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Triggering Activity

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IMIS-QA

Inspection Number / Program 311117162 / Health

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Account Number 01361000

Establishment DBA / Legal Name
CITY OF KIRKLAND / CITY OF KIRKLAND

Assignment Type / Site Region Referral / 1055320

CSHO ID / CSHO Region d0483 / 1055320

311117162

CSHO: Katie Keefe

DOSH compliance received a referral indicating a cluster of elevated blood lead levels among Kirkland Police Dept employees. The referral indicated that the exposure occurred while shooting at an indoor firing range. I made initial contact with Kathy Joyner, Safety/Risk Management Analyst for the City of Kirkland, on 7/3/07, explained the purpose of my visit, requested the Police Guild union representative be contacted, and then continued with the opening conference. Ms. Joyner explained that the incident involved Kirkland Police Department (KPD) employees and that she had minimal information on the circumstances surrounding the exposure incident and on the incident investigation findings. Ms. Joyner stated that the Police Dept. creates and manages their health and safety programs. She provided Lt. Bill Hamilton's name and number as the contact person for the police department. Ms. Joyner was unable to provide any written information pertaining to the exposure incidents. I met with Cpt (previously Lt) Hamilton on 7/16/07.

Inspection Findings

The exposure incident occurred on 3/13/07 at Issaquah Police Department's indoor firing range and involved City of Kirkland employees. Two Kirkland Police Dept (KPD) firearms instructors were conducting a 5-day firearms training and qualifications course for three Corrections Officers at an indoor firing range. Officers practiced firing weapons inside the range on three days during the training. On 3/13/07, officers practiced shooting in the range for approximately 5-6 hours. The mechanical ventilation system for the range was not turned on during the practice shoot on 3/13/07. When all three corrections officers reported symptoms associated with lead exposure, Cpt Hamilton sent all five officers to the dept physician who collected tested for blood lead levels. The 5 officers' blood lead levels ranged from 25-33 ug/dL.

KPD rents the facility from IPD for use in training courses, open shoots and quarterly qualifications. The indoor firing range is equipped with a mechanical ventilation system that is inspected and maintained by the City of Issaquah. The on/off switch for the ventilation system is located in the staging area adjacent to the door to the firing range. According to the KPD firearms instructors, the on/off switch for the ventilation system was not working on 3/13/07 and they couldn't figure out how to get the system to turn on. KPD Officer Rich was the lead instructor on 3/13/07. In a typed memo from Officer Rich to Cpt. Hamilton dated 3/18/07, he states he attempted to turn on the ventilation system for the firing range when he arrived at the facility but was unsuccessful. According to this memo and statements from both instructors, Rich left a voice message about this problem on the facility Range Master's phone and then proceeded with the scheduled target practice despite the fact that the ventilation system was not operating. Officer Rich stated the 3 corrections officers and both instructors operated firearms within the range for 5 hours without the ventilation system operating. Officer Rich noted that although he observed a slight haze inside the range, he proceeded with training to avoid scheduling conflicts. Corrections officers' statements indicate that the "smoke" within the range was very visible after the first hour of shooting and that one could see a laser sight through the haze.

KPD's Firearms Instruction Unit has protocols in place for range use that they must follow to ensure safety. Firearms instructors are trained in IPD's procedures for range use, which include activating the ventilation system before and while using the range. The senior firearms instructor stated that it is KPD's policy to follow all range rules, which lists using the ventilation system at all times when shooting in the range. Cpt Hamilton stated that under KPD's progressive disciplinary program, both firearms instructors received verbal reprimands for not following operating procedure for the range and continuing to shoot without the ventilation system operating. Cpt Hamilton stated that the officers were reprimanded shortly after the incident; he stated that neither instructor had violated range use policies or procedures in the past. According to the Senior Firearms Instructor, Cpl Wilson, all instructors will be re-trained on range use procedures and ventilation system operation.

## **Enforcement Case Summary**

information on the health effects of lead, symptoms of exposure, and routes of exposure was not provided to them before they began target practice in the firing range. According to the COs, they were instructed to "not eat on the range", to wash their hands when leaving the range and to change clothes before entering their homes to prevent lead exposure. Corrections officers stated that they did not receive specific training on how lead could enter their body while shooting at an indoor range. None knew that they could be exposed to lead by breathing in fume and dust generated during shooting. None of the COs I interviewed knew the health symptoms of lead exposure. Two of the three COs asked for more information on lead during their interviews with me. Each of the corrections officers stated they experienced flu-like symptoms following the shooting practice; none knew that those symptoms could be associated with an acute, high level exposure to lead. The COs were previously prohibited from carrying firearms and, therefore, had not received any safety training pertaining to firearms or firing ranges (including lead awareness) before this particular training in March 2007. KPD did not provide corrections officers with adequate training on the hazards, all potential routes of exposure, or health effects of lead before they worked in an area with airborne lead exposure.

Since it appeared that the exposure incident resulted from employee misconduct that was properly dealt with internally, no citations are proposed in regard to exposure monitoring. One serious violation citation is proposed for not providing lead training that meets the requirements of the lead standard to officers working in an area with potential exposure to lead above the action level.

Closing Conference

The closing was held with Cpt Hamilton, Cpl Wilson, Lt and police guild representative, Don Carroll on 10/9/07 at the Kirkland Police Dept.

HO signature date

Reviewer's initials/date:

10/29/07

after discussion of Compliance Mgt.

replaced pages 7-10.