July 7, 2004

THOMAS F. ROSATI
MANAGER, LONG ISLAND DISTRICT

VINNIE MALLOY
MANAGER, NEW YORK DISTRICT

SUBJECT: Audit Report – Efforts to Prevent Accidents, Injuries, and Illnesses in the Long Island and New York Performance Clusters (New York Metro Area) (Report Number HM-AR-04-008)

This report presents the results of our self-initiated audit of the Long Island and New York Performance Clusters' (New York Metro Area) efforts to prevent accidents, injuries, and illnesses (Project Number 03YG011LH004). Our overall objective was to determine whether the performance clusters were reducing the number of accidents, injuries, and illnesses through prevention methods. This report is the third in a series of 7 reports we will issue on accident prevention initiatives in 6 areas and 12 performance clusters. The seventh report will address issues with nationwide impact and will provide the results of our best practice review of safety issues.

The Long Island and New York Performance Clusters implemented prevention initiatives that have the potential to become best practices for reducing accidents, injuries, and illnesses. However, we could not determine whether the prevention initiatives reduced the number of accidents, injuries, and illnesses in the Long Island Performance Cluster. Conversely, the New York Performance Cluster had data showing that the reduction in the number of accidents, injuries, and illnesses was the result of the prevention initiatives.

The Long Island Performance Cluster implemented prevention initiatives to reduce the number of accidents, injuries, and illnesses in a timely manner. We did not evaluate the timeliness of prevention initiatives at the New York Performance Cluster because the new initiatives were not in place during our audit scope, which began September 8, 2001, and ended July 31, 2003. In addition, an opportunity for improvement exists concerning safety staff in both performance clusters. Also, both performance clusters were accumulating and analyzing accident, injury, and illness data for prevention initiatives; however, the systems used are antiquated and will be replaced. Finally, in all six facilities we visited in the Long Island and New York

1735 N Lynn St.
Arlington, VA 22209-2020
(703) 248-2100
Fax: (703) 248-2256

Performance Clusters, the reporting processes facilitated accurate reporting of accidents, injuries, and illnesses.

We have two recommendations to help management in the Long Island and New York Performance Clusters improve their accident prevention initiatives. Management agreed with the findings and recommendations and has initiatives completed or planned addressing the issues in this report. Management's comments and our evaluation of these comments are included in the report.

We appreciate the cooperation and courtesies provided by your staff during the audit. If you have any questions or need additional information, please contact Chris Nicoloff, Director, Human Capital, at (214) 775-9114 or me at (703) 248-2300.

/s/ Mary W. Demory

Mary W. Demory
Deputy Assistant Inspector General
for Operations and Human Capital

Attachment

cc: Suzanne F. Medvidovich
John A. Rapp
DeWitt O. Harris
Samuel M. Pulcrano
Raymond T. Murphy
Peter J. Bedard
Joseph K. Moore

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EXECUTIVE SUMMARY

Introduction

This report presents the results of our self-initiated audit to determine whether the Long Island and New York Performance Clusters, located in the New York Metro Area, were reducing the number of accidents, injuries, and illnesses through prevention initiatives.

Results in Brief

The Long Island and New York Performance Clusters' prevention initiatives have the potential to become best practices for reducing accidents, injuries, and illnesses. However, we could not determine whether the prevention initiatives reduced the number of accidents, injuries, and illnesses in the Long Island Performance Cluster because the measurement tools in place did not allow safety personnel to monitor the effectiveness of specific initiatives. Conversely, the New York Performance Cluster data showed that the reduced number of accidents, injuries, and illnesses was the result of the prevention initiatives.

The Long Island Performance Cluster implemented prevention initiatives to reduce the number of accidents, injuries, and illnesses in a timely manner. We did not evaluate the timeliness of prevention initiatives at the New York Performance Cluster because the new initiatives were not in place during our audit scope, which began September 8, 2001, and ended July 31, 2003. Both performance clusters also need additional trained safety staff.

In addition, both performance clusters were accumulating and analyzing accident, injury, and illness data for prevention initiatives; however, the Human Resource Information System and the Risk Management Reporting System are antiquated and will be replaced.

Postal Service Headquarters officials told us they are addressing these issues at the headquarters level. We will issue a summary report on the audit results for the six areas visited. In that report, we may make recommendations to the Senior Vice President, Human Resources, regarding the measurement tools and data systems.

Finally, in all six facilities we visited in the Long Island and New York Performance Clusters, reporting processes used within the various functional areas facilitated the accurate reporting of accidents, injuries, and illnesses.

Summary of Recommendations	We recommended that Postal Service management reassess the adequacy of safety staffing resources. We also recommended that management fill vacant positions where appropriate, and/or consider other alternatives, such as collateral duty assignments to existing staff.
Summary of Management's Comments	Management agreed with the findings and recommendations and has initiatives completed or planned addressing the issues in this report. Management did not believe it was practical to increase safety staff, but stated that adjustments to current operations management would be effective. Management stated that one vacant safety specialist position has been filled and other actions have been taken to address safety staffing issues identified in the report. Management stated they appreciated the time the Office of Inspector General took to discuss the review with the staff on March 29, 2004. Management stated the meeting was productive and that many of their concerns and proposed modifications were reflected in the report. Management's comments, in their entirety, are included in Appendix E of this report.
Overall Evaluation of Management's Comments	Management's actions taken or planned are responsive to the recommendations and should resolve the issues identified in this report.

INTRODUCTION

Background

With responsibility for more than 38,000 facilities, major transportation networks, and universal delivery, the Postal Service faces significant challenges in the areas of health and safety. These include making the health and safety of Postal Service employees a priority, managing the associated costs and lost productivity in operations, and responding when accidents and injuries have an unfavorable impact on the workplace. In addition, the Postal Service must address citations and monetary penalties for noncompliance with Occupational Safety and Health Administration (OSHA) standards.

In its April 2002 Transformation Plan, the Postal Service stated that to meet its challenges and prepare for transformation, it would implement a number of strategies to "push business effectiveness and operational efficiency." One of the strategies outlined was to reduce its workers' compensation costs. According to the Office of Workers' Compensation Programs' (OWCP) chargeback[1] reports, the Postal Service workers' compensation costs have increased from $538 million to $822 million between chargeback years 1997 and 2003.[2]

The following table is a comparison of Postal Service-wide accidents[3] and OSHA injuries and illnesses[4] for fiscal years (FYs) 2002 and 2003, which shows decreases in four categories. In addition, total expenses in FY 2003 decreased significantly.

[1] The OWCP's chargeback system is the mechanism by which the Department of Labor annually bills the cost of compensation for work-related injuries and deaths to employing agencies.
[2] The OWCP's chargeback year is July 1 through June 30.
[3] The Postal Service considers accidents as all reportable and nonreportable incidents including unadjudicated occupational illness cases that cover certain kinds of injuries, illnesses, or damages. OSHA defines an accident as any unplanned event that results in personal injury or property damage.
[4] OSHA defines an injury or illness as an abnormal condition or disorder. Injuries include, but are not limited to cuts, fractures, sprains, or amputations. Illnesses include both acute and chronic illnesses such as, but not limited to skin diseases, respiratory disorders, or poisoning.

Table 1. Comparison of Postal Service-wide Accidents and OSHA Injuries and Illnesses, FYs 2002 and 2003

Category	FY 2002	FY 2003
Motor Vehicle Accidents	23,404	23,100
Non-Motor Vehicle Accidents	99,195	93,251
OSHA Injuries	51,630	46,317
OSHA Illnesses	6,972	5,550
Total Accident, Injury, and Illness Expenses	$1,652,449,865	$1,620,024,027

Source: Postal Service Web-Enabled Enterprise Information System (WebEIS).

Postal Service Headquarters officials did not know specifically what was responsible for the reduction in accidents. They believed, however, it was the result of accident prevention initiatives.

To determine why the number of accidents, injuries, and illnesses declined, we conducted a survey of the accident prevention programs in the Postal Service's Western New York and Baltimore Performance Clusters located in the Northeast and Capital Metro Areas, respectively. Our results showed that accident prevention initiatives in each performance cluster were different and yielded contrasting results. We conducted this audit to determine whether similar situations existed in the Long Island and New York Performance Clusters. We did not audit the performance clusters' overall safety programs. Our focus was on accident prevention initiatives at the locations we visited.

Objectives, Scope, and Methodology

Our overall objective was to determine whether the Long Island and New York Performance Clusters were reducing the number of accidents, injuries, and illnesses through prevention initiatives. Our four subobjectives were to determine whether:

- The number of accidents and injuries was declining as a result of corrections to unsafe working conditions and practices.[5]
- Corrective actions and/or prevention initiatives were made in a timely manner.

[5] Corrections to unsafe working conditions and practices were considered both corrective actions and prevention initiatives. The purpose of this subobjective was to determine the effectiveness of prevention initiatives.

- Data were being accumulated and analyzed for prevention initiatives.
- Processes facilitated accurate reporting.

We discuss our scope and methodology in Appendix B.

Prior Audit Coverage	In the Long Island and New York Performance Clusters, we did not identify any prior audits or reviews related to the objectives of this audit.
Management's Comments	Although management comments were not required regarding prior audit coverage, the Manager, New York District stated the New York Metro Area has conducted safety audits, and therefore the prior audit coverage section of the report should be modified to state that no prior OIG audits were identified.
Evaluation of Management's Comments	Our statement concerning prior audits refers to performance audits of prevention initiatives in the Long Island and New York Performance Clusters. The background section of the report, page 2, contains a specific statement that we did not audit the performance clusters' overall safety programs and that our focus was on accident prevention initiatives at the locations we visited.

AUDIT RESULTS

The Long Island and New York Performance Clusters had implemented accident prevention initiatives. We could not determine, however, whether the prevention initiatives were reducing the number of accidents, injuries, and illnesses in the Long Island Performance Cluster. In the New York Performance Cluster, however, data showed the reduction in the number of accidents, injuries, and illnesses was the result of prevention initiatives.

In addition, although the Long Island Performance Cluster implemented prevention initiatives to reduce the number of accidents, injuries, and illnesses in a timely manner, we noted an opportunity for improvement concerning safety staffing in four of the six facilities visited in the Long Island and New York Performance Clusters.

Also, both performance clusters were accumulating and analyzing accident, injury, and illness data in two different automated systems; however, the systems are antiquated and will be replaced. Finally, the reporting processes used in both performance clusters within the various functional areas facilitated accurate reporting of accidents, injuries, and illnesses.

Accident Prevention Initiatives

The Long Island and New York Performance Clusters' prevention initiatives have the potential to become best practices in reducing accidents, injuries, and illnesses. These initiatives could also help other performance clusters enhance their safety programs. For example:

- Both performance clusters established accident review committees that (1) evaluated corrective actions taken on accidents and the timeliness and quality of accident reporting and (2) identified systemic causes and corrective/prevention actions.

- One Long Island facility, the Mid-Island Processing and Distribution Center, was a test facility for the Postal Service's Ergonomic Risk Reduction Program.[6] This program may help reduce mail handling and lifting injuries.

[6] The Postal Service developed the Ergonomic Risk Reduction Program in cooperation with OSHA, the American Postal Workers Union, and the National Postal Mail Handlers Union to identify musculoskeletal disorders and reduce ergonomic risk factors.

Effectiveness of Prevention Initiatives

For FY 2002 through accounting period 12 in FY 2003, we could not determine whether the Long Island Performance Cluster was reducing the number of accidents, injuries, and illnesses, through prevention initiatives. We could not make this determination because the measurement tools in place did not allow safety personnel to:

- Track and monitor specific prevention initiatives.
- Document when initiatives were implemented.

Some categories of accidents (repetitive motion, struck by objects, and industrial accidents) had decreased in the performance cluster; however, the reasons for the decreases could not be determined. District safety personnel told us they did not know the reasons because it was difficult to measure prevention initiatives when other factors, such as the weather, could influence the number of accidents.

In the New York Performance Cluster, however, data showed a reduction in the number of accidents, injuries, and illnesses as a result of prevention initiatives. For example, the New York District Office, in the New York Performance Cluster, measured the effectiveness of its driver improvement training program, which indicated that 90 percent of those receiving the training had no subsequent motor vehicle accidents.

Although both performance clusters implemented accident prevention initiatives, their numbers and frequency rates varied for OSHA injuries and illnesses and motor vehicle accidents. From FYs 2002 to 2003, Long Island's OSHA injury and illness and motor vehicle accident numbers and frequency rates[7] increased. Conversely, New York's OSHA injury and illness and motor vehicle accident frequency rates and numbers decreased for the same period. The following table illustrates these changes.

[7] OSHA injury and illness and motor vehicle accident frequency rates are the number of accidents per 100 employees for a specific period. These rates provide measurements that make accident data comparable between large and small facilities.

Table 2. OSHA Injury and Illness and Motor Vehicle Accident Numbers and Frequency Rates in the Long Island and New York Performance Clusters for FYs 2002 and 2003

Performance Cluster	Numbers		Average Frequency Rates	
	FY 2002	FY 2003	FY 2002	FY 2003
Long Island				
OSHA Injury and Illness	780	924	8.44	10.42
Motor Vehicle	228	259	11.64	13.84
New York				
OSHA Injury and Illness	590	542	4.14	4.06
Motor Vehicle	293	263	38.95	33.97

Source: Postal Service WebEIS.

Postal Service policy[8] states that safety personnel were responsible for developing and monitoring a comprehensive safety and health program and analyzing accident, injury, and illness data so they could advise management on corrective actions. Policy[9] also requires installations to develop methods to identify program needs for accident prevention. In addition, policy[10] requires supervisors to implement written programs and action plans, monitor employees' safety performance, and prevent operational safety accidents.

Without implementation dates and adequate measurement tools, the Postal Service does not have reasonable assurance that prevention initiatives help the performance clusters reduce the number of accidents, injuries, and illnesses. To follow prudent business practices, Postal Service managers should evaluate whether prevention initiatives are accomplishing their goal, and whether the resources expended are justified.

Headquarters officials told us the safety tool kit that safety managers use to assess their safety programs is being modified to include trend line charts to track prevention initiatives. The officials said the tool kit would also be modified to include a field for managers to

[8] Employee and Labor Relations Manual 17.2, Section 813.31, February 2003.
[9] Employee and Labor Relations Manual 17.2, Section 821.32, February 2003.
[10] Supervisor's Safety Handbook, Handbook EL-801, Chapter 1, Section 1-1, May 2001.

enter the date they implement the initiatives. Therefore, we will address the need for tracking and monitoring initiatives in a separate report.[11]

Timeliness of Prevention Initiatives

Timeliness of preventive initiatives was not evaluated at the New York Performance Cluster because new initiatives were not implemented during our audit scope, which began September 8, 2001, and ended July 31, 2003. However, the Long Island Performance Cluster implemented its accident prevention initiatives in a timely manner.

Specifically, the Long Island Performance Cluster initiated action to "champion" poorly performing units immediately after they established a pattern of poor performance in March 2003. District management assigned safety staff to work with local management to conduct office visits and street observations, to identify unsafe work practices, and to provide guidance to postmasters on corrective action/prevention initiatives.

Although initiatives were timely in Long Island, we noted an opportunity for improvement concerning safety staffing in four of the six facilities we visited in both the Long Island and New York Performance Clusters.

Management's Comments

Management stated that during the period September 8, 2001, through July 31, 2003, several prevention initiatives were in place. Management stated these changes were implemented before September 8, 2001, have proven their value over time, and the district continues to include them in their accident reduction plans. Management provided the following examples:

- A weekly review of district accidents by a review board.
- An Accident Awareness Prevention Training Program.
- A Driver Improvement Training Program.
- A Safety Captain Program.

[11] We will issue a summary report on the audit results for the six areas visited.

- The establishment of safety and health committees for facilities with 50 or more employees.

Evaluation of Management's Comments	We agree that the Long Island Performance Cluster implemented prevention initiatives, and provided examples in the Accident Prevention Initiatives section of the report.
Opportunity for Improvement	The Morgan Processing and Distribution Center, in the New York Performance Cluster, operates 24 hours a day, 7 days a week, with over 4,000 employees and was authorized two safety specialists. However, only one specialist was assigned at the time of our visit.[12] The Franklin D. Roosevelt Station, with over 1,000 employees, had no on-site safety specialist assigned and was supported by a safety specialist on the district staff, which, at the time of our visit, had one vacant safety position. In Long Island, the Mid-Island Processing and Distribution Center, with approximately 2,400 employees, had 1 safety specialist assigned. The Long Island Priority Mail Processing Center had no on-site safety specialists assigned. Although it had a smaller employee complement (approximately 400 employees), the district safety specialist who serviced the center also provided support for 40 other facilities within the performance cluster. According to the New York District Safety Manager and a New York Metro Area staff safety specialist, the staffing levels in both performance clusters were the result of past reorganizations, staff consolidations, and the difficulty experienced in recruiting and retaining qualified safety professionals in the high-cost metropolitan New York area. In addition, these officials said the downsizing environment within the Postal Service has discouraged hiring. Postal Service policy[13] states that organizational levels must plan budgets and provide funds that support effective and comprehensive safety and health programs and sufficient personnel to properly implement and administer the program. Plants with 1,000 or more career employees are authorized a safety specialist position.[14]

[12] According to the New York District Safety Manager, vacancies had not been filled as of February 11, 2004.

[13] Employee and Labor Relations Manual 17.2, Section 818, February 2003.

[14] Senior Vice President, Human Resources', letter to Area Human Resource Managers, dated September 16, 2003.

Additional staffing in these facilities could help to ensure the continued timely implementation of accident prevention initiatives.

Recommendations

To ensure the Long Island Performance Cluster continues to implement, and the New York Performance Cluster implements timely prevention initiatives, we recommend the Managers, Long Island and New York Districts:

1. Reassess the adequacy of safety staffing resources.

2. Fill vacant positions, where appropriate, and/or consider other alternatives such as collateral duty assignments to existing staff.

Management's Comments

Management agreed to both recommendations and has initiatives completed or planned addressing the issues in this report. Management stated the Safety Specialist position was filled at the Morgan Processing and Distribution Center on April 17, 2004. Management also stated the District Safety Specialist position was reposted in the New York Metro Area on May 3, 2004. Further, management stated the Facility Safety Coordinators have been trained and perform annual inspections and evaluations of facilities with less than 100 work years.

Management stated there was no disagreement with the overall findings of the audit; however, there is a moderate difference between management's vision for ensuring the effectiveness of prevention initiatives and the recommendations presented. Specifically, management stated the current level of safety staffing is adequate. Management also said all managers must understand they are accountable for ensuring that employees are provided with a safe work environment. Further, management said the role of the safety staff is providing operations managers with the tools necessary for an effective safety program within their work unit; and local managers must ensure the program is implemented and everyone is held accountable.

Management also stated that for any program to be truly effective, it must be managed daily. Management stated it would not be practical to increase safety staff to sufficient levels to accomplish this task, but it would be practical, with only minor adjustments to current operations management staff, to ensure the effective implementation of safety

programs using the managers who work with employees every day. Management stated this process would also reinforce the principle of individual accountability for maintaining a safe work environment.

Evaluation of Management's Comments

Management's actions taken or planned are responsive to our recommendation and should resolve the issues identified in this finding.

Accident Reporting Systems

Both the Long Island and New York Performance Clusters were accumulating and analyzing accident, injury, and illness data in the Human Resources Information Systems (HRIS) and the Risk Management Reporting System (RMRS). However, headquarters personnel told us these systems are antiquated and will be replaced.

The Long Island Performance Cluster developed a training program, based on an analysis of HRIS data, for employees who had more than one accident. The Long Island Performance Cluster also analyzed data to identify units with poor performance, the types and causes of accidents at those units, and started a program of safety talks[15] performed by members of the district's Joint Safety Committee.[16]

The New York Performance Cluster developed an accident reduction plan focusing on accidents from slips, trips, falls, and lifting, based on an analysis of HRIS data. The Performance Cluster also developed an accident awareness prevention training course, which focused on prevention of accidents other than motor vehicle or natural event accidents. In addition, both performance clusters had accident review committees consisting of managers from the district staff that performed analyses of individual accident cases and accident trends on a regular basis.

Postal Service policy[17] requires the safety offices responsible for facilities where accidents occurred to enter accident report information into HRIS. Postal Service policy[18] also states that the analysis of accidents and injuries was vital to effective accident prevention programs,

[15] Line supervisors were required to conduct safety talks at least once a week with their employee groups to promote safety awareness.
[16] The Joint Safety Committee was established to review safety issues. Committee members were the district's safety manager, safety specialists, and labor union representatives.
[17] Employee and Labor Relations Manual 17.2, Section 821.123, February 2003.
[18] Employee and Labor Relations Manual 17.2, Section 821.31, February 2003.

and required management to use reports and statistical analyses to identify and eliminate the principal causes of accidents and hazardous conditions. Postal Service policy[19] further requires each business area that managed source data to identify an individual or organization that is responsible for developing standards and usage rules to ensure data integrity. The policy also stated that the standards and rules must ensure that data was accurate, available, usable, and consistent with the data location and other business considerations.

According to the Headquarters Program Manager, Information Technology, Human Resource Portfolio, the Postal Service has developed the Injury Compensation Performance Analysis System and a component of it will replace HRIS and RMRS. The manager also stated that the system is scheduled for implementation late in calendar year 2004. We will address this issue in a separate report.

Reporting Processes

In all six facilities we visited in the Long Island and New York Performance Clusters, the reporting processes used within the various functional areas facilitated accurate reporting of accidents, injuries, and illnesses.

Both performance clusters had established safety committees to perform reviews of selected accidents to ensure the quality, accuracy, and timeliness of accident reporting. In addition, our tests of sample accident report[20] data from the HRIS, and sample accident report forms, indicated the accident reporting process was reasonably reliable (see Appendices C and D).

Postal Service policy[21] requires supervisors to fully complete the accident report, by including preventive action codes[22] and descriptions of accident prevention efforts. The policy also requires managers to review each accident report for accuracy and conduct a follow-up assessment to ensure that positive action had been taken to prevent similar

[19] Management Instruction 860-2003-2, Administrative Support, March 6, 2003.
[20] Postal Service Form 1769, Accident Report, was used to report accidents. The instructions on the form required it to be completed for all accidents, regardless of the extent of injury or amount of damage. This included all first aid injury cases both reportable and nonreportable.
[21] Employee and Labor Relations Manual 17.2, Section 821.13, February 2003.
[22] Preventive action codes were used to describe the action taken that would effectively eliminate or reduce the accident cause(s) and prevent similar accidents.

occurrences. In addition, supervisors and managers are required to sign the report as proof they had reviewed it. Policy[23] also requires that the safety officer enter the accident report information into HRIS.

Additional Management's Comments

The Manager, New York District, stated he appreciated the time the Office of Inspector General took to discuss the review with his staff on March 29, 2004. He stated the meeting was productive and that the report reflected many of the district's concerns and proposed modifications.

[23] Employee and Labor Relations Manual 17.2, Section 821.12, February 2003.

APPENDIX A. ABBREVIATIONS

e-FOIA	Electronic Freedom of Information Act
FOIA	Freedom of Information Act
FY	Fiscal Year
HRIS	Human Resources Information Systems
OSHA	Occupational Safety and Health Administration
OWCP	Office of Workers' Compensation Programs
RMRS	Risk Management Reporting System
WebEIS	Web-Enabled Enterprise Information System

APPENDIX B. SCOPE AND METHODOLOGY

Our performance cluster selections were based on the lowest and highest combined OSHA injury and illness rates and accident frequency rates from FY 2002[24] through accounting period[25] 7 in FY 2003.[26] The New York average total OSHA injury and illness rates and accident frequency rates were 4.23 percent and 9.69 percent, respectively. The Long Island average total OSHA injury and illness rates and accident frequency rates were 9.39 percent and 17.11 percent, respectively. The average total accident frequency rate of 9.69 percent in the New York Performance Cluster meant that out of every 100 employees, an average of 9.69 had an accident for that period.

We selected three facilities at each performance cluster based on size and type (for example, airport mail center, processing and distribution center, and main post office). The New York facilities we visited were the Morgan Processing and Distribution Center, the Franklin D. Roosevelt Station, and the Grand Central Station. The Long Island facilities we visited were the Huntington Station, the Mid-Island Processing and Distribution Center, and the Long Island Priority Mail Processing Center.

To accomplish our objectives, we reviewed applicable federal laws and Postal Service and OSHA policies and procedures related to accident and injury prevention.

To verify whether the number of accidents and injuries was declining as a result of corrections to unsafe working conditions and practices, we obtained data by accident category and code (slips, trips and falls, lifting, dog bites, repetitive motion, striking against, struck by objects, and motor vehicles) for each performance cluster. In addition, we obtained accident numbers and accident frequency rate data from the Postal Service WebEIS for FYs 2002 and 2003. We also obtained from RMRS the accident frequency rates and OSHA injury and illness rates for FY 2002 and the first eight accounting periods in FY 2003.[27] We reviewed data from both WebEIS and RMRS to determine whether downward trends indicated a reduction in accidents, injuries, and illnesses.

To determine whether corrective actions and prevention initiatives were made in a timely manner to reduce the number of accidents, injuries, and illnesses, we reviewed Postal Service policy to learn whether a national or other standard policy existed that addressed how unsafe working conditions and practices should be corrected in a timely manner. We reviewed documentation for corrective actions and prevention initiatives implemented from FY 2002 through accounting period 12[28] in FY 2003. Timeliness of preventive initiatives could not be evaluated at the New York Performance Cluster because new initiatives were not implemented during our audit scope.

To determine whether accident, injury, and illness data were accumulated and analyzed for prevention initiatives, we analyzed accidents, injuries, training documents, and workplace inspection data for sources and locations of accidents and jobs with high occurrences of accidents. We also analyzed accident and injury trends to determine whether a pattern of accidents with common causes could be identified in order to prevent future occurrences. We reviewed action plans and Program Evaluation Guide data that were accumulated and analyzed for prevention initiatives during FYs 2002 and 2003.

To determine whether processes used within the various functional areas facilitated accurate reporting of accidents, injuries and illnesses, we interviewed human resources, safety and health program personnel, and management at the area, performance cluster, and facility levels. We

[24] The FY 2002 period for the Postal Service began September 8, 2001, and ended September 6, 2002.
[25] An accounting period is defined as a four-week period that forms one-thirteenth of the Postal Service fiscal year.
[26] The first seven accounting periods for FY 2003, began September 7, 2002, and ended March 21, 2003. The FY 2003 period for the Postal Service began September 7, 2002, and ended September 5, 2003. However, the Postal Service transitioned its financial reporting system from accounting periods to monthly reporting periods on October 1, 2003. The transition period began September 6, 2003, and ended September 30, 2003.
[27] The first eight accounting periods for FY 2003, began September 7, 2002, and ended April 18, 2003.
[28] The first 12 accounting periods for FY 2003, began September 7, 2002, and ended July 31, 2003.

obtained information related to accident prevention such as resources, training, accident and hazard reporting, safety talks, and internal controls. In addition, we selected two statistical samples of accidents, injuries, and illnesses entered into HRIS for FY 2002 and the first eight accounting periods in FY 2003. We reviewed a sample of accident reports for accuracy and completeness; and reviewed a sample of accidents from HRIS to determine whether the information on the accident reports was entered accurately. (See Appendices C and D for a discussion of the sampling methodologies used.)

This audit was conducted from May 2003 through July 2004 in accordance with generally accepted government auditing standards and included such tests of internal controls as were considered necessary under the circumstances. We discussed our conclusions and observations with appropriate management officials and included their comments, where appropriate. We believe the computer-generated data was sufficiently reliable to support the opinion, conclusions, and recommendations in this report.

APPENDIX C

STATISTICAL SAMPLING FOR REVIEW OF ACCIDENT REPORTING PROCESSES IN LONG ISLAND PERFORMANCE CLUSTER

Purpose of the Sampling

One of the objectives of this audit was to assess the accuracy and completeness of the accident data in the HRIS. In support of this objective, the audit team employed a stratified two-stage random sample. Existence of the appropriate supporting accident report forms was also tested using the sample.

Definition of the Audit Universe

The audit universe consisted of 1,314 accidents, according to the HRIS database, for all of FY 2002 through accounting period 8 of FY 2003. The universe was obtained on site by requesting a HRIS data printout from the safety manager responsible for the accident and injury prevention program.

The accident report forms on file were stored in folders by accounting period and location. There were 125 folders.

Sample Design and Modifications

At the first stage of selection, we selected 30 folders randomly using the "randbetween" function in Microsoft Excel[29] to assign random numbers to the individuals on the universe listing. At the second stage, the audit team selected individual accident report forms within folders, using interval sampling.

To test the completeness and accuracy of the database, we tested six attributes:

- Was the accident shown on the accident report form listed in the database?
- Did the accident control number in the database agree with that on the form?
- Did the accounting period in the database agree with the accident date on the form?
- Did the date the data was entered in the database agree with the date entered on the form?
- Did the listing of the involved person(s) in the database agree with that on the form?
- Did the accident description in the database agree with that on the form?

For the completeness of the accident report forms, we tested two additional attributes:

- Was the preventive action code on the form?
- Was the preventive action on the form?

Additional Analysis and Results

We analyzed the sample results and observed low error rates for each attribute. While this analysis does not constitute a statistical projection, we believe the low error rates observed in the records reviewed support the audit team opinion that there is little likelihood of a major problem with the data in the files or in the database.

[29] Microsoft Excel is a spreadsheet program from the Microsoft Office suite of productivity tools for Windows and Macintosh.

APPENDIX D

STATISTICAL SAMPLING FOR REVIEW OF ACCIDENT REPORTING PROCESSES IN NEW YORK PERFORMANCE CLUSTER

Purpose of the Sampling

One of the objectives of this audit was to assess the accuracy and completeness of the accident data in HRIS. In support of this objective, the audit team employed a stratified random sample. Existence of the appropriate supporting accident report forms was also tested using the sample.

Definition of the Audit Universe

The audit universe consisted of 1,967 accidents, according to the HRIS database, for all of FY 2002 through accounting period 8 of FY 2003. The accident reports were stored at the Morgan Processing and Distribution Center and the JA Farley Building. The universe was obtained on-site by requesting a HRIS data printout from the safety manager responsible for the accident and injury prevention program.

The forms on file for the JA Farley Building were stored in folders by station and accounting period. There were 74 folders, representing 34 installations in FY 2002 and 40 installations in FY 2003.

Sample Design and Modifications

We stratified the Morgan Processing and Distribution Center accident report forms into two strata by fiscal year. The audit team selected individual accident report forms on-site, using interval sampling within each stratum for the selection of the forms: for FY 2002, selecting every seventh form starting with the first form; and for FY 2003, selecting every sixth form starting with the third form. The interval sampling yielded sample sizes of 53 and 61 forms for the 2 strata, respectively.

The audit team selected individual accident report forms on-site, within each folder at the JA Farley Building, using interval sampling.

The interval sample yielded a total sample size of 625 accident reports for the JA Farley Building.

The combined sample size for the Morgan Processing and Distribution Center and the JA Farley Building was 739 accident report forms.

To test the completeness and accuracy of the database, we tested six attributes:

- Was the accident shown on the accident report form listed in the database?
- Did the accident control number in the database agree with that on the form?
- Did the accounting period in the database agree with the accident date on the form?
- Did the listing of the involved person(s) in the database agree with that on the form?
- Did the accident description in the database agree with that on the form?
- Was the accident listed in HRIS?

For the completeness of the accident report forms, we tested two additional attributes:

- Was the preventive action code on the form?
- Was the preventive action on the form?

Additional Analysis and Results

We analyzed the sample results and observed low error rates for each attribute. While this analysis does not constitute a statistical projection, we believe the low error rates observed in the records reviewed support the audit team opinion that there is little likelihood of a major problem with the data in the files or in the database.

APPENDIX E. MANAGEMENT'S COMMENTS

DISTRICT MANAGER/ POSTMASTER
NEW YORK DISTRICT

UNITED STATES POSTAL SERVICE

May 13, 2004

Kim H. Stroud
Director, Audit Operations

SUBJECT: Response to Report Number HM-AR-04-Draft

On March 29, 2004, a telecon was conducted concerning the initial draft. It was a productive session and many of our concerns and proposed modifications are reflected in the revised draft. However, there are some issues that require clarification or comment. In addition, since the telecon, there has been progress made in filling our vacancies which I will provide in the body of my response.

Page 3

Prior Audit Coverage

Comment: The New York Metro Area has conducted safety audits of the New York Cluster. During the telecon, we requested the comment be modified to read: we did not identify any prior OIG audits or reviews related to the objectives of this audit.

Staffing Issues appear in several sections of the report as noted below:

Cover Page-Paragraph 3
Audit Results Page 4 – Paragraph 2
Timeliness of Prevention Initiatives Page 7-Paragraph 3
Recommendations – Page 8

Comment: The Safety Specialist position at the Morgan Processing & Distribution Center was filled (effective April 17, 2004). The District Safety Specialist position was re-posted in the New York Metro Area Vacancy announcement dated May 3, 2004. In addition, Facility Safety Coordinators have been trained and perform annual inspections and Program evaluation Guides (PEGS) of facilities with less than 100 work years.

Effectiveness of Prevention Initiatives

Page 5 –Paragraph 3

421 EIGHTH AVENUE, ROOM 3018
NEW YORK NY 10199-9998

For example, the performance Cluster measured the effectiveness of its driver improvement training program which indicated that 90 percent of those receiving the training had no subsequent motor vehicle accidents.

Comment: This is a District initiative. The data is for customer services only. Please change performance cluster to New York District.

Timeliness of Prevention –

Cover page –Paragraph 3
Page 7 Paragraph 1

Comment: During the period September 8, 2001 through July 31, 2003, there were several preventive programs/initiatives in place. They were implemented before September 8, 2001. They have proven their value over time and we continue to include them in our accident reduction plans. They include:

Weekly review of District accidents by review board
The Accident Awareness Prevention Training Program
The Driver Improvement Training Program
Safety Captain Program
Safety & Health Committees for facilities with complements of fifty or more employees.

I appreciate the opportunity for input and your taking the time to discuss this review with my staff.

Vinnie Malloy

DISTRICT MANAGER/EXECUTIVE-IN-CHARGE
LONG ISLAND DISTRICT

UNITED STATES POSTAL SERVICE

May 25, 2004

MARY W. DEMORY

SUBJECT: Efforts to Prevent Accidents, Injuries, and Illnesses in the Long Island and New York Performance Clusters (New York Metro Area) (Report Number HM-AR-04-DRAFT)

The audit disclosed that the Long Island Performance Cluster implemented prevention initiatives to reduce the number of accidents, injuries and illnesses in a timely manner. Further, it was determined that, in the facilities visited within this Cluster, the reporting processes facilitated accurate reporting of accidents, injuries, and illnesses.

There is no disagreement with the overall findings of the audit; however, there is a moderate difference between our vision for ensuring the effectiveness of our prevention initiatives and the recommendations that were presented.

Recommendations:

1. Reassess the adequacy of safety staffing resources.
2. Fill vacant positions where appropriate, and/or consider other alternatives, such as collateral duty assignments to existing staff.

Response:

It was the determination of the audit that, "*[t]o ensure the Long Island Performance Cluster continues to implement, and the New York Performance Cluster implements accident prevention initiatives in a timely manner, we recommend the district managers (1) reassess the adequacy of safety staffing resources, and (2) fill vacant positions where appropriate, and/or consider other alternatives such as collateral duty assignments to existing staff.*

PO BOX 7800
ISLANDIA NY 11760-9998
(631) 582-7410
FAX: (631) 582-7413

It is our position that the current safety staffing is adequate. To ensure that safety programs are effective, all managers must understand that he/she is accountable for ensuring that we provide our employees with as safe a work environment as possible.

To that purpose, we see the role of the safety staff as providing operations management with the necessary tools (i.e. prevention initiatives; analyses and reports [such as identifying employees who have incurred frequent accidents/injuries]; training; informational updates; service talks; recommended equipment; etc.) to implement an effective safety program within their work unit. It is the responsibility of the local managers to ensure that the program is implemented and that everyone is held accountable.

For any program to be truly effective, it must be managed daily. It would not be practical to increase a safety staff to sufficient levels to accomplish this task. However, it would be practical – with only minor adjustments to current operational management staffing, if any – to ensure effective implementation of safety programs using the managers that work with our employees everyday. This process would also reinforce the principle of individual accountability with regard to maintaining a safe work environment.

Thomas F. Rosati

Original mailed to:

Kim H. Stroud
Director, Audit Operations
Office of Inspector General
1735 N Lynn Street
Arlington VA 22209-2020

Copy sent to:

Mary W. Demory
Deputy Assistant Inspector General for Operations and Human Capital
Office of Inspector General
1735 N Lynn Street
Arlington VA 22209-2020