

IMPROVING OSHA'S ENHANCED ENFORCEMENT PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE PROTECTIONS

COMMITTEE ON

EDUCATION AND LABOR

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IMPROVING OSHA'S ENHANCED ENFORCEMENT PROGRAM

**Thursday, April 30, 2009
U.S. House of Representatives
Subcommittee on Workforce Protections
Committee on Education and Labor
Washington, DC**

The Subcommittee met, pursuant to call, at 10:02 a.m., in room 2175, Rayburn House Office Building, Hon. Lynn Woolsey [Chairwoman of the Subcommittee] presiding.

Present: Representatives Woolsey, Shea-Porter, Payne, Bishop, Hare, Price, and Wilson.

Also present: Representative McKeon.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Calemine, General Counsel; Lynn Dondis, Labor Counsel, Subcommittee on Workforce Protections; David Hartzler, Systems Administrator; Jessica Kahanek, Press Assistant; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Mark Zuckerman, Staff Director; Robert Borden, Minority General Counsel; Cameron Coursen, Minority Assistant Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Richard Hoar, Minority Professional Staff Member; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel; and Loren Sweatt, Minority Professional Staff Member.

Chairwoman WOOLSEY [presiding]. A quorum is present. The hearing of the Subcommittee on Workforce Protection will come to order.

I am going to present my opening statements and then yield to the ranking member, Mr. Price.

Thank you all for being here.

One year ago, almost to this very day, our subcommittee held a hearing on strengthening OSHA enforcement of multi-state employers. Our issue today, our subject today, relates to that directly. Because today, as part of the Workers Memorial Day commemoration, the Subcommittee is exchanging and examining OSHA's enhanced enforcement program, or EEP.

This is a program that OSHA unveiled in 2003 to deal with large employers that are indifferent to the health and safety of their em-

ployees and employers who have multi-properties and multi-states and are not in just one area, in other words.

The EEP was initiated in response to a widespread investigation by the New York Times and Frontline that exposed the horrendous working conditions at McWane. McWane is the biggest cast iron water and sewer pipe manufacturer in the world. From 1995-2003, at least 9 workers were killed, and 4,600 workers were injured at McWane facilities across the country.

McWane had received over 400 citations, but it had only received one criminal conviction, and that was in 2002. At that time, McWane paid a fine. Several years later, McWane was found guilty of several work and safety and environmental criminal violations. And just this last week some of its officials were sentenced to substantial prison time.

Had an EEP—an Enhanced Enforcement Program—been in place at an earlier date, many McWane workers could have been saved from death or serious injury.

Currently, under the EEP—did I say FEP?—if OSHA has reason to target a recalcitrant employer for the program, it is permitted to conduct enhanced enforcement activities, such as follow-up inspections and inspections of related worksites. It also can insist that a company hire a health and safety consultant to develop a health and safety program or apply the terms of any settlement that it reaches with the employer on a company-wide basis.

After 6 years of operation, it is clear that EEP's original design is flawed, and that OSHA under the Bush Administration didn't implement the program as intended.

The Office of Inspector General—the OIG—has conducted an audit of the program and has come up with some startling results. They include the fact that in 97 percent of the cases that the audit sampled, OSHA did not comply fully with the requirements of the program. These omissions were not trivial. They held very serious consequences.

Jesus Rojas, who is here with us today as a witness, will testify as to just how devastating these mistakes can be. He is the stepson of Raul Figueroa, who was killed in January 2008 while working as a mechanic for Waste Management, Inc. at one of the company's facilities in Broward County, Florida.

Mr. Rojas, I am so sorry for your loss. And I think you are very brave to be here today. Your stepfather died a gruesome and senseless death, when he was crushed by that hydraulic arm of a garbage truck—something that we believe could have been prevented.

Now, Waste Management, Incorporated is a large company with multi-state facilities. We all know that. It has a history of OSHA violations. In fact, before Mr. Figueroa died, another worker had suffered a similar fate at a different facility in Florida.

And Waste Management was one of the 32 employers the inspector general found that should have been targeted for the EEP, but it hadn't been.

If the company had been properly monitored under the EEP, would Mr. Figueroa be with us today? That is a sobering question and a sobering thought and one that deserves our full attention, which is why we are conducting this hearing. We need to know

why the program isn't working and what we can do to fix or re-vamp it.

I am very pleased to welcome all of our witnesses, including Acting Assistant Secretary for OSHA, Jordan Barab, who we have all worked with—who I am going to call “Secretary” until this gets all settled, because I am not going to say “Acting Assistant Secretary.” Okay? I am going to say “Secretary Barab”—who, until very recently, as I said, was on this side of the table.

Mr. Secretary, we know that both you and Secretary Solis share a deep commitment to worker health and safety, and so we are looking forward to hearing from you about the agency's suggestions—be they legislative or administrative—so that we can target larger employers who are indifferent to their employees and do it appropriately.

Now I would like to yield to Ranking Member Price.
[The statement of Ms. Woolsey follows:]

**Prepared Statement of Hon. Lynn C. Woolsey, Chairwoman,
Subcommittee on Workforce Protections**

One year ago almost to the day, this subcommittee held a hearing on strengthening OSHA's enforcement of multi-state employers.

Today—as part of the Workers Memorial Day commemoration—the subcommittee is examining OSHA's enhanced enforcement program (or EEP), which OSHA unveiled in 2003 to deal with large employers that are indifferent to the health and safety of their employees.

The EEP (Enhanced Enforcement Program) was initiated in response to a widespread investigation by the New York Times and Frontline that exposed the horrendous working conditions at McWane, the biggest cast iron water and sewer pipe manufacturer in the world.

From 1995-2003, at least 9 workers were killed and 4,600 workers were injured at McWane facilities across the country.

McWane had received over 400 citations, but it had only one criminal conviction in 2002. At that time McWane paid only a fine.

Several years later, McWane was found guilty of several work and safety and environmental criminal violations. And just this last week some of its officials were finally sentenced to substantial prison terms.

Had an EEP been in place at an earlier date, many McWane workers might well have been saved from death or serious injury.

Currently, under the EEP, if OSHA has reason to target a recalcitrant employer for the program, it is permitted to conduct enhanced enforcement activities, such as follow-up inspections and inspections of related worksites.

It also can insist that a company hire a health and safety consultant to develop a health and safety program or apply the terms of any settlement it reaches with the employer on a company-wide basis.

After 6 years of operation, it's clear that the EEP's original design is flawed, and that OSHA under the Bush Administration did not even implement the program as intended.

The Office of Inspector General (OIG) has conducted an audit of the program and has come up with some startling results.

In 97% of the cases the audit sampled, OSHA did not comply fully with the requirements of the program.

These omissions were not trivial and had serious consequences.

Jesus Rojas who is here with us today will testify as to just how devastating these kinds of mistakes can be. He is the step-son of Raul Figueroa who was killed in January 2008 while working as a mechanic for Waste Management, Inc. at one of the company's facilities in Broward County, Florida.

Mr. Rojas I am so sorry for your loss.

Your step-father died a gruesome and senseless death, when he was crushed by the hydraulic arm of a garbage truck he was working on. Now Waste Management, Inc. is a large company with multi-state facilities and it has a history of OSH act violations.

In fact, before Mr. Figueroa died, another worker had suffered a similar fate at a different facility in Florida. And Waste Management was one of the 32 employers the inspector general found should have been targeted for the EEP but wasn't.

If the company had been properly monitored under the EEP, would Mr. Figueroa be with us today?

That is a sobering thought and one that deserves our full attention, which is why we are conducting this hearing today. We need to know why the program is not working and what we can do to fix or revamp it.

I am very pleased to welcome all of our witnesses, including acting assistant secretary for OSHA, Jordan Barab, who until very recently used to sit on this side of the table.

Mr. Assistant Secretary, we know that both you and Secretary Solis share a deep commitment to worker health and safety, and so we are looking forward to hearing from you on the agency's suggestions—be they legislative or administrative—for targeting large employers who are indifferent to their employees.

Dr. PRICE. Thank you, Madam Chair. And I want to thank you for holding this hearing and for inviting the panel members.

I want to thank them, the distinguished panel members, for appearing today. And we appreciate the time that all of you have taken.

And, Mr. Rojas, we do extend our deepest sympathy to you in the loss that your family has suffered.

We meet today to examine OSHA's efforts on workplace safety. In particular, we are looking at one policy initiative: the Enhanced Enforcement Program. We look forward to hearing from both the inspector general and OSHA itself on their views about whether this program should be continued, or modified, or expanded, or eliminated.

But speaking more broadly, as we examine OSHA's efforts with respect to workplace safety, I think it is important that we ask ourselves some questions. How do we, or how should we, evaluate whether our workplace safety laws are effective? Is it the number of citations that are issued? The amount of fines that are collected by regulators? The number of lawsuits filed?

The best way to evaluate the effectiveness of our workplace health and safety laws should be to examine objective evidence, certain numbers. They show whether we are making progress in reducing workplace illnesses and injuries. When we look at those numbers, the trends over the past number of years are actually encouraging.

Earlier this week, we heard at a similar hearing on workplace safety that when OSHA works cooperatively with businesses, particularly small ones, there has been significant and measurable progress. For example, in 2007 the Bureau of Labor Statistics reports that the number of deaths on the job fell to less than 4 for every 100,000 workers—the lowest rate on record. The Bureau also says that in 2007, non-fatal injuries and illnesses were down by 4 percent, or 122 cases for every 10,000 workers.

Figures from OSHA tell a similar story. These numbers show that since 2001, workplace deaths have declined 14 percent, and the injuries and illnesses have dropped 21 percent.

Now, any—is too many. There is no acceptable level of workplace injury or illness. But it is important that as we evaluate the effectiveness of our laws that we do so with the goal of improving and building upon those that are actually working rather than reversing course for politics for an ideological agenda.

I hope that as we move forward in assessing our workplace safety regime that we keep that principle in mind.

With that, Madam Chairman, I look forward to the testimony and working with you on this very important issue.

[The statement of Mr. Price follows:]

**Prepared Statement of Hon. Tom Price, Ranking Republican Member,
Subcommittee on Workforce Protections**

Good morning and thank you, Chairwoman Woolsey. I would like to begin by thanking our distinguished panels of witnesses for appearing today. We appreciate that they have taken time out of their busy schedules to share their expertise and experiences with us.

We meet today to examine OSHA's efforts on workplace safety.

In particular, we are looking at one policy initiative, the Enhanced Enforcement Program. I look forward to hearing both from the Inspector General and OSHA itself on their views about whether this program should be continued, modified, expanded, or eliminated.

But speaking more broadly, as we examine OSHA's efforts with respect to workplace safety, we must ask ourselves some questions: How do we evaluate whether our workplace safety laws are effective? Is it the number of citations issued? The amounts of fines collected by regulators? The number of lawsuits filed?

The best way to evaluate the effectiveness of our workplace health and safety laws is to examine the objective evidence—the numbers. They show whether we are making progress in reducing workplace illness and injury. And when we look at those numbers, the trends are encouraging.

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Figures from OSHA tell the same story. These numbers show that since 2001, workplace deaths have declined 14 percent. Meanwhile, injuries and illness rates have dropped 21 percent.

I am not suggesting that there is an “acceptable” level of workplace illness or injury. But it is important, as we evaluate the effectiveness of our laws, that we do so with the goal of improving those that are working, rather than reversing course for politics or an ideological agenda. I hope that as we move forward in assessing our workplace safety regime that we keep that principle in mind.

With that, I look forward to hearing from our witnesses this morning. Thank you, Madame Chairwoman.

Chairwoman WOOLSEY. Thank you, Mr. Price.

Without objection, all members will have 14 days to submit additional materials for the hearing record.

Now, I would like to introduce our very distinguished panel of witnesses here with us today. We will have two panels. The first panel is seated. The second panel will be Secretary Bar—I am sorry, I said that wrong Jordan. But I never have called you by your last name. That is my problem.

So, welcome, all of our witnesses.

Just before I introduce you, know what our lighting system is all about. You have 5 minutes for your testimony. And so a green light will go on when you begin speaking. And when the orange light comes on, you have 1 minute remaining.

And we have the same amount of time. So it isn't like we aren't under the same restrictions. We are. But after the 1 minute, then a red light comes on. So we are hoping by the time you are into the orange light you are starting to tie up and bring your thoughts to conclusion.

If there are some thoughts that you haven't gotten out, get them out during question and answers if you can. If not, finish your thought for sure. The floor doesn't open up. You don't disappear.

So now I want to introduce our witnesses. And our witnesses will speak in the order that they are seated and how they will be introduced.

Mr. Elliot Lewis joined the U.S. Department of Labor in 1991, now serves as the assistant inspector general for audit, Office of Inspector General, U.S. Department of Labor. Prior to this, he served as the deputy assistant inspector general for audit.

He received his B.S. at the University of South Carolina in 1978. He is a certified public accountant in the state of South Carolina, a member of the American Institute of Certified Public Accountants.

Mr. Jesus Rojas is the stepson of Raul Figueroa, a mechanic at Waste Management who was the victim of a gruesome accident which resulted in his death. Since the accident, Jesus has spoken out about the need for employees to be held accountable for such accidents. He received an associate degree in homeland security from Everest University and is currently working at Comcast.

Mr. Jason Schwartz is a partner in the Washington, D.C., office of Gibson, Dunn & Crutcher and a member of the firm's Labor and Employment Practice Group and its litigation department. His practice includes the full range of labor and employment matters, including ERISA, the Occupational Safety and Health Act.

And Mr. Schwartz earned his J.D. from the Georgetown University Law Center, and received a B.A. degree in international affairs from the George Washington University.

Mr. Eric Frumin serves as the Health and Safety Coordinator for Change to Win. Mr. Frumin served as Chair of the Labor Advisory Committee on OSHA Statistics to the U.S. Bureau of Labor Statistics from 1983-2003. He received his B.A. from the State University of New York in 1979 and his master's degree from New York University in 1981.

I welcome all four of you.

And we will begin with you, Mr. Lewis.

**STATEMENT OF ELLIOT P. LEWIS, ASSISTANT INSPECTOR
GENERAL FOR AUDITS, U.S. DEPARTMENT OF LABOR**

Mr. LEWIS. Madam Chair and members of the Subcommittee—Chairwoman WOOLSEY. And you need to turn on your microphone, or either put it closer to you.

Mr. LEWIS. Okay.

Madam Chair and members of the Subcommittee, I appreciate the opportunity to discuss the Office of Inspector General's audit of OSHA's Enhanced Enforcement Program. I will summarize my statement and ask for my full statement to be entered in the record.

As you know, Madam Chair, the purpose of the Enhanced Enforcement Program is to identify high-risk employers and target their worksites with increased enforcement action. I will focus my testimony on our recent report that assessed whether establishments were properly identified, whether follow-up inspections were

conducted, and whether OSHA's January 2008 directive had an adverse impact on the program.

Madam Chair, our overall conclusion was that OSHA did not always properly identify establishments and conduct enhanced enforcement inspections. Specifically, for 97 percent of EEP qualifying cases that we sampled, OSHA did not comply with at least one of the following four requirements: designating enhanced enforcement cases, inspections of related worksites, enhanced follow-up inspections and enhanced settlement provisions.

First, OSHA did not properly designate 53 percent of sampled cases. As a result, the worksites were not subject to the full range of enhanced enforcement actions, and 24 employers had 33 subsequent fatalities.

Second, we found that OSHA did not generally inspect related worksites for 80 percent of the cases, and 34 of these employers had 47 subsequent fatalities at other worksites. Related worksite inspections were to be used to determine whether compliance was a company-wide problem.

OSHA either did not commit necessary resources or lacked information on other worksites needed to perform the inspections. Inspections may have deterred and abated hazards at worksites where 47 subsequent fatalities occurred.

Third, we found that OSHA did not conduct proper worksite follow up on 146 of 282 cases. And there were five subsequent fatalities at the same worksites. Enhanced enforcement requirements state that a follow-up inspection must be conducted to assess not only whether cited violations were abated but also whether the employer was committing similar violations.

Fourth, OSHA generally did not utilize enhanced settlement provisions to better ensure future compliance with the OSH Act. OSHA did not include enhanced settlement provisions in 153 of 188 cases with settlement agreements.

Finally, OSHA did not have specific criteria for issuing National Office Alert Memorandum on employers with worksites across regions or states. This occurred because OSHA did not place appropriate emphasis on compliance, commit necessary resources, or provide clear policy guidance.

Our sample included 22 employers with worksites across states or regions that had multiple facilities and/or cases. OSHA issued Alert Memoranda on only five of these employers, and the alerts were not issued until after the majority of fatalities had occurred.

Our audit also examined whether OSHA's January 2008 directive had an adverse impact on the Enhanced Enforcement Program. The 2008 criteria resulted in significantly fewer eligible cases. But despite this drop in the workload, OSHA still did not focus on qualifying employers with company-wide safety and health violations and issues.

OSHA has not placed the appropriate management emphasis and resources on this program to ensure its effectiveness. While we cannot conclude that enhanced enforcement would prevent subsequent fatalities, full and proper application of the program may have deterred and abated hazards at worksites for a total of 45 employers where 58 subsequent fatalities occurred.

We made six recommendations including that OSHA's Assistant Secretary form a task force to make recommendations to improve the efficiency and effectiveness of the program, revise its 2008 directive, provide specific criteria for issuing alert memorandum, and assuring that enhanced settlement provisions are used.

Madam Chair, this concludes my statement. I would like to thank you for the opportunity to share the OIG's findings on this important issue. I am happy to respond to any questions you or other Subcommittee members may have.

[The statement of Mr. Lewis follows:]

**Prepared Statement of Elliot P. Lewis, Assistant Inspector General for
Audit Office of Inspector General, U.S. Department of Labor**

Madam Chair, and Members of the Subcommittee, I appreciate the opportunity to discuss the Office of Inspector General's (OIG) audit of the Enhanced Enforcement Program (EEP) administered by the Occupational Safety and Health Administration (OSHA). As you know, the OIG is an independent entity within the Department of Labor (DOL); therefore, the views expressed in my testimony are based on the findings and recommendations of my office's work and are not intended to reflect the Department's position.

Background

Since OSHA's inception in 1971, its core mission has been "to promote the safety and health of America's working men and women * * *" With few exceptions, the OSH Act covers most private sector employers and their employees in the 50 states and all territories, either directly through Federal OSHA or through an OSHA-approved state program. OSHA's workforce comprises approximately 2,100 employees which include inspectors, whistleblower investigators, engineers, physicians, educators, standards writers, and other technical and support personnel. OSHA uses three basic strategies to help employers and employees reduce injuries, illnesses, and deaths on the job:

1. Enforcement.
2. Outreach, education, and compliance assistance.
3. Partnerships, Alliances, and other cooperative and voluntary programs.

Currently, OSHA covers 115 million workers at 7.2 million worksites. In FY 2008, OSHA's 1,000 inspectors conducted over 38,000 inspections of worksites to identify hazards and unsafe conditions that have significant impact on worker safety and health.

OSHA reported in its publication "All About OSHA" that annually:

- Almost 5,200 Americans die from workplace injuries in the private sector;
- As many as 50,000 employees die from illnesses in which workplace exposures were a contributing factor;
- Nearly 4.3 million people suffer non-fatal workplace injuries and illnesses; and
- The cost of occupational injuries and illnesses totals more than \$156 billion.

Because of its significant impact on the lives and well-being of American workers, it is essential that OSHA target its limited resources to inspect workplaces with the highest risk of hazardous conditions.

As you know Madam Chair, in 2003, OSHA augmented its enforcement program by establishing the Enhanced Enforcement Program for employers indifferent to their obligations under the Occupational Safety and Health Act of 1970, placing their employees at greater risk. The purpose of EEP is to identify these high-risk employers and target their worksites with increased enforcement attention. Employers are identified from all types of inspections where cited violations are: serious, high gravity, and related to fatalities; willful and/or repeat; or related to a failure-to-abate previously cited hazards. Once identified, EEP cases are supposed to receive additional enforcement efforts such as enhanced follow-up inspections, inspections of other workplaces of the employer, and more stringent settlement terms. EEP inspections represent a small percentage (1 percent) of total programmed inspections, but the targeted employers are deemed by OSHA to pose the highest risk to employee safety.

Enhanced Enforcement Program

Madam Chair, as requested by the Subcommittee, I will focus my testimony on our recent report that assessed (a) whether establishments were properly identified as EEP cases and inspections were conducted in accordance with OSHA's EEP Di-

rectives and (b) whether OSHA's January 2008 revised EEP Directive had an adverse impact on the EEP and its ability to protect the American worker. As part of our audit, we reviewed a total of 325 cases of which 282 were EEP qualifying cases. The 282 cases involved 196 employers and a total of 274 fatalities. In cases where we found a problem with effective implementation of EEP, we identified 45 employers who had a total of 58 subsequent fatalities.

Were Establishments Properly Identified as EEP Cases and Were Inspections Conducted in Accordance with OSHA's EEP Directives?

Our overall conclusion was that OSHA did not always properly identify and conduct EEP inspections. For 97 percent of EEP qualifying cases we sampled, OSHA did not comply with at least one of the following requirements: designating EEP cases; inspections of related worksites; enhanced follow-up inspections; or enhanced settlement provisions. In addition, OSHA did not have specific criteria for issuing National Office EEP Alerts on multi-state employers. These alerts are issued when OSHA believes it is necessary to notify regional and state administrators about employers with multiple worksites across regions and/or states. This shortcoming occurred because OSHA did not place appropriate emphasis on compliance; commit necessary resources; or provide clear policy guidance.

Full and proper application of EEP procedures may have deterred and abated hazards at the worksites of 45 employers where 58 subsequent fatalities occurred.

Following is a brief description of our specific findings.

OSHA Did Not Properly Designate 53 Percent of Sampled EEP Qualifying Cases and 24 Employers had 33 Subsequent Fatalities

OSHA management did not ensure indifferent employers were properly designated for the program. Specifically, OSHA did not properly identify 149 of 282 (53 percent) sampled EEP qualifying cases because area office staff did not understand EEP requirements or because of coding errors in OSHA's online data system (Integrated Management Information System, IMIS). As a result, the worksites were not subject to the full range of EEP actions. The EEP actions may have provided a deterrent and abatement to address violations at worksites where subsequent fatalities occurred.

OSHA Generally Did Not Inspect Related Worksites for 80 Percent of Sampled EEP Qualifying Cases and 34 Employers had 47 Subsequent Fatalities at Other Worksites

OSHA generally did not inspect related worksites even when company-wide safety and health issues indicated that workers at these sites were at risk for serious injuries or death. Specifically, OSHA did not properly consider related worksite inspections for 226 of 282, (80 percent), of sampled cases. Related worksite inspections were to be used to determine whether compliance problems in the EEP case were indications of a company-wide problem. OSHA either did not commit the necessary resources or lacked information on other worksites needed to perform the inspections. Inspections may have deterred and abated hazards at the worksites where the 47 subsequent fatalities occurred.

OSHA Did Not Conduct Proper Follow Up on 52 Percent of Sampled EEP Qualifying Cases and 5 Subsequent Fatalities Occurred at the Same Worksite

EEP requirements state that a follow-up inspection must be conducted to assess not only whether the cited violation(s) were abated but also whether the employer was committing similar violations. OSHA did not comply with requirements for follow-up inspections to ensure abatement and determine whether employers were committing similar violations. Specifically, OSHA did not conduct proper follow up for 146 of 282 (52 percent) sampled EEP qualifying inspections, or provide a compelling reason to not perform the follow-up inspections. Of the sampled employers with multiple EEP qualifying and/or fatality cases, 54 did not have proper EEP follow up, and 5 of the 54 employers had subsequent fatalities at the same worksite.

OSHA Generally Did Not Utilize Enhanced Settlement Provisions Effectively for Sampled EEP Qualifying Cases and 45 Employers had 32 Subsequent Fatalities

OSHA generally did not utilize enhanced settlement provisions to maximize the deterrent value of EEP actions and ensure future compliance with OSH Act. EEP criteria states that in some settlement agreements, particularly for egregious cases and for other significant enforcement actions, OSHA require employers to take steps to address systemic compliance problems or to provide OSHA with information to facilitate follow up inspections. However, we found enhanced settlement provisions were not included in 153 of 188 (81 percent) EEP qualifying cases with settlement agreements.

Employers with multiple EEP qualifying and/or fatality cases pose the greatest risk for workplace injuries or fatalities. Of these sampled employers, 60 had a total 108 settlement agreements, and enhanced provisions were not included in 89 agreements. For 45 of the 60 employers, none of their settlement agreements contained enhanced provisions, and the employers had 32 fatalities subsequent to the settlement agreement dates.

OSHA Has No Specific Criteria for Issuing National Office EEP-Alert Memorandum on Employers with Worksites Across Regions and/or States

OSHA criteria state that EEP-Alert Memoranda are issued when the National Office deemed it necessary to notify Regional Administrators and State Designees of the activity of a particular employer with many worksites across regions and/or states. However, the criterion was not specific on when to issue an EEP-Alert Memorandum and, nationally, OSHA has only issued memoranda on nine employers. Our sample contained 22 employers where multiple EEP qualifying and/or fatality cases occurred in more than one region (totaling 87 fatalities). OSHA issued EEP-Alert Memoranda on only 5 of those sampled employers and only after the majority of the fatalities had occurred.

Does OSHA's January 2008 Revised EEP Directive Have an Adverse Impact on the EEP and Its Ability to Protect the American Worker?

With the 2008 revised EEP directive, OSHA still did not focus EEP enforcement actions on qualifying employers with company-wide safety and health issues to protect workers from subsequent injuries or fatalities. Over the last five years, the purpose of EEP remained the same: to target employers who are indifferent to their OSH Act obligations. However, the revised directive incorporated a component of qualifying history (i.e., prior fatality and similar in-kind violations) which effectively reduced the number of EEP qualifying cases; delayed designation; and increased the risk that employers with multiple EEP qualifying and/or fatality cases may not be properly designated due to the lack of quality history data. Further OSHA continued to not properly designate and conduct EEP cases. As a result, fewer employers may be subjected to EEP enhanced enforcement actions and may incur more fatalities before designation occurs.

Less EEP Qualifying Cases Means Fewer Employers Subject to EEP Activities and Greater Risk for Subsequent Fatalities

Using the 2008 criteria, the number of EEP qualifying cases was reduced significantly. In 2008, OSHA designated 7 percent of all fatality cases for enhanced enforcement, whereas OSHA designated an average of 50 percent between 2003 and 2007. Analysis of 2008 fatalities revealed 260 cases would not have been designated under the 2008 criteria, but would have qualified under the original EEP criteria. Because the fatalities occurred in 2008, 260 employers would not be subject to EEP activities and their employees may be at risk for injury or death before company-wide safety and health issues are addressed through OSHA enforcement.

Issues in Determining Employer History Delayed Designation and Increased Risk That Employers May Not Be Properly Designated

To more specifically focus the program on recalcitrant employers, the revised directive incorporated a key component of qualifying history of OSHA violations (including history with the State Plans). History determination is a manual search process, which can be affected by final order status of prior inspections, differences in standards cited for state cases, and lack of quality data for history searches due to employer-related companies and name variations. Issues in determining employer history delayed designation and increased the risk that employers may not be properly designated.

- *Final Order Status of Prior Inspections*

History searches were complicated by the status of prior cases. Similar in-kind violations cannot be determined until there is a final order of settlement, which takes on average 6 months from the contest date.

- *Differences in Standards Cited For State Cases*

Another challenge of history searches is determining similar in-kind violations when using State inspection data. There were 26 states and territories which operate their own safety and health programs under an OSHA approved state plan. Although these state-plan states enter violations into OSHA's information system, the states' coding may be different from OSHA's. OSHA does not have a crosswalk between state and Federal codes to assist in determining similar in-kind history. Of the 26 state-plan states, 5 states use different coding for most, if not all, of their

safety and health standards: California, Washington, Michigan, Hawaii, and Oregon. Another 17 states have a few unique codes because Federal equivalent codes do not exist. Four states use coding identical to Federal OSHA. Without a crosswalk between state and Federal codes, determining similar in-kind history may be impossible or very time consuming.

- *Lack of Quality Data*

OSHA officials indicated that history searches are subject to errors due to the lack of quality information on the employer in IMIS. Employers could have several different names in IMIS due to spelling errors; abbreviations; punctuation; name variations; or different divisions, operating units or physical locale. History searches may also omit events of related companies such as parent and subsidiary, because the names are not linked in IMIS. OSHA officials stated that they plan to address naming issues in the new OSHA Information System, which is currently under development with a roll-out date in the fall of 2010.

- *OSHA Continued to Not Properly Designate and Conduct EEP Cases*

Although the 2008 criteria resulted in significantly fewer eligible cases, OSHA continued having issues with designating and conducting EEP cases. Out of 708 fatality cases, OSHA designated 50 fatality cases as EEP, but failed to identify 32 cases and improperly designated 16 cases.

Furthermore, we noted similar problems in complying with the 2008 criteria as we did the 2003 criteria. We reviewed 11 EEP cases from 2008, of which 7 had no documentation that OSHA considered related worksite inspections; 4 did not have proper follow up; and 3 with settlement agreements did not include enhanced provisions.

- *Criteria Gaps May Mean Delayed EEP Designation and Additional Fatalities*

There are gaps in the 2008 criteria which may mean delays and additional fatalities before an employer is designated as an EEP case. The revised directive has six criteria for becoming an EEP case, of which three require prior history of another fatality or similar in-kind violations within three years to qualify for the program. However, the criteria leaves gaps where employers would not qualify for EEP without an additional fatality or non-fatality case.

- *Employer's History Included Fatality and Non-Fatality Cases*

One gap occurred when the employer's history included both fatality and non-fatality cases. The non-fatality criterion does not consider prior fatalities as relevant history for EEP designation, unless the fatality cases have similar in-kind violations. This gap also applies in the inverse as the fatality criteria do not consider prior non-fatality cases unless the cases have similar in-kind violations.

From our limited sample of 2008 cases, we do not have any that illustrate this gap and the impact of additional fatalities before designation. Using cases prior to 2008 as an example, one employer Homrich Incorporated had a non-fatality case that had three serious, willful violations cited. Homrich Incorporated had a fatality which occurred 15 months prior, but did not have similar violations to the non-fatality case. If these cases occurred in 2008, then the prior fatality would not have been considered as relevant history for EEP designation. As such, Homrich Incorporated incurred an additional fatality 15 months later, and only then would have qualified for EEP under the 2008 criteria.

- *EEP Qualifying Case Occurred in a State That Did Not Adopt An EEP Plan*

Another gap occurs when the employer's history includes Federal and state OSHA cases. When a case that meets EEP criteria for designation occurs at a state that has not adopted EEP, no enhanced enforcement actions would be taken until a subsequent fatality or serious case occurs under Federal jurisdiction. The criterion is silent on how OSHA will address incidents that would qualify as an

EEP case that occur in a state that has not adopted EEP.

- *Overall Conclusion*

Madam Chair, our overall conclusion is that OSHA has not placed the appropriate management emphasis and resources on this program to ensure indifferent employers were properly designated for this program and subject to EEP actions. It is essential that OSHA target its limited resources to inspect workplaces with the highest risk of hazardous conditions that have greater potential to cause injuries and fatalities. By analyzing inspection information, OSHA can identify worksites with known hazardous conditions to target under EEP. By effectively utilizing EEP activities, OSHA could reduce the risk of future injuries, illnesses, and fatalities.

While we cannot conclude that enhanced enforcement would prevent subsequent fatalities, full and proper application of EPP procedures may have deterred and abated workplace hazards at the worksites of 45 employers where 58 subsequent fatalities occurred.

Recommendations

We recommend the Assistant Secretary for Occupational Safety and Health:

1. Form an EEP Task Force to make recommendations to improve program efficiency and effectiveness to include:
 - Targeting indifferent employers most likely to have unabated hazards and/or company-wide safety and health issues at multiple worksites.
 - Ensuring appropriate actions (i.e., follow-up and related worksite inspections) are taken on indifferent employers and related companies.
 - Centralizing data analysis to identify employers with multiple EEP qualifying and/or fatality cases that occur across Regions.
 - Identifying and sharing Regional and Area Offices' "best practices" to improve compliance with EEP requirements.
1. Revise EEP directive to address issues with prior qualifying history and designation, and to provide specific criteria when National Office EEP-Alert Memoranda are to be issued.
2. Provide formal training on EEP requirements including designation, consideration of related worksite inspections, enhanced enforcement follow up, and enhanced settlement provisions to ensure consistent application of EEP requirements.
3. Incorporate enhanced settlement provisions in OSHA's informal settlement template.
4. Establish controls for periodic reconciliation of the EEP log to OSHA's data system.
5. Develop and distribute a crosswalk to Federal OSHA citations for state standards that have a different coding than Federal OSHA standards.

Madam Chair, this concludes my statement. I would like to thank you for the opportunity to share the OIG's findings on this important issue. I am happy to respond to any questions that you or the other Subcommittee members may have.

Chairwoman WOOLSEY. Thank you.
Mr. Rojas?

**STATEMENT OF JESUS ROJAS, STEPSON OF RAUL FIGUEROA,
A WORKER WHO WAS CRUSHED TO DEATH AS A RESULT OF
UNSAFE WORKING CONDITIONS**

Mr. ROJAS. Chairwoman Woolsey, Representative Price, members of the Committee, thank you for inviting me here today to talk about accountability for work safety.

My name is Jesus Rojas. I live in West Palm Beach, Florida. I am the stepson of Raul Figueroa, who was a mechanic at Waste Management.

Chairwoman WOOLSEY. Can you put that a little bit closer?

Mr. ROJAS. Yes. Better?

Chairwoman WOOLSEY. That is way better.

Mr. ROJAS. On January 3rd, 2008, my stepfather died in a gruesome accident at Waste Management's facility in North Broward, Florida.

The company told me and my family what happened. They said a hydraulic arm on a truck malfunctioned and pinned my stepfather against the cab. His body was severed.

But that is not the whole story. Companies like Waste Management need to be held accountable for workers' deaths that could have been prevented.

After my stepfather's death, my family and I spoke with his co-workers. We learned other disturbing details. We learned that my stepfather began working on the truck, a front loader, at around

5:30 a.m. He was told the hydraulic arms on the truck were not working.

My stepfather was very safety conscious. And to make sure the repair job was done safe, he went to his supervisor and asked for a ladder. He was told there was no ladder, or that the ladder was broken.

Later, he went back to the supervisor and asked for a second mechanic to help with the repairs. Having a ladder or a second person was necessary for safety reasons. But he was told they didn't have a second person to help him.

The supervisors are also supposed to check on the mechanics every half hour to make sure that things are okay. But that didn't happen in the case of my stepfather. Instead, at around 8:30 or 9:00, his coworker came by and saw my stepfather. The coworker pulled the alarm, and the supervisors came to the scene.

Instead of cutting the line that powered the hydraulic arms, the supervisors started pulling at my stepfather to free his body. As a result, we will never know for sure what happened because the accident scene was compromised.

We also learned that a ladder was pictured in the photos of the accident scene. Since my stepfather's coworkers told us that he wasn't able to get a ladder for the repair job, we believe supervisors placed the ladder near the truck after the accident.

For some time before his death, my stepfather complained about safety problems at the facility. He complained about the long hours he and his coworkers had to work. Often they didn't have adequate help when they needed it.

He complained that the company didn't provide the proper parts for the trucks. He said they were forced to patch the trucks but weren't given parts they needed to repair them properly and make them safe.

My stepfather heard that the less money the company spent on parts, the more bonus money the managers received. My stepfather was repeatedly told by his supervisors, "You need to get the truck out on the roads." They said they didn't care how they fixed them.

After the accident, we found out that company officials backdated the service records on the truck my stepfather was working on when he was killed. My brother-in-law spoke to the person assigned to do the backdating of records.

Companies need to keep up-to-date safety records, and they need to be punished for backdating safety records. We can't just rely on the company's word when it comes to safety.

Waste Management did get fined in the case of my stepfather. I am not sure about the specific violations. OSHA told us that they investigated the accident and cited the company for two different safety violations. I believe that the fine was between \$9,000 and \$10,000.

Thankfully, my mother did receive money from my stepfather's life insurance, which she used to pay off her home. However, after the accident, my mother had to stop attending English classes and began working two jobs to make ends meet.

She still works two jobs, one at a Publix Supermarket and the other as a janitor at night. Because my mom had to discontinue

studying English, she cannot work as a medical assistant, which is the profession she has a degree in.

My stepfather left behind my mother, me, 27-year-old sister. He also left two daughters in Cuba and a grandson there who will never meet his grandfather.

Companies like Waste Management should not be allowed to cut corners and compromise safety. They need to provide enough staff to make sure workers are safe on the job. They need to be punished when they backdate safety records to cover up flaws in their safety procedures.

A lot of people know that Dr. Martin Luther King, Jr. was killed in Memphis in 1968. What they don't know is that Dr. King traveled to Memphis to support striking sanitation workers. They were striking because two sanitation workers were killed on the job.

Forty years after Dr. King was assassinated is time enough to hold companies accountable for practices that kill and injure workers.

Thank you for your time.

[The statement of Mr. Rojas follows:]

**Prepared Statement of Jesus Rojas, Stepson, Raul Figueroa,
Waste Management Inc. Mechanic**

Chairwoman Woolsey, Representative Price, members of the Committee: Thank you for inviting me here today to talk about accountability for workplace safety.

My name is Jesus Rojas. I live in West Palm Beach, Florida. I am the stepson of Raul Figueroa, who was a mechanic at Waste Management. On January 3rd, 2008, my stepfather died in a gruesome accident at Waste Management's facility in North Broward, Florida.

The company told me and my family what happened. They said a hydraulic arm on a truck malfunctioned and pinned my stepfather against the cab. His body was severed.

But that is not the whole story.

Companies like Waste Management need to be held accountable for workers' deaths that could have been prevented.

After my stepfather's death, my family and I spoke with his co-workers. We learned other disturbing details.

We learned that my stepfather began working on the truck, a front loader, around 5:30 a.m. He was told the hydraulic arms on the truck were not working.

My stepfather was very safety conscious. To make sure the repair job was safe, he went to his supervisor and asked for a ladder. He was told there was no ladder or that the ladder was broken.

Later, he went back to the supervisor and asked for a second mechanic to help with the repairs. Having a ladder or a second person was necessary for safety reasons. But he was told they didn't have a second person to help him.

The supervisors are supposed to check on the mechanics every half hour to make sure things are OK. But that didn't happen in the case of my stepfather.

Instead, at around 8:30 or 9 a.m., his coworker came by and saw my stepfather. The coworker pulled the alarm and the supervisors came to the scene.

Instead of cutting the line that powered the hydraulic arms, the supervisors started pulling at my stepfather to free his body. As a result we will never know for sure what exactly happened because the accident scene was compromised.

We also learned that a ladder was pictured in the photos of the accident scene. Since my stepfather's coworkers told us he wasn't able to get a ladder for the repair job, we believe supervisors placed the ladder near the truck after the accident.

For some time before his death, my stepfather complained about safety problems at the facility.

He complained about the long hours he and his coworkers had to work. Often they didn't have adequate help when they needed it. He complained that the company didn't provide the proper parts for the trucks. He said they were forced to patch the trucks, but weren't given the parts they needed to repair them properly and make them safe. My stepfather heard that the less money the company spent on parts, the more bonus money the managers received.

My stepfather was repeatedly told by his supervisors, "You need to get the trucks out on the roads." They said they didn't care how he fixed them.

After the accident, we found out that company officials backdated the service records on the truck my stepfather was working on when he was killed. My brother-in-law spoke to the person assigned to do the backdating of records.

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Because my mom had to discontinue studying English, she cannot work as a medical assistant, which is the profession she has a degree in.

My stepfather left behind my mother, me, and my 24-year-old sister. He also left two daughters in Cuba and a grandson there who will never meet his grandfather.

Companies like Waste Management should not be allowed to cut corners and compromise safety. They need to provide enough staff to make sure workers are safe on the job. They need to be punished when they backdate safety records to cover up flaws in their safety procedures.

A lot of people know that Dr. Martin Luther King Jr. was killed in Memphis in 1968. What they don't know is that Dr. King traveled to Memphis to support striking sanitation workers. They were striking because two sanitation workers were killed on the job.

Forty years after Dr. King was assassinated is time enough to hold companies accountable for practices that kill and injure workers.

Thank you for your time.

Chairwoman WOOLSEY. Thank you.

Mr. Schwartz? Can't hear you.

Mr. SCHWARTZ. Thank you.

Chairwoman WOOLSEY. Thank you.

**STATEMENT OF JASON C. SCHWARTZ, PARTNER, GIBSON,
DUNN & CRUTCHER, LLP**

Mr. SCHWARTZ. Thank you, Madam Chairwoman, Ranking Member Price and members of the Committee.

I am pleased to appear today on behalf of the U.S. Chamber of Commerce. The Chamber supports the conclusion of the Inspector General that the Enhanced Enforcement Program is a good idea that serves OSHA's purpose of improving workplace safety and focusing its resources where they can target the highest risk workplaces and worst offenders.

Let me make four points about the program, as the Committee and the Agency considers it on behalf of the Chamber.

Number one, we agree with the Inspector General that there is a need to examine the program criteria to ensure that it really is focusing on the most recalcitrant employers and the highest-risk workplaces.

We think that objective criteria are needed that focus on workplaces where repeat or willful violations relate to fatalities like Mr. Rojas's stepfather's or that relate to serious injuries that occur in the workplace.

We also think it ought to focus on workplaces where the employers are not abating violations that they have been advised of.

And we also think that it needs to focus on workplaces where there are high risks that have not been identified by prior citation history, because as we all know, there are many workplaces out there that have not been subject to OSHA's inspection programs. And looking at that as the sole pool of workplaces from which you draw we don't think is a very effective mechanism.

We agree that a task force should be created to define those criteria. And we think that it may make sense to do that on a trial basis as those criteria are refined. And we think all the stakeholders, including employers, ought to be involved in that effort to define those criteria where those resources are going to be focused.

We think that is critical because there are 7.2 million workplaces in the United States. At its current rate, OSHA is inspecting $\frac{1}{2}$ of 1 percent of those workplaces. Even magnifying those resources by multiple factors will never reach out to any significant percentage of those workplaces.

So you have got to figure out a way to leverage those resources to get at the worst, highest-risk offenders and to use outreach and education with others in order to expand OSHA's influence and improve safety.

Second point I would like to make is with respect to the resources committed to this program. We agree with the Inspector General's conclusion that there are not enough resources committed to the program. And that may very well have led to the various issues that the Inspector General identified where OSHA was not able to follow up to the degree that the program called for.

We think more resources ought to be committed to it. OSHA's response to the Inspector General indicated that the EEP was only 1 percent of the agency's enforcement program. We think that the Agency and, Madam Chairwoman, this Committee ought to focus on where the other 99 percent is going and whether, in fact, it is an effective use of resources.

For example, OSHA's principle programmed inspection program is called Site-Specific Targeting. That program selects employers based on injury and illness data for wall-to-wall inspections. It results, many times, in selecting employers who are very conscientious at reporting sprains and strains throughout their workplace, not the type of high-profile, high-risk workplaces that need this kind of attention.

This point is demonstrated in my testimony. If you see, we have done a comparison of the number of citations issued to SST-inspected workplaces vs. the number of citations issued to Voluntary Protection Program workplaces, those that are showcased by OSHA as the best of the best. The bottom line is the numbers are not materially different.

So SST is not focusing in the right area. And we think OSHA needs to take a good hard look at that in the context of this task force.

Number three, we concur with the Inspector General that creative enforcement and settlement tools are appropriate.

For example, we strongly believe that where you find a condition that is likely to be repeated in other worksites that OSHA ought to focus on those other worksites as well, so we can get the most health and safety benefit out of the inspection program and out of

the settlement results. And we think that needs to be looked at on a case-by-case basis to see what methods are appropriate in each instance.

Let me conclude with one final observation. The Inspector General is very careful to indicate that he can't conclude that any particular fatality resulted from a lapse in the Enhanced Enforcement Program. I think, though, the tone of the report certainly suggests that many fatalities did result. And we think that that is an unfair characterization.

There are very many hardworking men and women at the Occupational Safety and Health Administration who have worked to prevent those kinds of incidents. And I think that the conclusion without evidence that following up on this program in certain instances would have prevented them is an unwarranted one and is an unfortunate inference from the report.

I thank you for your time. And I would just suggest that preventing those kinds of injuries and illnesses ought to be our focus as we go forward in expanding and improving this program.

[The statement of Mr. Schwartz follows:]

**Prepared Statement of Jason C. Schwartz, on behalf of the
U.S. Chamber of Commerce**

Good morning, and thank you for the opportunity to testify today regarding OSHA's Enhanced Enforcement Program. My name is Jason Schwartz, and I am a partner in the law firm Gibson, Dunn & Crutcher LLP. I am also a member of the U.S. Chamber of Commerce's Labor Relations Committee. My practice includes the full range of labor and employment law, including Occupational Safety and Health Act matters.

I am pleased to appear before you today on behalf of the U.S. Chamber of Commerce, the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region to discuss the value of OSHA's Enhanced Enforcement Program and how it can be improved. The Chamber agrees with the Inspector General that the Enhanced Enforcement Program "has the potential for achieving [OSHA's] purpose as it was designed to identify high-risk employers and target their worksites with increased enforcement attention."¹

In that regard, I will address (1) Enhanced Enforcement Program criteria; (2) resources committed to the Enhanced Enforcement Program; (3) the use of creative enforcement and settlement tools in the Enhanced Enforcement Program; and (4) the Inspector General's conclusions regarding workplace fatalities.

1. Enhanced Enforcement Program Criteria

As an initial matter, as we examine the effectiveness of OSHA's enforcement efforts, including the Enhanced Enforcement Program, we must recognize the practical realities in which OSHA operates. In particular, there are approximately 7.2 million worksites in the United States and only 2,400 OSHA inspectors.² Those inspectors conducted 38,591 inspections in fiscal year 2008.³ Assuming each of those inspections occurred at a separate worksite, that would represent only about one-half of one percent of all worksites. Even doubling the number of OSHA inspectors would bring the number of worksites inspected each year to only one percent. While Congress recently appropriated \$80 million in the stimulus package targeted for more enforcement in various DOL agencies including OSHA, and expanded OSHA's FY 2008 appropriations by \$27 million for FY 2009 with explicit instructions to focus on enforcement, there will never be sufficient funds to change this ratio in a material way. Thus, the need for prioritization of enforcement efforts, coupled with education and outreach, is compelling.

Accordingly, the Enhanced Enforcement Program concept not only makes good sense, but is a practical necessity if OSHA is to fulfill its mission. The agency must focus its enforcement resources on those workplaces where citable violations creating serious risks to worker safety are most likely to be found, and where enhanced enforcement will be most likely to bring about effective corrective actions. The Inspector General's report recognized this very point, stating: "It is essential that

OSHA target its limited resources to inspect workplaces with the highest risk of hazardous conditions that have greater potential to cause injuries and fatalities.”⁴

The U.S. Chamber agrees with OSHA that it is appropriate to focus enforcement resources on “those employers who are indifferent to their obligations under the OSHA Act.”⁵ We support efforts to identify and properly define the employers who are subject to this program—especially those whose willful or repeated violations are linked to workplace fatalities or other serious injuries, as well as those who are indifferent to their obligation to abate prior cited violations. It is also important to recognize that certain employers who are “indifferent to their obligations under the OSHA Act” may not have been subject to prior inspections and, therefore, will not be identified through prior citation history. OSHA’s Director of Enforcement Programs noted that the “majority of these establishments [identified under the 2003 Enhanced Enforcement Program criteria] were not really ‘bad actors’ and few had any significant history with OSHA. Most companies cited were first-time offenders.”⁶ He further noted that the revised 2008 Enhanced Enforcement Program criteria are “better in that [OSHA is] not picking up large numbers of small employers with a fatality, but [OSHA is] still not targeting the ‘bad actors’ the program is intended for.”⁷ The Chamber concurs with the Inspector General’s recommendation that a task force be established to help identify appropriate criteria for the Enhanced Enforcement Program, and believes that such a task force should consider stakeholder views in refining these criteria. The Chamber looks forward to participating in that process. As a baseline, we believe the criteria should be designed to identify inspection targets where the agency’s efforts are most likely to result in the identification of “recalcitrant” employers with citable violations related to serious safety and health risks. It may be useful to implement different criteria on a trial basis as OSHA works to refine its approach.

2. Resources Committed to the Enhanced Enforcement Program

The Inspector General concludes that OSHA “has not placed the appropriate management emphasis and resources on this program to ensure indifferent employers were properly designated for this program and subject to EEP actions.”⁸ In its response to the report, OSHA stated that inspections under EEP constitute a mere one percent of OSHA’s enforcement efforts.⁹ We believe that the EEP could be more effective if more resources were re-directed to EEP from other, less effective enforcement programs.

For example, OSHA’s principal programmed enforcement program, Site-Specific Targeting (“SST”) inspections, represents a major commitment of agency resources, but is often misdirected. Under the SST program, wall-to-wall inspections are conducted of many employers whose operations do not pose significant risks to employee safety and health. Because the SST program targets employers based on reported injury and illness data, it often targets conscientious employers who report even minor workplace related injuries. It also operates on the unjustified assumption that injury and illness rates are an indicator of high-risk, noncompliant workplaces.

In many instances, this is simply not the case. Indeed, OSHA’s own recordkeeping criteria require the reporting of injuries and illnesses regardless of fault as the Note to 29 C.F.R. 1904.0 expressly states, “Recording or reporting a work-related injury, illness, or fatality does not mean that the employer or employee was at fault, that an OSHA rule has been violated, or that the employee is eligible for workers’ compensation or other benefits.” But this is precisely the assumption upon which the SST program is based.

A comparison of citation rates from the SST program and inspections of participants in OSHA’s Voluntary Protection Program (“VPP”) illustrates the point. In connection with comments submitted to OSHA in August 2004 regarding the SST program, the U.S. Chamber of Commerce, the National Association of Manufacturers and the Retail Industry Leaders Association reviewed inspection records during 2003 and 2004 for the ten companies whose workplaces appeared most frequently on the 2003 SST inspection priority list (the “SST top ten”).¹⁰ Less than 45 percent of the 247 SST inspections conducted at the SST top ten yielded even one citation. In all, an average of 1.61 citations were issued per inspection, and more than 13 percent of these were withdrawn. Less than eight percent resulted in collection of the full proposed penalty, and no penalty at all was assessed for more than 40 percent of the citations.

As a point of comparison, the commenters also reviewed non-SST inspection records during the same period for the ten companies with the highest number of workplaces that have achieved VPP status (the “VPP top ten”). One of the requirements for VPP status is an injury and illness rate below the industry average.¹¹ Thus, if injury and illness rates are an appropriate predictor of OSHA violations,

one would expect the VPP top ten to have far better performance during OSHA inspections than the SST top ten. The difference should be even more pronounced, in fact, because inspections at the VPP top ten are often limited in scope—complaint inspections or records-only reviews—in contrast to the wall-to-wall SST inspections to which they are being compared. OSHA inspectors actually issued citations in the VPP inspections more often than in SST inspections: more than 49 percent of the time at the VPP top ten, compared to 45 percent of the time for the SST top ten. The average number of citations at the VPP top ten is very slightly lower: 1.57 citations per inspection, compared to 1.61 at the SST top ten. Less than eight percent of the VPP top ten citations were withdrawn, however, compared to more than 13 percent of the SST top ten citations. When withdrawn violation claims are disregarded, the citation rate at the VPP top ten is actually higher: 1.45 citations per inspection, compared to 1.40 per inspection for the SST top ten. Moreover, less than 25 percent of citations at the VPP top ten resulted in no penalty, compared to more than 40 percent for the SST top ten.¹²

Notably, the Inspector General’s report found little overlap between EEP offenders and employers targeted under the SST system: “Only 40 sampled EEP qualifying employers were also targeted under SST.”¹³ This further underscores the fact that the SST program is not effectively targeting high-risk employers. Given the universal recognition that OSHA has resource constraints and should focus its enforcement efforts on higher-risk worksites, we recommend that, in addition to better leveraging its resources through outreach and education efforts, the agency reallocate some of its enforcement resources from the SST program to EEP. We further recommend that the mission of the task force recommended by the Inspector General be expanded to include an examination of the agency’s enforcement priorities and the effectiveness of its various programs so that enforcement resources can be most effectively deployed.

3. Use of Creative Enforcement and Settlement Tools

The U.S. Chamber supports the Enhanced Enforcement Program’s use of creative tools in the enforcement and settlement context to address likely hazards such as inspections of an employer’s other facilities when EEP efforts identify a violation that, by its nature, is likely to be occurring at the employer’s other facilities (e.g., an unguarded machine to which employees are directly exposed). Relatedly, we support the re-direction of resources away from repetitive inspections of different worksites of the same employer where there is no basis to believe such inspections will lead to the identification of serious, citable hazards.

We also concur with the Inspector General’s recommendations designed to ensure appropriate communication within the agency so that Area and Region Offices can coordinate their Enhanced Enforcement Program efforts for national or regional employers whose operations cross jurisdictional lines, and for better reconciliation of data in the IMIS system.

We disagree, however, that the evidence presented in the Inspector General’s report supports the conclusion that “OSHA generally did not utilize enhanced settlement provisions effectively.”¹⁴ As an initial matter, the metric used to justify this finding was that enhanced settlement provisions were not included in 153 of 188 “EEP qualifying cases”—which includes not only cases that OSHA properly designated as EEP, but also cases that the Inspector General believed should have been designated as EEP but were not.¹⁵ The report already contains a finding that OSHA did not properly designate certain cases that qualified for the EEP,¹⁶ so it should not include a separate finding that OSHA did not use enhanced settlement provisions in cases that OSHA did not believe were EEP—it naturally follows that OSHA would not include enhanced settlement provisions in such cases.

More substantively, this finding is inappropriate because neither the 2003 nor the 2008 EEP programs require OSHA to include any of the listed enhanced settlement provisions. The 2003 EEP memorandum states that “OSHA will consider including some or all of the following within the terms of the settlement agreement,”¹⁷ and the 2008 Directive states that “OSHA shall include some or all of the following, or other appropriate settlement provisions, in the settlement agreement.”¹⁸ The fact that such provisions were not included in any particular settlement agreement may, of course, reflect the discretion of OSHA and Solicitor’s Office personnel weighing each case on its merits—a one-size-fits-all approach to settlement provisions is not appropriate in light of the varying facts of each situation. While we concur with the report’s recommendation that enhanced settlement provisions should be listed in the informal settlement “template” as a reminder to enforcement and legal personnel, we caution against making any particular settlement provision mandatory and recommend that the region and area offices maintain their ability to exercise discretion given the individual nature of each worksite and each citation.

4. *The Inspector General's Conclusions Regarding Workplace Fatalities*

Finally, I would like to address the implication of the Inspector General's report that subsequent fatalities at employers enrolled in the EEP or that, in the view of the Inspector General should have been enrolled in the EEP, were the result of lax enforcement.¹⁹ As OSHA indicated in its response, with which we concur, it is "an inappropriate and unsupported assumption to suggest that a fatality did or did not occur because a given workplace did not receive an inspection."²⁰ Indeed, the Inspector General's report itself concedes, in its introduction, that "we cannot conclude that enhanced enforcement would prevent subsequent fatalities[.]"²¹

The report nonetheless repeatedly cites examples where there was a subsequent fatality at a worksite in the EEP or a worksite the Inspector General believed should have been in the EEP—but fails to state whether the subsequent fatality was caused by a similar violation, or for that matter, any OSHA violation at all.²² Without this information, it is improper to conclude that the subsequent fatality could have been prevented by additional OSHA activity—because the fatality could have been caused by an unforeseeable hazard, employee misconduct, natural causes, or something else beyond the control of the employer and beyond the enforcement authority of OSHA or ability of OSHA to prevent. We believe that the suggested task force could further examine issues like this in the context of evaluating and designing the most effective criteria for the EEP in the future.

Thank you again for the opportunity to testify. I would be happy to respond to any questions you may have.

ENDNOTES

¹ U.S. Department of Labor, Office of Inspector General—Office of Audit, "Employers With Reported Fatalities Were Not Always Properly Identified And Inspected Under OSHA's Enhanced Enforcement Program," Report No. 02-09-203-10-105 (Mar. 31, 2009) ("OIG Report"), Highlights.

² All About OSHA, <http://www.osha.gov/Publications/3302-06N-2006-English.html> (last updated Jan. 23, 2009).

³ <http://www.osha.gov/as/opa/2008EnforcementData120808.html> (last updated Dec. 19, 2008).

⁴ OIG Report at 15.

⁵ OSHA Enforcement and Complaint Directive (CPL) 02-00-145, Enhanced Enforcement Program (effective Jan. 1, 2008).

⁶ Memorandum for Donald G. Shalhoub, Deputy Assistant Secretary, Occupational Safety and Health Administration, from Richard E. Fairfax, Director, Directorate of Enforcement Programs (Mar. 19, 2009).

⁷ Id.

⁸ OIG Report at 15.

⁹ OIG Report, Appendix E.

¹⁰ A fuller discussion of this review appears in the Comments submitted by these organizations by letter from my law partner Baruch A. Fellner to the OSHA Docket Office for Docket No. C-08 (August 11, 2004).

¹¹ See 68 Fed. Reg. 68475 (Dec. 8, 2003).

¹² This does not detract in any way from the achievements of VPP employers, which represent some of the safest and most exemplary workplaces in America. To the contrary, it shows that the employers being inspected under the SST are in many respects comparable.

¹³ OIG Report at 7.

¹⁴ OIG Report at 9-10.

¹⁵ Id. (emphasis added).

¹⁶ OIG Report at 4.

¹⁷ Interim Implementation of OSHA's Enhanced Enforcement Program (EEP) (Sept. 30, 2003), <http://www.osha.gov/pls/oshaweb/owadisp.show—document?p—table=INTERPRETATIONS&p—id=24649> (emphasis added).

¹⁸ OSHA Enforcement and Complaint Directive (CPL) 02-00-145, Enhanced Enforcement Program (effective Jan. 1, 2008) (emphasis added).

¹⁹ OIG Report at 3, 15; OIG Ex. 1.

²⁰ OIG Report, App. E.

²¹ OIG Report, Highlights.

²² OIG Report at 5, 7-8, 9-10, 14-15; OIG Report, Ex. 1.

Chairwoman WOOLSEY. Thank you, Mr. Schwartz.
Mr. Frumin?

STATEMENT OF ERIC FRUMIN, DIRECTOR OF HEALTH AND SAFETY, CHANGE TO WIN

Mr. FRUMIN. Can you hear me okay?

Good morning, Chairman Woolsey, Ranking Member Price, members of the Subcommittee. Thank you for the opportunity to testify today.

On behalf of Change to Win, we greatly appreciate your leadership and interest in the serious problems confronting OSHA's enforcement program. These shortcomings endanger workers' lives, and the Congress has the power to help.

Today we hear the testimony of Jesus Rojas. A year ago, you heard the testimony of Emmanuel Torres Gomez, whose father Eleazar died at the Cintas Corporation on the job in 2005.

The conditions that Mr. Rojas has described are truly intolerable. If indeed Waste Management managers misled inspectors about the working conditions, they may well have committed the same felony interference in a federal investigation that just sent several McWane managers to prison for 3-5 years.

Last April, we testified before a Senate subcommittee about patterns of violations at large companies like Waste Management and Cintas. Today I regret to report that a continuing pattern of violations at large corporations continues where they are ignoring or avoiding their obligations to assure a safe workplace.

For instance, Cintas has finally acknowledged that they had 65 facilities around the country that lacked the basic guarding equipment. ShawnLee has accumulated additional willful and repeat violations on construction sites for fall protection hazards. The manager and owners of the Agriprocessors plant in Iowa has been charged with major immigration, child labor and financial crimes.

The top manager and dozens of supervisors at the notorious House of Raeford chicken plant in Greenville, South Carolina, has been indicted for violation of immigration-related labor violations, and federal investigators also found repeated cases of children working in House of Raeford's chicken plants. And, finally, Waste Management itself has incurred more serious lockout violations since Mr. Figueroa's death.

The enforcement program, the EEP, was specifically established to deal with these flagrant repeated offenders. However, it is far too limited.

Before discussing it in detail, we should look at two examples of the serious limitations in OSHA's overall enforcement program apart from those within the EEP. Some individual employers—in fact, some entire industries—have such disregard for their obligations that even the EEP is not enough.

Since the huge 2005 explosion at the BP plant in Texas City, one supervisor and two contract workers have died in that facility, and two more contract workers died at BP's plant in Cherry Hill, Washington. Clearly, BP indicates that the EEP is not enough.

Likewise, the continuing high death toll in the oil and gas drilling industry, which has one of the highest fatality rates in the country, demonstrates that flagrant and repeated violators persist at the level of entire industries as a whole. Not surprisingly, several drilling companies appear repeatedly on the IG's list of companies with repeat fatalities after EEP inspections. Wyoming, a major site for this industry, has the highest fatality rate in the country.

This industry requires more than just EEP designation. It requires a national or a regional emphasis program, a very strong

one. And in addition, OSHA should get on with issuing its industry-specific standards that it has been considering for 10 years.

Now, let us look at the EEP itself. At the outset, the EEP was at best a weak response to the notorious McWane cases. It relied heavily on fatalities to trigger more enforcement.

Even after the changes in 2008, it still lacks the proper focus on multiple severe workplace violations. And, as has been pointed out, OSHA's inspectors have indicated that they view the program as not catching the bad actors.

The IG's investigation, therefore, was a very welcome review. But because it was limited to the scope of the EEP program, it is limited in terms of the kind of guidance that it can offer for where we can go from here.

We need a systemic, holistic examination of the entire OSHA enforcement program designed in the era of giant corporations to find violations everywhere, not just at individual facilities.

We need a new enforcement regime that has stronger criminal sanctions, cutting-edge enforcement capability and investigation capability, more national alerts, corporate reporting requirements to facilitate detection of serious problems, and additional resources. And we salute you for introducing the Protecting America's Workers Act.

Finally, OSHA must—

Chairwoman WOOLSEY. You are forgiven.

Mr. FRUMIN [continuing]. OSHA must enhance responsible corporate performance. The act created the principle that employers are primarily responsible for safety on the job, not the government. And we believe that is an opportunity that must be pursued as well.

Americans voted for real change in the last election. We believe that the Protecting America's Workers Act and Secretary Solis are committed to giving us that. And we are happy to work with you and the Department on that change.

Thank you very much.

[The statement of Mr. Frumin follows:]

**Prepared Statement of Eric Frumin, Health and Safety Coordinator,
Change to Win**

Chairman Woolsey, Ranking Member Price, and members of the Subcommittee, thank you for the opportunity to testify today.

I am Eric Frumin. I serve as the Health and Safety Coordinator for Change to Win, and have worked in this field for 35 years. Change to Win is a partnership of seven unions and six million workers, in a wide variety of industries, building a new movement of working people equipped to meet the challenges of the global economy in the 21st century and restore the American Dream: a paycheck that can support a family, affordable health care, a secure retirement and dignity on the job. The seven partner unions are: International Brotherhood of Teamsters, Laborers' International Union of North America, Service Employees International Union, UNITE HERE, United Brotherhood of Carpenters and Joiners of America, United Farm Workers of America, and United Food and Commercial Workers International Union.

On behalf of Change to Win, we greatly appreciate the leadership of this Subcommittee in holding this hearing, and for your determined interest in the serious problems confronting workers, ethical employers, OSHA and others concerned with the severe gaps in OSHA's enforcement program. These shortcomings endanger workers' lives, and with Congress has the power to help.

Worse, Not Better

Today we hear the testimony of Jesus Rojas, the son of Raul Figueroa, a mechanic at Waste Management, Inc. (WMI) who was killed by the hydraulic arm of the garbage truck he was repairing. A year ago, this subcommittee heard the testimony of Emmanuel Torres Gomez, the son of Eleazar Torres Gomez, a Cintas Corp. employee who died after becoming trapped in an industrial-sized clothes dryer. Their statements describe the anguish that their families have suffered at the hands of companies with extensive records of citations for life-threatening violations of well-established OSHA standards—companies that have been criticized by this Committee and the public for putting production (and profits) before safety.¹

The conditions Mr. Rojas has described are truly intolerable. If indeed WMI managers misled OSHA inspectors about the working conditions at the time of his father's death, OSHA should have investigated to determine whether their stories were true. If they lied, they may well have committed the same felony interference in a federal investigation that just sent several McWane managers to federal prison for 3-5 years, particularly if they colluded in that deception.

Last April, Change to Win testified before your counterpart committee in the U.S. Senate about patterns of violations at WMI, Cintas Corp., the Agriprocessors meatpacking plant in Iowa, the scandal at the House of Raeford poultry plants in the Carolinas, and the construction sites in New England operated by Avalon Bay/ShawnLee/National Carpentry. (That testimony is appended here.²) Today, I regret to report that there appears to be a growing pattern of large corporations ignoring or avoiding their obligations to assure a safe workplace.

Sadly, since last spring:

- Cintas has now finally acknowledged that 65 of its automated laundries in federal jurisdiction lack the basic guarding essential to protecting their employees from tragedies such as the one that happened to Eleazar Torres Gomez.³ It has agreed to pay a nearly \$3 million fine. But despite these acknowledgements, Cintas has still not recanted its callous position that Mr. Torres Gomez was responsible for his own death.

- ShawnLee has accumulated additional “willful” and “repeated” violations for fall-protection hazards as recently as February 24, 2009.⁴

- Not long after this Committee reviewed the atrocious conditions at the Agriprocessors' infamous meatpacking plant in Postville, IA, the managers and owners of that plant were charged with major immigration and child-labor crimes, and more recently for financial crimes and violating U.S. Agriculture Department financial orders.⁵

- Despite its repeated denials of any wrong-doing, the top manager of the notorious House of Raeford chicken processing plant in Greenville, SC has been indicted for violations of immigration—related labor regulations, as have the Human Resource Manager and dozens of supervisors. As at Agriprocessors, Department of Homeland Security investigators also found repeated cases of children working in the House of Raeford's hazardous poultry environment—sparking demands for improved safety and child labor enforcement in North Carolina.⁶

- Finally, Waste Management has incurred more serious lockout violations since Mr. Figueroa's death.⁷

The Enhanced Enforcement Program (EEP) was specifically established to deal with flagrant and repeated offenders such as these. However, as will be discussed below, the EEP is far too limited to accomplish its objectives.

The Problems Beyond EEP

Before discussing the EEP itself in detail, we should look at two examples of the serious limitations in OSHA's enforcement regime apart from the limitations within the EEP.

Indeed, some employers—and even some industries as a whole—have such disregard for their obligations that the EEP alone is not enough.

BP Products North America: a corporate-level study in enforcement failure

In February, 2005, OSHA properly designated the Texas City as an EEP site following its investigation of the multiple deaths there in late 2004. As the IG report notes, OSHA failed to pursue investigations at additional sites based on this incident. The huge explosion occurred a month after OSHA issued its citations in 2005—and though the incidents were not closely related, they reflected the abysmal state of the company's safety program in Texas City. OSHA then designated BP as an EEP and issued a National Alert. However, one supervisor and two contract workers have died at the Texas City facility in the three years since 2005. Two other contract workers died in 2005 and 2007 at the company's Cherry Hill, WA plant.⁸ Clearly, BP indicates that for some companies, the EEP alone is simply not

enough to deter highly hazardous operations. Much more aggressive measures are required.

The Oil/Gas Drilling Industry: an industry-wide study in enforcement failure

The continuing high death toll in the oil and gas well drilling industry—which has one of the highest fatality rates of any industry sector—demonstrates that flagrant and repeated violators persist at the level of entire industries as a whole. In fact, in the most recent 2-year period for which data is available (2006-07), this industry still accounts for two-thirds of ALL deaths in the “mining” industry (see attached BLS data). The number has increased by 30% compared to the prior three-year period. Compare that to the 43% decrease in coal mining in 2007 alone.

Not surprisingly, several drilling companies appear repeatedly in the IG’s report, including companies like Patterson-UTI, Nabors Industries and Premium Well Drilling which even had subsequent fatalities after the initial EEP inspection.

And the major oil/gas drilling states—TX, LA, OK and WY—all suffered increases in their death tolls in 2007. Wyoming indeed has the highest fatality rate of any state in the Union. But notwithstanding these severe problems, OSHA Region VI reported a 24% reduction in the number of inspections in this industry.⁹

The oil/gas drilling industry requires more than just EEP designation, such as a National or Regional Emphasis Program.

Finally, when OSHA adopted the Process Safety Management Standard in 1992 to reduce refinery hazards, it created an exemption for this industry. In 1999, OSHA stated at the time that it was “* * * currently determining whether to place this standard back on its rulemaking agenda.”¹⁰ It is evident that this industry badly needs that additional regulation. More enforcement efforts alone are simply not enough.

The Problem With EEP: An Inadequate Enforcement Regime

At the outset, the EEP was at best a weak response to the the notorious McWane cases that prompted the creation of the EEP program in the first place. Initially, it relied heavily on fatalities to trigger enforcement, rather than relying as much on severe violations as well. Even after the changes in 2008, by limiting itself to both willful/repeat violations AND a recent history, it still lacks the proper focus on multiple, severe workplace hazards and violations.

The EEP has also suffered from inadequate procedures for follow-up. It only requires one additional inspection at “related” sites within the same company within the same Region. Finally, OSHA made only meager efforts under the EEP to launch wide-scale investigations when confronted by serious problems in large companies. In six years, it has issued only nine National Alerts to focus the necessary attention on larger companies with flagrant violations.

OSHA’s inspectors have already noted the many problems with the design of the program. Enforcement Director Rich Fairfax recently stated: “[W]e are still not targeting the ‘bad actors’ the program is intended for.”¹¹

The IG’s investigation into the EEP Program, therefore, was a welcome review that highlighted many problems and demonstrated the need to focus on the goals of the program.¹² However, because the IG’s investigation was limited to the scope of the existing program, that report cannot provide comprehensive guidance on what is necessary to establish a program that will fully identify and effectively deter flagrant and repeated violators.

What is needed is a more systemic, holistic examination of the current OSHA enforcement regime. In an era of giant corporate entities, OSHA is currently designed primarily to find violations at individual “establishments.” OSHA usually takes such action only after fatalities occur, at which point willful, repeated, and egregious violations often prompt broad “corporate-wide” settlement agreements. While some of these settlement agreements have worked well, others have not. In any case, they were reactive responses to problems, not proactive approaches in keeping with the overall preventive purposes the Congress originally intended.

The Solution: 21st Century Enforcement Powers

OSHA needs a new enforcement regime that includes stronger criminal sanctions, cutting-edge investigation capability and corporate reporting requirements to facilitate detection and follow-up, and sufficient additional resources to do the job. We need legislative reforms such as those in Protecting America’s Workers Act and other legislation to close loopholes and give OSHA the new tools and resources it needs.

Expanded Investigatory Capacity—It is vital that OSHA have the authority and the organizational tools to establish a national investigation program so it can identify dangerous conditions at an early stage when it can still intervene to prevent future deaths and serious injuries. In order to accomplish this goal, we urge Con-

gress to make sure that OSHA has a 21st Century information system with the ability to track companies that operate under multiple names or in states with a separate state enforcement programs. OSHA also must make sure that corporate officers—and those who work for them—are as much the subjects of investigations as the front-line supervisors and workers who OSHA first interviews. This is especially important when investigations involve either severe violations, potential employer deception, or both.

More National Alerts—The use of Regional or National investigations is necessary to create an effective deterrent to continued misconduct. As the IG has noted, in most cases the use of National Alerts were effective in greatly reducing and stopping deaths at the targeted companies. And if Regional or National Alerts are useful in the case of flagrant violators, then broader investigations of some kind should also be useful at companies with “high-severity” hazards—even if the cases do not involve the “flagrant” (i.e., repeat or willful) violations that trigger EEP cases.

Corporate-wide Reporting—If OSHA inspectors are to undertake the aggressive follow-up envisioned by the EEP program, they must know the full scope of the companies with which they are dealing. Compliance officers cannot be limited to sending letters to the corporate headquarters merely requesting such information. Companies must be required to report their unified compliance information directly to OSHA on a regular basis, allowing OSHA to plan its enforcement investigations and actions with full knowledge of a company’s operations. Corporate-wide information is also important for calculating penalties. The newly-issued Field Operations Manual specifically requires that an employer’s past violations must be considered in any penalty calculations, even if those violations were issued by a state-administered program or against the same employer operating under a different name.

Sufficient Resources—The failures identified in the IG report certainly do not diminish the dedication of career OSHA staff who are often fighting an uphill battle against these systematic abuses. OSHA staff simply cannot adequately perform with the current level of resources. In relation to the size of the workforce, the number of inspectors has dropped by more than 50% since its high-water mark at the end of the Carter Administration in 1980.¹³

Stronger Criminal Sanctions—Higher monetary penalties are not enough. Even the landmark nearly \$3 million civil penalty that Cintas has agreed to pay OSHA is less than one percent of its annual profits. The OSHAct currently authorizes criminal sanctions only in the case of fatalities resulting from a willful violation of a specific standard, and even that egregious misconduct is only a mere misdemeanor, punishable with a maximum six-month sentence. A violator faces more time in prison for killing a burro on federal land than a worker on the job. There must be stronger criminal sanctions in place.

Enhancing Responsible Corporate Performance—In 1970, Congress established a basic principle: employers—not the government and not individual workers—have the primary responsibility to protect workers’ lives on the job. Employers are obligated under law to provide workers with safe equipment and a healthy work environment. Employers have the additional obligation to maintain effective management systems to deliver that safety, and to hold managers accountable when they fail. Corporations have the infrastructure to know what equipment they operate, where it is, how it runs and whether or not they are committing the same or similar violations in multiple locations. Responsible employers already conduct their own “follow-up” inspections after OSHA finds a severe hazard. This should be an enforceable obligation for all companies.

A comprehensive internal investigation and safety management system at Cintas might have saved the life of Eleazar Torres Gomez. WMI’s OSHA violations increased by 28% over the period 2003-2007. If WMI had implemented a comprehensive safety program, and held its managers accountable, rather than allowing an increasing number of violations, Raul Figueroa might well be alive today.

Enforcement after workers die is not really enforcement at all. We need real change.

That is the change that America voted for last year, and we are more than willing to work with Congress, with responsible employers and with others to see that American workers receive that change. Fortunately, the Secretary of Labor has made it clear that she, too, wants real change, and we are delighted to support her efforts. We believe real change begins with the Protecting America’s Workers Act, and it ends with workers having safe, healthy places to work.

We appreciate the opportunity to testify, and will be happy to answer any questions.

For further information, see:

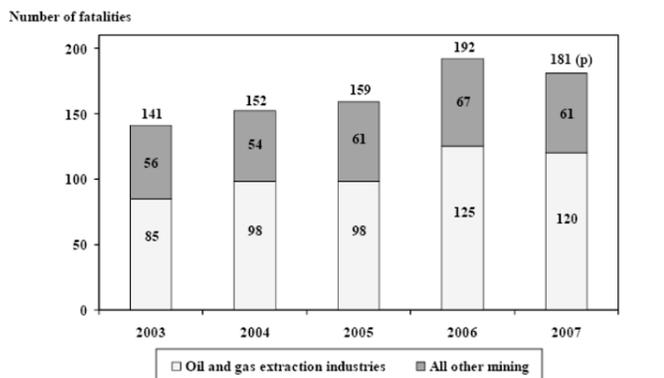
1. Testimony of Change to Win, Senate Subcomm. Employment and Workplace Safety, 4/1/08 at the following Internet address:

<http://help.senate.gov/Hearings/2008-04-01/Frumin.pdf>

2. Report by the National Commission of Inquiry into the Worker Health and Safety Crisis in the Solid Waste Industry—In Harm’s Way: How Waste Management, Inc. Endangers the Sanitation Workers who Protect the Public’s Health. Published April, 2008. <http://www.teamster.org/08news/nr-080325-1.asp>.

Excerpt from BLS Census of Fatal Occupational Injuries 2007

Fatal occupational injuries in the private mining industry, 2003–07



Fatal work injuries in the private mining industry declined in 2007, led by a 43 percent decrease in coal mining fatalities (from 47 in 2006 to 27 in 2007). Oil and gas industry fatalities accounted for nearly two-thirds of the fatal work injuries in mining in 2007.

p = Preliminary
NOTE: Oil and gas extraction industries includes NAICS 211 (oil and gas extraction), NAICS 213111 (drilling oil and gas wells), and NAICS 213112 (support activities for oil and gas operations).
SOURCE: U.S. Bureau of Labor Statistics, U.S. Department of Labor, 2008

ENDNOTES

¹J. Bandler, “House Panel to Examine Cintas Safety Record,” Wall Street Journal, April 23, 2008 [“Workers told OSHA investigators they were ‘under a lot of pressure to keep everything going.’”]; OSHA Press release, Aug. 16, 2007 [“Plant management at the Cintas Tulsa laundry facility ignored safety and health rules that could have prevented the death of this employee,” said Assistant Secretary of Labor for OSHA Edwin G. Foulke Jr.”]; OSHA Press Release, Oct. 31, 2007 [“As a large, national employer with a history of OSHA inspections and citations for hazards at other facilities, we are disappointed to find so many of the same or similar hazards at this facility,” said Ken Atha, OSHA’s area director in Mobile.”]; National Commission of Inquiry into the Worker Health and Safety Crisis in the Solid Waste Industry: In Harm’s Way: How Waste Management, Inc. Endangers the Sanitation Workers who Protect the Public’s Health. April, 2008.

²It is available also at: <http://help.senate.gov/Hearings/Hearings/2008-04-01/2008-04-01.html>

³Addendum A, Stipulation and Agreement, Secretary of Labor vs. Cintas, Dec. 18, 2008.

⁴OSHA inspections 312589302 and 309560183.

⁵Grant Schulte, Rubashkin Hit With 99-Count Indictment, Des Moines Register, Jan. 17, 2009.

⁶Charlotte Observer, March 8, 2008, Feb. 17, 2009 and April 17, 2009.

⁷OSHA inspections 311089510.

⁸Lise Olson and Tom Fowler, Costly Cleanup, Fines Have Failed To Halt BP Deaths, Houston Chronicle, Feb. 24, 2008. Olson and Fowler also noted that a total of 41 workers have died in the Texas City refinery “since the mid-1970’s.”

⁹Alisa Stingley, Critic: Not Enough Government Oversight, Shreveport Times, Feb. 23, 2009.

¹⁰Richard Fairfax, Memorandum for Regional Administrators: PSM Applicability to Oil/Gas Production Facilities, Nov. 4, 1999.

¹¹Memorandum for Donald G. Shaloub from Richard Fairfax, EEP End of Year Report, (FY2008), March 19, 2009. Found at: <http://thepumphandle.wordpress.com/2009/04/02/ig-slams-bushs-osea-twice-in-one-day/#more-4664>.

¹²US Department of Labor, Office of the Inspector General. Employers With Reported Fatalities Were Not Always Properly Identified And Inspected Under OSHA’s Enhanced Enforcement Program, Report # 02-09-203-10-105, Washington, DC., March 31, 2009. The IG limited its review to only three of OSHA’s 11 regions. It was also limited to the time period after OSHA’s mishandling of the notorious McWane cases that prompted the creation of the EEP in the first place.

¹³Center for American Progress Action Fund, Enforcing Change, January, 2009

Chairwoman WOOLSEY. Thank you, Mr. Frumin.

Mr. Lewis, I understand that OSHA has actually taken your recommendation seriously, and they have begun to form a task force to put some of your—if not all, but some of your recommendations into place based on your audit.

What additional resources do you think OSHA—and I am going to ask this of you, too, Mr. Secretary, so—will OSHA need in order to fulfill your recommendations?

Mr. LEWIS. Madam Chair, we did not specifically study OSHA's resources and what would be needed. We can't say how many would be needed to address this.

And it could also be a matter of the allocation or the utilization of the resources, not necessarily the total resources but how they are utilized. But we did not specifically look at what would be the resources required to do this.

Chairwoman WOOLSEY. Did you look at any cause of why since 2003, when EEP put into place, why there had been no follow up and review and—

Mr. LEWIS. What we heard—when the auditors were out doing the work, we did hear from folks in the field that resources were a problem.

There were not enough resources to do all the things that OSHA was attempting to do. That is why I say it could be a matter of, you know, prioritization and allocation of resources as well as total resources.

Chairwoman WOOLSEY. Okay. Thank you.

Mr. Rojas, you testified that your stepfather had complained about safety problems at his job. Did they have a formal complaint system? Did they have a safety committee? And how did Waste Management respond to his complaints? Or concerns—it might not even be a complaint.

Mr. ROJAS. As far as I know, they had no specific committee within Waste Management to focus on those complaints. As I said, it was our belief—or was his belief—that the less money they spent on parts, the more bonuses the managers would get.

So they really—the complaints were among the workers. And they could complain till they turned blue, but nothing ever changed.

Chairwoman WOOLSEY. Was this an assumption the workers, or had they ever seen anything in writing that said, “Dear Manager, Don't spend money on parts so you can have a bonus,” in so many words?

Mr. ROJAS. Well, no, no one is ever going to say, “I am not going to spend this much money on parts for you to fix the truck so I can get a bonus,” and “The less money that the company spends on certain assets, the more bonus that the manager gets.” Because it would look as if they are managing their people in a correct way, when—

Chairwoman WOOLSEY. And so it was like the practice, the actions they took or didn't take, actually, set in place—

Mr. ROJAS. Exactly.

Chairwoman WOOLSEY [continuing]. What you—

Mr. ROJAS. I mean, no one—I don't think anyone would be—
Chairwoman WOOLSEY [continuing]. The expectations.

Mr. ROJAS. I don't think anyone would step out and say, "Yeah, I am not going to give you this part because I want my bonus."

Chairwoman WOOLSEY. But you saw that—but your stepfather saw that in practice.

Mr. ROJAS. Yes. Yes, on a daily basis.

Chairwoman WOOLSEY. Okay. Thank you so much.

Mr. FRUMIN, certainly the employer bears the ultimate responsibility for an accident. We actually get witnesses here that tell us it is the employee's fault when they fall in a drying vat at Cintas. And they really believe it.

Even if the employee does something that they shouldn't do, and an accident or an illness occurs, who is the ultimate responsible entity in that? I mean, well, let me ask a different way, because I know the answer I want. Isn't it the employer's ultimate responsibility?

Mr. FRUMIN. The OSHA Act clearly places the overwhelming burden on the employer.

Now, we would be naive to say that there are no situations in which the employee bears a substantial responsibility for some violation. And, in fact, the courts have recognized there is an employee misconduct offense. But it is a very narrow defense,—

Chairwoman WOOLSEY. Yes.

Mr. FRUMIN [continuing]. One that employers typically try to ignore when they blame workers. And we have seen case after case.

The case of Mr. Torres Gomez is a sad but notorious one, where managers knew fully well about exactly how dangerous the situation was. They knew it for years. And they took little or no action to protect workers who were under tremendous pressure—pressure in the ways that Mr. Rojas has just described.

So the employers have the responsibility. And it is unfortunate—it is worse than unfortunate—when managers, even CEOs, will blame workers rather than accepting their own responsibility. That is why we encourage you to keep tabs on those companies and let them know you expect them to be responsible.

Chairwoman WOOLSEY. Thank you very much.

Mr. Price?

Dr. PRICE. Thank you, Madam Chair.

I again want to thank the witnesses for their testimony.

And, Mr. Rojas, again for your commitment to improving workplace safety, and our sympathy to you for your loss.

Mr. Lewis, in reviewing the report, it appears to be that the criteria for an EEP qualifying case continues to be confusing and muddled. Would you describe what constitutes a qualifying case—an EEP qualifying case?

Mr. LEWIS. Well, under the current requirement that came into effect in 2008, there can be a number of ways you can qualify.

One is that you have had a fatality inspection with one or more willful or repeated violation related to a death. You have fatality inspection with one or more serious violation related to a death, and the employer had an OSHA history of similar in-kind violations within the last 3 years; a fatality inspection with one or more

serious violation related to a death, and the employer had another fatality within the last 3 years.

Dr. PRICE. Now, you are going through a very specific list. And I appreciate that. Is that to say that there is no confusion about what ought to be a qualifying case?

Mr. LEWIS. I agree. I think it is confusing.

We found that there is perhaps some confusion over what counts for the history. It is confusing to me in terms of the fatalities. We have a problem with fatalities that are in state-plan states vs. federal-plan states that do or don't count towards this employer now being classified for enhanced enforcement.

Dr. PRICE. So greater focus on that criteria might be helpful?

Mr. LEWIS. Yes. Yes. I think greater focus on the criteria, clarity on that, would be a big help.

Dr. PRICE. Thank you.

Mr. Schwartz, I was interested in some of the statistics that you cited—that .5 percent, ½ of 1 percent, of workplace sites are reviewed by OSHA. Is that right?

Mr. SCHWARTZ. That is correct, Mr. Price.

In the last year's inspection data that we have, there were almost 40,000 worksites that were inspected out of 7.2 million across the country—inspected by federal OSHA.

Dr. PRICE. And, clearly, we can't review all of the worksites.

Mr. SCHWARTZ. That is right.

Dr. PRICE. You alluded to the fact that we may not be focusing on the worst offenders. Would you expand on that?

Mr. SCHWARTZ. Absolutely.

Mr. Price, the idea is that OSHA is spending the vast majority of its enforcement resources on the Site-Specific Targeting program. That program selects employers based upon their self-reported injury and illness rates. And what it tends to do is focus on employers who are overly conscientiousness in reporting minor sprains and strains in the workplace.

The reason that I know that that is the case, and that the SST program is not in fact targeting the worst offenders, is because if you look at the citations that are produced—the citable violations that result after one of those wall-to-wall inspections—and you compare it to the number of violations that are cited when OSHA inspects one of its showcase Voluntary Protection Program workplaces, there is no material difference.

So we know that these SST resources are being misdirected. And, frankly, the EEP resources ought to be increased, as I think pretty much every witness on this panel has indicated. There ought to be a focus on the worst of the worst, and there ought to be an objective look at who those employers really are so that they can be identified and the resources deployed appropriately.

Dr. PRICE. Your sense about focusing on the worst of the worst, which sounds like it makes a whole lot of sense and ought to be the direction in which we head in order to truly decrease workplace injuries and deaths: Is there a specific way in which one ought to proceed to have OSHA do that in terms of their criteria?

Mr. SCHWARTZ. Here is what I would recommend, Mr. Price. I think there are a number of approaches that you can take.

First, I think you need to start with a working group that includes all the stakeholders who have got the knowledge of this to try to figure it out.

I think one area you can focus on are the repeat and the willful violations that relate to a death or a serious workplace injury.

I think another area you can focus on is the employers that fail to abate after they have been cited for a violation.

And then I think you also need to focus on the larger pool of employers who are not already captive in the OSHA inspection system but who truly may be the ones posing the highest risk.

I mean, the problem with the current program is it tends to propagate on itself. It is looking to the people who have been inspected—who, as I said, are largely compliant employers with low-gravity injuries and illnesses—and it doesn't look to anybody that hasn't been looked at before.

Dr. PRICE. Thank you.

Chairwoman WOOLSEY. Mr. Hare?

Mr. HARE. Thank you, Madam Chair.

This is the second hearing that we have had about workplace safety. And the other day we had a woman here who testified that she lost her son. A lumber company modified a piece of equipment, and basically her son's shirt got caught in it, and it strangled him to death.

We have heard about Cintas, the death where the company initially tried to tell the family that the man committed suicide. And when that didn't work, they said that he basically wasn't smart enough to operate the equipment. And then finally, I guess they decided they were going to back off those two completely dumb remarks.

Today, Mr. Rojas comes and talks about his stepfather and what happens.

I believe that the vast majority of the companies in this country want to do the right thing. But we have got companies like Cintas, like the company that your stepfather worked for, like the lumber company.

And we have got to do something to make sure that these folks—in Cintas's case, the \$2.8 million fine. They paid a fine, and they just whistle as they leave.

And as you said, Mr. Frumin, they still haven't cleaned up their act. And they are not going to. Because it is cheaper for them to pay the fine, evidently, than it is to keep people from dying.

You know, one of the charts that was held up the other day said accidents are going down. But yet the very woman who testified about her son said that not too long after his death, a young man had his leg literally torn off and that the company didn't have to report it.

So the charts—my charts—are the pictures of the workers who have been killed and maimed. And we have got to put an end to this.

And what I would like to know from maybe anybody on the panel—Mr. Rojas, I want to ask you first, I am sorry. What kind of a fine did you say was levied on the company for your stepfather's death?

Mr. ROJAS. I don't know the specific fine that it was. I do know there were two different fines for safety totaling between \$9,000 and \$10,000.

Mr. HARE. \$9,000?

Mr. ROJAS. Yes.

Mr. HARE. So they were willfully negligent in the death of your stepfather, and it cost them a whopping \$9,000?

Mr. ROJAS. Correct.

Mr. HARE. And you said that your mother got enough from his life insurance to be able to pay off her house?

Mr. ROJAS. That is correct.

Mr. HARE. Did the company do anything to help your family? Did they come over? Did they send anybody over to try to help, you know, you and your family, your mother, with any other additional things and walk them through the process?

Mr. ROJAS. At the beginning, when everything happened, the company did send some representatives out to her home.

They sent a flower arrangement to the funeral. And I think they put up I believe it was \$9,000 for the funeral arrangements. That is about it.

Mr. HARE. And do you know if they have made any changes at that company since, to make it safer?

Mr. ROJAS. I know there have been meetings in the mornings. Serious changes, I don't believe there have been, no.

Mr. HARE. That is not surprising.

Mr. FRUMIN, what do we do with companies that just literally think that the law or the fine is just okay and continue to operate, like Cintas and these companies? What do we do to take those companies, and not—look, and I am not saying we go after the people that are doing what they are supposed to be doing every day.

But I am talking about—isn't there a moral obligation we have to allow workers to be able to go to work and come home safe with their families? So what do we do with companies like Cintas and other companies—this lumber company, the company that Mr. Rojas's stepfather worked at—that just don't seem to care?

Mr. FRUMIN. Well, accountability is a very critical aspect of this entire issue. And right now the required amount of accountability within American companies on health and safety is pretty low.

At the individual establishment level, OSHA does inspections, and either finds violations or not. And Mr. Schwartz has talked about some of the variation there.

But how about above the level of the company, the people who tell the managers what to do, who set the performance goals, who push the production requirements, who create the pressures that Mr. Rojas has talked about?

Mr. HARE. You think people ought to go to jail?

Mr. FRUMIN. When CEOs—

Mr. HARE. I do. I am just wondering if you would agree with that.

Mr. FRUMIN. When CEOs ignore their responsibility, they don't hold people accountable, as was the situation at McWane and we believe at Cintas then, they ought to face those same penalties. The PAWA would do that.

But we have got to create a system in this country where corporate structures are enforced on health and safety, not just on profits.

Mr. HARE. Thank you, Madam Chair.

Chairwoman WOOLSEY. And now, Mr. McKeon, the Ranking Member of the Education and Labor Committee?

Mr. MCKEON. Thank you, Madam Chair.

Mr. Lewis, I want to be sure the record is clear with respect to OSHA's role in reviewing its Enhanced Enforcement Program.

It was suggested earlier that the agency decided to constitute a task force only in response to the IG's audit and report. But isn't it true that in fact the agency had decided on its own in 2008 to review the EEP and had planned to convene a task force to consider changes but held off on that task force pending completion of the IG's report.

Mr. LEWIS. Correct. That is our understanding with OSHA that they were starting to look at this at the time we announced our audit.

Mr. MCKEON. Okay. I just wanted to make that clarification in the record.

Chairwoman WOOLSEY. Thank you.

Mr. MCKEON. This is really a serious subject. I think when we are talking about worker safety, workers that have very serious accidents, have injuries such as Mr. Hare noted, or death, this is something I think that we are all very, very concerned about.

And I think we have to be overly careful that we don't politicize this issue, that we are careful about how we attack companies that are involved. I think the overall purpose of OSHA is to protect people in the workplace. And when we have—I think it has been suggested earlier that the overwhelming majority of all companies have this same concern.

There are some bad actors. We know that. And it seems to me that, as has been stated in your testimonies, those are the companies that we should be going after.

The idea of going in and—I think, as Mr. Schwartz suggested in his testimony, that the companies that are trying to do well and make these reports, and then they are the ones that are followed up and visited. And perhaps OSHA then can say, "Well, look at the job we are doing," but not going after the companies that have repeated offenses.

And I think, some way, that would be the best thing that we could be doing is going after companies that have shown a disregard for when OSHA has come in, or for the safety of their employees. And when they have one offense after another, those are the things that seems like we should be really talking about.

I know something came up in the testimony yesterday. And I wasn't here, but I heard about the testimony. And I was a little bit upset because I know the gentleman from Illinois is my good friend, and probably I think went a little bit overboard, and then mentioned Cintas again today.

I met with some of the people from Cintas yesterday. And they are going to put a statement into the record that will clarify what happened, the incident that was referred to. And I think from what has been said—and even from what you said today, Mr. Hare—that

would indicate that the company has little regard for their employees.

There was a serious tragic accident where an employee lost his life. And they have made a great deal of change in their operation to prevent that from further happening. And I think that is the result that we should be looking for. And I think that we could all agree to that.

And if something comes of OSHA's looking into this and going after this Enhanced Enforcement Program, seems to me that that would be a very beneficial way to move forward.

Do you agree with me on that? Is that something that you would feel would be a good improvement on this program? Anybody?

Mr. FRUMIN. Mr. McKeon, I would agree with you that a very thoughtful, well-informed targeting program is necessary to make sure that OSHA finds out who the bad actors are.

And right now, that system doesn't exist. That information system doesn't exist.

OSHA is operating at a very archaic information system. We have very sophisticated information systems in companies in corporate structures today that OSHA has little or no access to.

And Mr. Hare's legislation would help remedy that, but it would go part of the way.

I would differ with you, though, that the outcome at Cintas is something that we could applaud because—

Mr. MCKEON. Did I say applaud?

Mr. FRUMIN. Well, you said that was an example of something we would approve of, or—you described it in a beneficial way.

Mr. MCKEON. What I said was that the company had made extensive changes to preclude that type of an accident happening in the future.

Mr. FRUMIN. And if they had actually been caught by surprise in that incident, one could salute their quick reaction in that way.

Unfortunately, senior corporate officers knew years in advance that that very hazard was a problem in the company, and they virtually predicted that it would happen.

Well, where was the deterrence to remind them that they had to act on that knowledge? There was no deterrence. We don't have that ability now to stop companies from ignoring problems like Cintas—

Mr. MCKEON. I guess probably rather than focusing on it, I look at—Madam Chair, he went a little long on his answer. I would like to hear Mr. Schwartz—

Chairwoman WOOLSEY. Well, no, I am sorry, Mr. McKeon. But we can go back around if you would like after we go through this series.

Mr. MCKEON. Maybe then when it comes back around I will not be here.

But maybe, Mr. Price, if you could give Mr. Schwartz—

Chairwoman WOOLSEY. Okay. Thank you.

Mr. MCKEON [continuing]. A chance to respond to that, I would appreciate.

Chairwoman WOOLSEY. Mr. Payne?

Mr. MCKEON. Thank you.

Chairwoman WOOLSEY. Thank you.

Mr. PAYNE. Thank you, very much.

And thank you, Madam Chair, for calling this important hearing and to stay on the whole issue of occupational safety.

As we have seen in the past several years, the safety of employees continued to decline. A number of deaths last year, 2 years ago—window washers in New York, several deaths in the course of several months. It is just that the safety of the employed has been compromised.

I just would like to ask Mr. Frumin—and I appreciate you attending the hearing in Linden, where we had the Cintas case where two employees unfortunately lost their lives, and—was it one or two?—but that they were blamed for the death. And the company was initially very insensitive to the situation.

But I wonder, Mr. Frumin, in the Cintas case, it is my understanding that the company agreed to pay a substantial fine but that its citations were downgraded to unclassified.

And so can you tell us the significance of an unclassified citation, particularly if another worker is killed or seriously injured at a Cintas facility?

Mr. FRUMIN. Thank you, Mr. Payne.

Unclassified violations have become, unfortunately, pretty popular in a larger number of high-visibility settlements. And what they do is make it difficult for OSHA to consider the severity of that violation in future cases.

We know, for instance, that further action against the company might require a willful violation. And yet if it is unclassified, well, then there is no willful violation.

So it creates a difficulty in proceeding aggressively with those same companies. And I think that is one of the reasons the companies work so very hard to secure them in their settlement negotiations.

Mr. PAYNE. Also, there was an Inspector General's—I don't know if anyone mentioned it; I have been in and out—report, assessment. And I wonder if you agree with the Inspector General's assessment that the 2008 revisions were detrimental to the program. And if not, could you please explain why, Mr. Frumin?

Mr. FRUMIN. Well, the 2008 changes were actually quite good in some ways because it relieved some of the pressure on the inspectors to find fatalities as a basis for going forward. And it also allowed the program to focus on larger employers with multiple sites.

The prior program was finding fatalities and finding them, in many cases, at individual sites in the construction industry and others. So a program which is designed to look at multiple sites and create a deterrence and stop companies from creating the same violation over and over again should focus on multi-site companies.

But having said that, it is still an incomplete program. And we have called today for a comprehensive review of it. We are glad to hear that the Labor Department is, in fact, undergoing such a review.

And I think the limitations that the government was operating under in 2008 were such that they were never going to be able to fix it properly. The time to fix it is now.

Mr. PAYNE. Have any of you found whether the new administration has been able to increase—I don't know, I guess, Mr. Lewis,

you must be representative of the government. Have there been an increase in employment, or is it just the first 100 days a little bit too soon to have an assessment of what is going on in OSHA?

We did see a sort of a lessening during the past 8 years, it appeared to me, of even weakening in NLRB and OSHA reform.

Oh, my time is up. So, quickly, I guess the question is have you seen the new administration move into the area of this OSHA yet?

Mr. LEWIS. All right. Simply because—I don't know the answer to that, simply because OSHA has not responded to us yet to the final audit report. It will be the end of March before we hear their response to the final recommendations we had. So they may very well be moving on that, and I am just not aware of it.

Chairwoman WOOLSEY. Thank you.

Ms. Shea-Porter?

Ms. SHEA-PORTER. Thank you.

Mr. Rojas, I am sorry about what happened. And I will tell you that this is the second time this week I heard about flowers coming. And it is incredibly disturbing.

And I will say that the hearing that we had the other day said that actually it has gotten so bad that if you really want to make a company pay for the damage that they have done, you should look at the EPA rules because they are tougher than the OSHA rules for loss of human life. And that is just astounding. That has to change.

I had one question, Mr. Lewis, and that had to do with OSHA not following up on the majority of cases. What, if anything, can we do to make sure the company eliminates the hazards. I mean, how do you know if they have eliminated the hazards, and if they are now in compliance, if they don't have the follow up?

Mr. LEWIS. Well, I think that is exactly the point. Without the follow up, you don't know, if you haven't verified that things have been corrected.

Ms. SHEA-PORTER. Okay. So that is exactly—

Mr. LEWIS. Yes.

Ms. SHEA-PORTER [continuing]. The crux of the problem here, that they can go another round, and another round, because we can't and don't follow up.

Mr. LEWIS. Right.

Ms. SHEA-PORTER. Thank you.

And at this point, I would like to yield the remainder of my time to Congressman Hare.

Mr. HARE. I thank my friend from New Hampshire.

I have tremendous respect for the Ranking Member. But I feel compelled to respond. He said he was disappointed in what I had to say the other day regarding Cintas, and he met with the executives of Cintas.

Let me just say for the record, Madam Chair, we met with the workers from Cintas. And if the companies calls cleaning up their act of 46 violations that they have been cited for for the very same thing that killed this man, I would have to say that I would thoroughly disagree with the Ranking Member. When 15 states that Cintas currently has plans in have not been—this problem has not been addressed as we sit here today.

When the workers came and testified here at this very hearing, the Cintas executives that met with McKeon were invited, but they went on the company picnic. They sent their legal counsel to sit and take very good notes in the back row.

The bottom line here, this is a company that has been fined—you know, I didn't make the numbers up—\$2.8 million. And the treatment of the family of this worker, to me, is reprehensible.

Now, they haven't met with me at my office. I would be happy to have them come in. But I have got a feeling I am not going to get a phone call from them.

But I think they owe an explanation. And I would be more than willing to sit down and ask them why—46 worth of violations. They are branded as one of the single biggest violators of worker safety in the nation.

So they can crow all they want to about how they are protecting their workers. But one of the workers told me—and then I will yield back my time to my friend—that they were told on this conveyor belt if it got stuck to jump up and down on it until it became unstuck. And if they didn't do it, they would be looking for another job.

The fact of the matter is, if that is corporate responsibility, then I don't know what the real definition of that is.

But I would just say, Mr. Frumin, in our second go-around, I am anxious to hear your result. But, again, I say this for the record because we had an opportunity to meet with these people. Facts are facts, and I am glad that they took the time to meet with the Ranking Member, who I consider a friend.

But I could not be in stronger disagreement with him on whether or not this company has in fact made an effort to clean up their act. I am still waiting for the other 15 states.

More importantly, I am waiting for word that one of the workers is going to be harmed again at one of these places for their haven't done it. And when they are fined, you can just bet the bank that these guys are going to go right along their merry little way, pay the fine, and wait for another person to be harmed.

And I thank my friend for yielding.

Chairwoman WOOLSEY. Mr. Bishop?

Mr. BISHOP. Thank you, Madam Chair. I am sorry I have arrived late.

Let me just stay on the Cintas issue that Mr. Hare was just speaking about. We had a series of hearings last year with respect to Cintas. And it became clear as a result of those hearings that they knew years earlier about the severe danger to their workers that was presented by some of their workplace conditions.

And it was in fact those dangers that eventually killed Eleazar Gomez, and it did trigger an EEP investigation. But to date, Cintas has done really very little to fix the problems.

Isn't this the kind—there was a case in New York that was identical to the case in Oklahoma. The case in Oklahoma was addressed in some measure, but there was no addressing the situation in New York.

And shouldn't we have a mechanism that would allow the existence of a condition in one component of a company that when there is a complaint filed about that condition in a particular site that

there also would be an investigation of other sites and the remediation of that condition in other sites, not just in the site that created a tragedy?

Mr. Lewis, I will put this question to you.

Mr. LEWIS. Yes. And that is one of the points that we brought out in our report: first identifying that and making it known to nationwide, and doing the inspections, particularly in the related worksites. So, yes, you are exactly correct in that.

Mr. BISHOP. It just seems so painfully obvious that we must have a mechanism that addresses problems that exist throughout a corporate structure.

Mr. Frumin, did you want to comment?

Mr. FRUMIN. The case in New York is instructive, because even though it dealt with many of the same hazards that eventually killed Mr. Torres Gomez in Oklahoma, it would not have been considered an EEP case. It was a serious violation, and unfortunately at the time the Labor Department was not, OSHA was not, aware of the extent of that hazard throughout the company. They only became aware of it, I believe, after the fatality.

So your point about individual incidents triggering a broad look is very well taken. And if the company had acted on its knowledge, if OSHA had been provided with the information and asked them to act broadly, Cintas might have done what its competitors were already doing. It is not like they were being asked to do anything different than the rest of the industry.

Their competitors were already installing this equipment. And, you know, we wouldn't have had millions of dollars in penalties and legal fees and hearings on it. People would have been protected.

So we need that kind of trigger, and we need it at a lower level than the EEP program currently provides.

Mr. BISHOP. Thank you very much.

Madam Chair, I yield back.

Chairwoman WOOLSEY. Thank you very much.

Thank you, panel. You were wonderful.

We are going to bring our Secretary up now. And hopefully before we vote, we can hear him and not interrupt everything so badly.

Mr. Secretary, I don't have to explain the lighting system to you. But welcome.

Jordan Barab is the Acting Assistant Secretary for the Occupational Health and Safety Administration. He served most recently as a senior policy advisor for the Education and Labor Committee. We were really fortunate to have his expertise.

Jordan was the Special Assistant to the Assistant Director of Labor for OSHA from 1998-2001 and directed the Safety and Health Program for the American Federation of State, County and Municipal Employees from 1982 to 1998. He graduated from Claremont McKenna College in California and received a master's degree in international relations from the Johns Hopkins University. Welcome.

STATEMENT OF JORDAN BARAB, ACTING ASSISTANT LABOR SECRETARY, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Mr. BARAB. Thank you, Madam Chairman.

Madam Chairman, Mr. Price, members of the Subcommittee, before I begin, I just want to say a few words to Mr. Rojas.

First, I am very sorry for your loss. The type of conditions that you describe in your stepfather's workplace, the attitude of putting speed in production before safety and not listening to the health and safety concerns workers raise—these are the type of things that this administration will not tolerate.

We are not only sending a strong message to employers who cut corners on safety, but because OSHA can't be everywhere all the time, we also need to work much harder to make sure that workers have the tools they need to ensure that their workplaces are safe and that OSHA is there to make sure that that happens.

I want to thank you for coming here today.

Madam Chairman, thank you very much for this opportunity to discuss the Occupational Safety and Health Administration's Enhanced Enforcement Program and to respond to the concerns expressed by the Department of Labor's Office of Inspector General in its March 31st report.

President Obama and Secretary of Labor Hilda Solis have both publicly expressed their desire that OSHA be more vigorous in protecting the nation's workers. OSHA employs some of the most dedicated and hardest working employees in the federal government, and under the leadership of Secretary Solis, they are inspired and eager to do their jobs of protecting the American workforce. I intend to help lead this agency in achieving that goal.

Despite the brevity of my tenure at OSHA, I have had time to fully review and analyze the OIG's report. I do agree with the recommendations in the report, and both agency staff and I share the concerns of the report.

Properly identifying employers who should be subject to EEP is essential. Similarly, it is not acceptable to fail to follow through with inspections or enhanced settlement agreements with employers that OSHA has placed on the EEP.

OSHA's targeted inspection efforts consist primarily of a Site-Specific Targeting system that focuses on establishments with high injury and illness rates and both Local and National Emphasis Programs. The Enhanced Enforcement Program was designed to supplement to these programs and to focus enforcement efforts on recalcitrant employers.

The EEP was initiated in September 2003 to help OSHA focus its resources on those employers who were indifferent to their obligations under the OSH Act, concentrating limited enforcement assets on employers who not only failed to meet their obligations under the OSH Act but who also appeared unlikely to decide on their own to improve working conditions at their workplaces.

OSHA had discovered that a number of employers continued to expose workers to very serious dangers even after having received OSHA citations for worker exposure to hazards that caused serious injuries and fatalities. Such was in the case at McWane facilities as reported the New York Times and Frontline in 2003.

In 2008, the EEP was amended in response to OSHA staff concerns that the program was not consistently accomplishing its purpose to focus on recalcitrant employers. However, it soon became clear that additional program modifications would be needed to better direct resources and that more stringent follow-up inspection criteria needed to be added to the program.

OSHA staff began revisions in March of 2008 and was in the process of developing those revisions prior to the OIG evaluation.

Obviously, in order for the EEP to be effective, OSHA area, regional, and national offices must accurately identify which employers are in need of enhanced enforcement and then apply its enhanced enforcement tools to these recalcitrant employers. The OIG report pointed out that this has not always occurred.

I assure you that OSHA is already hard at work rectifying the weaknesses in the OIG report. The agency has established a task force to revise the EEP which will design a new program, which we are preliminarily renaming the Severe Violators Inspection Program, which will be a comprehensive revision of the existing EEP.

Although the details are still being worked out, the new program will ensure that recalcitrant employers not meeting their obligations under the OSH Act are targeted for additional enforcement action, and will focus more on large companies and less on small businesses.

Some changes under consideration for the program include mandatory—not recommended—follow-up inspections, more inspections of other establishments of an identified company, and additional enhanced settlement provisions. The new program will include a more intensive examination of the employer's history for systemic problems that would trigger additional mandatory inspections.

And the new program would undergo continual review, and improvements will be made while deficiencies are identified. I believe that this new program will address each of the six OIG recommendations.

I want to emphasize that while the OIG report identified serious problems within the EEP, the EEP process also made OSHA more aware of criminal violations. Referrals of potentially criminal willful violations to the Department of Justice for prosecution increased from 6 per year from 1993-2003 to 12 cases in fiscal year 2008.

Although the EEP is an important component of OSHA's overall compliance strategy, it is not the only enforcement tool that we utilize, nor is it the main tool that OSHA utilizes. OSHA's main inspection strategy focuses primarily on its LEPs and NEPs, as well as the Site-Specific Targeting Program for the vast majority of its enforcement work.

Currently there are NEPs focusing on the hazards of combustible dust, amputations, lead, shipbreaking, crystalline silica, and trenching and excavation. We are also finalizing the NEP program on flavoring chemicals.

Thank you, Madam Chairman. And I would be glad to answer any questions.

[The statement of Mr. Barab follows:]

**Prepared Statement of Jordan Barab, Acting Assistant Secretary for
Occupational Safety and Health, U.S. Department of Labor**

Madam Chairman, Members of the Subcommittee, thank you for this opportunity to discuss the Occupational Safety and Health Administration's (OSHA) Enhanced Enforcement Program (EEP) and to respond to the concerns expressed by the Department of Labor's Office of Inspector General (OIG) in a report entitled "Employers with Reported Fatalities Were Not Always Properly Identified and Inspected Under OSHA's Enhanced Enforcement Program" (March 31, 2009). As you know, I have recently assumed the positions of Deputy Assistant Secretary of Labor for Occupational Safety and Health and Acting Assistant Secretary.

Until the Assistant Secretary is confirmed by the Senate, the Secretary has asked me to help provide the leadership, utilize the resources, and establish policies that enable OSHA's employees to do their jobs. I am very proud to join this organization. President Obama and Secretary of Labor Hilda Solis have both publicly expressed their desire that OSHA be more vigorous in protecting the Nation's workers. OSHA employs some of the most dedicated and hardest working employees in the federal government, and under the leadership of Secretary Solis they are inspired and eager to do their jobs of protecting the American workforce. I intend to begin the process of leading this agency in achieving that goal.

Because of the brevity of my tenure at OSHA, I have had limited time to fully review and analyze the OIG's report. OSHA responded preliminarily to the OIG in a Memorandum of March 30, 2009, and is in the process of thoroughly reviewing the report in order to determine the best ways to address each recommendation. OSHA shares the concerns raised in the report, and believes that properly identifying employers who should be subject to EEP is essential. Similarly, it is not acceptable to fail to follow through with inspections or enhanced settlement agreements with employers OSHA has placed in the EEP.

As background, OSHA's targeted inspection efforts consist primarily of a Site Specific Targeting system that focuses on establishments with high injury and illness rates and both Local and National Emphasis Programs (LEPs and NEPs). The emphasis programs focus on industries with high injury, illness, or fatality rates, or on hazards such as lead, silica, or amputations. The Enhanced Enforcement Program was designed as a supplement to these programs to focus enforcement efforts on recalcitrant employers. OSHA is exploring ways to reinvigorate the EEP, and the OIG report provides a starting point for our efforts to do this in the most effective way.

The authors of the Occupational Safety and Health Act (OSH Act) 39 years ago were far-sighted in providing enough flexibility in the law for the agency to innovate as it encounters tough enforcement cases. The EEP was initiated in September 2003 to help OSHA focus its resources on those employers who are indifferent to their obligations under the OSH Act, concentrating limited enforcement assets on those employers who not only failed to meet their obligations under the OSH Act, but who also appeared unlikely to decide on their own to improve working conditions at their workplaces. OSHA had discovered that a number of employers continued to expose workers to very serious dangers even after receiving OSHA citations for worker exposure to hazards that caused serious injuries and fatalities. Such was the case at the McWane facilities as reported by the New York Times and Frontline in 2003. Employers like McWayne had multiple worksites where related hazards existed and OSHA's existing targeting system did not provide a mechanism to enforce the OSH Act at these additional establishments.

In 2008, the EEP was amended in response to OSHA staff concerns that the program was not consistently accomplishing its purpose to focus on recalcitrant employers. A history filter for a serious violation related to a fatality was added to eliminate numerous small employers who should not have been added to the program as originally envisioned. In this situation, the employer must have, within the prior three years, a history of violations similar to the EEP violation. However, it soon became clear that additional program modifications would be needed to better direct resources and that more stringent follow-up inspection criteria needed to be added to the program. As such, OSHA began revisions in March of 2008, and was in the process of developing these revisions prior to the OIG evaluation.

Under the current EEP, it is standard protocol for OSHA to mail an information copy of all citations under the EEP to the employer's national headquarters if there is more than one worksite, thus ensuring that national headquarters is aware of safety and health problems at the local establishment. An employer identified as being a recalcitrant employer can also be targeted for additional enforcement action as follows:

- OSHA can conduct enhanced follow-up inspections to ensure not only that the violations that had been cited were corrected, but also to check on whether the employer is addressing other similar hazards throughout its facilities. One way this occurs is to identify establishments on the current Site-Specific Targeting (SST) lists belonging to employers that are enhanced enforcement targets. These establishments will receive a higher inspection priority by being placed in the SST's current inspection cycle.

- OSHA and its attorneys can negotiate to include more stringent provisions in settlements of EEP citations than those it might insist on otherwise.

- Finally, under section 11(b) of the OSH Act, DOL attorneys can, if necessary, obtain enforcement orders, and then seek to hold employers in contempt of those orders if the employers continue to fail to abate hazards or implement other provisions in citations, settlements, or orders of the Occupational Safety and Health Review Commission and Federal courts. Potential sanctions for contempt include daily penalties and other fines, incarceration of an individual company officer who flouts the court's order, as well as any other sanction that the court deems necessary to secure compliance.

Obviously, in order for the EEP to be effective, OSHA Area, Regional, and National Offices must accurately identify which employers are in need of enhanced enforcement and then apply its enhanced enforcement tools to these recalcitrant employers. The OIG report pointed out that this has not always occurred.

OSHA is already hard at work; revisions to the EEP were underway prior to the OIG report. Furthermore, consistent with the report's recommendations, the agency has established the EEP Revision Task Force. This task force, comprised of personnel from the Directorate of Enforcement Programs as well as Regional Administrators, their Deputies, and Departmental attorneys, is designing a new program, which we are preliminarily renaming the Severe Violators Inspection Program (SVIP), so that we will be able to identify and inspect recalcitrant employers more effectively. The SVIP will be a comprehensive revision of the existing EEP, focusing more on large companies and less on small businesses. Although the details are still being worked out, the new program will ensure that recalcitrant employers not meeting their obligations under the OSH Act are targeted for additional enforcement action.

Some changes under consideration for the program include mandatory—not recommended—follow-up inspections, more inspections of other establishments of an identified company, and additional enhanced settlement provisions. The new program will include a more intensive examination of an employer's history for systemic problems that would trigger additional mandatory inspections. OSHA believes that this new program will address each of the six OIG recommendations. OSHA is happy to share the revised Directive implementing the new program with the subcommittee once it is publicly released.

Finally, the new program will undergo continual review by field and headquarters staff in order to make ongoing improvements. Again, we will be happy to keep you apprised of the progress of this process.

I want to emphasize that while the OIG report identified serious problems with the EEP, the EEP process also made OSHA more aware of criminal violations. While a direct correlation between the EEP and the number of OSHA criminal referrals to DOJ has not yet been established, the EEP process increased awareness of criminal violations, and more awareness led to more referrals. Referrals of potentially criminal willful violations to the Department of Justice (DOJ) for prosecution increased from six per year (1993-2003) to 12 cases in FY 2008. This is the most serious sanction available under the OSH Act and can result in incarceration for an employer. Among the issues I will be looking at are whether OSHA is referring the proper number of such cases to DOJ and how we can work better with DOJ to prosecute these cases.

Although the EEP is an important component of OSHA's overall compliance strategy, it is not the only enforcement tool that we utilize. OSHA relies primarily on its LEPs and NEPs, and the Site Specific Targeting Program for the vast majority of its enforcement work. According to OSHA's Integrated Management Information System (IMIS), Federal and State OSHA programs conduct approximately 90,000 inspections each year. Federal OSHA cited almost 89,000 violations in FY 2008. Over 80% of these violations were classified as willful, serious or repeat. Over 120 inspections resulted in penalties totaling more than \$100,000.

Currently there are NEPs focusing on the hazards of combustible dust, amputations, lead, shipbreaking, crystalline silica, and trenching/excavations. We are also finalizing an NEP focusing on flavoring chemicals (diacetyl). In addition, OSHA has more than 140 Regional/Local Emphasis programs around the country.

OSHA's most comprehensive inspection program is the Site-Specific Targeting Plan (SST), which targets workplaces that have 40 or more employees and have reported the highest injury/illness rates. The targeting lists are updated every year to reflect the most recent data. Virtually all SST inspections are comprehensive visits in which the agency's compliance officers examine all aspects of the workplace's operations as well as the effectiveness of its safety and health efforts.

Madam Chairman, Secretary Solis has emphasized that strong, vigorous enforcement of the OSH Act is among her top priorities. OSHA will be adding inspectors to fulfill its responsibilities under the American Recovery and Reinvestment Act of 2009, and the President is requesting increased funding for OSHA in the 2010 budget.

In the meantime, we need to better utilize the resources that we already have. In order to direct more of OSHA's existing resources into enforcement and to provide time to address concerns in an upcoming GAO Report on the efficacy of OSHA's Voluntary Protection Program, I have informed the field staff that we will suspend the previous administration's practice of establishing goals for new Voluntary Protection Program sites and Alliances.

Madam Chairman, thank you once again for giving me the opportunity to appear today. OSHA will let the Subcommittee know when we have completed the design of the new enforcement program. No matter how well-intentioned or well-designed, if an enforcement policy is not implemented well it is a source of frustration—for workers, for Members of this Subcommittee, and for the American taxpayer. Not only are we committed to designing policies that protect workers, we are also committed to doing our utmost to implement those policies successfully.

Thank you and I'd be happy to answer any questions.

Chairwoman WOOLSEY. Thank you.

As you heard, the bells are ringing. What we would like to do, so you don't have to sit around here for an hour while we are voting—we have a whole series of votes. We are going to go 3 minutes each—and just the three of us, I guess, are here.

So thank you. I think we did the wrong thing. We should have had you first. I thought you would be the—you are the cleanup batter. But I would have preferred to have everybody here when you were speaking. So next time, you will be first.

All right. So, we have the report. OSHA penalties are too low. And the report tells us what we didn't do on EEP. But what are we going to do about making these penalties serious enough—and not just in funding penalties—so we have penalties that mean something to the CEOs where we hold corporate officers accountable, and multi-sited facilities and employers accountable? I think you know what I am asking.

Mr. BARAB. Yes, that is a good question, Madam Chairman.

As you know, to a certain extent OSHA penalties are prescribed by the law. The maximum OSHA penalties are set by the law, and were last set in 1990. It has been quite a while since they have been raised.

Within the law, however, we do have some discretion about where our penalties are. And I think there is a general consensus within OSHA, and certainly outside OSHA, that we need to take another look at our penalties.

And I have set up a task force since I have been there to take another look at OSHA's penalties, look at some of the reductions that we make in our penalties, and try to improve that process and raise those penalties to where they are a realistic deterrent to employers.

Chairwoman WOOLSEY. And when you talk about reductions, we were talking about what happened with Waste Management with

the gentleman before, on the last panel, his stepfather—that penalty of \$9,000-\$10,000 was reduced to \$6,300. Right?

Mr. BARAB. That is right. It was reduced, I believe, by the review commission.

Chairwoman WOOLSEY. Right. So you are going to put some—

Mr. BARAB. Yes. I mean, there is no doubt that, I think, many OSHA penalties are too low. And, again, we are taking a look at that, and we are going to try to see what we can do, again, within the parameters of the law.

We do note, however, that there has been quite a bit of criticism out there about OSHA penalties, as well as the introduction of the Protecting America's Workers Act, and we are busily analyzing that bill. And we hope to have a position on that very soon.

Chairwoman WOOLSEY. So, very quickly, on multi-sited, multi-state employer sites, is OSHA doing anything to make sure that if it happens in one place, then that employer has to look at all of the facilities?

Mr. BARAB. Yes. That is the main focus of the EEP program, and certainly our new program. Again, we did set up a task force. We are busily looking at that.

And we will have the new program finalized soon. And that is the major emphasis—

Chairwoman WOOLSEY. Good.

Mr. BARAB [continuing]. On the program, to make sure that we go to all other workplaces and look for similar hazards in those workplaces.

Chairwoman WOOLSEY. Thank you so much.

Mr. Price?

Dr. PRICE. Thank you, Madam Chair.

You now know what it is like to be on the clock, so, when the red light comes. I want to thank you for your testimony and thank you for your service and future service with OSHA.

Everyone watching this hearing might get the sense that things were going absolutely in the wrong direction all across this nation as it relates to workplace safety. And I think it is important to point out, as you did, that there are remarkably dedicated workers at OSHA.

And something, actually, is moving in the right direction. I showed this the other day at our hearing: workplace fatalities from 1994-2006 down from 5.3 per 100,000 to 3.9 per 100,000. Certainly, 3.9 is too high, but something is moving in the right direction.

By the same token, workplace injury and illness rates—this chart is from 1990 through 2006, and obviously the trend is significantly moving in the right direction.

I ask that to ask you: What is the best measure of progress in all of this? We have talked about numbers of citations, dollar fines, all those kind of things. What, in your opinion, is the best measure for how we should objectively evaluate whether or not we are making progress?

Mr. BARAB. Well, clearly, if we have accurate statistics on both workplace fatalities and injuries and illnesses, those would be good indicators.

I believe the fatality statistics are quite accurate because they are based on a census. This committee, actually the full committee,

held a hearing last year and the staff produced a report that revealed quite a bit of—quite a few studies and opinion out there in the world, in both inside and outside OSHA, that the injury and illness statistics particularly are not accurate, and in fact some studies that OSHA may be actually only counting about one-third of injuries and illnesses.

We received some money from Congress in this year's budget, and we are setting up a task force, again, to look at the accuracy of those statistics, working with BLS and working with NIOSH on that so that we have more accurate statistics.

We also know that because of the shift in industry from manufacturing to service that we are going to see a natural decline in fatalities as well as injuries and illnesses.

The problem is, Mr. Price, that when you look at the individual cases there are still far, far too many cases of workplace fatalities, injury and illnesses that could clearly be prevented. Far too many fatalities still, far too many injuries and illnesses overall, and that is what we are really focusing on.

Dr. PRICE. And the Severe Violators Program will hopefully get us in that direction, because all of us wants to find the outliers and make certain that we are concentrating on those folks as well.

I thank you for your testimony.

Chairwoman WOOLSEY. Mr. Bishop?

Mr. BISHOP. Thank you, Madam Chair.

And thank you, Mr. Secretary.

We had a hearing earlier this week in which a witness testified that because OSHA penalties are only misdemeanors, it is unlikely that the Department of Justice will prosecute those cases. Do you agree with that assessment?

Mr. BARAB. That is what I am told, yes.

Mr. BISHOP. Okay.

And are there ways, if the OSHA infractions remain misdemeanors, if that remains our construct, are there ways that OSHA can try to work with the DOJ to increase the number of referrals and prosecutions, or is the better way to make the transgressions be felonies as opposed to misdemeanors?

Mr. BARAB. Well, again, we are reading the Protecting America's Workers Act, and we understand that is where you are going on that bill. And we are analyzing that right now and will have an opinion for it.

But there is no doubt in anybody's mind that the fact that the worst penalty is a misdemeanor has raised a lot of problems in terms of making OSHA citations, OSHA penalties, a realistic deterrent to employers' cutting corners, especially where fatalities or serious injuries occur.

Mr. BISHOP. Okay.

One more question: If we were to move in the direction of making the behavior potentially criminal behavior, do you believe that the current cast of OSHA inspectors has the expertise to develop cases for criminal referral?

Mr. BARAB. We are working with the Justice Department on increasing the expertise of OSHA inspectors to follow up on potential criminal cases.

Clearly, if the law is changed and we happen to get a lot more criminal cases and the scope is expanded, we will need to do additional training, and OSHA inspectors will need additional skills.

Mr. BISHOP. Okay. Thank you very much.

I yield back, Madam Chair.

Chairwoman WOOLSEY. Thank you.

Today we have examined one in particular of OSHA's programs, the EEP, and we have highlighted some real flaws.

I am totally confident that OSHA, under the watchful eyes of the Secretary of Labor, Hilda Solis, and her Assistant Secretary will do all that it can do to make large companies—in fact, all companies—accountable for the safety and health of their employees.

We have got a lot of work to do. But we in Congress, on both sides of the aisle, are ready to do our part.

And I thank you very much, all of the witnesses, and you in particular, Mr. Secretary, for sitting here and then getting such a short shrift. Thank you very much.

So with that, as previously ordered, members will have 14 days to submit additional materials for the hearing record. Any member who wishes to submit follow-up questions in writing to the witnesses should coordinate with majority staff within 14 days.

[An additional submission by Mr. Price follows:]

Prepared Statement of the Cintas Corp.

Cintas Corporation submits this statement for the record to the House Education and Labor Committee for the hearing titled "Are OSHA's penalties adequate to deter health and safety violations?" held April 28, 2009 and to the House Education and Labor Subcommittee on Workforce Protections for the hearing titled "Improving OSHA's Enhanced Enforcement Program" held on April 30, 2009.

Throughout the Committee and Subcommittee hearings on April 28 and 30, 2009, various allegations were made against Cintas that are flatly untrue and deeply concerning. Allegations that Cintas does not care about the safety of our employee-partners, does nothing to protect its workers' safety, and did nothing in response to the 2007 accident in Tulsa, Oklahoma are completely false and misleading. The accident in March of 2007 was a tragic event, and we have re-committed our energy and resources to prevent such an accident again. This submission seeks to set the record straight.

In March of 2007, one of our employee-partners in Oklahoma lost his life when he climbed atop a moving conveyor and fell into an industrial dryer. This tragic accident shook our entire organization deeply. With our longstanding emphasis on safety, it seemed unimaginable to lose a friend and employee-partner. Before the tragic accident, the company's safety record was 11 percent better than comparable-sized facilities in our industry and had been showing constant improvement. The company is re-examining all of the facets of the company's safety program and working with outside experts to enhance the program further.

Below you will find a brief history of Cintas Safety efforts and more importantly, some of the efforts taken since the tragic accident.

Brief Safety History

- For the past 40 years, each Cintas uniform rental facility has maintained an employee-driven Safety and Improvement Committee. Each committee is comprised of frontline partners from production areas as well as plant management who meet monthly to review workplace safety procedures and guidelines.

- In 2003, the company hired Rick Gerlach, Ph.D. as Corporate Director of Safety and Health. Dr. Gerlach has more than 28 years of experience in the safety and health industry.

- Prior to the 2007 accident, the company had designated Regional Safety and Health Coordinators and partners responsible for safety at the locations.

- In the three years prior to the Tulsa accident, company employees attended more than 115,000 hours of classroom and safety training.

- 1,350 managers and supervisors completed the two-day OSHA "ten-hour course."

- We introduced a revised safety compliance auditing program in 2004. As a result of these efforts, the number of citations we received per OSHA inspection in 2004 was reduced by more than 75 percent in 2006.

Enhancements to our program since the accident:

- In 2007, we created the Executive Safety Council chaired by the CEO. This Council constantly monitors the compliance and ethics of our business practices. It helps us develop and implement processes to lead Cintas to world-class safety performance, and it includes Cintas executives and three nationally-recognized safety experts serving as advisors. These experts include former OSHA Administrator John Henshaw, former Proctor & Gamble worldwide health and safety director Dr. Richard Fulwiler, and former DuPont corporate safety and health director Michael Deak.

- Expanded wash alley training programs that include weekly re-training of all wash alley employee-partners.

- Limited wash alley access. Only partners trained in wash alley safety procedures are allowed in the alley.

- Implemented full time wash alley safety monitors whose role is to monitor activities and safe work practices any time a wash alley partner is working in the wash alley. This control is in place in all locations unless the location has a permanent engineered solution installed.

- Hired an additional 17 Regional Safety and Health Coordinators and Safety and Health Specialists around the country to help in monitoring safety initiatives in all Cintas facilities.

- Increased internal safety audits to three times annually.

- Several Cintas locations have enrolled in OSHA's Voluntary Protection Program (VPP) to achieve "Star" certification.

- Established safety scorecard to ensure compliance with all required safety initiatives and accountability by management.

- Working with manufacturers of wash alley equipment to create an engineered solution that will shut off all hazardous motion in the wash alley when someone enters it. This technology will be available to all companies within our industry.

Cintas is committed to continual improvement in our safety program and are working to become world class. We welcome the industry to utilize the best practices we are gathering and implementing to ensure accidents of this nature do not occur in the future for anyone in the industrial laundry industry. The results of our commitments are clearly demonstrated. Our total incident rate for 2008 is more than 20 percent better than the last reported government data for the same size facilities in our industry.

Founded on a family business created during The Great Depression, Cintas has become the leading business-services company in the United States, providing more than 800,000 business-customers with uniforms, entrance mats, restroom supplies, promotional products first aid and safety products, fire protection services and document management services. It's a unique value-based organization in which all employee-partners are made shareholders on their first anniversaries, sharing in combined growth and success of their company. For more than 75 years, together we have built a successful business based on "honesty and integrity in everything we do" and were recently named by FORTUNE magazine as one of "America's Most Admired Companies for the ninth consecutive year." More information can be found at www.cintas.com.

And without objection, this hearing is adjourned.

[Whereupon, at 11:25 a.m., the Subcommittee was adjourned.]

