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

BRIEFLY...

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OSHA'S VOLUNTARY PROTECTION
PROGRAMS REQUIRE BETTER INFORMATION
TO IDENTIFY PARTICIPANTS WITH
CONTRACT-WORKER FATALITIES AND
CATASTROPHES

WHY OIG CONDUCTED THE AUDIT

The Occupational Safety and Health Administration's (OSHA) Voluntary Protection Programs (VPP) create cooperative relationships with businesses and their workers that establish effective safety and health management systems to help prevent work-related fatalities, injuries, and illnesses. These systems also protect others working under contract (contract-workers) at the VPP participant's worksite. The Office of Inspector General (OIG) received a hotline complaint alleging that regional program officials did not take appropriate follow-up actions in response to a VPP contract-worker fatality. OSHA policy requires VPP program officials to notify the national office of fatalities and catastrophes, place the VPP participant on inactive status, review enforcement inspection reports and citations, and determine if the participant should be allowed to remain in VPP or be terminated. Between July 1, 2013, and September 30, 2016, OSHA received reports that 23 of 1,410 VPP participants experienced a worker or contract-worker fatality or catastrophe.

WHAT OIG DID

We conducted an audit to determine the following:

Did OSHA appropriately follow up on worker and contract-worker fatalities and catastrophes experienced by VPP participants?

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to: https://www.oig.dol.gov/public/reports/ oa/2017/02-17-202-10-105.pdf

WHAT OIG FOUND

Between July 1, 2013, and September 30, 2016, OSHA's VPP staff appropriately followed up on 23 participants that reported a worker or contract-worker fatality or catastrophe to determine if they should remain in VPP or be terminated. However, OSHA did not have assurance that VPP staff followed up on all VPP contract-worker fatalities and catastrophes because the program officials relied on participants, workers, and contract-workers to disclose VPP affiliation when reporting fatalities and severe injuries to OSHA. Under OSHA recordkeeping requirements, all employers must report work-related fatalities and severe injuries to OSHA. If the employer does not disclose their VPP affiliation, VPP staff may use the participant name and address to identify worker fatalities and catastrophes from lists of OSHA inspections and employer fatality and severe injury reports. However, VPP staff did not have adequate contractor information to identify VPP contract-worker fatalities and catastrophes.

VPP staff lacked adequate contractor information for several reasons. VPP program officials obtained basic contractor information (name and industry) from reports submitted manually by most VPP participants. However, program officials did not ensure the information was complete and distributed to staff. Additionally, VPP policy did not require approximately 12 percent of participants to include contractor information in their manual reports. As a result, there is the potential some VPP contract-worker fatalities or catastrophes went undetected and some participants remained in VPP when OSHA should have terminated them.

Finally, we concluded the hotline complaint did not have merit. Regional program officials acted appropriately. In this case, VPP follow–up actions were not required since the contract worker who died was not working at a covered VPP worksite.

WHAT OIG RECOMMENDED

We recommended the Acting Assistant Secretary for Occupational Safety and Health: 1) establish a system to collect and disseminate VPP contractor information; 2) establish controls to ensure the information is complete; and 3) expand collection of contractor information to all VPP participants. The Acting Assistant Secretary agreed to improve processes to address the recommendations.