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From: Naval Inspector General
To: Chief of Naval Operations

Subj: ANNUAL NAVAL INSPECTOR GENERAL SAFETY AND OCCUPATIONAL HEALTH (SOH) OVERSIGHT INSPECTION REPORT FOR FISCAL YEAR (FY) 2007

Ref: (a) OPNAVINST 5100.23G

Encl: (1) Annual SOH Oversight Inspection Summary Report for FY 2007

1. Per reference (a), a summary of SOH oversight inspection results for FY 2007 is provided in enclosure (1).

2. One of the goals of the oversight inspection process is to identify systemic and policy issues that may conflict and hinder an activity's ability to provide a safe and healthful work place. Mishap reduction is a strong indicator of achieving a safe environment. In FY 2007, as in previous years, we found that progress was made in reducing mishaps, but none of the inspected activities achieved the DOD mandated 75% injury reduction goal. Activities with more formal processes demonstrated better performance in reducing mishaps. Those that lack fully implemented mishap prevention and self-assessment processes were less successful. Outside support to inspected activities in the areas of industrial hygiene, occupational medicine, and workers' compensation remains customer-focused and meets or exceeds requirements. Greater involvement by the chain-of-command is needed to ensure subordinates have the resources to conduct self-assessments. Our inspections in FY2008 will focus on the quality and scope of these self-assessments.

3. During FY 2007, NAVINSGEN conducted eight SOH Activity Oversight Inspections, four Area Visits and one Command Inspection. In addition to evaluating implementation of the Navy mandated Process Review and Measurement System (PR&MS) methodology at the activity level, we focused on support being provided by higher echelons and supporting Navy activities.

4. My point of contact for oversight inspections is CAPT Thomas Cunningham, CEC, USN at DSN 288-6648, commercial (202) 433-6648.

JILL VINES LOFTUS
Deputy

Annual Safety and Occupational Health (SOH) Oversight Inspection Summary Report for FY 2007

1. NAVINSGEN conducted eight SOH Activity Oversight Inspections (SPAWARSYSCEN Charleston, NAVMEDCEN Portsmouth, COMSTRKFIGHTWING LANT, COMHELSEACOMBATWING LANT, COMNAVBEACHGRU TWO, COMELSG Williamsburg, SOUTHWEST RMC, San Diego and NAVSHIPYD & IMF Pearl Harbor), four Area Visits (Europe, Gulf Coast, Guantanamo Bay, and Hawaii), and one Command Inspection (COMPACFLT). The eight activity SOH oversight inspections included Category A (high-risk) shore activities from NAVSEASYSCOM (1), NAVFACENGCOM (1), BUMED (1), SPAWARSYSCOM (1), and four operational commands under USFLTFORCOM. NAVINSGEN area visits and the command inspection both included assessments of regional and headquarters SOH program implementation and management.

2. The inspected shore activities have mature safety programs and meet most of the safety program requirements. The safety officer position at most operational commands is a collateral duty. Collateral duty safety officers tend to have less knowledge of the program elements and rely primarily upon the Base Operating Support (BOS) Safety Services provided by CNIC. As noted in previous annual and semi-annual reports, most Navy activities are deficient in full implementation of the mishap prevention and self-assessment processes. Activities lack an overall mishap prevention plan or strategy, and fail to use leading indicator hazard data when analyzing mishap prevention data. Most activities are not fully using the self-assessment process to identify, plan, and make improvements to decrease mishaps. Our review of the SOH evaluation reports conducted by headquarters commands found a lack of self-assessments.

3. The level of safety support identified in both the FY 2006 Annual Report and this report continues to be inconsistent throughout CNIC Regions. CNIC funds the regions at Common Output Level 3, which only requires implementation of 75% of OPNAV safety requirements. Without any guidance or revisions to policy, Navy Regions are independently selecting which SOH programs to implement. These actions have a negative impact on activities that rely on regional safety support to identify and evaluate hazardous operations.

4. **Observations and Findings:** A review of the general oversight inspection observations and findings by major categories follows:

a. *Mishap Prevention Process*: One area requiring general improvement is in the establishment and maintenance of formal mishap prevention plans. Only two of the eight (25%) activities had plans firmly established and four of the remaining six (67%) activities had mishap prevention process deficiencies cited in NAVINSGEN reports. Most activities failed to collect or use leading indicator data to reduce mishaps. In those

commands where senior leadership was fully engaged and supportive of mishap prevention efforts, there was a corresponding decrease in injury and illness rates. Although we observed progress towards reducing overall injury and illness rates, none of the inspected activities has achieved the DOD mandated 75% injury reduction goals based upon FY 2002 baselines. A more proactive role from headquarters commands is required in supporting the mishap prevention process.

b. *Safety Management Systems*: Six of the eight (75%) inspected activities have implemented Navy SOH program requirements. Regional and activity safety offices with adequate staff, such as the Pearl Harbor Naval Shipyard and Intermediate Maintenance Facility, generally have mature, well implemented programs. The shipyard attained the Occupational Safety and Health Administration's (OSHA) Voluntary Protection Program (VPP) and achieved STAR status in 2007. Naval activities that fully implement the Navy's safety program tend to do well when seeking VPP certification. Operational units and smaller tenants lacking adequate safety staff and expertise have more deficiencies in the various sub-program areas.

Six of the eight (75%) activities have implemented Operational Risk Management (ORM) concepts. The operational activities and military components are further along in practicing ORM as outlined in the instruction, OPNAVINST 3500.39B. Rather than strict adherence to a formal instruction or program, activities are using the principles of ORM, whether on or off-duty, as a valuable decision-making tool to reduce further risk. We recognize the challenges of changing behavior through formal training and recommend CNO (N09F) revise the ORM Program to encourage a more user-friendly and wider application within the Navy community.

Safety office staff, supervisors and employees could identify most of the deficiencies we observed. Four of the eight (50%) activities had deficiencies in the procedures for employees to report unsafe or unhealthful working conditions. Many operational activities, like COMNAVAIRFOR, are moving toward web-based methods for reporting unsafe work conditions. These systems do not fully comply with all safety requirements. We recommended that CNO (N09F) take the opportunity to review and revise current procedures to include viable web-based alternatives for employees to report unsafe/unhealthful working conditions.

Deficiencies in safety training continue to be the most prevalent findings. Five of the eight (63%) activities and three of the four (75%) area visits had findings in safety training. The three findings of most significance are the lack of a formal training plan that identifies all required training and target audiences; no determination of the adequacy/completeness of the training; and no method to evaluate the effectiveness of the training. Some of the headquarters commands have begun to implement the Enterprise Safety Application Management System (ESAMS) as a means to provide safety training, with many activities finding the program very useful. Our review of ESAMS found some of the courses available do not contain all of the required information to meet both Navy and federal standards. A recommendation to correct this deficiency was provided to CNIC.

c. *Self-Assessment Process*: As noted in prior reports, there remains significant room for improvement in the self-assessment process since only one of the eight activities (12.5%) performed a self-assessment containing all of the required elements. Two of the eight inspected activities (25%) failed to conduct the required annual self-assessments. Those self-assessments we observed were most often limited to only regulatory compliance items. There was also a lack of command involvement in the process. Just two of the eight (25%) activities' safety policy councils reviewed self-assessments and tracked the progress of the required improvement plans. We also found that smaller tenant activities did not perform self-assessments due to the lack of qualified personnel. CNIC regional safety offices did not conduct self-assessments for the smaller tenants due to insufficient staffing or the belief that this requirement is not a CNIC responsibility. While many of the smaller tenants have less risk than larger more industrial activities, the lack of self-assessments could result in safety risks being overlooked. Recommend CNO (N09F) instruct headquarters commands review the self-assessment process and address required elements, especially for activities without their own safety staff.

d. *Outside Program Support*: Overall, industrial hygiene and occupational medicine support provided by the various medical treatment facilities remains customer-focused and meets or exceeds requirements. Regional and activity safety offices provided many favorable comments about the medical support they received. One notable exception is the lack of afloat industrial hygiene surveys. Since the re-establishment of the periodic shipboard survey requirement in December 2005, BUMED has not completed all of the required shipboard surveys. The lack of current exposure assessments has the potential to negatively impact overall occupational health, and lead to inefficiencies in occupational medicine and safety management.

Injury Compensation Program Administrators (ICPAs) continue to actively support the various regional and activities' efforts to reduce compensation costs and to implement employee return to work programs. Regional and activity safety offices provided many favorable comments about the services provided. We believe the strong working relationships among the ICPAs, safety staff, and supported activities are contributing to the reduction in injury compensation costs we observed at many of the inspected activities/regions.

e. *Headquarter Command Support*: The objective of Headquarters/Echelon II command inspections is to ensure that subordinate commands and field activities have effective safety programs. These evaluations should be of sufficient depth to enable the appropriate echelon commanders and the designated Navy's safety officials to monitor the effectiveness of the respective command or activity programs. We observed a lack of sufficient headquarter oversight, as only one out of four (25%) of the operational commands had received a higher echelon/headquarters command inspection within the past three years. Echelon II commands should be encouraged to ensure there is a process in place to identify and correct safety problems noted in their subordinate commands.

5. **Summary of Issues:** During FY 2007 NAVINSGEN inspections and area visits, a number of SOH program issues and recommendations were developed and provided to SECNAV, CNO and Echelon II commands requesting policy clarification, guidance and improved support. Specific findings and recommendations are summarized below:

a. *Headquarters Inspections*: Not all Headquarter/Echelon IIs conduct required inspections. Inspections reviewed do not always cover the required topics in sufficient depth to determine the effectiveness of subordinates' safety programs. NAVINSGEN recommended that the appropriate inspections be conducted for subordinate activities every three years as required by OPNAVINST 5100.23G. Refer to NAVINSGEN SOH Reports #1831 and #1834.

b. *Self-Assessments*: Not all tenant activities in the various Navy Regions perform self-assessments. NAVINSGEN recommended that CNO (N09F) review the OPNAVINST 5100.23G requirements for activity self-assessments and determine the most practical method to assess safety programs at tenant commands that receive BOS Safety Services from regional commands. Refer to NAVINSGEN SOH Report #1836.

c. *Contracting Officers Representatives*: Improvements are needed in the safety training of contracting officer representatives (COR). NAVINSGEN recommended that CNO (N09F) provide guidance to ensure that COR personnel are trained to oversee the safety of contractor operations as required by OPNAVINST 5100.23G. Refer to NAVINSGEN SOH Report #1833.

d. *ESAMS Training*: Safety training provided through ESAMS does not meet all Navy and federal standards. NAVINSGEN recommended that CNIC review all ESAMS training courses provided to Navy personnel (military and civilian); identify the courses that do not meet minimum Navy and federal standards; and take corrective action to ensure all future training meets Navy and federal standards. Refer to NAVINSGEN SOH Report #1835.

e. *Employee Reports Of Unsafe/Unhealthful Working Conditions*: The aviation community's "Anymouse Program" used to report employee unsafe/unhealthful working conditions does not comply with OPNAVINST 5100.23G requirements. NAVINSGEN recommended that COMNAVAIRFOR "Anymouse Program" reports which qualify as unsafe or unhealthful working conditions, be processed in accordance with procedures listed in OPNAVINST 5100.23G. Refer to NAVINSGEN SOH Report #1831.

f. *Fall Protection*: Adequate fall protection is not routinely provided to personnel in the aviation community. NAVINSGEN recommended that COMNAVAIRFOR establish and implement a Fall Protection Program for Naval Air Forces as required by OPNAVINST 5100.23G. Refer to NAVINSGEN SOH Report #1831.

g. *Aviation Gas Free Engineering*: Current Navy requirements regarding qualifications of Aviation Gas Free Engineering Technicians may place an unnecessary training burden on activities. NAVINSGEN recommended CNO (N09F) review the relationship between

the Confined Space Entry Program and the aviation Gas Free Engineering Program to ensure they complement each other. We also recommended they provide necessary policy clarifications during the next revision of OPNAVINST 5100.23G. Refer to NAVINSGEN SOH Report #1831.

h. *Afloat Industrial Hygiene Surveys*: Not all Navy ships receive required industrial hygiene surveys. NAVINSGEN recommends that BUMED assign responsibility for conducting the industrial hygiene surveys and ensure the surveys are conducted, as required by OPNAVINST 5100.23G and OPNAVINST 5100.19E. Refer to NAVINSGEN 2007 report of Command Inspection of COMPACFLT.

i. *Industrial Hygiene Ship Class Profiles*: Currently, the ship class profile database is not being maintained. NAVINSGEN recommended that CNO (09F) coordinate with BUMED M44 to determine whether the current policy requirement for ship class profiles in OPNAVINST 5100.19E is still valid. If so, NAVINSGEN also recommended that the Commanding Officer, Navy and Marine Corps Public Health Center, update and maintain ship class profiles as specified in OPNAVINST 5100.19E. Refer to NAVINSGEN 2007 report of Command Inspection of COMPACFLT.

6. **BRAVO ZULU:** The vast majority of commands and areas we inspected are working very hard and their SOH personnel are dedicated to improving the overall safety and health of Navy personnel. Below are a number of activities with significant outstanding achievements and/or "Best Practices".

a. *Naval Medical Center Portsmouth, VA*: A proactive Traffic Safety Program championed by the command. This program received the 2005 GEICO Public Service Award and was nominated for the Governor's Transportation Safety Award. Refer to NAVINSGEN SOH Report #1832.

b. *Southwest Regional Maintenance Center, San Diego, CA*: The Gas Free Engineering Program and Standard Operating Procedures Manual (SOP) provided outstanding guidance for the gas free engineering technicians within the operating area. Refer to NAVINSGEN SOH Report #1835.

c. *Strike Fighter Wing, U. S. Atlantic Fleet*: The ORM Program policies set forth by the command leadership touched on all areas of flight, ground, and off-duty safety for its personnel, and resulted in a marked decrease in injuries and illnesses throughout the command. Refer to NAVINSGEN SOH Report #1836.

d. *Naval Beach Group TWO Norfolk, Virginia*: The Alcohol Deglamorization Program implemented by the Commanding Officer resulted in an 80% decrease in alcohol related incidents within the command. Refer to NAVINSGEN SOH Report #1837.

e. *Pearl Harbor Naval Shipyard and Intermediate Maintenance Facility*: Upper management leadership and deck plate participation in the safety program resulted in the command receiving OSHA's VPP Star status. Refer to NAVINSGEN SOH Report #1838.