FY 2012 Abridged Federal Annual Monitoring and Evaluation (FAME) Report

Vermont Occupational Safety and Health Administration (VOSHA)

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Contents

I. Executive Summary 1

II. Major New Issues 7

III. State Progress in Addressing FY 2011 FAME Report Recommendations 8

IV. Assessment of FY 2012 State Performance of Mandated Activities 31

A. Enforcement

- Complaints
- Fatalities
- Targeting and Programmed Inspections
- Citations and Penalties
- Abatement
- Employee and Union Involvement

B. Review Procedures

- Informal Conferences
- Formal Review of Citations

C. Standards and Federal Program Changes Adoption

- Standards Adoption
- Federal Program/State Initiated Changes

D. Variances
E. Public Employee Program
F. Discrimination Program
G. Voluntary Compliance Program
H. Program Administration

V. State Progress in Achieving Annual Performance Goals 47

VI. Other Areas of Note 52

Appendix A – New and Continued Findings and Recommendations
Appendix B – Observations Subject to Continued Monitoring
Appendix C – Status of FY 2011 Findings and Recommendations
Appendix D – FY 2012 State Activity Mandated Measures (SAMM) Report
Appendix E – FY 2012 State OSHA Annual Report (SOAR) – Available Upon Request

I. Executive Summary

A. Introduction

This report was prepared in accordance with the guidance issued by OSHA's Directorate of Cooperative and State Programs (DCSP) on December 11, 2012. Its main purpose is to assess the Vermont Occupational Safety and Health Administration's (VOSHA) responses to the recommendations in the FY 2011 comprehensive Federal Annual Monitoring Evaluation (FAME) report and also the State's progress in achieving the actions specified in its Corrective Action Plan (CAP).

DCSP's guidance provided for an "abbreviated" review process in that onsite case file reviews were not required for the FY 2012 FAME—nor were they "prohibited." For this report, Region I chose not to conduct an onsite case file review. Instead, the Regional Administrator has been conducting monthly meetings with the Vermont Commissioner of Labor at VOSHA's headquarters in Montpelier. The purpose of these meetings is to closely monitor VOSHA's approach to addressing key problems cited in the FY 2011 FAME related to enforcement procedures, program management and the State's whistleblower program.

In addition to these meetings, Regional staff has also provided assistance to VOSHA throughout FY 2012 by reviewing some of the program's inspection case files, giving technical advice and guidance to management on enforcement and whistleblower issues, and by providing much-needed training to VOSHA's whistleblower investigators.

In some problem areas that were identified in the FY 2011 FAME, VOSHA has begun to show improvement. For example, after falling short of its inspections goal in each of the past few fiscal years, the State is on track to meet its inspection target in FY 2013. Over the past four fiscal years, VOSHA has also steadily increased its percentage of all violations classified as Serious, going from 65.4 percent in FY 2009 to 78.4 percent in FY 2012.

However, some issues with VOSHA's performance that were identified in the previous FAME continue to warrant serious concern: the State is unable to properly use OSHA's Integrated Management Information System (IMIS) to record required data and to track performance; seven of the program's nine veteran compliance safety and health officers (CSHOs) still have not completed their mandatory core training requirements, and some are not on track to do so until FY 2014; VOSHA is several months overdue in completing the process of adopting some of OSHA's standards; and the program fell short of meeting some key State Activities Mandated Measures (SAMM) related to abatement, complaints and citation lapse time.

In addition to these issues, the program has not made any significant progress in addressing the findings in the FY 2011 FAME that were related to VOSHA's whistleblower program. Of the eight findings made in this area, none have been completed thus far. VOSHA has made progress toward updating its website, but it is not yet online. The program has updated its letters to ensure that the parties are informed of their rights, and has also worked with the Region to provide its staff with more whistleblower training. But many other areas are still in need of improvement.

But in spite of all of these issues—and other problem areas discussed later in this report—Region I is most troubled by the fact that VOSHA has no front-line supervisors who have the technical expertise in occupational safety and health and knowledge of OSHA enforcement that is needed to effectively run the program—and to ultimately resolve the performance issues that afflict the program.

Since the issuance of the FY 2011 FAME, VOSHA's administrative staff has been in flux. In August 2012 the administrative support person retired and the compliance chief resigned a month later. In January 2013, the VOSHA director was re-assigned to work for another program in the Vermont Department of Labor. As a result, the Director of the State Workers' Compensation and Safety Division[1] became more involved in managing the program. To date, the compliance chief and director's positions remain vacant, and the Director of the Workers' Compensation and Safety Division is now the program's sole front-line supervisor.

Many of the key corrective actions in the FY 2011 CAP call for the program's "supervisors" to review case files to identify and correct problems with enforcement inspections (such as overdue abatement verification, misclassified violations, and gravity and probability assessments of violations, etc.) and to run IMIS reports "on a weekly basis" to track abatement verification, complaint response times, referrals, and citation lapse times, etc. Supervisors are supposed to closely monitor the whistleblower program, as well.

Unfortunately, the current supervisor (i.e., the Director of the Workers' Compensation and Safety Division) has not had the training or experience needed to satisfactorily perform these corrective actions, let alone perform the duties of both the compliance chief and the director on a day-to-day basis. The workers' compensation director acknowledges that since the VOSHA director was re-assigned, he has not been running IMIS reports, and he has also sought assistance from some of the program's CSHOs to help him keep up with the case file reviews.

Hiring qualified supervisors is the most critical issue confronting VOSHA at this time. Until VOSHA has managers in place who have the training and experience that is needed to run the program, the Regional Administrator will continue to work closely with the Vermont Commissioner of Labor and other state officials to ensure that this outcome is attained.

B. Overview of the Status of VOSHA's Corrective Actions in Response to the FY 2011 FAME Report

In this report, Region I analyzes the current status of each of the 41 findings in the FY 2011 FAME. VOSHA's key corrective measures to remedy many of these findings include management review of case files, discussion with CSHOs of significant findings noted during the review, and running and analyzing various IMIS reports on a "weekly basis." But it has been difficult for the workers' compensation director to properly implement these corrective actions

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[1] VOSHA falls under this division within the Vermont Department of Labor.

because prior to taking on the duties of both the compliance chief and the VOSHA director he had minimal, if any, training and experience in performing these functions. The workers' compensation director also has had no training in safety and health, and is thus unable to lead Vermont's CSHOs.

The 20 findings designated as "Awaiting Verification" in the FAME relate primarily to issues involving inspections that the Region identified during the onsite case file review that it conducted for the FY 2011 FAME. Although Vermont has taken the corrective measures listed above to remedy these findings, it will require another onsite case file review to fully assess the extent to which they have been corrected.

Some key examples of enforcement-related findings that are awaiting verification include: inadequate documentation of fatality inspections; improper assessments of penalties and of the gravity and probability of violations; lack of abatement documentation in case files; and misclassified violations (e.g., Serious violations that were misclassified as Other-than-Serious). Findings related to VOSHA not holding informal conferences within the 20 calendar-day contest period; improper coding of emphasis inspections; and other types of required documentation that was not included in some case files have also been designated as awaiting verification.

Four findings related to the State's whistleblower program that are awaiting verification pertain to case files that are not being organized in accordance with the whistleblower manual; lack of an appeals process; failure to notify complainants of their rights (for example, to dual file and to file Complaints Against State Plan Administration (CASPAs); and failure to adequately inform public-sector employees of their rights under the State's whistleblower provision. As discussed in more detail in Section III, VOSHA stated in its CAP that its actions to correct most of the findings related to the whistleblower program have been implemented and are ongoing. However, it is apparent that VOSHA has not been able to correct *any* of the findings in the FY 2011 FAME related to the whistleblower program.

In this report, Region I determined that four findings related to enforcement have not been corrected, and they have therefore have been designated as "Open." For example, in FY 2011, the State did not adopt standards within the allowable six-month time frame, and the same issue re-occurred in FY 2012; most of the program's CSHOs still have not completed the initial compliance training program as prescribed by the OSHA Training Institute (OTI); VOSHA has developed a draft State Internal Evaluation Plan (SIEP), but acknowledges that the actual implementation of the SIEP will not occur until new supervisors are hired; and as was the case in FY 2011, VOSHA did not meet its inspection goal in FY 2012. One finding from the FY 2011 FAME that was related to the State's Alliance program also remains open because VOSHA is still not posting Alliance-related documents and activities on its web site, as recommended by the Region.

Four findings related to the whistleblower program also remain open. These pertain to whistleblower investigators not receiving sufficient training and supervision to properly conduct investigations; supervisors not effectively managing the whistleblower program; and VOSHA not having an attorney to handle discrimination matters, and not updating the website to include information on the whistleblower program.

One finding has been deemed "Completed" (corrected) in FY 2012. In the FY 2011 FAME, Region I recommended that two CSHOs who conduct most of the fatality investigations should complete Course #1310 (Investigative Interviewing Techniques). Technically, these CSHOs were exempt from having to complete this training because they were hired before this course was included in the initial compliance training program. In FY 2012, however, the two CSHOs did complete this course.

As directed in the FY 2012 FAME guidance, data in the Interim State Indicator Report (SIR) and IMIS reports are to be used for "information purposes" and to "supplement" the SAMM data, rather than as a basis for making independent findings. Therefore, Region I has closed findings cited in the FY 2011 FAME that were based *primarily* on data from the SIR and IMIS Enforcement Statistics and Inspection Reports. This includes findings related to the FY 2011 SIR measures that were not met, and also the findings related to Average Number of Violations per Initial Inspection; Percentage of Serious/Willful/Repeat (S/W/R) Violations; Average Current Penalty per Serious Violation; and the Percentage of Inspections with Violations Cited.

Some findings were also closed because they duplicated other findings, and because an analysis of VOSHA's performance on each measure in the FY 2012 SAMM is provided in Section IV of this report, Finding #11-1 (which recommends that VOSHA meet all SAMM measures that were not met in FY 2010) has been closed to avoid repetition. In total, Region I closed 11 findings in this report.

In Section IV of this report, Region I has made three findings based on key SAMM measures that VOSHA did not meet. For example, VOSHA did not meet the standards for SAMM #2 (Average Number of Days to Initiate Complaint Inspections); VOSHA also had percentages for SAMM #6 (which measures the Percentage of S/W/ R violations Verified timely) that were too low; and VOSHA's calendar-day lapse time (from Opening Conference to Citation Issuance) far exceeded an acceptable range of days (SAMM #7).

In addition to these three findings related to the SAMM, Region I has also made two other findings in this Section: one is that VOSHA is not sufficiently tracking each CSHO's progress in completing all of the basic training courses, and thus should develop a Training Plan Progress report for each CSHO; the other finding is that VOSHA currently has no personnel who have been trained on running IMIS tracking reports (although this is one of the key corrective actions the State planned to take in its CAP), and therefore should have at least one staff member receive this training as soon as possible.

C. Vermont State Plan Background

State Designee: **Anne M. Noonan, Commissioner of Labor**[2]

Vermont Department of Labor

5 Green Mountain Drive

Montpelier, Vermont 05601

Program Manager: **Robert McLeod**[3]

FY 2009-2013 Funding History						
	Federal Award	**State Match**	**100% State Funds**	**Total Funding**	**% of State Contribution**	**Deobligated/One-Time Only/Reclaimed Funds**
2013	750,800	750,800	$72,910	$1,574,510	52	0
2012	750,800	$750,800	$0	$1,501,600	50	$30,900 *(one-time only)*
2011	$750,800	$750,800	$0	$1,501,600	50	$25,000 *(re-claimed)*
2010	$725,800	$725,800	$0	$1,451,600	50	$30,900 *(de-obligated)*
2009	$725,800	$725,800	$0	$1,451,600	50	0

In the FY 2011 FAME, Region I identified several deficiencies with VOSHA's website. For example, the site provided "little information regarding its discrimination program" and it was difficult to access the VOSHA site due to its location in the business section of the Vermont Department of Labor website. In response to these findings, VOSHA applied for and received one-time only funding in June 2012 to cover the cost of making improvements to its website, and also to purchase equipment (such as cameras, inclement weather gear, etc.) Federal OSHA and VOSHA each contributed $30,900 toward the total cost of the $61,800 project. Then new website appears to be excellent but has still not been launched formally.

In the FY 2011 FAME, Region I found that none of VOSHA's CSHOs had completed the basic training requirements prescribed by the OSHA Training Institute (OTI), which is located in

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[2] Appointed January 6, 2011; replaced Valerie Rickert.

[3] Mr. McLeod was re-assigned to work for another State program in January 2013.

Arlington Heights, IL. VOSHA plans to send several CSHOs to OTI in FY 2013 so that they can work toward completing basic training requirements. In FY 2013, VOSHA budgeted $72,910 in 100 percent State Funds, and allocated a significant portion of those funds to cover the expenses associated with increased travel to OTI.

Vermont 2012 Covered Workers/Establishments			
	Private Sector	**Public Sector**	**Total**
Employees	243,120	52,364	295,484
Establishments	22,588	1,612	24,200

FY 2012 Staffing		
23(g) Grant Positions	**Allocated Full-Time Equivalents (FTE)**	**FTE On Board as of 9/30/2011**
Managers/Supervisors (Administrative)	0.85	0.85
First Line Supervisors (Program)	1.00	0
Safety Compliance Officers	6.00	6.00
Safety Compliance Staffing Benchmark	*9.00*	
Health Compliance Officers	4.00	4.00
Health Compliance Staffing Benchmark	*13.00*	
Public Sector Safety Consultants	0.45	0.45
Public Sector Health Consultants	0.25	0.25
Compliance Assistance Specialist	1.00	1.00
Clerical	1.00	0
Other *(all positions not counted elsewhere)*	0.06	0.06
Total 23(g) FTE	**14.61**	**12.61**

D. Significant Program History

VOSHA has been administered under the Vermont Department of Labor, Division of Workers' Compensation and Safety, since July 1, 2005. The Department of Labor is the enforcing agency for the program. The Commissioner has the authority to issue safety and health citations. The program is operated through the program's headquarters at 5 Green Mountain Drive, Montpelier, Vermont, as well as several field offices located throughout the state. In FY 2012, VOSHA had no Complaints Against State Plan Administration (CASPAs).

Midway through FY 2011, one safety CSHO resigned, but in November 2011, VOSHA filled this vacancy with a person who had training and prior experience working in occupational safety.

Unfortunately, this new CSHO's tenure with VOSHA was short lived, because in December 2011, he resigned to begin working as a safety consultant for Project WorkSAFE (which is Vermont's private sector OSHA consultation project). In June 2012, VOSHA filled this vacancy and this new hire remains with the program and has already successfully completed four courses in the basic CSHO training track.

As discussed earlier, the VOSHA compliance chief and the administrative support person left the program near the end of FY 2012. The VOSHA director was re-assigned to another state program in January 2013. The director of the workers' compensation division—the agency in the Vermont Department of Labor that is responsible for administering the VOSHA program—is now technically the VOSHA supervisor.

VOSHA does not have sufficient funding to staff at its benchmark levels for compliance officers. Since Vermont currently does not have final approval status, it is not required to maintain its allocated staffing levels to meet its benchmarks.

VOSHA's public sector consultation program consists of two safety and health consultants who commit a fraction of their time to provide on-site consultation services to the public sector. The public sector staff is also utilized to help implement the VOSHA Strategic Plan.

Vermont has adopted most Federal standards by reference. The state has two unique standards: one addressing permissible exposure limits (PELs) at OSHA's ill-fated revised levels, and one for electrical power generation, transmission and distribution. The PELs enforced by VOSHA are those issued by Federal OSHA in 1988 and subsequently overthrown in court. They are considerably stricter than OSHA's current PELs. Construction, manufacturing, transportation and warehousing, non-durable goods wholesalers, and healthcare and social assistance sectors are the state's high-hazard targeted industries.

Vermont's coverage of public employees is identical to that of private employees, including citation issuance and first instance sanctions. VOSHA also offers a number of voluntary and cooperative programs, including Green Mountain (GM) Voluntary Protection Programs (VPP) and Project WorkSAFE (consultation), the Safety and Health Achievement Recognition Program (SHARP), and Project RoadSAFE (funded by the Federal Highway Safety Administration to inform employers about hazards associated with motor vehicles).

II. Major New Issues

Due to the serious nature of the findings in the FY 2011 FAME, the Regional Administrator has been meeting monthly throughout FY 2012 with the Vermont Commissioner of Labor to emphasize the urgency for the program to correct key findings in the FY 2011 FAME—many of which were based on the fact that the program (both field staff and supervisors) simply were not properly following many of OSHA's policies and procedures—especially with respect to fatality investigations and whistleblower cases.

Currently, VOSHA is operating with an interim supervisor who has no prior experience or training in OSHA enforcement. Although the current situation is not acceptable in the long term, the Region is optimistic that it may begin to change in the next few months. The Vermont Department of Labor, in consultation with Region I, has developed new job descriptions for the program's two top managerial positions, and they are now under recruitment. The State now has the opportunity to hire supervisors who have the managerial skills and technical expertise necessary to move the program forward.

III. State Progress in Addressing FY 2011 FAME Report Recommendations

The following is an analysis of the State's progress with respect to its FY 2012 CAP. These findings are grouped according to their designation as either one of the following: Awaiting Verification, Closed, Completed, or Open.

THE FOLLOWING FY 2011 FAME REPORT FINDINGS ARE *AWAITING VERIFICATION:*

Finding #11-4: Fatality Investigations—VOSHA did not meet the five-day time frame for sending the standard information letter to the next of kin of the fatality victim.

Recommendation #11-4: Ensure that fatality victims' next of kin receive an initial standard information letter "within 5 working days of determining the victim's identity and verifying the proper address where communications should be sent." Ensure that all procedures in OSHA's Field Operations Manual (FOM), Chapter 11, Section G, Families of Victims, are followed.

Corrective Action: Supervisors will require the letter to be sent within the time frame required by the FOM. Managers will ensure that all procedures in OSHA Directive CPL 02-00-153 (Communicating OSHA Fatality Inspection Procedures to a Victim's Family), are followed. CSHOs will include copies of the letter in the appropriate fatality inspection case file.

State Action Taken: The workers' compensation director is now ensuring that the standard information letter is sent to fatality victims' next of kin in a timely manner, and that copies of the letter are included in the appropriate case files.

Finding #12-1 (formerly #11-4): Fatality Investigations—Same as Finding #11-04

Recommendation #12-1: Same as Recommendation #11-4.

Finding #11-5: Gravity and Probability Assessments—In some cases, VOSHA is not properly assessing the probability and severity of violations. The program tends to assess lower probability and severity than warranted.

Recommendation #11-5: Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments.

Corrective Action: Supervisors compare the injury or illness listed by the CSHO on the VOSHA 1B with the alleged hazard description. Supervisors also closely review probability and severity assessments. When necessary CSHOs are asked to amend their severity/probability assessments and/or provide additional documentation to justify their assessments. VOSHA now requires CSHOs to classify all trenching/excavation violations as high greater, with the base penalty starting at $7,000. VOSHA also classifies violations of OSHA's fall protection standards in construction in the same manner.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-2 (formerly #11-5): Gravity and Probability Assessments—Same as Finding #11-5.

Recommendation #12-2: Same as Recommendation #11-5.

Finding #11-6: Field Notes—Some case files did not contain CSHOs' field notes.

Recommendation #11-6: Ensure that case files contain CSHOs' field notes, in accordance with the FOM, Chapter 5.

Corrective Action: Supervisors require CSHOs to submit their field notes with their completed and compiled case files. Managers contact CSHOs whose case files are missing field notes. In an email to all CSHOs, the VOSHA manager identified the materials that should be included in each case file, and also the proper order in which these documents must appear in the case files.

State Action Taken: According to the State, these corrective actions have been implemented and are ongoing.

Finding #12-3 (formerly #11-6): Field Notes—Same as Finding #11-6.

Recommendation #12-3: Same as Recommendation #11-6.

Finding #11-7: Evidence of Violations—In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.

Recommendation #11-7: Ensure that case files contain adequate evidence to support all violations cited, in accordance with the procedures set forth in Chapter 4 of the FOM.

Corrective Action: VOSHA's supervisors review inspection case files and VOSHA-1B forms to ensure that all violations are properly documented. If adequate documentation or evidence of violations is not adequate, the supervisors return the VOSHA-1B form to the CSHO for revision.

Upon completing their review of violation documentation, the managers will the log in the case file.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-4 (formerly #11-7): Evidence of Violations—Same as Finding #11-7.

Recommendation #12-4: Same as Recommendation #11-7.

Finding #11-9: Establishing Employer Knowledge of the Hazardous Condition—
As in the onsite review for the FY 2010 FAME Report, Region I found (during the most recent review) that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."

Recommendation #11-9: Ensure that CSHOs record evidence to substantiate that the employer could have known of the hazardous condition through reasonable diligence. A sampling of case files to be reviewed by the Region on a quarterly basis will indicate that CSHOs are adequately documenting evidence of violations cited in case files.

Corrective Action: Supervisors review CSHOs' completed VOSHA-1Bs and require CSHOs to fully substantiate employer knowledge of hazardous conditions if the information provided is not sufficient. The supervisors also review the CSHOs' severity and probability assessments.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-5 (formerly #11-9): Establishing Employer Knowledge of the Hazardous Condition—Same as Finding #11-9.

Recommendation #12-5: Same as Recommendation #11-9.

Finding #11-10: Complaints—Some case files did not contain any documentation that a letter had been sent to the complainant notifying them that citations had been issued to the employer.

Recommendation #11-10: VOSHA must adhere to Chapter 9 of the FOM, Section I, H, which provides for complainant notification of inspection results.

Corrective Action: VOSHA notifies complainants when citations are issued and provides each complainant with a copy of the citations. Complainants are also notified of the protections afforded to them under sections 231 and 232 of the VOSH Act (protection from discrimination for engaging in a protected activity and the VOSHA private right of action). A copy of the notification is placed in the file. The director is reviewing files with the CSHOs who conduct the investigations.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-6 (formerly #11-10): Same as Finding #11-10.

Recommendation #12-6: Same as Recommendation #11-10.

Finding #11-11: Fatality Cases – VOSHA did not follow proper Fatality Investigative Procedures as required in the FOM, Chapter 11, Section II, C., in that the State did not thoroughly investigate the fatality and attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and any effect the violation(s) had on the incident (FOM, Chapter 11. Section II, C).VOSHA did not follow proper Fatality Interview Procedures as required in the FOM, Chapter 11, Section II, D., in that the State did not identify and interview all persons with first-hand knowledge of the incident.

VOSHA did not follow proper Fatality Documentation Procedures as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Incident data, such as how and why the incident occurred; the physical layout of the worksite; sketches/drawings; measurements; video/audio/photos to identify sources, and whether the accident was work related.

VOSHA did not follow proper Fatality Documentation Procedures as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Equipment or Process Involved, such as equipment type; manufacturer; model; manufacturer's instructions; Kind of process; Condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.

Recommendation #11-11: VOSHA must ensure that CSHOs and managers follow all requirements for fatality investigations as set forth in the FOM, Chapter 11 (Imminent Danger, Fatality, Catastrophe and Emergency Response). Region I will review all VOSHA fatality cases and ensure correction of all fatality-related recommendations in this report."

Corrective Action: VOSHA has changed its review procedures for fatalities. Supervisors review all fatalities for completeness and appropriate documentation, and document the results of their review in a log. CSHOs use a check list to help ensure that they include all required fatality investigation documentation in the case file. When possible, fatalities are investigated by two person teams to ensure compliance with the FOM's fatality investigation and documentation procedures.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-7 (formerly #11-11: Fatality Cases – Same as Finding #11-11.

Recommendation #12-7: Same as Recommendation #11-11.

Finding #11-12: Emphasis Programs—VOSHA did not code some inspections for emphasis programs.

Recommendation #11-12: CSHOs must code all inspections involving LEPs, NEPs, and Strategic Plan activities, as appropriate.

Corrective Action: VOSHA will contact the Regional IT person for instructions on adding LEPs, NEPs, and Strategic Plan activities to our CSHO application. Where appropriate, CSHOs will be instructed to enter the emphasis program codes that apply to the inspection.

State Action Taken: The Regional IT administrator indicates that VOSHA contacted him regarding issues with using the CSHO application on new laptops. VOSHA confirmed that CSHOs have been instructed to accurately code all emphasis area inspections. However, an IMIS query run by OSHA's Directorate of Information Technology (DIT) shows different totals for some emphasis codes than those provided by VOSHA in its FY 2012 SOAR. According to the workers' compensation director, the emphasis code totals in the SOAR were tallied by re-opening case files and hand-counting the codes. The discrepancies between the IMIS data and the hand-counted totals in the SOAR warrant further review. Therefore, Region I will assess VOSHA's accuracy and consistency in coding emphasis inspections during the next onsite case file review.

FY 2012 Emphasis Code Totals (Comparison between VOSHA SOAR Data and IMIS Query Data)			
Type of Emphasis Program (National or Local)	**Emphasis Program**	**VOSHA SOAR Data for FY 2012**	**IMIS Query Data for FY 2012**
Local	FALL	80	86
National	SILICA	0	10
National	AMPUTATE	31	2
Local	TRENCH	8	23

Finding #12-8 (formerly #11-12): Emphasis Programs—Same as Finding #11-12.

Recommendation #12-8: Same as Recommendation #11-12.

Finding #11-15: Including air sampling and noise survey forms in case files—Some case files where the CSHO did perform sampling for air contaminants and surveys for noise, the case

files either did not contain copies of completed OSHA-91 (air sampling) and OSHA-92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. These forms are used to help support violations cited.

Recommendation #11-15: VOSHA must ensure that copies of all air sampling and noise survey forms are included in case files for inspections in which these surveys/ samplings have occurred.

Corrective Action: VOSHA supervisors require CSHOs to include health sampling and noise survey forms in their case files. The requirement to include these forms in case files is listed as an item on the CSHO case file review checklist. The VOSHA supervisors are monitoring the CSHOs' compliance with this requirement.

State Action Taken: The workers' compensation director has been reviewing case files as described above and monitoring CSHOs' compliance with this requirement. The program's CSHOs are also assisting him with case file reviews.

Finding #12-9 (formerly #11-15): Including air sampling and noise survey forms in case file— Same as Finding #11-15.

Recommendation #12-9: Same as Recommendation #11-15.

Finding #11-16: Citing all Apparent Violations—CSHOs did not cite all apparent violations during inspections, even though evidence of these violations was provided by CSHOs in some case files through photos and written descriptions.

Recommendation #11-16: CSHOs must cite all apparent violations.

Corrective Action: In the course of the case file review, supervisors review all the photographs taken of the worksite. CSHOs must explain why violations were not cited in photos that appear to show hazardous conditions.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews. VOSHA's FY 2012 average of .50 for SAMM #9 (Average Violations per Inspection with Violations—S/W/R and Other-than-Serious) did not meet the standard of 1.2 for Other-than-Serious Violations. VOSHA's results for this measure may indicate that CSHOs are overlooking citing some Other-than-Serious violations. Region I will perform a more in-depth analysis of whether CSHOs are citing all apparent violations during the next onsite case file review.

Finding #12-10 (formerly #11-16): Citing all Apparent Violations—Same as Finding #11-16.

Recommendation #12-10: Same as Recommendation #11-16.

Finding #11-18: **Violation Classification—**VOSHA misclassified some violations as Other-than-Serious that should have been classified as Serious. Some violations should have been classified as Repeat, and some violations could potentially have been classified as Willful, based on the outcome of further investigation, which the program chose not to pursue.

Recommendation: VOSHA must properly classify all violations and thoroughly investigate violations that have the potential to be cited as Willful, and cite them accordingly.

Corrective Action: CSHOs are required to conduct an establishment search to determine if the employer has previously been cited for the same or similar violations. In order for a violation to be classified as Repeat, the VOSHA review board must have previously issued a "final order" for that particular violation. The establishment search is also used to establish employer knowledge for possible Willful violations.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews. VOSHA classified one violation as Willful in FY 2012, after not classifying any violations as Willful in FY 2011 and FY 2010. However, Region I will determine the extent to which CSHOs are properly classifying violations during the next onsite case file review for the FY 2013 FAME.

Finding #12-11 (formerly #11-18): Violation Classification—Same as Finding #11-18.

Recommendation #12-11: Same as Recommendation #11-18.

Finding #11-19: Penalty Reductions— In some cases, VOSHA improperly granted penalty reductions.

Recommendation #11-19: VOSHA must follow the FOM requirements in Chapter 6 for granting penalty reductions based on size, history, and good faith.

Corrective Action: VOSHA supervisors review case files to ensure that CSHOs have properly determined the size of the employer. CSHOs are required to conduct establishment searches to obtain information on company size and history. CSHOs are also required to justify any reductions for good faith. CSHOs will be required to read the section on penalty reduction factors in Chapter 6 of the FOM.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews.

Finding #12-12 (formerly #11-19): Penalty Reductions— Same as Finding #11-19.

Recommendation #12-12: Same as Recommendation #11-19.

Finding #11-21: Abatement documentation—Some case files were closed without having any documentation of abatement or having only inadequate documentation.

Recommendation #21: VOSHA must ensure that all documentation of abatement is present in case files before they are closed.

Corrective Action: VOSHA supervisors are scrutinizing employer abatement information to assure that violations are appropriately and adequately abated. If there is any question, the CSHO will be asked to review the abatement information. IMIS reports, including complaint tracking, referral tracking, open inspections, citations pending, unsatisfied activity, default violation abatement, and the inspection summary report will be used to help identify cases where abatement documentation has not been entered.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews. However, the workers' compensation director has not been running the IMIS reports referenced in the corrective action.

Finding #12-13 (formerly #11-21): Abatement documentation—Same as Finding #11-21.

Recommendation #12-13: Same as Recommendation #11-21.

Finding #11-22: Informal Conferences—In some cases, the informal conference was held after the 20 calendar-day period had expired.

Recommendation #11-22: VOSHA must adhere to its own guidelines in its "Closing Conference Guide," which requires not extending a 20 calendar-day calendar period for holding informal conferences.

Corrective Action: When VOSHA receives the USPS return receipt, the 20 calendar-day informal conference deadline is noted on the front of the case file by the supervisor. Employers who request an informal conference close to the deadline are informed that they need to submit a letter requesting an informal and a notice of contest in order to preserve their rights. Employers who do not file a timely informal conference request or notice of contest are informed that the 20 calendar-day contest period has ended, and that the citations and penalties are a Final Order of the VOSHA Review Board and cannot be reviewed by any court or agency (21 VSA section 226 (a)).

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. During the onsite case file review for the FY 2011 FAME, the Region identified some cases where the compliance chief had not held informal conferences within the 20 calendar-day period—either because the employer was late in requesting the informal conference or because VOSHA simply did not follow its own policy of holding the informal conference within the 20 calendar-day time period. During the next onsite case file review for the FY 2013 FAME, Region I will evaluate the extent to which VOSHA has corrected this finding.

Finding #12-14 (formerly #11-22): Informal conferences—Same as Finding #11-22.

Recommendation #12-14: Same as Recommendation #11-22.

Finding #11-24: Discrimination Investigations-- Case files were not tabbed and organized according to the manual.

Recommendation # 11-24: VOSHA must organize case files in accordance with the format in the 2011 Whistleblower Investigations Manual.

- Exhibits must be tabbed and the file must contain a Contents of File. 5(III)
- All documents must be retained in the file, including investigators' notes and recordings of interviews downloaded to CDs.
- All emails must be printed and placed in the case file.
- Evidentiary materials should be separated from notes and emails.
- The ROI format provided to VOSHA by Region I must be used.
- All reports must contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination.
- The supervising official must sign and date the Report of Investigation (ROI), indicating concurrence with the findings.
- A uniform system to label case files with the complainant name, the respondent name and the case number must be created.

Corrective Action: According to the CAP, the workers' compensation and safety division director has assumed responsibility for working with CSHOs assigned to investigate whistleblower complaints. Three CSHOs were provided with additional whistleblower training by Carole Horowitz of the federal OSHA whistleblower program in Region I OSHA. The CSHO staff will report to the division director on the status, developments and actions in each whistleblower case. No case can be closed or issued without review by the director and agreement on the case by Carole Horowitz at the federal OSHA whistleblower program.

Possible changes to how whistleblower complaints are handled and investigated are also being studied. In particular, consideration is being given to combining the VOSHA whistleblower investigation responsibilities with other Department of Labor anti-retaliation provisions (for example, state wage-hour complainant protections and Workers' compensation claimant protections) to create a dedicated whistleblower investigative unit. Current evidence suggests that CSHOs frequently do not have enough background, training and caseloads to investigate these complaints on a regular basis and therefore a dedicated retaliation unit would resolve this issue.

Case files have been organized and placed in green three-ring binders. All exhibits are tabbed and there is a table of contents. All documents are retained in the file, including investigators' notes and recordings of interviews downloaded to CDs. All emails are be printed and placed in the case file. Evidentiary materials will be separated from notes and emails.

VOSHA is using the ROI format provided by Region I. All reports will contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination. The supervising official will sign and date the ROI, indicating concurrence with the findings. A uniform system to label case files with the complainant name, the respondent name and the case number has been created and is in use.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. However, because the Region did not conduct an onsite case file review, the corrective action with respect to case file organization has not been verified.

It should be noted that in the CAP, VOSHA stated that "no case can be closed or issued without review by Steve [the workers' compensation director] and agreement by Carole Horowitz at the federal OSHA whistleblower program." During FY 2012 and since the FY 2011 FAME report was completed, however, VOSHA has closed four cases without first sending them for review by OSHA. Further, since the audit only one ROI was submitted to OSHA for review (in FY 2013). OSHA advised the VOSHA supervisor of OSHA's opinion that the case has merit and should be settled or referred for litigation, but the VOSHA whistleblower supervisor decided to close it. Once OSHA was informed of this intent, VOSHA was instructed not to close the case. A second case was submitted to OSHA for review at the same time but the investigator had not written an ROI. The OSHA supervisor told VOSHA that she would not review case files unless an ROI was submitted. As of this date, no ROI for that case has been submitted to OSHA for review.

Finding #12-15 (formerly #11-24): Discrimination Investigations-- Same as Finding #11-24.

Recommendation #12-15: Same as Recommendation #11-24.

Finding #11-25: Discrimination Investigations— VOSHA does not have an appeals process.

Recommendation #11-25: VOSHA must immediately establish and implement an appeals process in conformance with the Whistleblower Investigations Manual Chapter 1(VII) (C).

Corrective Action: According to the CAP, VOSHA has developed an appeals process. This process will have to be formally adopted through rulemaking but is in place as an interim operating procedure pending adoption.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. In November 2012, VOSHA submitted an appeals process to the Region in response to the Federal Program Change (CPL 02-03-004, Section 11 (c) Appeals Program) that was issued a few months earlier in September 2012. Upon review of this proposal, the Region determined that the proposal does not definitively state who the final reviewer will be. The proposed appeals process states that it will be the Commissioner or her designee and that VOSHA anticipates the designee will be the Department's General Counsel staff. While the General Counsel staff would be an appropriate reviewer, VOSHA needs to make a final decision and send a written statement to the Region specifying who will review appealed cases.

Furthermore, VOSHA has a case that has been classified in IMIS as appealed since May 2011, and VOSHA has not informed OSHA of any action taken to review this case. A second case was appealed during FY 2012 and OSHA has not been informed of this, and it is not clear whether an appeal is being conducted.

Finding #12-16 (formerly #11-25): Discrimination Investigations—VOSHA's proposed appeals process (which the State submitted in response to Federal Program Change CPL 02-03-004, Section 11 (c) Appeals Program), does not state specify who will be responsible for reviewing appealed cases.

Recommendation #12-16: Before OSHA can approve VOSHA's proposed appeals process, the State must send a written statement to the Region specifying the person who will be charged with reviewing appeals.

Finding #11-26: Discrimination Investigations— VOSHA fails to notify complainants of their rights, such as the right to dual file, the right to file a CASPA, or the right to file an appeal of VOSHA's determination. Letters were not being sent to the parties.

Recommendation #11-26:

- VOSHA must send notification and determination letters to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year.
- VOSHA has developed a form that it gives to complainants to notify them of their obligations during a discrimination investigation. VOSHA asks the complainants to review and sign the form during the interview. VOSHA must discontinue using this form, because the legal language used throughout the form, in conjunction with the limited timeframe for complainants to review and consider the information given, makes the use of this form overly burdensome.
- While not required by the manual, OSHA considers it a best practice for states to notify the parties of their right to file a CASPA and encourages VOSHA to do so.
- Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY 2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e., give them 30 days from the date they are notified of their right to appeal.

Corrective Action: According to the CAP, upon receipt of the draft FAME report, the appropriate Vermont specific letters were developed and reviewed with the regional office staff to assure completeness, accuracy and compliance with the Whistleblower Investigations Manual. Once the regional investigator working with the state approved these letters, they were placed on the VOSHA shared drive as a template. Discrimination investigators send the appropriate information to the VOSHA manager. The initial letters are mailed USPS certified to both the complainant and respondent. The investigators are notified by e-mail that the letters have been sent and are given a copy of the letters. The USPS return receipt is addressed to the investigator for their information and file.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. OSHA has verified that VOSHA has developed the template letters and provided them to investigators.

As part of its continuing oversight of the VOSHA discrimination program, Region I requested that VOSHA copy the Regional Supervisory Investigator on all opening and closing letters. Since OSHA made this request, VOSHA opened four cases and closed four cases, but did not *voluntarily* provide any of these letters (although some were provided later upon request). And although OSHA instructed VOSHA to discontinue using the "Complainant Information Form," the State did not provide an adequate response to this instruction in the CAP.

Because VOSHA did not previously have an appeals process, OSHA instructed VOSHA to extend appeal rights to all complainants whose cases were dismissed during FY2010 to the present. VOSHA was instructed to send letters to all of these complainants and to provide OSHA with copies of these letters. VOSHA did not provide the letters to OSHA and it is unknown whether VOSHA wrote the letters at all. VOSHA did not respond to this in the CAP.

Finding #12-17 (formerly #11-26): Discrimination Investigations—Same as Finding #11-26.

Recommendation #12-17: Same as Recommendation #11-26.

Finding #11-32: Discrimination Investigations—VOSHA public employee stakeholders are not adequately informed of the rights provided to them under VOSHA's discrimination provisions.

Recommendation #11-32: Conduct outreach with stakeholders about employee rights and employer responsibilities.

Corrective Action: According to the CAP, VOSHA will provide the Vermont State Employees Association, AFSCME, Vermont NEA, the State Labor Council, and the Workers' Rights center with information on the discrimination provisions of Vermont law and the whistleblower rules adopted by VOSHA. The information will also be provided to the Vermont League of Cities and Towns (VLCT).

State Action Taken: According to the CAP, VOSHA intends to conduct outreach. However, it is not clear if any outreach has actually been conducted.

Finding #12-18 (formerly #11-32): Discrimination Investigations—Same as Finding #11-32.

Recommendation #12-18: Same as Recommendation #11-32.

Finding #11-33: VPP—A number of the required signed approval letters were not contained in the VPP files.

Recommendation #11-33: VOSHA must obtain copies of these signed letters and include them in the appropriate files.

Corrective Action: The signed letters will be placed in the files. All of the letters did exist; they were just not in the appropriate files. The VOSHA compliance assistance specialist (CAS) will assure that the signed letters are placed in the appropriate files.

State Action Taken: According to the State, these corrective actions have been implemented and are ongoing.

Finding #12-19 (formerly #11-33): VPP—Same as Finding #11-33.

Recommendation #12-19: Same as Recommendation #11-33.

Finding #11-34: VPP—Complaints at VPP sites were handled by the VPP manager, rather than by a compliance officer.

Recommendation #11-34: VOSHA must ensure that all complaints, referrals, and/or fatality/catastrophe investigations at VPP sites are to be handled by compliance staff.

Corrective Action: All complaints, referrals and/or fatality/catastrophe investigations at VPP sites will be conducted by compliance staff. Any CSHO that participated in the GMVPP onsite evaluation will not be allowed to conduct the investigation

State Action Taken: The CAS has implemented the corrective action.

Finding #12-20 (formerly #11-34): VPP—Same as Finding #11-34.

Recommendation #12-20: Same as Recommendation #11-34.

THE FOLLOWING FY 2011 FAME FINDINGS ARE *CLOSED:*

Finding #11-1: **VOSHA did not meet the following SAMM Measures: SAMM #2**—Average number of days to initiate complaint investigations; **SAMM #6**—Percent of S/W/R violations verified (private sector); **SAMM #7**—Average number of days from opening conference to citation issue (safety and health**); SAMM #8**—Percent of programmed inspections with S/W/R violations (health); **SAMM #9**—Average violations per inspection with S/W/R and other; **SAMM #10**—Average initial penalty per serious violation; and **SAMM #11**—Percent of total inspections in the public sector.

Recommendation #11-1: Meet these and all SAMM measures by the end of FY 2012.

Corrective Action: Supervisors use weekly IMIS reports, such as the complaint tracking, referral tracking, open inspections, citations pending, unsatisfied activity, default violation

abatement, and the inspection summary report, to identify problem areas. Supervisors work directly with CSHOs to reduce the time to initiate complaint inspections, and reduce the length of time between the opening conference and the issuance of citations. In cases where abatement verification is overdue from the employer, VOSHA supervisors work with CSHOs to ensure that evidence of abatement is obtained as quickly as possible. Supervisors are scrutinizing the assessment of gravity and probability to ensure that appropriate penalties are assigned to violations.

State Action Taken: The workers' compensation director has indicated that he has been reviewing some case files as described above. The program's CSHOs are also assisting with case file reviews. However, the workers' compensation director has acknowledged that he has been unable to implement the corrective action of running the SAMM and other IMIS reports to track performance with regard to abatements, complaints, penalties, violations, referrals and other areas of the inspection process.

In Section IV of this report, Region I conducts a thorough assessment of Vermont's performance with regard to each of the FY 2012 SAMM measures. To avoid duplication, Region I is closing this finding.

For informational purposes, the SAMM measures that VOSHA did not meet in FY 2012 are as follows: **SAMM #2**—VOSHA's fiscal year-end average of 7.72 days exceeded the negotiated standard of 5 days; **SAMM #6**—VOSHA's percent of 78.89 for the private sector did not meet the 100% standard; VOSHA's percent of 52.94 for the public sector did not meet the 100% standard; **SAMM #7**—VOSHA's average of 120.10 days for safety did not meet the standard of 55.9 days; VOSHA's average of 125.94 days did not meet the standard of 67.9 days for health; **SAMM #8**—VOSHA's percent of 50.00 for health did not meet the standard of 53.00 percent; **SAMM #9**—VOSHA's percent of .50 percent did not meet the standard of 1.2 percent for Other-than-Serious violations; and **SAMM #10**—VOSHA's average of $1,249.25 did not meet the standard of $1,990.50.

Finding #11-2: VOSHA did not meet the following SIR Measures: C.3.A. Private Sector Serious Safety Violations; **C.3.B.** Private Sector Serious Health Violations; **C.5.A.** Private Sector Average Penalty for Other-than-Serious Safety Violations; **C.5.B.** Private Sector Average Penalty for Other-than-Serious Health Violations; **C.6.A**. Private Sector Safety Inspections per 100 Hours; **C.9.** Private Sector Penalty Retention; **E.3.** Penalty Retention (%)

Recommendation #11-2: Meet these and all SIR measures by the end of FY 2012.

Region I is no longer using the SIR as a basis for findings and recommendations. Performance related to programmed inspections, violations, abatement and penalties, etc. are primarily assessed using SAMM measures. The Region will use the SIR and IMIS Enforcement Statistics and Inspection Reports as "supplemental data" when "SAMM indicators are at levels triggering further review."

Finding #11-3: Average Violations per Initial Inspection/Average Current Penalty per Serious Violation—VOSHA fell short of Federal OSHA's averages.

Recommendation #11-3: Align these measures more closely with the Federal averages by the end of FY 2012. FY 2012 year-end Enforcement statistics will indicate that VOSHA meets Federal OSHA's averages.

The data used in this finding is derived from the IMIS Enforcement Statistics Report. In keeping with DCSP's FY 2012 FAME guidance, data from the SIR and IMIS reports is being used only in cases where SAMM data indicates that further review is needed. Therefore, this finding has been closed.

Finding #11-8: S/W/R Violations—VOSHA's percentages for S/W/R violations in FY 2011 were not comparable to Federal OSHA's.

Recommendation #11-8: At the end of FY 2012, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.

The data used in this finding is derived from the IMIS Inspection Report. Therefore, this finding has been closed. In Section IV, Region I has evaluated VOSHA's performance with respect to S/W/R violations using SAMM #8 (Percent of Programmed Inspections with S/W/R Violations) and SAMM #9 (Average Violations per Inspection with Violations).

Finding #11-13: Inspections with Violations Cited—VOSHA did not align closely with Federal OSHA in terms of percent of inspections with violations cited. In FY 2011, VOSHA's percentage of 57 was far below Federal OSHA's percentage of 71, as well as below the nationwide average State Plan percentage of 60.

Recommendation #11-13: VOSHA must ensure that CSHOs cite all violations.

The data used in this finding is derived from the IMIS Inspection Report. Therefore, this finding has been closed.

Finding #11-14: Average Number of Violations per Initial Inspection—In FY 2011, VOSHA's average continued to fall below Federal OSHA's average.

Recommendation #11-14: VOSHA must increase its average number of violations per initial inspection.

This finding has been closed because it duplicated Finding #11-3.

Finding #11-17: Violation Classification—VOSHA's percentage for all violations cited as Serious did not align closely with Federal OSHA's in FY2011.

Recommendation #11-17: VOSHA's percentage for all violations classified as Serious must align more closely with Federal OSHA's percentage by the end of FY 2012.

The data used in this finding is derived from the IMIS Inspection Report. Therefore, this finding has been closed.

Finding #11-20: **Average Current Penalty per Serious Violation—**VOSHA's average continues to fall below Federal OSHA's average. In FY 2011, VOSHA's average was $899.00, while Federal OSHA's average was $2,133.00

Recommendation #11-20: VOSHA's average current penalty per serious violation must align more closely with Federal OSHA's average by the end of FY 2012.

This finding has been closed because it duplicated Finding #11-3.

Finding #11-27: Discrimination Investigations— Supervisors do not use or review the information entered into the IMIS.

Recommendation #11-27: The supervisor must:

- Have access to IMIS and be given training on how to run reports.
- Ensure that the correct allegation code is used.
- Ensure that the allegation summary describes the alleged protected activity and adverse action.
- Ensure that the closed date is the same as the date closing letters are sent.

In response to this finding, VOSHA stated in its CAP that "supervisors have access to the whistleblower website and are using the available reports." VOSHA also mentioned that the Region had provided three-days of training for VOSHA supervisors and investigators on the "whistleblower programs that are the sole jurisdiction of OSHA. This training was conducted to assist VOSHA in making appropriate referrals to OSHA. " However, there is nothing in this response that specifies a corrective action plan to address the finding that "supervisors do not use or review the information entered into the IMIS." In fact, since the FY 2011 FAME was issued, Region I has identified many errors in VOSHA's IMIS entries.

Although this finding that management is not using the IMIS system properly for whistleblower entries has by no means been resolved, Region I has closed this finding because all issues with the State's IMIS management are covered under Finding #12-34.

Finding #11-36: Training—Vermont has CSHOs who have yet to complete Course #1310 (Investigative Interviewing Techniques), as required under OSHA's Initial Compliance Training Program.

Recommendation #11-36: Enroll these CSHOs in this course so that they have all completed this training by the end of FY 2012.

According to the Region's analysis of VOSHA's training records, one CSHO remains who has not yet completed this training. However, Course #1310 is one of the courses included in the basic CSHO training track. Therefore, this finding is being closed because it is covered under #12-27 (formerly #11-39), which addresses the fact that most of VOSHA's veteran CSHOs have

gone far beyond the three-year period for completing all of the courses in the initial compliance training program.

Finding #11-38: Training—VOSHA has no documentation to show that one of the two veteran CSHOs who conduct fatality investigations has completed OTI Course #1410 (Inspection Techniques and Legal Aspects).

Recommendation: Ensure that the CSHO completes this course before the end of 2012, because this course is mandatory training for all CSHOs, and should have been completed in the first year of this CSHO's employment.

The Region's analysis of February 11, 2013 shows that this particular CSHO has neither been waitlisted nor enrolled in Course #1410. However, Course #1410 is one of the courses included in the basic CSHO training track. Therefore, this finding is being closed because it is covered under Finding #12-27 (formerly #11-39), which addresses the fact that most of VOSHA's veteran CSHOs have gone far beyond the three-year period for completing all of the courses in the initial compliance training program.

THE FOLLOWING FY 2011 FINDING HAS BEEN *COMPLETED*:

Finding #11-37: Training—Two of the program's "veteran" CSHOs who conduct fatality investigations require additional training in investigative and interviewing techniques at OSHA's Training Institute.

Recommendation: VOSHA must ensure that both CSHOs complete Course #1310, Investigative Interviewing Techniques, even though these CSHOs are technically exempt from taking this course due to their "veteran" CSHO status.

Corrective Action: VOSHA enrolled the veteran CHSOs in Course #1310 in FY 2012.

State Action Taken: The Region's analysis shows that VOSHA has complied with this recommendation, and that the two veteran CSHOs completed Course #1310.

THE FOLLOWING FY 2011 FINDINGS ARE *OPEN:*

Finding #11-23: Standard Adoption—VOSHA did not adopt 29 CFR 1915 in a timely manner, once it was determined that Vermont had facilities that are covered by this standard, and the State began the adoption process (February 2, 2011).

Recommendation #11-23: For all future standard adoptions, VOSHA must adhere to the six-month time frame in 29 CFR 1953 (a) (1).

Corrective Action: VOSHA will make every effort to adhere to adopt new rules or rule changes within the six- month time frame. VOSHA will begin the rule adoption process when notified of a final rule by OSHA.

State Action Taken: In FY 2012, VOSHA did not adopt the two final rules issued by OSHA within the six-month time frame. VOSHA is also overdue in adopting another standard that was required to be adopted as of November 2011.

Standard	FR Date	Response Due Date	Date State E-mailed Response	Adoption Required	Intent Required	Adoption Due Date	Adopt Identical	State Adoption Date
,1910,1910.102,1911 Revising Standards Referenced in the Acetylene Standard	3/8/2012	5/12/2012	5/7/2012	NO	YES	9/8/2012	YES	11/1/2012 (anticipated)
,1910, 1915, 17, 18, 26 Hazard Communication—Globally Harmonized System of Classification	3/26/2012	5/21/2012	3/24/2012	YES	YES	9/26/2012	YES	10/12/2012

Finding #12-21 (formerly #11-23) Standards Adoption-- In FY 2012, VOSHA did not complete the adoption of the *Acetylene Standard*, which was one of two final rules issued by OSHA during that year. VOSHA adopted the other final rule—*Globally Harmonized System of Classification*—after the adoption due date. In FY 2012, VOSHA confirmed that it would begin adoption of *29 CFR 1910, 1915, Working Conditions in Shipyards.* Adoption of this standard was required to be completed by November 2, 2011. However, the State said that it could not begin the process of adopting this standard until after it had completed adoption of *29 CFR PART 1915—Occupational Safety and Health Standards for Shipyard Employment,*[4] which occurred on February 24, 2012. To date, 29 CFR 1910, 1915, *Working Conditions in Shipyards*, still has not been adopted by VOSHA.

[4] VOSHA had initially declined adoption of 29 CFR 1915; however, upon further investigation, VOSHA determined that there are two marinas in the state that provide maintenance and repair services as well as storage. On the other hand, Vermont does not have any facilities that fall under either PART 1917 (Marine Terminals) or under PART 1918 (Occupational Safety and Health Regulations for Longshoring). In formally responding to Federal OSHA with its intent to adopt *29 CFR 1910, 1915, Working Conditions in Shipyards* on May 18, 2011, VOSHA stated that it would "begin the adoption process as soon as the current 1915 adoption process in complete."

Recommendation #12-21: VOSHA must complete the adoption of these standards, and for all future standards, VOSHA must adhere to the six-month time frame in 29 CFR 1953 (a)(1).

Finding #11-28: Discrimination Investigations—Investigators do not receive sufficient training and supervision to conduct proper investigations. Investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions. Those supervising the discrimination program have no training or experience in discrimination investigations.

Recommendation #11-28:

- Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 (now 21) federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA.
- Retrain managers and discrimination investigators in the investigative process, elements of a violation, and case analysis.
- Budget for investigators to attend national whistleblower conferences and Regional meetings.

Corrective Action: According to the CAP, VOSHA will send investigators and persons supervising discrimination work to the Basic Whistleblower investigations Course #1420 at the OSHA Training Institute. One investigator has completed the training and another is scheduled to complete the course in December 2012.

All VOSHA field staff members were brought in for training on the whistleblower programs that are the sole jurisdiction of OSHA. This training was conducted to assist VOSHA in making appropriate referrals to OSHA. Additional, more intensive, training was provided to three CSHOs who are expected to handle the bulk of the VOSHA discrimination investigations.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. Region I held a three-day basic training for VOSHA's investigators and supervisors. The current supervisor was unable to attend all of the training. One investigator attended OTI Course #1420 (Basic Whistleblower Investigations) in FY 2013. However, one investigator and the supervisor have still not taken Course #1420.

Finding #12-22 (formerly #11-28): Discrimination Investigations—Same as Finding #11-28.

Recommendation #12-22: Provide training detailed in Recommendation #11-28 to managers and staff who have not yet received it. Provide refresher training to staff as needed. When a new supervisor is hired he/she must attend Course #1420.

Finding #11-29: Discrimination Investigations— Supervisors do not manage the program effectively.

Recommendation #11-29:

- Supervisors must keep investigators informed about changes to federal OSHA's program.
- Supervisors and investigators must confer with OSHA on difficult cases.
- VOSHA must consult with the designated OSHA Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed.
- VOSHA must send the completed Report of Official Investigation (ROI) to the designated RSI before closing the case.
- VOSHA must send the completed case file to OSHA upon completion of the case.

Corrective Action: According to the CAP, VOSHA has implemented these recommendations and will work closely with the designated RSI.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. However, with only the workers' compensation director available to run VOSHA, communication has been lacking. For example, four cases have been closed since the FY 2011 FAME was completed and OSHA was not consulted prior to closing two cases and not provided with the report of investigation or case file in any cases. Due to the lack of front line supervisors, investigators have been unable to obtain advice or review of their work, to the detriment of their cases. It is imperative that VOSHA hire a supervisor who can manage the program effectively.

Finding #12-23 (formerly #11-29): Discrimination Investigations—Same as Finding #11-29.

Recommendation #12-23: Same as Recommendation #11-29.

Finding #11-30: Discrimination Investigations—VOSHA does not have an attorney designated to handle discrimination matters.

Recommendation #11-30: VOSHA will designate an attorney with expertise in discrimination matters to advise it on legal issues that arise.

Corrective Action: According to the CAP, in cases where discrimination is found, and settlement is not possible, the case is referred to the VT Attorney General's office Civil rights unit legal action. In Vermont workers also always (regardless of VOSHA finding) have a right to bring a private cause of action and recover costs, attorney fees, and damages.

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. However, VOSHA's answer is not responsive to the Finding. VOSHA's response is related to the appeals process, which is not the subject of this Finding. OSHA found

that VOSHA whistleblower investigators and supervisors did not have a designated attorney to give legal advice on questions that arise during the course of an investigation, regardless of the merits of the case. While the current supervisor is an attorney, it would be inappropriate for him to have the dual role of supervisor and legal advisor for whistleblower cases. Further, whoever is chosen as legal advisor to the program should have significant expertise and experience in whistleblower concepts, case law, and litigation.

Finding #12-24 (formerly #11-30): Discrimination Investigations—Same as Finding #11-30.

Recommendation #12-24: VOSHA will designate an attorney with expertise in discrimination matters to provide advice on legal issues that arise through all phases of investigation.

Finding #11-31: Discrimination Investigations— VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.

Recommendation #11-31:

- Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible to employers and employees.
- Provide a link to OSHA's website – www.whistleblowers.gov.

Corrective Action: According to the CAP, VOSHA requested and received $30,000 in one time only funding for the redesign of the VT Department of Labor website. This redesign will make the VOSHA and Project WorkSAFE onsite consultation programs more prominent and will have a whistleblower page that articulates employee discrimination rights and their private right of action (21 VSA sections 231 and 232).

State Action Taken: According to the CAP, these corrective actions have been implemented and are ongoing. From a review of the current VDOL/VOSHA website, it appears that no changes have been made thus far. VOSHA was instructed to make interim changes to the existing website to make information on employee rights and filing a discrimination claim accessible, but has not done so. It continues to be extremely difficult to find any information on whistleblower protections. It is important that the website is updated as quickly as possible so that employees and employers can get information about their rights and responsibilities.

Finding #12-25 (formerly #11-31): Discrimination Investigations—Same as Finding #11-31.

Recommendation #12-25: Same as Recommendation #11-31.

Finding #11-35: Alliance Program—VOSHA's Alliance documentation does not comply with the directive's requirements in Section XII Program Requirements, D. Alliance Documentation 1 and 2.

Recommendation #11-35: VOSHA must ensure that annual reports are completed and maintained in the Alliance files and that the electronically signed Alliance copies are posted on the VOSHA Website, along with relevant updates, milestones, success stories, events, or photographs.

Corrective Action: The VOSHA CAS will assure that annual reports are completed and maintained in the Alliance files. Additionally, the electronically signed Alliance copies are posted on the VOSHA Web site, along with relevant updates, milestones, success stories, events, or photographs. The addition of this information will occur after the revisions to the Vermont Department of Labor website.

State Action Taken: According to the CAS, annual reports have been completed and are being maintained in the Alliance files. However, the CAS has encountered many technical difficulties in attempting to post items on the current VOSHA Web site, and therefore is waiting for the new Web site to be launched to begin posting electronically signed Alliance copies and other Alliance-related information.

Finding #12-26 (formerly #11-35): Alliance Program—Same as Finding #11-35.

Recommendation #12-26: Same as Recommendation #11-35.

Finding #11-39: Training—Region I has performed an in-depth analysis of VOSHA's training records (which VOSHA provided to the Region upon request). This analysis has found that none of the program's CSHOs have completed their mandatory training track (prescribed by OTI's training directive) within the time frame permitted by the directive.

Recommendation #11-39: By no later than December 31, 2013, all CSHOs must have completed the training track for their appropriate discipline (safety or health) as required under the most recent OSHA training directive (TED 01 00-018, issued in 2008).

Corrective Action: Because of budgeting and travel restrictions, CSHOs were unable to travel to Chicago for training at OTI for several years. VOSHA has now enrolled all CSHOs in the OTI courses necessary to complete their training track. Although some CSHOs have been waitlisted for courses, they will eventually become enrolled in the courses. A document showing CSHOs' enrollments in upcoming OTI courses has been provided separately.

State Action Taken: According to VOSHA's staff training plan, at least six CSHOs will still need to complete some "core competency courses" by the end of FY 2014. The Region's analysis of VOSHA's training records shows that as of March 19, 2013, seven of the program's nine veteran CSHOs still had not completed all of the required core courses.

VOSHA's staff training plan lists some of the initial training track courses that CSHOs have completed, and some in which they are enrolled or waitlisted. However, this plan does not provide a complete picture of each CSHO's training record, in that it does not indicate which courses each CSHO still needs to take to fulfill the core training requirements. For several

CSHOs, the Region's analysis of their training histories indicates that they need to complete courses that are not even listed on this staff training plan.

Finding #12-27 (formerly #11-39): Training—Seven of the program's nine veteran CSHOs still have not completed all of the courses in the initial compliance training program. According to the CAP, some CSHOs may not complete their training until sometime in 2014.

Recommendation #12-27: VOSHA should ensure that all CSHOs who are overdue for completing their mandatory core courses do so as soon as possible.

Finding #11-40: State Internal Evaluation Plan (SIEP)—VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM).

Recommendation #11-40: VOSHA must develop a SIEP for use during FY 2013 that conforms to the requirements of the SPPPM.

Corrective Action: A SIEP is being drafted, but will not be finished until supervisory vacancies are filled.

State Action Taken: VOSHA provided a draft SIEP in its FY 2012 SOAR, but it has neither been finalized nor implemented.

Finding #12-28 (formerly #11-40): State Internal Evaluation Plan (SIEP)—VOSHA does not have an internal evaluation program that meets the criteria outlined in the SPPPM.

Recommendation: #12-28: VOSHA must finalize and implement a SIEP that conforms to the requirements of the SPPPM by September 30, 2013.

Finding 11-41: Inspection Activity—VOSHA fell far short of its inspection goal in FY 2011, by conducting only 317 of 400 inspections projected.

Recommendation: VOSHA must work harder to meet its inspection goal in order to adequately protect workers in the State of Vermont.

Corrective Action: In June of 2012 safety CSHOs were advised that they had to open one new inspection and close one inspection per week, and health CSHOs were advised to do the same every two weeks. Individual performance evaluations will consider the attainment of these goals. VOSHA met its modified goal of at least 300 inspections in 2012 despite being short one safety CSHO for the entire year. A new person was hired on June 28, 2012 and this new CSHO has already attended the first three OTI courses. This CSHO began conducting supervised inspections on September 4, 2012.

State Action Taken: VOSHA is continuing to work to ensure that safety and health CSHOs open and close the recommended number of inspections, as discussed above. As of the end of the first quarter of FY 2013, VOSHA had met its quarterly inspection goal of 87 inspections opened.

Finding #12-29 (formerly #11-41): Inspection Activity—According to the IMIS Enforcement report of December, VOSHA fell far short of its inspection goal in FY 2012 by conducting 306 inspections of 400 inspections projected.

Recommendation #12-29: VOSHA must meet its FY 2013 inspection goal of 350 inspections by the end of the fiscal year.

IV. Assessment of FY 2012 State Enforcement Measures

This section provides an assessment of the State's enforcement-related functions, and focuses on complaints, fatalities, targeting and programmed inspections, citations and penalties, and abatement. Information sources include data from the SAMM report for FY 2012 **(Appendix D)** and the VOSHA FY 2012 SOAR **(Appendix E)**. Some data from Inspection and Enforcement Statistics Reports which were run by the Region on December 17, 2012 are used to supplement the FY 2012 SAMM data. FY 2012 year-end data is compared to previous years in order to show trends in performance.

As discussed in Section III under Finding #11-1, VOSHA's CAP called for "supervisors" to use weekly IMIS reports to track its performance on various SAMM measures that the program did not meet in FY 2011. In addition to running and analyzing these reports, Supervisors were to "work directly with CSHOs" to reduce the time to initiate complaint inspections; reduce the lapse time between the opening conference and citation issuance; and ensure that CSHOs obtain evidence of abatement "as quickly as possible." Supervisors are also "scrutinizing the assessment of gravity and probability to ensure that appropriate penalties are assigned to violations."

According to the CAP, these corrective actions have been implemented and are ongoing. But since January 2013, VOSHA has been operating with only one front-line supervisor who is actually the director of the state agency that oversees VOSHA, and who has no training related to OSHA enforcement. He has acknowledged that he has been unable to implement the corrective action of running the SAMM and other IMIS reports to track performance with regard to abatements, complaints, penalties, violations, referrals and other areas of the inspection process.

This section also contains three measures of whistleblower program-related functions, focusing only on number of cases completed within 90 days, percent of cases found to have merit, and percent of merit cases settled. The current measures, while useful, do not give an accurate picture of the overall effectiveness of the program. SAMM measures #12 and #15 are continued in the FY 2013 SAMM "for information purposes only."

ENFORCEMENT

Complaints

- **Complaint Activity Measures**

SAMM measures 1-4 assess the program's efficiency in handling complaint inspections**.**

SAMM #1 measures the average number of days it takes the program to initiate complaint inspections. The standard for this measure is five days. As shown in the table below, VOSHA's average number of days to initiate complaint inspections has decreased considerably since FY 2008. While the State's FY 2012 average was a bit higher than it was in FY 2011, it was still below the five-day standard and well below the FY 2008 average.

Average Number of Days to Initiate Complaint Inspections (SAMM #1)				
FY 2008	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**
8.06	4.46	5.35	2.04	**3.08**

SAMM #2 measures the average number of days to initiate complaint investigations. More specifically, SAMM #2 measures the number of days from the complaint received date on the OSHA-7 to the date the "Non-formal Complaint Notification" letter is sent to the employer. In FY 2012, VOSHA did not meet the standard of one day for initiating complaint investigations, with an average of 7.72 days**.** In other words, VOSHA took a total of 85 days to initiate investigations for 11 complaints, which resulted in an average of 7.72 days for initiating an investigation for each complaint received.

VOSHA's FY 2012 average of 7.72 days was much higher than the State's FY 2011 average of 2.04 days. In FY 2009 and FY 2010, however, the plan did meet the standard, with averages of 0.81 and 0.86, respectively.

Average Number of Days to Initiate Complaint Investigations (SAMM #2)			
FY 2009	**FY 2010**	**FY 2011**	**FY 2012**
0.81	0.86	2.04	**7.72**

Finding #12-30: SAMM #2 (Average Number of Days to Initiate Complaint Investigations)—VOSHA's FY 2012 average of 7.72 days did not meet the standard of one day for initiating complaint investigations. Since FY 2009, this average has increased significantly.

Recommendation #12-30: Decrease the number of days to initiate complaint inspections so that the one-day standard is met.

SAMM #3 measures the percent of complaints where complainants were notified in a timely manner—within 20 workdays of citation issuance or 30 workdays of the closing conference without citations. According to SAMM #3, VOSHA notified 100 percent of all 62 complainants in a timely manner, and initiated inspections in all of the complaints filed. VOSHA also met the 100 percent standard for SAMM #3 in FY 2011, FY 2010 and FY 2009.

SAMM #4 measures the percent of imminent danger complaints and referrals responded to within one day. The standard is 100 percent. In FY 2012, VOSHA did meet the standard, responding to all four of the imminent danger complaints received during that year within one day. In FY 2011, VOSHA also met the standard by responding to the single imminent danger complaint received during that year within one day. However, In FY 2010, VOSHA did not meet the standard, responding to two out of three imminent danger complaints within one day, for a percentage of 66.67. In FY 2009, VOSHA had the same percentage as in FY 2010—66.67 percent. As this paragraphs shows, VOSHA has done a good job of meeting this measure in FY 2012.

Fatalities

An IMIS Fatality/Catastrophe Report of February 24, 2013 lists the following accidents that occurred in FY 2012:

FY 2012 Accident/Fatality Descriptions			
Insp. Open Date	**Description**	**Fatality**	**Hospital Injuries**
12/15/2011	The employee was crushed by hay.	1	
1/20/2011	The construction worker fell 12 feet from a truss deck.	0	1
3/21/2012	The victim died of positional asphyxiation.	1	
3/23/2012	The victim was electrocuted	1	
4/27/2012	The victim was electrocuted from contact with power lines.	1	
6/7/2012 (event date)	The operator was ejected during a vehicle roll-over.	1	
6/15/2012	The worker fell from an unstable platform lift.	1	
6/27/2012 (event date)	The victim was struck by lightning.	1	
7/23/2012	The victim possibly drowned.	1	
8/24/2012	The worker suffered a head injury from falling from a moving waste collection vehicle.	1	

In the FY 2011 FAME, Region I found several serious deficiencies in the manner in which one fatality inspection in particular was conducted, in that the CSHO who conducted the inspection

failed to follow OSHA's fatality investigative procedures as described in the FOM, Chapter 11. For example, the State did not thoroughly investigate the fatality and attempt to determine the cause of the event; the State did not identify and interview all persons with first-hand knowledge of the incident; and the State also did not adequately document incident data and equipment or process involved in the accident.

Because of the serious nature of the findings in the FY 2011 FAME related to VOSHA's conduct of fatality inspections, the Regional Administrator has been holding monthly phone calls or meetings with the Commissioner of Labor to ensure that VOSHA complies with the FOM in conducting fatality investigations. In addition, Region I has reviewed some of VOSHA's fatality–related case files prior to citation issuance to ensure that all inspection procedures were properly followed.

Targeting and Programmed Inspections

VOSHA continues to use the same targeting methods, as discussed in the FY 2011 FAME.

- **Inspection Targeting Methods**

VOSHA uses the McGraw-Hill Construction Dodge Reports to target construction employers for inspections, and uses a number of methods to target health inspections:

1. VOSHA targets employers with higher than average DART rates in industries where workers are exposed to silica, lead, and other toxic and hazardous substances.
2. VOSHA uses the McGraw-Hill Construction Dodge Reports to target construction employers at risk for hazards related to lead paint/asbestos removal, and drilling and grinding stone, etc.
3. VOSHA inspects employers at risk for health hazards identified in the Strategic Plan emphasis programs (e.g., blood-borne pathogens, combustible dust, ergonomics, food processing, and nursing homes, etc.).
4. Two programs under the Vermont Department of Health (the Health Surveillance and Asbestos and Lead Regulatory programs) make referrals to VOSHA as appropriate.

Each year, VOSHA adopts Federal OSHA's Site Specific Targeting directive for inspections in general industry. VOSHA also has Local Emphasis Programs (LEPs) in falls and trenching/excavation. In this section Region I analyzes VOSHA's effectiveness in targeting high-hazard employers for inspections using SAMM measures #8 (Percent of Programmed Inspections with S/W/R Violations) and #9 (Average Violations per Inspection with Violations).

- **Percent of Programmed Inspections with S/W/R Violations**

SAMM #8 is useful in evaluating the effectiveness of a State's inspection targeting program because it measures the percent of *programmed* inspections with (S/W/R) violations. States should focus their programmed inspections on the highest risk industries and worksites. If the State's percent of programmed inspections with S/W/R violations is below the standard for this measure, it may indicate that the State is not effectively targeting high hazard industries.

VOSHA's FY 2012 results for SAMM #8 shows that of a total of 91 safety programmed inspections conducted by VOSHA in FY 2012, 64 (70.33 percent) had S/W/R violations cited. Of 30 health-related programmed inspections, 15 (50.00 percent) had S/W/R violations cited.

Since FY 2009, VOSHA has consistently performed better than the national standard for safety-related programmed inspections. For health-related programmed inspections, the program performed better than the national standard in FY 2009 and in FY 2010, but dropped below the standard in FY 2011 and FY 2012. The FY 2013 SAMM for the first quarter indicates that VOSHA is just slightly below the standard in SAMM #8 for safety inspections and far below the standard for health inspections.[5]

Percent of Programmed Inspections with S/W/R Violations (SAMM #8)								
	FY2009		**FY2010**		**FY2011**		**FY 2012**	
	VOSHA (%)	**National Data (%)**	**VOSHA (%)**	**National Data (%)**	**VOSHA (%)**	**National Data (%)**	**VOSHA (%)**	**National Data (%)**
Safety	76.12	**58.5**	60.34	**58.4**	70.45	**58.5**	70.33	**58.5**
Health	54.55	**51.1**	58.33	**50.9**	47.22	**51.7**	50.00	**53.0**

- **Average Number of Serious/Willful/Repeat and Other-than-Serious Violations per Inspection with Violations**

SAMM #9 (which measures the average number of S/W/R and Other-than-Serious violations per inspection with violations) can also be used to evaluate the effectiveness of the State in targeting high-hazard industries and work sites for enforcement activities. In FY 2012, VOSHA conducted 185 inspections that had 415 S/W/R violations cited (for an average of 2.24 S/W/R violations per inspection with violations cited). This average is higher (better) than the national average of 2.1 and is an improvement over the VOSHA FY 2011 average of 1.99. For the average number of Other-than-Serious violations per inspection with violations, VOSHA continues to mark below the national average.[6]

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[5] According to the SAMM for the first quarter of FY 2013, which was run on February 7, 2013, VOSHA had the following results for SAMM #8: VOSHA (safety)—57.53 percent/ National Data Standard (safety)—58.5%;VOSHA (health)—19.35%/National Data Standard (health)—53.0%.

[6] FY 2013 first quarter data for SAMM #9: S/W/R—VOSHA—2.20/National Data Standard—2.1; Other-than-Serious—VOSHA--.38/National Data Standard—1.2

Average Violations per Inspection with Violations (SAMM #9)								
	FY 2009		**FY 2010**		**FY 2011**		**FY 2012**	
	VOSHA	**National Data**	**VOSHA**	**National Data**	**VOSHA**	**National Data**	**VOSHA**	**National Data**
Avg. number of S/W/R violations per inspection with violations	1.74	2.1	1.73	2.1	1.99	2.1	2.24	2.1
Avg. number of Other-than-Serious violations per inspection with violations	.71	1.2	.85	1.2	.71	1.2	.50	1.2

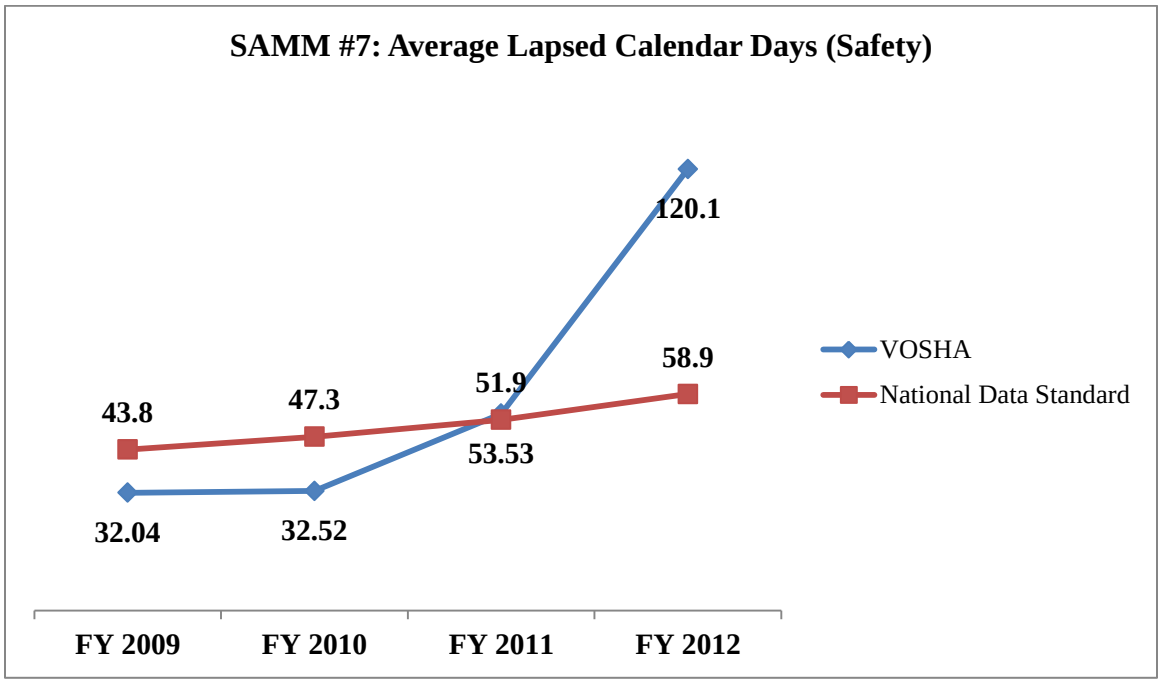
As discussed under Finding #12-10 (formerly #11-6), which relates to CSHOs not citing all apparent violations, VOSHA's average for SAMM #9 may be the result of CSHOs overlooking citing some Other-than-Serious violations. During quarterly discussions, Region I will track VOSHA's results for this measure, and take a closer look at whether CSHOs are citing all apparent violations during the next onsite case file review.

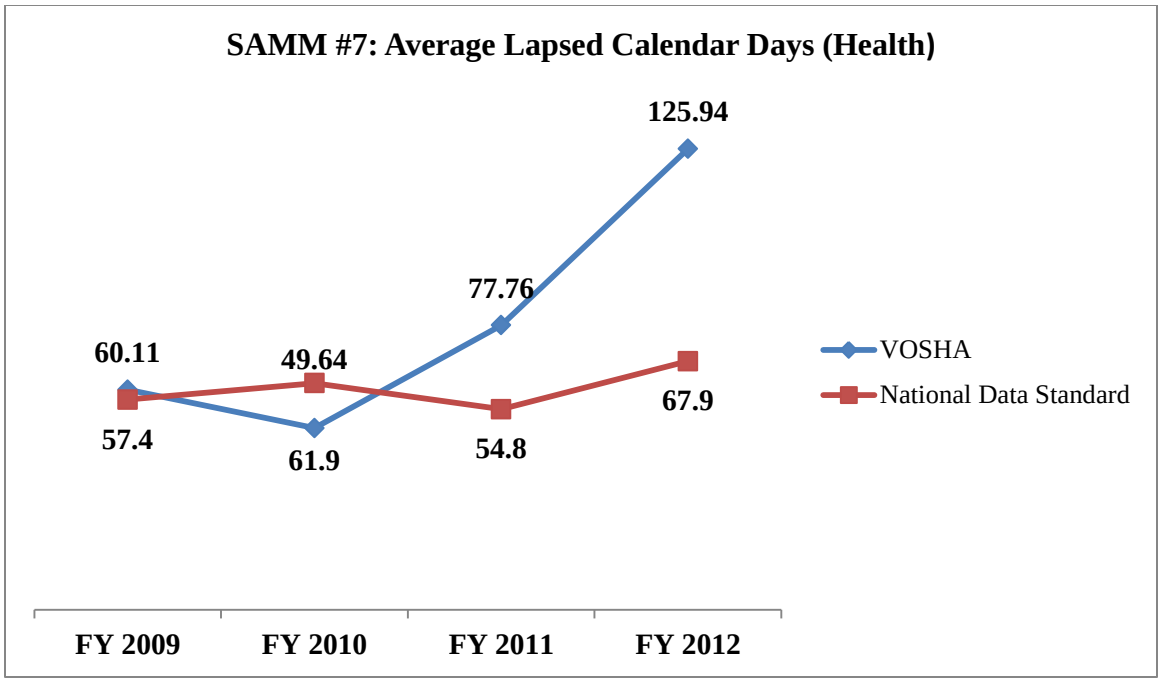
Citations and Penalties

SAMM #7 calculates the average lapse days from opening conference to citation issuance in terms of *calendar* days. As shown in the charts below, VOSHA's lapse time began increasing for both safety and health in FY 2011, and in FY 2012, it was even higher.

In FY 2011, the program attributed this increase in lapse time to several factors, such as the director's prolonged absence during the fourth quarter due to medical leave and the fact that the VOSHA compliance chief was tied up for a significant portion of the fourth quarter (from early September to mid-October) with Tropical Storm Irene emergency response efforts. According to the program, both of these factors delayed management's review of case files and the issuance of citations.

VOSHA began FY 2012 having to catch up on citation issuances that were long overdue from the previous fiscal year. Unfortunately, VOSHA was unsuccessful in decreasing its lapse times in FY 2012, and concluded FY 2012 with lapse times for both safety and health that were far greater than those that it had at the end of FY 2011. As of December 31, 2012 (the end of the first quarter of FY 2013), the program's lapse times of 96 days for safety and 86 days for health were still far above the standards.


SAMM #7: Average Lapsed Calendar Days (Safety)
120.1
58.9
51.9
43.8
47.3
53.53
32.04
32.52
FY 2009
FY 2010
FY 2011
FY 2012
VOSHA
National Data Standard



Finding #12-31: SAMM #7 (Average Number of Calendar Days from Opening Conference to Citation Issue)—VOSHA's FY 2012 average of 120.10 days did not meet the standard of 55.9 days for safety; VOSHA's FY 2012 average of 125.94 days did not meet the standard of 67.9 days for health.

Recommendation #12-31: By the end of FY 2013, VOSHA should decrease its lapse times for both safety and health. SAMM #7 is included in the FY 2013 SAMM for information purposes only. In FY 2013, VOSHA should meet the standards in SAMM #23 (Field Compliance Average Lapse Time).[7]

- **Average Initial Penalty per Serious Violation (Private Sector Only)**

VOSHA has not adopted the penalty structure described in Chapter 6 of the FOM, and has not adopted the changes to OSHA's administrative penalty calculation system as set forth in OSHA's Administrative Penalty Information Bulletin.

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[7] FY 2013 first quarter results for SAMM #7: VOSHA had 96.22 average lapse days for safety compared to the National Data standard of 55.9 average lapse days; for health, VOSHA's average lapse time was 86.05 days compared to the National Data Standard of 68.0 average lapse days. SAMM #23 in the FY 2013 report for the first quarter shows that VOSHA still needs to lower its average lapse times: VOSHA (safety)—73.20 days/National Data Standard—42.1 days; VOSHA (health)—63.80 days/National Data Standard—52.8 days.

For SAMM #10 (Average Initial Penalty per Serious Violation) VOSHA ended FY 2012 with an average of $1,249.25, compared to the national average of $1,990.5. As shown in the table below, VOSHA has experienced a steady increase in this average over the past four fiscal years. VOSHA's FY 2012 average increased by 50 percent over its FY 2009 average (but so did the national data standard). The table below also shows that the difference between VOSHA's average and the average for the national data standard was greater in FY 2012 than in any of the past four fiscal years.

Average Initial Penalty per Serious Violation ($) (SAMM #10)				
	National Data Standard	**VOSHA**	**Difference**	**VOSHA as % of National Data Standard**
FY 2009	1,335	833	502	62
FY 2010	1,515	1065	450	70
FY 2011	1,680	1142	538	68
FY 2012	1,991	1249	742	63

- **Average Current Penalty per Serious Violation**

IMIS Enforcement Statistics show that VOSHA's Average Current Penalty per Serious Violation has increased steadily since FY 2009 as well, but VOSHA's FY 2012 average of $1062.50 was about 50 percent below Federal OSHA's average of $2,153. However, VOSHA did have a higher average than the average of $992 for all State Plans nationwide.

Average Current Penalty per Serious Violation ($)				
	Federal OSHA	**VOSHA**	**Difference**	**VOSHA as % of Federal OSHA**
FY 2009	970	592	378	61
FY 2010	1,053	736	317	70
FY 2011	2,133	889	1,244	42
FY 2012	2,153	1,063	1,090	49

Abatement

- **Abatement Verification**

SAMM #6 measures the State's Percent of Serious, Willful, Repeat and Unclassified Violations verified abated within the abatement due date plus 30 calendar days. VOSHA's FY 2011 percentage of 97.05 (for private sector inspections) was the state's highest over the past four fiscal years. In FY 2012, VOSHA had the lowest percentage of S/W/R violations (private sector) verified in the past four fiscal years. VOSHA' percentage of S/W/R violations (public sector) was also the lowest over the same four-year period.

Percent of S/W/R Violations Verified (SAMM #6)								
	FY 2009		**FY 2010**		**FY 2011**		**FY 2012**	
	Private	**Public**	**Private**	**Public**	**Private**	**Public**	**Private**	**Public**
Percent S/W/R Violations Verified Timely	93.81	93.55	89.86	84.78	97.05	100	78.89	52.94

Finding #12-32: Abatement verification—VOSHA did not meet the standards (for both the private and public sectors) in SAMM #6 for Percent of S/W/R Verified. In FY 2012, VOSHA had the lowest percentage of S/W/R violations verified for both the private and public sectors in the past four fiscal years.

Recommendation #12-32: VOSHA should meet the standard in SAMM #22 (Open, Non-contested Cases with Abatement Incomplete > 60 Calendar Days). SAMM #6 is included in the FY 2013 SAMM for information purposes only; the new SAMM measure for abatement verification will be SAMM #22.

Employee and Union Involvement

Region I did not identify any significant issues with employee and union involvement in any of the previous FAME reports. However, Region I will review VOSHA's performance with regard to this element during the onsite case file review for the FY 2013 FAME.

REVIEW PROCEDURES (Informal conferences; Formal review of citations)

Region I discusses VOSHA's informal conference procedures under Finding #12-14 (formerly #11-22). As discussed under this finding, the Region's onsite case file review for the FY 2011 FAME identified cases in which VOSHA held informal conferences after the 20 calendar-day period had expired. During the next onsite case file review, Region I will assess the extent to which VOSHA's corrective measures have been effective in resolving this finding.

In addition to this finding, it appears that VOSHA has not been entering informal conferences into the IMIS system. In response to this finding, the worker's compensation director claimed that 15 informal conferences have been conducted during the first four months of FY 2013, but that none of them were ever recorded in the IMIS system. In Finding #12-34, Region I recommends that at least some VOSHA staff receive training on the IMIS system so that VOSHA correctly follows all procedures for IMIS data entries.

STANDARD ACTIONS AND FEDERAL PROGRAM CHANGE (FPC) ADOPTIONS

VOSHA did not adopt CPL-02-00-154 (Longshoring and Marine Terminals "Tool Shed" Directive). VOSHA adopted all other FPCs in a form identical to that of Federal OSHA, and responded with its intention to adopt or not to adopt on or before the due date.

VOSHA intended to adopt both of the standards issued by OSHA in FY 2012, but as shown in the table below, VOSHA did not complete the adoption of the *Revising Standards Referenced in* the Acetylene Standard; the program completed the adoption of the *Globally Harmonized System of Classification Standard*, but it did not become effective until October 12, 2012, which was beyond the adoption due date. See Finding #12-21(formerly #11-23) in Section III of this report.

In FY 2012, VOSHA also intended to complete the adoption process for *29 CFR 1910, 1915, Working Conditions in Shipyards.* The State indicated in May 2011 that it would begin the process of adopting this standard once the adoption of 29 CFR 1915 was complete (which occurred on February 24, 2012). However, the adoption of this standard has not been completed. When last consulted regarding this particular standard adoption, the workers' compensation director said that he was not aware that VOSHA had intended to adopt this standard.

VARIANCES

In FY 2012, VOSHA had no activity with respect to variances.

PUBLIC EMPLOYEE PROGRAM

In FY 2012, VOSHA planned to conduct 40 inspections in public sector establishments. This represents 10 percent of the total number of inspections that the State planned to conduct in FY 2012. By the end of the fiscal year, VOSHA had conducted 36 public sector inspections. This figure is 9 percent of the 400 inspections originally planned, and 18 percent of the 306 inspections that were actually conducted.

According to VOSHA's FY 2012 Annual Performance Plan,[8] there are approximately 1, 704 public sector workplaces in the State of Vermont, which represents 7 percent of all workplaces (private and public sector) in the State. Therefore, in FY 2012, VOSHA's percentage of public sector inspections (9 percent) exceeded the percentage of all worksites in the State that are public sector (7 percent).

As discussed earlier with regard to SAMM #6 (Percent of S/W/R Violations Verified), VOSHA fell far below the 100 percent standard in FY 2012, with a percentage of 53 for public sector inspections.

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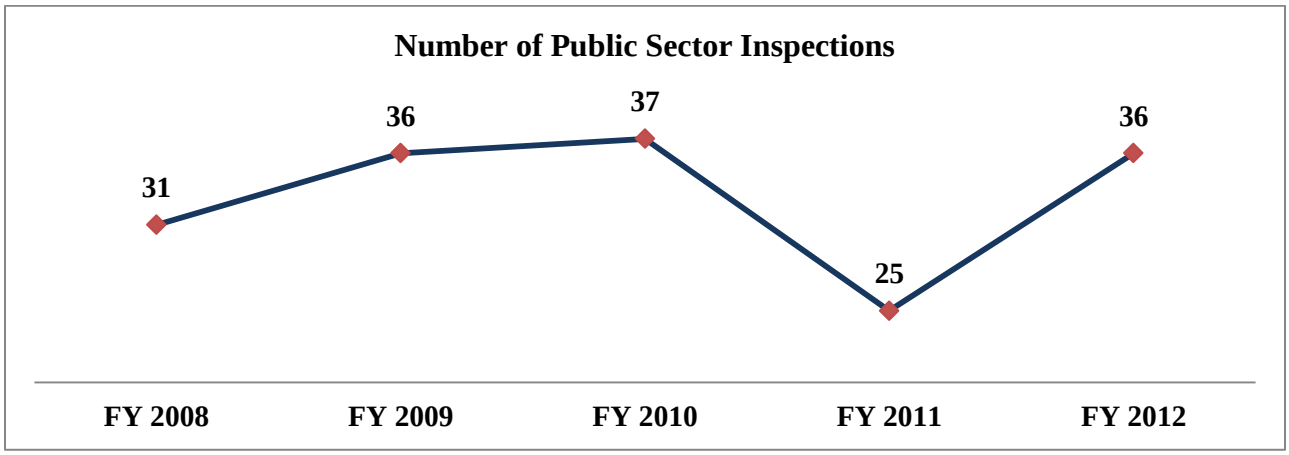
[8] According to VOSHA's FY 2012 Annual Performance Plan, there are a total of 24,422 work sites in the State of Vermont (1,704 public sector sites and 22,718 private sector establishments).

VOSHA also did not meet the 100 percent standard for private sector inspections, having verified 79 percent of all S/W/R violations as abated. However, for the public sector, VOSHA's percentage was even lower than for private sector inspections; therefore, VOSHA must focus on doing a better job in terms of tracking and verifying abatements for public sector inspections.

In terms of public sector consultation visits, Project WorkSAFE conducted 25 visits in FY 2012 (which included 10 safety, 7 health and 8 combined safety/health visits). Thus, Project WorkSAFE exceeded its goal of 20 public sector visits.



VOLUNTARY COMPLIANCE PROGRAMS (VPP, ALLIANCES)

- **Green Mountain VPP Program**

During the onsite review in FY 2011, Region I found that a number of the signed approval letters were not contained in the VPP files, and recommended that VOSHA must obtain copies of these signed letters and include them in the appropriate files.

Region I also found that some complaints at VPP sites were handled by the VPP manager. Region I advised VOSHA that the VPP manager may not become involved in enforcement issues. If citations have been issued, the VPP manager may not become involved until all items are abated and the case has been settled.

In response to these findings, the VPP manager is making sure that signed approval letters are now placed in the case files. VOSHA has also implemented a policy whereby only compliance staff will investigate complaints, referral and/or fatalities at VPP sites. In addition, CSHOs are prohibited from conducting complaint investigations at sites they have evaluated in the past. Region I will verify that these corrective actions have been taken during the next onsite case file review. See Findings #12-19 (formerly #11-33) and #12-20 (formerly#11-34).

- **Alliances**

VOSHA currently has two active Alliances: Vermont Rural Water Association and Vermont Safety and Health Council.

In compliance with CSP 04-01-001, OSHA's Alliance Programs directive, VOSHA's Alliances conduct the following core activities: training and education; outreach and communication; and promoting the national dialogue on workplace safety and health. However, in the FY 2011 FAME, Region I found that VOSHA's Alliance documentation did not comply with the directive's documentation requirements in Section XII, Program Requirements. For example, annual reports had not been completed. In addition, the electronically signed Alliance copies were not posted on the VOSHA Web site, as well as any updates, milestones, success stories, events, or photographs.

In the CAP, VOSHA planned to complete annual reports and include them in the appropriate Alliance files, and post the items mentioned above (such as photos and copies of the Alliances, etc.) on the VOSHA website. VOSHA's Compliance Assistance Specialist (CAS), the staff member responsible for managing VOSHA's Alliance program, has confirmed that he has been including all required documents in the program's Alliance files. However, the CAS also acknowledges that he does not have the technical expertise needed to post Alliance-related information on the current VOSHA website, and cannot do so without the assistance of a web expert who works in an office in another part of the State. The CAS anticipates that he will have no problem posting the Alliance information on the newly updated site, and is planning to do this when the new site is finally launched. See Finding #12-26 (formerly #11-35).

PUBLIC SECTOR ON-SITE CONSULTATION PROGRAM

In FY 2012, Project WorkSAFE conducted a total of 31 visits (23 initial; 3 training and assistance; and 5 follow-up). All visits conducted in FY 2012 included participation by worksite employees. Consultants identified 163 hazards; no Other-than-Serious hazards were identified by the project. In addition, Project WorkSAFE removed 2,070 workers from risk of serious injury. Project WorkSAFE did not refer any employers to enforcement in FY 2012.

In FY 2011, most of Project WorkSAFE's statistics were higher than in FY 2012, as shown in the table below.

Project WorkSAFE Public Sector Consultation Statistics				
	No. of Visits Opened	**No. of Employees Trained**	**No. of Hazards Identified/% Serious**	**Total No. of Workers Removed from Risk**
FY 2012	43	139	163/99%	2,081
FY 2011	31	336	202/93%	2,457

DISCRIMINATION

- **SAMMs**

VOSHA has met the following three SAMM measures as shown in the charts below. However, these three measures (all that are currently used to measure discrimination) do not provide an accurate overall assessment of the states' performance.

SAMM #13- VOSHA completed 50 percent of its closed cases within 90 days, compared to the national average of 27 percent.

Percent of 11(c) Investigations Completed within 90 Days (SAMM #13)			
Total Cases Completed in FY 2012	**Cases Completed within 90 Days**	**Percent**	**Percent Goal**
10	5	50	100

SAMM #14 – VOSHA found merit to 30 percent of its closed cases, compared to a national 3-year average of 24 percent.

Percent of 11 (c) Complaints that are Meritorious (Three years of national data) (SAMM #14)			
	Total Cases Completed	**Total Merit Cases Completed in FY 2012**	**Percent Meritorious**
VOSHA	10	3	30.0
National	6,921	1,619	23.4

SAMM #15 – VOSHA settled 100 percent of its merit cases, compared with a national average of 89.2 percent.

Percent of Meritorious 11(c) Complainants that are Settled (Three years of national data) (SAMM #15)			
	Total Merit Cases	**Total Merit Cases Settled in FY 2012**	**Percent Settled**
VOSHA	3	3	100.0
National	1,619	1,444	89.2

PROGRAM ADMINISTRATION

- Employee Training

In the FY 2011 FAME, Region I found that none of VOSHA's CSHOs had completed the mandatory training track (prescribed by OTI's training directive) within the time frame permitted by the directive. In response to this analysis, Region I recommended that all CSHOs complete their outstanding courses by December 31, 2013.

This finding remains "Open" because VOSHA has indicated that at least six CSHOs are not slated to complete the CSHO training track until sometime in FY 2014 (Finding #12-27). The Region's analysis of the CSHOs' training histories shows that as of March 19, 2013, seven of nine veteran CSHOs had not completed the basic training track.

As discussed under Finding #27 (formerly #11-39) VOSHA provided a staff training plan in conjunction with its CAP that lists some of the initial training track courses that CSHOs have completed, and some in which they are either enrolled or waitlisted. However, this plan does not provide a complete picture of each CSHO's progress in completing the mandatory training track, because it does not indicate the specific courses that each CSHO still needs to take in order to fulfill the core training requirements.

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Finding #12-33: Training-VOSHA does not track each CSHO's progress in completing all of the core training requirements.

Recommendation #12-33: VOSHA should use the Region's training analysis (which has been provided to the worker's compensation director) to develop a Training Plan Progress Report for each CSHO so that individual CSHO's progress in completing the basic training required by OTI can be monitored and tracked.

In its CAP, VOSHA states that its "training administrator" tracks "CSHO enrollments and waitlist status and notifies supervisors and CSHOs when they have moved up on the list." In actuality, from August 2012 (when the staff member who performed these duties retired) until mid-March 2013, VOSHA had no personnel on board who knew how to use LearningLink—OSHA's computerized system for performing enrollments at OTI.

For several months, the Regional training coordinator has been assisting VOSHA by enrolling the program's staff in OSHA's training webinars. This is a duty that is normally performed by the State Plan's own training coordinator. In February 2013, the workers' compensation director realized that the person who he thought was taking on the duties of VOSHA's training coordinator did not have access to the LearningLink system, nor did this person have the training needed to use the system to perform enrollments in OSHA's training courses.

Since that time, the OSHA Regional training coordinator has been working with OSHA's Department of Training and Education to set up a LearningLink account for this person, and to help this person to get the training she needs to effectively use the system. Having an individual

on staff who can use this system is critical for the program. On March 19, 2013, the VOSHA staff person was notified by DTE that her LearningLink account had been set up and that she could begin using the system.

- **IMIS Management**

According to VOSHA's CAP, "supervisors" are running various IMIS reports weekly to track performance with regard to SAMM measures that were not met. In fact, the director of workers' compensation who is currently running the VOSHA program has had no training on running IMIS reports and how to use them to monitor performance.

In addition, the Region has determined that VOSHA is not entering sufficient data on informal conferences into the IMIS system. For example, a detailed IMIS scan run by the Region on February 19, 2013 showed that no informal conferences were held for any of the 123 inspections opened from October 1, 2012 through January 31, 2013.[9] The State claims that "[a]t least 15 informal conferences were held in the first four months of FY 2013" but acknowledges that none of them were ever recorded in the IMIS system. With regard to VOSHA's whistleblower cases, the Region continues to identify errors in VOSHA's IMIS entries. Mistakes include incorrect allegation codes chosen, no statement of protected activity in the allegation summary, no information entered on settled cases, and wrong determination codes entered.

Finding #12-34: IMIS Reports—VOSHA management is not able to utilize IMIS reports to track performance or verify completeness of work. In addition, many inaccuracies in data entries for whistleblower cases have been identified.

Recommendation #12-34: IMIS Reports—VOSHA must ensure that appropriate staff members receive training on how to run and utilize IMIS reports for enforcement and whistleblower cases.

- **State Internal Evaluation Plan (SIEP)**

VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM). At the Region I OSHA Family Meeting held in June 2011, and again in June 2012, Region I requested that VOSHA develop a SIEP that meets the criteria outlined in the SPPPM. In past years, VOSHA had designated the SAMM as its SIEP.

In its FY 2012 SOAR, VOSHA included a draft SIEP and stated that this SIEP could not be implemented until a permanent supervisor was in place. Therefore, Region I continues to recommend that VOSHA finalize and implement a SIEP (by the end of FY 2013). See Finding

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[9] According to the IMIS Enforcement Statistics report of December 17, 2012, 29 (15.7%) of VOSHA's Not-In-Compliance Inspections (185) had informal conferences in FY 2012.

#12-28 (formerly #11-40). The Region is available to assist VOSHA with the development of an internal evaluation procedure.

V. State Progress in Achieving Annual Performance Goals

INSPECTIONS

- **Projected Compared to Actual**

During FY 2012, VOSHA completed a total of 306 inspections of 400 projected. [10] The tables below break out of the number of inspections projected and completed by safety and health compliance officers for the past three fiscal years.

FY 2012 Inspections			
	Projected	**Actual**	**Actual as Percent of Number Projected**
Safety	300	200	67
Health	100	106	106
TOTAL	**400**	**306**	**77**

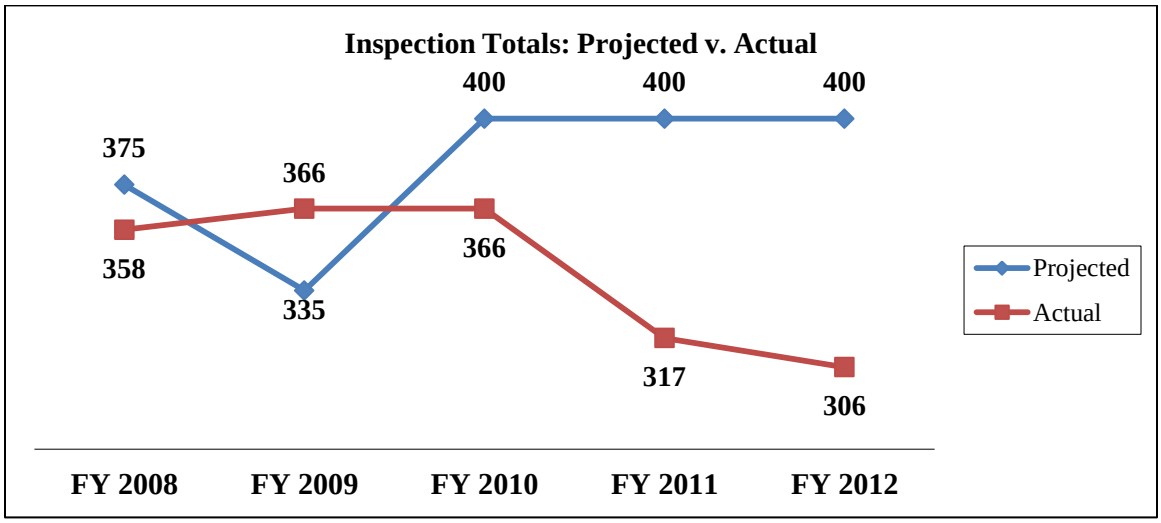
FY 2011 Inspections			
	Projected	**Actual**	**Actual as Percent of Number Projected**
Safety	300	217	72
Health	100	100	100
TOTAL	**400**	**317**	**80**

FY 2010 Inspections			
	Projected	**Actual**	**Actual as Percent of Number Projected**
Safety	300	267	89
Health	100	99	99
TOTAL	**400**	**366**	**92**

As shown in the chart below, VOSHA's total number of inspections conducted in FY 2012 was the lowest over the past five fiscal years. According to the VOSHA SOAR, the State was hampered by the fact that it was down one CSHO for most of the fiscal year; it had an unusually

[10] Source: IMIS Inspection Report of December 17, 2012. According to VOSHA's SOAR, the State opened 310 inspections in FY 2012.

high number of whistleblower cases that were opened during the fiscal year; and it also had by having to conduct more fatality investigations than what is normal for the program.[11]



Two of VOSHA's CSHOs also function as the program's part-time whistleblower investigators. For FY 2013, VOSHA proposed reducing its annual inspection goal of 400 inspections to 350 because the two CSHOs who handle the whistleblower complaints could not be expected to conduct the same number of inspections that they normally would if they devoted 100 percent of their time to enforcement. Region I agreed to this proposal, but notes that the VOSHA managers were not effective in ensuring that all the program's CSHOs were meeting their individual inspection goals.

For example, VOSHA's inspection activity was extremely sluggish during the first half of FY 2012. Mid-way through the fiscal year, the program had only conducted 114 inspections (or just about 29 percent of its goal of 400). In January 2012, VOSHA conducted only three inspections, and during the second and third quarters, one CSHO conducted 17 "No Inspections." [12]

In light of this scenario, Region I began tracking VOSHA's inspection activity on a weekly basis, and advised the VOSHA managers that each safety CSHO should open at least one new inspection per week and close at least one inspection per week. Health CSHOs were advised to do the same bi-weekly. The table below shows that VOSHA's inspection activity increased during the second half of the fiscal year as the program implemented this strategy and the Region

[11] According to the SOAR, "12 discrimination complaints were opened in FY 2012, which is much higher than the number of whistleblower investigations that the program typically handles during any fiscal year."

[12] This CSHO conducted a total of 18 "No Inspections" in FY 2012.

continued its weekly monitoring of VOSHA's inspection activity; Region I also continued the monthly meetings between the Regional Administrator and the Vermont Commissioner of Labor.

FY 2012 Monthly and Quarterly Inspection Totals[13]												
	OCT	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**
Monthly Totals	20	19	20	3	23	29	28	20	38	29	36	38
Quarterly Totals	59			55			86			83		

FY 2012 was the fourth year of VOSHA's five-year strategic plan, which extends from FY 2009 to FY 2013. In developing its five-year strategic plan, VOSHA planned to achieve a 15 percent reduction in industries' Bureau of Labor Statistics (BLS) Days Away, Restrictions and Transfers (DART) rates, and a 25 percent reduction in fatalities, from the 2007 baseline rates. The extent to which VOSHA meets these goals will be assessed at the end of the five-year plan (FY 2013).

According to a table in VOSHA's SOAR, DART rates decreased in each of VOSHA's strategic plan sectors (private sector, manufacturing, construction and public sector) in 2011 from the rates in the 2007 baseline year. However, the program provided no analysis in its SOAR of the extent to which VOSHA actually affected these reductions.

The next two tables summarize VOSHA's progress in meeting its FY 2012 Annual Performance Plan and objectives. The information presented in these tables was derived from the VOSHA's FY 2012 SOAR.

13 Source: IMIS Inspection Report of January 28, 2013.

<table>
<tr><th>Annual Performance Goal</th><th>Outcome Measures</th><th>Results</th></tr>
<tr>
<td>1.1: Reduce the rate of workplace injuries and illnesses in construction by 3% and reduce fatalities by 25%.

Areas of Emphasis:
• Residential & commercial building Highway, street & bridge construction
• Roofing
• Falls from elevation
• Trenching
• Struck by
• Electrical
• Noise
• Silica
• Youth (Outreach)
• Workzone Safety</td>
<td>Intermediate outcome Measure: Conduct 200 inspections in the construction industry

Primary Outcome Measure: VOSHA will effect a 15 percent reduction in the DART rate (to be evaluated at the conclusion of the five-year strategic plan).</td>
<td>Total inspections: 306
Total inspections in the construction industry: 140
Percent of goal achieved (construction inspections): 70

From 2007 to 2011, the DART rate for the construction industry decreased by 29.3 percent.

The table below compares VOSHA’s projected number of inspections in the emphasis areas in construction to the actual number conducted.
<table>
<tr><th>Area of Emphasis</th><th>Projected</th><th>Actual</th></tr>
<tr><td>Residential & commercial building</td><td>150</td><td>129</td></tr>
<tr><td>Highway, street & bridge construction</td><td>30</td><td>13</td></tr>
<tr><td>- Roofing</td><td>20</td><td>13</td></tr>
<tr><td>Falls from elevation</td><td>--</td><td>*86 LEP inspections)</td></tr>
<tr><td>Trenching</td><td>--</td><td>*23 LEP inspections and 8 NEP inspections</td></tr>
<tr><td>Struck by</td><td>--</td><td>-</td></tr>
<tr><td>Electrical</td><td>--</td><td>-</td></tr>
<tr><td>Noise</td><td>--</td><td>-</td></tr>
<tr><td>Silica</td><td>--</td><td>-</td></tr>
<tr><td>Workzone Safety</td><td>--</td><td>-</td></tr>
</table>
VOSHA’s compliance assistance interventions in the construction industry covered all emphasis areas. In addition, VOSHA provided OSHA 10-hour training to workers in the field of construction as well as youth and other inexperienced workers.</td>
</tr>
</table>

*Region I is using Federal data (which differs from the State’s data) from an IMIS query run by the Directorate of Information and Technology on January 29, 2013.

<table>
<tr><th>Annual Performance Goal</th><th>Outcome Measures</th><th>Results</th></tr>
<tr>
<td>1.2: Reduce the rate of workplace injuries and illnesses in general industry by 3% and reduce fatalities by 25%.

Areas of Emphasis:
• Food Processing
• Lumber & Wood Products
• Small Business
• Large Farm Initiative
• Targeted NAICS
• Amputations
• Isocyanates, Asthma & Allergies
• Electrical
• Powered Industrial Trucks (PIT)
• Noise
• Silica
• Transportation
• Youth Workers</td>
<td>Intermediate outcome Measure: Conduct 200 inspections in general industry.

Primary Outcome Measure: VOSHA will effect a 15 percent reduction in the DART rate (to be evaluated at the conclusion of the five-year strategic plan).</td>
<td>Total inspections: 306
Total inspections in non-construction: 166
Percent of goal achieved (non-construction inspections): 83

From 2007 to 2011, the DART rate for manufacturing decreased by 26.5 percent.

The table below compares VOSHA’s projected number of inspections in the emphasis areas in general industry to the actual number conducted.
<table>
<tr><th>Area of Emphasis</th><th>Goal</th><th>Actual</th></tr>
<tr><td>Food Processing</td><td>20</td><td>3</td></tr>
<tr><td>Lumber & Wood Products</td><td>12</td><td>5</td></tr>
<tr><td>Targeted NAICS</td><td>60
(all sites on list)</td><td>47</td></tr>
<tr><td>Amputations</td><td>--</td><td>*2</td></tr>
<tr><td>Isocyanates, Asthma, & Allergies</td><td>--</td><td>6</td></tr>
<tr><td>Electrical</td><td>Review electrical hazards on all inspections</td><td>Completed</td></tr>
<tr><td>PIT</td><td>Review PIT hazards on all inspections</td><td>Completed</td></tr>
<tr><td>Noise</td><td>--</td><td>3</td></tr>
<tr><td>Silica</td><td>--</td><td>--</td></tr>
</table>
VOSHA’s compliance assistance interventions in general industry covered all emphasis areas. In addition, VOSHA provided OSHA 10-hour training to workers in general industry as well as youth and other inexperienced workers.</td>
</tr>
</table>

*Region I is using Federal data (which differs from the State’s data) from an IMIS query run by the Directorate of Information and Technology on January 29, 2013.

VI. Other Areas of Note

Region I did not identify any other areas of note.

Appendix A – New and Continued Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec #	Findings	Recommendations	FY11 #
12-1	Fatality Investigations—VOSHA did not meet the five-day time frame for sending the standard information letter to the next of kin of the fatality victim.	Ensure that fatality victims' next of kin receive an initial standard information letter "within 5 working days of determining the victim's identity and verifying the proper address where communications should be sent." Ensure that all procedures in the FOM, Chapter 11, Section G, Families of Victims, are followed. *(Corrective action complete, awaiting verification)*	11-4
12-2	Gravity and Probability Assessments—In some cases, VOSHA is not properly assessing the probability and severity of violations. The program tends to assess lower probability and severity than warranted.	Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments. *(Corrective action complete, awaiting verification)*	11-5
12-3	Field Notes—Some case files did not contain CSHOs' field notes.	Ensure that case files contain CSHOs' filed notes, in accordance with the FOM, Chapter 5. *(Corrective action complete, awaiting verification)*	11-6
12-4	Evidence of Violations—In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.	Ensure that case files contain adequate evidence to support all violations cited, in accordance with the procedures set forth in Chapter 4 of the FOM. *(Corrective action complete, awaiting verification)*	11-7
12-5	Establishing Employer Knowledge of the Hazardous Condition—The CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."	Ensure that CSHOs record evidence to substantiate that the employer could have known of the hazardous condition through reasonable diligence. *(Corrective action complete, awaiting verification)*	11-9
12-6	Complaints—Some case files did not contain any documentation that a letter had been sent to the complainant notifying them that citations had been issued to the employer.	In cases where citations have been issued, VOSHA must adhere to Chapter 9 of the FOM which provides for complainant notification of inspection results. *(Corrective action complete, awaiting verification)*	11-10
12-7	Fatality Cases – VOSHA did not follow proper Fatality Investigative Procedures as required in the FOM, Chapter 11, Section II, C., in that the State did not thoroughly investigate the fatality and attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and any effect the violation(s) had on the incident (FOM, Chapter 11. Section II, C).VOSHA did not follow proper Fatality Interview Procedures as required in the FOM, Chapter 11, Section II, D., in that the State did not identify and interview all persons with first-hand knowledge of the incident.	VOSHA must ensure that CSHOs and managers follow all requirements for fatality investigations as set forth in the FOM, Chapter 11 (Imminent Danger, Fatality, Catastrophe and Emergency Response). Region I will review all VOSHA fatality cases and ensure correction of all fatality-related recommendations in this report." *(Corrective action complete, awaiting verification)*	11-11

Rec #	Findings	Recommendations	FY11 #
	VOSHA did not follow proper Fatality Documentation Procedures as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Incident data, such as how and why the incident occurred; the physical layout of the worksite; sketches/drawings; measurements; video/audio/photos to identify sources, and whether the accident was work related. VOSHA did not follow proper Fatality Documentation Procedures as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Equipment or Process Involved, such as equipment type; manufacturer; model; manufacturer's instructions; Kind of process; Condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.		
12-8	Emphasis programs—VOSHA did not code some inspections for emphasis programs.	CSHOs must properly code all inspections involving emphasis programs. *(Corrective action complete, awaiting verification)*	11-12
12-9	Including air sampling and noise survey forms in case files—Some case files where the CSHO did perform sampling for air contaminants and surveys for noise, the case files either did not contain copies of completed OSHA-91 (air sampling) and OSHA-92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. These forms are used to help support violations cited.	VOSHA must ensure that copies of all air sampling and noise survey forms are included in case files for inspections in which these surveys/samplings have occurred. *(Corrective action complete, awaiting verification)*	11-15
12-10	Citing All Apparent Violations—CSHOs did not cite all apparent violations during inspections, even though evidence of these violations was provided by CSHOs in come case files through photos and written descriptions.	CSHOs must review case file materials to ensure that they cite all apparent violations. Otherwise, hazardous conditions at worksites may continue unabated and cause injuries and illnesses. *(Corrective action complete, awaiting verification)*	11-16
12-11	Violation Classification—VOSHA misclassified some violations as Other-than-Serious that should have been classified as Serious. Some violations should have been classified as Willful, based on the outcome of further investigation, which the program chose not to pursue.	VOSHA must properly classify all violations and thoroughly investigate violations that have the potential to be cited as Willful, and cite them accordingly. *(Corrective action complete, awaiting verification)*	11-18
12-12	Penalty reductions—In some cases, VOSHA improperly granted penalty reductions.	VOSHA must follow the FOM requirements in Chapter 6 for granting penalty reductions. *(Corrective action complete, awaiting verification)*	11-19
12-13	Abatement documentation—Some case files were closed without having any documentation of abatement or having inadequate	VOSHA must ensure that all documentation of abatement is present in case files before they are closed. *(Corrective action*	11-21

Rec #	Findings	Recommendations	FY11 #
	documentation.	*complete, awaiting verification)*	
12-14	Informal Conferences—In some cases, the informal conference was held after the 20 calendar-day period had expired.	VOSHA must adhere to its own guidelines which require not extending the 20-day calendar period for holding informal conferences. *(Corrective action complete, awaiting verification)*	11-22
12-15	Discrimination Investigations--Case files were not tabbed and organized according to the manual.	VOSHA must organize case files in accordance with the format in the 2011 Whistleblower Investigations Manual. *(Corrective action complete, awaiting verification)*	11-24
12-16	Discrimination Investigations--VOSHA's proposed appeals process (which the State submitted in response to Federal Program Change CPL 02-03-004, Section 11 (c) Appeals Program), does not state specify the person who will be responsible for reviewing appealed cases.	Before OSHA can approve VOSHA's proposed appeals process, the State must send a written statement to the Region specifying the person who will be charged with reviewing Section 11 (c) appeals. *(Corrective action complete, awaiting verification)*	11-25
12-17	Discrimination Investigations— VOSHA fails to notify complainants of their rights - the right to dual file, the right to file a CASPA, or the right to file an appeal of VOSHA's determination. Letters were not being sent to the parties.	• VOSHA must send notification and determination letters to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year. • VOSHA has developed a form that it gives to complainants to notify them of their obligations during a discrimination investigation. VOSHA asks the complainants to review and sign the form during the interview. VOSHA must discontinue using this form, because the legal language used throughout the form, in conjunction with the limited timeframe complainants have to review and consider the information given, makes the use of this form overly burdensome for the typical complainant. • Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e. give them 30 days from the date you notify them of their right to appeal. *(Corrective action complete, awaiting verification)*	11-26
12-18	Discrimination Investigations—VOSHA public employee stakeholders are not adequately informed of the rights provided to them under VOSHA's discrimination provisions.	Conduct outreach with stakeholders about employee rights and employer responsibilities. *(Corrective action complete, awaiting verification)*	11-32

Appendix A – New and Continued Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec #	Findings	Recommendations	FY11 #
12-19	VPP—A number of the required signed approval letters were not contained in the VPP files.	VOSHA must obtain copies of these signed letters and include them in the appropriate files. *(Corrective action complete; awaiting verification)*	11-33
12-20	VPP—Complaints at VPP sites were handled by the VPP manager, rather than by a compliance officer.	VOSHA must ensure that all complaints, referrals, and/or fatality/catastrophe investigation at VPP sites are handled by compliance staff. *(Corrective action complete, awaiting verification)*	11-34
12-21	Standards Adoption-- In FY 2012, VOSHA did not complete the adoption of the *Acetylene Standard*, which was one of two final rules issued by OSHA during that year. VOSHA adopted the other final rule—*Globally Harmonized System of Classification*—after the adoption due date. In FY 2012, VOSHA confirmed that it would begin adoption of *29 CFR 1910, 1915, Working Conditions in Shipyards.* Adoption of this standard was required to be completed by November 2, 2011. However, the State said that it could not begin the process of adopting this standard until after it had completed adoption of *29 CFR PART 1915—Occupational Safety and Health Standards for Shipyard Employment*, which occurred on February 24, 2012. To date, 29 CFR 1910, 1915, *Working Conditions in Shipyards*, still has not been adopted by VOSHA.	VOSHA must complete the adoption process for these standards, and for all future standards, VOSHA must adhere to the six-month timeframe in 29 CFR 1953 (a) (1).	11-23
12-22	Discrimination Investigations—Investigators do not receive sufficient training and supervision to conduct proper investigations. Investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions. Those supervising the discrimination program have no training or experience in discrimination investigations.	• Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 (now 21) federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA. • Retrain managers and discrimination investigators in the investigative process, elements of a violation, and case analysis. • Budget for investigators to attend national whistleblower conferences and Regional meetings. • Provide refresher training to staff as needed. When a new supervisor is hired he/she must attend OTI Course # 1420.	11-28
12-23	Discrimination Investigations— Supervisors do not manage the program effectively.	• Supervisors must keep investigators informed about changes to federal OSHA's program. • Supervisors and investigators must confer with OSHA on difficult cases. • VOSHA must consult with the designated OSHA	11-29

Rec #	Findings	Recommendations	FY11 #
		Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed. • VOSHA must send the completed ROI to the designated RSI before closing the case. • VOSHA must send the completed case file to OSHA upon completion of the case.	
12-24	Discrimination Investigations—VOSHA does not have an attorney designated to handle discrimination matters.	VOSHA will designate an attorney with expertise in discriminations matters to advise it on legal issues that arise through all phases of investigation.	11-30
12-25	Discrimination Investigations— VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.	• Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible to employers and employees. • Provide a link to OSHA's website – www.whistleblowers.gov.	11-31
12-26	Alliance Program—VOSHA's Alliance documentation does not comply with the directive's requirements for Alliance documentation in in Section XII.	VOSHA must ensure that annual reports are completed and maintained in the Alliance files and that the electronically signed Alliance copies are posted on the VOSHA Website, along with relevant updates, milestones, success stories, events, or photographs.	11-35
12-27	Training—Seven of the program's nine veteran CSHOs still have not completed all of the courses in the initial compliance training program. According to the CAP, some CSHOs may not complete their training until sometime in 2014.	VOSHA should ensure that all CSHOs who are overdue for completing their mandatory core courses do so as soon as possible.	11-39
12-28	State Internal Evaluation Plan (SIEP)—VOSHA does not have a SIEP that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM).	VOSHA must finalize and implement a SIEP that conforms to the requirements of the SPPPM by June 30, 2013.	11-40
12-29	Inspection Activity—VOSHA fell far short of its inspection goal in FY 2012, by conducting only 306 of 400 inspections projected.	In FY 2013, VOSHA must work harder to meet its goal of 350 inspections in order to adequately protect workers in the State of Vermont.	11-41
12-30	SAMM #2 (Average Number of Days to Initiate Complaint Investigations)—VOSHA's FY 2012 average of 7.72 days did not meet the standard of one day for initiating complaint inspections. Because the program exceeded the one-day standard in FY 2011 (but was below the standard in FY 2009 and FY 2010), it appears that VOSHA's average for this measure has trended upward.	VOSHA must decrease the number of days to initiate complaint investigations so that the average meets the one-day standard.	
12-31	SAMM #7 (Average Number of Calendar Days from Opening	By the end of FY 2013, VOSHA should decrease its lapse times	

Appendix A – New and Continued Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec #	Findings	Recommendations	FY11 #
	Conference to Citation Issue)—VOSHA's FY 2012 average of 120.10 days did not meet the standard of 55.9 days for safety; VOSHA's FY 2012 average of 125.94 days did not meet the standard of 67.9 days for health.	for both safety and health. SAMM #7 is included in the FY 2013 SAMM for information purposes only. In FY 2013, VOSHA should meet the standards in SAMM #23 (Field Compliance Average Lapse Time).	
12-32	SAMM #6 (Abatement verification)—VOSHA did not meet the standards (for both the private and public sectors) in SAMM #6 for Percent of S/W/R Verified. In FY 2012, VOSHA had the lowest percentage of S/W/R violations verified for both the private and public sectors in the past four fiscal years.	In FY 2013, VOSHA should reduce abatement verification time in both the private and public sectors. VOSHA should meet the standard in SAMM #22 (Open, Non-contested Cases with Abatement Incomplete >60 Calendar Days). SAMM #6 is included in the FY 2013 SAMM for information purposes only; the new SAMM measure for abatement verification will be SAMM #22.	
12-33	Training-VOSHA does not track each CSHO's progress in completing all of the core training requirements.	VOSHA should use the Region's training analysis (which has been provided to the worker's compensation director) to develop a Training Plan Progress Report for each CSHO so that individual CSHO's progress in completing the basic training required by OTI can be monitored and tracked .	
12-34	IMIS Reports— VOSHA management is not able to utilize IMIS reports to track performance or verify completeness of work. In addition, many inaccuracies in data entries for whistleblower cases have been identified.	VOSHA must ensure that appropriate staff receives training on how to run and use IMIS reports for enforcement and whistleblower cases.	

Appendix B – Observations Subject to Continued Monitoring

FY 2012 VOSHA State Plan Abridged FAME Report

There were no Observations for fiscal year 2012.

Appendix C - Status of FY 2011 Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
11-1	VOSHA did not meet the following SAMM measures: SAMM #2—Average Number of days to initiate complaint investigations SAMM #6—Percent of S/W/R violations verified (private sector); SAMM#7—Average days from opening conference to citation issue (safety and health); SAMM #8—Percent of programmed inspections with S/W/R violations (health); SAMM #9--Average violations per inspection S/W/R and other; SAMM #10—Average initial penalty per serious violation; and SAMM #11—Percent of total inspections in public sector.	Meet these and all SAMM measures by the end of FY 2012	Supervisory Staff will now use weekly IMIS reports, including Complaint tracking, Referral tracking, Open inspections, Citations pending, Unsatisfied activity, Default violation abatement, and the Inspection summary report, to identify problem areas. Supervisors will then work directly with CSHOs to reduce the time to initiate complaint inspections, and reduce the amount of time between an opening conference and the issuance of citations. In all cases where abatement has not been verified, evidence of verification is being sought. Supervisors, and the division director, are now scrutinizing the assessment of gravity and probability to be sure appropriate penalties are assigned to violations.	The workers' compensation director has indicated that he has been reviewing some case files as described in this corrective action. The program's CSHOs are also assisting with case file reviews.	Closed
11-2	VOSHA did not meet the following SIR measures: C.3.A. Private Sector Serious Safety Violations C.3.B. Private Sector Serious Health Violations C.5.A. Private Sector Average Penalty for Other-than-Serious Safety Violations C.5.B. Private Sector Average	Meet these and all SIR measures by the end of FY 2012	N/A	N/A	Closed

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	Penalty for Other-than-Serious Health Violations C.6.A Private Sector Safety Inspections per 100 Hours C.9. Private Sector Penalty Retention E.3. Penalty Retention (%)				
11-3	Average Violations per Initial Inspection/Average Current Penalty per Serious Violations VOSHA fell short of Federal OSHA's averages. Align these measures more closely with the Federal averages by the end of FY 2012.	FY 2012 year-end Enforcement statistics will indicate that VOSHA meets Federal OSHA's averages.	N/A	N/A .	Closed
11-4	Fatality Investigations— VOSHA did not meet the five-day time frame for sending the standard information letter to the next of kin of the fatality victim.	Ensure that fatality victims' next of kin receive an initial standard information letter "within five working days of determining the victim's identity and verifying the proper address where communications should be sent." Ensure that all procedures of the FOM, Chapter 11, Section G, Families of Victims, are followed.	Fatality victims' next-of-kin will receive all required letters timely (within 5 working days of determining the victim's identity and verifying the proper address where communications should be sent). Chapter 11 of the FOM, Chapter 11, Section G, Families of Victims and OSHA directive CPL 02-00-153— "Communicating OSHA Fatality Inspection Procedures to a Victim's Family," is being followed. Also CSHOs receive copies of the letters for their files. CSHOs and management maintain contact with the victim's next of kin.	The workers' compensation director is now ensuring that the standard information letter is sent to the fatality victims' next of kin in a timely manner, and that copies of the letter are included in the appropriate case files. For six fatalities that occurred from October 1, 2011 to March 31, 2012, VOSHA reports that it was timely in sending all required letters to victims' next-of-kin.	Awaiting Verification

Appendix C - Status of FY 2011 Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
11-5	Gravity Probability Assessments—In some instances, VOSHA is not properly assessing the probability and severity of violations. The program still errs on the side of assessing lower probability and severity than warranted.	Adhere to the guidelines in Chapter 6 of the FOM for severity and probability assessments.	The injury/illness that is listed on the VOSHA-1B is reviewed in combination with the alleged hazard description. If this is found to be appropriate, then the severity is reviewed to make sure that it corresponds to the injury/illness listed. CSHOs must correct any discrepancies. This may include amending the severity/probability or additional documentation to justify the severity/probability the CSHO initially established on the VOSHA-1B. All trenching/excavations violations are automatically classified as high – greater with the base penalty starting at $7,000. Violations of the fall protection standards in construction are treated the same way.	According to the CAP, these corrective actions have been implemented and are ongoing.	Awaiting Verification
11-6	Field Notes—Some case files did not contain CSHOs' field notes.	The reviewing supervisor shall ensure that case files contain CSHOs' field notes, in accordance with the FOM, Chapter 5.	CSHOs are required to submit their field notes with their completed and compiled case files. If the field notes are not with the case file, the CSHO is notified that field notes must be submitted for the file. Each CSHO received an e-mail from the VOSHA manager specifying the information that should be included in the files and the order in which the information must be submitted.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files.	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
			The email also provided information on the proper organization of the documents in the case files.		
11-7	Evidence of Violations—In some cases, the CSHO did not provide adequate evidence to substantiate the violations that were cited.	The reviewing supervisor shall ensure that case files contain adequate evidence to support all violations cited, in accordance with the procedures set forth in Chapter 4 of the FOM.10-07	VOSHA-1Bs are reviewed by the Director of Workers' Compensation and Safety. If there is documentation or evidence lacking, the deficiencies are discussed with the CSHO and the VOSHA-1B is returned for revision.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files.	Awaiting Verification
11-8	S/W/R Violations—VOSHA's percentage of 68 for S/W/R violations in FY 2011were not comparable to Federal OSHA's percentage of 77.	At the end of FY 2012, VOSHA's percentages for S/W/R violations should be comparable to Federal OSHA's.	N/A	N/A	Closed
11-9	Establishing Employer Knowledge of the Hazardous Condition— As in the onsite review for the FY 2010 FAME Report, Region I found (during the most recent review) that the CSHO did not provide adequate evidence to substantiate that the employer could have known of the hazardous condition through "reasonable diligence."	Ensure that CSHOs record evidence to substantiate that the employer could have known of the hazardous condition through reasonable diligence. A sampling of case files to be reviewed by the Region on a quarterly basis will indicate that CSHOs are adequately documenting evidence of violations cited in case files.	VOSHA's-1Bs are reviewed by the Director of Workers' Compensation and Safety. The manager returns the 1Bs the CSHO to fully substantiate employer knowledge of a hazardous condition if the information provided is not sufficient. Additionally, the severity and probability factors are reviewed at the same time.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files.	Awaiting Verification

Appendix C - Status of FY 2011 Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
11-10	Complaints—Some case files did not contain any documentation that a letter had been sent to the complainant notifying them that citations had been issued to the employer.	In cases where citations have been issued, VOSHA must adhere to Chapter 9 of the FOM, Section I, H, which provides for complainant notification of inspection results.	Complainants are notified when citations are issued and are provided with a copy of the citations. Complainants are also notified of the protections afforded to them under section 231 and 232 of the VOSH Act (protection from discrimination for engaging in a protected activity and the VOSHA private right of action). A copy of the notification is placed in the file. The supervisor is reviewing files with the CSHO assigned to the investigation.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance form CSHOs in reviewing case files.	Awaiting Verification
11-11	Fatality Cases – VOSHA did not follow proper **Fatality Investigative Procedures** as required in the FOM, Chapter 11, Section II, C., in that the State did not thoroughly investigate the fatality and attempt to determine: the cause of the event; whether OSHA safety and health standards, regulations, or the general duty clause were violated; and any effect the violation(s) had on the incident (FOM, Chapter 11. Section II, C). VOSHA did not follow proper **Fatality Interview Procedures** as required in the FOM, Chapter 11, Section II, D., in that the State did not identify and interview all	VOSHA must ensure that CSHOs and managers follow all requirements for fatality investigations as set forth in the FOM, Chapter 11 (Imminent Danger, Fatality, Catastrophe and Emergency Response). Region I will review all VOSHA fatality cases and ensure correction of all fatality-related recommendations in this report.	VOSHA has changed its review procedures for fatalities, based on problems found in one other case. The problems in that case were corrected and citations were issued. The Workers' Compensation and Safety Director now also reviews all fatality files for completeness and appropriate documentation. FY 2012 fatalities have also been reviewed by Region I prior to issuance. CSHOs have been provided with a checklist, and the FOM requirements have been reviewed. Fatalities are now investigated by	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files. Region is monitoring VOSHA's fatality investigations.	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	persons with first-hand knowledge of the incident. VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Incident data, such as how and why the incident occurred; the physical layout of the worksite; sketches/drawings; measurements; video/audio/photos to identify sources, and whether the accident was work related. VOSHA did not follow proper **Fatality Documentation Procedures** as required in the FOM, Chapter 11, Section II, E., in that the State did not sufficiently document: Equipment or Process Involved, such as equipment type; manufacturer; model; manufacturer's instructions; Kind of process; Condition; misuse; maintenance program; equipment inspection (logs, reports); warning devices (detectors); tasks performed; how often equipment is used; energy sources and disconnecting means identified; and supervision or instruction provided to employees involved in the accident.		two-person teams, when possible, to reduce the chances that things may be overlooked.		
11-12	Emphasis Programs—VOSHA did	CSHOs must code all	VOSHA will contact the Regional	The Regional IT	Awaiting

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	not code some inspections for emphasis programs.	inspections involving emphasis program activities as appropriate.	IT person to get instructions on adding LEPs, NEPs, and Strategic Plan activities to our CSHO application. CSHOs will be instructed to check all that apply.	administrator indicates that VOSHA contacted him regarding issues with using the CSHO application on new laptops. VOSHA confirmed that CSHOs have been instructed to accurately code all emphasis area inspections. However, an IMIS query run in January 2013 shows different totals for emphasis inspections than those provided by VOSHA in its SOAR. Region I will assess VOSHA's accuracy and consistency in coding emphasis inspections during the next onsite case file review.	Verification
11-13	Inspections with Violations Cited—VOSHA did not align closely with Federal OSHA in terms of percent of investigations with violations cited. In FY 2011, VOSHA's percentage of 57 was far below Federal OSHA's percentage of 71, as well as below the state plan percentage of 60.	VOSHA must ensure that CSHOs cite all violations.	N/A	N/A	Closed
11-14	Average Number of Violations per Initial Inspection—In FY 2011, VOSHA's average continued to fall below Federal OSHA's	VOSHA must increase its average number of violations per initial inspection.	**N**/A	N/A	Closed

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	average.				
11-15	Including air sampling and noise survey forms in case files—Some case files where the CSHO did perform sampling for air contaminants and surveys for noise, the case files either did not contain copies of completed OSHA 91 (air sampling) and OSHA 92 (noise survey) forms, or the forms were not fully completed. In addition, some health inspection case files should have contained copies of the OSHA-93 (Direct Reading) form, but did not. These forms are used to help support violations cited.	VOSHA must ensure that copies of all air sampling and noise survey forms are included in case files for inspections in which these surveys/ samplings have occurred.	CSHOs have been required to include health sampling and noise survey forms in their case files. The requirement to include these forms in case files is listed as an item on the CSHO case file review checklist. The VOSHA supervisors are monitoring the CSHOs' compliance with this requirement.	CSHOs are using the checklist to ensure that the air sampling and noise survey forms are included in the case file. The extent to which the supervisor is monitoring compliance with this requirement is awaiting verification.	Awaiting Verification
11-16	Citing all Apparent Violations--- CSHOs did not cite all apparent violations during inspections, even though evidence of these violations was provided by the CSHO in some case files through photos and written descriptions.	CSHOs must cite all apparent violations.	In the course of the case file review, the supervisor reviews all the photographs taken of the worksite. CSHOs must explain why violations were not cited in any photos or written descriptions that appear to provide evidence of hazardous conditions. The CSHO must cite the hazard or document any circumstances that explain why the hazard should not be cited.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance form CSHOs in reviewing case files.	Awaiting Verification
11-17	Violation Classification— VOSHA's percentage for all violations cited as Serious did not align closely with Federal OSHA's	VOSHA's percentage for all violations classified as serious must align more closely with Federal OSHA's percentage by	N/A	N/A	Closed

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	in FY 2011.	the end of FY 2012.			
11-18	Violation Classification—VOSHA misclassified some violations as Other-than-Serious that should have been classified as Serious. Some violations should have been classified as Repeat, and some violations could potentially have been classified as Willful, based on the outcome of further investigation, which the program chose not to pursue.	VOSHA must properly classify all violations and thoroughly investigate violations that have the potential to be cited as Willful, and cite them accordingly.	VOSHA's case files are reviewed by the Director of Workers' Compensation and Safety prior to citation issuance. The classification of violations is reviewed in light of the potential injury or illness. Violations that are determined to be misclassified are returned to the CSHO for revision. If the CSHO disagrees with the assessment, he must revise the documentation to justify his initial classification. CSHOs are conducting establishment searches to assure that the employer had not been cited previously for the same or similar violation. This search is also used to establish employer knowledge for possible Willful violations. VOSHA will only use those violations that have become a "Final Order of the VOSHA Review Board" when determining whether a violation should be classified as repeat.	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files.	Awaiting Verification
11-19	Penalty Reductions— In some cases, VOSHA improperly granted penalty reductions.	VOSHA must follow the FOM requirements in Chapter 6 for granting penalty reductions based on size, history, and good	VOSHA case files and 1Bs are reviewed by the Director of Workers' Compensation and Safety. Violation classification, appropriate hazard description,	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		faith.	appropriate severity and probability assessments and accurate and justified penalty reduction factors are reviewed at each level. CSHOs conduct establishment searches and include the results in their case files. These searches will provide information on the company size and history. CSHOs will be required to justify any reductions for good faith. CSHOs will be required to read the FOM, Chapter 6, Penalty Reduction Factors.	receiving assistance form CSHOs in reviewing case files.	
11-20	Average Current Penalty per Serious Violation—VOSHA's average continues to fall below Federal OSHA's average. In FY 2011, VOSHA's average was $899.00, while Federal OSHA's average was $2,133.00.	VOSHA's average current penalty per serious violation must align more closely with Federal OSHA's average by the end of FY 2012.	N/A	N/A	Closed
11-21	Abatement documentation—Some case files were closed without having any documentation of abatement or having inadequate documentation.	VOSHA must ensure that all documentation of abatement is present in case files before they are closed.	VOSHA management will scrutinize employer abatement information to assure that violations are appropriately and adequately abated. If there is any question, the CSHO who conducted the inspection will be asked to review the abatement information. IMIS reports, including Complaint tracking, Referral tracking, Open inspections, Citations pending,	According to the CAP, these actions have been implemented and are ongoing. The workers' compensation director is receiving assistance from CSHOs in reviewing case files.	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
			Unsatisfied activity, Default violation abatement, and the Inspection summary report will assist in identifying cases where abatement documentation has not been entered.		
11-22	Informal Conferences—In some cases, the informal conference was held after the 20 calendar-day period had expired.	VOSHA must adhere to its own guidelines in its "Closing Conference Guide," which requires not extending a 20-day calendar period for holding informal conferences.	When VOSHA receives the USPS return receipt, the 20-day informal conference deadline is put on the front of the case file by the supervisor. Employers who request an informal conference close to the deadline are told to submit a letter requesting an informal and a notice of contest in order to preserve their rights. Employers that fail to file a timely informal conference request or notice of contest are informed that the 20-day contest period has passed and the citations and penalties are a Final Order of the VOSHA Review Board and cannot be reviewed by any court or agency, (21 VSA section 226(a)).	According to the CAP, these actions have been implemented and are ongoing. Region I will assess the extent to which VOSHA is adhering to its 20 calendar-day policy during the next onsite case file review.	Awaiting verification
11-23	Standard Adoption—VOSHA did not adopt 29 CFR 1915 in a timely manner, once it was determined that Vermont had facilities that are covered by this standard, and the State began the adoption process (February 2, 2011).	For all future standard adoptions, VOSHA must adhere to the six-month time frame in 29 CFR 1953 (a) (1).	VOSHA will make every effort to adopt new rules or rule changes within the six-month time frame. VOSHA will begin the rule adoption process when notified of a final rule by OSHA.	In FY 2012, VOSHA did not adopt the two final rules issued by OSHA within the six-month time frame. VOSHA is also overdue in terms of adopting another standard that was required to be adopted as of November 2011.	Open
11-24	Discrimination Cases—Case files were not tabbed and organized	VOSHA must organize case files in accordance	The Workers' Compensation and Safety division director has	According to the CAP, these corrective actions have been	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	according to the manual.	with the format in the 2011 Whistleblower Investigations Manual. • Exhibits must be tabbed and the file must contain a Contents of File. 5(III) • All documents must be retained in the file, including investigators' notes and recordings of interviews downloaded to CDs. • All emails must be printed and placed in the case file. • Evidentiary materials should be separated from notes and emails. • The ROI format provided to VOSHA by Region I must be used. • All reports must contain an analysis of the elements of a	assumed responsibility for working with CSHOs assigned to investigate whistleblower complaints. Three CSHOs were provided with additional whistleblower training by Carole Horowitz of the federal OSHA whistleblower program in Region 1 OSHA. The CSHO staff will report on the status, developments and actions in each whistleblower case to division director Steve Monahan. No case can be closed or issued without review by Steve and agreement by Carole Horowitz at the federal OSHA whistleblower program. Possible changes to how whistleblower complaints are handled and investigated are also being studied. In particular, consideration is being given to combining the VOSHA whistleblower investigation responsibilities with other department of labor anti-retaliation provisions (for example, state wage-hour complainant protections and Workers' Compensation claimant protections) to create a dedicated whistleblower investigative unit.	implemented and are ongoing. Since the FY 2011 FAME report was issued, VOSHA has closed four cases without first sending them to OSHA for review. Only one ROI was submitted to OSHA for review. (VOSHA closed this case despite OSHA's instructions that it not be closed because the Region thought the case had merit and should either be settled or litigated). A second case was submitted to OSHA for review but the investigator had not written an ROI.	

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		prima facie case, an examination of the respondent's defense, and an explanation of the determination. • The supervising official must sign and date the ROI, indicating concurrence with the findings. • A uniform system to label case files with the complainant name, the respondent name and the case number must be created.	Current evidence suggests that CSHOs frequently do not have enough background, training and caseloads to investigate these complaints on a regular basis – a dedicated retaliation unit would resolve this issue. Case files have been organized and placed in green three-ring binders. All exhibits are tabbed and there is a table of contents. All documents are retained in the file, including investigators' notes and recordings of interviews downloaded to CDs. All emails are be printed and placed in the case file. Evidentiary materials will be separated from notes and emails. VOSHA is using ROI format provided by Region I. All reports will contain an analysis of the elements of a prima facie case, an examination of the respondent's defense, and an explanation of the determination. The supervising official will sign and date the ROI, indicating concurrence with the findings. A uniform system to label case		

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
			files with the complainant name, the respondent name and the case number has been created and is in use.		
11-25	Discrimination Cases—VOSHA does not have an appeals process.	VOSHA must immediately establish and implement an appeals process in conformance with the Whistleblowers Investigations Manual Chapter 1(VII) (C).	VOSHA has developed an appeals process. This process will have to be formally adopted through rulemaking but is in place as an interim operating procedure pending adoption. In FY 2013 The VT Department of Labor (VDOL) will not sign a contract with the VT Attorney General's office for VOSHA legal support. The funds will be retained by VDOL, and in the interim the VDOL General Counsel and the Director of Workers Compensation and Safety shall each prosecute litigation before the VOSHA Review Board. Discrimination cases will still be referred to the Vermont Attorney General's Office.	According to the CAP, these corrective actions have been implemented and are ongoing. VOSHA has submitted an appeals process to the Region for review, but it does not state who the final reviewer will be. VOSHA anticipates the designee will be the Department General Counsel staff, but VOSHA needs to make a final decision as to who will review appealed cases before OSHA can approve the process.	Awaiting Verification
11-26	Discrimination Cases—VOSHA fails to notify complainants of their rights - the right to dual file, the right to file a Complaint About State Program Administration (CASPA), or the right to file an appeal of VOSHA's determination. Letters were not being sent to the parties.	VOSHA must send notification and determination letters to the parties (template letters can be found in the Whistleblower Investigations Manual at the end of Chapter 7) and copy OSHA on all letters sent to all parties for the next year.	Upon receipt of the draft FAME report, the appropriate Vermont specific letters were developed and reviewed with the regional office staff to assure completeness, accuracy and compliance with the Whistleblower Investigations Manual. Once the regional investigator working with the state approved these letters, they were placed on the VOSHA shared	According to the CAP, these corrective actions have been implemented and are ongoing. OSHA has verified that VOSHA has developed the template letters and provided them to investigators. VOSHA was instructed to copy the Regional	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		Stop giving the "Complainant Information Form" to complainants. While not required by the manual, OSHA considers it a best practice for states to notify the parties of their right to file a Complaint About State Program Administration (CASPA) and encourages VOSHA to do so. Upon establishment of the appeals process, notify all complainants whose cases were dismissed in FY2010 to the present, in writing, of their rights under this process and toll the time period for filing an appeal, i.e. give them 30 days from the date they are notified of their right to appeal.	drive as a template. Discrimination investigators send the appropriate information to the VOSHA manager. The initial letters are mailed USPS certified to both the complainant and respondent. The investigators are notified by e-mail that the letters have been sent and are given a copy of the letters. The USPS return receipt is addressed to the investigator for their information and filing.	Supervisory Investigator on all opening and closing letters. VOSHA has not voluntarily provided any of these letters, although some were provided later upon request. In the CAP, VOSHA did not respond to OSHA's instruction to cease giving out the "Complainant Information Form" to complainants during investigations. VOSHA has not provided the Region with copies of letters to all complainants whose cases were dismissed during FY2010 to the present. It is unknown whether VOSHA wrote the letters at all. VOSHA did not respond to this in the CAP.	
11-27	Discrimination Cases—Supervisors do not use or review the information entered into the IMIS.	The supervisor must have access to IMIS and training on how to run reports; ensure that the correct allegation code is used; ensure that the allegation summary describes the	N/A	N/A	Closed

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		alleged protected activity and adverse action; and ensure that the closed date is the same as the date closing letters are sent.			
11-28	Discrimination Cases—Investigators do not receive sufficient training and supervision to conduct proper investigations. Investigations frequently missed relevant lines of inquiry and the reports made it difficult to follow VOSHA's narrative of the facts of the case or its reasoning when reaching conclusions. Those supervising the discrimination program have no training or experience in discrimination investigations.	Train all VOSHA staff to answer basic questions about jurisdiction and coverage for 11(c) complaints, and to be familiar with the other 20 federal statutes enforced by OSHA, to enable them to refer appropriate complaints to federal OSHA. Retrain managers & discrimination investigators in the investigative process, elements of a violation, and case analysis. Budget for investigators to attend national whistleblower conferences and regional meetings.	VOSHA will send investigators and persons supervising discrimination work to the Basic Whistleblower investigations Course #1420 at the OSHA Training Institute. One CSHO has completed the training; another is scheduled to complete the course in December 2012. All VOSHA staff members were brought in for training on the whistleblower programs that are the sole jurisdiction of OSHA. This training was conducted to assist VOSHA in making appropriate referrals to OSHA. Additional, more intensive, training was provided to three CSHOs who are expected to handle the bulk of the discrimination investigations received in Vermont.	According to the CAP, these corrective actions have been implemented and are ongoing. Region I held a three-day basic training for VOSHA's investigators and supervisors. The current supervisor was unable to attend all of the training. One investigator attended OTI Course Basic Whistleblower Investigations #1420 in FY 2013. One investigator and the supervisor have still not taken basic Course #1420 training.	Open
11-29	Discrimination Cases—Supervisors do not manage the program effectively.	Supervisors must keep investigators informed about changes to federal OSHA's program. Supervisors and investigators must confer with OSHA on difficult cases.	VOSHA has implemented these recommendations and will work closely with the designated RSI.	According to the CAP, these corrective actions have been implemented and are ongoing. However, with only the workers' compensation director available to run	Open

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		VOSHA must consult with the designated OSHA Regional Supervisory Investigator (RSI) at the conclusion of every investigation, and earlier if needed. VOSHA must send the completed ROI to the designated RSI before closing the case. VOSHA must send the completed case file to OSHA upon completion of the case.		VOSHA, communication has been lacking. For example, four cases have been closed since the FY 2011 FAME was completed. Also, OSHA was not consulted prior to closing two cases and not provided with the ROI or case file in any cases. Due to the lack of front line supervisors, investigators have been unable to obtain advice or review of their work, to the detriment of the case.	
11-30	Discrimination Cases—VOSHA does not have an attorney designated to handle discrimination matters.	VOSHA will designate an attorney with expertise in discrimination matters to advise it on legal issues that arise.	In cases where discrimination is found, and settlement isn't possible, the case is referred to the VT Attorney General's office Civil Rights unit legal action. In Vermont, workers always (regardless of VOSHA findings) have a right to bring a private cause of action and recover costs, attorney fees, and damages.	According to the CAP, these corrective actions have been implemented and are ongoing. However, VOSHA's answer is not responsive to the finding. VOSHA's response is related to the appeals process, which is not the subject of this finding. Although the current supervisor is an attorney, it would be inappropriate for him to have the dual role of supervisor and legal advisor for whistleblower cases.	Open

Appendix C - Status of FY 2011 Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
11-31	Discrimination Cases—VOSHA's website does not include sufficient information about its discrimination program and the available information is difficult to locate.	Redesign the VOSHA Website to clearly articulate discrimination rights and make the information easily accessible to employers and employees. Provide a link to OSHA's website – www.whistleblowers.gov.	VOSHA requested and received $30,000 in one time only funding for the redesign of the VDOL website. This redesign will make the VOSHA and Project WorkSAFE onsite consultation programs more prominent and will include a whistleblower page that articulates employee discrimination rights and their private right of action (21 VSA sections 231 and 232)	According to the CAP, these corrective actions have been implemented and are ongoing. From a review of the current VDOL/VOSHA website, it appears that no changes have been made thus far.	Open
11-32	Discrimination Cases—VOSHA public employee stakeholders are not adequately informed of the rights provided to them under VOSHA's discrimination provisions.	Conduct outreach with stakeholders about employee rights and employer responsibilities.	VOSHA will provide the Vermont State Employees Association, AFSCME, Vermont NEA, the State Labor Council, and the Workers' Rights center with information on the discrimination provisions of Vermont law and the whistleblower rules adopted by VOSHA. The information will also be provided to the Vermont League of Cities and Towns (VLCT).	According to the CAP, VOSHA intends to conduct outreach. However, it is not clear if any outreach has actually been conducted.	Awaiting Verification
11-33	VPP—A number of the required signed approval letters were not contained in the VPP files.	VOSHA must obtain copies of these signed letters and include them in the appropriate files.	The signed letters will be placed in the files. All of the letters did exist; they were just not in the appropriate files. The VOSHA CAS will assure that the signed letters are places in the appropriate files.	According to VOSHA, these corrective actions have been implemented and are ongoing.	Awaiting Verification
11-34	VPP—Complaints at VPP sites were handled by the VPP manager, rather than by a compliance officer.	VOSHA must ensure that all complaints, referrals, and/or fatality/catastrophe investigations at VPP sites are to be handled by	All complaints, referrals and/or fatality/catastrophe investigations at VPP sites will be conducted by compliance staff. Any CSHO that participated in the GMVPP onsite	According to VOSHA, these corrective actions have been implemented and are ongoing.	Awaiting Verification

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
		compliance staff.	evaluation will not be allowed to conduct the investigation.		
11-35	Alliance Program—VOSHA's Alliance documentation does not comply with the directive's requirements in Section XII Program Requirements, D. Alliance Documentation 1 and 2.	VOSHA must ensure that annual reports are completed and maintained in the Alliance files and that the electronically signed Alliance copies are posted on the VOSHA Web site, along with relevant updates, milestones, success stories, events, or photographs.	The Vermont Compliance Assistance Specialist (CAS) will assure that annual reports are completed and maintained in the Alliance files. Additionally, the electronically signed Alliance copies are posted on the VOSHA Web site, along with relevant updates, milestones, success stories, events, or photographs. The addition of this information will occur after the revised VDOL website is fully operational.	The VOSHA CAS, the staff member who manages VOSHA's Alliance program, has confirmed that he has been including all required documents in the program's Alliance files. However, he also acknowledges that he does not have the technical expertise needed to post Alliance-related information on the current VOSHA website, and cannot do so without the assistance of a web expert who works in an office in another part of the State. The CAS is waiting for VOSHA's updated website to be launched, which will make it easier for users to post documents and other types of information.	Open
11-36	Training—Vermont has CSHOs who have yet to complete Course #1310 (Investigative Interviewing Techniques), as required under OSHA's Initial Compliance Training Program. .	Enroll these CSHOs in this course so that they have all completed this training by the end of FY 2012.	N/A	N/A	Closed
11-37	Training—Two of the program's	VOSHA must ensure that	VOSHA enrolled these two	Both CSHOs completed this	Completed

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
	"veteran" CSHOs who conduct fatality investigations require additional training in investigative and interviewing techniques.	both CSHOs complete Course #1310, Investigative Interviewing Techniques, even though these CSHOs are technically exempt from taking this course due to their "veteran" CSHO's status.	CSHOs in Course #1310 in FY 2012.	course.	
11-38	Training—VOSHA has no documentation to show that one of the two veteran CSHOs who conduct fatality investigations has completed OTI Course #1410 (Inspection Techniques and Legal Aspects).	Ensure that the CSHO completes this course before the end of 2012, because this course is mandatory training for all CSHOs, and should have been completed in the first year of this CSHOs employment.	N/A	N/A	Closed
11-39	Training—Region I has performed an in-depth analysis of VOSHA's training records (which VOSHA provided to the Region upon request).This analysis has found that none of the program's CSHOs have completed their mandatory training track (prescribed by OTI's training directive) within the time frame permitted by the directive.	By no later than December 31, 2013, all CSHOs must have completed the training track for their appropriate discipline (safety or health) as required under the most recent OSHA training directive (TED 01 00-018, issued in 2008).	VOSHA has enrolled all CSHOs in the OTI courses necessary to complete their training track. Although some CSHOs have been waitlisted for courses, they eventually become enrolled in the courses. A document showing the courses in which CSHOs are enrolled or waitlisted has been provided separately.	VOSHA did not provide a specific corrective action to address this finding. According to the "staff training plan" which was submitted separately from the CAP, at least six CSHOs will not complete some "core competency courses" until sometime in FY 2014. The Region's analysis of VOSHA's training records shows that as of February 11, 2013, most of the program's veteran CSHOs still had not completed all of the required core courses.	Open

Appendix C - Status of FY 2011 Findings and Recommendations

FY 2012 VOSHA State Plan Abridged FAME Report

Rec. #	Findings	Recommendations	Corrective Action Plan	State Action Taken	Status
11-40	State Internal Evaluation Plan (SIEP)—VOSHA does not have an internal evaluation program that meets the criteria outlined in the State Plan Policies and Procedures Manual (SPPPM).	VOSHA must develop a SIEP for use during FY 2013 that conforms to the requirements of the SPPPM.	A SIEP is being drafted, but will not be finished until supervisory vacancies are filled.	VOSHA has prepared a draft SIEP but it has not been implemented.	Open
11-41	Inspection Activity—VOSHA fell far short of its inspection goal in FY 2011, by conducting only 317 out of 400.	VOSHA must work harder to meet its inspection goal in order to adequately protect workers in the State of Vermont.	In June of 2012 safety CSHOs were advised that they had to at least open one new case and close one case per week, and health CSHOs were advised to open at least one new health case every two weeks and close one every two weeks. Individual performance evaluations will consider the attainment of these goals.	VOSHA is continuing to work to ensure that safety and health CSHOs open and close the recommended number of inspections, as discussed above. As of the end of the first quarter of FY 2013, VOSHA had met its quarterly inspection goal of 87 inspections opened.	Open

Appendix D - FY 2012 State Activity Mandated Measures (SAMM) Report

FY 2012 Vermont State Plan Abridged FAME Report

NOV 09, 2012
RID: 0155000

MEASURE	From: 10/01/2011 To: 09/30/2012	CURRENT FY-TO-DATE	REFERENCE/STANDARD
1. Average number of days to initiate Complaint Inspections	188	1	Negotiated fixed number for each state
	3.08	.33	
	61	3	
2. Average number of days to initiate Complaint Investigations	85	0	Negotiated fixed number for each state
	7.72		
	11	0	
3. Percent of Complaints where Complainants were notified on time	62	3	
	100.00	100.00	100%
	62	3	
4. Percent of Complaints and Referrals responded to within 1 day -ImmDanger	4	1	
	100.00	100.00	100%
	4	1	
5. Number of Denials where entry not obtained	0	0	0
6. Percent of S/W/R Violations verified			
	142	9	
Private	78.89	36.00	100%
	180	25	
	9	0	
Public	52.94	.00	100%
	17	2	
7. Average number of calendar days from Opening Conference to Citation Issue			
	15253	1887	2032800
Safety	120.10	85.77	55.9 National Data (1 year)
	127	22	36336
	7305	642	647235
Health	125.94	71.33	67.9 National Data (1 year)
	58	9	9527

0*VT FY12 **PRELIMINARY DATA SUBJECT TO ANALYSIS AND REVISION

Appendix D - FY 2012 State Activity Mandated Measures (SAMM) Report

FY 2012 Vermont State Plan Abridged FAME Report

RID: 0155000

MEASURE	From: 10/01/2011 To: 09/30/2012	CURRENT FY-TO-DATE	REFERENCE/STANDARD	
8. Percent of Programmed Inspections with S/W/R Violations				
	64	14	76860	
Safety	70.33	45.16	58.5	National Data (3 years)
	91	31	131301	
	15	2	9901	
Health	50.00	9.52	53.0	National Data (3 years)
	30	21	18679	
9. Average Violations per Inspection with Violations				
	415	67	367338	
S/W/R	2.24	2.16	2.1	National Data (3 years)
	185	31	175950	
	93	14	216389	
Other	.50	.45	1.2	National Data (3 years)
	185	31	175950	
10. Average Initial Penalty per Serious Violation (Private Sector Only)	477214	50961	624678547	
	1249.25	1341.07	1990.5	National Data (3 years)
	382	38	313826	
11. Percent of Total Inspections in Public Sector	36	2	102	
	11.84	5.41	10.0	Data for this State (3 years)
	304	37	1018	
12. Average lapse time from receipt of Contest to first level decision	0	0	3197720	
			187.0	National Data (3 years)
	0	0	17104	
13. Percent of 11c Investigations Completed within 90 days*	5	0		
	50.00		100%	
	10	0		
14. Percent of 11c Complaints that are Meritorious*	3	0	1619	
	30.00		23.4	National Data (3 years)
	10	0	6921	
15. Percent of Meritorious 11c Complaints that are Settled*	3	0	1444	
	100.00		89.2	National Data (3 years)
	3	0	1619	

*Note: Discrimination measures have been updated with data from SAMM reports run on 1/3/2013

0*VT FY12 **PRELIMINARY DATA SUBJECT TO ANALYSIS AND REVISION

Appendix E - State OSHA Annual Report (SOAR)

FY 2012 Vermont State Plan Abridged FAME Report

[Available Upon Request]