

Date: February 14, 2000

To: Eric Schmidt

From: Dawn Castillo

Subject: Performance Guidance

As we discussed, the purpose of this memorandum is to give you guidance for focusing your performance in the conduct of fatality investigations, a critical element of your performance plan. It is essential that you have concrete guidance so that you can demonstrate successful performance in your position prior to the end of your probationary period, in June 2000.

My concerns about your performance in the conduct of fatality investigations first surfaced in December, and then again in January— during the multiple fatality investigation in . . . In both instances, I provided you with guidance on the scope and procedures of the Fatality Assessment and Control Evaluation (FACE model), the model followed by traumatic injury investigators in the Division of Safety Research.

Improvement will be needed in several areas for you to demonstrate successful performance in the conduct of FACE investigations by the end of the probationary period: the identification of the types and level of detail of information that should be collected during the investigation; following standard procedures in gathering the information; and, working effectively as a Team member on investigations.

Identification of the types and level of detail that should be collected during the investigation:

It is very important that during the conduct of FACE investigations, information is gathered that is useful in summarizing the chain of events leading to death and/or making recommendations for the prevention of future similar events. Summaries of investigations should be concise, yet cover all points relevant to understanding direct contributors to the event and providing justification for recommendations for preventing future similar events. The FACE model does not go into depth on ancillary contributors— those whose contributions to the death were not directly relevant or for which there are no directly relevant prevention implications.

On occasion, you have expended your time and that of others in collecting information which is not of direct use in the investigation and summary report— collecting details which are not necessary or used in summarizing the chain of events leading to death and/or making recommendations for the prevention of future similar events. An example of this is your persistence in gathering complete autopsy reports, rather than simply getting information from the report on the cause of death. As we discussed, for injury death investigations, the cause of death is typically all that is needed. Other examples are your insistence on gathering exact measurements of the burned area of a fire hose in the . . . investigation in January, as this information is not necessary for describing the chain of events, and the specifics and shape of the turnout gear and clothing, as it is unlikely this information will have implications for recommendations for the prevention of future similar events.. The collection of detailed

information not of likely use in an investigation is an inefficient use of your time, a burden on those who help us in gathering the facts of the case, and a potential liability to the program if those who spend their time helping us to understand the case are upset by the absence of information that they helped provide in the summary report. You need to minimize your fact gathering during investigations to those pieces of information which are needed to summarize the chain of events or that have direct implications for prevention recommendations. When in doubt, please seek guidance from \_\_\_\_\_ and/or me.

Following standard procedures in gathering information:

Given limits on NIOSH's ability to protect information that is provided to us during the course of investigations, efforts are made to minimize information in our files with direct identifiers of individuals. For this reason, efforts are made to collect information in the field and through verbal contact rather than through formal correspondence that might help an outside requestor in the identification of individuals involved in specific cases.

You frequently use formal correspondence to request documentation (at levels which are not needed) when other investigators are able to collect pertinent information through verbal contacts. You need to increase your efforts to get information in the field and through verbal contacts to minimize formal correspondence which might be used to identify individuals in specific cases. In at least one example that I am aware of, in January, Mr. \_\_\_\_\_ in response to reviewing a formal request for a coroner's report, was able to get cause of death information, all that was needed for the report, through a phone call.

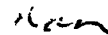
Work effectively as a team member:

At the current time, most fatality investigations are conducted by teams rather than individuals. Team work is critical for maximizing the quality of the investigation and report, and for positively representing NIOSH in the field.

An area for improvement is to work effectively as a team member in investigations and in the office. At times you appear inflexible and inconsiderate of issues or perspectives raised by team members. There were concrete examples in the \_\_\_\_\_ investigation, in which your answers to a team members inquiry as to why you felt certain information was needed for the report, were curt, and you demonstrated no attempt to understand or assimilate his perspective.

I truly hope this guidance is useful to you in focusing your conduct of fatality investigations. I would like to meet again on Monday, March 13, at 9am to assess progress and performance.

Sincerely,



Dawn Castillo