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DoN “Gets It” When It Comes to Safety

Mr. Paul Hanley, Deputy Assistant Secretary of the Navy (Safety) was selected by the National Safety Council as one of 2014’s CEOs Who “Get It,” an annual recognition of leaders of organizations who demonstrate world-class safety. Mr. Hanley was one of 10 individuals recognized, but he said his selection represents a team effort.

“Fortunately, this moment in the history of the DoN boasts the most committed and vigorous leadership in the safety arena ever,” he said. “Our task is to insure that this commitment is transferred down through the chain of command to the lowest level, because in any unit, Sailors, Marines, and civilians can sense how seriously that unit’s leader takes safety, and they respond accordingly.”



Correlating Medical Treatment and Mishap Reports

Our new WESS Injury Verification Feed receives medical data from the Navy and Marine Corps Public Health Center allowable under HIPAA laws. The system will send an email to a representative from each command that directs to a WESS page listing command personnel who have been involved in what may have been reportable mishaps. Medical data includes patient treatment at a Navy Medical Treatment Facility or TRICARE provider for an injury or occupational illness that appears to meet mishap reporting thresholds.

The command representative will be asked to validate whether or not each individual occurrence constitutes a reportable mishap. If it does, the rep will be prompted to take appropriate action to ensure the required report is submitted per the applicable guidance (OPNAVINST 5102.1D for on-duty and off-duty mishaps, and OPNAVINST 3750.6R for aviation mishaps). The medical data used to identify the possible mishap events reported back to commands comes from the International Classification of Diseases, 9th Revision (ICD-9) injury or illness classification codes and severity that are entered by the medical staff at the time treatment is received as part of routine patient care record maintenance.

This requirement originated several years ago, when the DoD IG found significant underreporting of injuries across the DoD. The Naval Safety Center was directed to obtain medical data that would help identify reportable mishaps that have not been reported.

Details about the Injury Verification Feed are available at <http://www.public.navy.mil/navsafecen/Pages/messages/alsafe.aspx>.



The Importance of Sleep

Studies show that a lack of sleep is not only a safety issue, but is directly related to elevated stress, low morale and poor performance. Naval culture has long celebrated sleep deprivation as a measure of toughness, but recent studies onboard several ships indicate adequate sleep is necessary for mission success.

We have just posted a series of Public Service Announcements designed to inspire commands around the Fleet to embrace a concept of establishing regular, circadian-based sleep cycles for Sailors. The adoption of consistent schedules in standing watch, eating, sleeping and physical fitness will create a strong foundation to build greater resilience throughout the Navy. The videos, other references and resources are at <http://www.public.navy.mil/navsafecen/Pages/video/sleep-fatigue.aspx>.



Admiral's Comments: Cutting Corners

Getting the job done with the resources at hand is a proud part of the Navy and Marine culture. It is undoubtedly one of the strongest and most valued characteristics of our sea service culture. Nevertheless, during Naval Safety Center interaction with fleet operational units, we have seen many examples where the "do more with less" mindset, often coupled with actual limited resources and/or time, inevitably leads to a command culture of cutting corners to get the job done. Sometimes the shortcuts are minor, but in many cases, cutting corners becomes so pervasive that basic requirements and procedures are bypassed for the sake of the mission.

Here's an example from a recent aviation safety survey ashore where a Sailor was in such a rush to get a job done that a required in-process quality assurance (QA) step was simply not done. He bypassed it because the right tool for the job was not available and the QA representative was engaged in another evolution. When our safety survey team stepped in to stop the evolution and started peeling back the layers to get to the "why," it became apparent that this step was routinely skipped, not only to expedite getting the job done quickly, but because the required tool was not even available at the detachment site. In other words, this squadron cultivated a culture where widespread violations of published procedure were an accepted practice.

We have established procedures and requirements for a reason. In many cases, those procedures were "written in blood" after Sailors and Marines hurt themselves, their shipmates, or destroyed valuable equipment. Those lessons written into our procedural guidance are really the foundation of Operational Risk Management. This is in-depth ORM that has already been done for us.

In addition to having the right tools for the job, having the right people is even more critical. VADM Tom Copeman recently told reporters at the annual Surface Navy Association meeting that there's a critical manning shortage in the surface force, especially in the CPO community. Proper manning fit/fill is a key component of a strong safety program. If you're not manned at the right level (fill) or with the right skill-sets (fit), then you're doing more with less and you are setting yourself up for an environment where cutting corners becomes the norm. We have mechanisms in place to articulate specific manning concerns and their impact on the mission up the chain. PERSMARs, EMIRs, DRS-N or even a hazrep are all ways to document manning deficiencies and their effect on your mission. Even though the manning issues have been recognized by senior Navy leadership and corrective actions are underway, the mission impacts of those manning concerns still need to be communicated and mitigated effectively.

Some questions to ask at the unit level:

1. Do you have an accurate perception of the amount of corner-cutting in your unit?
2. How does your unit monitor/correct those who cut corners?
3. Can personnel in your unit raise a "red flag" without fear of criticism or retribution?
4. Is your unit over-tasked to the point that deadlines are not attainable without cutting corners?
5. Can your higher headquarters assist (e.g., tasking, optempo, manning, resources)?



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