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IN REPLY REFER TO
COMNAVSURFPACINST 3040.1
N43
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COMNAVSURFPAC INSTRUCTION 3040.1

From: Commander, Naval Surface Force, U.S. Pacific Fleet

Subj: SIGNIFICANT EVENT/NEAR-MISS REPORTING

Ref: (a) OPNAVINST 5102.1D
(b) JAGINST 5800.7F

Encl: (1) Events Requiring a Significant Event/Near-Miss Report
(2) Critique Preparation and Conduct
(3) Sample Corrective Actions
(4) Standard Letter Report Format

1. Purpose. To promulgate guidance, procedures and requirements for significant event and near-miss critique conduct and reporting. Significant event/near-miss reporting is a key supporting element of the sound shipboard operating principles of integrity, procedural compliance, formality, questioning attitude, forceful backup, and level of knowledge. This instruction provides a structured process for conducting critiques and reporting significant events/near-misses via a critique report in order to:

a. Improve shipboard readiness through the conduct of a significant event/near-miss critique.

b. Improve Pacific Surface Force readiness by disseminating the reports from this process.

c. Instill a culture of continuous improvement, promote better understanding of the sound shipboard operating principles, and gain proficiency in root cause analysis to improve warfighting effectiveness.

2. Discussion. Enclosure (1) provides a listing of specific significant events/near-misses which would warrant conducting a critique and producing a report. Enclosure (1) is neither all inclusive, nor prescriptive, but rather designed as an aid for commanders.

a. Figure 1 below is meant as a further aid to identify where Significant Event/Near-Miss Reports fall on the scale of the numerous other reporting requirements as 2nd Order events.

b. Early identification and trend analysis of 3rd order deficiencies are designed to prevent 2nd order events. Maintaining a self-critical culture of critiquing 2nd order events/near-misses is designed to prevent 1st order events.

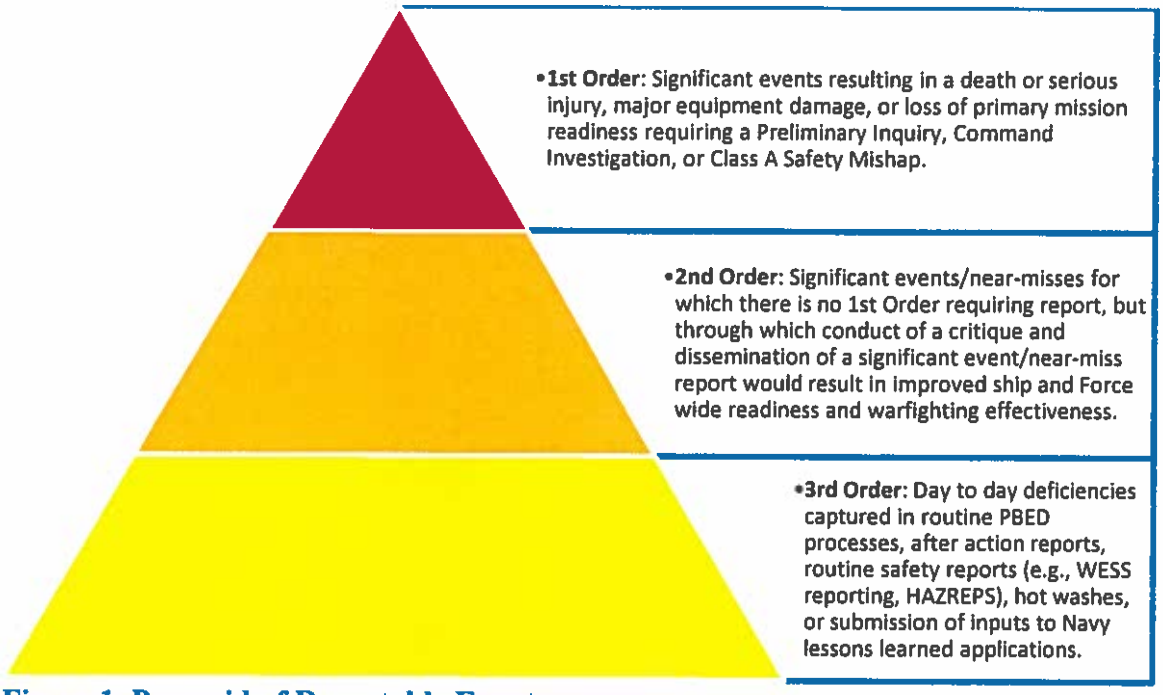


**Figure 1. Pyramid of Reportable Events**

3. Procedures.

a. Event Report Initiation. A culture of critical self-assessment in which commands self-identify the need to critique a significant event/near-miss is ideal. Immediate superior-in-command (ISICs) and COMNAVSURFPAC may also direct the conduct of a critique and production of a significant event/near-miss report.

b. Notification. Once it is determined that a significant event/near-miss warrants a critique, the command will notify their ISIC and COMNAVSURFPAC Force Readiness (N04) so that representatives from both may attend the critique. If requested by the initiating command, the COMNAVSURFPAC N04 will also formally assign a mentor to assist in the critique process.

c. Critique Process. Enclosure (2) provides a framework for conducting a critique.

d. Significant Event/Near-Miss Report Development, Submission, and Review.

(1) Format. These reports shall follow the format provided in enclosure (3) and should be unclassified unless the problems and corrective actions cannot be adequately described in an unclassified report. These reports should be written in the third person and individuals should be identified in the report by their watch station or billet; names should not be included.

(2) Submission and Review. Completed reports are due to the COMNAVSURPAC N04, via the ISIC, within 14 days of being assigned. Once received at COMNAVSURFPAC, reports

will be reviewed by the relevant Assistant Chiefs of Staff for comment. Within 14 days of receipt at COMNAVSURFPAC, the initiating Commanding Officer will be notified that the report has been accepted or will be provided guidance from the Chief of Staff for amplification or revision of the report. Final reports are due to COMNAVSURPAC within five days of receipt of amplifying guidance.

e. Report Dissemination. COMNAVSURFPAC is responsible for ensuring report dissemination.

(1) All reports will be posted on an unclassified web site accessible to COMNAVSURFPAC commands.

(2) Reports will also be forwarded by email to all Commanding Officers, Executive Officers, and ISICs of the involved ship classes as well as the Class Advocate.

(3) COMNAVSURFPAC will promulgate a quarterly message summarizing the circumstances, problems, and root causes of events reported for the previous quarter. Prior to promulgation, the COMNAVSURFPAC N04 will review this report at the Weekly COMNAVSURFPAC Readiness Brief. A summary of this message will be included in the routine reporting to U.S. Fleet Forces Command and Commander, Naval Surface Force, U.S. Pacific Fleet.

(4) Reports and the quarterly summary message will also be provided to Afloat Training Group, Surface Warfare Officer School Command, and other relevant commands and organizations for review and incorporation in training curricula as appropriate.

4. Records Management. Records created as a result of this instruction, regardless of the media and format, must be managed per Secretary of the Navy Manual 5210.1 of January 2012.

5. Review and Effective Date. Per OPNAVINST 5215.17A, COMNAVSURFPAC N04 will review this instruction annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, SECNAV, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will automatically expire 5 years after effective date unless reissued or canceled prior to the 5 year anniversary date, or an extension has been granted.

B. R. MCLANE
Chief of Staff

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## EVENTS REQUIRING A SIGNIFICANT EVENT/NEAR-MISS REPORT

1. Significant Events/Near-Misses requiring a report based on damages or injury, in accordance with reference (a).

a. Class "B" mishap in accordance with reference (a). A class B mishap is one where the resulting total cost of damages to DoD or non-DoD property is $500,000 or more, but less than $2 million. An injury and/or occupational illness resulting in permanent disability or when three or more personnel are hospitalized for inpatient care as a result of a single mishap.

b. Class "C" mishap in accordance with reference (a) **when deemed appropriate by the Commanding Officer**. A class C mishap is one where the resulting damage to DoD or non-DoD property is $50,000 or more, but less than $500,000; or an event involving one or more DoD personnel that results in one or more days away from work.

Note: A separate safety mishap report is required for all class "B" and "C" mishaps. A significant event/near-miss report does not replace the reports required by reference (a) or command investigations required by reference (b).

2. Other significant events/near-misses requiring a report.

a. Unplanned complete loss of propulsion or complete loss of electrical power due to operator error.

b. Violation of weapons controls practices resulting in or risking engagement of unintended contacts or inability to complete an intended engagement.

c. Inadvertent or negligent discharge of small arms or any shipboard weapons system.

d. Significant errors in navigation, seamanship, or ship control that endanger the ship or other vessels or personnel (potential examples include: unplanned close CPA, loss of steering/emergency breakaway during replenishment, unplanned anchorage due to unforeseen events, and parting of a mooring line.)

e. Significant unplanned overboard discharge of pollutants or other violation of environmental standards.

f. Incorrect operation or unplanned actuation of a safety device (including fire suppression systems) resulting in personnel injury or equipment damage.

g. Major mission area degradation due to operator error.

h. Personnel error that represents a significant deviation from sound shipboard operating principles and resulted, or could have resulted, in equipment damage, personnel injury, or significant safety risk (potential examples include: unauthorized stowage of flammable materials or improper tie down of embarked aircraft or landing craft.)

i. Significant fire or flooding.

# CRITIQUE PREPARATION AND CONDUCT

1. Purpose. The purpose of the critique is to identify the underlying root causes which led to the significant event/near-miss so that those root causes can be addressed to eliminate, or significantly reduce the chances of, reoccurrence.

2. Overview. Critiques are not legal investigations and information gathered at a critique must not lead to disciplinary action. Investigations of misconduct for the purpose of disciplinary action shall be separate and independent. Critiques are designed to investigate second order significant events/near-misses. Critiques serve a particular purpose to "celebrate" small problems to prevent major mishaps, disasters, injury, or even death. During the course of the critique process, if it becomes apparent that purposeful malicious action to cause harm, damage equipment, or violate procedures warrants accountability in the form of punitive action, then the critique process should be stopped to conduct an investigation of misconduct.

3. Organizing the Critique. Upon determining the need to conduct a critique, the Commanding Officer shall:

a. Determine the best person to lead the critique. The focus of the critique is fixing the problem at the right level. While it may be appropriate for the Commanding Officer to lead certain critiques, it is generally appropriate for the Senior Watch Officer or the cognizant watch officer (Officer of the Deck, Combat Information Center Watch Officer, Engineering Officer of the Watch, etc.) to lead the critique.

b. Determine the time and location of the critique. It is important to conduct a critique as soon after the event as possible (generally within 72 hours). Critiques will usually be held onboard.

c. Inform and invite (if in port) external organizations such as the ISIC, Type Commander (TYCOM), and the shipyard or maintenance activity, as appropriate. Due to the quick nature of critiques, it is important to set a date and time soon after the incident, so that invitees have time to plan to attend.

4. Preparing for the Critique. Prior to the critique, the critique leader should gather preliminary information such as logs, watchbills, event recordings, and the like so as not to delay the start of the critique. The critique leader is responsible for making the list of required attendees. Everyone involved, either directly or indirectly, should be present. Finally, the critique leader should ensure that any applicable references are available at the critique for referencing.

5. Conducting the Critique. A critique is divided into three distinct parts, all of which are equally important. The first is determining the facts involved. The second is determining the problems leading to the incident and the root causes of those problems. The final part is determining short and long term corrective actions to address the root causes and correct or prevent the problems from reoccurring.

a. Part 1, Determine the Facts.

(1) Critique Environment. In order to get the most honest and accurate representation of the facts, it is important that the critique leader sets the correct tone for the critique. He or she should remind attendees that the purpose of the critique is not for retribution, but rather to accurately assess problems and define meaningful, actionable solutions.

(2) Event Timeline. The first action of the critique is to create an event timeline. This should be done using all available resources, such as: logs, records, and verbal reports. Cases where accounts differ should be closely examined.

(3) Examine the Event. The event should be examined in detail. The critique will fail to identify the actual root causes of the problems if all of the facts are not identified. Examine the supporting facts and events that led to the event. It may be useful to compare what should have happened to what did happen, and the reasons for the gap.

b. Part 2, Determining the Problems and Root Causes. Once the critique leader feels satisfied that the facts are well defined, it is time to move on to determining the problems and root causes.

(1) Dismiss Unneeded Participants. During the fact finding portion of the critique, anyone who could possibly contribute should be present. Moving forward to the problem and cause definition, the critique leader should identify only those key personnel necessary to remain.

(2) Formulate Problem Statements. Each fact identified in part 1, will be rolled up into a problem statement in part 2. Make sure problem statements are crafted as simply and succinctly as possible, and are free of causal analysis. Each distinct problem should have its own problem statement.

(3) Identify Root Causes. A root cause is the most basic causal factor which, if identified and removed, would prevent reoccurrence of the problem. This is often the most difficult step of the critique, as it requires members to drill down to all of the applicable "whys" for the event. It is important that the critique members do not simply restate the problem or focus on symptoms. If you find that fatigue was a contributing factor, then it is essential to examine why that condition existed and not simply to state that it did. When looking for root causes, it is often helpful to examine the problem from many different angles. Some areas that may be useful to examine include:

(a) Process Breakdowns. These are the obvious "whys." Look to other divisions and departments and/or programs to expand the scope. Areas of process breakdowns include:

1. Training and Qualification Programs. Are the programs sufficient? Are they being run in practice as they are intended? Is the qualified signers list appropriate?

2. Drill Briefs. Did they actually occur? Were the correct people in attendance? Were they useful or perfunctory?

3. Planning and Scheduling. Was the plan flawed from the beginning?

4. Lack of Experience. Review the levels of knowledge and experience of both the operators/watchstanders and of the supervision. Was the level of experience/knowledge accurately assessed before the event? Were mitigations put in place to make up for gaps in either? Should there have been?

5. Breakdown in Supervision. Look at the individual level to examine not just whether the command had performed the particular evolution, but rather the specific watchstanders had. Were there unique or abnormal conditions which existed.

6. Cultural Breakdown. This can be the most uncomfortable area to examine. Some things to consider are:

a. Integrity, procedural compliance, formality, questioning attitude, forceful backup, and level of knowledge. The Watchstander's Guide, (COMNAVSURFORINST 3500.5) may be a useful guide for this discussion.

b. Command Climate. Are expectations communicated? How? Are they heard?

c. Planning. How is guidance put out? Who is the plan briefed to?

Note: There are many sources of root causes; these are just a few. It is also possible that the event is an isolated incident predicated on the personal failings of a few individuals, but that should not be the entering assumption. Look for signs of deeper, systemic problems. At the conclusion of part 2, each root cause should be supported by a linkage of facts to the problem statements.

c. Part 3, Formulating Corrective Action. Following the event, corrective actions should have been put into place to put the ship, plant, system, etc. into a safe condition. This should always be validated as part of the critique process. Next, the critique members should formulate both short and long term corrective actions which will correct or prevent the problems from reoccurring. Both short and long term corrective actions should directly address the root causes identified in part 2. They should be written in such a way that they are executable and measureable. Success should be both defined and verifiable. Both short and long term corrective actions should have an end that is well defined.

d. Short Term Corrective Actions. Short term actions almost always include some sort of remedial training and/or temporary disqualification. The training and/or requalification should be validated with some sort of test, drill, evolution, etc. Short term corrective actions should not create new dependencies, or add more layers of supervision or administration indefinitely. Although increased supervision, briefings, or administrative programs may be needed

temporarily, they should remain in place only long enough to make personnel thoroughly familiar with existing guidance and requirements (if they are deemed sufficient) or until long term corrective actions correct the deficiencies with the established programs.

e. Long Term Corrective Actions. Long term corrective actions are meant as the permanent fix. They may take time to implement, but should be continually tracked and evaluated until complete. Once all long term corrective actions are in place, they should be periodically examined for effectiveness.

## SAMPLE CORRECTIVE ACTIONS

1. The list below, while not all-inclusive, is provided as a ready reference when contemplating possible corrective actions. Both short term and long term corrective actions should be clearly defined, quantifiable, and assigned definitive due dates.

a. Short term corrective actions. Short term actions are temporary actions to correct or mitigate the causes of an event and minimize the probability of recurrence until long term actions are in place. Each short term corrective action should have an identified end that is either date or condition based. These should end, at latest, once long term actions are in place.

(1) System, valve or other equipment lineup checks.

(2) Review of related documentation to determine if the problem is widespread or systemic.

(3) Temporary procedural guidance, such as a temporary standing order, until permanent procedural changes are made.

(4) Increased supervision or monitoring.

(5) Level of knowledge checks to determine if the errors leading to the event are isolated or widespread.

(6) Additional training and briefings. One time training is a short term action; recurring training to maintain a new higher level of knowledge is a long term action.

(7) Restrictions on watch standing pending remediation.

b. Long term corrective actions. For each root cause identified during the critique, there should be a corresponding long term corrective action that is intended to correct it and/or minimize the possibility that it will recur. Each long term corrective action should have an identified end that is either date or condition based. The following are examples:

(1) Repairs to correct material deficiencies.

(2) Changes to qualification procedures or requirements.

(3) Changes to training, drill, and evolution programs.

(4) Changes to procedures, processes, or policies.

(5) Changes to command culture or climate. Note: these changes need to be measurable.

(6) Increased periodic monitoring.

(7) Watch stander disqualification.

# STANDARD LETTER REPORT FORMAT

(Command/Activity Letterhead)

Report Serial Number (Command YYYY##)
ISIC

Ref: (if any)
Encl: (if any)

1. Report Type: (Initial or Revision)

2. Summary of Significant Event/Near-Miss. Provide a one paragraph executive summary of the event. Include a brief discussion of the problem, as well as the most significant cause(s) and corrective action(s). The report should state that all corrective actions have been defined and either completed or firmly scheduled. In a revised report, summarize the new information and give reasons for the revision. Changes in revised reports should be indicated with side bars in the right-hand margin.

3. Designation of Apparent Cause ("X" in applicable blanks):

Design____ Material____ Personnel____ Procedure____

4. Plant/Equipment/Initial Conditions: State the operating mode and procedure in effect at the time of the event, as required to provide understanding of it.

5. Description of Significant Event/Near-Miss: Use short, clearly written paragraphs to describe the events (facts). Minor problems identified during the critique process that did not directly lead to the event need not be included. Note: personnel shall be referred to by watch station or position, but names shall not be used.

6. Problems and Root Causes: List the problems identified and identify the root causes of these problems (analysis).

7. Corrective Action: Describe, in order, the immediate actions, short term corrective actions, and long term corrective actions taken or planned. Ensure each corrective action lists the organization responsible and an actual or estimated completion date, as applicable.

8. Similar Events: If the ship has had similar events within three years, list these reports by serial number and discuss why previous corrective actions were not effective.