The Secretary of Labor's Report to the President on the Status of Federal Agencies' Occupational Safety and Health Programs

Calendar Year 2021

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PREFACE

The Occupational Safety and Health Act of 1970 (the Act), Executive Order (EO) 12196, and 29 CFR § 1960 require the heads of federal agencies to submit annual reports on their occupational safety and health (OSH) programs to the Secretary of Labor. Specifically:

- Section 19(a) of the Act (29 United States Code (U.S.C.) § 668(a)) directs, "the head of each Federal agency to establish and maintain an effective and comprehensive occupational safety and health program which is consistent with the occupational safety and health standards promulgated under Section 6" (of the Act (29 U.S.C. § 655)).

- Section 19(a)(5) of the Act (29 U.S.C. § 668(a)(5)) requires each Executive Branch federal agency head to, "make an annual report to the Secretary with respect to occupational accidents and injuries and the agency's program under this section."

- EO 12196, "Occupational Safety and Health Programs for Federal Employees," guides the heads of federal Executive Branch agencies in implementing Section 19 of the Act, and directs the Secretary to issue a set of basic program elements to assist agencies in carrying out their responsibilities.

- Title 29 Code of Federal Regulations (CFR) § 1960, "Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters," establishes the requirements for agency heads to implement OSH programs in their respective agencies.

Section 19(b) of the Act requires the Secretary to inform the President about the status of federal agencies' OSH programs and the accidents and injuries that occurred at federal worksites. This report provides an analysis of the reports each agency submitted to the Secretary, along with an account of the activities that the Occupational Safety and Health Administration (OSHA) conducted at or with federal agencies during Calendar Year (CY) 2021, thereby fulfilling the Secretary's responsibility.

EXECUTIVE SUMMARY

This report summarizes the information federal agencies provided to OSHA in their annual reports, including the injury and illness rates for federal Executive Branch employees, and describes how agencies analyzed trends and improved programs to assess the government's trends and overall progress toward improving worker safety and health. The report covers the CY 2021 reporting period. The coronavirus disease that began in 2019 (COVID-19) and caused a worldwide pandemic, persisted in calendar year 2021, highlighting the importance of the Occupational Safety and Health Administration's (OSHA's) mission "to ensure safe and healthful working conditions for workers by setting and enforcing standards, and by providing training, outreach, education, and assistance." In response to an executive order, OSHA published a COVID-19 National Emphasis Program (NEP) in March 2021 and updated the program a few months later in July. In addition, it published and updated guidance on mitigating and preventing the spread of COVID-19 in the workplace. OSHA continues to assess the effects of the pandemic: providing guidance to employers on how to best protect workers from contracting COVID-19 and enhancing the effectiveness of their OSH programs.

Annual Report Requirement

Section 19(a)(5) of the Act requires each Executive Branch agency to provide an annual report to the Secretary. That report must include information on occupational accidents, injuries, and illnesses, along with details on the agency's program for providing safe and healthful working conditions. In addition, the report should assess the effectiveness of the agency's OSH program.

Reporting Federal Agency Injury and Illness Information Requirement

Per 29 CFR § 1960.72(a), each agency must submit to the Secretary by May 1 of each year all information included on the agency's previous calendar year's occupational injury and illness recordkeeping forms. The information submitted must include all data entered on OSHA Form 300, Log of Work-Related Injuries and Illnesses; OSHA Form 301, Injury and Illness Incident Report; and OSHA Form 300A, Summary of Work-Related Injuries and Illnesses (or respective equivalent forms).

OSHA Activities

OSHA engaged in extensive enforcement, oversight, and compliance assistance activities to address OSH-related issues at federal agencies. Enforcement activities focused on inspections of federal worksites to identify violations of OSHA standards and to monitor agencies' injury and illness rates. Oversight activities consisted of calculating quarterly injury and illness rates and assessing agencies' OSH programs through the annual report submissions. Compliance assistance activities included consulting with federal agencies, explaining the importance of providing safe and healthy working environments, and highlighting best practices or methods to help agencies accomplish this goal.

Enforcement

In CY 2021, OSHA conducted 296 programmed and 326 unprogrammed inspections, respectively, at federal worksites, averaging 2.45 violations per inspection. OSHA inspected federal agencies under a variety of national and local emphasis programs targeting specific hazards (e.g., combustible dust) and types of industries (e.g., maritime). The nationwide Federal

Agency Targeting Inspection Program (FEDTARG) targeted federal agency establishments with high injury and illness rates. Compared to CY 2020, programmed inspections of federal worksites increased by more than 50% and unprogrammed inspections increased nearly 17% in CY 2021. And, while the average number of violations per programmed inspection decreased, the average number of violations per unprogrammed inspection increased. In CY 2021, OSHA issued four federal agency significant/novel cases. Of the four cases, one involved the Department of Interior (DOI), one the Department of Justice (DOJ), while two involved the Department of Veterans Affairs (VA).

Oversight

OSHA assesses federal agencies' occupational safety and health programs by reviewing agencies' injury and illness rates, tracking workers' compensation costs, evaluating their OSH program self-evaluations and tracking their injury and illness submissions. OSHA calculates injury and illness incidence rates for individual agencies using fiscal year (FY) injury and illness claims data reported to the Department of Labor's (DOL's) Office of Workers' Compensation Programs (OWCP), together with employment data from the Office of Personnel Management (OPM). OSHA also tracks workers' compensation costs to document the financial impact of federal worker injuries and illnesses. Workers' compensation benefits provided to employees include payments for medical treatment, rehabilitation services, replacement of lost wages, and compensation benefits to their survivors in cases of death.

OSHA's annual report request to federal agencies provided agencies with the opportunity to assess and improve their OSH programs. In the CY 2021 annual report request, OSHA asked agencies to rate the operations, management, and culture components of their OSH programs using a seven-question tool that helps agencies evaluate how they fulfill specific requirements of 29 CFR § 1960 and EO 12196. Most agencies reportedly met the regulatory requirements of 29 CFR § 1960 and noted improvements such as: extending safety-related communications, tools, resources, and training beyond safety professionals; implementing new policies requiring frequent facility evaluations, which resulted in more robust exposure assessments, improved recordkeeping, and development of controls.

Some agencies identified OSH program areas that needed improvement. A small number indicated that they were not fully aware of their OSH responsibilities or how to implement all the attributes of an effective OSH program. To assist these agencies, OSHA held teleconferences and videoconferences, and when necessary, initiated onsite visits to discuss the agencies' OSH responsibilities and ensure relevant agency personnel understood how to implement all the elements of an effective OSH program.

During the reporting period, OSHA received complete recordkeeping data from 79 agencies (80 percent). Of the remainder, 14 agencies (14 percent) failed to submit any data. OSHA kept a record of the 14 agencies that failed to submit any data, and these non-responder agencies are subject to having their establishments targeted for an OSHA inspection. For agencies that submitted data, the most common submission errors were failures to provide the number of employees or hours worked for an establishment. In addition to the analysis conducted for this report, OSHA will further assess the collection process and available data to identify ways to streamline and simplify the procedure, as well as encourage agencies to submit accurate and timely data.

Compliance Assistance

OSHA assists federal agencies to improve worker safety and health by responding to federal agency technical assistance requests (ATARs), encouraging participation in Field Federal Safety and Health Councils (FFSHCs) and Federal Agency OSH Managers' Roundtables, assisting agencies with developing alternate and/or supplemental standards, and providing training opportunities.

Like the Consultation Programs service for private-sector employers, ATARs provide federal agencies with technical assistance, including hazard abatement advice, training, consultation visits, and/or OSH program assistance through their local OSHA Area Office. While the request is considered consultative, agencies are expected to abate identified hazards and correct violations of the citable program elements of 29 CFR § 1960 or other OSHA standards observed during the visit. During CY 2021, OSHA Area Offices conducted one ATAR at a National Transportation Safety Board investigation site in Dauphin, Pennsylvania.

FFSHCs are federal interagency groups, chartered by the Secretary, that enable local OSH professionals to share knowledge and resources. In CY 2021, 32 FFSHCs worked to improve the effectiveness of OSH functions within the government. Over 30 departments and agencies participated in council activities and more than 2,000 federal employees attended meetings and/or council-provided training. Each year, OSHA assesses the councils' efforts so that the Secretary can recognize those that best exemplify the intent and purpose of the program; in CY 2021, OSHA identified nine FFSHCs to receive a Secretary's award for their activities.

The Federal Agency OSH Managers' Roundtables are a valuable tool that allows agencies to exchange information on safety and health issues and share best practices. For these meetings, OSHA brings national-level OSH managers together to share presentations and discuss current topics of interest. In 2021, OSHA held four Roundtable meetings and addressed a range of topics including alternate and supplemental standards and COVID-19, among others.

Under 29 CFR § 1960.17, if an agency cannot comply with an applicable OSHA standard, it may request permission to comply with an alternate standard to ensure appropriate protection for affected employees. An alternate standard is the federal agency equivalent of a private-sector variance from OSHA standards. There are seven OSHA-approved alternate standards that address air traffic control towers, special-purpose ladders, lifting devices, diving standards, weight-handling equipment, and gas-free engineering.

Under 29 CFR § 1960.18, if no OSHA standard exists for a specific working condition of federal agency employees, an agency must develop a supplementary standard for that working condition and provide the standard to OSHA. Currently, there are two supplementary standards: one addresses explosives, propellants, and pyrotechnics; the other covers portable tank transport.

OSHA provides training opportunities to federal agency OSH personnel through several venues, including the OSHA Training Institute (OTI). Federal OSH personnel may attend any of OTI's professional and technical courses throughout the year. OSHA also provides federal agency OSH personnel with a week of free training at OTI, commonly referred to as FEDWEEK. During FEDWEEK, OSHA provides nine half-day seminars, each offered twice during the week,

covering topics chosen by federal OSH personnel. During 2021, 805 federal employees attended these virtual seminars.

Federal Agency OSH Activities

Fatalities, Hospitalizations, and Amputations

The Act, provisions of 29 CFR § 1960, and other regulations require employers, both private and public, to investigate, track, and promptly report incidents involving work-related fatalities, hospitalizations, and amputations to OSHA.[1] As shown in Table 1, for the CY 2021 reporting period, federal Executive Branch departments and independent agencies reported 96 civilian employee fatalities, 410 hospitalizations, and 32 amputations. Each reported incident is a singular event.

Table 1: Major Department/Agency Incidents Reported for CY 2021

Agency	Fatalities	Hospitalizations	Amputations
Department of Agriculture	7	22	0
Department of Defense	2	8	3
Department of Health and Human Services	0	7	2
Department of Homeland Security	51	121	1
Department of Justice	6	37	12
Department of the Air Force	0	11	4
Department of the Army	1	13	2
Department of the Interior	1	25	0
Department of the Navy	3	10	3
Department of State	2	36	1
Department of Transportation	2	5	0
Department of the Treasury	0	0	1
Department of Veterans Affairs	21	113	2
Peace Corps	0	1	0
Smithsonian Institution	0	1	0
Tennessee Valley Authority	0	0	1
Total	**96**	**410**	**32**

COVID-19 was the leading cause of hospitalizations for CY 2021.

Certified Safety and Health Committees (CSHCs)

Under 29 CFR § 1960, Subpart F, any agency can form a certified safety and health committee (CSHC) to monitor and assist with its OSH program. An agency with a CSHC must have committees at both the national and field/regional levels. The national-level committees provide policy guidance, while the local committees monitor and assist in the execution of the agency's OSH policies. An agency with an approved CSHC is exempt from unannounced OSHA inspections. During CY 2021, the following agencies maintained Secretary-approved CSHCs:

[1] On January 1, 2015, OSHA implemented a new reporting rule requiring employers to report an incident resulting in the hospitalization of one or more employees, rather than three or more employees. In addition, employers must report incidents that result in an amputation or the loss of an eye.

the Central Intelligence Agency (CIA), DOL, and the Tennessee Valley Authority (TVA). These agencies provided information certifying to the Secretary that their respective CSHCs met Subpart F's requirements. Many other agencies have internal OSH committees but have not certified those committees under Subpart F.

Hazard Identification and Control Measures

OSHA asked agencies to report on the two most common causes of injuries and the efforts taken to mitigate those causes. Several agencies reported on their efforts to reduce employee slip, trip, and fall or overexertion injuries through implementing engineering and administrative controls to reduce or eliminate exposure. For example, several agencies reported installing warning signage, implementing proactive housekeeping procedures, and conducting ergonomic assessments. Agencies also conducted annual safety training classes and held agency-wide meetings to improve safety awareness.

Motor Vehicle Safety

OSHA asked for details on agencies' motor vehicle safety programs (MVSPs), including the number of motor vehicle accidents that occurred during the reporting period. In CY 2021, 28 federal agencies with MVSPs reported a total of 10,452 motor vehicle accidents. Most agencies reported having MVSPs that complied with the Executive Orders requiring the use of seatbelts in motor vehicles and banning texting while driving. Some departments and agencies offered hands-on training to employees, such as defensive driving, while most relied on training courses provided through either the General Services Administration (GSA) or the National Safety Council.

Agency Self-Inspections of Safety and Health Programs

Due to the ongoing pandemic in CY 2021, several agencies maintained only essential mission functions in office or official worksite locations, with most or all employees teleworking. Consequently, agencies reported they did not conduct workplace inspections, limited inspection frequency, inspected only high-risk operations, and/or conducted virtual inspections. According to several agencies, workplaces without employees meant self-inspections were unnecessary. Ninety-four percent of responding agencies (84 agencies) selected a rating of "highly effective" or "needs minor improvements" for the self-inspection attribute (see the discussion on the Operational Component's Self-Inspection Attribute for additional information).

Federal Employee Training

Agencies offered a wide range of OSH training opportunities to their employees during CY 2021. While most agencies provided employees with OSH training based on their job responsibilities, some augmented their efforts to ensure that collateral duty OSH personnel received all appropriate training. Many agencies also published OSH information on their websites and in newsletters, encouraged OSH personnel to participate in local FFSHCs and professional OSH organizations, and recognized employees who collaborated with safety professionals to identify and mitigate workplace hazards.

OSH Overseas

Section 19 of the Act, EO 12196, and 29 CFR § 1960 all require agencies to provide safe and healthful workplaces and those requirements have no geographic limits. In CY 2021, Executive Branch agencies reported 129,334 government employees worked overseas and received OSH

coverage through either DoD, the Department of State (State), or their own respective agency programs. All agencies ensured that their employees received prophylactic immunizations, training, and safety and health information prior to deployment.

Whistleblower Protection Programs

As 29 CFR § 1960, Subpart G requires, agencies must ensure that employees are not subjected to restraint, interference, coercion, discrimination, or reprisal for filing a report of unsafe or unhealthy working conditions. In their CY 2021 reports, agencies included information on their whistleblower protection programs, any allegations of reprisal, and their responses to those allegations. Almost all agencies acknowledged their whistleblower responsibilities and reported having well-designed protection programs. Four agencies reportedly investigated whistleblower allegations. Specifically, DoD, State, the Merit Systems Protection Board (MSPB), and National Aeronautics and Space Administration (NASA) investigated claims of reprisal during CY 2021. DoD received 14 formal complaints but did not substantiate any findings of retaliation. State substantiated one of two complaints. MSPB's single whistleblower complaint is currently in litigation. NASA had three complaints filed: two were unsubstantiated; one investigation is ongoing.

Product Safety

Federal agencies reported on compliance with the provisions of 29 CFR § 1960.34, which addresses the potential conflicts in standards for federal buildings, leased space, products purchased or supplied, and other requirements affecting federal employee safety and health. Specifically, agencies described how they comply with the product safety requirements of the standard, including using Safety Data Sheets (SDSs), and responding to product recalls. Two agencies (2 percent) indicated the absence of a product safety program and claimed they do not use chemicals while 73 (82 percent) reported being in compliance with the standard. OSHA will continue to work with agencies that are not in compliance to ensure they understand their responsibilities in this area.

Accomplishments

Agencies reported on a broad range of OSH program improvements, such as revising existing policies, procedures, and manuals; implementing new OSH training; and establishing new training methods. In addition, agencies increased the frequency of facility inspections and used risk assessment findings to develop relevant training. Overall, most agencies noted considerable resource expenditures to increase safety awareness and develop robust OSH programs.

Agencies Failing to Submit Annual Reports

While OSHA granted successive extensions to several agencies, and repeatedly contacted them with reminders of the requirement to submit an annual report, the following agencies failed to submit their reports as required under Section 19(a)(5) of the Act:

- Advisory Council on Historic Preservation
- African Development Foundation
- Commission of Fine Arts
- Commodity Futures Trading Commission
- Corporation for National Community Service

- Department of Housing and Urban Development
- Harry S. Truman Foundation
- Millennium Challenge Corporation
- Office of Special Counsel
- Selective Service System

THE SECRETARY'S REPORT TO THE PRESIDENT

SECTION 1 – OSHA ACTIVITIES

This section discusses OSHA's enforcement, oversight, and compliance assistance activities; significant/novel enforcement cases involving federal agencies; and agencies' self-evaluations of their OSH programs using components of a provided safety and health evaluation tool. Further, this section includes information on recordkeeping; agencies' reports on fatalities, hospitalizations, and amputations; and OSHA training opportunities available solely to federal personnel.

Enforcement

Inspections

OSHA's federal workplace inspections assess agencies' compliance with safety and health standards, as well as the requirements of 29 CFR § 1960, thus reducing the number of on-the-job hazards. Inspections commonly fall into one of two categories: programmed or unprogrammed. Programmed inspections generally focus resources on a particular safety or health issue, workplaces associated with specific hazards or adverse health outcomes/effects, and establishments where there are high rates of injuries and illnesses. Unprogrammed inspections occur primarily in response to employee complaints about, or notifications of, serious hazards.

OSHA further categorizes inspections as related to either safety or health. Safety inspections focus on workplace issues such as means of egress, electrical hazards, machine guarding, or confined space entry procedures. Health inspections may focus on worker exposures to specific chemical respiratory hazards, infectious disease agents, or physical hazards such as occupational noise and ergonomics. If OSHA discovers that workplace exposures to safety and/or health hazards exist, it documents the conditions and determines whether they violate an OSHA standard. For federal agencies OSHA issues "Notices of Unsafe or Unhealthful Working Conditions" (Notices), similar to private sector citations but without monetary penalties.

As in the private sector, different types of violations indicate the severity of the hazard or the agency's response to the condition:

- "De Minimis" violations have no direct or immediate relationship to safety or health and do not result in a Notice.
- Other-Than-Serious violations describe hazards that cannot reasonably be predicted to cause death or serious physical harm to exposed employees but have a direct and immediate relationship to their safety and health.
- Serious violations involve hazards that could cause injury or illness that would most likely result in death or serious physical harm to the employee(s).
- Willful violations exist where an agency has demonstrated either an intentional disregard for the requirements of the Act or a plain indifference to employee safety and health.
- Repeat violations occur when an agency's prior Notice for the same or a substantially similar condition has become a final order.
- Failure-To-Abate violations occur when the agency fails to correct a violation for which OSHA has issued a Notice, and the abatement date has passed or is covered under a

settlement agreement. A failure-to-abate also exists when the agency has failed to comply with the interim measures of a long-term abatement within the given timeframe.

OSHA conducted 296 programmed and 326 unprogrammed inspections at federal workplaces with an average of 2.45 violations for both types of inspections. OSHA found that 44.0 percent of establishments receiving programmed inspections and 59.2 percent receiving unprogrammed inspections were in compliance with safety and health standards. Overall, in CY 2021, OSHA identified 489 total violations during inspections.

OSHA continued to conduct programmed inspections that focused on specific federal agency establishments/hazards during CY 2021. As illustrated in Table 2, both programmed and unprogrammed inspection activity increased in CY 2021 as compared to CY 2020.

Table 2. OSHA Federal Agency Inspection Activity, CY 2019 – 2021.

	2021	2020	2019
Programmed Inspections	296	195	388
Percent in Compliance	44.0	20.0	30.4
Average Number of Violations	2.45	2.55	3.07
Serious, Willful, Repeat Violations	289	374	529
Percent of Violations Issued as Serious, Willful, Repeat	71.5	75.3	76.8
Unprogrammed Inspections	326	279	323
Percent in Compliance	59.2	63.1	51.1
Average Number of Violations	2.45	2.33	2.23
Serious, Willful, Repeat Violations	200	172	261
Percent of Violations Issued as Serious, Willful, Repeat	74.1	80.8	76.5
Total	**622**	**474**	**711**

Significant/Novel Cases

Although by law OSHA cannot assess penalties against federal agencies, it can determine the equivalent penalties that it would have assessed had the case involved a private sector employer. Federal agency significant cases involve equivalent penalties over $200,000. Novel cases involve specific enforcement issues. In addition, some federal agency enforcement actions become "significant/novel cases" because they require higher level review prior to headquarters-level interagency communication and discussions.

OSHA issued four federal agency significant/novel case reports in CY 2021. OSHA developed single cases against DOI and DOJ, and two cases against the VA, respectively. Table 3 provides details on the four cases.

Table 3. Summary of Federal Agency Significant/Novel Cases.

Department/Agency	Inspection Type	Violations
DOI – Bureau of Land Management Cliffside Helium Enrichment Unit Amarillo, Texas	Unprogrammed – Safety Referral	Willful: 1 Willful Repeat: 5 Serious: 12 Other-Than-Serious: 3

Department/Agency	Inspection Type	Violations
OSHA initiated the inspection due to BLM's failures to: inspect and test its process equipment and train operators on its energy control program. It was the first egregious case against a federal agency. An egregious inspection is a violation-by-violation inspection, which OSHA applies when an employer demonstrates one or more of: (1) persistently high rates of illness/injury or fatalities; (2) extensive history of prior violations; (3) intentional disregard of health and safety responsibilities; or (4) bad faith (a plain indifference to standards or requirements). In this case, OSHA issued one Willful violation for lack of LOTO training; Willful Repeats for failing to inspect or test Process Safety Management (PSM) equipment; 12 Serious violations for deficiencies in the PSM program; and three Other-than-Serious (OTS) violations for failing to follow program element regulations in 29 CFR 1960.		
DOJ – Federal Bureau of Prisons Federal Detention Center Honolulu, Hawaii	Unprogrammed – Complaint	Serious: 3 Other-Than-Serious: 1
OSHA initiated this inspection following a complaint alleging exposure to COVID-19. OSHA issued three Serious violations for failing to provide employees with necessary respirators, lack of annual fit testing, and for allowing unvaccinated employees to continue working after being in close contact with those infected with COVID-19. OSHA issued an OTS violation for failing to document fit tests.		
VA – Connecticut Healthcare System West Haven, Connecticut	Unprogrammed – Fatality	Willful: 1 Repeat: 3 Serious: 5
OSHA initiated this inspection after the VA reported two fatalities due to a sudden steam release. OSHA issued a Willful violation for failing to use or document LOTO procedures; three Repeat violations for failing to: annually review LOTO procedures, train employees, and ensure employees followed group LOTO regulations; and, five Serious violations for exposing employees to struck-by and thermal hazards, and other LOTO deficiencies.		
VA – Veterans Health Administration Salt Lake City, Utah	Unprogrammed – Complaint	Repeat: 1 Other-Than-Serious: 1
OSHA initiated this inspection following notification of an employee hospitalization due to COVID-19. OSHA issued a Repeat violation for failing to provide employees with medical evaluations prior to using respirators, and an OTS violation for lack of a written recommendation for medical evaluations.		

Oversight

Injury and Illness Statistics and Workers' Compensation Costs

OSHA calculates injury and illness incidence rates for individual agencies using FY injury and illness claims data reported to OWCP together with OPM's employment data.[2] In FY 2021,

[2] OWCP data are available only on an FY basis.

federal government employment increased by 48,460 (2.19 percent) to 2,261,359 employees. The total injury and illness cases increased by 5,064 (14 percent) to 40,141 and the total case rate increased 12 percent from 1.59 occurrences per 100 to 1.78. The Government's lost-time cases increased 25 percent from 5,411 to 27,240 and its lost-time case rate increased 21 percent from 0.99 occurrences per 100 to 1.20.

The costs related to the Federal Employees Compensation Act (workers compensation for the federal sector) for chargeback year (CBY) 2021 were approximately $1.33 billion compared to CBY 2020's $1.4 billion, CBY 2019's $1.5 billion, and CBY 2018's $1.5 billion.[3] Workers' compensation benefits provided to employees include payments for medical treatment, rehabilitation services, replacement of lost wages, and compensation benefits to their survivors in cases of death.

Evaluations

As 29 CFR § 1960.80 and Section 1-401(h) of EO 12196 both require, OSHA evaluated agencies' OSH programs. Under 29 CFR § 1960 agencies must develop and maintain effective safety and health management systems. Within this framework, OSHA assesses whether agencies regularly monitor, modify, and if necessary, implement OSH program policies and procedures to correct problems, adapt to changing worksite environments, and promote workplace safety and health.

To assess federal agencies OSH programs, OSHA used parts of an evaluation tool – Form 33 – it developed in 1985 and validated to measure the effectiveness of private sector employers' safety and health management systems. For the past several years OSHA has asked agencies to evaluate their programs using specific elements of Form 33. Based on the concept of an organizational safety and health program, Form 33 uses 58 attributes to assess the three main components of a structured OSH program: operations, management, and culture.

The operational component measures whether a program has a well-defined and communicated system to identify, correct, and control hazards. The managerial component assesses whether the program incorporates effective planning, administration, training, leadership, and supervision to support the prevention or elimination of workplace hazards. Finally, the cultural component evaluates whether the program has developed an effective culture in which management and labor collaborate to successfully reduce or eliminate hazards. While the attributes within each of the components are distinct, they are interdependent.

For the CY 2021 report, OSHA asked agencies to assess their OSH programs using the following seven of the tool's 58 attributes.

[3] On September 28, 1998, Congress amended the Occupational Safety and Health Act (the Act) to make it applicable to the U.S. Postal Service in the same manner as any other employer subject to the Act. Therefore, the U.S. Postal Service is not included in this report.

Table 4 – Evaluation Components and Attributes

Operational Component – 2 Attributes
Hazard Anticipation and Detection • **Effective safety and health self-inspections are performed regularly** determines if personnel in the agency regularly perform effective OSH inspections. **Hazard Prevention and Control** • **Effective safety and health rules and work practices are in place** determines if the agency has established both general workplace rules and specific work practices that prescribe safe and healthful behavior and task performance methods.
Managerial Component – 3 Attributes
Planning and Evaluation • **Hazard incidence data are effectively analyzed** determines if the agency uses hazard incidence data to set safety and health priorities. • **A review of the overall safety and health management system is conducted at least annually** determines if the agency periodically audits the management aspects of its SHMS, identifying progress and needed changes/improvements. **Administration and Supervision** • **Individuals with assigned safety and health responsibilities have the necessary knowledge, skills, and timely information to perform their duties** determines if the agency's personnel have the understanding, skill, and current information needed to effectively fulfill their OSH responsibilities.
Cultural Component – 2 Attributes
Management Leadership • **Managers allocate the resources needed to properly support the agency's safety and health program** determines if the agency's managers demonstrate OSH leadership, promote a culture of safety and health in the organization, and support effective operation of the OSH program by allocating needed resources. **Employee Participation** • **There is an effective process to involve employees in safety and health issues** determines if there is an established organizational process that employees know, trust, and use to provide input regarding safety and health issues.

OSHA asked agencies to rate each of the seven attributes based on their CY 2021 reporting period experiences and select one of the following responses:

- does not exist – the attribute was not in place at all;
- needs major improvements – some aspect of the attribute is present but it needs major improvements;
- needs minor improvements – some aspect of the attribute is present but it needs minor improvements;
- is highly effective – the attribute was completely effective and integrated into the OSH program without the need for improvement; or
- not applicable – the agency thought an attribute did not apply to its program.

In addition to scoring each attribute, OSHA asked agencies to provide detailed information supporting each chosen attribute rating.

Overall Assessment

For the CY 2021 reporting period, OSHA received responses from 88 of 98 agencies, a 91 percent response rate. Of the responding agencies, 22 (25 percent) provided an average rating of "highly effective" for each of the seven attributes, and 48 agencies (55 percent) indicated most of their OSH program components needed minor improvements. Fourteen of the responding agencies (16 percent) reported that most elements of their OSH programs required major improvements. Three agencies (3 percent) indicated that most OSH program elements did not exist.

According to their assessments, overall, agencies recognized the benefits of effective safety and health programs. Several reported a commitment to safety but also noted a lack of safety and health or collateral duty staff in CY 2021. These agencies further opined that because their operations were solely administrative, and they employed only a few workers, the attributes were inapplicable.

Table 5a. Average Safety and Health Program Ratings for Major Departments/Independent Agencies.

Agency	Rating	Agency	Rating
Department of Agriculture	●	Department of Veterans Affairs	▲
Department of Commerce	▲	Department of the Air Force	▲
Department of Defense	▲	Department of the Army	●
Department of Education	▲	Department of the Interior	▲
Department of Energy	▲	Department of the Navy	▲
Department of Health and Human Services	▲	Department of the Treasury	▲
Department of Homeland Security	★	Environmental Protection Agency	▲
Department of Housing and Urban Development	▲	General Services Administration	▲
Department of Justice	▲	National Aeronautics and Space Administration	★
Department of Labor	▲	Social Security Administration	★
Department of State	▲	Tennessee Valley Authority	▲
Department of Transportation	▲		

Legend

★ Highly Effective – Completely in place
▲ Needs Minor Improvements – Mostly in place but needs minor improvements
● Needs Major Improvements – Some portion/aspect is present but needs major improvements
O Does Not Exist – No discernible indication that any portion/aspect exists
NR – Agency did not provide a response

Table 5b. Average Safety and Health Program Ratings for Smaller Independent Agencies.

Agency	Rating	Agency	Rating
AbilityOne Commission	●	International Trade Commission	▲
Access Board	▲	James Madison Memorial Fellowship Foundation	★
Advisory Council on Historic Preservation	NR	John F. Kennedy Center for the Performing Arts	▲
African Development Foundation	NR	Marine Mammal Commission	▲
Agency for Global Media	▲	Merit Systems Protection Board	▲
Agency for International Development	▲	Millennium Challenge Corporation	NR
American Battle Monuments Commission	▲	Morris K. Udall & Stewart L. Udall Foundation	▲
Armed Forces Retirement Home	▲	National Archives and Records Administration	★
Central Intelligence Agency	▲	National Capital Planning Commission	▲
Chemical Safety and Hazard Investigation Board	★	National Council on Disability	★
Commission of Fine Arts	NR	National Credit Union Administration	▲
Commission on Civil Rights	▲	National Endowment for the Arts	★
Commodity Futures Trading Commission	NR	National Endowment for the Humanities	★
Consumer Product Safety Commission	★	National Gallery of Art	★
Corporation for National Community Service	NR	National Labor Relations Board	★
Court Services and Offender Supervision Agency	★	National Mediation Board	★
Defense Nuclear Facilities Safety Board	▲	National Science Foundation	★
Equal Employment Opportunity Commission	★	National Transportation Safety Board	★
Export-Import Bank of the United States	▲	Nuclear Regulatory Commission	★
Farm Credit Administration	▲	Nuclear Waste Technical Review Board	▲
Federal Communications Commission	★	Occupational Safety and Health Review Commission	★
Federal Deposit Insurance Corporation	★	Office of Government Ethics	★
Federal Election Commission	★	Office of Navajo and Hopi Indian Relocation	★
Federal Energy Regulatory Commission	★	Office of Personnel Management	▲

Agency	Rating	Agency	Rating
Federal Housing Finance Agency	●	Office of Special Counsel	NR
Federal Labor Relations Authority	●	Peace Corps	●
Federal Maritime Commission	★	Pension Benefit Guaranty Corporation	▲
Federal Mediation and Conciliation Services	★	Postal Regulatory Commission	▲
Federal Mine Safety and Health Review Commission	★	Presidio Trust	▲
Federal Reserve Board	▲	Railroad Retirement Board	★
Federal Retirement Thrift Investment Board	★	Securities and Exchange Commission	★
Federal Trade Commission	★	Selective Service System	NR
Harry S. Truman Foundation	NR	Small Business Administration	▲
Holocaust Memorial Museum	★	Smithsonian Institution	★
Institute of Museum and Library Services	★	Social Security Advisory Board	▲
Inter-American Foundation	▲	Trade and Development Agency	▲
International Boundary and Water Commission	★		

Legend

★ Highly Effective – Completely in place
▲ Needs Minor Improvements – Mostly in place but needs minor improvements
● Needs Major Improvements – Some portion/aspect is present but needs major improvements
O Does Not Exist – No discernible indication that any portion/aspect exists
NR – Agency did not provide a response

Operational Component Assessment

Most agencies reported that both operational component attributes were generally effective. Specifically, 75 agencies (85 percent) rated their self-inspection attribute as "needs minor improvements" or "highly effective." Most agencies stated that their methods for hazard recognition and control included employee identification and reports to managers and safety personnel verbally and by email. Some agencies maintained electronic hazard reporting systems and anonymous hotlines.

DoD reported that each division had work location specific procedures that provided the most efficient processes for reporting workplace hazards. These procedures included provisions for anonymity, prompt and impartial reprisal investigations, and administrative actions on any substantiated allegations. DoD noted that supervisors and employees received training in local hazard reporting procedures during new employee and supervisor orientation training and routine annual safety training and were encouraged to report workplace hazards without fear of reprisal. Examples of such policies and procedures include: recognition programs acknowledging those who collaborate with safety professionals to mitigate and identify workplace hazards; use of on-line, intranet hazard reporting systems; establishment of organizational reporting hotlines or help desks; daily task briefings encouraging identification and reporting of hazards; use of "Report a Hazard" buttons (links) located strategically throughout the Agency's information management

platforms; and distribution of periodic "Safety Grams" that include reminders and procedures for hazard reporting.

In CY 2021, agencies with onsite workforces reported conducting regular self-inspections to ensure compliance with applicable OSH standards. The Armed Forces Retirement Home (AFRH), for example, noted that it performed cyclical daily inspections in all areas accessible to its residents, employees, and visitors, immediately correcting identified deficiencies or tracking them until abated. It used deficiencies demonstrating a pattern or trend as the basis for staff education and training. DHS requires all subagencies to complete annual self-assessment worksheets that allow departmental OSH personnel to assess subagencies' OSH programs. Additionally, subagencies use internal self-inspections to evaluate their OSH programs and conduct safety inspections.

Nearly all agencies (85; 97 percent) rated themselves as "needs minor improvements" or "highly effective" for the work rules and practices attribute, claiming that policies and procedures supported robust OSH programs, with several reportedly implementing engineering controls to eliminate or reduce workplace hazards. DOI's Office of Occupational Safety and Health established a set of Department-wide polices for administering its safety and health program while its subagencies maintained a collection of policies and procedures to administer their respective programs. DOI worked with its subagencies and respective field staff to continually evaluate OSH-related policies, procedures, and practices.

A few agencies indicated a need for major improvements in the operational component. For example, one agency (1 percent) provided a rating of "needs major improvements" and "does not exist" for the self-inspection attribute. To address this concern, in January 2021, the Army developed and fielded an information management system application for hazard management. The application mandates using the assessments, inspections, and survey tools within 24 months of fielding to support enterprise continuity, inspection visibility, and hazard management; and provides leaders with data on hazards identified during assessments and inspections.

In CY 2021, a few agencies provided ratings of "not applicable" or "not reported" for the self-inspections (nine agencies; 10 percent) and work rules and practices (two agencies; 2 percent) attributes. OSHA continues to work with these agencies to help them implement these programs.

Managerial Component Assessment

Agencies reported that all three attributes of the managerial component were generally effective, rating them "needs minor improvements" or "highly effective." Of the 88 responding agencies, 63 (71 percent) provided higher ratings for the incident data attribute.

DOE reported that its OSH team had the necessary knowledge and skills to perform required duties under current program guidelines, but did not always receive timely information, suggesting that employees could benefit from additional training. It continued to look for ways to improve and expand the overall OSH program and reported that it plans to review its policy and procedures during CY 2022 and implement additional training in CY 2023 if necessary.

Agencies providing higher ratings on the attribute addressing the effective analysis of hazard incidence data (63 agencies; 72 percent) offered examples of the process. DOT noted that it used

DOL's ECOMP internet portal for reporting all employee injuries and illnesses and routinely analyzed hazards and employee injuries during the accident investigation and reporting process. Its safety personnel reviewed accidents for trends and identified control measures to help prevent similar recurrences while also evaluating the safety of high hazard areas, facilities, or tasks.

Agencies providing the higher ratings on the annual SHMS review attribute (70 agencies, 80 percent) offered examples assessment and program improvement techniques. DHS conducted an annual evaluation of each of its divisions to ensure it complied with federal and DHS safety standards, identified/controlled risks, and prevented workplace injuries by focusing leadership's attention on critical safety and health issues. DoD organizations at all levels annually assessed their SHMS program performance and received an external assessment at least every four years. DoD continued to operate its Safety Management Center of Excellence, which has provided tailored, site-specific SHMS support to DoD organizations. Agencies that reported lower ratings for this attribute indicated either that they were implementing a SHMS or working to improve a system already in place. For example, in January 2022, the Peace Corps issued a revised policy for staff safety and health along with initial procedures for selected issues and hazards. The initial procedures included an annual review of the OSH program.

Within the managerial component, the knowledge, skills, and information attribute used to assess the Administration/Supervision subcomponent received the highest number of "needs minor improvements" and "highly effective" ratings (82 agencies; 93 percent).

Like many agencies, AFRH reported that individual facility Safety Officers were responsible for conducting inspections, and monitoring and reporting safety requirements. To ensure that its Safety Officers were well prepared to perform their duties, AFRH provided training on NFPA's Life Safety Code and OSHA regulations, and required continuing education. According to DoD, its subagencies must provide personnel with the OSH training and education necessary to competently fulfill their roles and responsibilities for implementing OSH programs and risk management. Commanders and Senior Management Officials provided education to leaders and supervisors at all levels on OSH policies, procedures, and initiatives. Full-time OSH staff provided formal and informal training to more junior staff and collateral duty personnel. DoD affirmed a commitment to providing continuing education and professional credentialing for OSH personnel through cost reimbursement or sponsorship programs.

While overall the ratings suggested relatively strong managerial components for agencies' safety programs, a few agencies assessed various relevant attributes as "not applicable" or simply did not respond. Specifically, 16 agencies (18 percent), six agencies (7 percent), and one agency (1 percent) selected "not applicable" or "not reported" ratings for the incidence data; annual SHMS review; and knowledge, skills, and information attributes; respectively. OSHA will work with these agencies to determine how best to incorporate some level of managerial aspects to ensure the safety of their workforces.

Cultural Component Assessment

Like the other two components, most federal agencies provided a "needs minor improvements" or "highly effective" rating for both cultural component attributes. For resource allocation, 80 agencies (91 percent) selected either "needs minor improvements" or "highly effective," while four agencies (5 percent) rated the attribute as "not applicable" or "not rated." Most agencies

reported that managers received the resources they needed to support their OSH programs and several, such as the Federal Trade Commission (FTC), obtained budgetary program support. Agencies that self-assessed lower ratings, such as the Peace Corps, lacked support but said they were working to improve access to the necessary resources.

Regarding the process involvement attribute, 83 agencies (94 percent) provided a "highly effective" or "needs minor improvements" rating. Several agencies reported having an effective process for involving employees in safety issues. The Chemical Safety and Hazard Investigation Board (CSHIB), for example, reported that it typically solicited employee involvement through e-mail postings, "all hands" meetings, and small group debrief meetings. It also held periodic investigator training sessions, and conducted anonymous safety perception surveys during Safe + Sound Week. The Defense Nuclear Facilities Safety Board (DNFSB) noted a large and very involved cadre of safety professionals. Other agencies, such as the Department of Commerce (Commerce), used employee engagement strategies such as electronic and print media, along with in-person presentations, meetings, and personal conversations.

Agencies with a lower rating for employee involvement generally described lacking a designated OSH officer. The USDA reported that its headquarters does not have a process in place for this attribute because its Safety Officer position had been vacant since August 2020.

As with other assessment components, some agencies omitted responses for cultural attributes. Four agencies (5 percent) rated the resource allocation attribute as either "not applicable" or "not reported," while one agency (1 percent) provided a similar response regarding the process involvement attribute. OSHA continues to work with agencies to ensure they fully understand the importance of managerial leadership and employee involvement.

Recordkeeping

As set forth in 29 CFR § 1960, federal agencies must maintain injury and illness records in a similar format as the private sector. The recordkeeping requirement allows agencies and OSHA to identify worksites with the highest injury and illness rates and assess federal agency training needs. The Bureau of Labor Statistics (BLS) annually collects the required injury and illness records from all Executive Branch agencies and provides the records to OSHA.

The OSHA data collection cycle first began in CY 2014; the eighth completed data collection cycle occurred in CY 2021. OSHA provided agencies with guidance on the data collection process and followed up with information on errors identified in the submissions. Working with BLS, OSHA tracked the data collected and monitored its quality. In addition, OSHA worked with OWCP to assist agencies using the Employees' Compensation Operations & Management Portal[4] (ECOMP) to explain the procedures for transferring the data from ECOMP to BLS.

During the reporting period, OSHA received complete establishment data from 79 of 98 agencies (81 percent) and partial data from an additional five agencies (5 percent). The most common errors were failures to provide the number of employees or hours worked for each establishment. OSHA will analyze the collected data for key findings and the collection process for lessons

[4] ECOMP is an electronic claim filing system for OWCP information that also allows federal agencies to maintain their OSHA-required injury and illness data.

learned to further streamline and simplify the procedure. In addition, OSHA will work with BLS to improve the response rate.

Compliance Assistance

Agency Technical Assistance Request

OSHA's ATAR service resembles the Consultation Program OSHA provides for private-sector employers. Federal agencies may contact an OSHA Area Office and request technical assistance, such as hazard abatement advice, training, a partial or comprehensive visit, and/or program assistance. While the request is consultative, an agency's subsequent failure or refusal to abate serious hazards may result in an inspection referral.

In CY 2021, the Harrisburg, Pennsylvania Area Office conducted OSHA's sole ATAR for the National Transportation Safety Board in Dauphin, Pennsylvania. The AO conducted a health-related ATAR for noise monitoring while investigating an accident involving a railroad spiker.

Field Federal Safety and Health Councils

FFSHCs are federal interagency groups, chartered by the Secretary, that bring local OSH professionals together for education, problem solving, and cooperation in the safety and health field. Located throughout the nation, FFSHCs work to reduce the incidence, severity, and cost of accidents, injuries, and illnesses within their designated geographic areas.

In CY 2021, 32 FFSHCs (see Appendix 1 for a list of FFSHCs by OSHA region) actively carried out efforts to improve the effectiveness of OSH functions within the government. According to the annual reports submitted to OSHA, 35 departments and agencies participated in the FFSHCs and more than 2,000 federal employees attended meetings and/or council-provided training. Participation decreased for some because of limited funds and personnel shortages.

Agency involvement in council activities varied from extensive engagement to occasional attendance at FFSHC meetings. DoD, for example, reported that approximately 20 percent of its subagencies participated in local FFSHCs during CY 2021. GSA reported that all regions and the headquarters office supported employee participation, while NASA said that its field centers participated, and both DOT and EPA reported encouraging employees to attend meetings and hold leadership positions.

Under 29 CFR § 1960.89, each active FFSHC must submit an annual report to the Secretary describing activities and programs for the previous calendar year along with plans, objectives, and goals for the current year. OSHA uses these reports to assess each FFSHC's program plans to determine the success of these goals and objectives. The FFSHCs that best exemplify the intent and purpose of the FFSHC program may receive an achievement award from the Secretary.

In determining award recipients, OSHA forms three categories, based on the size of the federal populations served, which allows FFSHCs to compete with other councils that have similar resources. OSHA evaluates and rates each council's annual report, ranking it against other

FFSHCs in its category. The top three FFSHCs in each category receive awards for Superior Performance, Meritorious Achievement, and Notable Recognition.

In CY 2021, OSHA identified nine FFSHCs as eligible for a Secretary's Award for their activities. By category, these were:

Category I: Federal employee population exceeding 24,000
- Superior Performance – Greater Kansas City
- Meritorious Achievement – Atlanta
- Notable Recognition – Dallas/Fort Worth

Category II: Federal employee population between 12,000 and 24,000
- Superior Performance – Puerto Rico
- Meritorious Achievement – Minneapolis
- Notable Recognition – North Carolina

Category III: Federal employee population of fewer than 12,000
- Superior Performance – Mississippi Gulf Coast
- Meritorious Achievement – Louisville Area
- Notable Recognition – Greater Des Moines

Alternate and Supplementary Standards

Under 29 CFR § 1960.17, if an agency cannot comply with an applicable OSHA standard, it may submit a request to OSHA to comply with an alternate standard.[5] There are seven OSHA-approved alternate standards:
- Federal Aviation Administration – Alternate Standard for Fire Safety in Air Traffic Control Towers;
- National Archives and Records Administration – Standard on Special-Purpose Ladders;
- NASA – Standard for Lifting Devices and Equipment;
- NASA – Alternate Standard for Diving Operations
- National Oceanic and Atmospheric Administration – Alternate Diving Standards;
- Department of the Navy (Navy), Naval Facilities Engineering Command – Management of Weight-Handling Equipment; and
- Navy – Gas Free Engineering Manual.

Under 29 CFR § 1960.18, if no existing OSHA standard applies to a working condition of an agency's federal employees, the agency must develop a supplementary standard. There are two supplementary standards:
- NASA – Safety Standard for Explosives, Propellants, and Pyrotechnics; and
- DOI/National Park Service – Supplementary Standard for Containers and Portable Tanks Transport.

[5] An alternate standard is the federal sector's equivalent of a private-sector variance. Any alternate standard must provide protection for affected federal employees that is equal to or greater than the applicable OSHA standard.

FEDWEEK

Each year, OSHA provides a week of training, known as FEDWEEK, specifically for federal agency OSH personnel at OTI in Arlington Heights, Illinois. OSHA seeks input from federal agencies and federal OSH personnel when developing the FEDWEEK curriculum. While attendance decreased slightly, there were more federal agencies represented at the CY 2019 event than in prior years (Table 7). In CY 2019, the participant count substantially increased due to the virtual attendance option. OSHA provided nine half-day seminars and offered twice during the week. Due to the COVID-19 pandemic OTI cancelled the event in CY 2020. Following that cancellation, in CY 2021, OSHA provided nine virtual half-day seminars where federal OSH participants could attend up to six different sessions on: fall protection, cranes in construction, electrical standards, emergency preparedness at the federal workplace, management of change, safety and health programs for federal agencies, lead hazard awareness, managing an effective respiratory protection program, and industrial hygiene sampling.

Table 7: FEDWEEK Participation by Attendees and Calendar Year (2019-2021).

	Calendar Year		
	2021	2020	2019
Participants	805	*	80
Agencies Represented	30	*	30

* CY 2020 training cancelled due to the COVID-19 pandemic.

Federal Agency OSH Managers' Roundtable

The Federal Agency OSH Managers' Roundtable is a valuable tool that allows agencies to exchange information on safety and health issues and best practices. For these meetings, OSHA brings national-level OSH managers together to share presentations and discuss current topics of interest. In 2021, OSHA held Roundtable meetings in February, May, August, and November and addressed a range of topics, such as DOL's COVID-19 Safe Workplace Plan, COVID-19 policy updates, and baseline hazard assessment surveys at headquarters-level facilities. Individual agency presentations included information on DoD's response to COVID-19, an overview of DOL's FFSHC program, and DoD's development of Occupational Exposure Limits. In addition to scheduled presentation topics, all roundtable meetings include a general discussion session to allow federal agency representatives to talk about their experiences with the topics presented and/or express concerns about safety and health issues in their respective agencies.

SECTION 2 – FEDERAL AGENCY OSH ACTIVITIES

This section contains agency-specific OSH program information. Agencies' annual reports include data on fatalities, hospitalizations, and amputations; injury and illness trend analyses and hazard mitigation methods; OSH training programs; OSH committee and council participation; and whistleblower protection provisions.

In accordance with 29 CFR §§ 1960.34 and 1960.35, GSA and the National Institute for Occupational Safety and Health (NIOSH), respectively, must provide specified services to federal agencies to support improved safety and health conditions for federal employees. This section ends with summaries of their reported activities.

Fatalities, Hospitalizations, and Amputations

The Act, provisions of 29 CFR § 1960, and other regulations require employers to investigate, track, and promptly report to OSHA incidents that involve work-related fatalities, hospitalizations, and amputations.

Major Departments and Agencies

Over the course of CY 2021, the departments and agencies reported 538 fatalities, hospitalizations, and amputations. Since not all agencies submitted reports for both CY 20 and 21, annual comparisons are limited to individual departments or agencies. Reported incidents decreased at 10 of the departments/agencies, while increasing at eight.

Department and/or agency summaries follow Table 8a only for those departments and agencies that realized a significant year-over-year change within the context of the overall reported number. For example, while DOJ's total reports increased by 450 percent, the department reported no fatalities or amputations in CY 2020, but six fatalities and 12 amputations in CY 2021. Given this context, no further assessment was necessary or relevant.

Table 8a: Major Department/Agency Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Agencies	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Department of Agriculture	1	7	18	22	1	0	↑	45
Department of Defense	1	2	8	8	4	3	↔	0
Department of Health and Human Services	10	0	39	7	0	2	↓	76
Department of Homeland Security	23	51	46	121	2	1	↑	58
Department of Justice	0	6	10	37	0	12	↑	450
Department of the Air Force	0	0	10	11	3	4	↑	13

Agencies	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change	
Department of the Army	2	1	25	13	1	2	↓	42
Department of the Interior	2	1	4	25	3	0	↑	65
Department of the Navy	4	3	16	10	0	3	↓	20
Department of the State	1	2	16	36	0	1	↑	56
Department of Veterans Affairs	25	21	68	113	0	2	↑	46

The ↑ indicates a respective increase, ↓ indicates a respective decrease, and ↔ indicates no change in the Total Reports in CY 2021 compared to CY 2020.

Major Department/Agency Summaries

The Department of Agriculture reported 45 percent more incidents in CY 2021 than in CY 2020. Overall, while USDA's workers experienced fewer slips, trips, falls; and falls from height, every incident resulted in a hospitalization. Of course, as was the case with most agencies, USDA's COVID-19 related hospitalizations increased.

Table 8b: USDA Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change	
Crushed by, caught in	0	0	0	1	1	0	↔	0
Fall	0	1	1	2	0	0	↑	66
Fire	1	0	3	2	0	0	↓	50
Fitness	0	0	0	2	0	0	↑	200
Heat, dehydration	0	0	1	4	0	0	↑	60
Horse	0	0	0	1	0	0	↑	100
Illness	0	0	1	0	0	0	↓	100
Slip, trip, fall	0	0	5	0	0	0	↓	500
Strain, over-exertion	0	0	0	1	0	0	↑	100
Struck, struck by	0	1	3	0	0	0	↓	50
Unclassified	0	0	0	1	0	0	↑	100
Vehicular (land)	0	0	4	6	0	0	↑	33
Vehicular (air)	0	1	0	0	0	0	↑	100
COVID-19	0	4	0	2	0	0	↑	600
Total	**1**	**7**	**18**	**22**	**1**	**0**	↑	**45**

The **Department of Defense** reported a 25 percent increase in incidents: from nine to 12. In CY 2021 there was one fatality, eight more hospitalizations, and two more amputations. The greatest increase was due to struck, struck-by.

Table 8c: DoD Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Crushed by, caught in	0	0	0	1	1	1	↑	200
Electrical	0	0	0	1	0	0	↑	100
Insect bite	0	0	1	0	0	0	↓	100
Over-exertion	0	0	0	2	0	0	↑	200
Physical Attack	0	1	0	0	0	0	↑	100
Slip, trip, fall	0	0	3	1	0	0	↓	67
Strain, sprain	0	0	2	0	0	0	↓	200
Struck, struck by	0	0	0	3	0	2	↑	500
Vehicular (land)	0	0	1	0	0	0	↓	100
COVID-19	0	1	1	0	0	0	↔	0
Total	**0**	**2**	**8**	**8**	**1**	**3**	↑	**44**

The **Department of Health and Human Services'** incident reports decreased 76 percent in CY 2021, from 49 in CY 2020 to 12 in CY 2021. The largest reported increases (200 percent) occurred in the categories of strain, over-exertion; patient handling; and struck, struck-by.

Table 8d: HHS Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Assault	0	0	1	0	0	0	↓	100
Caught in	0	0	0	0	0	1	↑	100
Patient handling	0	0	2	0	0	0	↓	200
Slip, trip, fall	0	0	3	1	0	0	↓	67
Strain, over-exertion	0	0	0	2	0	0	↑	200
Struck, struck by	0	0	0	1	0	1	↑	200
COVID-19	10	0	33	3	0	0	↓	93
Total	**10**	**0**	**39**	**7**	**0**	**2**	↓	**76**

The **Department of Homeland Security's** reported incidents increased 59 percent in CY 2021 compared to CY 2020. Customs and Border Protection accounted for most of the COVID-19 related incidents, followed by Immigration and Customs Enforcement. Incidents related to heat and/or dehydration increased by 600 percent.

Table 8e: DHS Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Aneurysm	1	0	0	0	0	0	↓	100
Animal	0	0	1	0	0	0	↓	100
Assault/battery	0	0	2	0	0	0	↓	200

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change	
Bite	0	0	4	1	0	0	↓	75
Crushed by, caught in	0	0	0	0	1	1	↔	0
Cut, pierce	0	0	0	0	1	0	↑	100
Dehydration, Heat	0	0	0	6	0	0	↑	600
Fall from height	0	0	0	2	0	0	↑	200
Firearm	0	0	1	2	0	0	↑	50
Fitness	0	0	2	1	0	0	↓	50
Illness	2	2	3	1	0	0	↓	40
Material handling	0	0	1	1	0	0	↔	0
Slip, trip, fall	0	0	4	4	0	0	↔	0
Struck, struck by	0	0	2	0	0	0	↓	200
Unclassified	4	7	9	12	0	0	↑	28
Vehicular (land)	0	2	7	11		0	↑	46
COVID-19	18	40	10	80[1]	0	0	↑	76
Total	**23**	**51**	**46**	**121**	**2**	**1**	↑	**59**

[1] One hospitalization related to a COVID-19 vaccine.

The **Department of Justice's** reported incidents increased 450 percent in CY 2021 compared to CY 2020. The Bureau of Prisons accounted for 11 of the 37 hospitalizations and 11 of the 12 amputations. All other subagencies saw an increase in hospitalizations, most of which were due either to injuries during fitness training or COVID-19.

Table 8f: DOJ Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change	
Burn	0	0	0	1	0	0	↑	100
Crushed by, caught in	0	0	0	0	0	6	↑	600
Cut, pierce	0	0	0	0	0	5	↑	500
Illness	0	0	0	3	0	0	↑	300
Firearm	0	2	3	3	0	0	↑	40
Heart attack	0	0	0	1	0	0	↑	100
Heat, dehydration	0	0	7	6	0	0	↑	14
Slip, trip, fall	0	0	0	4	0	0	↑	400
Fitness	0	0	0	6	0	1	↑	700
Struck, struck by	0	0	0	2	0	0	↑	200
Vehicular (land)	0	1	0	4	0	0	↑	500
Unknown	0	0	0	2	0	0	↑	200
COVID-19	0	3	0	5	0	0	↑	800
Total	**0**	**6**	**10**	**37**	**0**	**12**	↑	**450**

The **Department of the Air Force's (USAF)'s** reported incidents increased 15 percent in CY 2021 compared to CY 2020. The greatest increase occurred in the repetitive motion category.

Table 8g: USAF Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Caught by, caught in	0	0	0	0	3	1	↓	66
Repetitive motion	0	0	0	2	0	0	↑	200
Slip, trip, fall	0	0	7	7	0	0	↔	0
Strain, over-exertion	0	0	1	0	0	0	↓	100
Struck by	0	0	2	1	0	3	↓	100
Vehicular (land)	0	0	0	1	0	0	↑	100
Total	**0**	**0**	**10**	**11**	**3**	**4**	↑	**15**

The **Department of the Army's** incident reports decreased 75 percent in CY 2021 compared to CY 2020. The greatest decreases occurred in the categories of vehicular (land) and struck, struck-by. The Army reported that a worker lost an eye.

Table 8h: Army Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Burns	0	0	1	0	0	0	↓	100
Crushed by, caught in	0	0	1	0	1	1	↓	50
Dehydration/heat	0	0	1	3	0	0	↑	67
Electrical	1	0	0	0	0	0	↓	100
Insect bite	0	0	2	1	0	0	↓	50
Material handling	0	0	0	1	0	1	↑	200
Slip, trip, fall	0	1	10	7	0	0	↓	20
Struck, struck by	0	0	4	1	0	0	↓	300
Vehicular (land)	0	0	4	0	0	0	↓	400
COVID-19	1	0	3	1	0	0	↓	75
Total	**2**	**1**	**25**	**13**	**1**	**2**	↓	**75**

The **Department of the Interior's** reported incidents increased 65 percent in CY 2021 compared to CY 2020. The greatest increases involved illnesses; slip trip, and falls; and COVID-19. The National Park Service reported the most incidents, all 14 of which were hospitalizations.

Table 8i: DOI Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities		Hospitalizations		Amputations		Percent Change	
	2020	2021	2020	2021	2020	2021		
Allergy	0	0	0	2	0	0	↑	200
Animal	0	0	1	0	0	0	↓	100

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change
Cut, pierce	0	0	0	0	3	0	↓ 300
Fall from height	0	0	0	1	0	0	↑ 100
Fire	0	0	0	3	0	0	↑ 100
Heat, dehydration	0	0	0	1	0	0	↑ 100
Illness	0	0	0	4	0	0	↑ 400
Insect	0	0	3	1	0	0	↓ 66
Slip, trip, fall	0	0	0	4	0	0	↑ 400
Unclassified	1	0	0	0	0	0	↓ 100
Vehicular (land)	0	1	0	4	0	0	↑ 300
COVID-19	1	0	0	4	0	0	↑ 400
Total	**2**	**1**	**4**	**25**	**3**	**0**	**↑ 65**

The **Department of the Navy's** incident reports decreased 36 percent in CY 2021 compared to CY 2020. An analysis indicates general illness incidents decreased, along with struck, struck-by; and COVID-19-related fatalities and hospitalizations.

Table 8j: Navy Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change
Crushed by, caught in	0	0	0	0	2	1	↓ 50
Cut, pierce	0	0	1	0	0	0	↓ 100
Electric shock	0	0	0	1	0	0	↑ 100
Fall from height	0	0	0	1	0	0	↑ 100
Heat, dehydration	0	0	1	1	0	0	↔ 0
Insect	0	0	0	1	0	0	↑ 100
Illness	0	0	2	0	0	0	↓ 200
Slip, trip, fall	0	0	3	3	0	0	↔ 0
Sports	0	0	0	1	0	0	↑ 100
Struck, struck by	0	0	2	0	0	0	↓ 200
COVID-19	4	3	7	2	0	0	↓ 55
Total	**4**	**3**	**16**	**10**	**2**	**1**	**↓ 36**

The **Department of State's** reported incidents increased 56 percent in CY 2021 compared to CY 2020. An analysis indicates cut/pierce incidents increased 700 percent while slip, trip, and fall incidents increased 69 percent.

Table 8k: State Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change
Caught by, caught in	0	0	1	3	0	1	↓ 100
Cut/pierce	0	0	0	7	0	0	↑ 700

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change
Drowning	0	1	0	0	0	0	↑ 100
Electric shock	0	0	0	1	0	0	↑ 100
Firearm	0	0	1	0	0	0	↓ 100
Fitness	0	0	1	1	0	0	↔ 0
Slip, trip, fall	0	0	5	16	0	0	↑ 69
Strain, over-exertion	0	0	2	1	0	0	↓ 50
Struck by	0	0	2	1	0	0	↓ 50
Unclassified	0	0	0	2	0	0	↑ 200
Vehicular (land)	1	1	4	3	0	0	↓ 20
COVID-19 vaccine	0	0	0	1	0	0	↑ 100
Total	**1**	**2**	**16**	**36**	**0**	**1**	↑ **56**

The **Department of Veterans Affairs'** reported incidents increased 46 percent in CY 2021 compared to CY 2020, primarily due to an increase in COVID-19-related hospitalizations.

Table 8l: VA Fatalities/Hospitalizations/Amputations for CY 2020 and 2021.

Cause	Fatalities 2020	Fatalities 2021	Hospitalizations 2020	Hospitalizations 2021	Amputations 2020	Amputations 2021	Percent Change
Allergy	0	0	0	2	0	0	↑ 200
Burn	0	0	0	1	0	0	↑ 100
Crushed by, caught in	0	0	0	0	0	2	↑ 200
Cut, pierce	0	0	0	1	0	0	↑ 100
Electrical	1	0	0	0	0	0	↓ 100
Fall from height	0	0	0	1	0	0	↑ 100
Fume	0	0	0	1	0	0	↑ 100
Illness	0	0	0	1	0	0	↓ 100
Slip, trip, fall	0	1	5	7	0	0	↑ 60
Steam	1	0	0	0	0	0	↓ 100
Struck, struck by	0	0	0	3	0	0	↑ 300
Unclassified	2	0	2	0	0	0	↓ 400
Vehicular (land)	0	0	1	1	0	0	↔ 0
COVID-19	22	20	59	95[1]	0	0	↑ 42
Total	**25**	**21**	**68**	**113**	**0**	**2**	↑ **46**

[1] One hospitalization was due to a COVID-19 vaccine.

Certified Safety and Health Committees

A CSHC is an agency OSH committee that the Secretary has approved and the agency's head has certified as meeting the requirements of 29 CFR § 1960, Subpart F. A CSHC monitors and supports an agency's OSH program and improves safety awareness by providing the agency an open channel of communication between employees and management. A CSHC also allows an agency to facilitate employee input on OSH-related policies, conditions, and practices.

An agency that wants to form a CSHC must report its intent to the Secretary. Specifically, the agency must provide the Secretary with information regarding the location and coverage area (establishments and populations) of the committee. The agency must also provide the name and phone number of each committee chair and certify that the committee meets all the requirements of 29 CFR § 1960, Subpart F. Also, as part of the required annual report to the Secretary, the agency must provide an update of its OSH program activity.

While agencies with CSHCs that meet all requirements are exempt from unannounced OSHA inspections, they may request an inspection. For CY 2021, the Secretary recognized three Executive Branch agencies as having functional CSHCs within the requirements of Subpart F:

- CIA
- DOL
- TVA

CIA, DOL, and TVA submitted information certifying to the Secretary that their respective CSHCs met the requirements of the subpart during the CY 2021 reporting period. DOL made no changes to its CSHC in CY 2021.

Other OSH Committees and Councils

OSHA asked that federal agencies provide information on their involvement in both internal and external OSH committees and councils, including their participation in FFSHCs. For internal activity, 35 out of 98 agencies (36 percent) reported that they encouraged employee participation in OSH-related committees at the departmental, agency, and field operation levels; and in a variety of local OSH committees, including FFSHCs. Of the 35 agencies involved in OSH committees or councils, 26 (74 percent) reported having internal OSH committees.

Internal OSH committee memberships varied among agencies; for some agencies membership included only management, while others opened committee participation to all employees, and required it for those with OSH-related expertise, duties, or responsibilities. For example, the Navy listed numerous OSH committees and councils and noted that employees participated as chairs and vice-chairs as well as supported councils as SMEs and action officers. Navy's OSH committees and councils provided advice on safety challenges, current trends, corrective actions taken or required, local safety issues, on- and off-duty mishaps; and were a critical mechanism for recommending improvements in safety management systems, data analysis efforts, and safety assurance efforts. FEC reported that its internal OSH committees included the Occupant Emergency Team and a Joint Safety Committee with its Union, both of which were voluntary and open to all staff.

When asked whether they supported and recognized OSH-related certifications from outside organizations, 39 out of 98 agencies (40 percent) reported employee participation in external OSH committees, including OSHA's Office of Federal Agency Programs' Roundtable meetings, and six agencies (6 percent) reported encouraging employees to seek professional certification and participate in professional OSH organizations. Most agencies, such as the Environmental Protection Agency (EPA) and the Department of Energy (DOE), reported encouraging employees to participate in OSH professional organizations, such as the International Air Transport Association and the American Industrial Hygiene Association. Agencies encouraged

OSH personnel to obtain and maintain professional certifications such as Certified Safety Professional and Certified Industrial Hygienist, and licenses such as Professional Engineer, to demonstrate competence in assigned duties. The National Aeronautics and Space Administration (NASA) indicated that it is currently involved in external OSH committees, and also indicated that it highly encourages all the NASA Field Centers to participate in local FFSHCs; and noted that NASA's leadership echoed the encouragement. NASA's OSH Manager often communicated with OSHA and attended OSHA sponsored training and council meetings held at DOL.

Identifying, Controlling, and Analyzing Hazards

Reporting Hazards

An effective OSH program encourages all workers (such as the agencies' workers and contractors) to participate and feel comfortable providing input and reporting their safety and health concerns; and prohibits retaliation when they report safety and health concerns, injuries, illnesses, and hazards; participate in the program; or exercise their safety and health rights. A crucial element of an effective hazard reporting system is notifying employees about actions taken to resolve their reported concerns.

OSHA asked agencies how they encouraged employees to report hazards and the reporting mechanisms employees could use. Agencies listed a variety of methods to encourage hazard reporting and advise employees of their rights such as:

- safety training sessions;
- new employee orientation sessions;
- shop safety talks/toolbox talks;
- reminders in standard operating procedures and official memoranda;
- newsletters, emails, and intranet posts;
- electronic (intranet, etc.) publication of OSH related policies and directives that include information on hazard reporting methods;
- recognition programs to acknowledge employees who collaborate with safety professionals to identify and mitigate workplace hazards;
- posting the "OSHA Job Safety and Health: It's the Law" poster;
- posters on bulletin boards in common areas identifying the site's safety and health designees;
- encouraging employees to participate in site surveys and inspections;
- disseminating safety shares or relevant lessons learned;
- establishing an Employee Concerns Program;
- workplace safety meetings, committees, advisory councils;
- participating in OSHA sponsored programs like the Safe and Sound Campaign;
- holding "Find and Fix" campaigns; and
- supportive messages from senior leaders.

Agencies provided various examples of hazard reporting methods such as:

- supervisors;

- local safety managers;
- collateral duty safety officers;
- safety and health committees;
- safety stand downs/safety awareness programs;
- town hall meetings;
- safety walkthroughs;
- web-based systems (e.g., intranet, SharePoint);
- safety apps;
- safety hotline;
- dedicated email address;
- dedicated help desk;
- suggestion box for anonymous reporting;
- agency email or phone for facilities management;
- hazard reporting form on the intranet; and
- daily task briefing in which employees analyze their workplaces and tasks.

Safety and Health Self-Inspections

Due to the COVID-19 pandemic, some agencies maintained only mission-essential functions at their physical worksites during CY 2021; these agencies placed most employees on a "maximum telework" status and transitioned to a virtual workspace. Of the 88 agencies that provided information on performing self-inspections, less than half (42 agencies; 48 percent) reported that they inspected all workplaces in CY 2021. The remaining 53 percent (47 agencies) did not inspect all their workplaces due to the COVID-19 pandemic. According to several agencies, the absence of employees from workplaces negated the need for self-inspections.

Fifty-three (60 percent) agencies reported that mission essential employees were at worksites during CY 2021 while others continued on a maximum telework status. Twenty-seven (31 percent) agencies reported that employees were on a maximum telework status and were not coming onsite. Eight (9 percent) agencies reported that employees were on a maximum telework status at the beginning of CY 2021 but started to return to the office on a hybrid schedule as the year progressed.

Of responding agencies, 85 percent (75 agencies) selected a rating of "highly effective" or "needs minor improvements" for the self-inspection attribute. (For additional information see the discussion on the Operational Component's Self-Inspection Attribute).

Abatement Tracking

As a key component of a SHMS, agencies must ensure the existence of established processes not only to routinely identify and report hazards, but also to select and track appropriate abatement measures (or controls) and then monitor those abatements or controls to ensure they continue to remain effective.

Effective controls protect workers from workplace hazards; help avoid injuries, illnesses, and incidents; minimize or eliminate safety and health risks; and help employers provide workers

with safe and healthful working conditions. These include instituting interim control measures to protect workers from hazards until the implementation of permanent measures.

OSHA asked agencies how they control workplace hazards (i.e., please describe how your agency tracks abatement of hazards and adheres to abatement dates). Most agencies (69 percent) either specified the hazard abatement tracking tool and/or described the hazard abatement tracking process. (See Appendix 7 for agency-specific abatement tracking information.)

The remaining 31 percent of agencies:

- did not provide a response;
- indicated that this inquiry was not applicable;
- responded that they had no abatement issues;
- stated they relied on property management or GSA for hazard abatement, but did not describe a coordination or tracking process;
- claimed successful hazard abatement but provided no information on a tracking method for such;
- claimed a tracking system but failed to describe it; or
- reported that no injury or illness occurred in CY 2021.

Hazard Data Analysis

Analyzing OSH data (i.e., lagging and leading indicators) provides information for setting safety and health priorities such as goals, objectives, and action items for an organization's OSH program. OSHA asked that agencies rate their effectiveness in analyzing hazard incidence data.

Among responding agencies, 48 percent rated their hazard data analysis as highly effective. However, although several agencies indicated routinely analyzing hazard incidence data, almost a third stated that they did not have incidents or had very few incidents so did not perform any data analysis. OSHA will work with these agencies to help them determine how best to implement this attribute in their programs.

For other agencies, 22 percent indicated that they needed minor improvements, citing problems such as an inadequate analysis tool. Another 21 percent of agencies: failed respond, indicated that the attribute was inapplicable, or stated it did not exist in their organizations. Some agencies claimed their workplaces: included no hazardous duties, had no history of incidents, or had no incidents in CY 2021; were small organizations, with one major facility; or had only infrequent incidents (accidents), and as such, did not need complex incident data management. Other agencies reported that they could identify incident trends without data analysis and then act to reduce or eliminate hazards; or that because few onsite injuries occurred data was insufficient for analysis.

Only seven percent of agencies indicated that this attribute needed major improvement. These agencies cited the lack of a mechanism to ensure accurate identification, reporting, data collection, and/or analysis of workplace hazards.

COVID-19 Response

Federal agencies reported on the steps taken during CY 2021 to protect employees from contracting COVID-19; most referenced following CDC, OMB, OPM, OSHA, and local guidance. Agencies noted that the evolving guidance required ongoing modification of policies and procedures to protect workers.

When feasible, agencies required employees to telework. Agencies with missions requiring onsite work used a range of controls to protect employees, from creating physical barriers to providing PPE. To help track the evolving guidance and develop internal policies, many agencies established workgroups comprised of senior management officials with decision making authority, safety professionals, industrial hygienists, and at times, medical staff.

Employees who provided direct services to the public, such as patient care and international border monitoring, had an increased risk of exposure to and contracting COVID-19. Among Executive Branch agencies, the Departments of Veterans Affairs and Homeland Security recorded the most fatalities due to the illness in CY 2021, reporting 26 and 15, respectively. (See Appendix 6 for detailed information on the fatalities, amputations, and hospitalizations agencies reported for CY 2021.)

Employee Awareness Protocols

Agencies used various means to engage employees and continuously shared new/updated information on the pandemic and avoiding COVID-19. Agency reports mentioned engagement and communication methods such as training, webinars, websites, intranets, SharePoint, town halls, virtual meetings, broadcast emails, newsletters, employee reviews, briefings to labor organizations, electronic bulletins, and informational hotlines, among many others.

Actions Taken to Limit COVID-19 Exposure in 2021

Agencies minimized transmission of COVID-19 through employee education campaigns – providing information about hand and surface hygiene, cough and sneeze etiquette, when to seek medical attention, and how to find out more information. Agency workgroups monitored the evolving guidance for changes and reports of new variants and used this information to make decisions throughout the year regarding the transition to normal federal business.

For mission-essential work at their facilities through 2021, agencies continued developing and implementing onsite protocols to protect the safety and health of their employees, visitors, and contractors. These onsite protocols included:

Policy Updates

- Incorporated all recommendations and requirements from Executive Orders and the Safer Federal Workforce Task Force COVID-19 safety response plan;
- Updated policies and reviewed scientific findings and guidance regarding COVID-19; and
- Required that onsite employees be fully vaccinated and exempt employees continue to telework.

Facility Access

- Maximized telework and remote work;
- Staggered work schedules and used cohort seating strategies for onsite employees;

- Adjusted restrictions in accordance with transmission rates;
- Developed and implemented a respiratory protection program, and conducted fit testing for N95 respirators; and
- Closed high-density assembly areas.

Facility Modifications

- Enhanced office ventilation systems;
- Mandated social distancing and masks;
- Installed touchless hand sanitizers;
- Increased cleaning of office common areas and high touch surfaces;
- Disinfected shared items after each use or before transfer;
  Marked elevators for social distancing and limited occupants;
- Installed anti-microbial surface protectors for high-touch surfaces such as elevator call buttons;
- Added signage at entry points to remind entrants to follow mandatory precautions;
- Installed physical barriers open workspaces;
- Used ultraviolet and electrostatic disinfection; and
  Incorporated hands-free exit and entrance mechanisms.

Personal Protective Equipment, Testing, and Protocols

- Provided face coverings, gloves, and respirators;
- Supplied home PCR and rapid test kits;
- Used digital self-check systems;
- Developed case tracing applications; and,
- Developed a trend analysis dashboard.

Procedures for COVID-19 Positive Employees

All agencies reported establishing policies and procedures to address workplace-related positive COVID-19 test results, suspected cases, and potential exposures that followed CDC, OMB, OPM, GSA, and local health departments' guidelines. For example, the USAID activated a Critical Coordination Structure (CCS) to facilitate quick response to COVID-19 cases and maintain agency continuity of operations. According to USAID, the CCS worked with its incident response command center to evaluate each case to determine potential staff exposure, perform contact tracing, and communicate incident details to the leadership team. The CCS coordinated a response to isolate and clean any exposed work areas using advanced cleaning techniques.

In general, agencies developed policies and procedures for workers with positive test results, suspected cases, or potential exposures. Those procedures required employees to report to their supervisors or other designated persons. A designated team then reviewed any positive cases and determined whether they were work-related. When feasible, the team traced the cases and notified affected employees, providing instruction on testing, self-isolation, and quarantine timelines. Agencies cleaned and sanitized affected work areas, developed policies to allow asymptomatic quarantined employees to telework, addressed appropriate leave status for affected employees, and allowed employees to return to work when they met established requirements.

The Department of Health and Human Services continued to update and post the HHS COVID-19 Workplace Safety plan as it amended its internal processes and CDC updated guidance throughout the year. HHS also updated the safety plan and posted update notifications to the Safer Federal Workforce Task Force website.

Motor Vehicle Safety

In CY 2021, 71 agencies (73 percent) reported having a Motor Vehicle Safety Program (MVSP), and most noting compliance with EOs 13043 and 13513, which require using seatbelts in motor vehicles and ban texting while driving, respectively. Most agencies reported that MVSPs were major OSH program elements and that EO compliance was necessary to reduce the deaths, injuries, and property damage related to vehicular mishaps. Twenty-eight agencies with MVSPs (40 percent) provided information on the roughly 10,452 motor vehicle accidents their employees experienced during CY 2021.

Most agencies reported offering motor vehicle safety awareness training from DOT, GSA, USDA, or similar organizations. Covered training topics included distracted driving prevention, safe holiday/seasonal driving, accident reporting procedures, driver improvement training for personnel involved in vehicle mishaps, vehicle safety inspection procedures, driver education for personnel deployed overseas, use of travel planning tools, and defensive driving. Agencies like the USAF supported nationally recognized safe driving programs. DoD fielded motor vehicles that featured safety technologies (e.g. back-up cameras, lane assist, blind-side alerts, and close collision alerts) and trained motor vehicle operators on their use. The Department of State planned to expand its Event Recorder (i.e. DriveCam) program to additional posts overseas. DOT promoted the National Safety Council's Defensive Driving Course program to reinforce motor vehicle safety and mishap prevention.

Sixteen agencies reported that they did not have any MVSP because either they employed only a few workers or did not need a dedicated vehicle fleet. Agencies without any MVSP included: Access Board, African Development Foundation, Commission on Civil Rights, DNFSB, Export-Import Bank, Federal Mediation and Conciliation Services, Federal Labor Relations Authority, Federal Retirement Thrift Investment Board, Inter-American Foundation, Institute of Museum and Library Services, National Council on Disability, National Credit Union Administration, National Endowment for the Humanities, Pension Benefit Guaranty Corporation, Postal Regulatory Commission, and Social Security Advisory Board.

Some agencies asserted that an MVSP was "not applicable" to their situations or simply ignored the item. Yet other agencies deemed to provide little to no training reported compliance with EOs 13043 and 13513 but provided no information on safety protocols or measures. OSHA will follow up with agencies to offer assistance in addressing motor vehicle safety.

Table 9: Summary of Reported Motor Vehicle Accidents by Department/Agency CY 2019 – 2021.

Department/Agency	2021	2020	2019
Department of Agriculture	1,918	NR	2,060
Department of the Air Force	19	94	16
Department of the Army	514	288	212

Department/Agency	2021	2020	2019
Department of Commerce	25	306	306
Department of Defense	929	812	943
Department of Energy	89	63	74
Department of Health and Human Services	45	25	304
Department of Homeland Security	1,042	1,765	2,190
Department of Housing and Urban Development	NR	NR	NR
Department of Justice	2,825	2,311	4,124
Department of Labor	227	213	452
Department of the Interior	595	564	501
Department of the Navy	2	12	10
Department of State	1,598	1,102	NR
Department of Transportation	11	13	40
Department of the Treasury	127	93	176
Department of Veterans Affairs	147	21	144
Environmental Protection Agency	10	12	33
General Services Administration	20	26	59
National Aeronautics and Space Administration	123	104	103
Social Security Administration	8	13	24
Tennessee Valley Authority	153	175	245
Office of Personnel Management	2	1	212
AbilityOne	0	0	0
Access Board	0	NR	0
African Development Foundation	0	0	0
Agency for Global Media	0	0	NR
Agency for Internal Development	0	0	0
American Battle Monuments Commission	0	1	1
Armed Forces Retirement Home	0	0	0
Chemical Safety and Hazard Investigation Board	0	0	1
Commission of Fine Arts	NR	NR	NR
Commission on Civil Rights	0	0	0
Commodity Futures Trading Commission	0	0	0
Consumer Product Safety Commission	0	0	0
Court Services and Offender Supervision Agency	0	1	5
Defense Nuclear Facilities Safety Board	0	0	0
Equal Employment Opportunity Commission	2	2	3
Export-Import Bank of the United States	0	0	0
Farm Credit Administration	0	0	1
Federal Communications Commission	0	NR	3
Federal Deposit Insurance Corporation	0	NR	NR
Federal Election Commission	0	0	0
Federal Housing Finance Agency	0	0	0
Federal Labor Relations Authority	0	0	0
Federal Maritime Commission	0	0	0
Federal Mediation and Conciliation Service	0	0	0

Department/Agency	2021	2020	2019
Federal Mine Safety and Health Review Commission	0	0	0
Federal Reserve Board	0	0	0
Federal Retirement Thrift Investment Board	0	0	0
Federal Trade Commission	0	0	0
Harry S. Truman Foundation	NR	NR	NR
Holocaust Memorial Museum	0	0	0
Institute of Museum and Library Services	0	0	0
Inter-American Foundation	0	0	0
International Trade Commission	0	0	0
International Boundary and Water Commission	2	2	4
James Madison Memorial Fellowship Foundation	0	0	NR
John F. Kennedy Center	0	0	0
Marine Mammal Commission	0	0	NR
Merit Systems Protection Board	0	0	0
Millennium Challenge Corporation	NR	0	NR
Morris K. Udall & Stewart L. Udall Foundation	0	0	0
National Archives and Records Administration	0	1	0
National Capital Planning Commission	0	0	0
National Council on Disability	0	0	0
National Credit Union Administration	0	0	2
National Endowment for the Arts	0	0	0
National Endowment for the Humanities	0	NR	0
National Gallery of Art	0	0	5
National Labor Relations Board	0	0	1
National Mediation Board	0	0	NR
National Science Foundation	0	0	0
National Transportation Safety Board	0	0	0
Nuclear Regulatory Commission	1	0	0
Nuclear Waste Technical Review Board	0	0	0
Occupational Safety and Health Review Commission	0	0	0
Office of Government Ethics	0	0	0
Office of Navajo and Hopi Indian Relocation	0	0	0
Office of Special Counsel	NR	NR	NR
International Development Finance Corporation	0	NR	NR
Peace Corps	9	2	39
Pension Benefit Guaranty Corporation	0	0	0
Postal Regulatory Commission	0	0	0
Presidio Trust	4	4	NR
Railroad Retirement Board	1	0	0
Securities and Exchange Commission	0	0	0
Selective Service System	NR	NR	NR
Small Business Administration	0	2	0
Smithsonian Institution	5	11	NR
Social Security Advisory Board	0	NR	0

Department/Agency	2021	2020	2019
Trade and Development Agency	0	NR	0

Federal Employees Overseas

The Act, EO 12196, and 29 CFR § 1960 have no geographical limits; agencies must provide safe and healthful workplaces to all federal civilian employees, including those who work outside U.S. borders. OSHA asked agencies about the number of federal employees stationed overseas during CY 2021 and how they provided those employees with safe and healthful workplaces.

According to agency reports, at least 129,334 employees from 24 agencies worked outside the borders of the United States during CY 2021. DoD (including civilians in the armed services) employed the largest overseas workforce – 52,678 employees – and indicated that its OSH programs and coverage included those workers. It noted that it followed OSHA standards in all operations worldwide, where feasible. When compliance with OSHA standards was impracticable, infeasible, or inappropriate, DoD applied risk management procedures. Leaders and supervisors communicated the results of risk management decisions to all affected personnel. Other agencies, such as Commerce, indicated that they relied on State's Safety, Health, and Environmental Management program to address safety and health issues for their overseas employees.

Table 10: Number of Federal Civilian Employees in Overseas Locations by Department/Agency (CY 2019 – 2021)

Department/Agency	2021	2020	2019
Department of Agriculture	NR	No Data Requested*	999
Department of Commerce	212		252
Department of Defense	52,678		55,762
Department of Energy	19		50
Department of Health and Human Services	368		438
Department of Homeland Security	6,363		1,500
Department of the Interior	318		881
Department of Justice	1,122		1,062
Department of Labor	5		6
Department of State	58,997		NR
Department of Transportation	10		20
Department of Veterans Affairs	138		94
Department of the Treasury	39		41
Environmental Protection Agency	2		1,150
General Services Administration	22		24
National Aeronautics and Space Administration	8		8
African Development Foundation	NR		12
Agency for Global Media*	56		NR
Agency for International Development	6,417		1,399
American Battle Monuments Commission	40		38
Consumer Product Safety Commission	1		1
Export-Import Bank	NR		0

Department/Agency	2021	2020	2019
Millennium Challenge Corporation	NR		NR
Nuclear Regulatory Commission	3		2
Overseas Private Investment Corporation	NR		NR
Peace Corps	2,298		245
Smithsonian Institute	429		NR
Trade and Development Agency	0		1
Total	**129,334**		**63,985**

* Given the pandemic-related fluctuations in the overseas federal workforce, in CY 2020 OSHA did not ask agencies to provide data on the numbers of workers employed outside U.S. borders.

OSH Training and Resources

EO 12196 requires agencies to provide OSH training for all employees. Additionally, 29 CFR § 1960, Subpart H, prescribes the necessary OSH training for employees with respect to applicable standards. Nearly all responding agencies provided details regarding resources dedicated to OSH training efforts; 80 agencies (90 percent) reported that supervisors could requisition training, although funds for training varied dramatically by agency.

Most agencies reported that that they provided OSH training to employees using conventional methods, such as virtual (41 agencies; 47 percent); online (63 agencies; 72 percent); and/or classroom training (31 agencies; 35 percent). Twenty agencies (22 percent) required practical exams or drills. The Navy, for example, completed 378 training evolutions that trained 8,493 students. The Naval Safety and Environmental Training Center also hosted a week-long professional development symposium that offered 111 safety webinars and break-out sessions to nearly 2,600 participants. However, 18 agencies (20 percent) reported they did not conduct OSH training during CY 2021 because most or all their employees continued to telework.

In CY 2021, 805 participants from 30 agencies attended FEDWEEK while 42 agencies (48 percent) encouraged OSH employees to participate in FFSHC activities. And 36 agencies (40 percent) indicated that employees actively participated in FFSHC activities.

As in prior years, OSHA asked about agencies' OSH training for supervisors and newly hired employees. Most agencies reported that their new-hire orientation included information on agency-specific OSH policies, general safety and health rules, agency-specific hazards and protections, and emergency procedures. Supervisory training included a review of the topics covered in new-hire orientation, along with information on the requirements of 29 CFR § 1960 and EO 12196. Commerce reported that it continued to promote OSH training in CY 2021, and increased participation due to an online format and a maximized telework status. It noted that its employees could take job-related safety courses from the Skillsoft online catalog.

Whistleblower Protection Programs

Per 29 CFR § 1960, Subpart G, agencies must have procedures in place to assure that no employee faces restraint, interference, coercion, discrimination, or reprisal for filing a report of an unsafe or unhealthful working condition. To assess agencies' whistleblower protection programs, OSHA requested information on any federal employee allegations of reprisal in CY 2021, how agencies investigated the allegations, and the impact of investigation findings on the

agencies' OSH programs. Eighty agencies (90 percent) reported having functional whistleblower protection programs.

During CY 2021, four agencies reported investigating allegations of reprisal: DoD, State, MSPB, and NASA. DoD did not substantiate retaliation in any of the 14 investigations. State's OIG investigated two complaints of retaliation in CY21, and substantiated one allegation. MSPB's one whistleblower complaint is currently in litigation. NASA did not substantiate two of three whistleblower allegations; one remains under investigation.

Product Safety Programs

OSHA asked agencies how they ensure that the products and services they procure comply with the product safety requirements of 29 CFR § 1960.34, including the availability and use of safety data sheets (SDSs). Of the responding agencies, 73 (82 percent) reported compliance with the standard; two (2 percent) reported lacking product safety programs; and 13 (15 percent) responded that standard did not apply to them with regards to hazardous materials. Of those 73 agencies, 58 (79 percent) confirmed that their programs included SDSs, while the remaining 15 (21 percent) did not provide such verification.

In addition to describing their compliance with the provisions of the standard, OSHA asked agencies to provide details on their policies for addressing chemicals in fragrances, such as those in perfumes and air fresheners. In total, 57 agencies (64 percent) indicated the absence of specific policy but, of those agencies, 12 (21 percent) reported dealing with such issues on a case-by-case basis.

Most agencies indicated that their product safety programs complied with safety and health requirements established under 29 CFR § 1960, Subpart E. For example, as part of its overall Consolidated Hazardous Material Reutilization and Inventory Management Program, the Navy managed hazardous materials through hazardous material minimization centers designated to inventory, label, issue, and return all hazardous materials; verify the existence of an SDS; and confirm the material complied with regulatory requirements.

NASA required all its locations to comply with 29 CFR §§ 1960.34 and 1910.1200 and explained that employees could acquire SDSs both electronically and in hard copy, depending on the employee's location and computer access. NASA also uses the Government-Industry Data Exchange Program (GIDEP) to ensure the most up-to-date information is available for products that are procured. GIDEP is a cooperative activity between government and industry participants seeking to reduce or eliminate expenditures of resources by sharing technical information essential during research, design, development, production, and operational phases of the life cycle of systems, facilities, and equipment.

Specific Agency Reporting Programs

Under 29 CFR § 1960, Subpart E, GSA and NIOSH must assist federal agencies with specific activities affecting safety and health conditions of federal employees. Each year, GSA and NIOSH provide details on these activities in their annual reports. In its annual report, GSA provided information on its programs for ensuring that federal facilities are designed, operated, and maintained in accordance with OSH requirements and best practices; that products and

services offered to federal agencies complied with product safety requirements; how federal purchasers received information on the safe use of such products; and how it implemented safety recalls. NIOSH's annual report detailed its Request for Technical Assistance program and included information on the assistance provided to federal agencies during CY 2021.

General Services Administration

GSA reported that it provided extensive information and guidance on protecting building occupants from COVID-19. It noted that it contracts most operations and maintenance (O&M) activities and that most contracts include safety and health clauses. GSA continued updating the safety and health requirements for all federally owned and commercially leased facilities in CY 2021.

GSA noted that if it receives information concerning a product recall in the commodity line it manages, it initiates a review of that line to determine if agencies received the recalled item. GSA immediately notifies suppliers to cease shipments of products associated with a recall, identifies customers that have ordered the item, and provides contact instructions concerning the recall.

National Institute for Occupational Safety and Health

NIOSH received eight agency requests for health hazard evaluations[6] (HHEs) in CY 2021, compared to 11 in 2020, and 40 in 2019. (See Appendix 2 for information on agencies' assistance requests to NIOSH.) NIOSH completed the eight (100 percent) requests it received in CY 2021 along with three from prior years.

NIOSH did not perform any field investigations in CYs 2021 or 2020, but conducted six in 2019. It completed eight desk investigations in CY 2021, compared to 17 in 2020, and 34 in 2019. (See Appendix 3 for information on completed investigations.)

Federal agencies asked for NIOSH's help with both exposures and health problems; each completed request addressed multiple exposure groups and/or health issues. For the reporting period, the exposure group categories NIOSH evaluated were indoor environmental quality, biological hazards, and chemical hazards; while health problems ranged from localized respiratory or nervous system effects to viral or bacterial systemic body issues. (See Appendix 4 and Appendix 5 for breakdowns of investigation exposure group and health problem categories, respectively.)

[6] NIOSH's response to a federal agency's Request for Technical Assistance usually involves an HHE: a workplace study to learn whether workers are exposed to hazardous materials or harmful conditions. Based on the information provided, NIOSH answers an HHE/technical assistance request in one of the following ways: in writing with pertinent information or a referral to a more appropriate agency, by telephone to discuss the problems and possible solutions, or with a visit to the workplace. During a visit, NIOSH will meet with the employer and employee representatives to discuss the issues and tour the workplace. During one or more visits, NIOSH may review exposure and health records, interview or survey employees, measure exposures, and perform medical testing. At the end of an evaluation, NIOSH will provide a written report to the employer and employee representatives. Depending on the type of evaluation, the final report may require a development time of a few months to a few years.

APPENDICES

Appendix 1: CY 2021 Active Field Federal Safety and Health Councils by OSHA Region

Region I (CT, MA, ME, NH, RI, VT)	Region V (IL, IN, MI, MN, OH, WI)
Greater Boston FFSHC	Chicago FFSHC Detroit FFSHC Duluth/Superior FFSHC Minneapolis FFSHC
Region II (NJ, NY, PR, VI)	**Region VI (AR, LA, NM, OK, TX)**
Greater New York FFSHC Puerto Rico FFSHC Southern New Jersey FFSHC Western New York FFSHC Hudson Valley FFSHC	Dallas/Fort Worth FFSHC Oklahoma FFSHC South Texas FFSHC
Region III (DC, DE, MD, PA, VA, WV)	**Region VII (IA, KS, NE, MO)**
Hampton Roads FFSHC Metropolitan Washington, DC FFSHC	Greater Des Moines FFSHC Greater Kansas City FFSHC Greater Omaha FFSHC Greater St. Louis FFSHC
Region IV (AL, GA, FL, KY, MS, NC, SC, TN)	**Region VIII (CO, MT, ND, SD, UT, WY)**
Atlanta FFSHC Central Florida FFSHC Coastal Empire FFSHC Louisville Area FFSHC Middle Tennessee FFSHC Mississippi Gulf Coast FFSHC North Carolina FFSHC South Florida FFSHC	Denver FFSHC
	Region IX (AS, AZ, CA, GU, HI, MP, NV)
	Phoenix FFSHC San Francisco Bay Area FFSHC
	Region X (AK, ID, OR, WA)
	Mt. Rainier FFSHC

Appendix 2: Requests to NIOSH for Technical Assistance CY 2019 – 2021

Requesting Department/Agency	2021	2020	2019
Agriculture	0	0	0
Commerce	0	0	1
Defense	0	4	10
Energy	0	0	0
General Services Administration	0	0	1
Health and Human Services	1	0	0
Homeland Security	1	1	6
Interior	0	0	2
Justice	0	0	4
U.S. Postal Service	1	3	9
Social Security Administration	0	0	0
Transportation	0	0	1
State	0	0	0
Treasury	2	0	1
Veterans Affairs	3	3	5
Other	0	0	0
Total	**8**	**11**	**40**

Appendix 3: Completed NIOSH Investigations by Type CY 2019 – 2021

	Investigation Type					
	Desktop			Field		
Requesting Department/Agency	2021	2020	2019	2021	2020	2019
Agriculture	0	1	2	0	0	1
Commerce	0	0	1	0	0	0
Defense	2	4	9	0	0	1
Energy	0	0	0	0	0	0
General Services Administration	0	0	1	0	0	0
Health and Human Services	1	0	1	0	0	0
Homeland Security	0	1	1	0	0	2
Interior	0	1	1	0	0	1
Justice	0	1	3	0	0	1
U.S. Postal Service	1	4	9	0	0	0
Social Security Administration	0	0	0	0	0	0
Transportation	0	0	2	0	0	0
State	0	0	0	0	0	0
Treasury	2	0	1	0	0	0
Veterans Affairs	2	5	3	0	0	0
Other	0	0	0	0	0	0
Total	**8**	**17**	**34**	**0**	**0**	**6**

Appendix 4: CY 2021 Assistance Requests to NIOSH by Exposure Group

Requesting Department/Agency	Exposure Group*							
	Chemical	Biologic	Indoor Environmental Quality	Noise	Heat	Stress	Radiation	Ergonomics
Agriculture	0	0	0	0	0	0	0	0
Commerce	0	0	0	0	0	0	0	0
Defense	0	0	0	0	0	0	0	0
Energy	0	0	0	0	0	0	0	0
General Services Administration	0	0	0	0	0	0	0	0
Health and Human Services	1	0	0	0	0	0	0	0
Homeland Security	1	0	0	0	0	0	0	0
Interior	0	0	0	0	0	0	0	0
Justice	0	0	0	0	0	0	0	0
Labor	0	0	0	0	0	0	0	0
U.S. Postal Service	0	0	1	0	0	0	0	0
Social Security	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0
Treasury	0	1	0	0	0	0	0	0
Veterans Affairs	1	0	2	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
Total	**3**	**1**	**3**	**0**	**0**	**0**	**0**	**0**

* A Request for Technical Assistance, also known as a Health Hazard Evaluation request, may involve an investigation under more than one exposure group category, as seen with VA's single request to investigate two exposure groupings: "Chemical," and "Indoor Environmental Quality."

Appendix 5: CY 2021 Assistance Requests to NIOSH by Health Problem

Requesting Department/Agency	Health Problem								
	Respiratory	Viral/Bacterial	Cancer	Musculoskeletal	Mental/Behavioral	Sensory	Skin Disorder	Nervous System	Non-Specific
Agriculture	0	0	0	0	0	0	0	0	0
Commerce	0	0	0	0	0	0	0	0	0
Defense	0	0	0	0	0	0	0	0	0
Energy	0	0	0	0	0	0	0	0	0
General Services Administration	0	0	0	0	0	0	0	0	0
Health and Human Services	0	0	0	0	0	0	0	0	1
Homeland Security	1	0	0	0	0	0	0	0	0
Interior	0	0	0	0	0	0	0	0	0
Justice	0	0	0	0	0	0	0	0	0
Labor	0	0	0	0	0	0	0	0	0
U.S. Postal Service	1	0	0	0	0	0	0	0	0
Social Security	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0
Treasury	0	1	0	0	0	0	0	0	1
Veterans Affairs	2	0	0	0	0	0	0	0	1
Other	0	0	0	0	0	0	0	0	0
Total	**4**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**3**

Appendix 6: Fatalities, Hospitalizations, and Amputations Reported in CY 2021

Department of Agriculture

Fatalities

- A smokejumper jumped, deployed the parachute, and sustained critical injuries due to a hard landing. The employee died after eight days hospitalization.
- An employee and a contractor were conducting visual reconnaissance and aviation command and control over a fire when the plane crashed.
- Two employees were exposed to COVID-19 at a fire camp. The exposure resulted in their deaths.
- A volunteer was exposed to COVID-19 at a fire camp. The exposure resulted in the volunteer's death.
- An employee was exposed to COVID-19 while training employees. The exposure resulted in the employee's death.
- A volunteer was struck and killed by a falling limb while planting trees.

Amputations (None)

Hospitalizations

- An employee participating in physical fitness suffered rhabdomyolysis.
- An employee participating in a prescribed burn and using a drop torch dripped fuel on their Nomex pants, catching their pants on fire.
- An employee on horseback suffered a shattered pelvis and internal injuries when the horse fell on top of the employee.
- An employee participating in rookie smokejumper camp experienced shortness of breath and cardiac symptoms.
- An employee playing volleyball with Job Corps students injured their ulna.
- An employee riding an ATV rolled the ATV and lost consciousness. The employee regained consciousness and was taken to the work center then the hospital.
- An employee was riding an ATV while spraying weeds and rolled the ATV.
- An employee was being transported to the hospital for a knee injury sustained while fighting a forest fire when a dump truck struck the ambulance. The employee suffered a fractured skull, jaw, and eye socket.
- A smokejumper's parachute caught in a tree. The tree branch broke and the employee fell to the ground.
- An employee conducting firefighting operations at one site went to another site to help another crew. Upon arrival the employee exited the vehicle and began having seizures.
- An employee operating a chainsaw collapsed during firefighting operations.
- An employee was using a three-legged orchard ladder to pick cones from a tree. The ladder caught on branches, became unstable, and tipped over with the employee on it. The employee fell approximately 15 feet to the ground, breaking their left lower leg.
- A volunteer was exposed to COVID-19 at a campground where the volunteer interacted with the public.

- An employee was lifting a vehicle with a five-ton hand floor jack. The jack's lifting arm saddle slipped on the axle's lifting point causing the jack to move and pinning employee's lower right leg between the jack's handle and a concrete wall.
- An employee conducting a prescribed burn dripped fuel on their pants while filling their drip torch. The employee did not change pants and continued to work. Later in the operation the employee walked over open flame and the employee's pant cuff caught on fire. The employee suffered first and second degree burns to the leg.
- An employee was exposed to COVID-19 at the workplace.
- An employee riding a motorcycle attempted a U-turn on gravel. One or both tires lost traction on the gravel and the motorcycle fell on the employee's left side and leg.
- An employee driving a vehicle was struck by another employee in another vehicle.
- An employee bent over to pick up a box of paper.
- An employee was walking to the building and encountered what appeared to be a dead snake.
- An employee was sampling vegetation outside in the heat with limited cloud cover. The employee went home and started showing signs of heat illness. The employee went to the emergency room to seek treatment and was held for observation.
- An employee was crossing the street but was not in a crosswalk, and was struck by a motor vehicle.

Department of Defense

Fatalities

- An employee stationed at a mass transit facility was fatally attacked for unknown reasons.
- An employee was exposed to COVID-19 in the workplace. The exposure resulted in the employee's death.

Amputations

- An employee was moving a piece of kitchen equipment when the equipment fell from the dolly, crushing the employee's finger and resulting in an amputation.
- An employee was cleaning out the beef bulker when the employee's hand activated the bulker knife, amputating a fingertip.
- An employee became distracted while cutting beef neck bones, and the employee's right ring finger contacted the band saw, removing the fingertip.

Hospitalizations

- An employee was loading bottles onto a conveyor belt and struck their head on the conveyor frame.
- An employee cleaning a bathroom struck their head on a sink.
- An employee over-exerted while moving merchandise, exacerbating their blood pressure and causing the employee to fall and hit their head.
- An employee lost consciousness and fell while making labels and printing them to use on sales floor. Stress exacerbated the employee's blood pressure and caused them to lose consciousness and fall.

- An employee exited a car without putting the car in park. The car rolled backwards, catching the employee between the vehicle and its door, and knocking the employee to the ground.
- An employee repairing HVAC equipment received an electrical shock.
- An employee walking down the stairs turned to speak to a coworker, lost balance, fell, and suffered a fractured their left leg.
- An employee fractured their femur when trying to stop a rolling cabinet.

Department of the Air Force

Fatalities (none)

Amputations

- An employee who exited a forklift without setting the parking brake was struck by the forklift.
- An employee was cutting welds from angle iron when the grinder disc shattered and struck the employee's hand.
- An employee was struck on finger with a crimping cable.
- An employee was moving containers and caught a thumb during the process.

Hospitalizations

- An employee was performing firefighting escape training.
- An employee was descending stairs and missed a step.
- An employee was descending a fixed ladder; missed step and fell.
- An employee was rappelling during firefighting training. The employee lost control of the rope and fell eight feet.
- An employee was responding to a medical emergency.
- An employee was descending outdoor stairs and slipped and fell.
- An employee was driving a vehicle, encountered ice, and lost control of the vehicle.
- An employee was removing rock from between objects. The objects contacted the finger.
- An employee was walking in the parking lot, slipped on ice, and fell.
- An employee was walking in work area, tripped, and fell.
- An employee was walking and tripped on their own shoes.

Department of the Army

Fatalities

- An employee was using a ladder to read the plates of the lightning arrestors when the ladder came out from underneath the employee. The employee fell and hit their head on the concrete or the lightning arrestor frame.

Amputations

- An employee was moving a cart of steel and tools. The cart became stuck on the floor and tipped over, pinching the employee's finger between two pieces of steel – amputating the right middle finger above the knuckle – and trapping the employee's foot under the

cart. The foot was injured but not broken. The employee was released from the hospital the next day, after surgery.
- An employee was removing the top gland bushing of a hydraulic cylinder. The bushing came from the bonnet and fell approximately 16 inches onto their left middle finger, crushing the finger. The employee was treated and returned the next day to remove the nail bed, crushed bone, and reattach what they could.

Hospitalizations

- An employee slipped and fell on a patch of ice in the parking lot on the way to the workplace.
- An unexploded ordnance exploded when an employee picked it up during target maintenance.
- An employee was standing on a counter to install a wall mount when the employee's right foot slipped off the edge and the employee fell three feet.
- An employee was installing an air conditioner but the mezzanine did not have closed flooring. The employee slipped and fell through the ceiling to the floor below.
- An employee was washing/drying a vehicle when the employee slipped and fell off the top of the vehicle.
- An employee was participating in physical training.
- An employee who was completing the running portion of physical training test collapsed and spent four days in the hospital.
- An employee who was participating in a fitness program lifted too much weight and tore their pectoralis muscle and tendon.
- An employee was moving a rattlesnake from an enclosure to a larger one. The employee put the rattlesnake into a holding bucket. The employee was bitten when moving the snake from the bucket to the second enclosure.
- An employee was getting out of his vehicle and lost his footing. He fell and suffered a fractured hip that required surgery and four days hospitalization.
- An employee who was exiting a crane slipped on the wet track and fell approximately three feet to the deck of the barge, fracturing the employee's left hip and requiring five nights in the hospital.
- An employee was struck by a ceiling tile that was saturated with water. The employee was hospitalized for 24 days with a severe concussion.
- An employee contracted COVID-19 while working in the vaccination clinic.

Department of the Navy

Fatalities

- An employee was exposed to COVID-19 on a vessel. The exposure resulted in the employee's death.
- An employee was exposed to COVID-19. The exposure resulted in the employee's death.
- An employee was exposed to COVID-19. The exposure resulted in the employee's death.

Amputations

- An employee who was moving a 150 lb cylinder crushed a middle finger between the cylinder and the floor.
- An employee repairing an outboard motor caught a finger in the flywheel, amputating the fingertip.
- An employee was using a lathe to polish a piece of pipe. The employee's glove became caught between the lathe and the emery board, amputating a finger to the second knuckle.

Hospitalizations

- An employee was exposed to COVID-19.
- An employee who was playing kickball collided with another employee and suffered a fractured ankle.
- An employee was bitten by a Brown Recluse spider while changing a boiler.
- An employee was riding a bike when their hand slipped off the handlebar, causing a fall off the bike.
- An employee was exposed to COVID-19.
- An employee who was performing a vessel inspection fainted. The employee was taken to the hospital and treated for heat stress.
- An employee who was walking onto the ship slipped on metallic debris, fell on a knee, fracturing the lower leg and requiring surgery.
- An employee was working on a roof near a skylight. The employee was not wearing fall protection and fell through the skylight.
- An employee tripped over a stair.
- An employee was repairing a runway light and received an electric shock.

Department of Health and Human Services

Fatalities (none)

Amputations

- An employee caught a finger in a self-closing door.
- An employee was removing snow using a tractor in 25˚F temperatures. The employee stubbed a toe, but due to cold and a preexisting condition, did not realize severity of the injury. The employee sought medical treatment the next day. The toe became infected and had to be amputated.

Hospitalizations

- An employee was bent over tying a shoe. Another employee did not see the employee tying the shoe, tripped over that worker, and fell to the floor.
- Four employees were exposed to COVID-19. The exposures resulted in a hospitalizations.
- An employee was removing a patient from an ambulance when the cot's wheel caught on a piece of metal and its legs dropped unexpectedly. The employee got control over the cot, preventing the patient from being dropped, but complained of pain later in the day. Ten days later the employee was admitted to the hospital for pain management.
- An employee was restocking portable water for an event.

Department of Homeland Security

Fatalities

- Forty employees (Border Patrol Agents and Officers, and Immigration and Customs Agents and Officers) were exposed to COVID-19 on duty, which resulted in their deaths.
- An employee was found unresponsive in their patrol vehicle. EMS transported the employee to the hospital where the hospital diagnosed a stroke. The employee did not recover and died.
- A Border Patrol Agent (BPA) was found unresponsive in their government-owned vehicle (GOV). EMS transported the BPA to the hospital where the agent died due to a stroke and pneumonia.
- A BPA was tending to an MVC when another vehicle struck and pinned the agent. A sheriff deputy applied a tourniquet and called EMS. Aviation was unable to respond due to weather conditions. The BPA was transported to the hospital and pronounced dead.
- An employee was found unresponsive in a facility by a co-worker. EMS transported the employee to the hospital where they were pronounced dead.
- An employee on telework status attended one meeting via Microsoft Teams but did not sign in for another. A supervisor and a family member conducted a welfare check. The employee was deceased.
- A BPA experienced chest pain while on duty. The BPA was transported to the hospital where the agent died.
- A Customs and Border Patrol (CBP) technician at his workstation told co-workers he was not feeling well and passed out. He was transported to the hospital where he later died.
- A BPA was involved in an on-duty MVC.
- An employee was found unresponsive in their home office.
- An employee was found unresponsive in the IT server room.
- An employee was found deceased in a hotel room.

Amputations

- An employee was putting a snowboard case on the conveyor at the airport after screening when the conveyor began to move. The employee's index finger pad was caught in the belt and the tissue was torn off.

Hospitalizations

- Seventy-nine employees (Border Patrol Agents and Officers, and Immigration and Customs Agents and Officers) were exposed to COVID-19 on duty, which resulted in their hospitalizations.
- One employee suffered an adverse reaction to a COVID-19 vaccination.
- A BPA experienced a stroke while patrolling the border.
- A BPA was driving their patrol car, experienced a medical event, and crashed the vehicle. The BPA was airlifted to the hospital due to cardiac arrest.
- A BPA was participating in takedown training and experienced an abnormal lung expansion. The employee experienced pain and trouble breathing the next day. The lung expansion caused pinholes in a lung and the agent was admitted to the hospital, which reinflated the agent's lung.

- A BPA was operating an ATV when they collided with a civilian car. Employee suffered multiple fractures.
- A BPA was operating an ATV when they hit a berm and were thrown from the ATV. The employee suffered a concussion, broken humerus (required surgery), and bruised lungs.
- A mechanic experienced chest and abdominal pains, receiving a diagnosis of dissecting aorta. The employee checked themselves out against medical advice and died at home the next day.
- A BPA was riding a motorcycle and was thrown from the bike. The BPA suffered multiple fractures and a punctured lung.
- A BPA experienced chest pain at work and was transported to the hospital.
- A BPA was participating in ATV training and flipped the ATV flipped over on top of them, injuring their back.
- A BPA fell into a wash while working in the desert. The agent was transferred to the hospital with multiple fractures and a lacerated liver.
- A BPA complained of a severe headache, was evaluated onsite, and had elevated blood pressure. He was transported to hospital and diagnosed with a possible brain bleed.
- A trainee was participating in Muscle Endurance Training (MET) and started to feel ill. The trainee was taken to the hospital for dehydration and rhabdomyolysis.
- A BPA suffered a ruptured blood vessel in the stomach while on duty. Transported to hospital from treatment.
- A BPA was involved in an ATV accident and suffered multiple injuries.
- A BPA was driving from his place of work to a required location for physical training. The BPA was involved in a vehicle accident and suffered multiple fractures.
- A BPA lost control and rolled an ATV on a steep hill, injuring the agent's back.
- A BPA lost control of an ATV and hit a tree causing internal injuries.
- A BPA was pursuing an illegal migrant on foot when the agent sustained a broken leg.
- A BPA was experiencing dizziness, was transported to hospital, and received treatment for dehydration.
- A BPA was in pursuit of a subject and jumped from a 6-foot fence, injuring both knees.
- A trainee exhibiting heat related symptoms was diagnosed with rhabdomyolysis.
- A BPA began experiencing stroke-like symptoms. EMS was called. Employee was diagnoses with stress and/or blood pressure related illness.
- A BPA was sitting in a chair when it began to fall over. The employee made an awkward motion to try to prevent the fall. The employee suffered back injuries requiring surgery.
- A BPA complained about difficulty urinating. The employee was evaluated onsite and transported to a hospital for treatment. The employee was diagnosed with rhabdomyolysis.
- A BPA was experiencing slurred speech and a headache. The agent transported to the hospital for further treatment.
- A trainee noticed blood in their urine and went to the emergency room. The trainee was diagnosed with rhabdomyolysis and liver failure.
- An employee reported not feeling well and had shortness of breath. The employee went to the hospital, which diagnosed a blood clot.

- A Special Agent was searching a residential attic when the agent fell through the floor, 10-15 feet to the ground below..
- An employee experienced stomach pain and required emergency appendix surgery.
- An employee experienced chest pain and numbness in the left arm.
- An employee experienced back pain after lifting boxes weighing 50-100 lbs throughout their 18-hour workday.
- An employee suffered an accidental self-inflicted gunshot wound while at the firing range.
- An employee was descending the helicopter rope and lost control, hitting the ground 10-15 feet below, fracturing a leg and dislocating an ankle.
- An employee was driving their GOV when the employee was hit by another vehicle and suffered a head injury.
- An employee was attempting to secure a canine when the dog bit the employee on the right bicep. The employee received a laceration and puncture wounds.
- An employee experienced chest pain and started to sweat. The employee had a heart attack.
- An employee accidentally discharged their weapon while removing it from a concealed carry holster. The bullet wounded the employee's upper and middle thigh, grazed the calf, and exited the foot.
- Employee reported – on the July 4th holiday – that his right arm went numb and his right hand was cramping. Since urgent care was closed for the holiday, he went the next day and was admitted to the hospital due to a stroke.
- An employee was driving a GOV when the back bumper hit a guardrail. The airbag deployed when the side of the car then impacted the guardrail. The force of the airbag deployment injured the employee's face.
- An employee was boarding a vessel for inspection and slipped and fell on the wet gangway.
- An employee was diagnosed with rhabdomyolysis.

Department of the Interior

Fatalities

- An employee was killed in an MVC.

Amputations (none)

Hospitalizations

- Four employees were exposed to COVID-19 at work, leading to their hospitalizations.
- An employee started experiencing severe cramping while hiking back from a remote fire in mountainous terrain. The area under a prolonged excessive heat warning.
- An employee was walking alongside a small river, slipped on a wet moss-covered rock and fell, landing on a rock with the right buttock and hip. The employee was wearing the required work boots.
- During wildland fire line work, environmental conditions (winds) suddenly shifted and increased, driving the fire directly towards the firefighters, creating a "burn-over"

situation. Three employees received burns via direct and indirect heat from the fire and hot gases. The burns ranged in severity from superficial to third degree, but all survived.
- Two employees were in an MVC and were hospitalized.
- An employee slipped on an icy spot and fell, landing on their left side.
- An employee was on a bulldozer pulling a wedge up a steep road. The bulldozer slid on a patch of ice and rolled, throwing the employee off the machine.
- A trail maintenance volunteer suffered what appeared to be a stroke during trail maintenance activity. The volunteer was given basic first aid and EMS was dispatched. The volunteer was transported to local hospital.
- An employee was assisting a stranded AirBoat in a swamp, using adhesives to try to repair the boat. The next day the employee had a severe rash and could barely walk. The employee went to the hospital. It was later determined that the employee is allergic to certain clothing and adhesives.
- An employee conducting a wildlife survey was walking on a slope and placed a hand on a rock for support. The rock came loose, fell with the employee, landed on top of the worker. The employee was transported via ambulance and helicopter.
- An employee was involved in an MVC while travelling from one worksite to another.
- An employee was conducting a survey. To take pictures, the employee moved vegetation out of the way. The vegetation was poison sumac.
- An employee was pulling up planks to erect a scaffold. While untying a knot in the rope, the employee fell through the guard approximately 24 feet to the ground below.
- An employee told a co-worker they were feeling lightheaded. The employee bent over at the waist and lost consciousness, striking their head on the concrete floor in the fall.
- An employee was driving their POV to a search and rescue site when they lost control and crashed.
- The employee was string trimming when they were stung by insect and suffered a reaction to the sting.
- Employees were erecting a scaffold and moving material throughout their shift. An employee started showing symptoms of shortness of breath, difficulty standing up straight, and difficulty with verbal communication, but stated they were “ok.” Shortly afterwards the employee was slumped over asking to be taken to the hospital.
- An employee was walking into their office in the dark, tripped over a low retaining wall, flipped over the wall, and landed on their hip.
- An employee, operating a jackhammer, began to feel chest pain and was hospitalized.

Department of Justice

Fatalities

- An employee was exposed to COVID-19. The exposure resulted in the employee’s death.
- An employee was exposed to COVID-19. The exposure resulted in the employee’s death.
- An employee was exposed to COVID-19. The exposure resulted in the employee’s death.

- While employees were executing a federal search warrant at a private residence, the person of interest opened fire on several employees, fatally shooting two employees, and seriously injuring a third.
- An employee was driving a GOV assigned motorcycle and collided with a tractor-trailer.

Amputations

- An inmate employee was pushing stock through a table saw when his right thumb contacted the blade.
- An inmate employee was cutting plywood with a circular saw and cut fingers on his left hand.
- An inmate employee amputated skin and part of the nail of his left thumb tip while using a knife to cut vegetables. Inmate stated he was momentarily distracted and looked away from the cutting area while continuing to cut vegetables.
- An inmate employee attempted to lift a commercial size mixing bowl from its support cart. The weight of the bowl and contents caused them to slightly drop the bowl back down on the cart, pinching their finger.
- An inmate employee was working in dining room and went to the restroom. Once finished they closed the restroom door and inadvertently shut their finger in the door.
- An inmate employee placed their hand into a machine pinch point trying to free a jam.
- An inmate employee amputated their finger in a grommet machine.
- An inmate employee was slicing meat with meat slicer and amputated their finger.
- An inmate employee placed their hand into the cutting area of Powermatic jointer.
- An inmate employee amputated a finger when he inadvertently placed his hand into a pulley system on a fan motor.
- An inmate employee was sorting television remotes into a large Gaylord box and amputated his finger when the heavy box crushed his finger.
- While lifting weights in support of fitness for duty, an employee was returning a squat bar to the rack. The employee caught the fifth metacarpal tip between the lifting bar and the retaining rack, amputating the fingertip.

Hospitalizations

- An inmate employee was working in the institution's pasture when they slipped/tripped, lacerating a knee on a metal object on the ground, and requiring treatment and hospitalization.
- An inmate employee was summoned to front lobby. They drove a utility vehicle to the front lobby, rolled the vehicle, and got pinned underneath.
- An employee was driving a GOV from the main institution parking lot to the power house, lost consciousness, and wrecked the vehicle.
- An inmate employee was cleaning and sanitizing food trays. The employee slipped on the wet floor and suffered a leg injury.
- An inmate employee was cleaning a restroom in the unit. The employee applied disinfectant to the floor, which made it slippery. The inmate slipped and fell, fracturing an arm against the wheelchair rail.
- An inmate worker attempted to transport a 15-gallon bucket of hot water over their head, spilling water on their neck area and causing burns.
- An employee was exposed to COVID-19. The exposure led to a hospitalization.

- An employee was exposed to COVID-19. The exposure led to a hospitalization.
- An inmate worker was driving a tractor in an agriculture field and dismounted from the tractor to make an adjustment to the machine. The tractor engaged and ran over the employee's leg.
- An inmate worker was using a lathe when the stock was thrown from the machine and struck the inmate in the face.
- An inmate employee was standing in the bed of a pickup truck when the driver took off, causing the inmate worker to fall, hit their head, and suffer severe contusions.
- An employee engaged in operational activity developed rhabdomyolysis.
- An employee engaged in physical training had a heart attack.
- An employee had a reaction to a COVID-19 vaccination.
- An employee performing duties was injured.
- While employees were executing a federal search warrant at a private residence, the person of interest opened fire on several employees, fatally shooting two and seriously injuring one employee.
- An employee was participating in a grappling exercise for a defensive tactics training course. The individual rolled an ankle, fracturing both the tibia and fibula, which required surgery.
- Employee was participating in a martial arts club as a part of defensive tactics training. The employee fractured their ankle.
- An employee was hiking with a rucksack and lost feeling in their legs. The employee suffered a herniated disc and rhabdomyolysis.
- An employee was performing back extensions and heard a pop in their back. Employee suffered two slipped discs in their back.
- An employee was participating in a firearms training exercise requiring the employee to run and roll with the weapon. The employee exacerbated bursitis due to hitting a concrete pad with significant energy. The employee incurred septic bursitis and required antibiotic treatment overnight.
- An employee was completing SCUBA diving in support of a Bureau incident. The employee surfaced from underwater exercise and developed shortness of breath and blood-tinged sputum. The employee was hospitalized overnight due to pneumonia symptoms.
- An employee was feeling ill after participating in a fitness for duty test. The employee was seen by a Bureau medic, was given water, and rested. Several hours later the employee passed out and then woke up. The employee was immediately hospitalized.
- An employee was participating in on-the-job drone training. The employee began experiencing several strokes, was taken to the hospital, and was diagnosed with a blood infection.
- An employee participating in physical fitness training became dehydrated and passed out. The employee developed rhabdomyolysis.
- The employee was serving an arrest warrant and was shot.
- An employee participating in physical fitness training became dehydrated and suffered heat stress. The employee developed rhabdomyolysis.
- An employee stepped on a nail, and it punctured his boot and great toe.

- An employee was on duty in their GOV when they started to feel the right side of their body go numb. Another employee called EMS. Possible diagnosis is several strokes.
- An employee transported COVID-19-positive inmates.
- An employee started experiencing chest pains while on duty.
- An employee participating in outdoor exercise became dehydrated and suffered heat exhaustion. The employee developed rhabdomyolysis.
- An employee was exposed to COVID-19-positive inmates.
- An employee responded to shots fired and was shot in the shoulder.
- An employee participating in physical training became dehydrated and passed out. The employee developed rhabdomyolysis.
- An employee was possibly exposed to pneumonia.
- An employee was in an MVC.

Department of State

Fatalities

- A GOV was hit from behind by a semi-truck traveling over the speed limit while attempting to pass the GOV.
- A maintenance employee's body was found in a pool.

Amputations

- An employee was removing a timber that was dunnage on a container using forklift, rope, and bolt cutters. While under tension from the rope and forklift, the timber came loose, and the forklift's front lift assembly came down quickly onto the worker's foot, resulting in the loss of four toes.

Hospitalizations

- A GOV was hit from behind by a semi-truck traveling over the speed limit while attempting to pass the GOV.
- A GOV driver in an armored vehicle changed the lanes suddenly, left the pavement, and rolled, totaling the vehicle.
- An employee was exiting a truck backwards, fell, and hit their head on the base of metal cabinet shelves.
- An employee looking for a water leak in the switch room knelt and received an electric shock.
- An employee tripped and fell on their arm while walking in the Consulate Compound.
- An employee participating in training jumped a wall and fell approximately five feet.
- An employee slipped on ice in the parking area while patrolling the grounds.
- An employee lost their footing on uneven flooring and slipped and fell.
- An employee sitting on the back of a truck jumped down and broke a knee on impact.
- An employee was riding a Segway and fell.
- An employee slipped on freshly mopped floor.
- An employee lost their balance while reaching for an item on a sharp-edged shelf. When the employee tried to catch their balance, they cut their hand on the shelf.

- An employee entering the front gate put down a water bottle, entered through the gate, and reached back for the bottle as the guard activated the gate. The closing gate caught the employee's arm, fracturing the arm.
- A gardener was using a trimmer when it jammed on a large branch. The trimmer remained energized while the employee freed the limb and cut two of the employee's fingers.
- An employee became dizzy and collapsed, hitting their head. It was determined it was related to alcohol consumption.
- An employee was using crutches while navigating a path. A crutch slipped, causing the employee to fall on their back and suffer a fractured pelvis.
- An employee slipped while carrying a lamp down a ladder. The lamp landed on the employee's ankle fracturing it.
- An employee was carrying objects while walking down the stairs. The employee slipped and fell, hitting their head and back.
- An employee was walking down a corridor when they misstepped and fell. The employee fractured a leg.
- An employee was attempting to move a ladder on wheels. The ladder moved suddenly and struck the employee's toe, causing a severe injury.
- An employee participating in a security drill twisted a knee and tore the meniscus.
- An employee was trying to open an armored door when their hand slipped off the handle. The employee fell backwards, landed on an arm, and fractured their wrist.
- An employee waiting to board a boat had one foot on the dock and the other in mid-air when a wave caused the boat to hit their leg, catching it between the dock and the boat and fracturing the employee's ankle.
- An employee fell down the stairs, suffering an injured back.
- An employee fainted while stepping on a ladder.
- An employee was placing corrugated steel panels on a shed when a panel slipped. While the employee was trying to stabilize the panel, the employee suffered a laceration to the hand that required surgery.
- An employee had an industrial tape dispenser in his hand and reached for a box with the other hand. His hand contacted the serrated blade of the tape dispenser, which cut his hand.
- An employee fell down the stairs, injuring the head and legs.
- An employee was assisting another employee who was working with a circular saw. The employee reached under the saw to catch the waste, suffering thumb and finger lacerations from the saw.
- An employee walking outside lost balance, fell into a ditch, and suffered a fractured arm and dislocated shoulder.
- An employee driving a GOV was in an MVC.
- An employee felt a sharp pain while moving and lifting mail bags. The employee suffered an inguinal hernia.
- An employee was injured while performing maintenance on a split A/C coil leak problem. While charging the gas, the flow viewer glass in the gas charging manifold suddenly broke. The flying glass injured the employee on the left forearm, forehead, and near the left eyebrow.

- An employee was investigating a vehicle collision with the security barrier. The employee approached the barrier to check the damage to the car, stood right in the path of the delta barrier top plate, and another operator put down the barrier without the employee's order. The barrier injured the employee's pinky toe, which required surgery.
- An employee was working as a role player in a defensive tactic scenario. During the scenario, a student introduced a live fixed blade knife instead of the red training knife. The employee received a stab wound to the neck.
- Eight days after receiving a COVID-19 vaccination an employee developed a widespread rash which caused skin damage.

Department of Transportation

Fatalities

- An employee was exposed to COVID-19 in the workplace. The exposure resulted in death.
- An employee was exposed to COVID-19 in the workplace. The exposure resulted in death.

Amputations (none)

Hospitalizations

- An employee was descending an attached ladder on an antenna inside the radome. The employee lost hand grip and fell approximately 12 feet onto the deck.
- An employee was exposed to COVID-19 and was hospitalized.
- An employee was exposed to COVID-19 and was hospitalized.
- A forklift operator exited a parked forklift and proceeded to the back of the lift to attach it to the charging station. Another operator attempted to park their lift alongside. The second lift hit the parked lift and pinned the first operator between the parked lift and the wall.
- An employee was exposed to COVID-19 and was hospitalized.

Department of the Treasury

Fatalities (none)

Amputations (none)

Hospitalizations

- An employee using a door interlock bypass tool injured their hand while trying to determine why planchets were not feeding correctly.

Department of Veterans Affairs

Fatalities

- Twenty employees were exposed to COVID-19. These exposures resulted in their deaths. The employees worked in several roles within the VA including, but not limited to, administrative support, healthcare, laboratory technicians, housekeeping, and maintenance.

- An employee working to untangle the line on a flagpole fell backwards approximately four feet the ground. The employee suffered a fatal head injury.

Amputations

- An employee wiping an unguarded conveyor cover area caught fingers in the machine and suffered amputation of the tips of the 3rd and 4th digits of the left hand.
- An employee was working on an air handling unit when their finger became caught between the belt and the pulley.

Hospitalizations

- Ninety-four employees were exposed to COVID-19. These exposures resulted in their hospitalizations. The employees worked in several roles within the VA including, but not limited to, administrative support, healthcare, laboratory technicians, housekeeping, and maintenance.
- An employee's finger was caught in a self-closing door.
- An employee was using a hand grinder on a valve. While using the grinder without the guard, the blade bound on the steel bolt of the valve, kicked back, and cut the employee's right hand and wrist, severing a tendon, two nerves, and an artery. The employee was hospitalized.
- An employee conducting maintenance on the Leica Microtome in the Histology Lab sliced off the tip of the 5th digit on their right hand on the microtome's cutting blade.
- An employee had a seizure at their desk. During the seizure, the employee hit their head and suffered respiratory arrest. CPR was performed until the medical team arrived.
- An employee walking from their vehicle toward the elevator lobby slipped on ice in the parking garage. The employee suffered fibular and bimalleolar fractures.
- An employee slipped and fell on wet floor.
- An employee fell off a loading dock.
- An employee was exposed to fumes, started feeling dizzy, and had trouble focusing their eyes. The fumes were cleared, and employee returned to work. The fumes returned and the employee was hospitalized.
- An employee on crutches took the stairs, fell, and broke a leg.
- An employee was changing filters on a commercial coffee maker that still contained hot water. The hot water spilled on the employee's chest and arm.
- An employee mopping the floor needed to move a bed to continue. The employee slipped on the wet floor and fractured a hip.
- An employee fell while using the stairs.
- An employee was walking from behind a desk, caught a foot on the desk, and fell.
- An employee riding his bike on wet roads fell when the bike slipped out from underneath him.
- An employee was driving a patient transport vehicle when they were hit from behind by another vehicle.
- An employee had a allergic reaction to flowers in a conference room.
- An employee had a stroke after receiving a COVID-19 vaccine.
- An employee had an anaphylactic reaction to the Hepatitis B vaccine.
- An employee suffered a heart attack while working in a sleep lab.

Peace Corps

Fatalities (none)

Amputations (none)

Hospitalizations

- An employee was struck by a tree branch while trimming trees and suffered an eye lens injury.

Smithsonian Institute

Fatalities (none)

Amputations (none)

Hospitalizations

- Employee fell when attempting to get in the vehicle due to a broken handle on the small cart.

Tennessee Valley Authority

Fatalities (none)

Amputations

- While performing contact inspection of an LTC diverter a Power Service Shop staff augmented electrician – using the vendor taught method – inadvertently repositioned his hand into the line of fire during manual manipulation of the diverter resulting in a partial amputation of his left middle finger.

Hospitalizations (none)

Appendix 7: Best Practices for Tracking Hazard Abatement

Some agencies elaborated on mechanisms for reporting and/or tracking workplace hazards and their abatement. This appendix lists those mechanisms.

American Battle Monuments Commission

1. The "ABMC Safety and Health Inspection Checklist" is used to perform inspections of work areas and operations.
2. After conducting the inspection, a completed certification is submitted by the inspector.
3. Leadership then coordinates with cemetery operations to implement controls to reduce risk to an acceptable level.
4. All mitigation plans must be approved by Cemetery Operations. OSH risk acceptance must be in writing and signed by the applicable acceptance authority prior to resuming related operational capability.
5. When completed, a printed form is signed by the Superintendent. In addition, a completed Hazard Abatement Plan is submitted that identifies deficiencies that cannot be corrected on the same day, or the correction is beyond the control of the cemetery Superintendent.

Central Intelligence Agency

1. Environmental Safety Officers are responsible for collaborating with their site management in monitoring the progress and effectiveness of hazard abatement and controls that are implemented in their work areas.
2. Environmental Safety Division utilizes Archibus – a commercial off-the-shelf workplace management system that includes safety and environmental management modules.
3. It has improved documentation and tracking of incident investigations, and safety audit findings and corrections.
4. The Archibus system issues scheduled reminders for upcoming correction dates.

Defense Nuclear Facilities Safety Board

1. OSH Manager maintains a hazard tracking spreadsheet, updates and reviews the status of hazards monthly.
2. If a hazard presents an immediate threat to safety, it is tracked daily until abated.

Department of Commerce

1. DOC policy requires that hazards be tracked from identification through abatement but leaves the exact mechanism by which such tracking will occur up to the individual bureaus. Bureau hazard tracking mechanisms may be as simple as a work order log for smaller bureaus co-located in the Herbert C. Hoover Building (HCHB) or may utilize fully developed information management systems for those bureaus with multiple buildings, facilities, or unique workspaces. National Oceanic and Atmospheric Administration's (NOAA) facility and safety managers at all levels are responsible for developing and maintaining a Hazard/Deficiency Tracking Log to track and manage hazards and deficiencies. Hazards and deficiencies that cannot be resolved immediately must be logged, tracked, and managed.

2. National Institute of Standards and Technology (NIST) records all formal inspection dates and findings, as well as all abatement actions and dates, in a single electronic information management system, the Workplace Inspection Recording System (WIRS). WIRS automatically communicates a list of the findings to the supervisor of each workplace. For each finding in the list, the supervisor records both the interim and final abatement actions that were taken and their dates. WIRS sends monthly reminders to supervisors when findings remain uncorrected for more than 30 days.
3. At Census headquarters, the Remedy System is used to report unsafe conditions or building problems that require repairs. The system reports issues directly to the GSA to allow prompt remediation. Census facilities and safety staff use Remedy to check on reported problems and the status of corrective actions, and to generate reports useful in assessing trends of problems or hazards. Census and the GSA meet biweekly at facilities meetings to assess hazards as they arise. Hazards and other facilities' issues are noted and placed on a standing agenda to be addressed until they are resolved or mitigated to the maximum extent possible. The Safety and Claims Branch also collaborated with Census IT staff to develop SAFER, which provides an automated process for Safety Representatives to perform building inspections and hazmat inventories once every fiscal quarter, and to assign safety monitors when needed.
4. At the Bureau of Economic Analysis, once hazards are identified, the Safety and Health Coordinator will investigate and work with staff members to correct the issue as quickly as possible. The Safety and Health Coordinator maintains a detailed document of the deficiency, which lists who is assigned to correct the issue, what corrective action was taken, and the date the correction was completed.
5. The Bureau of Industry and Security (BIS) Safety and Health Coordinator tracks abatement of hazards that are identified and reported to them on a spreadsheet. The hazard remains on the spreadsheet in an open status until corrected. Forms are provided on the BIS intranet for supervisors and employees to retrieve, complete, and post in the office/workplace to identify the hazardous work area. Once the hazard is identified, it should be corrected within 3 working days. Hazards that are identified during annual safety and health assessments that cannot be corrected on the spot are generally allowed 45 days for correction and are tracked on the spreadsheet.

Department of Energy

1. In most cases, the abatement of hazards that are identified during the inspections are followed up and tracked through various management information systems. Hazards identified by DOE headquarters (HQ) staff are categorized as high, medium, and low hazards and are entered into the Office of Management's (MA) computerized facilities maintenance management software program. This is an internal program used to initiate all repair and maintenance work orders at the HQ buildings. Each individual hazard or instance is assigned a unique identification number for tracking purposes. Each identification number corresponds to an active service request that is distributed to the appropriate facilities team or individual(s) for correction. MA tracks the progress of all hazard abatements and reports on the status on a weekly basis. High and medium hazard findings are fixed or mitigated immediately. For example, during the annual Federal Employee Occupational Safety and Health (FEOSH) inspection of public and higher hazard areas such as mechanical equipment rooms, all high hazard findings were reported

immediately to Facilities, given a unique identification number, and corrected immediately.

2. At the DOE Savannah River Operations Office, the abatement of hazards and due dates are tracked via the Site Tracking Analysis and Reporting database for tracking and trending of safety data and to ensure satisfactory corrective actions are implemented to eliminate the identified hazards.
3. At National Nuclear Security Administration sites for example, hazards are tracked and abated by the Management and Operating contractor, as appropriate, and by Safety and Health Professionals as appropriate, in the DOE-HQ Computer Accident Incident Reporting System database. Identified hazards and abatement are dispositioned and tracked through the laboratories, plants, and sites facility and maintenance support service contractors through closure.

Department of Health and Human Services

1. Abatement of hazards are tracked by the HHS Safety Chief and the OS Safety Officer. They will work directly with the employee to resolve the issue. Hazards found during the annual safety inspections will be annotated on the report along with suggestions and abatement methods. A reasonable amount of time is given for all minor findings, along with several email reminders. Upon completion of abatement methods leadership must report directly with the appropriate safety personnel to verify completion. Follow up inspections will then be held.
2. The CDC tracks hazard correction using Cority™, the Survey Tracking System (STS), and the Integrated Facilities Management System (IFMS). STS is used by the Occupational Safety and Health Office (OHSO) and the Office of Laboratory Science and Safety (OLSS) to identify all CDC spaces requiring a survey and manage the results of all associated surveys while IFMS is used by the Office of Safety, Security, and Asset Management to create, review, authorize, or track the progress of changes to CDC owned facilities. Incidents and their corrective actions are tracked in these systems, assigned a date by which a response is required and are not closed out by the initiating safety personnel until resolved by the appropriate staff and their supervisor. Additionally, in CDC laboratory areas, OLSS created a “Lab Alert” system of rapid communication to share awareness of reported hazards with all laboratory programs.
3. NIOSH personnel report safety concerns through the local Environmental, Health and Safety (EHS) Team, managers, the local Health and Safety Committees, and through anonymous mechanisms that are available at each worksite. Safety concerns are expected to be corrected within 30 days. Requests or concerns are logged and tracked to completion by the local EHS Office within NIOSH using a SharePoint database.
4. The Food and Drug Administration (FDA) utilizes accident and incident reporting that have structured timelines for submission of Employee Resources and Information Center ERIC system tickets, DOL Employee Compensation and Operations Management Portal (ECOMP) submittals. The Workplace Incident Management System and Quality Management information System all of which provide time tracking of the abatement of hazards as well as documentation on notification and corrective action. All of these systems utilized by FDA have integrated schedule features that provide notification if issues are not corrected within specific time bound parameters.

Department of Homeland Security

1. Customs and Border Protection (CBP): Inspection findings are issued within 15 days of the inspection date. Findings are tracked in CBP's Human Resources Business Engine – Safety Tracking and Reporting (HRBE-STAR) System. The Management Official in Charge has 30 days to correct the hazard and report the corrective action in HRBE-STAR. The inspection results are also reported to the local safety and health committee and the union official that accompanied the inspector. The corrective actions are discussed at the next local safety committee meeting. CBP Health Physicists and Safety and Occupational Health Specialist monitor corrective actions and conducts follow up inspections as deemed necessary. Most hazards are corrected within 30 days. Repeat violations are rare.
2. Federal Emergency Management Agency (FEMA): Each fixed site facility conducts an annual safety & health self-evaluation via a self-evaluation checklist that requires an abatement plan for each identified deficiency. The local Safety Official provides their completed checklist to the Environmental Safety and Health (ESH) Division for review and follow up on abatement of identified deficiencies. FEMA's ESH Division performs routine Safety & Health technical assistance reviews at FEMA locations to evaluate facility and its operations to assess safety and health program strengths and weaknesses, identify compliance issues, best management opportunities, and recommended corrective actions. ESH Division tracks the findings with the local Safety Official until they are successfully closed.
3. U.S. Coast Guard: The Coast Guard Hazard Condition Management System (HCMS) is used to document and track hazardous conditions from identification to corrective action. Safety managers are required to provide specific corrective actions for each hazardous condition in the system and the unit Executive officer (XO) is required to endorse completion of corrective actions within the HCMS system. All imminent and serious hazardous conditions are closely tracked by OSH professionals to ensure implementation of appropriate interim and permanent controls within policy-required timelines.

Department of Justice

1. Bureau of Alcohol, Tobacco, Firearms and Explosives: During Facility Safety Inspections, for example, any office hazard discovered and documented requiring immediate attention is brought to the attention of the Supervisor and GSA. Environmental, Safety, and Health (ESH) typically performs follow-up action at thirty-day intervals.
2. Drug Enforcement Agency: In addition to the return of the Certification page to HQ upon completion of the self- inspection, for a potential hazard that will take longer than 30 days to correct the deficiency and abatement form is attached. The abatement form is reviewed and followed up on until reported completed.
3. Federal Bureau of Investigation (FBI): Findings associated with regular workplace inspections are maintained on the Division's Hazard Abatement Log that tracks the hazard in addition to the abatement practices. The Regional Occupational Safety and Environmental Program Managers and Full-time Field Office or Division ESH professional assist in abating hazards. Most FBI properties are leased facilities, and the lessor is responsible for facility- related hazard reduction and mitigation. Before properties are leased, a market survey is conducted to identify and eliminate hazards

before moving into the space. Hazards are assessed and mitigated during the planning process for operational activities.

4. United States Marshals Service (USMS): The USMS attempts timely tracking of the abatement of hazards and weekly tracks for correction. USMS District/Division Management and OEOSH coordinates to track the abatement of hazards. The hazards are tracked via email, on the Form USM-468, and all abatement notes, updates, and resolutions are documented on the form. Of note, any hazard information documented on the Form USM-468 is shared with supervisors for immediate action and/or abatement.

Department of the Interior

1. Abatement tracking is decentralized in many DOI Bureaus/Offices. Most use spreadsheets or a database to track abatement of reported hazards and safety deficiencies. Status updates to inspection hazards and safety deficiencies are recorded at various intervals depending on the Bureau/Office with quarterly updates being the most frequent.
2. Two Bureaus have developed a more comprehensive means to track abatement hazards.
3. Bureau of Indian Affairs (BIA) developed a system known as the Safety and Condition Assessment Portal (S&CAP) which enables BIA safety inspectors to document the results of several types of inspections into the Indian-Affairs Facilities Management System. S&CAP enables authorized users to create an abatement/correction for the hazard/deficiency identified during the inspection. This system also provides an automated abatement plan email notification that follows the hazard through the duration of the abatement process.
4. U.S. Geological Survey uses an electronic system (Safety Management Information System Inspection and Abatement System) to create Abatement Plans that integrate Risk Assessment Codes for all safety and health findings and those initially identified through condition assessments. All inspection findings not abated within 30 days are automatically transferred to the local organization's hazard abatement log within the IAS. This system provides automated email notifications on the status of the hazard abatement to both management and those responsible for the abatement.

National Aeronautics and Space Administration

1. The Safety, Health, and Environmental Tracking System (SHEtrak) is used at most Centers for tracking and correction of hazardous situations found as part of annual safety inspections. Hazards or non-compliances identified by safety and health inspectors, during routine and unannounced inspections, are coordinated with applicable personnel (i.e., facility safety heads, building managers, system or facility managers, or employee supervisors) and tracked to closure using this application.
2. A set amount of time is allotted for the abatement plan to be incorporated. If it is not completed by this time, an interim abatement plan is required, and a final closure date is agreed upon. A fixed time period is assigned for final closure. Not achieving an end date generates an automatic email every day to the safety professional that issued the finding along with the employee assigned to correct the finding until it is properly closed.
3. As noted earlier, we are developing an application tool that will replace SHEtrak's functionality and be more aligned with a centralized agency approach to facilities funding. This new tool is expected to be operational near the close of CY2021.

4. Hazards identified as a result of a mishap or employee injury require immediate abatement to an acceptable level of risk. Final abatement is documented as part of a corrective action plan to prevent occurrence of similar work-related injury, property damage, or mission failure. Depending on the mishap classification, the tracking and completion of corrective actions is assigned to the appropriate management level. Corrective actions are tracked in the NASA Mishap Information System until resolved. They are then reviewed and authorized as complete by the appropriate Office of Safety and Mission Assurance Engineer.