NAVSEA
STANDARD ITEM

FY-15

ITEM NO: 009-120
DATE: 06 JAN 2014
CATEGORY: I

1. SCOPE:

1.1 Title: Fact Finding and Critique of Unplanned Events; manage

2. REFERENCES:

2.1 None

3. REQUIREMENTS:

3.1 Accomplish the requirements of this item upon discovery of an unplanned event as directed by the SUPERVISOR.

3.1.1 Ensure immediate corrective actions are taken to mitigate the impact of the unplanned event, reduce or confine the area of concern, and place the work site in a safe and stable condition.

3.1.2 Secure work until approval to recommence is authorized by the SUPERVISOR.

3.1.3 Accomplish preliminary investigation to obtain immediate first-hand information at the job site concerning the unplanned event and ensure adequate immediate corrective action has been taken.

3.1.4 Determine the severity level of problems associated with the unplanned event using Attachment A (Severity Classification Guide).

3.1.4.1 Severity Level One (critical) or Severity Level 2 (major) problems require an investigation and normally a Critique Meeting.

3.1.4.2 Severity Level 3 (minor) problems require an investigation, however a Critique Meeting is not required.

3.1.5 Provide update to the SUPERVISOR on the status of the preliminary investigation and the assigned severity level within 4 hours of being directed by the SUPERVISOR to conduct a critique.

3.1.6 Obtain SUPERVISOR concurrence that the immediate corrective actions have been taken.

3.1.6.1 Resume work concurrently with Fact Finding Investigation process only with SUPERVISOR authorization.

3.1.7 Assign a Fact Finding Investigator to accomplish the Fact Finding Process.

3.1.7.1 Accomplish Fact Finding Investigation with the objective of preparing a complete chronological statement of the facts relative to the occurrences leading up to and through the unplanned event, and of the immediate corrective actions taken. Include only facts such as what happened, when, where, who was present, who took action, and what could have happened if the outcome was different.

3.1.7.2 Obtain written independent statements from all witnesses to the unplanned event to establish the relevant facts.

3.1.7.3 Review all appropriate references, technical work documents, or other information pertinent to the problem and ensure that they are available for examination and discussion at the Critique Meeting.

3.1.7.4 Review similar unplanned events and corrective actions previously documented to identify repeat problems and the effectiveness of those previous corrective actions.

3.1.7.5 Complete the Fact Finding Investigation prior to the Critique Meeting without being influenced by pressure to resume work.

3.1.7.6 Document the initial Fact Finding Investigation of the unplanned event using Attachment B (Fact Finding Report and Preparation Requirements).

3.1.7.7 Obtain a unique Fact Finding Report Serial Number from the SUPERVISOR. This number shall be used as the serial number for the Fact Finding Report and all related documents.

3.1.8 Assign a Critique Chairperson and identify required Critique Meeting members (Contractor, Government, Ship's Force).

3.1.8.1 A Critique Meeting is normally required; however, based on the results of the investigation, it may be deemed not warranted. For Critique Meeting to be not warranted, the problem(s) must be fully understood, cause(s) clearly known, and there must be concurrence from the SUPERVISOR to not hold a Critique Meeting.

3.1.8.2 Submit one legible copy, in hard copy or approved transferrable media, of the preliminary Fact Finding report, Attachment B, to the SUPERVISOR prior to the Critique Meeting, or a final Fact Finding report,

if the Critique Meeting is deemed not warranted, within 20 working days of being directed by the SUPERVISOR to conduct a critique.

3.1.9 Coordinate the time and location of the Critique Meeting with the SUPERVISOR and meeting members. Ensure appropriate personnel (including ships force) are notified of the time, location and subject of the Critique Meeting.

3.1.10 Conduct Critique Meeting within 24 hours of being directed by the SUPERVISOR to conduct a critique.

3.1.10.1 Commencement of the Critique Meeting may be extended up to 3 working days with SUPERVISOR authorization.

3.1.11 Document all attendees using Attachment C, the Critique Meeting Attendance Sheet.

3.1.12 Ensure all pertinent documentation is available and distributed at the Critique Meeting (e.g. Fact Finding Report, appropriate references, technical work documents, chronological statement of relative facts, other information relevant to the problem and a list of any similar problems and corrective actions previously documented).

3.1.13 Introduce the Critique Chairperson, Fact Finding Investigator and all meeting members at the commencement of the Critique Meeting.

3.1.14 Brief all attendees that the purpose of the meeting is to encourage open discussion of the relevant facts and problems associated with an unplanned event, so that apparent causes of the problems and effective solutions can be determined. Critique Meetings are not examinations or investigations for the purpose of disciplinary action. Any disciplinary action investigation will be conducted separately and independently of this critique process.

3.1.15 Review all pertinent documentation and open the floor for discussion to determine any additional relevant facts. Obtain agreement/consensus on the relevant facts from all attending personnel.

3.1.16 Update the chronological statement of relevant facts to reflect additional pertinent information discovered during the Critique Meeting.

3.1.17 Document each problem identified during the Critique Meeting on the List of Problems and Corrective Actions form, Attachment D.

3.1.18 Coordinate with the SUPERVISOR to assign actions for each problem to the appropriate contractor or designated representative of an organization.

3.1.18.1 More than one action may be required for each problem.

3.1.18.2 Ensure the contractor or designated representative of the organization assigned an action item signs the Fact Finding Report Form, Attachment B, acknowledging concurrence.

3.1.18.3 Ensure a Cause and Corrective Action (CCA) form, Attachment E, has been issued to the appropriate organization for follow-up and action.

3.1.19 Submit one legible copy, in hard copy or approved transferrable media, of the Critique paperwork and associated reports to the SUPERVISOR within three working days after conclusion of the Critique Meeting.

3.1.20 Ensure the organization assigned an action from the Critique Meeting provides an update using the Cause and Corrective Action Form, Attachment E, for all actions taken or in progress within two working days of assignment and as required thereafter.

3.1.20.1 All corrective actions must have an actual or estimated completion date. The terms “continuing” or “continuous” are not acceptable. If an action is of a repetitive or continuous nature, the completion date will match the date the policy for that action was disseminated.

3.1.21 Notify the SUPERVISOR of any new problems related to the unplanned event that are discovered while working action items.

3.1.21.1 Changes to the Fact Finding Report after the Critique Meeting was adjourned will only be made by the Chairperson with SUPERVISOR concurrence.

3.1.22 Manage the Fact Finding and Critique Process for each problem until satisfactory conclusion.

3.1.23 Collect all completed Cause and Corrective Action forms to review for completion and compliance.

3.1.24 Submit one legible copy, in hard copy or approved transferable media, of the Final Fact Finding report listing the results of the investigation, along with all associated paperwork to the SUPERVISOR within 20 working days of being directed to conduct a critique.

3.1.25 Maintain a record of all Fact Finding and Critique process documents for a minimum of three years.

3.1.25.1 Stored records shall be used to conduct trend analysis for any similar problems and corrective actions previously documented to identify repeat problems and to evaluate the effectiveness of those corrective actions.

4. NOTES:

4.1 Definitions.

4.1.1 Apparent Cause: The most likely reason for a problem to have occurred based on a review of relevant facts determined during the preliminary investigation, subsequent investigations and the critique. There may be more than one apparent cause for a problem.

4.1.2 Critique: A formal review meeting of a critical or major unplanned event (as defined in Attachment A, Severity Level Classification Guide) 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 the apparent causes of problems and their severity levels, and to validate the adequacy of the immediate corrective actions taken. Apparent cause(s) and corrective and preventive action(s) for each problem should be determined during the critique. Participants will include personnel directly involved with or knowledgeable about the incident, system, or work processes and a cross-section of senior level management.

4.1.3 Fact Finding: A formal investigation conducted by the contractor for all unplanned events to identify and document the facts surrounding the unplanned event to include the identification of all problems and their severity levels, apparent causes, immediate corrective actions, and short and long-term corrective actions taken to prevent recurrence of the unplanned event. A formal Critique Meeting may be conducted as part of some Fact Findings. The results of the Fact Finding and Critique Meeting (when conducted) are documented in a Fact Finding report.

4.1.4 Critique Chairperson: Appointed by the contractor and responsible for ensuring that the problems associated with unplanned events are properly identified, characterized by severity level, investigated, critiqued (if necessary), have adequate short and long-term corrective actions identified, and are reported in a timely manner. Collects the Cause and Corrective Action (CCA) memos for each problem identified in the critique meeting, reviews them for adequacy, prepares the final Fact Finding report and obtains the concurrence of the SUPERVISOR with the final Fact Finding report.

4.1.5 Fact Finding Investigator: Appointed by the contractor to conduct Investigation of an unplanned event to determine the relevant facts, chronology, and circumstances of the event and to determine if the event

warrants conducting a critique meeting. Provides results of the investigation to the Critique Chairperson.

4.1.6 Fact Finding Report Serial Number: Each unplanned event to be investigated is assigned a unique serial number used for accountability and tracking. Serial Numbers will be provided by the SUPERVISOR.

4.1.7 Immediate Corrective Action: Action(s) 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.

4.1.8 Long-Term Corrective Action: Action(s) taken to correct the apparent cause(s) of the problem(s) to minimize the probability of recurrence and to correct any problems that may be discovered during the fact finding and critique process.

4.1.9 Short-Term Corrective Action: Temporary action(s) taken to correct or mitigate the apparent cause(s) of the problem(s) associated with an unplanned event. Such actions minimize the probability of problem recurrence and allow work to continue until long-term corrective actions are taken.

4.1.10 Unplanned Event: An unexpected occurrence that is not normal behavior or anticipated condition for the process.

4.2 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 within the command. Systemic problem areas identified may be addressed through other administrative reporting procedures with cognizant Immediate Superior In Command (ISIC) personnel.

4.3 If problems are identified to contractors working for AIT managers, the Alteration Installation Team (AIT) managers are required to initiate and conduct the Fact Finding process for unplanned events. The Naval Supervisory Authority (NSA) shall participate as necessary to ensure effectiveness.

4.4 A Process Flow Chart, Appendix F is provided as a quick reference guide for the Critique process.

SEVERITY LEVEL CLASSIFICATION GUIDE

1. PROBLEM SEVERITY LEVELS:

1.1 Problems associated with unplanned events shall be assigned one of three levels of severity (Level One, 2, or 3) 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.

1.2 For each unplanned event identified, attempt to determine the level of severity of the problem(s) during the preliminary investigation.

1.2.1 Problems meeting the criteria of Levels One or 2 normally require both a Fact Finding Investigation and a Critique Meeting to determine and correct the cause(s) of the unplanned event.

1.2.2 Problems meeting the criteria of Level 3 shall be investigated to determine and correct the cause(s) of the unplanned event, normally on the spot, but a Fact Finding Report is not required for a Level 3 problem. For completeness, Level 3 problems identified in conjunction with a Fact Finding Investigation for a Level One or 2 problem shall be included in the Fact Finding Report for the Level One or 2 problem.

1.3 The severity level for each problem shall be determined using the following guidelines:

1.3.1 Level One “CRITICAL”

1.3.1.1 A problem or trend which has or could endanger personnel, result in significant rework, significant environmental hazard, significant personnel injury or renders safeguards ineffective. Level One problems normally require Technical Authority and/or senior management attention to resolve.

1.3.1.2 Level One deficiencies often result in significant recovery time/cost. A series or trend of Level 2 deficiencies should be grouped together and identified as Level One.

Examples of Level One problems include:
- Equipment damage greater than $50K
- Any rework costing over $100K
- Work Control/Tag Out violations
- Loss of control during testing
- Crane accident resulting in an event such as derailment, overload, injury to personnel, dropped material, equipment damage, unplanned contact between the load, crane or object
- Serious personnel injury (i.e. chemical burn, electric shock, fall)

-Flammable liquid spill
-Fire or Flooding
-Broken weight handling equipment (while in use)
-Personnel in a toxic environment without proper gas free certification (space not gas free)

1.3.2 Level 2 “MAJOR”

1.3.2.1 A problem or trend which, if not found and corrected, has the potential to result in a Level One problem or which results in equipment degradation requiring DFS approval. Level 2 problems may require Technical Authority involvement and senior management attention.

1.3.2.2 A series or trend of Level 3 deficiencies should be grouped together and identified as Level 2.

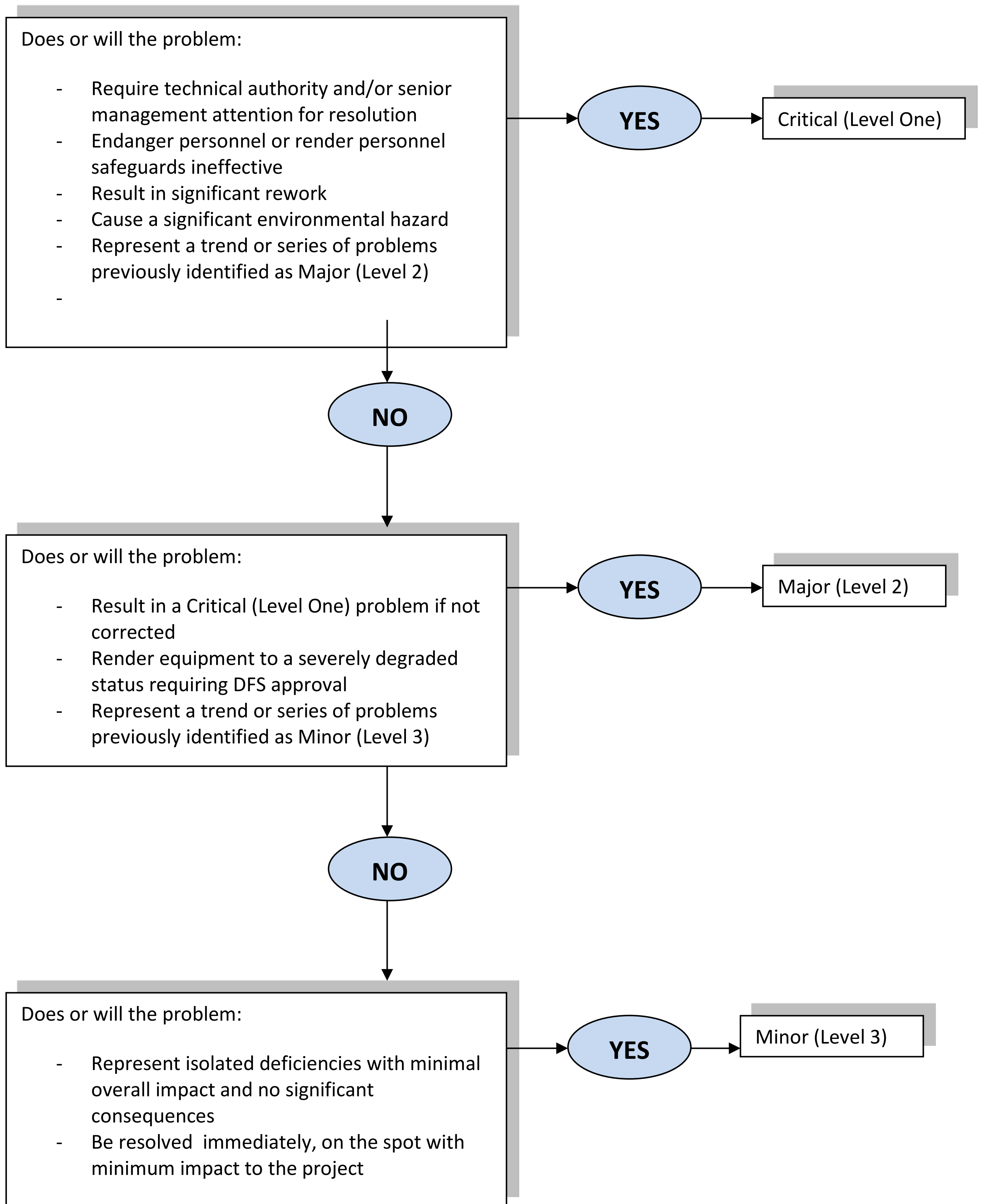
Examples of Level 2 problems include:
-Equipment damage of less than $50K
-Using improper test procedures
-Loss of cleanliness of a system or equipment
-Component found out of position (i.e. valve or switch open in lieu of shut)
-Systemic problems regarding safety requirements
-Personnel in a toxic environment without gas free certification properly posted (not posted but space was Gas Free)
-Not following written procedures (e.g. Expanded Process Control Procedures, Process Control Procedures, Test Plan)

1.3.3 Level 3 “MINOR”

1.3.3.1 Isolated deficiencies with minimal overall impact and no significant consequences. Level 3 problems are normally corrected on the spot (i.e. document the deficiency and brief personnel involved) with an immediate corrective action.

Examples of Level 3 problems include:
-Any problem not categorized as Level One or Level 2
-Required notification of the problem was not made in a timely manner
-Paint sample taken at incorrect location
-Required procedures not on site
-OQE or reports not recorded or submitted in required time
-Unsafe work practices
-Poor craftsmanship
-Repeated housekeeping violations

Problem Severity Level Determination Chart



Attachment B

FACT FINDING REPORT AND PREPARATION REQUIREMENTS

*Note: Mark the security classification on the report as applicable based on the sensitivity of the information contained in the report.

1. Preliminary Fact Finding Report:

1.1 An in-progress report that may consist of the following:

1.1.1 Fact Finding Report Form filled out with the "Preliminary Report" box checked.

1.1.2 List of Problems and Corrective Actions Form(s) (Attachment D).

1.1.3 Cause and Corrective Action Form(s) (Attachment E).

1.1.4 Chronological statement of relevant facts.

1.1.5 Any other document(s) used during the Fact Finding Investigation.

2. Final Fact Finding Report:

2.1 A final Fact Finding Report shall consist of the following:

2.1.1 Completed Fact Finding Report Form with the "Final Report" box checked and senior manager review.

2.1.2 Completed List of Problem and corrective Action Form(s) (Attachment D).

2.1.3 Completed Cause and corrective Action Form(s) (Attachment E)

2.1.4 Complete chronological statement of relevant facts from the unplanned event.

2.1.5 Any other document(s) used during the Fact Finding Investigation (e.g. Independent statements from individual(s), appropriate references, technical work documents).

2.1.6 Critique Meeting attendance form (Attachment C), if a Critique Meeting was held.

FACT FINDING REPORT FORM

Preliminary Report ☐ ☐ UNCLAS
Final Report ☐ ☐ NOFORN
SENIOR MANAGER REVIEW:____________________________ ☐ CONFIDENTIAL

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
SHOP:________ SHOP:________ SHOP:________ SHOP:________ SHOP:________ SHOP:________

CONCURRENCE SIGNATURES

CHAIRPERSON/DATE:________________________ SUPERVISOR/DATE:__________________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________

ATTACHMENT C

CRITIQUE MEETING ATTENDANCE SHEET FORM

REPORT SERIAL NUMBER: _______________ DATE/TIME: _________________________________

PRINT NAME	ORGANIZATION/SHOP Check block if you are a Senior Manager	☐	PHONE #

ATTACHMENT D

LIST OF PROBLEMS AND CORRECTIVE ACTIONS

REPORT SERIAL NUMBER: ______________

PROBLEM #: ______________________________ SEVERITY LEVEL: ______________________________
ORGANIZATION RESPONSIBLE FOR ANALYSIS AND RESOLUTION: ______________________________
PROBLEM STATEMENT: ____
____
APPARENT CAUSES: ____
____
____
SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____
____
ESTIMATED COMPLETION DATE: ____________ ACTUAL COMPLETION DATE: _____________________

PROBLEM #: ______________________________ SEVERITY LEVEL: ______________________________
ORGANIZATION RESPONSIBLE FOR ANALYSIS AND RESOLUTION: ______________________________
PROBLEM STATEMENT: ____
____
APPARENT CAUSES: ____
____
____
SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____
____
ESTIMATED COMPLETION DATE: ____________ ACTUAL COMPLETION DATE: _____________________

PROBLEM #: ______________________________ SEVERITY LEVEL: ______________________________
ORGANIZATION RESPONSIBLE FOR ANALYSIS AND RESOLUTION: ______________________________
PROBLEM STATEMENT: ____
____
APPARENT CAUSES: ____
____
____
SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____
____
ESTIMATED COMPLETION DATE: ____________ ACTUAL COMPLETION DATE: _____________________

ATTACHMENT E

CAUSE AND CORRECTIVE ACTION FORM

REPORT SERIAL NUMBER: ______________________ SEVERITY LEVEL: _________________________

MANAGER/TECHNICAL CODE: ____________________ DATE ISSUED: ___________________________

1. This form contains the problem descriptions that were identified as being partially or wholly the responsibility of shop ______. As the __________________ manager, you are responsible to follow up and take the appropriate actions to correct the listed problems.

PROBLEM # ___ DESCRIPTION: ____
____
____
____

CAUSE: ____
____
____
____

SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ________________ ACTUAL COMPLETION DATE: _________________

LONG-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ________________ ACTUAL COMPLETION DATE: _________________

PROBLEM # ___ DESCRIPTION: ____
____
____
____

CAUSE: ____
____
____
____

SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ________________ ACTUAL COMPLETION DATE: _________________

LONG-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ________________ ACTUAL COMPLETION DATE: _________________

Attachment F

Process Flow Chart