Appendix A
FY 2009 Vermont State Plan (VOSHA) Enhanced FAME Report prepared by Region I
Summary of Findings and Recommendations

Italics = paraphrase

	Findings	Recommendations
1	*Nine out of **19 State Activity Mandated Measures (SAMM)** standards were not met – % of complaints/referrals responded to within 1 day (imminent danger); % of S/W/R violations verified (private and public); average no. of calendar days from opening conference to citation issuance; average violations per inspections with violations (S/W/R and other-than-serious); average initial penalty per serious violation-private sector only; % of total inspections in the public sector; and % of 11(c) investigations completed within 90 days.*	We strongly recommend that VOSHA improve its performance with respect to the nine standards of the SAMM report that have not been met.
2	***State Indicator Report (SIR)** standards were not met – private sector serious safety/health violations; private sector average penalty for other-than-serious safety/health violations; private sector safety inspections/100 hrs.; private sector penalty retention; % of violations reclassified; and % of penalty retention.*	We strongly recommend that VOSHA improve its performance with respect to the eight standards of the SIR report that have not been met.
3	*Based on statistical comparison of enforcement performance with other State Plans and Federal OSHA, VT's **average violations per initial inspection** and **average current penalty per serious violation** marked below the data for all State Plans and Federal OSHA.*	We recommend that VOSHA improve its performance with respect to the highlighted *[enforcement performance]* areas to come more into line with the Federal system.
4	***Case file deficiencies** included absence of CSHO's field notes; inadequate documentation of abatement verification; and failure to document labor organization notification of the informal conference. The CSHOs were not meeting the FOM diary sheet requirements. Documents were not in the order established by Appendix C of ADM 03-01-005.*	We recommend that all VOSHA staff members review and follow Appendix C of ADM 03-01-005, which provides detailed information regarding "Inspection Case File Organization." This directive provides detailed instructions about which materials should appear on the left of the case file and which materials should appear on the right side of the file, and the specific order in which these documents should be placed.
5	***Case file review** found that in several instances the OSHA-7 Complaint Form was not contained in the case files. A few files did not contain copies of the letter sent to the complainant advising of the outcome of the inspection.*	VOSHA must send all response letters to complainants advising them of the results of the inspections or investigations resulting from their complaints. In accordance with the FOM, the letters must include an appropriate response detailing the outcome of the inspection or investigation for each alleged complaint item.
6	***Fatality investigation case files 1**:* *(A) Discussions between CSHOs and supervisors regarding investigations were not well documented.* *(B) The CSHO did not reconstruct the scene of the accident.* *(C) There was no evidence that an initial letter and a copy of the citations had been sent to the victim's family.* *(Other finding: the CSHO assessed the probability "lesser" when it should have been rated "greater")*	(A) VOSHA must ensure that important discussions between CSHOs and supervisors regarding fatality investigations are documented in the case file diary sheet. (B) In addition to discussions between CSHOs and their supervisors, all information relevant to the fatality investigation must be documented in the case file diary sheet in accordance with the Field Operations Manual (FOM) (Chapter 5, Section X), which states that: "All case files shall contain an activity diary sheet, which is designed to provide a ready record and summary of all actions relating to a case. It will be used to document important events or actions related to the case, especially those not noted elsewhere in the case file …." (C) VOSHA must adhere to the FOM, Chapter 11, Section II.G. that discusses the requirements to follow with regard to contact with families of victims during an inspection.
7	***Fatality investigation case files 2**:* *VOSHA cited the incorrect standard (cited 1910.26(c)(2)(iv) but should have cited 1910.26(c)(3)(i)), and the case file did not contain notes reconstructing the scene of the accident.*	We recommend VOSHA review and follow the FOM, Chapter 11, Section II.E.2., which discusses potential items to be documented in the case file, such as how and why the incident occurred; the physical layout of the worksite;

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		sketches/drawings; measurements; video/audio/photos to identify sources; and whether the accident was work-related.
8	*VOSHA's **average of 2.4 violations cited** per initial inspection is below the Federal OSHA average of 3.1 violations.*	VOSHA's average violations cited per inspection should increase to align with Federal OSHA's average of 3.1 per initial inspection.
9	Case file review revealed several **hazard identification** issues: all apparent violations were not cited or some ***[standards]*** were misclassified in the citations sent to the employer (p.28).	VOSHA should review the pictures taken by CSHOs more closely and do more research and also should train and network with appropriate staff throughout region to improve hazard recognition and referencing of the correct standards when hazards are identified.
10	We found that CSHOs **grouped serious violations** that should not have been grouped, which also reduces penalties. *Nine out of 137 (6.5%)* serious violations were grouped as serious. Of these nine grouped citations, we found that four were grouped incorrectly.	To group serious violations appropriately, VOSHA CSHOs must adhere to the guidelines established in the FOM for grouping. Chapter 4, Section X of the FOM lists the situations that normally call for grouping violations.
11	*The [case file]* review revealed that, in a number of cases, the CSHOs did not correctly assess **the gravity of the violation**, and erred on the side of assessing lower probability and severity than warranted, thus reducing the overall penalties.	VOSHA must ensure that CSHOs use penalty calculations that conform to the FOM. The minimum and maximum penalties are discussed in Chapter 6.II.C. and D, respectively. Section III discusses the four factors to take into consideration: 1) The gravity of the violation; 2) Size of the employer's business; 3) The good faith of the employer; and 4) The employer's history of previous violations. VOSHA staff should also review the Gravity-Based Penalty (GBP) section in the FOM, which is discussed in Chapter 6.III, sections 3, 4 and 5.
12	*[Case file reviews found that]* a few **violations** were incorrectly **classified** as "other" rather than "serious."	We recommend that VOSHA staff review Chapter 4, Section II of the FOM, which discusses the factors that determine whether a violation is to be classified as serious, and also Chapter 4, Section IV of the FOM, which discusses the factors that determine whether violations should be classified as other-than-serious.
13	Six of the case files involving **unions** did not contain any **documentation** to indicate that the union had been sent a copy of the citations. In addition, **field notes**, which likely contained the information obtained from the employees during interviews, were not kept in the files.	VOSHA should adhere to the FOM, Chapter 5, Section XI.B.2 by sending a notification to the unions of the citations sent to the employer and retaining a copy of such in the case file. In addition, VOSHA should review the FOM, Chapter 5, Section XII.A.2 regarding maintaining field notes in the official case files.
14	We found some cases which lacked sufficient evidence to legally support the **standards** cited or the actions taken by VOSHA to delete citations. In other cases, the CSHO cited the incorrect standard or assessed the penalties incorrectly.	VOSHA must review and follow the FOM, Chapter 4 which discusses the evidence necessary to support violations.
15	The data in SAMM #6 shows that VOSHA fell short of the goal of 100 percent for **verifying S/W/R violations abated** in a timely manner, with a year-end percentage of 93.81 in the private sector and 93.55 percent in the public sector.	We strongly recommend that VOSHA work harder to ensure timely abatement of serious, willful or repeat violations which helps ensure that workers are protected from injuries and illnesses.
16	Some of the case files we reviewed lacked **proper evidence of abatement.** *(A)-(B)* We found that 13 out of the 76 cases (17%) we reviewed did not contain adequate documentation of abatement. Some of these case files had been closed without any documentation of adequate proof of abatement. *(C)* In addition to providing written verification of hazard abatement, employers must also provide relevant "documents, plans and progress reports." In some cases, we noted that the file did not contain such documents, such as written hazard communication programs, evidence of training, and emergency action plans, that were required to be provided by the employer.	(A) VOSHA must adhere to the directives in Chapter 7 of the FOM, Section IV (b), which also states the "case file remains open throughout the inspection process and is not closed until the Agency is satisfied that abatement has occurred. If abatement was not completed, annotate the circumstances or reasons in the case file and enter the proper code in the IMIS." (B) VOSHA should also ensure that Chapter 7 of the FOM, Section XV is adhered to. This section states: "The closing of a case file without abatement certification(s) must be justified through a statement in the case file by the Area Director or his/her designee, addressing the reason for accepting each uncertified violation as an abated citation."

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		(C) We recommend that VOSHA thoroughly review and adhere to Chapter 7 of OSHA's FOM on Abatement Documentation, particularly Section B, which relates to Adequacy of Abatement Documentation. As stated in that section, examples of documents that demonstrate that abatement is complete include "(a) copy of program documents if the citation was related to a missing or inadequate program, such as a deficiency in the employer's respirator or hazard communication program."
17	Some of the case files we reviewed lacked **proper evidence of abatement**. *Case files related with Petitions for Modification of Abatement (PMA) were missing the abatement completion date or interim protections to be followed during the PMA.*	VOSHA must also ensure that all documentation related to Petitions for Modification of Abatement (PMA) are contained in the relevant case files, such as copies of the petition itself, as well as VOSHA's approval (or denial) of the PMA, and any written objections by employees to the PMA. See Chapter 7 of the FOM, Section III for more information on PMAs.
18	There were a few cases in which the proper ***[informal conference]*** **procedures** were not followed (e.g., missing original citation following violation reclassification; inadequate documentation on the reason for citation deletion, on the informal settlement agreement or abatement; or held after the 20-day period).	(A) VOSHA should review and follow the FOM, Chapter 7, which discusses the procedures to follow for informal conferences and informal settlement agreements. It states that the informal conference will be conducted within the 20 calendar day contest period. In addition, this section discusses the requirement that an affected employee or his representative shall be given the opportunity to participate, and VOSHA must be sure to follow this direction. (B) The VOSHA supervisor who conducts the informal conference must be sure to document reasons for granting penalty reductions (and extended abatement dates) on the case file diary sheet.
19	*When we conducted the on-site review, VOSHA was in the process of having legal counsel establish a formal policy on* ***debt collection procedures****, and provided us with the draft "VOSHA Penalty Collection Protocol," currently being formalized.*	We advise VOSHA to follow through in establishing formal debt collection procedures based on those set forth in Chapter 6 of the FOM. State Plan programs must have "an effective debt collection mechanism in place" in accordance with the State Plan grant requirements established in OSHA Directive 09-02 (CSP-02). This debt collection mechanism must also be documented in the State Plan. VOSHA procedures, once finalized, should be sent to the regional office for approval and then will become part of VOSHA's State Plan.
20	*VOSHA has fallen behind in promulgation and adoption of new and revised Federal OSHA* ***standards****, due to the State's time-consuming rulemaking procedures. One of the effects of severe budgetary constraints has been to hold off on advertising some* ***federal program changes*** *($2,500/ad), which is a factor for the delay in some FPCs.*	We urge VOSHA to respond in a timely manner to FPCs and Federal Standard Actions.
21	***VPP*** - Two SGEs participated on the IBM onsite on April 2-10, 2008 without having received approval from the SGE Coordinator.	VOSHA must request prior approval from the SGE Coordinator at the National Office to use SGE's on *Green Mountain (GM)* VPP onsite reviews.
22	The **VPP** onsite evaluation that involved the PSM standard was conducted on September 17-20, 2007, although none of the seven team members had received PSM Level 1 auditor training.	VOSHA must have at least one CSHO trained in PSM to ensure compliance with the PSM Standard.
23	Our review found that the PSM questionnaire was not sent to the VOSHA **VPP** site covered under the PSM standard.	VOSHA must send the PSM questionnaires for completion by the VPP site covered under PSM for completion and must be included in the site's 2009 annual self-evaluation.
24	Effective April 18, 2008, CSP 03-01-003 modifies procedures for VPP onsite evaluations. Review of the GM**VPP** files we found discrepancies related to Medical Access Orders (MAOs), final reports containing 90-day items, abatement verification or documentation.	VOSHA should use the revised report format for initial and recertification VPP onsite evaluations.

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25	VOSHA staff are required to enter an OSHA 55 intervention form for each **VPP** onsite evaluation that is conducted. Staff must also enter the OSHA form 31 timesheet into IMIS. We found that the team leader has entered a 55 intervention for each of the sites evaluated.	VOSHA must ensure that staff enter their weekly activity on the OSHA form 31 timesheets. The OSHA 55 intervention form should be incorporated into the OSHA form 31 when appropriate.
26	The GM**VPP** manager verbally accepts the application and schedules the onsite within two months at the convenience of the applicant. Files were lacking in that they did not contain the dates the applications were received and accepted.	VOSHA should ensure that GMVPP files contain the date the application was received and the date the application was accepted. In addition, VOSHA should send a letter to the applicant acknowledging receipt of the VPP application.
27	The **VPP** records are located on the VPP program manager's personal drive.	All of the GMVPP electronic documents must be placed on the "S" (public) drive to allow access to management in the Montpelier office in the event of a public request.
28	Some ***[discrimination]*** files had detailed phone logs, and others did not contain any phone log. The OSHA Form 87 (or the IMIS Case Activity Worksheet) was not found in some of the files. In addition, copies of notification letters and closing letters to the complainant and respondent were not included in some of the case files.	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.
29	Some CSHOs have exceeded the time frame of three years from date of hire to complete all courses required under TED 01-00-018.	Since some of the program's CSHOs have not met this timeframe, the VOSHA director should ensure that all staff complete their remaining courses as soon as possible.
Issues identified with informal suggestions		
1	VOSHA did not adopt the longshoring and marine terminal standard because there is no maritime industry in the state. However, according to the IMIS and as a result of further research on **Maritime** enforcement, we found that Vermont may in fact have sites subject to Section 29 CFR 1915 and 1917 (p. 48).	VOSHA must reevaluate the need to adopt the longshoring and marine terminal standard and advise the region of its findings.
2	VOSHA was using OSHA-1 inspection numbers to assign a case number to **11(c) cases** and also was filing the 11(c) complaint on an OSHA-7 complaint form (p. 61).	VOSHA management and investigators were informed *that safety and health inspection forms have a separate purpose from 11(c) forms*, and were instructed not to use the OSHA-1 and the OSHA-7 forms for 11(c) complaints. Following this practice will avoid duplication of files. In addition, in writing up the final analysis in a case, listing the elements separately will help ensure that all required elements are covered.