Defense Logistics Agency

INSTRUCTION

DLAI 6055.07
Effective August 18, 2014

SUBJECT: Mishap and Near Miss Reporting and Investigation

References: See Enclosure 1.

1. PURPOSE. This instruction incorporates and cancels Directive-Type Memorandum (DTM) 13-004, “Mishap and Near Miss Reporting and Investigation” (Reference (a)) to establish policy and define the roles and responsibilities for mishap and near miss reporting and investigation for DLA.

2. APPLICABILITY.

   a. This Instruction applies to all DLA activities and to all DLA bargaining and non-bargaining unit employees. If there is an applicable collective bargaining agreement and its provisions are in conflict with those of this Instruction, the provisions of the agreement prevail over the relevant provisions of this Instruction.

   b. In addition, these provisions consider limitations on the applicability of section 651 of title 29, United States Code (Reference (b)), Executive Order 12196 (Reference (c)), and part 1960 of title 29, Code of Federal Regulations (Reference (d)) (to the Department of Defense (DoD)). These limitations include the exemptions or exceptions from Department of Labor oversight for military personnel, military-unique operations and workplaces, specific conditions governed by the statutory authorities, and in certain overseas areas, conditions governed by international agreements.

3. DEFINITIONS. See Glossary.

4. POLICY. It is DLA policy that all work-related mishaps (injury, illness, and property damage) and near misses will be recorded in Enterprise Safety Application Management System.
and investigated. Occupational Safety and Health (OSH) personnel will document and track investigation results and corrective actions in ESAMS.

5. **RESPONSIBILITIES.** See Enclosure 2.

6. **INFORMATION REQUIREMENTS.**

   a. Record mishaps (injury, illness, and property damage) and near misses will be recorded in ESAMS.

   b. Complete DLA Form 1591, “Supervisor Mishap Report,” (only used by supervisors) when ESAMS is unavailable (e.g., no computer, no internet service, power outage, ESAMS system problems). The form will be submitted to designated OSH personnel within one workday of the DLA supervisor being notified of an incident. Designated OSH personnel will enter these paper reports into ESAMS within one workday of receipt.

   c. Employees may use DLA Form 1404, “Near Miss/Hazard Report,” when ESAMS is not available. Send the completed DLA Form 1404 to the designated OSH personnel who enter the information into ESAMS.

   d. Use DLA Form 1880, “Privacy Act Cover Sheet,” or DD Form 2923, “Privacy Act Data Cover Sheet,” to protect personally identifiable information (PII) and information designated for official use only (FOUO) documented in the report.


   e. ESAMS generates deficiency notices and corrective action requests for hazards identified as a result of a mishap or near miss investigation.

   f. Forward the investigation report through DS-O to the Designated Agency Safety and Health Official (DASHO) and DLA Director for all mishaps resulting in patient hospitalization, any fatality or property damage equal to or greater than $2 million.

7. **INTERNAL CONTROLS.** Monthly, DS-O monitor the ESAMS data and accident investigation reports, to gauge compliance with this instruction.

8. **RELEASEABILITY.** UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DLA Issuances Internet Website.
9. **EFFECTIVE DATE.** This Instruction:

   a. Is effective on August 18, 2014.

   b. Must be reissued, cancelled, or certified current within 5 years of its publication in accordance with DLAI 5025.01, DLA Issuance Program. If not, it will expire effective August 18, 2024 and be removed from the DLA Issuances Website.

   PHYLLISA S. GOLDENBERG
   Director, DLA Strategic Plans and Policy

   Enclosure(s)
   - Enclosure 1 – References
   - Enclosure 2 – Responsibilities
   - Enclosure 3 – Mishap and Near Miss Investigation Procedures
   - Enclosure 4 – Causal Factor Flow Chart
   - Enclosure 5 – Sample Mishap and Near Miss Analysis Sheet
   - Enclosure 6 – Causal Factor - Root Cause Analysis Chart
   - Enclosure 7 – Sample Investigation Report Outline

Glossary
# TABLE OF CONTENTS

ENCLOSURE 1: REFERENCES

ENCLOSURE 2: RESPONSIBILITIES

ENCLOSURE 3: MISHAP AND NEAR MISS INVESTIGATION PROCEDURES

ENCLOSURE 4: CAUSAL FACTOR AND ROOT CAUSE S FLOW CHART

ENCLOSURE 5: SAMPLE MISHAP AND NEAR MISS ANALYSIS SHEET

ENCLOSURE 6: CAUSAL FACTOR – ROOT CAUSE ANALYSIS CHART

ENCLOSURE 7: SAMPLE INVESTIGATION REPORT OUTLINE

GLOSSARY
ENCLOSURE 1

REFERENCES

(a) Directive-Type Memorandum (DTM) 13-004, Mishap and Near Miss Reporting and Investigation, 13 February 2013 (hereby cancelled)
(b) Section 651 of Title 29 United States Code
(c) Executive Order 12196, Occupational Safety and Health Programs for Federal Employees
(d) Part 1960 of title 29, Code of Federal Regulations
(e) Part 1904 of title 29, Code of Federal Regulations
(f) DLA Instruction 5025.01, “DLA Issuance Program,” January 4, 2013
(g) DoD Instruction 6055.07, “Accident Investigation, Reporting and Recordkeeping,” June 6, 2011
(h) DLA Instruction 6106, “Situation Reporting,” May 1, 2010
(i) DLA Instruction 7207, “Injury Compensation,” January 4, 2012
RESPONSIBILITIES

1. DLA INSTALLATION SUPPORT OCCUPATIONAL SAFETY AND HEALTH (DS-O), UNDER THE AUTHORITY, DIRECTION, AND CONTROL OF THE DIRECTOR, DLA INSTALLATION SUPPORT (DS-D). DS-O must:

   a. Provide policy, guidance, and oversight on accident reporting and investigation.

   b. Maintain mishap reports for serious incidents and use information from mishap investigations to modify DLA Occupational Safety and Health (OSH) policies and procedures to prevent future mishaps.

   c. Provide lessons learned from serious mishaps to DLA and the Department of Defense (DoD).

   d. Report all mishaps to DoD in accordance with DoD Instruction 6055.07, “Accident Investigation, Reporting and Recordkeeping” (Reference (g)).

   e. Interface with OSHA investigative teams for mishaps involving multiple hospitalizations or a fatality in accordance with Reference (d) and Part 1904 of title 29 (Reference (e)) requirements.

   f. Ensure accident investigation training is provided to the applicable DLA workforce.

   g. Review DLA deficiency notices and corrective action requests generated from mishap, unsafe, unhealthful, and near miss incidents in ESAMS. Conduct a review to identify missing, inaccurate or incomplete documentation of events and actions by OSH personnel as they implement site specific program in accordance with this instruction. This information will be captured on a Mishap, Unsafe Unhealthful, and Near Miss Audit spreadsheet on a monthly basis.

   h. Analyze ESAMS data to identify trends and perform hazard analysis. Trend results may be used in the development of safety goals and objectives or in the development of actions or activities (e.g., posters, flyers, training aids, employee committees, etc.) to educate, increase awareness and prevent future occurrences.

2. THE DLA HEADQUARTERS AND PLFA DIRECTORS / COMMANDERS. The Directors/Commanders must:

   a. Work in collaboration with designated OSH personnel to develop a single site specific mishap near miss investigation program and procedures to ensure all mishaps and near misses are investigated by qualified personnel (DLA or Host). A site specific program will identify responsibilities for managers, supervisors, and OSH personnel implementing the program. The
program should include the investigation report (see Enclosure 7) approval process for mishaps resulting in patient hospitalization, any fatality or property damage equal to or greater than $2 million.

b. Ensure supervisors submit mishap reports in ESAMS within one workday of receiving information relative to an incident (injury, equipment or property damage). Provide the OSH person investigating the mishap all documentation or information (e.g., medical reports, work order information, job hazard analysis, diagrams, etc…) relevant to the mishap. The DLA Form 1591 (Supervisory Mishap Report) will only be used to report mishaps when ESAMS is not available (i.e., no internet access, no computer).

c. Ensure the Local Union President or designee is notified in a timely manner after a mishap is reported.

d. Designate OSH personnel to provide oversight and guidance for investigations of minor incidents and to take the lead when the investigation involves a serious injury, patient hospitalization, a fatality, or extensive property damage. Designate OSH personnel to document incident investigation results and corrective actions in ESAMS.

e. Designate an incident investigation team. The team should consist of the workplace supervisor for the employee involved in the incident and other employees who have technical knowledge, objectivity, familiarity with the job process, or operation, tact in communicating with others and an analytical approach to problems. The union representative may also be offered the opportunity to participate in an incident investigation.

f. Ensure designated OSH personnel attend and have a certificate for a mishap or accident investigation training course (e.g., DLA, OSHA, or Military Services Accident Investigation Training Course).

g. Ensure supervisors and employees assigned to the incident investigation team receive basic accident investigation awareness training consistent with their assigned responsibilities. If the mission allows the local union president and/or his representative be provided the same training to facilitate their representational duties.

h. Ensure investigations are conducted and investigation reports prepared using an independent party (investigation team members who have nothing to gain or no vested interest in the outcome of the investigation) for all mishaps resulting in patient hospitalization of an employee and any fatality.

i. Ensure incident reenactments are conducted for all mishaps resulting in patient hospitalization, any fatality or property damage equal to or greater than $2 million. Reenactments may also be conducted for minor mishaps and near miss incidents.

j. Participate in mishap and near miss incident reenactments.

ENCLOSURE 2
k. Notify DS-O and the DLA Human Resources Services Injury Compensation (DHRS-I) Office by phone or email within 2 hours of any mishaps resulting in hospitalization of an employee or any fatality.

l. Ensure all mishap and near miss incidents are reported in ESAMS within one work day of their occurrence or within one work day of the incident being reported to the supervisor.

m. Report mishaps in accordance with Reference (g). The Situation Report (SITREP) process does not supersede other mishap reporting requirements.

n. Ensure the investigation report for all mishaps resulting in patient hospitalization, any fatality or property damage equal to or greater than $2 million is forwarded through DS-O to the Designated Agency Safety and Health Official (DASHO) and DLA Director.

o. Within eight (8) hours after the death of any employee from a work-related incident or hospitalization of three or more employees as a result of a work-related incident, orally report the fatality/multiple hospitalization by telephone or in person to the Area Office of the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor, that is nearest to the site of the incident. You may also use the OSHA toll-free central telephone number, 1-800-321-OSHA (1-800-321-6742). Provide details for each fatality or multiple hospitalization incident in accordance with Reference (e).

p. Document, implement and follow up on corrective actions in ESAMS to prevent future mishaps from occurring.

3. DLA HUMAN RESOURCES (J1). J1 in collaboration with DS-O will develop and provide access to Accident Investigation Training for DLA personnel.
ENCLOSURE 3

MISHAP AND NEAR MISS INVESTIGATION PROCEDURES

1. Submit all mishap and near miss incidents in ESAMS within one work day of their occurrence or of them being reported.

2. Commanders and Directors will work in collaboration with designated OSH personnel and their local union, as appropriate, to develop a single site specific mishap and near miss investigation program and procedures to cover all DLA activities. The program and procedures identify roles and responsibilities of designated OSH employees, the workplace supervisor of the employee involved in the incident and employees designated as investigation team members in accordance with the guidance in References (d) through (e), (g) through (j). The site specific program should address, but is not limited to identifying:

   a. Roles and responsibilities of designated OSH personnel, the workplace supervisor of the employee involved in the incident and the employees designated as investigation team members.

   b. Actions required to assist the injured.

   c. Who investigate mishaps and near miss incidents.

   d. Who makes calls (Personnel responsible for making notifications.) (e.g., supervisor, police, Host or local DLA safety, union representative, etc.).

   e. Who to contact when a serious event occurs.

   f. What to do for conditions immediately dangerous to life and health (IDLH).

   g. Actions to secure the area.

   h. An investigation kit. The investigation kit may include, but is not limited to the following items:

      (1) Flashlight

      (2) Camera

      (3) Retractable Tape Measure

      (4) Notebook

      (5) Clip Board

      (6) Caution Tape
(7) Personal protective equipment (PPE) based on hazards associated with task/area. 
(Note: Ensure personnel receive appropriate training, fit testing or medical surveillance based on 
PPE requirements).

(8) Binoculars

3. Designated OSH personnel will provide oversight and guidance for investigations of minor 
incidents and take the lead when the investigation involves a serious injury, a fatality, or 
extensive property damage. Designated OSH personnel document the incident investigation 
results and corrective actions in ESAMS.

4. Designate incident investigation teams based on tasks performed on site and the potential 
severity of incidents. Teams should consist of employees who have technical knowledge, 
objectivity, familiarity with the job process, or operation, tact in communicating with others and 
an analytical approach to problems.

5. Mishap and Near Miss Investigation Process.
   a. Person(s) at the scene at time of incident:
      (1) Contact emergency responders (e.g., fire, medical, environmental, safety – Host or 
          DLA, etc…).
      (2) Check for danger before approaching the scene.
      (3) If trained, assist any injured individual.
      (4) Contact other persons according to local procedures.
      (5) Secure the scene (caution tape, cones, etc.) to keep it intact until the investigation is 
          complete.
   b. Person(s) conducting the investigation:
      (1) Arrive as soon as possible after the incident occurs to inspect/observe the site before 
          any changes occur.
      (2) Check for danger before approaching the scene.
      (3) Take several photographs from different angles to capture the scene of the incident.
      (4) Obtain information from sources (Emergency Medical Services, Nurse, Security, 
          etc.) verifying the status of the injured employee.
(5) Information obtained will be treated in accordance with DLA Instruction 6303, “For Official Use Only Material,” (Reference (j)).

(6) Draw sketches of the scene of the incident; include scale and directional indicator on sketches.

(7) Document the location noting the location of victims, witnesses, machinery, furniture, energy sources, weather conditions, hazardous materials or other items relative to the scene.

(8) Keep complete and accurate notes documenting the facts.

(9) Obtain reports (e.g., Medical (directly related to the incident), Police, Fire and Rescue, Maintenance, Facility Diagrams, Hazard Reports, Past Mishap/Near Miss Reports, Job Hazard Analysis, Inspections, etc.).

c. Interviews:

(1) Interview employee involved in incident. A representative of the Union will be given an opportunity to be present at any interview of an employee in connection with an investigation if the employee requests such representation before or during the interview.

(2) Interview witnesses and the workplace supervisor as soon as possible. Interview employees present before the event and those who arrived shortly after the event occurred.

(3) Choose a quiet private place to talk.

(4) Talk as equals.

(5) Ask open ended questions (who, what, where, when, how, why).


(7) Don’t assume you know the answers.

(8) Information obtained will be treated in accordance with Reference (j).

d. Mishap reenactment:

(1) Conduct mishap reenactments in a timely manner for all serious incidents. Reenactments should also be conducted for minor mishaps and near miss incidents.

(2) Reenactment participants include the Commander, Deputy Commander, or Director, Respective Division Chief, first line supervisor and or next level of management, the employee(s) involved in the incident, safety staff, union representative, employees volunteering to participate in mishap reenactments and other personnel as appropriate.
e. Analyze the facts. Incident causes (Enclosure 4):

(1) Task: Explore the actual work procedure used at the time of the accident.

(2) Material: System inadequacies. Evaluate the equipment, furniture, chemicals, material, and PPE used to perform the task. Review applicable manuals and Safety Data Sheets (formally called Material Safety Data Sheets).

(3) Environment: The physical environment (weather, housekeeping, noise, light, etc.) at the time of the incident are factors that need to be identified.

(4) Personnel: Human factors. Explore the physical and mental condition of the employees directly involved in the incident. Look at training, experience, stress, illness, or injuries that could have contributed to the incident. The purpose for exploring human factors is not to establish blame but, rather, to consider all potential causes to help prevent a reoccurrence.

(5) Management: Management has the legal responsibility to provide a workplace free of recognized hazards. Explore whether supervisors and management are taking appropriate actions to communicate and enforce safety rules, implement required safety programs, correct hazards, provide adequate supervision, ensure equipment has required maintenance, and that workplace inspections are conducted.

(6) Review employee interview notes.

(7) Look at all pertinent facts and use a systematic analytic technique.

(8) Develop conclusions, casual factors and root causes supported by the facts. The conclusions should answer the who, what, where, when, how and why questions.

(9) Determine recommendations and corrective actions necessary to prevent a reoccurrence. Corrective actions will be clear, address the causal factors and root causes, identify interim controls, the immediate actions required and long term corrective actions (Enclosure 5 and Enclosure 6).

(10) Review all the facts and corrective action recommendations to ensure nothing was missed and that the recommended actions are effective.

6. Document Mishap (injury, illness, property damage) and Near Miss Investigation Results.

a. Document incident analysis results on a mishap and near miss analysis sheet (Enclosure 6).

b. Document investigation results in ESAMS completing all sections in each tab of the mishap or near miss. Issue lessons learned to all employees. Issue and follow up on corrective actions in ESAMS. Attach pictures, mishap near miss analysis sheet and other relevant
information documenting the investigation was completed in ESAMS. Take appropriate precautionary measures in accordance with federal or local guidance (privacy, controlled area, sensitive information, etc…) when posting documents or pictures.

c. Follow up with the workplace supervisor and other appropriate personnel responsible for action on the ESAMS corrective action request to ensure recommended corrective actions are implemented and actions are effective.


a. Conduct investigations, prepare investigation reports and document the investigation results in ESAMS. All mishaps resulting in hospitalization or any fatality will be investigated by an independent party.

b. Leadership (i.e., Commander, Director, supervisor) has access to review mishap reports in ESAMS for employees identified in ESAMS within their chain of command.

c. Investigation reports will be prepared for all mishap and near miss incidents in a format commensurate with the severity of, or the interest in, the mishap. Mishaps involving patient hospitalization, multiple injuries, a fatality or property damage equal to or greater than $2 million require a much more expansive formal report like the sample provided in Enclosure 7. The mishap and near miss investigation results will be thoroughly documented in ESAMS. Memorandum format (Enclosure 7).

(1) Subject: Describe the nature of the memorandum (e.g., Mishap Investigation Report Class “D”, Restricted Work Activity”, Type of Injury, Name, Job Title, Location, Date).

(2) References: Reference only applicable standards.

(3) Executive Summary: Provide a brief summary of events, findings, and Conclusions.

(4) Purpose: Describe the intent of the report.

(5) Background: Who conducted the investigation, when was it reported, who it was reported to and how was it reported.

(6) Description:

(a) Date and time of time of incident

(b) Employee job title

(c) Operation being conducted when mishap occurred

(d) Details of what happened
(7) Findings: Document the facts obtained from the cause analysis results.

(8) Conclusions: Identify specific causes of the incident.

(9) Recommendations: Corrective actions and interim controls recommended to prevent a reoccurrence.

(10) Enclosures:

(a) Pictures

(b) Diagrams

(c) Mishap analysis sheet

(d) Other supporting documents (e.g., Job Hazard Analysis, Standard Operating Procedures, etc.).

d. Unless violation(s) is (are) related to the mishap, screen pictures for potential OSHA violations before including them in the report.

e. Use the DLA Form 1880 or DD Form 2923 to protect personally identifiable information (PII) and information designated for official use only (FOUO) documented in the report.

f. Copies of the mishap investigation results will be forwarded to the appropriate local safety and health committee and the exclusive employee representative, if any.

g. The investigative report will be made available to the Secretary of Labor or his authorized representative on request.
ENCLOSURE 4

CAUSAL FACTOR AND ROOT CAUSE FLOW CHART

Unplanned Release of Energy and/or Hazardous Material Results in a Mishap or Near Miss

- Indirect Causes
  - Management, Policy & Procedures, Training, Environmental Conditions
  - Equipment/Building Design
  - Human Behavior
  - Unsafe Conditions
  - Unsafe Acts

- Direct Causes
  - Contributing Causes

**CAUSAL FACTOR - ROOT CAUSE ANALYSIS CHART**

- **Mishap (Injury/Illness/Damage)**
  - Was support provided to individual to perform task: 
    - Personnel 
    - Equipment/Material/Condition 
    - Supplies 
    - Services/facilities 
    - Personal Protective Equipment
  - **Yes**
  - **No**
- **Do Standards/Procedures Exist for the Task?**
  - **Yes**
  - **No**
- **Did individual receive training on how to perform the task?**
  - **Yes**
  - **No**
- **Did Leader(s) enforce standards?**
  - **Yes**
  - **No**
- **Did individual know standard and was he/she trained on standard?**
  - **Yes**
  - **No**

**Suggested Corrective Action**
- Issue a corrective action request or deficiency notice addressing all causal factors/root causes. ***NOTE: These actions should occur for all mishaps, near miss unsafe unhealthful reports.***
- Support not responsible
- Correct Standards or write new Procedure; Retrain personnel
- Standards/Procedures not responsible
- Correct training; Retrain personnel
- Training not responsible
- Hold Supervisor/Leader accountable for enforcing rules or instructions
- Leader not responsible
- Issue corrective action request to the supervisor to provide a plan of action taken to address the specific issue
- Individual not responsible

**Causal factors** are human errors or equipment problems that directly led to the loss event or allowed the consequences of the event to be more severe. **Root causes** are the management system weaknesses that allowed the causal factor to occur. The root causes of the causal factors must be identified and corrected.
# SAMPLE MISHAP AND NEAR MISS ANALYSIS SHEET

<table>
<thead>
<tr>
<th>ESAMS Case Number</th>
<th>Date of Incident</th>
<th>Employee Name</th>
<th>Employee Job Title</th>
<th>Status</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA20111XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Prepared By</th>
<th>On Duty</th>
<th>Off Duty</th>
<th>Restricted Work Days</th>
<th>Lost Work Days</th>
<th>Mission Days Lost</th>
<th>OSH Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist</td>
<td></td>
<td>Yes</td>
<td></td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>Organization</td>
</tr>
</tbody>
</table>

### What Happened

Describe what happened in great detail. Do not include names in this section. If more than one employee was involved, Employee A and Employee B may be used. Include pictures to show the scene of the incident.

**Support Failure** *(Equipment, Material, Supplies, etc.)*

**Standards Failure** *(SOP, JHAs, etc.)*

**Training Failure** *(was correct, complete and sufficient training provided)*

**Leader Failure** *(are standards communicated and enforced)*

**Individual Failure** *(did not follow standards, tired, haste, self-induced fatigue)*

***Provide the details on what contributed to or caused the incident to occur.***

### Why Did It Happen?

(Causal Factors and Root Causes)

### What to do About It

Corrective Action Request (CAR)

Corrective actions will be a direct reflection of the causal factors and root causes identified during the mishap investigation.

---Provide details on the corrective action requests or deficiency notices issued to address the root cause/causal factors. List specific actions and interim controls (if needed). Include the corrective action ID number or deficiency notice number issued in ESAMS here as well.

### Causal Factor and Root Cause Determination

<table>
<thead>
<tr>
<th>Supervisor Comments (Corrective Actions Taken)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Failure</td>
</tr>
<tr>
<td>Standards Failure</td>
</tr>
<tr>
<td>Training Failure</td>
</tr>
<tr>
<td>Leader Failure</td>
</tr>
<tr>
<td>Individual Failure</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

The supervisor of the employee involved in the mishap or near miss will fill in the actions they took in response to the corrective action request or deficiency notice. List specific actions taken to include placement of interim controls.

***e.g., briefing employees on hazards, putting interim controls in place, calling in work orders, etc., ***

### Routing

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety Representative</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Supervisor</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Senior Management Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(The Supervisors Boss)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deputy Director</th>
</tr>
</thead>
</table>

---

**ENCLOSURE 6**
MEMORANDUM FOR
• SUMMARY
• SUBJECT
• REFERENCES
• INVESTIGATION TEAM MEMBERS
• APPROVAL PROCESS
  – Investigation Board
  – Safety
  – Commander or Director
• PURPOSE
• BACKGROUND
• DESCRIPTION-WHAT HAPPENED
• FINDINGS-WHY DID IT HAPPEN
  – Human factor
  – System inadequacies
  – Environmental factors
• CONCLUSIONS
  – Direct (or Primary) Cause
  – Indirect cause(s)
  – Contributing factor(s)
  – Root Cause(s)
• RECOMMENDATIONS
  – Corrective Action Request or Deficiency Notice issued
  – After action review
  – Lessons learned
• ENCLOSURES
  – Pictures
  – Mishap Near Miss analysis sheet
  – Other supporting documents (SOP, JHA, manufacturer’s instruction of use, etc.).
GLOSSARY

PART 1. ABBREVIATIONS AND ACRONYMS

CONUS  Continental United States
DA PAM  Department of the Army Pamphlet
DASHO  Designated Agency Safety and Health Official
DHRS-I  DLA Human Resources Services Injury Compensation Office
DLA  Defense Logistics Agency
DLAI  Defense Logistics Agency Instruction
DoD  Department of Defense
DS-O  DLA Occupational Safety and Health Directorate
ESAMS  Enterprise Safety Applications Management System
FOUO  For Official Use Only
IDLH  Immediately Dangerous to Life and Health
OCNOUS  Outside the Continental United States
OSH  Occupational Safety and Health
OSHA  Occupational Safety and Health Administration
PII  Personally Identifiable Information
PLFA  Primary Level Field Activity
PPE  Personal Protective Equipment

PART II. DEFINITIONS

Designated OSH Staff. Staff identified as responsible for providing OSH guidance and support to meet OSH requirements for all DLA organizations at a DLA location (Conus or OConus).

Mishap. An unintended event resulting in injury, illness or property damage.

Near Miss. An undesired event that, under slightly different circumstances, would have resulted in personal harm, property damage, or an undesired loss of resources (e.g., an employee standing next to a door talking was almost struck by the door when a coworker opened the door, an employee tripped on an uneven walking surface but no fall or injury occurred, a forklift backing down an aisle almost hit an employee).

Serious Mishap. A mishap resulting in patient hospitalization, any fatality or property damage equal to or greater than $2 million.