

AIR FORCE AUDIT AGENCY



AIR FORCE GROUND SAFETY PROGRAM



AUDIT REPORT

F2010-0006-FD1000

22 January 2010

INTRODUCTION

The Air Force established a ground safety program to comply with the Occupational Safety and Health Act of 1970 and to reduce preventable mishaps that damage equipment or injure personnel. During Fiscal Year (FY) 2008, the Air Force lost 50 Airmen and 34,966 workdays, and incurred \$35.8 million in property damage and environmental cleanup cost due to 8,530 ground (afloat, motor vehicle, industrial, or sports and recreation) mishaps. In addition, the Air Force spent \$131 million on workers' compensation claims and processed 4,986 new claims due to civilian workplace injuries and illnesses.

OBJECTIVES

We performed this audit because the Air Force's safety program is essential to protect Airmen, increase productivity, and enhance mission readiness by reducing preventable ground injuries. Our objective was to determine whether the Air Force effectively and efficiently managed the ground safety program. Specifically, we determined whether Air Force personnel:

- Adequately accomplished unit safety program assessments, annual facility inspections, and no-notice spot inspections.
- Timely reported mishaps.
- Adequately analyzed mishap trends, implemented trend-based proactive safety programs, and tracked program effectiveness.

CONCLUSIONS

The Air Force did not effectively and efficiently manage the ground safety program. Installation safety personnel adequately accomplished unit safety program assessments; however, personnel at the 13 installations reviewed did not:

- Accomplish 34 percent of required annual unit facility inspections. Further, installation safety officials and functional supervisors did not perform as many as 67 percent of required spot inspections, including inspections of high-risk areas such as fuel and munitions storage sites. Adequate facility inspections reduce and prevent industrial mishaps, help protect Airmen's lives, and ensure operational capability. (Tab A, Page 1)

Executive Summary

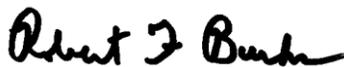
- Report more than 400 (23 percent) mishaps reviewed to wing safety offices, and wing safety did not report nearly 200 (11 percent) reportable mishaps to the Air Force Safety Center (AFSC). Further, injured employees did not timely report 39 percent of mishaps reviewed, and safety offices reported mishaps to the AFSC, on average, 21 days late. Complete and timely mishap reporting helps the Air Force promptly collect investigative evidence, accurately identify root causes, and implement appropriate corrective actions. (Tab B, Page 7)
- Adequately analyze mishap trends, implement trend-based proactive safety programs or track program effectiveness. Targeted prevention programs based on adequate trend analysis reduce mishaps, save Airmen's lives, and improve mission readiness. (Tab C, Page 13)

RECOMMENDATIONS

We made three recommendations to the Air Force Chief of Safety (AF/SE) to strengthen management controls over the ground safety program. (Reference the individual Tabs for specific recommendations.)

MANAGEMENT'S RESPONSE

Management concurred with the audit results and the intent of the recommendations. Management officials addressed the issues raised in the audit results, and management actions planned are responsive to the issues and recommendations included in this report.



ROBERT F. BURKS
Associate Director
(Engineering and Environment Division)



JAMES W. SALTER, JR.
Assistant Auditor General
(Support and Personnel Audits)

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BACKGROUND

In compliance with the Occupational Safety and Health Act, the Air Force implemented the ground safety program to identify and control hazards and to prevent mishaps. Specifically, Occupational Safety and Health Administration regulations (29 CFR, Part 1960, *Basic Program Elements for Federal Employee Occupational Safety and Health Program*) require safety specialists to inspect all areas and operations of each work place at least annually. Air Force guidance (AFI 91-202, *Air Force Mishap Prevention Program*, 1 August 1998) requires installation safety personnel to perform unit program assessments at least once every 3 years and perform facility inspections annually. In addition, the guidance requires installation safety personnel to perform spot inspections and follow-up reporting to ensure units took corrective action and mitigated hazards, and requires unit managers and supervisors to use no-notice spot inspections to monitor the day-to-day safety and health of an organization, work center, or facility. The installation Chief of Safety is responsible for determining spot inspection frequency and verifying inspection completion.

MAJCOM safety personnel evaluate the safety program management of each organization at wing or installation level at least once every 3 years. Installation Occupational Safety and Health (AFOSH) and Environment, Safety, and Occupational Health (ESOH) councils¹ discuss safety problems, advise wing and unit commanders on safety-related matters, and recommend safety problem solutions.

AUDIT RESULTS 1 – INSPECTIONS

Condition. Air Force personnel did not accomplish all required annual facility inspections and spot inspections at the 13 installations reviewed.²

- Annual Inspections. Safety personnel at 9 installations did not annually inspect 995 (34 percent) of 2,942 facilities reviewed.³ For example, safety personnel at Charleston AFB did not inspect 147 facilities occupied by high-risk functional areas,⁴

¹ Installations reviewed combined quarterly AFOSH council meetings and biannual ESOH council meetings and called ESOH council meetings.

² Both wings audited at Robins AFB, the 78th Air Base Wing (78 ABW) and the 402d Maintenance Wing (402 MXW), had their own safety offices and programs. We audited them as separate “installations” and refer to them as such in this report.

³ We reviewed inspection documentation for FY08 or Calendar Year (CY) 08 as applicable for each installation.

⁴ We reviewed Civil Engineer, Maintenance, Services, Logistics Readiness, Medical, and Security Forces as high-risk functional areas because these areas incurred approximately 70 percent of mishaps during FY08 and received a majority of Occupational Safety and Health Administration citations.

Tab A Inspections

including civil engineer, maintenance, and logistics readiness squadrons; and safety personnel at Elmendorf AFB did not inspect 290 facilities, including the youth center and power substations. Further, personnel did not document inspections of 955 (32 percent) additional facilities (Table 1).

Installation	Facility Inspections Required	Facilities Not Inspected During FY08	Facility Inspections Not Documented FY08
USAFA	250	16	163
Charleston	224	147	0
Elmendorf	416	290	0
Holloman	430	286	0
Langley	127	30	0
Laughlin	196	28	0
Luke	171	11	93
McChord	162	**	125
Robins – 78 ABW	222	141	0
Robins – 402 MXW	55	**	55
Spangdahlem	342	46	232
Vandenberg	*	*	*
Wright-Patterson	347	**	287
TOTAL	2,942	995	955
*Facility inspections not reviewed at this installation.			
**Safety offices documented only inspected units and facilities with findings; therefore, we could not determine which facilities were inspected.			

Table 1. Facility Inspections.

- Spot Inspections. Safety and unit personnel did not perform 38 to 67 percent of required follow-up, high interest area, supervisory, and after-hour spot inspections.
 - Follow-up Spot Inspections. Safety personnel at 6 installations did not perform required follow-up spot inspections for 449 (38 percent) of 1,171 corrected hazards identified during annual inspections. Furthermore, personnel at 9 installations did not track 154 (43 percent) of 356 uncorrected hazards. For example, at Charleston AFB, safety personnel identified improperly installed fire doors (RAC1)⁵ and a malfunctioning kitchen ventilation system (RAC2) at Charleston Club, but did not periodically follow-up to verify prompt corrective actions. Installation personnel did not correct and close both hazards until 24 June 2009, 252 days later. Further, Robins AFB 402 MXW safety personnel did not follow-up inspect corrected hazards or track uncorrected hazards.

⁵ Risk Assessment Code (RAC) is an expression of the degree of risk in terms of hazard or deficiency severity and probability of occurrence: RAC1-Imminent Danger, RAC2-Serious, RAC3-Moderate, RAC4-Minor, and RAC5-Negligible.

- High Interest Area Spot Inspections. Safety personnel at 12 installations did not perform 319 (67 percent) of 473 required monthly high interest area⁶ spot inspections. For example, safety personnel at the USAF Academy (USAFA) did not inspect the Munitions Storage Area and Rocket Launches, and personnel at Charleston AFB did not inspect the Hydraulic Shop and Fuel Storage Tank. Further, safety personnel at Elmendorf and Robins AFBs (both 402 MXW and 78 ABW) did not designate any high interest areas.
- Supervisory Spot Inspections. Functional-area supervisors at 12 installations did not perform 642 (45 percent) of 1,434 required spot inspections of industrial areas at Civil Engineer, Maintenance, Services, and Security Forces. For example, managers and supervisors did not periodically inspect work areas, including the Electrical Shop (Elmendorf, Holloman AFBs and Spangdahlem AB), Fuels Shop (Luke AFB), and Armory (Holloman and Robins AFBs).
- After-Hour Spot Inspections. Safety personnel and functional-area supervisors at 11 installations did not perform 463 (60 percent) of 768 required after-hour spot inspections of around-the-clock operations.⁷ In particular, USAFA and Holloman AFB did not perform any after-hour spot inspections while Charleston and Wright-Patterson AFBs did not document the time of spot inspections. Further, safety personnel at Elmendorf AFB did not perform after-hour spot inspections of the snow barn, the aircraft maintenance facility, the K-9 facility, or the armory.

Cause. This condition occurred because the Air Force did not provide sufficiently specific inspection guidance, and adequate inspection oversight and tracking tools.

- Guidance. AFI 91-202 did not provide specific guidance for identifying all facilities requiring inspection, documenting inspected facilities, justifying no designated high interest areas,⁸ performing follow-up inspections, and tracking open findings. Wing

⁶ High interest areas pose the greatest risk to life or property damage due to the nature of the work performed, physical conditions, materials handled, or repeated mishaps. The installation Chief of Safety or Ground Safety Manager designates high interest areas in writing.

⁷ The installation Chief of Safety is responsible for ensuring inspections of around-the-clock operations at times other than normal duty hours.

⁸ Safety personnel at Robins AFB (both 402 MXW and 78 ABW) stated they did not identify any high interest areas and that AFI 91-202 did not require high interest area designation. However, per the Air Force Safety Automated System FY08 mishap data, 402 MXW had the highest mishap count among all installations reviewed. Due to insufficient documentation requirements, we could not determine whether safety personnel analyzed mishap data before deciding not to designate high interest areas.

Tab A Inspections

safety offices at 11 of 13 installations maintained no unit facility listings or relied on inaccurate unit listings instead of utilizing base property listings to ensure all facilities were inspected. Further, based on the AFI 91-202 requirement that inspection reports contain “the unit, activity, or work area inspected,” wing safety inspectors documented only inspected units rather than inspected facilities. Finally, MAJCOM supplementary instructions did not provide specific guidance for follow-up inspections on closed findings, periodic tracking of open findings, after-hour spot inspections, and supervisory spot inspections.

- **Oversight.** The AFSC did not verify MAJCOMs ensured installation AFOSH/ESOH councils placed necessary emphasis on facility inspections and MAJCOMs conducted comprehensive installation safety program evaluations. To illustrate, AFOSH/ESOH council members at seven installations did not discuss facility inspections. In addition, MAJCOM⁹ safety program evaluations did not include high interest area inspections at 8 installations, after-hour inspections at 9 installations, and supervisory spot inspections at 11 installations. Further, HQ AFMC did not evaluate the 88 ABW, Wright-Patterson AFB, safety program at all during FYs 06-08.
- **Tracking Tools.** The AFSC did not provide installation safety offices a standardized corrective action-tracking tool. As a result, safety offices developed their own tracking systems, but these systems did not always work properly. For example, tracking systems at USAFA and 78 ABW, Robins AFB, did not allow input for follow-up status. Further, safety personnel at Charleston and Holloman AFBs did not properly transfer open findings from inspection reports to their tracking systems.

Audit Comment. Of 104 authorized ground safety positions at 13 installations, 26 positions (25 percent) were not filled during FY08. These unfilled positions may have contributed to inspection deficiencies, but we do not have support connecting this manpower shortage to any specific deficiencies at 11 installations. Therefore, we did not identify unfilled authorizations as a systemic cause requiring corrective action at the Air Force-level. However, two installation-level audit reports addressed unfilled authorizations and included recommended corrective actions. At Spangdahlem AB, we identified four unfilled positions out of six authorized positions as a cause for 46 (4 percent) of 995 uninspected facilities. At Vandenberg AFB, we identified two unfilled positions out of seven authorized positions as a cause for 24 (8 percent) of 319 unaccomplished high interest spot inspections.

Impact. During FY08, the Air Force lost approximately 11,000 workdays due to more than 4,400 industrial mishaps, spent more than \$131 million on workers’ compensation claims due to civilian workplace injuries and illnesses, and processed approximately 5,000 new civilian

⁹ Because USAFA is a direct reporting unit, Air Force Inspection Agency evaluated USAFA.

claims. Adequate and periodic facility inspections reduce and prevent industrial mishaps, help protect Airmen's lives, and ensure operational capability.

Recommendation A.1. The AF/SE should:

a. Revise AFI 91-202 to require all facility inspections be documented and provide guidance for identifying all facilities requiring inspection and documenting justification for no high interest area designations. For example, Air Education and Training Command (AETC) supplement to AFI 91-202 requires the lack of high interest areas be documented as well as designated high interest areas.

b. Provide more thorough oversight of MAJCOM safety program evaluations. Specifically, the AF/SE should require:

(1) The AFSC to revise MAJCOM evaluation checklists to include a requirement to spot check installations in each command to verify compliance.

(2) MAJCOMs to revise wing evaluation checklists to verify wing safety personnel, or designated representatives (administrative areas), report annual facility inspection and spot inspection activities to installation AFOSH/ESOH council meetings at least semi-annually, conduct an inventory of facilities prior to annual inspections, inspect all facilities annually, perform follow-up inspections, and track open findings.

c. Direct the AFSC to provide a standardized corrective action-tracking tool that meets installations' needs and provide associated training to installation safety personnel.

Management Comments. AF/SE concurred with the audit results and intent of the recommendations and stated, "AF/SE will:

a. "Revise AFI 91-202 to require all facility inspections and high interest area designations be documented. AFI 91-202, currently in two-letter coordination, contains the requirement for all facilities to be inspected and documented. This version also requires high interest areas to be designated in writing with no exceptions and all facilities to be inspected annually. Estimated completion date: 28 February 2010.

b. "Provide more thorough oversight of MAJCOM safety program evaluations. Specifically, the AF/SE will require:

(1) "AFSC to revise MAJCOM evaluation checklists to include a requirement to spot check installations in each command during safety Program Management Evaluations to verify compliance. Estimated completion date: 15 October 2010.

Tab A Inspections

(2) “AFSC to revise MAJCOM evaluation checklists to ensure they verify wing safety personnel inspect all facilities annually, perform follow-up inspections, and track open findings. Estimated completion date: 15 October 2010.

- “Guidance for both AFSOH (AFI 91-301) and ESOH (AFI 90-801) councils will be followed and their requirements incorporated into evaluation checklists.

c. “Direct the AFSC to provide a standardized corrective action-tracking tool that meets installations’ needs and provide associated training to installation safety personnel. Estimated completion date: 30 April 2010.

- “The Auditor did not take into consideration current or future plans for a standardized corrective action tracking tool. The AFSC contracted the development of the Hazard Deficiency Reporting System (HDRS) in August of 2007 and made it available to installations as of September of 2008. Fifty instructors were trained and charged with training others within their commands. HDRS currently has 420 registered users.
- “HDRS is currently being revised and is included as part of the AFSO 21 - OSIRIS¹⁰ initiative which will make it more user friendly as a module of the Air Force Safety Automated System program (AFSAS).”

Evaluation of Management Comments. Management addressed the issues raised in the audit results, and actions planned are responsive to the issues and recommendations included in this report. The HDRS was not deployed during the timeframe of the FY08 deficiencies disclosed in this audit. The AFSC distributed the HDRS in September 2008; however, our discussions with installation safety personnel indicated the system was not available for installation use until early 2009 and that the system allowed data input but did not allow data queries or extraction, including report generation. We agree that once the HDRS is revised to allow data queries and report generation, and supplementary training is provided, the HDRS will function as a standardized corrective action-tracking tool.

¹⁰ An AFSC data warehouse for Geobase and safety mishap data.

BACKGROUND

A mishap is an unplanned occurrence that results in damage to equipment or injury to an individual. A ground mishap is a mishap that falls into one of the following mishap categories: afloat, motor vehicle, industrial, and sports and recreation.

Units report any non-combat on- and off-duty military and on-duty civilian injuries to the Wing Safety Office. Then, safety office personnel investigate and determine whether the notified injuries are reportable to the AFSC in accordance with AFI 91-204, *Safety Investigation and Reports*, 24 September 2008. All injuries and events defined as Class A through Class E (See Appendix I for definition) are reportable to the AFSC. While injuries that do not meet mishap reporting criteria are not reported to the AFSC, the Wing Safety Office collects these mishaps for local mishap trend analysis.

Air Force guidance does not provide a mishap notification template, so units use MAJCOM- or wing-prescribed mishap notification forms to report injuries to the Wing Safety Office. Primarily, the Wing Safety Office relies on unit mishap notifications to identify, investigate, and report mishaps to the AFSC; however, safety personnel are also required to review medical treatment records and workers' compensation reports to ensure all injuries are reported to the safety office.

Injured employees must notify their supervisor of all work-related accidents and injuries as soon as possible, but no later than the end of the work shift or the day of occurrence, in accordance with DoD memo, *Injury Reporting Requirements*, February 2007. This memo also mandates supervisors to notify their supervisory chain of command, within one working day of receiving the mishap information. Unit commanders or unit safety representatives, in turn, notify the safety office. AFI 91-204 requires safety offices to investigate and report all reportable mishaps to the AFSC via the AFSAS within 30 days of the mishap although the investigating officer may request an extension from the AFSC for a complete and accurate safety report.

AUDIT RESULTS 2 – MISHAP REPORTING

Condition. Air Force personnel did not report all FY08 mishaps and reported mishaps to the AFSC, on average, 21 days late.

- Complete Reporting. Air Force personnel at 11 of 13 installations did not report 401 (23 percent) of 1,747 mishaps reviewed to the safety office. For example, Civil Engineer units at Vandenberg AFB did not report industrial mishaps such as knee injuries, scalp lacerations, strains, and sprains. Further, safety personnel at 9 installations did not report 197 (11 percent) reportable mishaps in AFSAS or clearly document why 200 (11 percent) mishaps were not reported (Table 2). For

Tab B Mishap Reporting

example, Elmendorf AFB safety personnel did not report three Aircraft Maintenance unit head injuries.

Installation	Mishaps Reviewed	Mishaps Not Reported to Safety Office	Reportable Mishaps Not Reported in AFSAS	Inadequate Documentation
USAFA	290	170	128	8
Charleston	114	0	0	0
Elmendorf	165	64	16	9
Holloman	168	26	2	15
Langley	151	21	1	6
Laughlin	114	5	0	0
Luke	154	8	0	0
McChord	128	27	4	46
Robins (78 ABW)	49	0	0	10
Robins (402 MXW)	67	3	0	0
Spangdahlem	132	34	7	2
Vandenberg	144	36	21	52
Wright-Patterson	71	7	18	52
TOTAL	1,747	401*	197*	200*
*Some mishaps are included in more than one category; a reportable mishap not reported in AFSAS may also be a mishap not reported to the safety office or inadequately documented.				

Table 2. Incomplete Mishap Reporting.

- **Timely Reporting.** Injured personnel at 6 installations¹¹ did not timely notify their supervisors of 37 (39 percent) of 94 injuries reviewed, reporting up to 36 days late. Additionally, units at 8 installations¹² did not timely notify the safety office¹³ of 63 (50 percent) of 125 mishaps reviewed, reporting as many as 44 days late. Further, seven wing safety offices¹⁴ did not track employee injury notification dates and could not determine whether employees timely reported injuries. Finally, safety office personnel reported 75 (29 percent) of 261 Class C, D, and E mishaps reviewed¹⁵ more than 30 days after the injury and 17 (7 percent) more

¹¹ Holloman, Langley, Laughlin, McChord, Spangdahlem, and Wright-Patterson AFBs.

¹² Holloman, Langley, Laughlin, Luke, Robins (78 ABW and 402 MXW), Spangdahlem, and Wright-Patterson AFBs.

¹³ The maximum allowed days among the installations reviewed were 7 calendar days; therefore, we counted a mishap reporting as untimely when reporting from unit to wing safety took more than 7 days.

¹⁴ USAFA, Charleston, Elmendorf, Luke, Robins (78 ABW and 402 MXW), and Vandenberg AFBs.

¹⁵ Class A and B mishaps generally take more than 30 days to investigate and report due to their severity and complexity.

than 60 days after the injury. One USAFA Class D injury was not reported for 5 months.

Cause. This condition occurred because the Air Force did not provide adequate oversight and specific guidance for complete and timely mishap reporting.

- **Oversight.** The AFSC did not verify MAJCOMs addressed complete and timely mishap reporting during safety program evaluations. Further, the AFSC did not verify MAJCOMs ensured installation AFOSH/ESOH councils placed necessary emphasis on complete and timely mishap reporting. To illustrate, MAJCOM safety program evaluations of 11 installations and AFOSH/ESOH councils at 12 installations did not address the importance of complete and timely mishap notifications. On the other hand, the AETC safety program evaluation report and the AFOSH/ESOH council at Laughlin AFB addressed both completeness and timeliness, contributing to considerably low deficiency rates.
- **Guidance.** AFI 91-204 did not require safety personnel to validate and document non-reportable mishaps and mishap notification dates. In addition, mishap notification forms used at 11 of 13 installations did not include a non-reportable justification section to verify safety personnel investigated mishaps and determined reporting based on prescribed criteria. Further, the notification forms had no section for injured employees' mishap reporting dates. Finally, the AFSC did not distribute DoD Memo, *Injury Reporting Requirement*, February 2007, requiring injured employees to report injuries by the end of the day of occurrence. AETC was the only MAJCOM that had supplementary guidance requiring safety personnel to document rationale when not reporting a mishap. Laughlin and Luke AFBs reported all reportable mishaps to the AFSC and provided adequate documentation for not reporting mishaps. Additionally, AETC Form 435, *Mishap Data Worksheet*, 1 July 2006, includes a section for the Wing Safety Office to document the reason for non-reportable mishaps.

Impact. Delayed mishap notifications result in delayed investigations and reporting. Timely unit mishap notifications help Wing Safety Office personnel promptly collect investigative evidence and interview injured employees and witnesses, leading to more accurate mishap trending and corrective actions. Further, the Air Force used incomplete and untimely mishap data for trend analyses, impairing the service's ability to accurately identify local and widespread safety vulnerabilities and implement appropriate corrective actions.

Recommendation B.1. The AF/SE should:

- a. Require MAJCOMs to revise wing evaluation checklists to address complete and timely reporting.

Tab B

Mishap Reporting

b. Direct MAJCOMs to verify installation mishap data worksheets include a section documenting the reason a mishap did not qualify as reportable,¹⁶ the date, and signature of all parties, including injured employees, accountable for timely reporting.

c. Ensure MAJCOM program management evaluations assess installation-level AFOSH/ESOH councils address complete and timely mishap reporting.

d. Require installation and unit commanders to update their mishap reporting procedures to include language that holds individuals and supervisors accountable for timely mishap reporting.

e. Revise AFI 91-204 to:

(1) Require MAJCOMs to provide a process for reviewing medical and workers' compensation records, including documentation for review results.¹⁷

(2) Include the DoD requirement for employees to report injuries to supervisors by the end of the day of occurrence.

Management Comments. AF/SE concurred with the audit results and the intent of the recommendations and stated, "AF/SE will:

a. "Direct AFSC to revise MAJCOM evaluation checklists to ensure MAJCOM program management evaluations of wings address complete and timely reporting. Estimated completion date: 15 October 2010.

b. "Develop a standardized mishap worksheet that will include sections for supervisors, unit safety representatives, commanders and safety personnel. The supervisor section will include an employee notification date. Worksheets will also include a section for documenting the reason a mishap did not qualify as reportable, if applicable. Estimated completion date: 15 October 2010.

c. "Develop procedures to evaluate timely mishap reporting, including AFOSH/ESOH council actions, during MAJCOM program management evaluations. Estimated completion date: 15 October 2010.

¹⁶ AETC Supplement to AFI 91-204, 19 October 2005, requires wing safety personnel to annotate mishap notification forms with a report number for a reportable mishap or rationale when not reporting a mishap.

¹⁷ AETC Supplement to AF Manual 91-224, *Ground Safety Investigations and Reports*, 19 October 2005, provides guidance for documenting non-reportable mishaps: "cite an appropriate reference or provide an explanation next to the incident."

d. “Provide training to installation and unit commanders through MAJCOM safety offices on mishap reporting procedures which holds individuals and supervisors accountable for timely mishap reporting. Estimated completion date: 15 October 2010.

e. “Revise applicable AFIs to:

(1) “Require MAJCOMs provide a process for reviewing medical and workers’ compensation records, including documentation for review results. While medical records are protected by federal Health Insurance Portability and Accountability Act (HIPPA) laws, allowances are made for review of medical records that pertain to mishaps or work related illnesses. Estimated completion date: 15 October 2010.

(2) “Include DoD requirement for employees to report injuries to supervisors by the end of the day of occurrence. Estimated completion date: 1 March 2010.”

Evaluation of Management Comments. Management agreed with the audit results and addressed the issues raised in the audit results, and actions planned are responsive to the issues and recommendations included in this report.

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BACKGROUND

Analyzing and distributing mishap data trend information is crucial to mishap prevention. AFI 91-202 requires installation safety offices to perform an installation-level trend analysis, develop appropriate preventive programs based on mishap trend analysis, and measure program effectiveness. An adequate analysis program should identify successes, problem areas, trends, and root causes for mishaps and guide prevention actions.

To prevent and reduce motorcycle mishaps, DoD requires riders successfully complete an approved safety course before operating motorcycles. In addition, AFI 91-207, *US Air Force Traffic Safety Program*, 22 May 2007, requires unit commanders to maintain a roster of motorcycle riders assigned to their unit and brief motorcycle safety requirements and guidance to each rider. This roster should indicate, at a minimum, training completed, motorcycle make and model, engine size, and operator experience. Further, AFI 91-207 recommends operators complete at least one MAJCOM approved motorcycle rider education course every 3 years.

AFPD 90-8, *Environment, Safety, and Occupational Health*, 1 September 2004, mandates commanders at each Air Force MAJCOM and installation implement and use an Environment, Safety, and Occupational Health Management System (ESOHMS) to ensure operational capability through a systematic identification and prioritization process to reduce ESOH risks and costs. The AFPD directs the Assistant Secretary of the Air Force for Environment and Logistics (SAF/IE) to develop and provide ESOHMS implementing guidance for all command levels.

AUDIT RESULTS 3 – MISHAP DATA UTILIZATION

Condition. Air Force safety personnel did not adequately analyze mishap data, implement trend-based proactive safety programs, or track program effectiveness.

- Mishap Analysis. Safety personnel at 13 installations reviewed did not adequately analyze mishap data. To illustrate, safety personnel at Elmendorf, McChord, and Wright-Patterson AFBs presented only mishap types in a spreadsheet or slide format with no root cause analysis and corrective action recommendations. USAFA analyzed only 15 FY08 mishaps while reporting 283. In addition, although motorcycle mishaps occurred at all 13 installations during FY08, trend analysis reports did not indicate whether lack of training was a contributing factor. In contrast, the Holloman AFB trend analysis report identified lack of training as a contributing factor for motor vehicle mishaps; however, the training data did not provide a motorcycle sub-category. Further, safety offices at 6 installations did not document training status or completion dates for 69 (33 percent) of

Tab C

Mishap Data Utilization

206 injured riders to determine if lack of training caused the mishaps and if injured riders received refresher training.

- Proactive Safety Programs.** All 13 installations reviewed established several proactive safety programs, such as 101 Critical Days of Summer, Fall Safety, Winter Safety, and 52 Weeks of Safety Campaigns, to prevent or reduce industrial, sports, recreation, and motor vehicle mishaps. However, safety offices at 13 installations did not adequately design safety programs targeting specific industrial, sports, recreation, or motorcycle mishap types. For example, Holloman and Laughlin AFBs identified basketball as a leading injury cause, but the installations did not implement prevention programs targeting those injuries. In contrast, 78 ABW at Robins AFB conducted proactive ergonomic assessments and training to prevent overexertion, a leading cause of industrial injuries. Further, while all installations had motorcycle safety programs, the programs did not sufficiently target training to prevent injuries. At 5 installations, 147 (13 percent) of 1,118 riders on rosters did not complete a required basic rider course; at 11 installations, 380 (34 percent) riders did not complete a recommended refresher course (Table 3); and at 9 installations, gate guards did not check for motorcycle training proof.¹⁸

Installation	Motorcycle Riders on Roster	Riders Lacking Required Training	Riders Lacking Refresher Training
USAFA	*	*	*
Charleston	75	3	56
Elmendorf	68	48	8
Holloman	102	0	23
Langley	139	38	55
Laughlin	79	0	29
Luke	181	0	56
McChord	72	0	31
Robins - 78 ABW**	30	0	12
Spangdahlem	181	44	16
Vandenberg	147	0	87
Wright-Patterson	44	14	7
TOTAL	1,118	147	380
*USAFA did not maintain a rider roster, so we could not determine training completion. **We excluded 402 MXW at Robins because we reviewed only host wing safety offices for motorcycle safety programs.			

Table 3. Motorcycle Rider Training.

¹⁸ Gate guards at Charleston AFB checked riders' training cards, and gate guards at Holloman and Langley AFBs checked ACC Form 15, *ACC Motorcycle Trained Decal*, for training proof.

- Tracking Program Effectiveness. Safety offices at nine installations did not track whether the mishap prevention programs were effective in reducing mishaps. Even at the four other installations, safety office personnel measured only seatbelt usage.¹⁹

Cause. This condition occurred because the Air Force did not provide complete mishap data utilization guidance, mishap data system analysis capabilities, training, and oversight.

- Guidance. The Air Force did not provide specific guidance for analyzing mishap data, generating trend analysis reports,²⁰ implementing trend-based proactive programs, and tracking program effectiveness. Moreover, the Air Force did not provide guidance for establishing an ESOHMS safety management system enabling installation commanders to identify safety goals, targets, and performance tracking.²¹ Finally, the Air Force did not require periodic motorcycle refresher training. Safety personnel surveyed stated periodic refresher training should be mandatory because as riders “get older, their riding abilities change and reaction time slows down. Recurring training is paramount to help keep our riding community safe.”
- Mishap Data System. The AFSC’s AFSAS did not provide sufficient analysis capabilities. While AFSAS had basic analysis capabilities for reportable mishaps, it did not allow input of non-reportable mishaps.²² To analyze trends, safety personnel at all 13 installations maintained local databases and spent additional time entering reportable mishaps in both AFSAS and local databases.

¹⁹ Trend analysis reports at nine installations did not include discussions on any successful safety programs. This absence of success area discussions indicates safety personnel do not know which programs were effective.

²⁰ Six installations used a formal report format while seven used a spreadsheet or slide format. The installations that issued a formal report included more in-depth analysis than those that used a spreadsheet or slide format.

²¹ Installations tracked only mishap rates in various categories, including military vs. civilian, on-duty vs. off-duty, industrial, motor vehicle, or sports and recreation mishaps. However, no installations reviewed tracked effectiveness of various safety programs by measuring any program components against targets and analyzing possible correlations between specific prevention efforts and mishap rates other than seatbelt compliance rates. No installations reviewed established and implemented an ESOHMS.

²² While entering only reportable mishaps in AFSAS for AFSC purposes, installation safety offices record both reportable and non-reportable mishaps in their local systems (e.g., Excel spreadsheets, Access databases) for locally oriented mishap analyses.

Tab C

Mishap Data Utilization

- Training. The Air Force did not provide installation safety offices adequate AFSAS data input, analysis, and retrieval training. To illustrate, of 82 safety personnel interviewed at 13 installations, 10 percent did not receive AFSAS data input training and 51 percent did not receive data retrieval training. More than 50 percent wanted additional training because AFSAS was not user-friendly and they had to enter all mishaps into local databases to analyze the data.
- Oversight. The AFSC did not verify that MAJCOMs placed necessary emphasis on adequate mishap trend analysis, trend-based safety programs, and program effectiveness tracking at the installation level. For example, the AFOSH/ESOH councils at 13 installations did not discuss trend-based safety programs or determine whether the programs reduced targeted mishaps. Further, MAJCOM safety evaluations at eight installations did not address mishap trend analysis, trend-based safety programs, and program effectiveness during their safety program evaluations.

Impact. During FY08, the Air Force lost 50 Airmen and almost 35,000 workdays due to preventable mishaps, with motorcycle accidents causing 15 of the 50 fatalities. Targeted prevention programs based on adequate trend analyses reduce mishaps, save Airmen's lives, and improve mission readiness. Further, a track record of program effectiveness helps determine whether resources allocated to current safety programs resulted in reducing mishaps or added values to the overall safety program.

Recommendation C.1. The AF/SE should provide:

a. Specific guidance for analyzing mishap data, implementing trend-based proactive programs, and tracking program effectiveness. Specifically, the AF/SE should:

(1) Revise AFI 91-202 to require MAJCOMs to provide guidance for analyzing mishap data, generating a trend analysis report for distribution, establishing and implementing trend-based proactive programs, and tracking program effectiveness.

(2) Coordinate with SAF/IE to provide guidance for establishing a safety management system as part of ESOHMS.

(3) Revise AFI 91-207 to require motorcycle refresher training and coordinate with SAF/IE to fund the training.²³

²³ Of 28 wing safety offices surveyed, 16 (57 percent) offices emphasized training as the most important factor in reducing motorcycle mishaps, 9 (32 percent) offices recommended the Air Force require periodic refresher training, and 13 (46 percent) offices recommended the Air Force or MAJCOMs allocate a separate line item for training funding. Services other than the Air Force use a centralized funding and course delivery method.

(4) Revise AFI 91-207 to require motorcycle training completion dates on rider rosters to verify periodic training.

(5) Revise AFI 91-204 to require installation safety personnel to investigate and document injured operators' training status, including training completion dates, in motorcycle mishap reports.²⁴

(6) Direct the AFSC to verify installations validate motorcycle riders received required training prior to riding a motorcycle in accordance with AFI 91-207.

b. An adequate mishap data system for effective trend analyses. Specifically, the AF/SE should direct the AFSC to modify AFSAS to allow non-reportable mishap input.

c. Periodic AFSAS data input and retrieval training to all installation safety personnel.

d. Adequate oversight of mishap data utilization. Specifically, the AF/SE should ensure MAJCOMs:

(1) Require installation safety personnel to discuss trend analysis, trend-based safety programs, and program effectiveness tracking at AFOSH/ESOH council meetings.

(2) Include in wing safety program evaluations the adequacy of installation mishap trend analysis, trend-based safety programs, and program effectiveness tracking.

Management Comments. AF/SE concurred with the audit results and intent of the recommendations and stated, "AF/SE will provide:

a. "Guidance for analyzing mishap data, implementing trend-based proactive programs, and tracking program effectiveness. Specifically, AF/SE will:

(1) "Revise AFI 91-202 and provide training materials to MAJCOMs for further analyzing mishap data, generating a trend analysis report for distribution, establishing and implementing trend-based proactive programs, and tracking program effectiveness. Estimated completion date: 15 October 2010.

²⁴ For example, AETC Supplement to AFMAN 91-224, *Ground Safety Investigations and Reports*, 19 October 2005, requires safety personnel to address in the mishap notification report the type of motorcycle safety training received, total street-riding experience, and riding experience for the type of motorcycle involved in the mishap.

Tab C

Mishap Data Utilization

(2) “Coordinate with SAF/IE to ensure merger of SE management systems into overall ESOHMS where possible (ESOH CAMP Tier 2, and 3 inspections etc.). Estimated completion date: 15 October 2010.

- “Performance measures and objectives have been provided as of September 2009.

(3) “Revise AFI 91-207 when directed by DODI 6055.04, *DoD Traffic Safety Program*, to require motorcycle refresher training and coordinate for funding. Estimated completion date: 15 October 2010.

- “The AFSC is currently working with the other services as well as OSD to determine the need and frequency of follow-on or refresher motorcycle safety training. This requirement is being driven from the DoD with the participation of all services. Any change to AFI 91-207 will need to fall in line with DoD requirements, which have not yet been implemented.

(4) “Revise AFI 91-207 to require motorcycle training completion dates on rider rosters to verify periodic training. Estimated completion date: 28 February 2010.

- “The AFSC is currently developing an automated unit motorcycle tracking tool which will include rider training completion dates. AFI 91-207 is under re-write and will require mandatory use of the tool.

(5) “Revise AFSAS to require installation safety personnel investigate and document injured operators’ training status, including training completion dates, in motorcycle mishap reports. Closed.

- “Training status, including training completion dates for motorcycle mishaps, was incorporated into AFSAS as a mandatory field as of 5 November 2009.

(6) “Direct the AFSC to validate commander tracking of military motorcycle rider training in accordance with AFI 91-207. Estimated completion date: 10 September 2010.

b. “Pursue the feasibility of modifying AFSAS to allow non-reportable mishap input. Estimated completion date: 15 October 2010.

- “Public Law (OSHA record keeping) and DODI 6055.07, *Accident Investigation, Reporting, and Record Keeping*, do not require the collection of this data. The burden to the field of this additional requirement will need to be studied extensively before moving forward.

c. “Perform periodic AFSAS data input and retrieval training to all installation safety personnel. Estimated completion date: 15 October 2010.

- “AFSAS training is currently being provided at all new Chief of Safety Courses as well as 3 level Safety Career Field tech schools. There is an AFSAS specific training site which also allows personal training directly from a work station. The AFSC is currently looking into revising the Mishap Investigation Non-Aviation (MINA) course to include AFSAS training. AFSAS also has numerous “Hover” helps that explain how to fill in data for every field. AFSAS has a very powerful Data Extraction Tool (DET) capability that is available to all users of AFSAS. It is a plain language “Business Intelligence” tool that takes little to no training to us.

d. “AFSC will provide oversight of mishap data utilization. Specifically,

(1) “Direct MAJCOM and installation safety personnel to utilize trend analysis, trend-based safety programs, to target prevention emphasis in both on- and off-duty Mishap Prevention Program areas. Ensure effectiveness by tracking trends at both AFOSH and ESOH council meetings. Estimated completion date: 15 October 2010.

(2) “Follow-up and ensure adequacy and program effectiveness of these analyses and trend based programs through utilization of program evaluation checklists during PMEs. Estimated completion date: 15 October 2010.”

Evaluation of Management Comments. Management agreed with the audit results and addressed the issues raised in the audit results, and actions planned are responsive to the issues and recommendations included in this report.

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MISHAP CLASSES

Class A Mishaps. A mishap resulting in (1) direct cost (property damage costs and environmental cleanup costs) totaling \$1 million or more; or (2) a fatality or permanent total disability.

Class B Mishaps. A mishap resulting in (1) direct cost totaling \$200,000 or more but less than \$1 million; (2) a permanent partial disability; or (3) inpatient hospitalization of three or more personnel.

Class C Mishaps. A mishap resulting in (1) direct cost totaling \$20,000 or more but less than \$200,000; or (2) any injury or occupational illness or disease that causes loss of one or more days away from work beyond the day or shift it occurred.

Class D Mishaps. Any nonfatal injury or occupational illness that does not meet the definition of Lost Time. These are cases where, because of injury or occupational illness, an Air Force employee works only partial days, restricted work or were transferred to another job, required medical treatment greater than first aid, lost consciousness, or significant injury or illness diagnosed by a physician, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment greater than first aid, or loss of consciousness.

Class E Mishaps. These occurrences do not meet mishap classification criteria but are deemed important to investigate and report for mishap prevention. Class E reports provide an expeditious way to disseminate valuable mishap prevention information (such as high accident potential events, property damage events that do not have an injury or illness and the direct cost is totaling \$2,000 or more but less than \$20,000).

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AUDIT SCOPE

Audit Coverage. We audited 13 Air Force locations (Appendix III). We performed the audit from October 2008 through July 2009 reviewing documentation, including safety program assessment and facility inspection reports, base facility listings, spot inspection logs, unit mishap notification forms, medical treatment records, workers' compensation reports, mishap logs, mishap analysis reports, motorcycle rider rosters, and MAJCOM program evaluation reports dated January 2004 through March 2009. We issued the draft report to management in September 2009.

- Unit Safety Program Assessments. To determine whether wing safety personnel performed unit safety program assessments, we reviewed FYs 06-08 assessment reports for all host wing units. To determine whether safety personnel included required components in the assessment reports, we reviewed FY08 reports for six host wing units: Civil Engineer, Maintenance, Services, Logistics Readiness, Medical, and Security Forces. We replaced with other subordinate units when wings did not have any of the selected units and reviewed FY06 or FY07 assessment reports when FY08 reports were not available.
- Annual Facility Inspections. To determine whether safety personnel accomplished required unit facility inspections, we reviewed FY08 or CY08 facility inspection reports for all host wing and tenant units. To determine whether wing safety personnel inspected all facilities, we sampled six host wing units and two tenant units and compared Automated Civil Engineer System – Real Property (ACES-RP) facility listings to the unit facility listings obtained from wing safety personnel or unit safety representatives. Then, we compared the two listings to inspection reports and interviewed wing safety personnel and unit safety representatives to identify facilities required for inspection. To determine whether safety personnel included required components in facility inspection reports, we reviewed FY08 or CY08 facility inspection reports for six host wing units and two tenant units.
- Spot Inspections. To determine whether personnel performed spot inspections (such as follow-up, high interest area, functional area, and after-hour), we reviewed wing safety inspection logs and functional supervisors' inspection logs.
- Complete Mishap Reporting. To determine whether employees, units, and safety offices reported all mishaps, we reviewed FY08 mishap notification forms obtained from wing safety offices, medical treatment records from the base Medical Services, workers' compensation claim reports from the Civilian Personnel Flights, and mishap logs from wing safety offices and high risk functional units (Civil Engineer, Maintenance, Services, and Security Forces). When wings did not have the sampled units, we replaced with other units. Then, we

Audit Scope and Prior Audit Coverage

compared these source documents to data retrieved from AFSAS and interviewed wing safety personnel and unit safety representatives for mishap reporting clarification.

- Timely Mishap Reporting. To determine whether employees, units, and safety offices timely reported mishaps, we sampled FY08 Class C, D, and E mishaps reported in AFSAS, compared the sample to mishap notification forms and mishap logs, and reviewed mishap report completion dates (message release dates) retrieved from AFSAS.
- Mishap Data Utilization. To determine whether the Air Force adequately analyzed mishap data, implemented trend-based proactive safety programs, and tracked program effectiveness, we reviewed FYs 06-08 mishap analysis reports; motorcycle training records for four selected units (Civil Engineer, Maintenance, Services, and Security Forces); and mishap notification forms and logs for injured motorcycle riders. We also discussed policies, procedures, existence of trend-based proactive programs, and program effectiveness tracking with wing safety personnel.
- AFSAS Training. To determine whether AFSAS data input and retrieval training was adequate, we interviewed wing safety personnel and obtained their input.
- Guidance and Oversight. To determine whether the Air Force provided adequate guidance and oversight, we reviewed AFIs 91-202, -204, -207, -301 and MAJCOM supplements. In addition, we reviewed MAJCOM safety program evaluation reports and installation AFOSH/ESOH council meeting minutes and presentation slides.
- Motorcycle Training. To obtain additional input from the safety community regarding motorcycle training and funding, we surveyed wing safety offices via MAJCOM data calls and reviewed responses from 28 wing safety offices.

Sampling Methodology. We used judgmental sampling to select audit locations and judgmental and statistical sampling methods to select audit data. We also used Computer-Assisted Auditing Tools and Techniques (CAATTs) to capture and analyze data.

- Sampling.
 - We judgmentally selected 13 audit locations while considering MAJCOM distribution, mishap count, mishap rates, and locations.

Audit Scope and Prior Audit Coverage

- We selected all host wing units to determine whether wing safety personnel performed unit safety program assessments and all host and tenant units for facility inspections.
 - We judgmentally selected six high-risk subordinate units at the host wing and two tenant units to determine whether wing safety personnel inspected all facilities,²⁵ addressed required components in program assessments, performed follow-up inspections, and tracked open findings.
 - We judgmentally selected four high-risk subordinate units at the host wing to determine whether industrial area supervisors performed required spot inspections.
 - We judgmentally selected two mishaps each month for FY08 from mishap notification forms, medical treatment records, workers' compensation reports, and mishap logs at four high-risk units to test complete mishap reporting.²⁶
 - We selected all FY08 mishaps reported in AFSAS as of 29 September 2008 for the 13 audit locations. Of a total of 1,267 mishaps, the AFAA statistician selected 275 mishaps for a timely mishap reporting test by using a simple random sampling method. Then, we selected only Class C, D, and E events, totaling 266 mishaps. We did not project because several safety offices did not document notification dates.
- CAATTs. We used pivot tables to capture mishap magnitude and trend, and categorize mishap count by installation, category, lost day, and injury severity. We also used auto filters to capture mishap fatality data. Further, we used various Excel functions (such as *COUNTA*, *COUNTIF*, *COUNTIFS*, *IF*, *MINIMUM*, *MAXIMUM*, *SUM*, *SUMIF*) to summarize and analyze the local audit results.

Data Reliability. We used base facility listings generated from the Automated Civil Engineer System-Real Property (ACES-RP) to determine whether the wing safety office inspected all facilities. However, we did not rely on information from this system for our audit conclusions. Instead, we compared ACES-RP to unit facility listings provided by the wing safety office or inspected units and reconciled the two listings. In addition, we relied on computer-processed data contained in the AFSAS to determine the completeness and timeliness of mishap reporting. We did not evaluate the system's general and

²⁵ Auditors at USAFA and Elmendorf AFB tested all host wing units and all tenant units, and the auditor at 78 ABW (Robins AFB) tested all host wing units and two tenant units.

²⁶ The auditor at USAFA tested all Cadet Wing mishaps not reported to the wing safety office.

Audit Scope and Prior Audit Coverage

application controls. Instead, we compared the AFSAS output data to manual documents (such as mishap notification forms, medical treatment records, workers' compensation reports, and other available supporting documentation) to validate data accuracy and reviewed output products for obvious errors, reasonableness, and completeness. Based on these tests, we concluded that the AFSAS data were sufficiently reliable in meeting the audit objectives.

Auditing Standards. We accomplished this audit in accordance with generally accepted government auditing standards and, accordingly, included such tests of internal controls as considered necessary under the circumstances. Specifically, we evaluated internal controls related to program assessments, facility inspections, complete and timely reporting, mishap trend analysis, and motorcycle safety programs. In addition, we evaluated management controls such as guidance, training, oversight, and database use.

PRIOR AUDIT COVERAGE

Review of Air Force Audit Agency, Government Accountability Office, and DoD Inspector General audit files did not identify any audits within the past 5 years that related to our audit objectives.

Locations Audited/ Reports Issued

Air Combat Command

49th Fighter Wing Holloman AFB NM	F2009-0041-FBS000 1 July 2009
1st Fighter Wing Langley AFB VA	F2009-0048-FDM000 27 July 2009

Air Education and Training Command

47th Flying Training Wing Laughlin AFB TX	F2009 24 August 2009
56th Fighter Wing Luke AFB AZ	F2009-0052-FBS000 13 August 2009

Air Force Materiel Command

78th Air Base Wing Robins GA	F2009-0043-FCR000 23 June 2009
402d Maintenance Wing Robins AFB GA	F2009-0045-FCR000 7 July 2009
88th Air Base Wing Wright-Patterson AFB OH	F2010-0005-FCW000 19 October 2009

Air Force Space Command

30th Space Wing Vandenberg AFB CA	F2010-0006-FBM000 3 December 2009
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Air Mobility Command

437th Airlift Wing Charleston SC	F2009-0054-FDM000 6 August 2009
62d Airlift Wing McChord AFB WA	F2010-0029-FBN000 17 December 2009

Locations Audited/ Reports Issued

Pacific Air Forces

3d Wing
Elmendorf AFB AK

F2009-0088-FBN000
21 August 2009

United States Air Forces in Europe

52d Fighter Wing
Spangdahlem AB Germany

F2009-0094-FDE000
17 September 2009

Direct Reporting Unit

USAF Academy
Colorado Springs CO

F2009-0050-FBM000
17 September 2009

Points of Contact

Engineering and Environmental Division (AFAA/SPE)
Support and Personnel Audits Directorate
2509 Kennedy Circle
Brooks City-Base TX 78235-5116

Robert F. Burks, Associate Director
DSN 240-8035
Commercial (210) 536-8035

Anna C. Heinsohn, Program Manager

Sunhee L. Fritsche, Audit Manager

We accomplished this audit under project number F2008-FD1000-0480.000.

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