Appendix A
FY 2009 Washington State Plan (DOSH) Enhanced FAME Report prepared by Region X
Summary of Findings and Recommendations

[ ] = added text

	Findings	Recommendations
1	As noted in the FY 2008 FAME, the number of untimely FAT/CAT investigations is inflated by the reporting of non-work related fatalities into the WIN [state MIS] system. This issue has been discussed in quarterly meetings but has not been resolved.	Discontinue entering fatalities that are not work-related into the IMIS data system (p.13).
2	In five of the [18] fatality cases, critical decisional information was not maintained in the case file. Although the case files were closed, documentation to explain why the files were closed without citations was not present. When brought to DOSH's attention, emails that were not copied to the case files were provided…[that] supported DOSH's case closure decisions. Two of these five case files did not have a narrative of the fatal event and the email information was the only explanation of what happened and why a citation was not issued. One case file stated that the employee died of a heart attack, but no supporting documentation, such as [a] death certificate or medical examiner's report, was included in the file to document the cause of death.	Develop a clear policy identifying what documents must be maintained with the case file. When discussions regarding the case file are held, key information should be reduced to a memorandum and maintained in the case file, especially if it involves decisions on the disposition of the case (p. 14).
3	The state rated probability lower than would be expected for a violation that related to fatalities. Of the 36 violations issued, the probability assigned to 25 of them was classified as either a 1 or 2, or as a low on the state's probability system. Further, eleven violations were classified as either 3 or 4, or as a medium… Finally, none of the case files reviewed had any citations that were classified with a probability of 5 or 6, or high. ..The data suggest that DOSH was reluctant to use the high probability classification when developing fatality-related violations and penalties.	Closely monitor the use of probability when calculating penalties for violations directly related to a fatality (p.14).
4	The Related Event Code was properly marked on the documentation for 11 of the 13 case files reviewed [with citations]. Two case files did not have the REC code marked even though citations were issued and sustained for violations directly related to the fatality.	Ensure that REC codes [Related Event Codes] are properly applied to violations related to fatalities (p.15).
5	The state did not collect injury and illness data in every case file reviewed where it was required. 12 employers from the study files were required to maintain logs [but none of their case files included] a copy of the injury and illness logs. Only one of the 12 case files showed that the employer's logs were checked.	Ensure that injury and illness logs are reviewed and copied for the case file on all inspections where logs are required. Document findings in the case file (p.16).
6	The DOSH compliance manual…states "As appropriate, CSHOs must review injury and illness records to the extent necessary to determine compliance and identify trends." There is no mention of a requirement to obtain a copy of the injury and illness logs.	Revise the DOSH compliance manual to require that injury and illness logs be obtained from the employer, where appropriate, and that a copy be maintained in the case file (p.16).
7	The average penalty assessed per serious violation in FY 2009 was $530. That average was $143 (21%) less than DOSH's average in FY 2008. It is also $805 less than the three-year national average (both state and federal data).	Increase penalty amounts significantly in order to encourage voluntary compliance and to serve as a strong deterrent. Policy adjustments should be made to impose higher penalties for serious violations (p17).
8	According to the MARC [Mandated Activities Report for Consultation], there were two initial consultation visits in the public sector in FY 2009. Further investigation revealed that the MARC report is not accurately reflecting public sector data for Washington. The actual number of visits was 215, including both state and municipal employers.	Revise WIN system [state MIS] code(s) so that public sector consultation visit information can be entered into the IMIS (p.22).

	23(g) Private Sector Consultation Audit Findings	Consultation Audit Recommendations
9	Nine case files were missing OSHA 300 [injury and illness] logs out of 31 [case files reviewed], resulting in 29% missing 300 logs and log information.	If a company is not keeping the [OSHA] 300 [injury and illness] logs and is required to, an item should be included in the case file. Copies of 300 logs should be collected from businesses and put into the case file for the previous three years (Appendix F p.1).
10	Fifteen of the 31 case files reviewed (48%) did not contain an evaluation of the employer's safety and health management system. One of the case files had scores entered from the form but a copy of the form was not included. Some of the case files were partial visits and should have had partial evaluations completed.	Assure that all case files have a completed form 33 or equivalent [on the employer's safety and health program] and the evidence or rationale for the score awarded is evident (Appendix F p.1).
11	Employers in three cases did not abate hazards in the agreed-upon time frame and did not ask for extensions. In some cases, the extensions were given without the employer submitting the required information of why the extension was needed, what was being done to protect employees in the interim and when the abatements would be complete.	If the employer does not respond to requests for abatement certification and will not ask for an extension, the case should be turned over to enforcement for follow-up (Appendix F p.2).
12	Most OSHA 30 forms stated that one employee was interviewed. The case file notes reflected more than one person was interviewed in most cases. It appears that the consultants are entering one in the box for the number of employees interviewed regardless of the number of employees they interviewed.	Enter the correct number of employees interviewed in the OSHA form 30 box requesting the information (Appendix F p.2).
13	Abatement procedures and certification were inadequate or missing in some case files. Abatement certifications in some case files were received up to six months later without [the employer] requesting extensions.	Assure that the abatement language provided by the employer abates the hazard. A statement such as "Complied" does not abate the hazard. If the language does not abate the hazard, the consultation project should consider if an extension of time is necessary and the employer should be advised to either abate the hazard or ask for an extension (Appendix F p.3).
14	The consultant measured air contaminants with a direct reading instrument (PID) that produced data for area sampling and drew conclusions about 8 hour average exposures without calculating possible time weighted averages. A noise dosimeter was used for area surveys in two cases that resulted in conclusions being drawn about employees' overexposures to machine noise in a complex work environment. Employees moving between machine areas need to be monitored during the workday to quantify the exposure to noise or calculations can be done estimating the exposure to noise.	Require consultants to use recognized practices to determine employee exposure to air contaminants and noise before making statements or recommendations about employee exposures (Appendix F p.3).
15	Three of the five cases reviewed [had industrial hygiene sampling information that] did not include calibration logs, sampling forms or other instruments or results data.	Review industrial hygiene [instrumentation] requirements with the industrial hygienists as this [sampling instrument calibration] requirement is designed to assure proper [sampling] techniques are used (Appendix F p.4).
	Discrimination Audit Findings	**Discrimination Audit Recommendations**
16	Thirty-two percent of DOSH's [discrimination] complaints were withdrawn after they were filed. [This] was discussed with DOSH…and DOSH provided its rationale for them. When a complaint is withdrawn, the case file should include either a written request from the complainant or a withdrawal form signed by the complainant, filed as a separate exhibit.	For [discrimination] complaints that are withdrawn, DOSH's case files should include a written request for withdrawal from the complainant. The request to withdraw the complaint should be filed as a separate exhibit (Appendix E p.3).

	Discrimination Audit Findings	Discrimination Audit Recommendations
17	DOSH's [discrimination] settlement agreements allow for unemployment compensation benefits to be deducted from settlement monies. This is not correct. The *Whistleblower Investigations Manual* states that "unemployment compensation benefits may never be considered as back pay offset."	DOSH should not deduct unemployment compensation from settlement monies in its [discrimination] settlement agreements (Appendix E p.3).
18	DOSH's [discrimination] investigative reports should include a section which describes how the employer is covered under the Act in order to establish jurisdiction. This will help to clarify why the agency accepted the complaint instead of referring it to federal OSHA or another government agency.	DOSH should include a section in its [discrimination] investigative reports and/or memos for coverage and/or jurisdiction. This section should describe why the state has jurisdiction to investigate a complaint as well as include detail similar to what is written in DOSH safety inspection reports (Appendix E p.3).