

DEPARTMENT OF INDUSTRIAL RELATIONS

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Ken Nishiyama Atha  
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San Francisco Federal Building  
90 – 7<sup>th</sup> Street, Suite 18100  
San Francisco, CA 94103

Dear Mr. Atha:

I have received the advance copy you sent me of a document entitled “FY 09 Baseline Special Evaluation Report (Enhanced Federal Annual Monitoring and Evaluation Report-EFAME).” Let me first state that Cal/OSHA has never shied away from opportunities to audit the effectiveness of our programs and seek a greater level of performance. We engage in regular stakeholder meetings to assist in identifying areas for program improvements. We have engaged in proactive strategic planning sessions which have moved us toward a greater level of accomplishment, including taking corrective actions where most needed. A number of the items outlined in this report have previously been identified and addressed through these processes, resulting in significant improvements.

We fully recognize the need for monitoring or auditing to ensure program effectiveness. However, the EFAME audit falls short in many areas and ignores critical elements of the Cal/OSHA Program that make it a successful and unique model for other states as well as OSHA itself. The following provides examples of the uniqueness of the Cal/OSHA Program and describes some of our major concerns about the EFAME effort.

#### Background on Cal/OSHA.

For over 35 years, Cal/OSHA has been a national leader in occupational safety and health regulation. The Cal/OSHA Program pioneered the partnership excellence process now called the Voluntary Protection Program by OSHA, adopted the first laws guaranteeing workers the right to know about the hazards associated with chemicals they work with, and more recently has lead the nation in spearheading several new initiatives, including requiring the use of anti-stick needles to protect workers from bloodborne pathogens, adopting and enforcing the nation’s first comprehensive heat illness prevention standard for outdoor workers, and adopting and enforcing the nation’s only aerosol transmissible disease standard.

Many of Cal/OSHA’s fundamental protective programs for workers simply do not have a fed-OSHA counterpart. For example, Cal/OSHA requires the general contractor and all major subcontractors at every high-hazard construction project in the state to obtain a permit before

starting work at the project. The permit process requires them to demonstrate their understanding of the general and unique safety requirements of the project.

Contractors who engage in work that disturbs asbestos containing material must obtain a registration from Cal/OSHA demonstrating that they and their workers are competent and adequately trained to perform the work safely. Every crane operator in the state is required to be certified, and Cal/OSHA operates an entire program dedicated to crane oversight and safety.

Recently, OSHA conducted several meetings around the nation to discuss the prospect of adopting an Injury and Illness Prevention Program requirement that would require all employers to implement comprehensive safety procedures. When the OSHA representatives conducted their meeting in California, there was virtually a chorus of advice from stakeholders to take a lesson from Cal/OSHA's experience and adopt the requirements that have been in place here since the early 1990's.

#### General concerns about the EFAME.

Perhaps our greatest concern about this process is what appears to be a lack of clear definition of its necessity and purpose. Cal/OSHA Program representatives have stated publicly since the first time OSHA announced its intention to conduct this special audit that we welcome any constructive and competent inquiry that will move us further in the direction of providing better service to all of our stakeholders. We are well aware that the Cal/OSHA Program has service delivery issues to confront, and we believe this is equally true for all state plans as well as OSHA itself.

Our awareness stems in large part from oversight and transparency measures already in place. As you also know, we have met several times a year for decades with OSHA Region 9 representatives precisely for the purpose of discussing Cal/OSHA service delivery and how to improve it.

As you also know, we conduct public meetings every other month with the Cal/OSHA Advisory Committee, a group of labor, management, and professional stakeholders interested in what we do. We report regularly at these meetings on our most important operations, and we take questions from the floor from any member of the public who wishes to ask about any matter related to our mission.

Every single issue raised in the EFAME would be fair game for discussion at either the meetings of the Cal/OSHA Advisory Committee or those we have with Region 9, and many of the issues have been discussed. Consequently, up to this point, we are seeing a process that seems to be little other than more of the same, coupled with a more than significant expenditure of precious resources, when what we were hoping to see was a process that would bring new and more effective insight into critical issues like how the Cal/OSHA Program, other state plan programs, and OSHA itself can improve effectiveness, or how best to prioritize activities given the constraints presented by fiscal realities.

It is no secret that the budgetary situation in California, as in most other states throughout the country, has been severely stressed for several years now due to the worldwide recession.

Despite the current economic conditions we have been able to maintain a strong Cal/OSHA Program in California.

However, the Executive Summary barely acknowledges this with the statement that “it is unclear what impact this funding situation has had on the problems identified in this report.” One might well question why a primary focus of the EFAME has not been to confront the need to prioritize our services in light of reduced resources, so that those that are most needed will be assured of provision without interruption.

Systematic bias in the EFAME and the difference between the phrases “at least as effective as” and “same as.”

The Occupational Safety and Health Act of 1970 provides, among other things, that OSHA shall approve any state plan that

“provides for the development and enforcement of safety and health standards relating to one or more safety or health issues, which standards (and the enforcement of which standards) are or will be at least as effective in providing safe and healthful employment and places of employment as the standards promulgated under [the OSH Act]. . . .”

The Act requires states to be “at least as effective as” OSHA, not “the same as.” However, statements like “Cal/OSHA should adopt policies equivalent to Federal OSHA’s,” coupled with the utter absence of any attempt to factor state program accomplishments that exceed OSHA’s into the evaluative process, point to a working premise that states must do things exactly the way OSHA does.

California has spent the last half decade conducting its first large-scale experiment to determine whether we can develop data to indicate the extent to which our programs actually change employer and employee behavior and reduce fatalities on the job. Adoption of the emergency heat-illness prevention standard in 2005 kicked off this initiative, and Cal/OSHA has devoted considerable resources since that time to the creation and evaluation of a comprehensive regulatory program to reduce fatalities due to heat.

We believe that this initiative exemplifies the kind of work we need to be doing much more of, and perhaps with our highest priority, yet there is no counterpart to it at OSHA. The experience and data we have derived from it illustrate how the laboratory of a state plan can bring vital new approaches that should be made a part of any overall evaluation of effectiveness.

One small outgrowth of this project is employment of a concrete and highly effective Cal/OSHA enforcement tool, which OSHA does not have, known as “Orders Prohibiting Use,” or OPUs. These are direct orders from Cal/OSHA to stop the operation of dangerous machinery or prohibit entry into a dangerous area.

As part of Cal/OSHA’s Heat Illness Prevention Program and with the support of the Agricultural Industry, inspectors conducting “sweep” programmed inspections have used the OPU to completely close down the operations of agricultural employers who were in flagrant violation of California’s heat illness prevention standard. Over 25 OPUs have been issued for this purpose

since 2008. These orders do not substitute for citations, but they have a substantial impact on those few bad-actor employers who may be considering ignoring the heat illness prevention standard, and we believe they have been an important factor in driving down the number of serious violations we are finding in our heat-related inspections.

Issuing a higher percentage of “serious” violations as a measure of effectiveness.

OSHA criticizes California for having a low rate of “serious” citations versus all citations issued, on the premise that a low rate of serious citations necessarily means the California Program is less effective than OSHA. We would certainly concede that the percentage of serious citations issued tells an important part of the story, but taken out of context, the rate of issuance of serious citations is a statistic that is of little value and potentially misleading.

To illustrate this point, consider the programmed heat illness inspections mentioned above, which now yield a very low rate of serious violations due to enforcement strategies like issuance of Orders Prohibiting Use and other essential behavior-changing initiatives like the extensive partnering Cal/OSHA has engaged in with the Agricultural Industry, media campaigns, and educational programs.

What the OSHA auditors do not state, and apparently do not understand, is that as the rate of serious violations issued overall for California has fallen over the last several years, the rate of workplaces found to be in compliance with the heat standard has risen dramatically, along with the number of programmed sweep inspections we have conducted to look for heat violations.

This is not an accidental relationship. It is a deliberate consequence of Cal/OSHA’s commitment to focus clearly on the bottom line and to finish the job. We cannot evaluate our true effectiveness until we gather the data necessary to demonstrate whether we have actually changed employer behavior and reduced fatalities due to heat. This will necessarily cause the percentage of serious citations we issue to fall every year, which is what should be happening if we are truly having an impact.

Fatalities to outdoor workers in California due to exposure to heat on the job since our heat illness prevention campaign began have been as follows:

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>
12	7	1	6	1

The outdoor occupational fatality number dropped from 12 in 2005 to seven in 2006, more than a one third reduction, as California experienced one of its most severe heat waves in recent history, resulting in over 150 *non-occupational* deaths to heat, the highest number on record, during the summer of 2006. This type of service evaluation is what we need to see more of if we are truly going to address “effectiveness” as the OSH Act requires.

Targeting of high hazard Places of employment.

We will respond in detail to each and every finding of the EFAME within the 30-day deadline set by OSHA. We provide here on a preliminary basis an analysis of three findings, for two of which

we include a description of our experience in trying to obtain further explanation from the auditors. We provide these in order to illustrate what causes us significant concern about the ability of the auditors to understand and document what the Cal/OSHA Program does and does not do.

#### Finding 7

This finding states that “Cal/OSHA’s targeting system is not identifying industries where serious hazards are more likely to exist,” the recommendation being that Cal/OSHA should “re-evaluate the targeting system and the focus of enforcement resources to ensure that programmed inspections are being conducted at establishments where serious hazards are most likely to exist.”

What the auditors have done here is to lump all of Cal/OSHA’s “programmed inspections” into the category of high hazard targeting. This means, for example, that all of the heat inspection sweeps we have conducted to evaluate the effectiveness of our campaign to bring the agricultural and other outdoor work industries into compliance with the heat-illness prevention standard have been erroneously characterized as the result of high-hazard targeting. For the reasons discussed above, it is not possible to evaluate whether we are having a successful impact unless we conduct these inspections, which will indeed show a low incidence of serious violations if we are succeeding in our mission.

We believe our targeting system is among the best in the nation. Our High Hazard Unit, which is the part of Cal/OSHA that selects high-hazard places of employment based on a predicted likelihood of having a high rate of serious violations, shows, for FY 2009, a rate of 5.7 violations per inspection, with 2.25 of them classified as serious, willful, or repeat (SWR), versus a national average of 3.3 violations per inspection, with 2.1 classified as SWR.

#### Findings 4 and 24

Finding 4 states that “two of the 52 fatality inspections were not initiated in a timely fashion and the reasons for the delay were not documented in the case file.” Finding 24 states, contradictorily, that “seven fatalities were not opened [sic] within one day of reporting [i.e., the inspections were not initiated in a timely fashion]; lapse time for inspection of all accident reports ranged from 7.6 days to 38.4 days.”

The following describes what took place when we tried to resolve this inconsistency.

We asked for the identities of the files reflecting these findings, and we were given only three. All three of these files showed that the inspections were conducted within 24 hours of our receiving notice of the fatality. The auditors we contacted were not able to explain the discrepancy between the number of late inspections identified in Finding 4 and the number identified in Finding 24.

We are currently speculating that different staff came up with these findings; one used the federal Integrated Management Information System (IMIS) to arrive at a finding while the other used actual file review, and the difference might be due to data-entry errors.

As we were pursuing this inquiry, we speculated that data-entry errors might be due to the fact that the IMIS system in our Sacramento office was down for about three months due to the unavailability of replacement parts for defective hardware. This turned out not to be the case, and we are still trying to determine what files were reviewed by the auditors and revealed a problem regarding timeliness.

This, unfortunately, is not the only case in which we have attempted to get explanatory detail from the auditors and they have been unable to explain their findings.

#### Appeals Board Process.

OSHA criticizes California for its appeals process but makes no mention of any of the Appeals Board's successes, such as its reduction of a previous and long-standing backlog and its new expedited abatement program which has made significant progress in obtaining abatement of serious unabated violations on appeal despite employers' legal entitlement to remain out of compliance while an appeal is pending.

#### What the purpose of the EFAME should be.

We respectfully submit that the purpose should not be to simply repeat with greater fervor the kind of oversight OSHA has provided regularly each year for decades. We agree, for example, that Cal/OSHA's citation lapse time is too long, as has been noted in the EFAME and by OSHA Region 9 for many years now.

We fully recognize the problem and are trying to fix it. What we need is a dialog about *how* we can fix it, including improving the tools we have to do so, e.g., the antiquated and barely serviceable Integrated Management Information System (IMIS).

As the EFAME barely acknowledges, resources are a huge part of the equation, and this fact needs to be openly confronted. Much of our service tracking depends on the IMIS system, yet our offices have experienced inability accessing the system for significant periods of time, as noted above, due to lack of available hardware and other problems.

We would also respectfully submit that the purpose of the EFAME should be to initiate a national dialog about how to measure and improve the effectiveness of OSHA regulation of occupational safety and health in the workplace. How effectively do new regulations, new enforcement initiatives, partnership programs, and education programs actually reduce fatalities, injuries and illnesses? How do we measure that? How do we find the right mix of enforcement and cooperative programs, with the overall goal being to improve safety culture in the nation's businesses? And how do we address these issues in light of anticipated resource scarcity over the next several years. This is the national dialog we need to have, and it is long overdue.

#### Conclusion.

Cal/OSHA will respond fully to the EFAME within the time frame allowed by OSHA. While we are disappointed in the manner in which this process has unfolded to date, we still believe there is time to develop a national dialog about the OSHA paradigm and how to improve it. We look

Page 7—EFAME Response  
September 20, 2010

forward to making the best we can out of this opportunity to improve, and we hope you will take our thoughts to heart.

Sincerely,  
/signed/

John C. Duncan

CC: Steven F. Witt  
Barbara Bryant