OCCUPATIONAL SAFETY AND HEALTH ACT REVIEW, 1974

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

ON

ISSUE PAPERS PREPARED BY LABOR SUBCOMMITTEE STAFF WITH ASSISTANCE FROM GAO AUDITORS AND CORRESPONDENCE BETWEEN SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE AND U.S. DEPARTMENT OF LABOR

APPENDIX

NOVEMBER 1974

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CORRESPONDENCE BETWEEN SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE AND U.S. DEPARTMENT OF LABOR

United States Senate
COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

September 5, 1974

Honorable Peter J. Brennan
The Secretary
Department of Labor
Washington, D. C. 20210

Dear Mr. Secretary:

Three years have passed since the implementation of the Occupational Safety and Health Act (OSHA), hailed at its passage by the President as one of the most important pieces of legislation ever passed by the Congress in that it involves the lives of about 60 million people.

We concur with this assessment of the importance of the Act, and in this regard we have been conducting oversight hearings to ascertain its effectiveness on the safety and health of American workers.

As part of these efforts, the Labor Subcommittee requested assistance from the General Accounting Office in examining the OSHA operations which we felt to be of the utmost importance. The Subcommittee staff then developed 17 OSHA-related issue papers intended to point out areas in which OSHA seems not to have demonstrated effectiveness. A copy of the staff report is enclosed with this letter.

The results are not encouraging. In fact, some of our findings would seem to necessitate the immediate application of corrective measures if OSHA is to have any meaningful effect on the safety and health conditions of the American workplace. The following is a partial list of the more disturbing problem areas:

1. After 3 years of record-collecting, OSHA has failed to develop the necessary statistical information by which to measure OSHA's impact on safety and health conditions. In fact, the current data system does not provide information in a form that is useful for management information and monitoring purposes. For instance,

it is impossible to determine whether serious violations have been followed up, whether hazards have in fact been abated, and whether OSHA is inspecting those establishments which are most accident-prone.

2. There seem to be no uniform application of guidelines covering the issuance of citations in circumstances where there is employer unawareness of hazardous conditions; where multiple-employer worksites are involved; where there is no obvious employee exposure; and where the employer agrees to the immediate abatement of a hazard.

3. There have been claims that OSHA is based on punitive measures rather than voluntary compliance. However, these claims do not seem to be substantiated by the available statistics. Non-serious violations, with average penalty assessments of only $18. In contrast, the number of serious violations totals only 1.3%, while willful, repeat, and imminent danger violations constitute less than 1%. The low number of serious violations being cited would seem to indicate either that (1) there is haphazard selection of establishments to be inspected which, consequently, bears little or no relationship to the serious accidents and illnesses which are occupationally related; or that (2) serious hazards are, in fact, being found but are not being cited as serious violations; or that (3) OSHA is devoting an inordinate amount of time to non-serious violations.

4. There have been instances of unduly lengthy periods between inspections and the issuance of a citation even where death of an employee was involved. Long delays, sometimes averaging over three months, are also involved in the processing of complaints.

5. OSHA has not excercised its authority to require employers to conduct inspections of their own worksites.

6. Inspection activity in the maritime industry has declined dramatically since OSHA's pre-emption of

the safety and health program formerly administered by the Bureau of Labor Standards under the Longshoremen's and Harbor Workers' Compensation Act. During fiscal year 1974, the number of establishments found in compliance by OSHA officials was 68% as compared to the general industry average of 26%, in spite of the fact that accident frequency rates in the maritime industry remain excessivley high. This indicates that OSHA has failed to direct its inspection activity into high hazard areas.

7. OSHA has promulgated standards for only three hazardous substances in the past three years. Criteria documents submitted as long as two years ago are still languishing somewhere on OSHA's standards-making process.

As a result of these findings, our Subcommittee has been forced to conclude that the Act has yet to be properly implemented. It has been shackled by an administrative ineptness which is being compounded by the lack of relevant management information.

I feel certain that you can appreciate the seriousness of this situation and will take the necessary steps to rectify it.

We are requesting that you provide answers to the questions raised in the GAO papers for the Record, and submit to us some proposals as to how you plan to correct each of the problem areas mentioned above. In addition, we further request that a progress report on the implementation of these proposals be forwarded to us within three months.

We will continue to maintain an interest in the safety and health of American workers through oversight hearings.

With best wishes.

Sincerely,

Harrison Williams

Harrison A. Williams, Jr.
Chairman

HAW:pcn

IMPACT OF OSHA ACTIVITIES ON SAFETY AND HEALTH CONDITIONS

In signing the Occupational Safety and Health Act of 1970, the President stated that, from the standpoint of those covered, the Act is probably the most important piece of legislation ever passed by the Congress of the United States, because it involves the lives of about 60 million people.

Section 2 of the Act states that the Congress found that personal injuries and illnesses arising out of work situations impose a substantial burden upon, and are a hindrance to, interstate commerce in terms of lost production and wages, medical expenses, and disability compensation payments.

In Section 2 of the Act, the Congress declared that its purpose and policy was to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources. One of the primary means provided in the Act for accomplishing that goal was authority for OSHA to set and enforce, through a program of inspections, citations, and penalties, occupational safety and health standards.

Although it has been over 3 years since OSHA was implemented, it is difficult, if not impossible, to accurately assess the impact of the law on the health and safety of American workers. The only available statistics

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on occupational illness and injury with which to assess impact are from 1972, and those from 1973 are not due until next year. Further, there is no accurate method of comparing even these limited figures to those collected before OSHA was implemented. In addition, there are no figures on the number of hazards actually abated, which should be one of the essential criteria with which to assess the Act's effectiveness. Given these limitations in data collection, attempts to assess OSHA's impact at the present time are likely to be fruitless.

Since passage of the Act, OSHA has promulgated literally hundreds of safety and health standards. Also, from July 1972, through March 1974, OSHA made 104,945 compliance inspections at workplaces, including 89,483 initial inspections and 15,462 follow-up inspections. In 24,447 or about 27% of the initial inspections, OSHA inspectors reported that the workplaces were in full compliance (i.e., the inspectors did not issue any citations for violations).

In the remaining 80,498 inspections (104,945 less 24,447) OSHA issued citations covering 364,955 violations. Of those, OSHA classified 360,102 or 98.7 percent as non-serious violations, 4,330 or 1.2 percent as serious violations, and 523 (less than 1 percent) as willful, repeat,[1] or imminent danger violations. Penalties averaged $16 each for non-serious violations, $648 each for serious violations and $1,104 each for willful, repeat, or imminent danger violations.

The Department of Labor budget justification for fiscal year 1975 contains the following comments on occupational accidents and illnesses:

> "Preliminary estimates *** indicate that, on the average, 1 out of every 10 workers experienced a job-related illness or injury during calendar year 1972 requiring more than first aid treatment. Over 5.6 million recordable injuries and illnesses occurred in private non-farm industries, resulting in a loss of 25 million workdays or 100,000 man-years of work. An average of 14 workdays were lost in those cases involving lost work-days."

---

[1]Willful or repeat violations can include serious and non-serious violations.

OSHA's management information system reports do not show how many hazards, either serious or non-serious, were actually abated as a result of OSHA's inspection efforts.

Responsibility for conducting an annual national survey of occupational illness and injury under OSHA has been delegated to the Bureau of Labor Statistics (BLS). Employers throughout the nation are required to keep records of work-related injuries and illnesses (except those requiring only first aid treatment), and must furnish such information to BLS upon request.

Since OSHA became law, BLS has made three statistical surveys of data reported under the procedures. Despite these surveys, OSHA does not have statistics that would be needed to make valid comparisons of illnesses, injuries, and deaths prior to OSHA and for the first three years of OSHA activity.

The first survey covered the last 6 months of CY 1971 (new OSHA reporting procedures went into effect July 1, 1971). BLS stated that this survey could not be used as a base year for future statistics because it covered only 6 months and may not have reflected possible seasonal patterns. In addition, since the last half of 1971 marked the initial period of recordkeeping by employers, some confusion may have resulted over interpretation of definitions.

At the same time, a "crossover-target-industry survey" was conducted covering calendar year 1971. This crossover survey was intended to cover approximately 9,500 units in manufacturing and construction. One of its purposes was to provide a comparison of data reported under the pre-OSHA system with data collected under the OSHA reporting system. These systems contained definitional differences that make it impossible to directly compare statistics gathered by the two systems.

Prior to OSHA's implementation, the Z16.1 method had previously been used to report injury and illness figures. By this method, only disabling injuries were counted in the computation of injury rates. This category was limited to only 3 types of injuries:

(1) those resulting in death

(2) those involving permanent impairment, and

(3) those temporary disabilities that would prevent an employee from working beyond the day of his injury. In addition, occupational illnesses were seldom reported.

The new system under OSHA includes:

(1) occupational illness

(2) changes in jobs as a result of the injury or illness

(3) the exact number of full lost workdays, and

(4) reports of all injuries with or without lost workdays, except those requiring only first aid.

The crossover survey would have made adjustments in definitional differences and expressed those differences in ratio form so that pre- and present OSHA activity could be validly compared. However, BLS had difficulty in obtaining a sufficient sample size because of the voluntary nature of the survey. Employers were not required to furnish this additional information, and many simply neglected to return the completed surveys to BLS. When it was determined that the survey would not be completed because the forms were not being returned, the project was assigned a low priority rating and in turn was the target for budget cuts by the Commissioner of BLS. The crossover project was then dropped. Consequently, there is no present means to evaluate OSHA's impact as a comparison of pre-OSHA figures.

The National Safety Council has in the past compiled statistics on work-related injuries. This data has also been based on the Z16.1 method and will continue to be based on that system. The NSC's data, however, tends to reflect the more safety-conscious firms, because participation in the survey has been limited to NSC members.

The third BLS survey covered calendar year 1972, and was a Federal/State program in that reports were received and processed by state statistical grant agencies in cooperation

with BLS. 600,000 private nonfarm employers were surveyed. Of these, 200,000 were sampled to determine the national statistics, while the remainder were used for State statistical purposes. The 1972 survey reported:

(1) 5,656,700 total recordable cases of injuries and illnesses. (A BLS official stated that the reliability of this figure is a 95% chance that the true or actual number falls between 5,640,700 and 5,672,700).

(2) 5,500 fatalities. (Reliability is a 95% chance that the true or actual number falls between 4,620 and 6,380).

This 1972 survey contains the latest published statistics on occupational illness and injury. BLS is currently collecting data from employers for 1973, and publication of preliminary estimates is planned for November, 1974. The reasons for the delay are that BLS and the states did not begin to collect data for 1973 until March 1974, and that the collection phase is scheduled from March through August 1974.

QUESTIONS

1. In view of the statistics on occupational accidents and illnesses, what is OSHA's assessment of the impact of its efforts to date on safety and health conditions at workplaces and what is the basis for such assessment? Does OSHA have any information on or insight into whether accident and illness frequency rates have increased or decreased since OSHA initiated its activities? How can OSHA evaluate the effectiveness of its inspection efforts without reviewing data on serious hazards abated as a result thereof?

For program evaluation purposes, does OSHA equate violations cited to hazards abated?

2. Concerning the calendar year 1972 data and estimates of job-related accidents and illnesses, how did this data impact on the direction and emphasis of OSHA's inspection program?

3. Does OSHA know, in addition to the frequency of accidents and illnesses, the causes of serious accidents and illnesses and whether OSHA standards are adequate to prevent them? Does OSHA believe that such knowledge is essential to effective administration of the entire Act?

7/29/74

SELECTION OF WORKPLACES FOR INSPECTION

OSHA estimates that there are about 5 million workplaces subject to inspection under the act. OSHA made 47,595 inspections in FY 1973, approximately 75,000 inspections in FY 1974, and anticipates over 100,000 inspections in FY 1975.

Senate Report No. 91-1282 on the bill that became the 1970 act contains the following statement concerning the selection of workplaces for inspection.

> "In recognition of the possibility of limited inspection manpower in the earlier phases of the program, the committee expects that the Secretary will initially place emphasis on inspections in those industries or occupations where the need to assure safe and healthful conditions is determined to be the most compelling."

House Report No. 91-1291 contains a statement similar to that quoted above.

OSHA's compliance operations manual and supplementary directives in effect since fiscal July 1, 1973, provided that inspection priorities were as follows:

PRIORITY	CATEGORY
First	Investigation of evidence of imminent danger
Second	Catastrophe and/or fatality investigations
Third	Complaint investigations
Fourth	Special programs including target industry and target health hazard inspections
Fifth	General inspections and related activities

Imminent danger investigations are based on complaints that are usually received from employees or union representatives. These complaints are generally communicated by telephone and occasionally by letter.

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Investigations in the second and third priority categories are based on accident reports from employers and complaints from employees or their representatives. In the fourth and fifth priority categories, OSHA must identify and select the workplaces.

The principal purpose of the fourth priority category -- target industry and target health hazard inspections -- is to provide for coverage on a "worst-first" basis. The principal purpose of the fifth priority category is to establish OSHA's presence as widely as possible.

On the basis of their relatively high injury rates, OSHA selected five target industries for the fourth priority category: longshoring; lumber and wood products; roofing and sheet metal; meat and meat products; and manufacturing of mobile homes and other transportation equipment.

OSHA also selected five health hazards as special targets for inspection coverage in the fourth priority category. These were asbestos, cotton dust, silica dust, lead, and carbon monoxide. According to OSHA, the selection of the health hazards was based on (1) extent and severity of employee exposure, (2) existence of standards, and (3) ability to adequately measure exposure levels.

According to an OSHA headquarters official, OSHA began emphasizing inspections of trenching and excavation hazards in

the latter part of fiscal year 1973 because cave-ins had resulted in death or serious injury to a number of workers.

OSHA headquarters purchased listings of names and addresses of employers in the target industries, target health hazard industries, and general industries. The listings were sent to OSHA area offices for use in selecting employers for inspection. In addition to these listings, OSHA area offices have used such sources as telephone directories and industry listings prepared by States to identify employers for inspections.

Area Directors (AD's) for OSHA are primarily responsible for selecting workplaces to be inspected. Priorities for inspections are directed to be based on the "urgency and seriousness of any alleged violation or situation." Consequently, area directors may utilize full existing manpower for investigations of fatalities or catastrophes and serious complaints before target industries and general industries are inspected.

In planning general industry inspections, OSHA's field operations manual directs AD's to select counties within their jurisdictions, taking into account population and establishment concentration. Then, at least one large and one small establishment (based on employment size) are to be chosen from each two-digit SIC code group in the general industry listings. Additional establishments within these SIC listings may be selected on the basis of the proportion of such industry in the selected county.

During July 1972 to May 1974, OSHA's inspections by size of establishment were as shown below. These do not include reinspections or follow-up inspections.

Number of employees	Inspections	
	Number	Percent
1 to 15	32,184	39
16 to 25	9,138	11
26 and over	40,660	50
Total	81,982	100

According to OSHA's Office of Management Data Systems, statistics on inspections of employers with 26 to 100 employees and on the distribution of inspections by size of employer and priority category were not readily available as of July 1974.

From July 1973 through May 1974, OSHA made about 72,000 inspections of workplaces. In 22 percent of initial inspections OSHA did not issue any citations for violations.

Moreover, the inspections made during that year included 8,642 in target industries, 2,251 in industries suspected of having target health hazards, and 60,957 in general industries. Although target industry and target health hazard inspections were intended to provide coverage on a "worst-first" basis, OSHA did not issue any citations in 40 percent of the initial target industry inspections and 24 percent of the initial target health hazard inspections. In contrast, OSHA did not issue citations in 21 percent of the initial general industry inspections.

The percentages of target industry inspections resulting in no citations was greater than the percentages in general industry inspections in eight of OSHA's ten regions. The following table shows the percentages for each category of inspections in the ten regions during fiscal year 1974 (as of May, 1974).

For statistical purposes, investigations and inspections generated by accidents and complaints are included in the three categories. Follow-up inspections are not included.

OSHA Regional offices	General industry		Target industry		Target health hazard	
	Inspections made	Percent resulting in no citations	Inspections made	Percent resulting in no citations	Inspections made	Percent resulting in no citations
1. Boston, Mass.	5,277	23%	659	68%	106	54%
2. New York, New York	6,715	23%	989	49%	164	23%
3. Philadelphia, Pa.	5,122	26%	441	49%	148	30%
4. Atlanta, Ga.	8,915	21%	1,520	34%	126	25%
5. Chicago, Ill.	16,114	18%	1,274	16%	854	17%
6. Dallas, Texas	5,767	28%	849	50%	495	36%
7. Kansas City, Mo.	4,479	20%	430	15%	97	36%
8. Denver, Colo.	4,397	11%	263	12%	181	10%
9. San Francisco, Calif.	2,407	25%	516	64%	61	25%
10. Seattle, Wash.	1,764	35%	697	55%	60	46%

Questions

1. What is OSHA's assessment of the results of its efforts to emphasize inspections in those places where the need to reduce safety and health hazards is the most compelling?

2. Does OSHA believe that the 22 percent "full-compliance" factor for inspections made during fiscal year 1974 (through May) points up a need for improvements in the data and criteria used for selection of workplaces for inspection?

3. In view of the fact that target industry and target health hazard inspections have resulted in issuing no citations in 40 percent and 24 percent of the inspections, respectively, does OSHA believe that these programs are achieving the purpose of inspection coverage on a "worst-first" basis?

4. Aside from the comparative data on the number of employers found in full compliance, does OSHA have any means of ascertaining and comparing the extent that target industry, target health hazard and general industry inspections have resulted in citing and abating hazards that could cause serious physical harm or death?

5. Has OSHA considered modifying its policies and procedures to insure that its scheduled inspections, including general industry inspections, are primarily directed to finding and eliminating safety and health hazards that are causing serious injuries and illness? To accomplish such a purpose, would OSHA need to accumulate and analyze data on what is causing serious injury and illness, whether such causes relate to specific OSHA standards that could prevent or reduce them, and where they are likely to be?

7/31/74

CITING HAZARDS NOTED DURING INSPECTIONS

Section 9 (a) of the act provides that OSHA shall issue a citation if, upon inspection or investigation, it believes that an employer has violated either of the following:

---A requirement in Section 5 that employers provide workplaces free of recognized hazards that are causing or are likely to cause serious physical harm or death.

---Any safety and health standard, rule, or order promulgated under section 6 of the act.

---Any regulation prescribed pursuant to the act.

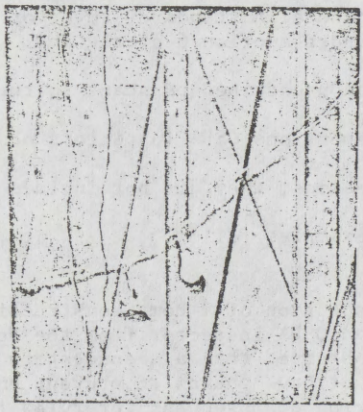
During their inspections OSHA inspectors observed hazards which, for various reasons, they did not include in citations to employers. Some examples follow:

---During an inspection of a home construction site in August 1973 an OSHA inspector from the New York area office observed that a second-story floor opening did not have guards to prevent employees from falling. During a subsequent interview the inspector said that although OSHA standards require guards around such openings, he did not issue a citation covering this hazard because workmen at the site had told him that the opening was a stairwell, and that the stairway would be constructed shortly. The inspector's report did not mention this hazard and his reason for not citing it.

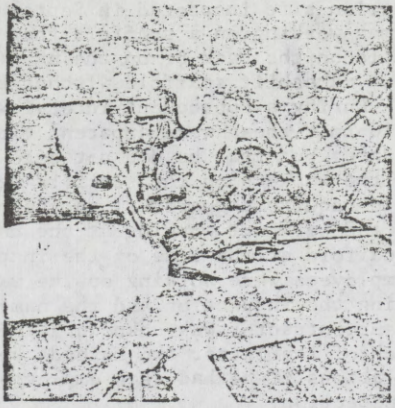
---During an inspection of a construction site in August 1973 an OSHA inspector from the Chicago area office observed that the drive chain on a cement mixer was not guarded as required by OSHA standards. During a subsequent interview the inspector said that he

did not cite this hazard because the employer agreed to put a guard on the drive chain.

---An OSHA inspector from the Chicago area office did not cite the following hazards which he observed during his inspection of a construction site in August 1973: (1) ungrounded wiring in an elevator shaft (picture 1); (2) lack of a safety cap on a gasoline can; and (3) unguarded chain drive on a hoisting machine and improper anchoring of the hoisting machine with rolls of roofing paper (picture 2). During a subsequent interview, the inspector said that each of these hazards were violations of OSHA standards but that he did not issue citations covering them because the responsible subcontractor was not working at the time the inspection was made.



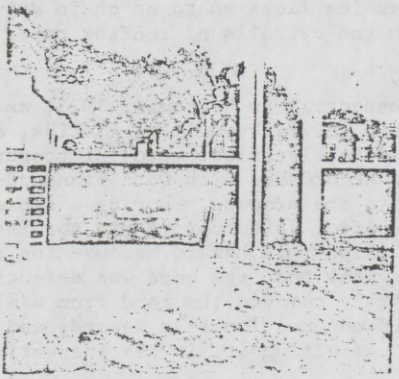
1. Ungrounded wiring in elevator shaft.
(Actual photograph in Labor Subcommittee staff file.)



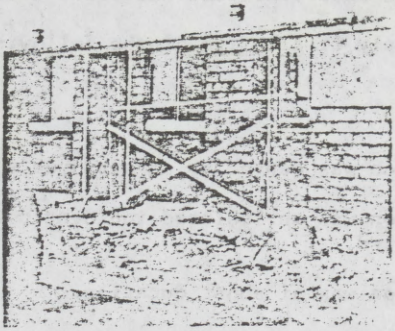
2. Hoisting machine lacks guard on chain drive and is anchored by rolls of roofing paper.

---During an inspection in September 1973, an OSHA inspector from the Jacksonville, Florida, area office tested an electrical cord for proper grounding in accordance with OSHA standards and was shocked in the process. During a subsequent interview the inspector said that he did not issue a citation covering this hazard because the employer (1) did not know that the cord was defective and (2) he immediately removed the cord from use. The inspector did not mention this hazard, and the reasons for not citing it, in his inspection report.

---An OSHA inspector from the Chicago area office observed but did not cite the following hazards at a construction site inspected in September 1973: (1) men working on a scaffold that did not have guardrails on the back or on the end (picture 3) and (2) a makeshift scaffold without guardrails (picture 4). During a subsequent interview the inspector said that these were apparent violations of OSHA standards but that he did not cite them because (1) the workers on the scaffold were not yet high enough to require a guardrail on the back of the scaffold and were not working at the unguarded end of the scaffold at the time of the inspection and (2) no employees were working on the makeshift scaffold during the inspection and the name of the responsible subcontractor was unknown. The inspector said that each of the latter two hazards would have been cited as violations if he had seen employee exposure during the inspection.



3. Workers on scaffold without guardrails on the back or end.



4. Makeshift scaffold without guardrails.

---During an inspection of a construction site in September 1973 an OSHA inspector from the Chicago area office observed but did not issue citations covering an improperly built ladder and four instances of missing protective guardrails. The inspector stated during a subsequent interview that he did not cite these hazards because there was no employee exposure at the time of the inspection. He said that he would have cited these hazards as violations if there had been employee exposure at the time of the inspection.

In May 1974, OSHA revised its compliance operations manual to provide that the inspector will not issue a citation for failure to comply if all five of the following conditions are present:

1. The violation was caused by an employee's action.
2. The violation was an isolated incident not normally anticipated.
3. The violation was of short duration.
4. The violation was not participated in, observed by, or performed with the knowledge of any supervisory personnel.
5. The employee's action was in conflict with a well-established company policy that is generally enforced through disciplinary action or other appropriate procedures.

This policy was adopted partly in recognition of Review Commission decisions in certain cases involving violations resulting from employee actions.

Additional information on guidelines for citing violations resulting from employee actions may be found in the paper of that title.

Questions

1. Other than certain violations resulting from employee actions, does OSHA believe that there are other conditions under which apparent violations should not be cited? If so, what are they? What instructions, if any, has OSHA issued to its field officers on such matters?

2. Does OSHA intend that apparent violations should not be cited if the employer did not know that the hazard existed?

3. Is it OSHA's policy not to issue a citation for an apparent violation if the employer abates the hazard immediately or agrees to abate it?

4. What does OSHA expect its inspectors to do when they see an apparent violation at a multiple-employer worksite and the responsible employer (e.g., a subcontractor at a construction site) is not working at the time of the inspection? Is this a valid reason for not issuing a citation for the apparent violation? Also, if the inspector does not know the name of the responsible employer at the time of the inspection, what is the inspector required to do?

5. Does OSHA believe that an inspector should not issue a citation for an apparent violation unless he has proof of employee exposure to the hazard? For example, if an inspector sees an unsafe ladder in a workplace, must he obtain proof that employees used or will use the ladder before he can issue a citation? If so, does that proof have to be the inspector's direct observation of employee exposure to the hazard?

6. Are OSHA inspectors required to record all hazards noted during an inspection and to record their reasons for not issuing a citation or citations covering all such hazards? How does OSHA monitor the performance of its inspectors in this regard?

CLASSIFICATION OF VIOLATIONS AS SERIOUS AND NON-SERIOUS

In fiscal 1973, 47,595 initial inspections were made covering only 1.3% of the eligible workplaces, and 10.2% of the workforce intended by the Congress to be protected from occupational safety and health hazards. Since OSHA's enactment over three years ago, some 95.5% of all covered employers have yet to experience an OSHA inspection.

When one takes into account the millions of disabling injuries and 14,000 occupationally related deaths which are reported yearly, a question arises as to the efficacy of OSHA's inspection process, particularly with regard to the classification of serious violations.

Section 17 (k) of the Occupational Safety and Health Act provides: "... a serious violation shall be deemed to exist in a place of employment if there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations, or processes which have been adopted or are in use, in such places of employment unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation."

The above definition of a serious violation in the law allows that not all hazardous situations that would result in serious injuries can be cited as serious violations, due to the employer knowledge factor. Therefore, one must

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consider that the number of serious violations cited may understate the number of serious hazardous situations identified, and, conversely, the total non-serious violations cited may include some situations identified as likely to result in death or serious physical harm. It is not known how many non-serious violations represent situations which would have been cited as serious had there been employer knowledge.

The OSHA Compliance Operations Manual defines serious physical harm and sets forth general policy guidelines for OSHA inspectors to follow in interpreting the key statutory phrases, and deciding whether there is substantial probability that a violation could result in death or serious physical harm, and whether the employer knew or, with reasonable diligence, should have known, of the hazard.

The manual states that the compliance officer must ask two threshold questions to determine whether or not a serious violation exists. (1) Is there a substantial probability that death or serious physical harm could result? And, if so; (2) did the employer know, or with the exercise of reasonable diligence should he have known, of the hazard?

To determine if a violation creates a substantial probability of death or serious physical harm, two factors must first be determined:

1) That the violating condition could result in accident or illness; and

2) If the accident or illness occurred, there is a real probability, in light of experience gained by general observation of similar work situations in industry, that the result would be death or serious physical harm.

The inspector then proceeds to the issue of what is meant by "serious physical harm" ; for which guidelines are as follows (Chapter VIII, Sec. 2 (a)):

1) Serious physical harm is that type of harm which could cause permanent or prolonged impairment of the body or is the type of harm, which while not impairing the body on a prolonged basis, could cause such temporary disablement which would warrant in-patient treatment at a hospital.

2) Serious physical harm also includes that type of non-readily observable harm that could inhibit an internal bodily system in the performance of its normal function to such a degree as to shorten life or cause reduction in physical or mental efficiency, even if a remission of the condition may be accomplished through later abatement or medical treatment. Guidelines have been issued for certain toxic substances for which exposure levels constituting serious physical harm have been determined.

3) Consideration of the most likely results of the hazard when assessing serious physical harm and such assessment must be independent of any consideration of what effect abatement or medical treatment would have on the injury. Where the hazard has already resulted in an accident, a resulting injury would be quite relevant in determining the probable consequence of an accident. However, the resulting injury is not conclusive of the type of injury (or illness) that is the probable consequence of the violation.

The final step in the compliance officer's analysis concerns what is meant by "known or could have known." OSHA guidelines suggest (Chapter VIII, Sec. 3):

1) A violation is serious if there is a substantial probability that death or serious physical harm could result; unless the employer "...did not, and could not with the exercise of reasonable diligence, know of the presence of the violation."

2) If the CSHO is satisfied that the employer actually knew of the condition which constituted the violation the knowledge requirement is met.

3) In many cases the CSHO will not be able to determine employer knowledge. In such an event, the reasonable diligence test must be applied; i.e., could the employer, through the exercise of reasonable diligence, have known of the violation, assuming that the employer is safety conscious and possesses the technical expertise normally expected of an employer engaged in that particular activity (business.)

In fiscal year 1973, OSHA issued citations covering 153,225 violations. OSHA classified 98.6% of those violations as non-serious, 1.3% serious, and less than 1% as willful, repeat, or imminent danger. Proposed penalties averaged $18 for the violations classified as non-serious and $687 for those called serious. (Section 17 of the Act provides discretionary authority for assessing a civil penalty of up to $1,000 for a violation specifically determined not to be of a serious nature. For a serious violation, however, section 17 makes a civil penalty of up to $1,000 mandatory.)

In fiscal year 1974 (thru May), a total of 71,774 inspections were made in which 268,385 OSHA violations were found; and some 2,920 violations were cited by inspectors as being of serious nature. This extremely low figure of less than 1% found to be serious (as compared to all violations), is exacerbated when contrasted with results of

inspections which have been triggered by reports of accidents involving disability injury or death. In 2,103 accident inspections conducted during FY 1974 (thru May), OSHA issued citations covering 3,737 violations, of which it classified over 17% or 637 as serious.

The disparity between classifying as serious less than 1% of all violations and 17% of those found during investigations of fatal or catastrophic accidents is most striking. Since it must be assumed that not every serious violation has, in fact, caused an accident (even though by definition there is an increased likelihood), the number of total serious violations should be far greater than that which have been reported.

During fiscal year 1974 (thru May), only 0.3% of the more than 100,000 violations cited were classified as serious by the inspectors of OSHA Region #5 (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin). This is in sharp contrast to over 3.5% serious found in Region #10 (Alaska, Idaho, Oregon, and Washington). The other six regions reporting during this same time period ranged between 0.8% and 2.9%.

This large differential among OSHA regions in the percentage of serious violations to the total number of violations cited suggests a need to further evaluate the Department's concept of decentralization. A survey of area offices in fiscal year 1973 indicated that variations could be even more

substantial throughout the country. In two such offices, Portland (Oregon), and Norfolk (Virginia), inspectors classified more than 5% of the violations they cited as serious.

Indications of differences in attitude among area offices can be found both in the variety of philosophical approaches to the role of enforcement, and in the multiplicity of interpretations involving the violation of a single OSHA standard.

OSHA area offices have cited violations of the same or similar standards as serious and non-serious. For example:

--29 C.F.R. 1910.213 sets forth OSHA's standards for woodworking machinery, several of which require protective guards and other safety features to prevent employees from being cut on saw blades or struck by debris thrown by saw blades.

--During the first 6 months of fiscal year 1973, three OSHA area offices (Boston, Concord, and Hartford) in the Boston region issued citations for 101 violations of the saw-guard standards in 29 C.F.R. 1910.213. The area offices classified each of the 101 violations as non-serious.

--During the same period, an area office (Portland) in the Seattle region classified 27 violations of the saw-guard standards in 29 C.F.R. 1910.213 as serious.

Some OSHA area office directors and other OSHA officials were asked, during interviews, why they had not cited more violations as serious. Their responses are summarized as follows:

--The director of the Tulsa area office said that the intent of the act could be better accomplished with

non-serious citations and small penalties.. Officials at the Dallas regional office (which has jurisdiction over the Tulsa area office and four other area offices) said that (1) they agreed with Tulsa's philosophy, (2) this was the philosophy for the whole region, and (3) more could be accomplished by having employers spend their money on correcting hazards rather than on penalties.

--The director of the Atlanta area office said that his office placed more emphasis on getting violations corrected than on determining whether they were serious or non-serious. He said that citations for serious violations are more likely to be contested and, therefore, require more documentation than citations for non-serious violations. He said further that, in most cases, his inspectors have not taken the additional time required to document a serious violation because they believed that compliance could be achieved just as well with a non-serious citation.

--An OSHA inspector at the Jacksonville area office said that he generally would not classify a violation as serious unless a serious accident had already occurred as a result of the violation.

The director of the Portland area office, which, percentage-wise, cited more serious violations than any other area office during fiscal year 1973, said that OSHA should maintain a strict enforcement policy to encourage voluntary compliance. He said that in February 1972, he started reviewing data on serious accidents and their causes for use in determining how violations should be dealt with. It would appear that the meticulous analysis done by the Portland area director is the exception rather than the rule.

Another dimension of the serious/non-serious citation paradox concerns the attitudes and practices of the individual compliance officers. Interviews with inspectors have revealed

a tendency to classify citations as non-serious violations which could have been otherwise cited as serious. The inspectors indicate that the reason why this is done is because of the extensive amount of time and effort it takes to document a serious citation. They have exhibited such hesitation in the belief that a serious citation with a large penalty would most likely be litigated, and cause additional drain on their time. Inspectors further expressed a feeling the Review Commission has placed a greater burden on the Department to prove its case when a serious violation is involved, and that they probably won't be able to meet the evidence requirements demanded, with the result that the case will be dismissed. Some inspectors rationalized that citing an otherwise serious violation as non-serious is a necessary expedient despite the fact that they were not enforcing the law to the fullest extent possible.

Although the Department maintains a periodic computer printed list of standards violations, no comprehensive analysis has been undertaken to ascertain such basic things as the extent and nature of the most frequently violated standard classified as a serious violation, or an analysis of standards which have been cited as both serious and non-serious and why. A random review of the OSHA print-out indicates numerous examples in which inspectors have in the aggregate issued both serious and non-serious citations for violations of the same standard.

After reviewing the OSHA manual regarding serious violations in conjunction with the statutory language of the Act, it is clear that appropriate guidelines have been established to define the parameters of administrative interpretation. Despite established guidelines, OSHA inspection officials have been permitted to classify violations according to individual views as to how the Act should be applied.

Enforcement policy and citation authority has been delegated to the area director, and in certain instances, even to the Compliance Officer. (See OSHA Program Directive #200-28, dated April 22, 1974.) Little attempt has been made to coordinate the inspection policies of the various areas into a single comprehensive enforcement effort.

In this regard, it is important to note that the OSHA compliance manual states that citations involving breach of the "general duty clause" [Sec. 5(a)(1) -- employment "free from recognized hazards that are causing or are likely to cause death or serious physical harm"] should be cited as serious violations. The manual provides this rationale (Chapter VIII, Sec. 2(d)):

> Because of the virtually equivalent language used in Sections 17(k) and 5(a)(1) of the Act, in describing serious and general duty clause violations, respectively, a non-serious citation should not be issued for violations based on the general duty clause. Citations based on the general duty clause should be limited to alleged serious violations (including willful and/or repeated violations which would otherwise qualify as serious violations, except for their willful or repeated nature).

However, the manual appears to misread the law, as Sections 17(k) and 5(a)(1) do not contain "virtually equivalent language." Section 17(k) addresses serious violations and Section 5(a)(1) addresses serious hazards; they are not necessarily equivalent. The manual's interpretation of the clause does not allow for the non-serious general duty citation of a serious hazard dituation due to lack of employer knowledge.

Questions

1. What assurance does OSHA have that its inspectors are classifying violations as serious or non-serious in accordance with the Act and related OSHA policies? Does OSHA believe that the classification of 98.6 percent of violations cited in fiscal year 1973 as non-serious is a reasonably accurate reflection of safety and health conditions at the workplaces inspected?

2. Does OSHA know or can OSHA ascertain how many violations were such that they could cause serious physical harm or death but were not classified as serious because of the employer-knowledge factor? What factors other than employer knowledge can justify not citing a serious hazard as a serious violation? What specific conditions and circumstances would justify citing different violations of the same standard as serious and non-serious?

3. Are OSHA inspectors required to explain and document in the files why and how they specifically determine that a violation is or is not of a serious nature? Does OSHA believe that such explanations and documentation are necessary to provide for effective monitoring and reviewing of inspectors' decisions? How does OSHA monitor inspectors' performance in this regard?

4. Concerning reasons given by OSHA field office personnel for not citing more violations as serious, does OSHA agree that compliance can be obtained just as well with non-serious citations? Is the answer to this question the same with respect to stimulating voluntary compliance? Does OSHA agree that additional documentation is needed for citing a violation as serious? If so, is the additional time required to get such documentation a valid reason for not citing the violation as serious?

5. Has OSHA considered identifying, on the basis of historical data on accidents and their causes, specific standards which, if violated, should normally be cited as serious violations? What problems would there be in this approach?

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TIME TAKEN TO ISSUE CITATIONS AFTER INSPECTIONS

Section 9(a) of the act provides that citations for violations of safety and health standards found during inspections shall be issued "with reasonable promptness." The Conference Report (House Report No. 91-1765) on the enacted bill states that:

> "In the absence of exceptional circumstances any delay is not expected to exceed 72 hours from the time the violation is detected by the inspector."

The time periods for abating violations generally do not start until the citations are received by the employer.

However, the Review Commission (in Chicago Bridge & Iron Co., OSHR Docket No. 744) vacated a citation for a serious violation which had resulted in death because the citation had not been issued until 30 days after the submission of draft citation papers to the Area Director by the inspector and 9-16 days of the delay beyond 72 hours could not be explained by the Area Director's workload.

The Review Commission also ruled that the issue of reasonable promptness in issuing citations must be raised by the respondent at the issue formulation stage of the proceedings to be validly considered as reason for vacating penalties..

Statistics compiled by OSHA headquarters showed that, during July 1972 to April 1973:

--OSHA Field offices issued 16,310 citations.

--On the average, the citations were issued 20 days after the inspection dates.

--The average time between inspection and citation dates ranged from 13 days in the OSHA Atlanta region to 37 days

in the Dallas region.

--Only about 5 percent of the 16,310 citations were issued within 3 days after the inspection dates, while about 20 percent were issued more than 30 days after the inspection dates.

The following chart shows the average period from the inspection to the citation date for serious and non-serious vidations. These figures are national figures, and are limited by the fact that they represent only the month of May, 1974.

Time in days from inspection to citation date	No. of citations for serious violations	% of total serious citations	No. of citations for non-serious violations	% of total non-serious citations
1-5	61	(22.8)	3,989	(19.6)
6-10	123	(46.1)	10,124	(49.8)
11-15	61	(22.8)	3,892	(19.1)
16-20	12	(4.5)	940	(4.6)
21-30	4	(1.5)	944	(4.6)
30+	6	(2.2)	453	(2.2)

Average time period for serious: 9

Average time period for non-serious: 10

(This chart does not include willful, repeat, de minimus, or other violations)

Neither the OSHA compliance manual in effect prior to May 10, 1974, nor the revised manual that became effective on that date contain specific guidelines of issuing citations after inspections. However, certain inspectors may issue citations during closing conferences for some violations under certain conditions.

After advising the AD by phone, A CSHO may issue a citation if, among other considerations, laboratory analyses, professional advice (such as industrial hygienists), legal advice, or reference to documents are not needed to determine a violation, or if there are no questions as to OSHA's jurisdiction to enforce compliance. Further, if all citations cannot be issued by the CSHO at the site, none can be issued.

Questions

1. Does OSHA believe that promptness in issuing citations is important?

2. What does OSHA consider to be a reasonably prompt period within which citations generally should be issued?

3. Has OSHA evaluated why it has taken its field offices so long to issue citations and whether action could be taken to reduce the time taken?

4. Why would the average time between inspection and citation dates be considerably longer in one OSHA region compared to another (e.g., more than 100 percent longer in the Dallas region than in the Atlanta region)?

HAZARD ABATEMENT PERIODS

Section 9(a) of the act provides that a citation shall fix a reasonable time for abatement of the violation. Section 17(d) provides that a penalty of up to $1,000 may be assessed for each day the violation continues after the abatement period expires.

OSHA's compliance operations manual states that:

--the abatement period should be the shortest time within which the employer can reasonably be expected to correct the violation,

--all relevant factors of each situation should be used in determining what a reasonable time is, and

--relevant factors could be the seriousness of the violation, the number of exposed employees, the availability of needed equipment or personnel, the estimated time required for delivery and installation of needed equipment, and any other relevant circumstances.

An analysis of abatement periods established for violations cited by three OSHA area offices during the first 6 months of fiscal year 1973 follows.

	San Francisco Violations		New York Violations		Boston Violations	
	Number	Percent	Number	Percent	Number	Percent
Time allowed for abatement:						
1 day or less	238	13	309	16	247	18
2 to 15 days	536	29	358	19	513	37
16 to 30 days	176	10	566	29	310	23
More than 30 days	884	48	691	36	304	22
Total	1,834	100	1,924	100	1,374	100

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The following chart contrasts the average period from citation to abatement date for serious and non-serious violations. However, these figures are national figures and are limited by the fact that they cover only the month of May, 1974. It should be remembered that a non-serious violation could be cited for a serious hazard when the employer did not or could not with reasonable diligence know of the hazard.

Time in days from citation to abatement	No. of citations for serious violations	% of total for serious violations	No. of cit. for non-serious	% of total non-ser.
1 - 5	237	69.5%	7615	28%
6 - 10	24	7.0%	1602	5.9%
11 - 15	5	1.5%	1506	5.5%
16 - 20	13	3.8%	1364	5.0%
21 - 30	21	6.2%	4055	14.9%
30+	41	12.0%	11064	40.7%

Average time period for serious: 11 days

Average time period for non-serious: 25 days

(This chart does not include de minimus, repeat, willful, and other violations.)

In a decision that became a final order on July 8, 1974, the OSHA Review Commission ruled that an abatement period of less than 15 working days may not normally be set. On November 15, 1971, a citation was issued to Kesler and Sons Construction Company calling for immediate abatement of seven violations. On November 30, a reinspection was made and additional penalties assessed for failure to abate the hazards.

The Occupational Safety and Health Act, however, gives an employer 15 working days in which to contest a citation -- in this case until December 7. The Review Commission decided that until the 15-day period ends, a citation is no more than an accusation. The Commission noted, "It would be unreasonable to require an employer to expend time, money, and labor to make changes in his workplace in order to 'correct' conditions which may or may not be in compliance with the regulations". The Commission also noted that this decision does not preclude immediate abatement in the case of an immient danger situation, since the Act gives the Secretary an opportunity to provide for immediate relief.

Commissioner Cleary, in his dissenting opinion, stated that since an uncontested citation becomes a final order after the 15-day period, "use of the adjective 'final' ... suggests that a citation itself at an earlier stage is also an order, albeit a preliminary one". Commissioner Cleary noted that an employer, if he believes he has not violated the Act, may file a notice of contest promptly. "When faced with competing considerations of an inconvenience to employers and a continued risk of injury and illness to employees, the purpose of the Act suggests that

the protection of the employees is paramount." Finally, Commissioner Cleary questioned whether the Commission could properly rule on the issue when it had not been raised by either party to the proceedings.

Since an extension of the abatement period may not be granted by the Secretary of Labor, an employer who wishes to extend the period must file a petition for modification of abatement with the Review Commission. Even if the Secretary and the employer agree on a modified date for abatement, the final order is made by the Review Commission Administrative Law Judge.

GAO auditors provided the Labor Subcommittee with 47 decisions made by these judges concerning the hazard abatement period. In 43 of the 47 cases, the Secretary of Labor and the employer agreed on a modified abatement period (ranging from an extension of a few days to almost 3 years) before the hearing actually commenced. In none of these 43 cases did the presiding judge rule against the joint agreement. Therefore, it seems that, in the vast majority of cases, the Secretary of Labor rather than the Review Commission actually decides the terms of an extension of the abatement period.

In only 4 decisions did the judge actually decide whether the abatement period was proper:

--An asbestos textile company was granted an extension of nine months to reduce concentration of airborne asbestos fibers. Original abatement period: 8 months. (O.S.H.R.C. Docket No. 3957-P)

--The abatement periods assigned to a timber company concerning noise levels, machine guarding, identifiable exits, and lack of barriers were upheld. Abatement period: 26 days. (O.S.H.R.C. Docket No. 2258)

--The abatement period assigned to a printing company concerning 1) belt and pulley guards, 2) gear, chain, and sprocket guards, and 3) guarding of inrunning nip points were upheld. Abatement period for 1) and 2): 33 days; for 3): 3 months. (O.S.H.R.C. Docket No. 1924 P & M)

--A battery manufacturing plant was granted an extension of 2 1/2 months to abate excessive lead concentrations. Original abatement period: 5 months. (O.S.H.R.C. Docket No. 3632-P)

Questions

1. In view of the fact that the three area offices set abatement periods of more than 30 days for 48 percent, 36 percent, and 22 percent, respectively, of the violations cited, what assurance does OSHA have that inspectors are setting abatement periods in accordance with the established requirement that they be the shortest intervals within which the employers can reasonably be expected to correct the violations?

2. Does OSHA know whether area offices and individual inspectors are reasonably consistent in setting abatement periods for violations of the same standards under similar circumstances? Has this ever been evaluated by OSHA?

3. Concerning the manual instructions, it is not clear why OSHA states that the number of exposed employees could be a relevant factor in determining a reasonable time within which an employer can be expected to correct a violation. Does OSHA believe that exposure of only a few people to a hazard would justify a longer abatement period that would exposure of many?

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ASSURANCE OF ABATEMENT

Section 17 (d) of the act provides that any employer who fails to correct a cited violation within the fixed abatement period may be assessed a civil penalty of not more than $1,000 for each day during which such failure or violation continues.

The OSHA compliance operations manual and supplementary directives contain the following instructions for obtaining assurance of abatement within the specified period.

-- For each cited violation with an abatement period of 30 days or less, the OSHA area office shall require the employer to give written notification to the area office of the specific corrective action taken and the date thereof. For each violation with an abatement period of more than 30 days, the area office shall require the employer to give written progress reports at the end of each 30-day period and a final notification when abatement is complete.

-- Prompt follow-up inspections to insure abatement are mandatory for (1) all serious violations as defined in the act and willful or repeated violations and (2) all non-serious violations for which the employer fails to give the required written notification of corrective action taken

or the required written progress reports on actions being taken. Follow-up inspections on other non-serious violations may be made at the discretion of the area director.

-- Except in unusual circumstances, follow-up inspections should be made within 7 working days after the abatement date set forth in the citation.

-- Strict adherence to the follow-up inspection requirements is essential to protect the safety and health of employees and to make it clear to employers that abatement requirements will be strictly enforced.

From July 1973 through May 1974, OSHA conducted 10,969 follow-up inspections nationally, covering over 2 million employees. This number is 15% of the 71,744 establishment inspections made in total. Approximately 75% of the establishments receiving follow-up inspections were found in compliance, compared with a compliance rate for initial inspections of 24%. OSHA does not maintain information on the number of citations or violations followed up on. Follow-up inspection figures reflect only the number of establishments inspected, making it nearly impossible to determine accurately the number of violations actually abated.

Records at the Atlanta area office showed that, during the first six months of fiscal year 1973, the area office issued 17 citations for serious violations. As of June 1973,

4 of the 17 cases had been contested by the employers and the abatement deadline had not yet passed for one other case, leaving 12 serious violation cases on which follow-up inspections were mandatory under OSHA procedures. Although the abatement deadline in each of the 12 cases was several months prior to June 1973, the area office has made a follow-up inspection in only one case. In that one case, the follow-up inspection was made 18 days after the abatement deadline. The Atlanta area office director stated that the follow-up inspections were not made because the area office was concentrating on performing initial inspections.

Records at the Portland, Oregon area office showed that, during July 1971 through March 1973, the area office issued 54 citations for serious violations on which follow-up inspections were mandatory under OSHA procedures.[1] As of August 1973, the area office had made follow-up inspections in only 18 of the 54 cases. The abatement dates in the 36 cases in which the mandatory follow-up inspections were not made had expired from 3 to 21 months prior to August 1973.

The Portland area office director cited a general lack of staff as the reason for not conducting follow-up

[1]Does not include cases in which employers' contests were pending as of August 1973, or cases in which employers' contests had resulted in vacating the citations or reducing them to non-serious.

inspections. The Portland area office conducted numerous initial inspections of other workplaces during the period in which mandatory follow-up inspections were not made.

Questions

1. What assurances does OSHA have that its area offices are implementing its policies and procedures for obtaining letters from employers and making follow-up inspections to insure that cited hazards are abated within the established abatement periods?

2. What priority does OSHA intend that mandatory follow-up inspections be given compared to initial inspections at other workplaces? Does OSHA believe that its guidelines on this matter are clear enough to insure that the desired priority be given to making mandatory follow-up inspections?

3. What unusual circumstances existed at the two area offices, discussed above, that would permit failure to make mandatory follow-up inspections within 7 days after the abatement date?

4. Does OSHA know the extent that area offices are making follow-up inspections in cases in which such follow-up is not mandatory under OSHA procedures? How do area offices select such cases for follow-up? Has OSHA considered making such selections on a sample basis?

7/29/74

ACCIDENT REPORTS AND INVESTIGATIONS

Pursuant to general provisions in section 8 of the Act relating to record-keeping and reporting, OSHA regulations (29 CFR 1904.8) require employers to notify the nearest OSHA area office within 48 hours of any job-related accident that results in either (1) death of one or more employees or (2) hospitalization of five or more employees.

OSHA does not maintain figures on the number of accidents reported by employers as opposed to the number reported by other sources. A special survey made by the Department of Labor indicated, that, for the last six months of 1973, only one employer was cited for failing to report a fatality. During the same period, employers reported only 1,335 of the 1,881 fatalities reported to OSHA. The other 546 fatalities (approximately 30%) were reported to OSHA from sources other than the employer.

The probable explanation for the 30% figure (according to several asistant regional directors) is that, in cases where OSHA finds out about such accidents from other sources such as the news media, the employer need not report the accident. OSHA's new compliance manual (dated January 22, 1974) states, "If an inspection of the incident is made prior to the 48-hours requirement, no citation shall be issued to the employer for failing to report under 1904.8"

The OSHA compliance operations manual further requires that investigations of such reported accidents shall be given priority second only to imminent danger situations and shall be made before other compliance inspections.

During fiscal year 1974,(as of May, 1974), a total of 2,103 accident inspections were made, which represented 3% of the total inspections. Of these, 670 (or about 32%) were found to be in compliance. The number of violations cited as a result of the accident investigations totaled 3,737 with dollar penalties of $571,500. Of these, 637 were classified as serious violations, with dollar penalties totaling $481,730.

During fiscal year 1973, OSHA investigated a total of 2,409 accidents reported pursuant to the regulations, which represented about 5 percent of the total number of workplace inspections made during that year.

During the first 6 months of fiscal year 1973, the Chicago area office and the Atlanta area office investigated 39 and 28 reported accidents, respectively. The time lapses between the dates the accidents were reported and the dates OSHA made the inspections are shown below. However, there is no breakdown that would compare the number of employer reports of accidents which have resulted in death or hospitalization of 5 or more employees and the number of reports from other sources (such as the media), which may use a broader definition of accident.

Days lapsed between date reported and date investigated	Accidents investigated Chicago	Atlanta
0-5	5	21
6-15	2	4
16-60	8	2
61-100	8	1
	23	28

For 16 of the 39 accidents investigated by the Chicago area office, the case files did not show the dates that accidents were reported.

Questions

1. With regard to the purpose of the mandatory reporting requirement in 29 CRF 1904.8 and the priority given to investigating accidents reported thereunder, has OSHA considered the desirability of expanding the mandatory reporting requirements and accident investigations to include, in addition to fatalities and multiple-employee injuries, accidents which obviously caused immediate serious injury, such as amputation, to an employee?

2. What assurance does OSHA have that the purpose of the mandatory reporting requirement and accident investigations is being achieved?

3. What does OSHA consider to be a reasonable time within which a reported accident should be investigated? Does OSHA know whether its area offices are making accident investigations as soon as practicable after they are reported? Are there valid reasons why the elapsed time between accident reporting dates and accident investigation dates should vary significantly between area offices as well as between the individual cases reported?

4. In cases where the area office has been made aware of deaths or serious accidents from sources other than the employer, does OSHA take the responsibility for filling out the forms necessary for complete recordkeeping? If so, does OSHA rely on the source for the information necessary to complete the form?

5. In light of the fact that in the last six months of 1973, only one employer was cited for failing to report a fatality, does OSHA know whether its field officers are enforcing the mandatory reporting requirement? If so, how?

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EMPLOYEE COMPLAINTS

Section 8(f)(1) of the act provides that any employee or employee-representative who believes that a violation of a safety or health standard exists and threatens physical harm, or that an imminent danger exists, may request an inspection by giving OSHA a written notice meeting certain requirements. Section 8(f)(1) requires that

--if there are reasonable grounds to believe that such violation or danger exists, OSHA shall make a special inspection as soon as practicable to determine if it actually exists, and

--if OSHA determines that there are no reasonable grounds to believe that such violation or danger exists, OSHA shall notify the employee or employee-representative in writing of such determination.

Senate Report No. 91-1282 (91st Congress) on the bill which became the 1970 act states that:

"By requiring that the special inspection be made 'as soon as practicable,' the committee contemplates that the Secretary, in scheduling the special inspection, will take into account such factors as the degree of harmful potential involved in the condition described in the request and the urgency of competing demands for inspectors arising from other requests or regularly scheduled inspections."

The OSHA compliance operations manual provides the following with respect to the handling of complaints.

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--Inspections relating to complaints are second in priority only to accident investigations. Complaints must be acted upon as soon as possible based on priorities established by OSHA area offices considering the urgency and seriousness of the alleged violation or situation.

--If it is determined that a complaint is valid (i.e., the complaint meets the formality requirements and there are reasonable grounds for believing that the violation or danger exists) an inspection shall be scheduled as soon as practical. After the inspection, the complainant should be notified of the results by sending him either (1) a copy of the citation issued to the employer on the violation or danger set forth in the complaint or (2) a letter explaining why a citation is not warranted on the matter and the complainant's right to request further review of the determination.

--If a complaint is determined to be invalid (i.e., it does not meet the formality requirements or an inspection is not warranted because there are no reasonable grounds for believing that the violation or danger exists) the complainant shall be notified in writing. If the reason for such determination is the complainant's failure to meet the formality requirements, the notification shall explain what is needed to meet the requirements. If the reason is that there are no reasonable grounds for believing that the violation or danger exists, the notification shall state why and explain the complainant's right to request further review of the matter.

Time lapses between the dates complaints were received during the first 6 months of fiscal year 1973 and the dates inspections were made are shown below for four OSHA area offices. The time lapses averaged 35 days in the Atlanta area office, 101 days in the Chicago area office, 12 days in the New York area office, and 28 days in the San Francisco area office.

	Area office and number of cases				Total
	Atlanta	Chicago	New York	San Francisco	cases
Valid complaints for which inspections were made	26	120	21	74	241
Time lapsed between date complaint was received and date of inspection:					
Days					
0 to 5	4	12	8	16	40
6 to 15	10	6	9	18	43
16 to 30	3	9	2	12	26
31 to 60	3	20	1	21	45
Over 60	6	73	1	7	87
Total	26	120	21	74	241

The area offices had problems insuring that complainants were advised in writing of the reasons why their complaints were determined to be invalid or of the outcome of inspections generated by their complaints. For example:

--The Atlanta area office determined that 19 of the complaints it received during the first 6 months of fiscal year 1973 were invalid. The complaint log and other records at the area office did not show whether letters were sent to any of the 19 complainants. The area director said that he did not know whether the required letters were sent.

--The San Francisco area office determined that 21 of the complaints it received during the 6-month period were invalid. For 10 of these cases, the complaint log and the invalid complaint file did not show whether the required letters were sent to the complainants. Also, for 24 of 74 cases in which the area office made inspections as a result of complaints received during the 6-month period, the complaint log did not show whether letters or copies of citations were sent to the complainants to notify them of the results of the inspections.

Questions

1. Does OSHA believe that the complaint program is an effective way to identify and eliminate significant safety and health hazards? How do the results of the special inspections in response to complaints compare with the results of other inspections in terms of the number and severity of hazards detected and abated? In what percentage of cases is a citation issued on the specific alleged violation or danger set forth in a complaint?

2. Does OSHA know why weeks and sometimes months elapse between complaint and inspection dates? Does OSHA know how much, if any, of the average elapsed time between these dates was required to get the complainant to conform to the formality requirements? Why should the average time lapses between these dates vary considerably among area offices?

3. What is OSHA doing or planning to do to insure that such inspections are made as soon as practicable, considering such factors as the degree of potential harm involved and the urgency of competing demands for inspections? When scheduling special inspections, are area offices required to establish a specific target date for each inspection on the basis of relative priority and to follow up to insure that such dates are met when practicable?

4

4. What is OSHA's view on the importance of giving complainants' written notification of why their complaints are considered invalid or of the results of inspections generated by complaints considered valid? Has OSHA evaluated whether area offices have adequate complaint processing procedures and controls to insure that such notifications are sent as soon as possible? Would it be feasible and desirable to establish and prescribe uniform procedures and controls for accomplishing this?

7/31/74

GUIDELINES FOR CITING VIOLATIONS RESULTING FROM EMPLOYEE ACTIONS

Section 5(a) of the Act provides that each employer shall (1) furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm and (2) comply with occupational safety and health standards promulgated under the Act. Section 5(b) provides that each employee shall comply with occupational safety and health standards applicable to his own actions and conduct.

Senate Report No. 91-1282 on the bill that became the 1970 Act contains the following statement concerning the intent of section 5(b).

> "The Committee does not intend the employee-duty provided in section 5(b) to diminish in any way the employer's compliance responsibilities or his responsibility to assure compliance by his own employees. Final responsibility for compliance with the requirements of this act remains with the employer."

Under the Act, OSHA has authority to issue citations and propose penalties against employers for violations of safety and health standards and other requirements. There are no provisions in the Act for citing and penalizing employees for violations resulting from their actions.

In May 1974, OSHA revised its compliance operations manual to provide that the inspector will not issue a citation for failure to comply with a standard if all five of the following conditions are present.

-- The violation was caused by an employee's action.

-- The violation was an isolated incident not normally anticipated.

-- The violation was of short duration.

-- The violation was not participated in, observed by or performed with the knowledge of any supervisory personnel.

-- The employee's action was in conflict with a well-established company policy that is generally enforced through disciplinary action or other appropriate procedures.

The manual provides that in all cases where an isolated incident of violations by employees is found by an inspector, he shall discuss the employee conduct with the employee and the employer and advise the employer of (1) the employer's responsibility under the Act to assure compliance by employees and (2) the possibility of a citation being issued if such a situation is found upon reinspection.

The manual includes the following provision:

> "The CSHO shall also advise the employer that an appropriate memo entry will be made in the inspection file so that if such a situation is found to exist on reinspection, a citation may be issued."

If the same violation were found upon inspection, a citation for a willfull violation would not be issued unless that violation met the criteria set forth in the Field Operations Manual. For a violation to be willful, the employer must commit it intentionally and knowingly, or, even if he is not consciously violating the Act, he must be aware of the hazardous condition and make no reasonable effort to eliminate it.

An OSHA headquarters official, however, has stated that the Assistant Secretary has decided to revise the new guidelines. A program directive is expected shortly that will set out the following policy in the compliance operations manual:

> The CSHO will take into account the following four circumstances:
>
> (1) the violation was caused by an employee's willful action.
>
> (2) the violation was an isolated incident not normally anticipated.
>
> (3) the violation was not participated in, observed by or performed with the knowledge of any supervisory personnel.
>
> (4) the employee's action was in conflict with a well-established company policy that is generally enforced through disciplinary actions or other appropriate procedures

The change in policy indicated by the first revision

was made partly in recognition of some Review Commission decisions on employee responsibility in certain circumstances. Secretary v. Standard Glass Co., Inc., OSHRC Docket No. 259, is illustrative of the specific situation that the policy change is meant to accommodate. There was a very brief violation of Federal safety standards when two employees failed to wear hard hats for several minutes at a construction site. Company policy, which was generally enforced, dictated the wearing of hard hats at all times. There was no supervisory personnel present. The employer was cited for the violation and a penalty proposed. Both were vacated by the Commission.

The Commission decisions all adhere to the proposition that the Act is not meant to put the employer in the position of an absolute guarantor or insurer. § 5 of the Act sets out duties for both the employers and employees. While the intent of §5(b) is not to diminish the employer's responsibility, the cases hold that if the employer meets his general duty set out in § 5(a), he cannot be held responsible for actions of a non-conforming employee. This proposition has been the subject of much debate and is not a universally accepted interpretation of the law.

Three other Commission cases which bear on the issue of responsibility for violations are noted below:

In Secretary v. National Realty & Construction Company, Inc., OSAHRC Docket No. 85, September 6, 1972, where a foreman stood on the running board of moving construction equipment, contrary to the employer's unwritten order, and was killed when the machine went out of control, the Commission found the employer in violation of §5(a) of the Act because it felt that since no other suitable means of transportation existed and no positive enforcement of the employer's unwritten rule was in effect, it would be reasonable to anticipate that someone in the deceased employee's position would ride the equipment.

In Secretary v. Hanovia Lamp Division, Canrad Precision Industries, Inc., OSHRC Docket No. 89, where a brief yet hazardous condition existing in a laboratory was caused by a lab technician and he was killed, the Commission said that to hold that an experienced lab technician must be constantly watched by a supervisor would be totally impractical and generally an unrealistic burden. The citation for a serious violation was vacated.

Cases also indicate that an employer may not delegate his responsibilities under §5 to an employee-supervisor. In Secretary of Labor v. Maher Distribution Center, OSAHRC Docket No. 981, October 25, 1973, an employer assigned a supervisor to watch the employees. This supervisor permitted

a fellow worker to violate a federal safety standard by allowing the employee to operate a forklift truck without an overhead guard. Even though there was no possibility of the employer himself knowing of the hazardous conditions, the Commission held him liable for the violation, stating: "Under the Act, as well as under the Common Law, the duty of an employer to furnish a safe working place for his employees is positive, continuing and non-delegable."

QUESTIONS

1. Why did OSHA decide that there are certain conditions under which a citation should not be issued for violations of safety and health standards that could result in injury to employees? Does OSHA disagree with the congressional intent, as expressed in Senate Report No. 91-1282, that final responsibility for compliance with the standards remains with the employer? Does OSHA believe that making exceptions to this principle will not result in watering-down of OSHA's enforcement actions?

2. In view of the subjective judgments that will have to be made to implement the criteria for not issuing a citation, how does OSHA expect that its inspectors will uniformly and equitably apply it? When an inspector sees a violation during his short-lived visit, how will he know whether he is looking at an "isolated incident"? On what basis will he decide that such incident is "not normally anticipated"? How long or how short is a "short duration" and how will the inspector know how long the violation has existed before he sees it? What kind of evidence should the inspector obtain concerning supervisory personnel's participation in, observation of, or knowledge of the violation? What form of proof should he get concerning whether the violation conflicts with a well- established company policy that is generally enforced?

3. What requirements has OSHA established to insure that inspectors adequately record the bases for decisions not to issue citations in these cases?

6/26/74

EMPLOYERS' SELF-INSPECTIONS

Section 8(c)(1) of the act provides that OSHA may prescribe regulations requiring employers to conduct periodic inspections of their own workplaces. Senate Report No. 91-1282 on the bill that became the 1970 act states that:

> "The committee, bearing in mind that the number of inspections which it would be desirable to have made will undoubtedly, for an unforseeable [sic] period, exceed the capacity of the inspection force, has incorporated a further provision, authorizing the Secretary to adopt regulations obliging employers to conduct periodic inspections to determine their own state of compliance with applicable health and safety requirements ***. Such a procedure could well provide a valuable, and probably indispensable, supplement to the Secretary's own inspections, since it would cause an employer regularly to review conditions in the workplace which might otherwise be ignored between official inspections." (Underscoring supplied.)

As of May 1974, OSHA had not exercised its authority to require employers to conduct periodic inspections to determine their own state of compliance with applicable safety and health requirements.

Question

Why has OSHA not exercised its authority to require such self-inspections and does OSHA plan to exercise that authority in the future?

SEPARATE STANDARDS FOR THE LIGHT RESIDENTIAL CONSTRUCTION INDUSTRY

Many bills have been introduced in the 93rd Congress to amend the Occupational Safety and Health Act of 1970 to require that OSHA establish a separate and distinct set of safety and health standards to recognize the difference in hazards between the light residential construction industry and the heavy construction industry. The bills would require that OSHA, in setting such separate standards, recognize the less hazardous working conditions and smaller size of most employers in the light residential construction industry. The bills define light residential construction as all construction activities with respect to residential structures of three stories or less without elevators.

The rationale for advocating separate standards is based on a number of factors. Those involved in light residential construction maintain that the work is different because of the smaller number of employees on a given job, and the smaller scale of activities needed to complete the work.

These proponents contend that because construction is limited to small buildings, excavations are done on a smaller scale and work is generally completed in one section of the building before another section is started. They maintain that in heavy construction, work is often being done on a number of floors at one time, resulting in a much greater potential for injury from falling objects. In addition, because of the greater activity in heavy construction, the number of workers exposed to dangerous conditions is greater. On smaller

projects, the workers are usually familiar with all areas in which work is being done and can avoid dangerous situations.

Interviews were held with 19 light residential construction contractors or representatives of their local associations who believed that separate standards should be established for their industry. Generally, the basis for their belief was that some of the existing standards were either too complex, not applicable, too rigid, or too costly to comply with. For example, the National Association of Home Builders has raised some of the following problems with the current standards:

1. There should be a requirement for employees to assume responsibility in wearing safety equipment and maintaining tools.

2. The present standards state that when dropping waste materials more than 20 feet, an enclosed chute must be used. The 20-foot figure would often include 3 story buildings in light residential construction, yet a chute is not felt to be necessary because the possibility that employees would not know that materials are being dropped is remote.

3. Presently, a fire extinguisher must be provided for each 3,000 square feet of a building. This requirement represents a large investment for small builders. In 3 story buildings, evacuation is much easier to achieve both because of the design and the small number of employees involved. Fire-fighting equipment is unnecessary.

4. The required protection for floor and wall openings includes a variety of devices -- safety nets, guardrails, toeboards, safety belts, etc. In light construction, the strict requirements concerning these devices are often unnecessary because the workers who created the openings are usually the only ones who work near them.

Questions

1. What specific problems, if any, have OSHA inspectors encountered in enforcing the construction standards in the light residential construction industry? What is OSHA's position on the bills that have been introduced to require OSHA to establish a separate and distinct set of standards for that industry?

2. What specific differences exist between hazards in the light residential construction industry and hazards in the heavy construction industry which would require different standards? If there are such differences, is it necessary to establish a completely separate set of standards to deal with them? If so, could this be done, without additional legislation, through the established mechanism for developing and promulgating standards?

3. Concerning the possibility of changing certain standards, what specific data would have to be compiled to show that such standards could be changed without lessening the protection of workers in the light residential construction industry?

7/26/74

SAFETY AND HEALTH PROGRAM IN THE MARITIME INDUSTRY

Before the Occupational Safety and Health Act of 1970, the Department of Labor's Bureau of Labor Standards (LSB) administered a safety and health program in the maritime industry under the Longshoremen's and Harbor Workers' Compensation Act.[1]

Under the Longshoremen's Act, LSB did not have direct authority to assess penalties for violations of its standards, but could bring action in court if employers willfully violated or refused to comply with standards or willfully hindered LSB from carrying out its responsibilities. LSB inspectors were on the waterfront almost daily, making inspections, consulting with employers, resolving complaints, conducting training sessions, and holding or participating in safety meetings. LSB rarely sought legal action.

After the 1970 act, the Secretary transferred LSB's responsibilities to OSHA. Pursuant to section 4 of the 1970 act which became effective in April, 1971, OSHA adopted the safety and health standards that had been promulgated by LSB under the Longshoremen's Act.

In April, 1971, OSHA headquarters sent a memorandum instructing OSHA field offices to continue, until further instructions were issued, inspection and enforcement actions in the maritime industry according to procedures established under the Longshoremen's Act.

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[1]Employees covered by this act include longshoremen, who load and unload ships, as well as employees who repair, service, construct or disassemble ships.

In a May, 1972 memorandum to the director of OSHA's compliance and standards office, an OSHA headquarters official discussed some of the impacts of OSHA's policy in the maritime industry. He stated in the memorandum that he had discussed the subject with OSHA inspectors attending a training course and that:

> "***There is a wide range of interpretation of the maritime policy throughout the country. Some of this is a result of our decentralization but most of it is because of a lack of specific policy and guidelines for the maritime***(inspector).
>
> "***The maritime program overall has deteriorated rapidly in the past year as compared to what it was before OSHA.
>
> * * * * *
>
> "Morale is low in some of the *** (maritime inspectors); they feel they have been left behind or neglected and made to fend for themselves. ***
>
> "***They all expressed distress in that they know there is no specific maritime office in Washington that they or their Area Directors can contact for overall guidance and assistance when needed."

In December, 1972, the Assistant Secretary for Occupational Safety and Health established a task force to make a study and submit recommendations on how OSHA should realign its policies and procedures for dealing with the maritime industry. The 7-man task force included one official each from four OSHA regional offices, two OSHA headquarters' officials, and a representative of the Department of Labor's Office of the Solicitor.

In its report dated February 2, 1973, the task force advised the Assistant Secretary:

"It is a known fact that the present maritime program, which in effect is a continuation of the old maritime program is both unworkable from *** (OSHA's) point of view***and unworkable for the maritime industry if in fact it were administered as OSHA dictates.

"To this date there has been no strict policy or section in the Compliance Manual pertaining to the maritime industry. Consequently, even though the OSH Act was passed on December 29, 1970, we have had a continuation of inspections, promotional, consultative, (sic) that were established under LSB where in fact OSHA policy dictates that we perform quite differently. ***The following are *** problems that have been created:

"1. We are providing a safety service which should rightfully be in the hands of management ***. This is accomplished by numerous visits to vessels on all coasts on a daily basis. Management in many cases relies upon our visits to point out poor safety conditions and practices. Management *** should be performing this for themselves (voluntary compliance). It is well noted also that approximately 76% of the ships inspected throughout the country are in compliance and citations are at a minimum in direct reversal to our findings in other industries. Are we performing under OSHA when we don't call it as we see it and bringing it to the attention of top management through citations and penalties ***?

"2. The maritime industry at present is over-exposed to our type of inspection. If in fact, we did as the Act dictates, because of our numerous inspections, every stevedore company in the country could in all probability be *** (cited for willful violations) within a 30-day period.***

"3. Due to the present policy (numerous inspections) the Compliance Officer cannot be expected to exercise the authority vested in him. He is quite human and knows that all companies in the maritime industry would be wilful (sic) violators within a matter of weeks just by his presence alone. This is undoubtedly the reason for a 76% compliance factor nationally for stevedoring and a 26% compliance factor for all other industries nationally and yet the frequency rates of accidents in the maritime industry remains excessively high.

"4. We must not continue treating this industry different than the rest of American industry. We are going to be criticized by this industry itself if we continue." (Underscoring supplied.)

The task force report suggested several steps for carrying out the proposal to treat the maritime industry as any other industry to accomplish OSHA's goal of stimulating companies to

voluntarily comply with safety standards and provide safe workplaces for employees. These included (1) adjusting the frequency of inspections in accordance with OSHA's established system for other industries, (2) announcing to the maritime industry and to OSHA personnel, with full explanations, what is to be done and that the frequency of OSHA's presence in the maritime industry would depend upon the level of voluntary compliance as evidenced by complaints to OSHA, and (3) insisting that OSHA inspectors call conditions as they see them to stimulate voluntary compliance by the industry.

Realizing the special problems encountered by maritime compliance officers, OSHA has instituted specialized training in maritime inspection. The OSHA Training Institute in Chicago has a separate one week course dealing with such areas as longshoring, shipyard operations, hazard recognition, contaminants, gear certification, containers, and electrical machinery.

In most major port areas such as Boston, New York, Philadelphia, and Baltimore, OSHA has inspectors who are assigned exclusively to maritime. In areas where the maritime workload is relatively small, OSHA inspectors are generalists, in that they perform inspections in maritime, construction and other industries.

OSHA has also initiated training for employers and employees in maritime industry. The National Fire Protection Association has been awarded a contract to develop a 24-hour course for training of employees in the ship-repairing, shipbuilding, and shipbreaking industries. The course is scheduled to be developed by February 27, 1976, and will deal with

prevention of accidents involving flammable liquids, oxygen, and carbon dioxide in shipyards.

Another course will be developed by Westinghouse Electric Corporation by December 24, 1975, to develop training materials in the health and safety area for employers and employees in longshoring. Westinghouse is expected to produce a 30-hour course in longshoring safety, 10 job safety and health analyses to be used for employee training purposes, and 7 operation safety and health analyses to be used by both employers and employees.

In October 1973, OSHA issued a new program directive, the stated purposes of which were to (1) set forth the OSHA policy and procedures for enforcement in longshoring and (2) establish the overall compliance policy for maritime industry in general. The directive provides that:

--Enforcement in the longshoring activities of the maritime industry will be programmed the same way as in any other industry.

--All standards applicable to longshoring shall be enforced. All violations of standards shall be cited and appropriate penalties proposed. All instances of repeated and willful violations shall be cited as such.

Except for the general purpose statement, the October, 1973 directive did not mention OSHA's policy and procedures for maritime activities other than longshoring.

In July, 1974, OSHA officials provided the following list of health hazards which are found in maritime activities. They stated that all such hazards are covered by existing OSHA standards.

Health hazards in longshoring

1. Carbon monoxide
2. Noise
3. Chemical burns and irritations
4. Toxic cargo (pesticides, radioactive cargo, and fumigants)
5. Hydrogen sulfide in fishing boats
6. Heat stress in hot climates
7. Toxic and irritating dusts (castor bean pomace, cement dust, grain dust, and others)
8. Coast Guard list of hazardous materials
9. Skin hazards
10. Oxygen depletion in holds and other areas
11. Poor ventilation
12. Lack of protective clothing
13. Unsafe drinking water and dirty toilets
14. Welding, chipping and painting
15. Inadequate respirators
16. Inadequate first aid provisions

Health hazards in ship construction, repairing, and disassembling

1. Welding, cutting, and heating (fumes and gases, ozone oxides, and eye burns from flashes)
2. Confined space entry (lack of oxygen, poor ventilation and toxic gases)
3. Dust (sandblasting, paint particles, asbestos)
4. Painting (toxic cleaning solvents, paint solvents, vapors toxic metal in paint, anti-fouling coatings)
5. Radiation (x-ray, laser and isotopes)
6. Heat stress
7. Noise
8. Metal fumes (lead)
9. Poor ventilation
10. Inadequate respirators
11. Unsafe drinking water
12. Inadequate protective clothing
13. Dirty toilet facilities
14. Inadequate first aid provisions

The Acting Solicitor of Labor advised OSHA in a memorandum dated October 18, 1971, that Article 3, section 2 of the Constitution prohibits OSHA from delegating to States the development and enforcement of safety standards with respect to employment covered by the Longshoremen's and Harbor Workers'

Compensation Act.

During an interview in July, 1974, OSHA headquarters officials stated that:

--Precise data was not available on what portion of the Nation's maritime activities involves employment not subject to the Longshoremen's Act, but a rough guess would be about 50 percent.

--States' approved plans include provisions on whether and to what extent the State program will cover maritime employment not subject to the Longshoremen's Act. Of 25 States' plans that had been approved, 12 provide that the State will cover all of such employment[1] and 13 provide that the State program will exclude all or part of such employment.[2]

--There has not yet been enough activities under the State programs for OSHA to evaluate and compare their maritime enforcement activities with OSHA's.

OSHA headquarters officials stated during an interview in July, 1974 that OSHA has no jurisdiction over the owner of a foreign vessel in an American port. They stated that OSHA could not require the owner of a foreign vessel to correct hazards aboard the vessel but could require a stevedore to take such action as blocking off hazards while his crew is working aboard the vessel. They stated also that, if there were hazards such as unsafe equipment aboard the vessel, OSHA would not cite the stevedore unless his employees were observed using the equipment.

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[1]Includes Oregon, California, Minnesota, Maryland, Kentucky, Vermont Illinois, Connecticut, Nevada, Indiana, Wisconsin, and Wyoming.

[2]Includes South Carolina, Utah, Washington, New York, North Carolina New Jersey, Tennessee, Iowa, Alaska, Virgin Islands, Colorado, Michigan, and Hawaii.

OSHA officials said that OSHA's relationship to foreign vessels was the same as the Bureau of Labor Standards' relationship to such vessels under the safety and health program formerly administered by the Bureau under the Longshoremen's and Harbor Workers' Compensation Act.

The following chart shows the result of OSHA's attention to longshoring as a target industry during fiscal year 1974. Data on other maritime industries such as ship repairing, servicing, building, and disassembling were not included because they were not target industries. The figures shown are national figures.

No. of inspections		4,037
Total employees		76,422
No. of inspections in compliance		2,744
No. of instances of violations[1]		9,335
No. of non-serious violations		3,257
No. of serious violations/citations[2]		28
No. of imminent danger violations/citations[2]		0
No. of willful and repeat viol/cit.[2]		72
$proposed penalty for non-serious viol.		66,264
$proposed penalty for serious viol.[3]		31,878
No. of violations with penalties		1,453
No. of violations for specific standards:[4]		
1918.25	Ladders	85
1918.43	Handling beams and covers	73
1918.93	Ventilation and atmospheric conditions	25
1918.33	Deck loads	16
1918.81	Slinging	37
1918.105	Head protection	199

1. No. of instances of violations does not equal no. of violations since one violation may consist of a number of instances.

2. In this category, a citation must be issued for every violation.

3. Includes serious and willful and repeat violations.

4. Most frequent violations.

The preceding chart shows that:

--68% of longshoring employers inspected were found to be in compliance

--97% of the total violations were non-serious

--The average proposed penalty for serious violations (including willful and repeat violations) was $318.78

--1904 violations had no penalties assessed.

In addition, no notices for imminent danger have been issued to employers in the maritime industry. OSHA's Field Operations Manual states that:

> "No Notice of Alleged Imminent Danger, OSHA-8 Form, shall be prepared and no imminent danger proceedings instituted, if voluntary elimination of the danger is immediately accomplished by permanent correction of the condition, or if the employer gives satisfactory assurance that he will not permit employees to work in the area of danger until the danger is permanently eliminated. Otherwise, the CSHO shall post the OSHA-8 Form and recommend court action."

Consequently, OSHA's management information system would not show if any imminent danger situations were identified for which notices of imminent danger were not issued because of voluntary elimination of the danger.

Under provisions of the Longshoremen's Act, LSB compiled statistics from employers on injuries in longshoring and in ship construction, repairing, servicing, and disassembling. LSB's reports on such statistics showed that injury frequency rates in longshoring decreased each year from 1960 through 1970, which was the last full year LSB administered the program. According to the reports, the rate in longshoring decreased by almost 50 percent during that period. The reports showed even larger

decreases in the injury rates in ship construction, repairing, servicing and disassembling.

The data compilation under the Longshoremen's Act was continued through calendar year 1971, during which the transition from LSB to OSHA took place. OSHA did not continue the LSB reporting system beyond that year.

In April 1973, an OSHA study team analyzed the data compiled for calendar year 1971 and prior years--for longshoring only--and observed that:

--the national accident frequency rate in longshoring increased from 69.1 per million hours worked in 1970 to 71.1 per million hours worked in 1971, and

--almost every geographic area except those on the West Coast had an increase in longshoring accident frequency.

In a March 1974 interview an official in the Department of Labor's Bureau of Labor Statistics (BLS), which gathers and analyzes injury data for OSHA, said that the current data system does not identify or break out frequency data for employment covered by the Longshoremen's Act. He said that the current OSHA data system is based strictly on the new Standard Industrial Classification Code Manual, under which there is not a "maritime industry" as such or activities that could be identified specifically as maritime. He said that, under the new system, classifications such as"marine cargo handling," "ship and boat building," and "ship repairing" include, but are not limited to, employment covered by the Longshoremen's Act.

LSB internal reports showed that during fiscal year 1970--the last full year of LSB operations under the Longshoremen's and Harbor Workers' Compensation Act--LSB inspected 21,723 ships being loaded or unloaded (longshoring operations). These do not include LSB inspections of such other maritime activities as ship construction, repairing, servicing, and disassembling.

Because OSHA's internal reports did not identify the number of ships included in inspections of longshoring activities, they could not be compared with LSB's. After being questioned on how OSHA's level of inspections compared to LSB's, OSHA headquarters officials made a survey by telephone to obtain data that could be used to compare with LSB's. They found that, during fiscal year 1972, OSHA inspected 7,150 ships being loaded or unloaded, or about 67 percent fewer than the 21,723 inspected by LSB in fiscal year 1970.

Also, records at five OSHA area offices showed that, during fiscal year 1972, those offices inspected about 85 percent fewer ships being constructed, repaired, serviced or disassembled than LSB made in fiscal year 1970.

Two factors appeared to have contributed to OSHA's making fewer inspections than LSB. First, LSB had 66 inspectors in 1970. In 1972 OSHA had 52 inspectors assigned to maritime activities. Second, OSHA area office officials pointed out that OSHA inspectors had to spend more time than LSB inspectors on paperwork. Unlike LSB inspectors--who could issue notices of violations at the inspection site and who could not propose penalties--OSHA inspectors were required to take photographs, prepare working papers, and write several reports on each

inspection prior to issuing citations and proposing penalties.

OSHA headquarters officials stated during an interview in February, 1974 that implementation of the October 1973 program directive--which states that enforcement in the longshoring activities of the maritime industry will be programmed the same way as in any other industry--would result in a further decrease in the number of maritime inspections. It appears that this is borne out by the data the Committee staff has, which indicates that OSHA made 4,488 maritime inspections from July, 1972 to February, 1973 and 3,717 from July, 1973 to February 1974.

Because of the basic differences between the LSB and OSHA programs, the sheer number of inspections made under one program compared to the other should not be viewed as an indicator of which program was more effective. Effective use of the stronger, more comprehensive, and more direct enforcement provisions in the 1970 act by OSHA could stimulate voluntary compliance by employers with fewer inspections than were made by LSB.

An official in OSHA's Office of Standards Development stated during an interview on July 10, 1974, that the proposed maritime accident reporting procedures were under discussion with the Department's Office of the Solicitor. He said that it was contemplated that the new procedures will incorporate essentially the same requirements that existed prior to OSHA.

In June, 1974, OSHA awarded a contract to Cooper and Company, Connecticut, to conduct a study to evaluate OSHA's efforts in longshoring. The study is expected to be completed in July, 1975 and should include (1) information on OSHA's success in reducing longshoring injuries, and (2) specific recommendations directed toward potential improvements in OSHA recordkeeping, training, standards and enforcement programs. OSHA personnel will aid the contractor in the determination of effectiveness.

Questions

1. Why did it take OSHA from April, 1971 to October, 1973 to decide that the enforcement policy in longshoring should be the same as in any other industry?

2. Concerning the October, 1973 directive, is it OSHA's intent that the procedures set forth for longshoring are to be applied to other activities in the maritime industry? In view of the fact that the directive did not state directly whether such procedures were also applicable to other maritime activities, does OSHA believe that its intent is sufficiently clear to insure uniform interpretation by field offices?

3. What specific actions has OSHA headquarters taken since October, 1973 to insure that field offices are effectively implementing the requirements that all violations be cited, that appropriate penalties be proposed, and that willful and repeat violations be treated as such? What are the results of your monitoring efforts? How do these results compare with similar data compiled prior to October, 1973?

OSHA'S DEVELOPMENT OF STANDARDS FROM NIOSH'S CRITERIA DOCUMENTS

NIOSH submits its research data and recommendations for comprehensive standards on safety and health hazards to OSHA in the form of "criteria documents." In unusual circumstances where a standard is essential before a comprehensive criteria document can be drawn up, as with vinyl chloride, NIOSH issues a letter of recommendation on a standard based on as much data as it has available.

As of July 26, 1974, NIOSH had submitted to OSHA 18 criteria documents and two letters of recommendation. OSHA has promulgated final standards for two of the hazards, asbestos and carcinogens, and a proposed standard for vinyl chloride (to be made final by October 5, 1974). OSHA received the criteria document for asbestos on January 21, 1972, and promulgated the final standard about 5 months later, on June 7, 1972. OSHA received the letter of recommendation on carcinogens on July 14, 1972, and promulgated the final standards on January 29, 1974 (about 19 months later). OSHA received the letter of recommendation from NIOSH on vinyl chloride on March 11, 1974, published an emergency temporary standard on April 5, 1974, and formally proposed a final standard on May 10, 1974.

As shown below, OSHA received the other 17 criteria documents and letters of recommendation up to 24 months prior to July 1974.

Criteria Document	Date Submitted to OSHA by NIOSH	Months Between Date Submitted and July 1974
Asbestos	1-21-72	--
Beryllium	6-30-72	24
Heat Stress	6-30-72	24
Carbon Monoxide	8-3-72	23
Noise	8-10-72	23
Ultraviolet radiation	12-20-72	19
Inorganic lead	1-5-73	18
Coke oven emissions	2-28-73	16
Toluene diisocyanate	7-13-73	12
Chromic acid	7-17-73	12
Trichloroethylene	7-23-73	11
Toluene	7-23-73	11
Inorganic mercury	8-13-73	11
Arsenic	1-21-74	5
Sulfur dioxide	2-11-74	5
Sulfuric acid	6-6-74	1
Ammonia	7-15-74	0
Benzene	7-24-74	0
Letter of Recommendation		
Carcinogens	7-14-72	--
Vinyl Chloride	3-11-74	--

As of July 1974, OSHA had not published a proposed standard in the Federal Register for any of the 17 hazards. According to OSHA officials, it will probably take OSHA several months to promulgate a final enforceable standard after publication in the Federal Register of a proposed standard.

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Once the Secretary of Labor determines that a rule should be promulgated, he may request the recommendations of an advisory committee. The Committee, after reviewing proposals and information from the Secretary of HEW and the Secretary of Labor, submits its recommendations. The Secretary then publishes a proposed rule in the Federal Register, and gives any person the opportunity to file objections and request a hearing. After hearings, the Secretary usually promulgates the final standard. However, if there are substantial changes in the proposed standard, the Secretary may publish the new proposal in the Federal Register and invite further comment, although he is not formally required to do so by law.

The Secretary of Labor did not appoint advisory committees to make recommendations on the criteria documents concerning the following: beryllium, noise, ultraviolet radiation, inorganic lead, toluene diiosocyanate, chromium, trichloroethylene, toluene, inorganic mercury, arsenic, and sulfur dioxide.

The criteria document on asbestos was forwarded by NIOSH on January 21, 1972, and an advisory committee was appointed on January 24, 1972. The criteria document on noise was forwarded by NIOSH on August 10, 1972, and an advisory committee was appointed on February 23, 1973.

OSHA does assign high priority to the development of standards from criteria documents. Target dates are established to assure timely processing of the standards

within their respective organizations, but no overall target date for promulgating a standard from a criteria document is established because of the various processing steps, outside of the Office of Standards Development, through which a draft standard must pass before promulgation.

The drafting of a particular standard of high priority may be delayed because of the need to develop standards of higher priority.

As of July 23, 1974, the Office of Standards Development had 85 persons on its staff -- 5 employees in the Budget Office, 6 on the Council on Environmental Quality, 45 in the Division of Safety Standards Development, and 29 in the Division of Health Standards Development. This staffing pattern includes such non-technical personnel as secretaries and clerk/typists.

Of the 45 in the Division of Safety Standards Development, there are: 16 Safety Engineers, a position requiring a bachelor's degree in engineering or four years of education and/or experience which has provided an equivalent body of professional knowledge; 13 Safety Specialists, a position requiring three years of general experience and three years of specialized experience in one or more phases of an organized safety program. The remainder of the positions in this division include technical writers, program analysts, secretaries, and clerk/typists.

Of the 29 people employed in the Division of Health Standards Development there are: 15 Industrial Hygienists, a position requiring (1) a bachelor's degree in engineering, physical or natural science, or four years of progressive technical experience which has demonstrated the possession of a working knowledge of scientific theories and principles and their application to science and/or engineering, and (2) three years of professional industrial hygiene experience; 6 Safety Engineers; and 3 Safety Specialists. The remaining positions in this division include secretaries and typists. However, the Office of Health Standards has stated that only 14 of the personnel in the Division of Health Standards Development are involved in taking the criteria documents, reviewing them and writing the standard. This group includes 12 Industrial Hygienists and 2 Safety Engineers.

Neither OSHA's accounting system, nor the Office of Standards Development show any information on man-year costs for promulgating a standard from a criteria document.

QUESTIONS

1. Assuming that no unusual problems are encountered, how long should it typically take OSHA to develop and promulgate a standard from a criteria document submitted by NIOSH?

2. What problems is OSHA having in developing and promulgating standards from the criteria documents submitted by NIOSH?

3. Has OSHA actively worked on each standard during the entire period after receiving the criteria documents? If not, what other activities have caused interruptions and on what basis were they given a higher priority than the criteria documents?

4. What needs to be done to insure prompt development and promulgation of standards from criteria documents?

5. Does OSHA believe that the standards on asbestos and carcinogens were promulgated as soon as practicable after receipt of NIOSH's criteria document and letter of recommendation? In view of the fact that these final standards were promulgated within 5 months and 19 months, respectively, after receipt of the criteria document and letter of recommendation, why is it taking OSHA 12 months or longer in several other cases to publish proposed standards in the Federal Register? When does OSHA expect to publish proposed standards and promulgate final standards on the hazards covered in the 17 criteria documents listed above?

PLANNING AND MANAGEMENT OF NIOSH RESEARCH TOWARD STANDARDS DEVELOPMENT

NIOSH has estimated that American workers may be exposed to 25,000 toxic substances and harmful physical agents and that the effects of 1,000 to 2,000 of these are significant enough to warrant the development of standards to protect workers' health.

These figures are a rough estimate of those substances in terms of degree of severity and number of persons exposed. Out of these 1,000 to 2,000 substances, NIOSH has developed a priority list for use in planning its research efforts toward developing criteria needed to support such standards. This priority list includes 471 substances which are having the greatest effect on the workforce and is flexible in that items can be added, deleted, or given a new priority rating when new information becomes available.

The priority list is established by consideration of five basic factors:

1) expected exposure
2) production rates
3) trend in use
4) severity of effect of exposure
5) likelihood of disease resulting from exposure

Only the first two of these are measurable at the present time.

The estimates of exposure are determined from surveys conducted by both NIOSH and those states which participate in the

National Surveillance Network. The estimates resulting from these surveys are then studied by NIOSH industrial hygienists, physicians, and statisticians, and are adjusted if there are questions concerning the accuracy of the surveys. Trend in use is estimated from national enforcement agency restrictions on a particular substance as well as technological changes affecting the use of a substance.

Severity rates are determined by a Delphi technique whereby 50 occupational health professionals assign a severity rating to particular substances. The responses and explanations for those responses are then fed back to each individual to narrow the range of responses. Since there is no source from which to estimate the likelihood of a disease, likelihood is only an implied outcome of these ratings. The present priority list was cut off at 471 items because it was felt that at this point the priority rating system ceased to be effective.

The Priority List has undergone two stages of review. The first stage occurred during preparation of the List. A list of candidates for consideration for inclusion on the Priority List was sent to the following people who were asked to suggest additions and deletions of items for the list:

1. NIOSH Office and Division Directors
2. A number of scientists outside of government
3. OSHA

The Second review occurred after the calculations had been done to the Priority List. The List was then sent out and the following people were asked to review the List to identify any estimates that they felt were out of line:

1. NIOSH Office and Division Directors
2. OSHA officials
3. NACOSH members
4. Other interest parties

The list was then revised to reflect the comments of the second review and then sent to the Department of Labor for final approval.

NIOSH headquarters officials made the following comments in July, 1974, concerning how closely research has followed the priority list:

> "In conducting both laboratory and field research the Institute has directed its efforts toward filling the research gaps that have been identified for the substances and physical agents for which criteria documents were being prepared. Where short term research requirements were made known as criteria documents were being prepared, laboratory and field research efforts were responsive to providing missing information. There have been problems in the past providing the needed gap filling research in a timely manner where long-term epidemiological studies and animal toxicological studies were required. With the establishment of a policy to move down the priority list in sequential order in preparing criteria documents, we feel that in the future, laboratory and field research efforts can become more responsive in anticipating and conducting research that will be required to produce a comprehensive criteria document."

The priority list includes the number of persons exposed, the severity index for each substance, NIOSH's schedule for producing criteria documents, and the number of criteria documents completed.

A substantial amount of research and criteria documentation is performed by contractors because NIOSH has insufficient manpower and facilities which make it impossible to perform all the work in-house. The following chart shows the amount of research that is contracted out.

	Fiscal Year				
	1973 (Actual)		1974 (Estimated)		1975 (Budgeted)
In-house	$12,800,000		$10,000,000		$13,900,000
Total Contracted	$ 6,300,000		$13,300,000		$ 7,000,000
Research	$5,320,000	$11,900,000		$5,400,000	
Criteria Document Preparation	$ 980,000	$ 1,400,000		$1,600,000	
Totals for research and criteria documentation	$19,100,000		$23,000,000		$20,900,000
Percent contracted	33		57		33

In a July 1974 interview, the Director of NIOSH's Office of Research and Standards Development stated that all necessary long-term research is completed before initiating work to prepare a criteria document -- only short-term research necessary to support a specific part of a proposed standard is performed after initiating work on a criteria document. He stated also that 80 percent of all criteria documents and letters are prepared by contractors -- 13 of the 17 criteria documents transmitted to the Department of Labor as of July 12, 1974, were prepared by contractors.

The Director explained that the various steps followed in preparing a criteria document were as follows:

1. Literature search -- In this initial step the contractor searches the international scientific literature for all relevant data pertaining to the particular substance (all literature searches have been done by contractors).

2. First draft of a criteria document -- The contractor or NIOSH (for about 20 percent of the criteria documents) writes a draft after considering the information obtained in the literature search. The draft is then reviewed by NIOSH scientists with the contractor present to defend his work. Based on this review, the NIOSH criteria manager directs the contractor to make any necessary changes.

3. Second draft -- The draft is reviewed by scientists outside of NIOSH who are considered experts in their field. Based on this review, the criteria manager directs the contractor to make any necessary changes.

4. Third draft -- This draft is submitted for review by NIOSH's directorate. If the draft is approved by the Director of NIOSH, the criteria document is transmitted to the Department of Labor.

He stated also that on the average, the criteria document preparation process requires about 4,400 man-hours of contract

time and 3,000 man-hours of in-house time for a total cost of more than $200,000.

With regard to NIOSH's current policy on the criteria development and documentation process, he stated the following:

1. The development of criteria documents will follow the sequence established by the priority list.

2. Criteria documents will be issued within two years after initiating work.

NIOSH had 180 active contracts at the beginning of fiscal year 1975. The monitoring of these contracts is done by approximately 90 project officers, each one handling from 1 to 10 contracts (the average per person is 2). These project officers are normally journeymen -- level professionals, and are Branch Chiefs and/or their senior staff. The contract load per employee is such that he still may conduct the benchtype or field research needed to continue his professional growth in his field.

GAO reviewed 171 of the 211 contracts that NIOSH awarded during fiscal years 1969 through 1972. For 67 of these, the contractors failed to submit at least one of the several periodic progress reports required in the contracts. For 13 of the 67 contracts, the contractors did not submit any of the required progress reports. Moreover, in 12 out of these 13 cases, there was no evidence that the project officers had notified the contracting officer of the contractors' failure to submit the required reports.

At the time of the field work, final report dates had passed for 66 of the 171 contracts reviewed. For 15 of these contracts,

NIOSH received the final reports from 1 to 7 months after the due date. An additional 11 were from 1 1/2 to 12 months overdue and 3 more were from 13 to 34 months past due.

A check of the contracting officer's files for 10 past due reports revealed that in 8 cases, there was no evidence that the project officer had notified the contracting officer of the contractors' failure to submit reports. For 15 contracts, the project officers' files did not contain copies of all important documents, and for 29 contracts, reports were not prepared on visits the project officers had made to the contractors' sites to evaluate performance.

NIOSH, aware of the deficiencies in its contract monitoring, has instituted a series of one-week training courses under the auspices of the Ohio State University Research Foundation. All NIOSH project officers are being required to participate in this training.

According to NIOSH headquarters officials, criteria documents are comprehensive in that they provide valid criteria and a recommended standard based on relevant research available at that time. Under NIOSH's current policy - to issue a criteria document two years after initiating work - future criteria documents transmitted to the Department of Labor will contain a chapter citing research gaps but the criteria document will be comprehensive in that the recommended standard will reflect all the relevant information available at that time.

When given a limited time frame under which to operate, NIOSH has issued recommendations rather than full criteria documents because of the inadequate state of technology on certain hazardous substances. Out of the 20 topics on which the Department of Labor received health standards recommendations from NIOSH, 18 were full criteria documents and two (vinyl chloride and carcinogens) were actually only recommendations for standards and were based on the available data, which was limited.

OSHA has returned the criteria document on hot environments to NIOSH for "lack of sufficient evidence to justify an occupational health standard for heat stress . . . OSHA recommends that future research take into greater consideration the acclimitization of workers to hot environments and individual adjustments in work procedures which compensate for the heat exposure."

OSHA stated that the Bendix Aerospace Systems has a contract with OSHA to evaluate the impact of a heat stress standard, and that a report would be forwarded to NIOSH by early summer. OSHA also noted that the Advisory Committee on Heat Stress had endorsed the development of a guide or manual to cover heat stress, and requested that NIOSH evaluate the Committee's recommendations.

NIOSH, however, found no reasons to change its recommendations in the document and urged swift implementation of a heat stress standard, stating that "there is more than enough information

already available on which a work practices type of heat stress standard can be set."

Although NIOSH's view is that standards can be developed by OSHA from NIOSH criteria documents, NIOSH personnel are available for additional advice or consultation after the criteria document is sent to OSHA. The joint NIOSH/OSHA effort is continued until the standard is promulgated.

During fiscal year 1973, NIOSH evaluated its planning and management system and concluded that improvements were needed to insure that research projects are planned and managed more specifically toward NIOSH objectives. NIOSH officials said that, under the then existing system, some projects were initiated by researchers on the basis of personal interests rather than NIOSH goals and priorities.

Prior to the beginning of fiscal year 1974, NIOSH revised its planning and management system to provide the improvements it believed were needed. The new system provides for the following:

--An annual meeting of NIOSH management officials to decide on policy, long-range objectives, and research priorities for each NIOSH program area.

--A two-year plan for each program area, which explains how the plan fits in with the long-range objectives and priorities.

--Review by a management committee to insure that program plans are in line with the long-range objectives and priorities.

--Individual project plans for each program area, detailing the specific activities to be carried out and how they will contribute to the accomplishment of the program plan.

--Increased emphasis on monitoring of individual projects and reporting of progress on individual projects to the program director and the management committee.

Questions

1. In implementing the new planning system for fiscal year 1974, did NIOSH review and evaluate all on-going research projects to insure that they were consistent with established objectives? Did NIOSH terminate any research projects that had been initiated under the old system? If so, what were they? How much had been expended on them? What did they contribute toward NIOSH's mission?

2. Under the new system, do the written plans for individual projects spell out the objectives of the projects and whether and how they will contribute toward development of needed criteria for standards? What portion of the on-going projects are specifically to fill research gaps for specific criteria documents?

7/31/74

NIOSH PERSONNEL LEVELS

In September 1973 the General Accounting Office (GAO) issued a report to the Senate Committee on Labor and Public Welfare which (1) described the nature and magnitude of NIOSH's mission of developing criteria for standards and (2) generally discussed personnel problems impeding progress. (Slow Progress Likely in Development of Standards for Toxic Substances and Harmful Physical Agents Found in Workplaces, B-163375, September 28, 1973). In that report, GAO recommended that, because of NIOSH's slow progress in developing criteria for standards, HEW should consider the adequacy of NIOSH's resources to effectively carry out its responsibilities under the act.

GAO's September 1973 report was based primarily on information obtained from the headquarters offices of NIOSH and OSHA. Additional information on personnel problems has since been obtained from the NIOSH headquarters office (in Rockville, Maryland) and NIOSH's laboratory facilities located in Cincinnati, Ohio; Morgantown, West Virginia; and Salt Lake City, Utah.

Rockville

One of the Rockville headquarters' functions is the writing of criteria documents, based on completed research, for setting safety and health standards. This requires a critical evaluation of all known research publications, from sources throughout the world, pertaining to the occupational health or safety hazard to be covered by the criteria document. As GAO stated in its September 1973 report, NIOSH has estimated that it would need to prepare criteria documents for 1,000 to 2,000 toxic substances and harmful physical agents.

As of July 1973, the organizational unit responsible for identifying, obtaining, and analyzing the pertinent research publications and preparing criteria documents had 31 authorized positions, including secretarial and clerical positions. This staff completed 13 documents in fiscal years 1972 and 1973. Although NIOSH's formal long-range plans called for completing from 20 to 25 criteria documents a year beginning with fiscal year 1974, a NIOSH official at Rockville said in September 1973 that the current staff could complete about 12 documents a year.

Cincinnati

A major function of NIOSH's Cincinnati operation is to do laboratory research which NIOSH considers necessary to carry out its responsibilities under the 1970 act. In his program plan for fiscal years 1974 and 1975, the Cincinnati laboratory research director stated that research efforts would continue to be impeded for several reasons, one of which was difficulty in obtaining

the services of high-level, experienced, and qualified personnel, specifically for the urgent work of analytical methods development. He stated also that, while some of his research staffs have highly qualified leaders, they did not have lower level personnel to obtain routine data and provide other technical support.

As an example of the personnel problem, the Cincinnati laboratory's program plan contained the following statements concerning the staff assigned to do research in the area of toxicology:

> "During FY 1973 the staff *** has been depleted by personnel losses without consideration for replacement. This has now reduced the total work force to 34.0 man years *** [from 41 man years at the end of fiscal year 1972]. In our projected project analysis for fiscal 74, the number of projects *** has increased from 15 to 27 by adding 10 gap-filling efforts to the present load. *** However, *** <u>it will not be possible</u> to accomplish the work load with responsible scientific achievement unless some reassignment of positions can be made ***. This problem was made even more acute by the loss of 3.6 man years of temporary, part time and overtime help during the last quarter of 1973.
>
> * * * * *
>
> "***The Acute Toxicology Program is severely restricted in staff (3 members) ***. This *** delays the development of critical data for 'gap-filling' and hazard evaluation research.
>
> "***Pathology Service is severely limited due to difficulties in obtaining trained histology laboratory staff. ***
>
> "***The professional staff of 21 research scientists have available only 2 secretaries to handle preparations of reports, publications, correspondence, purchase orders, and routine activities of office management.
>
> * * * * *
>
> "***Dermatologic, skin absorption, sensitization, and immunologic studies are severely limited and only qualitative in nature due to a staff of one person."

Another function of the Cincinnati operation is to make industry-wide field studies, as required by the act, to discover occupational diseases and their causes and devise ways to detect and minimize them. NIOSH considers that information obtained in such studies is essential for developing sound criteria for controlling exposures to occupational health hazards.

The program plan for fiscal year 1974 contained the following comments on personnel problems affecting field-study activities:

> "For fiscal year 1973, a total of 39 man years *** were allocated to the Field Research Program area of NIOSH. Superimposed on this were the additional constraints of:
>
> (a) an average GS Level of 6.02 (lowest of any Division or Office in NIOSH),
>
> (b) an average length of field experience in governmental service or occupational health of 0.75 years for the four physicians *** of the program,
>
> (c) a paucity of career professionals for administration or program direction.
>
> "The impact of these constraints has had a noticeable impact on the program originally projected for FY 1973 and a significant impact on the development of a more viable FY 74-75 program. Despite these limitations, the Field Research Program has initiated or completed some 26 industrywide studies."

The originally-projected program for fiscal year 1973 indicated that a total of about 48 man years were to be spent on field studies during that year. NIOSH allocated 42 man years to this effort. The Director of Field Studies and Clinical Investigations stated during an interview that, as a result of the reduced allocation, three studies were dropped from the 1973 research program and one study was reduced in scope.

A third function of the Cincinnati operation is to evaluate workplace hazards upon requests by employers or representatives of employees as required by the 1970 act. As of August 31, 1973, NIOSH had received 289 requests. Of those, 66 had been answered, 107 proved to be invalid or were referred to other agencies, and 116 were being evaluated. Personnel assigned to the Salt Lake City laboratory worked on 25 of the requests.

The act states that hazard evaluations should be completed as soon as possible. NIOSH guidelines state that an evaluation should generally be completed within 3 months after NIOSH receives the request for the evaluation. An analysis of the 20 evaluation reports issued in the last quarter of fiscal year 1973 showed that completion of each took at least twice as long as the 3-month standard and that the average completion time was about 1 year for each evaluation. NIOSH officials stated that a shortage of medical staff was one of several factors which had contributed to the delays.

Morgantown

Under the 1970 act, NIOSH is responsible for conducting research, experiments, and demonstrations relating to occupational safety and health, including respiratory diseases. NIOSH's Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD) in Morgantown is responsible for respiratory disease research.

In addition to this broad responsibility under the 1970 act, ALFORD is responsible for implementing the requirements of the Federal Coal Mine Health and Safety Act of 1969 to:

—offer periodic chest x-rays to every coal miner,

—perform free autopsies to help survivors of coal miners establish claims for benefits authorized under the act, and

—conduct research into the prevention of diseases of coal miners and workers who, although not miners, work with or around coal mine products.

In a January 1973 memorandum to headquarters officials, the director of ALFORD made the following comments concerning the lack of efforts by ALFORD in areas not related to coal:

> "Although the title 'Occupational Respiratory Disease Program' implies a range of activities which is catholic indeed, to a large extent ALFORD's program has for a variety of reasons been almost entirely limited to coal. *** If the title ALFORD is not to be a misnomer, then the program should be extended into other fields. At present this can only be achieved by spending some of the ALFORD coal budget for these other activities. In this regard it is felt that ALFORD is in a position to help in the investigation of asbestosis, bysinnosis, berylliosis and TDI [toluene diisscyanate] exposure, etc. Other fields of interest that should be encouraged relate to normal respiratory physiology, particle deposition and the immunology and biochemistry of occupationally related diseases. These more basic investigations will have application to all occupational respiratory diseases, not simply CWP (coal workers' pneumoconiosis)." (Underscoring supplied.)

Salt Lake City

Activities at the Salt Lake City laboratory include (1) evaluating hazards in response to requests by employers and representatives of employees and (2) analyzing air samples and materials collected by OSHA and NIOSH personnel from workplaces.

During a discussion in September 1973, NIOSH officials at the laboratory said that employee morale at the laboratory was low because of low grade levels, particularly when compared with grade levels for comparable positions in the Department of Labor. They said that NIOSH industrial hygienists were in grades GS-5 to GS-9, while the Department of Labor industrial hygienists were in grades GS-11 and GS-12.

Overall Funding and Personnel Levels

Attached are two pages from the House Appropriations hearings which show the fiscal year 1974 and the estimated fiscal year 1975 NIOSH budget figures by program area. Also included is information on the action by OMB on the fiscal year 1975 budget.

Dr. SENCER. Yes; we have that right here.

Mr. OBEY. Put it in the record.

[The information follows:]

NIOSH 1974–75 BUDGET BY FUNCTION (PROGRAM AREA)

[Dollars in millions]

Program area	1974		Estimated 1975	
	Positions	Amount	Positions	Amount
A. Surveillance	25	2.0	25	1.8
B. Criteria documentation for standards	30	3.6	54	7.6
C. Laboratory research	84	5.6	84	5.0
D. Laboratory service	101	2.4	102	2.2
E. Field research	21	1.2	21	1.1
F. Technical services	78	2.3	80	2.0
G. Manpower development	32	.9	32	.9
H. Occupational health program	4	4.1	5	1.0
I. Mining (formerly ORD)	84	3.0	87	3.0
J. Research grants	9	3.9	9	2.4
K. Agriculture		.3	3	.8
L. Safety	13	1.2	15	1.2
M. Occupational carcinogenesis	15	1.3	18	1.0
N. Administrative support and policy direction	115	3.6	115	2.9
Total	[1] 611	[2] 35.4	[1] 651	27.9

[1] Includes 9 positions supported from reimbursements.
[2] Includes 1973 funds restored.

NIOSH BUDGET REQUESTS TO OMB

Mr. OBEY. What was the National Institute for Occupational Safety Health budget request as it came out of the National Institute for Occupational Safety Health before it got up to you or anybody else?

Dr. SENCER. $29,865,000 and 660 positions.

Mr. OBEY. And the budget you are presenting today is?

Dr. SENCER. $25,848,000 and 565 positions.

Mr. OBEY. What was the cut of $4 million for?

Dr. SENCER. The Department transmitted a budget of $29,865,000 and 605 positions to the Office of Management and Budget.

Mr. OBEY. What programs were cut out? What $4 million was cut out?

Dr. SENCER. I can't tell you, sir.

Mr. OBEY. When can you?

Dr. SENCER. I have just been told it was in the area of technical assistance, providing assistance to industry and standards setting.

Mr. OBEY. Can you expand for the record and explain in much more detail specifically what that $4 million request was for, how many positions were eliminated and what kind of work you could have done with that money that you won't be able to do now?

Dr. SENCER. Yes, sir.

Mr. OBEY. What it would have meant in terms of criteria packages proposal to what you can do now?

Dr. SENCER. Yes.

[The information follows:]

EFFECT OF $4 MILLION OMB CUT

The 1975 budget request submitted to OMB would have supported 80 new positions and 18 to 20 new starts on criteria document production. Resources now requested will support approximately 14 new starts.

In addition, in response to the acknowledged problems of impact of the Occupational Safety and Health Act on small businesses, the fiscal year 1975 request to OMB would have supported a technical assistance effort to enable industry to comprehend its own problems and provide its own solutions. There are over 5 million workplaces at present, of which approximately 99 percent are considered as small business, and it would, of course, be impossible to provide direct assistance to each; however, by approaching industry-specific problems through a mix of direct assistance and educational and technical assistance aids, it would be possible to prevent many major problems before individual employees are affected or there is a compliance action. We will conduct some activity in support of this strategy in fiscal year 1975 on a pilot type basis.

OUTPUT OF CRITERIA DOCUMENTS

Mr. OBEY. How many years at the present rate, Doctor, do you think it would take to provide criteria standards for all of the chemicals and agents people work with?

Dr. KEY. There is some professional consensus that the universe toward which we should be striving to develop health standards is approximately 1,000 to 2,000 rather than the many, many thousand named or known chemicals in the environment.

If we get up to a rate of some 50 a year, approximately 20 years.

I should correct something I told you earlier or make it more accurate. The estimate I gave to you for doubling the output of criteria documents was based on continued use of the contract mechanism, and it assumed that the research would also be conducted in order to have the dose-effect information on which one could go ahead and develop a criteria document and recommended standards.

Dr. SENCER. I think there is another limiting factor in this Mr. Obey and that is in the shortage of certain categories of professional personnel, namely toxicologists. This has not been a popular field over the years for people to go into, and we are limited just by the availability of adequately trained professional people.

Mr. OBEY. Why isn't it a popular field?

Dr. SENCER. For much the same reason that venereal disease research hasn't been a popular field—there is no big payoff.

Going back into the fifties there have been committees trying to figure out ways to stimulate people to go into toxicology. It is not a glamorous scientific area. It is sort of sitting there with your rats and mice and waiting a long period of time to see what the effect is.

VINYL CHLORIDE

Mr. OBEY. What programs and activities are going to have to be dropped Dr. Key, because of your efforts in the vinyl chloride area?

Dr. KEY. I have asked the staff for an accounting of this and expect to have the answer within another week.

At this time I think I can say that although the responses for hazard evaluations may be lengthened——

Mr. OBEY. By how much?

Dr. KEY. I can't quantitate this other than by the same number of weeks that the individuals were working on vinyl chloride.

Mr. OBEY. How many people did you have to research?

Dr. KEY. For vinyl chloride.

Questions

1. Does NIOSH believe that current funding, personnel positions, and grade levels are adequate to make reasonable progress toward accomplishing its various missions under the act?

2. How, and to what extent, did the funding and personnel levels allocated to NIOSH for fiscal years 1974 and 1975 differ from what NIOSH estimated its needs to be?

3. Where, and on what basis, would NIOSH allocate any future increases in funds and personnel? Is NIOSH in a position to specifically justify requests for increases in funds and people on the basis of benefits that could be gained in terms of making workplaces safer? To what specific research projects or other activities will NIOSH assign the estimated 40 additional personnel positions for fiscal year 1975 and what does NIOSH expect to gain from such projects?

4. In attempting to obtain increases in grade levels, has NIOSH made any specific comparisons of NIOSH grade levels with those of personnel in other Federal agencies with comparable responsibilities?

7/26/74

NIOSH RESEARCH FACILITIES IN CINCINNATI, OHIO

The Cincinnati research facility is housed in an old rented building that was formerly a paint warehouse. NIOSH officials estimated that the space in the building fell short of needs by about 25,000 square feet for the laboratory housed there. NIOSH also has storage space and administrative offices in two other buildings in Cincinnati.

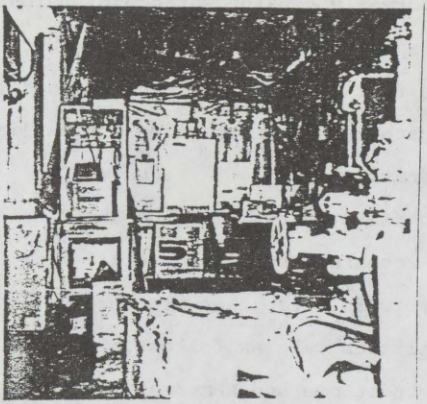
A consultant to NIOSH, after visiting the Cincinnati laboratory and discussing the research program in detail with NIOSH officials, told NIOSH in a May 1973 letter that his observations concerning the Cincinnati facilities were as follows.

> --The crowded conditions and temporary nature of the laboratory quarters constituted a severe handicap to carrying out the research activities of the laboratory.
>
> --It was essential that qualified personnel be attracted to the lab and that there be sufficient inducement to retain such individuals.

During a tour of the Cincinnati laboratory in June 1973, NIOSH officials said that the building was generally unsuitable for their laboratory research activities because of (1) over-crowded conditions for the research personnel, equipment, and test animals, (2) limited and make-shift storage space, (3) safety hazards, and (4) poor ventilation and unsuitable climate controls needed for certain research activities.

For example, the photograph below shows a storage room used occasionally for laboratory work. The room is in the basement, which extends out beyond the outside walls of the upper part of

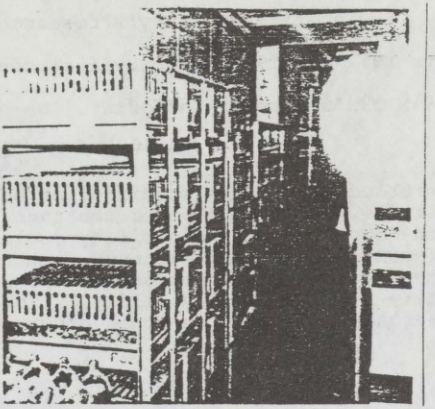
the building so that it is directly beneath a concrete sidewalk. The plastic sheet stretched across the water pipes overhead is to catch concrete chips falling from the sidewalk and water leaking from the pipes.



Room beneath the sidewalk

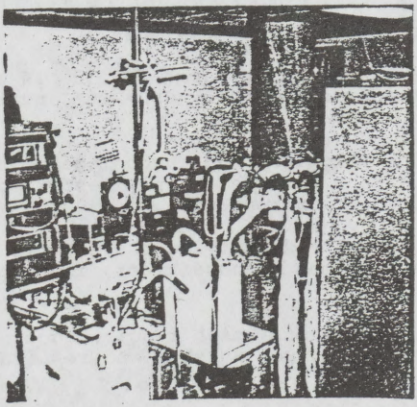
(Actual snapshot is located in Labor Subcommittee Staff file)

The next picture shows a set of rat cages stored in a hallway that leads to a fire emergency exit. NIOSH officials said that they need two complete sets of cages so that one set can be used while the other is being cleaned. They said that the hallway is the only space they have for keeping the clean set.



Rat cages obstruct access to fire exit.
(Actual snapshot is located in Labor Subcommittee Staff file)

The next picture shows a file cabinet, work benches, and research equipment crowded into a small work area. Similar conditions were observed in other work areas in the building.



Crowded work area.

According to the Cincinnati laboratory's research program plan for fiscal years 1974 and 1975, the physical conditions at the building impeded NIOSH's research efforts. The plan stated that:

> "A *** serious problem *** is the acquiring of adequate laboratory facilities. Though manpower shortage is a serious handicap, the in-house research capability could not be increased significantly by adding manpower without the facilities for them to work in. Because of the present inadequate facility it is extremely difficult to attract outstanding researchers, even if we could offer competitive salaries.
>
> * * * * *
>
> "***Due to expanded research activities, animal housing space is severely limited, i.e., monkey colony on hand has grown from 12 to 94 animals; no facilities for housing dogs are available; only one room is available for housing guinea pigs and one room for rabbit housing.
>
> "***No facilities or personnel are available for mutagenic, teratogenic, carcinogenic, or life-time cumulative doseresponse studies."

In July, 1974, the Deputy Director of NIOSH's Cincinnati operations stated that inadequate facilities were impeding the following research and other laboratory work.

--Occupational carcinogenic research for (1) 14 chemicals contained in standards issued by OSHA in January 1974 and (2) vinyl chloride.

--Testing of the neurological and psychological responses of animals to various hazards (mainly respiratory), such as lead, in the work environment.

--Thermo stress research identifying the effects of working under various environmental conditions, i.e., heat, cold, and humidity.

--Hazard evaluation requests which require acute animal toxicological testing, such as skin and respiratory testing.

--The testing of protective equipment such as eye and face masks, gloves, and firemen's protective boots.

--New work such as testing new substances for toxic effects before the substances are marketed for use in the work environment.

In April 1973 the Secretary of Health, Education and Welfare (HEW) announced in a press release that HEW planned to construct a new NIOSH research center in Cincinnati. However, there have as yet been no budget requests for laboratory construction. In August 1973 HEW advertised in the Commerce Business Daily that it intended to select an architect-engineer for preliminary planning of the new facility. According to an HEW official involved in the planning, a contract for the architect-engineer services had not been awarded as of June 18, 1974, but a contract for such services will be awarded soon after HEW acquires the land needed for the new facility.

NIOSH officials stated that NIOSH's site preference for the new laboratory would be on land adjacent to the University of Cincinnati. The Environmental Protection Agency (EPA) has land adjacent to the University which NIOSH officials consider suitable for the new laboratory. By letter dated June 3, 1974, EPA told HEW that it would transfer the needed land to HEW, provided that certain aspects of the building plans meet with EPA's approval.

Since then, 4 acres have been provided in Cincinnati by EPA and plans for building construction are moving ahead. HEW is currently in the process of granting a contract for the preliminary architectural design of the laboratory facilities. A year is the projected period for developing the preliminary drafts, after which final designs will be drawn up and construction contracts can be let. The construction costs are estimated at $42 million.

Questions

1. When did NIOSH first decide that the Cincinnati laboratory was unsuitable? Why has it taken so long to initiate steps to obtain a new laboratory?

2. What is the status of NIOSH's efforts to get the new building constructed? When will construction start? What is the estimated completion date for the new laboratory building? Are any delays expected and, if so, why?

U. S. DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

WASHINGTON

SEP 23 1974

Honorable Harrison A. Williams
United States Senate
Washington, D.C. 20510

Dear Senator Williams:

This is to acknowledge receipt of your letter of September 5, 1974, forwarding the 17 issue papers covering various aspects of the administration of the Occupational Safety and Health Act of 1970.

These papers are being examined and responses are being prepared to the issues raised therein. An initial report will be submitted to the Subcommittee no later than September 30, 1974. In addition, the issue papers raise a number of complex policy questions which have been and are now under consideration. We will be in communication with the Subcommittee on these questions over the three-month period mentioned in your letter.

In order to continue our close working relationship with the National Institute for Occupational Safety and Health, I am forwarding those issue papers relating to their operations to Secretary Weinberger for his review and response.

I can assure you that I will take any necessary steps to guarantee that the Occupational Safety and Health Act of 1970 is implemented with optimum effectiveness for protecting America's working men and women. I am certain that with our mutual concern for their welfare we can work together in achieving this goal.

Sincerely,

Secretary of Labor

U. S. DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

WASHINGTON

OCT 1 1974

Honorable Harrison A. Williams
Chairman
Committee on Labor and Public Welfare
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The issue papers relating to the implementation of the Occupational Safety and Health Act of 1970 that you forwarded on September 5, 1974, are being carefully examined by the staff of the Occupational Safety and Health Administration (OSHA). The enclosed material constitutes the Department of Labor's initial response to the issues discussed in the papers developed by the staff of the Committee on Labor and Public Welfare's Subcommittee on Labor. Two of the issues raised by the Subcommittee are discussed in the initial package; the remaining papers require considerable additional in-depth study and analysis. As review of each of these issues is completed, responses will be forthcoming.

I considered the questions raised by the Subcommittee staff not in an adversary manner; the issues developed will be given our fullest consideration in any changes we make in the operation of this program. I also hope that the papers may serve as the foundation for a closer working relationship between the Department and the Subcommittee in the area of occupational safety and health. I trust that the issues raised and the answers provided will give the impetus to an increased dialogue regarding implementation of this most vital law.

In general I have been satisfied that the Act is presently being adequately enforced, but there is clear room for improvement. I have, however, not the slightest doubt that the program is being implemented with a real concern for the working men and women of this Nation. While recognizing that there are problems in its administration, the record of increased inspections, the creation of the foundation for a true Federal-State partnership, the inducement of voluntary compliance with the law, and the provision of job safety and health training all reflect a capability to implement these purposes of the Act. In other areas, as the Subcommittee-GAO papers point out, there is a clear need to examine current OSHA policies and procedures and to implement corrective measures.

Two of the problems permeating the Subcommittee issue papers are already being addressed by OSHA: measurement of the impact of OSHA enforcement activities and coordination of policy between national and field offices. In the case of the first of these, OSHA is very concerned with the actions of OSHA area offices allegedly enforcing the Act in a manner at variance with provisions of the law or established OSHA policy. It is perhaps inevitable that there will be some problems in administering any program not run exclusively from a single authority, but the advantages of enforcing this program with a correctly balanced decentralized structure clearly outweigh the resultant difficulties. OSHA has been aware of the need for improved coordination between its national and field offices and is now testing a Field Performance Evaluation System designed to set forth program performance effectiveness criteria to provide a continuous assessment of the program and to enable OSHA management personnel to make necessary program course corrections in a timely manner.

The annual BLS survey on occupational injury-illness incidence is one of the analytical tools available for use in concert with this system. These data will

provide some needed feedback on both annual and long-range changes or trends in injuries and illnesses at the workplace. These trends, in turn, will better focus the OSHA inspections and other work efforts as well as indicate issues requiring special studies, information, and research. In addition, various other data sources are being developed to improve OSHA's capability for utilizing its enforcement resources more effectively.

A major problem brought forth by the issue papers, and one with which I have been most concerned, is the rate at which OSHA has been proposing occupational health standards. The record of the past is not an exemplary one, and, although the matters are extremely complex, I offer no excuse for past delay. There is and will continue to be a significant improvement in this area as a result of the actions described in the enclosed response to issue paper number 14. I assure you that I will continue to focus the utmost attention upon the problem of workplace health hazards and the means for their elimination.

I am certain that you are aware of the milieu within which this program exists. The Act is a complex piece of legislation, virtually unprecedented when passed, which the Department had to implement on a full-scale basis almost immediately after its enactment. There is considerable and vocal opposition to many of the policies and decisions involved in implementing the law as well as to the statute itself. Such factors as availability of qualified personnel, finite resources, court decisions, and jurisdictional questions all impinge upon the manner in which we implement the Act. You can be assured, however, that consideration of these factors will not lead to any lessening in our efforts to enforce this legislation.

The initial responses and those to follow are presented, therefore, with the intent of enabling both the Subcommittee and the Department to begin renewed efforts

to improve the administration of the Act in order that the working people of America can be confident that their government is working to protect their lives. Many of our responses will describe administrative changes already made in areas mentioned by the Subcommittee and GAO; in other areas, changes will be forthcoming. The issues discussed in the papers enclosed are: Number 12, Separate Standards for the Light Residential Construction Industry; and number 14, OSHA's Development of Standards from NIOSH Criteria Documents.

I should also like to take this opportunity to express my appreciation for the long hours you spent on the Senate floor during the recent discussion of possible restrictions on OSHA inspection authority. Your valiant efforts contributed materially in preventing any weakening of the force of the Act during consideration of the bill.

Sincerely,

Secretary of Labor

Enclosures

[EDITOR'S NOTE—THE ENCLOSURES REFERRED TO WILL BE PRINTED IN A SEPARATE DOCUMENT WHEN THE COMMITTEE RECEIVES THE COMPLETE RESPONSE.]