



DEPARTMENT OF THE NAVY  
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MEMORANDUM FOR CHIEF OF NAVAL OPERATIONS (09F)

Subj: ANNUAL FISCAL YEAR (FY) 2005 NAVAL INSPECTOR GENERAL NAVY  
OCCUPATIONAL SAFETY AND HEALTH (NAVOSH) OVERSIGHT INSPECTION  
REPORT

Ref: (a) OPNAVINST 5100.23F

1. As required by reference (a), a summary of safety oversight inspection results for Fiscal Year (FY) 2005 is provided. Eighteen Naval Inspector General (NAVINSGEN) Safety Oversight Inspections were conducted during FY 2005. This included six stand-alone Category A (CAT A) inspections of high-risk activities, and ten CAT B activities were reviewed during two NAVINSGEN Area Visits. These reviews determine the efficiency and effectiveness of current Navy safety programs.

2. In addition to reviewing Occupational Safety and Health (OSH) programs, NAVINSGEN has expanded the scope of area visits to include Traffic Safety, Recreation and Off Duty Safety (RODS), Operational Risk Management (ORM), SECDEF 50% Mishap Reduction Efforts, Federal Employee Compensation Act (FECA), Federal Fire and Emergency Management, Occupational Health Support and contractor oversight.

3. Regional systemic issues were noted and addressed to Commander, Navy Installations (CNI) concerning the definition, use and application of Common Output Levels (formerly Capability Levels), which had created confusion concerning the development and implementation of Intra Service Support Agreements (ISSAs), resourcing, and staffing levels. Additionally, CNI did not perform any Occupational Safety Health Management Evaluations (OSHMEs) of their subordinate commands during FY05.

4. Major OSH findings noted in each key process area for the CAT A type inspections were:

a. Immediate Superior In Command (ISIC) NAVOSH Oversight. We found the ISIC OSHME program required by reference (a) to be virtually non-existent. Without improvement in the ISIC OSHME program, improvement in the Navy's NAVOSH program at field activities will be limited.

b. Mishap Prevention Process. Commands continued to focus their mishap reduction efforts on analysis of, and reaction to, mishap data and workplace conditions. Mishap investigations failed to identify "root causes" of mishaps; but many were attributed to "human factors." Incidences of mishaps attributable to actual workplace deficiencies commonly noted during compliance inspections occurred less frequently. The majority of commands were still collecting and analyzing trailing indicators (mishaps) rather than leading indicators (e.g., industrial hygiene

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survey results, job hazard analyses or use of operational risk management) in their efforts to reduce mishaps. This has been a recurring problem for over five years. The lack of lines of accountability remains a contributor to the Navy's inability to meet DoD's mishap reduction goals.

c. Supervision Process. Commands failed to incorporate specific OSH performance criteria in supervisor and employee performance standards. Performance evaluations rarely documented superior or deficient performance. Inclusion of OSH performance criteria in supervisor and employee performance standards and use of the standards to document performance is still inadequate. This is also a repeat finding over the last several years. There was however, a general improvement in the assignment of safety responsibilities and accountability to upper management and supervisors by the commanding officers and senior management. The integration of Safety into the command culture and business goals and objectives was observed at only one activity inspected this period.

d. OSH Training process. Commands failed to develop a comprehensive safety training plan (or failed to incorporate safety training into the command's training plan) and frequently had less than adequate processes in place to determine training effectiveness. Although most commands had OSH training plans, most failed to include all the necessary information, (i.e., identification of personnel required to be trained; the frequency training is required/provided; and assigned responsibility) for ensuring the training is attended or provided. Consequently supervisors had to rely on other sources to obtain information on safety training requirements. Without a good tool for scheduling training around work requirements, supervisors frequently requested and received an unscheduled training class for their shop in order to "catch-up." An adequate planning tool is not available to supervisors. A tool should be provided in order to hold supervisors accountable for ensuring employees attend the scheduled OSH training. The lack of a comprehensive training plan contributed to the failure to provide all required training to personnel who needed the training. This is also a repeat finding from prior inspection results.

e. OSH Self-Assessment. Most commands had a fairly accurate view of their safety program status. However, the written self-assessments often failed to address the adequacy of resources or the level of personnel participation in the OSH program/process. Also, the self-assessments frequently did not substantiate conclusions or provide an adequate audit trail for actions resulting from the assessments. The self-assessments were conducted primarily by the OSH office, there was little or no input from other command personnel. Results and improvement plans were not always effectively communicated throughout the command, thus contributing to misperceptions concerning the implementation and effectiveness of the OSH program at the shop level. This remains a systemic problem throughout naval commands.

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f. OSH Regulatory Compliance Process. Several program element deficiencies were consistently identified.

1) Energy control (lockout/tag out). Commands failed to provide specific energy control procedures, training and annual audits were less than adequate, policy documents did not address all required elements, and lockout/tag out devices was not standardized.

2) Employee hazard reporting. Commands failed to post employee hazard reporting procedures, forms, and applicable appeal processes. Interim/final responses often omitted required elements or were not provided within required timeframes.

3) Hearing conservation. Commands failed to provide training and/or annual audiograms to personnel in the Hearing Conservation Program. Employees needing follow-up audiograms either did not return for testing or supervisors were not ensuring employee attendance for the exams scheduled.

4) Hazardous material control management. Commands failed to consider reproductive hazards when screening hazardous materials for inclusion on the activity authorized use list.

5. My point of contact for NAVOSH Oversight Inspections is CDR Warren Jederberg, MSC, USN, at DSN 288-6644, (202) 433-6644, or email warren.jederberg@navy.mil.



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