DEPARTMENT OF DEFENSE

ANNUAL OCCUPATIONAL SAFETY & HEALTH REPORT

TO THE SECRETARY OF LABOR

CALENDAR YEAR 2020

4000 Defense Pentagon

Washington, DC 20301-4000

The estimated cost of this report for the Department of Defense is approximately $485,000 for the 2021 Fiscal Year. This includes $9,000 in expenses and $476,000 in DoD Labor.

Generated on 2021Apr16 RefID: 8-BB8A7E5

AGENCY INFORMATION:

1. Where is the occupational safety and health (OSH) function located within your agency's organizational structure?

Response: The OSH function within the Office of the Secretary of Defense (OSD) is led by the Director of Force Safety and Occupational Health (FSOH). The FSOH office is located within the Office of the Assistant Secretary of Defense for Readiness (OASD(R)), within the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)). The FSOH office develops OSH policy, provides OSH oversight of the DoD Components, develops defense planning guidance, and provides resource advocacy for the DoD Components' OSH programs in order to implement Occupational Safety and Health Administration (OSHA) and DoD OSH policies. The ASD(R) is the DoD Designated Agency Safety and Health Official (DASHO). Each of the DoD Components has appointed a DASHO to provide executive-level oversight of OSH programs and responsibilities. The locations of the DoD Agency DASHOs and the descriptions of their organizational structure are detailed within their individual OSH reports, included as Appendices to this report.

2. Describe how your agency engages employees in safety and health, and include examples.

Response: Employee engagement is a key component of effective DoD OSH programs and safety and health management systems. Employee participation is encouraged and solicited from individuals throughout all levels of the agency. Examples of employee OSH engagement include:

- Serving as collateral duty safety representatives or assistants for their workplace.
- Serving as OSHA Voluntary Protection Programs (VPP) team members at their work site or as Special Government Employees mentoring and assessing work sites for other employers.
- Performing workplace inspections to identify and report hazards to supervisors.
- Using leaders' open door policies to quickly report unsafe conditions or acts.
- Using anonymous hotlines, supported by strong whistleblower protection programs, to report unsafe conditions.
- Using command web portals to report hazards and submit ideas, observations, and concerns.
- Completing general and safety-specific organizational climate surveys.
- Serving as employee representatives on safety advisory councils.
- Providing direct feedback during training sessions and safety stand-down activities.
- Conducting interviews during command inspection programs, special interest surveys, and command requested surveys.

3. Describe your agency's goals and discuss how your agency's OSH program aligns with the organizational mission.

Response: DoD is a department within the executive branch of the Federal Government. The mission of the DoD is to provide military forces to deter war and protect the security of the

United States. The DoD is the largest employer in the world, with over 810,000 civilian employees, approximately 1.4 million men and women on active military duty, and 800,000 National Guardsmen and Reservists. The DoD is composed of three Military Departments; five Military Services, four national intelligence services (the Defense Intelligence Agency, National Security Agency, National Geospatial-Intelligence Agency, and the National Reconnaissance Office) and more than 20 other Defense Agencies and DoD Field Activities, each with a distinct and specialized capability in support of the Department's overarching mission. The Defense Agencies and DoD Field activities are as follows: Defense Logistics Agency, Defense Contract Audit Agency, Defense Contract Management Agency, Defense Counterintelligence and Security Agency, Defense Commissary Agency, Defense Finance and Accounting Service, Defense Health Agency, Defense Information Systems Agency, Defense Media Activity, DoD Education Activity, Defense Threat Reduction Agency, Missile Defense Agency, Army and Air Force Exchange Service, Washington Headquarters Services (WHS), and the Uniformed Services University of the Health Sciences. All of these DoD Components' OSH Programs were reviewed in order to complete the DoD's annual report. Those Defense Agencies and DoD Field Activities not listed obtain their OSH support from WHS.

In CY 2020, FSOH developed a draft strategic plan with DoD goals and objectives for safety and occupational health (SOH) programs. This plan supports and aligns with the strategic plan of the Under Secretary of Defense for Personnel and Readiness. The purpose of this plan is to provide the Defense Department an SOH strategy designed to reduce risk, improve mission readiness, reduce mishaps, preserve resources, and execute effective SOH programs across the DoD. The plan articulates the goals, objectives, and measures the DoD will track and accomplish across the organization. A Department-wide approach that synchronizes, aligns, and leverages best practices within the organization will allow us to collaboratively focus on the SOH aspects of our missions and meet the prescribed goals and objectives presented in the strategic plan. The following goals support the National Defense Strategy to restore military readiness and build a more lethal force. The following goals and objectives represent a collaborative, enterprise approach to target SOH areas for improvement.

Goal 1. Promote a Positive DoD SOH Culture. Enhance a proactive, preventive "SOH Culture" across the DoD to ensure senior leaders and all DoD personnel regularly engage, focus, and advocate the importance of SOH.

- Objective 1: Develop and manage DoD and DoD Component SOH program and performance goals that enhance a proactive, preventive SOH culture.
- Objective 2: Ensure all SOH issuances are current and modernized with risk management techniques.
- Objective 3: Leverage Services SOH communication plans for senior leaders (Office of the Secretary of Defense (OSD) and DoD Components) to regularly engage on mishap prevention and lessons learned sharing.
- Objective 4: Develop a standard set of minimum requirements and a recognition program for DoD SOH Management Systems (SOHMS).

Goal 2. Ensure SOH Information is Accessible across the DoD. Improve SOH information accessibility and sharing within DoD, leveraging information to prevent future mishaps, injuries, occupational illnesses, and damage to government property.

- Objective 1: Identify a centralized DoD knowledge management and information technology approach that maximizes the use of existing resources to institutionalize and leverage information accessibility and sharing, including risks, leading indicators, lessons learned, hazards, near misses, and recommendations across the DoD to include: securing funding for the system identified, and implementing the system.
- Objective 2: Improve availability and use of data (military injury and occupational illness medical treatment, civilian work-related injury and occupational illness, OSHA 300 Series, and mishap data) for SOH risk management and mishap and loss prevention.
- Objective 3: Define and implement DoD Safety Business Enterprise Architecture (BEA) for all DoD systems to include common processes, definitions, data elements, and lists of values that enable effective analysis and information sharing.
- Objective 4: Define and implement DoD Occupational Health legal and user requirements in all DoD systems (e.g. Defense Occupational Environmental Health Readiness System (DOEHRS)).
- Objective 5: Integrate DOEHRS data with centralized DoD knowledge management and information technology system.

Goal 3. Reduce SOH Risks across all DoD Operations.

- Objective 1: Assess current and potential new risk-based leading and lagging indicators for performance measurement. Implement, validate, and monitor reporting of approved measures.
- Objective 2: Evaluate, recommend, and implement mishap classification updates to better examine the linkages between causes, corrective actions, and readiness, and focus on those that are successful in preventing additional mishaps and illnesses.
- Objective 3: Evaluate and recommend mishap classification cost thresholds by mishap category to improve visibility of high-impact, lower cost mishaps.
- Objective 4: Reduce time to correct identified hazards from investigations, inspections, employee reports, workplace safety and occupational health risk assessments, and hazard and close-call reports.
- Objective 5: Develop and issue DoD-specific policy for SOH risks not sufficiently controlled by existing regulatory standards or DoD policy.

Goal 4. Resource SOH Programs. Ensure SOH programs are adequately planned, programmed, budgeted and executed (PPBE) – including staffing – in order to support program requirements and SOH responsibilities.

- Objective 1: Develop and track the percent of required program management resources that are funded for each DoD Component in the Future Years Defense Program (FYDP).
- Objective 2: Ensure qualified SOH personnel meet staffing and competency requirements, including mission critical positions.
- Objective 3: Recruit and retain personnel in all SOH-related job series.

Goal 5. Advocate for SOH Technologies and Solutions. Research and implement modern technologies and solutions to meet SOH requirements and reduce mishaps, injuries, illnesses, and property damage.

- Objective 1: Secure DoD-wide funding for demonstration and validation of SOH technologies and solutions focused on reducing risk and preventing mishaps.

- Objective 2: Develop and implement process for vetting, prioritizing, and testing SOH technologies and solutions.
- Objective 3: Advocate and implement successfully demonstrated SOH technologies and solutions, and validate implementation results in corrective actions and mishap reduction.

The goals and objectives in this strategic plan will be implemented across the DoD with oversight and direction provided by the Defense Safety Oversight Council (DSOC). The DSOC is made up of senior leaders at the Under Secretary of Defense level. It is the DoD's senior departmental governance, decision-making, and oversight body for safety and occupational health. The DSOC provides direction and oversight of DoD-wide efforts to reduce mishaps, incidents, and occupational illnesses and injuries. The Chair of the DSOC is the USD(P&R). DSOC membership consists of the Under Secretaries of Defense, Under Secretaries of the Military Departments, Vice Chiefs of Staff of the Army and Air Force, Vice Chief of Naval Operations, Vice Chairman of the Joint Chiefs of Staff, and the Assistant Commandant of the Marine Corps.

4. Describe, and provide examples of, any agency-specific hazardous work activities that affect/impact employee safety and health.

Response: Protection of worker health involves well-trained and engaged leaders, supervisors, and employees at all levels within the organization. DoD personnel engage in a variety of activities with physical, chemical, and biological hazards that have the potential to impact employees' safety and health. Examples of hazardous work activities with physical and chemical hazards include aircraft, ship, and heavy weapon systems maintenance; ship building and breaking; armament demilitarization; underwater testing and maintenance; testing of new equipment and weapons systems; operation and maintenance of historic properties and equipment; and support to tactical ground, surface, sub-surface, and aviation operations in austere environments inside and outside the United States. DoD personnel are exposed to biological hazards during workplace operations such as medical treatment, dental care, veterinary care, and research and development in both fixed and temporary facilities. This year's pandemic and associated introduction of SARS-CoV-2, the virus that causes coronavirus 2019 (COVID-19) illness, required all supervisors – from the Secretary of Defense to front-line workplace supervisors – to evaluate the risk of COVID-19 and implement workplace controls to prevent disease transmission and protect the workforce.

5. If your agency has employees working overseas, how does your agency ensure their safety and health and advise them of applicable OSHA-mandated programs?

Response: DoD conducts worldwide operations and thus has personnel working overseas. DoD policy, DoD Instruction (DoDI) 6055.01, "DoD Safety and Occupational Health Program," (available at *https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605501p.pdf?ver=2018-11-19-110543-180*) directs the DoD Components to follow OSHA standards in all DoD operations worldwide. DoD Components follow the same approach at their level in applying their OSH program to protecting Component personnel. In foreign countries where the DoD employs local

national employees, DoD applies the more protective of host-nation OSH standards and OSHA standards. For uniquely military operations (as defined in 29 CFR 1960.2(i)) where military necessity makes compliance with OSHA standards impracticable, infeasible, or inappropriate, the DoD Components must assess the risk and apply risk mitigation actions. Leaders and supervisors must communicate the results of risk management decisions to all affected personnel.

AGENCY ASSESSMENT:

Attribute 1. Effective safety and health self-inspections are performed regularly.	Attribute needs minor improvements.

Please provide your rationale for your rating of Attribute 1.

Response: DoDI 6055.01 requires all organizations within the DoD to conduct annual safety and health inspections of all workplaces and report inspection status as part of their SOH program management review (PMR). This policy requires increased inspection frequency for high-risk operations (i.e., those operations that change over the course of the year or operations with elevated mishap experience). These inspections are documented at local and Command levels. Workplace hazards identified during these inspections are assessed, documented, and tracked within installation hazard abatement plans and in the Defense Occupational and Environmental Health Readiness System – Industrial Hygiene (DOEHRS-IH).

How has COVID-19 impacted your agency's performance of Attribute 1?

Response: The COVID-19 pandemic resulted in the delay of the completion of some annual workplace inspections, particularly during the second and third quarters of the Calendar Year. Early on in the pandemic (March 2020), workplaces were restricted to key and essential personnel, remote work was maximized where possible, and travel was restricted. This severely hampered the ability to complete workplace inspections. Inspection focus was placed on higher-risk locations. Collateral duty safety officers conducted annual inspections that may otherwise have been completed by full-time safety and health professionals.

Were all workplaces inspected in 2020? No
If not, what percentage of workplaces were inspected?

Response: The percentage of workplaces inspected was not specifically recorded. The DoD DASHO requires the Military Departments and DoD Defense Agencies to complete an annual SOH PMR where this statistic is reported. No agencies reported less than 80% completion of their annual workplace inspections and DoD Components reported an inspection focus on high-risk work areas.

What steps are being taken to ensure all locations will be inspected in 2021?

Response: The DoD aims to complete all workplace inspections when it is safe to increase travel and have more personnel in the workplace. COVID-19 remains a moderate-to-high risk in many geographic and work locations and many personnel are still conducting operations remotely. In the meantime, the DoD will focus attention on conducting more directed inspections of workplaces that have the potential to cause the greatest harm or injury to personnel. It is estimated that it will be late 2021 before DoD has lifted all COVID-19 related travel restrictions so that routine inspections can be performed.

Who conducts these inspections?
☒ Supervisors and Managers ☒ Safety and Health Professionals
☒ Other Staff, please describe: Collateral duty safety personnel and trained employees.

Please provide the percentage for each inspection type: DoD only tracks scheduled annual inspections as required by 29 CFR Part 1960.25(c). DoD does not make distinctions between a 'formal' vs an 'informal' inspection.

Announced	100%	Unannounced	0%	Formal	100%	Informal	0%

Please describe how your agency tracks abatement of hazards and adheres to abatement dates.

Response: DoD Components have systems in place to track identified workplace hazards, corrective actions, and risk management actions at local (installation), regional, and enterprise-wide levels following the risk management procedures prescribed in DoDI 6055.01, "DoD Safety and Occupational Health (SOH) Program" (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605501p.pdf?ver=9w5ACMyAR4HKrYamZVQY7w%3d%3d*). DoD Component safety and health offices track identified hazards and associated controls using information management systems like the Air Force Safety Assessment System (AFSAS). Integrated functional committees composed of workplace, facilities management, and safety and health representatives (e.g., OSH, facilities and engineering, fire and life safety, human resources) meet regularly to collaboratively address workplace hazards and to develop hazard controls and risk management recommendations for implementation by senior leaders and managers. Hazards are routinely reviewed, controls identified, and abatement planned as part of a formal unit or installation hazard abatement plan. DoD established a performance metric of the average number of days to abate a hazard with the objective of reducing the time to abate. The Military Department DASHOs report this metric to the DoD DASHO during the annual safety and occupational health program management review.

Attribute 2. Effective safety and health rules and safe work practices are in place.	Attribute is highly effective.

Please provide your rationale for your rating of Attribute 2.

Response: The DoD has established policies and procedures for occupational safety and health that incorporate OSHA and other Federal Agency requirements and include DoD-specific SOH requirements where DoD has determined that Federal Agency standards are insufficient to

manage the risk. Examples of DoD Policies include: DoDI 6055.01, DoDI 6055.05, DoDI 6050.05, "DoD Hazard Communication Program," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605005p.pdf?ver=2019-06-10-101510-927);* DoDI 6055.04, "DoD Traffic Safety Program," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605504p.pdf?ver=2019-04-04-095235-350)*; DoDI 6055.07, "Mishap Notification, Investigation, Reporting and Record Keeping," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605507p.pdf?ver=2018-11-20-081332-067)*; DoDI 6055.08, "Occupational Ionizing Radiation Protection Program," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605508p.pdf?ver=2019-04-04-095236-493)*; DoDI 6055.11, "Protecting Personnel from Electromagnetic Fields," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605511p.pdf?ver=2019-04-04-095225-447)*; and DoDI 6055.12, "DoD Hearing Conservation Program," (*https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605512p.pdf?ver=2019-08-14-073309-537).* DoD Components have more specific policies and procedures to comply with OSHA, DoD, and additional DoD Component requirements. The DoD Components develop and conduct employee training to ensure the workforce understands their roles and responsibilities in protecting themselves and their fellow workers in the workplace.

How has COVID-19 impacted your agency's performance of Attribute 2?

Response: COVID-19 is a new workplace hazard with the potential to impact the health of personnel in all DoD workplaces. Existing DoD SOH policies and procedures were expanded to address COVID-19 hazard identification and risk management procedures within all DoD workplaces and operations. COVID-19 risk management has involved the implementation of engineering and administrative controls to protect DoD personnel from COVID-19 exposure following both the Centers for Disease Control and Prevention (CDC) and OSHA workplace protection guidelines. Specific DoD policies and guidance documents focused on the protection of the health and safety of DoD personnel during the COVID-19 pandemic to include: workplace safety, travel, the wearing of face masks, other non-pharmaceutical interventions, and COVID-19 testing. These guidance documents can be found on the following DoD websites: https://www.defense.gov/Explore/Spotlight/Coronavirus/Latest-DOD-Guidance/ and *https://health.mil/Military-Health-Topics/Combat-Support/Public-Health/Coronavirus*.

How does your agency communicate these rules and practices? Please select all that apply.

☒ Written manuals and guidance

☒ Verbal instructions or directions

☒ Websites and emails

☒ Other communication, please describe: Organizational bulletin boards, weekly SOH meetings, newsletters, intranet, safety campaigns focused on specific events (e.g. holiday safety, 100 Days of Summer)

How can employees report hazards? Please select all that apply.

☒ Electronic (form, email, website, etc.)

☒ Inform safety personnel

☒ Inform supervisor or manager

☒ Anonymous reporting

☒ Other method, please describe: Commander's open door policies, climate surveys.

How does your agency encourage employees to report hazards? Please provide examples.

Response: DoDI 6055.01 directs the DoD Components to establish procedures for supervisors and employees to identify and promptly report unsafe or unhealthful working conditions. Each of the Components have specific reporting procedures that are unique to work locations and provide the most efficient process for reporting workplace hazards. Supervisors and employees are trained in local procedures for reporting workplace hazards and encouraged to report hazards without fear of reprisal. This is often a highlighted topic during employee and supervisor orientation training. Reporting procedures include provisions for streamlined reporting, employee anonymity if desired, a prompt and impartial investigation of reprisal allegations if they occur, and administrative action when allegations are substantiated. Many of the DoD Components have published specific policies and procedures for reporting hazards — typically involving the use of the supervisory chain or organizational safety staff. Examples of ways employees are encouraged to report hazards include: recognition programs to acknowledge those who collaborate with safety professionals in mitigating and identifying workplace hazards, installation safety offices that advertise reporting methods on bulletin boards throughout assigned organizations; and on-line, web-based hazard reporting systems made available to employees and supervisors through organizational intranet.

Attribute 3. Hazard incidence data are effectively analyzed.	Attribute needs minor improvements.

Please provide your rationale for your rating of Attribute 3.

Response: DoDI 6055.07, "Mishap Notification, Investigation, Reporting and Record Keeping," establishes consistent requirements and procedures for the DoD Components to conduct mishap investigations which involve the collection, aggregation, and analysis of mishap data. Mishap investigations inform DoD leadership for them to make decisions about risk management and mishap prevention. This includes the collection and analysis of human performance data, human factors, reports of human error, and materiel failure. This information is maintained by each DoD Component as part of mishap investigation records. The DoD is conducting a comprehensive data reform initiative to standardize and improve on safety data collection, analysis, and reporting to improve the ability to share lessons learned for risk mitigation across DoD.

The DoD has some of the lowest civilian employee injury and lost time case rates among all Federal agencies. Since 2009, DoD's total injury and lost time case rates have steadily declined by approximately 65% and 57%, respectively; see Table below. The DoD Components attribute these reductions to early reporting of safety and health hazards; engaged, well-trained, and motivated employees, supervisors, and SOH staff; a commitment to continuous improvement at all levels in implementing SOH management systems (SOHMS); and OSHA VPP and other SOHMS recognition program implementation at major industrial installations with the largest concentration of civilian employees and most significant hazards.

Table. DoD Injury and Illness Rates, 2009-2020*

Fiscal Year	Total Case Rate	% Change from Previous Year	% Change from 2009	Lost Time Case Rate	% Change from Previous Year	% Change from 2009
2009	2.76	--	--	1.48	**--**	--
2010	2.58	↓ 6.5	↓ 6.5	1.41	↓ 4.7	↓ 4.7
2011	2.44	↓ 5.4	↓ 11.6	1.33	↓ 5.7	↓ 10.1
2012	2.27	↓ 7.0	↓ 17.8	1.23	↓ 7.5	↓ 16.9
2013	2.08	↓ 8.4	↓ 24.6	1.11	↓ 9.8	↓ 25.0
2014	2.10	↑ 0.96	↓ 23.9	1.15	↑ 3.6	↓ 22.3
2015	1.89	↓ 10.0	↓ 31.5	1.06	↓ 7.8	↓ 28.4
2016	1.63	↓ 13.8	↓ 40.9	1.05	↓ 1.0	↓ 29.1
2017	1.50	↓ 8.0	↓ 45.6	1.02	↓ 2.9	↓ 31.1
2018	1.40	↓ 6.7	↓ 49.3	0.95	↓ 6.9	↓ 35.8
2019	1.10	↓ 21.4	↓ 60.1	0.71	↓ 25.3	↓ 52.0
2020	0.96	↓ 12.7	↓ 65.2	0.64	↓ 9.8	↓ 56.8

* Data source: Federal Agency Program Injury and Illness Statistics. (https://www.osha.gov/enforcement/fap/statistics)

How has COVID-19 impacted your agency's performance of Attribute 3?

Response: The COVID-19 pandemic necessitated efforts to prevent COVID-19 transmission within the DoD community and resulted in a decrease in employees in the workplace to teleworking from their homes. COVID-19 had minimal impact on the management of mishap data.

Please identify the information included in your agency's incidence data. Select all that apply.

☒ Number and types of near misses

☒ Failure to use specified PPE

☒ Number of OSHA non-compliance incidents

☒ Number of workers without required training

☒ Other information, please describe: Mishaps tracked by mishap cost (i.e., resultant cost exceeding a specified threshold and whether the mishap resulted in a death, or hospitalization, or permanent total or partial disability): mishap resulting in amputation, loss of eyesight, hearing loss, days away from work or restricted duty; whether the mishaps involved a wheeled vehicle, aircraft, explosive, weapon, or pedestrian; OSHA citation and type of violation.

Does your agency's analysis include the following? Select all that apply.

☒ Identifying injury types

☒ Detecting trends and patterns

☒ Setting priorities for hazard corrections ☒ Identifying workers most impacted
☒ Other information, please describe: Mishap classification, special reporting groups, and contents of mishap investigation reports. Complete details are found in DoDI 6055.07 at *https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/605507p.pdf?ver=2018-11-20-081332-067*.

Attribute 4. A review of the overall safety and health management system is conducted at least annually.	Attribute needs minor improvements.

Please provide your rationale for your rating of Attribute 4.
Response: DoDI 6055.01 policy regarding SOHMS requires DoD organizations at all organizational levels to self-assess their program performance annually and receive an external assessment at least every four years. The DoD DASHO performs an annual SOH Program Management Review of each DoD Component with the respective Component DASHO.

The DoD continues to operate the DoD Safety Management Center of Excellence (SMCX) (https://www.smscx.org/). Since 2006, the SMCX has provided tailored, site-specific SOHMS support to organizations throughout the DoD. The SMCX is composed of subject matter experts who provide support in the following areas: SOHMS implementation, information sharing, safety and health compliance and training, employer-employee relations, and culture change. Specific elements of support include technical assistance visits, compliance reviews and gap analyses, on-site assessments and audits, and safety training. The SMCX assists organizations prepare for and achieve external recognition programs as OSHA's VPP Star or the Army or Navy Star Programs. The Figure below identifies the 162 sites that been recognized as Stars as of April 2021.

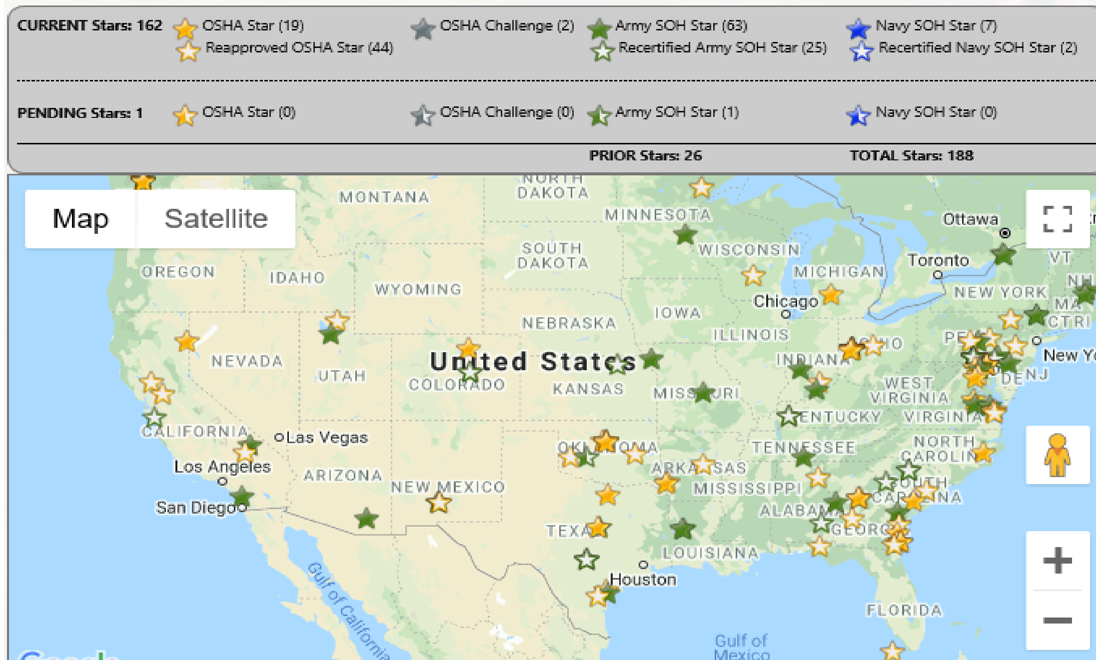

Figure. Organizations within the Continental U.S. whose SOHMS have earned external recognition

How has COVID-19 impacted your agency's performance of Attribute 4?

Response: The COVID-19 pandemic had a moderate impact on attribute 4. DoD's COVID-19 travel restrictions resulted in a significant reduction in safety and health management system assessments. In addition, travel restrictions reduced SMCX visits for on-site technical assistance. Assessments were modified to provide for assessments and assistance using remote meeting capability.

Does your review include the following? Select all that apply.

☒ Written report
☒ Management briefed on results
☒ Management involvement
☒ Root cause analysis
☒ OSH accomplishments
☒ OSH system failures
☒ Other components, please describe: Completion of: Job hazard analyses, audiometric examinations, workplace inspections, and medical surveillance examinations. Tracking the number of personnel with unacceptable occupational exposures (i.e., where exposures exceed an established occupational exposure limit), and tracking the abatement of hazards and the time required to achieve abatement.

Does your review include leading indicators? Yes If yes, select all that apply.

☒ OSH training record review
☒ OSH budget review
☐ Tracking management participation in walkthroughs and inspections
☒ Employee perception survey on workplace safety
☒ Other leading indicators, please describe: Completion rate for audiometric and medical surveillance examinations and annual workplace surveys. Tracking the number of personnel with unacceptable occupational exposures (i.e., where worker exposures, without the use of personal protective equipment, exceed an established occupational exposure limit).

Does your review include lagging indicators? Yes If yes, select all that apply.

☒ Review of OSHA recordables
☒ Workers' compensation cost review
☒ Other lagging indicators, please describe: hearing loss rates, number of fatalities, number of aviation and motor vehicle mishaps, repeat OSHA violations.

Provide examples of tracking hazard abatement and adhering to correction dates.

Response: DoDI 6055.01 requires each installation to track hazard abatement in an installation hazard abatement plan. The plan prioritizes abatement by risk level as measured by a "Risk Assessment Code". DoD Components have individual procedures and information management systems to support this tracking. At the local level, SOH committees composed of commanders, workplace supervisors, facilities management staff, and safety and health representatives (e.g., OSH, facilities and engineering, fire and life safety, human resources, and bargaining unit representatives) actively track the status of hazard abatement actions. DoD reviews the timeliness of hazard abatement during annual SOH PMRs. Workplace health hazards are identified in the DoD standard industrial hygiene information management system, DOEHRS-IH.

Describe what reviews were conducted in CY 2020 to identify improved methods for ensuring the safety and health of your agency's employees and discuss how these methods were or are being implemented.

Response: The DoD DASHO uses this OSH report to assess all the DoD Components' OSH Programs. In addition, the DoD DASHO receives a detailed SOH PMR from all of the DoD Components annually. During these PMRs, the DoD Components report program effectiveness using leading indicators of program performance (e.g., safety and health management system implementation, completion of workplace inspections, timeliness of hazard abatement, occupational medicine examination completion rates) and lagging indicators (e.g., number of mishap fatalities, total cases of injuries, total cases of injuries resulting in job restriction or days away, rate of permanent threshold shifts for hearing loss). During the PMR, DoD Components also request assistance from the DoD DASHO for program improvements.

Provide an overall assessment of your agency's approach to root cause analysis and identify who is responsible for implementing changes based on the findings from investigations.

Response: DoDI 6055.07, "Mishap Notification, Investigation, Reporting and Recordkeeping," describes the specific DoD requirements and procedures for mishap investigation, reporting, and recordkeeping, and provides for consistency in mishap investigation procedures throughout the enterprise. All mishap investigators are trained, as a standard practice, to perform root cause analysis to consider root causes and to develop mishap findings, conclusions, and recommendations. Mishap findings and recommendations are provided to the affected unit leaders for implementation of recommendations and corrective actions. For fatalities within the Military Departments, mishap investigation recommendations and actions are tracked to completion by their respective Service Safety Centers. In addition to the standard DoD mishap investigation process, the DoD is conducting a comprehensive mishap data reform initiative to aid in mishap data collection and reporting to improve investigation consistency and completeness.

Attribute 5. Individuals with assigned OSH responsibilities have the necessary knowledge, skills, and timely information to perform their duties.	Attribute is highly effective.

Please provide your rationale for your rating of Attribute 5.

Response: In accordance with DoDI 6055.01, DoD Components must provide personnel with the SOH training and education necessary to competently fulfill their roles and responsibilities for implementing SOH program management and for SOH risk management. Commanders and Senior Management Officials provide education to leaders and supervisors at all levels on SOH policies, procedures, and initiatives in their organization and parent organizations. Supervisors are responsible for providing training on the risk management skills needed to implement the DoD Component and organization's SOH policies and programs throughout their assigned workplaces. Full-time SOH staff provide formal and informal training courses, educational programs, and other training to more junior SOH staff and to collateral duty SOH personnel to

ensure they can conduct inspections to recognize and report hazards within their workplaces and track the completion of necessary hazard abatement actions. In addition, the DoD is committed to providing continuing education and professional credentialing for SOH personnel through cost reimbursement or sponsorship programs.

How has COVID-19 impacted your agency's performance of Attribute 5?

*Response***:** COVID-19 response actions curtailed the ability to travel and for personnel to attend meetings and attend in-person training events. Because of this, many DoD-sponsored training and professional conferences and training courses migrated to remote or distanced-learning formats. In cases where in-person training was necessary, local training was conducted within current CDC and DoD guidelines regarding social distancing, mask-use, and sanitation protocols. Thus, this attribute remained highly effective during CY 2020.

Please indicate the training your agency provides to staff with assigned safety and health responsibilities (Safety Coordinators/Safety Committee members/Other OSH personnel). Select all that apply.

☒ Agency-provided classroom training
☒ OSHA Education Center training
☒ Agency-provided online training
☒ OSHA Training Institute courses
☐ OSHA FedWeek
☒ Professional organization training
☒ Other types of training, please describe: DoD component-specific safety training events associated with site-specific and job-specific tasks, supervisor's on-the-spot corrective training.

Attribute 6. Managers allocate the resources needed to properly support the organization's safety and health management system.	Attribute needs minor improvements.

Please provide your rationale for your rating of Attribute 6:

Response: DoDI 6055.01 requires DoD components to include sufficient resources to effectively implement the SOH Program in their planning, programming, budgeting, and execution processes. Commanders, managers, and supervisors are required to:

- Plan, program, and budget for resources required to implement SOH program requirements, and to manage the SOH risks in their organizations and during mission execution.
- Provide SOH staffing of sufficient quantities and technical competencies to assist in implementing the requirements of this instruction.
- Assign qualified SOH personnel to serve as SOH advisors to identify hazards and recommend elimination or mitigation, develop mishap prevention policies and programs, monitor safety performance; and to serve as points of contact for SOH matters. Staffing considerations include:
    - Quantity and mix of professional staffs.
    - Whether to assign SOH responsibility as a primary or collateral duty.
    - Professional qualifications. DoD recognizes licensure and professional certification as evidence of competency and supports all eligible DoD personnel to obtain and maintain licenses and accredited certifications.

    - The military grade or civilian grade levels of SOH officials.
    - Whether to use DoD personnel or contract for SOH services. Certain SOH functions are inherently governmental in nature and may not be outsourced to the private sector. In general, SOH positions providing policy making and direct advice to commanders, deployment and military contingency operations, and contracting officer technical representatives will not be contracted out. Where SOH services are contracted out, DoD personnel providing quality assurance oversight must have the necessary technical competencies for this oversight.
- Authorize expenses to obtain and maintain professional credentials.
    - Payment of costs associated with obtaining and renewing professional credentials, including professional accreditation, licenses, and professional certifications, and examinations to obtain such credentials is authorized.
    - Payment for licenses and certifications and their subsequent renewals may include, at the discretion of the activity and command, additional expenses such as dues or fees required by the licensing or certifying agency, fees for preparation for examinations, examinations, registration fees, and travel and per diem costs.

Since 2019, the DoD has been planning to develop a safety "program element" code for use by the DoD Components to capture and manage the costs of administering Component OSH programs. The aim is to gain better fidelity on the resource requirements for OSH program execution and management for use in future years' budget planning.

How has COVID-19 impacted your agency's performance of Attribute 6?

Response: Since the beginning of the COVID-19 pandemic, use of on-site safety and health professionals to conduct routine inspections and medical surveillance was disrupted as a large number of employees began working from their homes and available safety and health staff were directed to focus on higher risk activities, COVID-19 response actions, and the development of policies and procedures to prevent workplace transmission.

Please select the resources used.

☒ Encourage participation in FFSHCs	☒ Provide necessary PPE to employees
☒ Encourage participation in OSH committees	☒ OSH staff hired at appropriate GS level or equivalent
☒ Provide stipend for off-site OSH activities	☒ OSH budget exists and is easily identified
☐ Other resources, please describe:	

Attribute 7. There is an effective process to involve employees in safety and health issues.	Attribute is highly effective.

Please provide your rationale for your rating of Attribute 7:

Response: As described on page 1, paragraph 2 of this OSH report, employee involvement is a key component of DoD safety and health management systems and OSH programs. DoD safety policy provides opportunities for employees to participate in SOH programs. Leaders,

supervisors, safety and health professionals, OSH councils, and bargaining units encourage individual employees to participate in workplace inspections, hazard identification and assessment, hazard control recommendation, and corrective action implementation processes.

How has COVID-19 impacted your agency's performance of Attribute 7?

Response: The COVID-19 pandemic had some effect on this performance of this attribute caused by the requirement for many employees to work remotely and sustain distancing from co-workers.

Please indicate how your agency solicits OSH-related employee input:

☒ Posted notices
☒ Emails to employees
☒ OSH meetings with employee input
☒ Other input methods, please describe: Involvement of bargaining units representatives
☒ Stop work authority given to employees
☒ Suggestion box

COVID-19

Provide an overall assessment of your agency's response to COVID-19.

Response: Excellent

What precautions did your agency implement to protect employees from workplace exposure to SARS-CoV-2, the virus that causes COVID-19?

Response: The DoD established clear, concise COVID-19 policy, and published updates covering all aspects of the DoD mission to include SOH, following guidelines established by the CDC and OSHA. Beginning in March 2020, the DoD established a COVID-19 Task Force to systematically develop COVID-19 response actions necessary to protect DoD personnel while continuing DoD operations and to coordinate with other Federal agencies. Since March 2020, DoD published COVID-19 policy and procedure documents addressing: leave, telework, illness case reporting, wearing of face coverings and employment of other non-pharmaceutical interventions; institution of travel guidelines and restrictions; requirements for hand hygiene and distancing; isolation and quarantine requirements for personnel exposed or presumed to have been exposed to COVID-19; temporary suspension of some routine workplace safety inspections, surveys, and surveillance activities; increase in workplace housekeeping procedures; and modification of ventilation system operation to increase outside air circulation and filtration. DoD COVID-19 policies and procedures is found at https://www.defense.gov/Explore/Spotlight/Coronavirus/Latest-DOD-Guidance/.

Describe how your agency ensures that employees are aware of, implement, and practice COVID-19-related protocols?

Response: DoD Components developed COVID-19 training, often leveraging information technology communication platforms to inform and update the workforce. Policies and procedures were distributed to all DoD Component OSH managers directly, via e-mail, as soon as they became final. The DoD established a COVID-19 website, as shown above, where the

latest DoD policy and guidance documents were published. The OSHA COVID-19 website was checked daily for the publication of COVID-19 guidance and temporary enforcement criteria. This information was incorporated into DoD policy and procedures and distributed, via e-mail, to all DoD Component OSH managers as information was posted or updates occurred. COVID-19 updates and shared lessons were included in the monthly meetings of the Defense Safety Oversight Council Steering Group and the DoD Industrial Hygiene, Environmental Health, and the Occupational Medicine Working Groups whose members represent the DoD Component's OSH communities.

Describe your agency's policies/procedures for employees who test positive for COVID-19.

Response: The DoD established policy for COVID-19 testing which specified approved testing procedures, identified eligible populations for DoD COVID-19 testing, and prescribed actions that the tested individual would take based on the results of their COVID-19 test. Isolation requirements and associated timeframes are included within this policy for personnel who test positive. In addition, DoD policy described actions that personnel should take if they were exhibiting signs and symptoms of COVID-19 but who had not yet been tested and described quarantine requirements for personnel who had a close contact with someone confirmed to have had COVID-19. All policy requirements are aligned with CDC guidance. The policy is available for review at *https://www.whs.mil/Portals/75/Coronavirus/20210315%20FHP%20Guidance%20(Supplement%2015)%20Revision%201%20-%20DoD%20Guidance%20for%20COVID-19%20Laboratory%20Testing%20Services.pdf?ver=U-wyUTAq8L2p_ZOXp9pydQ%3d%3d.*

During CY 2020, did your agency exercise temporary enforcement discretion for provisions of OSHA standards, such as those for initial or recurring training, audits, reviews, testing, and assessments? Yes

If yes, please describe those discretionary measures:

Response: The DoD exercised temporary enforcement discretion for the provisions in 29 CFR 1910.137 governing the annual fit testing of health care workers (OSHA memorandum dated 14 March 2020). Annual fit tests of N-95 respirators for health care workers were waived if the same make and model of respirator was still being used. Additionally, the DoD temporarily suspended requirements to complete some occupational health exams (i.e., audiograms, spirometry, respiratory) in accordance with the 16 April 2020 OSHA memorandum. Most exams were reinstated in late summer (i.e., July-August) of 2020. In addition, annual workplace inspections were temporarily suspended for lower-risk work areas due to the limitations on group sizes, stay-at-home orders, and high percentage of personnel who were teleworking as described in OSHA's memo, "Discretion in Enforcement when Considering an Employer's Good Faith Efforts During the COVID-19 Pandemic", found at *https://www.osha.gov/memos/2020-04-16/discretion-enforcement-when-considering-employers-good-faith-efforts-during.*

MOTOR VEHICLE PROGRAMS

Please provide the total number of motor vehicle accidents your agency's employees were involved in while on duty: 812

Is your agency in compliance with E.O. 13043, which requires wearing a seatbelt? Yes
If you answered "no," how does your agency plan to achieve compliance with the E.O.?

Is your agency in compliance with E.O. 13512, which bans texting while driving? Yes
If you answered "no," how does your agency plan to achieve compliance with the E.O.?

Summarize any CY 2020 changes to your agency's motor vehicle program, along with any initiatives your agency plans to implement in CY 2021.

Response: OSD reports weekly statistics to DoD leaders on motor vehicle (e.g., 4-wheeled, 2-wheeled) mishaps that result in $2.0 million (or more) of damage or that result in a Service member's death. This information is closely tracked for lessons learned that can be applied throughout the Department. In CY 2020, the DoD Motor Vehicle Working Group and OSD identified specific changes needed in the revision to DoDI 6055.04. Currently, the policy focuses on general traffic safety requirements. Updates to the policy will include mandatory motor vehicle operator safety training, mishap investigation procedures, rules for pedestrians, updated motorcycle operations considerations, personal transportation device considerations, and traffic safety program metrics. The revision to DoDI 6055.04 will occur in CY 2021-CY2022. In addition, the DoD is focusing on human fatigue issues associated with total force fitness and sleep deprivation monitoring as a leading indicator of mishaps, to include mishaps associated with motor vehicle operations.

DoD Component leaders, supervisors, and OSH managers encourage DoD personnel to use vehicles that feature safety technologies (e.g., back-up cameras, lane assist). Fortunately, most rental vehicles possess these technologies and the General Services Administration and DoD are acquiring vehicles with these added safety features when procuring new vehicles.

OSH TRAINING:

Please list the safety training courses your agency provided in CY 2020.

Response:
Aircraft Mishap Investigation Course
Aviation Safety Program Management
Safety and Accident Investigation Board President Course & Chief of Safety Course
Human Factors Workshop for Safety Professionals
Mishap Investigation Non-Aviation
Risk Management
Safety Manager Course
Commanders and Supervisors: Immersion training to familiarize them with related safety responsibilities and concerns.
Occupational Safety professionals: Occupational Safety Apprentice Course; Occupational Safety Craftsman Course
Occupational Health professionals: Bioenvironmental Engineering Apprentice Course; Bioenvironmental Engineering Officer Course; Occupational & Environmental Health Measurements Course

Unit Safety Representatives (Collateral Duty Safety)
Supervisors: Supervisors Safety Training
Hazard Communication program
OSHA Rights
Emergency Response
Fire Extinguisher Use
Injury/Incident/Hazard Reporting
Active Shooter
Fire Escape
Severe Weather
Lockout/Tagout (LOTO) for Affected Personnel
Respiratory Protection
Hand Tool Safety
Powered Hand Tool Safety
Compressed Gas Cylinder Safety
Hearing Conservation
Banding Safety
Compressed Air Safety
Permit-Required Confined Space Entry
Alert, Lockdown, Inform, Counter, and Evacuate Training
Hexavalent Chromium Safety Training
Retail Safety
Globally Harmonized System (GHS)
Bloodborne Pathogen Awareness
Material Handling Equipment Safety
Union Safety
Onboarding and Safety
Cadmium Annual Safety Training,
Safety Cleaning/Handling of Cadmium Contaminated PPE
Motor Vehicle Traffic Safety Training
Personal Protective Equipment
COVID-19 Awareness
Mishap Reporting
OSHA Reception Plan
Contractor Site-Specific Safety
Ergonomics
Disaster and Emergency Preparedness
Explosives Safety
Introduction to Radiation
Virtual Air Operations Symposium
Pre-Deployment Safety
Safety Management Systems Integration Team
Certified Safety Professional Preparation Course
OSHA 10-Hour General Industry: Industrial Hygiene
Holiday Safety
Bicycle Safety

Swimming Safety
Travel Safety
Wildfire Safety
Recreational Boating
Risk Management
Sharps management/needlestick prevention
Job Hazard Analysis
On-duty off-duty safety
Slips, Trips, Falls
Asbestos Awareness
Distracted Driving
Office Safety
Motorized Scooter Operation
Certified Playground Safety Inspector
Chip Guard Training
Hazardous Waste Operations and Emergency Response
Heat Stress
Winter Driving Safety
Local Area Traffic Safety Orientation
Construction Safety Standards
Emergency Asbestos Response Team
Facility Response Team
General Industry Safety Standards
Hazardous Material Control and Management Technician
Hazardous Substance Incident Response Management
Incident Command System
Industrial Noise
Introduction to Hazardous Materials [Ashore]
Introduction to Industrial Hygiene for Safety Professionals
Introduction to Navy Occupational Safety and Health [Ashore]
Oil Hazardous Substance Spill Response Tabletop Exercise
Safety Programs [Afloat]
Tank Managers
Radiofrequency Hazards
Static Electricity Hazards
Proper Lifting
Raised Floor Safety
Launch Hazard Safety Briefing
Cold Weather Driver Training
Personal Fall Protection System
Machine Guarding
Electrical Safety
Ladder Safety
Fall Protection
Warehouse Safety
Silica Hazards

Cardiopulmonary Resuscitation/Automatic External Defibrillator Operation
Temperature Screening
Smoke Detector Operation
Compressed Cylinder Safety
Arc Flash Explosion
Back-in-the-Saddle (BITS)
First Aid
Forklift Operation
Ground Safety Officer
Recreational Off-duty Safety
Chemical Hygiene
Regulated Medical Waste
Safe Handling of Liquid Nitrogen, and Formaldehyde
Safe Handling of Controlled Substances
Overhead cranes and hoists
Powered Industrial Trucks
Report, track and investigate ac
Self-propelled vehicle use
Incidents and property damage
Great Lakes-OSHA Occupational Health & Safety Courses
OSHA 6005 Collateral Duty for Other Federal Agencies by Georgia Tech (Virtually)
OSHA 6015 Occupational Safety & Health Course for Other Federal Agencies by OSHA Training Institute Chicago (prior to pandemic)
OSHA 2225 Respiratory Training by the OSHA Training Institute Keene State College
OSHA 510 Standards for the Construction Industry by the OSHA Training Institute Keene State

Describe the training platforms used (e.g. classroom, online, drill, practical) in CY 2020.

Response: Many training events were offered in an on-site classroom setting prior to March 2020 and the beginning of the COVID-19 restrictions. After March 2020, most training was conducted using distance learning, and online capabilities through organization intranets and meeting platforms such as Microsoft Teams®.

PRODUCT SAFETY:

Describe how your agency ensures that the products and services it procures comply with the product safety requirements of 29 CFR § 1960.34, including the use of Safety Data Sheets (SDSs).

Response: DoDI 6050.05, “DoD Hazard Communication”, prescribes the requirement for the DoD Components to establish a Hazard Communication (HAZCOM) Program that requires the chemical manufacturer and distributor of hazardous chemicals to provide SDSs to the Component’s HAZCOM official or designated point of contact. The requirement to provide SDSs is found within Defense Federal Acquisition Regulation Supplement Subpart 223.3, “Hazardous Material Identification and Material Safety Data” (*https://www.acq.osd.mil/dpap/dars/dfars/pdf/r20180530/223_3.pdf*). The Defense Logistics Agency maintains a “Hazardous Materials Information Resources System”, available for use by

all DoD Components, which includes SDS information and product safety requirements for over 500,000 hazardous materials in use within the DoD.

Does your agency have policies that address chemicals in fragrances, such as those in perfumes and air-fresheners? No
If yes, please describe those policies: N/A

WHISTLEBLOWER PROTECTIONS:

Does your agency have a written anti-retaliation policy for employees who report unsafe or unhealthy working conditions? Yes

Describe any changes to your agency's Whistleblower Protection Program in CY 2020:

Response: No changes to the DoD Whistleblower Protection Program and anti-retaliation policies were reported in CY 2020.

How do employees report retaliation?

Response: DoDI 6055.01 mandates that DoD personnel have the right to decline performance of an assigned task because of a reasonable belief that the task poses an imminent risk of death or serious bodily harm and where there is insufficient time to seek effective redress. DoD policy requires DoD Components to provide written notification of whistleblower rights and protections pursuant to Public Law 107-174, also known as the "No Fear Act." The DoD Components maintain effective whistleblower protection programs at all organizational levels and workplaces by publishing policies and procedures on websites, providing employee and supervisory training, publishing rights and reporting procedures on posters, and using anonymous reporting hotlines and Web-based hazard reporting mechanisms. Employees may file a grievance through supervisory or supporting human resources channels or can contact the DoD Office of the Inspector General (OIG).

Describe any cases of retaliation that were reported in CY 2020 and explain how they were investigated. Describe the findings and how they impacted the agency's program.
Response: One complaint of retaliation was reported in CY 2020, originating from the Department of the Army. This complaint is still under investigation. Once resolved, any findings and recommendations that can improve the DoD OSH programs will be incorporated.

OCCUPATIONAL SAFETY AND HEALTH COMMITTEES:

Describe the internal OSH committees at your agency and explain how employees participate in them.

Response: The DSOC is the DoD's senior departmental governance, decision-making, and oversight body for safety and occupational health. The DSOC provides direction and oversight of DoD-wide efforts to reduce mishaps, incidents, and occupational illnesses and injuries. Subordinate to the DSOC are two additional bodies that provide oversight and integration support to the Department's safety and occupational health programs—the DSOC Integration Group (DSOC IG), chaired by the Assistant Secretary of Defense for Readiness (this position

also serves as the DoD DASHO), and the DSOC Steering Group (DSOC SG), co-chaired by the Deputy Director of Operational Safety and the Deputy Director of Occupational Safety and Health of the Force Safety and Occupational Health office. The DSOC SG is composed of senior (GS-15/military grade O-6) OSH personnel from the DoD Components. The group meets monthly to discuss strategic and operational issues relating to OSH policy, oversight, data and information management, strategic communications, resource advocacy, and program management. The DSOC SG routinely reports to the DSOC IG on these key issues. The DSOC IG convenes enduring technical working groups with representatives from the DoD Components to address specific SOH areas including occupational medicine, industrial hygiene, hearing conservation, motor vehicle safety, and safety information management. The DoD Components provide the Chairs and employee representation on all of these working groups. In addition, each of the DoD Components have internal OSH councils, committees, and working groups at multiple organizational levels to address Component-specific OSH-related issues.

Summarize how your agency encourages employee involvement in local Field Federal Safety and Health Councils (FFSHCs) and explain how your agency provides support to these Councils.

Response: DoDI 6055.01 states that DoD Components will support FFSHCs through the promotion of membership and participation in local councils. This policy also encourages the use of DoD facilities and DoD educational resources (e.g., training materials, libraries, guest speakers) to conduct meetings and training events. The DoD Component Secretariats, OSD, and DLA OSH staff routinely attend Washington Metropolitan Safety and Health Council meetings. DoD OSH personnel serve as the Chairpersons for the Hampton Roads, Coastal Empire, South Florida, Duluth/Superior, and South Texas FFSHCs.

Describe your agency's involvement with other external OSH committees and councils, and provide the names of these organizations.

Response: The DoD participates in routine Federal Agency Safety and Health Managers Roundtable meetings hosted by OSHA. The Assistant Secretary of Defense for Sustainment serves as the DoD designated representative on the Roundtable. The DoD Components provide senior OSH managers to directly support agenda items.

PART 2

REPORTS OF FATALITIES, HOSPITALIZATIONS, AND AMPUTATIONS

-Fatalities-

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/16/2020		**Provide Number Impacted**
Nature of incident	Fatality	1
	Hospitalization	
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Security Guard.		
Describe incident: Contracted COVID-19.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Civilian worker contracted COVID and passed away due to complications of the illness.		
Were corrective actions taken?	Yes	
If yes, please describe: Continued use of mask and social distance were used.		
Were programmatic changes made?	No	

If yes, please describe:

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">6/2/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td>1</td></tr>
<tr><td>Hospitalization</td><td></td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Vehicle maintenance facility parking area</td></tr>
<tr><td colspan="3">Describe incident: While performing maintenance on an M1120 Heavy Expanded Mobility Tactical Truck Load Handling System beneath live power lines within the motor pool on Fort Leonard Wood, Missouri, the Crane operator violated procedures and policies. Crane operator maneuvered the crane boom and associated load into the industrial standard 20-foot “prohibited zone” around live power lines.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): Crane operator maneuvered the crane boom and associated load into the industrial standard 20-foot “prohibited zone” around live power lines.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: A formal briefing was presented to all Division Chiefs and Branch Managers by the Logistics Readiness Center Director and Safety Manager and included the importance of adhering to Job Hazard Analysis steps, not deviating from standards and ensuring supervisors are part of daily task planning.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">12/9/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td>1</td></tr>
<tr><td>Hospitalization</td><td></td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Administrative office building providing counsel and non-clinical support to Army soldiers post injury recovery. Unit ensures soldiers successfully return to duty or transition to civilian workforce.</td></tr>
<tr><td colspan="3">Describe incident: Employee admitted to hospital COVID-19 positive, discharged then 4-5 days later was found unresponsive and rushed to the emergency room. Admitted to the Intensive Care Unit (ICU) and died early next morning.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td>ongoing</td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Investigation is still active.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Strict adherence to Centers for Disease Control and Prevent (CDC) and Army required COVID 19 protocols and reeducation of coworkers to help stop spread.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">12/10/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td>1 (Same Person)</td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Employee was aboard a Navy vessel supporting training operations.</td></tr>
<tr><td colspan="3">Describe incident: Once underway a member of the crew began to exhibit symptoms of COVID-19. Within a day several other members began to exhibit symptoms of COVID-19. Training operations were cancelled and the vessel returned to port where all members were tested for COVID-19. Member was admitted to the hospital on 12/11/2020 and succumbed to complications of the virus on 1/4/2021.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Member was exposed to COVID-19 during motor vessel operations.
Contact tracing was completed to identify all possible exposures.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Medical staff met members at the port and tested them for COVID-19. Members were quarantined in accordance with CDC guidelines and directed to seek medical attention if symptoms worsened. Vessel was disinfected and cleaned.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEFENSE HEALTH AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">4/26/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td>1</td></tr>
<tr><td>Hospitalization</td><td></td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: The environment and operation is a healthcare facility medical-surgical unit designated to take all COVID-19 patients under investigation (PUI) or known positive admissions.</td></tr>
<tr><td colspan="3">Describe incident: Employee worked on the medical-surgical unit for COVID-19 positive patients caring for a COVID-19 positive patient for approximately 4 shifts. The employee last worked on 4/12/2020. Employee called out sick on 4/15/2020, was directed to stay home by the personal physician on or about 4/21/2020 due to COVID 19 symptoms, was admitted to a local hospital the next day, transferred to an ICU on 4/24/2020 and passed on 4/26/2020. Employee was reportedly COVID-19 positive when the employee passed away on 4/26/2020.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Investigation revealed that employee may have been exposed to COVID-19 while working on the medical-surgical unit. It was determined that the individual was properly trained in donning, doffing and wearing of PPE in accordance with the facility policy.
COVID-19 training included specific written, hands-on safety training on PPE and fit testing for respirators to include N-95.
N95 respirator masks, isolation gowns, gloves, and face shields and surgical masks when outside patient rooms or off ward were available to staff.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Corrective actions included:
Social distance was implemented to include reducing gathering to less than 10 personnel, electric/virtual meeting platforms and telework to reduce staff exposure.
Housekeeping was provided with disposable cleaning kits to terminally clean between rooms and to prevent cross contamination between cleanings.
Plexiglas shields were added to reduce staff exposure at receptions areas and public eateries.
Respiratory Program was expanded to include areas with potential exposure to positive COVID-19 patients (housekeeping, patient transport, chaplains, and social workers, etc.).
Assessment Rounds were changed to patient phone calls when clinically possible.
Restricted Access Control Points (RACP) were established to screen staff and patients for symptoms upon entrance.</td></tr>
</table>

Were programmatic changes made?	Yes	
Several guidelines were updated to include the following: PPE guidance to include wearing goggles for eye protection Department of Defense COVID-19 Practice Management Guidelines Force Health Protection DOD Guidance SOP for Admission During the COVID 19 Pandemic Guidance for Environmental Cleaning and Disinfection		

-Hospitalizations-

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

1/3/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Worker was an HVAC worker, working in a pump/equipment room.		
Describe incident: Individual was trying to remove a pump, did not properly drain it and was splashed with high temp line water-resulted in bodily burns.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Failure to recognize hazard Failure to execute lockout/tagout. Lack of PPE.		
Were corrective actions taken?	Yes	
If yes, please describe: Staff were all trained up on recognition of hazard. PPE procured for workers exposed Lockout tagout procedures reemphasized via training/JHA		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

1/5/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: U.S. Army Europe and Africa Mission Command Center (USAREUR-AF).		
Describe incident: Twisted Right ankle.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Slippery surface. Ice and snow removal by Garrison.		
Were corrective actions taken?	Yes	
If yes, please describe: Garrison improve ice and snow removal at USAREUR-AF Mission Command Center.		
Were programmatic changes made?	Yes	
If yes, please describe: Garrison improve ice and snow removal at USAREUR-AF Mission Command Center.		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">1/11/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Wreath removal operations at Arlington National Cemetery.</td></tr>
<tr><td colspan="3">Describe incident: Employee 1 placed himself on the left side of the dumpster and placed his hand on the top of the door to hold it in place until the backhoe applied pressure. After employee 1 motioned for employee 2 to bring the backhoe forward to push the door shut the boom of the backhoe made contact with the door causing it to pinch/crush employee 1's hand between the door and body of the dumpster. Employee 1 then motioned for employee 2 to back up to release the pressure.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): Employee and equipment operator failed to follow established procedures to stay clear of dumpster roll off doors while heavy equipment is in use. Lack of attention by the employee was also a contributing factor.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Personnel were briefed on the hazards of working around heavy mechanized equipment after the incident and we also provided the briefing again this year prior to removing wreaths just a few weeks ago.</td></tr>
<tr><td>Were programmatic changes made?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Operators were instructed that it is not acceptable to have anyone inside their operating area when attempting to close dumpster roll off doors with the equipment. Personnel working around the dumpsters were also briefed to keep hands off the dumpsters and stand back when equipment is being utilized around the dumpster.</td></tr>
</table>

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">1/15/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Employee was working on a Computer Numerical Control (CNC) Mill</td></tr>
<tr><td colspan="3">Describe incident: Employee was on a CNC Mill and sustained contusions and laceration as a result of impact from the die set.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): Employee exploit none vulnerabilities of the interlock system on the CNC.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Software and hardware update being implemented.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

2/11/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: USAREUR-AF Mission Command Center.		
Describe incident: Twisted Right ankle.		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions)		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

2/13/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee claims that a spider bite occurred while she was at her work desk of facility 2/13/2020 at approximately 1130 am.		
Describe incident: Employee claims that a spider bite occurred while she was at desk of facility 2/13/2020 at approximately 1130 am.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Conclusion was an insect bite.		
Were corrective actions taken?	Yes	
If yes, please describe: Directorate of Public Works (DPW) Service order was submitted 30 Jan #3381339. Environmental investigated issues and had Houchins Pest Control spray exterior of the facility on 2/12/2020.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">2/21/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident: Strained arm muscle</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Warehouse stockroom moving draft beer kegs. Full kegs weighing 160lbs. 2-person lift policy is the practice in the warehouse.</td></tr>
<tr><td colspan="3">Describe incident: Warehouse worker was moving beer keg stock but tried to move the keg(s) onto the transport cart single-handedly. While doing so, strained his left, upper arm</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): The employee did not seek assistance from another coworker to tray and lift the beer keg onto the transport cart. The employee delayed reporting the matter until the day after the incident after being on duty 4 hours. The employee took 4 hours leave to see a doctor who diagnosed him with a strained limb and directed the employee perform light duty. The employee was scheduled for light duty for 5 days (20 hours). There have been no follow-on problems associated with the incident.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: The employee was counseled and reminded of the requirements for using the 2-person rule for moving heavy weighted stock items, such as the beer kegs, etc., and using handcarts for palletized stock.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: The employee was trying to move the kegs without a second person as per the Warehouse policy.</td></tr>
</table>

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">3/10/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Housekeeping duties.</td></tr>
<tr><td colspan="3">Describe incident: Two staff witnessed an individual fall flat on his back while standing and holding an empty cardboard box. Upon landing, potential shoulder and head injury. Ambulance was summoned and employee was placed under observation at hospital.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Employee lost balance and fell over during routine tasks.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

3/19/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Field site.		
Describe incident: Insect (tick) bite. Lyme disease and supplemental respiratory conditions.		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions)		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/20/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Home office.		
Describe incident: Twisted ankle.		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions): Slippery surface, lack of ice and snow removal by garrison.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/22/2020		**Provide Number Impacted**
Nature of Incident: COVID-19 Respiratory Illness	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Civilian was teaching student how to operate a bulldozer.		
Describe incident: The trainer was standing next to the student who was operating the bulldozer, when the bulldozer suddenly lurched forward and caused the trainer to fall off the side striking his head on the tracks.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Failed to maintain a safe distance from the equipment.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/4/2020		**Provide Number Impacted**
Nature of incident: Hip Joint Fracture	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Housekeeping Administrative Office. The incident occurred at end of duty day when the staff member was getting ready to leave the office for the day.		
Describe incident: As the housekeeping employee was getting ready to close the office door, she attempted to kick loose a wood door wedge being used to prop the door open. When she kicked at the wedge, she lost her balance and fell to the floor onto her side.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): The employee was admitted to the hospital for five days with a diagnosis of having sustained a fractured hip joint. Following her discharge, the employee was absent from work for a total of 544 hours through 11/9/2020. The employee's first duty day back to work was 11/11/2020. The accident was the result of the employee trying to kick loose a door wedge used to keep the office door open.		
Were corrective actions taken?	Yes	
If yes, please describe: As a result of the aforementioned accident event, the engineering staff were directed to replace doors with inoperative door stops with new hook and eye-base door holders to preclude a recurrence of this type of event. The hotel staff were advised to exercise caution kicking loose doors with door wedges during the process time the door stop upgrade work was being performed.		
Were programmatic changes made?	No	
If yes, please describe: (Please see Corrective Action taken).		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/15/2020		**Provide Number Impacted**
Forklift Rollover	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Forklift operation – outdoor, paved road, dry/clear conditions.		
Describe incident: Forklift was traveling on tank road. Operator struck a divot and lost control of vehicle, causing vehicle to roll on the left side		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Divots in roadway and speed resulted in failure to maintain control of forklift on incline while traversing a bend in the road.		
Were corrective actions taken?	Yes	
If yes, please describe: Roadwork was completed to correct divots in roadway. All forklift operators participated in a Safety Stand Down for forklift operations. Speed limits signs were place on tank road limiting speed to 5MPH.		
Were programmatic changes made?	Yes	
If yes, please describe: Pursuing a contract for additional training support for material handling operators.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/18/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Housekeeping duties.		
Describe incident: Employee was performing clean up duties along the lake's shoreline. At some point employee bumped his leg on the skid steer bucket causing injury. Employee continued to work and did not report the incident. On 5/24/2020, employee was unable to work due to an unknown medical condition. The employee's medical condition became worse and on 5/30/2020 the worker was admitted to local hospital with a leg infection. Employee was released on 6/1/2020.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): During task, the employee did not see the bucket of the skid steer in their travel path.		
Were corrective actions taken?	Yes	
If yes, please describe: Walkways were cleared and employees were briefed on importance of situational awareness during tasks around heavy equipment.		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">6/3/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: North end of Building 209 (Weld & Metal Fabrication Shop</td></tr>
<tr><td colspan="3">Describe incident:
Welder was assigned to perform maintenance on the M3A1 Container Roll-in/Out Platform (CROP) suspended from a 10-ton remote operated gantry crane. Preparing to return the load to the ground, task lead removed safety chains while the welder gathered tools and equipment for removal from work area. Once safety chains were removed, the weight of the load (5,900 lbs.) transferred to the 2,400 lbs. rated lifting strap. The strap failed, causing the CROP to strike the welder on his right side upper torso and hip.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Absence of safety planning. This job was not coordinated with or evaluated by the safety office. This precluded the job from being effectively evaluated for hazards and risks. Lacking Job Hazard Analysis (JHA). No JHA – no understanding of safe work procedure. Improper training procedures. The crane operator had no documented record of crane training. Inappropriate rigging selected for the job. The web sling failed due to being overloaded by 3,300 lbs. Inadequate pre-use inspections for rigging equipment. The web sling found at the scene was observed as having previous wear and tear. This indicates that the sling was possibly non-serviceable prior to the mishap. Lack of periodic inspections of rigging equipment. No local inspection tag found. According to the SIAD lifting device shop, this sling was manufactured prior to 2012 but was never input into our system for periodic inspection. No safety / exclusion zone controls or communications established. The injured employee should not have been positioned in the area or under the load when the safety chains were removed.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:
Load test employees conducted inspection of facility and removed all non-complaint lifting devices.
Daily inspection of crane and rigging. New employee training.
JHA review and update on all processes conducted in the weld shop. Use and enforcement of exclusion zone are identified during the rotation process.</td></tr>
</table>

- Engineering/safety review of use of flat racks on container rotator.
- Safety Stand Down conducted in areas that utilize container rotators and include the following:
  - ✓ Document review of JHAs
  - ✓ Rigging selection criteria & practical demonstration
  - ✓ Swinging hazard specific toolbox talk
  - ✓ Brief crane and rigging refresher training

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

6/26/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee was running outside on soft surface of playground in front of swings.		
Describe incident: Employee was running on soft surface of playground in front of swings when she fell resulting in leg injury to her left leg.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Employee tripped causing her to fall awkwardly, inattention to surroundings.		
Were corrective actions taken?	Yes	
If yes, please describe: Employee was given a safety briefing on proper procedures.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

7/2/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Housekeeping duties.		
Describe incident: Employee pulled their General Services Administration (GSA) vehicle into the intersection of Stewart and Otis from Otis. Employee reportedly thought Stewart also had a Stop sign, but it did not. Employee proceeded into the intersection in front of oncoming truck and their GSA vehicle was struck on passenger side. Employee was taken by ambulance to the hospital.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Employee failed to observe signage on road.		
Were corrective actions taken?	Yes	
If yes, please describe: Employee will not be permitted to drive GSA vehicles for future duties.		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

8/4/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Mission Command Center.		
Describe incident: Fell down stairs and twisted left knee.		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions): Slippery surface. Ice and snow removal by Garrison.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

9/29/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Boat operations providing security on Military Ocean Terminal Concords (MOTCOs) tidal area (water security)		
Describe incident: As operations were coming to a shift change, the boat pulled up to the dock and guard personnel did not leave vessel properly by jumping over the side, landing, and subsequently breaking ankle.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Personnel not using appropriate risk mitigation measures during a medium risk activity. Personnel not following SOP to expedite vessel crew shift change.		
Were corrective actions taken?	Yes	
If yes, please describe: Ensure police and guards properly disembark vessels and in the appropriate area of the boat dock.		
Were programmatic changes made?	Yes	
If yes, please describe: Training and SOPs.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">10/12/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Chainsaw operations in a recreational area.</td></tr>
<tr><td colspan="3">Describe incident: Employee was using a chainsaw to cut up two downed trees in a recreation area. As the employee cut a section within ~ 8-10 ft. of the base of the tree, the weight of the root balls sprung the trees into an upright position. The employee was hit with the moving tree and thrown into a metal chain-link fence and the wood line. Somehow, the employees left arm got trapped under another piece of log. The employee dislodged his arm, got himself back to the maintenance complex where he notified the Resource Manager and called 911.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): Personnel not using appropriate risk mitigation measures during a medium risk activity.
Worker was complacent with task at hand.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: All chain saw operators were retrained on toll safe operation.</td></tr>
<tr><td>Were programmatic changes made?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: The chain saw training program was updated, improved, and standardized across the District.</td></tr>
</table>

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">11/11/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Housekeeping duties.</td></tr>
<tr><td colspan="3">Describe incident: Employee was performing a routine inspection of a powerhouse transformer. To enter or exit the secondary containment area, the employee had to step over a 23" high by 6" wide wall with a concrete floor on either side. On the day of the accident the employee entered the containment area containing less than 1" of standing water and obtained the readings without issue. The employee slipped and fell when exiting the containment area in the same location, resulting in head and lower leg injuries.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): A step of 23" high does not meet Army Corps of Engineers/OSHA requirements. This hazard existed for some time and was not corrected. The employee failed to recognize the hazard. The design of the containment did not incorporate safe access.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Employees were trained to use a ladder or stair for all access to the containment.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

11/17/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee was operating a Government Owned Vehicle (Ram 1500 truck) and was in-route back to Hunter Army Airfield, Georgia after picking up repair parts at an off-post establishment.		
Describe incident: Employee veered into oncoming traffic (two-lane road) to avoid a stopped vehicle ahead of him that was making a left-hand turn into business.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): A limited accident investigation was conducted because the driver was still in the hospital. Due to COVID-19 restrictions, there is limited access to the driver of the vehicle. The driver was cited for failure to maintain his lane.		
Were corrective actions taken?	Yes	
If yes, please describe: Individual is still recovering but it's suspected that the accident resulted because he became distracted. As a result, additional training on the hazards of distracted driving was conducted to the workforce.		
Were programmatic changes made?	Yes	
If yes, please describe: The driver was picking up vehicle part off-post. A course-of-action of having the parts delivered versus picking them up is being reviewed.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/14/2020		**Provide Number Impacted**
COVID-19 Respiratory Illness	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations:		
Describe incident: Employee was sharing the same general office space with another employee who became symptomatic and tested positive. Several days later Mr. Dixon became symptomatic and subsequently went to the emergency room when his symptoms worsened. He tested positive for COVID-19 and was admitted to the hospital.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): A contact trace was performed on this employee as required by the CDC and an evaluation of the working area determined that there were 4 employees working in an area where it was not possible to maintain the 6-foot social distancing requirement. This finding was discussed with the supervisor and manager for Interment Services and they were given additional guidelines to follow when scheduling personnel to work and seating them properly to ensure the proper social distancing as well as enforcing the use of masks in these open environment office areas.		
Were corrective actions taken?	Yes	
If yes, please describe: This finding was discussed with the supervisor and manager for Interment Services and they were given additional guidelines to follow when scheduling personnel to work and seating them properly to ensure the proper social distancing as well as enforcing the use of masks in these open environment office areas		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE ARMY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/25/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Housekeeping duties.		
Describe incident: Employee was attempting to enter the Pier 0 elevator with an electric cart. Instead of pressing the brake pedal the employee accidentally pressed the gas pedal causing the electric cart to collide with the closed elevator doors. The employee sustained a small laceration to his right leg and refused any medical treatment. A few days later the employee sought medical attention following what he thought was shingles. The medical facility determined the employee did not have shingles and instead had an infection in their leg caused by the laceration from the 12/25/2020 incident. The employee was hospitalized for 8 days/7 nights for treatment of the infection.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Unintended operation of equipment led to mishap occurring. This type of mishap had occurred before.		
Were corrective actions taken?	Yes	
If yes, please describe: Employees that utilize electric carts were trained on updated requirements and safe operation of equipment.		
Were programmatic changes made?	Yes	
If yes, please describe: Electric carts are no longer permitted in elevators.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

1/17/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Walking in a paved laydown yard.		
Describe incident: An employee was walking towards a stack of wood to remove a tag for material tracking when employee slipped and fell on ice resulting in fractured ribs. Employee was admitted to the hospital for treatment.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): 1. Laydown area did not have snow and ice removed before the start of work. 2. The Base Operating Service Contractor (BOSC) Contract for snow and ice removal does not include the laydown area.		
Were corrective actions taken?	Yes	
If yes, please describe: • In the future, the laydown area will be closed to all activity while the base is operating under adverse weather conditions or delays. • A request has been submitted to add the laydown area to the BOSC Contract for snow/ice removal.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

1/27/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee was working from an alternate work space while the main area was being renovated. Furniture and file cabinets were moved and stacked in available spaces to accommodate the renovation. Employee was standing in the walkway of the work area, engaged in a conversation with fellow employee.		
Describe incident: Employee was standing in the walkway engaged in a conversation with fellow employee when they turned and hit their foot on a file cabinet. Foot later became infected requiring medical treatment.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Investigation was performed by work center supervisor. Hazard assessment of the alternate work location did not effectively asses the risk of the staged office furniture.		
Were corrective actions taken?	Yes	
If yes, please describe: Furniture and file cabinets were removed from walkway.		
Were programmatic changes made?	No	
If yes, please describe: N/A		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/3/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Maintenance operations		
Describe incident: Member was exposed to a co-worker who tested positive for COVID-19. Member became infected with COVID-19 and required hospitalization for advanced medical support.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member was notified of a possible exposure from co-worker.		
Were corrective actions taken?	Yes	
If yes, please describe: Member was quarantined at home. If symptom worsen they were directed to seek medical attention. Office space was disinfected prior to allowing anyone to return to work.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/9/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Administrative /Office environment		
Describe incident: A worker contracted COVID-19 from a presumed work-related transmission of SARS-CoV-2 virus that eventually required hospitalization		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions): Contact tracing was conducted to determine possible exposures.		
Were corrective actions taken?	Yes	
If yes, please describe: Employee was directed to quarantine at home and the office was disinfected.		
Were programmatic changes made?	Yes	
This case occurred very early in the pandemic, just as social distancing, mask usage, and disinfection procedures were being developed and implemented. The office is fully compliant with the Navy's COVID-19 Standardized Operating Guidance.		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/11/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Physical Agility Test		
Describe incident: Security guard was completing their physical agility test as part of their annual evaluation. Employee began having chest pains and was transported to the hospital.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Employee stated they felt fine prior to the annual testing. Employee notified supervisor of the change in medical condition during the test. Employee was admitted to the hospital for diagnosis and treatment.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/20/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Animal Control Agent working outdoors.		
Describe incident: Employee suffered a heart attack after capturing and removing an alligator from a running track.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Weather conditions were warm but not excessively hot. Employee was one of five individuals involved in capturing and relocating an alligator. Evolution took approximately 25 minutes followed by 20 minutes of rest / hydration. Employee showed no signs of distress during evolution and rest period. Medical condition occurred while transiting alligator to relocation site using a pickup truck.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

6/10/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Abrasive blasting work area inside a submarine ballast tank.		
Describe incident: The employee was performing sandblasting work when they lost their grip on the blasting nozzle, which caused it to recoil back into their leg. This resulted in blast grit striking the employee in the leg and becoming embedded in the skin. The employee was hospitalized to remove abrasive blasting grit embedded in the skin.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): The blast nozzle's safety pin malfunctioned due to a build-up of blast grit and debris from a lack of maintenance. The safety pin must be depressed before the trigger of the blast line can be activated by the operator. The lack of maintenance appears to have prevented the safety pin from fully engaging after the trigger was released. Operators are trained to evaluate the functioning of the safety pin throughout blasting operations to ensure that the blast debris does not prevent the safety pin from fully engaging. .		
Were corrective actions taken?	Yes	
All abrasive blast work was stopped and safety pins were function checked. Training was enhanced to ensure employees were aware of the importance of performing routine maintenance as a method to prevent the potential of malfunctions of trigger operation. As an interim control, manager are also evaluating enhanced coveralls for increased protection until a better surface preparation method with results comparable to the current process can be identified.		
Were programmatic changes made?	Yes	
Engineers are evaluating different switch designs through consultation with other naval shipyards and equipment vendors. Engineers are also evaluating the feasibility of replacing operators with robotic options.		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

6/19/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Administrative, Office environment.		
Describe incident: Member experienced symptoms of COVID-19 while at work. Member tested positive for COVID-19 and later required hospitalization for advanced medical support.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Contact tracing was completed but was inconclusive whether the member contracted COVID-19 at work. Member did not exhibit any symptoms prior to coming to work.		
Were corrective actions taken?	Yes	
If yes, please describe: Member was quarantined at home. If symptoms worsen they were directed to seek medical attention. Office space was disinfected prior to allowing anyone to return to work.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

6/22/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Administrative, Office environment.		
Describe incident: Member was exposed to a co-worker who tested positive for COVID-19. Member became infected with COVID-19 and required hospitalization for advanced medical support.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member was notified of a possible exposure from co-worker.		
Were corrective actions taken?	Yes	
If yes, please describe: Member was quarantined at home. If symptoms worsen they were directed to seek medical attention. Office space was disinfected prior to allowing anyone to return to work.		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

6/30/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Member was performing electrical testing inside Auxiliary Machinery Room (AMR) on a ship.		
Describe incident: Member was feeling unwell and went home early after finishing work in the AMR. Employee sought medical attention when symptoms did not improve by 9pm. Employee was diagnosed and hospitalized to receive treatment for severe dehydration & heat exhaustion.		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions): - Employee stated that they had felt lightheaded and dizzy as the day progressed. - Employee stated that it was particularly warm in the AMR, so they had to take breaks from time to time in the cool area of the ship. - Employee stated that they had not been properly hydrating throughout that day. - Member had to walk outside in unshaded areas to get to the ships. - Ventilation in AMR was not adequate for comfort cooling.		
Were corrective actions taken?	Yes	
If yes, please describe: - Provided stand-down for heat stress training. - Implemented the use of heat stress surveys using wet bulb globe thermometers to pier side work in warm areas inside the ship. - Authorized the use of golf cart to transport employees required to make long walk in unshaded areas during heat advisories.		
Were programmatic changes made?	No	
If yes, please describe: N/A		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">8/19/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Employee was working on self-help project using a personally owned table in the mechanical room inside the fire station. Employee had completed approximately 17 cuts when their hand slipped causing a laceration to left thumb.</td></tr>
<tr><td colspan="3">Describe incident: A fire fighter lacerated their left thumb while cutting ¾-inch plywood on a table saw while working on a self-help project. Employee was admitted overnight awaiting surgery the following morning.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
- Guards were not installed on the employee’s personal table saw and the employee did not utilize a push stick.
- Self-help project was not summited to or approved by the facilities department.
- Use of personal power tools or equipment for any project is not authorized on the installation.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:
- Employees at the Fire Department have been instructed to ensure all self-help projects are submitted to the facility department for approval and no tools from home are authorized in the workplace.
- Personal tools were removed from workplace.</td></tr>
<tr><td>Were programmatic changes made?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Self-Help policy was revised to clarify the requirements for when self-help projects are authorized during working hours.</td></tr>
</table>

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">9/24/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: An on-site training event held by the supervisor.</td></tr>
<tr><td colspan="3">Describe incident:
Several employees began feeling sick and later tested positive for COVID-19.
One person required hospitalization to treat severe symptoms.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
COVID-19 precautions were being exercised by the group.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: All employees in attendance were quarantined at home following CDC guidelines for possible exposure. The spaces were professionally cleaned following the event. Contact tracing was completed with all employee to ensure that there are no additional contacts.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

11/23/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Office work environment		
Describe incident: Employee tested positive for COVID-19 while working in an area where other co-workers had also recently tested positive. It is presumed that workplace transmission of SARS-CoV-2 virus occurred.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Social distancing, mask usage, and disinfection procedures were being implemented at the time of the incident.		
Were corrective actions taken?	Yes	
An evaluation of the work area was performed by Industrial Hygienists. It was determined that ventilation in the work area could be improved and might reduce the potential for airborne transmission of SARS-CoV-2.		
Were programmatic changes made?	Yes	
The HVAC system supplying the work area was significantly improved to increase the number of fresh air changes that it supplied. In addition, HEPA filtered air cleaners were installed throughout the work area to reduce the potential for the circulation of airborne aerosols.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

11/25/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Administrative / Office environment		
Describe incident: Employee tested positive for COVID-19 while working in an area where other co-workers had also recently tested positive. It is presumed that workplace transmission of SARS-CoV-2 occurred.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Social distancing, mask usage, and disinfection procedures were being implemented at the time of the incident.		
Were corrective actions taken?	Yes	
An evaluation of the work area was performed by Industrial Hygienists. It was determined that ventilation in the work area could be improved and might reduce the potential for airborne transmission of SARS-CoV-2.		
Were programmatic changes made?	Yes	
The HVAC system supplying the work area was significantly improved to increase the number of fresh air changes that it supplied. In addition, High Efficiency Particulate Air filtered air cleaners were installed throughout the work area to reduce the potential for the circulation of airborne aerosols.		

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/29/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Icy conditions in a shipyard parking lot		
Describe incident: Employee slipped and fell on ice while walking to his work station, injuring his head, knee and hands. The following day the employee suffered from slurred speech and went to an emergency room for evaluation where he was admitted for treatment of a blood clot and subsequent stroke.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Several employees were interviewed who corroborated that the employee had admitted to slipping and falling on the ice and that that the employee felt that the injuries were not serious and did not warrant medical attention.		
Were corrective actions taken?	Yes	
The transportation department sanded and salted the area where the fall occurred as soon as they became aware of the situation.		
Were programmatic changes made?	No	
If yes, please describe: N/A		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

1/21/2020		**Provide Number Impacted**
Nature of incident: Walking through dock; tripped over an aircraft grounding cord; landed on left hip and broke femur; 8 days hospitalized.	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Aircraft maintenance		
Describe incident: Walking through dock; tripped over an aircraft grounding cord; landed on left hip and broke femur; 8 days hospitalized.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Supervision failed to remove inappropriate or damaged equipment.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

4/28/2020		**Provide Number Impacted**
Nature of incident: Descending ladder; fell; fractured left ankle; hospitalized for 2 days	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Electrical work		
Describe incident: Descending ladder; fell; fractured left ankle; hospitalized for 2 days		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member inattention.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/15/2020		**Provide Number Impacted**
Nature of incident: Descending stairs; lost balance; fractured leg/ankle; 3 days hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Office work		
Describe incident: Descending stairs; lost balance; fractured leg/ankle; 3 days hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member lost balance for unknown reasons.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

5/20/2020		**Provide Number Impacted**
Nature of incident: Installing exhaust cover; slipped/fell in puddle; left wrist fracture; 1 day hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Industrial		
Describe incident: Installing exhaust cover; slipped/fell in puddle; left wrist fracture; 1 day hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Inappropriate equipment for the job		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">6/10/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident: Standing; fell; fractured sternum; 6 days hospitalized</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Clerical/Office</td></tr>
<tr><td colspan="3">Describe incident: Standing; fell; fractured sternum; 6 days hospitalized</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Tripped on own shoe laces.</td></tr>
<tr><td>Were corrective actions taken?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

7/16/2020		**Provide Number Impacted**
Nature of incident: Member was walking on a paved walkway; foot slipped off edge onto grass; broken femur; 6 days hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Walkway		
Describe incident: Member was walking on a paved walkway; foot slipped off edge onto grass; broken femur; 6 days hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Lacked situational awareness while transitioning from sidewalk to grassy area.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

8/27/2020		**Provide Number Impacted**
Nature of incident: Playing basketball; hyperextended elbow; tore bicep tendon; 1 day hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Fitness Center		
Describe incident: Playing basketball; hyperextended elbow; tore bicep tendon; 1 day hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): An unavoidable sports injury due to hyperextension.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">11/6/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident: Worker helping move 60k-loader deck extension outward; two fingers pinched in between extension arm; multiple injuries; 5 days hospitalized</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Vehicle shop</td></tr>
<tr><td colspan="3">Describe incident: Worker helping move 60k-loader deck extension outward; two fingers pinched in between extension arm; multiple injuries; 5 days hospitalized</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Member did not follow proper technical data and was not trained to on specific vehicle.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:
Training on how to perform extension of deck on loader.</td></tr>
<tr><td>Were programmatic changes made?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:
Training on how to perform extension of deck on loader.</td></tr>
</table>

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

11/10/2020		**Provide Number Impacted**
Nature of incident: De-burring metal on disc sander; sander caught metal and left thumb; severed thumb tip; permanent partial disability and 1 day hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Machine shop		
Describe incident: De-burring metal on disc sander; sander caught metal and left thumb; severed thumb tip; permanent partial disability and 1 day hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member used an unsafe technique when holding piece to grinder.		
Were corrective actions taken?	Yes	
If yes, please describe: Recommendation to verbiage to specific AAir Force Instruction (AFI) regarding angle and flushness of piece to grinder.		
Were programmatic changes made?	Yes	
If yes, please describe: Recommendation to verbiage to specific AFI regarding angle and flushness of piece to grinder.		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

11/27/2020		**Provide Number Impacted**
Nature of incident: Struck by door; fell down; fractured leg; 4 days hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Building door		
Describe incident: Struck by door; fell down; fractured leg; 4 days hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Wind gust made member lose his balance and fall.		
Were corrective actions taken?	No	
If yes, please describe		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/3/2020		**Provide Number Impacted**
Nature of incident: Descending stairwell; mis-stepped; fractured left arm; 6 days hospitalized	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Stairwell		
Describe incident: Descending stairwell; mis-stepped; fractured left arm; 6 days hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member was distracted and missed the last step of stairwell.		
Were corrective actions taken?	No	
If yes, please describe		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">12/11/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident: Walking on walkway; slipped on sand; broken hip; surgery, 3 days hospitalized</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Walkway</td></tr>
<tr><td colspan="3">Describe incident: Walking on walkway; slipped on sand; broken hip; surgery, 3 days hospitalized</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Buildup of grit in the walkway from the crumbling landscaping stones caused member to loose traction on the concrete.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Walkway was cleaned and cleared of debris and crumbling stones replaced.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEFENSE COMMISSARY AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

7/17/2020		**Provide Number Impacted**
Nature of incident: COVID-19 Contraction	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee's position is quality assurance so it is hard to determine where the employee contracted the virus.		
Describe incident: Employee contracted COVID-19 while working in the store. Employee was hospitalized for 14 days and quarantined and stayed at home or 97 days,		
Was an accident investigation conducted?	No	
What were results of investigation (causes, contributing factors and conditions):		
Were corrective actions taken?	Yes	
If yes, please describe: Store was cleaned, sanitized.		
Were programmatic changes made?	No	
If yes, please describe: No programmatic changes necessary.		

DEFENSE COMMISSARY AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

10/23/2020		**Provide Number Impacted**
Nature of Incident: Employee had experience and episode of distress while picking up/moving cases of product in warehouse. Employee was taken to Emergency Room on date of incident. She was then admitted to hospital and released following day 10/24/2020.	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Grocery Dry Product Warehouse, temperature estimated 78 degrees Fahrenheit. Operations was pulling of product from the warehouse location to the sales floor.		
Describe incident: Employee reached to pick up a 24-pack case of canned soup/broth. Employee felt a sharp pain radiate from her chest to her back. Physician later determined employee had a previous undetected heart condition.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): There was no identifiable causes, contributing factors, conditions/hazards.		
Were corrective actions taken?	No	
If yes, please describe: No corrective action required.		
Were programmatic changes made?	No	
If yes, please describe: No programmatic changes necessary.		

DEFENSE COMMISSARY AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/11/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Employee working in Produce department		
Describe incident: Employee was moving banana cases and strained back. Hospitalized overnight.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Improper lifting techniques. Employee lifting, while twisting and turning.		
Were corrective actions taken?	Yes	
If yes, please describe: All employees retrained on proper lifting techniques, assisted lifting (buddy system), and reminded to utilize mechanical lifting equipment whenever possible.		
Were programmatic changes made?	No	
If yes, please describe:		

DEFENSE INTELLIGENCE AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

10/27/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Transporting government-owned materials.		
Describe incident: Individual stated "wind caused by a semi-truck moving in front of him, caused him to veer right, lose control, and run into a ditch." Police report states condition of driver (tired/fatigued) as primary factor of incident.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Human Error (Fatigue and Dehydration) in addition to environmental conditions (wind) as contributing factors.		
Were corrective actions taken?	Yes	
If yes, please describe: Safety training focused on human factors and improved awareness has been conducted.		
Were programmatic changes made?	No	
If yes, please describe:		

DEFENSE LOGISTICS AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">4/23/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Indoor warehousing operations involving storing and retrieving material manually and using powered material handling equipment.</td></tr>
<tr><td colspan="3">Describe incident: The employee transported a pallet of material via forklift from its location to a staging area in preparation for packing and shipping and parked with the load raised approximately two feet off the ground to process the issue. This allows the material to be processed more ergonomically, precluding the need for the employee to bend down to reach the material. (Note: OSHA requirements for using tines as a work platform were followed.) At approximately 0840, he cut the plastic wrap vertically at the center of one side of the pallet. At the same side of the pallet, the employee tugged on one side of the cut plastic in an attempt to remove it from the pallet. He initially attempted to remove the plastic wrap from the materiel by pulling one side toward him, believing the wrap would “unravel” from around the materiel. However, the wrap would not budge. He attempted again, this time leaning back and using his weight to try and pull the plastic wrap from around the materiel. In doing so, he lost his grip on the plastic, causing him to fall backwards to the cement floor. He landed on his right backside, resulting in a fractured right hip.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):

<u>Support Factors</u>: The plastic wrapping was caught on the corner of the pallet opposite of where he was standing. The employee tugged on the plastic wrapping with increasing force, while leaning backwards.
<u>Standards and/or documentation inadequacies (Standard Operating Procedures (SOP), Job Hazard Analysis (JHA), etc.):</u> There is no SOP that covers removing plastic wrapping from a pallet. “Hazard Category Identification and Hazard Characterization, Building 87 (All Bays),” completed on 9/6/2018, sufficiently listed the hazards involved in the act of removing plastic from a pallet, including awkward posture, sustained effort, high force, intermittent effort, pulling/tugging, aisles, or work areas shared by pedestrians and motorized equipment, and potential fall hazard (on same level). However, a completed risk assessment (DD Form 2977) was not conducted for this process.</td></tr>
</table>

Training Factors: There is no electronic, classroom, or on the job training on how to safely remove plastic wrapping from a pallet. Leadership Factors: Leadership did not ensure that the supervisor completed a risk assessment (DD Form 2977) on their processes. Site leadership realizes that a routine process such as removal of plastic wrap can involve certain practices conducted by the employee which may have the potential to place that employee at risk of injury. Individual: The employee tugged on the plastic while leaning backwards. He indicated that he was not rushed and did not have an above average workload. Environmental factors: No environmental factors were identified as having contributed to this incident. The floor was clean, dry, and not exceptionally slippery. The air temperature was comfortable.		
Were corrective actions taken?	Yes	
If yes, please describe: Issued Enterprise Safety Application Management System Deficiency Notices to document and track to completion the following actions: a. Document risk and control measures on a DD Form 2977 (Deliberate Risk Assessment Worksheet) for operations to include the task of removing shrink wrap from pallets of material and ensure risk is accepted at the appropriate level. b. Provide leaders risk management training to include guidance on documenting risk and control measures on a DD Form 2977 and ensuring risk is accepted at the appropriate level. Additional actions included creating and publishing Safety Alert on removing plastic wrapping from pallets and conducting proper risk assessments using DD Form 2977.		
Were programmatic changes made?	Yes	
If yes, please describe: Updating local SOH procedures to include the risk management using the DD Form 2977.		

DEFENSE LOGISTICS AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">5/6/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Office environment. Employee worked in the contracting office.</td></tr>
<tr><td colspan="3">Describe incident: Employee was in a work capacity when he was involved in a car accident. After delivering a document to the worksite, the employee left to continue teleworking at home, when they were involved in a multi-car accident. The main car that caused the accident hit another car that then hit the employee’s car.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
The cause of the accident was an out-of-control driver. Road conditions and lighting were adequate.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Personnel were briefed on the lessons learned.
Briefed Employees: When driving, always wear your seat belt, be aware of your surroundings, remember to check your mirrors.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEFENSE LOGISTICS AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">7/20/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td></td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Industrial Operations/Wood Packing Area</td></tr>
<tr><td colspan="3">Describe incident: Employee bit on the back of left leg by a spider after working crates from Reclamation.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Environmental</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:
1. Be aware of work conditions and possible hazards such as spiders, insects, and bees.
2. Schedule areas (Reclamation and 9001 PPP&M) for pest control.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEFENSE LOGISTICS AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

10/7/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Fire Fighting Operations		
Describe incident: Engine 69 responded to the report of a dwelling fire at in Fairview. Companies arrived on the scene to find a two-story split level with smoke coming from the attached garage. Engine 69 arrived just behind Rescue 68 and both companies placed lines in service. One line went to side (D) delta and the other to the front door on the (A) alpha side. The employee followed the hose line of Rescue 68 though the front door. Companies made their way down a small flight of steps and down a small hallway to the door of the garage. Due to the hoarding conditions inside the crew on the (D) side was unable to gain access to the seat of the fire. Interior crews made entry into zero visibility and while climbing over the contents of the garage and five-gallon bucket of paint was spilled. Unaware at the time and still making progress on the fire employee slipped on the paint and twisted or buckled his knee.		
Was an accident investigation conducted?	Yes	
What were results of investigation? (causes, contributing factors and conditions): Even though the employee suffered this injury, it was not preventable due to the hording conditions of the house.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

2/18/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Administrative teaching position of 6th grade students.		
Describe incident: DoDEA teacher chose to walk up an embankment leading to the parking lot because the stairway which leads to the parking lot is blocked by a metal gate which remains padlocked to prevent unauthorized entry/exit. Employee exited the double perimeter doors of building 1375 and immediately made a right turn to exit the fenced area through the double gate and made a sharp left turn, walking up a grassy embankment. The employee was able to walk up the embankment (approximately 13 ft.) and retrieve item(s) from her parked car (approximately 21 ft.). Upon returning to the building, the employee attempted her descent down embankment. The employee slipped on the wet grass and while attempting to reduce her forward momentum, fracture her left fibula in two places and left tibia in one place.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Heavy morning rain contributed to the slipperiness of the grass on the embankment, the wet and muddied soil, coupled with the steepness of the embankment was the root cause of the employee's injury. Walking up the embankment provides a shorter distance than the appropriate exit route which is approximately 40 meters to the east of building from the double-sided gate.		
Were corrective actions taken?	Yes	
If yes, please describe: The padlocked gate was fitted with a door function that allows for exit and access to the stairs leading to the parking lot but prevents re-entry from outside the perimeter fence without an access key or card. Staff and students were cautioned not to walk up the embankment to access the parking lot and signage indicating the correct egress path were installed.		
Were programmatic changes made?	No	
If yes, please describe: N/A		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

-Amputations-

DEPARTMENT OF THE NAVY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

10/5/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	1
	Amputation	1 (same patient)
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Descending a submarine access ladder		
Describe incident: Individual was descending the access ladder into the workspace. While in transit, individual attempted to reposition footing, lost grip and fell to bottom of ladder resulting in a severed femoral artery. Medical complications eventually required surgical amputation of the lower leg three days later.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): No safety or work violations found. Employee's excessive body weight created limited maneuverability and difficulty climbing or descending ladders.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">7/10/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident: Lifting cover; lost grip; finger amputated at first knuckle; permanent partial disability; 4 days hospitalized</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td>1</td></tr>
<tr><td>Amputation</td><td>1</td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Industrial area</td></tr>
<tr><td colspan="3">Describe incident: Lifting cover; lost grip; finger amputated at first knuckle; permanent partial disability; 4 days hospitalized</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions):
Member did not have proper tools on-hand and made decision to attempt removal of cover by hand.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Purchase lifting apparatus's specifically designed to open manhole covers withstanding the weight of a 300lb concrete slab.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>

DEPARTMENT OF THE AIR FORCE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

12/8/2020		**Provide Number Impacted**
Nature of incident: Worker performing maintenance on equipment; left hand contacted rotating fan blade; pinky finger amputated and 2 days hospitalized	Fatality	
	Hospitalization	1
	Amputation	1
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Industrial heavy equipment shop		
Describe incident: Worker performing maintenance on equipment; left hand contacted rotating fan blade; pinky finger amputated and 2 days hospitalized		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Member bypassed safety interlocks, and wet floor caused him to slip into rotating fan blade.		
Were corrective actions taken?	No	
If yes, please describe:		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

ARMY AND AIR FORCE EXCHANGE SERVICE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">1/15/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td></td></tr>
<tr><td>Amputation</td><td>1</td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: Distribution Center – Material Handling Equipment (MHE) Maintenance – Battery Cleaning</td></tr>
<tr><td colspan="3">Describe incident: Employee was operating a battery lift beam and crane to lift a MHE battery, for cleaning. Left middle figure was caught in the lift beam clamp/hook, removing the tip of his left middle figure. First aid given, a clean compression dressing was applied and Emergency Medical Support called for transport.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): Investigation identified that this job function (rotating the batteries, using the life beam) was the root cause of the accident and that it should have been a two person job. The member's board felt that Doug actions of trying to use the crane lift with his right hand, while simultaneously positioning the battery clams/hooks with his left hand, was unsafe and required two persons to complete this task safely and that complacency and inattention played a role in this accident.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: The involved equipment was removed from service and updated safer equipment ordered as a replacement. In addition, regular training on the task and equipment safety inspections have been put into place.</td></tr>
<tr><td>Were programmatic changes made?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Involved equipment was removed from service and replaced with new equipment.</td></tr>
</table>

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

ARMY AND AIR FORCE EXCHANGE SERVICE
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

10/27/2020		**Provide Number Impacted**
Nature of Incident: Blister became infected resulting in amputation of toe.	Fatality	
	Hospitalization	
	Amputation	1
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Material handler. Selects boxes of merchandise to be shipped.		
Describe incident: Associate developed a blister on her toe that became infected.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): Associate failed to inform management of injury until it became infected. Management has reminded associates to notify of all injuries		
Were corrective actions taken?	Yes	
If yes, please describe: All associates were reminded to inform management of all injuries		
Were programmatic changes made?	No	
If yes, please describe:		

DEFENSE COMMISSARY AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

8/5/2020		**Provide Number Impacted**
Nature of incident	Fatality	
	Hospitalization	
	Amputation	1
	Loss of Eye	
Was incident work-related?	Yes	
Describe work environment and operations: Meat cutting worker was operating a bulker. The bulker is connected to the meat grinder. Meat travels through a conveyor to the bulker which chops ground beef into one and two pound blocks for packaging.		
Describe incident: Ground beef was stuck on the conveyor as it passed through the conveyor from the grinder to the bulker. The employee reached into the bulker to unclog the bulk and her sleeve activated the cutting blade switch triggering the blades to come down and amputated the tips of three fingers.		
Was an accident investigation conducted?	Yes	
What were results of investigation (causes, contributing factors and conditions): The employee failed to adequately secure the power before performing maintenance on the bulker. The department has an exclusive control program which requires employees to secure the power by unplugging the equipment and maintaining exclusive control over the plug. The employee did not execute these procedures.		
Were corrective actions taken?	Yes	
If yes, please describe: Proper exclusive control procedures were reviewed with all affected employees. Store leaders were instructed to observe and enforce required procedures.		
Were programmatic changes made?	No	
If yes, please describe:		

CY 2020 FEDERAL AGENCY REPORT
Department of Defense (DoD)

DEFENSE COMMISSARY AGENCY
FATALITY, HOSPITALIZATION, AMPUTATION, LOSS OF AN EYE REPORT

<table>
<tr><td colspan="2">11/4/2020</td><td>Provide Number Impacted</td></tr>
<tr><td rowspan="4">Nature of incident</td><td>Fatality</td><td></td></tr>
<tr><td>Hospitalization</td><td></td></tr>
<tr><td>Amputation</td><td>1</td></tr>
<tr><td>Loss of Eye</td><td></td></tr>
<tr><td>Was incident work-related?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">Describe work environment and operations: The meat department where meat is processed, cut and packaged.</td></tr>
<tr><td colspan="3">Describe incident: Meat cutter was preparing to cut steaks using the bone-in saw. The meat cutter was securing the meat against the plate to begin cutting. While applying pressure to the meat against the guide plate, the employee's left hand slipped and went into the blade and the employee's left thumb tip was completely severed off.</td></tr>
<tr><td>Was an accident investigation conducted?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">What were results of investigation (causes, contributing factors and conditions): It was discovered that the blade guard was not properly adjusted to the required minimum blade exposure. Proper blade guard adjustment would have, most likely, prevented the amputation.</td></tr>
<tr><td>Were corrective actions taken?</td><td>Yes</td><td></td></tr>
<tr><td colspan="3">If yes, please describe: Consistent with DeCA policy and trained procedures, the blade guard shall always be adjusted to the minimum exposure (maximum 1/2 inch exposure). All meat employees were required to review all training material to include proper blade guard adjustment procedures. Store leaders were instructed to observe and enforce required procedures.</td></tr>
<tr><td>Were programmatic changes made?</td><td>No</td><td></td></tr>
<tr><td colspan="3">If yes, please describe:</td></tr>
</table>