MILITARY COMBAT EYE PROTECTION: PRESERVE YOUR SIGHT

KNOWLEDGE

VOL 7 MARCH 2013

OFFICIAL SAFETY MAGAZINE OF THE U.S. ARMY

REDEPLOYING SAFELY

+

- WEATHER BRIEFS
- HOUSEHOLD CHEMICALS
- PMV MAINTENANCE

WANDERING RIDERS

U.S. ARMY

ARMY STRONG.™

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OFFICIAL SAFETY MAGAZINE OF THE U.S. ARMY

LEADERS SOLDIERS CIVILIANS FAMILIES

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U.S. ARMY COMBAT READINESS/SAFETY CENTER

ARMY SAFE IS ARMY STRONG

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Mission statement: The United States Army Combat Readiness/Safety Center (USACR/Safety Center) supports our Army by collecting, analyzing and communicating actionable information to assist Leaders, Soldiers, Families and Civilians in preserving/protecting our Army's combat resources.

We welcome your feedback. Please email comments to **usarmy.rucker.hqda-secarmy.list.safe-knowledge@mail.mil**

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BRIEF SMART

It's March, and that means it's time for another talk about driving safety. As a leader, you know that's just what your Soldiers want to hear, right? Few things elicit more groans from Soldiers than the mandatory safety brief. I'm of the belief, however, that since safety briefings are required, we might as well make them useful and enjoyable experiences.

Getting the message across in safety briefings, but keeping it fun, isn't hard. For the most part, Soldiers really aren't a tough crowd. They share common general experiences and get what it's like to be in the Army today. That means you don't have to be a master comedian or mind reader to relate to them. All safety briefs do need to have a few things in common, though.

First, have an idea of what you want to discuss, but keep the floor open for conversation — and humor. Drinking, driving and motorcycles should always be part of your briefs, but you'll want to cover those things unique to your local area too, like water safety if a lake or beach is nearby. It's also possible your Soldiers will come up with issues you haven't thought of yet. It's important to give them the opportunity to identify their own concerns and talk about solutions amongst themselves. This interaction makes them an active part of the safety process, rather than a passive participant in a top-down event.

Second, keep your safety briefings relevant to not only what your Soldiers are doing, but what's happening in Army accidents in general. Indiscipline is a huge topic in safety right now, and chances are at least a few of your Soldiers are making unwise decisions off duty. As an engaged leader, you should know who they are, but everyone could benefit from a discussion on the subject. Even your most straight-laced Soldiers are bound to be tempted by indiscipline sometime, and it's better they go into the situation ready to make smart choices. The USACR/Safety Center's preliminary loss reports, which detail every fatal accident in the Army and link to outside resources like news reports and obituaries, are a very effective tool for reinforcing the negative effects of indiscipline. Few things speak more clearly to Soldiers than real-world examples of how one bad decision led to the end for someone just like them.

Third, don't use safety briefings as a tattle session. No one should be standing around with a clipboard taking notes about who's doing what wrong, nor should that time be used for punitive action. Keep the atmosphere light enough that your Soldiers will talk, with both you and their buddies, about how to stay safe during the weekend. Peer-to-peer mentoring is crucial in safety, because you won't be hanging out with your Soldiers during their down time; they'll be around each other! We have to keep the conversation open so when they're out on their own, they continue it as a group.

Finally, think beyond the typical safety brief. Just because your unit's always done their briefings a certain way doesn't make it right. Today's Soldiers won't necessarily relate to what worked for us when we were young. Keep your briefings fresh, and remember the "brief" — no one wants to sit through a long safety lecture. If you're conducting yours effectively, safety briefs shouldn't take too much time away from the job or your Soldiers getting out the door for the weekend.

If you haven't already, check out the BOSS Safety Awareness Presentation, available on the USACR/Safety Center website at https://safety.army.mil. This is a great tool that incorporates humor into traditional safety topics and is sure to generate discussion among your team. We also just released the online edition of the Army Safe Spring Campaign, which includes feature articles and posters to share with your Soldiers.

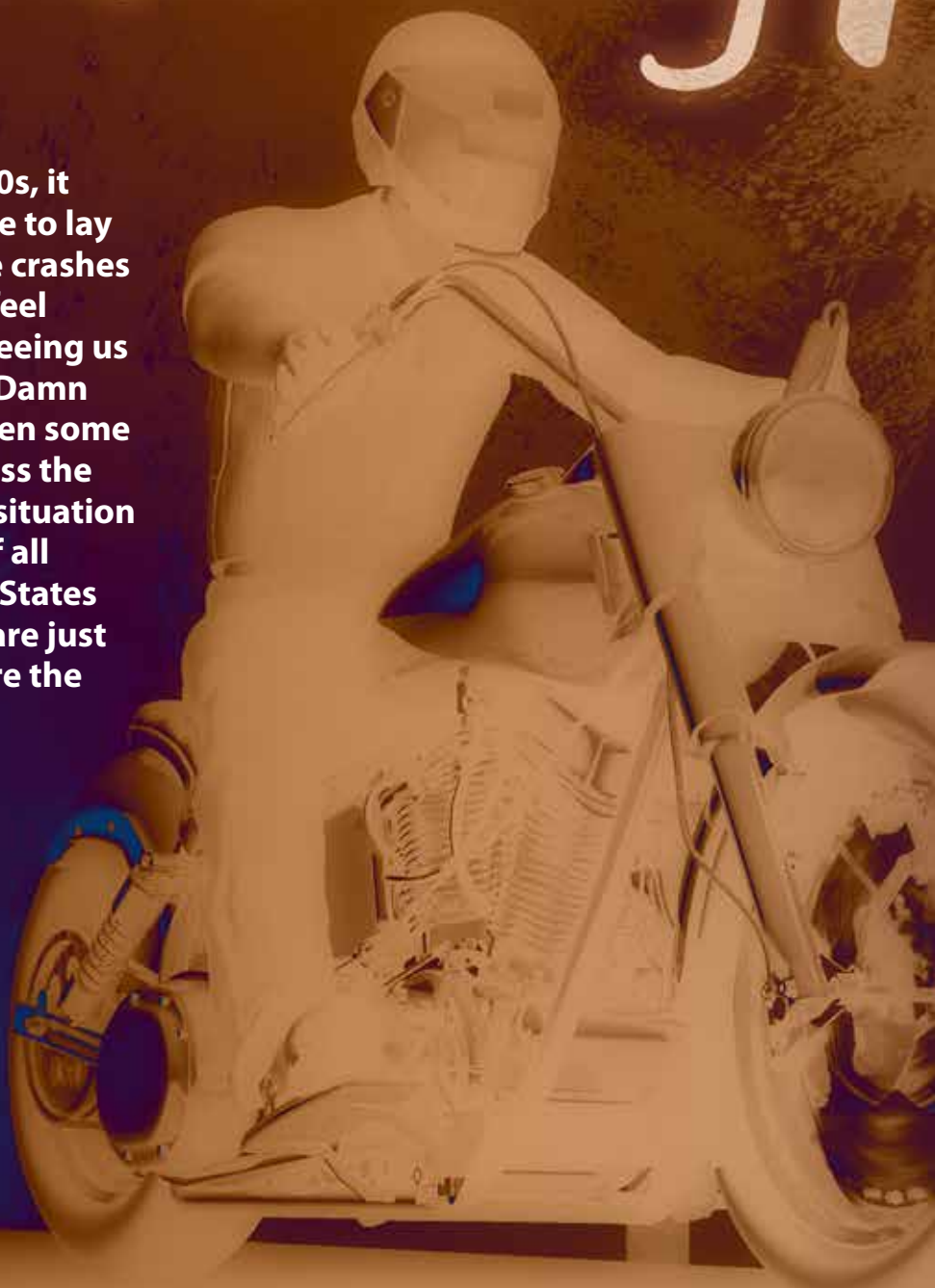
Remember that spring is when we'll start seeing the creep in driving and motorcycle fatalities. Ensure your Soldiers are current on their training and have adequate personal protective equipment before they hit the road. Their safety is our business, so don't be afraid to be in their business on these critical issues.

Thanks for all you do every day, and I hope you have a wonderful spring!

Army Safe is Army Strong!

RICK STIDLEY
Command Sergeant Major
U.S. Army Combat
Readiness/Safety Center

Wandering



Back in the 1980s and 1990s, it was comforting to be able to lay the blame for motorcycle crashes on car drivers. We could feel victimized by errant drivers not seeing us or not yielding the right of way. "Damn blind cager!" we could mutter when some driver made a quick left turn across the path of the motorcycle. Well, the situation has changed. Today, about half of all motorcycle crashes in the United States are car/bike collisions, but there are just as many motorcycle crashes where the rider lost control.

It's getting very obvious that too many riders are unable to control their bikes. Over the past few years, U.S. motorcycle fatalities have been hovering around 5,000 per year. About 2,500 of those were single-vehicle crashes; and for every fatal crash, there are approximately 22 "morbid" crashes resulting in serious injuries.

One scary scenario occurs when the motorcyclist goes wide in a right-hand curve and collides with an oncoming vehicle. An example of this occurred a couple of years ago on the Olympic Peninsula northwest

Riders

DAVID L. HOUGH
www.soundrider.com

of Seattle, where a novice rider was out with some friends on a group ride. She had just learned to ride a couple of months before.

According to newspaper reports, "*… the motorcycle failed to negotiate a right curve. The motorcycle crossed the centerline and struck the right-front bumper of a southbound pickup truck that was towing a boat trailer. The rider was pronounced dead at the scene by a deputy coroner.*"

This isn't an isolated incident. There have been a huge number of motorcycle crashes where the rider crossed the centerline. There was one situation in Marin County (north of San Francisco) in which a Sunday rider crossed the centerline in a curve just as an SUV was approaching. The rider sideswiped the SUV with considerable force and fatal results. What I found appalling is that a San Francisco motorcycle paper wagged an emotional finger at the SUV driver for failing to see the oncoming rider and getting out of his way. The writer apparently felt that a motorist in Marin County on a Sunday morning should know that bikers use the twisty back roads for high-speed shenanigans.

Sorry, survivors, but I say the motorcyclist did it to himself! It's pretty lame to attempt to pass off the blame for bad riding on others. Even when another motorist does something dumb, a motorcyclist needs to be prepared to get out of the way. In my view, the responsible party is whoever was holding onto the handlebar grips at the moment.

Let's take a moment to consider why riders might cross the centerline. First, there is the temptation to use the other side of the road to gain a faster cornering line — as if the public roads were somehow a legitimate public racetrack. The temptation to go fast is almost irresistible when riding a high-performance sport bike.

Last summer, at a rally, I overheard a famous roadracer/journalist giving a seminar in which he was attempting to convey the message that riding really fast on public roads was not as enjoyable as riding at a brisk but reasonable pace. He described the previous day's ride with some companions, in which he noted that they had not exceeded 85 mph all day. For a veteran road racer, 85 mph may seem like dawdling along. But in many states, more than 20 mph over the posted speed limit is defined as "reckless driving," with hefty fines and the potential for confiscating the motorcycle.

I respect this famous rider, but I have a much different attitude about riding fast on public roads.

The Pace May Be the Problem

I suspect that one prime reason for corner crashes is failure to decelerate quickly enough to get the bike down to an appropriate speed for conditions. It's fun to ride a steady pace with speed controlled only with the throttle, but when sight distance closes up, you can't see the hazards. More and more, I'm braking when the vanishing point of the road suddenly retracts. Not just rolling off the gas and hoping for the best, but scrubbing off speed quickly.

I'll admit to having cruised the back roads at an aggressive pace once in a while, but for me, 85 mph on a public road is way too fast. It's not just an issue of being able to control the bike to avoid running off the road. We face a number of potential hazards out there, including wild animals, gawking tourists, wandering drivers and loose gravel. If you want to avoid running into such things, you need to be able to get the bike stopped within the roadway you can see. To put this another way, you need to be in control of the bike, but you also need to be in control of the situation. Even an experienced road racer with quick responses can't outfox the laws of physics.

For example, let's say you are riding a nice, curvy back road. The surface is clean and dry, the curves are nicely cambered and traffic is light. You're cruising along at about 60 mph, just a little over the posted limit. Ascending a hill, you can't see over the crest, but it appears the road curves to the left and descends a hill. You're about 150 feet from the crest, doing 60 mph. What would you do?

- Hold a steady throttle, but watch the situation ahead for possible hazards.
- Roll off the throttle to reduce speed and cover the brakes.
- Transition from throttle to front brake to reduce speed quickly.

If this road were a closed track, you would already know where the pavement goes over the hill, and you would know there are no hidden hazards such as a wandering elk or stalled logging truck. There would be no need to slow down because you know how fast the bike will take the corner without sliding out.

But this isn't a closed track; it's a public road, and there could be a hazard just over the hill. Most of us would roll off the throttle and cover the brakes. But at 60 mph, you are covering 88 feet per second. Assuming you have a very quick reaction time of 0.5 seconds, you would eat up 44 feet just getting on the brakes. And even if you are skilled enough to brake to 0.9g, your braking distance from 60 mph would be about 130 feet. Total stopping distance would then be 44 feet plus 130 feet, or 174 feet.

Let's say you roll off the throttle. That would have about the same effect as stepping on the rear brake, which would possibly slow the bike to 40 mph by the crest of the hill. If you then reached for the brakes, it would take about 30 feet for reaction, plus 60 feet to brake to a stop, a total distance of 90 feet beyond the crest. If you want to check my figures, there's a handy braking computer at http://hyperphysics.phy-astr.gsu.edu/hbase/crstp.html#c2. What these stopping distances suggest is that if you're not already on the brakes before you crest the hill, it's questionable whether you would be able to come to a stop short of a hazard (such as a logging truck pulling out of a side road or a wrecker pulling a car out of the ditch).

Rolling the Dice

Of course, there's a good chance

> “I **SUSPECT** that one prime **REASON** for corner **CRASHES** is failure to **DECELERATE** quickly enough to get the **BIKE** down to an **APPROPRIATE** speed for **CONDITIONS.**”

that the road goes where you think, and there isn't a hazard blocking the lane today. Many riders gamble their lives there won't be a hidden hazard in a blind situation. But, according to the fatality statistics, more than a few riders are losing that gamble.

Four Steps to Stack the Odds

So, if you want to stack the cornering odds in your favor, I have four suggestions. First, hone your balancing/steering/braking skills. You must be proficient at controlling the bike so you can put it exactly where you want it to go. And you should be skilled enough to brake aggressively — even when leaned over. Your goal should be to develop the muscle memory to control the bike without having to think about the details.

Second, make a habit of delayed apexing, even when you have a good view through the corner. Some day, when you suddenly find yourself in an unexpected off-camber or decreasing-radius turn, you'll be more likely to handle it without a lot of drama.

Third, plan your cornering line entirely within your own lane, even if that means a speed reduction. Frequently borrowing the opposing side of the road is unwise, because other vehicles can appear suddenly when you aren't prepared. In a crisis, you'll very likely resort to habits, good or bad.

Fourth, when sight distance closes up, immediately transition from throttle to front brake and get the bike slowed smoothly and quickly to enable a quick stop within your sight distance. When the view opens up, it doesn't take long to get back up to speed.

I also suggest either avoiding group rides or selecting your group companions carefully. The latest statistics — at least for northwestern states — is that a significant number of crashes are occurring during group rides. The fatal crash video mentioned below gives us some clues about why that is.«

FYI

There are many motorcycle crash videos online. One of the most somber is a brief ride in a European country, ending in a high-speed collision with an oncoming rider, shot from a camera taped to the fuel tank. It's worth watching because once you've overcome the shock of the crash, you can replay it and observe the rider of the camera bike making minor mistakes, including increasing speed when another rider passes him. The minor mistakes eventually lead to an excursion across the centerline and a high-speed collision. It seems obvious to me that the camera bike rider just didn't know how to make his motorcycle lean and turn. To watch the video, click the QR code to the right with your smartphone or visit http://www.ebaumsworld.com/video/watch/80503216.

Check Your WE

On my most recent deployment, I was assigned to Task Force ODIN to operate and eventually provide instruction on the MQ-1B Warrior Alpha unmanned aircraft system. Shortly after reporting to Fort Hood, Texas, each UAS operator was assigned to a small 10- to 12-Soldier element as they attended their airframe qualification course. They were then deployed to their theater of operation. All of these events would occur within a six- to eight-month period, so, for the majority of the personnel assigned, this was quite a unique experience.

Like the rest of the Army aviation world, the UAS element performs its mission planning and receives a mission brief as well as a weather brief. On this particular training flight, we went through the usual routine — mission brief, weather brief, preflight, engine run-up, trainee records review and briefing the trainee on his flight requirements. Finally, we were all ready to go.

We had thunderstorms to the north of us and also in our mission area. Since there weren't any imminent signs of danger in the weather brief, the crew thought nothing of it. After about an

ATHER

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hour or so of instruction on the aircraft operator side (which is typically the left seat), we switched sides to the payload operator side (typically the right seat). It didn't take us long to become engrossed in the instruction and the ever-so-interesting tasks of the PO side. We soon realized that for some reason the video quality was slowly diminishing. What we didn't realize was that the grainy video we saw through the infrared lens was actually raindrops. We were so engulfed in looking at the ground that we forgot about panning the camera around to keep an eye on the impending storm!

It didn't take very long for us to realize this had the potential to be a highly dangerous situation. After updating the mission coordinator on our predicament, the decision was quickly made to return to base. It's like the old saying: Better late than never! We asked the MC to get us a storm update in hopes we could get out of it and beat it home. It was a long shot; nevertheless, we needed to take it.

Unfortunately, our lack of situation awareness was to blame for our predicament. After going back and looking at the recording, we saw we'd been inside the storm for up to 15 minutes before we realized we were in trouble. The newly designated readiness level one operator at the aircraft controls got his baptism by fire that evening. He had the challenge of dealing with some extremely intense downdrafts along with a laundry list of other dangers that could have all been avoided.

By the grace of God we were all able to work together to fly the aircraft out of the storm and safely recover it by the time the weather arrived at the airfield. Miraculously, the aircraft came back without any damage whatsoever.

What lesson did we learn from this experience? Being aware of the weather when you're flying a UAS is an essential part of situational awareness. Just because things are calm where you're sitting doesn't mean your UAS is cruising smoothly in a cloudless sky. Think about where you're flying, not where you're sitting.

PRESERVE YOUR SIG

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Today's Soldiers understand the importance of mission readiness. We prepare our equipment and we train to ensure we are ready to go. But what about your eyes? Are they ready to go? You know you need protection from dust, wind and ultraviolet and bright sunlight, but how about a 0.15-caliber steel fragment coming at you at 660 feet per second?

Here are the facts: eye injuries are a large part of combat injuries and can lead to blindness. Your sight is important, and the Army's Military Combat Eye Protection program wants to protect your eyes. To better do that, the Army has teamed with commercial manufacturers to develop, test and field combat eyewear. The spectacles and goggles are tested to meet not only the industry standard, but also the even more stringent military standards. For example, the military ballistic fragmentation standards are five to six times stronger than industry standards for impact protection.

After passing rigorous inspection, Program Executive Office Soldier then places all approved eyewear on the

Authorized Protective Eyewear List. Units and/or Soldiers can choose spectacles and goggles to suit their mission needs. This provides Soldiers the opportunity to check proper fit and ensure the product can accommodate their prescription inserts. The APEL provides assurance that the items have been certified to meet military and industry standards and approved by users downrange.

In a 2009 survey of MCEP users, 33 percent indicated personal experiences where they felt the combat eye protection saved their eye(s) from injury. Another report showed MCEP users had nearly 10 percent less eye injuries in combat operations. The same report also showed a significant decrease in the severity of eye injuries in MCEP users. The U.S. Army Public Health Command monitors battlefield data on eye injuries, and the results clearly show ballistic eye protection works.

The current APEL has six goggles and nine spectacles, and all come with both clear and neutral gray tinted lenses that are interchangeable and replaceable. The products, as well as all replacement parts, have national stock numbers and can be obtained through normal logistic channels. The program also has products that protect from lasers.

For Soldiers who need vision correction, four of the goggles and seven of the spectacles are compatible with prescription inserts (similar to the gas mask inserts). Unfortunately, not all prescription inserts are interchangeable between brands. However, the program office is working to create universal prescription inserts. Until then, it is important to know what brand of MCEP you are issued so your local optometry clinic can order the correct prescription inserts.

Even though different prescription inserts may look alike or be of similar size and shape, any "work around" is not recommended. The APEL items are tested as a "unit" with matching inserts to ensure proper protection. Testing has shown unapproved inserts may shatter upon impact. The shattered pieces can get into the eyes and possibly cause injury. Since August 2011, the APEL logo has appeared on the left temple of all approved goggles and spectacles to make identification of authorized products easier. Make MCEP a part of your readiness. Use it in training and preserve your sight to fight!

GHT TO FIGHT

FYI

To learn more about the MCEP program, the APEL or to see the latest authorized protective eyewear list, go to https://peosoldier.army.mil/equipment/eyewear/.

Out of

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Options

The weather in South Carolina is often unpredictable. I found that out firsthand one summer evening as I left work with clear skies showing only to get caught in a gullywasher a few miles down the road. That wouldn't have been a problem had I been driving a car. On my motorcycle, however, it nearly cost me my life.

It was dark, and the skies didn't show any signs of inclement weather as I traveled along Leesburg Road, followed by McCords Ferry Road, on my 1994 Honda VFR 750. But as I turned onto Screaming Eagle Road, I rode into pouring rain. I soon found myself behind a utility tractor-trailer hauling a cherry picker, which began kicking up a great deal of water off the road that impeded my field of view. In an attempt to create additional space between the trailer and myself, I started backing away. Suddenly, my rear tire hydroplaned when I rode through a shallow puddle. I instantly applied light pressure to the front and rear brakes — careful to not lock up the rear tire in an attempt to prevent it from sliding. Had I been forced to release the rear brake early, it could have caused the motorcycle to flip.

Shortly after floating the brakes, I felt the tires regain traction. Then I hit another water puddle, causing the rear tire to sway to the right before quickly swinging back to the left. I instinctively scanned the oncoming traffic as the motorcycle drifted back to the right. I thought, "Jorge, the bike is going down. It's either your life or the bike."

With no other options, I pushed myself off the motorcycle with both hands and feet, like a paratrooper leaping out of a plane. I slid about 60 feet down the road, coming to rest on the shoulder. My motorcycle barreled another 100-150 feet down the road, ending up on the opposite side in the tree line.

While some Soldiers may not see the need to wear personal protective equipment, mine likely saved my life. I was wearing my duty uniform, a helmet, reflective vest and gloves. In the midst of the heavy downpour, the gear was of great use.

Despite riding a motorcycle for about a year, I can honestly say the tutelage of my instructor for the Motorcycle Safety Foundation's Basic and Experienced *RiderCourses* was of great help. The fundamentals of safe motorcycle riding may have been the difference between survival and death. I now own a 2001 Honda VFR 800 and continue to ride safely without being complacent.

Flying on Fumes

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We've all been there — that "will-I-make-it?" moment. If you're lucky enough to have avoided that experience, then you've heard it from the mouths of others — probably with a few nervous chuckles thrown in. For most, it's the first, and hopefully last, time as well as a valuable learning point. I had one of those moments. Here is my story.

It had been about a week since we arrived at our operating location. We had flown the route daily, some days with multiple turns, and had a good lay of the land. We were flying humanitarian relief missions and would launch from our airfield, fly up to 40 minutes to a remote staging area, pick up patients and fly them to a Navy hospital ship a few miles offshore for surgery. Given the remote area we were operating in and the distance to our airfield and refueling, our UH-60L was equipped with two full crashworthy external fuel system tanks. We were trained and familiar with CEFS and it was common knowledge that you could expect to get about 4½ hours of continuous cruise flight from a full bag of gas. Our mission profile had us flying hops of seven to 10 minutes from our staging area with substantial ground time for passenger loading and unloading. This gave us significantly more station time.

We'd been conducting this mission for a week and routinely refueled and swapped out crews around the five-hour mark. Normally, by the time we landed (at the five-hour mark), we still had over an hour of fuel remaining

and it was never an issue. This particular day, though, we had an early show. That made fuel, not time, our limiting factor. We departed as on any other day, but with an added eye on fuel checks. I did the routine fuel checks as we entered our mission profile, then closed out and continuously monitored our fuel during the mission.

The five-hour mark was drawing near. According to our fuel numbers, we had about an hour and 20 minutes of fuel remaining. We wondered, "Do we have time for one more load?" We decided we had enough time to take another load of passengers out to the ship and then head back to our airfield for refueling. According to our fuel checks, we'd still have about an hour's fuel remaining after we dropped off the patients. Feeling confident, we decided we were good to go.

After dropping off the last patients, we proceeded back to the airfield. I started another fuel check for the flight back and closed it out after 15 minutes. This time, however, I noticed we were burning fuel at a slightly higher rate. No big deal, I thought; I'd just continue to monitor and we'd be fine. Ten minutes later, we were still burning more fuel than expected, further eroding our reserve. We were 10 minutes away from landing and down to 400 pounds of fuel. For anyone who's ever flown with CEFS tanks, you know that's enough to be nerve wracking. We crested the last hills and entered the city limits. By then we were within five minutes of landing, but we also had less than 300 pounds of fuel and still needed to overfly the city to reach the airfield on the far side. Given our situation, we started looking for places where we could make a forced landing and also scanned for the best route around the city. We decided to skirt the city's edge and follow the beach. If we had to put the Black Hawk down, that's where we would do it.

With between 150 and 200 pounds of fuel remaining and both fuel-low caution lights flashing, we were cleared for landing. We flew the straight-in approach down the runway and proceeded to our ramp for shutdown. By that time, we had between 90 and 120 pounds fuel remaining on the fuel gauge. Once we landed, there was some nervous laughter and a few chuckles — but at least we were safe.

We talked about what went wrong during our crew after-action report. When we launched on that final mission, we had plenty of fuel, plus a reserve. We'd been continually doing fuel checks that day during our earlier flight legs and thought we knew what to expect. So why were things so different on that last leg?

As it turned out, we did our earlier fuel checks while flying

short legs between the ship and shore or in holding patterns at maximum endurance airspeed waiting for the ship's deck to be cleared. We didn't think to note the fuel burn rate from our first long flight in the morning as a guide for the fuel required to get back.

What about our common knowledge of CEFS burn rates? We had hundreds of hours in CEFS aircraft, so we should have known what to expect. When I checked the fuel that day during our hops out to the ship and back, everything appeared normal. How could there have been such a big change in our burn rate on that last hop?

The answer, as it turned out, was simple. On our earlier legs, we flew slower and, as a result, burned less fuel. However, on the last flight leg we were operating over water with passengers onboard. As a safety egress precaution for overwater flight, we had opened the cargo doors on both sides of the aircraft and removed the cockpit doors. That created extra drag, which increased our fuel consumption. Our mission nearly ended in catastrophe because we didn't take that into account. The only thing that saved us was operating by the book and ensuring we had the required reserve when we left the operating area.

> "WITH between 150 and 200 POUNDS of FUEL remaining and both FUEL-LOW caution LIGHTS flashing, we were CLEARED for LANDING."

What about you? When you plan your reserve, do you take into consideration that the flight profile for your return flight may be different than your mission profile? Remember, you might run out of fuel, but you'll never run out of gravity.

ARE YOU READY?

Wouldn't you like to know if your unit is about to experience a mishap?

Wouldn't you like to prevent the loss of personnel and equipment?

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ARAP

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Redeploying S

Safety is such a constant part of a Soldier's life they sometimes get complacent. After a while, one of two things usually happens: Soldiers forget about the measures that kept them safe because there have been no accidents, or they become focused on the outcome of a mission instead of their well-being. Often, the prime time for this to happen is when a unit is in the process of redeploying.

Based on my experience, I'm convinced the most dangerous time for a Soldier during deployment is near the end. Safety is normally the last thing on a Soldier's mind. During the relief-in-place or transfer-of-authority is when most accidents occur. Soldiers lose focus of the redeployment mission and start thinking about what they'll be doing when they get home. Risk management often becomes an afterthought.

During one of my deployments in support of Operation Iraqi Freedom, there was a notable period of increased accidents. Soldiers' frequent trips to the aid station coincided with our unit's RIP/TOA phase. Their injuries weren't mission related; the majority of Soldiers ending their tour were no longer being sent out. They were passing the time by playing football and basketball and, unfortunately, hurting themselves. There were so many Soldiers medically evacuated out of theater that the forward operating base commander put a restriction on all sports. That decision drastically reduced the

Safely

RETIRED SGT. MAJ. TONY SMITH
Enterprise, Ala.

number of Soldiers reporting to the aid station for sports-related injuries.

In retrospect, if leaders would've conducted proper risk management throughout the deployment, many of these accidents might not have happened. Sports-related activities seem harmless enough, but if Soldiers don't take proper precautions and protect themselves and their battle buddies, injuries are sure to occur.

Our Soldiers involved in moving equipment to the embarkation and departure points were especially susceptible to accidents. Before our equipment was loaded onto a ship, it needed to be meticulously washed, inspected and packed by these Soldiers. A wash rack can be considered a death trap if not used safely because at any given time, a number of vehicles are maneuvering in a very confined space. There's a tendency for drivers to whip around the wash rack, trying to get their vehicles cleaned quickly and ready for transport. Other Soldiers in the area become vulnerable to impatient drivers and their vehicles.

Once the vehicles left the cleaning area, they had to be staged in the inspection area. After passing inspection, they were ready for shipment. Any movement of vehicles is dangerous, and when these Soldiers moved vehicles onto the ship, extra vigilance and attention to detail ensured none of our troops was hurt. We incorporated risk management during the military decision-making process for this operation and there were no personnel injuries.

Soldiers need to stay focused and not lose sight of the mission, even when they're just a plane ride away from home. Incorporate risk management into all missions, not just during deployment/redeployment. Talk to your Soldiers about the decisions they make and why they make them. Soldiers always talk. It takes a good leader to listen.

DID YOU KNOW?

The USACR/Safety Center has a reference guide intended to assist safety professionals in advising their commands in preparing and maintaining accident prevention programs before, during and after deployment. The Deployment Guide for Brigade Combat Team Safety Professionals covers a myriad of common hazards, potential controls, TTPs and lessons learned for topics such as base operations, ammunition and explosives storage and handling, vehicle and convoy operations and weapons handling. The guide also offers links to briefings, checklists, sample standard operating procedures and risk management worksheets, relevant publications, posters, videos, websites and toolboxes. Much of the content comes from previously deployed safety professionals. Check it out today by visiting https://safety.army.mil/deploymentguide (AKO login required).

Playing the Percen

CHIEF WARRANT OFFICER 3 MARK SMITH
TRADOC Flight Detachment
Fort Eustis, Va.

We've all heard the various causes of traffic accidents. These are just a few of the ones I was exposed to while traveling one holiday weekend.

After being on the road for a few hours, I came across an accident where a car hydroplaned off I-65, skidded across the road and struck a tree. The couple driving was two exits away from being home. A thunderstorm had just passed through the area, reducing visibility and soaking the highway and leaving puddles. This was a brief, intense storm that lasted less than 10 minutes.

I stopped to see if anyone required first aid. Several other people also stopped, among them a nurse. Since no ambulance was there, the only first aid would be rendered by private citizens. Fortunately, the occupants of the two vehicles traveling behind this car saw the accident, stopped to help and called the paramedics.

As a group, we decided to move the couple away from the car, which was leaking fuel. Since I have seen accidents where vehicles on the highway would hit cars stopped along the road, I suggested we move away from the interstate and keep any vehicle from parking where we were located. After about 18 minutes, the first police car arrived, followed by an ambulance.

As I was talking to the couple who crashed, I wanted to try to piece together the accident so I could share this experience with other people to help prevent similar incidents in the future. The woman driving the wrecked vehicle told me she was only a few minutes away from her destination and had no idea that it would be raining hard that day. Even though it was raining, she did not want to slow down. She'd heard of people hydroplaning on wet roads but figured it would never happen to her. Her husband told me it all happened so fast and before he knew what was going on, they were in the trees.

Fortunately, they were wearing their seat belts and received only minor injuries. However, the car was totaled. As the couple left for medical care at a nearby hospital, I drove away from the accident thinking how lucky they had been. This accident involved many of the safety topics I hear in safety briefings almost every week.

Many times over my career, I've heard about accidents involving

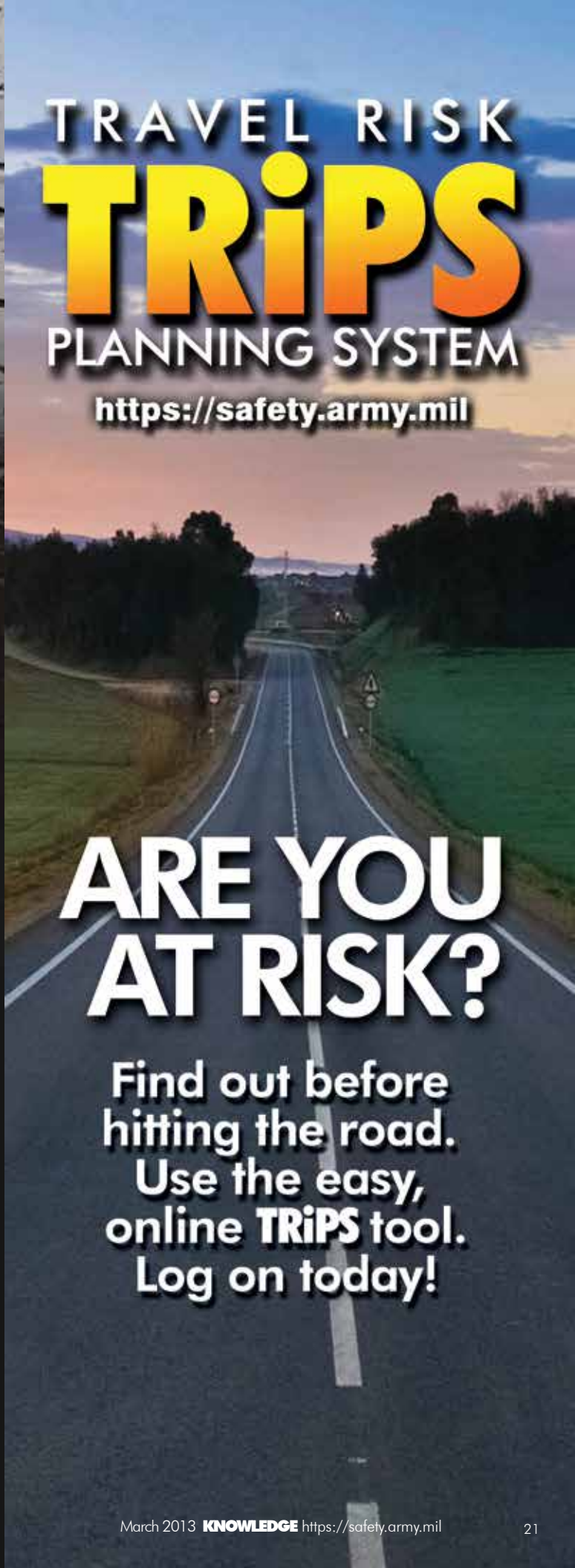
tages

Soldiers who have given many of these very same excuses. I had a mentor who told me that he always "plays the percentages." I thought about that later as I continued down the highway. The Army does a great job identifying trends and hazards. We're required to complete a Travel Risk Planning System assessment, which was developed to help commanders and leaders mitigate risk and reduce fatalities for personnel driving a privately owned vehicle or motorcycle outside their local area.

In all the paperwork I have seen, most of the common reasons for accidents are covered in one way or another. So the Army, as a whole, "plays the percentages." These are the reasons we have safety briefings, POV inspections and the TRiPS assessment. Because of the statistics, all of these things were put in place to reduce accidents.

When you head out for a pass or leave, think about the statistics and how you can avoid becoming one. Remember, bad things can happen to you — even if you're close to your destination — so wear your seat belt, reduce your speed in rainstorms and be aware of hazardous conditions.

It takes very little time to identify hazards and implement controls. However, it takes even less time to get into an accident and be stuck with life-long consequences. Learn from others so that you do not become a statistic.



It was back in the summer of 2000 and I hadn't yet gone to flight school. At the time, I was serving as a flight engineer on a CH-47D Chinook. Our mission was a simple, routine night vision goggle flight with a couple of very experienced pilots on the controls. During the brief, the pilot in command said he wanted to focus on slingload training and told me it was my night in the cargo hole.

CHIEF WARRANT OFFICER 2 THOMAS SEAL
Detachment 1, B Company, 2nd Battalion, 149th General Support Aviation Battalion
Oklahoma Army National Guard
Muldrow Army Airfield
Lexington, Okla.

Complacency

During the startup, we confirmed all the hooks were operational and I prepared the cargo hole for slingload operations. As the flight progressed, everything seemed to be going smoothly and according to plan. Prior to beginning our slingload iterations, the PC landed next to the load and I readied myself in the cargo hole as the other flight engineer inspected the load. I reviewed my setup to ensure I wouldn't have any issues during the hookup, and the PC briefed the crew on slingload operations.

As we began to hover, I took my position in the cargo hole and called the aircraft over the load. With two experienced pilots flying the aircraft, the hookup went well. Since we were doing multiple iterations, we typically hooked up a load, came to a hover, placed the load on the ground, repositioned and did it all over again (aka "elevators"). Everything was going as planned. What could go wrong with something that's so simple and routine?

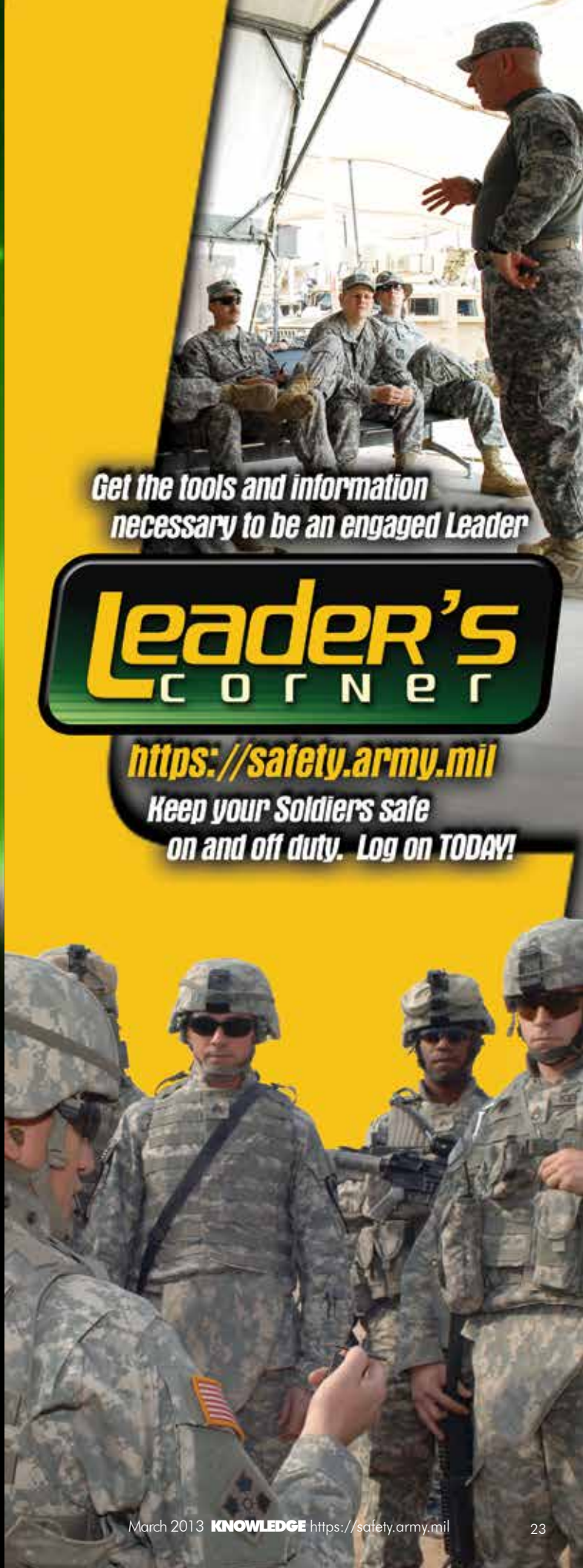
During the last iteration, the PC hovered over the load and, like each time before that evening, the hookup went smoothly. Then something different happened. As we were hovering with the load, the pilots began discussing techniques and failed to notice the aircraft had begun to settle and the load was back on the ground. I notified the pilot, but received no response.

As the Chinook began to drift, I noticed we were dragging the load. This went on for a minute or so with the load bobbing up and down and, from time to time, dragging across the ground. Finally, I announced the load was still hooked up and we were dragging it. The PC immediately released the load while the slings were still tight. Before I knew what had happened, I heard a loud bang and saw the center cargo hook fly into the cabin, bounce off the floor and fly back out. Luckily, I did something right

Bites

that night and was positioned clear of the hook, saving myself the pain of getting whacked in the face. During the debrief, we determined the PC thought he had released the load after setting it on the ground. For my part, I'd assumed he knew what was going on 30 feet behind him.

On this night, I let complacency and poor crew coordination win over my better judgment. I assumed because the PC was experienced that he knew what he was doing. Because of that, I let my complacency interfere with good crew coordination. I should have challenged the PC for a response as soon as I noticed the load was being dragged and not let it continue. Had I done that, I could have avoided the frightening end to that night's flight.



State of Sk

CHRIS RAINWATER
Red River Army Depot Safety and Occupational Health Office
Texarkana, Texas

It was a gorgeous weekend in Atlanta with temperatures in the 80s and lots of sunshine. This was perfect weather for my older brother, Ralph, to move his family into their new home. He asked if I would mind lending a hand with the moving chores, and I gladly agreed. Once all the boxes were loaded, we made our way across town to their new home.

After bringing in the boxes, I helped Ralph with some minor cleaning. Like anyone moving into a new place in the Deep South, he was concerned about ants, spiders and other critters. To be safe, Ralph had set off five "bug bombs," devices that exhaust insecticide into every nook and cranny of the house, the day before.

Moving is hard work, and by now I was tired and sweating. But along with the normal wear and tear that comes with the job, I noticed I was experiencing some unusual itching in my groin. I figured it was surely the result of overheating and would subside if I took a break. However, as the minutes passed, I realized the itching was far more intense than anything I'd ever experienced. Excusing myself to the restroom, I decided to take a look at the affected area. To my astonishment, the skin around my groin was a deep crimson color. Suddenly, I felt my palms

also begin to itch uncontrollably and, as I looked at them, the same crimson pattern was taking shape.

I told my brother I thought he needed to take me to the hospital. As I explained what was happening to me, we both laughed. Surely I was overreacting to what was simply heat rash, right? Fortunately, I decided to trust my instincts and training and told Ralph to rush me to the nearest emergency room. As we drove, I realized the situation was becoming worse by the second. I could feel the rash spreading to other parts of my body. All of a sudden, as I looked out the window to my right, I realized I had lost my color vision. Everything was now black and white. Beginning to panic now, I told Ralph what was happening and urged him to start running lights and to get me to the ER as fast as he could.

His reply, which were the last words I would hear for awhile, was, "You're the safety guy, and you want me to run lights?" At that point, I lost my vision completely. I slumped over in my seat and, succumbing to shock, lost consciousness. As my brother would later tell me, he realized at this point that I was actually serious. Now racing, he pulled up to the ER and ran inside to summon help. Emergency room personnel dragged me unconscious from the passenger seat and threw me onto a gurney. The impact with the waiting gurney woke me up.

I was rushed into the emergency room, where I heard voices all around me and felt numerous sets of hands removing my clothes. I could also hear my brother trying to explain what I had been doing. I felt like everyone was overreacting, and even joked about being the only naked person in the room. But the joke was lost on the medical staff when, without warning, my upper body and my legs began to convulse. I felt my torso jumping as if shocked, and my legs were kicking into the air uncontrollably. I had no control over anything my body was doing and pleaded for answers.

"What's going on? Why is this happening?" I asked. The doctor leaned down to my face and began explaining. I was suffering from acute anaphylactic shock, a full-blown allergic reaction to what, at that point, was an unknown substance. He explained that my airway was closing and they were going to intubate me to ensure I could keep breathing. As my body spasmed and lurched, I realized the situation was grim.

The doctor looked over to someone in the room and instructed them to give me another dose of epinephrine, a drug used to stop allergic reactions. Another voice chimed in, "He's already been given the max!" The doctor

replied, "We've got no choice."

Immediately after the final dose of epinephrine was administered to try and stop the runaway allergic reaction in my body, I went into cardiac arrest. Everything became crystal clear and I could make out each voice. The pressure in the middle of my chest was incredible and I was having difficulty breathing. I became extremely nauseated, as if I would throw up at any second.

The doctor screamed, "Get the crash cart over here now!" Seconds later, he was standing over me with the paddles in his hands. I told myself, "You have time for one final prayer." I closed my eyes and recited the Lord's Prayer in my head, which restored my peace of mind. Incredibly, my heart resumed its normal rhythm and the cardiac arrest ended. I was taken to the intensive care unit for observation because the danger was far from over. The doctors told me I could relapse into anaphylactic shock at any time.

That evening, with my wife by my side, the doctors came in to see me. Their explanation of the day's events was an incredible tale of the dangers we face every day, the unnecessary risks we take and just how lucky some of us get. They told me I was within seconds of death in the emergency room and that they'd never seen a patient in such severe distress from anaphylactic shock survive. But what caused the anaphylactic shock? Why did it happen to me? Could it have been prevented? It wasn't until later that I had my answers.

The bug bombs my brother had set off, technically referred to as total release foggers, contained a mixture of chemicals, including the poisons intended to kill insects and the agents used to disperse the insecticides. One key agent in the TRFs, pyrethrins, derived from chrysanthemums or their synthetic counterparts, have been identified as the culprit in a number of emergency room visits. Past incidents resulted in respiratory issues, rashes and anaphylactic responses such as mine. The severity of the response to these insecticides is directly related to the intensity of the exposure. Each of the TRFs used by my brother was designed to saturate a 700 square-foot space. My brother's new home was 1,100 square feet. Believing that if one TRF was good then five would be better, he set off enough to saturate a 3,500 square-foot home. In other words, he used more than three times the insecticide needed. By ignoring the instructions for use clearly labeled on the bug bomb packaging, he unknowingly created a toxic environment in his new home.

This event almost ended in tragedy. No one should experience the terror of full-blown anaphylactic shock, the closing of your airways or the literally heart-stopping horror of a cardiac arrest. Household chemical agents carry strict instructions and limitations on their use for very good reasons. Every person who uses or is exposed to these common household agents must remember that there is no such thing as a harmless chemical. Read the instructions carefully and heed the warnings. You may not get a second chance.

FYI

Are you aware that the Hazardous Materials Information Resource System is the central repository for Material Safety Data Sheets for the U.S. Government military services and civil agencies? HMIRS is a Department of Defense automated system developed and maintained by the Defense Logistics Agency. It also contains value-added information input by the service/agency focal points. This value-added data includes HAZCOM warning labels and Department of Transportation information. HMIRS provides this data for hazardous materials purchased by the federal government through the DoD and civil agencies. The system assists federal government personnel who handle, store, transport, use or dispose of hazardous materials. To learn more, visit http://phc.amedd.army.mil/topics/workplacehealth/ih/Pages/usMaterialsInformationResourceSystem.aspx.

HAZARDS!

As of June 1, 2015, the Hazard Communication Standard (HCS) will require pictograms on labels to alert users of the chemical hazards to which they may be exposed. Each pictogram consists of a symbol on a white background framed within a red border and represents a distinct hazard(s). The pictogram on the label is determined by the chemical hazard classification.

HCS Pictograms and Hazards

Health Hazard

- Carcinogen
- Mutagenicity
- Reproductive Toxicity
- Respiratory Sensitizer
- Target Organ Toxicity
- Aspiration Toxicity

Flame

- Flammables
- Pyrophorics
- Self-Heating
- Emits Flammable Gas
- Self-Reactives
- Organic Peroxides

Exclamation Mark

- Irritant (skin and eye)
- Skin Sensitizer
- Acute Toxicity (harmful)
- Narcotic Effects
- Respiratory Tract Irritant
- Hazardous to Ozone Layer (Non-Mandatory)

Gas Cylinder

- Gases Under Pressure

Corrosion

- Skin Corrosion/ Burns
- Eye Damage
- Corrosive to Metals

Exploding Bomb

- Explosives
- Self-Reactives
- Organic Peroxides

Flame Over Circle

- Oxidizers

Environment (Non-Mandatory)

- Aquatic Toxicity

Skull and Crossbones

- Acute Toxicity (fatal or toxic)

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For more information:
OSHA Occupational Safety and Health Administration
U.S. Department of Labor
www.osha.gov (800) 321-OSHA (6742)

What's Holding Up Your Car?

DURAND DURGA
U.S. Army Armament Research, Development and Engineering Center
Picatinny Arsenal, N.J.

Saturday was my day for making repairs on my car, and I'd been having problems with my old, rusty brake rotors. Every time I'd hit the brakes, the steering wheel would vibrate. I wanted to put an end to that, so I bought some good slotted and drilled replacement rotors. I gathered all the tools I needed — including a jack, wrenches, sockets and screwdrivers — and went to my garage to get started. I'd changed rotors on several cars in the past, so I basically knew how to do it.

The first thing I did was loosen the lug nuts on the wheel and raise the car with the new hydraulic jack I'd bought. Then, I took off the wheel and placed it beside the car so I could begin removing the brake caliper. After I got it off, the phone rang inside the house and I got up to answer it. After talking on the phone for about five minutes, I went back out to the garage and was surprised by what I saw. The jack had failed and one side of the car was sitting on the floor! I could see where hydraulic fluid had leaked out of the jack. Luckily, the car was resting on the jack's body so nothing was damaged.

I was shocked. When I got over my surprise, I used a different jack to raise the car again and finished replacing the rotors. As soon as I finished, I bought a couple of jack stands and a new hydraulic jack.

I learned a valuable lesson that day. I'd realized that safety isn't just for when you're on the road; it also applies when you're doing repairs. Since then, whenever I work on my car, I use the jack stands as fail-safes and, for extra measure, place a wheel beneath the car.

Thinking back on that day, I could only imagine what would've happened had I been under the car. Had the jack failed then, I would've been injured or possibly even killed. I'd always heard stories about how dangerous it could be to work on your vehicle, but I'd never thought something like this could happen to me. After all, my hydraulic jack was new. I'd trusted it — but it failed.

I now take all the proper safety precautions to protect myself and others when I work on my vehicles. I would encourage anyone else who does their own auto repairs to plan for safety in the process. After all, should your jack suddenly "get the drop on you," the last place you want to be is underneath 3,000 pounds of car.

BY THE NUMBERS

If you think what happened to the author is a rare event, you're wrong. Since 2007, there have been several reported off-duty and on-duty accidents where jacks and jack stands were either used improperly or failed. The off-duty accidents injured four Soldiers and killed a fifth when his vehicle fell off a jack and landed on top of him. The on-duty accidents included a Soldier performing maintenance on the front brake caliper of an M1114. The Soldier, who was reportedly using "bottle jacks," was pinned beneath the vehicle and killed when it fell on him.

Written in FLAM

How many times do our lessons learned come within moments of being written in flames?

CHIEF WARRANT OFFICER 2 RAYMOND ANDERSON
1st Battalion, 183rd Aviation Regiment
Idaho Army National Guard
Boise, Idaho

It was a clear, sunny morning and I was the pilot in command of an OH-58C Kiowa. Our task was to follow and observe two AH-64D Apache helicopter crews during combat training. I was in the right seat; to my left was the instructor pilot — an experienced attack pilot who was evaluating the performance of the Apache air weapons team. The 64s flew in support of ground units as part of a large-scale scenario. Since it was already a warm day, we had removed both doors from our aircraft.

We had been following the Apaches for nearly three hours, ever since sunrise. They had been flying security for a convoy followed by providing air cover for Soldiers doing a cordon-and-search. When lead announced "bingo," we headed to the forward arming and refueling point. Anticipating a routine quick turn with hot refuel, I thought we would be taking off again within 10 minutes. I had experienced countless hot refuels without incident in both the Kiowa and Apache, and this time seemed no different.

We landed on the far right at the number one point and had the Apaches to our left at points two and three. The refueling HEMTT was to their left off in the distance. Due to the position of the two Apaches, the personnel at the refuel truck could not see our helicopter. This problem was normally dealt with by positioning a Soldier at the fire extinguisher to watch us and send hand signals to the refueling personnel at the truck.

After landing, I brought the helicopter to flight idle as usual and casually reminded my PI of our emergency egress procedures, should the need arise. Perhaps 30 seconds later, I smelled an overwhelming odor of JP-8 fuel. I immediately yelled, "Get out! Get out!" and quickly moved through my emergency shutdown steps. Before I had completed those steps, I looked over my right shoulder through the aft Plexiglas window and was surprised to see fuel flowing down the entire window and door exterior. Without warning, the Soldier with the refueling hose had pulled the nozzle from the aircraft fuel port without shutting off the flow.

Quickly moving through my shutdown steps, I again looked to my right through my open doorway (remember, the doors were off). I saw the Soldier soaked in fuel from head to foot standing five feet away, pointing the spraying nozzle in my direction. I watched as a steady stream of jet fuel sprayed under my seat and onto the floor and chin-bubble beneath my legs and feet. I soon found out he had also sprayed fuel on the engine cowling and into the engine compartment.

Moving rapidly, I was able to shut down, unbuckle, disconnect and move out of the cockpit. Fortunately, my PI had followed my briefing instructions and was already well clear of the helicopter. As I ran to the 11-o'clock position under the still-spinning rotor blades, I saw the

fuel-soaked refueler still dousing the right-side of my aircraft. I estimated that lasted about 20 seconds.

My PI and I spent several minutes regaining our composure and then called our boss and others who obviously needed to know what happened. Luckily, no one was injured. Not wanting to slow the ongoing training, we began making arrangements to continue the mission with a replacement aircraft. About 40 minutes after the incident, our replacement helicopter arrived and we were re-briefed and continued the mission. A senior NCO from the training team was aware of the situation and was steering a staff sergeant at the FARP to deal with what had transpired. Confident the problem would be resolved, we departed behind our two Apaches.

Another bag of fuel later, we found ourselves back at the same FARP at the same three refuel points as before. That is when details of the earlier event became even clearer. First, I realized no one had been manning the fire extinguisher at our one-o'clock position to send fuel cut-off signals to the personnel at the fuel truck. Second, I found out the fuel-soaked refueler simply walked off without getting help or informing anyone of what had happened.

However, what really got my attention was what was happening now during our second refueling. Despite the significant fuel spill that happened on our running helicopter only a couple of hours before, the three Soldiers now fueling my aircraft were a specialist (who was there during the spill) and two privates. Apparently, none of the officers or NCOs responsible for fueling operations had taken any interest in what had happened. During our second turn, our fuel cut-off signals were not readily understood and fueling continued for 15-20 seconds after we signaled to stop. I was stunned to see such a lack of leader interest after all that had transpired.

Fortunately, we all walked away from the incident without serious injury or loss of equipment. But I left having learned some important lessons.

- Leaders must be involved and aware of what their Soldiers do.
- A lack of training and supervision can quickly end in catastrophe.
- Complacency can lead to a routine situation becoming uncontrolled.
- Communication of hazards to leaders is essential if a fix is to occur.

I believe that a substantial part of that last bullet rested on me. Although I spoke with the training NCO shortly after the incident and eventually submitted an occupational hazard report, I still had not properly dealt with the immediate problem. I had assumed the FARP training NCO had handled the situation and drove on. What I should have done was immediately stop the training and let everyone know we had a problem that needed attention. I should have then followed up to ensure the correct people were informed, involved and taking appropriate action.

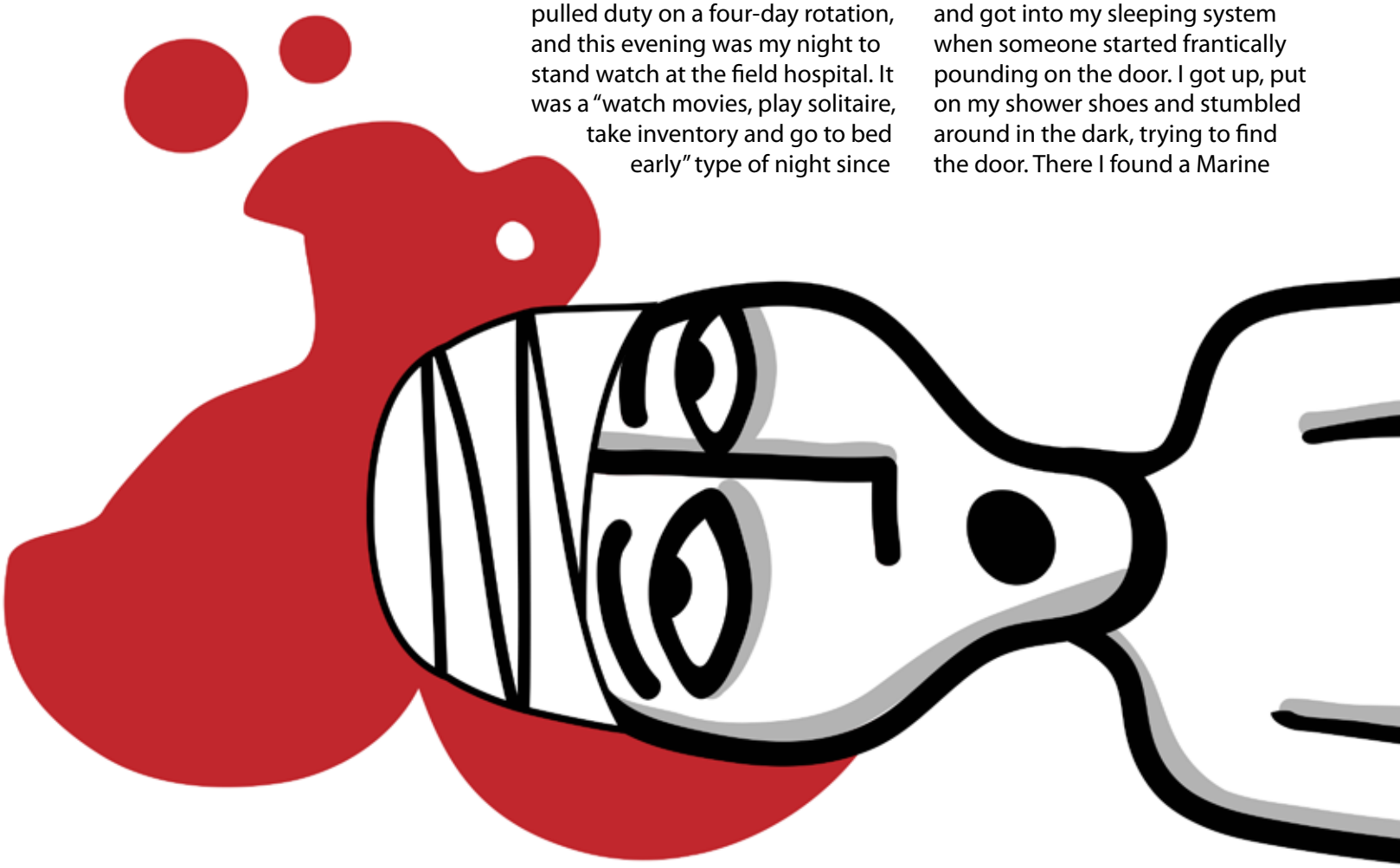
I'm grateful this story was written in ink and not in flames. But how close did we come? I don't want to know.

SCALPED

There I was. Seriously, how many deployment stories do we have that start with those three words? I'm sure many of you reading this article have a few of your own. I'm a safety professional now, but when I reflect back on my time as a Fleet Marine Force corpsman (similar to an Army medic), I realize I have quite a few stories that start that way. This one is no different.

So there I was at Camp Samae San, Thailand, in Support of Operation Cobra Gold 2003. I pulled duty on a four-day rotation, and this evening was my night to stand watch at the field hospital. It was a "watch movies, play solitaire, take inventory and go to bed early" type of night since my fellow Marines were on liberty in Pattaya Beach.

I had just turned off the light and got into my sleeping system when someone started frantically pounding on the door. I got up, put on my shower shoes and stumbled around in the dark, trying to find the door. There I found a Marine

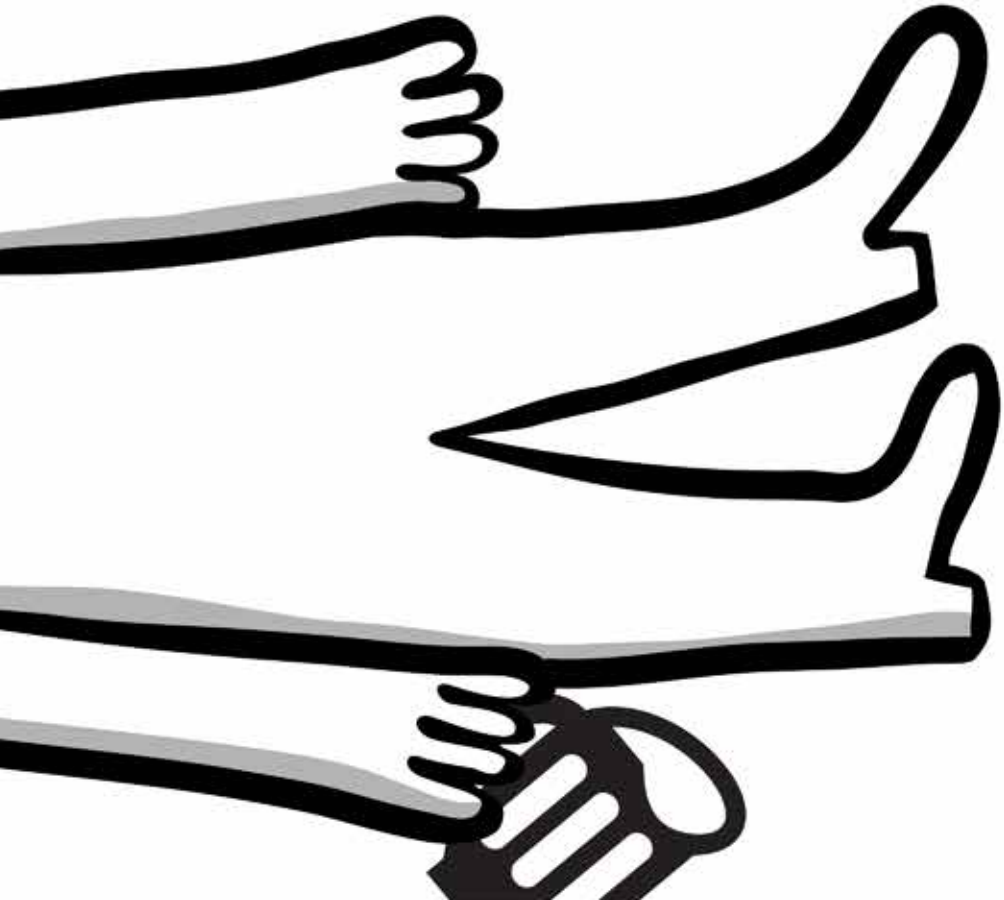


MICHELLE WOOD
West Point Safety Office
West Point, N.Y.

(Marine 1) holding up another Marine (Marine 2) with a blood-soaked towel on his head. I said, "What the heck happened?" Marine 1 replied, "My buddy got scalped!" You can imagine what my initial response might have been, but I got out, "Get him in here!" I then helped Marine 1 bring intoxicated, wounded Marine 2 into the exam hooch.

As I assessed the injury, Marine 1 shed a little light on what happened. Marine 2 was drinking heavily at a club and, when Marine 1 wasn't looking, decided to climb onto the bar. Once up there, he stood up and was struck in the head by a ceiling fan. His scalp was peeled back and he was knocked down onto the bar. Bystanders immediately applied pressure to the wound with the towel and brought the injured Marine back to base for medical attention.

Usually in a field hospital, few circumstances call for waking-up the duty physician. This situation, however, merited a wake-up. I contacted the surgeon on call and proceeded to clean the wound as I awaited his arrival. The surgeon got there as I was laying out my closing tray and asked what type of situation I had. As I turned to tell the doctor the details, he was picking up the towel covering Marine 2's head. Before I could say anything, he shouted, "Oh my God!"



I briefed the surgeon on what I had already completed and how I planned to close the wound. He agreed staples would be the best route and that anesthesia definitely wasn't required since Marine 2 wasn't feeling much anyway. Staples go in rather quickly, so by the time he would've dealt with the pain of anesthesia injections, the staples would be in place. So, Marine 2 received a lot of staples and now has a post-deployment scar showing how alcohol caused him a night in the field hospital.

I know this story may sound funny to some, but this Marine could've been more seriously injured. It may not sound like he was lucky, but considering the height of the bar, this Marine could've died if he'd fallen to the floor. Alcohol clouds our judgment, which sometimes leads us to do stupid things. We need to have situational awareness at all times and keep in mind the risks of not only our actions, but also of those around us. Fortunately for Marine 2, this incident wasn't permanently disabling or fatal. Always remember safety first and safety always!

LOST

AVIATION

UH-60M

CLASS A

- The instructor pilot was on approach to a dirt/gravel road adjacent to a manmade pinnacle in the training area when the main rotor blades contacted the pinnacle at 20 feet above ground level. The crew maneuvered the aircraft forward and set it down on the road for shutdown.

FIXED-WING

C-26B

CLASS C

- The aircraft was damaged during landing.

UAS

MQ-5B

CLASS A

- The system began losing power at 7,000 feet AGL. When the system descended to 2,000 feet AGL, the crew initiated emergency procedures. The system was later located and destroyed in place.

RQ-7B

CLASS C

- After the engine failed at 7,000 feet AGL, the crew deployed the recovery chute. The system was recovered with damage.
- The system crashed after an engine failure and was recovered with damage.

PUMA

CLASS C

- The system crashed after the mobile training team trainer and crew lost link during flight.
- The crew experienced an uncommanded flight input, after which the system entered a nose-low attitude and impacted the ground.

GROUND

Personnel Injury

CLASS A

- A Soldier died after collapsing during physical training.
- A Soldier died while participating in Airborne operations training.

DRIVING

PMV-4

CLASS A

- A Soldier died when the vehicle he was riding in struck a tree after the driver lost control, overcorrected and left the highway. Seat belt use was not reported.
- A Soldier was killed when his vehicle left the roadway and struck a culvert. A Marine riding with the Soldier also died when he was ejected from the vehicle. Local authorities suspect alcohol and speed as contributing factors.

LOSSES AVIATION — FISCAL 2013 Class A/Fatalities thru Jan. 2013

ATTACK	0/0
RECON	0/0
UTILITY	2/0
CARGO	1/0
TRAINING	0/0
FIXED-WING	0/0
UAS	3/0
TOTAL	6/0

as of Feb. 20, 2013

LOSSES GROUND — FISCAL 2013 Class A/Fatalities thru Jan. 2013

AMV	2/2
ACV	1/0
PERSONNEL INJURY (includes weapons-handling accidents)	6/5
FIRE/ EXPLOSIVE	3/2
PROPERTY DAMAGE	0/0
TOTAL	12/9

as of Feb. 20, 2013

Editor's note: Information published in the accident briefs section is based on preliminary loss reports submitted by units and is subject to change. For more information on selected accident briefs, email usarmy.rucker.hqda-secarmy.list.safe-knowledge@mail.mil.

- A Soldier was riding in his vehicle, which was being driven by a friend, when they struck a stalled tractor-trailer that was partially on the road. The Soldier was not wearing his seat belt and pronounced dead at the scene.

- A Soldier died when his vehicle crossed the centerline and collided head-on with a tractor-trailer.

- A Soldier was ejected and killed when his car overturned after veering off a freeway.

- A Soldier died when he lost control of his vehicle, which left the road and struck a tree. The Soldier was reportedly not wearing his seat belt and died on impact. His passenger was wearing her seat belt and was hospitalized for injuries.

- A Soldier died after he was struck by a passing vehicle.

- A Soldier was killed when his vehicle, reportedly traveling at a high rate of speed, left the road and struck a utility pole. Seat belt use was not reported.

- A Soldier and his civilian passenger died when he lost control of his vehicle, entered the opposing lane of traffic and collided with an approaching vehicle. Seat belt use was not reported.

- A Soldier died after he lost control of his vehicle in a curve and struck a tree.

PMV-2

CLASS A

- A Soldier suffered a permanent total disability in a motorcycle accident. The Soldier was thrown from his bike and landed in a ditch, resulting in fractured vertebrae and permanent paralysis from the neck down.

LOSSES POV/POM	FISCAL 2013 Class A/Fatalities thru Jan. 2013
CAR	17/15
SUV/JEEP	1/1
TRUCK	4/3
MOTORCYCLE	10/8
PEDESTRIAN	2/2
OTHER*	3/3
TOTAL	37/32

*Includes vans, ATVs, snowmobiles and bicycles

as of Feb. 20, 2013

Fiscal 2012 Year to Date: 30

Three YearAverage Year to Date: 29

Pedestrian

CLASS A

- A Soldier died after he was struck by a vehicle while crossing a major roadway at an intersection.

The signs are all around.

It's up to YOU to recognize and act on them.

KNOW WHAT'S RIGHT

know the signs

DO WHAT'S RIGHT

Training, Discipline and Standards

Training, discipline and standards are the bedrock of our Army, and as Soldiers, you've been taught what right looks like. As leaders, you have a duty and a responsibility to maintain standards in your formation. You also have an obligation to your Soldiers and their families to manage risk and take action to correct problems. In our fight against accidental fatalities, knowledge is the weapon of choice.

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https://safety.army.mil