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[Occupational Health Efforts of the Department of Defense]. HRD-79-9; B-163375. November 21, 1978. 6 pp.

Report to Harold Brown, Secretary, Department of Defense; by Gregory J. Ahart, Director, Human Resources Div.

Issue Area: Consumer and Worker Protection: Employers Compliance With Occupational Health Standards (912).
Contact: Human Resources Div.
Budget Function: Health: Consumer and Occupational Health and Safety (559).
Organization Concerned: Department of the Navy; Department of the Army.
Congressional Relevance: House Committee on Armed Services; Senate Committee on Armed Services.

Occupational health efforts of three military installations were reviewed to determine whether their programs were effective in protecting employees from exposure to toxic substances and harmful physical agents. Of the three installations reviewed, none were routinely requesting material safety data sheets when they bought toxic items, and data sheets were not on hand for most of the toxic items found at the installations. Most of the workers interviewed at the Picatinny Arsenal and about half of the workers interviewed at the Norfolk Naval Shipyard were unaware of the potential harmful effects of the substances they worked with and had not been given training in safe use of emergency procedures for the substances. Workers at the Portsmouth Naval Regional Medical Center indicated that they were aware of the hazards of some of the substances they worked with and were trained in their safe use. At all three installations, the industrial hygiene surveys were not adequate to detemine whether employees working with toxic substances were adequately protected. The Departments of Defense, the Army, and the Navy have established occupational safety and health policies and have issued directives and guidelines for establishing and maintaining effective programs. However, adequate action has not been taken to assure that the programs were properly implemented. The Secretary of Defense should take actions to assure that effective occupational health programs are implemented at Department of Defense installations. (HRS)

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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HUMAN RESOURCES
DIVISION

B-163375

November 21, 1978

The Honorable Harold Brown
The Secretary of Defense

Dear Mr. Secretary:

We reviewed the occupational health efforts of several Federal agencies, including the Departments of the Army and the Navy, to determine whether their programs were effective in protecting employees from harmful exposures to toxic substances and harmful physical agents.

While the military departments have developed comprehensive occupational safety and health programs, a need exists for more effective implementation of these programs in the Department of Defense's workplaces. Our work at the Norfolk Naval Shipyard, the Portsmouth Naval Regional Medical Center, and the Picatinny Arsenal showed that (1) greater efforts are needed to protect the health of workers and (2) higher level involvement is needed to assure that departmental occupational health regulations are effectively implemented.

INADEQUATE IDENTIFICATION
OF TOXIC SUBSTANCES

Federal Standard 313A 1/ requires that Federal agencies obtain material safety data sheets for the hazardous items they buy. These sheets show hazardous ingredients, fire and health hazards, emergency and first aid procedures, and any special precautionary or protective measures which should be taken when using the items. Of the three installations reviewed, none were routinely requesting data sheets wher they bought toxic items, nor were data sheets on hand for most of the toxic items we found.

1/This standard was issued by the General Services Administration in June 1976 and deals with the preparation and submission of material safety data sheets for hazardous items sold to the Government.

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(20665)

At all three installations, substances often were not labeled or were inadequately labeled as to their toxicity, and no inventory records of toxic substances existed.

WORKERS NOT AWARE OF HAZARDS AND NOT ADEQUATELY TRAINED IN HANDLING TOXIC SUBSTANCES

We interviewed workers at the three installations. Most of the workers interviewed at the arsenal and about half of the workers interviewed at the shipyard said they (1) were unaware of the potential harmful effects of the substances they worked with and (2) had not been given training in safe use and emergency procedures for the substances. However, medical center workers indicated they were aware of the hazards of some of the substances they worked with and were trained in their safe use.

INSUFFICIENT WORKPLACE MONITORING TO ASSURE EMPLOYEES' PROTECTION

At all three installations, the industrial hygiene surveys were not adequate to determine whether employees working with toxic substances were adequately protected. At the arsenal the industrial hygienist position was unfilled and necessary equipment was unavailable so industrial hygiene surveys were not made prior to the initiation of our review. During our review the position was filled and the commanding officer advised us that proper equipment had been made available.

At the shipyard and the medical center, the available staff was insufficient (1) to make the number of surveys that should have been made and (2) to make indepth surveys. It appeared that most surveys were made either at the request of management or as a result of employee complaints. When air samples were taken at the shipyard, they were often of short duration, such as 10 minutes, rather than for a complete 8-hour shift.

The Occupational Safety and Health Administration's (OSHA's) industrial hygienist, who assisted us at the shipyard, said there should be industrial hygiene surveys and/or improved ventilation at several worksites where employees were exposed to toxic substances. At both the arsenal and the shipyard we noted situations that were inappropriate in view of the toxic substances being used. For example, (a) at the shipyard:

--A popsicle was stored in a freezer with tubes of MOCA, a carcinogen.

--Consumption of food and beverages was permitted in areas where toxic substances were being used.

--Exhaust ventilation in the plating shop needed improvement.

--Set procedures did not exist for the use of personal protective clothing or equipment during mixing operations in the pesticide mixing room and no washing or quick drench facilities were located in the building.

(b) at the arsenal:

--Protection of employees working with MOCA was not adequate. (For example, MOCA cartridges were opened outside the exhaust ventilation area, the ventilation system was unsatisfactory, and employees' work practices needed improvements.)

--Incompatible items were stored together; for example, an oxidizing agent was stored on top of a hydrocarbon.

--Employees ate where toxic substances were used and stored.

--Workers were not provided nor were they using personal protective equipment or clothing.

We noted one instance where the presence of a toxic substance exceeded permissible exposure levels. This instance involved asbestos at the shipyard. The workers were wearing protective clothing and equipment including airline respirators; however, the OSHA industrial hygienist said the number of violations of the asbestos standard taken collectively was serious. These included (1) not wetting the asbestos prior to rip-out (removal), (2) inadequate protective clothing to prevent contamination of employees' personal clothing, and (3) improper disposal of asbestos waste and scrap.

MEDICAL SURVEILLANCE

At the arsenal medical surveillance was usually limited to workers referred to the health clinic by supervisors or the Safety Office. No list existed of personnel working

in hazardous operations. Occupational health personnel were not visiting potentially hazardous operations to determine the extent of the health hazards and the desirability of medical surveillance.

At the medical center the industrial hygiene unit had not made periodic inspections of several workplaces and had made limited inspections of others. During our review medical center officials identified 320 employees who needed periodic physicals because of workplace exposure. Prior to our review the center had identified only 11 of the 320 employees as needing periodic physical examinations. Of the 11 employees 1 had received the recommended physical, 9 had received chest X-rays only, and 1 had not been examined at all. We were told that, due to an oversight, the 10 employees had not received complete physicals.

The shipyard's hygienists had identified over 3,300 employees who should receive periodic physical examinations. However, less than 30 percent of these employees were receiving physicals.

HEALTH PROGRAM EFFECTIVENESS NOT EVALUATED AT WORKING LEVEL

The Departments of Defense, the Army, and the Navy have (1) established occupational safety and health policies and (2) issued directives and guidelines for establishing and maintaining effective programs. However, adequate action had not been taken to assure that the programs were properly implemented.

Department of Defense officials told us that evaluations of Defense agency occupational health programs were primarily administrative reviews to determine if the programs complied with Defense policy and OSHA requirements. Because of a lack of enough qualified personnel, they seldom made workplace inspections to determine how effectively the policies were implemented.

Army officials said that they generally did not make program effectiveness evaluations or workplace inspections. They said major commands and installation commanders, and the Army Environmental Hygiene Agency were responsible for such inspections and evaluations. Hygiene Agency officials told us that they usually made workplace inspections only when requested. They said that the Hygiene Agency has many

programs and occupational health generally is not a high priority program.

For the Navy, the Bureau of Medicine and Surgery is responsible for making program effectiveness evaluations but had not made any for the last few years. However, the Bureau was developing a program to make such evaluations. Bureau officials said the Regional Naval Medical Centers were making some program evaluations but the results had not been reported to the Bureau.

CONCLUSIONS

Workers were being exposed to toxic substances at military installations. The workers were often (1) unaware that the substances were toxic and (2) untrained in the proper way to work with toxic substances.

Workplace monitoring was insufficient to assure that adequate controls were used to protect workers from the effects of toxic substances. The identification of workers needing medical surveillance was not adequate and, even when workers were identified as needing surveillance, medical examinations often were not made.

Top management needs to do more to assure that its occupational health programs are effectively implemented at Defense's workplaces.

RECOMMENDATION

We recommend that you take actions to assure that effective occupational health programs are implemented at Defense workplaces. Such actions should include (1) establishing procedures for the military departments and Defense agencies to verify through worksite inspections the implementation of their occupational health programs and (2) making worksite visits by Defense personnel to evaluate program effectiveness.

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As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and

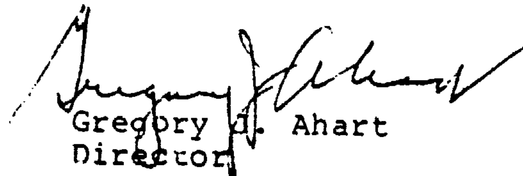
to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent today to the Chairmen, House Committee on Government Operations and its Subcommittee on Manpower and Housing; the Chairman, Senate Committee on Governmental Affairs; the Chairmen, House and Senate Committees on Armed Services; the Chairman, House Committee on Appropriations; the Chairman, Senate Appropriations Subcommittee on Defense; and the Director, Office of Management and Budget.

We would appreciate your comments on the findings and recommendation in this report, including any actions you take or plan to take on the recommendation.

We appreciate the courtesy and cooperation extended by Department of Defense personnel to our representatives during this review.

Sincerely yours,



Gregory J. Ahart
Director