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult for employees and employers to locate; this section of the VOSHA website needs to be completely revised.

To ensure that Vermont's discrimination program improves to a level of acceptable performance, Region I has compiled an extensive list of recommendations, which are discussed in more detail in Section IV of this report. Although all of these recommendations should be implemented as soon as possible, the State should consider implementation of the following recommendations as urgent:

- Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be generally familiar with the other 20 federal statutes enforced by OSHA, which would enable VOSHA staff to refer appropriate complaints falling under these other statutes to federal OSHA.
- Immediately implement an appeals process in conformance with the Whistleblowers Investigations Manual.
- Train managers and discrimination investigators in the investigative process, the elements of a violation, and case analysis.
- Ensure that all reports contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination.
- Ensure that the supervisor has access to IMIS and has had training on how to run reports; keep investigators informed about changes to Federal OSHA's program; and require Vermont supervisors and investigators to confer with Federal OSHA on all complex cases.

- Establish a budget for Vermont staff attendance at whistleblower investigator national conferences and regional whistleblower meetings.
- Redesign the VOSHA website to clearly articulate discrimination rights and make the information easily accessible to employers and employees.

In addition to making these findings and recommendations, Region I will play an active role in ensuring that VOSHA implements the recommendations made in this report. To this end, Region I will require VOSHA to submit completed whistleblower case files for review to the Region, and to send investigators and those supervising discrimination work to the Basic Whistleblower Investigation Course #1420 at OTI. Region I OSHA will also provide training for investigators and managers on investigations, case file analysis, and case file management, as discussed in more detail in Section IV.

II. MAJOR NEW ISSUES

The Region's onsite case file review identified serious concerns with VOSHA's conduct of fatality investigations, administration of its whistleblower program, and conduct of whistleblower investigations. These items are fully addressed in Section IV of this report.

III. STATE RESPONSE to FY 2010 RECOMMENDATIONS

VOSHA's Corrective Action Plan (CAP) addresses each of the 11 findings cited in the state's FY 2010 EFAME Follow-Up Report. Seven of these 11 findings related to findings that were also cited in the FY 2009 EFAME Report; four were newly cited in the FY 2010 EFAME Follow-Up Report.

Each of the corrective actions that VOSHA reports on taking in its CAP applies to multiple findings in the FY 2010 EFAME Report, and the state's efforts are ongoing. For example, the VOSHA compliance chief is reportedly reviewing *all* case files before they are closed to help ensure proper classification of violations and gravity assessments, and ensure that case files contain sufficient documentation to verify abatements and substantiate violations cited. The VOSHA compliance chief is also checking case files for labor union notifications, and to ensure that the files contain copies of letters sent to fatality victims' next of kin.

Another corrective measure that applies to multiple findings is the state's plan to re-train staff on Chapters 4 (Violations) and 6 (Penalties) of the FOM. VOSHA is also running monthly SAMM and IMIS Inspection and Enforcement reports, and reviewing quarterly SIRs to monitor classification of violations, penalty assessments, and the progress of employers in abating violations.

Of the 11 findings contained in the FY 2010 Follow-Up Report, 10 remained uncorrected throughout FY 2011 (although the program's performance on a few SAMM and SIR Measures improved to the point where the Region deemed these individual measures to be corrected). In FY 2012, Region I will enhance its monitoring of the State, which will include periodic onsite reviews of selected case files. This action is necessary because Federal OSHA believes that VOSHA's review of case files has been ineffective in identifying and correcting glaring case file deficiencies. Also, basic investigative procedures as outlined in the FOM are not being followed by compliance staff, despite the training

that VOSHA reports conducting on the FOM. The status of the FY 2010 findings and recommendations is discussed in more detail below.

- **Finding 10-01**

(Related to FY09-01)

Finding 10-#1: Based on the FY 2010 SAMM and the FY 2011 (1st Qtr.) SAMM, VOSHA has not shown consistent improvement in the measures cited as "not met" in the FY 2009 EFAME: SAMM #4—Percent of imminent danger complaints responded to within 1 day; **SAMM#6**—Percent of S/W/R violations verified (private and public sector); **SAMM #7**—Average days from opening conference to citation issuance (safety and health); **SAMM#9**--Average violations per inspection S/W/R and other; **SAMM#10—**Average initial penalty per serious violation; and **SAMM#11**—Percent of total inspections in public sector.

Recommendation 10-#1: Work to meet the **SAMM measures listed above—and all SAMM measures**—by the end of FY 2011.

Status of Finding: Pending Correction
As of the end of FY 2011, only SAMM #4 and SAMM #6 (public sector) were corrected; all other measures cited above remained uncorrected. Thus, of nine SAMM measures identified in FY 2011, only two had been met by the end of that year.

IMIS Data:
FY 2011

- SAMM #4 (Percent of complaints and referrals responded to within 1 day-imminent danger)—100; the 100% standard was met;
- **SAMM #6** (Percent of S/W/R violations verified)—97.05 (private sector); the 100% standard was not met for the private sector;
- SAMM #6 (Percent of S/W/R violations verified)— 100 (public sector); the 100% standard was met for the public sector;
- **SAMM #7** (Average number of calendar days from opening conference to citation issue)—53.53 (safety); the standard of 51.9 average days was not met for safety inspections;
- **SAMM #7** (Average number of calendar days from opening conference to citation issue)—77.76 days (health); the standard of 64.8 average days was not met for health inspections;
- **SAMM #9** (Average violations per inspection with violations) 1.99 (S/W/R); the standard of 2.1 was not met for S/W/R violations;
- **SAMM #9** (Average violations per inspections with violations) 0.71 (other-than serious violations; the standard of 1.2 was not met for other-than-serious violations);
- **SAMM #10** (Average initial penalty per serious violation)--$1141.37; the standard of $1679.7 was not met; and
- **SAMM #11** (Percent of total inspections in the public sector)—7.89%; the standard of 9.3% was not met.

Finding 11-1 (10-1): VOSHA did not meet the following SAMM measures: SAMM #2—Average Number of days to initiate complaint investigations **SAMM #6**—Percent of S/W/R violations verified (private sector); **SAMM #7**—Average days from opening conference to citation issue (safety and health); **SAMM #8**—Percent of programmed inspections with S/W/R violations (health); **SAMM #9**--Average violations per inspection S/W/R and other; **SAMM #10—**Average initial penalty per serious violation; and **SAMM #11**—Percent of total inspections in public sector.
Recommendation 11-1 (10-1): VOSHA must meet these and all SAMM measures by the end of FY 2012.

- **Finding 10-02**
  (Related to FY09-02)

Finding 10-#2: State Indicator Report (SIR) standards were not met— SIR measure E2 (Percent of Violations Reclassified) was the only SIR measure (out of the eight cited in the **FY 2009 EFAME**) that VOHSA consistently met in both FY 2010 and in the first quarter of FY 2011.

Recommendation 10-#2: Work to meet the standards in the remaining **SIR measures** that were not consistently met by the end of FY 2011.

Status of Finding:

C.3.A. Private Sector Serious Safety Violations—**Pending Correction**

C.3.B. Private Sector Serious Health Violations—**Pending Correction**

C.5.A. Private Sector Average Penalty for Other-than-Serious Safety Violations—**Pending Correction**

C.5.B. Private Sector Average Penalty for Other-than-Serious Health Violations—**Pending Correction**

C.6.A Private Sector Safety Inspections per 100 Hours—**Pending Correction**

C.9. Private Sector Penalty Retention—**Pending Correction**

E.3. Penalty Retention (%)—**Pending Correction**

IMIS Data: These data show that in FY 2011, VOSHA did not meet the standard established by Federal OSHA for these seven measures.

FY 2011 SIR		
Measure	**VOSHA Data**	**Federal Data**
C.3.A. Private Sector Serious Safety Violations (%)	73.9	76.7
C.3.B. Private Sector Serious Health Violations (%)	49.3	64.4
C.5.A. Private Sector Average Penalty for Other-than-Serious Safety Violations ($)	150.0	1126.9
C.5.B. Private Sector Average Penalty for Other-than-Serious Health Violations ($)	350.0	980.9
C.6.A Private Sector Safety Inspections Per 100 Hours	2.8	5.5
C.9. Private Sector Penalty Retention (%)	54.2	62.8
E.3. Percent of Penalty Retention *(review procedures)*	50.3	62.3

Finding 11-02 (10-2): VOSHA did not meet the following SIR measures:
C.3.A. Private Sector Serious Safety Violations

C.3.B. Private Sector Serious Health Violations

C.5.A. Private Sector Average Penalty for Other-than-Serious Safety Violations

C.5.B. Private Sector Average Penalty for Other-than-Serious Health Violations

C.6.A Private Sector Safety Inspections per 100 Hours

C.9. Private Sector Penalty Retention

E.3. Penalty Retention (%)

Recommendation 11-02 (10-2): VOSHA must meet these and all SIR measures by the end of FY 2012.

- **Finding 10-03**

(Related to FY09-03)

Finding 10-#3: Average Violations per Initial Inspection/Average Current Penalty per Serious Violation—Although VOSHA has shown improvement over its FY2009 averages, the program's averages for these two indicators are below Federal OSHA's averages.

Recommendation 10-#3: By September 30, 2011, VOSHA's averages for violations per initial inspection and current penalty per serious violation will be more closely aligned with the federal data. This recommendation has not been met by VOSHA

Status of Finding:
Average Violations per Initial Inspections—**Pending Correction**
Average Current Penalty per Serious Violations—**Pending Correction**

IMIS Data:

	Average Violation per Initial Inspection		Average Current Penalty per Serious Violation ($)	
	VOSHA	**Federal OSHA**	**VOSHA**	**Federal OSHA**
FY2009	2.4	3.1	592	970.20
FY2010	2.6	3.2	735.90	1052.80
FY2011	2.6	2.9	889.20	2,132.60

Finding 11-03 (10-03): Average Violations per Initial Inspection/Average Current Penalty per Serious Violation—VOSHA fell short of Federal OSHA's averages.

Recommendation 11-03 (10-3): VOSHA must align these measures more closely with the Federal averages by the end of FY2012. FY 2012 year-end Enforcement statistics will indicate that VOSHA meets Federal OSHA's averages.

- **Finding 10-04**

(Related to 09-06)

Finding 10-#4: Fatality Investigations—There was no evidence in the case file that an initial letter and a copy of the citations had been sent to the victim's family.

Recommendation 10-#4: VOSHA must ensure that the victim's family members receive copies of the citations and the initial letter, and that the letter and citations have been sent is documented in the case file.

Status of Finding: Pending Correction.

Results of Case File Review: Region I reviewed a file relating to a fatality that occurred in July 2011. As of the date of the onsite review in January 2012, no initial letter had been sent to the victim's next of kin in Mexico. However, during the case file review, VOSHA indicated that it would soon be sending the letter, since the program had finally managed to have the letter translated into Spanish.

Finding 11-04 (10-04): Fatality Investigations—VOSHA did not meet the five-day time frame for sending the standard information letter to the next of kin of the fatality victim.

Recommendation 11-04 (10-04): Ensure that fatality victims' next of kin receive an initial standard information letter "within 5 working days of determining the victim's identity and verifying the proper address where communications should be sent." Ensure that all procedures of the FOM, Chapter 11, Section G, Families of Victims, are followed.

- **Finding 10-05**

(Related to 09-11)

Finding 10-#5: Gravity/probability assessments—In many instances, VOSHA is not properly assessing the probability and severity of violations. The program has a strong tendency to err on the side of assessing lower probability and severity than warranted by OSHA rules or the circumstances of the case.

Recommendation 10-#5: Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments.

Status of Finding: Pending Correction

Results of Case File Review: While conducting the FY 2011 FAME, however, Region I found seven case files in which the probability and severity were not properly assessed. In all of these case files, VOSHA erred on the side of lower probability and severity than warranted.

Finding 11-05 (10-05): Gravity/Probability Assessments—In some instances, VOSHA is not properly assessing the probability and severity of violations. The program still has a tendency to err on the side of assessing lower probability and severity than warranted.

Recommendation 11-05 (10-05): VOSHA must adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments.

- **Finding 10-06**

(Related to 09-13)

Finding 10-#6: Letters to Unions—Some case files did not contain documentation to show that citations had been sent to labor unions. Some files also did not contain the CSHO's field notes.

Recommendation 10-#6: Ensure that case files contain documentation that the program has properly notified labor unions of citations and that all files contain the CSHO's field notes.

Status of Finding: Pending Correction

Results of Onsite Case File Review: Region I identified several case files (11) that did not contain the CSHO's field notes.

Finding 11-06 (10-06): Field Notes—Some case files did not contain CSHOs' field notes.

Recommendation 11-06 (10-06): Ensure that case files contain CSHOs' field notes, in accordance with the FOM, Chapter 5.

- **Findings 10-07**

(Related to 09-14)

Finding 10-#7: Evidence of Violations—In some cases, the file did not provide adequate evidence to substantiate the violations that were cited.

Recommendation 10-#7: Ensure that case files include all evidence necessary to substantiate the violations that were cited.

Status of Finding: Pending Correction

Results of Case File Review: Region I found four case files that did not contain adequate evidence of violations cited.

Finding 11-07 (10-07): Evidence of Violations—In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.

Recommendation 11-07 (10-07): Ensure that case files contain adequate evidence to support all violations cited, in accordance with the procedures set forth in Chapter 4 of the FOM.

Findings 10-08 through 10-11 were "new" in the FY2010 EFAME Follow-Up report and did not relate to findings in the FY2009 EFAME Reports.

- **Finding 10-08**

Finding 10-#8: S/W/R Violations—VOSHA's percentages for S/W/R in FY2009 and FY2010 were not comparable to Federal OSHA's.

Recommendation 10-#8: As of the end of FY2011, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.

Status of Finding: Pending Correction

Additional Information:

Percentages of Serious and S/W/R Violations		
	FY2011	
	%Serious	%S/W/R
VOSHA	**67**	**68**
Federal OSHA	**73**	**77**

Finding 11-08 (10-08): S/W/R Violations—VOSHA's percentages for S/W/R in FY 2011 were not comparable to Federal OSHA's.

Recommendation 11-08 (10-08): At the end of FY 2012, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.

- **Finding 10-09**

Finding 10-#9: Establishing Serious Violations—Region I found that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."

Recommendation 10-#9: VOSHA managers and staff should review Chapter 4 of the FOM, Section II.B on the four factors used to determine whether a violation is to be classified as Serious. Although VOSHA has already completed a review of Chapter 4 of the FOM, this section should be more thoroughly reviewed again by the end of the third quarter of FY2011, and VOSHA should verify that its CSHOs understand these factors.

Status of Finding: Pending Correction

Results of Case File Review: In one fatality case, a violation was cited because the CSHO felt the employer should have known about the violation through "reasonable diligence." However, the CSHO did not document how she/he arrived at this determination. In other case files, Region I did not find sufficient documentation to support classifying the violation(s) as serious.

Finding 11-09 (10-09): Establishing Employer Knowledge of the Hazardous Condition—As in the onsite review for the FY 2010 FAME Report, Region I found (during the most recent review) that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."

Recommendation 11-09 (10-9): Ensure that CSHOs record evidence to substantiate that the employer could have known of the hazardous condition through reasonable diligence. A sampling of case files to be reviewed by the Region on a quarterly basis will indicate that CSHOs are adequately documenting evidence of violations cited in case files.

- **Finding 10-10**

Finding 10-#10: Average Initial Penalty per Serious Violation—Although VOSHA's average penalty per serious violation has shown an upward trend since FY2009, it still falls well below the national data average.

Recommendation 10-#10: VOSHA's average initial penalty per serious violation should come closer to meeting the national data standard (SAMM #10) by the end of FY2011.

Status of Finding: Pending Correction

Additional Information: VOSHA's FY2011 average initial penalty per serious violation was $1,141.37 compared to the national data standard of $1679.7. In FY2010, VOSHA's average penalty was $1064.59 (compared to the national data standard of $1360.4).

Results of Case File Review: Region I found six cases in which penalties were too low for one or more of the following reasons: a good faith reduction was given at the informal conference, but there was no documentation in the case file to justify such a reduction; one or more violations were reclassified at the informal conference from serious to other-than-serious with no supporting documentation in the case file(s); the initial probability and severity assessment was too low.

This finding is addressed under **Finding 11-01.**

- **Finding 10-11**

Finding 10-#11: PSM Inspections— VOSHA has not developed a list of employers that would be subject to inspection under the PSM standard.

Recommendation 10-#11: VOSHA must refine the list of employers who may be covered by OSHA's PSM standard, in preparation for adoption of OSHA's PSM NEP.

Status of Finding: Corrected

Results of Case File review: VOSHA obtained a list of companies with extremely hazardous substances or chemicals that meet the PSM threshold quantity from Vermont Emergency Management (SERC), and is using this list to assign inspections to the CSHO who is qualified to conduct PSM inspections.

IV. FY 2011 STATE ENFORCEMENT

This section provides an assessment of the State's enforcement related functions, and focuses on inspections, violations, abatement verification, penalties and citation issuance. Information sources include Federal/State IMIS comparison data for FY 2011 **(Appendix C)**; the SAMM report for FY 2011 **(Appendix D);** the SIR for FY 2011 **(Appendix E);** and the VOSHA FY2011 SOAR

(Appendix F). FY2011 year-end data is compared to that of previous years in order to show trends in performance. These data were provided by OSHA's Directorate of Cooperative and State Programs (DCSP), Office of State Programs (OSP), and the dates that these reports were run are shown in the table below.

	FY 2011 Federal/State IMIS Data	*FY 2011 SAMM*	*FY 2011 SIR*
Report Run Dates	11/8/2011	11/9/2011	11/11/2011

Where relevant, Region I also used information gained from the onsite case file review to help evaluate some of the enforcement-related functions discussed below. Region I also performed an in-depth analysis of VOSHA's training records, and found that none of the program's CSHOs have completed their mandatory training track that is prescribed by OTI. Also, two of the Plan's "veteran" CSHOs who conduct fatality investigations have not taken OTI Course #1310 (Investigative Interviewing Techniques), and one has not taken OTI Course #1410 (Inspection Techniques and Legal Aspects). To adequately address several of the findings that follow in this section of the report, VOSHA must comply with the Region's recommendations in the sub-section on Training in this report.

In addition, the Region's recommendations with regard to training for the program's Whistleblower investigators are equally as important as those made with regard to enforcement, and the urgency for compliance with *all* of the Region's recommendations for training cannot be overstated.

COMPLAINTS

- **COMPLAINT ACTIVITY MEASURES**

SAMM measures 1-4 provide an assessment of the program's efficiency in handling complaint inspections**.**

SAMM#1 measures the average number of days it takes the program to initiate complaint inspections. The standard for this measure is five days. As shown in the table below, VOSHA's average number of days has decreased considerably since FY 2008, to the point where the state actually beat the standard of five days in FY 2011.

Average Number of Days to Initiate Complaint Inspections (SAMM #1)				
FY 2007	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**
4.26	8.06	4.46	5.35	**2.00**

The onsite case file review shows an average of 2.68 days to initiate a complaint inspection. This calculation is based on 16 complaint cases where the file contained documentation of the date the

complaint was received. Two complaint case files, however, did not contain an indication of when the complaint was received (and thus could not be used in the calculation).

SAMM #2 measures the average number of days to initiate complaint investigations. More specifically, SAMM #2 measures the number of days between the time the complaint is received (i.e., the date on the OSHA-7) to the date the "Nonformal Complaint Notification" letter is sent to the employer. In FY 2011, Region I found that VOSHA did not meet the standard of one day for initiating complaint investigations, but instead had an average of 2.04 days (see Finding 11-1). In FY 2009 and FY 2010, however, the plan did meet the standard, with averages of 0.81 and 0.86 days, respectively.

SAMM #3 measures the percent of complaints where complainants were notified in timely manner—within 20 workdays of citation issuance or within 30 workdays of the closing conference when no citations were issued. According to SAMM #3, VOSHA notified 100 percent of all 49 complainants in a timely manner, and initiated inspections in all of the complaints filed. VOSHA also met the 100 percent standard in FY 2009 and FY2 010 as well for SAMM #3.

However, the onsite case file review found two cases in which citations were issued and the complainant was not notified within 20 workdays. Region I also found that some case files (7%) did not contain any documentation that a letter had been sent notifying the complainant of citations that had been issued to the employer.

Finding 11-10: Complaints—Some case files did not contain any documentation that a letter had been sent to the complainant notifying them that citations had been issued to the employer.

Recommendation 11-10: In cases where citations have been issued, VOSHA must adhere to Chapter 9 of the FOM, Section I, H, which provides for complainant notification of inspection results.

SAMM #4 measures the percent of imminent danger complaints and referrals responded to within one day. The standard is 100 percent. In FY 2011, VOSHA did meet the standard, responding to one imminent danger complaint within one day. In FY 2010, VOSHA did not meet the standard, responding to two out of three imminent danger complaints within one day, for a percentage of 66.67. In FY 2009, VOSHA had the same percentage as in FY 2010—66.67 percent.

FATALITIES

During the onsite case file review, Region I reviewed four fatality inspections opened in FY 2011, and also one fatality investigation that was opened in FY 2010 and closed in FY 2011.

Fatality Description	Fiscal Year Case was Opened	Fiscal Year Case was Closed
Flagger struck by vehicle	2010	2011
Logging incident	2011	
Carnival worker killed by unguarded fan blades	2011	
Water plant worker swept away by strong currents caused by	2011	

Tropical Storm Irene		
Electrician found deceased on floor beneath an electrical panel	2011	

VOSHA determined that the case that involved a worker who was found lying on the floor in front of an electrical panel holding a conductive tool (non-insulated screw driver) was not work-related. However, after thoroughly reviewing this case, the Region found that VOSHA did not follow proper fatality investigative procedures as required in the FOM. More specifically, the State did not thoroughly investigate this fatality because it did not attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and whether any violations had any effect on the incident (FOM, Chapter 11. Section II, C.).

- ***VOSHA did not thoroughly investigate the cause of the fatality—***Region I has determined that VOSHA's investigation of this event was superficial, and that the State reached two major conclusions about the fatality that were not supported by the facts of the case as documented in the case file. The first conclusion reached by VOSHA was that the electrical panel that the victim was working on was de-energized at the time of the accident; the second VOSHA conclusion is that the worker's death was *not* caused by exposure to live electrical parts.

  Throughout the case file, the CSHO indicated that the electrical panel the victim was working on when the fatality occurred was "energized." However, the compliance chief noted on his case file review check list that the panel was "de-energized." According to the VOSHA compliance chief, the CSHO found out later that the panel was actually de-energized. However, there is no documentation in the case file to support the CSHO's later claim that the panel was actually de-energized. As discussed below, the documentation that does exist in the case file (such as photographs) indicates that the panel *was* energized.

  The CSHO stated in his fatality report of this incident that he learned from the police report and the medical examiner's autopsy report that the victim died of a heart attack that was *not* caused by electrical shock. However, the case file contains no copies of either report.

- ***VOSHA did not thoroughly investigate whether OSHA standards were violated—***Based on documentation included in this case file, the Region I electrical expert identified serious violations of OSHA's electrical standards that the CSHO should have cited, but did not. The Region I expert identified these violations based on the CSHO's own narrative and copies of the photos found in the case file.

  The only violation cited by VOSHA in this case was the failure of the employer to notify OSHA of the fatality, for which VOSHA awarded the employer a reduction of 15 percent for good faith (VOSHA's improper awarding of good faith penalty reductions is discussed later in this section under Penalty Assessments).

- ***VOSHA did not thoroughly investigate any effect these violations had on the incident—***On one hand, the police and autopsy reports allegedly state that the victim died of a heart attack

that was *not* caused by electrical shock (although there is no documentation of either of these reports in the case file). On the other hand, the case file also states that the victim was found dead, lying on the floor in front of the electrical panel, with a conductive tool in his hand. The lights in the over-head were on, indicating that the panel was energized when the victim was working on it. In overlooking the violations that were evident at the time the incident occurred (and which were supported by photos and narrative found in the case file), VOSHA settled too hastily on the conclusion that the victim did not sustain a fatal injury from working on the electrical panel.

Region I also found that the case file contained several comments from the employer about the victim's lifestyle and personal habits. In addition, there was no documentation in the case file to support the employer's observations. Unfortunately, comments of this nature, which should have no bearing whatsoever on the investigation, appear to have unduly influenced VOSHA, to the point where the program was too quick to conclude that the victim succumbed to a pre-existing medical condition. Consequently, the program did not conduct an objective and thorough investigation of this event.

Below are additional deficiencies that Region I has found with respect to VOSHA's fatality interview procedures and fatality investigation documentation. As is the case with the finding regarding fatality investigation procedures discussed above, these findings are based on the program's inattention to the basic requirements of the FOM.

- In accordance with the FOM, Chapter 11, Section II, D., VOSHA did not **identify and interview persons** with firsthand knowledge of the incident, including first responders, police officers, medical responders, and management, as early as possible in the investigation.
- In accordance with the FOM, Chapter 11, Section II, E., VOSHA did not adequately document **Incident Data**, such as how and why the fatality incident occurred; the physical layout of the worksite, sketches/drawings and measurements, etc.; and whether the accident was work-related.
- In accordance with the FOM, Chapter 11, Section II, E., VOSHA did not adequately document the **Equipment or Process Involved,** such as equipment type; manufacturer; model; manufacturer's instructions; kind of process; condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.

VOSHA's conduct of this investigation is especially troublesome, given the fact that five months before this unfortunate event occurred, the CSHO who conducted the investigation had received three days worth of training on electrical safe work practices (including voltage testing and electrical investigative techniques) from the Region's electrical expert who later reviewed this case. In addition, VOSHA conducted internal staff training on the FOM as part of its corrective action plan for addressing findings in the FY 2009 EFAME.

In another fatality case reviewed by the Region, it is apparent that VOSHA's investigation had several deficiencies, in that FOM procedures were not followed.

For example, this particular case file did not contain:

- documentation that a comprehensive review was conducted of the employer's safety and health program;
- copies of the autopsy report and death certificate; and
- the traffic control plan activities, and any disciplinary records and training records for the deceased employee.

This file also lacked a depiction of the physical layout of the work site and sketches/drawings and measurements. In addition, there was no documentation in the case file of any sources who were interviewed by the CSHO to gain more knowledge and information of the circumstances and conditions that existed when the incident occurred.

Finding 11-11: Fatality Cases –

VOSHA did not follow proper **Fatality Investigative Procedures** as required in the FOM, Chapter 11, Section II, C., in that the State did not thoroughly investigate the fatality and attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and any effect the violation(s) had on the incident (FOM, Chapter 11. Section II, C).

VOSHA did not follow proper **Fatality Interview Procedures** as required in the FOM, Chapter 11, Section II, D., in that the State did not identify and interview all persons with first-hand knowledge of the incident.

VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: **Incident data**, such as how and why the incident occurred; the physical layout of the worksite; sketches/drawings; measurements; video/audio/photos to identify sources, and whether the accident was work related.

VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: **Equipment or Process Involved,**, such as equipment type; manufacturer; model; manufacturer's instructions; Kind of process; Condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.

Recommendation 11-11: VOSHA must ensure that CSHOs and managers follow all requirements for fatality investigations as set forth in the FOM, Chapter 11 (Imminent Danger, Fatality, Catastrophe and Emergency Response). Region I will review all VOSHA fatality cases and ensure correction of all fatality-related recommendations in this report.

In another fatality case file, Region I found that VOSHA did not follow the procedures outlined in the FOM, Chapter 11, Section II, G, and far exceeded the five-day time frame for sending the standard information letter to the next of kin of the fatality victim (who was temporarily employed under H-1B

status[3], and whose family lives in Mexico). During the case file review, VOSHA indicated that it would soon be sending the letter, since it had finally managed to have it translated into Spanish. This fatality occurred in July 2011. This finding is addressed under **Finding 11-4.**

TARGETING AND PROGRAMMED INSPECTIONS

- **INSPECTION TARGETING METHODS**

VOSHA uses the McGraw-Hill Construction Dodge Reports to target construction employers for inspections, and uses a number of methods to target health inspections:

1. VOSHA targets employers with higher than average DART rates in industries where workers are exposed to silica, lead, and other toxic and hazardous substances.
2. VOSHA uses the McGraw-Hill Construction Dodge Reports to target construction employers at risk for hazards related to lead paint/asbestos removal, and drilling and grinding stone, etc.
3. VOSHA inspects employers at risk for health hazards identified in the Strategic Plan emphasis programs (e.g. blood-borne pathogens, combustible dust, ergonomics, food processing, and nursing homes, etc.).
4. Two programs under the Vermont Department of Health (the Health Surveillance and Asbestos and Lead Regulatory programs) make referrals to VOSHA as appropriate.

Each year, VOSHA adopts Federal OSHA's site specific targeting directive for inspections in general industry. VOSHA also has Local Emphasis Programs (LEPs) in falls and trenching/excavation.

According to the VOSHA compliance chief, VOSHA has codes in the NCR for National Emphasis Programs (NEPs), LEPs and Strategic Plan Activities. For all inspections involving emphasis programs, compliance officers have been instructed to enter the appropriate codes on the OSHA 1/1A Forms. However during the onsite case file review, Region I found that in a few cases, CSHOs did not code the inspection for emphasis programs as required.

It should be noted that Region I discussed the matter of coding inspections for emphasis programs with the VOSHA managers during the onsite review that the Region conducted in January 2011, and also emailed a copy of the Regional Administrator's memo on "Current Applicable IMIS Codes" to the VOSHA managers on February 2, 2011.

Finding 11-12: Emphasis Programs—VOSHA did not code some inspections for emphasis programs.

Recommendation 11-12: CSHOs must code all inspections involving LEPs, NEPs and Strategic Plan activities, as appropriate.

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[3] The **H-1B** is a non-immigrant visa in the United States under the Immigration and Nationality Act, section 101(a)(15)(H). It allows U.S. employers to temporarily employ foreign workers in specialty occupations.

- **PROGRAMMED INSPECTIONS**

The table below provides a comparison of programmed to complaint inspections for Federal OSHA and VOSHA.

	FY 2009		*FY 2010*		*FY 2011*	
	VOSHA	**OSHA**	**VOSHA**	**OSHA**	**VOSHA**	**OSHA**
Percent Programmed	67	62	61	60	61	58
Percent Complaint	17	17	24	20	18	21

VOSHA's percentages for programmed and complaint inspections are more or less in line with Federal OSHA's percentages. FY2011 SIR data shows that VOSHA performed better than the Federal performance standard for the percentage of programmed inspections in the *private sector* that were related to both safety and health. On the other hand, VOSHA's *public sector* percentages for programmed inspections related to safety and health were slightly below its own private sector measures (see tables below).[4]

FY 2011 SIR Enforcement (Private Sector): Programmed Inspections (%)		
	FED	***STATE***
C.1.A Safety	62.5	67.0
C.1.B Health	34.6	47.7

FY 2011 SIR Enforcement (Public Sector): Programmed Inspections (%)		
	Private Sector	***Public Sector***
D.1.A Safety	67.0	66.7
D.1.B Health	47.7	41.7

- **INSPECTIONS WITH VIOLATIONS CITED**

VOSHA's performance with respect to inspections with violations cited is an indicator of the effectiveness of the State's targeting program. Region I found that VOSHA's percent of inspections with violations cited did not align closely with Federal OSHA's percent. As shown in the table below, VOSHA's percentage for all inspections with violations cited plummeted in FY 2011 from previous fiscal year percentages. VOSHA's percentage of 57 is far below Federal OSHA's percentage of 71, and even below the overall State Plan percentage of 60.

[4] In SIR measure D, the State's public sector performance is compared to its own data for private sector programmed inspections.

On the other hand, VOSHA's FY 2011 percentage for not-in-compliance (NIC) inspections with serious violations was higher in FY 2011 than in the previous two fiscal years. However, the data in the table below shows that VOSHA does not cite quite as many serious violations as Federal OSHA when inspecting NIC employers.

	% Inspections with Violations Cited			*% Not In Compliance (NIC) with Serious Violations*		
	FY 2009	***FY 2010***	***FY 2011***	***FY 2009***	***FY 2010***	***FY 2011***
VOSHA	80	72	57	75	72	80
Federal OSHA	70	71	71	87	88	86

Finding 11-13: Inspections with Violations Cited—VOSHA did not align closely with Federal OSHA in terms of percent of investigations with violations cited. In FY 2011, VOSHA's percentage of 57 was far below Federal OSHA's percentage of 71, as well as below the state plan percentage of 60.

Recommendation 11-13: VOSHA must ensure that CSHOs cite all violations.

- **NUMBER AND PERCENTAGE OF SERIOUS, WILLFUL, REPEAT VIOLATIONS**

SAMM #8 measures the percent of *programmed* inspections with Serious/Willful/Repeat (S/W/R) violations. The table below shows VOSHA's results for SAMM #8 over the past three fiscal years. VOSHA's percentages for both safety and health were higher (better) than the national data[5] in FY2009 and FY2010. In FY2011, Region I found that VOSHA's percentage for safety was higher than the national standard, but that VOSHA did not meet the standard for health.

SAMM #8 (Percent of Programmed Inspections with S/W/R Violations)						
	FY 2009		**FY 2010**		**FY 2011**	
	VOSHA (%)	**National Data (%)**	**VOSHA (%)**	**National Data (%)**	**VOSHA (%)**	**National Data (%)**
Safety	76.12	**58.5**	60.34	**58.4**	70.45	**58.5**
Health	54.55	**51.1**	58.33	**50.9**	47.22	**51.7**

The FY 2011 SIR measures State Plan performance with respect to percentage of *programmed* inspections (broken out by safety and health) with violations cited. As shown in the table below, VOSHA fell just below the Federal percentage for safety inspections, and performed better than the Federal standard for health inspections.

[5] For all SAMM measures, national data includes data from Federal OSHA as well as from State Plan programs nationwide.

Although VOSHA's results for SAMM #8 (which measures percent of inspections with S/W/R violations) and **SIR measure C.2** (which measures percent of *programmed* (private sector) inspections with *all* violations) do not correspond exactly with the Federal results, it appears that VOSHA is generally in line with the Federal data for percent of *programmed* inspections with violations cited.

FY 2011 SIR Enforcement (Private Sector): Programmed Inspections with Violations (%)		
	FED	***STATE***
C.2.A Safety	70.1	69.0
C.2.B Health	56.2	65.0

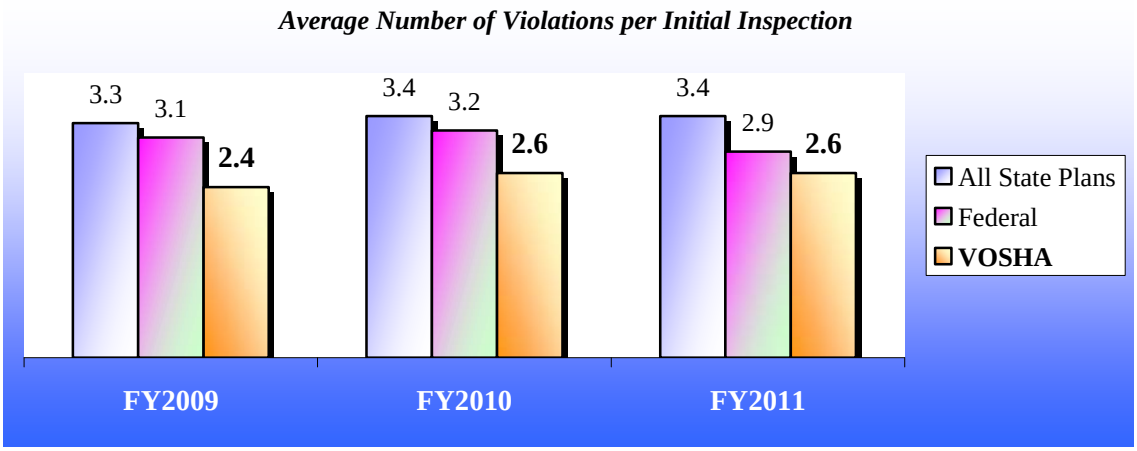
SAMM #9 measures the average number of Serious/Willful/Repeat (S/W/R) and other-than-serious violations per inspection with violations. In FY2011, VOSHA conducted 212 inspections that had 423 S/W/R violations cited (for an average of 1.99 S/W/R violations per inspection with violations cited). Although this average is lower than the national average of 2.1, it is a meaningful improvement over the FY 2010 average of 1.73.

SAMM #9 (Average Violations per Inspections with Violations)						
	FY 2009		**FY 2010**		**FY 2011**	
	VOSHA	**National Data**	**VOSHA**	**National Data**	**VOSHA**	**National Data**
Avg. number of S/W/R violations per inspection with violations	1.74	2.1	1.73	2.1	1.99	2.1
Avg. number of Other-Than-Serious violations per inspection with violations	.71	1.2	.85	1.2	.71	1.2

For the average number of Other-than-Serious violations per inspections with violations, VOSHA remains below the national average.

- **AVERAGE NUMBER OF VIOLATIONS PER INITIAL INSPECTION**

The chart below shows VOSHA's average number of violations per initial inspection over the past three fiscal years. Region I found that VOSHA's average continues to fall below Federal OSHA's average (as well as the national State Plan average).



This review of data (SAMM measures #8 and #9; SIR measures C.2 (A & B); and Enforcement Data for Average Number of Violations per Initial Inspection, Percent of Inspections with Violations Cited and Percent of NIC Inspections with Serious Violations) shows that VOSHA must improve its CSHOs' performance with regard to identifying and citing violations, especially Serious, Willful and Repeat Violations.

The onsite case file review did not indicate deficiencies in VOSHA's targeting program, but did show that CSHOs had a tendency to classify too many violations as other-than-serious (when they should have been classified as serious). In addition, the case file review revealed many instances in which CSHOs neglected to cite violations that clearly existed at the time of the inspection (as documented by case file photos).

Finding 11-14: Average Number of Violations per Initial Inspection—In FY 2011, VOSHA's average continued to fall below Federal OSHA's average.

Recommendation 11-14: VOSHA must increase its average number of violations per initial inspection.

CITATIONS AND PENALTIES[6]

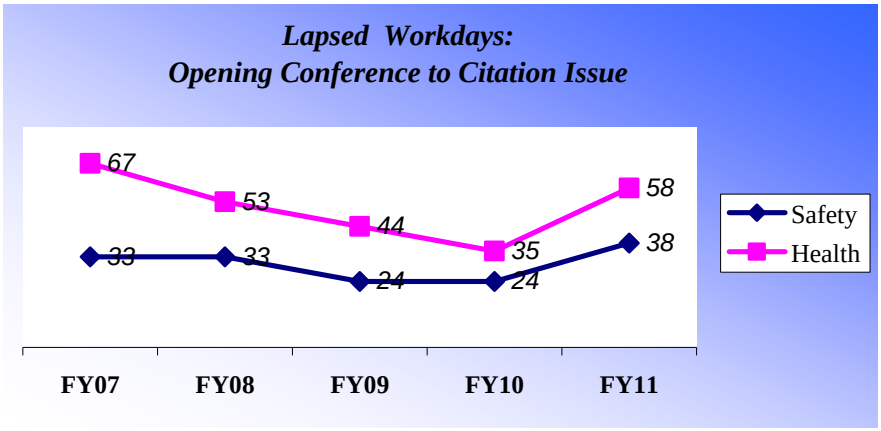
- **INSPECTIONS WITH CONTESTED VIOLATIONS/LAPSE TIME**

IMIS enforcement activity data shows that VOSHA has a good track record of comparing favorably to Federal OSHA in terms of percentage of inspections with contested violations. These data also show that VOSHA has better results than Federal OSHA for lapse days from inspection to citation issuance for both safety and health (with the exception of health inspections in FY 2011). The table

[6] VOSHA has not adopted the penalty structure described in Chapter 6 of the FOM, and has not adopted the changes to OSHA's administrative penalty calculation system as set forth in OSHA's Administrative Penalty Information Bulletin.

below provides data on lapse times over the past three fiscal years, while the chart below shows that in the past five fiscal years, VOSHA achieved its best results for lapse times in FY 2010.

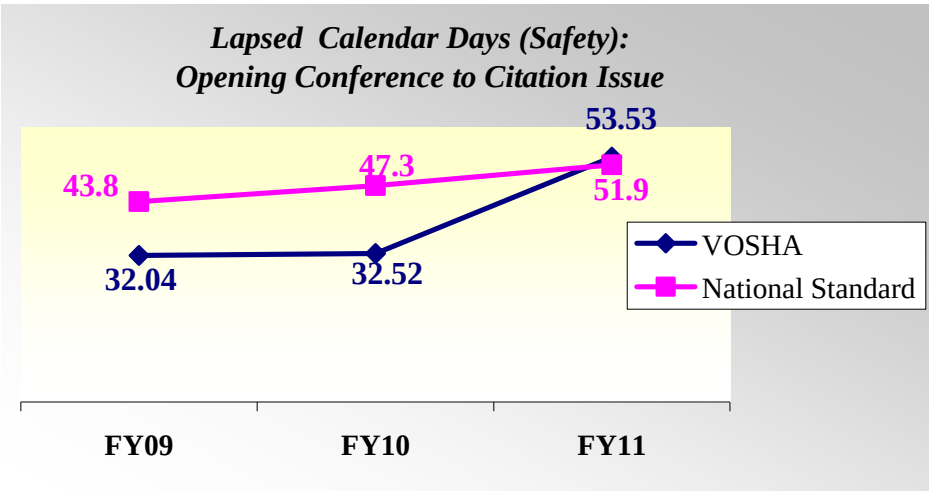
	IMIS Enforcement Data					
	FY 2009		*FY 2010*		*FY 2011*	
	VOSHA	*FED*	*VOSHA*	*FED*	*VOSHA*	*FED*
Inspections with contested violations (%)	1.6	7.0	3.8	8.0	2.4	10.7
Lapsed *workdays* (from inspection to citation issue)—*Safety*	23.6	34.3	23.9	37.9	38	43.2
Lapsed *workdays* (from inspection to citation issue)—*Health*	44.2	46.7	34.8	50.9	57.6	54.8

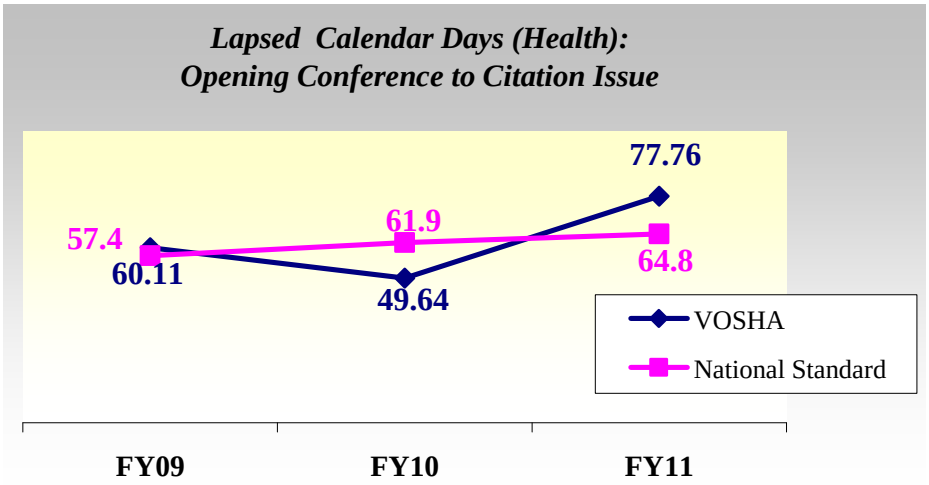


SAMM #7 calculates average lapse days from opening conference to citation issuance in terms of *calendar* days. As shown in the table below, VOSHA did not meet the national lapse time standard for health inspections in FY 2009, but achieved it in FY 2010. Region I found that during FY 2011, VOSHA's lapse times increased for both safety and health inspections over the State's previous years' results.

According to the VOSHA program manager, the program's increase in lapse times in FY 2011 time was caused, in large part, by his prolonged absence (medical leave) during the fourth quarter. Also, the VOSHA compliance chief was tied up for a significant portion of the fourth quarter (from early

September to mid-October) with Tropical Storm Irene emergency response efforts. Both of these factors delayed management's review of case files and the issuance of citations.





- **ADEQUATE EVIDENCE TO SUPPORT VIOLATIONS**

During the FY 2010 FAME onsite review, the Region found that the program was using the term "reasonable diligence" to establish employer knowledge of the hazardous condition. In that report, the Region advised that the CSHO must record evidence that substantiates that the employer could have known of the hazardous condition. During the most recent onsite review, Region I found that a CSHO continued to cite a violation on the basis that he/she believed the employer *should* have known existed through "reasonable diligence," but did not record any evidence that substantiates that the employer could have indeed known of the hazardous condition.

As stated in the FOM, Chapter 4, Section II, C, 4:

> If it cannot be determined that the employer has actual knowledge of a hazardous condition, the knowledge requirement may be established if there is evidence that the employer could have known of it through the exercise of reasonable diligence. CSHOs shall record any evidence that substantiates that the employer could have known of the hazardous condition.

According to this section of the FOM, examples of evidence include; the violation was in plain view and obvious; the duration of the hazardous condition was not brief; the employer failed to regularly inspect the workplace for readily identifiable hazards; and the employer failed to train and supervise employees regarding the particular hazard. This finding is covered under **Finding 11-09.**

Region I also found one or more of the following deficiencies in 11 percent of the case files reviewed: case files where the CSHO performed sampling for air contaminants and surveys for noise, the case files either did not contain copies of completed OSHA 91 (air sampling) or OSHA 92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. All of these forms are to be completed by the CSHO in the IMIS database (when appropriate), with copies maintained in the case file.

Finding 11-15: Including air sampling and noise survey forms in case files—Some case files where the CSHO did perform sampling for air contaminants and surveys for noise, the case files either did not contain copies of completed OSHA 91 (air sampling) and OSHA 92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. These forms are used to help support violations cited.

Recommendation 11-15: VOSHA must ensure that copies of all air sampling and noise survey forms are included in case files for inspections in which these surveys/ samplings have occurred.

Region I also found that some case files (14 %) did not contain copies of the CSHO's field notes. As stated in Chapter 5 of the FOM, Case File Preparation and Documentation, "Inspection records are any record made by the CSHO that concern, relate to, or are part of, any inspection…." In addition, the FOM also states that "All official forms and notes constituting the basic documentation of a case must be part of the case file. All original field notes are part of the inspection record and shall be maintained in the file." See **Finding 11-06.**

- **CITATIONS FOR ALL APPARENT VIOLATIONS**

Region I found that some CSHOs did not cite all apparent violations during inspections, even though evidence of these violations appears to have been provided by the CSHO in some case files through photos and written descriptions. As previously discussed, Region I raised concerns about two fatality investigations in which the CSHO did not cite all apparent violations.

Finding 11-16: Citing all Apparent Violations—CSHOs did not cite all apparent violations during inspections, even though evidence of these violations was provided by the CSHO in so me case files through photos and written descriptions.

Recommendation 11-16: VOSHA must ensure that CSHOs cite all apparent violations.

- **VIOLATION CLASSIFICATION (SERIOUS, OTHER-THAN-SERIOUS)**

As shown in the table below, Region found that VOSHA's percentage for all violations cited as serious did not align closely with Federal OSHA's in FY 2011. However, VOSHA fared much better in FY2011 than in the previous fiscal year in terms of this percentage. VOSHA also compared favorably to the percentage for all for all State Plans nationwide (44 percent).

FY 2009-FY 2011 Violation Classifications				
Fiscal Year	***VOSHA Percent Serious***	***Federal OSHA Percent Serious***	***VOSHA Percent Other-than-Serious***	***Federal OSHA Percent Other-than-Serious***
FY 2009	65	77	32	19
FY 2010	60	77	37	18
FY 2011	67	73	32	22

The FY 2011 SIR breaks out the percentage of all violations classified as serious for safety and health for both VOSHA and Federal OSHA (private sector only). As shown in the table below, VOSHA has consistently scored below the Federal percentage for safety, and far below the Federal percentage for health over the past few fiscal years.

FY 2011 SIR Enforcement (Private Sector): Serious Violations (%)						
	FY 2009		***FY 2010***		***FY 2011***	
	FED	***State***	***FED***	***State***	***FED***	***State***
C.3. A Safety	*80.0*	*73.4*	*81.0*	*68.4*	*76.7*	*73.9*
C.3.B Health	*69.7*	*45.9*	*70.2*	*43.3*	*64.4*	*49.3*

Finding 11-17: Violation Classification—VOSHA's percentage for all violations classified as Serious did not align closely with Federal OSHA's percentage.

Recommendation 11-17: VOSHA's percentage for all violations classified as serious must align more closely with Federal OSHA's percentage by the end of FY 2012.

- **CLASSIFICATION OF WILLFUL (AND REPEAT) VIOLATIONS**

IMIS data show that VOSHA did not classify any violations as Willful in FY 2011. VOSHA also generally classifies fewer repeat citations than Federal OSHA, as indicated in the table below.

	Repeat (%)		*Willful (%)*		*S/W/R (%)*	
	VOSHA	**Federal OSHA**	**VOSHA**	**Federal OSHA**	**VOSHA**	**Federal OSHA**
FY 2009	1.7	3.1	.68	.47	70	81
FY 2010	2.3	2.8	--	1.6	65	82
FY 2011	.93	3.7	--	.71	68	77

Region I found that in 10 percent of the case files reviewed, VOSHA misclassified violations as Other-than-Serious when they should have been cited as Serious. In addition, the Region identified some violations that should have been classified as Repeat, and some violations that could have been classified as Willful, based on further investigation (which the program chose not to conduct).

Finding 11-18: Violation Classification—VOSHA misclassified some violations as Other-than-Serious that should have been classified as Serious. Some violations should have been classified as Repeat, and some violations could potentially have been classified as Willful, based on the outcome of further investigation, which the program chose not to pursue.

Recommendation 11-18: VOSHA must properly classify all violations and thoroughly investigate violations that have the potential to be cited as Willful, and cite them accordingly.

- **PENALTY ASSESSMENTS**

In addition to the fact that VOSHA's percentages for violations classified as Serious should be more in line with Federal OSHA's (as demonstrated by the IMIS data from the SAMM, SIR and Federal OSHA's State Plan Federal Inspection and Enforcement Reports discussed above), Region I found some cases in which VOSHA did not properly assess the severity of the violation, erring on the side of lower severity than warranted (nine percent of all cases reviewed). This tendency has been a recurrent finding in past FAMEs. See **Finding 11-05.**

In one case, VOSHA granted an employer a penalty reduction of 20 percent based on size; however, this employer has multiple facilities nationwide and employs hundreds of workers. Therefore, this particular employer does not qualify for a penalty reduction based on size, since it is not a "small employer." As stated in Chapter 6 of the FOM: "A maximum penalty reduction of 60 percent is permitted small employers….Size of employer shall be calculated on the basis of the maximum number of employees of an employer at **all** workplaces nationwide, including State Plans, at any one time during the previous 12 months."

VOSHA also granted this same employer a penalty reduction of 10 percent for history. According to the FOM: A reduction of 10 percent shall be given to employers who have not been cited by OSHA nationwide, or by any State plan state for any Serious, Willful, or Repeated violations in the prior three years. However, a history search performed by the case file reviewer showed that this employer had been issued citations for serious violations at other locations nationwide as recently as 2010.

In some cases (seven percent), VOSHA granted the employer a 15 percent penalty reduction for good faith. However, there was no documentation in any of these case files to support these reductions. In one of these cases, VOSHA granted a reduction based on the fact that the employer had not had an inspection in the past three years; and in another, a good faith reduction was granted even though the employer was cited for hazards likely to result in death or serious injuries.

As stated in the FOM, Chapter 6: "A 15 percent reduction for good faith shall normally be given if the employer has a documented and effective safety and health management system, with only incidental deficiencies." The FOM also states that no good faith reduction is permitted in cases having high gravity, serious violations.

In another case, VOSHA granted a good faith penalty reduction based on the fact that the employer had abated the hazardous conditions. However, good faith penalty reductions are permitted in recognition of an employer's effort to implement an effective safety and health management system in the workplace (FOM, Chapter 6), and not for abating hazards.

Finding 11-19: Penalty Reductions—In some cases, VOSHA improperly granted penalty reductions.

Recommendation 11-19: VOSHA must follow the FOM requirements in Chapter 4 for granting penalty reductions based on size, history, and good faith.

- **AVERAGE CURRENT PENALTY PER SERIOUS VIOLATION**

Region I found that in FY 2011, VOSHA's average current penalty per serious violation continued to be below that of Federal OSHA. VOSHA must increase its average penalty per serious violation to align more closely with Federal OSHA's average. It should be noted that VOSHA's penalty calculations are based on those used in Chapter 6 of the FOM rather than Federal OSHA's interim administrative penalty policy. Therefore, VOSHA's penalty calculations differ from Federal OSHA's.[7]

The program's average has steadily increased over the past few fiscal years, and has increased by 52 percent over the FY 2009 average. On the other hand, Federal OSHA's increase of 81 percent for average current penalty per serious violation (from FY 2009 to FY 2011) was much higher. In FY 2009 and FY 2010, VOSHA managed to keep its penalty reduction below 50 percent, but this figure rose to 50.5 percent in FY 2011.

[7] On September 27, 2010, Federal OSHA implemented several changes to its administrative penalty calculation system. Many of the agency's penalty adjustment factors had been in place since the early 1970s, and were resulting in penalties which were too low to have an adequate deterrent effect The Federal Program Change requirement for the States regarding penalty calculations will be included in upcoming revisions to Chapter 6—Penalties and Debt Collection of the FOM. When revisions to the FOM are issued, States will have 60 days to provide notice of their intent and 6 months to adopt an identical or at least as effective as penalty policy. In the meantime, States are not required to adopt Federal OSHA's interim penalty policy.

	Total Penalties ($)		Average Current Penalty ($)/Serious Violation		Percent Penalty Reduced	
Fiscal year	***State***	***Fed***	***State***	***Fed***	***State***	***Fed***
2009	484,819	96,254,766	592	970	44.3	43.7
2010	326,514	183,594,060	736	1,052	44.8	40.9
2011	355,618	181,829,999	889	2,133	50.5	43.6

As shown in the table below, **SIR measure C.5** compares Federal and State results for average penalty per other-than-serious violation (broken out by safety and health). For both safety and health, the Federal averages have far exceeded VOSHA's averages. In FY 2009, VOSHA had its strongest showing for average penalty per other-than-serious violation for both safety and health, with its average for safety dropping substantially from FY 2009 to FY 2010 (to $150.00 compared with the Federal figure of $1126.9).

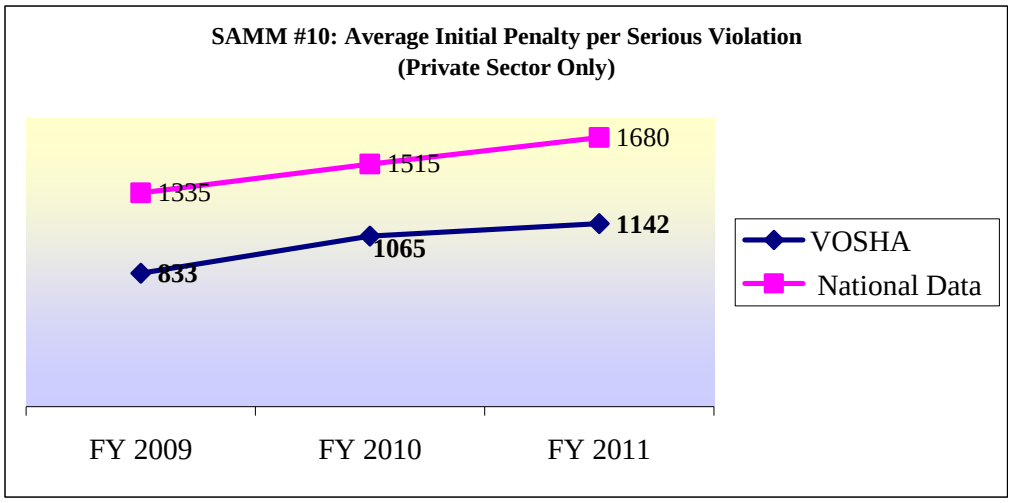
FY 2011 SIR Enforcement (Private Sector): Average Penalty						
	FY 2009		***FY 2010***		***FY 2011***	
	FED	***State***	***FED***	***State***	***FED***	***State***
C.5.A Other-than-Serious—Safety	*1030.7*	*641.7*	*894.3*	*100.0*	*1126.9*	*150.0*
C.5.B Other-than-Serious	*855.3*	*450.0*	*835.8*	*300.0*	*980.9*	*350.0*

Finding 11-20: Average Current Penalty per Serious Violations—VOSHA's average continues to fall below Federal OSHA's average. In FY 2011, VOSHA's average was $899.00, while Federal OSHA's average was $2,133.00

Recommendation 11-20: VOSHA's average current penalty per serious violation must align more closely with Federal OSHA's average by the end of FY 2012.

- **AVERAGE INITIAL PENALTY PER SERIOUS VIOLATION (PRIVATE SECTOR ONLY)**

SAMM #10 measures the state's average initial penalty per serious violation compared to the national data standard. VOSHA ended the fiscal year with an average of $1,141.73, compared to the national average of $1,679.7. As shown in the chart below, VOSHA has experienced a steady increase in this average since at least FY 2009; VOSHA's average increased by 37 percent since FY 2009. This compares favorably with the national data standard increase of 26 percent from FY 2009-FY 2011. See **Finding 11-01.**



ABATEMENT

- **ABATEMENT VERIFICATION**

SAMM #6 measures the State's percent of S/W/R violations verified. VOSHA's FY 2011 percentage of 97.05 (for private sector inspections) was the state's highest over the past three fiscal years. VOSHA also performed very well in FY 2011 compared to previous years in terms public sector inspections, with a percentage of 100.

As discussed earlier in this report, VOSHA's performance on SAMM #6 was a finding in the FY2009 EFAME, and again in the FY2010 EFAME Follow-Up report. Although VOSHA has shown improvement since FY2009, and met the standard for public sector inspections on FY2011, the Region continues to recommend that VOSHA work to meet the 100 percent standard for this measure for private sector inspections. See **Finding 11-01.**

According to the VOSHA compliance chief, VOSHA is closely tracking abatement due dates. For example, one of the State's corrective actions to help remedy the fact that it has fallen short of the standards for SAMM #6 is to require CSHOs to submit weekly case file status reports to the VOSHA managers. Included in these reports are abatement due dates and the progress employers are making in terms of complying with these deadlines.

SAMM #6 (Percent of S/W/R Violations Verified)	*FY 2009*		*FY 2010*		*FY 2011*	
	Private	**Public**	**Private**	**Public**	**Private**	**Public**
Percent S/W/R Violations Verified Timely	93.81	93.55	89.86	84.78	97.05	100

In addition to SAMM #6, **SIR C.4 (A and B)** measure the state's performance with regard to abatement verifications. As shown in the table below, VOSHA did not meet the federal average of 17.9 for percentage of safety inspections with an abatement period lasting more than 30 days. However, the state fared better than the federal standard of 9.4 days for health violations, with a percentage of 1.2.

FY 2011 SIR Enforcement (Private Sector): Abatement Period for Violations						
	FY 2009		***FY 2010***		***FY 2011***	
	FED	***State***	***FED***	***State***	***FED***	***State***
C.4.A Safety Percent >30 days	*17.6*	*12.6*	*17.2*	*35.0*	*17.9*	*29.1*
C.4.B Health Percent >60 days	*10.0*	*4.7*	*8.5*	*1.1*	*9.4*	*1.2*

- **ABATEMENT DOCUMENTATION**

In accordance with Chapter 5 of OSHA's FOM, a case file "remains open throughout the inspection process and is not closed until the Agency is satisfied that abatement has occurred." In addition, "employers are required to verify in writing that they have abated cited violations, in accordance with §1903.19." Region I found that 10 percent of the case files reviewed were closed without having any documentation of abatement, or having inadequate documentation of abatement. VOSHA must ensure that case files remain open until adequate documentation of abatement has been received from the employer, as discussed in Chapter 7 of the FOM, and in accordance with §1903.19.

Finding 11-21: Abatement Documentation—Some case files were closed without having any documentation of abatement or having inadequate documentation of abatement.

Recommendation 11-21: VOSHA must ensure that all documentation of abatement is present in case files before they are closed.

EMPLOYEE AND UNION INVOLVEMENT

Out of 70 case files reviewed by the Region, only six cases involved unions. Region I found no issues with union involvement in inspections. However, the Region did identify some cases in which it appears that VOSHA did not conduct employee interviews, when it should have done so **(9 %).** As discussed under Fatalities, the CSHO did not document in the case file that he had interviewed employees at the work site where the fatalities occurred.

In another case where a non-fatal accident occurred, the Region I found written statements from employees in the case file, but it did not appear that the CSHO actually interviewed these employees. In this same case file, the reviewer noted that "the employer provided training records, but I [the reviewer] could find nothing in the [case file] to document that employees were adequately

trained/instructed on the hazard addressed in the citation. This is where detailed interviews with employees on the site and the victim become very important."

INFORMAL CONFERENCES

The Vermont State Plan's contest procedures are similar to Federal OSHA's, except for the fact that the employer has 20 calendar days from receipt of the citation and notification of penalty to contest the citation, penalty, and/or abatement date. Federal OSHA allows the employer 15 workdays (FOM, Chapter 7).

Similar to Federal OSHA, VOSHA permits employers to request an informal conference, which does not extend the period in which the employer must either pay penalties or contest the violations and/or penalties. VOSHA's *"Closing Conference Guide,"* a pamphlet that the State created to explain to employers "what happens after a VOSHA inspection," states the following: If a citation is issued, an informal conference or a request for an informal conference will not extend the 20 calendar day period within which you must either pay penalties or contest the violations and/or penalties. Despite these procedures, however, Region I found four cases in which the informal conference was held after the 20 calendar-day period had expired.

Finding 11-22: Informal Conferences— In some cases, the informal conference was held after the 20 calendar-day period had expired.

Recommendation 11-22: VOSHA must adhere to its own guidelines in its *"Closing Conference Guide,"* which requires no more than for not extending a 20-day calendar period for holding informal conferences.

STANDARD ACTIONS AND FEDERAL PROGRAM CHANGE (FPC) ADOPTIONS

VOSHA did not adopt the following FPCs for which state adoption was not required (CPL-02-00-152)—*Guidelines for Administering Corporate-Wide Settlement Agreements;* and ADM 04-00-001-*OSHA Safety and Health Management System*). VOSHA also did not adopt DIR 11-01 (CPL 03*)-National Emphasis Program—Microwave Popcorn Processing Plants,* because no such plants have been established in the State of Vermont.

With the exception of CPL-02-11-03-*Site Specific Targeting 2011 (SST-11*) and CPL-02-00-150-*Revisions to Field Operations Manual (FOM),* VOSHA adopted all FPCs in a form identical to that of Federal OSHA. VOSHA will adopt CPL-02-01-051—*Confined Spaces in Shipyards* identical to the Federal version, but has not yet done so since the State just recently completed adoption of the maritime standard (*29 CFR PART 1915—Occupational Safety and Health Standards for Shipyard Employment)* in February 2012.

VOSHA began the adoption process for the maritime standard on February 2, 2011, and had intended to complete the process by May 1, 2011. However, as shown in the table below, VOSHA did not

effectively adopt this standard until February 24, 2012.[8] Region I found that VOSHA did not adopt *29 CFR PART 1915* in a timely manner, once it was determined that Vermont had facilities that are covered by this standard**.** According to 29 CFR 1953 (a) (1):

> Where a Federal program change is a new permanent standard, or a more stringent amendment to an existing permanent standard, the State shall promulgate a State standard adopting such new Federal standard, or more stringent amendment to an existing Federal standard, or an at least as effective equivalent thereof, within six months of the date of promulgation of the new Federal standard or more stringent amendment.

Now that adoption of the maritime standard has been completed, VOSHA has begun the process of adopting the final rule on *29 CFR 1910, 1915, Working Conditions in Shipyards.* Adoption of this standard should have been completed by November 2, 2011.

Finding 11-23: Standard Adoption—VOSHA did not adopt 29 CFR 1915 in a timely manner, once it was determined that Vermont had facilities that are covered by this standard, and the State began the adoption process (February 2, 2011).

Recommendation 11-23: For all future standard adoptions, VOSHA must adhere to the six month time frame in 29 CFR 1953 (a) (1).

VOSHA STANDARD ACTIONS LOG
FY 2011

Standard	FR Date	Response Due Date	Date State E-mailed Response	Adoption Required	Intent Required	Adoption Due Date	Adopt Identical	Effective Date
1910,15,18,19,26,28 Standard Improvements Project, Phase III	6/8/2011	8/16/2011	8/17/2011	YES	YES	12/8/2011	YES	12/1/2011
1910, 1915 Working Conditions in Shipyards	5/2/2011	7/2/2011	5/18/2011	YES	YES	**10/1/2012**	YES	**10/1/2012**

[8] VOSHA had initially declined adoption of this standard; however, upon further investigation, VOSHA determined that there are two marinas in the state that provide maintenance and repair services as well as storage. On the other hand, Vermont does not have any facilities that fall under either PART 1917 (Marine Terminals) or under PART 1918 (Occupational Safety and Health Regulations for Longshoring).

VOSHA FEDERAL PROGRAM CHANGE LOG *(excluding standards)*
FY 2011

Directive	Date	Response Due Date	Date State E-mailed Response	Adoption Required	Intent Required	Intent to Adopt	Adopt Identical	Adoption Date
CPL-02-11-03 Site-Specific Targeting 2011 (SST-11)	9/9/2011	11/12/2011	11/14/2011	YES	YES	YES	NO	12/31/2011
CPL-02-03-0032011 464 Whistleblower Investigations Manual	9/20/2011	11/21/2011	11/9/2011	YES	YES	YES	YES	12/1/2011
CPL-02-01-052 Enforcement procedures for Investigating and Inspecting Incidents of Workplace Violence	9/8/2011	11/12/2011	11/9/2011	NO	YES	YES	YES	1/1/2012
CPL-02-00-151 29CFR Part 1910, Subpart T—Commercial Diving Operations	6/13/2011	8/16/2011	6/29/2011	NO	YES	YES	YES	8/1/2011
CPL-03-00-013 NEP-Primary Metals	5/19/2011	8/1/2011	8/1/2011	YES	YES	YES	YES	10/15/2011
CPL-02-01-051 Confined Spaces in Shipyards	5/20/2011	7/24/2011	**8/17/2011**	NO	YES	YES	YES	**3/15/2012** **VOSHA postponed adoption until after adoption of the maritime standard**
CPL-02-00-150 April 2011 Revisions to Field Operations Manual (FOM)	4/22/2011	7/2/2011	5/18/2011	YES	YES	YES	NO	8/1/2011
CPL-02-01-050 Enforcement Guidance for	2/10/2011	4/16/2011	4/18/2011	NO	YES	YES	YES	6/1/2011

VOSHA FEDERAL PROGRAM CHANGE LOG *(excluding standards)* FY 2011								
Directive	**Date**	**Response Due Date**	**Date State E-mailed Response**	**Adoption Required**	**Intent Required**	**Intent to Adopt**	**Adopt Identical**	**Adoption Date**
Personal Protective Equipment (PPE) in General Industry								
CPL-03 (11-01) NEP—Microwave Popcorn Processing Plants	1/18/2011	4/16/2011	2/18/2011	YES	YES	NO		
STD-03-11-002 Compliance Guidance for Residential Construction	12/16/2010	2/26/2011	12/28/2010	NO	YES	YES	YES	5/1/2011
CPL-02-01-049 Enforcement Guidance for PPE in Shipyards	11/4/2010	1/11/2011	1/6/2011	NO	YES	YES	YES	6/1/2011

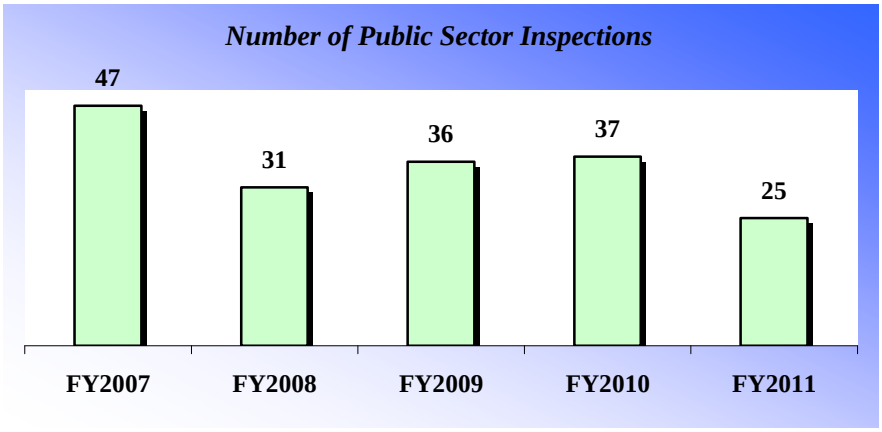
PUBLIC EMPLOYEE PROGRAM/INCIDENCE RATES

In FY 2011, VOSHA conducted 25 public sector inspections out of a total of 40 projected public sector inspections, or 63 percent of projected public sector inspections. For public sector consultation visits, however, Project WorkSAFE more than doubled the number it projected for the fiscal year, by conducting 43 out of 20 projected. Out of a total of 58 complaint inspections conducted by the State in FY 2011, only 5 of these inspections were conducted in the public sector.

As mentioned previously, VOSHA contends that Tropical Storm Irene impacted the State's ability to meet its goal for inspections, due to the fact that VOSHA's enforcement personnel focused on conducting interventions (rather than inspections) in the aftermath of this event. In addition to conducting interventions, CSHOs also worked shifts in the emergency operations center.

However, the storm occurred during the last few days of August 2011. With only one month remaining in the fiscal year, VOSHA had 15 more inspections to conduct in order to meet its goal. Since VOSHA was conducting public sector inspections at the rate of only 2-3 per month (at best) up until the time the storm hit in late August, it is not realistic to believe that the program would have conducted 15 inspections during the month of September had it not been for the storm.

As shown in the chart below, VOSHA's public sector inspection total in FY 2011 was the lowest recorded by the State over the past five years. Out of the 317 inspections conducted by the program in FY 2011, only 8 percent were conducted in the public sector. This percentage is almost less than half of the national State Plan percentage of 15.



INCIDENCE RATES IN VERMONT[9]

Over the past three years, Vermont's Total Case Incidence Rate (TCIR) and Days Away from Work, Job Transfer or Restriction (DART) rates have been consistently higher than the national TCIR and DART rates in the private sector. Although Vermont's TCIR and DART rates decreased from 2008 to 2009, they increased from 2009 to 2010. Percentage wise, the DART rate increase from 2009 to 2010 was especially high—18.2 percent. From 2008 to 2010, VOSHA's TCIR decreased by 5.5 percent, but the DART rate increased by 4.0 percent. The national rates for both TCIR and DART decreased significantly from 2008 to 2010.

	Private Sector											
	Total Case Incidence Rate (TCR)			Percent Change			Days Away from Work, Job Transfer or Restriction (DART) Rate			Percent Change		
	2008	2009	2010	08-09	09-10	08-010	2008	2009	2010	08-09	09-10	08-10
Vermont	5.5	4.9	5.2	-10.9	6.1	-5.5	2.5	2.2	2.6	-12.0	18.2	4.0
National	3.9	3.6	3.5	-7.7	-2.8	-10.3	2.0	1.8	1.8	-10.0	0.0	-10.0

[9] Data obtained from Bureau of Labor Statistics (BLS) at http://www.bls.gov/iif/oshstate.htm#VT (unless otherwise stated).

In terms of the public sector (state and local government), Vermont's TCIR and DART rates increased from 2008-2010. Percentage wise, the DART rate increased significantly—35.7 percent—from 2008 to 2010. There was also an especially high increase of 46.2 percent between 2009 and 2010.

	State and Local Government											
	Total Case Incidence Rate (TCR)			Percent Change			Days Away from Work, Job Transfer or Restriction (DART) Rate			Percent Change		
	2008	2009	2010	08-09	09-10	08-010	2008	2009	2010	08-09	09-10	08-10
Vermont	5.1	4.7	5.4	-7.8	14.9	5.9	1.4	1.3	1.9	-7.1	46.2	35.7

DISCRIMINATION PROGRAM—SPECIAL STUDY

PURPOSE AND SCOPE

Monitoring a State's 11(c) discrimination program is a mandated activity. In accordance with 29 CFR 1977.23 (Appendix A), the State's 11(c) Discrimination Program must be "as effective" as the program required by the paragraph 11(c) of the OSH Act. §1977.23 states, in part that "a State which is implementing its own occupational safety and health enforcement program pursuant to section 18 of the Act…must have provisions as effective as those of section 11(c) to protect employees from discharge or discrimination." In the context of §1977.23, Vermont is considered a "State Plan."

The Vermont Occupational Safety and Health Administration (VOSHA) operates its discrimination program pursuant to Title 21, V.S.A. § 231, Employee Rights. VOSHA has jurisdiction over whistleblower discrimination cases arising from private and public sector employees in Vermont.

The goal of the FY 2011 FAME is "to fully assess the current performance of each state plan and to identify areas of concern and areas of excellence." The 2011 assessment is to include a special focus on each state's whistleblower program. This opportunity is provided by the FY 2011 Federal Annual Monitoring and Evaluation (FAME) Guidance memo issued by the Directorate of Cooperative and State Programs on December 22, 2011.

This special study was conducted to determine whether Vermont's health and safety discrimination program is at least as effective as the Federal program established under authority of §11(c) of the OSH Act. While the review identified some areas where VOSHA has made improvements since the last review in 2009, many more areas were identified where the program is deficient and must be improved.

SUMMARY

VOSHA's discrimination program is not as effective as the Federal program and does not meet the §1977.23 standards. VOSHA's discrimination program has failed to adopt most recommendations made after program audits in 2004 and 2009. The purpose of this Special Study is to aid VOSHA in establishing a solid procedure and structure so that cases will be properly screened and investigated in the future, with proper notifications to the parties and an appropriate appeals process, in conformance with §1977.23.

From a review of all available closed 2010 and 2011 case files, the audit team noted the following improvements in the VOSHA discrimination program:

- VOSHA corrected the duplication of IMIS entries and stopped linking discrimination case file numbers to safety and health inspection forms. The IMIS-generated case activity number now serves as the case number.
- It appears that VOSHA is no longer screening out as many complaints as it did prior to the 2004 review. Screenings are now done exclusively by an individual with knowledge about the discrimination program.
- The average days-to-complete a case was excellent. VOSHA is completing its cases in an average of 53 days - well below the national average of 185 days for the same time period.
- In 2009, VOSHA sent an investigator to OTI Course #1420, Basic Whistleblower Investigations—11 (c).

The audit team noted the following serious weaknesses in the VOSHA discrimination program:

- VOSHA failed to implement important recommendations from previous audits. For example, files were not tabbed and organized according to the manual, letters were not sent to the parties, case logs were not used in each case, FIRs did not address each element of the prima facie case, and VOSHA never established an appeals process.
- VOSHA failed to notify complainants of their rights - the right to dual file, the right to file a CASPA, or the right to file an appeal of VOSHA's determination.
- In a few cases, OSHA would not have reached the same determination as VOSHA. In other cases, the investigation and final report lacked the evidence and/or analysis necessary to determine whether OSHA would have reached the same conclusion.
- Investigators do not receive sufficient training and supervision.
- Those supervising the discrimination program have no training or experience in discrimination investigations.
- VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.

METHODOLOGY

Regional Investigators Jennifer Nohl and Carole Horowitz conducted a Special Study of the VOSHA discrimination program on site on January 23, 2012 and January 24, 2012. The team examined ten of the eleven cases recorded on IMIS Case Listing from October 11, 2009 through September 30, 2011. The other case selected for review was missing and VOSHA did not provide it during the site visit.

The Special Study team interviewed the principal personnel responsible for the discrimination program, including the VOSHA Director and two staff members who function as CSHOs as well as Discrimination Investigators. State Plan investigators were cooperative, helpful, and exhibited a positive and dedicated attitude toward the operation and mission of the state plan.

Also interviewed was one stakeholder who is the Senior Field Representative for the Vermont State Employees Association, and staff liaison to the Statewide Safety, Health and Maintenance Committee, a union-management group.

The team reviewed whistleblower IMIS reports on VOSHA discrimination activity, including number of cases completed, lapse times, and settlement rate. The team also reviewed IMIS reports for cases that VOSHA screened out as not appropriate for investigation.

BACKGROUND

This office reviewed VOSHA's discrimination program in 2004 and again in 2009, each time finding areas in need of improvement. In 2004, reviewers noted that complaint calls were not being tracked properly; case files were poorly organized; Final Investigative Reports were deficient in that they did not contain a witness list, an analysis, a recommendation or details of the closing conference with the complainant. They also noted that files did not contain copies of correspondence to the complainant and respondent such as initial and determination letters; files did not contain a telephone log; some case files did not contain an OSHA 87 form; and some OSHA 87 forms contained too much information in the allegation summary section.

In May 2004, Region I provided a two-day training for all VOSHA staff involved in investigating and supervising discrimination cases. OSHA provided each staff member with a binder including copies of all presentations, reference materials and aids to be used during investigations.

In 2009, OSHA again evaluated VOSHA's discrimination program. Although OSHA did not conduct an in-depth audit, the review revealed that the case files were still not organized in a consistent manner, the IMIS had duplicate entries, case files did not include letters to either party, case file numbers were inappropriately linked to safety and health inspection forms, and VOSHA did not have an appeals process in place.

FINDINGS

Screening

The VOSHA screening process has improved since previous reviews. An experienced investigator usually screens complaints and determines whether a prima facie allegation has been made. A review of cases that VOSHA administratively closed in IMIS showed that VOSHA correctly decided not to investigate these complaints.

However, the team noted that a couple of cases that failed to meet the threshold requirements may have been screened in and investigated. Of specific concern were complaints that involved work refusals and potential constructive discharge (e.g. Complainant/22615124 and Complainant/22599740). In one case, Complainants/311483846, VOSHA conducted an investigation although the Complainants did not allege that they engaged in protected activity prior to the adverse action. Although when in doubt, it is always correct to conduct an investigation, VOSHA should be mindful not to expend resources on complaints that do not meet the threshold requirements.

It also appears that VOSHA may be missing opportunities to refer cases to OSHA for investigation under other federal statutes. For example, in Complainant/22596886, the complainant raised concerns about improper food handling and storage, but VOSHA did not refer this matter to OSHA for consideration as a possible Food Safety Modernization Act case.

Investigation

Overall, VOSHA's two investigators should be credited for conducting diligent investigations. In most cases, the relevant witnesses were interviewed and statements were obtained. However, due to lack of training and supervision, investigations routinely tended to overlook certain relevant lines of investigation such as disparate treatment (e.g. Complainant/1764513, Complainant/1755990, and Complainant/22583090).

Further, in some cases the respondents' legitimate reason for the adverse action was not tested or analyzed. For example, in Complainant/22583090, the Complainant alleged that after he made a safety complaint to his supervisor his hours were changed, interfering with his childcare responsibilities. According to the Complainant, the Respondent was well aware of these responsibilities. The investigation concluded that the Respondent had a legitimate reason for changing the Complainant's hours without ascertaining what the new hours were and why this necessitated changing the Complainant's hours, or whether other employees' hours were changed.

It appeared that investigators often used techniques that could undermine reliable fact gathering. For example, investigators frequently asked parties and witnesses very specific questions, instead of open-ended questions. This prevented witnesses from being able to tell their full story. Occasionally, interviews were not conducted in an appropriate manner or setting. In one case, Complainant/22599740, several managers were interviewed together. In another case, the Respondent's attorney was allowed to attend the non-management witness interviews (Complainant/311482996). In still another, Complainant/1764513, a witness was interviewed in a

public place such that others were in a position to overhear. Occasionally, interviews of managers who backed the Respondent's position seemed to be credited as if they were neutral witnesses and not the Respondent's witnesses. This gave an erroneous appearance of neutrality.

In many cases it did not appear that relevant lines of investigation were followed to conclusion. In several cases, complainants were not given an opportunity to rebut respondents' assertions. In other cases, investigators did not attempt to obtain neutral evidence to verify assertions made by each party.

Report Writing

In 2004, this office recommended that, "The cases should be laid out properly in the final investigation reports. The Federal Investigative Report (FIR) should list all the witnesses, with their titles and indicate who were interviewed and not interviewed. The FIR should also contain an analysis, a recommendation and details of the closing conference with the complainant. The format of the FIR can be found in chapter 4 – Case Disposition of the 2003 Whistleblower Investigations Manual." [10]

To assist in these improvements, OSHA conducted training which included an example of the proper FIR format to follow, yet VOSHA did not implement the format. This recommendation stands.

In addition to VOSHA's failure to follow the format of a basic FIR, the reports need other improvements as well. For the most part, the reports did not clearly explain the facts of the case. Frequently, no distinction was made between established fact and uncorroborated assertion. Further, the writers often did not use dates or explain the fact pattern in chronological order, making the report difficult to follow (Complainant/1747062). In fact, several FIRs seemed to chronicle not the facts of the case, but the investigation itself.

VOSHA's legal analysis in virtually each case was incomplete. In each report, the writer tended to reach conclusions without examining each element of the prima facie case. Most reports lacked an analysis of the Respondent's alleged legitimate reason for the adverse action. Instead, the analysis was usually a conclusory statement with little justification as to how that conclusion was reached.

Some of the case files contained documentation showing that a supervisor had reviewed the FIR, while others did not. While we presume that a supervisor did review each report, we were not able to establish this with certainty. It should be noted that even when a supervisor did review the FIR, deficiencies were not addressed. This is likely due to the fact that supervisors have not received sufficient training to identify errors in a discrimination investigation.

Concurrence with VOSHA Determinations

Deficiencies in VOSHA's investigations and report writing made it challenging for reviewers to determine whether OSHA concurred with VOSHA's findings in several cases. As discussed, above, the investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions.

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10 The 2011 Whistleblower Investigations Manual has changed the FIR to a Report of Investigation (ROI).

This difficulty in review is illustrated by Complainant/1764513. In that case, the Complainant alleged he was dismissed because he filed a safety and health complaint with VOSHA. The Respondent contended that the Complainant was dismissed for legitimate performance issues, such as a history of discipline for excessive cell phone use, showing up to work intoxicated, using vulgar language, and, ultimately engaging in a domestic dispute while at work where the local police had to come to the workplace. VOSHA dismissed this complaint, finding the Respondent discharged Complainant for legitimate, nondiscriminatory reasons. The investigation, however, did not look into evidence of disparate treatment. There was no evidence and no analysis of whether the Complainant's performance and conduct were the same before and after he engaged in protected activity, or whether others engaged in similar conduct without being disciplined. Further, the FIR was written in a style that chronicled the investigator's interviews of each party and witness, which made it difficult to follow the story of the actual case. The analysis contained a simple conclusion that the Respondent had a legitimate reason for dismissal without examining any of the elements. While OSHA most likely would have reached the same conclusion in this matter, reviewers cannot be certain.

Overall, in five of the ten cases reviewed, the reviewers were not able to ascertain whether they would concur with the outcome of the investigation.

Case File Management

Despite the fact that VOSHA has been criticized for failing to organize its case files in a manner consistent with the Whistleblower Investigations Manual in 2004 and 2009, its case files still lack organization. Not a single file was assembled, never mind in the proper order and format required by Chapter 5 of the DIS 0-0.9 Manual. Evidence was not tabbed or given an exhibit number, nor was it indexed with contents of the case file, making case file review difficult. In some cases, multiple copies of documents made case files unwieldy. None of the case files contained investigator notes. Also missing from files were recordings of interviews. Further, case files were not labeled or named consistently. Complainant/22602726 was missing upon our arrival and was not produced to us for review during the on-site audit.

Finding 11-24: Discrimination Cases— Case files were not tabbed and organized according to the manual.

Recommendation 11-24:

- VOSHA must organize case files in accordance with the format in the 2011 Whistleblower Investigations Manual. Exhibits must be tabbed and the file must contain a Contents of File. 5(III)
- All documents must be retained in the file, including investigators' notes and recordings of interviews downloaded to CDs.
- All emails must be printed and placed in the case file.
- Evidentiary materials should be separated from notes and emails.
- The ROI format provided to VOSHA by Region I must be used.
- All reports must contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination.
- The supervising official must sign and date the ROI, indicating concurrence with the findings.

- A uniform system to label case files with the complainant name, the respondent name and the case number must be created.

Settlement

VOSHA had a settlement rate of 18 percent, settling 2 of 11 cases in FY 10 and 11. This is slightly below the national average settlement rate of twenty-four percent during the same time period.[11] Since 1995, VOSHA has conducted 63 investigations and settled eight cases for a settlement rate of 12.5 percent.

Of concern is that both of these settlements might have resulted in inappropriate outcomes. In the first case, Complainant/22615124, VOSHA settled a case that it might have been able to screen out because the Complainant refused an assignment under circumstances that most likely did not meet the *Whirlpool* criteria for work refusal. Further, the Complainant quit under circumstances that probably did not meet the level of intolerability necessary to prevail under a constructive discharge theory. While it is not improper to open a case whenever there is doubt about the strength of the allegation, VOSHA should be aware that settling a case where there is no possibility of a merit finding could be seen as overreaching if the respondent is led to believe that the case could have merit.[12]

OSHA believes that VOSHA acted inappropriately when it settled the second case, Complainant/1766609, bilaterally. The Respondent proposed to settle this case by paying the Complainant back wages. The Complainant rejected that offer because he believed he was owed additional compensatory and punitive damages. VOSHA was correct to conclude that punitive damages could not be included in a bilateral settlement. Even though VOSHA was correct in not awarding punitive damages, the issue of additional compensatory damages is less clear. Although there was evidence in the case file showing that the Complainant claimed he had suffered compensatory damages other than lost wages, nothing in the case file documented whether or not VOSHA investigated or considered adding these potential losses in calculating a remedy. VOSHA erroneously concluded that because the Complainant refused to be a party to the agreement, he was declining the award. Therefore, VOSHA never required the Respondent to send the award to the Complainant. Ultimately, this led to a result in which a complainant in a meritorious case received no compensation and the respondent resolved the matter with no penalty paid.

Furthermore, the complainant in the above case contacted OSHA to complain that he had not received a written determination in his case. When OSHA contacted the VOSHA Director, he assured us that VOSHA was sending a letter the next day and that he would provide it to us. However, even after repeated requests, VOSHA never sent OSHA a letter or any explanation. During the audit, we learned that no letter had been written.

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11 Because VOSHA's total number of investigations is so small, the settlement rate cannot be compared either favorably or unfavorably with the national rate for such a short time period.

12 This is not to infer that VOSHA misled the respondent in this case. It is only to point out the importance of not appearing coercive when attempting to settle cases.

Timeliness

Nine of the 11 cases reviewed were completed within the 90-day statutory timeframe. On average, it took VOSHA 53 days to complete a discrimination case, well below the national average of 185 days for the same time period. VOSHA presented reasonable justification for those cases that were not completed in time.

While we commend VOSHA on its timely resolution of discrimination cases, we are concerned about the shortcuts VOSHA has taken in the investigation, report writing, and file management of cases that have resulted in the short lapse times. In light of the numerous problems found during this audit, we find that VOSHA would better serve its constituents by taking the necessary time to thoroughly complete its cases, even if that results in longer lapse times.

Program Management

On the positive side, VOSHA gave discrimination investigations equal priority to safety and health inspections. Investigators felt they had the time and resources necessary to conduct thorough investigations. However, VOSHA's management has failed to bring its discrimination program up to an acceptable level.

Of primary concern is the absence of supervision and training. CSHOS are largely responsible for ensuring their cases are properly screened, assigned, investigated and entered into the IMIS. The VOSHA Director acknowledged that he does not know how to access IMIS although, in fact, the VOSHA Director does have an IMIS account but he has not attempted to learn to use it. Supervisors, therefore, are unable to run reports, verify the accuracy of information, and assess the program. For example, several cases reviewed had incorrect allegation codes in the IMIS. In most cases, the allegation code chosen was "participation in safety and health activities" when another code such as "filing with primary agency" was appropriate. An IMIS trained supervisor could have corrected this problem. If VOSHA's management used IMIS to review its program statistics, it would have an accurate accounting of its own program.

It is clear from deficiencies throughout the program that supervisors and investigators have not been adequately trained to run an effective program. While it appears that VOSHA has diligent staff eager to conduct good investigations, management has not provided the supervision and training necessary to allow them to accomplish this goal.

Only one of two investigators has attended the OTI Course #1420 training. The more senior investigator has never attended this training. Supervisors of the program have received no training in discrimination investigations. VOSHA did not send investigators to the September 2011 State/Federal Whistleblower Investigator's Conference where they would have received valuable training and information on policy changes in the new Whistleblower Investigations Manual. Management has stated that it will reserve funds to send investigators to the next national conference in 2012.

It is notable that VOSHA managers have not conducted CSHO performance evaluations for several years, and that the existing performance standards do not include any elements related to conducting discrimination investigations.

It is also worth noting that there is no reliable mechanism by which investigators are kept up to date with developments in the federal program. As it stands, they must take the initiative to learn about new statutes or changes in federal OSHA policy. One investigator commented that he learned about OSHA's new manual though a trade publication. Management acknowledged that it receives notification of changes to the federal program and that it knew about the new manual. It appears, then, that managers are not ensuring that investigators receive and understand these updates.

The VOSHA Director asserted that many programmatic deficiencies were the result of inexperience because VOSHA had relatively few cases until 2009, when it received an influx of about five cases per year. According to the VOSHA director, VOSHA was unprepared to deal with the increased caseload. The VOSHA director intimated that he considers the recent increase in caseload to be an aberration due to the weak economy, and said that he expects that the number of discrimination cases will decrease within the next year or so. The implication could be that devoting resources to VOSHA's discrimination program will ultimately be unnecessary.

An IMIS review for the past 10 years, however, shows that VOSHA's number of cases received increased in 2008 and has remained fairly level since. Given the large increase in whistleblower cases nationwide, and the changes VOSHA must adopt to make its program known and accessible to the public (see recommendations, below), VOSHA must assume that the caseload will remain the same or increase in the future, and plan accordingly.

VOSHA Discrimination Cases FY 2002 - 2011

Fiscal Year	# Cases Received	# Cases Completed
2002	4	5
2003	0	0
2004	3	2
2005	2	3
2006	3	2
2007	4	3
2008	7	7
2009	5	6
2010	5	6
2011	8	5
Total	41	39

During the audit, there appeared to be some resistance in VOSHA's upper management to put forth the effort necessary to bring the program up to an acceptable standard. This is evidenced by the fact that VOSHA has not implemented most of the recommendations made in previous audits. For

example, in the 2009 FAME review, OSHA recommendation #28 stated that VOSHA "must assemble discrimination case files in an orderly fashion and in accordance with OSHA's Discrimination Manual, Chapter 5.III.B.1, which includes a Case Activity Worksheet, or OSHA 87 and notification and closing letters to the parties. In addition, an activity/telephone log must be accurately documented with telephone calls and significant events that occur with respect to the case."

VOSHA replied that "management will complete a review of Chapter 5.III.B.1 of the Discrimination Manual by February 1, 2011 (or at an earlier date should there be a discrimination complaint in the interim) with the discrimination investigators and will follow the requirements in the section. Discrimination case files will be organized per the instructions in the Discrimination Manual and will include a case file activity/telephone log to track all case file activity." As previously noted, VOSHA's current files not only do not follow the manual, but they are barely organized at all. Some do not contain activity logs. It is worth noting that even in VOSHA's response to this recommendation, it neglected to address the issue that notification and closing letters were not being sent to the parties. Of the ten files reviewed during the audit, none contained a letter to the parties.

In 2009, OSHA told VOSHA that it must develop an appeals process, but as of the audit date no appeals process was in place. Further, OSHA told VOSHA that it must notify parties of their appeal rights. While some cases did document that a closing conference was held in which the Complainant was advised of the right to appeal, most case files did not. This is little wonder since there is no process in place to notify them. Also in 2009, OSHA told VOSHA that it must notify complainants they had the right to dual file, but to date no such notifications are made. VOSHA must immediately address its failure to make available to complainants the rights guaranteed them under the law.

As further evidence of VOSHA's dismissive position toward OSHA audits, VOSHA did not have the case files requested by the audit team available when we arrived. Approximately one hour of the auditors' limited time on-site was wasted waiting for VOSHA to provide the case files for review.

Overall, the review team found that investigators were hampered because management did not assume responsibility for the discrimination program.

Finding 11-25: Discrimination Cases (Program Management)—VOSHA does not have an appeals process.

Recommendation 11-25: VOSHA must immediately establish and implement an appeals process in conformance with the Whistleblowers Investigations Manual Chapter 1(VII) (C).

Finding 11-26: Discrimination Cases (Program Management)—VOSHA fails to notify complainants of their rights, such as the right to dual file, the right to file a CASPA, and the right to file an appeal of VOSHA's determination. Letters were not being sent to the parties.

Recommendation 11-26:

- VOSHA must send notification and determination letters to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year.
- Stop giving the "Complainant Information Form" to complainants.
- While not required by the manual, OSHA considers it a best practice for states to notify the parties of their right to file a CASPA and encourages VOSHA to do so.
- Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e. give them 30 days from the date you notify them of their right to appeal.

Finding 11-27: Discrimination Cases (Program Management)—Supervisors do not use or review the information entered into IMIS.

Recommendation 11-27:

The supervisor must:

- Have access to IMIS and training on how to run reports.
- Ensure that the correct allegation code is used.
- Ensure that the allegation summary describes the alleged protected activity and adverse action.
- Ensure that the closed date is the same as the date closing letters are sent.

Finding 11-28: Discrimination Cases (Program Management)—Investigators do not receive sufficient training and supervision to conduct proper investigations. Investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions. Those supervising the discrimination program have no training or experience in discrimination investigations.

Recommendation 11-28:

- Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA.
- Retrain managers and discrimination investigators in the investigative process, elements of a violation, and case analysis.
- Budget for investigators to attend national whistleblower conferences and regional meetings.
  VOSHA will send investigators and those who supervise discrimination work to attend the Basic Whistleblower Investigations course #1420 at the OSHA Training Institute.

Finding 11-29: Discrimination Cases (Program Management)—Supervisors do not manage the program effectively.

Recommendation 11-29:

- Supervisors must keep investigators informed about changes to federal OSHA's program.
- Supervisors and investigators must confer with OSHA on difficult cases.
- VOSHA must consult with the designated OSHA Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed.

- VOSHA must send the completed ROI to the designated RSI before closing the case.
- VOSHA must send the completed case file to OSHA upon completion of the case.

Finding 11-30: Discrimination cases (Program Management)—VOSHA does not have an attorney designated to handle discrimination matters.

Finding 11-30: VOSHA will designate an attorney with expertise in discrimination matters to advise it on legal issues that arise.

Website

The VOSHA website contains little information regarding its discrimination program, and worse, the limited information that is found is buried in a "Frequently Asked Questions" link pertaining to confidentiality of complaints.[13] The answer does not clearly state that a complainant can make a discrimination complaint with VOSHA and the site does not provide a clear mechanism by which a complainant can file an electronic discrimination complaint. Nor does the VOSHA website provide a link to federal OSHA's website, which in the absence of its own information, could provide workers with basic whistleblower information. It is also worth noting that it is difficult to navigate to the VOSHA website through the Vermont DOL site. VOSHA is located in the section for businesses, which may make it difficult for workers looking for information to find it.

It is particularly egregious that an organization that is supposed to protect workers' rights does not inform workers of the rights that exist under the law that it enforces.

Finding 11-31: Discrimination Cases (Outreach)—VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.

Recommendation 11-31:

- Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible to employers and employees.
- Provide a link to OSHA's website – www.whistleblowers.gov

Finding 11-32: Discrimination Cases (Outreach)—VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.

Recommendation 11-32: Conduct outreach with stakeholders about employee rights and employer responsibilities.

Public Sector Complaints Lacking

Although VOSHA covers both the public and private sector, of the discrimination cases reviewed during this audit, none was from public sector employees. An IMIS review of all VOSHA

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[13] **If I file a complaint, will it be kept confidential?** Yes. Complaints are retyped and all personal identifiers are removed. Your name is not put on the complaint form. Employees are also protected from discrimination for filing a complaint with VOSHA. If you are a victim of discrimination as the result of having filed a complaint, you should contact VOSHA within 30 days. Employees who are discriminated against may also file a private action against their employer.

discrimination cases received revealed only one or two public employee discrimination complaints, at most.[14] A union official interviewed on this topic, who was unaware of VOSHA's discrimination protections, believed that this could be a result of: 1) ignorance among public workers that this protection exists; 2) a possible reluctance to involve a state agency in solving another state agency's problems (lack of trust), and 3) the ability of the union to resolve issues of retaliation on its own, without seeking outside assistance.

VOSHA-Created Form

In an apparent effort to notify complainants of their obligations during a discrimination investigation, VOSHA has begun using a form it created. VOSHA asks the Complainants to review and sign the form in person during the interview process. The Complainants are not given a copy of the form for their personal records and use. The legal language used throughout the form, in conjunction with the limited timeframe given to complainants to review and consider the information given, makes the use of this form, while perhaps well intended, overly burdensome for the typical complainant. Moreover, nowhere in this form are complainants notified of the right to dual file, appeal or file a CASPA.

FOIA

While OSHA did not specifically audit how VOSHA replied to FOIA-type requests, in the case of Complainant/1766609, the audit team found that the complainant had requested a copy of the case file. The audit team could find no documentation to show if or how VOSHA responded to this request. A future audit may want to examine VOSHA's FOIA process.

CONCLUSION AND RECOMMENDATIONS

VOSHA's discrimination program is not as effective as that of federal OSHA.

In order to bring its discrimination program to a minimally acceptable level of performance, VOSHA must immediately implement the following:

- Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA.
- Immediately implement an appeals process in conformance with the Whistleblowers Investigations Manual Chapter 1(VII)(C).
- Send notification[15] and determination letters[16] to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year.

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[14] In FY 2011, VOSHA received only five safety and health complaints from public sector employees.

[15] The notification letters must:
Notify complainants of their right to dual file;
Provide a copy of the statute and regulation to the parties;
Provide Respondent with Complainant's allegation;
Explain to the parties that their submissions will be provided to the opposing party;
Advise them of their right to obtain legal counsel.
(See template letter P. 7-21. For dual-filed complaints use letter on P. 7-23 for Complainant and P. 7-25 for Respondent)

- Immediately stop giving the "Complainant Information Form" to complainants.
- While not required by the manual, OSHA considers it a best practice for states to notify the parties of their right to file a CASPA and encourages VOSHA to do so.
- Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY 2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e. give them 30 days from the date you notify them of their right to appeal.

Investigation and Case File Management

- Retrain managers and discrimination investigators in the investigative process, elements of a violation, and case analysis.
- Organize case files in accordance with the format in the 2011 Whistleblower Investigations Manual. Exhibits must be tabbed and the file must contain a Contents of File. 5(III)
- All documents must be retained in the file, including investigators' notes and recordings of interviews downloaded to CDs.
- All emails must be printed and placed in the case file.
- Evidentiary materials should be separated from notes and emails.
- Use the ROI format provided to you by Region I. [17]
- All Reports must contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination.
- The supervising official must sign and date the ROI, indicating concurrence with the findings.
- The supervisor must have access to IMIS and training on how to run reports.
- A uniform system to label case files with the complainant name, the respondent name and the case number must be created.
- Supervisors must keep investigators informed about changes to federal OSHA's program.
- Supervisors and investigators must confer with OSHA on difficult cases.
- Budget must be available for staff attendance at whistleblower investigator national conferences and regional meetings.

IMIS

- Ensure that the VOSHA managers use the IMIS reports for tracking cases.
- Ensure that the correct allegation code is used.
- Ensure that the allegation summary describes the alleged protected activity and adverse action.
- Ensure that the closed date is the same as the date closing letters are sent.

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16 The determination letters must:
Explain the reason for the outcome (dismissal, referral for litigation, withdrawal, etc.)
Provide appeal rights to complainants.
In dual-filed complaints, a copy of the determination letter must be sent to OSHA.

17 The ROI in the new manual is under revision and we will provide you with the new format when the revision is complete.

Outreach

- Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible.
- Provide a link to OSHA's website – www.whistleblowers.gov.
- Conduct outreach with stakeholders about employee rights and employer responsibilities.

Because VOSHA has disregarded recommendations made in previous audits, OSHA must play a more active role in ensuring that VOSHA implements recommendations made in this report. OSHA will closely monitor VOSHA's progress over the next year and provide training and guidance.

- VOSHA must consult with the designated OSHA Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed.
- VOSHA will send the completed ROI to the designated RSI before closing the case.
- VOSHA will send the completed case file to OSHA upon completion of the case.
- VOSHA will designate an attorney with expertise in discrimination matters to advise it on legal issues that arise.
- VOSHA will send investigators, and those who supervise discrimination investigators, to attend the Basic Whistleblower Investigations Course #1420 at the OSHA Training Institute.

OSHA will assist VOSHA in making its program as effective as federal OSHA's.

- OSHA will provide training to VOSHA staff on investigations, case analysis, and case file management.
- OSHA will invite VOSHA discrimination staff to regional conferences.
- OSHA will provide training to all VOSHA staff on federal statutes and making referrals to federal OSHA.
- OSHA will provide IMIS training for investigators and managers.

VOLUNTARY COMPLIANCE PROGRAMS (VPP, ALLIANCES)

- **GREEN MOUNTAIN VPP PROGRAM**

VOSHA adopted the following OSHA Directives on March 20, 2003: TED 8.1a, Revised Voluntary Protection Programs (VPP) Policies and Procedures Manual and TED 3.5, Interim Guidance for Voluntary Protection Programs. VOSHA has also implemented the Challenge Program.

VOSHA currently has eight Star sites. Three sites have employees who are represented by collective bargaining agent(s). One site (Ben and Jerry's) is covered under the Process Safety Management (PSM) standard. The following are the current Star sites in VOSHA's Green Mountain VPP:

- Ben & Jerry's
- Energizer Battery Manufacturing, St. Albans
- Energizer Battery Manufacturing, Bennington
- Entergy (Vermont Yankee)
- General Electric, Rutland

- IBM
- United Water
- Vermont Agency of Transportation (VTrans) District 7

According to CSP 03-01-003, Chapter II, Section III (F) (A) 1, the Agency is responsible for maintaining a public file on all approved participants to include the following:

a. the General Information section from the application;
b. the VOSHA Director's memorandum to the Commissioner requesting approval of a VPP onsite evaluation report;
c. onsite evaluation reports;
d. the Commissioner's letter to the participant (which includes notification of a copy sent to any and all collective bargaining agents);
e. Congressional and Gubernatorial letters; and
f. any formal correspondence to and from the Regional Administrator, the VPP site, or the public.

During the onsite review, Region I found that a number of the signed approval letters were not contained in the VPP files. VOSHA must obtain copies of these signed letters and include them in the appropriate files.

Finding 11-33: VPP—A number of the required signed approval letters were not contained in the VPP files.

Recommendation 11-33: VOSHA must obtain copies of these signed letters and include them in the appropriate files.

According to CSP 03-01-003, Chapter II, Section VII (C), VOSHA must use routine procedures for conducting complaint, referral, and/or fatality/catastrophic investigations at VPP worksites**.** The Region found that a complaint of an ammonia leak at a VPP PSM site was assigned to the VPP manager to investigate. Another informal complaint, which was reported on September 19, 2011, was not yet entered into the NCR at the time of the review. This complaint was also handled by the VPP manager. VOSHA must conduct all complaints, referrals, and/or fatality/catastrophe investigations at VPP sites in accordance with the FOM. The VPP manager must not become involved in enforcement issues until the incidents have been addressed by VOSHA enforcement. If citations have been issued, the VPP manager may not become involved until all items are abated and the case has been settled.

Finding 11-34: VPP—Complaints at VPP sites were handled by the VPP manager, rather than by a compliance officer.

Recommendation 11-34: VOSHA must ensure that all complaints, referrals, and/or fatality/catastrophe investigations at VPP sites are handled by compliance staff.

VOSHA has an active GMVPP Challenge Program. Each of the eight GMVPP sites has signed commitment letters to participate in the VOSHA Challenge Program as a Challenge Administrator. The program has quarterly administrators' meetings held in the Vermont Department of Transportation facility in White River Junction, Vermont. The program manager also conducts application workshops. The program's goal is to have each site mentor at least one site.

For each site, VOSHA has reviewed the annual injury and illness rates and calculated three-year averages of these rates. All three-year averages were below the 2009 BLS rates for their respective industries. To date, no fatalities have occurred at any of the GMVPP sites since they began participating in the program.

- **ALLIANCES**

VOSHA currently has two active Alliances: Vermont Rural Water Association and Vermont Safety and Health Council. The Alliance with Associated General Contractors of Vermont expired on January 1, 2011, and management does not anticipate that this Alliance will be re-established.

In compliance with CSP 04-01-001, OSHA's Alliance Programs directive, VOSHA's Alliances conduct the following core activities: training and education; outreach and communication; and promoting the national dialogue on workplace safety and health. However, Region I found that VOSHA's Alliance documentation does not comply with the directive's requirements in Section XII Program Requirements, D. Alliance Documentation 1 and 2.

For example, annual reports were not completed. In addition, the electronically signed Alliance copies are not posted on the VOSHA Web site, along with any updates, milestones, success stories, events, or photographs. The Alliance folders did contain a signed copy of each Alliance and copies of intervention forms (OSHA-55).

Finding 11-35: Alliance Program—VOSHA's Alliance documentation does not comply with the directive's requirements in Section XII Program Requirements, D. Alliance Documentation 1 and 2.

Recommendation 11-35: VOSHA must ensure that annual reports are completed and maintained in the Alliance files; that the electronically signed Alliance copies are posted on the VOSHA Web site, along with relevant updates, milestones, success stories, events, or photographs.

PUBLIC SECTOR ON-SITE CONSULTATION PROGRAM

In FY 2011, Project WorkSAFE more than doubled its goal of 20 visits, by conducting a total of 43 (28 initial; 12 training and assistance; and 3 follow-up). All consultation visits conducted in FY 2011 included participation by employees at the worksite.

Consultants identified 202 hazards, including188 Serious (93%) and 14 Other-than-Serious (7%). In addition, Project WorkSAFE removed 2,281 workers from risk of serious injury, and 176 workers from the risk of hazards that were other-than-serious. Project WorkSAFE exceeded the 65 percent

standard for Mandated Activities Report for Consultation (MARC) measure #4D (percent of serious hazards verified onsite and within the original timeframe) for a percentage of 100.

PROGRAM ADMINISTRATION

- **EMPLOYEE TRAINING**

In the FY 2009 EFAME, Region I found that some CSHOs had exceeded the time frame of three years from date of hire to complete all courses in the initial compliance program as required by OSHA training directive TED 01-00-018, which was issued in 2008. Specifically, these CSHOs had not completed two courses conducted by OSHA's Training Institute (OTI): Course #2450, Evaluation of Safety and Health Management Systems, and Course #1310, Investigative Interviewing Techniques.

As of the end of FY 2011, VOSHA still had several CSHOs who were required to complete OSHA Training Institute (OTI) Course #2450, Evaluation of Safety and Health Management Systems. However VOSHA received permission from OTI to have this course conducted in Vermont in November 2011. All VOSHA CSHOs who were required to complete this training did so at that time. Region I found that there are four CSHOs who have yet to complete Course #1310, and so far have not been enrolled in this course in FY 2012.

Finding 11-36: Training—Vermont has CSHOs who have yet to complete Course #1310 (Investigative Interviewing Techniques), as required under OSHA's Initial Compliance Training Program.

Recommendation 11-36: VOSHA must enroll these CSHOs in this course so that they have all completed this training by the end of FY 2012.

In FY 2011, one CSHO completed all three courses in the PSM series (#3300—Safety and Health in the Chemical Processing Industries; #3400—Hazard Analysis in the Chemical Processing Industries; and #3430—Advanced Process Safety Management) at OTI. This CSHO also participated in PSM inspections performed by the Region's Area Office in Concord, New Hampshire, and is now qualified to conduct PSM inspections.

Region I has found that two of the program's "veteran" CSHOs who conduct most—if not all—of the program's fatality investigations, require additional training in investigative and interviewing techniques. For example, neither of these CSHOs has completed Course #1310 (Investigative Interviewing Techniques), and they have not been enrolled in this course, due to their long-term status as CSHOs.[18] However, in light of the investigative deficiencies cited in this report with regard

[18] When these CSHOs were hired in the late 1990s, the OSHA training directive that was in effect (OSHA Instruction TED 1.12) did not require completion of Courses #1310 and #2450. This directive was superseded in August 2008 by OSHA Instruction TED 01 00-018, Initial Training Program for OSHA Compliance Personnel, which *does* require CSHOs to complete these two courses as part of their initial training. However, the veteran CSHOs are exempt from the requirements of the newer directive.

to VOSHA's fatality cases, and regardless of the CSHOs' exempt status, Region I requires that these CSHOs complete Course #1310 before the end of the calendar year.

Finding 11-37: Training—Two of the program's "veteran" CSHOs who conduct fatality investigations require additional training in investigative and interviewing techniques at OSHA's Training Institute.

Recommendation 11-37: VOSHA must ensure that both CSHOs complete Course #1310, Investigative Interviewing Techniques, even though these CSHOs are technically exempt from taking this course due to their "veteran" CSHO status.

Region I found that one of the two veteran CSHOs who conduct fatality investigations has not yet completed OTI Course #1410 (Inspection Techniques and Legal Aspects). Under OSHA Instruction TED 1.12A, the training directive that was in effect when this particular CSHO began working for the program (in the late 1990s), this course was due to be completed during the first year of employment. As discussed in much detail earlier in this report, it is evident that the program's CSHOs are neglecting to perform fundamental steps in the inspection/investigation process, and therefore require this training to help ensure that these practices do not recur.

Finding 11-38: Training—VOSHA has no documentation to show that one of the two veteran CSHOs who conduct fatality investigations has completed OTI Course #1410 (Inspection Techniques and Legal Aspects).

Recommendation 11-38: VOSHA must ensure that the CSHO completes this course before the end of 2012, because this course is mandatory training for all CSHOs, and should have been completed in the first year of this CSHO's employment.

Finding 11-39: Training—Region I has performed an in-depth analysis of VOSHA's training records (which VOSHA provided to the Region upon request). This analysis has found that none of the program's CSHOs have completed their mandatory training track (as prescribed by OTI's training directives) within the time frame permitted (by the directives).[19]

Recommendation 11-39: By no later than December 31, 2013, VOSHA must ensure that all CSHOs have completed the training track for their appropriate discipline (safety or health) as required under the most recent OSHA training directive (TED 01 00-018, issued in 2008). (Region I can assist the program in determining the courses that each CSHO is required to complete).

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19 As previously discussed, some of the program's more senior CSHOs (in terms of length of service) were hired under a training directive (OSHA Instruction TED 1.12) that was in effect before the newer directive was issued in 2008 (TED 01 00-018). The mandatory training track for CSHOs that is prescribed by OTI in the latest directive differs in some respects from the training track in the older directive. However, *none* of the program's CSHOs have completed their mandatory training track—whether they were hired under the older directive or the newer one.

- **IMIS MANAGEMENT**

Region I verified that VOSHA is running the SAMM monthly and is reviewing IMIS Inspection and Enforcement data to monitor performance. For tracking purposes, VOSHA managers also review the following IMIS reports on a bi-weekly to monthly basis:

- Open Inspection;
- Complaint Tracking;
- Cases with Citations Pending;
- Inspection Summary Report;
- Violation Abatement Report; and
- Unsatisfied Activities Report.

An Open Inspection Report run on January 17, 2012, showed 7 inspections that were open for more than 90 days. According to the VOSHA director, this occurred because VOSHA's staff was mainly engaged in interventions and emergency response work (related to Tropical Storm Irene) until the middle of October 2011. This caused a backlog in cases that needed to be closed and citations that were awaiting issuance. A tracking report reviewed by the Region indicated that VOSHA's debt collection is monitored satisfactorily.

- **STATE INTERNAL EVALUATION PLAN (SIEP)**

Region found that VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM). Instead of developing such a plan, VOSHA designated the FY 2010 FAME Corrective Action Plan as its SIEP for FY 2011. At the Region I OSHA Family Meeting held in June 2011, the Region I State Plan monitor requested that VOSHA develop a SIEP that meets the criteria outlined in the SPPPM. In past years, VOSHA had designated the SAMM as its SIEP, which was also not a satisfactory response.

Rather than designating CAPs and IMIS reports as SIEPs, VOSHA should develop periodic in-depth audits that focus on key areas of concern, and share written findings with Region I. The Region is available to assist VOSHA with the development of an internal evaluation procedure.

Finding 11-40: State Internal Evaluation Plan (SIEP)—VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM).

Recommendation 11-40: VOSHA must develop a SIEP for use during FY 2013 that conforms to the requirements of the SPPPM.

V. ASSESSMENT OF STATE PROGRESS IN ACHIEVING ANNUAL PERFORMANCE GOALS

INSPECTIONS

- **PROJECTED COMPARED TO ACTUAL**

During FY 2011, VOSHA completed a total of 317 inspections out of 400 projected. The tables below break out of the number of inspections projected and completed by safety and health CSHOs for FY 2011 and FY 2010.

FY 2011 Inspections			
	Projected	***Actual***	***Actual as Percent of Number Projected***
Safety	300	217	72
Health	100	100	100
TOTAL	**400**	**317**	**80**

FY 2010 Inspections			
	Projected	***Actual***	***Actual as Percent of Number Projected***
Safety	300	267	89
Health	100	99	99
TOTAL	**400**	**366**	**92**

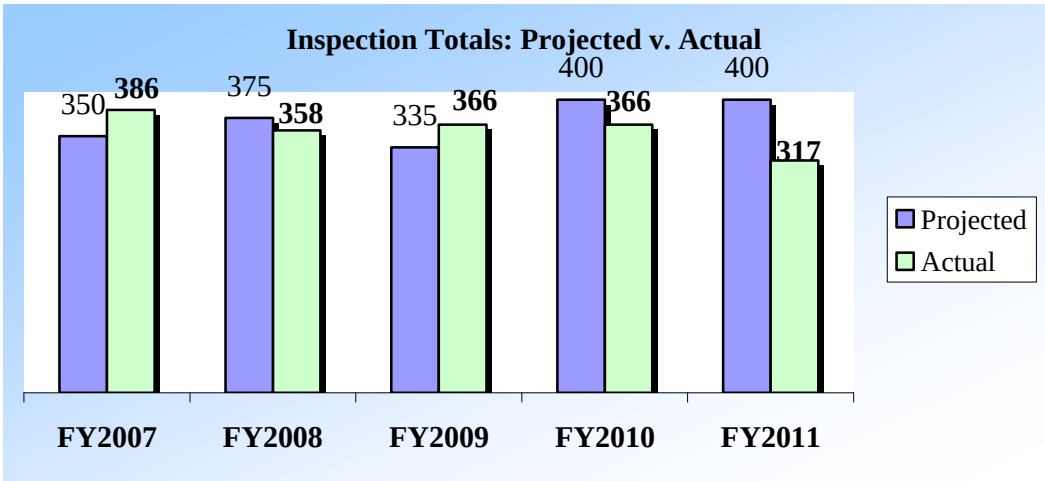
As shown in the chart below, VOSHA's total number of inspections conducted has declined over the past few fiscal years. According to the VOSHA managers, one obstacle to reaching this goal in FY2011 has been the loss of one safety CSHO in July 2011 to another state agency.

As discussed with regard to public sector inspections, VOSHA contends that Tropical Storm Irene adversely affected VOSHA's FY 2011 year-end inspection total. During the month of September, VOSHA field staff conducted 42 interventions in response to this storm, which caused massive flooding and wreaked havoc on roads, the state office complex in Waterbury, and other infrastructure. In addition to these interventions, four CSHOs and the compliance chief worked various shifts in the state emergency operations center over a one-week period. Also, the VOSHA director and an administrative assistant were both on medical leave for several weeks during the fourth quarter.

There is no question that the storm strained the program's resources during the last month of the fiscal year. But it is unrealistic to think that VOSHA would have been able to conduct 83 inspections (the number of inspections that VOSHA needed to conduct in order to reach its goal of 400) during the month of September if the storm had never occurred. This is borne out by the fact that VOSHA, on average, was conducting only 82 inspections *per quarter* during the first three quarters of the fiscal year. Therefore, Region I found that VOSHA fell far short of its goal for total number of inspections in FY 2011, and that the program's level of performance in this regard did not meet

OSHA's expectations. In FY 2012, VOSHA must work harder to meet its inspection goals in order to adequately protect Vermont's workers from workplace injuries and illnesses.

The table below compares VOSHA's yearly projections and actual inspection totals over the past five fiscal years (2007- 2011).



Finding 11-41: Inspection Activity—VOSHA fell far short of its inspection goal in FY 2011, by conducting only 317 out of 400 inspections projected.

Recommendation 11-41: In FY 2012, VOSHA must work harder to meet its inspection goal in order to adequately protect workers in the State of Vermont.

FY 2011 was the third year of VOSHA's five-year strategic plan, which extends from FY 2009 to FY 2013. In FY 2011, VOSHA accomplished most of its FY 2011 annual performance plan goals, but did not meet its target for inspections. In developing its five-year strategic plan, VOSHA planned to effect a 15 percent reduction in industries' DART rates, and a 25 percent reduction in fatalities, from the 2007 baseline rates. The extent to which VOSHA meets these goals will be assessed at the end of the five-year plan (FY 2013). As shown in the table below, it appears that VOSHA is on track for meeting its strategic plan goal for the manufacturing sector (general industry) by the end of the five-year plan.

Vermont BLS DART Rates 2007-2010 (all NAICS Divisions)				
Calendar year	**Private Sector**	**Manufacturing**	**Construction**	**Public Sector**
2007	2.8	3.4	4.1	2.0
2008	2.5	3.4	4.0	1.4
2009	2.2	2.6	3.8	1.3
2010	2.6	2.6	3..9	1.9
Percent reduction from baseline year (2007)	-7.1	-23.5	-4.8	-0.5

The next two tables summarize VOSHA's progress in meeting its FY2011 Annual Performance Plan and objectives. The information presented in these tables was derived from the VOSHA's FY 2011 State OSHA Annual Report (SOAR), the full contents of which are contained in **Appendix F.**

<table>
<tr><th>ANNUAL PERFORMANCE GOAL</th><th>OUTCOME MEASURES</th><th>RESULTS</th></tr>
<tr>
<td>1.1: Reduce the rate of workplace injuries and illnesses in construction by 3% and reduce fatalities by 25%.

Area of Emphasis:
1A- Residential & commercial building
1B- Highway, street & bridge construction
1C- Roofing
1D- Falls from elevation
1E- Trenching
1F- Struck by
1G- Electrical
1H- Noise
1I- Silica
1J- Youth (Outreach)
1K- Workzone Safety</td>
<td>Intermediate outcome Measure: Conduct 200 inspections in the construction industry

Primary Outcome Measure: VOSHA will effect a 15 percent reduction in the DART rate (to be evaluated at the conclusion of the five-year strategic plan).</td>
<td>Total inspections: 317
Total inspections in the construction industry: 153
Percent of goal achieved (construction inspections): 77

From 2007 to 2010, the DART rate for the construction industry decreased by 4.8 percent.

The table below compares VOSHA’s projected number of inspections in the emphasis areas in construction to the actual number conducted.
<table>
<tr><th>Area of Emphasis</th><th>Projected</th><th>Actual</th></tr>
<tr><td>1A- Residential & commercial building</td><td>150</td><td>125</td></tr>
<tr><td>1B- Highway, street & bridge construction</td><td>30</td><td>29</td></tr>
<tr><td>1C- Roofing</td><td>20</td><td>27</td></tr>
<tr><td>1D- Falls from elevation</td><td>--</td><td>63</td></tr>
<tr><td>1E- Trenching</td><td>--</td><td>10</td></tr>
<tr><td>1F- Struck by</td><td>--</td><td>4</td></tr>
<tr><td>1G- Electrical</td><td>--</td><td>38</td></tr>
<tr><td>1H- Noise</td><td>--</td><td>4</td></tr>
<tr><td>41I- Silica</td><td>--</td><td>1</td></tr>
<tr><td>1K- Workzone Safety</td><td>--</td><td>5</td></tr>
</table>
VOSHA’s compliance assistance interventions in the construction industry covered all emphasis areas. In addition, VOSHA provided OSHA 10-hour training to workers in the field of construction as well as to youth and other inexperienced workers.</td>
</tr>
</table>

<table>
<tr><th>ANNUAL PERFORMANCE GOAL</th><th>OUTCOME MEASURES</th><th>RESULTS</th></tr>
<tr>
<td>1.2: Reduce the rate of workplace injuries and illnesses in general industry by 3% and reduce fatalities by 25%.

Area Of Emphasis:
2A- Food Processing
2B- Lumber & Wood Products
2C- Small Business
2D- Large Farm Initiative
2E- Targeted NAICS
2F- Amputations
2G- Isocyanates, Asthma & Allergies
2H- Electrical
2I- Powered Industrial Trucks (PIT)
2J- Noise
2K- Silica
2L- Transportation
2M- Youth Workers</td>
<td>Intermediate outcome Measure: Conduct 200 inspections in general industry.

Primary Outcome Measure: VOSHA will effect a 15 percent reduction in the DART rate (to be evaluated at the conclusion of the five-year strategic plan).</td>
<td>Total inspections: 317
Total inspections in general industry: 188
Percent of goal achieved (non-construction inspections): 94

From 2007 to 2010, the DART rate for general industry decreased by 23.5 percent.

The table below compares VOSHA’s projected number of inspections in the emphasis areas in general industry to the actual number conducted.

<table>
<tr><th>Area of Emphasis</th><th>Goal</th><th>Actual</th></tr>
<tr><td>2A- Food Processing</td><td>20</td><td>8</td></tr>
<tr><td>2B- Lumber & Wood Products</td><td>12</td><td>4</td></tr>
<tr><td>2E- Targeted NAICS</td><td>60 (all sites on list)</td><td>55</td></tr>
<tr><td>2F- Amputations</td><td>--</td><td>42</td></tr>
<tr><td>2G- Isocyanates, Asthma, & Allergies</td><td>--</td><td>14</td></tr>
<tr><td>2H- Electrical</td><td>Review electrical hazards on all inspections</td><td>Completed</td></tr>
<tr><td>2I- PIT</td><td>Review electrical hazards on all inspections</td><td>Completed</td></tr>
<tr><td>2J- Noise</td><td>--</td><td>3</td></tr>
<tr><td>2K- Silica</td><td>--</td><td>--</td></tr>
</table>
VOSHA’s compliance assistance interventions in the general industry covered all emphasis areas. In addition, VOSHA provided OSHA 10-hour training to workers in general industry as well as to youth and other inexperienced workers.</td>
</tr>
</table>

Appendix A
FY 2011 Vermont Occupational Safety and Health Administration (VOSHA) State Plan FAME Report
Findings and Recommendations

Rec #	Findings	Recommendations	FY 10 #
11-01	**VOSHA did not meet the following SAMM measures: SAMM #2—** Average Number of days to initiate complaint investigations **SAMM#6**—Percent of S/W/R violations verified (private sector); **SAMM#7**—Average days from opening conference to citation issue (safety and health); **SAMM #8**—Percent of programmed inspections with S/W/R violations (health); **SAMM#9**--Average violations per inspection S/W/R and other; **SAMM#10—**Average initial penalty per serious violation; and **SAMM#11**—Percent of total inspections in public sector.	Meet these and all SAMM measures by the end of FY 2012.	10-01
11-02	VOSHA did not meet the following SIR measures: **C.3.A**. Private Sector Serious Safety Violations **C.3.B**. Private Sector Serious Health Violations **C.5.A**. Private Sector Average Penalty for Other-than-Serious Safety Violations **C.5.B**. Private Sector Average Penalty for Other-than-Serious Health Violations **C.6.A** Private Sector Safety Inspections per 100 Hours **C.9**. Private Sector Penalty Retention **E.3.** Penalty Retention (%)	Meet these and all SIR measures by the end of FY 2012.	10-02
11-03	**Average Violations per Initial Inspection/Average Current Penalty per Serious Violation—**VOSHA fell short of Federal OSHA's averages.	Align these measures more closely with the Federal averages by the end of FY2012. FY 2012 year-end Enforcement statistics will indicate that VOSHA meets Federal OSHA's averages.	10-03

11-04	**Fatality Investigations—** VOSHA did not meet the five-day time frame for sending the standard information letter to the next of kin of the fatality victim.	Ensure that fatality victims' next of kin receive an initial standard information letter "within 5 working days of determining the victim's identity and verifying the proper address where communications should be sent." Ensure that all procedures of the FOM, Chapter 11, Section G, Families of Victims, are followed.	10-04
11-05	**Gravity Probability Assessments—**In some instances, VOSHA is not properly assessing the probability and severity of violations. The program still has a tendency to err on the side of assessing lower probability and severity than warranted.	Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments.	10-05
11-06	**Field Notes—**Some case files did not contain CSHOs' field notes.	Ensure that case files contain CSHOs' field notes, in accordance with the FOM, Chapter 5.	100-6
11-07	**Evidence of Violations—**In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.	Ensure that case files contain adequate evidence to support all violations cited, in accordance with the procedures set forth in Chapter 4 of the FOM.	10-07
11-08	**S/W/R Violations—**VOSHA's percentages for S/W/R in FY 2011 were not comparable to Federal OSHA's.	At the end of FY 2012, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.	10-08
11-09	**Establishing Employer Knowledge of the Hazardous Condition—** As in the onsite review for the FY 2010 FAME Report, Region I found (during the most recent review) that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."	Ensure that CSHOs record evidence to substantiate that the employer could have known of the hazardous condition through reasonable diligence. A sampling of case files to be reviewed by the Region on a quarterly basis will indicate that CSHOs are adequately documenting evidence of violations cited in case files.	10-09
11-10	**Complaints—**Some case files did not contain any documentation that a letter had been sent to the complainant notifying them that citations had been issued to the employer.	In cases where citations have been issued, VOSHA must adhere to Chapter 9 of the FOM, Section I, H, which provides for complainant notification of inspection results.	
11-11	**Fatality Cases –** VOSHA did not follow proper **Fatality Investigative Procedures** as required in the FOM, Chapter 11, Section II, C., in that the State did not thoroughly investigate the fatality and attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and any effect the violation(s) had on the incident (FOM, Chapter 11. Section II, C). VOSHA did not follow proper **Fatality Interview Procedures** as	VOSHA must ensure that CSHOs and managers follow all requirements for fatality investigations as set forth in the FOM, Chapter 11 (Imminent Danger, Fatality, Catastrophe and Emergency Response). Region I will review all VOSHA fatality cases and ensure correction of all fatality-related recommendations in this report.	

	required in the FOM, Chapter 11, Section II, D., in that the State did not identify and interview all persons with first-hand knowledge of the incident. VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: **Incident data**, such as how and why the incident occurred; the physical layout of the worksite; sketches/drawings; measurements; video/audio/photos to identify sources, and whether the accident was work related. VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: **Equipment or Process Involved,**, such as equipment type; manufacturer; model; manufacturer's instructions; Kind of process; Condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.		
11-12	**Emphasis Programs—**VOSHA did not code some inspections for emphasis programs.	CSHOs must code all inspections involving LEPs, NEPs, and Strategic Plan activities, as appropriate.	
11-13	**Inspections with Violations Cited—**VOSHA did not align closely with Federal OSHA in terms of percent of investigations with violations cited**.** In FY 2011, VOSHA's percentage of 57 was far below Federal OSHA's percentage of 71, as well as below the state plan percentage of 60.	VOSHA must ensure that CSHOs cite all violations.	
11-14	**Average Number of Violations per Initial Inspection**—In FY 2011, VOSHA's average continued to fall below Federal OSHA's average.	VOSHA must increase its average number of violations per initial inspection.	
11-15	**Including air sampling and noise survey forms in case files**—Some case files where the CSHO did perform sampling for air contaminants and surveys for noise, the case files either did not contain copies of completed OSHA 91 (air sampling) and OSHA 92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. These forms are used to help support violations cited.	VOSHA must ensure that copies of all air sampling and noise survey forms are included in case files for inspections in which these surveys/ samplings have occurred.	
11-16	**Citing all Apparent Violations---**CSHOs did not cite all apparent violations during inspections, even though evidence of these violations was provided by the CSHO in some case files through photos and written descriptions.	CSHOs must cite all apparent violations.	

11-17	**Violation Classification**—VOSHA's percentage for all violations cited as serious did not align closely with Federal OSHA's in FY2011.	VOSHA's percentage for all violations classified as serious must align more closely with Federal OSHA's percentage by the end of FY 2012.	
11-18	**Violation Classification—**VOSHA misclassified some violations as Other-than-Serious that should have been classified as Serious. Some violations should have been classified as Repeat, and some violations could potentially have been classified as Willful, based on the outcome of further investigation, which the program chose not to pursue.	VOSHA must properly classify all violations and thoroughly investigate violations that have the potential to be cited as Willful, and cite them accordingly.	
11-19	**Penalty Reductions—** In some cases, VOSHA improperly granted penalty reductions.	VOSHA must follow the FOM requirements in Chapter 4 for granting penalty reductions based on size, history, and good faith.	
11-20	**Average Current Penalty per Serious Violations**—VOSHA's average continues to fall below Federal OSHA's average. In FY 2011, VOSHA;s average was $899.00, while Federal OSHA's average was $2,133.00	VOSHA's average current penalty per serious violation must align more closely with Federal OSHA's average by the end of FY 2012.	
11-21	**Abatement documentation—**Some case files were closed without having any documentation of abatement or having inadequate documentation.	VOSHA must ensure that all documentation of abatement is present in case files before they are closed.	
11-22	**Informal Conferences**—In some cases, the informal conference was held after the 20 calendar-day period had expired.	VOSHA must adhere to its own guidelines in its *"Closing Conference Guide,"* which requires no more than for not extending a 20-day calendar period for holding informal conferences.	
11-23	**Standard Adoption—**VOSHA did not adopt 29 CFR 1915 in a timely manner, once it was determined that Vermont had facilities that are covered by this standard, and the State began the adoption process (February 2, 2011).	For all future standard adoptions, VOSHA must adhere to the six month time frame in 29 CFR 1953 (a) (1).	
11-24	**Discrimination Cases**—Case files were not tabbed and organized according to the manual.	• VOSHA must organize case files in accordance with the format in the 2011 Whistleblower Investigations Manual. Exhibits must be tabbed and the file must contain a Contents of File. 5(III) • All documents must be retained in the file, including investigators' notes and recordings of interviews downloaded to CDs. • All emails must be printed and placed in the case file. • Evidentiary materials should be separated from notes and emails. • The ROI format provided to VOSHA by Region I must be used. • All reports must contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination. • The supervising official must sign and date the ROI, indicating concurrence with the findings. • A uniform system to label case files with the	

		complainant name, the respondent name and the case number must be created.	
11-25	**Discrimination Cases—**VOSHA does not have an appeals process.	VOSHA must immediately establish and implement an appeals process in conformance with the Whistleblowers Investigations Manual Chapter 1(VII) (C).	
11-26	**Discrimination Cases—**VOSHA fails to notify complainants of their rights - the right to dual file, the right to file a Complaint About State Program Administration (CASPA), or the right to file an appeal of VOSHA's determination. Letters were not being sent to the parties.	• VOSHA must send notification and determination letters to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year. • Stop giving the "Complainant Information Form" to complainants. • While not required by the manual, OSHA considers it a best practice for states to notify the parties of their right to file a Complaint About State Program Administration (CASPA) and encourages VOSHA to do so. • Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e. give them 30 days from the date you notify them of their right to appeal.	
11-27	**Discrimination Cases—**Supervisors do not use or review the information entered into the IMIS.	The supervisor must: • Have access to IMIS and training on how to run reports. • Ensure that the correct allegation code is used. • Ensure that the allegation summary describes the alleged protected activity and adverse action. • Ensure that the closed date is the same as the date closing letters are sent.	
11-28	**Discrimination Cases—**Investigators do not receive sufficient training and supervision to conduct proper investigations. Investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions. Those supervising the discrimination program have no training or experience in discrimination investigations.	• Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA. • Retrain managers and discrimination investigators in the investigative process, elements of a violation, and case analysis. • Budget for investigators to attend national whistleblower conferences and regional meetings. • VOSHA will send investigators and those supervising	

		discrimination work to attend the Basic Whistleblower Investigations course #1420 at the OSHA Training Institute.	
11-29	**Discrimination Cases—**Supervisors do not manage the program effectively.	• Supervisors must keep investigators informed about changes to federal OSHA's program. • Supervisors and investigators must confer with OSHA on difficult cases. • VOSHA must consult with the designated OSHA Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed. • VOSHA must send the completed ROI to the designated RSI before closing the case. • VOSHA must send the completed case file to OSHA upon completion of the case.	
11-30	**Discrimination Cases—**VOSHA does not have an attorney designated to handle discrimination matters.	VOSHA will designate an attorney with expertise in discrimination matters to advise it on legal issues that arise.	
11-31	**Discrimination Cases—**VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.	• Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible to employers and employees. • Provide a link to OSHA's website – www.whistleblowers.gov	
11-32	**Discrimination Cases—**VOSHA public employee stakeholders are not adequately informed of the rights provided to them under VOSHA's discrimination provisions.	Conduct outreach with stakeholders about employee rights and employer responsibilities.	
11-33	**VPP—**A number of the required signed approval letters were not contained in the VPP files.	VOSHA must obtain copies of these signed letters and include them in the appropriate files.	
11-34	**VPP—**Complaints at VPP sites were handled by the VPP manager, rather than by a compliance officer.	VOSHA must ensure that all complaints, referrals, and/or fatality/catastrophe investigations at VPP sites are to be handled by compliance staff.	
11-35	**Alliance Program—**VOSHA's Alliance documentation does not comply with the directive's requirements in Section XII Program Requirements, D. Alliance Documentation 1 and 2.	VOSHA must ensure that annual reports are completed and maintained in the Alliance files; that the electronically signed Alliance copies are posted on the VOSHA Web site, along with relevant updates, milestones, success stories, events, or photographs.	
11-36	**Training—**Vermont has CSHOs who have yet to complete Course #1310 (Investigative Interviewing Techniques), as required under OSHA's Initial Compliance Training Program.	Enroll these CSHOs in this course so that they have all completed this training by the end of FY 2012.	
11-37	**Training**—Two of the program's "veteran" CSHOs who conduct fatality investigations require additional training in investigative and interviewing	VOSHA must ensure that both CSHOs complete Course #1310, Investigative Interviewing Techniques, even though these CSHOs	

	techniques at OSHA's Training Institute.	are technically exempt from taking this course due to their "veteran" CSHO status.	
11-38	**Training—**VOSHA has no documentation to show that one of the two veteran CSHOs who conduct fatality investigations has completed OTI Course #1410 (Inspection Techniques and Legal Aspects).	Ensure that the CSHO completes this course before the end of 2012, because this course is mandatory training for all CSHOs, and should have been completed in the first year of this CSHO's employment.	
11-39	**Training—**Region I has performed an in-depth analysis of VOSHA's training records (which VOSHA provided to the Region upon request). This analysis has found that none of the program's CSHOs have completed their mandatory training track (prescribed by OTI's training directive) within the time frame permitted by the directive.	By no later than December 31, 2013, all CSHOs must have completed the training track for their appropriate discipline (safety or health) as required under the most recent OSHA training directive (TED 01 00-018, issued in 2008).	
11-40	**State Internal Evaluation Plan (SIEP)—**VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM).	VOSHA must develop a SIEP for use during FY 2013 that conforms to the requirements of the SPPPM.	
11-41	**Inspection Activity—**VOSHA fell far short of its inspection goal in FY 2011, by conducting only 317 out of 400 inspections projected.	In FY 2012, VOSHA must work harder to meet its inspection goal in order to adequately protect workers in the State of Vermont.	

Appendix B
FY 2011 Vermont Occupational Safety and Health Administration (VOSHA) State Plan FAME Report
Status of FY 2010 Findings and Recommendations

Rec #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
10-1	**Finding 10-#1: Based on the FY2010 SAMM and the FY2011 (1st Qtr.) SAMM, VOSHA has not shown consistent improvement in the measures cited as "not met" in the FY2009 EFAME: SAMM#4**—Percent of imminent danger complaints responded to within 1 day; **SAMM#6**—Percent of S/W/R violations verified (private and public sector); **SAMM#7**—Average days from opening conference to citation issue (safety and health); **SAMM#9**--Average violations per inspection S/W/R and other; **SAMM#10—**Average initial penalty per serious violation; and **SAMM#11**—Percent of total inspections in public sector.	Meet these SAMM measures—and all SAMM measures—by the end of FY2011.	Run monthly and year to date **IMIS Inspection and Enforcement reports and SAMM reports** to track performance on these measures. Managers will re-train CSHOs on the **FOM, Chapter 4 (Violations) and Chapter 6 (Penalties),** with specific emphasis on the classification of violations and the assessment of probability and severity. Training on Chapter 4 will occur in January 2012 and training on Chapter 6 will be held in February 2012. CSHOs must provide a weekly report to the VOSHA compliance chief on the status of their cases. These weekly status reports, along with **IMIS Inspection and Enforcement reports,** enable the VOSHA compliance chief to track the length of time that cases have been open.	FOM training has been completed. All other actions are ongoing.	**Measures #4 and #6 (public sector) were corrected**. **All other measures are Pending Correction**.

10-2	**State Indicator Report (SIR) standards were not met— SIR measure E2 (Percent of Violations Reclassified) was** the only SIR measure (out of the measures cited in the **FY2009 EFAME**) that VOSHA consistently met in both FY 2010 and in the first quarter of FY 2011. SIR measures not consistently met in FY 2009 and FY 2010: C.3.A. Private Sector Serious Safety Violations C.3.B. Private Sector Serious Health Violations C.5.A. Private Sector Average Penalty for Other-than-Serious Safety Violations C.5.B. Private Sector Average Penalty for Other-than-Serious Health Violations C.6.A Private Sector Safety Inspections per 100 Hours C.9. Private Sector Penalty Retention E.3. Penalty Retention (%)	Meet the standards in the remaining seven **SIR measures** that were not consistently met by the end of FY2011.	Managers will continue to run monthly **IMIS Inspection and Enforcement reports** and to closely track performance on SIR measures. Managers will re-train CSHOs on the **FOM, Chapter 4 (Violations) and Chapter 6 (Penalties),** with specific emphasis on the classification of violations and the assessment of probability and severity. Managers will review case files prior to citation issuance to ensure that adequate documentation is in the case files to support violations and that violation grouping complies with the FOM.	FOM training has been completed. All other actions are ongoing.	**All seven SIR measures are Pending Correction**.
10-3	**Average Violations per Initial Inspection/Average Current Penalty per Serious Violation—** The program's averages for these two indicators are below Federal OSHA's averages.	By 9/30/2011, VOSHA's averages for violations per initial inspection and current penalty per serious violation will be more closely aligned with the federal data.	Managers will re-train CSHOs on **the FOM, Chapter 4 (Violations) and Chapter 6 (Penalties),** with specific emphasis on the classification of violations and the assessment of probability and severity.	FOM training has been completed. All other actions are ongoing.	Average Violations per Initial Inspections— **Pending Correction** Average Current

			Managers will continue to conduct a through review of all case files to monitor violation classification, violation grouping, and probability and severity assessments. VOSHA managers will continue to run monthly **IMIS Inspection and Enforcement reports** to closely track performance with regard to these measures.		Penalty per Serious Violations—**Pending Correction**
10-4	**Fatality Investigations—**There was no evidence in the case file that an initial letter and a copy of the citations had been sent to the victim's family.	VOSHA must ensure that the victim's family members receive copies of the citations and the initial letter, and that documentation that the letter and citations have been sent is included in the case file.	Managers will ensure that the initial letter and a copy of the citations are sent to the victim's family.	The VOSHA managers review all case files before they are closed.	**Pending Correction**
10-5	**Gravity/probability assessments—**In some instances, VOSHA is not properly assessing the probability and severity of violations. The program still has a tendency to err on the side of assessing lower probability and severity than warranted.	Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments. The case file review for the FY2011 FAME will show that VOSHA is properly assessing probability and severity.	Managers will continue to review all case files in order to closely monitor violation classification, violation grouping, and probability and severity assessments. Managers will re-train CSHOs on **the FOM, Chapter 4 (Violations) and Chapter 6 (Penalties),** with specific emphasis on the classification of violations and the assessment of probability and severity.	FOM training has been completed. All other actions are ongoing.	**Pending Correction**
10-6	**Letters to Unions—**Some case files did not contain adequate documentation to show that citations were sent to labor unions. Some files did not contain CSHOs' field notes.	Ensure that case files contain documentation that the program has properly notified labor unions of citations. All files also must contain CSHOs' field notes.	Managers and CSHOs will continue to use the **case file review checklist** to ensure that case files contain field notes and all documentation related to labor unions.	These corrective actions are ongoing.	**Pending Correction**

			Managers will continue to review all CSHO case files to assure that labor union contact information is included (if appropriate) and that field notes are included in the case file.		
10-7	**Evidence of Violations—**In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.	Ensure that case files include all evidence necessary to substantiate the violations that were cited. The case file review for FY2011 FAME will indicate that VOSHA is performing adequately in terms of providing all evidence necessary to substantiate violations.	Managers will re-train all CSHOs on **the FOM, Chapter 4**, which discusses the evidence necessary to support violations. VOSHA management will review case files prior to citation issuance to assure that there is adequate documentation (such as photographs) to substantiate violations.	FOM training has been completed. All other actions are ongoing.	**Pending Correction**
10-8	**S/W//R Violations—**VOSHA's percentages for S/W/R in FY2009 and FY2010 were not comparable to Federal OSHA's.	As of the end of FY2011, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.	VOSHA managers will continue to run monthly **IMIS Inspection and Enforcement reports** to closely track performance with regard to percentages of S/W/R violations. Managers review cases to assure that violations have been properly classified and that violations are properly grouped if applicable VOSHA managers will re-train all CSHOs on the **FOM, Chapter 4.**	FOM training has been completed. All other actions are ongoing.	**Pending Correction**
10-9	**Establishing Serious Violations—**Region I found that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."	VOSHA managers and staff should review Chapter 4 of the FOM, Section II.B on the four factors used to determine whether a violation is to be classified as Serious. Although VOSHA has already	VOSHA managers will continue to review citations and violations to assure that the CSHOs' narratives provide adequate information to substantiate employer knowledge. This will be a subject that will be covered	FOM training has been completed. Management review of citations and violations is ongoing.	**Pending Correction**

		completed a review of Chapter 4 of the FOM, this section should be reviewed once again by the end of the third quarter of FY2011.	in a staff meeting in conjunction with the training on **FOM, Chapter 4,** violations.		
10-10	**Average Initial Penalty per Serious Violation—**Although VOSHA's average penalty per serious violation has shown an upward trend since FY2009, it still falls below the national data average	VOSHA's average initial penalty per serious violation should come closer to meeting the national data standard (SAMM #10) by the end of FY2011.	VOSHA managers will re-train CSHOs on the **FOM, Chapter 4 (Violations) and Chapter 6 (Penalties)** with specific emphasis on the classification of violations and the assessment of probability and severity. VOSHA managers will closely review all case files in order to monitor violation classification, violation grouping, and probability and severity assessments. VOSHA managers will continue to run **monthly SAMMs and IMIS Enforcement and Inspection reports** to closely track performance with regard to average current penalty per serious violation.	FOM training has been completed. All other actions are ongoing.	**Pending Correction**
10-11	**PSM Inspections—** VOSHA has not developed a list of employers that would be subject to inspection under the PSM standard.	VOSHA must refine the list of employers who may potentially be covered by OSHA's PSM standard, in preparation for adoption of OSHA's PSM NEP.	By **December 1, 2011,** VOSHA will request from Vermont Emergency Management (SERC) a list of companies with extremely hazardous substances or chemicals that meet the PSM threshold quantity.	VOSHA obtained a list of companies with extremely hazardous substances or chemicals that meet the PSM threshold quantity from Vermont Emergency Management (SERC), and is using this list to assign inspections to the CSHO that is qualified to conduct PSM inspections.	**Corrected**

Appendix C
Vermont State Plan
FY 2011 Enforcement Activity

	VT	State Plan Total	Federal OSHA
Total Inspections	**317**	**52,056**	**36,109**
Safety	*217*	*40,681*	*29,671*
% Safety	*68%*	*78%*	*82%*
Health	*100*	*11,375*	*6,438*
% Health	*32%*	*22%*	*18%*
Construction	*146*	*20,674*	*20,111*
% Construction	*46%*	*40%*	*56%*
Public Sector	*25*	*7,682*	*N/A*
% Public Sector	*8%*	*15%*	*N/A*
Programmed	*192*	*29,985*	*20,908*
% Programmed	*61%*	*58%*	*58%*
Complaint	*58*	*8,876*	*7,523*
% Complaint	*18%*	*17%*	*21%*
Accident	*5*	*2,932*	*762*
Insp w/ Viols Cited	*181*	*31,181*	*25,796*
% Insp w/ Viols Cited (NIC)	*57%*	*60%*	*71%*
% NIC w/ Serious Violations	*79.6%*	*63.7%*	*85.9%*
Total Violations	**536**	**113,579**	**82,098**
Serious	*359*	*50,036*	*59,856*
% Serious	*67%*	*44%*	*73%*
Willful	*-*	*295*	*585*
Repeat	*5*	*2,014*	*3,061*
Serious/Willful/Repeat	*364*	*52,345*	*63,502*
% S/W/R	*68%*	*46%*	*77%*
Failure to Abate	*-*	*333*	*268*
Other than Serious	*171*	*60,896*	*18,326*
% Other	*32%*	*54%*	*22%*
Avg # Violations/ Initial Inspection	*2.6*	*3.4*	*2.9*
Total Penalties	**$355,618**	**$ 75,271,600**	**$ 181,829,999**
Avg Current Penalty / Serious Violation	*$ 889.20*	*$ 963.40*	*$ 2,132.60*
% Penalty Reduced	*50.5%*	*46.6%*	*43.6%*
% Insp w/ Contested Viols	**2.4%**	**14.8%**	**10.7%**
Avg Case Hrs/Insp- Safety	*18.5*	*17.1*	*19.8*
Avg Case Hrs/Insp- Health	*34.3*	*26.8*	*33.1*
Lapse Days Insp to Citation Issued- Safety	*38*	*35.6*	*43.2*
Lapse Days Insp to Citation Issued- Health	*57.6*	*43.6*	*54.8*
Open, Non-Contested Cases w/ Incomplete Abatement >60 days	*36*	*1,387*	*2,436*

Source: DOL-OSHA. State Plan & Federal INSP & ENFC Reports, 11.8.2011.

Appendix D
FY 2011 State Activity Mandated Measures Report

U. S. D E P A R T M E N T O F L A B O R — NOV 09, 2011
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION — PAGE 1 OF 2
STATE ACTIVITY MANDATED MEASURES (SAMMs)

State: VERMONT

RID: 0155000

MEASURE	From: 10/01/2010 To: 09/30/2011		CURRENT FY-TO-DATE		REFERENCE/STANDARD	
1. Average number of days to initiate Complaint Inspections	105		0		Negotiated fixed number for each State	
	2.01					
	52		0			
2. Average number of days to initiate Complaint Investigations	47		0		Negotiated fixed number for each State	
	2.04					
	23		0			
3. Percent of Complaints where Complainants were notified on time	50		0		100%	
	100.00					
	50		0			
4. Percent of Complaints and Referrals responded to within 1 day -ImmDanger	1		0		100%	
	100.00					
	1		0			
5. Number of Denials where entry not obtained	0		0		0	
6. Percent of S/W/R Violations verified						
	265		0			
Private	97.07		.00		100%	
	273		4			
	19		0			
Public	100.00				100%	
	19		0			
7. Average number of calendar days from Opening Conference to Citation Issue						
	8566		31		2631708	
Safety	53.53		31.00		51.9	National Data (1 year)
	160		1		50662	

	4044		0	767959	
Health	77.76			64.8	National Data (1 year)
	52		0	11844	

*VT FY11 **PRELIMINARY DATA SUBJECT TO ANALYSIS AND REVISION

State: VERMONT

RID: 0155000

MEASURE	From: 10/01/2010 To: 09/30/2011		CURRENT FY-TO-DATE		REFERENCE/STANDARD	
8. Percent of Programmed Inspections with S/W/R Violations						
	93		0		90405	
Safety	70.45				58.5	National Data (3 years)
	132		0		154606	
	17		0		10916	
Health	47.22				51.7	National Data (3 years)
	36		0		21098	
9. Average Violations per Inspection with Vioations						
	423		1		419386	
S/W/R	1.99		1.00		2.1	National Data (3 years)
	212		1		198933	
	152		0		236745	
Other	.71		.00		1.2	National Data (3 years)
	212		1		198933	
10. Average Initial Penalty per Serious Violation (Private Sector Only)	434863		600		611105829	
	1141.37		600.00		1679.6	National Data (3 years)
	381		1		363838	
11. Percent of Total Inspections in Public Sector	25		0		98	
	7.89		.00		9.3	Data for this State (3 years)
	317		7		1057	
12. Average lapse time from receipt of Contest to first level decision	0		0		3533348	
					199.7	National Data (3 years)
	0		0		17693	
13. Percent of 11c Investigations Completed within 90 days	5		0		100%	
	100.00					
	5		0			
14. Percent of 11c Complaints that are Meritorious	1		0		1517	
	20.00				23.0	National Data (3 years)
	5		0		6591	
15. Percent of Meritorious 11c	1		0		1327	

Complaints that are Settled	100.00			87.5	National Data (3 years)
	1		0	1517	

*VT FY11 **PRELIMINARY DATA SUBJECT TO ANALYSIS AND REVISION

MEASURE NUMBER: 6 CITATION LISTING PAGE 1

OWNER	REPORT-ID	INSP-NR	ABATE-DATE	VERIFY-DATE	CITATION-NR	ITEM-NR
PRI	01550 0	311480396	20110930	00000000	01	001
PRI	01550 0	311480396	20110930	00000000	01	002
PRI	01550 0	314215526	20110118	20110324	01	001
PRI	01550 0	314217324	20110531	20110707	01	001
PRI	01550 0	314217324	20110531	20110707	01	002
PRI	01550 0	314217951	20110930	00000000	01	001
PRI	01550 0	314218215	20110726	20110923	01	001
PRI	01550 0	314218587	20110811	00000000	01	001

*******TOTAL ****** 8

MEASURE NUMBER: 14 MEASURE 14 PAGE 1

REPORT-ID	ACT-NR	DISP-DATE	DISP-CODE	DISP-LEVEL
0155000	022583090	20110119	D	R
0155000	022599740	20110413	D	R
0155000	022602726	20110517	D	R
0155000	022615124	20110719	S	R
0155000	022596886	20110412	D	R
	000000000	00000000		

*******TOTAL ****** 6

MEASURE NUMBER: 15 MEASURE 15 PAGE 1

REPORT-ID	ACT-NR	DISP-DATE	DISP-CODE	DISP-LEVEL
0155000	022615124	20110719	S	R

*******TOTAL ****** 1

Appendix E
Interim State Indicator Report

SIR Q4SIR50 SIR50 111011 111852 PROBLEMS - CALL Y Goodhall 202 693-1734

1111011 U. S. D E P A R T M E N T O F L A B O R PAGE 1

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

CURRENT MONTH = SEPTEMBER 2011 INTERIM STATE INDICATOR REPORT (SIR) STATE = VERMONT

PERFORMANCE MEASURE	3 MONTHS FED	3 MONTHS STATE	6 MONTHS FED	6 MONTHS STATE	12 MONTHS FED	12 MONTHS STATE	24 MONTHS FED	24 MONTHS STATE
C. ENFORCEMENT (PRIVATE SECTOR)								
1. PROGRAMMED INSPECTIONS (%)								
	3694	16	8169	67	18137	136	40070	300
A. SAFETY	61.3	64.0	61.4	72.8	62.5	67.0	63.7	66.7
	6026	25	13312	92	29042	203	62876	450
	480	13	1020	25	2126	41	4357	81
B. HEALTH	39.7	68.4	36.4	54.3	34.6	47.7	34.7	46.6
	1208	19	2806	46	6150	86	12569	174
2. PROGRAMMED INSPECTIONS WITH VIOLATIONS (%)								
	3378	27	7266	41	14959	100	32614	223
A. SAFETY	73.7	75.0	72.4	61.2	70.1	69.0	69.1	66.6
	4583	36	10036	67	21330	145	47196	335
	456	8	890	15	1723	26	3487	57
B. HEALTH	57.0	72.7	57.2	62.5	56.2	65.0	55.3	74.0
	800	11	1555	24	3068	40	6309	77
3. SERIOUS VIOLATIONS (%)								
	11703	47	23768	111	48704	261	109064	534
A. SAFETY	79.6	69.1	77.4	73.0	76.7	73.9	78.4	70.4
	14698	68	30703	152	63528	353	139117	759
	2634	26	5290	45	10266	72	21598	147
B. HEALTH	66.6	63.4	64.7	55.6	64.4	49.3	66.7	45.7
	3957	41	8180	81	15930	146	32380	322

4. ABATEMENT PERIOD FOR VIOLS								
	2394	13	4978	35	10776	84	23693	201
A. SAFETY PERCENT >30 DAYS	16.6	27.7	16.8	28.0	17.9	29.1	17.9	32.7
	14465	47	29573	125	60243	289	132414	615
	259	0	711	1	1451	1	3159	3
B. HEALTH PERCENT >60 DAYS	6.5	.0	8.6	2.0	9.4	1.2	10.0	1.7
	4006	31	8234	51	15507	83	31619	174

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

CURRENT MONTH = SEPTEMBER 2011 INTERIM STATE INDICATOR REPORT (SIR) STATE = VERMONT

	------ 3 MONTHS----		------ 6 MONTHS----		------12 MONTHS----		------24 MONTHS-----	
PERFORMANCE MEASURE	FED	STATE	FED	STATE	FED	STATE	FED	STATE
C. ENFORCEMENT (PRIVATE SECTOR)								
5. AVERAGE PENALTY								
A. SAFETY								
	505479	0	1258835	150	2803637	150	5086228	250
OTHER-THAN-SERIOUS	1181.0	.0	1195.5	150.0	1126.9	150.0	1055.2	125.0
	428	0	1053	1	2488	1	4820	2
B. HEALTH								
	219203	350	441915	700	853346	700	1667151	1300
OTHER-THAN-SERIOUS	1184.9	350.0	1077.8	350.0	980.9	350.0	958.7	325.0
	185	1	410	2	870	2	1739	4
6. INSPECTIONS PER 100 HOURS								
	6874	39	15417	122	33850	250	73070	539
A. SAFETY	6.0	2.1	5.6	2.9	5.5	2.8	5.4	2.9
	1138	19	2730	42	6145	90	13476	187
	1458	24	3330	56	7311	103	14958	204
B. HEALTH	2.4	2.4	2.2	1.9	2.2	1.6	2.0	1.6
	615	10	1501	29	3390	64	7404	130
	1270	6	3026	12	6577	29	12352	70
7. VIOLATIONS VACATED %	5.6	5.1	6.6	4.5	7.0	5.2	6.2	5.6
	22608	118	46128	265	93448	561	200310	1239

	737	4	1997	6	4456	19	9147	49
8. VIOLATIONS RECLASSIFIED %	3.3	3.4	4.3	2.3	4.8	3.4	4.6	4.0
	22608	118	46128	265	93448	561	200310	1239
	19478404	55050	40012395	97493	77322520	233068	134938244	495057
9. PENALTY RETENTION %	61.0	59.7	61.6	60.4	62.8	54.2	62.8	53.2
	31918969	92200	65001782	161468	123124542	430187	214845679	930634

CURRENT MONTH = SEPTEMBER 2011 INTERIM STATE INDICATOR REPORT STATE = VERMONT

PERFORMANCE MEASURE	3 MONTHS PRIVATE	3 MONTHS PUBLIC	6 MONTHS PRIVATE	6 MONTHS PUBLIC	12 MONTHS PRIVATE	12 MONTHS PUBLIC	24 MONTHS PRIVATE	24 MONTHS PUBLIC
D. ENFORCEMENT (PUBLIC SECTOR)								
1. PROGRAMMED INSPECTIONS %								
	16	4	67	7	136	8	300	30
A. SAFETY	64.0	100.0	72.8	87.5	67.0	66.7	66.7	78.9
	25	4	92	8	203	12	450	38
	13	4	25	4	41	5	81	6
B. HEALTH	68.4	80.0	54.3	50.0	47.7	41.7	46.6	26.1
	19	5	46	8	86	12	174	23
2. SERIOUS VIOLATIONS (%)								
	47	8	111	8	261	20	534	45
A. SAFETY	69.1	100.0	73.0	100.0	73.9	71.4	70.4	63.4
	68	8	152	8	353	28	759	71
	26	3	45	3	72	9	147	25
B. HEALTH	63.4	60.0	55.6	60.0	49.3	81.8	45.7	75.8
	41	5	81	5	146	11	322	33

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

CURRENT MONTH = SEPTEMBER 2011 COMPUTERIZED STATE PLAN ACTIVITY MEASURES STATE = VERMONT

PERFORMANCE MEASURE	3 MONTHS FED	3 MONTHS STATE	6 MONTHS FED	6 MONTHS STATE	12 MONTHS FED	12 MONTHS STATE	24 MONTHS FED	24 MONTHS STATE
E. REVIEW PROCEDURES								
	579	0	1131	4	2220	13	4270	14
1. VIOLATIONS VACATED %	22.8	.0	23.4	80.0	23.5	43.3	23.0	28.6
	2542	0	4834	5	9442	30	18586	49
	328	0	620	1	1259	1	2360	2
2. VIOLATIONS RECLASSIFIED %	12.9	.0	12.8	20.0	13.3	3.3	12.7	4.1
	2542	0	4834	5	9442	30	18586	49
	3616720	0	9500018	250	16062961	4550	28079915	7500
3. PENALTY RETENTION %	56.1	.0	62.4	50.0	62.3	50.3	60.6	48.4
	6443756	0	15212620	500	25766759	9050	46371522	15500

APPENDIX F

FY 2011 State OSHA Annual Report (SOAR)

(Available Separately)

Appendix G
FY 2011 23(g) Consultation Data

Vermont State Plan

	VT Public Sector	Total State Plan Public Sector
Requests	**28**	**1,328**
Safety	*10*	*576*
Health	*7*	*560*
Both	*11*	*192*
Backlog	**3**	**123**
Safety	*1*	*51*
Health	*2*	*58*
Both	*-*	*14*
Visits	**43**	**1,632**
Initial	*28*	*1,336*
Training and Assistance	*12*	*175*
Follow-up	*3*	*121*
Percent of Program Assistance	*75%*	*67%*
Percent of Initial Visits with Employee Participation	*100%*	*96%*
Employees Trained	**336**	**5,030**
Initial	*69*	*2,144*
Training and Assistance	*267*	*2,886*
Hazards	**202**	**6,063**
Imminent Danger	*-*	*3*
Serious	*188*	*4,804*
Other than Serious	*14*	*1,171*
Regulatory	*-*	*85*
Referrals to Enforcement	*-*	*6*
Workers Removed from Risk	**2,457**	**171,075**
Imminent Danger	*-*	*55*
Serious	*2,281*	*136,884*
Other than Serious	*176*	*26,046*
Regulatory	*-*	*8,090*