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From: Naval Inspector General
To: Chief of Naval Operations

Subj: ANNUAL NAVAL INSPECTOR GENERAL (NAVINGEN) SAFETY AND
OCCUPATIONAL HEALTH (SOH) OVERSIGHT INSPECTION SUMMARY
REPORT FOR FY12

Ref: (a) OPNAVINST 5100.23G, Change 1, 21 Jul 11
(b) CNO Washington DC, NAVADMIN 372/11, 08 Dec 11
(c) A Guide for Commanding Officers and Top Command
Leadership, Voluntary Protection Program Center for
Excellence, Jun 12
(d) Naval Audit Service Report, N2012-0027, 22 Mar 12
(e) CNIC Washington DC, NAVSHORE 003/12, undated

Encl: (1) Annual SOH Oversight Inspection Summary Report for
FY12

1. As required by reference (a), and in accordance with the oversight role of the NAVINGEN, enclosure (1) provides the Summary Report for FY12. The report addresses SOH findings and concerns identified during area visits and command inspections conducted this fiscal year, findings tracked from prior summary reports, and new areas of focus.

2. Prior NAVINGEN annual SOH reports identified the lack of trained collateral duty safety officers. During FY12, we noted improved availability of training courses and an increase in personnel receiving required training. NAVINGEN will continue to monitor this training requirement during area visits and command inspections.

3. NAVINGEN previously reported the failure of commands to designate motorcycle safety representatives and a concurrent lack of accountability for the motorcycle safety program. In reference (b), Vice Chief of Naval Operations directed commands to designate a motorcycle safety representative and use the Enterprise Safety Applications Management System to manage the motorcycle safety program. With one exception, all commands visited in FY12 designated a motorcycle safety representative.

Motorcycle and traffic safety remain a top safety priority for the Navy and NAVINSGEN will continue to focus on these programs during FY13.

4. During FY12 command inspections, 3 of the 5 inspected Echelon II commands did not implement a headquarters SOH management oversight inspection process. Twenty-three findings related to Echelon II safety oversight were documented since FY05; this negative trend is firmly established. Since FY10, NAVINSGEN documented that 6 of 14 Echelon II commands failed to establish a comprehensive SOH program or assign an SOH professional to head their safety organization. NAVINSGEN found other Echelon II commands (that were not part of the FY12 inspection schedule) reduced their safety staff. Safety oversight is currently under review by the Naval Safety Center (NAVSAFECEN), Navy Bureau of Medicine and Surgery, and NAVINSGEN.

5. NAVINSGEN added two new areas of focus during FY12: Voluntary Protection Program (VPP) and Mishap Recommendation (MISREC) Response Time.

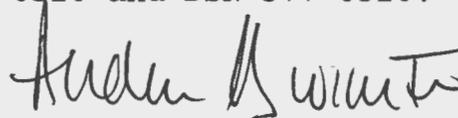
a. The Occupational Safety and Health Administration's (OSHA) VPP is a performance-based safety excellence recognition program. A key element of this program is reducing illness and injury rates below the Bureau of Labor Statistics national average. As reported in reference (c), Navy activities invested in VPP reduced Lost Work Day Rates by as much as 40.2 percent in one year. In FY12, NAVINSGEN visited four commands that achieved VPP Star status, the highest OSHA certification level.

b. MISRECs are corrective actions resulting from mishap causal factors and hazards identified in a safety investigation report after a mishap. MISRECs are submitted using the Web-Enabled Safety System to the NAVSAFECEN, which in turn monitors corrective actions through to completion. In FY12, NAVINSGEN observed two challenges with this system. First, MISRECs are not categorized into short-term (e.g., procedural) and long-term (e.g., jet engine redesign) corrective actions. Second, headquarters commands do not have access to subordinate commands' MISRECs which impedes the corrective action process. Based on the limited amount of data collected to date, NAVINSGEN is not able to provide substantial process improvement recommendations and will continue to assess MISRECs in FY13.

6. NAVINSGEN is concerned about the comprehensive safety posture at our shore commands and observed negative trends in

safety oversight, workplace safety inspections, and facility conditions. A Naval Audit Service report, reference (d), found that 24 of the 54 activities visited failed to conduct the required annual workplace inspections. In reference (e), Commander, Navy Installations Command announced reductions in FY13 facilities funding to Common Output Level (COL) 4. These trends in safety oversight may increase the risk of unsafe workplaces, increase mishap rates, and increase associated occupational health-related costs. NAVINSGEN Special Studies Division is developing a proposal to conduct a special study of the degrading facility and infrastructure conditions; safety and health considerations will be integrated into this study.

7. Should you have any further questions, my point of contact for this matter is CDR Gerald T. DeLong, MSC, USN. He can be reached at commercial (757) 953-0320 and DSN 377-0320.



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**Annual Safety and Occupational Health (SOH)
Oversight Inspection
Summary Report for FY12**

1. The Naval Inspector General (NAVINGEN) conducted five command inspections (Commander, Naval Legal Service Command; Director, Field Support Activity; Commander, Naval Air Systems Command; President, Naval Postgraduate School; Commander, Office of Naval Intelligence) and four area visits (Naval District Washington, District of Columbia; Navy Installations in South Texas; Navy Installations in Pacific Northwest; Navy Region Europe) in FY12. NAVINGEN command inspections and area visits included assessments of Echelon II headquarters and regional SOH program implementation and management.

2. The NAVINGEN Annual SOH Oversight Inspection Summary Report reviews the status of SOH programs, highlights deficiencies identified in previous reports and identifies new areas of concern. The predominant SOH program issues identified are as follows:

a. **Headquarters Oversight:** Headquarters safety and occupational health management evaluations (SOHME) ensure that subordinate commands and field activities have effective safety programs. These evaluations provide valuable insight to Echelon II commanders concerning subordinate commands' mishap prevention efforts, quality of self-assessments, compliance with Navy safety policy, and evaluations of mishap trends. The failure of headquarters commands to implement a comprehensive safety oversight evaluation prevents identification of gaps in mishap prevention, guidance to subordinate commands, funding and resource requirements, and the overall SOH program.

Commander, Naval Air Systems Command is the only Echelon II command of the five inspected during FY12 that implemented a headquarters SOH management oversight inspection process. Three commands (Commander, Naval Legal Service Command; President, Naval Postgraduate School; and Commander, Office of Naval Intelligence) did not implement a headquarters SOH oversight process. Director, Field Support Activity has no subordinate commands; therefore, the oversight process is not required.

NAVINGEN inspection findings during the past few years conclude that industrialized commands such as Commander, Naval Sea Systems Command; Commander, Naval Air Systems Command; and Commander, Naval Facilities Engineering Command conduct SOHMEs according to reference (a) requirements. However, intermediate industrial and administrative commands have not resourced their safety staffs to implement rigorous SOH oversight inspection programs. The shortfalls range from commands with no SOHME process to commands that do not fully evaluate all four key program areas required by reference (a).

A recent Naval Audit Service report, reference (d), reviewed workplace inspections at selected Commander, Navy Installations Command (CNIC) tenant activities. The study found 24 of the 54 reviewed activities did not have required annual workplace inspections. Reference (d) lists the following reasons for the lack of inspections:

- CNIC could not identify all activities potentially needing safety services

- CNIC and activities did not maintain sufficient documentation of communication with tenants specifying services to be provided by CNIC Regional Safety Offices, or records of service request and denials
- CNIC and activities reported insufficient resources to perform workplace inspections
- Subordinate commands were not required to report workplace inspection results to Echelon II commands

CNIC is not solely responsible for shortfalls in the completion of required tenant command workplace inspections; the lack of adequate headquarters safety oversight is also a factor. For example, assessing subordinate mishap prevention efforts is one of the four key elements of the headquarters SOHME process and conducting annual workplace safety inspections is a vital component of the mishap prevention process. If CNIC is not conducting annual safety inspections of tenant commands, then the tenant commands' headquarters should identify this deficiency during the SOHME process and take corrective action. As stated in reference (d), "If safety and occupational health workplace inspections are not performed as required, the Navy misses opportunities to identify and abate safety issues in a timely manner and avoid potentially costly mishaps and hazards." Headquarters commands are equally responsible and must ensure annual workplace safety inspections of subordinate commands are conducted.

In reference (e), CNIC reduced FY13 facility and safety services to COL 4, the lowest service level. While mitigation of safety-driven issues under COL 4 has the highest abatement priority, safety leadership at headquarters commands must factor COL 4 facility services into the SOHME strategy. NAVINSGEN will monitor the impact of COL 4 funding during FY13 area visits and command inspections.

Nonexistent or inadequate headquarters SOH management oversight has challenged the Navy for years. NAVINSGEN documented this deficiency in multiple annual reports without corresponding response or action from leadership. NAVINSGEN continues to recommend that Navy leadership reaffirm the requirement of Echelon II commanders to follow Navy policy, per reference (a).

b. **Headquarters Safety Managers:** In the past several years, NAVINSGEN identified 6 of 14 Echelon II commands that did not establish a comprehensive SOH program or employ an SOH professional to manage the safety program. The six commands identified and corresponding years of inspection are as follows:

- FY10 – Commander, U.S. Naval Forces Europe, U.S. Naval Forces Africa
- FY11 – Commander, Naval Supply Systems Command
Director, Naval History and Heritage Command
- FY12 – Commander, Naval Legal Service Command
President, Naval Postgraduate School
Commander, Office of Naval Intelligence

In order to establish a sound safety program command-wide, provide technical advice, direction and guidance to subordinates, and effectively support and represent their commander, it is imperative that headquarters commands establish a comprehensive SOH program and designate

a safety professional to head the safety organization. NAVINSGEN will continue to monitor this requirement and strongly recommends that Navy leadership enforce this requirement at all Echelon II activities.

c. **Collateral Duty Safety Officer Training:** In FY12, NAVINSGEN noted an increase in the number of trained collateral duty safety officers during the command inspections and area visits. Only one visited command failed to ensure collateral duty safety personnel received the required training.

In response to previous NAVINSGEN reports of deficient training, the Naval Safety and Environmental Training Center (NAVSAFENVTRACEN) developed an online course to reduce training cost. During FY12, 8 classroom and 10 online courses were convened, training a total of 459 personnel. By the end of the FY13 third quarter, NAVSAFENVTRACEN plans to convene 4 classroom and 10 online courses, training approximately 552 students. Depending on the success of the online course, additional online courses may be added to the schedule.

Due to the Navy's past shortcomings in accomplishing this training and the importance to implementing a sound SOH program, NAVINSGEN will continue to track this program. NAVINSGEN strongly recommends that activities ensure personnel assigned collateral duty safety officer responsibilities receive the required training to properly execute their duties.

d. **Vehicle/Motorcycle Safety Training:** Navy regions continue to provide motorcycle safety training and facilities to our Sailors including the motorcycle basic rider, experienced rider, and military sport bike rider courses. During FY12, NAVINSGEN noted an improvement in the processes to identify motorcycle riders, enroll them in the appropriate training course, and track training. Only one command visited by NAVINSGEN failed to designate a motorcycle safety representative. Regional and activity commanders emphasized the need to identify delinquent motorcycle training, determine the cause, and develop solutions. For example, in response to Sailors' concerns that motorcycle training could negatively impact completion of required aviation training, Chief of Naval Air Training (CNATRA) sent a message on 27 September 2011 to all wings and squadrons stating, "Motorcycle training shall take precedence over syllabus events except for ground school, detachments, or other events where a one or two day delay could result in a training delay of several weeks." This message successfully addressed Sailors' concerns. Some commands make a concerted effort to include tenant motorcycle safety representatives into their traffic safety committee. Motorcycle safety training is a top priority for NAVINSGEN and we will continue to closely monitor this program.

3. In February 2012, NAVINSGEN began reviewing the following new programs in area visits and command inspections: Voluntary Protection Program (VPP) and Mishap Recommendation (MISREC) Response Time.

a. **Voluntary Protection Program:** The Occupational Safety and Health Administration's (OSHA) VPP is a performance-based safety excellence recognition program. VPP builds on SOH processes already in place to reduce workplace mishaps and increase readiness. A key element of this program is to reduce illness and injury rates below the Bureau of Labor Statistics national average.

In 2005 (and again in 2007), the Secretary of Defense challenged Department of Defense to meet a 75 percent injury and illness reduction goal. Navy leadership identified the VPP as one method to achieve this accident reduction goal. As reported in reference (c), commands invested in the VPP reduce their civilian Lost Work Day Rate (LWDR). Examples of commands that reduced the LWDR one year after initiating VPP include: Pearl Harbor Naval Shipyard (-40.2 percent); Naval Air Station (NAS) Jacksonville (-35.8 percent); Naval Weapons Station Charleston (-22.5 percent); and Puget Sound Naval Shipyard & Intermediate Maintenance Facility (-19.4 percent). The VPP reduces accidents, the number of lost work days, and occupational health costs; thereby saving money and increasing operational readiness.

In FY12, NAVINSGEN visited four commands that achieved VPP Star status (the highest OSHA certification) including Puget Sound Naval Shipyard & Intermediate Maintenance Facility, Naval Health Clinic Corpus Christi, Naval Station Everett, and Naval Facilities Engineering Command Northwest. Visited activities pursuing VPP recognition include NAS Corpus Christi, Naval Magazine Indian Island, NAS Whidbey Island, Naval Undersea Warfare Center, Division Keyport, and Naval Base Kitsap.

b. **Mishap Recommendation Response Time:** MISRECs are corrective actions resulting from mishap causal factors and hazards identified in a safety investigation report. MISRECs are submitted using the Web-Enabled Safety System to Naval Safety Center, which monitors corrective actions until complete. During FY12 NAVINSGEN observed:

- MISRECs are not categorized into short-term (e.g., procedural) and long-term (e.g., jet engine redesign) corrective actions which may impede the mitigation process
- Headquarters commands do not have access to subordinates' MISRECs which further impedes the corrective action process

Based on the limited amount of data collected to date, NAVINSGEN is not able to provide substantial process improvement recommendations and will continue to assess MISRECs in FY13.

4. Since 2005, NAVINSGEN documented chronic under-investment in facility sustainment and recapitalization, and deteriorating facilities conditions in area visit reports. These reports identify equipment in use beyond recommended service life, maintenance back-logs, deferment of critical repairs to future maintenance budgets, water intrusion issues, degraded mechanical systems, and resultant mold growth problems in workspaces and Navy housing. Due to high concern, risk to Sailor's health, and media attention, NAVINSGEN Special Studies Division is developing a proposal to conduct a special study of the degrading facility and infrastructure conditions; safety and health considerations will be integrated into this study.