NAVEXOS-108 (REV. 1-60)
EXCEPTION TO STANDARD FORM 92
APPROVED BY BUREAU OF THE BUDGET, JAN. 1960

ACCIDENT REPORT

REPORT EXOS-5100-6

DATE (*Day, Month, Year*): 18 AUG., 1966

Do not use

1. REPORTING SHIP, ACTIVITY OR UNIT: USNS GEN. JOHN POPE T-AP 110 (0E710)

FLEET OR NAV. DIST. NO.: MSTS

2.

PERSONNEL INJURED (*Name, Rank, Rate or Trade, and Branch of Service*)	AGE	YEARS EXPER.	DUTY OR WORK ASSIGNMENT: REG.	TEMP.	RECR.	LV/LIB.	TRAV.	OTHER	EST. DAYS LOST OR TIME CHGS.	TOTAL DISABLING INJURIES
YOUNG, GEORGE E.S., QUARTERMASTER, MSTS	45	10	X							

3.

PROPERTY/EQUIPMENT DAMAGE: TYPE	OWNERSHIP	ESTIMATED DAMAGE COST: LABOR	MATERIAL	OVERHEAD	TOTAL
N/A					

4.

DATE AND TIME OF ACCIDENT: HOUR	DAY	MONTH	YEAR	WEATHER: GOOD	ADVERSE	NOT APPLIC.	LIGHT: GOOD	POOR	NOT APPLIC.
0815	17	AUGUST	66	X			X		

5. DESCRIPTION OF ACCIDENT: *Describe the accident so that the Reviewing Official can get a clear picture of the accident and the reasons for it. Select and check closest applicable item in each section on back of form.*

WHILE ENTERING WEATHER DECK FROM PASSAGEWAY, SOOT FROM STACK BLEW INTO RIGHT EYE.

6. FORMS SUBMITTED APPLICABLE TO INJURED CIVILIAN EMPLOYEES

A. C.A.1 [X] YES [ ] NO   B. C.A.2 [X] YES [ ] NO   C. OTHER (INDICATE): ____

7. RECOMMENDED CORRECTIVE ACTION: *What recommendations have been made which will help prevent another accident like this?*

EMPLOYEE ADVISED TO BE ALERT REGARDS DIRT PARTICLES FROM STACK AT ALL TIMES.

SIGNATURE OF SUPERVISOR, CHIEF OF WORKING PARTY OR HEAD OF WORK DETAIL:	TITLE, RANK, RATE OR GRADE	DATE
WM. H. CUNNINGHAM FOR MR. LARSON	FIRST OFFICER	18 AUG., 1966

8. REVIEW AND COMMENT OF REVIEWING OFFICIAL

SIGNATURE OF REVIEWING OFFICIAL:	TITLE, RANK, RATE OR GRADE	DATE
JOHN HARRINGTON	MASTER	18 AUG., 1966

SECTION 9 AGENCY INVOLVED

Check (x) and specify in space provided the object or substance most closely associated with the injury and which in general could have been properly guarded or corrected. One check (x) MUST be entered in this section.

Do not use

- [ ] 1. MACHINES: *(Agitators, grinders, sewing machines, vices, saws, lathes, welding machines, etc.)*
- [ ] 2. PRIME MOVERS & PUMPS: *(Steam, internal combustion or air, compressors, fans, blowers, etc.)*
- [ ] 3. ELEVATORS: *(Passenger, freight, aircraft or dumbwaiters)*
- [ ] 4. HOISTING APPARATUS: *(Cranes, hoists (air or electric), shovels, dredges, jacks, etc.)*
- [ ] 5. CONVEYORS: *(Belt, monorail, pneumatic, drag line, tiering or piling, etc.)*
- [ ] 6. BOILERS & PRESSURE VESSELS: *(Fired or unfired, pressure lines, etc.)*
- [ ] 7. VEHICLES: *(All types; except in traffic or flight)*
- [ ] 8. ANIMALS: *(Including insects and reptiles)*
- [ ] 9. MECHANICAL POWER TRANSMISSION APPARATUS: *(Belts, gears, couplings, etc.)*
- [ ] 10. ELECTRICAL APPARATUS: *(Motors, transformers, lamps, appliances, etc.)*
- [ ] 11. HAND TOOLS: *(Hand, mechanical or electrical motive power; hammers, wrenches, welding tools, sandblasters, etc.)*
- [ ] 12. CHEMICALS: *(Explosives, gases, vapors, acids, caustics, poisonous vegetations, etc.)*
- [ ] 13. HIGHLY INFLAMMABLE & HOT SUBSTANCES: *(Fire, alcohol, steam, paints, etc.)*
- [x] 14. DUSTS: *(Explosive, organic or inorganic; leather, emery, coal, etc.)*
- [ ] 15. RADIATIONS & RADIATING SUBSTANCES: *(X-Ray, radium, ultra violet rays, etc.)*
- [ ] 16. WORKING SURFACES: *(Floors, decks, roofs, roads, stairs, platforms, stagings, scaffolds, etc.)*
- [ ] 17. AGENCIES: *(Any object or substance not otherwise classified.)*

WHAT PART OF AGENCY CHECKED (X) ABOVE WAS MOST CLOSELY INVOLVED?

SECTION 10 UNSAFE MECHANICAL CONDITION

Check (x) and specify the PRINCIPAL unsafe condition which led to or was responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 18. IMPROPER GUARDING: *(Unguarded, inadequately guarded, etc.)*
- [ ] 19. DEFECTIVE SUBSTANCES OR EQUIPMENT: *(Broken, rough, slippery, poorly designed, etc.)*
- [ ] 20. HAZARDOUS ARRANGEMENT: *(Unsafe piling, poor layout, etc.)*
- [ ] 21. IMPROPER ILLUMINATION: *(Insufficient light, glare, etc.)*
- [ ] 22. IMPROPER VENTILATION: *(Dusty, gassy, impure air source, etc.)*
- [ ] 23. UNSAFE CLOTHING: *(Lack of, unsuited or defective shoes, goggles, gloves, respirators, etc.)*
- [x] 24. NO UNSAFE CONDITION:
- [ ] 25. UNSAFE CONDITION NOT OTHERWISE CLASSIFIED: *(Explain)*

SECTION 11 TYPE OF ACCIDENT

Check (x) type of accident. One check (x) MUST be entered in this section.

- [ ] 26. STRIKING AGAINST *(Contact with rough or sharp objects, resulting in cuts, etc., due to striking against, kneeling on, or slipping on objects.*
- [ ] 27. STRUCK BY *(Falling, flying, sliding, or moving objects.)*
- [ ] 28. CAUGHT IN, ON, OR BETWEEN.
- [ ] 29. FALL ON SAME LEVEL.
- [ ] 30. FALL TO DIFFERENT LEVEL.
- [ ] 31. SLIP *(not fall)* OR OVER-EXERTION. *(Resulting in strain, hernia, etc.)*
- [ ] 32. EXPOSURE TO TEMPERATURE EXTREMES. *(Resulting in burning, scalding, heat exhaustion, sunstroke, freezing, etc.)*
- [ ] 33. INHALATION, ABSORPTION, SWALLOWING. *(Asphyxiation, poisoning, drowning, etc.)*
- [ ] 34. CONTACT WITH ELECTRIC CURRENT.
- [ ] 35. ELECTRIC WELDING FLASH.
- [x] 36. FOREIGN BODIES IN EYE. *(Resulting from dust, chips, airborne particles, etc.)*
- [ ] 37. TYPE OF ACCIDENT NOT OTHERWISE CLASSIFIED. *(Explain)*

SECTION 12 UNSAFE ACT

Check (x) and explain PRINCIPAL unsafe act. One check (x) MUST be entered in this section.

- [ ] 38. OPERATING WITHOUT AUTHORITY. *(Failure to secure or warn)*
- [ ] 39. OPERATING OR WORKING AT UNSAFE SPEED. *(Too slow, too fast, throwing materials, etc.)*
- [ ] 40. MAKING SAFETY DEVICES INOPERATIVE. *(Removing, misadjusting, disconnecting, etc.)*
- [ ] 41. USING UNSAFE EQUIPMENT, HANDS INSTEAD OF EQUIPMENT, OR EQUIPMENT UNSAFELY.
- [ ] 42. UNSAFE LOADING, PLACING, MIXING, ETC.
- [ ] 43. UNSAFE POSITION, POSTURE OR ACT, ETC. *(Under suspended loads, lifting with bent back, etc.)*
- [ ] 44. WORKING ON MOVING OR DANGEROUS EQUIPMENT. *(Cleaning, adjusting, oiling, etc.)*
- [ ] 45. DISTRACTING, TEASING, ABUSING, STARTLING, ETC. *(Quarreling, horseplay, etc.)*
- [ ] 46. FAILURE TO USE SAFE CLOTHING OR PERSONAL PROTECTIVE DEVICES. *(Hats, goggles, etc.)*
- [x] 47. NO UNSAFE ACT.
- [ ] 48. UNSAFE ACT NOT OTHERWISE CLASSIFIED *(Explain)*

SECTION 13 UNSAFE PERSONAL FACTOR

Check (x) and explain the unsafe personal factor chiefly responsible for the accident. One check (x) MUST be entered in this section.

- [ ] 49. IMPROPER ATTITUDE *(Disregard of instructions, failure to understand instructions, nervous, excitable, etc.)*
- [ ] 50. LACK OF KNOWLEDGE OR SKILL *(Unaware of safe practice, unskilled, etc.)*
- [ ] 51. BODILY DEFECTS *(Defective eyesight, hearing, fatigue, intoxicated, existing hernia, weak heart, etc.)*
- [x] 52. NO UNSAFE PERSONAL FACTOR:
- [ ] 53. UNSAFE PERSONAL FACTOR NOT ELSEWHERE CLASSIFIED *(Explain)*:

SECTION 14 TYPE OF INJURY

Check (x) type of injury, one check (x) MUST be entered in this section.

- [ ] 54. WOUNDS *(Concussion, abrasion, incision, laceration)*
- [ ] 55. SPRAINS
- [ ] 56. STRAINS *(Muscular)*
- [ ] 57. HERNIA
- [ ] 58. FRACTURES
- [ ] 59. AMPUTATIONS *(Loss of bony substances)*
- [ ] 60. AVULSION *(Loss of non-bony substance by shearing or tearing away)*
- [ ] 61. BURNS AND SCALDS
- [ ] 62. FOREIGN BODY IMBEDDED
- [x] 63. FOREIGN BODY, LOOSE *(Dust, etc.)*
- [ ] 64. FLASHES
- [ ] 65. FUMES AND GASES
- [ ] 66. POISONS
- [ ] 67. SKIN DISEASE *(Occupational)*
- [ ] 68. TYPE OF INJURY NOT OTHERWISE CLASSIFIED: *(Drowning, Electrocution, Heat Exhaustion, etc.)*

SECTION 15 PART OF BODY

Check (x) part of body. Part of body chiefly identified with injury MUST be checked (x).

- [ ] 69. HEAD FACE
- [x] 71. EYES
- [ ] 73. ARMS
- [ ] 75. FINGERS
- [ ] 77. FEET
- [ ] 79. SYSTEMIC *(Stomach, intestines, lungs, heart, nerves, etc.)*
- [ ] 70. BACK
- [ ] 72. TRUNK
- [ ] 74. HANDS
- [ ] 76. LEGS
- [ ] 78. TOES
- [ ] 80. PART OF BODY NOT ELSEWHERE CLASSIFIED: *(Explain)*

U.S. DEPARTMENT OF LABOR
Bureau of Employees' Compensation

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE
(Under the Federal Employee's Compensation Act)

The immediate superior should complete the reverse side of this form.

1. Name of Injured Employee (Last, first, middle)

YOUNG, GEORGE E.S.

2. Date of this Notice(mo,day yr

8/18/66

3. Place of Employment (Name & location)

USTS, USNS J. POPE

4. Date of Injury (Mo, day, yr.)

3/17/66

5. Occupation

M

6. Hour of Injury (a.m. or p.m.)

0815

7. Place or Location Where Injury Occurred

02-132-2-L

8. Cause of Injury (Describe how and why injury occurred)

THE HOW WAS WHEN I STEPT OUT OF SAID PASSAGE WAY SHOT FELL BETWEEN MY RIGHT EYE AND GLASSES. THE WHY I WAS ON MY WAY TO MY ROOM TO GET SOME SLEEP FOR WATCH, OR I WOULD HAVE BEEN INSIDE.

9. Nature of Injury (Name of body affected-fractured left leg, bruised thumb, etc.)

RIGHT EYE

10. Names of Witnesses to Injury

NONE THAT I SAW

11. If this Notice was not given within 48 hours after the injury, explain reason for delay. If earlier notice was given, verbal or written, state when and to whom.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.

12. Signature

GEORGE E.S. YOUNG

13. Home Address of Injured Employee

3744 S. [illegible]
STOCKTON, CALIF. 95204

Form CA-1

STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit a statement and secure statements of witnesses where possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. Date CA-1 Received by Agency (Mo., day, yr.)

15. CA-1 Received by whom

16. Statement of immediate superior

N/A

17. Signature of immediate superior

18. Date (Mo., day, yr.)

19. Statement of Witness

N/A

20. Signature of Witness

21. Date (Mo., day, yr.)

22. Statement of Witness

23. Signature of Witness

24. Date (Mo., day, yr.)

U.S. DEPARTMENT OF LABOR
Bureau of Employees' Compensation

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE
(Under the Federal Employee's Compensation Act)

The immediate superior should complete the reverse side of this form.

1. Name of Injured Employee (Last, first, middle)
George E. S. Young

2. Date of this Notice(mo,day yr
8-18-66

3. Place of Employment (Name & location)
MSTS, U.S.N.S. J. PoPe

4. Date of Injury (Mo, day, yr.)
8-17-66

5. Occupation
QM.

6. Hour of Injury (a.m. or p.m.)
0815

7. Place or Location Where Injury Occurred
~~[illegible]~~ 02-132-2-L

8. Cause of Injury (Describe how and why injury occurred)
The how was when I steep out of said Possage way soot feel between my ~~left~~ Right eye and glasses the why I was on my way to my room to get some sleep for watch or I would have been inside

9. Nature of Injury (Name of body affected-fractured left leg, bruised thumb, etc.)
~~left~~ eye Right Eye.

10. Names of Witnesses to Injury
None That I saw

11. If this Notice was not given within 48 hours after the injury, explain reason for delay. If earlier notice was given, verbal or written, state when and to whom.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.

12. Signature
George E. S. Young

13. Home Address of Injured Employee
3744 So. Mourfield
Stockton Calif. 95204

Form CA-1

STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit a statement and secure statements of witnesses where possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. Date CA-1 Received by Agency (Mo., day, yr.)

15. CA-1 Received by whom

16. Statement of immediate superior

17. Signature of immediate superior

18. Date (Mo., day, yr.)

19. Statement of Witness

NONE

20. Signature of Witness

Same as above

21. Date (Mo., day, yr.)

22. Statement of Witness

NONE

23. Signature of Witness

Same as above

24. Date (Mo., day, yr.)

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department NAVY (Army, Navy, etc.) 2. Bureau or office MSTS (Engineer, Navigation, etc.)
3. Place of employment MSTS NAVAL SUPPLY CENTER (Arsenal, navy yard, etc.) OAKLAND (City), CALIF. (State)
4. Reporting office USNS GEN. JOHN POPE T-AP 110 (06710) (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred

The injured employee

6. Name of injured employee GEORGE E. C. YOUNG (Given, middle initial, family) 7. Age 45 8. Sex M 9. Citizenship US
10. Home address 3744 S. MOURFIELD AVE. (Street and number), STOCKTON (City or town), CALIF. (State)
11. Occupation and division QUARTERMASTER (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? NO If not, what work? NONE
13. Total length of service with the Government as a civilian?
14. How long at present work in this establishment?
15. Dates of other injuries
16. Rate of pay on date of injury, $ 6,480 per ANNUM { and subsistence valued at $ per ; and quarters valued at $ per
17. Employee begins work at 0001-1200 (Hour, a. m. or p. m.) 18. Regular day's work ends m. (Hour, a. m. or p. m.)
19. Hours worked per day 8 20. Days paid per week 7

The injury

21. Place where injury occurred 08-138-2-L (Give exact location, as name or number of building and division, etc.)
22. Date of injury AUGUST 17, 19 66; day of week WEDNESDAY; hour of day 0815 m. (a. m. or p. m.)
23. Date employee stopped work , 19 ; day of week ; hour of day m. (a. m. or p. m.)
24. Date employee's pay stopped , 19 ; day of week ; hour of day m. (a. m. or p. m.)
25. Has employee returned to work? YES. 0835 AUGUST 17, 1966 (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
(a) Annual leave (Give exact dates)
(b) Sick leave (Give exact dates)
(c) Any other reason (Give exact dates)
27. Describe in full how injury occurred THE MOW WAS WHEN I STEPP OUT OF SAID PASSAGE WAY SOOT FELL BETWEEN MY RIGHT EYE AND GLASSES. THE WHY I WAS ON MY WAY TO MY ROOM TO GET SOME SLEEP FOR WATCH, OR I WOULD HAVE BEEN INSIDE.
28. State part of body injured and nature and extent of injury FOREIGN MATTER IN EYE
29. Did injury cause loss of any member or part of member? NO If so, describe exactly
30. Was employee injured while in performance of duty? NO If not, or in doubt, give detailed statement
31. Was injury caused by:
(a) Willful misconduct of the employee? NO (b) Intention of employee to bring about injury or death of himself or another? (c) Employee's intoxication?
(If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)
32. Was written notice of injury given within 48 hours? YES If not, did immediate superior have actual knowledge of injury? YES
(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)
33. Names and addresses of witnesses to injury N/A
(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)
34. Was injury caused by a third party other than a Government employee or agency? NO If so, has employee been instructed in procedure under the Bureau's regulations?
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case
36. How soon after injury?
37. To what hospital sent? Location
38. Name and address of physician now attending case

Signed this 18 day of AUGUST, 1966 WM. E. CUNNINGHAM FOR MR. LARSON
(Signature of reporting officer)
at USNS GEN. JOHN POPE T-AP 110 (06710) FIRST OFFICER

C. A. 2
December 1961

(OVER)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

N/A

Signed this ______ day of ______________, 19____

______________________ (Signature of witness)

N/A

Signed this ______ day of ______________, 19____

______________________ (Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that George [illegible] S. YOUNG (Name of employee) was given first-aid treatment, or examined, on 17 AUGUST, 19 66, at 0830 m., and was not (Was or was not) disabled for work. Probable length of disability will be none. In my opinion disability was not (Was or was not) due to injury on 17 AUGUST, 19 66

Nature of injury as found on examination FOREIGN BODY (SOOT), RIGHT EYE

Hospitalized no

Will return for further treatment no

Discharged was not hospitalized

Other disposition Fit for duty.

Remarks ______________________

Signed this 28th day of OCTOBER, 19 66

at [illegible] GEN. [illegible] PORE/TAP 110

Samuel R. EDWARDS LT MC USNR
(Signature of medical officer)

LT MC USNR
(Title)

U.S. GOVERNMENT PRINTING OFFICE: 1964—O-734-915