U.S. Department of Labor

Office of Inspector General—Office of Audit

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

OSHA NEEDS TO IMPROVE OVERSIGHT OVER THE MANAGEMENT ACCOUNTABILITY PROGRAM

Date Issued: September 27, 2012
Report Number: 02-12-204-10-105

U.S. Department of Labor
Office of Inspector General
Office of Audit

BRIEFLY…

Highlights of Report Number 02-12-204-10-105, issued to the Assistant Secretary for Occupational Safety and Health.

WHY READ THE REPORT

With the Occupational Safety and Health (OSH) Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) to ensure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance. The OSH Act covers employers and their employees either directly through Federal OSHA or through an OSHA-approved state program.

In response to a Government Accountability Office (GAO) report, OSHA sought to improve its oversight of OSHA programs by implementing the Management Accountability Program (MAP) in FY 2006. The program was established as one component of OSHA's internal control system, as required by OMB Circular A-123. Specifically, MAP was implemented to: (1) assess the efficiency and effectiveness of field activities in relation to established policies and procedures, and (2) identify best practices and deficiencies in performance with the goal of improving program results.

WHY OIG CONDUCTED THE AUDIT

During FY 2009-2010, GAO and Department of Labor (DOL) Office of Inspector General (OIG) issued seven reports with concerns of the efficiency and effectiveness of several programmatic internal controls. OSHA officials have identified MAP as the solution to several of the reported findings.

In order to determine how effectively the Directorate for Evaluation and Analysis (DEA) had exercised oversight over MAP, we designed our audit to answer the following objective:

Did DEA's oversight of the MAP help ensure that OSHA programs were effective and in compliance with national policies and procedures?

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to:
[http://www.oig.dol.gov/public/reports/oa/2012/ 02-12-204-10-105.pdf](http://www.oig.dol.gov/public/reports/oa/2012/02-12-204-10-105.pdf)

September 2012

OSHA NEEDS TO IMPROVE OVERSIGHT OVER THE MANAGEMENT ACCOUNTABILITY PROGRAM

WHAT OIG FOUND

The OIG found DEA's oversight of MAP did not help ensure that OSHA programs were in compliance with national policies and procedures and performed effectively. First, DEA did not analyze and disseminate MAP report results to affect management's decision making process. Second, DEA did not provide comprehensive procedures for carrying out MAP duties or develop training guidelines for staff. As a result, audit reviews were not consistent from region to region and OSHA did not use the results of these reviews to improve operations.

The systemic weaknesses in DEA's oversight of the MAP occurred because OSHA had not emphasized the critical importance of the MAP in providing OSHA with information on the performance of its programs. For example, DEA assigned only one position the responsibility for performing day-to-day MAP operational activities, a position that carried additional responsibilities beyond monitoring MAP operations

WHAT OIG RECOMMENDED

The OIG recommended the Assistant Secretary of Occupational Safety and Health strengthen DEA's oversight by prioritizing the development and enforcement of procedures, holding DEA management responsible for MAP, and determining how best to allocate resources.

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U.S. Department of Labor

Office of Inspector General
Washington, D.C. 20210

September 27, 2012

Assistant Inspector General's Report

Dr. David Michaels
Assistant Secretary
for Occupational Safety and Health
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

In August 2004, the Government Accountability Office (GAO) issued a report entitled, "Occupational Safety and Health Administration's (OSHA's) Oversight of its Civil Penalty Determination and Violation Abatement Processes Has Limitations," Report Number GAO-04-920. GAO reported that while OSHA's National Office received copies of regional reports, it did not review them or use them to monitor the extent to which penalties were calculated correctly and violations were properly abated. In addition, GAO pointed out that the information in the reports was not complete.

In response to this report, OSHA sought to improve its oversight of OSHA programs by implementing the Management Accountability Program (MAP) in 2005. The program, which was revised most recently in September 2010, is implemented through Directive EAA 01-00-004 and named Directorate for Evaluation and Analysis (DEA) as the responsible office for overseeing the program. MAP comprises the part of OSHA's internal control system devoted to monitoring by: (1) assessing the efficiency and effectiveness of field activities in relation to established policies and procedures, and (2) identifying best practices and deficiencies in performance with the goal of improving program results.

During fiscal years (FY) 2009-2010, the GAO and DOL OIG issued seven additional reports expressing continuing concerns over the efficiency and effectiveness of OSHA programs. OSHA officials identified the MAP as the solution to several of the reported findings.

In order to determine how effectively DEA had exercised oversight over MAP, we designed our audit to answer the following objective:

> Did DEA's oversight of the MAP help ensure that OSHA programs were effective and in compliance with national policies and procedures?

Our audit examined FY 2007-2011 work plans and reports submitted to DEA in FY 2010 and 2011, as of March 31, 2011. We reviewed policies, related reports from GAO and OIG, and the applicable MAP Directive from July 2007 and September 2010[1]. We conducted interviews and tested compliance of both MAP directive at OSHA Headquarters in Washington, DC, and the sample of four statistically selected regional offices (Philadelphia, Denver, Chicago, and Dallas). There have been no changes made in the directive since our audit was conducted.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Our objective, scope, methodology, and criteria are detailed in Appendix B.

Results In Brief

DEA's oversight of the Management Accountability Program (MAP) did not help ensure that OSHA programs were in compliance with national policies and procedures and performed effectively. First, DEA did not analyze and disseminate MAP report results to affect management's decision making process. Second, DEA did not provide comprehensive procedures for carrying out MAP duties or develop training guidelines for staff. As a result, audit reviews were not consistent from region to region. The main component of MAP requires regions to identify both deficiencies in performance and best practices with the goal of improving OSHA program results. Regional offices did conduct reviews and identified areas of weakness consistent with GAO and OIG reports. However, OSHA did not use the results of these reviews to improve operations.

The systemic weaknesses in DEA's oversight of the MAP occurred because OSHA had not emphasized the critical importance of the MAP in providing OSHA with information on the performance of its programs. For example, DEA assigned only one position the responsibility for performing day-to-day MAP operational activities, a position that carried additional responsibilities beyond monitoring MAP operations.

In view of the crucial importance of the MAP in alerting OSHA to systemic weaknesses in its programs, we recommend the Assistant Secretary of Occupational Safety and Health strengthen DEA's oversight by prioritizing the development and enforcement of procedures, holding DEA management responsible for MAP, and determining how best to allocate resources.

[1] The directive was changed, on September 15, 2010, to improve communication of review priorities and response to report findings; clarify the frequency, scope, and methodology of field reviews; and provide for greater, independent through DEA participation in Regional and selected Area Office Audits.

OSHA's RESPONSE

OSHA appreciated the time, thought, and effort expended by the OIG in conducting the audit of MAP and, at this time, had no comment. OSHA's response is included in its entirety at Appendix D.

RESULTS AND FINDINGS

Objective — Did DEA's oversight of the Management Accountability Program (MAP) help ensure that OSHA programs were effective and in compliance with national policies and procedures?

DEA's Oversight of the MAP did not help ensure programs were effective and in compliance with national policies and procedures.

DEA Did Not Analyze and Disseminate MAP Results to Affect OSHA Management's Decision Making.

DEA serves as the focal point for the collection and dissemination of reported results. While regional offices provided reports containing findings, DEA could not show that it disseminated report results as required by the MAP Directive namely to report annually to the Deputy Assistant Secretary on the status of MAP reports and identify significant findings and/or trends. DEA did not identify and disseminate information of either systemic program weaknesses or best practices. In fact, DEA management did not demonstrate MAP results had been provided to OSHA management during the entire period of our audit. Without analyzing regional reports as required and disseminating relevant findings or best practices, OSHA was not aware of systemic weaknesses in areas such as civil penalty determination and violation abatement.

OMB A-123 Section II.B states, "Management should identify internal and external risks that may prevent the organization from meeting its objectives…Identified risks should then be analyzed for their potential effect or impact on the agency."

Each region was responsible for preparing reports for Regional and Area Office reviews of specific topics (see Exhibit 1). In FY 2010, OSHA's 59 regions had provided DEA reports with a total of 623 findings (see Exhibit 2). With each finding, the Regional Administrators were required to ensure corrective actions were taken. OSHA officials stated DEA was involved with ensuring corrective actions were taken on a regional level. Yet, OSHA did not use the results of these reviews to improve operations.

GAO and Labor-OIG reports found deficiencies in OSHA's civil penalty determination and violation abatement processes during FYs 2009-2010, as shown by the following two examples. First, a September 30, 2010, OIG report on OSHA's Gravity Based Penalties stated, "OSHA Area Directors did not document the justification for reductions resulting from informal settlement agreements for an estimated 49 percent of reductions

or $31.8 million." As part of our work on this audit, we analyzed FY 2010 MAP reports and determined that OSHA regional review teams found 37 areas of weakness concerning penalties. Examples of the regions' concerns included that penalties were changed without supporting documentation and penalty reduction justifications were missing from the case files.

Second, reports by both GAO and OIG of the Whistleblower Protection Program (WPP) found OSHA lacked supporting documentation to ensure that data were accurately recorded and verified in its database. Approximately 80 percent of applicable investigations did not meet one or more of eight elements essential to the investigative process.

Our analysis of the FY 2010 MAP reports revealed that OSHA review teams found weakness in this same area, namely the lack of WPP supporting documentation. The regions identified 12 additional WPP findings, including missing signed witness interview reports, untimely processing, and missing draft copies of statements by the complainants and their representatives. DEA did not document disseminating these findings to OSHA.

DEA Did Not Provide Comprehensive Procedures for Carrying Out MAP Duties or Develop Training Guidelines

DEA did not provide comprehensive procedures detailing how employees were to carry out MAP duties concerning specific review topics. Current guidance for conducting reviews lacked the detail and clarity needed to ensure reviews achieved the intended results on a consistent basis across regions. While DEA did provide a checklist containing the steps necessary for conducting reviews, DEA did not provide comprehensive procedures to the regions on how to select and document the rationale for the focus topics or communicate appropriate subjects for review based on DEA's analysis of MAP results. At the time of the audit, DEA assigned only one position the responsibility for performing day-to-day MAP operational activities, a position that carried additional responsibilities beyond monitoring MAP operations.

MAP Directive IX.A.1 states, "the Director of Evaluation and Analysis shall be responsible for establishing policy and procedures, and overseeing the MAP through periodic review of IMIS data and the Regions' audit reports."

Documentation showed that DEA was aware that regions did not select focus topics consistently. For example, one region selected its focus topics based on requests from regional management while another office selected topics based on statistical data. With little consistency among the four sampled regional offices as to how focus topics for review were selected, DEA could not demonstrate that serious weaknesses detected through MAP were addressed systematically.

In addition, DEA did not specify reporting standards and formats as required to ensure reports were consistent and therefore comparable. For example, FY 2010 reports were

submitted in a summary format using a template provided by DEA that did not provide comprehensive guidance. As a result, regions completed the template inconsistently and with varying levels of detail. For FY 2011, DEA required regions to submit comprehensive reports, but DEA again did not provide an approved report format to ensure information was reported consistently. Our review of the 13 reports submitted for FY 2011 revealed that 2 reports followed a summary format, 10 reports used a slightly more detailed summary format, and 1 report was comprehensive. As a result, audit reviews were not consistent from region to region.

DEA did not establish procedures for all planning reviews and did not provide procedures on selecting and documenting the rationale for the focus review topic. The MAP Directive requires Regional Administrators to prepare and submit an annual work plan to DEA at the beginning of each fiscal year. The Directive requires a comprehensive on-site review of each Area Office to be done on a regular scheduled basis, but at least once every four years. The Directive allows, in the intervening years between comprehensive reviews, a focus review on one or more selected work plan topics or other aspects of an office's operations. Review of the four sampled regions revealed each region had reviewed Area Offices following the Directive's requirements (see Exhibit 3). However, because the Regional Administrators have discretion on what topics to choose, there was no consistency at the four sampled regional offices as to how focus topics were selected. Regional staff stated that focus topics were selected at management's discretion during general meetings or from statistical data.

The instruction required DEA further to identify specific training needs and establish training guidelines. OSHA officials have stated they do not provide any formal training to staff to perform reviews because they did not have the funding resources. However, if OSHA does not identify specific training needs and establish training guidelines, staff involved in the MAP will lack the necessary knowledge, skills and abilities to perform the reviews.

CONCLUSION

The attitude of management toward oversight can have a profoundly positive effect on the implementation of internal controls. OSHA management has yet to demonstrate complete commitment to recognizing and addressing management problems through proactive national oversight of the MAP. The systemic weaknesses in DEA's oversight of the MAP occurred because OSHA has not emphasized the critical importance of the MAP in providing OSHA with information on the performance of its programs. For example, DEA assigned only one position the responsibility for performing day-to-day MAP operational activities, a position that carried additional responsibilities beyond monitoring MAP operations.

RECOMMENDATIONS

In view of the crucial importance of the MAP in alerting OSHA to systemic weaknesses in its programs and processes, we recommend the Assistant Secretary for Occupational Safety and Heath strengthen DEA's oversight by:

1. prioritizing the development and enforcement of procedures for planning and reporting results to ensure that report results are consistent and comparable,

2. holding DEA management responsible for disseminating MAP analyses to OSHA management as required, and

3. determining how best to reallocate resources so that DEA is able to perform its monitoring oversight.

We appreciate the cooperation and courtesies that OSHA personnel extended to the Office of Inspector General during this audit. OIG personnel who made major contributions to this report are listed in Appendix E.

Elliot P. Lewis
Assistant Inspector General
for Audit

Exhibits

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Exhibit 1

Accountibility Program Review Topics

PROGRAMMATIC FUNCTIONS	**ADMINISTRATIVE ACTIVITIES**
1. Inspection Targeting and Scheduling 2. Programmed Safety and Health Inspections 3. Construction Inspections 4. Fatality/Catastrophe Investigations 5. Complaints 6. Referrals 7. Verification of Abatement 8. Settlement of Cases 9. Case File Documentation 10. Citation Processing 11. Petitions to Modify Abatement 12. Technical Equipment/PPE 13. Information Technology 14. Response to Significant Events 15. Denial of Entry/Warrant Application 16. Management Controls 17. Freedom of Information (FOIA) Requests 18. Federal Agency Programs 19. Area Office Outreach Activities 20. Discrimination Complaints 21. Safety and Health Program 22. Teams 23. State Plan Policies 24. Partnership Programs 25. VPP Programs 26. Alliance Program 27. Monitoring Consultation Projects	1. Property Accountability 2. Government Service Administration Vehicles 3. Records Systems 4. Space Management 5. Personnel Management 6. Personnel Actions and Procedures 7. Equal Employment Opportunity (EEO) 8. Timekeeping 9. Labor Relations 10. Financial Management 11 Procurement 12 Debt Collection 13 Field Libraries 14 Training

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Exhibit 2

FY 2010 Accountability Program Findings Summary

Program Area	*Findings*	*Percent*
Case File Documentation	218	35.0%
Complaints	55	8.9%
Verification of Abatement	46	7.4%
Freedom of Information (FOIA) Requests	41	6.6%
Management Controls	40	6.4%
Fatality/Catastrophe Investigations	37	5.9%
Settlement of Cases	37	5.9%
Technical Equipment/PPE	28	4.5%
Citation Processing	18	2.9%
Referrals	14	2.3%
Response to Significant Events	13	2.1%
Safety and Health Program	13	2.1%
Discrimination Complaints	12	2.0%
Inspection Targeting and Scheduling	10	1.6%
Programmed Safety and Health Inspections	9	1.4%
Construction Inspections	9	1.4%
Petitions to Modify Abatement	7	1.1%
Information Technology	7	1.1%
State Plan Policies	4	0.6%
Federal Agency Programs	2	0.3%
Partnership Programs	2	0.3%
Alliance Program	1	0.2%
Denial of Entry/Warrant Application	0	0.0%
Area Office Outreach Activities	0	0.0%
Teams	0	0.0%
VPP Programs	0	0.0%
Monitoring Consultation Projects	0	0.0%
Total	623	100%

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Exhibit 3

Sample Regions Focused (F) and Comprehensive (C) Workplan Schedule

Office	*FY 2007*	*FY 2008*	*FY 2009*	*FY 2010*	FY 2011
Philadelphia Region					
Philadelphia Regional Office	F	F	C	F	F
Baltimore/ D.C. Area Office	F	F	C	F	F
Wilmington Area Office	F	C	F	F	F
Allentown Area Office	F	F	F	C	F
Erie Area Office	F	F	C	F	F
Harrisburg Area Office[2]	*	C	F	F	C
Philadelphia Area Office	C	F	F	F	C
Pittsburgh Area Office	F	F	F	C	F
Wilkes-Barre Area Office	F	C	F	F	F
Norfolk Area Office	C	F	F	F	C
Charleston Area Office	F	F	F	C	F
Denver Region					
Denver Regional Office	F	F	C	F	F
Denver Area Office	F	C	F	F	F
Englewood Area Office	F	F	C	F	F
Billings Area Office	F	F	F	C	F
Bismarck Area Office	C	F	F	F	C
Chicago Region					
Chicago Regional Office[3]	*	*	*	*	C
Calumet City Area Office	C	F	F	F	C
Chicago North Area Office	C	F	F	F	C
Fairview Heights District Office	F	F	F	C	F
North Aurora Area Office	F	C	F	F	F
Peoria Area Office	F	F	F	C	F
Indianapolis Area Office	F	F	F	C	F
Lansing Area Office	C	C	F	F	F
Eau Claire Area Office	F	C	F	F	F
Cincinnati Area Office	F	F	C	F	F
Cleveland Area Office	F	F	C	F	F
Columbus Area Office	F	F	C	F	F
Toledo Area Office	F	F	F	C	F
Appleton Area Office	C	F	C	F	F
Madison Area Office	F	F	C	F	F
Milwaukee Area Office	F	C	F	F	F

[2] While there was no documentation of Harrisburg being in the workplan in 2007, they are currently in compliance with the requirement.
[3] No reviews of the regional office were done in the past. However, OSHA national office provided independent participation in Chicago's comprehensive review in FY 2011.

Dallas Region					
Dallas Regional Office	F	F	C	F	F
Little Rock Area Office	C	F	F	C	F
Baton Rouge Area Office	F	F	C	F	F
Oklahoma City Area Office	F	C	F	F	F
Austin Area Office	F	C	F	F	C
Corpus Christi Area Office	C	F	F	F	C
Dallas Area Office	F	F	C	F	F
El Paso Area Office	C	F	F	C	F
Fort Worth Area Office	C	C	F	F	F
Houston North Area Office	F	F	C	F	F
Houston South Area Office	F	C	F	F	F
Lubbock District Office	C	F	F	C	F
San Antonio District Office	F	C	F	F	C

Appendices

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Appendix A

Background

With the Occupational Safety and Health (OSH) Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) to ensure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance. The OSH Act covers employers and their employees either directly through Federal OSHA or through an OSHA-approved state program.

In August 2004, the Government Accountability Office (GAO) issued a report entitled, "Occupational Safety and Health Administration's (OSHA's) Oversight of its Civil Penalty Determination and Violation Abatement Processes Has Limitations," Report Number GAO-04-920. GAO reported that while OSHA's National Office received copies of regional reports, it did not review them or use them to monitor the extent to which penalties were calculated correctly and violations were properly abated. In addition, GAO pointed out that the information in the reports was not complete.

In response to this report, OSHA sought to improve its oversight of OSHA programs by implementing MAP in FY 2006. The program, which was revised most recently in September 2010, is implemented through Directive EAA 01-00-004 which established Directorate for Evaluation and Analysis (DEA) as the responsible office for overseeing the program. The program was established as one component of OSHA's internal control system, as required by OMB Circular A-123.[4] Specifically, the MAP was implemented to: (1) assess the efficiency and effectiveness of field activities in relation to established policies and procedures, and (2) identify best practices and deficiencies in performance with the goal of improving program results. The MAP Directive provides policy for reviewing agency programs and activities conducted by Regions and Area Offices. Reviews of field activities are the main component of MAP and Regional Administrators have responsibility for the review of all operations within their Regions.

DEA served as the focal point for the collection and dissemination of information concerning the accountability program. The directive outlines specific responsibilities of DEA, such as establishing policy and procedures, providing independent participation in the comprehensive reviews, identifying specific training needs, and establishes training guidelines. The directive also outlines specific responsibilities of the Regional Administrators relating to: (1) planning the review, (2) conducting the review, and (3) reporting results. There have been no changes made in the directive since our audit was conducted.

During FY 2009-2010, GAO and DOL OIG issued seven reports with concerns of the efficiency and effectiveness of several programmatic internal controls. OSHA officials have identified MAP as the solution to several of the reported findings. In addition,

[4] OMB Circular A-123 requires that internal controls be an integral part of the entire cycle of planning, budgeting, management, accounting, and auditing. Controls should support the effectiveness and integrity of every step of the process and provide continual feedback to management.

OSHA stated the directive was updated in September 2010 to address concerns of the efficiency and effectiveness of several programmatic internal controls. The directive was changed to improve communication of review priorities and response to report findings; clarify the frequency, scope, and methodology of field reviews; and provide for greater independence through DEA participation in Regional and selected Area Office Audits.

Appendix B

Objective, Scope, Methodology, and Criteria

Objective

Did DEA's oversight of the MAP help ensure that OSHA programs were effective and in compliance with national policies and procedures?

Scope

The audit examined FY 2007-2011 work plans and reports submitted to DEA in FY 2010 and FY 2011 (as of March 31, 2011). We performed work at the OSHA Headquarters in Washington, DC, and Philadelphia, Denver, Chicago, and Dallas Regional Offices. The audit included examining OSHA's 27 programmatic functions and excluded the 14 administrative activities (see Exhibit 1).

Methodology

The audit included gaining an understanding of internal controls considered significant to the audit objective and testing compliance with Federal Standards. In planning and performing our audit, we considered if internal controls significant to the audit were properly designed and placed in operation. This included reviewing OSHA's policies and procedures for conducting its Regional and Area Office reviews. There have been no changes made in the directive since our audit was conducted. We gained an understanding of factors such as review history and nature of potential critical work plan topics for the subject office. We confirmed our understanding of these controls and procedures through interviews and documentation review.

We reviewed policies, related reports from GAO and OIG, the applicable MAP Directive from July 2007 and September 2010, and OSHA internal monitoring reports. We tested compliance with monitoring procedures through a random statistical sample of 4 of the 10 regional area offices. We obtained testimonial and documentary evidence (through management and staff interviews, policy and procedure reviews, and report testing) to support our results and conclusions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Criteria

- Occupational Safety and Health Act of 1970
- OMB Circular A-123, Management's Responsibility for Internal Control
- EAA-01-00-004, OSHA Management Accountability Program Directive, September 15, 2010
- EAA-01-00-003, OSHA Management Accountability Program Directive (superseded by EAA-01-00-004), July 23, 2007

Appendix C

Acronyms and Abbreviations

DEA	Directorate of Evaluation and Analysis
FOIA	Freedom of Information Act
FY	Fiscal Year
GAO	Government Accountability Office
GOV	Government Owned Vehicles
MAP	Management Accountability Program
OIG	Department of Labor Office of Inspector General
OMB	Office of Management and Budget
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
PPE	Personal Protective Equipment
VPP	Voluntary Protection Programs
WPP	Whistleblower Protection Program

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Appendix D

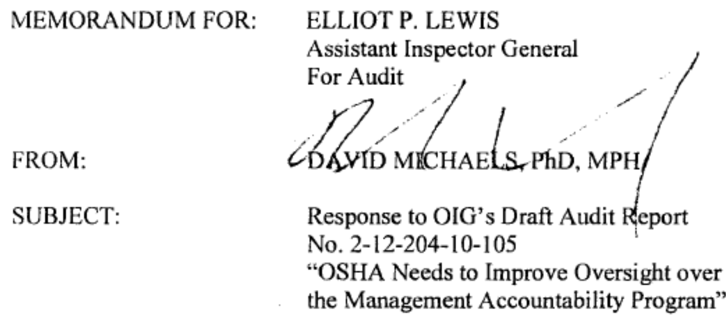
OSHA Response to Draft Report

U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210

SEP 14 2012

MEMORANDUM FOR: ELLIOT P. LEWIS
Assistant Inspector General
For Audit



FROM: DAVID MICHAELS, PhD, MPH

SUBJECT: Response to OIG's Draft Audit Report
No. 2-12-204-10-105
"OSHA Needs to Improve Oversight over
the Management Accountability Program"

This memorandum is in response to your September 6, 2012, transmittal of the Office of Inspector General (OIG) Draft Audit Report No. 2-12-204-10-105, "OSHA Needs to Improve Oversight over the Management Accountability Program." OSHA appreciates the time, thought and effort expended by the OIG in conducting the audit of the Management Accountability Program (MAP). At this time OSHA has no comment.

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Appendix E

Acknowledgements

Key contributors to this report were Mark Schwartz (Director), Mary Lou Casazza, Renata Hobbs, Badara Kamara, and Eliacim Nieves Perez.

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