



DEPARTMENT OF THE NAVY
COMMANDER, NAVY REGIONAL MAINTENANCE CENTER
9170 SECOND STREET, SUITE 245
NORFOLK, VA 23511-2325

CNRMCIINST 4700.3E
Code 200
16 May 17

CNRMCI INSTRUCTION 4700.3E

From: Commander, Navy Regional Maintenance Center

Subj: UNPLANNED EVENTS, CRITIQUES AND TROUBLE REPORTS

Ref: (a) NAVSEAINST 4700.17
(b) COMUSFLTFORCOMINST 4790.3
(c) OPNAVINST 3100.6J
(d) OPNAVINST 5100.23G
(e) OPNAVINST 5102.1D
(f) JAGINST 5800.7
(g) NAVSEA Standard Item 009-120
(h) NAVFAC P307, Management of Weight Handling Equipment
(i) MIL-STD-1625C (SH), Safety Certification Program for
Drydocking Facilities and Shipbuilding Ways for U.S. Navy Ships

Encl: (1) Terms and Definitions
(2) Unplanned Event Process Flowchart
(3) Unplanned Event Process Guide
(4) Severity Level Classification Guide
(5) Critique/Trouble Report Notification Letter Format
(6) Sample Trouble Report Format
(7) Fact Finding Report Form

1. Purpose. To define policy and procedures for the reporting and investigation of unplanned maintenance related events that result from contracted work and/or fleet maintenance activity work related to the repair, maintenance, conversion and alteration of naval ships.

2. Scope. This instruction applies to work under the purview of the Regional Maintenance Centers (RMC) performed by either contractors or government activities, other than Ship's Force.

3. Cancellation. CNRMCIINST 4700.3D.

4. Discussion

a. Unplanned maintenance events are occurrences that are not normal behavior or expected results for the process, and are classified by severity level. The appropriate level of corrective action, investigation, critique, reporting and documentation will be determined by the severity

level of the event. Significant problems are required to be reported to Commander, Naval Sea Systems Command (NAVSEA) and other activities involved in the construction, repair and maintenance of naval ships through the use of Trouble Reports (TRs), as directed by reference (a). Significant problems are those that affect ship safety, cause significant damage to the ship or its equipment, delay ship deployment or completion of a key event, incur substantial cost increase, or involve severe personnel injury. Systemic problems and issues that constitute significant lessons learned for other activities should also be identified through TRs. The unplanned event and critique process will be used in the preparation of TRs; however, not all unplanned events will result in the submission of a TR.

b. The investigation and reporting of unplanned events may overlap with the requirements set forth in higher level directives, references (a) through (g). This instruction does not supersede the investigation or reporting requirements of those directives but should serve to complement the processes. If a conflict arises, the higher level directive will take precedence. Collaboration between the different branch / division/department heads is vital to ensure all requirements and timelines are met.

c. This instruction does not apply to problems associated with lifting and handling or dry docks that are already reported per reference (h) and (i), respectively.

5. Definitions. Terms and definitions used in this instruction are provided in enclosure (1).

6. Policy

a. Unplanned Events. Upon discovery or identification of an unplanned event, the RMC will execute the process in enclosures (2) and (3) and follow the guidance provided in enclosure (4). For contracted availability work, this may be accomplished by directing investigation and critique processes in accordance with reference (g), otherwise specific actions are outlined below.

(1) Immediate Corrective Actions will always be taken upon discovery or identification of an event, regardless of the severity level, in order to stabilize or mitigate the impact of the event. Problems identified to Ship's Force will only require a response for Immediate and Short Term Corrective Action. Long Term Corrective Actions will be taken through the established processes for the command. Systematic program areas identified may be addressed through other administrative reporting procedures with cognizant squadron personnel.

(2) Unplanned Events that result from significant problems that come under the responsibility of Ship's Force will normally be investigated and reported by the ship in accordance with guidance provided by the appropriate higher authority. This includes violation of Work Control or Tag-Out requirements, caused by Ship's Force, which occur on work being performed by or under the purview of an RMC. If Ship's Force determines that an investigation is not warranted but the RMC believes that one is necessary, the RMC will initiate the process and collaborate with Ship's Force. There should only be a single investigation, critique and report on the event. It is important that the causes for a problem are understood and Short-Term Corrective Actions have been taken before work is allowed to be resumed.

(3) After Preliminary Investigation, the severity level will be confirmed and assigned to the event. See enclosure (4) for guidance. The severity level will determine the follow-on requirements and reporting necessary to resolve the event.

(4) Initiate the Corrective Action Request (CAR) process, outlined in reference (b), if the non-conformance(s) identified in the critique is the responsibility of the contractor to perform. The RMC is not expected to issue a CAR for every problem identified in the critique.

(5) Review similar problems and corrective actions previously documented of all contractors over the last three years to identify repeat problems and effectiveness of corrective actions.

b. Critique Meetings. Critique Meetings are formal reviews conducted on unplanned events to gather relevant facts about the event, ascertain the chronology of the occurrences surrounding the events, determine apparent root causes of the event, validate the assigned severity level and the effectiveness of the Immediate Corrective Actions taken upon discovery of the event, and identify the follow-on Short and Long-Term Actions. The process is described in enclosure (3).

(1) Critique Meetings should be held within three days of determination that a Critique Meeting is required. Ideally, the meeting should be held as soon as possible once sufficient facts are known.

(2) Critiques will be conducted on all unplanned events categorized as Level 1: Critical, as defined in enclosure (4).

(3) Critiques may be conducted on Level 2 or 3 events at the discretion of the command or at the direction of higher level authority. Any unplanned event brought to the attention of Commander, Navy Regional Maintenance Center (CNRMC), regardless of severity level that is deemed high-visibility or high-interest will require the conduct of a critique. CNRMC will formally direct the RMC to conduct the critique using the format provided in enclosure (5).

(4) Participation in a Critique should normally, at a minimum, include senior level management from Waterfront Operations, Environmental and Safety, Engineering, Quality Assurance, Ship's Force, and Production personnel that are directly involved or knowledgeable about the event, system or work processes associated with the unplanned event. The local NAVSEA Regional Maintenance Office (NRMO) will be notified of the time, date and location of the Critique Meeting. This notification will be provided far enough in advance to permit attendance. Other participants to consider are contractors and NAVSEA Engineering Field Representatives (EFR).

c. Trouble Reports(TR). The TR is the vehicle for reporting significant problems to NAVSEA and other activities involved in the construction, modernization, repair, and maintenance of naval ships. Reference (a) details the requirements for the preparation and review of TRs. Incorporate the requirements of reference (a) with the following modifications:

(1) Initial reporting of significant problems will be made within 24 hours to: Navy Regional Maintenance Center (NRMC C200); the appropriate technical warrant holders at NAVSEA;

NAVSEA 04XQ; NRMO and the NAVSEA EFR. The ship, Fleet Commander, Type Commanders (TYCOM) and other involved activities should also be notified as appropriate.

(2) Final TRs will be submitted within 20 days of identification of the significant problem. In addition to the above addressees, provide copies to the other RMCs, Naval Shipyards and Supervisors of Shipbuilding.

(3) Private shipyards will prepare TRs when required by NAVSEA Standard Item 009-120. Final reports will be submitted within 30 days through the responsible Naval Supervisory Authority (NSA). When private shipyards or other contractors are not required by contract to submit TRs, the responsible NSA shall prepare and submit the TR, including information obtained from investigations accomplished in accordance with reference (g).

(4) All other guidelines in reference (a) are to be followed.

7. Reporting. Unless otherwise identified, all notifications and reports to NRMC, as described in this instruction, will be made to Code 200, Technical Director.

a. All Unplanned Events classified as Severity Level 1 or Level 2 will be reported in-person or via phone call; with a department head or higher at NRMC.

b. Any Unplanned Event, regardless of severity level, that requires issuing a higher-level report, such as those directed by references (b) through (f), will also be reported directly to the Commander, and Executive Director of NRMC.

c. Initial voice notifications will be made by direct contact with a department head or higher at NRMC (E-mail or voicemail are not direct contact) as soon as possible upon identification of the event but not to interfere with the Immediate Corrective Actions to stabilize or mitigate the impact of the event.

d. Initial TR shall be submitted electronically within 24 hours when the reporting activity determines that other activities or NAVSEA Headquarters (HQ) would benefit from notification in advance of the normal TR distribution timeframe. Only the asterisked items of enclosure (6) are required for an initial report.

e. Final Fact Finding Reports will be submitted within 20 days of the event using the format of enclosure (7). The final report must be written in sufficient detail that persons not familiar with the problem can understand the report. Issuance of the final report does not require that all corrective actions have been completed. In addition to updating the information contained in the initial report, the final report will contain, at a minimum, the following information:

(1) Identification of apparent causes

(2) All corrective and preventive actions identified and estimated completion dates.

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(3) Areas identified for further evaluation.

(4) Pertinent information obtained from any ongoing higher-level reports, including NAVSEA TRs, generated from the unplanned event.

f. Private shipyards will prepare Fact Finding Reports when required by contract. Final reports will be submitted within 30 days through the responsible RMC.

g. A single report may be submitted for an unplanned event if the problem has been fully resolved, all required information can be provided at the time of the initial report and a Critique Meeting or TR is not required.

8. Actions

a. Maintain historical records of all unplanned events and the associated documentation for six years and three months.

b. RMC track completion and effectiveness of corrective and preventive actions assigned during the unplanned event process.



S. A. DOUGLAS
Acting

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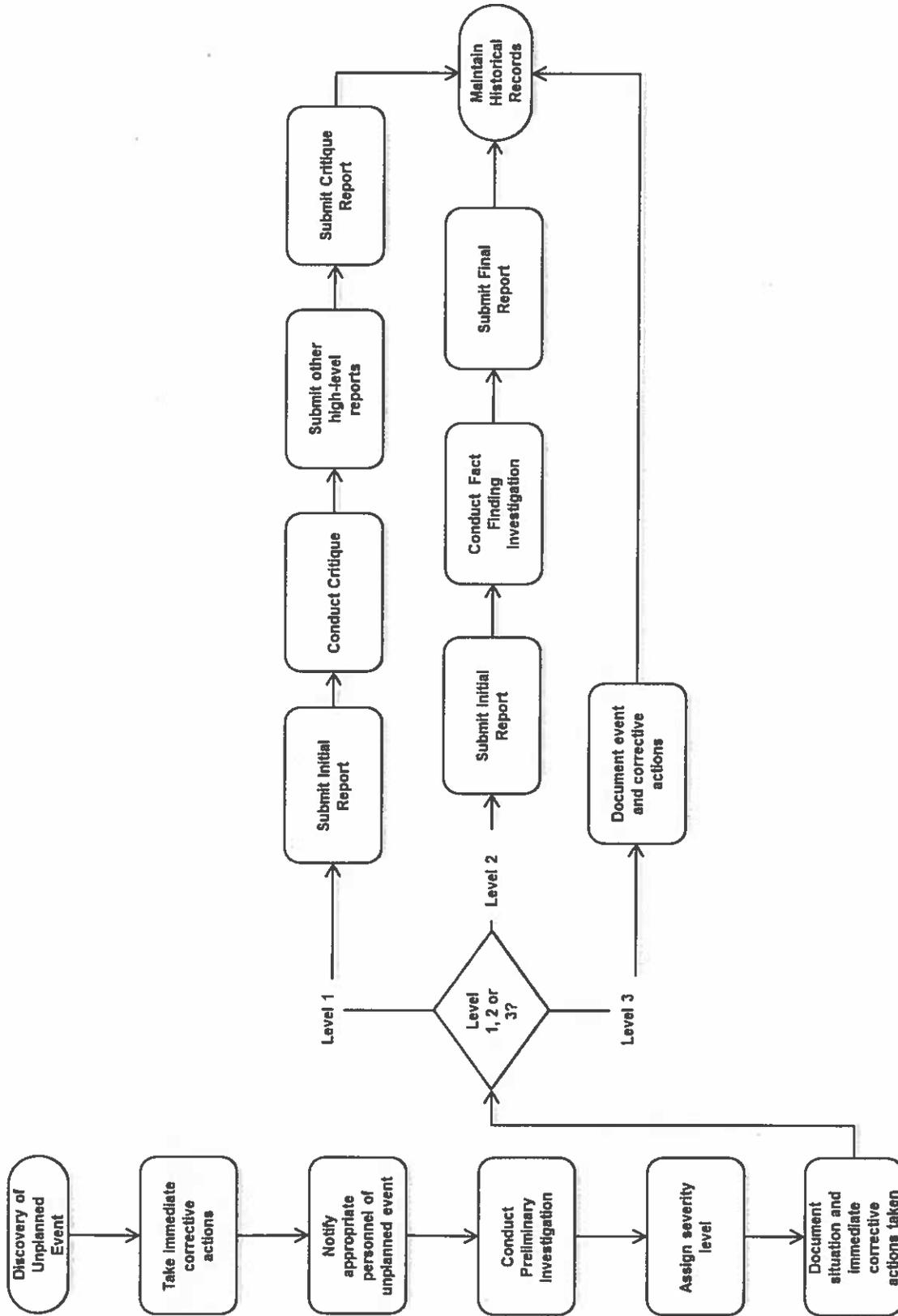
TERMS and DEFINITIONS

1. Apparent Cause. The most likely reason for a problem to have occurred based on a review of the relevant facts determined during the preliminary investigation, subsequent investigations and the critique. There may be more than one apparent cause for a problem. The determination of an apparent cause for a significant problem provides added assurance that the corrective and preventive actions taken shall minimize the potential for the problem to reoccur.
2. Corrective Action. Actions taken to correct the identified problem associated with an unplanned event.
 - a. Immediate Corrective Action. Actions taken immediately upon discovery of an unplanned event to put the component or system in a safe condition and correct any problems requiring immediate attention so that it does not escalate into a greater problem.
 - b. Short-Term Corrective Action. Actions taken for an unplanned event to correct or mitigate a component or system to a safe condition. Such actions minimize the probability of problem reoccurrence and allow work to continue until long term corrective actions are taken.
 - c. Long-Term Corrective Action. Actions taken for an unplanned event to restore a component or system to its original condition or better than before the unplanned event. This may also include changes in procedures, additional training or supervision.
3. Critique. A formal review of an unplanned event to determine the relevant facts, to provide an accurate and documented chronology of the relevant occurrences surrounding the event (before, during and after), to determine problems and their severity levels, to determine who is responsible, and to validate the adequacy of the immediate corrective actions taken. Apparent causes and corrective and preventive actions for each problem should be determined during the critique. Participants shall include people directly involved with or knowledgeable about the incident, system, or work processes and a cross-section of senior level management.
4. Higher-level Reporting. Reporting mandated by formal instruction or regulations for high-visibility or high-interest incidents and mishaps. Requirements for the submission of these reports are usually Navy-wide and may be brought to the attention of organizations such as the Office of the Chief of Naval Operations, Naval Safety Center and Judge Advocate General. Examples include Safety Investigation Reports (SIREP), Hazard Reports (HAZREP) or Operational Reports (OPREP). For the purpose of this instruction, the NAVSEA Trouble Report is defined as a higher-level report.
5. Fact Finding Investigation. An analysis of the Unplanned Event to corroborate the chronology of events and relevant facts, determine the effectiveness of the Immediate Corrective Actions, identify Apparent Causes, and who was responsible. Additional corrective and preventive actions may be identified and subsequently implemented during the investigation. An investigation is not as in-depth as a Critique Meeting, and therefore does not require a formal meeting or the degree of personnel involvement as the Critique.

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6. Preliminary Investigation. An investigation performed immediately after the occurrence of an Unplanned Event to quickly determine the relevant facts, chronology, who is responsible and circumstances of the event, to determine the severity level and whether the event warrants conducting a Critique Meeting or issuing a Trouble Report.
7. Preventive Action. Actions taken to correct the identified apparent causes of a problem and to minimize the probability of recurrence.
8. Senior Level Management. Department Head or deputy/assistant department head, equivalents and above. This also includes personnel acting in these capacities.
9. Severity Level. A problem classification that focuses the appropriate level of response for identified problems and helps ensure appropriate resources are focused on the most significant problems. See enclosure (4).
10. Trouble Report. The vehicle for reporting significant problems to NAVSEA and other activities involved in the construction, repair and maintenance of naval ships for use in training and improving the weaknesses identified as a result of the problems.
11. Unplanned Event. An unexpected occurrence that is not normal behavior or anticipated condition for the process.

UNPLANNED EVENT PROCESS FLOWCHART



UNPLANNED EVENT PROCESS GUIDE

Discovery of Unplanned Event	
Take Immediate Corrective Actions	Put the component or system in a safe condition and correct any problems requiring immediate attention so that it does not escalate into a greater problem.
Notify appropriate personnel	Elevate awareness of the unplanned event to the appropriate RMC management level and Ships Force. In addition, notify contractor management as applicable. Additional notifications should be made, as the situation warrants, to technical personnel that can assist in the resolution of the problem, NRMC (with the exception of minor events), management of involved persons, and other key personnel as appropriate.
Preliminary Investigation	Gather the known facts related to the unplanned event: <ul style="list-style-type: none"> • Chronology of events leading up to and through the event <ul style="list-style-type: none"> ○ Where it occurred ○ Who was present ○ Who took action ○ Who is responsible (may be different than “Who was present” and “Who took action”) ○ What were the actions ○ What were the results • Determine whether work can safely resume.
Assign Severity Level	Based on the Preliminary Investigation and enclosure (4) assign severity level and determine next actions.
Document	Capture the information collected thus far and maintain in historical records. <ul style="list-style-type: none"> • Level 3: no further analysis required.
Submit Initial Trouble Report	Provide an initial Trouble Report when required by paragraph 7 of this instruction, within 24 hours. Include the following information: <ul style="list-style-type: none"> • Preparing activity. • Performing activity. • Ship name and hull number or shore activity. • Date and time of event. • Title. • Summary of event. • Condition of the ship (such as dry-docked or pierside) at the time of the event. • System/component affected and condition (such as tagged out, energized, operational, etc.) at the time of the event. • Immediate Corrective Actions taken.
Critique Meeting Required	
Conduct Critique	Critiques are formal reviews and analysis of critical unplanned events to identify the various problems and apparent causes that led to the event. Since these events can result in significant recovery time and/or cost, it is

	<p>important that the apparent causes are accurately identified and preventive actions carried out to preclude any recurrences. Participants in a Critique should include a cross-section of senior-level management and personnel that are directly involved or knowledgeable about the event, system or work processes associated with the unplanned event.</p> <p>The formal Critique Meeting should be held within three days of determination that a critique meeting is required, but ideally as soon as possible once sufficient factors are known.</p> <p>The following actions should be included during the planning, execution and follow-up of a Critique:</p> <ul style="list-style-type: none"> • Obtain written, independent witness statements. • Review appropriate references, such as Instructions, Regulations, Technical Work Documents, Tech Manuals, and other pertinent information such as Process Control Procedures and Corrective Action Requests. • Review previous Fact Finding Reports from the last three years to identify repeat problems and the effectiveness of the corrective and preventive actions from those prior events. • Document Critique Meeting attendance and maintain with historical record. • Obtain agreement on the facts surrounding the unplanned events, and who was responsible. • Update the chronological statement of facts to reflect any new information discovered at the Critique Meeting. • Develop a list of problems. • Assign severity level to identified problems. • Determine apparent causes of identified problems. • Evaluate effectiveness and appropriateness of corrective actions taken to date. • Identify additional corrective and preventive actions required for Long-Term Corrective actions. • Assign responsibility and Estimated Completion Dates (ECD) for Short and Long-Term Corrective and Preventive Actions. • Identify areas that require further evaluation and assign responsibility. • If work was suspended pending the outcome of the Critique, determine when work can resume based on the ECD of the corrective and preventive actions. • Draft Fact Finding Report. • Route report for appropriate senior manager review. • Identify any higher-level reports to be completed, such as NAVSEA Trouble Report or Safety Investigation Report.
<p>Submit higher-level reports</p>	<p>Submit reports IAW higher level directives and include CNRMC in distribution.</p>
<p>Submit Fact Finding Report</p>	<p>Provide to CNRMC and other commands, as outlined in paragraph 7 of this instruction, within 20 days. Include the following information:</p>

	<ul style="list-style-type: none"> • Ship name, hull number and compartment number/location or shore activity. • Date and time of event. • Date and time of the Critique Meeting. • Condition of the ship at the time of the event. • System/component affected and condition. • Summary of the event. • Description of each problem and associated apparent causes. • Immediate corrective actions taken and results. • Any additional corrective actions and estimated completion date. • Long-Term Actions and estimated completion date. • Areas requiring further evaluation and responsibility. • Identify higher-level reporting (if submitting a Trouble Report, identify previously submitted Trouble Reports of a similar nature).
Fact Finding Report Only	
Conduct Investigation	<p>Preliminary Investigations and Fact Finding Investigations are less in-depth than Critiques and do not require the same level of scrutiny or personnel involvement. The focus is to corroborate the sequence of events and relevant facts surrounding the event and to uncover additional items that may have been omitted or overlooked at the time of the Preliminary Investigation. As many of these events may not be able to be corrected on the spot, apparent causes should be identified to determine additional corrective and preventive actions to minimize the likelihood of recurrence.</p> <p>Preliminary Investigations and Fact Finding Investigations should include the following actions:</p> <ul style="list-style-type: none"> • Obtain witness statements. • Review appropriate references, such as Instructions, Regulations, Technical Work Documents, Tech Manuals, and other pertinent information such as Process Control Procedures and Corrective Action Requests. • Review the historical records of unplanned events to identify repeat problems and the effectiveness of the corrective and preventive actions from those prior events. • Update the chronological statement of facts to reflect any new information, and who was responsible. • Determine apparent causes of identified problems. • Evaluate effectiveness and appropriateness of corrective actions taken to date. • Identify additional Short and Long-Term Corrective and Preventive Actions. • Assign responsibility and ECD for corrective and preventive actions. • Identify areas that require further evaluation and assign responsibility.

Submit Final Report	Provide to CNRMC and other commands as appropriate within 20 days. Include the following information: <ul style="list-style-type: none">• Ship name, hull number and compartment number/location.• Date and time of event.• Condition of the ship at the time of the event.• System/component affected and condition.• Summary of the event.• Identification of apparent causes.• Any additional corrective and preventive actions and estimated completion dates.• Areas requiring further evaluation and responsibility.• Identify higher-level reporting (if submitting a Trouble Report, identify previously submitted Trouble Reports of a similar nature).
Maintain historical records	For all Unplanned Events, maintain historical records and associated documentation for 6 years and 3 months.

SEVERITY LEVEL CLASSIFICATION GUIDE

1. Problem Severity Levels

a. Problems associated with unplanned events shall be assigned one of three levels of severity to distinguish those problems that have the most impact on an activity in accomplishing its mission. Severity levels also help ensure appropriate resources are focused on the most significant problems. The Corrective Action Request (CAR) process may need to be initiated at all levels.

(1) Level 1: Critical

(2) Level 2: Major

(3) Level 3: Minor

b. For each Unplanned Event identified, attempt to determine the level of severity of the problem(s) identified during the initial review of the occurrence and preliminary investigation.

c. The severity level requirements and documentation process for each problem shall be determined using these guidelines.

2. Level 1: Critical

a. A problem or trend which has or could result in significant rework, significant environmental hazard, radiological incident, equipment malfunctions, nuclear violations, serious personnel injury, or renders safeguards ineffective. A Level 1 deficiency often results in significant recovery time and cost. Level 1 problems normally require Technical Authority and/or senior management attention to resolve.

b. Problems meeting the criteria of a Level 1 require the conduct of a Critique Meeting to determine the apparent causes and to identify corrective and preventive action. A Fact Finding Report is required to be submitted to NRMC. Level 1 problems will often require the submission of a higher level report, such as a Safety Investigation Report (SIREP) or a NAVSEA Trouble Report.

c. Examples of Level 1 Problems

(1) Breakdown in Work Control/Tag-out processes leading to personnel injury or equipment damage.

(2) A shipboard or facility fire that cannot be (or was not) controlled by a Firewatch and requires Ship's Force in port Emergency Response and/or Fire Department assistance to extinguish.

(3) Equipment damage greater than \$50K.

- (4) Any rework costing over \$100K.
- (5) Any environmental incidents that have the potential to generate public interest.
- (6) Serious personnel injury or death.

3. Level 2: Major

- a. A problem or trend which, if not found and corrected, would result in a Level 1 problem.
- b. Problems meeting the criteria of a Level 2 require a degree of investigation to determine the apparent causes and identify corrective and preventive action; however, the scrutiny and direct senior level management involvement may not be required for a Critique Meeting at this level. A Fact Finding Report shall be submitted to NRMC.
- c. Examples of Level 2 Problems
 - (1) Breakdown in Work Control/Tagout processes not resulting in personnel injury or equipment damage.
 - (2) Equipment damage of less than \$50K.
 - (3) Component found out of position.
 - (4) Non-compliance with documented work procedures, such as Process Control Procedures (PCP).
 - (5) Safety discrepancies that pose an immediate threat or danger.
 - (6) Minor shipboard or facility fire that can be extinguished with handheld fire extinguisher or hose by a Firewatch. (NOTE: If a Firewatch or hot worker extinguishes minor sparks or flames as part of the hot work process, then it is a Level 3 event.)
- d. A series of related problems or the identification of a trend of Level 2 problems should be categorized as a Level 1 problem.

4. Level 3: Minor

- a. Isolated deficiencies with minimal overall impact and no significant consequences.
- b. Problems meeting the criteria of Level 3 are normally corrected on the spot. Level 3 problems shall be documented. A formal report is not required to be submitted to NRMC.
- c. Examples of Level 3 Problems
 - (1) Repeated housekeeping violations.
 - (2) Required notifications not made in a timely manner.

- (3) Paint or lagging sample taken at incorrect location.
 - (4) Potential safety discrepancies such as a hot work chit not posted on-site.
- d. A series of related problems or the identification of a trend of Level 3 problems should be categorized as a Level 2 problem.

CNRMCINST 4700.3E
16 May 17

4700
Ser C200/
Date

From: Commander, Navy Regional Maintenance Center
To: XXXXXXXXXXXX Regional Maintenance Center

Subj: CRITIQUE/TROUBLE REPORT NOTIFICATION

Ref: (a) CNRMCINST 4700.3B, Unplanned Events, Critiques and
Trouble Reports
(b) USS XXXXXX ltr/msg of xxxxxxxx (Notification of event)

1. Per references (a) and (b), you are directed to conduct a critique of the events detailed in reference (b) within three days. Per reference (a), submit a Fact Finding Report on XXXXX within 20 days.

2. Commander, Navy Regional Maintenance Center point of contact is: Code 200, Technical Director. Per reference (a), all notifications and reports to CNRMC shall be made to Code 200, Technical Director.

J. P. DOWNEY

Copy to:
NAVSEA Code (xxx)
CNRMC
Servicing RMC (SERMC/SWRMC/MARMC/NWRMC/HRMC/FDRMC)

Enclosure (5)

SAMPLE TROUBLE REPORT FORMAT

TROUBLE REPORT

*PREPARING ACTIVITY _____ (1) _____ DATE OF ISSUE _____ (2) _____
PREPARING ACTIVITY POC _____
*ACTIVITY PERFORMING THE WORK _____ (3) _____
REPORT NO _____ *DATE OF EVENT _____
*SHIP _____ (4) _____ *TIME OF EVENT _____
DATE IT WAS DETERMINED A TROUBLE REPORT WAS ECESSARY _____ (5) _____

Preliminary _____ Final _____ Revised _____
SUBSAFE _____ NNPP _____
DSS _____ FBW/SCS _____
LEVEL 1 SAFETY _____

1. *TITLE: (6)
2. *SUMMARY OF EVENT AND HOW IT WAS DISCOVERED: (7)
3. DESCRIPTION OF PROBLEM(S), GENERAL DESIGNATION AND DISCUSSION OF APPARENT CAUSE(S): (8)

DESIGN _____ MATERIAL _____ PERSONNEL _____ PROCEDURE _____

- A. DESCRIPTION OF EACH PROBLEM: (9)
- B. DISCUSSION OF APPARENT CAUSE(S): (10)
1. *CONDITION OF SHIP AND SYSTEM/COMPONENT AT TIME OF EVENT:
 - A. LOCATION AND CONDITION OF SHIP:
(e.g., Dry Docked or Waterborne, etc.)
 - B. CONDITION OF SYSTEM/COMPONENT:
(e.g., Tagged-out, Under Test, Operational, Energized)
1. IMMEDIATE CORRECTIVE ACTION(S) TAKEN AND RESULTS: (11)
2. TEMPORARY AND PERMANENT CORRECTIVE ACTION(S): (12)
3. AREAS OF, AND RESPONSIBILITY FOR, FURTHER EVALUATION: (13)
4. SIMILAR TROUBLE REPORTS (BYREPORTNO.): (14)
5. ORIGINATED BY:
6. CONCURRENCES: (15)
7. APPROVED BY: (16)

Trouble Report Notes

- (1) Activity that prepared the Trouble Report.
- (2) Date the Trouble Report was approved, not the date typed or prepared.
- (3) If different from the preparing activity, the Alteration Installation Team or other activity that performed the work shall be identified.
- (4) Ship name and hull number.
- (5) Date it was determined that the event met the criteria for a Trouble Report.
- (6) Provide a title that briefly describes the event.
- (7) Provide a brief executive summary of the event. For revised reports, also summarize the new information or reason for revision as appropriate. Changes and new information should also be indicated with sidebars in the right margin.
- (8) Designate and discuss cause(s) of the problem as follows:
 - a. **Design** – Problem designated as involving a design deficiency or error shall clearly identify the specific design deficiency and explain the rationale for designating design as a cause.
 - b. **Material** – Before designating materials as a cause, careful attention shall be given to the possibility of inadvertent substitution of incorrect material or improperly performed maintenance; which are personnel errors. However, if a material failure occurs and the reason cannot be determined, material should be designated as a cause. Trouble Reports of problems caused by material failures shall adequately identify the failed equipment via National Stock Number, manufacturer, length of time in service and operation (estimate), and past problems, if known.
 - c. **Personnel** – Trouble Reports involving personnel error shall indicate the nature of the error and the specific corrective action(s) with regard to the training, qualification, or supervision of individual(s) involved. Where the cause of the problem is traceable to improper action by a specific individual, mechanic, watchstander, etc., individuals shall be referred to by job title or watchstation, not by name. The specifics of corrective actions regarding disciplinary actions should not be included in Trouble Reports.
 - d. **Procedure** – This category applies to procedures provided by an outside agency or another activity. Errors in locally developed procedures shall be designated as personnel errors.
- (1) Provide a description of each problem in sufficient detail that persons not familiar with the actual problem can read this report and understand what happened and its significance. A chronology of events should be included if timing or sequence of events is important to

understanding the problem. For activities that use the Quality Performance System (QPS), annotate the QPS category for each problem.

(2) State the cause(s) for the problem identified via the problem investigation. There should be a least one cause for each identified problem. The specific causes (and any key pertinent lessons learned) should be listed after the general description of the event in the order that the problems are identified in the general description.

(3) State the Immediate Corrective Actions taken in response to the event and the results of those actions.

(4) For each cause, identify the corresponding temporary and permanent corrective actions. Temporary corrective actions are interim actions taken to correct or mitigate the apparent causes of the problems associated with an Unplanned Event. Such actions allow work to safely continue until permanent corrective actions are taken. Permanent Corrective Actions are actions taken to correct the cause of the problems to minimize the probability of reoccurrence (e.g./ changing engineering procedures, revising the process, changing lesson plans, mockups, strengthening supervision, etc.). Specify responsible organizations and/or individuals and completion dates for each action. Where a cause requires corrective action by NAVSEA Headquarters HQ), such as deficient equipment or system designs, or inadequate specifications, standards, or procedures, the need for NAVSEA HQ action shall be made clear in the Trouble Report. However, a recommendation for NAVSEA HQ action within a Trouble Report is not a substitute for the submission of other required documents such as manual change requests, liaison action requests, or requests for technical non-conformance approval.

(5) Where appropriate, note planned or completed actions taken to determine the effectiveness of corrective actions.

(6) Previous similar Trouble Reports should be listed by report serial number. Assess why corrective actions taken for similar Trouble Reports were not effective at preventing this occurrence.

(7) The Chief Engineer and Quality Assurance Director shall document their concurrence on the completed Trouble Report. The Ship's Force representative and other cognizant senior manager shall also concur with the completed Trouble Report, as applicable. The Submarine Safety Program Director, Deep Submergence System Program Director, Fly-By-Wire Ship Control System Program Representative shall document their concurrence on Submarine Safety, Deep Submergence System and Fly-By-Wire Ship Control System Trouble Reports, as applicable.

(8) Completed Trouble Reports shall be reviewed and signed for approval by the preparing activity's Commanding Officer or his designated representative.

FACT FINDING REPORT FORM

Preliminary Report
Final Report

UNCLAS
NOFORN
CONFIDENTIAL

SENIOR MANAGER REVIEW: _____

ACTIVITY RESPONSIBLE FOR INVESTIGATION OF UNPLANNED EVENT: _____

CRITIQUE DATE/TIME (indicate "report only" if no critique held): _____

REPORT SERIAL NUMBER: _____ DATE REPORT ISSUED: _____

DATE/TIME OF ACTUAL UNPLANNED EVENT: _____

DATE/TIME WHEN UNPLANNED EVENT WAS DISCOVERED: _____

LOCATION OF UNPLANNED EVENT (i.e. building/facility, room/space): _____

TITLE (based on the most obvious problem): _____

SEVERITY LEVEL ASSIGNED: _____

DESCRIPTION OF THE UNPLANNED EVENT: _____

IMMEDIATE CORRECTIVE ACTIONS TAKEN: _____

PROCEDURE NUMBER: _____ STEP BEING WORKED: _____

DISCOVERED BY: _____ PHONE #: _____

CHAIRPERSON: _____ PHONE #: _____

ORGANIZATION(S) RESPONSIBLE FOR IDENTIFIED PROBLEMS OR ASSIGNED ACTIONS/OPEN ITEMS

ORG: _____ ORG: _____ ORG: _____ ORG: _____ ORG: _____ ORG: _____

CONCURRENCE SIGNATURES

CHAIRPERSON/DATE: _____ SUPERVISOR/DATE: _____

CONCURRENCE BY/DATE: _____ CONCURRENCE BY/DATE: _____