



DEPARTMENT OF THE NAVY
NAVAL INSPECTOR GENERAL
1014 N STREET SE SUITE 100
WASHINGTON NAVY YARD DC 20374-5006

IN REPLY REFER TO:

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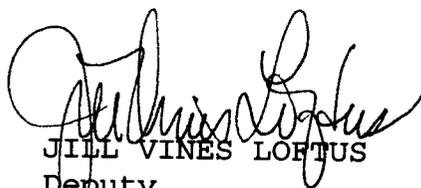
MEMORANDUM FOR CHIEF OF NAVAL OPERATIONS (09FB)

Subj: SEMIANNUAL FISCAL YEAR (FY) 2004 NAVAL INSPECTOR GENERAL
NAVY OCCUPATIONAL SAFETY AND HEALTH (NAVOSH) OVERSIGHT
INSPECTION REPORT

Ref: (a) OPNAVINST 5100.23F

Encl: (1) Semiannual Fiscal Year (FY) 2004 NAVOSH Oversight
Inspection Summary Report

1. As required by reference (a), a summary of NAVOSH oversight inspection results for the first half of Fiscal Year (FY) 2004 is provided. A report of trends and data summary is forwarded in enclosure (1).
2. Ten NAVOSH oversight inspections were conducted during the first half of FY 2004 using the Chief of Naval Operations mandated Process Review and Measurement System (PR&MS) methodology. The inspections identified reoccurring trends in ineffective self-assessments and poor mishap prevention analysis and reporting. Also noted was a continued lack of a clear understanding and interpretation of the PR&MS.
3. My points of contact for oversight inspections are CAPT R. Natsuhara, CEC, USN at DSN 288-6648 and commercial (202) 433-6648 and CDR L. Byrnes, MSC, USN, at DSN 288-6644 and commercial (202) 433-6644.


JILL VINES LOFTUS
Deputy

Semiannual Fiscal Year (FY) 2004 NAVOSH Oversight Inspection Summary Report

Ten NAVOSH oversight inspections were conducted using PR&MS. The average PR&MS inspection process score for this period was 78 percent. This represented a marked process improvement trend for command support of the PR&MS methodology. (Chart 1). Since each command is unique, it is difficult to compare score values but the increase may indicate that PR&MS, as a methodology, is starting to mature and become a part of the safety culture at many Navy shore commands. Trending model score results for this semiannual period indicate self-assessment has improved overall, but remains the most difficult process to meet the performance measures applicable. (Chart 2)

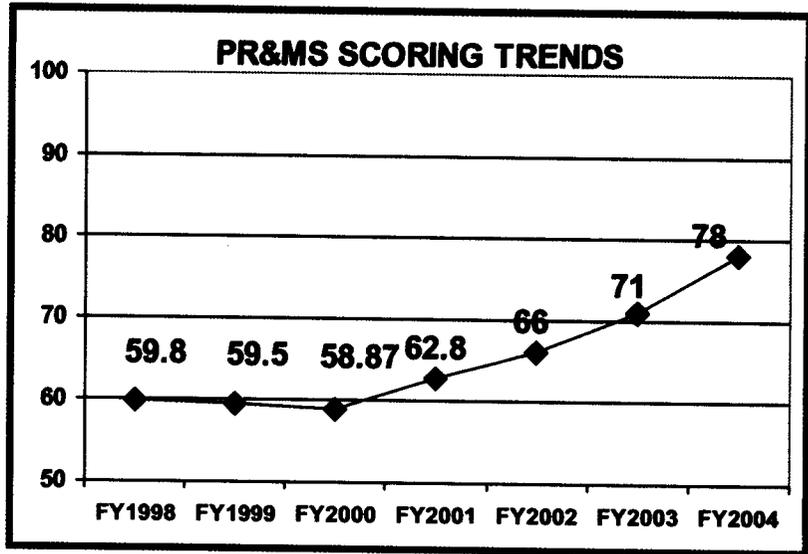


Chart 1

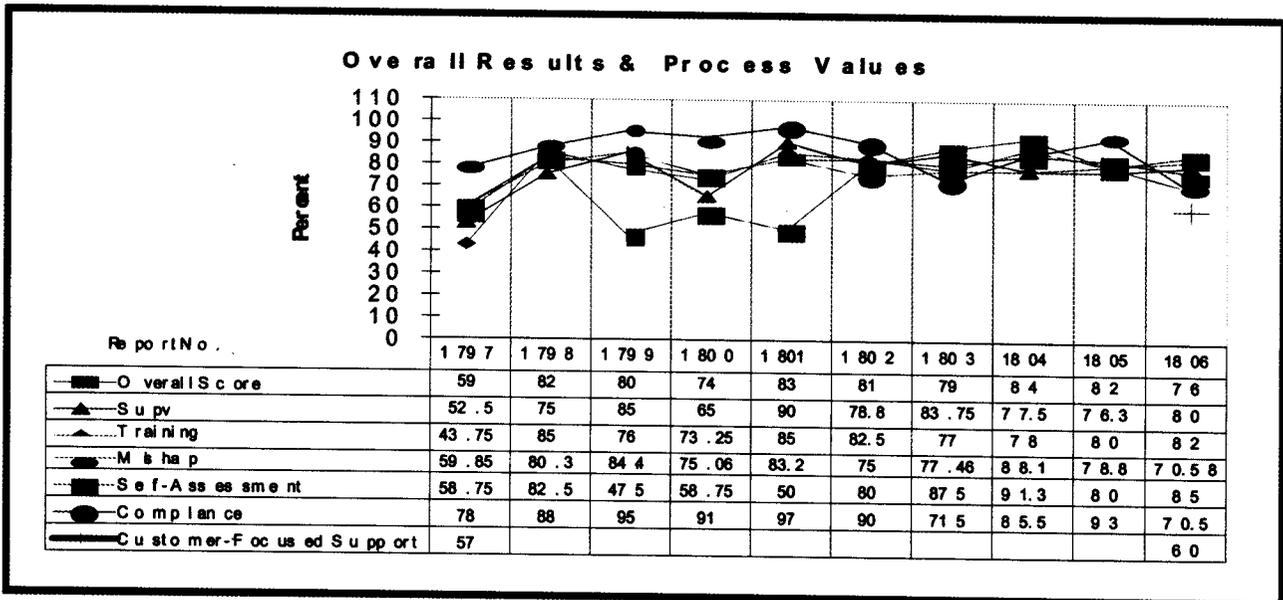


Chart 2

The major findings we noted in each key process area were:

Self-Assessment Process: Lack of a comprehensive self-assessment of the command's OSH program. Inspection results for eight of ten (80%) activities and regions inspected indicated OSH office self-assessments were not comprehensive. They did not assess the primary models

ENCLOSURE(1)

addressed in the PR&MS, did not address the adequacy of OSH resources, personnel participation, communication of mishap data collection/ reporting information, and mishap data analysis. The PR&MS self-assessment (SA) process has historically been difficult to apply because of limited design and application for command use. Various internal Navy organizations and contractor attempts have been applied to help satisfy PR&MS SA concepts. The CNO NAVOSH PR&MS Quality Management Board (QMB) is in final development of an SA tool for field implementation.

Action: Regional and Activity Commanders/Commanding Officers should be prepared to integrate the forthcoming CNO NAVOSH QMB Self-Assessment Process tool for process improvement strategies.

Mishap Prevention Process: Lack of guidance, direction and use of collected mishap data. Seven of the ten (70%) inspections noted systemic problems in Mishap Prevention Programs attributed to the lack of proper analysis of mishap data and trends. One of the ten activities continued to rely solely on a regulatory compliance format rather than a process system. Root cause analysis of mishaps was rarely, if ever, conducted at several activities to effectively trend data and process flows for mishap reductions.

Action: Continue emphasis on operational risk management and job hazard analysis at the department and shop level. Improved efforts are needed to ensure line supervisors are held accountable for data collection, analysis and reporting mishap trends. Additional mishap training for new personnel assigned recordkeeping responsibilities is needed to circumvent this continuing inaccurate mishap reporting issue.

Supervision Process Model: OSH performance criteria in supervisor and employee performance standards and failure to make "safety" a measurable element in performance standards. Eight of the ten (80%) inspections had findings attributable to OSH not being addressed in supervisory performance standards. A large majority of those activities had generic elements of information in their performance standards, but failed to address OSH information and expectations to members of the work unit.

Action: Commands/Regions need to develop specific criteria, which can be measured and to which personnel are held accountable to ensure those actions that prevent mishaps, are addressed. These could include such actions as shop inspections, job hazard analysis, pre-operational briefs, etc. Additional guidance from Human Resources Offices on how to include criteria in employee performance standards would be beneficial.

Training Process: Lack of developed Training Plan, ineffective lesson plans and no processes in place to measure the effectiveness of developed and provided training. Seven of the ten (70%) activities/regions had deficiencies attributed to the lack of a developed training plan for implementation, resulting in failure to ensure employees received appropriate training for potentially hazardous work processes. Three organizations failed to assess the requirements and needs for the provision of effective training development. A process to determine training effectiveness had not been conducted at nine of the ten (90%) inspections conducted. One region had established a feedback mechanism whereby safety specialists observed safe/unsafe behavior in the workplaces during the inspection process and reported findings to the OSH training department to determine training effectiveness and potential changes needed.

Action: Commander, Naval Safety Center establish a format, and or methodology for assessing the effectiveness of Navy Occupational Safety and Health training.

Regulatory Compliance: Scores remain constant and identical workplace deficiencies continue to be identified. Most of the deficiencies identified were those that could be easily identified and corrected by supervisors and employees; however, traditionally, the "fix" has been to correct the deficiency (symptom) and not the cause of these recurring deficiencies. The most predominant workplace deficiencies noted were those within the following areas: electrical, machine guarding, hazardous material, material storage, respiratory protection, and material handling.

Action: Activities must train supervisors and employees to identify these common deficiencies, require supervisors to conduct periodic worksite inspections (as required by OPNAVINST 5100.23F) and recognize (measure) supervisor and employee efforts in identifying and abating deficiencies to ensure more consistent compliance and identification of hazards, rather than relying solely on the annually-required inspections by OSH professionals.