



DEPARTMENT OF THE NAVY

NAVAL SEA SYSTEMS COMMAND  
1333 ISAAC HULL AVE SE  
WASHINGTON NAVY YARD DC 20376-0001

IN REPLY TO

9077  
Ser 07TC/221  
17 APR 03

SEA 07T STANDARD OPERATING PROCEDURE (SOP) NO. 15

From: Director, Submarine Hull Mechanical and Electrical  
(H,M&E) Engineering management Division, NAVSEA 07T

Subj: CRITIQUES PROCESS

Ref: (a) NAVSEAINST 5510.01A, Command Headquarters Security  
Program Regulation Notice

Encl: (1) Critique Process Flowchart  
(2) Critique Report

1. **Purpose:** This standard operating procedure (SOP) defines the responsibilities and procedures for investigating undesirable events, conducting critiques, preparing required reports, and completing and tracking follow up actions. A critique should be a tool to prevent problem recurrence and inform of the detailed information on the causes of a significant problem or incident. The critique also ensures formal corrective action is taken. Further, this process makes available information on the failure of equipment, procedures, operations, or undesired behavior. The resulting information is useful when developing personnel training material and future risk mitigation strategies.

2. **Background:** A critique is performed when a significant failure associated with a program, process, or product is uncovered. Section heads determine the need to conduct a critique based on the significance of the issue (e.g. uncertified submarine at sea, NAVSEA approval of an unacceptable condition, etc...). Section heads will consult with NAVSEA 07TC, the SEA 07T Submarine Safety (SUBSAFE) and Deep Submergence Systems (DSS) Director (SS/DSSD) to evaluate the need to conduct a critique. The critique process is represented in enclosure (1).

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3. **Responsibilities:** The SS/DSSD (SEA 07TC) is responsible for oversight of all critiques to ensure that undesirable events are properly investigated, reported, documented, and corrected in a timely manner. The section head and the person discovering the problem are responsible for compliance with this instruction and ensuring the undesirable event is brought to management's attention.

4. **Customers:** The primary customers of this instruction are all SEA 07T personnel.

5. **Procedure:**

a. **Notification of Problem:**

(1) The Person discovering the problem shall:

(a) Notify the section head(s).

(b) Take immediate action to reduce or confine the area of concern.

(2) The section head(s) shall:

(a) Obtain first hand information concerning the situation and assure adequate immediate action has been taken.

(b) Upon determination of a potential significant problem, notify the branch head(s), SEA 07TC, and SEA 07T. All suspected SUBSAFE or DSS issues should be brought to the immediate attention of SEA 07TC.

(c) If the event is a significant problem, assign a critique leader (usually the section head where the problem originated) to handle the rest of the investigation.

b. **Preliminary Investigation:**

(1) Critique leader shall:

(a) Conduct a preliminary investigation to the maximum extent possible. Prepare a complete chronological statement of the facts relative to the events, which led to the occurrence.

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(b) Identify immediate corrective actions.

(c) Develop a list of questions not answered by the preliminary investigation to be asked during the critique meeting.

(d) Ensure all references, documents or other information pertinent to the problem are available for examination and discussion at the critique meeting. Also, impact to other areas of SEA 07 must be considered, identified, and addressed.

(e) Schedule a critique meeting and invite attendees.

(f) Obtain a critique serial number from SEA 07TC.

c. Critique Meeting:

(1) A critique meeting should be held as soon as possible once the problem is discovered.

(2) Attendance at the critique meetings should be limited to those personnel required to accomplish the goals of the meeting. SEA 07TC shall be informed of and invited to attend all critiques. If it becomes apparent that additional personnel are necessary to provide information relative to the problem, the meeting should be reconvened when the necessary personnel can attend.

(3) At the beginning of the critique meeting, the critique leader will distribute a written summary of the non-compliance, facts, and list of problems (critique report items 1, 2, and 4 respectively) determined during their preliminary investigation. Once these items are understood by attending personnel, the floor will then be opened to solicit any additional facts and/or related problems.

(4) Once all the facts have been determined, the personnel in attendance will finalize the list of problems. **Special attention should be focused on impact to ship's safety, mission, reliability, and whether there is a need to elevate the problem (e.g., message).** At this time, identification of readily apparent root causes, immediate, short term, permanent

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(long-term) corrective actions for the identified root causes, and problems will be accomplished. For any problem where the root cause cannot be determined, the root cause, and associated corrective actions shall be determined as soon as possible. For all actions, a lead action section, and estimated completion date shall be determined.

d. Critique Report Preparation/Documentation:

(1) The critique leader shall prepare a critique report (see enclosure (2)) and distribute it to applicable parties, following the identification of the occurrence.

(2) Corrective actions should address all of the identified problems, all NAVSEA processes/programs or products that are affected, lead action section, and estimated completion date.

(3) The summary of the facts should accurately describe the pertinent facts that are known to have happened and the sequence of events related to the incident or which could have contributed to the problem. Personnel not directly involved with the event should be able to understand what happened by reading this account.

(4) Once the critique report has been prepared, the document must be marked per reference (a).

(5) The critique report will be approved by the cognizant/responsible section head, program manager, branch head, critique leader, SEA 07TC, and SEA 07T. All other sections that were wholly or partially responsible for causing the problem(s) associated with the incident shall have an opportunity to review the critique prior to the critique report's approval. Upon completing the critique report, the critique leader shall obtain appropriate concurrences and make distribution.

(6) The critique leader shall issue the critique report (all signatures obtained) within thirty days of the critique meeting.

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(7) SEA 07TC shall be on distribution for all critique reports and will maintain the SEA 07T official files and is responsible for tracking all critique actions to completion.

(8) When an evaluation of the issue will benefit another activity, the critique leader or SEA 07TC shall ensure the critique report is forwarded to that activity in order to provide the activity an opportunity to evaluate their current conditions with respect to the problem.

(9) SEA 07TC forwards to NAVSEA 07Q, all SEA 07T SUBSAFE and DSS Critiques upon completion of Critique process.

e. Critique Action Item Closeout. All Objective Quality Evidence (OQE) that will be used to close the critique action shall be forwarded to SEA 07TC.

6. Training: Personnel who conduct critique meetings and/or facilitate root cause determination shall receive training.

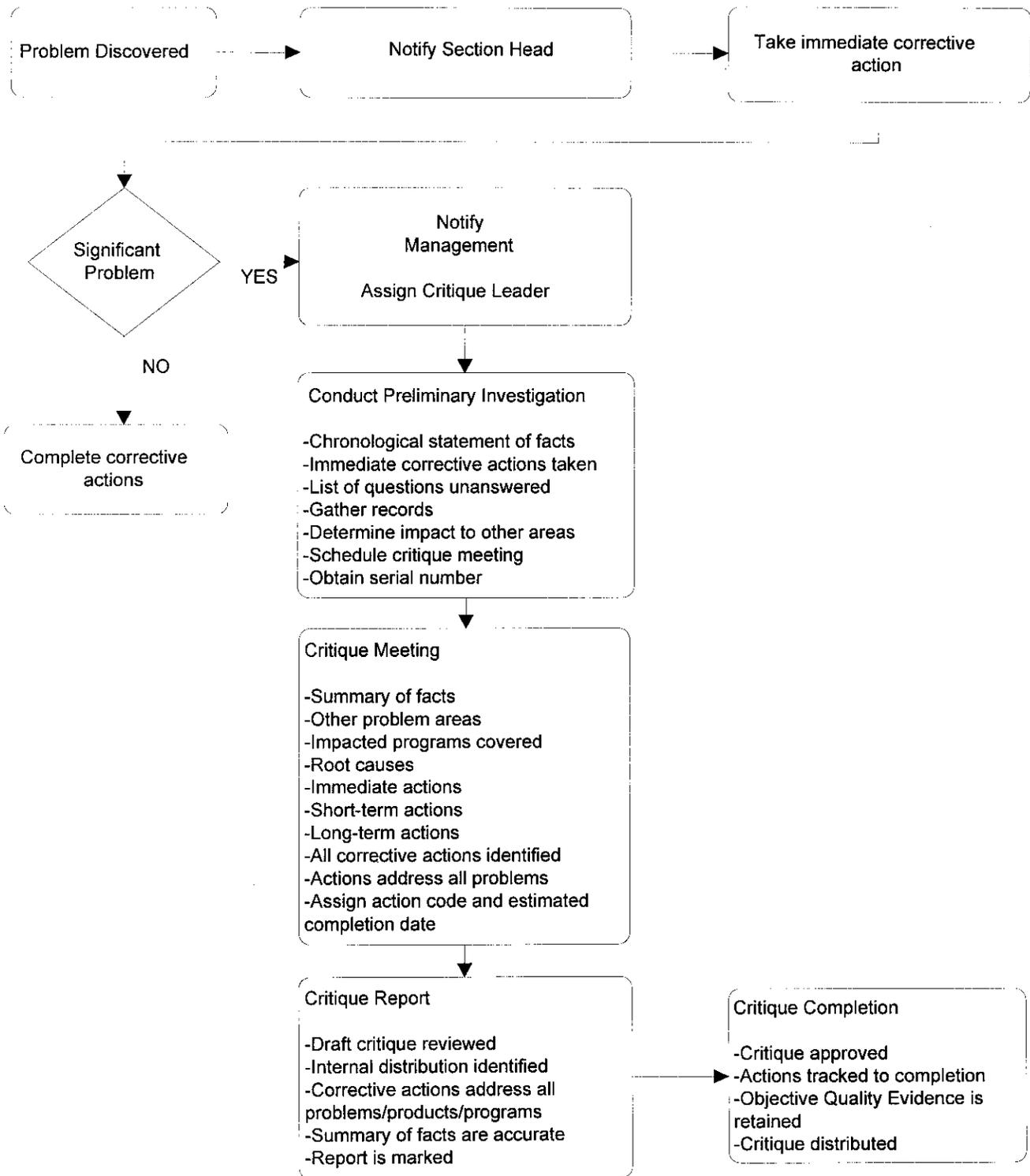
7. Process Measurement: Not applicable.

8. Quality Records: The quality records generated by this instruction are the critique report and the OQE for completion of critique actions. Quality records shall be organized and filed in a manner which facilitates identification and access of individual records in support of the NAVSEA SUBSAFE and DSS Functional Internal Audits and SEA 07T Engineering Quality Assessments (EQA). Quality records shall be retained on-site for a minimum of five years after which time, they may be destroyed.

9. Leadership Oversight: SEA 07T will monitor compliance with the provisions of this instruction via SEA 07T EQA process.

  
S. SCHULZE

## CRITIQUE PROCESS FLOWCHART



NO: Year-Section-###

**NAVSEA  
CRITIQUE REPORT**

**SUBSAFE/DSS** YES (Circle one)  
No

**TITLE:** *Title based on the most obvious problem.*



**NAVSEA APPROVAL**

DATE CODE  
PREPARED BY SEA 07\_##

DATE CODE  
SEA 07T# SECTION HEAD

DATE CODE  
SEA 07T## BRANCH HEAD

DATE CODE  
SS/DSSD (SEA 07TC)

APPROVED BY      DATE CODE  
NAVSEA 07T

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DISTRIBUTION:  
NAVSEA (SEA 07Q)

INFO:

## CRITIQUE REPORT

PREPARED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

CRITIQUE SERIAL NUMBER: \_\_\_\_\_  
YEAR SECTION SEQ. NO.

1. Non-compliance:

*State the Non-compliance in a brief statement.*

2. Summary of the facts (including description of the problem):

*Provide a brief description of the problem. Typically will be a chronological statement of the facts relative to the events, which led to the occurrence, and immediate corrective actions taken.*

3. All root causes:

*Specify the actual root cause and not merely a restatement of the problem.*

*The root cause should dig deep enough into the cause of the problem and is not shallow or vague. For example, "inattention to detail" and "lack of mental attention" are normally inappropriate as root causes since they are typically problems that resulted from the root cause.*

*Does the root cause specified match the problem identified?*

*Root cause evaluation requires a critical look into the inner workings of the subject process and a realization of the weaknesses that led to the problem. The most common failure in this area is insufficient depth of evaluation to determine the root cause. For example, apparent root causes such as "lack of mental attention" or "inattention to detail" typically results in ineffective corrective actions. Another common error is that the problem cited is restated as the root cause. The root cause determination is critical since it ultimately determines the appropriate permanent corrective action.*

4. Problems which contributed to occurrence of the event:

*Identify all the problems, which contributed to the problem.*

5. Immediate corrective actions:

*Briefly describe all actions taken to immediately contain the condition.*

6. Short-term corrective actions:

*List all short-term corrective actions associated with the given problem. For any outstanding actions List the section(s) responsible to perform the specified short-term corrective actions, and the estimated date(s) for completing the specified short-term corrective action(s).*

*Indicate action(s) taken to resolve the specific problem noted. These actions are designed to be temporary in nature and not programmatic (i.e., only to last until the permanent corrective actions are in place).*

*Are the short-term corrective actions specified adequate to prevent problem recurrence until the permanent corrective actions are in place or are the completion dates for permanent corrective actions of such a long lead time that the short term corrective actions would be rendered ineffective?*

7. Long-term (permanent) corrective actions:

*List all long-term corrective actions associated with the given problem. List the action section(s) responsible to perform the specified long-term corrective actions and the estimated date(s) for completing the specified long-term corrective action(s).*

*Long-term actions taken should correct the root cause and prevent recurrence (e.g., changing a SOP, revising the process, changing training/plans, etc.) of the significant problem.*