NAVSEA
STANDARD ITEM

FY-19

ITEM NO: 009-120
DATE: ***01 OCT 2017***
CATEGORY: I

1. SCOPE:

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

2. REFERENCES:

2.1 ***Standard Items***

3. REQUIREMENTS:

3.1 Accomplish the fact finding and critique and the requirements of this Standard Item upon discovery of an unplanned event as directed by the SUPERVISOR.

3.1.1 Stop work and ensure immediate 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 Initiate a preliminary investigation to identify and capture relevant facts regarding the unplanned event. Provide ongoing updates to the SUPERVISOR on immediate actions being taken and the status of the preliminary investigation. Complete the preliminary investigation and submit Attachment E to the SUPERVISOR within 24 hours of receiving direction to initiate actions under this Standard Item.

3.1.2.1. The Preliminary Investigation shall contain at a minimum a summary of the relevant facts, chronology of events, actions and results of those actions, damage estimations, where it occurred, who was present and who took action, and any additional circumstances of the event. There should be enough detail to give an overview of the event, to establish the severity level, and allow for the determination of follow on actions. Document the preliminary investigation using Attachment E.

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

3.1.4 Obtain SUPERVISOR concurrence that adequate immediate corrective actions have been taken. Resume work only when authorized by the SUPERVISOR.

3.1.5 When directed by the SUPERVISOR, proceed with the Fact Finding Investigation and, if directed, conduct a Critique Meeting.

3.2 Assign a Fact Finding Investigator/Critique Chairperson (See 4.1.3, 4.1.4 and 4.1.5)

3.2.1 Accomplish initial Fact Finding Investigation and prepare a Preliminary Fact Finding Report using Attachment B, Fact Finding Report and Preparation Requirements. Submit a copy of the Preliminary Fact Finding Report to the SUPERVISOR within 3 days of being directed by the SUPERVISOR to proceed in accordance with 3.1.5 or 4 hours prior to the scheduled Critique Meeting, whichever occurs first. Request for additional time shall be submitted to and approved by the SUPERVISOR. The Preliminary Fact Finding Report shall contain a complete chronological statement of the facts relative to the occurrences leading up to and through the unplanned event, the immediate corrective actions taken, a working copy of Cause and Corrective Action Form to be refined during the Critique Meeting and any other documents used during the fact finding investigation. Include only facts such as what happened, when, where, who was present, who took action, etc.

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

3.2.3 Compile and review all appropriate references, technical work documents, or other information pertinent to the problem.

3.2.4 Review similar unplanned events from the previous 3 years and corrective actions previously documented to identify repeat problems and the effectiveness of those previous corrective actions.

3.2.5 Coordinate the time and location of the Critique Meeting with the SUPERVISOR and meeting members. Ensure appropriate personnel (including Ship’s Force) are notified of the time, location and subject of the Critique Meeting.

3.2.5.1 A Critique Meeting may be deemed not warranted based on the results of the Fact Finding investigation. The problem(s) resulting in the unplanned event must be fully understood and cause(s) clearly known. The SUPERVISOR must concur in the decision to not hold a Critique Meeting and a Final Fact Finding Report must still be prepared and submitted.

3.2.6 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.

3.3 Conduct Critique Meeting within 3 days of being directed by the SUPERVISOR to conduct a critique.

3.3.1 Commencement of the Critique Meeting may be extended with SUPERVISOR authorization.

3.3.2 Introduce all meeting members at the commencement of the Critique Meeting. Document all attendees using Attachment C, the Critique Meeting Attendance Sheet.

3.3.3 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).

3.3.4 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.

3.3.5 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.

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

3.3.7 Document each problem identified during the Critique Meeting on a Cause and Corrective Action form(s), Attachment D.

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

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

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

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

3.3.8.4 Changes to the Fact Finding Report after the Critique Meeting was adjourned ***or after the fact finding report has been accepted/signed by the SUPERVISOR,*** will only be made by the Chairperson with SUPERVISOR concurrence.

3.3.9 Submit one legible copy, in hard copy or approved transferrable media, of the Critique paperwork and associated reports to the SUPERVISOR within 3 days after conclusion of the Critique Meeting.

3.3.10 Track all corrective actions assigned in the Final Fact Finding Report to completion. Ensure the organization assigned actions from the Critique Meeting/Fact Finding provides documentation of completion using the Cause and Corrective Action Form, Attachment D, for all actions taken or in progress within 3 days of assignment and as required thereafter.

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

3.4 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 30 days of being directed to investigate the Unplanned Event.

3.5 Maintain a record of all Fact Finding and Critique process documents for a minimum of 4 years.

3.5.1 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. 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.

4.1.2 Critique: A formal meeting to review 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 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.

4.1.4 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, and therefore does not require a formal meeting or the degree of personnel involvement as the Critique.

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 Short-Term Corrective Action: Actions taken for an unplanned event to collect or mitigate a component or system to a safe condition. Such

actions minimize the probability or problem reoccurrence and allow work to continue until long term corrective actions are taken.

4.1.9 Long-Term Corrective Action: Actions taken for an unplanned event to restore a component or system to its original condition or better before the unplanned event. This may also include changes in procedures, additional training or supervision.

4.1.10 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 or issuing a Trouble Report.

4.1.11 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 SUPERVISOR shall participate as necessary to ensure effectiveness.

4.4 Each Crane accident occurring on US Naval installations will be reported and investigated in accordance with 009-40 of 2.1 unless otherwise directed by the SUPERVISOR.

4.5 Initial submission of Attachment A under 009-74 of 2.1 may be substituted for Attachment E under this Standard Item. Duplicate submission of Attachment E is not required.

ATTACHMENT A

SEVERITY LEVEL CLASSIFICATION GUIDE

1. PROBLEM SEVERITY LEVELS:

1.1 Problems associated with unplanned events shall be assigned one of 3 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 result in significant rework, significant environmental hazard, radiological incident, equipment malfunctions, nuclear violations, serious personnel injury or renders safeguards ineffective. A Level One deficiency often results in significant recovery time and cost. 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
-Breakdown in Work Control (not administrative errors)/Tag Out processes leading to personnel injury or equipment damage

-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 (e.g., chemical burn, electric shock, fall)
-Flammable liquid spill
-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
-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 identified 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 identified 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., Process Control Procedures, Test Plan)
-Safety discrepancies that pose an immediate threat or danger
- 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.)

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

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 shall consist of the following:

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

1.1.2 Chronological statement of relevant facts.

1.1.3 Working copy of cause and Corrective Action Forms(s) Attachment (D)

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

2.1.3 Completed Cause and Corrective Action Form(s) (Attachment D)

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

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

2.1.6 Identify any similar Unplanned Event(s).

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: ____
____

PREVIOUS SIMILAR UNPLANNED EVENT(s): YES ☐ NO ☐, IF YES, LIST SERIAL NUMBER(s)_____

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:______________________
CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________
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CONCURRENCE BY/DATE:_____________________ CONCURRENCE BY/DATE:______________________

ATTACHMENT C

CRITIQUE MEETING ATTENDANCE SHEET FORM

REPORT SERIAL NUMBER: _____________ DATE/TIME: _____________________________

PRINT NAME	ORGANIZATION/SHOP	PHONE #

ATTACHMENT D

CAUSE AND CORRECTIVE ACTION FORM

REPORT SERIAL NUMBER: _______________ EVENT 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 __________. As the _______________ manager, you are responsible to follow up and take the appropriate actions to correct the listed problems.

PROBLEM # __________ PROBLEM SEVERITY LEVEL _______________

DESCRIPTION: ____
____
____
____

CAUSE: ____
____
____
____

SHORT-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ___________ ACTUAL COMPLETION DATE: ______________

LONG-TERM CORRECTIVE ACTIONS: ____
____
____
____

ESTIMATED COMPLETION DATE: ____________ ACTUAL COMPLETION DATE: _____________

ACTION ASSIGNMENT SIGNATURES

CRITIQUE CHAIRPERSON ____________________________ DATE: _____________________
(prime contractor)

SUPERVISOR REPRESENTATIVE: ______________________ DATE: _____________________

RESPONSIBLE ORGANIZATION: _______________________ DATE: _____________________

ACTION COMPLETION/ACCEPTANCE SIGNATURES

RESPONSIBLE ORGANIZATION: _______________________ DATE: _____________________

PRIME CONTRACTOR ACCEPTANCE: ____________________ DATE: _____________________

SUPERVISOR REPRESENTATIVE: ______________________ DATE: _____________________

Attachment E

PRELIMINARY INVESTIGATION	
Proposed Severity Level	☐Level 1 ☐Level 2 ☐ Level 3

SHIP: DATE: TIME:	COMPANY: SUB-CONTRACTOR(s):
LOCATION OF EVENT:	INJURIES:
APPARENT CAUSE:	EQUIPMENT DAMAGE:
WORK ITEM NUMBER:	CONTRACT NUMBER:

WITNESS AND/OR INDIVIDUALS INVOLVED

NAME(S)	DEPT.	COMPANY

SUMMARY OF EVENT

IMMEDIATE CORRECTIVE ACTION(include who performed the action)

INVESTIGATED BY (PRINT NAME):	TITLE/PHONE NUMBER: