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July 5, 2020

Ms. Nancy Hauter, Acting Regional Administrator Region V Occupational Safety and Health Administration United States Department of Labor 230 South Dearborn Street, Room 3244 Chicago, Illinois 60604

Subject: MIOSHA's Statement in Response to Final FY 2019 Comprehensive Federal Annual Monitoring and Evaluation (FAME) Report - October 1, 2018 to September 30, 2019

Dear Ms. Hauter:

Thank you for the opportunity to partner with Federal OSHA and to work collaboratively during the FY 2019 Comprehensive FAME process to ensure that Michigan's state plan program continues to be effective at protecting the safety and health of workers. This letter provides MIOSHA's statement in response to the FY 2019 Comprehensive FAME report. We request this letter be posted with the FAME report on the OSHA webpage.

MIOSHA greatly appreciates your recognition in the FY 2019 Comprehensive FAME of the noteworthy accomplishments we had towards our annual performance goals. We believe the Michigan program for occupational safety and health continues to be highly effective in protecting Michigan workers from on-the-job injuries, illnesses, and exposures as evidenced by Michigan's downward trend in injury and illness rates and program-related workplace fatalities.

MIOSHA has established and maintains a positive relationship with Federal OSHA. Many Area OSHA Office, Region V, and National Office staff are included in the distribution of MIOSHA policy documents, publications, and newsletters, and are invited to participate in staff training, meetings, and conferences.

While MIOSHA was very pleased that there was only a single finding and two observations as a result of the FY 2019 FAME, for the reasons set forth more fully in this response, MIOSHA does not believe that the finding and observations raised in the report rise to the level of requiring action in order for the State to maintain its "at least as effective" status. Nevertheless, MIOSHA appreciates the thorough review of our OSH program and feedback provided.

MIOSHA prides itself on being a continuous improvement organization and truly values constructive input and feedback. MIOSHA has carefully considered the constructive feedback provided through the evaluation process and FY 2019 Comprehensive FAME and will continue





to take all actions that we feel are appropriate for our state plan program. To that end, the actions MIOSHA has already taken in response to the FY 2019 FAME include:

- Review of the FY 2019 Comprehensive FAME Report with all staff to increase awareness of the evaluation process, feedback provided, and resulting changes.
- Implementation of the use of diary sheets for all construction enforcement inspections and investigations consistent with its pre-existing usage in general industry enforcement inspections and investigations.
- Modification and expansion of MIOSHA's content expectations for field narrative documentation in construction investigation and inspection files to provide greater context and chronology for actions taken during field investigations.
- Modification of MIOSHA's Field Operations Manual to correct differences in MIOSHA's coding of related activity in the OSHA Information System (OIS) coding compared to OSHA's coding practices.
- Modification of MIOSHA's practices concerning when to open inspections with employers on multi-employer worksites to minimize in-compliance inspections and to ensure that MIOSHA's limited resources are directed toward employers whose workers are exposed to hazards.
- Implementation of increased monitoring and evaluation methods to promote early detection, evaluation, and correction of in-compliance rates which exceed the acceptable level.

Although not required as part of the Corrective Action Plan (CAP) per the revised State Plan Policies and Procedures Manual, the following formal response is provided to you to specifically address the observations noted in the FY 2019 FAME.

Observation FY 2019-OB-01: Twenty-two of the 37 (59%) fatality case files reviewed did not contain evidence and/or documentation consistent with MIOSHA's FOM, Fatality Procedures Manual, and/or instruction MIOSHA-COM-06-1R4 Inclusion of Victim's Families in Fatality Investigations. These included: complete and accurate fatality/catastrophe report, investigation summary, violation worksheets, field narrative, diary sheet, letters to the next-of-kin, victim's personal data, photographs, measurements, police and medical examiner reports, witness statements, and/or multi-employer worksite description.

State Response: MIOSHA disagrees with the combining of these varied and infrequent documentation anomalies as an observation. MIOSHA believes that the statistical compilation of these stand-alone discrepancies, therefore suggesting an overarching trend is misleading and inaccurate. MIOSHA further believes that several infractions referenced in the Observation as being contrary to MIOSHA policy or procedure are not contrary to our written policies. In addition, many of the slight documentation inconsistencies from expectations set forth in MIOSHA's policies or procedures were reasonable and/or had no direct or negative impact upon the interests of the employer, employees or their representatives, or the effectiveness of the MIOSHA enforcement actions taken. Several examples which shed light upon the lack of infraction or lack of a negative impact from these discrepancies include:

A. Nine of 37 (24%) Investigative Summary (OSHA 170) Reports and Three of 37 (8%) Fatality/Catastrophe Reports (OSHA 36) were not in the case file.

While MIOSHA acknowledges a small number of files lacked paper copies of the OSHA 170 and OSHA 36 reports in the case file as outlined in MIOSHA policies and procedures, the observation reference fails to fairly paint the full context of these documents or their impact on enforcement action by the agency. The OSHA 170 and OSHA-36 are reports generated within the OSHA Information System (OIS) and therefore are continued to be maintained within the OIS system despite any absence from the paper case file. These reports are generally for data collection and reporting purposes by the state program to OSHA and are not documentation utilized by the agency to support the issuance or non-issuance of citations in an administrative review or appellate process. Therefore, the inclusion of the forms in the paper case files in addition to their presence in the OIS are largely for the convenience of evaluators during file reviews. The 2019 FAME report provides no context for these documents, nor acknowledges that the necessary information contained on these forms was nonetheless collected and available in an electronic format.

B. Letters to Next of Kin were not contained in the case file (Six of 37 files-16%) or Next of Kin was not identified on the Investigation Summary OSHA 170 Form (Five of 37 files (13.5%).

Next of Kin letters are designed to notify a designated person on behalf of a deceased worker of the MIOSHA investigation related to the fatality and the results of that investigation. In most instances, the next of kin is not directly involved in some capacity with the same employer who is the subject of the enforcement investigation and therefore MIOSHA notifies the person of the activity. However, there are rare instances where such a notification is not possible or would be contrary to basic logic principles. These instances can include when the next of kin is also directly involved in the business and hence is already aware of MIOSHA's investigatory activities; when MIOSHA is not investigating the fatality due to lack of jurisdiction, or when there is no next of kin. In the latter sets of circumstances, MIOSHA believes sending the letter would be ill advised.

While MIOSHA acknowledges a small number of instances where next of kin information was not obtained, next of kin letters were not sent, or paper copies of letters were not contained in the case file, the report focuses solely on this failure without recognizing several key considerations for these instances. Notably, as previously explained to the evaluation team, MIOSHA's policies and procedures do not require next of kin letters to be sent in instances where MIOSHA has determined that the fatality is not covered under MIOSHA's jurisdiction. The report further fails to acknowledge that several of the files reviewed involved situations where MIOSHA determined our program lacked jurisdiction to investigate, thus relieving MIOSHA of the next of kin letter requirements under the Fatality Procedures Manual and nullifying the purpose behind recording next of kin information on the investigation summary. In several other cases, the next of kin was the employer representative for purposes of MIOSHA's investigation and hence would be independently made aware when the investigation began, or when

results were issued, rending the letters redundant and potentially insensitive. In one such instance, the deceased worker's father was both the next of kin and the subject of the investigation. The 2016 MIOSHA FOM at page 68 specifically identifies these situations may warrant not following the usual next of kin procedures:

In some situations, these procedures should not be followed to the letter; e.g., in some small businesses, the employer, owner, or supervisor may be a relative of the victim.

Removing these instances from consideration, only two of the 37 files (5%) lacked paper copies of the next of kin letters in the case file where a next of kin letter was appropriate. MIOSHA disagrees that this relatively small quantity warrants elevation into consideration as a trend. In addition, there is no evidence that the absence of strict adherence to sending a next of kin letter or ensuring a copy was in the case file rendered any impact on the effectiveness of MIOSHA's investigations in comparison to OSHA.

C. Case files lacking Police and Medical Examiner reports.

The Observation in the 2019 FAME suggests a lack of evidence or documentation in fatality investigation files related to police or medical examiner reports in contradiction to MIOSHA's FOM, Fatality Procedures Manual, and/or instruction MIOSHA-COM-06-1R4 Inclusion of Victim's Families in Fatality Investigations. However, the 2019 FAME report fails to acknowledge that this is not an absolute requirement. The MIOSHA Fatality Procedures Manual refers to information from the medical examiner only as a potential source for determining if a death by heart attack or stroke was work-related. The 2016 MIOSHA FOM indicates that fatality files shall "typically include" witness statements which could include statements from a police department or medical examiner. The FOM further indicates the autopsy and police reports are example supporting documentation when relevant to documenting employee exposure. Where a policy or procedure includes discretionary terms such as "typically include" or "relevant" MIOSHA believes it is improper to hold it accountable for acting within its discretionary authority. Additionally, MIOSHA feels it important to note that the evaluation identified the absence of a police or medical examiner report in only 1 of the 37 (3%) fatality files reviewed. This minor infraction further emphasizes that MIOSHA's actual noncompliance with OSHA's apparent expectation to include such reports in every investigation is far less than the Observation's 59% deficiency rate would indicate.

Notwithstanding MIOSHA's disagreement with the representation that these distinct and individualized anomalies rise to the level of frequency to justify consolidation and inclusion in the report as an observation, MIOSHA does acknowledge that improvements are possible and warranted. MIOSHA has identified the following steps it will take to avoid future occurrences of similar policy or procedural missteps:

• The Fatality Procedures Manual will be revised, and staff retrained, to clarify the expectations with regard the following concerns identified in the 2019 FAME:

- The measures and methods to be taken to obtain police and medical examiner reports in all fatality investigations.
- The handling of next-of kin letters for unusual circumstances such as when MIOSHA lacks jurisdiction, the employer representative is also the next of kin, or a next of kin cannot be found/identified.
- In depth audit of fatality case files to ensure copies of documentation such as investigation summary, fatality catastrophe report, next of kin letters, etc., are present in virtual and paper case files.

In addition to the above changes to the MIOSHA Fatality Procedures Manual, MIOSHA has already initiated, or will soon initiate, the following measures:

- Use of diary sheets for all construction enforcement inspections and investigations, including fatalities, consistent with its pre-existing usage in general industry enforcement inspections and investigations.
- Modification and expansion of MIOSHA's content expectations for field narrative documentation in construction investigation and inspection files to provide greater context and chronology for actions taken during field investigations.
- Modification of MIOSHA's Field Operations and Fatality Procedures manuals to correct differences in MIOSHA's coding of related activity in the OSHA Information System (OIS) coding compared to OSHA's coding practices.
- Modification of MIOSHA's practices concerning when to open inspections with employers on multi-employer worksites to minimize in-compliance inspections and to ensure that MIOSHA's limited resources are directed toward employers whose workers are exposed to hazards.
- Division-level discussion with staff of the fatality case files with observations that
 were specific to the division. Management will retrain and reiterate the
 requirements of the FOM for fatality investigations, the Fatality Procedures
 Manual and Agency Instruction MIOSHA-COM-06-1R4 Inclusion of Victim's
 Families in Fatality Investigations.

Observation FY 2019-OB-02: Twenty-six of the 58 (49%) programmed, complaint, referral, and related inspection files reviewed did not contain evidence and/or documentation consistent with MIOSHA's FOM and instruction MIOSHA-COM-15-4R1 Employee Interviews in Safety and Health Investigations. These included: complete and accurate diary sheet, chronology of actions taken, field narrative, violation worksheets, employee exposure, potential employee exposure, photographs, measurements, witness statements, and/or documentation of interviews.

State Response: Like Observation FY 2019-OB-1, MIOSHA disagrees with the combining of these varied and infrequent documentation anomalies as an observation. MIOSHA believes that the statistical compilation of these stand-alone discrepancies, therefore suggesting an overarching trend is misleading and inaccurate. MIOSHA further believes that certain infractions referenced in Observation FY 2019-OB-2 as being contrary to MIOSHA policy or procedure are not contrary to our written policies. In addition, many of the slight documentation inconsistencies from expectations set forth in MIOSHA's policies or procedures were reasonable and/or had no direct or negative impact upon the interests of the employer, employees or their

representatives, or the effectiveness of the MIOSHA enforcement actions taken. Several examples which shed light upon the lack of infraction or lack of a negative impact from these discrepancies include:

A. Insufficient Photographic and Measurement Evidence

Observation FY 2019-OB-2 indicates twenty-six of the 58 (49%) programmed, complaint, referral, and related inspection files reviewed did not contain evidence and/or documentation consistent with MIOSHA's FOM and instruction MIOSHA-COM-15-4R1 Employee Interviews in Safety and Health Investigations, including a reference to photographs and measurements. However, the evaluation team identified an issue related to photos in only three of the 58 files (5%), and an issue related to measurements in only one of the 58 files (2%). This low quantity severely lacks justification for inclusion within an Observation. Furthermore, the nature of the deficiencies noted by the evaluation team are not indicative of the type of deficiency that negatively affected the proper enforcement of MIOSHA rules and regulations. In one case, the sole deficiency noted by the evaluation team was that the photos in the fatality file were supplied by the police department, with no supplemental photos taken by the MIOSHA inspector. This evaluation finding fails to acknowledge that the fatality was determined to fall outside of MIOSHA's jurisdiction prior to a walkaround inspection being conducted, thus eliminating the need or opportunity for additional photographic evidence collection. In addition, it is unclear to MIOSHA why photographs taken contemporaneous to the occurrence of the accident would not suffice as the best evidence of the existing conditions.

An additional example from the evaluators of deficient photographic and/or measurement evidence was a case in which the onsite inspection was initiated due to lack of prior satisfactory response by the employer to a request for information via a letter inspection (commonly referred to as a rapid response letter by OSHA). Upon MIOSHA's arrival, the employer provided the requested information rendering further investigation unnecessary. MIOSHA believes the background of these incidents is important to bring clarity to the lack of severity of the 2019 FAME report's representation of evidentiary deficiencies in MIOSHA's investigation and inspection techniques. MIOSHA feels this is further evidence of the lack of negative impact of these purported deficiencies on MIOSHA's effectiveness during individual inspections and overall.

B. Lack of Employee Interviews or Documentation of Interviews

MIOSHA disagrees with the representation in Observation FY 2019-OB-2 that it has not complied with its policies and procedures regarding employee interviews. From discussions with the evaluation team, the evaluation team disagreed with the way MIOSHA's informal employee interviews in construction inspection files were documented. While MIOSHA understands that the OSHA inspectors have a format for the documenting of statements of employees during interviews, MIOSHA's FOM prescribed minimal recordkeeping of information from employees. Per the MIOSHA FOM, there are two types of interviews: formal and informal. Formal interviews are

reserved for where the information from the employee is necessary to prove the existence of a violation. However, its counterpart informal interviews are less stringent regarding format.

MIOSHA acknowledges our FOM states that "the information provided by the employee interviewed shall *typically* be documented on the Violation Worksheet or Field Narrative." However, the FOM also authorizes the interview to be documented in the case file by, "at a minimum," including "the interviewee's name and job title." In addition, the functionality of OIS enables the MIOSHA inspector to document the interviews electronically which is identified on the OSHA OID Long Report.

Contrary to the representation in the FAME report, in most instances MIOSHA's construction inspectors did document interviews, just simply not in the manner the OSHA evaluation team is accustomed to seeing them. MIOSHA inspectors exercised the discretion afforded to them under the FOM and agency instruction. Most files complied with the minimal documentation requirement of including the name and job title of the interviewee. Information identifying that employees were interviewed did in fact appear on the OIS Long Report to clearly indicate who was interviewed. Therefore, while MIOSHA understands this is not the preferred method of documentation for informal interviews by the FAME evaluation team, MIOSHA strongly feels that a difference in style preference should not be escalated to a deficiency in the FAME report.

MIOSHA firmly believes that the establishment of a state plan enables the state plan to enjoy some deviation in practice and policies from those of OSHA, so long as those differences do not negatively impact the enforcement of the plan. The FAME report makes no representation that the difference in documentation strategies used by MIOSHA negatively impacted the enforceability of the rule or regulations or in some way diluted the effectiveness of MIOSHA's Construction Safety and Health Division. Disagreement as to how the interviews are to be best documented in the case file, is not tantamount to an inspection being void of interviews and hence ineffective. MIOSHA would therefore dispute this is a valid example of MIOSHA's noncompliance with its own policies and procedures.

Notwithstanding MIOSHA's disagreement with the report's characterization of Observation FY2019-OB-2, MIOSHA agrees that several improvements to MIOSHA's practices are appropriate. Therefore, MIOSHA has already initiated, or is in the process of initiating, the following measures:

- Use of diary sheets for all construction enforcement inspections and investigations, consistent with its pre-existing usage in general industry enforcement inspections and investigations.
- Modification and expansion of MIOSHA's content expectations for field narrative documentation in construction investigation and inspection files to provide greater context and chronology for actions taken during field investigations, including interviews.

- Modification of MIOSHA's Field Operations Manual to correct differences in MIOSHA's coding of related activity in the OSHA Information System (OIS) coding compared to OSHA's coding practices.
- Modification of MIOSHA's practices concerning when to open inspections with employers on multi-employer worksites to minimize in-compliance inspections and to ensure that MIOSHA's limited resources are directed toward employers whose workers are exposed to hazards.
- Improved clarity and detail of informal employee interviews in case file documentation.
- Division-level discussion with staff of the fatality case files with observations that were specific to the division. Management will retrain and reiterate the requirements of the FOM and Agency Instruction MIOSHA-COM-15-4R1 Employee Interviews in Safety and Health Investigations for programmed, complaint, referral, and related inspection files.

The following formal response is provided to you to specifically address the finding in the FY 2019 FAME:

Finding FY 2019-01: The percentage of safety (40.91%) and health inspections (47.02%) that were in-compliance was higher than the FRL of 24.24% to 36.36% for safety and 28.90% to 43.35% for health.

State Response: MIOSHA accepts that the percentage of safety and health inspections that were in-compliance was not within an acceptable range. MIOSHA management began to address this issue in September 2019. In MIOSHA's General Industry Safety and Health Division (GISHD), the issue was on the health side; the in-compliance rate for GISHD safety was excellent. GISHD discussed the issue at a manager/supervisor meeting to identify the possible causes and solutions. Since that time, GISHD has put the following corrective actions in place to bring the incompliance rate back to acceptable levels:

- 1. Identify the root causes. Among other ideas, managers and supervisors with staff with high in-compliance rates were instructed to go out in the field with their IHs evaluate their investigation techniques to see if they are thoroughly investigating serious hazards to identify and documenting the ones that actually are there.
- 2. Develop an action plan to address the causes. Managers and supervisors were instructed to develop a written plan to address the root causes.
- 3. Implement the action plan.
- 4. Prevent unintended negative consequences. Management was required to monitor staff to prevent the non-attainment of other goals from decreasing to meet the in-compliance goal.
- 5. Monitor and track. Management was instructed to track the in-compliance rate for their staff. An Excel workbook was developed and provided.
- 6. Report. Management was required to report on the first workday of each month the tracking data.

As of June 30, 2020, GISHD safety had an in-compliance rate of 17.57% with the national rate of 29.75% +/- 20%. GISHD health had an incompliance rate of 34% with the national rate of 35.32% +/-20%. GISHD is currently meeting or exceeding the goal for in-compliance rate.

In the Construction Safety and Health Division (CSHD), the disproportion was present in safety inspections. MIOSHA and CSHD management have attributed many of those disproportionate figures to be the result of MIOSHA's inspection practices related to multi-employer worksites which resulted in initiation of inspections with all contractors on a given worksite at the outset. This resulted in an excess of inspections being generated which, due to that employer's compliance or lack of involvement in the source activity for the inspection, resulted in closure without the issuance of citations, i.e. in-compliance status. To remedy this unintentional and disproportionate result, CSHD has retrained its staff and revised its practices for multi-employer worksites which takes a more focused approach to identify which contractors require inspections to be initiated.

MIOSHA is confident these changes implemented by its two enforcement divisions will rectify the prior disproportion and bring MIOSHA more in-line with anticipated compliance levels.

In conclusion, MIOSHA appreciated working with the evaluation team. The team was courteous in working with our staff. Please know that MIOSHA's commitment to providing a comprehensive and effective program remains firm. MIOSHA will continue to work with the Eau Clair Area OSHA Office and Region V staff to address the single finding and two observations listed in the FY 2019 Comprehensive FAME.

Thank you for this opportunity to submit a statement in response to the FY 2019 Comprehensive FAME Report. If you have questions or would like additional information, please contact me at (517) 284-7772.

Sincerely,

Barton G. Pickelman, CIH

Barton G. Pickelman

MIOSHA Director

cc: Sean Egan, Deputy Director, LEO Nancy Nash, OSHA Region V Darnell Crenshaw, OSHA Region V

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