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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 FY 2008

Ref: (a) OPNAVINST 5100.23G

Encl: (1) Annual SOH Oversight Inspection Summary Report for FY 2008

1. Per reference (a), a summary of Safety and Occupational Health (SOH) oversight inspection results for FY 2008 is provided in enclosure (1).

2. One of the goals of our inspection process is to identify systemic and policy issues that may conflict and hinder the Navy's ability to provide a safe and healthful work place. In FY 2008, as in previous years, we found that progress was made in SOH efforts Navy-wide. However, several recurring challenges were identified in the following areas:

a. *Insufficient identification and trending of DOD's 75% Mishap Reduction Goal.*
The Navy has not clearly defined what mishaps affect the goal and how to report and track them.

b. *Difficulties and inconsistencies with current Navy mishap reporting systems.*
There are multiple competing software systems for reporting SOH mishaps. Most activities report that the Navy mandated Web Enabled Safety System is too cumbersome and that it lacks data analysis capabilities.

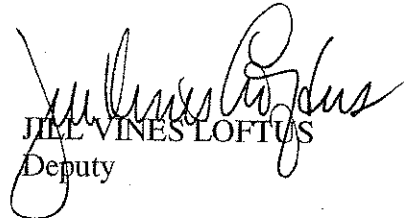
c. *Inconsistent and insufficient levels of Base Operating Support Safety Services.*
Differences in policy interpretation create gaps in SOH support. Individual Activities are unclear about their SOH management responsibility and requirements.

d. *Lack of proper Command Evaluation / Headquarters SOH oversight.*
Required evaluations are not always conducted. As a result, higher echelons do not have sufficient knowledge of the status of subordinate SOH programs.

e. *Activity SOH self-assessments are not being conducted.* Confusion exists as to who is to conduct SOH self-assessments for tenant Activities supported by Commander, Navy Installations Command (CNIC) safety offices.

3. The new traffic and motorcycle instructions have increased the emphasis and headquarters involvement with the Traffic Safety Program. There has not been sufficient time to judge the impact and observe any notable results. Traffic and motorcycle safety will continue to be an area of focus for FY 2009 Command Inspections and Area Visits.

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



JILL VINES LOFTUS
Deputy

Annual Safety and Occupational Health (SOH) Oversight Inspection Summary Report for FY 2008

1. NAVINSGEN conducted six activity SOH Oversight Inspections (NAVSHIPYD Norfolk, HELSEACOMBATWINGPAC, PATRECONWING FIVE, COMHELMARSTRIKEWINGLANT, COMVAQWINGPAC, and NAS Oceana), three Area Visits, (Key West, Northeast, and Great Lakes), and three Command Inspections (COMNAVRESFOR, COMNAVFACENGCOM, and COMUSFLTFORCOM). The six Activity Oversight Inspections included shore activities from NAVSEASYSKOM, CNIC, and four operational commands under COMUSFLTFORCOM. NAVINSGEN Area Visits and Command Inspections both included assessments of regional and Headquarters SOH program implementation and management. The following are overarching challenges NAVINSGEN identified throughout the year.

2. DOD 75% MISHAP REDUCTION GOAL: Although there is senior leadership involvement in mishap prevention efforts, Navy commands did not achieve DOD's goal of reducing mishaps by 75% by the end of FY 2008. Individual Activities visited were unaware of their tracking and reporting role in meeting the DOD 75% mishap reduction goal due to a lack of communication from their Headquarters. As a result, Activities neither established plans nor tracked mishaps in terms which specifically addressed the DOD goal.

NAVINSGEN recommends clearly identifying what mishap data and information is required to be tracked at the Activity level. Emphasis needs to be in place to ensure alignment of data collecting and reporting methods that correspond to the DOD 75% mishap reduction targets. Additionally, Echelon II and Headquarters Commands need to identify where in their chain-of-command, mishap data will be tracked, analyzed, and compared to DOD goals.

3. SOH MISHAP REPORTING SYSTEMS: Multiple Activities reported that the Navy's system to report, record, and track mishaps, the Web Enabled Safety System (WESS), is not "user friendly" and is not focused on the needs of the operational Navy. As a result, under reporting of mishaps by operational units is suspected, due largely to the time consuming procedures inherent in the WESS system. Another method of mishap reporting and tracking is the Enterprise Safety Application Management System (ESAMS), a comprehensive tracking and management system. CNIC requires its subordinate shore installations, including tenant Activities supported by CNIC, use ESAMS as a management tool to report and track mishap data. Many of the Activities NAVINSGEN visited reported that ESAMS was preferred over the WESS system because it was easier to use and is part of an integrated electronic data management system. COMNAVFACENGCOM and COMNAVRESFOR use ESAMS as their single safety program database management tool with very positive results. In fact, COMNAVFACENGCOM modified the safety training imbedded in the ESAMS system to apply to their specific needs. COMUSFLTFORCOM is working with DoD and other Navy Activities to develop and implement yet a third

reporting system, the Risk Management Information System (RMIS), which will ultimately serve as an integrated safety records management system. A prototype of RMIS is scheduled for testing in 2009.

NAVINGEN recommends using a single "user friendly" mishap reporting system for the entire Navy to encourage mishap data and trend analysis.

4. BASE OPERATING SUPPORT (BOS) SAFETY SERVICES: Despite the comprehensive definitions of BOS safety services listed in reference (a), many tenant Activities are not being fully supported by CNIC and are left to perform SOH management functions internally. Activity collateral duty safety personnel lack sufficient SOH training to perform essential SOH services, especially in the areas of self-assessments, training and mishap prevention. This finding has been noted in previous NAVINGEN annual reports. The level and types of SOH safety services vary among CNIC Regions. This is due to the differences in interpretations between CNIC regional safety offices and tenant Activities concerning what constitutes BOS safety services. In the absence of CNIC BOS safety service support, tenant Activities are not fulfilling the requirements of the SOH program. COMNAVFACENGCOM realigned their SOH resources and re-established their own safety offices due to inconsistencies in support from CNIC. Reference (a) requires CNIC Regions to establish individual Inter-Service Support Agreements or Memorandums of Understanding. This can result in inconsistent levels of BOS safety services being provided Navy-wide which contributes to increasing overall risk to the Navy.

NAVINGEN recommends CNIC clearly define the level of BOS safety service they will provide to all Activities. Additionally, NAVINGEN recommends that the individual agreements requirement in reference (a) be removed.

5. COMMAND EVALUATIONS: Insufficient Headquarters oversight of subordinates continues to hamper SOH oversight evaluations. CNIC and COMUSFLTFORCOM did not conduct all required evaluations for their subordinate activities. CNIC delegated SOH oversight to its regional offices. SOH oversight inspections of all regional storefronts were not completed. Although not comprehensive, our inspections for FY 2008 found only COMNAVFACENGCOM and COMNAVRESFOR were meeting their Headquarters requirements.

NAVINGEN recommends CNO emphasize the importance of conducting SOH program oversight evaluations to Echelon II / Headquarter Commands.

6. SOH SELF-ASSESSMENTS: Within the CNIC Regions we visited, there was some confusion between the CNIC regional safety offices and individual tenant Activities over the responsibility for conducting annual SOH self-assessments. Shore commands lack the qualified SOH personnel needed to conduct adequate SOH self-assessments. Without complete self-assessments, the chain-of-command cannot properly assess the overall SOH program status of their subordinate commands or develop improvement plans.

NAVINGEN recommends clarifying the SOH self-assessment process including roles and responsibilities. CNIC should provide comprehensive self-assessments of BOS safety support for installation and tenants Activities.

7. TRAFFIC AND MOTORCYCLE SAFETY: Private Motor Vehicle (PMV) and motorcycle off-duty accidents and deaths continue to rise. Although only 5% of the PMV operators are motorcycle riders, more than half of the PMV deaths involved motorcycles. CINC provides training facilities and motorcycle training courses at no cost to the sailor. However, CNIC does not track the number of motorcycle owners on shore bases. Since individual commands are responsible to track traffic safety training of their personnel, CNIC Regions are unaware of the overall traffic safety training quota requirements. Individual commands need to coordinate with CNIC Regions to ensure adequate training is available. Regional traffic safety councils are proactive with local law enforcement agencies. However, participation by tenant Activities is inconsistent.

NAVINGEN recommends that CNIC regional safety offices, in coordination with Commanders, Commanding Officers, and Officers-in-Charge, compile and track motorcycle rider demographics. This will allow for coordination and implementation of motorcycle safety training at the local level.

8. GOOD NEWS: Senior leadership and employees, working in concert with the professional safety staffs at COMNAVRESFOR and COMNAVFACENGCOM Headquarters, developed proactive safety and occupational health programs. Communication throughout both chains-of-command is excellent. The COMNAVFACENGCOM process for mishap prevention and self-assessments is one of the best NAVINGEN has seen.

The Navy's Operational Risk Management (ORM) Program as addressed in OPNAV-INST 3500.39B is becoming part of the Navy culture. Operational activities are further along in practicing ORM than other shore activities.

Overall, we found the support provided by the medical treatment facilities for industrial hygiene and occupational medicine continues to be good.

9. NOTEWORTHY ACHIEVEMENTS: There were a number of Activities with hardworking dedicated SOH staff who demonstrated excellence through this reporting period.

a. Norfolk Naval Shipyard obtained the Occupational Safety and Health Administration's (OSHA) Voluntary Protection Program (VPP) Star status.

b. Naval Air Station Key West obtained the OSHA VPP Star status.

c. NAS Oceana received a satisfactory progress report from OSHA towards achieving VPP Star status.

d. The Helicopter Sea Combat Wing Pacific pursued individual Squadron incentives to promote safety mishap prevention efforts.

e. Patrol and Reconnaissance Wing Five implemented a motorcycle mentorship program which supports responsible motorcycle riding.

f. Helicopter Maritime Strike Wing Atlantic developed a PMV questionnaire to obtain information from individuals at check-in, including motorcycle ownership and previous traffic and/or motorcycle safety training attended. This was recognized as a best practice by the Naval Safety Center.