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September 20, 2011

OSHA Docket Office
Docket No. OSHA-2009-0044
U.S. Department of Labor
Room N-2625
200 Constitution Avenue, NW
Washington, DC 20210

Re: Proposed Rule; Occupational Injury and Illness Recording and Reporting Requirements, -- NAICS Update and Reporting Revisions; Docket No. OSHA – 2010-0019; June 22, 2011 (76 FR 120)

Dear Sir/Madam:

Mercer ORC Health, Safety and Environmental (HSE) Networks welcomes this opportunity to provide comments on the above-referenced Occupational Safety and Health Administration (OSHA) rulemaking. The rulemaking has two key elements. First, it proposes to update a list, contained in Appendix A of Subpart B of its injury and illness recording and reporting requirements, of low-rate industries that are partially exempt from maintaining records of occupational injuries and illnesses. The proposed rule would replace the existing list that is based on the Standard Industrial Classification System (SIC) codes with a list of industries based on the North American Industrial Classification System (NAICS) codes and would use more recent injury and illness data to identify lower rate industries that qualify for the partial exemption.

Second, the Rule would expand the scope and modify the requirements for reporting occupational fatalities and multiple hospitalizations contained in Subpart E of the recordkeeping regulation (29 CFR Part 1904.39).

Mercer ORC HSE Networks will comment on these two elements separately.

As background, Mercer ORC HSE Networks focuses on domestic and global worker safety and health and environmental issues. Currently, more than 120 large (mostly *Fortune 500*) employers in diverse industries are members of our nine Occupational Safety and Health and Environmental Networks.

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Our Washington, D.C. office has, for nearly 40 years (through our legacy organization, ORC Worldwide) specialized in providing a wide array of occupational safety and health consulting services to businesses operating in the U.S. and in every part of the globe. Our basic goals are to promote effective occupational safety and health programs and practices in business and to facilitate constructive communication between business and government agencies responsible for establishing national and global occupational safety and health and environmental policy. The activities of Mercer ORC's HSE Networks are based on the premise that providing safe and healthful working conditions is of mutual interest to employers, employees and government agencies.

Mercer ORC HSE Network member companies trying to assure OSHA compliance contact us on a daily basis for assistance on injury and illness recordkeeping and related matters. So our staff is thoroughly familiar with current recordkeeping concepts and definitions and with their practical application in the workplace. Furthermore, our consultants have worked with recordkeeping issues for decades and understand the core concepts that underpin the current recordkeeping system.

Mercer ORC HSE Network member companies have a substantial interest in OSHA recordkeeping requirements and concepts. The OSHA injury and illness data – for better or worse – are the primary data used in this country (and by many of our members abroad) to drive and gauge safety and health performance. So it is important that OSHA insures that the recordkeeping requirements produce accurate, reliable and meaningful information.

It is also important, given the economic pressures facing many of our businesses, that OSHA keep the burden for recording and reporting these cases to a necessary minimum.

At the outset it should be noted that members of Mercer ORC's HSE Networks have provided information, opinions, and advice in the development of these comments; however, these comments are solely those of Mercer ORC HSE Networks and may differ from the views and comments of individual member companies.

I. Proposed Modifications to the List of Partially Exempt Industries

Mercer ORC HSE networks generally supports OSHA's approach. Applying a three-year average and using the DART rate (the total rate for nonfatal injuries and illnesses that result in days away from work, restricted work activity, and /or job transfer per 100 full-time equivalent workers) make sense. Setting the cut off at or below 75% of the most recent national DART rate and limiting eligibility to sectors that have historically experienced lower injury and illness rates also seem reasonable.

We recognize the need to update the list of industries contained in Appendix A of Subpart B of the injury and illness recordkeeping regulation. We support the shift from the current approach of basing the list of partially exempt industries on SIC codes to basing it on the more modern NAICS codes, which are now widely used by the Bureau of Labor Statistics (BLS), other federal and State agencies,

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academic institutions, employers and others. We believe that 4-digit NAICS codes provide sufficient granularity.

In addition to the coding change, we also support basing the list on more current injury and illness data. The existing list has not been updated for years and was based on injury and illness data compiled by the Bureau of Labor Statistics for 1997, 1998, and 1999. The revised list is based on data for 2007, 2008, and 2009.

Certainly other models could be built that would serve the same purpose. But the OSHA model seems to have withstood the test of time and served the agency well, without causing too much consternation or confusion in the regulated community.

Our only recommendation to OSHA at this time would be to update this list on a more regular basis. We realize that an annual update would provide little or no added benefit and would be difficult to administer. However, the list could be renewed every 5 years or so to maintain its relevance and insure a sense of fairness.

II. Proposed revision to Section 29 CFR Part 1904.39 – Reporting Fatality, In-Patient Hospitalization, and Amputation Incidents to OSHA.

The proposed rule would also change the more immediate reporting requirements in 29 CFR Part 1904 by requiring employers to report to OSHA within eight hours all work-related fatalities and all work-related in-patient hospitalizations of one or more employees; and within 24 hours, all work-related employee amputations. The current regulation requires that fatalities and the in-patient hospitalization of three or more employees be reported to OSHA within eight hours.

OSHA's resources are clearly stretched when it comes to meeting the Agency's broad mandate in the context of its current compliance-based model. So we generally support the expanded use of data to strategically deploy scarce Agency resources where they are needed the most.

However, in order to justify the collection of new types of data, the agency, as a policy matter, needs to make some credible demonstration or argument that the new data collection is likely to add significant value for the intended purposes to which the data would be put. That is especially true where, as here, OSHA is proposing to require the immediate reporting by employers of a substantial amount of additional data. Instead, OSHA only summarily and vaguely describes a few general purposes for this proposed expansion of collected data. Unfortunately, the agency provides virtually no explanation of how, realistically and practically, it would use the data to achieve those purposes. In a nutshell, in Mercer ORC HSE Networks' opinion, OSHA has not sufficiently made the case for change. We also note that OSHA's very narrow view of the costs of these proposed new reporting obligations appears to significantly understate the true cost to employers.

Mercer ORC HSE Networks has serious reservations about whether OSHA has the capacity or resources to evaluate and utilize the new collected data on an ongoing basis in a way that would

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significantly improve the targeting of its resources or, at the end of the day, would result in improved worker safety and health. OSHA is proposing in this rulemaking to collect through prompt employer reporting of up to 210,000 new pieces of data annually – that amounts to 30 to 35 times more data than it is collecting now on fatalities and hospitalizations. In the Benefits section of the preamble, OSHA states that if its use of these new data "save even one life every three to four years as a result of this proposed rule, they will more than pay for the costs associated with such notifications." First, this doesn't appear to be an analytical conclusion, but merely a wishful one. More importantly, surely there would be more efficient ways for OSHA either to use the vast amount of data it is already collecting or to collect a more limited and targeted set of additional data in order to accomplish that glibly stated objective.

Mercer ORC HSE Networks does not come to these conclusions lightly. We dedicate ourselves every day to preventing fatalities and serious incidents, and currently have over 40 member companies engaged in a task force focused on fatality and serious injury prevention. We well-understand the value of data in analyzing causes, evaluating risk and assessing intervention. However, we do not believe the proposed new data reporting requirements will result in significant improvements in OSHA's ability to prevent such occurrences.

Mercer ORC HSE Networks recommends that OSHA consider identifying a subset of the hospitalization/amputation data that it is proposing to collect and that might be more clearly and directly related to a high risk of serious injury or illness. A more focused and limited set of data might make it more feasible for OSHA to evaluate and respond to promptly, less burdensome for companies to report and more directly relevant to OSHA intervention. For example, instead of collecting data on all hospitalizations, a final rule might limit reporting to those hospitalizations resulting from acute injury or exposure to a chemical which results in medical treatment for one or more of the following conditions:

1. Concussions and cerebral hemorrhages
2. Spinal cord injuries
3. Puncture, tearing or laceration of internal organs
4. Diagnosed symptoms of heat "stroke"
5. Acute radiation exposure

This is not intended to be an exhaustive list but merely illustrative of kinds of conditions that result in hospitalization and that are likely to be indicative of a substantial future risk warranting OSHA's intervention. Mercer ORC HSE Networks would be pleased to work with OSHA to develop a more complete list.

OSHA Assertions of Value from the Proposed Rule Are Overstated and Unsubstantiated When It Comes To their Practical Application

In making the case for change, OSHA notes that requirements were initially established in 1971 for employers to report, within 48 hours after occurrence, work-related incidents resulting fatality and/or the hospitalization of five or more employees. These requirements were revised in 1994 to require employers to report, within eight hours, fatalities or the in-patient hospitalization of three or more workers.

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1. Getting to the accident scene while the evidence is fresh: In attempting to justify the current proposed revision, OSHA quotes the preamble to the 1994 revision: "… that more prompt reporting enables OSHA to inspect the site of an incident and interview personnel while their recollections are immediate, fresh, and untainted by other events, thus providing more timely and accurate information about possible causes of the incident."

Certainly it seems intuitive that OSHA can respond to an incident faster when notified of the incident shortly thereafter, and that the evidence at the scene of the accident (and information obtained from interviews) is likely to be more accurate closer to the event. We do not dispute those assertions. But that logic applies to most work-related injury incidents and acute illness exposures.

The question is where should the Agency draw the line in having these incidents reported and in responding to them?

We agree with OSHA that part of the answer should be based on the severity of the case. But part should also be based on practical considerations, especially OSHA's capacity to evaluate and act on the information in a timely manner. OSHA is proposing to collect an enormously expanded set of data and the agency only makes broad assertions about using it to "facilitate the timely investigation of harmful incidents and quick mitigation of hazards." It makes no sense to collect data that OSHA has insufficient resources to evaluate quickly and act on promptly. In short, if quick incident response is a main reason for the proposed expansion in reporting requirements, then OSHA must make a showing that it has the necessary resources to actually do so.

With 40 years of rich agency "fat-cat" investigation experience and data, it would have been reasonable to expect OSHA to have provided some (any) demonstration of how those investigations and the information gleaned from them have resulted in safer workplaces and how, with some specificity, the collection of the proposed substantially increased reports of incidents is expected to improve the agency's effectiveness. As the proposal stands, there is almost no evidence (or data) in the record to support OSHA's "belief" that collecting this new information will make a positive difference in Agency efficiency or in serious injury reduction.

2. The assertion that making all hospitalizations and amputations reportable will provide OSHA with needed causal information: All of the cases that would be reported under the new OSHA criteria should already be captured on the OSHA log. To target inspections, OSHA already collects summary data that includes these cases from a census of sites in portions of the private sector that the Agency feels tend to involve higher risk. BLS also captures the same information in more detailed form in a parallel (and some would say, redundant) data collection effort. In addition to its annual survey that produces incidence rates and detailed case characteristics across industry, BLS also conducts a Census of Fatal Occupational Injuries (CFOI) that produces accurate counts and very detailed descriptive data on fatal work related injuries. So data on fatalities and amputations should clearly be accessible from existing data collections.

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Granted it might be harder to capture data on some in-patient hospitalizations. But some of that information could be obtained from existing OSHA supplementary records. Data that could not be extracted from existing OSHA records could be obtained by less burdensome means than proposed, such as conducting follow-back studies of a small sample of employers.

3. The assertion that the proposed reporting requirements would help establish a "comprehensive database that would more accurately reflect the hazards that cause hospitalizations and amputations as well as identify the associated industries, processes, and other relevant factors." As referenced above, many of these data are already available through other means. Surprisingly, the record is devoid of any evidence that the Agency has used data from existing requirements to identify or analyze the hazards that contribute to those cases. If OSHA has not been able to fully harness information obtained from existing requirements, it seems a stretch to expect the Agency to respond to more reports and to effectively leverage the added data that could be generated under the expanded scope of the proposal.

Perhaps more importantly, merely establishing such a database may not be the best way, or even a very good way, to better determine how to better focus OSHA's resources on high-hazard workplaces. Put another way, it is not at all clear that employers experiencing the new case categories identified in the rulemaking (hospitalizations of one or two employees and/or amputations) pose increased future risk to workers, or are any more likely than other employers to experience future serious cases. OSHA makes that implicit assumption without support. For example, a study conducted by Rand several years ago for the Duke Energy Foundation found that sites experiencing fatalities usually posed less risk to workers for future serious injury, not more.

OSHA Underestimates the Potential Additional Reporting Burden

OSHA also underestimates the added costs imposed by these proposed new requirements. OSHA focuses strictly on the amount of time it takes an individual to "pick up a phone" and make the report to OSHA. This is an unduly narrow view of the impact of the proposal on employers.

For example, compressed time frames for reporting cases will impact existing incident investigation methods. Under the existing recordkeeping criteria in 29 CFR Part 1904, employers must make an entry in the OSHA records within seven calendar days of learning that an OSHA recordable case occurred. That gives them a reasonable amount of time to conduct an incident investigation, sift through the facts, and determine whether or not the case is work related.

Under the proposed reporting criteria, employers will have greatly reduced time frames to make the same determination. While this will not likely be factor for amputations and many hospitalizations, it will affect some portion of the thousands of additional hospitalizations that would be reported. That will require reallocation of resources not reflected in the OSHA rulemaking.

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Finally, making an oral report to OSHA requires making sure that a connection is made with the Agency in the time frames specified in the regulation. All fatalities, in-patient hospitalizations, and amputations do not occur within normal Agency hours of operation. Mercer ORC networks is aware of at least one case where an employer called OSHA after hours to notify the Agency of an incident, was unable to connect with anyone, and received a citation for leaving a message on OSHA's answering machine. The point is that requirements such as these frequently have unanticipated consequences and are not as "burden free' as they might initially appear.

III. Mercer ORC Networks Recommends A Government-Wide Safety and Health Data Review

We believe that this proposal is emblematic of a larger problem; that the *national system for collecting and compiling data on occupational injuries and illnesses is really a hodge-podge of disparate data requirements* developed by different Agencies to meet their own particular needs. BLS, OSHA, and NIOSH all collect data on occupational injuries and illnesses. So do many State agencies. These different data producers (and data users) do seem to communicate with each other and share data where appropriate within existing requirements. But each system operates, to a large degree, within its own data "silo." As a result, there is really no comprehensive view of what data are needed to effectively administer federal and State programs or to support the reduction of occupational injury, illness or death; no one really knows the gaps that exist in existing safety and health data systems; and no one has really taken stock of system overlaps and potentially redundant data requirements.

Consequently, forty plus years after passage of the Occupational Safety and Health Act, we have no real handle on the occurrence (or prevalence) of occupational illness in the United States, and many even question the accuracy of the data we use to track injuries and acute ill health conditions.

This patchwork quilt of data systems has taken decades to evolve. No one Agency is to blame – certainly not OSHA. But the problem exists – and persists - nonetheless. On the governmental side, it likely results in inefficient use of scarce federal funds and produces less than optimum information. Consequently, OSHA, state Agencies, and others lack the information they need to optimally target key hazards and drive needed improvements.

Employers (who end up being the source for much of the requested information) often feel that they are subject to a barrage of requests for information – much of which seem to add little tangible value to the injury and illness prevention process.

The last study of the national injury and illness data system was conducted over two decades ago by the National Academy of Sciences. Although all of the findings were not implemented, the 1987 report, *Counting Injuries and Illnesses in the Workplace*, served as the basis for a major overhaul of the BLS safety and health statistical programs.

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Mercer ORC Networks believes that we are overdue for another systems-wide review, and would be glad to participate in, and even help coordinate, the effort. The initial cost for such a review might seem high given the current budget climate. However, we are convinced that the investment would be "drop in the bucket" compared to the potential savings in program efficiencies and improvements in prevention effectiveness.

Conclusion

Mercer ORC HSE Networks greatly appreciates the opportunity to provide comments on this proposed rulemaking and would be pleased to provide additional information and to work with OSHA to develop an appropriate and effective final rule.

Sincerely,

Frank A. White
Global Director, Mercer ORC HSE Networks

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