

# Naval Audit Service



## Audit Report



## Reporting of Safety Mishaps

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**N2010-0016 (revised)**

**12 March 2010**

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**MEMORANDUM FOR DISTRIBUTION**

**Subj: REPORTING OF SAFETY MISHAPS (AUDIT REPORT N2010-0016)**

Ref: (a) NAVAUDSVC memo 7510/N2008-NIA000-0055.000 dated  
9 September 2008  
(b) SECNAV Instruction 7510.7F, "Department of the Navy Internal Audit"

1. The report provides results of the subject audit announced in reference (a). Section A of this report provides our findings and recommendations, summarized management responses, and our comments on the responses. Section B provides the status of the recommendations. Consolidated management responses for all recommendations were submitted via the Commander, Naval Safety Center. The full text of management responses is included in the Appendixes.

2. The following chart notes the action commands for each recommendation.

<b>Command</b>	<b>Finding No.</b>	<b>Recommendation No.</b>
Surgeon General of the Navy/Bureau of Medicine and Surgery	1	1, 2, & 3
Chief of Naval Operations (N09F)/Commander, Naval Safety Center	1,2 & 3	2,3,4,5,6,11,12,14,15, & 16
Commander, U. S. Fleet Forces Command	1 & 2	9,10, & 13
Commander, U. S. Pacific Fleet	1 & 2	9,10, & 13
Commander, Naval Installations Command	1	7 & 8

3. Actions taken by Chief of Naval Operations (N09F)/Commander, Naval Safety Center, meet the intent of Recommendation 5; actions taken by Commander, Naval Installations Command meet the intent of Recommendation 7. Therefore, Recommendations 5 and 7 are considered closed.

4. Actions planned by the applicable commands meet the intent of Recommendations 1-4, 6, and 8-16. Because Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet did not provide a target completion date for Recommendation 13, we have assigned a target completion date to that recommendation (see the finding and Section B). Because the target completion dates for

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Recommendations 6, 11, and 16 are more than 6 months in the future, we have assigned interim target dates for those recommendations.

5. Recommendations 1-4, 6, and 8-16 are considered open pending completion of the planned corrective actions, and are subject to monitoring in accordance with reference (b). Management should provide a written status report on the recommendations applicable to them within 30 days after target completion dates.

6. Please provide all correspondence to the Assistant Auditor General for Installations and Environment Audits, XXXXXXXXXXXXXXXXXXXXXXXXXXXX, with a copy to the Director, Policy and Oversight, XXXXXXXXXXXXXXXXXXXXXXXX. Please submit correspondence in electronic format (Microsoft Word or Adobe Acrobat file), and ensure that it is on letterhead and includes a scanned signature.

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7. Any requests for this report under the Freedom of Information Act must be approved by the Auditor General of the Navy as required by reference (b). This audit report is also subject to followup in accordance with reference (b).

8. We appreciate the cooperation and courtesies extended to our auditors.



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XXXXXXXXXXXXXXXXXXXX  
Assistant Auditor General  
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**Distribution:**

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# Executive Summary

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## Overview

The Department of the Navy's (DON's) Fiscal Year (FY) 2008 Risk Assessment identified the underreporting of safety mishaps as a high-risk area.

Office of the Chief of Naval Operations (OPNAV) Instruction (OPNAVINST) 5102.1D, "Navy [and Marine Corps] Mishap and Safety Investigation Reporting and Recordkeeping Manual," issued 7 January 2005, defines a mishap as any unplanned or unexpected event causing death, injury, occupational illness, and material loss or damage. A reportable mishap includes military on- and off-duty mishaps, as well as incidents involving damage to Government property. Additionally, OPNAV requires that all afloat fires (excluding small trashcan fires), floodings, collisions, and groundings be reported as mishaps.

Per the OPNAVINST, mishaps are classified into three main categories (A, B, and C) depending upon severity. Broadly defined, Class A mishaps involve death, permanent total disability, or equipment damages exceeding \$1 million. Class B and C mishaps are those that involve all other injuries incurring greater than one lost workday or equipment damage exceeding \$20,000 but less than \$1 million.

In addition, the instruction: (a) provides for standardized investigation, reporting, and recordkeeping procedures for afloat and shore commands; and (b) requires that mishap causal factors be identified to enable development of appropriate corrective actions to help prevent mishaps. The Web-Enabled Safety System (WESS) is the official mandated system for reporting and tracking all DON personnel and equipment mishaps. WESS is managed and maintained by the Commander, Naval Safety Center (COMNAVSAFECEN), who uses the data to identify mishap trends and to help develop effective Navy-wide mishap prevention strategies, as well as to maintain safety statistics and other information in support of Naval commands.

This audit focused on: (1) Class B and C non-combat mishaps occurring both on and off-duty that involved active-duty, shore-based personnel; and (2) Class B and C equipment mishaps afloat. The audit scope did not include aviation-related mishaps.

We performed the audit from 9 September 2008 through 16 October 2009. Conditions noted existed during Fiscal Year (FY) 2006 through May 2008, and in some cases continued through FY 2009, as noted in the report.

## Reason for Audit

This audit was performed to address concerns about mishap reporting identified in DON's FY 2008 Risk Assessment, which identified underreporting of safety mishaps as a high risk. The stated vulnerability was that current reporting patterns underrepresented the actual rate of safety events. Our overall objective was to verify that the Navy's current safety mishap reporting processes were efficient and effective. This audit was agreed to by the Chief of Naval Operations (CNO) Special Assistant for Safety Matters (OPNAV N09F/COMNAVSAFECEN).

## Noteworthy Accomplishments

All parties interviewed – most notably NAVSAFECEN, U.S. Fleet Forces Command (USFFC), U.S. Pacific Fleet Command (COMPACFLT); Commander, Naval Surface Forces; and afloat and shore command personnel we spoke with during the audit were frank in discussing issues involving mishap reporting and why reports were not always made, and offered many suggestions to help improve the Navy's mishap reporting processes. We also appreciate the assistance of personnel with the Navy and Marine Corps Public Health Center (NMCPHC) under the DON Bureau of Medicine and Surgery (BUMED) who provided support in obtaining medical treatment data needed to identify potential reportable mishap-related injuries.

In addition, we want to acknowledge the proactive efforts of NAVSAFECEN in taking actions on its own initiative and in response to the audit that went beyond what we recommended, for example to release several ALSAFE messages to increase the awareness of mishap reporting requirements; and during the audit submitting a Data Sharing Agreement to BUMED for using restricted medical data to identify personnel mishaps; working with Naval Warfare Development Command to include mishap reporting requirements in casualty report (CASREP) guidance; and establishing a Data Strategy Working Group to review the mishap reporting data set and eliminate unnecessary data elements. Also, during the audit, Commander, Naval Installations Command initiated systems changes to the Enterprise Safety Application Management System (ESAMS) to provide complete verification of mishap reporting in accordance with OPNAVINST 5102.1D.

## Conclusions

We found that the Navy's mishap reporting processes were inefficient and ineffective. Specifically, Class B and C mishaps involving active-duty, shore-based military personnel, and reportable afloat equipment damages and events, were not typically captured and reported to NAVSAFECEN by the responsible commands. Additionally,

the Navy did not have a link between safety reporting and medical treatment data to identify potential personnel mishaps. As a result, the Navy's official mishap reporting system, the WESS, was incomplete, hampering the Navy's ability to analyze mishap data, identify trends and concerns, develop mishap prevention strategies, and take effective corrective actions. We matched inpatient medical treatment data for active duty Navy personnel from the NMCPHC's Standard Inpatient Data Record (SIDR) inpatient medical database to Class B and C mishap data from the NAVSAFECEN's WESS database. The medical treatment data was used to identify potential reportable mishap-related personnel injuries. Our results showed that about 87 percent of the potential mishap-related injuries were not reported in WESS.

We also conducted site visits at 25 shore activities to determine why the mishap-related injuries identified to their command had not been reported. The percentage of mishaps not reported at the sites visited ranged from 83 percent to 98 percent. Overall, mishaps were not reported by an average of 95 percent (305 of 322) for the 25 shore activities visited. These results confirmed that personnel mishaps at these locations are significantly underreported. Class B and C mishaps went unreported for a variety of reasons; however, the primary reason was that injured personnel and their supervisors were often unaware of the reporting criteria, and were uncertain as to what injuries were reportable. Therefore, the responsible command had no record or documentation of an injury.

In some cases, shore commands under Commander, Naval Installations Command (CNIC) reported the mishaps via the contractor-developed Enterprise Safety Application Management System (ESAMS) -- a system that incorporates its own mishap reporting capability; but the reports did not upload to WESS when the users did not have active WESS accounts.

We also found that injuries sustained by personnel at a prior command and then temporarily assigned to a Medical Hold Unit (MEDHOLD) or to a Transient Personnel Unit (TPU) were not reported. This occurred because the prior command did not report and/or the guidance was not clear as to which command's responsibility it was to report. The guidance addresses Permanent Change of Station (PCS) but not temporary assignments to MEDHOLD or TPU. The guidance clearly states for "injuries occurring during Permanent Change of Station (PCS) orders, it is the responsibility of the gaining command to submit the mishap report..." It does not specifically address the prior command's responsibility to submit mishap reports for personnel temporarily assigned to MEDHOLD or a TPU.

We obtained unclassified CASREP data to identify equipment mishaps that occurred to assess how well equipment mishaps were being reported, based on consultation with NAVSAFECEN, and to confirm whether the mishaps had been reported to NAVSAFECEN. We performed three separate reviews of this data. First, we identified 26 equipment mishaps that occurred in the first quarter of FY 2008. We found that none

of the 26 mishaps had been reported. We also identified a limited random sample of 10 equipment mishaps in FYs 2006 through 2008, and found that only 3 of the 10 had been reported. We identified a third, expanded random sample of 30 equipment mishaps occurring between FYs 2006 and 2008, and found that only 2 of the 30 mishaps had actually been reported.

We then visited 20 Continental U.S. ships homeported on the East and West Coasts, ranging from small patrol craft to aircraft carriers, to identify reasons that mishaps were not being reported. Additionally, we reviewed all initial FY 2009 CASREPs issued by each of the 20 ships we visited, and identified 10 more equipment mishaps, of which none had been reported via WESS or to NAVSAFECEN as of May 2009. These results, combined with those stated in the previous paragraph, confirm that equipment mishaps were substantially underreported since at least FY 2006.

Based on the results of our reviews, we concluded that the Navy's current processes and procedures to ensure that Class B and C mishaps are captured and reported to NAVSAFECEN using WESS are ineffective and inefficient. Without proper reporting by Navy personnel and their commands, the NAVSAFECEN and Naval leadership are unable to accurately assess the extent and nature of active-duty personnel, afloat equipment, and other reportable afloat mishaps that are occurring, or to devise appropriate solutions for minimizing associated hazards and resolving other causative issues.

Similarly, the Navy did not establish internal controls to ensure that Afloat Safety Officers were informed of equipment mishaps, and personnel in positions to initially identify equipment mishaps were not trained on what constituted an equipment mishap. Additionally, safety personnel considered NAVSAFECEN guidance on what constituted a reportable equipment mishap to be too broad and unclear.

We also found that the Fleet units often did not consider Class B and C mishap reporting to be a high priority, particularly in cases in which the Safety Officer function was assigned as a collateral duty. Safety and applicable maintenance personnel were not sufficiently trained or refreshed on what equipment and other mishaps required reporting (i.e., in general, those related to fire, flooding, collisions, groundings, or exceeding \$20,000 in damage).

Compounding these situations were the difficulties that safety personnel experienced trying to enter data into WESS once a mishap was identified, including constant data refreshes and system timeouts, expiring passwords, problems locating Common Access Card (CAC)-supported machines to use for data entry, and ships' limited bandwidth. While these issues were generally the result of DON information technology requirements, all of these conditions resulted in a time-consuming data entry process that required a modal average of 4 hours to complete one report for ships afloat.

While this audit was in process, the Naval Audit Service also completed an audit on the acquisition of a Navy-wide Risk Management Information System (RMIS). The RMIS audit reported that DON did not have a single online management information system to integrate and report all critical safety functional data, such as: mishap/injury reporting, near-miss reporting, job hazard analysis, fire inspections/protection management, private motor vehicle management, safety inspections, industrial hygiene, trend analysis, and safety training. The report also stated that “there are about 26 independent safety applications used to meet their [DON’s] safety reporting needs.” ESAMS is the only safety application mentioned in our report. However, the fact that so many other safety applications exist, supports the need for a corporate information system that brings all DON information together for use in performing analyses and making management decisions.

**Command Ethics Program.** During the audit, we also reviewed NAVSAFECEN’s and NMCPHC’s ethics programs. We determined that the commands did have effective ethics programs in place in terms of the systems, processes, and procedures required to reasonably ensure compliance with DoD 5500.7-R, “Joint Ethics Regulation,” and Executive Order 12674, “Principles of Ethical Conduct for Government Officers and Employees.”

**Communication with Management.** Throughout the audit, we kept OPNAV N09F/COMNAVSAFECEN, USFFC, COMPACFLT, CNIC, and the activities and ships we visited, informed of the conditions noted as related to their individual commands.

Specifically, we held meetings with OPNAV N09F/COMNAVSAFECEN to obtain his endorsement of the audit (11 June 2008) and report on results (8 April 2009). We met with the Executive Director, NAVSAFECEN to brief him during research (12 August 2008) and to identify areas of specific concern, as well as to inform him of audit results to date (11 June 2009). We also met with the Head, Epi Data Center, NMCPHC, to obtain medical treatment data on active-duty personnel for comparison to WESS data (13 November 2008).

As the audit fieldwork was being completed, we also met with USFFC, 02IG, Director, Inspector General and Management Controls and N4S, Director, Fleet Safety, (6 May 2009); and Commander, COMPACFLT, represented by Commander, Naval Facilities Pacific (NAVFACPAC) N01CE, (23 April 2009); to provide status briefs. Both USFFC and COMPACFLT agreed with our findings and recommendations.

Following completion of our fieldwork, we met with the Deputy Assistant Secretary of the Navy (Safety) (3 June 2009) and with the Director, Industrial Hygiene/Occupational Health and Safety, BUMED (M44) (10 June 2009). Both Deputy Assistant Secretary of the Navy (Safety) and BUMED (M44) agreed with our findings and recommendations.

Since CNIC was also an action addressee for our potential recommendations, we briefed CNIC, Deputy Special Assistant, N35 Safety/Shore Occupational Health, on the results of our audit to date, and potential findings and recommendations, which CNIC also supported (13 May 2009). In addition, on 3 August 2009, senior leaders of the Naval Audit Service presented our preliminary audit results to the Under Secretary of the Navy, Assistant Secretary of the Navy (Installations and Environment), and Deputy Assistant Secretary of the Navy (Safety). Prior to the presentation, we sent copies of the briefing material to the NAVSAFECEN, CNIC, and the Director of Safety, Commandant of the Marine Corps.

## **Federal Managers' Financial Integrity Act**

The Federal Managers' Financial Integrity Act (FMFIA) of 1982, as codified in Title 31, United States Code, requires each Federal agency head to annually certify the effectiveness of the agency's internal and accounting system controls. In our opinion, the conditions noted in this report may warrant reporting in the Auditor General's annual FMFIA memorandum identifying management control weaknesses to the Secretary of the Navy.

## **Corrective Actions**

To improve the efficiency and effectiveness of Class B and C mishap reporting and reduce underreporting of mishaps, we made recommendations to the Surgeon General of the Navy, OPNAV N09F/COMNAVSAFECEN, USFFC, COMPACFLT, and CNIC. We recommended that the Surgeon General of the Navy (BUMED) direct the medical community to provide medical treatment data to NAVSAFECEN; provide a Plan of Action and Milestones, and obtain the funding necessary to accomplish this recommendation. To OPNAV N09F/COMNAVSAFECEN and BUMED, we recommended they determine and develop the best process for transferring and using available electronic medical treatment data to identify reportable mishaps; provide a Plan of Action and Milestones, and obtain the funding necessary to accomplish this recommendation; and develop interim means of regularly obtaining medical treatment data that will alert NAVSAFECEN of possible mishaps. We also recommended that OPNAV N09F/COMNAVSAFECEN develop a process to use the medical treatment data to notify commands of potential mishaps that require investigation and completion of a mishap report, as appropriate; provide a Plan of Action and Milestones, and obtain necessary funding to accomplish this recommendation. We also recommended that OPNAV N09F/COMNAVSAFECEN develop and issue appropriate guidance that requires shore based establishments and operating forces to incorporate comprehensive safety mishap identification and reporting requirements for on- and off-duty injuries as part of indoctrination training and safety stand downs.

We recommended that USFFC and COMPACFLT establish standard fleet procedures and controls to identify and capture equipment mishap information for reporting to NAVSAFECEN and retain records of all reportable mishaps in accordance with OPNAVINST 5102.1D, and provide all required equipment mishap reports to WESS/NAVSAFECEN. We also recommended that the Fleet Commanders measure performance and provide continuous oversight to ensure afloat commands are complying with all mishap reporting requirements. Additionally, we recommended that COMNAVSAFECEN submit change proposal for Naval Weapons Publication 1-03-1 to Naval Warfare Development Command revising Casualty Report guidance to clearly state that a mishap statement is required; provide server-based WESS onboard ships to reduce time consuming online entry; and revise data requirements cited in OPNAVINST 5102.1D and data input requirements programmed into WESS to ensure that requirements are reasonable and necessary based on the nature and severity of the event being reported.

We recommended that CNIC take action to incorporate a receipt confirmation/validation process into ESAMS; and measure performance and provide continuous oversight to ensure shore commands and installations are complying with all mishap reporting requirements. Finally, we recommended that OPNAV N09F/COMNAVSAFECEN revise OPNAVINST 5102.1D guidance to:

- Specify who is responsible for reporting injuries for personnel assigned to MEDHOLD or to TPUs;
- Clarify equipment mishaps that require reporting, particularly those involving fire and flooding, and those where no personal injury is involved; and
- Remove references to the WESS-Disconnected System (WESS-DS; an offline disk used to upload WESS data) and update the NAVSAFECEN Web site to remove the option to request a WESS-DS disk.

Management took or plans appropriate corrective actions on all the recommendations.

## Section A:

# Findings, Recommendations, and Corrective Actions

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## Finding 1: Reporting of Personnel Safety Mishaps

### Synopsis

Navy commands rarely reported Class B and C safety mishaps involving personnel injury and/or lost workdays efficiently and effectively; and the Navy did not use medical treatment data from medical treatment facilities (MTFs) to identify personnel mishaps as required by the Department of Defense (DoD) and Navy guidance. The Navy's current reporting process requires individual service members to self-report any on- or off-duty injuries to their responsible Navy command. Once the individual submits a report, the command is responsible for creating a mishap report and submitting it into the Web-Enabled Safety System (WESS). According to Navy guidance, WESS is the official mandated system for reporting and tracking all Department of the Navy (DON) personnel mishaps. Specifically, we found that 87 percent (3,649 of 4,208) of potential mishap-related injuries for active duty Navy personnel occurring in Fiscal Years (FYs) 2006 through May 2008 were not reported in WESS. Those commands responsible for reporting safety mishaps did not have procedures in place to ensure that reportable mishaps were reported and recorded in WESS. DoD and Navy guidance requires injured military personnel and their supervisors to report each mishap-related injury. Injured personnel and their supervisors did not report mishaps because they were often not aware of the reporting criteria, and were uncertain as to what injuries were reportable. Additionally, it is our opinion that injured personnel have no vested interest in reporting mishaps or in ensuring the DON's official database contains an accurate and complete record of mishaps for analysis and decisionmaking. Therefore, we concluded that self-reporting alone is not efficient and effective in ensuring that Class B and C mishaps involving personnel injury and lost workdays are reported in WESS.

We also found that injuries sustained by personnel at a prior command and then assigned to a Medical Hold (MEDHOLD) or a Transient Personnel Unit (TPU) were not reported. This occurred because the prior command did not report and/or the guidance was not clear as to who was responsible for reporting. Additionally, because some users of the Enterprise Safety Application Management System (ESAMS) were not aware that an active WESS account was needed, some mishaps may not have been successfully submitted to WESS. Although ESAMS may show that the mishap report was sent to WESS, there is no validation or confirmation of receipt from WESS. As a result, the

total number of Class B and C mishaps the Naval Safety Center (NAVSAFECEN) reports to Navy leadership is significantly underreported. Without complete and accurate data, the extent of mishap problems cannot be known, the causes cannot be assessed, and effective mishap prevention strategies cannot be developed or evaluated.

## Discussion of Details

### Background

Mishap reports are designed to provide Navy leadership with vital information needed to develop effective preventive measures that can eliminate or reduce future mishaps.

DoD Instruction (DoDINST) 6055.7, “Accident Investigation, Reporting and Recordkeeping,” 3 October 2000, as modified by Undersecretary of Defense for Acquisition, Technology and Logistics (USD (AT&L)) Memo, “Injury Reporting Requirements,” 20 February 2007, requires injured military personnel and their supervisors to report each mishap-related injury, and requires the use of military medical treatment information in identifying personnel mishaps.

Office of the Chief of Naval Operations (OPNAV) Instruction (OPNAVINST) 5102.1D, “Navy and Marine Corps Mishap and Safety Investigation Reporting and Record Keeping Manual,” dated 7 January 2005, requires all commands to investigate, report, and maintain records of all mishaps; and requires identification and analysis of mishap causal factors to develop appropriate corrective actions to prevent future mishaps. Chapter 3 provides standardized mishap record keeping requirements and reporting procedures. The instruction states that all Navy recordable/reportable mishaps shall be reported electronically to NAVSAFECEN using WESS.

## Audit Results

### Medical-Safety Data Matching

The Navy does not have sufficient controls in place to capture mishap-related injuries in cases where personnel report to a medical treatment facility or hospital. DoD Instruction 6055.7, as modified by the 2007 USD (AT&L) Memo, requires the use of medical treatment reports in the identification of active-duty military personnel mishaps. The results of our medical-safety data matching and site visits to 25 shore activities fully support the need for the sharing of medical treatment data to identify mishap-related injuries. Medical treatment data provides the first-line notification of a potential mishap-related injury. Linking these two reporting systems is vital to reducing the number of unreported mishaps involving active duty military personnel.

To determine the potential magnitude of underreported Class B and C active duty personnel mishaps in the Navy, we obtained Fiscal Year (FY) 2006 through May 2008 inpatient medical treatment data from the Navy and Marine Corps Public Health Center (NMCPHC) for active duty Navy personnel only. The NMCPHC medical treatment data was used to identify potential reportable mishap-related personnel injuries. We also obtained FYs 2006 through 2008 Class B and C mishap data from NAVSAFECEN's WESS database. Some of the records in WESS did not contain valid or complete Social Security numbers (SSNs). The Naval Audit Service Data Analysis team initially performed a combination of two matches on the data. First, the records in NMCPHC database were matched by SSN/personnel identification numbers and event date to the records in the WESS database. Next, records with invalid or incomplete SSNs in the WESS database were matched to the records in the NMCPHC database by first name, last name, and event date. The results of the two initial matches, combined, showed that 131 of the 4,208 NMCPHC potential mishap-related records were reported in NAVSAFECEN's WESS database. Of the 131 matches, 19 resulted from the first name, last name, and event date match of records with invalid or incomplete SSNs. Therefore, we concluded that invalid or incomplete SSNs would not have a significant impact on the results.

Taking a different approach, we requested that the Data Analysis team perform a third match of the two databases using data mining techniques to identify potential unreported mishap-related personnel injuries. Using SSNs only, the medical treatment data from NMCPHC was matched to the WESS Class B and C mishap data. Of the 4,208 NMCPHC potential mishap-related records, 559 records were included in NAVSAFECEN's WESS database and 3,649 records were not and were considered unreported. By comparing the medical treatment data from NMCPHC to the WESS Class B and C mishap data, we found that 87 percent (3,649 of 4,208) of the potential mishap-related injuries were not reported in WESS.

### **Shore Visits**

We selected a sample from the initial results of potential mishap-related injuries that were not reported. These results consisted of 3,211<sup>1</sup> unique Continental United States (CONUS) records and the remaining records were Outside the Continental United States (OCONUS). From the total number of unique CONUS records, we judgmentally selected 25 shore activities to visit based on: (1) location of the Medical Treatment Facility, (2) number of NMCPHC records by Unit Identification Code, and (3) percentage of unmatched records by Unit Identification Code. Our objectives were to: (1) review processes and procedures for identifying and reporting personnel mishaps; and (2) determine why the potential mishap-related injuries identified to their command had not been reported. The sample selected represented 11 percent of the unique unmatched

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<sup>1</sup> Subsequently, we determined that there could have been potentially as many as 3,536 CONUS records. However, the difference was not significant to our judgmental sample and did not impact our audit results.

CONUS NMCPHC records (359 of 3,211 records). We visited 10 activities in the Hampton Roads area of Virginia (Norfolk/Virginia Beach/Portsmouth); 5 activities in the Jacksonville and Mayport, FL area; 5 activities in San Diego, CA; and 5 activities in Pearl Harbor, HI. Overall, mishaps were not reported by an average of 95 percent (305 of 322) for the 25 shore activities visited. The percentage of mishaps not reported at the sites visited ranged from 83 percent to 98 percent. The results of our site visits confirmed that Class B and C active duty personnel mishaps were significantly underreported. Table 1 summarizes the results, by location, of the unmatched CONUS NMCPHC records.

**Table 1. Mishap Summary**

<i>Location</i>	<i>Unmatched NMCPHC Records<sup>2</sup></i>	<i>Misclassified<sup>3</sup> Not Reportable</i>	<i>Reportable</i>	<i>Reported to WESS</i>	<i>Not Reported</i>	<i>Percent Not Reported</i>
<i>Hampton Roads</i>	189	24	165	10	155	94%
<i>Jacksonville/ Mayport</i>	19	1	18	3	15	83%
<i>San Diego</i>	99	7	92	3	89	97%
<i>Pearl Harbor</i>	52	5	47	1	46	98%
<i>Total</i>	<b>359</b>	<b>37</b>	<b>322</b>	<b>17</b>	<b>305</b>	<b>95%</b>

### **Reasons Mishaps Were Not Reported**

**Reliance on Self Reporting.** Activities visited provided a number of reasons that Class B and C mishap-related injuries were not reported. However, the primary reason given was that injured personnel and supervisors were unaware of the reporting criteria, and were uncertain as to what injuries were reportable. The current reporting process requires individual service members to self-report any on- or off-duty injuries to their responsible Navy command. Once the individual submits a report, the command is responsible for creating a mishap report and submitting it into WESS. Since the responsibility to report a mishap lies with the injured individual, many mishaps are often not being reported, especially off-duty mishaps. In our opinion, that is because individuals have no vested interest in reporting the mishaps and ensuring that the DON has a complete and accurate record of all mishaps in the WESS database for analysis and decisionmaking. Therefore, self-reporting is not efficient and effective in ensuring that Class B and C mishaps involving personnel injury and lost workdays are reported in WESS. For this reason, additional controls and processes are needed to improve mishap reporting.

<sup>2</sup> These records were selected from the initial results of potential mishap-related injuries that were not reported.

<sup>3</sup> Chronic Injury, medical issue/condition, subsequent visit for prior reported mishap, injury received from direct enemy action.

Personnel generally receive indoctrination training when reporting to a new assignment, and activities conduct periodic safety stand-downs. Responsible safety personnel stated that they are only allowed a limited amount of time to discuss pertinent safety-related information, and mishap reporting and identification are either never discussed or discussed only briefly. Based on these results, all Navy personnel, both shore-based and afloat, need specific training in mishap identification and reporting.

**Responsibility.** We also found that injuries sustained by personnel at a prior command and then temporarily assigned to either a MEDHOLD or TPU were not reported. This occurred because the prior command did not report and/or the guidance was not clear as to which command's responsibility it was to report this particular type of mishap. OPNAVINST 5102.1D addresses Permanent Change of Station (PCS) but not temporary assignments to a MEDHOLD or TPU. The guidance clearly states that for "injuries occurring during Permanent Change of Station (PCS) orders, it is the responsibility of the gaining command to submit the mishap report." It does not specifically address the prior command's responsibility to submit mishap reports for personnel assigned to MEDHOLD or TPU. The guidance should be clarified to address the prior command's responsibility for personnel assigned to MEDHOLD or TPU as a result of a mishap-related injury.

**Use of Other Systems.** Additionally, 14 of the 25 activities visited used ESAMS to report safety mishaps instead of the mandated WESS system. Ten of the 14 activities were under the Commander, Naval Installation Command (CNIC) and were directed to use ESAMS; while the other four activities elected to use ESAMS. Those activities using ESAMS stated that it was more user-friendly than WESS. ESAMS can electronically send mishap data from ESAMS to WESS; however, an active WESS account is required. We found that 2 of the 14 activities using ESAMS were not aware that an active WESS account was needed and believed that mishaps were automatically sent to WESS. These 2 activities had a total of 25 mishaps that were neither reported in ESAMS or WESS. Had these activities entered the mishaps in ESAMS, the mishaps would not have successfully transmitted to WESS because they did not have an active WESS account. Also, ESAMS will not transfer reports to WESS until the mishap investigation is finished and the report is completed. Although ESAMS may show that the mishap report was sent to WESS, there is no validation or confirmation of receipt from WESS. As long as ESAMS is used, a validation/confirmation process of receipt of mishap report is needed.

In a recent Naval Audit Service audit on the acquisition of a DON-wide Risk Management Information System (RMIS), it was reported that "DON does not have a single online management information system to integrate and report all critical safety functional data such as: mishap/injury reporting, near-miss reporting, job hazard analysis, fire inspections/protection management, private motor vehicle management, safety inspections, industrial hygiene, trend analysis, and safety training." The report also said "that there are about 26 independent safety applications used to meet their [DON's]

safety reporting needs.” Other than ESAMS, none of the other safety applications, as mentioned in the RMIS report, were cited as a reason for underreporting active duty personnel mishaps at the activities we visited. However, the fact that so many other safety applications exist supports the need for a corporate information system that brings all the DON information together for use in performing analyses and making management decisions.

### **Effect**

As a result, the total number of Class B and C mishaps NAVSAFECEN reports to Navy leadership is significantly underreported. Since the Navy uses mishap data to identify trends and report safety data to Navy leadership, complete and accurate data is necessary. Without complete and accurate data, effective mishap prevention strategies cannot be developed or evaluated.

## **Recommendations and Corrective Actions**

Our recommendations, summarized management responses, and our comments on the responses are provided below. A consolidated management response to all the recommendations was provided via the Commander, NAVSAFECEN (COMNAVSAFECEN). COMNAVSAFECEN also provided an additional consolidated management response with more information on the actions planned in response to selected recommendations. The complete text of the responses is in the Appendixes.

To improve the reporting process for active duty military personnel mishaps, we recommend that the Surgeon General of the Navy (Bureau of Medicine and Surgery (BUMED)):

**Recommendation 1.** Direct the medical community to provide medical treatment data to NAVSAFECEN in accordance with DoDINST 6055.7 as modified by USD (AT&L) Memo dated 20 February 2007, that requires the use of medical treatment information in the identification of mishaps. To ensure protection of patient privacy, data provided should be that which is minimally necessary to accomplish the authorized purpose.

**Management response to Recommendation 1.** Concur. The minimum data necessary will be determined collaboratively with NAVSAFECEN and BUMED. The working group will provide its recommendations by 1 March 2010. New requirements will be incorporated into a modified Data Sharing Agreement with TRICARE.

Naval Marine Corps Public Health Center (NMCPHC) will provide the identified and filtered data to NAVSAFECEN on a weekly basis commencing 1 April 2010, until the automated feed is implemented.

**Naval Audit Service comments on response to Recommendation 1.**

Actions planned by management (in response to this recommendation and Recommendation 2) to work jointly to determine the medical data necessary for identifying potential mishaps and implementing interim means of providing the data to NAVSAFECEN, meet the intent of the recommendation.

We recommend that OPNAV 09F/COMNAVSAFECEN and BUMED:

**Recommendation 2.** Determine and develop the best process for transferring and using available electronic medical treatment data to identify reportable mishaps. Provide a Plan of Action and Milestones (POA&M) and obtain necessary funding for accomplishment of this recommendation.

**Management response to Recommendation 2.** Concur. NAVSAFECEN submitted a Data Sharing Agreement to the TRICARE Privacy Office via BUMED. TRICARE Privacy Office has asked that Office of the Undersecretary of Defense (Personnel and Readiness) (OSD) (P&R) approve the request. Upon data access approval, OSD (P&R), TRICARE, BUMED, and NAVSAFECEN will collaborate to determine the appropriate data transport mechanism and generate a POA&M. OSD (P&R) has proposed the Defense Safety Enterprise System will provide the interface for NAVSAFECEN. A POA&M will be developed and approved by 1 April 2010.

Without knowing the full requirements for the electronic feed, a cost estimate and subsequent funding request cannot be made. NAVSAFECEN is currently working to identify out-of-cycle funding sources for this initiative.

**Naval Audit Service comments on response to Recommendation 2.** Actions planned by management (in response to this recommendation and Recommendation 4) to obtain approval of the Data Sharing Agreement by OSD, further collaborate to determine the appropriate data transport mechanism, and develop a POA&M for using medical treatment data to notify commands of potential mishaps, meet the intent of the recommendation. In subsequent communication, 6 January 2010, management indicated the target approval date for the Data Sharing Agreement is March 2010. In addition, actions planned by management to proactively identify out-of-cycle funding sources for implementing the corrective actions also meet the intent of the recommendation.

**Recommendation 3.** Develop interim means of regularly obtaining medical treatment data that will alert NAVSAFECEN of possible mishaps, until Recommendation 2 is fully implemented.

**Management response to Recommendation 3.** Concur. See management response to Recommendation 1. NAVSAFECEN is standing by to receive medical treatment data from BUMED by the interim method until Recommendation 2 is fully implemented. BUMED will task NMCPHC with providing agreed-upon data to NAVSAFECEN. NMCPHC will commence providing interim data on 1 April 2010.

**Naval Audit Service comments on response to Recommendation 3.**  
Planned actions meet the intent of the recommendation.

We recommend that OPNAV 09F/COMNAVSAFECEN:

**Recommendation 4.** For the interim and when Recommendation 2 is fully implemented, develop a process to use the medical treatment data to notify commands of potential mishaps that require investigation and completion of a mishap report, as appropriate. Provide a POA&M for accomplishment of this recommendation.

**Management response to Recommendation 4.** Concur. NAVSAFECEN will develop a POA&M for the interim and final solutions to notify commands of potential mishaps that require investigation and completion of a mishap report, as appropriate using medical treatment data provided by BUMED under Recommendations 2 and 3. POA&M will be developed by 1 April 2010.

**Naval Audit Service comments on response to Recommendation 4.**  
Planned actions meet the intent of the recommendation.

**Recommendation 5.** Develop and issue appropriate guidance that requires shore-based establishments and operating forces to incorporate comprehensive safety mishap identification, and reporting requirements for on- or off-duty injuries as part of indoctrination training and safety stand downs, and ensure personnel are fully aware of all requirements.<sup>4</sup>

**Management response to Recommendation 5.** Partially concur. NAVSAFECEN is not the custodian of the policy for indoctrination training and safety stand downs. To meet the intent of the recommendation, NAVSAFECEN will develop an instructional PowerPoint presentation and post it on the NAVSAFECEN website by 1 March 2010 so that it is available to shore-based and operating forces. Also, NAVSAFECEN will release an ALSAFE message

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<sup>4</sup> Note: This recommendation also relates to Fleet ships and carriers as well as shore activities. Ships also reported that personnel as well as equipment mishap identification and reporting were not typically covered during indoctrination training or during safety stand-downs.

outlining mishap reporting requirements and advocating that commands make the PowerPoint presentation part of indoctrination training and use periodically during safety stand downs.

**Naval Audit Service comments on response to Recommendation 5.**

Actions to develop training materials and make them accessible to shore and operating forces for use during indoctrination training and safety stand downs meet the intent of the recommendation. Subsequently, we determined that the actions were completed as of 1 March 2010; therefore, we consider this recommendation closed. It should also be noted that in management comments to Recommendation 10, U.S. Fleet Forces Command (USFFC) and Commander, Pacific Fleet (COMPACFLT) also plan to establish Fleet procedures to ensure mishap reporting requirements are included in command indoctrination training.

**Recommendation 6.** Revise OPNAVINST 5102.1D to specify who is responsible for reporting injuries for personnel assigned to MEDHOLD or to TPUs, and ensure responsible personnel are made aware of the change.

**Management response to Recommendation 6.** Concur. NAVSAFECEN will develop clarifying language to address responsibilities for reporting injuries of personnel assigned to MEDHOLD or TPUs. These responsibilities will be promulgated through an ALSAFE message by 1 June 2010 and included in the 1 June 2011 revision of OPNAVINST 5102.1D.

**Naval Audit Service comments on response to Recommendation 6.**

Actions planned meet the intent of the recommendation. Because the target completion date is more than 6 months in the future, we are assigning an interim target date of 10 September 2010, and asking NAVSAFECEN to provide us with a status report on the corrective actions at that time.

We recommend that Commander, Navy Installations Command (CNIC):

**Recommendation 7.** Take action to incorporate a receipt confirmation/validation process into ESAMS and provide a POA&M for accomplishment of this recommendation.

**Management responses to Recommendation 7.** Concur. Navy Installations Command directed ESAMS contractor to initiate system changes to ESAMS that provides verification of complete mishap reporting as required by OPNAVINST 5102.1D. This action was completed 30 September 2009.

**Naval Audit Service comments on response to Recommendation 7.** Actions taken by management meet the intent of the recommendation. We consider this recommendation to be closed.

**Recommendation 8.** Develop a set of performance measures and provide continuous oversight to ensure CNIC regions and or installations are compliant with all mishap reporting requirements.

**Management response to Recommendation 8.** Concur. CNIC established an acceptable mishap reporting rate of 100 percent. Starting 15 April 2010, Headquarters Safety (CNIC N35) will work with Regions to perform monthly analyses of Region mishap reporting performance and ensure reporting compliance using a standardized mishap query report. In addition, they will monitor ESAMS and OPREP-3/SITREP message traffic to determine if mishaps are being reported, and work closely with Region Commander Safety Staff to rectify instances of noncompliance.

**Naval Audit Service comments on response to Recommendation 8.**  
Planned actions meet the intent of the recommendation.

We recommend that Commanders, USFFC and PACFLT:

**Recommendation 9.** Develop a set of performance measures and provide continuous oversight to ensure afloat commands are compliant with all mishap reporting requirements.<sup>5</sup>

**Management responses to Recommendation 9.** Management's planned actions include issuing messages by 26 February 2010 to (a) direct afloat commands to ensure safety personnel and all hands understand their responsibilities for reporting injuries and property damage resulting from mishaps in accordance with OPNAVINST 5100.19E; (b) remind afloat commands of OPNAVINSTs 5102.1D and 5100.19E requirements to submit all reportable injury mishaps to NAVSAFECEN via WESS, retain records for 5 years, and analyze mishap trends; and (c) remind afloat type commanders (TYCOMS) and immediate superiors in command (ISICS) of their responsibility to provide oversight of afloat commands in accordance with stated guidance to ensure they conduct timely, thorough safety investigations, retain mishap records for 5 years, and analyze mishap trends. TYCOMS and ISICS shall conduct safety and occupational health oversight inspections at a minimum of once every 3 years in accordance with USFFC and COMPACFLT 5100.7/5100.5E guidance. In addition, USFFC Code N4S and COMPACFLT Code N01CE2 will implement a new evaluation step to assess Fleet mishap reporting compliance by adding a review of medical logs and mishap report records of selected commands during Safety and Occupational Health

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<sup>5</sup> This recommendation pertains to both personnel and equipment mishaps.

Management Evaluations of TYCOMS to ensure all reportable injuries are reported in WESS.

**Naval Audit Service comments on response to Recommendation 9.** Taken as a whole, USFFC's and PACFLT's planned actions to remind commands of their various oversight responsibilities as outlined in OPNAV, COMUSFFC, and COMPACFLT guidance; their direction to ensure all hands understand their responsibilities; and their action to add a review of medical logs and mishap report records of selected commands during safety and occupational health management evaluations of TYCOMS to ensure all reportable injuries are reported in WESS to NAVSAFECEN, meet the intent of the recommendation. In addition, the existing guidance noted in management's response (specifically OPNAVINST 5100.19 E) outlines the responsibilities for setting safety, occupational, and health performance targets and measures. It further states that these targets shall be reviewed annually. This aspect of the guidance meets the intent of the recommendation. In subsequent communication, management provided an updated target completion date of 31 March 2010.

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## Finding 2: Reporting of Equipment Mishaps

### Synopsis

Responsible Naval commands afloat did not typically report Class B and C equipment mishaps, including those involving fires and flooding, to COMNAVSAFECEN, as required by the Office of the Chief of Naval Operations (OPNAV) Instruction 5102.1D.<sup>6</sup> This occurred for several reasons:

- Maintenance personnel were often unaware of the need to report equipment mishaps or were not trained sufficiently to identify what constitutes a reportable equipment mishap;
- The Fleet had not established specific mechanisms to alert Safety Officers and those responsible for reporting to NAVSAFECEN that an equipment mishap had occurred; and
- The Fleet units considered the reporting criteria for equipment mishaps to be too broad and unclear and frequently did not consider mishap reporting to be a high priority, particularly in cases in which the Safety Officer function was assigned as a collateral duty.

As a result, most equipment mishaps went unreported, making it difficult for the Navy to identify mishap trends and take effective and efficient action to help prevent future equipment mishaps. In cases in which similar types of equipment mishaps occur frequently, such as electrical fires, the inability to properly capture associated mishap information and develop appropriate solutions could ultimately affect mission readiness.

### Background

OPNAVINST 5102.1D requires that all afloat fires (except small trash can fires not involving injury to personnel), floodings, collisions, groundings, and any equipment damage costs exceeding \$20,000, be reported to NAVSAFECEN as mishaps. The instruction does not require that these situations be reported only in the event of personnel injuries.

Naval Warfare Publication (NWP) 1-03-1, published by the Naval Warfare Development Command, addressed preparation of Casualty Reports (CASREPs), which are reports describing equipment in need of immediate repair. This publication also provides a table describing what information should be included in the remarks section of the CASREPs.

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<sup>6</sup> For the purposes of this report, the term “equipment mishap” is used to denote any instances of equipment damage exceeding \$20,000 or cases of fires, floodings, collisions, or groundings as defined by OPNAVINST 5102.1D.

The NWP 1-03-1 guidance, while not presented clearly, indicates that CASREPs should state “whether a mishap report is or is not required.”

## Audit Results

**Identifying Unreported Equipment Mishaps.** To identify unreported Class B and C equipment mishaps in the Navy based on consultation with NAVSAFECEN personnel, we obtained unclassified databases of initial CASREPs issued by all surface ships and aircraft carriers during FY 2006 through FY 2008 and reviewed all ship CASREPS for the first two quarters of FY 2009. Databases were obtained from Commander, Naval Surface Forces (CNSF). We then reviewed the databases in conjunction with NAVSAFECEN’s subject matter expert to identify any equipment mishaps that required reporting (see Exhibit B, Methodology section of this report for more detailed information on how we located the reportable equipment mishaps).

We performed three CASREP sample reviews. First, we performed a preliminary review of all 26 first quarter FY 2008 equipment mishaps that we identified to determine if the mishaps had been reported to NAVSAFECEN via WESS, and whether the CASREPs included a statement that a mishap report was or was not required. We found that none of the 26 equipment mishaps had been reported in WESS. For the 26 CASREPs that required a mishap report, 10 stated that “no mishap report was required.” The remaining CASREPS did not include a mishap statement.

Following this review, we randomly sampled 10 identified equipment mishaps that occurred between FYs 2006 through 2008 to confirm whether reporting was consistently low over the period.<sup>7</sup> We found that 3 of the 10 mishaps had been reported to NAVSAFECEN. Since the 3 reported mishaps had occurred in the FYs 2006-2007 timeframe, we performed another, larger random sample of these mishaps, selecting 10 from each fiscal year, FY 2006 through FY 2008, for a total of 30, to gauge whether reporting had decreased over the 3-year period. We found that one in FY 2007 and one in FY 2008 had been reported, and 28 mishaps over the 3-year period had not been reported to NAVSAFECEN. Although this sample did not indicate a downward trend, it does support that mishap reporting was consistently underreported over the period reviewed.

**Determining Processes Used to Identify and Report Equipment Mishaps.** Since our preliminary first quarter FY 2008 sample revealed relatively significant underreporting of equipment mishaps (i.e., 0 of 26 had been reported), we selected 20 ships for review to determine what processes they used to identify and report equipment mishaps and any reasons they may have for not reporting them (see Exhibit B, Scope and Methodology, for more information on how we selected the 20 ships). For each ship, we interviewed Safety

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<sup>7</sup> Note: these 10 were not part of the original 26 we reviewed for the first quarter of FY 2008 or part of the 30 that we reviewed for the 3-year period between FY 2006 through FY2008.

Officers (SOs), their assistants (ASSTs), and persons responsible for preparing CASREPs, as they were available, to determine whether these personnel were aware of the equipment reporting criteria and to determine how they identified and reported mishaps.

Additionally, to assess the shipboard processes, we reviewed 500 initial (i.e., no subsequent or follow-on) FY 2009 CASREPs the ships had issued to date to determine whether the CASREPs involved any reportable equipment mishaps and to see if the CASREPs included a mishap statement. Results are described below:

**Awareness and Training of Safety and Other Personnel.** We found that SOs, ASSTs, and maintenance personnel responsible for preparing CASREPs were rarely aware of the equipment reporting criteria and were not specifically trained to identify equipment issues that required reporting (affected 18 of 20 ships, or 90 percent). In general, personnel believed that equipment mishaps need only be reported in those cases involving injury.

When we reviewed 500 initial CASREPs issued during the first half of FY 2009 for the 20 ships we visited, we found that 10 of the 500 involved reportable mishaps; however, none of the 10 had been reported to NAVSAFECEN. For these 10 reportable mishaps, 3 stated “no mishap report required,” and the remaining 7 did not contain any mishap statement. Additionally, we found that, of the 500 shipboard CASREPs we reviewed, 168 (34 percent) included a statement of whether the mishap was reportable or not, and 332 (66 percent) did not contain the mishap statement.

Safety personnel interviewed stated that they and other shipboard personnel requiring safety training, such as Division Petty Officers, either had not received any training to identify equipment mishaps, or that training they received was insufficient. Personnel also reported difficulties in getting into Naval Safety and Environmental Training Center classes to obtain required training due to conflicts with the ship’s schedule, which often resulted from increased deployments and operational tempo, as well as ship enrollment quotas.<sup>8</sup> At least 17 SOs/ASST SOs stated that training on mishap reporting they received was minimal or insufficient.

**Procedures in Place to Identify Equipment Mishaps.** In addition to insufficient training and awareness by the SOs and other pertinent shipboard personnel, we found that 18 of 20 ships (90 percent) were unaware of criteria for reporting mishaps, particularly equipment mishaps. For example, while we found that some SOs, particularly those who were Operations Officers, did review CASREPs as well as shipboard Situation Reports (SITREPs), in terms of safety mishaps Commander, Naval Surface Forces stated that they typically only reviewed them to identify critical, or Class A, mishaps. Since CASREPs, and perhaps more significantly, SITREPs, contain

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<sup>8</sup> Since verification of these issues was beyond the scope of this audit, we are unable to make recommendations in this regard. However, these issues are identified as reasons that ships’ personnel stated for not being able to identify equipment mishaps, as well as mishaps in general.

valuable information that can be used to identify and prepare mishap reports, we recommend that procedures be established for SOs to review such reports routinely for required mishap reports or that other similar internal mechanisms for capturing equipment mishap information be established.

**Guidance for Determining Reportable Equipment Mishaps.** In terms of identifying equipment mishaps, NAVSAFECEN guidance on what constitutes a reportable equipment mishap was considered by half (10 of 20) of ship safety personnel interviewed, to be too broad and unclear, particularly in cases involving fire or flooding. For example, personnel we interviewed were uncertain whether equipment that was smoking or that had been burnt prior to being discovered (such as a burned-out electrical component) were reportable mishaps. Personnel expressed similar confusion as to what level of flooding actually required reporting and under what conditions. We concur that OPNAVINST 5102.1D is unclear and lacks desired specificity in this regard.

**Reporting Priority.** We also found that the Fleet units frequently did not consider mishap reporting, in general, to be a high priority, particularly in cases in which the SO function was assigned as a collateral duty. This collateral duty was typically assigned to Operations Officers or other key shipboard personnel who frequently reported being overwhelmed with other more pressing work. At least 6 of 20 SOs we spoke with actually stated that safety was a low priority given all the other duties they had to perform. Additionally, although OPNAVINST 5102.1D requires that ships maintain all safety mishap reporting records for 5 years, at least 9 of 20 had not retained records for the required period.

As a result of these issues, Class B and C equipment mishaps are significantly underreported in the Navy. If equipment mishaps are not reported when required, the Navy loses the ability to identify recurring hazards and to develop appropriate corrective actions and preventive measures to minimize future mishaps; the ultimate outcome is that Fleet readiness may be compromised.

## Recommendations and Corrective Actions

Our recommendations, summarized management responses, and our comments on the responses are provided below. A consolidated management response to all the recommendations was provided via COMNAVSAFECEN. COMNAVSAFECEN also provided an additional consolidated management response with more information on the actions planned in response to selected recommendations. The complete text of the responses is in the Appendixes.

To improve the mishap reporting processes afloat, we recommend that USFFC/COMPACFLT:

**Recommendation 10.** Establish standard Fleet procedures and controls to identify and capture equipment mishap information for reporting to NAVSAFECEN (for example, require SOs to review all SITREPs and/or CASREPs to determine the need for mishap reporting or implement other mechanisms to identify and capture equipment mishap information).

**Management responses to Recommendation 10.** Concur. By 30 June 2010, USFFC and PACFLT will establish and publish the following Fleet standard procedures and controls for capturing equipment mishaps and to ensure mishap reporting requirements are included in command indoctrination training: When damaged equipment is discovered, department heads shall immediately notify the Command SO of all cases of flooding or fire, and all equipment damage or losses exceeding \$50,000 as a result of mishap. The Command SO, in collaboration with the department heads, shall conduct a mishap investigation, submit a mishap report via WESS to NAVSAFECEN, retain the mishap records for a minimum of 5 years, and analyze mishap trends.

**Naval Audit Service comments on response to Recommendation 10.** Per the USFFC/COMPACFLT response, in October 2009 (which was after the time period covered by our review), USD (AT&L) changed the minimum threshold for Category C reporting to \$50,000. Planned actions meet the intent of the recommendation.

We recommend that OPNAV N09F/COMNAVSAFECEN:

**Recommendation 11.** Revise OPNAVINST 5102.1D guidance on reportable equipment mishaps to clarify situations requiring reporting, particularly those involving fire and flooding, and those where no personal injury is involved.

**Management response to Recommendation 11.** Concur. NAVSAFECEN is in the process of better defining fire and flooding mishaps. Proposed definitions will be vetted through TYCOMs for concurrence. New definitions will be promulgated via an ALSAFE message by 15 May 2010 and subsequently included in the 1 June 2011 revision of OPNAVINST 5102.1D.

**Naval Audit Service comments on response to Recommendation 11.** Planned actions meet the intent of the recommendation. Because the target completion date is more than 6 months in the future, we are assigning an interim target date of 10 September 2010, and asking NAVSAFECEN to provide us with a status report on the corrective actions at that time.

**Recommendation 12.** Submit change proposal for NWP 1-03-1 to Naval Warfare Development Command revising CASREP guidance to clearly state that a mishap reporting statement is required.

**Management response to Recommendation 12.** Concur. NAVSAFECEN is currently writing a change proposal to include a mishap reporting statement in CASREP guidance. Naval Warfare Development Command agreed to make the change once the proposal was submitted. The change proposal was forwarded to Naval Warfare Development Command on 8 January 2010. NAVSAFECEN estimates the message change will be out no later than 1 May 2010. Once the message is promulgated, NAVSAFECEN will post the change on our Web page and reference the change in our monthly safety digest message to the Fleet.

**Naval Audit Service comments on response to Recommendation 12.** Actions planned meet the intent of the recommendation.

We recommend that USFFC/COMPACFLT:

**Recommendation 13.** Provide oversight to ensure that Fleet units retain records of all reportable mishaps in accordance with OPNAVINST 5102.1D and provide all required equipment mishap reports to WESS/NAVSAFECEN.

**Management response to Recommendation 13.** Management's planned actions include reviewing equipment mishap records of selected commands during USFFC/COMPACFLT Safety and Occupational Health Management Evaluations of TYCOMS. All afloat TYCOMS will be evaluated every 3 years.

**Naval Audit Service comments on response to Recommendation 13.** Actions planned by management in response to this recommendation and Recommendations 9 and 10 to direct afloat commands to ensure safety personnel and all hands understand their responsibilities for reporting injuries and property damage resulting from mishaps in accordance with OPNAVINST 5100.19E; and to establish and publish Fleet standard procedures and controls for capturing equipment mishaps and ensure mishap reporting requirements are included in command indoctrination training respectively, meet the intent of the recommendation. Since USFFC/COMPACFLT did not provide a target completion date for this recommendation, we are using 30 June 2010, which was the target completion date provided for Recommendation 10, as the target completion date for this recommendation.

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## Finding 3: WESS

### Synopsis

Safety personnel find NAVSAFECEN's WESS cumbersome and time-consuming to use. OPNAVINST 5102.1D requires that all mishaps be reported via WESS. However, personnel at both shore and Fleet activities we visited described various issues that made WESS difficult to use. Security issues pose particular problems for Fleet and shore users. Additionally, because of the low and limited bandwidth available on ships, Fleet users felt that data entry to the online WESS system, when made during deployments, was untenable, taking hours or even days to complete. Data entries made by the Fleet when in port took 4 hours on average (mode) as reported by users – almost four times as long as the optimal times some shore users reported (up to an 1 hour). Fleet users desired use of an offline system, such as the WESS Disconnected System (WESS-DS) offered in OPNAVINST 5102.1D and NAVSAFECEN's Web site, but which is no longer a feasible option due to resource issues and Privacy Act requirements. Finally, shore and Fleet users also complained that too much information was being required for data input for Class B and C mishaps, and not all of it was pertinent to the specific mishap being reported. As a result of the various difficulties they faced using WESS and the perceptions that not all information being requested was truly needed for various Class B and C mishaps, many shore and Fleet mishaps may simply not have been reported, making it difficult for the Navy to identify Class B and C mishap trends and take effective and efficient action to help prevent future personnel and equipment mishaps.

### Background

OPNAVINST 5102.1D requires that all mishaps be reported to NAVSAFECEN via WESS, WESS-DS (an offline data-entry disk that is uploaded to WESS), or, in cases in which WESS is not available, via Naval message. WESS-DS is designed for use by Fleet units and activities that have low bandwidth or that do not have internet connectivity. However, in 2007, due to resource issues, NAVSAFECEN discontinued further modifications of WESS-DS. Additionally, recent DON security requirements make the use of WESS-DS unfeasible due to the Privacy Act information required for mishap reporting.

### Audit Results

**System Security Issues.** During our initial audit research, we heard many comments about problems with WESS usability. Based on these comments, we interviewed Fleet and ashore safety personnel during the audit phase to learn more about their experiences using WESS. We found that WESS users, in general, were extremely frustrated with the system.

Specifically, they cited constant page refreshes, frequent system time-outs, and the need to update passwords every 60 days, as issues that made the system cumbersome to use. Both shore and Fleet system users also expressed concerns about having to reestablish their accounts after 60-days of inactivity. While these particular issues occurred because of NAVSAFECEN's implementation of DoD and Navy-mandated system information technology security requirements, users were vocal about data input problems they experienced as a result. Fleet users were particularly frustrated, explaining that the low and limited bandwidth available on the ships made data entry under these conditions particularly time consuming.

**Low Bandwidth on Ships.** While shore users also experienced many of the data entry issues described above, Fleet users experienced additional problems caused by the low bandwidth available on ships, which was similar to a low-speed dial-up connection. Because of the low bandwidth, personnel on ships reported that it took about 2-4 hours to complete a report that should generally only take about an hour or less to complete based on some users' optimal experiences that were reported to us.

**WESS-DS.** Fleet WESS users we interviewed who had a WESS-DS disk available to them typically reported more positive experiences with WESS than users who did not have the disk. Those SOs who did not have access to the disk universally requested that copies of the disk be made available to them or suggested that another off-line system be developed that would enable them to enter data offline and then upload the data to WESS during periods of low bandwidth use.

However, while the option to request a WESS-DS disk is provided on the NAVSAFECEN Web site and the option to use a disk is cited in OPNAVINST 5102.1D, due to difficulties maintaining the disk versions and recent DoD/Navy-mandated security requirements, WESS-DS is no longer a valid data entry method and further modifications of WESS-DS have been discontinued. Since the disk version of WESS is no longer a viable alternative, NAVSAFECEN is currently considering the possibility of installing a server-based application on each ship that will function similarly to WESS-DS.

**Data Input Requirements.** In addition to slow and difficult data entry, over one-half of safety personnel interviewed felt that WESS required input of too much information for Class B and C mishaps (26 of 45 Fleet and shore users combined, or 58 percent). Shore and Fleet users felt that too much information is required for reporting. Users also felt that they were required to answer redundant questions or difficult-to-answer questions based on the information they can reasonably obtain (for examples, reporters were required to know the wind direction at the time of the accident, or if a person was injured while running, how much experience a person had doing the "task" (i.e. running)). Although this information may be pertinent for Class A and perhaps some Class B mishaps, some safety personnel think that NAVSAFECEN is attempting to capture too much and sometimes unnecessary information.

When we addressed these concerns with NAVSAFECEN personnel, they advised that NAVSAFECEN is currently in the process of reviewing data elements to help streamline data input efforts. Additionally, the Office of the Secretary of Defense (OSD) is conducting a Defense-wide review to standardize required mishap reporting elements across the services. Both of these efforts should help to address some of these issues raised by Fleet users.

**Other Issues.** Still other Fleet personnel interviewed (8 of 20 users, or 40 percent) also expressed concerns about, and questioned the need for, all the reports that they were potentially required to prepare on a given incident, which could include preparation of SITREPs, CASREPs, and Mishap Reports. While we were unable to confirm the validity of these sentiments due to time constraints, we did note these as additional potential factors affecting whether ships reported mishap incidents or not.

Taken in conjunction, these various system and security issues, as well as data entry requirements, made WESS something that both shore and Fleet users tried to avoid. We concluded that, confronted with a difficult and time-consuming system to use, personnel may simply have chosen not to report some Class B, and particularly Class C, mishaps.

We noted that NAVSAFECEN is aware of many of these issues as reported by users, and, in fact, requested that we attempt to quantify the scope of mishap underreporting in the Navy and confirm reasons that commands did not report. While the majority of unreported mishaps are caused by individuals and their supervisors not alerting SOs when incidents occur, we believe that mishap reporting Navy-wide will also improve if WESS improvements are made. These improvements include providing a server-based WESS system onboard ships; refining data elements and input requirements to accommodate the particular needs of shore and Fleet activities; tailoring data requirements to the severity of the event (by eliminating data elements not necessary for Class B or C events); and, potentially, incorporating data from SITREPs and/or CASREPs via electronic data capture (i.e. to auto-populate data fields in WESS) if feasible to minimize duplication of effort when reporting incidents.

## Recommendations and Corrective Actions

Our recommendations, summarized management responses, and our comments on the responses are provided below. A consolidated management response to all the recommendations was provided via COMNAVSAFECEN. COMNAVSAFECEN also provided an additional consolidated management response with more information on the actions planned in response to selected recommendations. The complete text of the responses is in the Appendixes.

We recommend that OPNAV N09F/COMNAVSAFECEN:

**Recommendation 14.** Revise OPNAVINST 5102.1D guidance to remove references to WESS-DS and update the NAVSAFECEN Web site to remove the option to request a WESS-DS disk.

**Management response to Recommendation 14.** Concur. WESS-DS is an interim option available to deploying units until Navy Information Application Product Suite (NIAPS) becomes available. Until then, WESS-DS provides a useful tool for reporting mishaps. Management estimates WESS will enter into the NIAPS pipeline on 1 October 2010. Additionally, the NIAPS program office will determine the delivery schedule to meet the data protection requirements. They estimate the schedule and determination will occur by 31 January 2011 and POA&M by 1 February 2011. References to WESS-DS will be removed from OPNAVINST 5102.1 in the 1 June 2011 revision. Status reports will be provided by 1 July 2010 and 1 January 2011.

**Naval Audit Service response to Recommendation 14.** Actions planned meet the intent of the recommendation.

**Recommendation 15.** Establish a Plan of Actions and Milestones (POA&M) for providing server-based WESS onboard ships to reduce time consuming online entry (server will transmit during non-peak periods).

**Management response to Recommendation 15.** Concur. The initial capability is through NIAPS as indicated in response to Recommendation 14. NIAPS currently does not meet DoD requirements to fully protect data with public key infrastructure (PKI) access controls. NAVSAFECEN will work with PMA 240 to determine the earliest NIAPS release that will provide sufficient protection of Health Insurance Portability and Accountability Act (HIPAA) and safety-privileged information. The current estimate and earliest possible date that this recommendation can be implemented is 1 October 2010 for testing and 1 June 2011 for delivery. A detailed POA&M will be developed and delivered when notified by PMA 240 that NIAPS will support PKI requirements. In the interim, NAVSAFECEN is modifying WESS to utilize technology to operate in a more efficient asynchronous mode. Additionally, WESS will utilize authoritative data sources to minimize the entry of data by all users. Status reports will be provided by 1 July 2010 and 1 January 2011.

**Naval Audit Service comments to Recommendation 15.** Actions planned meet the intent of the recommendation.

**Recommendation 16.** Review data requirements cited in OPNAVINST 5102.1D and data input requirements programmed into WESS to ensure that requirements are reasonable and necessary based on the nature and severity of the event being reported.

**Management responses to Recommendation 16.** Concur. NAVSAFECEN established a Data Strategy Working Group in early 2009 with the intent of reviewing the full mishap reporting data set and eliminating unnecessary data elements. This review will be completed by 1 March 2010. NAVSAFECEN will hold discussions with applicable Echelon II and III commands by 1 September 2010 and revise OPNAVINST 5102.1D to reflect the new data set and other required policy changes by 1 June 2011.

**Naval Audit Service comments to Recommendation 16.** Planned actions meet the intent of the recommendation. In subsequent communication, NAVSAFECEN indicated that the review of the mishap reporting data set will be completed by 1 May 2010, and that discussions with applicable Echelon II and III commands will be held by 1 November 2010. Because the final target completion date of 1 June 2011 is more than 6 months in the future, we are assigning an interim target date of 10 September 2010, and asking NAVSAFECEN to provide us with a status report on the corrective actions at that time.

**Section B:**

# Status of Recommendations

Recommendations							
Finding <sup>9</sup>	Rec. No.	Page No.	Subject	Status <sup>10</sup>	Action Command	Target or Actual Completion Date	Interim Target Completion Date <sup>11</sup>
1	1	13	Direct the medical community to provide medical treatment data NAVSAFECEN in accordance with DoDINST 6055.7 as modified by USD (AT&L) Memo dated 20 February 2007 that requires the use of medical treatment information in the identification of mishaps. To ensure protection of patient privacy, data provided should be that which is minimally necessary to accomplish the authorized purpose.	O	Surgeon General of the Navy (BUMED)	4/1/10	
1	2	14	Determine and develop the best process for transferring and using available electronic medical treatment data to identify reportable mishaps. Provide a Plan of Action and Milestones (POA&M) and obtain necessary funding for accomplishment of this recommendation.	O	OPNAV N09F/COMNAVSAFECEN/BUMED	4/1/10	
1	3	15	Develop interim means of regularly obtaining medical treatment data that will alert NAVSAFECEN of possible mishaps, until Recommendation 2 is fully implemented.	O	OPNAV N09F/COMNAVSAFECEN/BUMED	4/1/10	
1	4	15	For the interim and when recommendation 2 is fully implemented, develop a process to use the medical treatment data to notify commands of potential mishaps that require investigation and completion of a mishap report as appropriate. Provide a Plan of Action and Milestones (POA&M) for accomplishment of this recommendation.	O	OPNAV N09F/COMNAVSAFECEN	4/1/10	

<sup>9</sup> / + = Indicates repeat finding.

<sup>10</sup> / O = Recommendation is open with agreed-to corrective actions; C = Recommendation is closed with all action completed; U = Recommendation is undecided with resolution efforts in progress.

<sup>11</sup> If applicable.

Recommendations							
Finding <sup>9</sup>	Rec. No.	Page No.	Subject	Status <sup>10</sup>	Action Command	Target or Actual Completion Date	Interim Target Completion Date <sup>11</sup>
1	5	15	Develop and issue appropriate guidance that requires shore based establishments and operating forces to incorporate comprehensive safety mishap identification and reporting requirements for on- or off-duty injuries as part of indoctrination training and safety stand downs, and ensure personnel are fully aware of all requirements.	C	OPNAV N09F/COMNAVSAFECEN	3/1/10	
1	6	16	Revise OPNAVINST 5102.1D to specify who is responsible for reporting injuries for personnel assigned to MEDHOLD or to TPUs, and ensure responsible personnel are made aware of the change.	O	OPNAV N09F/COMNAVSAFECEN	6/1/11	9/10/10
1	7	16	Take action to incorporate a receipt confirmation/validation process into ESAMS and provide a POA&M for accomplishment of this recommendation.	C	CNIC	9/30/09	
1	8	17	Develop a set of performance measures and provide continuous oversight to ensure CNIC regions and or installations are compliant with all mishap reporting requirements.	O	CNIC	04/15/10	
1	9	17	Develop a set of performance measures and provide continuous oversight to ensure afloat commands are compliant with all mishap reporting requirements.	O	USFFC/COMPACFLT	3/31/10	
2	10	23	Establish standard Fleet procedures and controls to identify and capture equipment mishap information for reporting to NAVSAFECEN (for example, require SOs to review all SITREPs and/or CASREPs to determine the need for mishap reporting or implement other mechanisms to identify and capture equipment mishap information).	O	USFFC/COMPACFLT	6/30/10	
2	11	23	Revise OPNAVINST 5102.1D guidance on reportable equipment mishaps to clarify situations requiring reporting, particularly those involving fire and flooding, and those where no personal injury is involved.	O	OPNAV N09F/COMNAVSAFECEN	6/1/11	9/10/10

Recommendations							
Finding <sup>9</sup>	Rec. No.	Page No.	Subject	Status <sup>10</sup>	Action Command	Target or Actual Completion Date	Interim Target Completion Date <sup>11</sup>
2	12	23	Submit change proposal for Naval Weapons Publication (NWP) 1-03-1 to Naval Warfare Development Command revising CASREP guidance to clearly state that a mishap reporting statement is required.	O	OPNAV N09F/COMNA VSAFECEN	5/1/10	
2	13	24	Provide oversight to ensure that Fleet units retain records of all reportable mishaps in accordance with OPNAVINST 5102.1D and provide all required equipment mishap reports to WESS/NAVSAFECEN.	O	USFFC/COMP ACFLT	6/30/10	
3	14	28	Revise OPNAVINST 5102.1D guidance to remove references to WESS-DS and update the NAVSAFECEN Web site to remove the option to request a WESS-DS disk.	O	OPNAV N09F/COMNA VSAFECEN	6/1/11	7/1/10
3	15	28	Establish a Plan of Actions and Milestones (POA&M) for providing server-based WESS onboard ships to reduce time consuming online entry (server will transmit during non-peak periods).	O	OPNAV N09F/COMNA VSAFECEN	6/1/11	7/1/10
3	16	28	Review data requirements cited in OPNAVINST 5102.1D and data input requirements programmed into WESS to ensure that requirements are reasonable and necessary based on the nature and severity of the event being reported.	O	OPNAV N09F/COMNA VSAFECEN	6/1/11	9/10/10

## Exhibit A:

# Background

In response to the 2008 Navy-wide Risk Assessment, underreporting of safety mishaps was identified as a high risk. Cited as Risk number 8C1 in the 2008 Assessment, this risk was similar to Risk number 8C3, submitted by the Navy Inspector General (IG) during the 2007 Navy-wide Risk Assessment. Based on these continuing identified high risks, we performed this audit to assess the scope of mishap underreporting in the Navy and to determine reasons that mishaps were not being reported. This audit was endorsed and supported by senior Navy management, including Chief of Naval Operations (CNO) N09F/Commander, Naval Safety Center (NAVSAFECEN).

Undersecretary of Defense for Acquisition, Technology and Logistics (USD (AT&L)) policy memorandum “Injury Reporting Requirements,” dated 20 February 2007, requires injured military and civilian personnel and their supervisors to report each mishap-related injury, and requires use of medical treatment and civilian personnel compensation reports in the identification of personnel mishaps.

Office of the Chief of Naval Operations (OPNAV) Instruction (OPNAVINST) 5102.1D, “Navy and Marine Corps Mishap and Safety Investigation Reporting and Record Keeping Manual,” issued 7 January 2005, (a) provides standardized investigation, reporting and recordkeeping procedures for afloat and shore mishaps and hazards; and (b) requires that mishap causal factors be identified to develop appropriate corrective actions to prevent future mishaps.

OPNAVINST 5102.1D defines a mishap as any unplanned or unexpected event causing death, injury, occupational illness and material loss or damage. Mishaps also include injuries that result in lost work time or work restrictions; material loss or damage; as well as all instances of fire (except small trashcan fires that do not involve personnel injury), floodings, groundings, and collisions. Mishaps are formally classified as categories A, B, or C, depending upon severity.

In general, Class A mishaps involve death, extreme disability or disfigurement, or equipment damages exceeding \$1 million. Class B mishaps are generally defined as mishaps in which the resulting total cost of damages to Department of Defense (DoD) or non-DoD property is \$200,000 or more, but less than \$1 million; an injury and/or occupational illness resulting in permanent partial disability; or when three or more personnel are hospitalized for inpatient care (beyond observation) as a result of a single mishap. Class C mishaps are generally defined as mishaps in which the resulting total cost of damages to DoD or non-DoD property is \$20,000 or more, but less than \$200,000; nonfatal injuries that caused any loss of time from work beyond the day or shift on which it occurred; or a nonfatal occupational illness that caused loss of time from work or

disability at any time. Because Class A mishaps are typically well-reported, this audit focused primarily on Class B and C mishaps.

Military personnel are required to report both on- and off-duty mishaps as well as mishaps that occur to equipment under their responsibility, as described in OPNAVINST 5102.1D. Supervisors then typically advise the Safety Office and the Safety Office creates a mishap report. Mishap reports are then submitted to the NAVSAFECEN in one of four ways: (1) directly through the Web-Enabled Safety System (WESS); (2) via WESS-Disconnected System (DS) upload to WESS (shipboard use only); (3) via Naval message for those who do not have internet access; or (4) via the Enterprise Safety Application System (ESAMS), which is used by shore-based activities under the Commander, Naval Installations Command (CNIC) and others utilizing ESAMS contracts.

NAVSAFECEN uses the resulting data to identify mishap trends and to develop solutions for mitigating potential safety hazards.

## Exhibit B:

# Scope and Methodology

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## Scope

The audit covered Navy-wide reporting of safety mishaps by ashore and afloat commands, excluding the aviation and submarine communities, but including Naval Aircraft Carriers. We focused on Class B and C mishaps. Specifically, we reviewed safety mishaps related to shore-based active duty inpatient injuries and illnesses and equipment mishaps afloat. We visited the shore activities and Fleet commands listed in Exhibit C. Our original scope focused on Class B and C personnel and equipment mishaps. However, we also tested Fiscal Years (FYs) 2006 through 2008 and the first two quarters of FY 2009, Class A mishaps to ensure that all of the Class A mishaps we identified had been reported.

## Methodology

We evaluated internal controls and reviewed compliance with applicable regulations. We performed preliminary reviews to determine the potential scope of unreported shore-based active-duty personnel and ship-based equipment mishaps.

### Personnel Mishaps

To assess the potential magnitude of unreported active-duty personnel Class B and C mishaps, we coordinated with the Department of the Navy Bureau of Medicine and Surgery (BUMED) and the Navy and Marine Corps Public Health Center (NMCPHC) under BUMED, to obtain inpatient medical treatment data for active duty Navy personnel for the period of FY 2006 through May 2008. We also obtained FY 2006 through FY 2008 Class B and C mishap data from the Naval Safety Center's (NAVSAFECEN's) Web-Enabled Safety System (WESS). Both sets of data were uploaded to the Naval Audit Service (NAVAUDSVC) Data Analysis team using the NAVAUDSVC Secure Upload Component. Some of the WESS data had either no Social Security number (SSN) or a bad SSN. Using data mining techniques, the Data Analysis team initially performed a combination of two matches on the data. First, they matched the records in the NMCPHC database to the records in the WESS database using SSN/personnel identification numbers (IDs) and event date. Next, they matched the records in the NMCPHC database to the records in the WESS database with invalid or incomplete SSNs using first name, last name, and event date. When the results of the two initial matches were combined, we found that 131 of the 4,208 NMCPHC potential mishap-related records were reported in

NAVSAFECEN's WESS database. Only 19 of 131 matches resulted from the first name, last name, and event date match of records with invalid or incomplete SSNs. The results of these two matches were summarized by Unit Identification Code (UIC).

Taking a different approach, we requested that the Data Analysis team perform a third match of the two databases using data mining techniques to identify potential unreported mishap-related personnel injuries. The Data Analysis team matched the records in the NMCPHC and WESS databases by SSN only. The ID field in the NMCPHC database was matched to the SSN field in the WESS database to identify records not reported in NAVSAFECEN's WESS database. Of the 4,208 NMCPHC potential mishap-related records, 559 records were included in NAVSAFECEN's WESS database and 3,649 records were not and were considered unreported. By comparing the medical treatment data from NMCPHC to the WESS Class B and C mishap data, we found that 87 percent (3,649 of 4,208) of the potential mishap-related injuries were not reported in WESS.

We used the initial summary results provided by our Data Analysis team and judgmentally selected 25 shore activities to visit. We selected 10 activities in the Hampton Roads area of Virginia (Norfolk/Virginia Beach/Portsmouth), 5 activities in the Jacksonville and Mayport, FL area, 5 activities in San Diego, CA, and 5 activities in Pearl Harbor, HI. At each activity, we interviewed responsible safety personnel to determine their level of experience regarding mishap reporting, training received, knowledge of mishap reporting criteria, and reviewed processes and procedures for identifying and reporting personnel mishaps. We also reviewed what processes and controls they had in place to ensure that mishaps were properly reported to NAVSAFECEN.

### **Equipment Mishaps**

To assess the scope of unreported shipboard equipment mishaps, based on consultation with NAVSAFECEN, we obtained unclassified data on initial (we did not review any follow-on) Casualty Reports (CASREPs) submitted for the first quarter of FY 2008, covering all surface ships and aircraft carriers. We reviewed all records in this database to identify equipment mishaps that should have been reported to NAVSAFECEN. We did this by performing key word searches of more than 20 different terms related to a reportable event. Terms searched included, but were not limited to, fire, smoke, burn, collide, collision, flood, grounding, and variations of the words and associated terms.

After extracting records that met our search criteria, we coordinated with NAVSAFECEN subject matter experts to determine whether the CASREPs we extracted involved reportable mishaps. Following this initial confirmation of which reports involved mishaps, we conferred with shipboard inspectors at the Board of Inspection and Survey to see whether they agreed with the identified mishaps. After reaching agreement

on which records involved reportable mishaps, we then coordinated with NAVSAFECEN to validate whether the mishaps had actually been reported in WESS.

Subsequent to this review, we obtained similar unclassified CASREP data for FYs 2006 through 2008 and, using data mining techniques, conducted additional key word searches to extract records of potentially reportable mishaps. Again, we conferred with NAVSAFECEN subject matter experts to identify actual, reportable mishaps. Based on consultation with the NAVAUDSVC statistician, we then completed a limited review of 10 randomly sampled equipment mishaps occurring over the 3-year time period to confirm that reporting was consistently low over the period. Per NAVSAFECEN's request, we performed a third random sample of 10 records per fiscal year (a total of 30 randomly identified mishaps) to assess whether mishap underreporting was becoming progressively worse over time.

After completing our preliminary reviews, we judgmentally selected 20 ships (see Exhibit C). We conducted onsite interviews at selected ships in four different locations – two Continental East Coast locations and two Continental West Coast locations, in coordination with the Commander Naval Surface Forces/Commander Naval Air Forces, Inspector General's Office. Our objectives were to determine how mishaps were identified and reported as well as to determine reasons that both safety and general personnel may not be reporting mishaps.

Our goals in selecting ships for review were to (1) target ships and locations that showed up in our initial review as having unreported equipment mishaps; (2) include a variety of ship types and sizes; and (3) include representative ships with a collateral duty Safety Officer (SO) assigned, and those with a full-time SO assigned.

We met with personnel from five homeported ships at each of the four locations: Norfolk/Virginia Beach, VA; Mayport, FL; San Diego, CA; and Pearl Harbor, HI. The 20 ships visited represented all hull types except auxiliary and mine warfare (these vessels were not available during the time of our scheduled site visits), and ranged from small patrol craft (PC) to aircraft carriers (CVN). The 20 ships represent about 11 percent of the Fleet vessels within our audit scope (20 divided by 178), based on data published on the Naval Vessel Registry Website as of 20 April 2009.

For the 20 ships we reviewed, we ascertained whether the SO and Assistant (ASST) SOs were aware of reporting of both personnel mishaps and equipment mishaps as described in OPNAVINST 5102.1D. Additionally, we obtained safety personnel's' input as to how activity personnel in general were informed of the need to report mishaps, including what relevant training they received. We also obtained copies of any training materials, local instructions and published standard operating procedures governing mishap reporting that the activities and ships used.

To gauge the scope of the ships' workload, we identified the number of personnel serviced by each shipboard SO, identified the number of division safety petty officers assigned on the ship and, for those ships having SOs assigned as a collateral duty, inquired into the approximate number of hours the SOs and ASSTs spent performing safety-related duties on board the ship. Although their input was generally testimonial and lacked documented support, this information was requested to assess the level of priority currently assigned to the ships' safety program and thus potentially to the ships' mishap reporting processes.

In addition to the SOs and ASST SOs, we interviewed independent duty corpsman (IDC) personnel on each ship to find out how they coordinate with their ship's SO to report personnel injuries. We also reviewed available Accident and Injury (A&I) reports and sick call logs generated from the Shipboard Automated Medical System for the first two quarters of FY 2009.

Since we are not medical experts, we reviewed A&I reports and the sick call logs only for obvious types of Class B and C injuries that would require a mishap report, such as broken limbs and injuries involving auto accidents. We also assessed whether the A&I reports and/or sick call logs indicated that the individual had received more than 24 hours of lost time due to the injury. Based on this conservative review, we identified injuries that should have been reported as mishaps. Where we had questions or concerns, we conferred with IDC and SO personnel to confirm the nature of the injuries. Once we confirmed the reportable injuries, we determined whether the ship had submitted a mishap report. Additionally, we coordinated with NAVSAFECEN to validate whether WESS actually contained the associated report.

To determine how equipment mishaps were identified, we queried the SOs and ASST SOs as well as personnel responsible for preparing equipment CASREPs. Additionally since CASREPs guidance shown in the Naval Weapons Publication (NWP) 1-03-01 provides that CASREPs should include a statement in the remarks section that a mishap report is or is not required, we checked all FY 2009 initial CASREPs issued by the ship to date, to confirm whether this statement was being included. This same step was also performed for all FYs 2006 through 2008 CASREPs we reviewed.

Again, since we did not have sufficient expertise to properly assess all of the equipment issues recorded in the CASREPs, we relied on our laymen's experience to review CASREPs, as well as comparison to similar incidents that had been identified as reportable based on our CASREPs reviews performed in conjunction with NAVSAFECEN and Board of Inspection and Survey. Once we determined that the CASREPs identified reportable mishaps, we coordinated with NAVSAFECEN to confirm whether the WESS database contained the required WESS reports.

Finally, we also queried the various interviewees as to: (1) reasons that personnel and management, including those assigned to perform safety responsibilities were not reporting all mishaps; (2) issues they experienced with reporting mishaps to NAVSAFECEN and with using WESS; and (3) recommendations they had for improving the mishap reporting process.

After conducting all interviews and completing our review, we prepared summary spreadsheets to identify and assess significant issues affecting mishap reporting within the Navy.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**Exhibit C:**

# Activities Visited and/or Contacted

Office of the Assistant Secretary of the Navy, Installations and Environment (Safety),  
Arlington, VA

Commander, Naval Safety Center, Norfolk, VA\*

Commander, Naval Installations Command\*

Bureau of Medicine and Surgery, Washington DC\*

Naval and Marine Corps Public Health Center, Portsmouth, VA\*

Commander, Naval Surface Forces\*

Commander, Naval Surface Forces/Commander, Naval Air Forces, Inspector General\*

Naval Activities and Fleet Vessels as shown below:

Naval Medical Center, Portsmouth, VA\*

Mid-Atlantic Regional Maintenance Center, Norfolk, VA\*

Carrier Airborne Early Warning Squadron, VAW-120, Norfolk, VA \*

Transient Personnel Unit Norfolk, VA \*

Fleet Readiness Center, Norfolk, VA \*

Commander Naval Special Warfare Development Group, Virginia Beach, VA\*

Sewells Point Safety Office, Naval Station Norfolk\*

Fleet Readiness Center Oceana, Virginia Beach, VA\*

Naval Computer and Telecommunications Area Master Station Atlantic, Norfolk, VA \*

Naval Air Station Jacksonville, FL\*

Fleet Readiness Center Southeast, Jacksonville, FL\*

Naval Station Mayport, FL\*

Strategic Weapons Facility Atlantic, Kings Bay, GA\*

Fleet Area Control and Surveillance Facility, Jacksonville, FL\*

Helicopter Strike Squadron 41, San Diego, CA\*

Transient Personnel Unit San Diego, CA\*

Southwest Regional Maintenance Center, San Diego, CA\*

Naval Special Warfare Center, San Diego, CA\*

Naval Medical Center, San Diego, CA\*

Seal Delivery Vehicle Team One, Pearl City, HI\*

Naval Station Pearl, Pearl Harbor, HI\*

Naval Security Group Activity Kunia , HI\*

Commander, Pacific Fleet, HI\*

**NAVAL STATION NORFOLK VA:**

USS COLE  
USS GONZALEZ\*  
USS HAWES  
USS WASP  
USS HARRY S. TRUMAN\*  
USS STOUT

**LITTLE CREEK AMPHIBIOUS BASE, VA:**

USS ASHLAND  
USS CARTER HALL  
USS MONSOON\*  
USS OAK HILL  
USS SQUALL\*  
USS TEMPEST  
USS WHIDBEY ISLAND\*

**MAYPORT FL:**

USS CARNEY  
USS DOYLE\*  
USS GETTYSBURG  
USS HALYBURTON\*  
USS HUE CITY\*  
USS JOHN L. HALL\*  
USS MCINERNEY  
USS PHILIPPINE SEA\*  
USS SIMPSON  
USS STEPHEN W. GROVES  
USS TAYLOR

**SAN DIEGO**

USS BENFOLD  
USS BONHOMME RICHARD  
USS CAPE ST. GEORGE  
USS CURTS  
USS GRIDLEY  
USS HIGGINS\*  
USS HOWARD  
USS JARRETT\*  
USS NIMITZ\*

USS PEARL HARBOR\*  
USS PELELIU\*  
USS RONALD REAGAN  
USS SAMPSON

**PEARL HARBOR HI**

USS REUBEN JAMES  
USS CHAFEE  
USS CHOSIN\*  
USS CROMMELIN\*  
USS OKANE\*  
USS PORT ROYAL\*  
USS RUSSELL\*

\*Activities/Ships visited

Appendix 1:

# Consolidated Management Response



DEPARTMENT OF THE NAVY  
NAVAL SAFETY CENTER  
375 A STREET  
NORFOLK, VA 23511-4399

7510  
Ser 02/0569  
21 Dec 09

From: Commander, Naval Safety Center  
To: Assistant Auditor General for Installations and  
Environment Audits, Naval Audit Service, 1006 Beatty  
Place SE, Room 312, Washington Navy Yard, DC 20374-5005  
Subj: DRAFT NAVAUDSVC AUDIT REPORT ON REPORTING OF SAFETY  
MISHAPS (DRAFT AUDIT REPORT N2008-NIA000-0055)  
Ref: (a) NAVAUDSVC memo 7510 N2008-NIA000-0055 of 16 Oct 09  
Encl: (1) Coordinated Navy Responses to NAVAUDSVC Draft Audit  
Report on Reporting Safety Mishaps (Draft Audit  
Report N2008-NIA000-0055)

1. The Naval Safety Center has completed its review of reference (a) and has worked with the other stakeholders to produce a coordinated response to all the recommendations contained in the reference. Enclosure (1) contains the coordinated response.
2. The Naval Safety Center has reviewed reference (a) from a Freedom of Information Act perspective and submit that the audit report does not require the "For Official Use Only" designation.
3. My point of contact for this audit is [REDACTED] Executive Director, who can be reached at [REDACTED] or by email at [REDACTED]

FOIA (b)(6)

FOIA (b)(6)

**Coordinated Navy Responses To  
NAVAUDSVC DRAFT AUDIT REPORT ON REPORTING OF SAFETY MISHAPS  
(DRAFT AUDIT REPORT N2008-NIA000-0055)**

What follows is a coordinated response developed by applicable Navy commands with Actions identified in the audit report. This response was reviewed and approved by the Executive Safety Committee Steering Group.

**Finding 1.** "Navy commands rarely reported Class Band C safety mishaps involving personnel injury and/or lost workdays efficiently and effectively; and Navy did not use medical treatment data from medical treatment facilities (MTF) to identify mishaps required by the Department of Defense (DOD) and Navy guidance."

**Finding 1, Recommendation 1.** "Direct the medical community to provide medical treatment data to NAVSAFECEN in accordance with DoDINST 6055.7 as modified by USD (AT&L) Memo dated 20 February 2007, that requires the use of medical treatment information in the identification of mishaps. To ensure protection of patient privacy, data provided should be that which is minimally necessary to accomplish the authorized purpose.

**Naval Safety Center and BUMED response:** Concur. The minimally necessary data to be provided will be determined collaboratively with Naval Safety Center and BUMED. The expertise at the Navy Health Research Center (NHRC) and Navy and Marine Corp Public Health Center (NMCPHC) will be brought in to the discussion. They have valuable experience in identifying medical data that will provide data as it relates to the usefulness to safety. The working group will provide its recommendations by 1 March 2010. Necessary data elements and any filtering criteria will be developed. These new requirements will be incorporated into a modified Data Sharing Agreement with Tricare.

NMCPHC will provide on a weekly basis the identified and filtered data to the Naval Safety Center commencing 1 April 2010 until the automated feed is implemented.

**Finding 1, Recommendation 2.** "Determine and develop the best process for transferring and using available electronic medical treatment data to identify reportable mishaps. Provide a Plan of Action and Milestones (POA&M) and obtain necessary funding for accomplishment of this recommendation."

Enclosure 1

Naval Safety Center and BUMED response: Concur. NAVSAFECEN has submitted a Data Sharing Agreement (DSA) to the TRICARE privacy office via BUMED. TRICARE Privacy Office has asked that OSD (P&R) approve the request. OSD (P&R) staff is reviewing the agreement. Upon data access approval, OSD (P&R), TRICARE, BUMED and NAVSAFECEN staff will collaborate to determine appropriate data transport mechanism and generate a POA&M to accomplish the recommendation. OSD(P&R) has proposed that the Defense Safety Enterprise System (DSES) will provide the interface for the Naval Safety Center. A POA&M will be developed and approved by 1 April 2010.

**Finding 1, Recommendation 3.** "Develop interim means of regularly obtaining medical treatment data that will alert NAVSAFECEN of possible mishaps, until Recommendation 2 is fully implemented."

Naval Safety Center and BUMED response: Concur. See finding 1, recommendation 1 response. NAVSAFECEN is standing by to receive medical treatment data from BUMED by the interim method until Recommendation 2 is fully implemented. BUMED will task NMCPHC with providing agreed upon filtered data to Naval Safety Center. NMCPHC to commence providing interim data on 1 April 2010 until automated feed is provided.

**Finding 1, Recommendation 4.** "For the interim and when recommendation 2 is fully implemented, develop a process to use the medical treatment data to notify commands of potential mishaps that require investigation and completion of a mishap report, as appropriate. Provide a Plan of Action and Milestones (POA&M) for accomplishment of this recommendation."

Naval Safety Center response: Concur. NAVSAFECEN will develop a POA&M for the interim and final solutions to notify commands of potential mishaps that require investigation and completion of a mishap report, as appropriate using medical treatment data provided by BUMED under Recommendations 2 and 3. POA&M will be developed by 1 April 2010.

**Finding 1, Recommendation 5.** "Develop and issue appropriate guidance that requires shore based establishments and operating forces to incorporate comprehensive safety mishap identification, and reporting requirements for on or off-duty injuries as part of indoctrination training and safety stand downs, and ensure personnel are fully aware of all requirements."

Naval Safety Center response: NAVSAFECEN concurs with recommendation's intent, however, NAVSAFECEN is not the custodian of the policy for indoctrination training and safety stand downs. In order to meet the intent of the recommendation, NAVSAFECEN will develop an instructional PowerPoint presentation describing comprehensive safety mishap identification and reporting requirements for on or off-duty injuries and post it on the NAVSAFECEN website so information is obtainable for shore based establishments and operating forces. PowerPoint presentation to be developed and posted by 1 Feb 2010. Additionally, to increase awareness of mishap reporting requirements, NAVSAFECEN will release an ALSAFE by 1 Mar 2010 outlining mishap reporting requirements and advocating commands make this a part of their indoctrination training and use periodically during safety standdowns.

Finding 1, Recommendation 6. "Revise OPNAV Instruction 5102.1D to specify who is responsible for reporting injuries for personnel assigned to Medical Hold or to Transient Personnel Units, and ensure responsible personnel are made aware of the change."

Naval Safety Center response: NAVSAFECEN concurs with comment. NAVSAFECEN highlights current instruction guidance, Chapter 1, Introduction and Responsibilities which reads, "Safety officers, safety directors, safety managers, safety specialists and civilian supervisors shall: Ensure all mishaps are investigated and required reports are submitted, as outlined in Chapters 3 and 5." This language requires installations/commands having the assigned person at the time of mishap as the responsible reporting command. In order to meet the intent of the recommendation, NAVSAFECEN shall release an ALSAFE by 1 Mar 2010 providing amplification on this requirement in relation to Medical Hold or Transient Personnel Units.

Finding 1, Recommendation 7. "Take action to incorporate a receipt confirmation/validation process into ESAMS and provide a Plan of Action and Milestones (POA&M) for accomplishment of this recommendation."

CNIC response: Concur. Navy Installations Command directed ESAMS contractor to initiate system changes to ESAMS that provides verification of complete mishap reporting as required by OPNAVINST 5102.1D (Actual Completion Date: 30 Sep 2009) Description of actual changes include:

(1) E-mail notices to responsible investigators weekly for all WESS reportable open and closed mishap events that have not been submitted to WESS.

(2) Automatically submit all mishap reports requiring submittal to WESS via existing file transfer mechanism at 30-days after event report date in either a partial or completed state.

(3) Forward updated/amended reports to WESS until receipt of completed report is validated by WESS.

**Finding 1, Recommendation 8.** "Develop a set of performance measures and provide continuous oversight to ensure CNIC regions and or installations are compliant with all mishap reporting requirements.

**CNIC response:** Concur. Target completion date is 15 Apr 2010. Headquarters Safety (CNIC N35), working in coordination with Regions, will perform the following mishap report analyses to track Region mishap reporting performance and ensure reporting compliance:

(1) Track and monitor monthly reporting from ESAMS Mishap module using a standardized mishap query report to identify mishap report claimant number, command assigned, case file number, closed date, name of person who closed the report, date report submitted to WESS, and name of person submitting report to WESS.

(2) Conduct quality control/quality assurance (QC/QA) roll-up analyses for each Region.

(3) Complete performance tracking roll-up reports for each Region.

(4) Provide results of monthly performance to CNIC Region Program Directors for Safety, ESAMS contractor, and ESAMS CCB Chairperson for process improvement recommendations and follow-up action.

(5) Monitor ESAMS and OPREP-3/SITREP message traffic to determine if mishaps are being reported. The acceptable mishap reporting rate is 100 percent.

(6) Track monthly reporting from ESAMS Mishap module to ensure identified mishaps are reported in accordance with OPNAVINST 5102.1D requirements. When CNIC reportable mishap events are identified, CNIC HQ Safety will work closely with Region Commander safety staff to rectify instances of non-compliance.

**Finding 1, Recommendation 9.** "Develop a set of performance measures and provide continuous oversight to ensure afloat commands are compliant with all mishap reporting requirements."

U.S. Fleet Forces (USFF)/Commander Pacific Fleet (CPF)  
response: USFF and PACFLT will take the following specific corrective actions:

(1) USFF and CPF will release messages by 29 Jan 2010 with the following:

(a) Direct afloat commands to ensure the safety officer, ship's medical department representative (MDR), officer of the deck, department heads, and all hands understand their responsibilities for reporting injuries and property damage resulting from mishaps in accordance with OPNAVINST 5100.19E.

(b) Remind afloat commands of OPNAVINST 5102.1D and OPNAVINST 5100.19E requirements to submit all reportable injury mishaps to Naval Safety Center via the Web Enabled Safety System (WESS), retain mishap records for a minimum of five years, and analyze mishap trends.

(c) Remind afloat Type Commanders (TYCOMs) and Immediate Superiors in Command (ISICs) of OPNAVINST 5102.1D and OPNAVINST 5100.19E requirements to provide oversight to ensure afloat commands conduct timely, thorough safety investigations, retain mishap records for five years, and analyze mishap trends. TYCOMs and ISICs shall conduct safety and occupational health oversight inspections at a minimum of once every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

(2) USFF and CPF will assess Fleet mishap reporting compliance by adding a review of medical logs and mishap report records of selected commands during USFF/CPF Safety and Occupational Health Management Evaluations (SOHMEs) of TYCOMs to ensure all reportable injuries are reported to the Naval

Safety Center (NAVSAFECEN) via the Web Enabled Safety System (WESS). All afloat TYCOMs will be evaluated every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

**Finding 2.** "Responsible Naval commands did not typically report Class Band C equipment mishaps, including those involving fire and flooding, to the Commander, Naval Safety Center (COMNAVSAFECEN), as required by the Office of the Chief of Naval Operations (OPNAV) Instruction 5102.10."

**Finding 2, Recommendation 10.** Establish Fleet standard procedures and controls to identify and capture equipment mishap information for reporting to NAVSAFECEN (for example require SOs to review all SITREPS and/or CASREPs to determine the need for mishap reporting or implement other mechanism to identify and capture equipment mishap information).

**U.S. Fleet Forces (USFF)/Commander Pacific Fleet (CPF) response:** USFF and PACFLT will establish and publish the following Fleet standard procedures and controls for capturing equipment mishaps by Jun 2010:

(1) Upon discovery of damaged equipment, department heads shall immediately notify the Command Safety Officer of all cases of flooding or fire, and all equipment damage or losses exceeding \$50,000 as a result of mishap.

(2) The Command Safety Officer, in collaboration with the department heads, shall conduct a mishap investigation and submit a mishap report to Naval Safety Center via WESS, retain mishap records for a minimum of five years, and analyze mishap trends.

(3) Commanding Officers shall ensure mishap reporting requirements are included in command indoctrination training.

**Finding 2, Recommendation 11.** "Revise OPNAVINST 5102.1D guidance on reportable equipment mishaps to clarify situations requiring reporting, particularly those involving fire and flooding, and those where no personal injury is involved."

**Naval Safety Center response:** Concur with recommendation. NAVSAFECEN is in the process of better defining fire and flooding mishaps. Once written, proposed definitions will be vetted through Type Commanders for concurrence. New definitions will be promulgated via an ALSAFE message by 15

May 2010 and subsequently included in next revision of OPNAVINST 5102.1D. Mishaps where no personal injury is involved are defined as HAZREPs, NSC will continue to engage HAZREP under-reporting through current HAZREP, Near Miss, and Lessons Learned reporting cultural change initiative.

**Finding 2, Recommendation 12.** "Submit change proposal for Naval Weapons Publication (NWP) 1-03-1 to Naval Warfare Development Command revising CASREP guidance to clearly state that a mishap reporting statement is required."

**Naval Safety Center response:** Concur. Coordination with Naval Warfare Development Command has been initiated; NAVSAFECEN is in the process of writing a change proposal to include mishap reporting requirements for CASREPs. Naval Warfare Development Command will promulgate change after review. NAVSAFECEN will submit the change proposal by 15 Jan 2010.

**Finding 2, Recommendation 13.** Provide oversight to ensure that Fleet units retain records of all reportable mishaps in accordance with OPNAV Instruction 5102.1D and provide all required equipment mishap reports to WESS/NAVSAFECEN.

**U.S. Fleet Forces (USFF)/Commander Pacific Fleet (CPF) response:** USFF and CPF will assess Fleet mishap reporting compliance by reviewing equipment mishap records of selected commands during USFF/CPF Safety and Occupational Health Management Evaluations (SOHMEs) of TYCOMs. All afloat TYCOMs will be evaluated every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E

**Finding 3.** "Safety personnel find NAVSAFECEN's WESS cumbersome and time-consuming to use. OPNAV Instruction 5102.1D requires that all mishaps be reported via WESS. However, personnel at both shore and Fleet activities we visited described various issues that made WESS difficult to use... Fleet users felt that data entry to the online WESS system, when made during deployments, was untenable, taking hours or even days to complete. Fleet users desired use of an offline system, such as the WESS Disconnected System (WESS-DS) offered in OPNAV Instruction 5102.1D and NAVSAFECEN's Web site, but which is no longer a feasible option due to logistical considerations and Privacy Act requirements. Finally, shore and Fleet users also complained that too much information was being required for data input for Class B and C mishaps, and not all of it was pertinent to the specific mishap being reported. As a result of the various

difficulties they faced using WESS and the perceptions that not all information being requested was truly needed for various Class B and C mishaps, many shore and Fleet mishaps may simply not have been reported, making it difficult for the Navy to identify Class B and C mishap trends and take effective and efficient action to help prevent future personnel and equipment mishaps."

**Finding 3, Recommendation 14.** "Revise OPNAV Instruction 5102.1D guidance to remove references to WESS-DS and update the NAVSAFECEN Web site to remove the option to request a WESS-DS disk."

**Naval Safety Center response:** NAVSAFECEN concurs with comment. As an interim option until Navy Information Application Product Suite (NIAPS) becomes available, WESS-DS provides a useful means for deploying units to report mishaps. As under reporting is always a concern, keeping WESS-DS available will help mitigate under reporting in the short term. References to WESS-DS can be removed from 5102.1D in the next update, but references to WESS-DS on the NAVSAFECEN website should remain until the NIAPS solution has been implemented.

**Finding 3, Recommendation 15.** "Establish a Plan of Actions and Milestones (POA&M) for providing server-based WESS onboard ships to reduce time consuming online entry (server will transmit during non-peak periods)."

**Naval Safety Center response:** Concur with the initial strategy to distribute WESS onto shipboard networks and server. The initial capability available is via NIAPS. NIAPS does not currently meet DoD requirements to fully protect data with PKI access controls. NAVSAFECEN will work with PMA 240 to determine the earliest NIAPS release that will provide sufficient protection to HIPAA and Safety privileged information. The current estimate and earliest possible date that this recommendation could be executed is 1 Oct 2010 for testing and 1 June 2011 for delivery. Detailed POA&M will be developed and delivered upon notification by PMA 240 when NIAPS will support PKI requirements. In the interim to mitigate the impact of the limited ship to shore bandwidth, NAVSAFECEN is modifying WESS to utilize technology to operate in a more efficient asynchronous mode. The Aviation Module is expected to deploy in the summer of 2010 and the remaining modules in the summer of 2011. Additionally, WESS will utilize authoritative data sources to minimize the entry of

data by all users (including shipboard users). The first two data sources are Military medical data and civilian injury compensation data. Follow-on data sources will be integrated within resource constraints.

**Finding 3, Recommendation 16.** "Review data requirements cited in OPNAV Instruction 5102.1D and data input requirements programmed into WESS to ensure that requirements are reasonable and necessary based on the nature and severity of the event being reported."

**Naval Safety Center response:** Concur with recommendation. NAVSAFECEN established a Data Strategy Working Group in early 2009 with the intent of reviewing the full mishap reporting data set and eliminating unnecessary data elements from the data set. NAVSAFECEN will complete its review of the OPNAVINST 5102.1D data set by 1 Mar 2010. NAVSAFECEN will then begin discussions with applicable Navy Echelon II and III commands and the Marine Corps Safety Division to reach an agreed upon data set by 1 Sep 2010. Once agreed, NAVSAFECEN will revise OPNAVINST 5102.1D to reflect the new data set and other required policy changes. OPNAVINST 5102 revision will be completed by 1 Jun 2011. Additionally, NAVSAFECEN will update and align WESS consolidated data collection with the newly revised OPNAVINST 5102.1D. The update and alignment of WESS to be completed by 1 Sep 2011.

Appendix 2

# Additional Management Response to Selected Recommendations



DEPARTMENT OF THE NAVY  
NAVAL SAFETY CENTER  
375 A STREET  
NORFOLK, VA 23511-4398

7510  
Ser 02/0065  
22 Feb 10

From: Commander, Naval Safety Center  
To: Assistant Auditor General for Installations and Environment Audits, Naval Audit Service, 1006 Beatty Place SE, Room 312, Washington Navy Yard, DC 20374-5005  
Subj: DRAFT NAVAUDSVC AUDIT REPORT ON REPORTING OF SAFETY MISHAPS (DRAFT AUDIT REPORT N2008-NIA000-0055)  
Ref: (a) NAVSAFECEN ltr 7510 of 21 Dec 09  
(b) NAVAUDSVC Email [REDACTED] of 1018, 24 Dec 09  
(c) NAVAUDSVC Email [REDACTED] of 1108, 6 Jan 10  
(d) NAVAUDSVC Email [REDACTED] of 1414, 19 Jan 10  
(e) NAVAUDSVC Email [REDACTED] of 1540, 19 Jan 10  
(f) NAVAUDSVC Email [REDACTED] of 0828, 21 Jan 10  
Encl: (1) Coordinated Navy Responses to NAVAUDSVC requests for information concerning Draft Audit Report on Reporting Safety Mishaps (Draft Audit Report N2008-NIA000-0055)  
1. Following submission of reference (a), Naval Audit Service personnel requested addition information for specific recommendations. See references (b) through (f). Enclosure (1) provides the additional amplification and clarification requested. This response has been coordinated and agreed within the Executive Safety Committee Steering Group.  
2. My point of contact for this audit is [REDACTED] Executive Director, who can be reached at [REDACTED] or by email at [REDACTED]  
[REDACTED]  
[REDACTED]

FOIA (b)(6)

FOIA (b)(6)

FOIA (b)(6)

**Response to additional information requested by NAVAUDSVC  
staff, NAVAUDSVC DRAFT AUDIT REPORT ON REPORTING OF SAFETY  
MISHAPS (DRAFT AUDIT REPORT N2008-NIA000-0055)**

Following submission of the Coordinated Response, NAVAUDSVC staff requested additional information for selected recommendations. This enclosure provides the additional information requested.

**Finding 1.** "Navy commands rarely reported Class Band C safety mishaps involving personnel injury and/or lost workdays efficiently and effectively; and Navy did not use medical treatment data from medical treatment facilities (MTF) to identify mishaps required by the Department of Defense (DOD) and Navy guidance."

**Finding 1, Recommendation 1.** "Direct the medical community to provide medical treatment data to NAVSAFECEN in accordance with DoDINST 6055.7 as modified by USD (AT&L) Memo dated 20 February 2007, that requires the use of medical treatment information in the identification of mishaps. To ensure protection of patient privacy, data provided should be that which is minimally necessary to accomplish the authorized purpose."

**Naval Safety Center and BUMED response:** Concur. The minimally necessary data to be provided will be determined collaboratively with Naval Safety Center and BUMED. The expertise at the Navy Health Research Center (NHRC) and Navy and Marine Corp Public Health Center (NMCPHC) will be brought in to the discussion. They have valuable experience in identifying medical data that will provide data as it relates to the usefulness to safety. The working group will provide its recommendations by 1 March 2010. Necessary data elements and any filtering criteria will be developed. These new requirements will be incorporated into a modified Data Sharing Agreement with Tricare.

NMCPHC will provide on a weekly basis the identified and filtered data to the Naval Safety Center commencing 1 April 2010 until the automated feed is implemented.

**Additional NAVAUDSVC Request For Information (RFI):**

1. How will Naval Safety Center collaborate with NHRC and NMCPHC?
2. Who is the working group and who will task the setup?

Enclosure 1

Response to RFI:

1. NSC has passed the Data Sharing Agreement (DSA) and initial ICD-9 filtering criteria to NHRC and NMPHC. NHRC, NMPHC and NSC staffs are conducting a review of the DSA to determine gaps and recommendations to the process. NSC has had conversations with NMPHC over the last 24 months regarding data for mishap purposes. NSC will work with BUMED staff to facilitate any direct support tasking with their subordinate commands. Method of collaboration will be via email, teleconferences, DCO or face-to-face meetings.
2. The DSES CCB had recommended that the OSD Enterprise Information Data Task Force take for action. The current parties working the agreement include US Air Force Safety Center, US Army Combat Readiness Center, and OSD (P&R) representative. Future members may include a NORTHCOM, Defense Commissary Agency and Civilian Personnel Management System representative. OSD (P&R) will consolidate the requirements into their DSA with TRICARE.

**Finding 1, Recommendation 2.** "Determine and develop the best process for transferring and using available electronic medical treatment data to identify reportable mishaps. Provide a Plan of Action and Milestones (POA&M) and obtain necessary funding for accomplishment of this recommendation."

**Naval Safety Center and BUMED response:** Concur. NAVSAFECEN has submitted a Data Sharing Agreement (DSA) to the TRICARE privacy office via BUMED. TRICARE Privacy Office has asked that OSD (P&R) approve the request. OSD (P&R) staff is reviewing the agreement. Upon data access approval, OSD (P&R), TRICARE, BUMED and NAVSAFECEN staff will collaborate to determine appropriate data transport mechanism and generate a POA&M to accomplish the recommendation. OSD(P&R) has proposed that the Defense Safety Enterprise System (DSES) will provide the interface for the Naval Safety Center. A POA&M will be developed and approved by 1 April 2010.

Additional NAVAUDSVC Request For Information (RFI):

1. Can you provide us the Date that the Data Sharing Agreement (DSA) was submitted?
2. Can you provide us the Date for data access approval?
3. Any idea of how long this will take?
4. What about funding issue?
5. What is the projected date for DSES to provide the interface for medical data transport?

Response to RFI:

1. Initial conversations with BUMED CIO occurred on 20 February 2009. The DSA was submitted on 11 September 2009 to BUMED. The DSA was reviewed and the sponsor was determined to be OSD(P&R) by the TRICARE Privacy Office on 29 September 2009. The request was submitted to the OSD(P&R) representative, [REDACTED] on 29 September. Awaiting OSD (P&R) approval.
2. The DSA has not been approved. Approval date will be provided in future update.
3. The goal as expressed by OSD (P&R) is a March 2010 approval date.  
Without knowing the full requirements for the feed, a cost estimate and subsequent funding request can not be made.
4. NSC is currently working to identify out-of-cycle funding sources for this initiative.
5. DSES CCB has tasked a contractor, CAMBER with developing a project plan some time within the next 60 days. The project plan should include this information.

FOIA (b)(6)

**Finding 1, Recommendation 5.** "Develop and issue appropriate guidance that requires shore based establishments and operating forces to incorporate comprehensive safety mishap identification, and reporting requirements for on or off-duty injuries as part of indoctrination training and safety stand downs, and ensure personnel are fully aware of all requirements."

Naval Safety Center response: NAVSAFECEN concurs with recommendation's intent, however, NAVSAFECEN is not the custodian of the policy for indoctrination training and safety stand downs. In order to meet the intent of the recommendation, NAVSAFECEN will develop an instructional PowerPoint presentation describing comprehensive safety mishap identification and reporting requirements for on or off-duty injuries and post it on the NAVSAFECEN website so information is obtainable for shore based establishments and operating forces. PowerPoint presentation to be developed and posted by 1 Feb 2010. Additionally, to increase awareness of mishap reporting requirements, NAVSAFECEN will release an ALSAFE by 1 Mar 2010 outlining mishap reporting requirements and advocating commands make this a part of their indoctrination training and use periodically during safety standdowns.

Additional NAVAUDSVC Request For Information (RFI):

Update the target completion date if the corrective action has not been completed or provide actual completion date.

Response to RFI:

Change completion date from 1 Feb 2010 to 1 Mar 2010.

**Finding 1, Recommendation 6.** "Revise OPNAV Instruction 5102.1D to specify who is responsible for reporting injuries for personnel assigned to Medical Hold or to Transient Personnel Units, and ensure responsible personnel are made aware of the change."

Naval Safety Center response: NAVSAFECEN concurs with comment. NAVSAFECEN highlights current instruction guidance, Chapter 1, Introduction and Responsibilities which reads, "Safety officers, safety directors, safety managers, safety specialists and civilian supervisors shall: Ensure all mishaps are investigated and required reports are submitted, as outlined in Chapters 3 and 5." This language requires installations/commands having the assigned person at the time of mishap as the responsible reporting command. In order to meet the intent of the recommendation, NAVSAFECEN shall release an ALSAFE by 1 Mar 2010 providing amplification on this requirement in relation to Medical Hold or Transient Personnel Units.

Additional NAVAUDSVC Request For Information (RFI):

1. Can you clarify how a 'release an ALSAFE' will satisfy intent of recommendation of 'revise OPNAV Instruction 5102.1D' and when will the next revision occur?
2. Will the next revision of the instruction include the amplified language?

Response to RFI:

1. NAVSAFECEN's response of 21 Dec 09 was incomplete. Change NAVSAFECEN response to read:  
NAVSAFECEN concurs. NAVSAFECEN will develop clarifying language to specifically address responsibilities for reporting injuries of personnel assigned to Medical Hold or to Transient Personnel Units. NAVSAFECEN will take the interim step of releasing an ALSAFE by 1 Jun 2010 clarifying these reporting responsibilities.
2. NAVSAFECEN will also include the clarifying language in the next revision of OPNAVINST 5102.1D planned for 1 Jun 2011 as outlined in the NAVSAFECEN response to Finding 3, Recommendation 16 of this audit report.

**Finding 1, Recommendation 9.** "Develop a set of performance measures and provide continuous oversight to ensure afloat commands are complaint with all mishap reporting requirements."

**U.S. Fleet Forces (USFF)/Commander Pacific Fleet (CPF)**  
**response:** USFF and PACFLT will take the following specific corrective actions:

(1) USFF and CPF will release messages by 29 Jan 2010 with the following:

(a) Direct afloat commands to ensure the safety officer, ship's medical department representative (MDR), officer of the deck, department heads, and all hands understand their responsibilities for reporting injuries and property damage resulting from mishaps in accordance with OPNAVINST 5100.19E.

(b) Remind afloat commands of OPNAVINST 5102.1D and OPNAVINST 5100.19E requirements to submit all reportable injury mishaps to Naval Safety Center via the Web Enabled Safety System (WESS), retain mishap records for a minimum of five years, and analyze mishap trends.

(c) Remind afloat Type Commanders (TYCOMs) and Immediate Superiors in Command (ISICs) of OPNAVINST 5102.1D and OPNAVINST 5100.19E requirements to provide oversight to ensure afloat commands conduct timely, thorough safety investigations, retain mishap records for five years, and analyze mishap trends. TYCOMs and ISICs shall conduct safety and occupational health oversight inspections at a minimum of once every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

(2) USFF and CPF will assess Fleet mishap reporting compliance by adding a review of medical logs and mishap report records of selected commands during USFF/CPF Safety and Occupational Health Management Evaluations (SOHMEs) of TYCOMs to ensure all reportable injuries are reported to the Naval Safety Center (NAVSAFECEN) via the Web Enabled Safety System (WESS). All afloat TYCOMs will be evaluated every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

**Additional NAVAUDSVC Request For Information (RFI):**

1. For response 1 (a) - How will USFF and CPF know that steps were taken to ensure personnel understand their responsibilities? Will there be any feedback from afloat commands indicating they complied with messages? This would be necessary to close the loop.
2. What is the target date for release of the NAVADMIN that includes a requirement to report information from unit self assessments?
3. Since everything can't be included in the NAVADMIN message, how do you plan to communicate guidance on completing the assessment? An acceptable way of communicating guidance and laying out the process is to publish it in Fleet Standard Procedures and Controls. Corrective actions for Recommendation 10, indicate the Fleet will publish procedures and controls for capturing equipment mishaps by Jun 2010. Including both personnel and equipment mishap reporting procedures and controls in one document is an effective way of communicating guidance and ensuring the procedures, controls and process improvements are consistent and sustained over time.

USFF and CPF response to NAVAUDSVC RFI:

1. USFF/CPF will assess compliance on mishap reporting during TYCOM Safety and Occupational Health Management Evaluations every 3 years per COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E and OPNAVINST 5100.19E.
2. Believe the NAVADMIN message you refer to is VCNO's NAVADMIN concerning the Navy Implementation and Oversight Plan for the DON Safety Vision and SECDEF Mishap Reduction Goals. NAVADMIN 048/10 was released on 12 Feb 10.
3. Fleet guidance for completing unit self-assessments is defined in COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

Lastly, USFF/CPF has adjusted the release date of its message, originally planned for 29 Jan 10, will now be released by 26 Feb 10.

**Finding 2.** "Responsible Naval commands did not typically report Class Band C equipment mishaps, including those involving fire and flooding, to the Commander, Naval Safety Center (COMNAVSAFECEN), as required by the Office of the Chief of Naval Operations (OPNAV) Instruction 5102.10."

**Finding 2, Recommendation 10.** Establish Fleet standard procedures and controls to identify and capture equipment mishap information for reporting to NAVSAFECEN (for example require SOs to review all SITREPS and/or CASREPs to determine

the need for mishap reporting or implement other mechanism to identify and capture equipment mishap information).

U.S. Fleet Forces (USFF) response: USFF will publish the following Fleet standard procedures and controls for capturing equipment mishaps by 30 Jun 2010 in accordance with OPNAVINST 5102.1D:

(1) Upon discovery of damaged equipment, department heads shall immediately notify the Command Safety Officer of all cases of flooding or fire, and all equipment damage or losses exceeding \$50,000 as a result of mishap.

(2) The Command Safety Officer, in collaboration with the department heads, shall conduct a mishap investigation and submit a mishap report to Naval Safety Center via WESS, retain mishap records for a minimum of five years, and analyze mishap trends.

(3) Commanding Officers shall ensure mishap reporting requirements are included in command indoctrination training.

Additional NAVAUDSVC Request For Information (RFI):

1. When did the \$50,000 threshold become official?

USFF response to NAVAUDSVC RFI:

1. USD (AT&L) memo dated 5 Oct 09 revised the cost thresholds for all services effective the beginning of FY2010. Class A, B and C thresholds were changed. The \$50,000 is the new Class C threshold. NAVSAFECEN released ALSAFE 056/09 on 6 Oct 09 announcing this change to DON.

Finding 2, Recommendation 12. "Submit change proposal for Naval Weapons Publication (NWP) 1-03-1 to Naval Warfare Development Command revising CASREP guidance to clearly state that a mishap reporting statement is required."

Naval Safety Center response: Concur. Coordination with Naval Warfare Development Command has been initiated; NAVSAFECEN is in the process of writing a change proposal to include mishap reporting requirements for CASREPs. Naval Warfare Development Command will promulgate change after review. NAVSAFECEN will submit the change proposal by 15 Jan 2010.

Additional NAVAUDSVC Request For Information (RFI):

1. After your proposed submission to Naval Warfare Development Command, can you provide effective date?

2. Has Naval Warfare agreed to make the change once the change proposal is submitted? If so please provide the date.
3. What date was the change proposal submitted to NAVWARDEVCOM?

Response to RFI:

1. Our proposed submission has already been forwarded to NAVWARDEVCOM. Estimate message change will be out NLT 1 May 2010. Once promulgated, we will post the change on our Web page and reference the change in our monthly safety digest message to the Fleet.
2. Yes, [REDACTED] from NAVWARDEVCOM on 28 Oct 2009.
3. Change proposal submitted 8 January 2010.

FOIA (b)(6)

**Finding 2, Recommendation 13.** Provide oversight to ensure that Fleet units retain records of all reportable mishaps in accordance with OPNAV Instruction 5102.1D and provide all required equipment mishap reports to WESS/NAVSAFECEN.

U.S. Fleet Forces (USFF)/Commander Pacific Fleet (CPF) response: USFF and CPF will assess Fleet mishap reporting compliance by reviewing equipment mishap records of selected commands during USFF/CPF Safety and Occupational Health Management Evaluations (SOHMEs) of TYCOMS. All afloat TYCOMS will be evaluated every three years in accordance with COMUSFLTFORCOMINST 5100.7/COMPACFLTINST 5100.5E.

Additional NAVAUDSVC Request For Information (RFI):

Target date not provided in the Fleets response. May the Fleets provide a target date for starting review of equipment mishap records during SOHMEs?

USFF response to NAVAUDSVC RFI:

USFF will review equipment mishap records starting with Military Sealift Command's SOHME in Apr 2010.

CPF response to NAVAUDSVC RFI:

CPF will review equipment mishap records starting with COMNAVSURFPAC and COMNAVAIRPAC SOHME to be conducted NLT July 2010.

**Finding 3.** "Safety personnel find NAVSAFECEN's WESS cumbersome and time-consuming to use. OPNAV Instruction 5102.1D requires that all mishaps be reported via WESS. However, personnel at both shore and Fleet activities we visited described various issues that made WESS difficult to use... Fleet users felt that data entry to the online WESS

system, when made during deployments, was untenable, taking hours or even days to complete. Fleet users desired use of an offline system, such as the WESS Disconnected System (WESS-DS) offered in OPNAV Instruction 5102.1D and NAVSAFECEN's Web site, but which is no longer a feasible option due to logistical considerations and Privacy Act requirements. Finally, shore and Fleet users also complained that too much information was being required for data input for Class B and C mishaps, and not all of it was pertinent to the specific mishap being reported. As a result of the various difficulties they faced using WESS and the perceptions that not all information being requested was truly needed for various Class B and C mishaps, many shore and Fleet mishaps may simply not have been reported, making it difficult for the Navy to identify Class B and C mishap trends and take effective and efficient action to help prevent future personnel and equipment mishaps."

**Finding 3, Recommendation 14.** "Revise OPNAV Instruction 5102.1D guidance to remove references to WESS-DS and update the NAVSAFECEN Web site to remove the option to request a WESS-DS disk."

**Naval Safety Center response:** NAVSAFECEN concurs with comment. As an interim option until Navy Information Application Product Suite (NIAPS) becomes available, WESS-DS provides a useful means for deploying units to report mishaps. As under reporting is always a concern, keeping WESS-DS available will help mitigate under reporting in the short term. References to WESS-DS can be removed from 5102.1D in the next update, but references to WESS-DS on the NAVSAFECEN website should remain until the NIAPS solution has been implemented.

**Additional NAVAUDSVC Request For Information (RFI):**

1. What is the estimated date for NIAPS availability? Are the dates mentioned in response 15 applicable and reasonable for this as well? If so need POA&M.
2. Request an interim action between now and 1 Oct 10 when WESS will enter NIAPS pipeline.

**Response to RFI:**

1. Response 15 is applicable. Estimate for WESS entry into the NIAPS pipeline to occur on 1 October 2010. As part of the NIAPS on-boarding process, the NIAPS program office will determine delivery schedule to meet the data protection

requirements. Estimate the schedule and determination will occur NLT 31 Jan 2011. POA&M will be provided NLT 1 Feb 2011.  
2. Status reports to be provided by 1 July 2010 and 1 January 2011.

**Finding 3, Recommendation 15.** "Establish a Plan of Actions and Milestones (POA&M) for providing server-based WESS onboard ships to reduce time consuming online entry (server will transmit during non-peak periods)."

Naval Safety Center response: Concur with the initial strategy to distribute WESS onto shipboard networks and server. The initial capability available is via NIAPS. NIAPS does not currently meet DoD requirements to fully protect data with PKI access controls. NAVSAFECEN will work with PMA 240 to determine the earliest NIAPS release that will provide sufficient protection to HIPAA and Safety privileged information. The current estimate and earliest possible date that this recommendation could be executed is 1 Oct 2010 for testing and 1 June 2011 for delivery. Detailed POA&M will be developed and delivered upon notification by PMA 240 when NIAPS will support PKI requirements. In the interim to mitigate the impact of the limited ship to shore bandwidth, NAVSAFECEN is modifying WESS to utilize technology to operate in a more efficient asynchronous mode. The Aviation Module is expected to deploy in the summer of 2010 and the remaining modules in the summer of 2011. Additionally, WESS will utilize authoritative data sources to minimize the entry of data by all users (including shipboard users). The first two data sources are Military medical data and civilian injury compensation data. Follow-on data sources will be integrated within resource constraints.

Additional NAVAUDSVC Request For Information (RFI):

1. Can you be more specific on the dates? Our tracking system uses the month day year format.
2. Request an interim action between now and 1 Oct 10 when WESS will enter NIAPS pipeline.

Response to RFI:

1. Aviation Module will be come available for user testing third quarter fiscal year 2010 with anticipated IOC in fourth quarter fiscal year 2010. Use 1 Sep 2010 as the deploy date.
2. Status reports to be provided by 1 July 2010 and 1 January 2011.

**Finding 3, Recommendation 16.** "Review data requirements cited in OPNAV Instruction 5102.1D and data input requirements programmed into WESS to ensure that requirements are reasonable and necessary based on the nature and severity of the event being reported."

**Naval Safety Center response:** Concur with recommendation. NAVSAFECEN established a Data Strategy Working Group in early 2009 with the intent of reviewing the full mishap reporting data set and eliminating unnecessary data elements from the data set. NAVSAFECEN will complete its review of the OPNAVINST 5102.1D data set by 1 Mar 2010. NAVSAFECEN will then begin discussions with applicable Navy Echelon II and III commands and the Marine Corps Safety Division to reach an agreed upon data set by 1 Sep 2010. Once agreed, NAVSAFECEN will revise OPNAVINST 5102.1D to reflect the new data set and other required policy changes. OPNAVINST 5102 revision will be completed by 1 Jun 2011. Additionally, NAVSAFECEN will update and align WESS consolidated data collection with the newly revised OPNAVINST 5102.1D. The update and alignment of WESS to be completed by 1 Sep 2011.

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