Agenda

1. Introduction
2. Supervisor Responsibilities
3. Accident Reporting
   a. CA-1 Form, LS-201 Form
   b. LN Accident Reports
   c. AGAR
   d. LN First Aid Book
4. Composite Risk Management
   a. Risk Assessment Worksheet
   b. Job Hazard Analyses

Supervisor Training

Requirements

AR 385-10 and AR 385-40
AER 385-29 and AER 385-40

Supervisor Responsibilities

Supervisor Responsibilities

Supervisor Responsibilities for US & LN Employees
Basic obligations employer-provide safe workplace

LN Job Hazard Analyses/US Risk Assessments
Appointment of CDSOs and LN Safety Reps
Accident Reporting for US and LN accidents
First Aid and Fire/Emergency Measures
Training of Employees for Hazardous Equipment
Chemical Hazard Communication and MSDS
Personal Protective Equipment (PPE)
Noise Level Surveys- 85 dB “A” or higher
Provide Fall Protection for over 6 Feet
Confined Spaces Marked & Restricted
Electrical high-voltage lockout / tagout

Employee Responsibilities
Comply with all safety SOPs and risk controls, PPE

Supervisor Responsibilities

Chemical Hazard Communication (HAZCOM)

- US Labor/OSHA regulation 29 CFR 1910.12
- All employees must be trained for using chemicals in workplace, including use of PPE: Respirators, Gloves, Goggles, Apron and Protective Clothing
- Material Safety Data Sheets (MSDS) for all chemicals must be available in both languages
- Minimize use of hazardous & toxic chemicals by consulting Safety, Industrial Hygienist, DPW-EMO
- Eye “flushing” lavage and hand-washing sink required for caustic & acidic chemicals

Accident Reporting

US Civilian FECA Claims (AF employees)

- US Labor CA-1 Form: Occupational Injury
- US Labor CA-2 Form: Occupational Illness

*File claim at Hohenfels CPAC Personnel Office

Mr. Bruno Wagner or Ms. Karin Obletzhauser

AGAR Army Accident Report (DA 285-AB-R) must also be filed with Garrison Safety Office

Tel DSN 466-2865/ 1670, Bldg. 388, Hohenfels

Form CA-1

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Reset Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth Mo. Day Yr.
4. Sex Male Female
5. Home telephone
6. Grade as of date of injury Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
8. Dependents
   - Wife, Husband
   - Children under 18 years
   - Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
10. Date injury occurred Mo. Day Yr. Time a.m. p.m.
11. Date of this notice Mo. Day Yr.
12. Employee's occupation
13. Cause of injury (Describe what happened and why)
14. Nature of injury (identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code
b. Type code
c. Source code
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf **Date**

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness
Signature of witness
Date signed
Address
City
State
ZIP Code

Form CA-1
Rev. Apr. 1999

NAF Employee (MWR) Injury Claims

For: US Civilian NAF employees injury claims:

File the US Labor LS-201/LS-202 Forms with Mr. Robert Dudley, NAF Personnel at Grafenwoehr

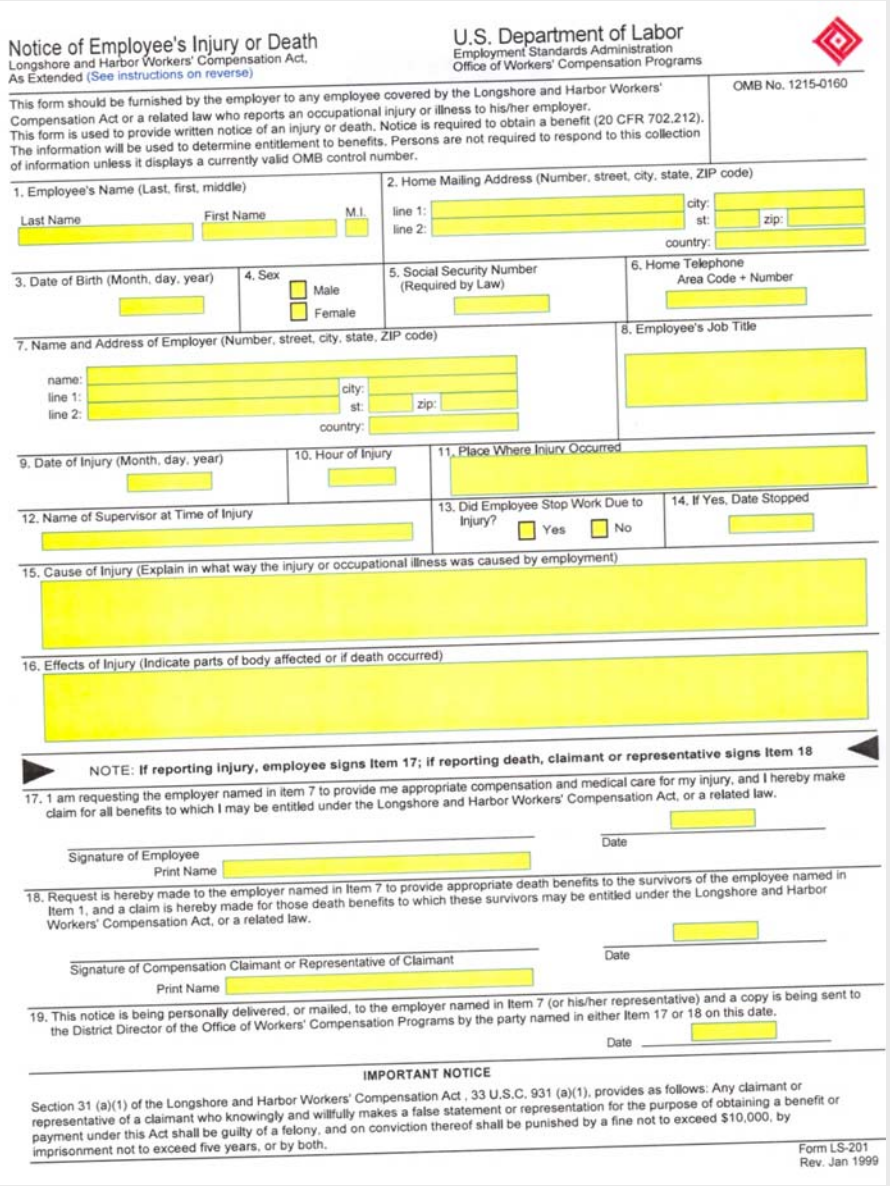
For: Local National/LN Employees (NAF) accidents:

File the LN Unfallanzeige, UK-Bund Form (LN-NAF) with Hans Hammer, USAG Hohenfels Safety Office

* AGAR Accident Reports are also required for all NAF employees (both US & LN) lost-days accidents

Form LS-201

Notice of Employee's Injury or Death



Notice of Employee's Injury or Death
Longshore and Harbor Workers' Compensation Act,
As Extended (See instructions on reverse)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0160

This form should be furnished by the employer to any employee covered by the Longshore and Harbor Workers' Compensation Act or a related law who reports an occupational injury or illness to his/her employer. This form is used to provide written notice of an injury or death. Notice is required to obtain a benefit (20 CFR 702.212). The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

1. Employee's Name (Last, first, middle)
Last Name | First Name | M.I.

2. Home Mailing Address (Number, street, city, state, ZIP code)
line 1: | line 2: | city: | st: | zip: | country:

3. Date of Birth (Month, day, year)

4. Sex ☐ Male ☐ Female

5. Social Security Number (Required by Law)

6. Home Telephone Area Code + Number

7. Name and Address of Employer (Number, street, city, state, ZIP code)
name: | line 1: | line 2: | city: | st: | zip: | country:

8. Employee's Job Title

9. Date of Injury (Month, day, year)

10. Hour of Injury

11. Place Where Injury Occurred

12. Name of Supervisor at Time of Injury

13. Did Employee Stop Work Due to Injury? ☐ Yes ☐ No

14. If Yes, Date Stopped

15. Cause of Injury (Explain in what way the injury or occupational illness was caused by employment)

16. Effects of Injury (Indicate parts of body affected or if death occurred)

NOTE: **If reporting injury, employee signs Item 17; if reporting death, claimant or representative signs Item 18**

17. I am requesting the employer named in item 7 to provide me appropriate compensation and medical care for my injury, and I hereby make claim for all benefits to which I may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

Signature of Employee | Date
Print Name

18. Request is hereby made to the employer named in Item 7 to provide appropriate death benefits to the survivors of the employee named in Item 1, and a claim is hereby made for those death benefits to which these survivors may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

Signature of Compensation Claimant or Representative of Claimant | Date
Print Name

19. This notice is being personally delivered, or mailed, to the employer named in Item 7 (or his/her representative) and a copy is being sent to the District Director of the Office of Workers' Compensation Programs by the party named in either Item 17 or 18 on this date.

Date

IMPORTANT NOTICE

Section 31 (a)(1) of the Longshore and Harbor Workers' Compensation Act , 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

Form LS-201
Rev. Jan 1999

LN Accident Report

required within three days after the accident

Property damage
No LN accident
Report required

LN Commuting Accidents

Supervisor and Work Council Signature required

LN First Aid Book for minor injuries

UNFALLANZEIGE

1 Name und Anschrift des Unternehmens
8530th Civilian Support Group (Smoke)
Truppenuebungsplatz Hohenfels
Lager Poellnricht, Geb. 431
92366 Hohenfels

2 Unternehmensnummer des Unfallversicherungsträgers: 4 1 1 1 0 0

3 Empfänger
Unfallkasse des
Bundes
26380 Wilhelmshaven

4 Name, Vorname des Versicherten: [redacted]

5 Geburtsdatum: Tag 2 6 | Monat 1 1 | Jahr 1 9 7 7

6 Straße, Hausnummer: Bayreuther Str. 30 | Postleitzahl 9 2 2 3 7 | Ort: Sulzbach-Rosenberg

7 Geschlecht: [X] männlich [ ] weiblich

8 Staatsangehörigkeit: Deutschland

9 Leiharbeitnehmer: [ ] ja [X] nein

10 Auszubildender: [ ] ja [X] nein

11 Ist der Versicherte: [ ] Unternehmer [ ] mit dem Unternehmer verwandt [ ] Ehegatte des Unternehmers [ ] Gesellschafter/Geschäftsführer

12 Anspruch auf Entgeltfortzahlung besteht für 1 2 Wochen

13 Krankenkasse des Versicherten (Name, PLZ, Ort): BKK, Faber-Castell u. Partner, Postfach 12 65, 94202 Regen

14 Tödlicher Unfall? [ ] ja [X] nein

15 Unfallzeitpunkt: Tag 1 3 | Monat 0 5 | Jahr 2 0 0 8 | Stunde 1 1 | Minute 3 0

16 Unfallort (genaue Orts- und Straßenangabe mit PLZ): Truppenuebungsplatz Hohenfels

17 Ausführliche Schilderung des Unfallhergangs (Verlauf, Bezeichnung des Betriebsteils, ggf. Beteiligung von Maschinen, Anlagen, Gefahrstoffen)
Herr [redacted] ueberpruefte nach einer Fehlermeldung bei einer Schiessuebung die Abschussvorrichtung fuer Simulationsmunition (MGSS). Nachdem kein Fehler am System erkennbar war, zog ein Schiedsrichter das Kabel zur Zielhebelvorrichtung (Lifter) ab, um es zu ueberpruefen. Als er es wieder anbrachte, loeste sich ein Schuss aus der Abschussvorrichtung fuer Simulationsmunition. Herr [redacted] stand dabei nahe der MGSS und hatte danach ein starkes Pfeiffen im Ohr.

Bilder des Simulationsgeraetes liegen zum besseren Verstaendnis bei.

Die Angaben beruhen auf der Schilderung [X] des Versicherten [ ] anderer Personen

18 Verletzte Körperteile: linkes Ohr

19 Art der Verletzung: Knalltrauma

20 Wer hat von dem Unfall zuerst Kenntnis genommen? (Name, Anschrift des Zeugen): Werner Uwe, Sommergasse 17, 92364 Deining-Mittersthal
War diese Person Augenzeuge? [X] ja [ ] nein

21 Name und Anschrift des erstbehandelnden Arztes/Krankenhauses: Dr. Stefan Wagner (HNO), Neutorgasse 9, 92237 Sulzbach-Rosenberg

22 Beginn und Ende der Arbeitszeit des Versicherten: Beginn Stunde 0 6 | Minute 0 0 | Ende Stunde | Minute

23 Zum Unfallzeitpunkt beschäftigt/tätig als: Manoevereinsatzfuehrer

24 Seit wann bei dieser Tätigkeit? Monat 0 5 | Jahr 2 0 0 3

25 In welchem Teil des Unternehmens ist der Versicherte ständig tätig?
Manoeverunterstuetzung auf dem Truppenuebungsplatz Hohenfels

26 Hat der Versicherte die Arbeit eingestellt? [ ] nein [ ] sofort [X] später, am Tag 1 3 | Monat 0 5 | Stunde 1 5

27 Hat der Versicherte die Arbeit wieder aufgenommen? [X] nein [ ] ja, am Tag | Monat | Jahr

28 Datum	Unternehmer/Bevollmächtigter	Betriebsrat (Personalrat)	Telefon-Nr. für Rückfragen (Ansprechpartner)
14. Mai 2008	Roman MIDLEJA	Maximilian Schulze	09472/83- 4244

Army Ground Accident Report

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see AR 385-40 and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENT CONTROL SYMBOL CSOCS-308

1. TIME & DATE OF ACCIDENT | a. Yr | b. Mth | c. Day | d. Time | 2. PERIOD OF DAY | Day | Night | 3. ACDT CLASS | 4. ACDT OCCURRED DURING | Combat | Non-Combat

5. UNIT IDENTIFICATION | a. UIC *(6-digit Code)* | b. Name of Unit | c. Unit's Branch | d. MACOM

6. LOCATION OF ACCIDENT | a. Exact Location *(Detailed enough to locate site)* | b. Type Location

c. State / Country | d. | Off-post | On-post Name: | 7. EXPLOSIVES/AMMO | a. Present | Yes | No | b. Involved | Yes | No

First, lets talk about the form itself.

Designated as the DA Form 285-AB-R,
Abbreviated Ground Accident Report (AGAR),
it can be found on Form Flow, Forms Engine and all the other current form producing software available to the US Army.
It may also be found as a Microsoft Word® document or template.

The AGAR has 7 main parts:

Yes | #1: | #1: | #1: | OPERATE | Yes | No | Yes | No | Yes If Yes, provide name | No | Yes If Yes, provide name | No

No | #2: | #2: | #2:

36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED / CONTRIBUTED TO THE ACCIDENT? *In 36A.a., indicate if individual made a mistake. If yes, provide the code (from instructions) in 36A.b. and describe in 36A.c.*

a. Mistake
Yes
No

b. Code

c. Tell what mistake was and how it caused / contributed to the accident.

DA FORM 285-AB-R, JUL 94

The AGAR has 7 main parts;

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see AR 385-40 and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENT CONTROL SYMBOL CSOCS-308

1. TIME & DATE OF ACCIDENT | a. Yr | b. Mth | c. Day | d. Time | 2. PERIOD OF DAY | Day | Night | 3. ACDT CLASS | 4. ACDT OCCURRED DURING | Combat | Non-Combat

5. UNIT IDENTIFICATION | a. UIC *(6-digit Code)* | b. Name of Unit | c. Unit's Branch | d. MACOM

6. LOCATION OF ACCIDENT | a. Exact Location *(Detailed enough to locate site)* | b. Type Location

c. State / Country | d. | Off-post | On-post Name: | 7. EXPLOSIVES/AMMO | a. Present | Yes | No | b. Involved | Yes | No

8. MISSION | a. Briefly describe the mission | b. MEVE Fabr. | Yes | No

9. VEHICLE / EQUIPMENT / MATERIAL INVOLVED — Material Failure / Malfunction Information

a. Type of Item (Nomenclature)	b. Model #	c. Ownership	d. Estimated Cost of Damage	e. Vehicle Collision	f. Failure Mode	g. Part Nomenclature	h. Part #	i. Part NSN	j. Part Manufacturer Code	k. EIR / QDR Submitted

1) The Date-Time-Group with unit and accident location

No

No

ain why

a. LEADER *(Not ready, willing to enforce standards)*	STUST PROCEDURES *(Not clear, Not practical)*	SUPPORT *(Shortcomings in type, capability, amount or condition of equip / supplies / services / facilities)*
Direct Supervision	AR	SOP	Equip / Material improperly designated	Inadequate Manufacture
Unit Command Supervision	TM	Other	Equip / Material not provided	Inadequate Maintenance
Higher Command Supervision	FM	None Exists	Inadequate Facilities/Services	Other

11. NAME (Last, First, MI) (Include address & UIC if different than Blks 5a & b.)

12. SOCIAL SECURITY # | 13. PERSONNEL CLASSIFICATION | 14. MOS | 15. DUTY STATUS | On-duty | Off-duty

16. AGE | 17. SEX | 18. PAY GRADE | 19. FLIGHT STATUS | Yes | No

20. MOST SEVERE INJURY *(See instructions)* | a. Degree | b. Type | c. Body Part | d. Cause

21. DAYS HOSPITALIZED

ACTIVITY OF INDIVIDUAL
Provide code (from list in instructions) and describe in space below

22. WORKDAYS
a. Lost
b. Restricted

23. CODE

24. SPECIFIC DESCRIPTION OF ACTIVITY / TASK

25. PERSONAL PROTECTIVE EQUIPMENT | 26. ALCOHOL / DRUGS / CAUSED / CONT ☐ Yes ☐ No ☐ Unk | 27. EQUIP THIS PERSON ASSOCIATED WITH? *(Enter item No. from Blk 9a):*

a. Required	b. Type Equip	c. Available	d. Used	28. LICENSED TO OPERATE	29. HRS ON DUTY	30. HRS SLEEP	31. TACTICLE TRAINING	32. TYPE TRAINING FACILITY	33. LAST TRAINING	34. FIELD TRAINING EXERCISE	35. NIGHT VISION SYSTEM USED
☐ Yes	#1:	#1:	#1:							☐ Yes If Yes, provide name	☐ Yes If Yes, provide name
☐ No	#2:	#2:	#2	☐ Yes ☐ No			☐ Yes ☐ No			☐ No	☐ No

36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED / CONTRIBUTED TO THE ACCIDENT? *In Blk a., indicate if individual made a mistake. If yes provide the code (from instructions) in Blk b. and describe in Blk c.*

a. Mistake
☐ Yes
☐ No

b. Code

c. Tell what mistake was and how it caused / contributed to the accident.

DA FORM 285-AB-R, JUL 94

The AGAR has 7 main parts;

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see AR 385-40 and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENT CONTROL SYMBOL CSOCS-308

1. TIME & DATE OF ACCIDENT | a. Yr | b. Mth | c. Day | d. Time | 2. PERIOD OF DAY | Day | Night | 3. ACDT CLASS | 4. ACDT OCCURRED DURING | Combat | Non-Combat

5. UNIT IDENTIFICATION | a. UIC *(6-digit Code)* | b. Name of Unit | c. Units Branch | d. MACOM

6. LOCATION OF ACCIDENT | a. Exact Location *(Detailed enough to locate site)* | b. Type Location

c. State / Country | d. | Off-post | On-post Name: | 7. EXPLOSIVES/AMMO | a. Present | Yes | No | b. Involved | Yes | No

8. MISSION | a. Briefly describe the mission | b. METL Task? | Yes | No

9. VEHICLE / EQUIPMENT / MATERIAL INVOLVED — Material Failure / Malfunction Information

a. Type of Item (Nomenclature)	b. Model #	c. Ownership	d. Estimated Cost of Damage	e. Vehicle Collision	f. Failure Mode	g. Part Nomenclature	h. Part#	i. Part NSN	j. Part Manufacturer Code	k. EIR / QDR Submitted	
#1										Yes	No
#2										Yes	No

10. WHY DID THE MATERIAL FAIL / MALFUNCTION? *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to material failure / malfunction)*

a.	LEADER *(Not ready, willing to enforce standards)*		STDS / PROCEDURES *(Not clear, Not practical)*		SUPPORT *(Shortcomings in type, capability, amount or condition of equip / supplies / services / facilities)*		
	Direct Supervision		AR		SOP		Equip / Material Improperly designated		Inadequate Manufacture
	Unit Command Supervision		TM		Other		Equip / Material not provided		Inadequate Maintenance
	Higher Command Supervision		FM		None Exists		Inadequate facilities/Services		Other

b. Describe how the material failed / malfunctioned and explain why *(root cause)*

2) Equipment Information involved in the accident

d. Cause

22. WORKDAYS
a. Lost
b. Restricted

23. CODE

24. SPECIFIC DESCRIPTION OF ACTIVITY / TASK

25. PERSONAL PROTECTIVE EQUIPMENT | 26. ALCOHOL / DRUGS / CAUSED / CONT ☐ Yes ☐ No ☐ Unk | 27. EQUIP THIS PERSON ASSOCIATED WITH? *(Enter Item No. from 9A, 9a):*

a. Required	b. Type Equip	c. Available	d. Used	28 LICENSED TO OPERATE	29. HRS ON DUTY	30. HRS SLEEP	31. TACTICLE TRAINING	32. TYPE TRAINING FACILITY	33. LAST TRAINING	34. FIELD TRAINING EXERCISE	35. NIGHT VISION SYSTEM USED
☐ Yes	#1:	#1:	#1:	☐ Yes ☐ No			☐ Yes ☐ No			☐ Yes If Yes, provide name	☐ Yes If Yes, provide name
☐ No	#2:	#2:	#2							☐ No	☐ No

36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED / CONTRIBUTED TO THE ACCIDENT? *In 36 a., indicate if individual made a mistake. If yes, provide the code (from instructions) in 36. b. and describe in 36. c.*

a. Mistake
☐ Yes
☐ No

b. Code

c. Tell what mistake was and how it caused / contributed to the accident.

DA FORM 285-AB-R, JUL 94

The AGAR has 7 main parts;

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see AR 385-40 and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENT CONTROL SYMBOL CSOCS-308

1. TIME & DATE OF ACCIDENT | a. Yr | b. Mth | c. Day | d. Time | 2. PERIOD OF DAY | Day | Night | 3. ACDT CLASS | 4. ACDT OCCURRED DURING | Combat | Non-Combat

5. UNIT IDENTIFICATION | a. UIC *(6-digit Code)* | b. Name of Unit | c. Units Branch | d. MACOM

6. LOCATION OF ACCIDENT | a. Exact Location *(Detailed enough to locate site)* | b. Type Location

c. State / Country | d. | Off-post | On-post Name: | 7. EXPLOSIVES/AMMO | a. Present | Yes | No | b. Involved | Yes | No

8. MISSION | a. Briefly describe the mission | b. METL Task? | Yes | No

9. VEHICLE / EQUIPMENT / MATERIAL INVOLVED | Material Failure / Malfunction Information

| | | |

The AGAR has 7 main parts;

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see AR 385-40 and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENT CONTROL SYMBOL CSOCS-308

1. TIME & DATE OF ACCIDENT | a. Yr | b. Mth | c. Day | d. Time | 2. PERIOD OF DAY | Day | Night | 3. ACDT CLASS | 4. ACDT OCCURRED DURING | Combat | Non-Combat

5. UNIT IDENTIFICATION | a. UIC *(6-digit Code)* | b. Name of Unit | c. Units Branch | d. MACOM

6. LOCATION OF ACCIDENT | a. Exact Location *(Detailed enough to locate site)* | b. Type Location

c. State / Country | d. | Off-post | On-post Name: | 7. EXPLOSIVES/AMMO | a. Present | Yes | No | b. Involved | Yes | No

8. MISSION | a. Briefly describe the mission | b. METL Task? | Yes | No

9. VEHICLE / EQUIPMENT / MATERIAL INVOLVED — Material Failure / Malfunction Information

a. Type of Item (Nomenclature)	b. Model #	c. Ownership	d. Estimated Cost of Damage	e. Vehicle Collision	f. Failure Mode	g. Part Nomenclature	h. Part#	i. Part NSN	j. Part Manufacturer Code	k. EIR / QDR Submitted
#1										Yes / No
#2										Yes / No

10. WHY DID THE MATERIAL FAIL / MALFUNCTION? *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to material failure / malfunction)*

a.	LEADER *(Not ready, willing to enforce standards)*	STDS / PROCEDURES *(Not clear, Not practical)*		SUPPORT *(Shortcomings in type, capability, amount or condition of equip / supplies / services / facilities)*	
	Direct Supervision	AR	SOP	Equip / Material Improperly designated	Inadequate Manufacture
	Unit Command Supervision	TM	Other	Equip / Material not provided	Inadequate Maintenance
	Higher Command Supervision	FM	None Exists	Inadequate Facilities/Services	Other

b. Describe how the material failed / malfunctioned and explain why *(root cause)*

11. NAME (Last, First, MI) *(Include address & UIC if different than Blks 5a & b.)* | 12. SOCIAL SECURITY # | 13. PERSONNEL CLASSIFICATION | 14. MOS | 15. DUTY STATUS | On duty | Off duty

16. AGE | 17. SEX | 18. PAY GRADE | 19. FLIGHT STATUS | Yes | No

20. MOST SEVERE INJURY *(See instructions)* | a. Degree | b. Type | c. Body Part | d. Cause

21. DAYS HOSPITALIZED | ACTIVITY OF INDIVIDUAL *Provide code (from list in instructions) and describe in space below*

4) Mistake Information

25. PERSONAL PROTECTIVE EQUIPMENT | 26. ALCOHOL / DRUGS / CAUSED / CONT | Yes | No | Unk | 27. EQUIP THIS PERSON ASSOCIATED WITH? *(Enter item No. from Blk. 9a)*:

a. Required	b. Type Equip	c. Available	d. Used	28 LICENSED TO OPERATE	29. HRS ON DUTY	30. HRS SLEEP	31. TACTICLE TRAINING	32. TYPE TRAINING FACILITY	33. LAST TRAINING	34. FIELD TRAINING EXERCISE	35. NIGHT VISION SYSTEM USED
Yes	#1:	#1:	#1:							Yes If Yes, provide name / No	Yes If Yes, provide name / No

36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED / CONTRIBUTED TO THE ACCIDENT? *In Blk a., indicate if individual made a mistake. If yes provide the code (from instructions) in Blk. b. and describe in Blk. c.*

a. Mistake
- Yes
- No

b. Code

c. Tell what mistake was and how it caused / contributed to the accident.

DA FORM 285-AB-R, JUL 94

The AGAR has 7 main parts:

37. WHY WAS THE MISTAKE MADE (ROOT CAUSES) *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to mistake)*

a.	LEADER (Not ready, willing to enforce standards)	TRAINING (Insufficient in content / Amount)	STDS / PROCEDURES (Not clear, Not practical)	SUPPORT (Shortcomings in type, capability, amount or condition of equip/ supplies/ services / facilities)	INDIVIDUAL (Mistake due to own personal factors)
	Direct Supervision	School	AR	SOP	Equip / Material Improperly designated	Inadequate Manufacture	Poor / Bad attitude	Fatigue
	Unit Command Supervision	Unit	TM	Other	Equip / Material not provided	Inadequate Maintenance	Overconfident	Alcohol / Drugs
	Higher Command Supervision	Experience, OJT	FM	None Exists	Inadequate Facilities/Services	Other	Hurry	Fear / Excitement

b. Describe rootcause(s) and tell how it/ they caused the mistake

38. ENVIRONMENTAL CONDITIONS

a. Present	b. Caused / Contributed		
#1:	Yes	No	Unk
#2:	Yes	No	Unk
#3:	Yes	No	Unk

39. PROVIDE BRIEF SYNOPSIS OF ACCIDENT *(Use additional sheets if required.) (Explain sequence of events, tell how accident happened)*

4) Mistake Information (continued)

40. CORRECTIVE ACTION(S) TAKEN OR PLANNED>

41. POINT OF CONTACT FOR INFORMATION ON THE ACCIDENT

a. Name (Last, First, MI):

b. Telephone #

42. COMMAND REVIEW a. Name	c. Rank	43. SAFETY OFFICE REVIEW	b. Date
b. Signature	d. Date:	a. Name	

The AGAR has 7 main parts:

37. WHY WAS THE MISTAKE MADE (ROOT CAUSES) *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to mistake)*

a.	LEADER (Not ready, willing to enforce standards)	TRAINING (Insufficient in content / Amount)	STDS / PROCEDURES (Not clear, Not practical)	SUPPORT (Shortcomings in type, capability, amount or condition of equip/ supplies/ services / facilities)				INDIVIDUAL (Mistake due to own personal factors)			
				Material improperly designated		Inadequate Manufacture		Poor / Bad attitude		Fatigue	
				Material not provided		Inadequate Maintenance		Overconfident		Alcohol / Drugs	
				Inadequate Facilities/Services		Other		Inattentive		Fear / Excitement	

5) Synopsis of accident

b. Describe root cause(s) and tell how it/ they caused the mistake

38. ENVIRONMENTAL CONDITIONS

a. Present	b. Caused / Contributed		
#1:	Yes	No	Unk
#2:	Yes	No	Unk
#3:	Yes	No	Unk

39. PROVIDE BRIEF SYNOPSIS OF ACCIDENT *(Use additional sheets if required.) (Explain sequence of events, tell how accident happened)*

40. CORRECTIVE ACTION(S) TAKEN OR PLANNED>

41. POINT OF CONTACT FOR INFORMATION ON THE ACCIDENT

a. Name (Last, First, MI):

b. Telephone #

42. COMMAND REVIEW a. Name	c. Rank	43. SAFETY OFFICE REVIEW	b. Date
b. Signature	d. Date:	a. Name	

The AGAR has 7 main parts:

37. WHY WAS THE MISTAKE MADE (ROOT CAUSES) *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to mistake)*

a.	LEADER (Not ready, willing to enforce standards)	TRAINING (Insufficient in content / Amount)	STDS / PROCEDURES (Not clear, Not practical)	SUPPORT (Shortcomings in type, capability, amount or condition of equip/ supplies/ services / facilities)	INDIVIDUAL (Mistake due to own personal factors)
	Direct Supervision	School	AR / SOP	Equip / Material Improperly designated / Inadequate Manufacture	Poor / Bad attitude / Fatigue
	Unit Command Supervision	Unit	TM / Other	Equip / Material not provided / Inadequate Maintenance	Overconfident / Alcohol / Drugs
	Higher Command Supervision	Experience, OJT	FM / None Exists	Inadequate Facilities/Services / Other	Hurry / Fear / Excitement

b. Describe rootcause(s) and tell how it/ they caused the mistake

38. ENVIRONMENTAL CONDITIONS

a. Present	b. Caused / Contributed		
#1:	Yes	No	Unk
#2:	Yes	No	Unk
#3:	Yes	No	Unk

39. PROVIDE BRIEF SYNOPSIS OF ACCIDENT *(Use additional sheets if required.) (Explain sequence of events, tell how accident happened)*

6) Corrective Action

40. CORRECTIVE ACTION(S) TAKEN OR PLANNED>

41. POINT OF CONTACT FOR INFORMATION ON THE ACCIDENT

a. Name (Last, First, MI):

b. Telephone #

42. COMMAND REVIEW a. Name	c. Rank	43. SAFETY OFFICE REVIEW	b. Date
b. Signature	d. Date:	a. Name	

The AGAR has 7 main parts:

37. WHY WAS THE MISTAKE MADE (ROOT CAUSES) *(Check the root cause(s) in Block a. In Block b, explain how the root cause(s) led to mistake)*

a.	LEADER (Not ready, willing to enforce standards)		TRAINING (Insufficient in content / Amount)		STDS / PROCEDURES (Not clear, Not practical)			SUPPORT (Shortcomings in type, capability, amount or condition of equip / supplies / services / facilities)				INDIVIDUAL (Mistake due to own personal factors)		
	Direct Supervision		School		AR		SOP		Equip / Material improperly designated		Inadequate Manufacture		Poor / Bad attitude		Fatigue
	Unit Command Supervision		Unit		TM		Other		Equip / Material not provided		Inadequate Maintenance		Overconfident		Alcohol / Drugs
	Higher Command Supervision		Experience, OJT		FM		None Exists		Inadequate Facilities/Services		Other		Hurry		Fear / Excitement

b. Describe root cause(s) and tell how it / they caused the mistake

38. ENVIRONMENTAL CONDITIONS

a. Present	b. Caused / Contributed		
#1:	Yes	No	Unk
#2:	Yes	No	Unk
#3:	Yes	No	Unk

39. PROVIDE BRIEF SYNOPSIS OF ACCIDENT *(Use additional sheets if required.) (Explain sequence of events, tell how accident happened)*

40. CORRECTIVE ACTION(S) TAKEN OR PLANNED>

7) Command Review and Point of Contact Information

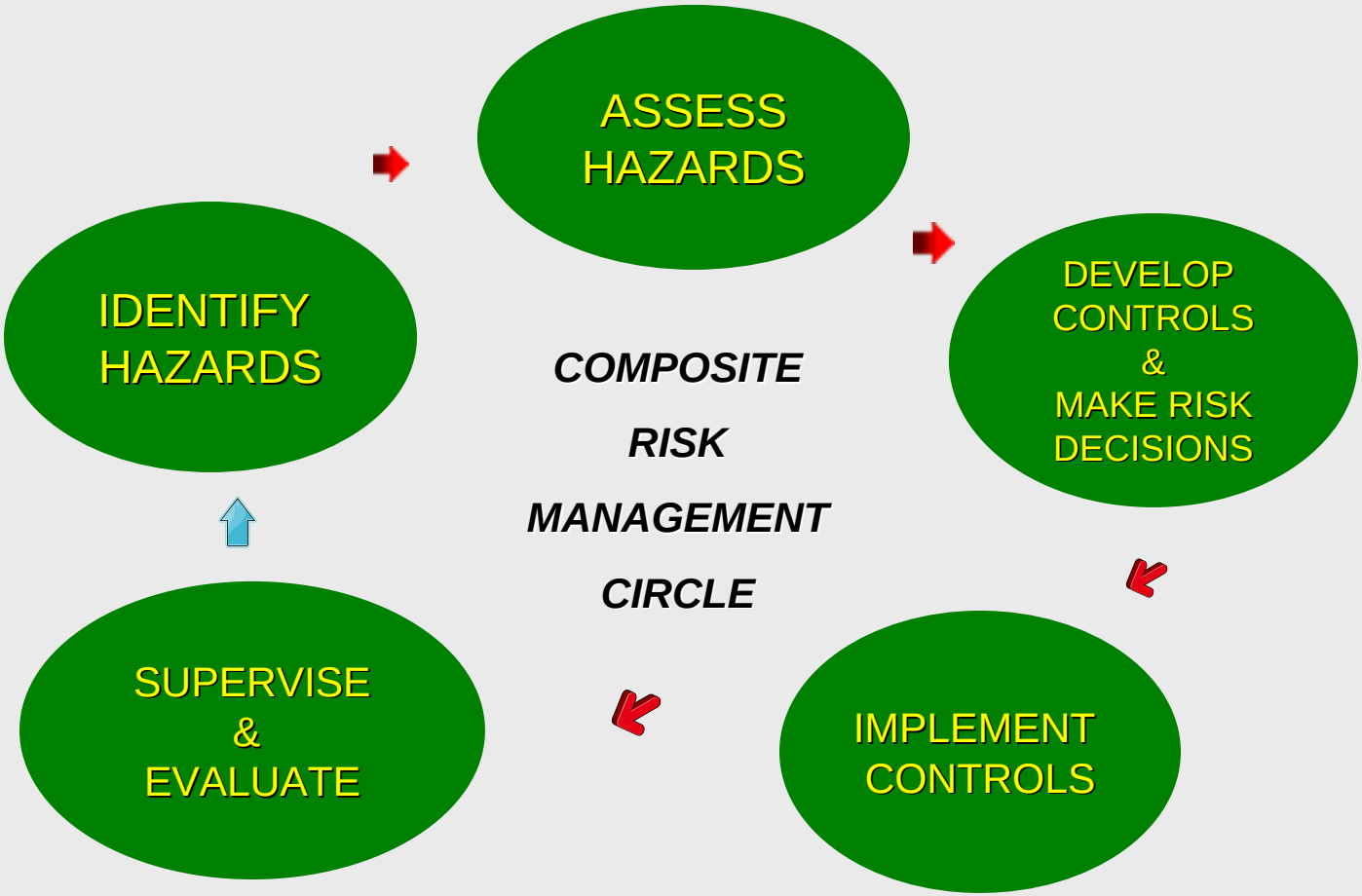
41. POINT OF CONTACT FOR INFORMATION ON THE ACCIDENT

a. Name (Last, First, MI):

b. Telephone #

42. COMMAND REVIEW a. Name	c. Rank	43. SAFETY OFFICE REVIEW	b. Date
b. Signature	d. Date:	a. Name	

COMPOSITE RISK MANAGEMENT


ASSESS HAZARDS
DEVELOP CONTROLS & MAKE RISK DECISIONS
IMPLEMENT CONTROLS
SUPERVISE & EVALUATE
IDENTIFY HAZARDS
COMPOSITE RISK MANAGEMENT CIRCLE

- What does this circle look like in a real life situation?
- How can we use it both on the job and off?
- If I am just relaxing at a command picnic do I need to think about CRM?

Scenario 1

- You have just been asked to serve on your command's MWR committee.
- Your first task is to develop a plan for the command picnic scheduled next month.
- How can you use CRM to reduce the risk of an accident at the picnic?

COMPOSITE RISK MANAGEMENT WORKSHEET

For use of this form, see FM100-14; the proponent agency is TRADOC.

1.MSN/TASK	2a. DTG BEGIN	2b. DTG END	3. DATE PREPARED (YYYYMMDD)
MWR Picnic	2008 05 16 0900	2008 05 16 1330	2008 05 15

4. PREPARED BY

a. LAST NAME	b. RANK	c. POSITION
Martin Anagell	YA-02	Safety Specialist

5. SUBTASK	6. HAZARDS	7. INITIAL RISK LEVEL	8.CONTROLS	9. RESIDUAL RISK LEVEL	10. HOW TO IMPLEMENT	11. HOW TO SUPERVISE (WHO)	12. WAS CONTROL EFFEC-TIVE?
Drinking alcohol?	Drinking too much and getting drunk.	H	Serve only softdrinks and water	L	Serve only soft drinks and water	Organizers keep eyes open during picnic for any potential violators.	
Food Storage	Contamination if not kept cool	H	Cold boxes to keep food fresh, Raw and cooked food stored separately, No raw meat served, Temperature probe used	L	Stock cold boxes, Check meat temperatures, Have ice available	Keep on top of what is happening and make changes as necessary during the picnic to the original plan	
Cooking; Heat, fire, location	Fire, burns, BBQ tools are sharp	M	Fire extinguishers by grills, Separate cooking area, BBQ tools for each BBQ, BBQ PPE		Have fire ext. by grills, Separate cooking area, BBQ tools and gloves for each grill	Make a note of any changes, so you can review your implementation plan for any lessons learned	
Location; access, parking	Not enough parking, hard to get too, water safety	M	Easy access, enough parking for all, Water safety brief and lifeguards	L	Use Checklist		
Equipment; condition, renting	Rented equipment, electrical safety	M	Use checklists to check condition, ensure rented equip. is checked/properly used, electrically safe	L	UseChecklist and check equipment electrically		
Weather; temperature, rain	Rain, very hot	M	Rain date, First Aid station, Shade/cover from Sun.	L	Set rain date, Set up First Aid station, Shade/Cover from Sun available		
Animals; Critters, mosquitos	Bites, ticks	M	Apply pesticide, Publish leash requirement for dogs, don't feed wild an.	L	Publish rules and request adherance	Organizers and Heads of family	

13. OVERALL RISK LEVEL AFTER CONTROLS ARE IMPLEMENTED *(Check one)*

☑ LOW ☐ MODERATE ☐ HIGH ☐ EXTREMELY HIGH

Last Name Rank Commander's Signature _____

Step 1: Identify Hazards

- Drink
  - Alcohol?
- Food
  - Preparation, Storage
- Cooking
  - Heat/Fire, Location
- Location
  - Access, Parking
- Equipment
  - Condition, Renting
- Weather
  - Temperature, Rain
- Animals/Critters
  - Insects, Dogs

Step 2: Assess Hazards

- Probability
  - Drink
  - Food
  - Cooking
  - Location
  - Equipment
  - Weather
  - Animals/Critters

Probability

- Severity
  - Drink
  - Food
  - Cooking
  - Location
  - Equipment
  - Weather
  - Animals/Critters

Severity

Step 3: Make Risk Decisions

- Drink
  - Only water/soft drinks served, No alcohol
- Food
  - Cold boxes to keep food fresh, Raw and cooked food stored separately, No raw meat served, Temperature probe
- Cooking
  - Fire extinguishers by grills, Separate cooking area, BBQ tools for each BBQ, BBQ PPE

- Location
  - Easy access, Enough parking, Water safety
- Equipment
  - Use checklists to check condition, Ensure rented equipment is checked/properly used, Electrical safety
- Weather
  - Rain Date, First Aid station, Shade/Cover
- Animals/Critters
  - Pesticide application, Leash requirement for dogs

Step 4: Implement Controls

- Drink
  - Serve only soft drinks & water
- Food
  - Stock cold boxes, Check meat temperatures, Have ice available
- Cooking
  - Have fire extinguishers by grills, Separate cooking area, Have BBQ tools and gloves for each grill

- Location
  - Use checklist
- Equipment
  - Use checklist and check equipment
- Weather
  - Set Rain Date, Set up First Aid station, Shade/Cover available
- Animals/Critters
  - Apply pesticide, Publish leash requirement for dogs

Step 5: Supervise

- Keep your eyes open for potential problems during the picnic
- Make changes as necessary during the picnic to your plan
- Make a note of any changes, so you can review your implementation plan for any lessons learned

Scenario 1 Summary

- The command picnic was a great success
- Using CRM allowed you to choose a good location and ensure that everything was ready to go safely

Job Hazard Analyses

Supervisor Training

Gefährdungsanalyse US Truppenübungsplatz Hohenfels

Work Section	CLASS III YARD		
Mission	Storage and issue of fuel and chemicals		
Employees	NERB Josef, WEIGERT Ludwig, KOLLER Ewald, GADDY Donald		
Medical Examination			
Hazards	**Controls**	**Status/How implemented**	**Supervised**
Hazards while refilling fuelers	All vehicles must use the existing grounding system installed at Class III Yard. The grounding system is checked and maintained frequently thru a service contract	Completed	Workleader/Supervisor
Manual lifting of heavy loads by employees	A fork lift is available to move heavy loads. More than one employee will be used to lift loads > 25 kg manually.	Completed	Workleader/Supervisor
Hazards due to slip, trip and falls	Safety shoes are available and must be used. All spills must be cleaned up immediately	Ongoing	Workleader/Supervisor
Eye injuries due to spills	All products are stored and issued in original containers. Eye wash stations are available in all storage warehouses.	Ongoing/Completed	Workleader/Supervisor
Health Hazards from products like windshield cleaner, containing methyl alcohol	SOP's are available for all products. Methyl alcohol is stored in plastic bottles and will be issued in original containers only.	Completed	Workleader/Supervisor

Supervisor Training

Gefährdungsanalyse US Truppenübungsplatz Hohenfels

Slips and falls due to ice and snow	Snow and ice removal must be conducted from all employees. Employees are responsible for snow and ice removal from main gate to the office and also from the pump station to the storage building. General ice and snow control for Class III Yard will be conducted by DPW.	Ongoing	Employees/Workleader/ Supervisor
Health hazards due to work in unheated warehouses	Proper protective clothing is available and issued to all employees. Work in cold environment is limited to 30 minutes.	Ongoing	Employees/Workleader/Supervisor
Fire and explosive hazards while refilling operations from contractor	Contractor delivery firms are supervised by Class III personnel. Grounding points are available and must be used by contractor	Ongoing	Employees/Workleader/Supervisor
Falls from elevated workplaces	Fall protection and slip proof stairs are available. Elevated fuel tanks are checked only one time per week manually. A automatic fuel level measuring system is available.	Completed	Workleader/Supervisor
Falls in underground fuel control manholes	All underground fuel tanks will be conected to the automatic system also. Work order was submitted to extend the existing gage system.	Not completed. WOR # 06767-4.	Supervisor

Supervisor Training

Gefährdungsanalyse US Truppenübungsplatz Hohenfels

Hazards to to fork lift operations	Only proper trained personnel is allowed to operate forklifts	Ongoing	Supervisor
Hazards to to spills	Spill plan is available. All spills must be cleaned up immediately. Spills > 3 gal must be reported to the Fire Department and Environmental Office.	Ongoing	Supervisor
Fire and explosive hazards in general	Open flames are strictly forbidden at Class III Yard. Smoking areas are established in front and behind Bldg. # 513. The Class III Yard is frequently inspected by the fire department.	Completed	Supervisor
General Hazards	Protective clothing and equipment is provided IAW 7ATC Reg 385-1.	Completed	Supervisor
Health hazards due to fuels and chemical products	All employees are enrolled into the medical examination program. The Class III Yard is frequently inspected by Preventive Medicine.	Ongoing	Supervisor/Preventive Medicine

Gefährdungsanalyse gelesen und genehmigt.

Die Beschäftigten sind auf Grund der Gefährdunganalyse zu unterweisen und die Unterweisung ist von den Beschäftigen durch Unterschrift zu bestätigen.

Supervisor Training

Gefährdungsanalyse US Truppenübungsplatz Hohenfels

MICHAEL DOBLER, WS-7, Supervisor Class III Yard

_____ Unterschrift _____ Datum

Durch meine Unterschrift bestätige ich, dass ich die Unterweisung erhalten und verstanden habe:

NERB, Josef _____ Unterschrift _____ Datum

WEIGERT, Ludwig _____ Unterschrift _____ Datum

KOLLER, Ewald _____ Unterschrift _____ Datum

GADDY, Donald _____ Signature _____