ACCSH/1988-1
EX 21

REPORT TO THE

ADVISORY COMMITTEE ON CONSTRUCTION SAFETY AND HEALTH

SUBMITTED BY THE

SUBCOMMITTEE ON FATALITY/CATASTROPHE INVESTIGATIONS

JOE ADAM
V. SHERWOOD KELLY
JIM E. LAPPING

MARCH 29, 1988

On May 23, 1983, the Advisory Committee on Construction Safety and Health's (ACCSH) Subcommittee on Fatality/Catastrophe Investigations reported its recommendations to the full committee (see attachment). The recommendations were discussed by the ACCSH and approved and transmitted to the OSHA administration.

Since the report OSHA has done little to act on the ACCSH recommendations. The only positive action has been the Fatal Facts reports recently instituted by OSHA (see attachment).

The Bridgeport L'Ambiance Plaza tragedy again focused attention on many of the deficiencies associated with OSHA's fatality/catastrophe investigation and reporting procedures. The ACCSH has been briefed on the accident and the deficiencies so they will not be repeated in this report.

The present members of the subcommittee agree that the issues discussed by the ACCSH on May 23, 1983, and the recommendations made to OSHA by the ACCSH are still topical and important.

Our recommendation is that the ACCSH request that OSHA, at the next ACCSH meeting, provide to the committee a detailed briefing regarding the following issues.

ISSUE 1
Has OSHA taken any action to lower the present 48 hour reporting time allowed by 29 CFR 1904.8? (see attachment) If not, why not?

ISSUE 2
Has OSHA taken any action to require the initial report to be by telephone or telegram? If not, why not?

ISSUE 3
OSHA regulation 29 CFR 1904.8 now requires an employer to report to OSHA within 48 hours any employment accident which results in the hospitalization of 5 or more employees. Has OSHA taken any action to lower this number? If not, why not?

ISSUE 4
Has OSHA taken any action to require the employer to freeze the accident site until OSHA completes its physical investigation? If this action requires a change in the OSHA act, would OSHA support such a change? If not, why not?

ISSUE 5
Does OSHA have a 24 hour national 800 watts line available to employers and employees to report a fatality/castrophe? If not, why not? If OSHA has this number, has it been made available to hospitals and clinic emergency rooms? If not, why not?

ISSUE 6
Has OSHA required state plan states to develop and implement the Fatal Facts program in their states? If not, why not?

ISSUE 7
Does OSHA require the area office or state agency investigating each and every fatality/catastrophe to issue a final report to the national office stating the answers to the 4 questions found in the OSHA Field Operation Manual Chapter VIII, Para. A3 (a) (b)(c)(d)? (see attachment) If not, why not?

ISSUE 8
Has OSHA initiated any action to improve the present reporting system to eliminate or at least substantially reduce the amount of under-reporting of accidents and injury now present in those employments covered by OSHA? If not, why not?

The subcommittee recognizes that some of the issues presented overlap issues discussed by other ACCSH subcommittees. We believe that this overlap is unavoidable and further emphasizes the scope and size of the continuing unresolved problems that OSHA seems unwilling to confront.

We strongly urge the full committee to approve the subcommittee's recommendation that the ACCSH request that OSHA, at the next meeting, provide the full committee a detailed briefing regarding the 8 listed issues.

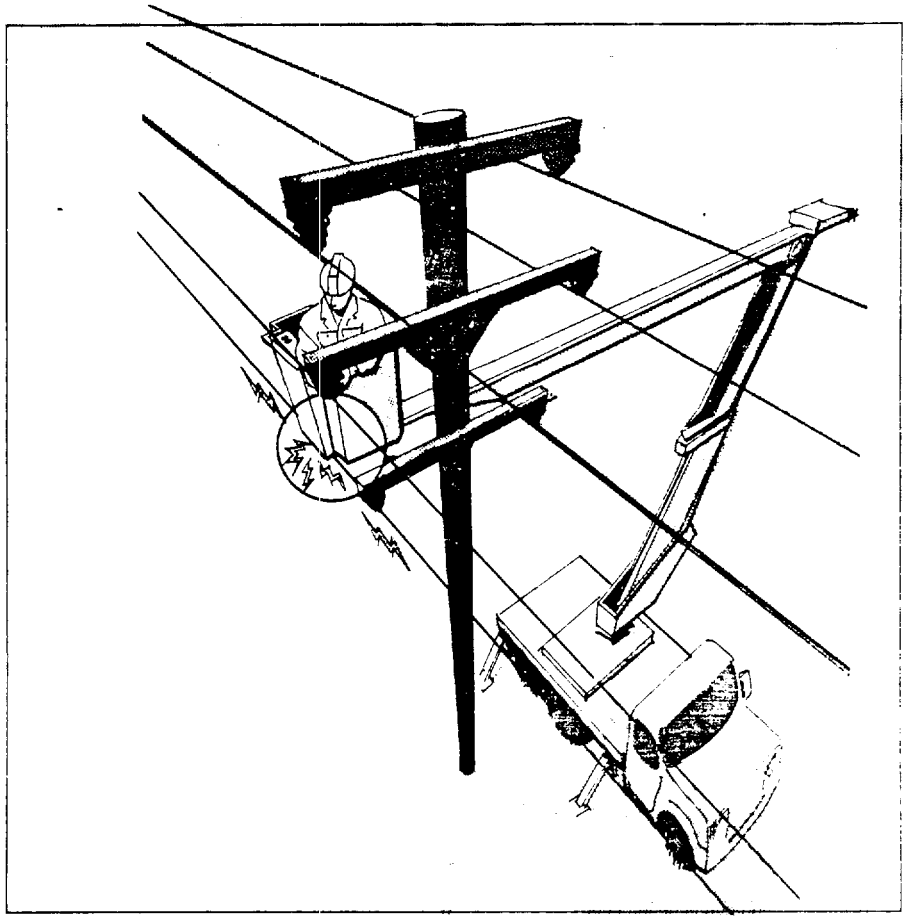
ACCIDENT REPORT FATAL FACTS

U.S. Department of Labor
Occupational Safety and
Health Administration

No. 28

ACCIDENT SUMMARY

Accident Summary	Electrocution
Weather	Clear
Type of Operation	Power Line Work
Crew Size	2
Collective Bargaining?	Yes
Competent Safety Monitor on Site?	Yes
Safety and Health Program in Effect?	No
Was the Worksite Inspected Regularly by the Employer?	No
Training and Education Provided?	No
Employee Job Title	Lineman
Age/Sex	44/M
Experience at this Type Work	11 Months
Time on Project	6 Weeks



BRIEF DESCRIPTION OF ACCIDENT

A lineman was electrocuted while working on grounded deenergized lines. He was working from a defective basket on an articulated boom aerial lift when the basket contacted energized lines which ran beneath the deenergized lines. The defective basket permitted current to pass through a drain hole cut into the body of the basket, then through the employee, and to ground via the deenergized line.

INSPECTION RESULTS

OSHA cited the company for two serious violations and one other than serious violation of its construction standards. Had barriers been erected to prevent contact with adjacent energized lines, the electrical shock might have been prevented.

ACCIDENT PREVENTION RECOMMENDATIONS

1. Guards or barriers must be erected as necessary to adjacent energized lines (29 CFR 1926.950(d)(1)(v)).

2. Existing conditions of mechanical equipment, energized lines, equipment, conditions of poles, and location of circuit must be determined by an inspection or test before starting work. (29 CFR 1926.950(b)(1) and .952(a)(1)).

3. Employees must be instructed on how to recognize and avoid unsafe conditions and on regulations that apply to their work environment (29 CFR 1926.21)(b)(2)).

SOURCES OF HELP

• Construction Safety and Health Standards (OSHA 2207) which contains all OSHA job safety and health rules and regulations (1926 and 1910) covering construction.

• OSHA-funded free consultation services. Consult your telephone directory for the number of your local OSHA area or regional office for further assistance and advice (listed under U.S. Labor Department or under the state government section where states administer their own OSHA programs).

• OSHA Safety and Health Training Guidelines for Construction (available from the National Technical Information Service—Order No. PB-239-312/AS) comprised of a set of 15 guidelines to help construction employees establish a training program in the safe use of equipment, tools, and machinery on the job.

NOTE: The case here described was selected as being representative of fatalities caused by improper work practices. No special emphasis or priority is implied nor is the case necessarily a recent occurrence. The legal aspects of the incident have been resolved, and the case is now closed.

CHAPTER VIII

FATALITY/CATASTROPHE INVESTIGATIONS

A. General.

1. **Policy.** All job-related fatalities and catastrophes, however reported, shall be investigated as thoroughly and expeditiously as resources and other priorities permit.

2. **Definitions.** The following definitions apply for purposes of this chapter:

a. **Fatality.** An employee death resulting from an employment accident or illness; in general, from an accident or illness caused by or related to a workplace hazard.

b. **Catastrophe.** The hospitalization of five or more employees resulting from an employment accident or illness; in general, from an accident or illness caused by a workplace hazard.

NOTE: "Accidents involving significant publicity" or any other accident not involving a fatality or a catastrophe, however reported, shall be considered as either a complaint or a referral, depending on the source of the report, and shall be handled according to the directions given in Chapter IX. Accidents discovered from a records review or during the walkaround on a programmed inspection shall be handled as part of the programmed inspection in accordance with Chapter II, E.2.b.

c. **Hospitalization.** To be sent to, to go to, or to be admitted to a hospital or equivalent medical facility for examination or treatment, irrespective of whether or not treatment was actually provided or what the length of stay in the hospital was.

d. **Reporting.** Area Directors and District Office Supervisors shall report multiple fatalities and catastrophes directly and immediately to the Regional Administrator, who shall inform the Director of Field Operations in accordance with the instructions given in C.1.

NOTE: For purposes of the reporting requirement of this paragraph, "multiple fatalities and catastrophes" shall include the following:

(1) Fatalities totaling two or more;

(2) All catastrophes;

(3) Single fatalities involving or likely to involve significant national or local publicity; or

(4) Single fatalities involving extensive property damage.

3. **Fatality/Catastrophe Investigations.** Upon initial contact the employer shall be informed that an investigation will be conducted and extensive interviews with witnesses will be necessary. The purpose of an accident investigation shall be explained, namely, to determine:

a. The cause of the accident.

b. Whether a violation of OSHA safety or health standards related to the accident occurred.

c. What effect the standard violation had on the occurrence of the accident.

d. If OSHA standards should be revised to correct the hazardous working condition that led to the accident.

B. Action.

1. **Preinvestigation Activities.** It is essential to the proper conduct of a fatality or catastrophe investigation that preparations be carefully made. OSHA will often be the subject of public scrutiny in the conduct of such investigations, and it is imperative that they be complete and professionally competent.

a. **Area Director.** If the fatality or catastrophe appears to require an OSHA investigation (i.e., it is or may be occupationally related and OSHA's jurisdiction is not preempted), the Area Director shall ensure that the required IMIS forms are completed and shall report the event to the Regional Administrator and give all pertinent information to the National Office, when required by C.1, as soon as it is

1904.7—ACCESS TO RECORDS

(a) Each employer shall provide, upon request, records provided for in §§ 1904.2, 1904.4, and 1904.5, for inspection and copying by any representative of the Secretary of Labor for the purpose of carrying out the provisions of the act, and by representatives of the Secretary of Health, Education, and Welfare during any investigation under section 20(b) of the act, or by any representative of a State accorded jurisdiction for occupational safety and health inspections or for statistical compilation under sections 18 and 24 of the act.

(b)

(1) The log and summary of all recordable occupational injuries and illnesses (OSHA No. 200) (the log) provided for in § 1904.2 shall, upon request, be made available by the employer to any employee, former employee, and to their representatives for examination and copying in a reasonable manner and at reasonable times. The employee, former employee, and their representatives shall have access to the log for any establishment in which the employee is or has been employed.

(2) Nothing in this section shall be deemed to preclude employees and employee representatives from collectively bargaining to obtain access to information relating to occupational injuries and illnesses in addition to the information made available under this section.

(3) Access to the log provided under this section shall pertain to all logs retained under the requirements of § 1904.6.

[43 F.R. 31329, July 21, 1978.]

1904.8—REPORTING OF FATALITY OR MULTIPLE HOSPITALIZATION ACCIDENTS

Within 48 hours after the occurrence of an employment accident which is fatal to one or more employees or which results in hospitalization of five or more employees, the employer of any employees so injured or killed shall report the accident either orally or in writing to the nearest office of the Area Director of the Occupational Safety and Health Administration, U.S. Department of Labor. The reporting may be by telephone or telegraph. The report shall relate the circumstances of the accident, the number of fatalities, and the extent of any injuries. The Area Director may require such additional reports, in writing or otherwise, as he deems necessary, concerning the accident.

REPORT TO THE

ADVISORY COMMITTEE ON CONSTRUCTION SAFETY AND HEALTH

BY THE

SUB-COMMITTEE ON FATALITY/CATASTROPHE INVESTIGATIONS

Joe A. Adam
V. Sherwood Kelly
James A. Oppold

May 23, 1983

On December 1, 1982 chairman Ed Lore appointed a three member sub-committee (SC) to investigate OSHA's fatality/catastrophe investigation procedure. The SC was instructed to recommend to the full committee whether the subject of fatality/catastrophe investigations should be an agenda item.

The SC, through a conference call, discussed the issue on April 27, 1983. It was agreed that the issue of fatality/catastrophe investigations should be made an announced committee agenda item for the next meeting.

The SC also reviewed various OSHA documents and decided to present to the committee an outline of OSHA's present fatality/catastrophe investigations system. We also developed some discussion points on which the committee may wish to focus attention.

The present OSHA fatality/catastrophe investigation process is based upon the OSHA Act passed by Congress in 1970, and the supporting regulations and policy documents developed by the OSH Administration. Some of these documents were sent to the committee by Ken Hunt.

Section 8(a)(1) of the OSHAct authorizes OSHA to enter any work-place where work is performed, and Section 8(a)(2) authorizes OSHA to inspect and investigate any such place of employment and to question employers and employees.

Section 8(c)(2) requires OSHA to prescribe regulations requiring employers to maintain accurate records of, and to make reports on, work-related deaths, injuries and illnesses.

OSHA regulation 29 CFR 1904.8 requires employers to report to OSHA, within 48 hours, fatal accidents or accidents resulting in multiple hospitalizations.

OSHA's Field Operation Manual (FOM) Chapter VIII interprets OSHA policy on fatality/catastrophe investigations.

Probably the most important language in FOM Chapter VIII is found in Section A3. Section A3 states that "Upon initial contact the employer shall be informed that an investigation will be conducted and extensive interviews with witnesses will be necessary. The purpose of an accident investigation shall be explained, namely, to determine:

a. The cause of the accident.

b. Whether a violation of OSHA safety or health standards related to the accident occurred.

c. What effect the standard violation had on the occurrence of the accident.

d. If OSHA standards should be revised to correct the hazardous working condition that led to the accident."

On May 2, 1983 OSHA initiated a Pilot Program on fatality/catastrophe investigations in one area office in each of regions IV, V and VII. The announcement of this program was included in the committee mailing.

In May 1979 the Comptroller General of the General Accounting Office submitted a report to the Congress. The report is titled "How can Workplace Injuries Be Prevented? The Answers May Be In OSHA Files." The report is critical of OSHA's 1979 and prior record in using information gathered in serious work-related accidents. The report recommends that OSHA should:

-- define and designate the responsibility for data collection and analysis, and require that program offices' needs be surveyed and recognized in data systems designs;

-- revise procedures for reporting investigation information to better classify and describe hazards causing serious accidents and countermeasures to help prevent similar accidents;

-- establish lists of hazards which warrant special emphasis in standards development, enforcement, and education and training;

-- provide information on the causes of fatal and other serious accidents for industries and labor groups to use in identifying hazards and preventing accidents;

-- have States submit information on State accident investigations and incorporate such information into the data system; and

-- require each major program office to report annually on how its activities were directed at areas with the highest number of fatal and other serious accidents and the results of their efforts.

After discussion the SC agreed that the following subjects deserve the attention of the full committee at subsequent meetings.

1. Should 29 CFR 1904.8 be amended to lower the 48 hour reporting time?
2. Should 29 CFR 1904.8 be amended to require the report to be by telephone or telegraph?
3. Should 29 CFR 1904.8 be amended to lower the multiple injury reporting requirement from 5 to some lower number?
4. Should language be added to 1904.8 requiring the "freezing" of the accident site until federal or state OSHA completes its investigation of the physical evidence? Should the freeze apply to multiple hospitalization accidents as well as fatal accidents? Along with this discussion there should be consideration of a maximum time limit for OSHA to respond before the site can be "thawed"?

5. Are there valid reasons why OSHA does not have a 800 wats line available to employers to report fatality/catastrophes? Should hospital and clinic emergency rooms be made aware of this number?
6. Should OSHA and state plan states be asked to develop a system of Fatalgrams similar to those currently used by the Mine Safety and Health Administration (MSHA)?
7. Should FOM Chapter VIII be revised to require federal and state compliance officers to report on each of the four items listed in Section A3?
8. Should language be added to FOM Chapter VIII requiring that a narrative description of the accident be transmitted to the national office of all federal and state fatality/catastrophe investigations? The narrative would include an account of the accident, possible causes, and recommendations for preventing similar accidents in the future.
9. The committee should discuss how information regarding fatality/catastrophe investigations can be quickly communicated to the affected industry employers and employees.
10. The committee can consider asking OSHA for a report on how Bureau of Labor Statistics (BLS) accident information is coordinated and utilized by OSHA.
11. The SC agreed that there should be discussion on whether OSHA should be required to publicly report federal and state fatality/catastrophe statistics on a periodic basis such as monthly or quarterly.