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When Training Becomes Too Real

STAFF SGT. TIMOTHY T. SANK JR.
Maryland Army National Guard
Edgewood, Maryland

It was a brisk morning and we were into our second week of military police field training at Fort Indiantown Gap, Pennsylvania. We'd been practicing military operations on urban terrain tactics for several days. Our equipment consisted of all the vehicles and weapons a military police platoon would have. We were having a great time and feeling a little invincible. Our confidence level was high because all of our iterations had gone off without a hitch. We'd even done some unscheduled rappelling operations. Safety was the last thought on anyone's mind.

Eventually, the time came for force-on-force exercises, which allowed us to combine all of the skills we'd been practicing. We would be entering into the MOUT site for squad individual tactics. The "opposing force" would consist of no more than three individuals, and our job would be to neutralize any threats. Both sides would have weapons with blank ammunition, smoke grenades and grenade simulators.

My squad was up first and performed all of our tactics flawlessly. We eliminated the threats in record time. Everyone was really pumped as second squad readied for its turn.

In an effort to outdo us, second squad decided to change up things a bit. Rather than have their two teams enter the town on foot while their M1025 HMMWVs maintained overwatch — as my squad had done — their plan called for one of the HMMWVs to drive slowly down the road while the teams moved behind it. The HMMWV would act as concealment from the OPFOR, which, at the time, sounded like a good idea.

The M1025 crew was simple — just a driver and an M240B machine

"She threw the vehicle in reverse and stomped on the gas to escape the grenade. The vehicle lurched backward, causing the two teams — which were following closely behind — to scatter."

gunner. The vehicle commander was outside with the teams so he could better coordinate the exercise. As the squad entered the town complex, a member of the OPFOR team stepped out from behind a building and skittered a grenade simulator down the road toward the front of the HMMWV. Unfortunately, the inexperienced driver panicked. She threw the vehicle in reverse and stomped on the gas to escape the grenade. The vehicle lurched backward, causing the two teams — which were following closely behind — to scatter.

One Soldier did not get out of the way quickly enough. He was knocked to the ground and the vehicle began to run over him. The rear driver-side wheel came up his right leg, causing an open compound fracture of his tibia and fibula. The HMMWV continued to travel up the Soldier's body, crushing his right hip and pelvis, and then ran across his abdomen and onto his chest, breaking several ribs and puncturing a lung. The vehicle finally came to rest on the left side of his upper chest, breaking his left clavicle.

Everyone was screaming at the driver that she had parked on top of a Soldier. Still in a state of panic, she threw the vehicle back into gear and stomped on the gas again, peeling off the Soldier. I, a trained paramedic, and another Soldier, who was a trained emergency medical technician, rushed to the injured Soldier so we could stabilize him until an ambulance arrived. The Soldier was then transported to a local medical center, where he spent several hours in surgery.

The moral of this story is that even something as simple as routine training can be dangerous. We were out there to learn and ended up losing two Soldiers to a training accident. Neither the injured Soldier nor the driver was ever able to return to duty.

No one had thought about safety that day. We hadn't given a safety brief, nor had we appointed someone as a safety officer. No one wanted to volunteer to take on the extra responsibility of safety. We also failed to identify all the hazards, such as having an inexperienced vehicle operator who had not rehearsed the mission. In addition, leaders never talked about potential threats and what the proper responses to those threats would be.

Sadly, the principles of risk management were never used, which lead to a tough lesson learned. It doesn't matter where or how a loss occurs, the result is the same — decreased combat power or mission effectiveness. ■

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Celebrating Decision-making

LT. COL. TONY SOMOGYI
High-Altitude Army Aviation Training Site
Gypsum, Colorado

Celebrating decision-making sounds about as exciting as celebrating the move from fifth grade to middle school. But decision-making is the key for a successful day that involves multiple search-and-rescue missions flown in the high country of Colorado.

People like to celebrate the hoist operations we conduct at 14,000 feet or the one-wheel landing that made the news because that's "sexy." Even as pilots, good decisions are rarely applauded, but you can bet your wings a poor decision will be revisited more often than you would like.

As the commander of the High Altitude Army Aviation Training Site, I have multiple levels of risk to evaluate. In training, I must trust that my instructors can read a student quickly, challenge that student by pushing their limits, yet allow learning to take place without damaging the aircraft. This is high frequency because the training is conducted weekly and low probability because of the experience of my instructors. What makes the hair stand up on the back of my neck is search-and-rescue decision-making.

SAR for the HAATS tends to be a medium-frequency, high-risk mission. Medium frequency meaning we flew 29 missions last fiscal year, so there's some familiarity, but still high risk for a multitude of reasons. In addition to "normal" risk associated with flying in the mountains, SAR missions can become complicated quickly. These complications arise from variables such as relying on SAR teams as our ground counterpart, the elevations where people get lost or injured in Colorado, the severity of the situation before we are notified, the expectation of what we are supposed to be able to accomplish and the ever present sense of urgency.

On July 11, 2015, we received a call about two missing hikers around Mount Blanca. Flight for Life Colorado, whom we work with quite frequently, was also called to search because it was presumed that since the two had been missing for two days they were probably in need of medical attention. Ground teams began to move into the area and FFL was able to locate the two individuals. Due to the terrain they were in, it was decided a hoist operation might be needed; in any event, FFL was not going to be able to land near them.

"This was a first good decision to set the tone for the day — land and talk to the individuals controlling the operation."

The crew received this information after launching and landing at the incident command center for a face-to-face briefing on the situation. This was a first good decision to set the tone for the day — land and talk to the individuals controlling the operation. A face-to-face typically alleviates any

misperceptions we may get from translating the situation through numerous operations centers. It also updates information that changed since our dispatching.

It was especially important in this case since we do not work with this county often and communication available with the field teams was already in question. This also prevented us from entering the search area and being surprised by FFL. Even though we have a memorandum of understanding with them that places us on a common frequency, we typically forget to blind call or even tune it up at times if we do not suspect they are there.

After receiving accurate latitude and longitude coordinates, the crew launched to assess the situation. It was determined it would take hours for the ground team to get to the victims. About this time, we received word from Mountain Rescue Aspen about a follow-on mission on Mount Snowmass for a fallen climber. This was relayed to the crew roughly at the time they arrived over the survivors. They decided that it was just as easy to pick up the two seemingly OK survivors and save fuel for the possible follow-on mission.

We have a SAR standard operating procedure that calls for us to land first, use a two-wheeled landing second, a one-wheel landing third and hoist as a last resort. Since there were no ground teams onsite and wouldn't be for a few hours due to the terrain and three- and two-wheel landings were not possible, a hoist was determined to be the best option.

We do not have medics at HAATS who are well trained in riding the hoist down to assess a victim. Because of this, the crew chief went down on the rescue seat, making this the second decision to celebrate even though this was out of the norm. This gave him the opportunity to assess the survivors and determine if the seat would work. More importantly, he made sure they were securely attached to the seat vice, relying on them being able to read and comprehend the instructions on the seat after no sustenance for two days.

While conducting the hoist work on Mount Blanca, back at HAATS we received word from the Colorado Joint Operations Center of a third mission that was approved and became the next priority. A female hiker who happened to be 10 weeks pregnant had fallen on Crestone Peak and had a possible broken femur and ribs, difficulty breathing and was becoming hypothermic, as reported by her hiking partner.

Crestone Peak and Crestone Needle, like so many mountains in the Aspen area, are nasty places to work and one of the few places that make me cringe when we have to send aircrews there. The crew was going to Alamosa for fuel, so we decided to talk to them by phone when they landed to give them the follow-on mission, hopefully with a little more clarity. Although not celebrated at the time, this decision slowed the operational tempo and allowed us at HAATS to coordinate ground teams and talk with a good connection. Slowing the OPTEMPO is sometimes difficult, especially with a victim like this, but it is necessary to prevent pushing a bad situation. One thing we like to reiterate from time to time for both our aircrews and ground team members is: "Don't make their emergency your emergency!"

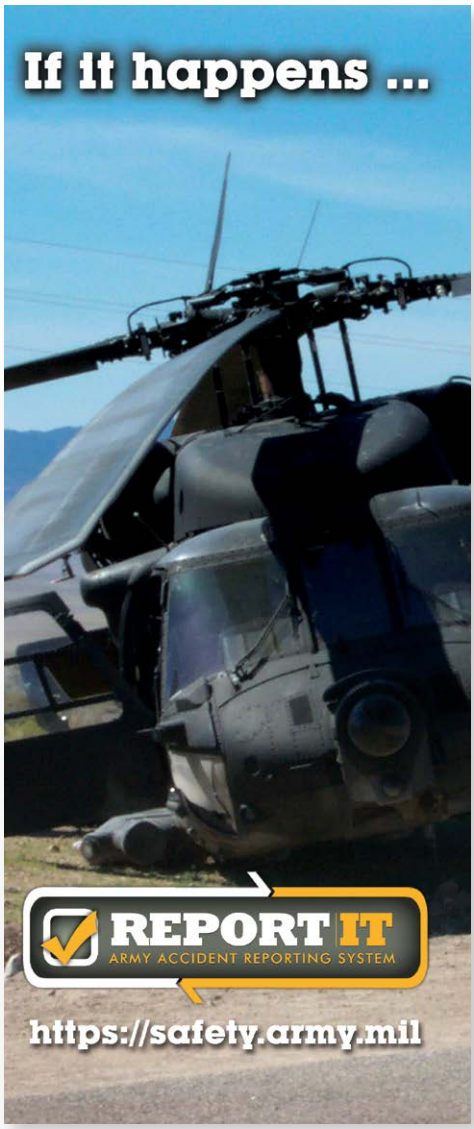
It was pretty evident that this mission was going to require a hoist. Patient packaging is not our forte; we rely on the SAR teams we work with for that. As luck would have it, the team from Western

State we had trained for hoist operations during the spring were on their way there from Gunnison. It was decided to have them go to another airfield, where we would link up with them and a team from Saguache County, insert the teams, package the victim, then hoist and go. It was also determined this mission had the possibility to run into night, which meant the crew would fly with night vision goggles.

At this point, it was determined crew rest was not an issue, so we adjusted the risk accordingly and didn't have much in the way of mitigation to apply yet. Now it was time for the real "decision party" to begin.

While en route to Crestone Peak, the aircrew was notified that FFL was taking the Snowmass mission. After picking up the Saguache team and locating the survivors, the team was inserted. The survivors were on the leeward side of the mountain, in a steep drainage on an "island" of sorts made of one large rock and running water on both sides from the melting snowpack above. There was no place to land near the injured party, so the team was inserted as close as possible and would have to traverse the couloir to make contact with them. (Coincidentally, one week later we would be back at the same spot for a climber who was not so lucky and missed the island in the fall and subsequently died.) The aircrew went back to pick up the Western State team, donned their NVG and inserted them to package and hoist the survivor.

The teams made it to the survivor, packaged her, and were ready for the hoist. The Black Hawk is a powerful machine, but, at 14,000 feet, even it has limits.



Operating on the leeward side of the mountain, the downdraft and turbulence was so strong that maintaining a stabilized hover was virtually impossible.

Working backward now through our SAR SOP from hoist to landing had to occur. I say backward because now the ground team has to move the survivor with ropes in unforgiving terrain. Their safety had to be balanced along with the capabilities of the aircraft and crew. This was the best decision of the night and the reason to tell the story: moving away from the hoist and opting to land, sacrificing speed and the "hero" image that comes with doing a live hoist. It was also one of the hardest for both the ground teams and the survivor to hear.

The turbulence was bad to the point that a one-wheel landing was not going to be stable enough to load the survivor over the rugged terrain. Two wheels was marginally better, and there wasn't a place for it to be executed. Unfortunately, the team would have to move the survivor 1,500 feet vertically down the mountain, possibly at night with no illumination, to where the aircraft could get all three wheels on the ground to load. The decision became complicated because there was a serious concern as whether the survivor would make it through the night given limited medical support available from the SAR teams. This was a tough decision to make given the circumstances but the right call from a safety standpoint.

The aircrew went back to Alamosa for fuel and planned on returning at 0100 for pick up and a status check since they were going to be out of communications with the team. Meanwhile, the rest of us in the HAATS Command Center were beginning to wonder what the issue was. I know from our

experiences with fallen climbers about how much time it takes to complete the complicated portion of the mission, and I am respectful of the workload going on in the aircraft enough to stay out of the cockpit, but the lack of contact was becoming disturbing. We finally received a call from the aircraft when they were back in Alamosa about what the proposed plan was.

Now I had some decisions to make as a risk manager. I understand they do not want to leave the victim or the team in the field, but I have to be the one weighing the risk versus the reward. The risk was that this crew had completed one mission and was just jerked around on another mission, only to end up on this mission. They took NVGs with them, but those were for recovery purposes.

Flying unaided in the mountains of Colorado can be a death sentence. We had not cycled the crew for NVG, so they had been at work since noon and were going on nine hours of duty day already and the pickup was not until 0100. Pickup at 0100 placed the most dangerous portion of the mission in the 11th hour of their duty day and they still had a two-hour flight home to HAATS on top of it through the Colorado high country. I know they have not eaten and probably hadn't hydrated much. I normally wouldn't worry so much about a person's diet, but I also knew they only had two small bottles of oxygen each and had probably exhausted one so far, so I was concerned about hypoxia adding to the issue.

We discussed all the variables and why the crew made the decision not to do the hoist. I had to make a decision whether they should go back and pick up the victim or trust that she was in good hands to this point and was going to be able to be roped down and carried out. At a minimum, the crew needed to make contact and let the ground team know what was going on, which could happen on the way home. There was a waiting air ambulance on a soccer field in town, but that is as "remote" as that aircraft's contract would allow under NVGs.

"The risk was that this crew had completed one mission and was just jerked around on another mission, only to end up on this mission."

So, the carry-out of the victim would be a long and arduous process. A victim who was 10 weeks pregnant and suffering from hypothermia, broken ribs and a broken femur in the backcountry factored into the situation. We are not heartless, so it was decided that the crew would return at 0100. If the team made it to the pickup zone and a safe extraction and delivery to the awaiting air ambulance could be conducted, the mission would continue with some mitigation.

First of all, and not because I was worried about the crew becoming Aretha Franklin-like in the Snicker's commercial from a lack of food, they needed to eat. They were able to coordinate late-night food with the airport. Secondly, they needed to make sure they were good with oxygen for the pickup and the trip home. As luck would have it, the first mission was only around 12,000 feet mean sea level and was executed fairly quickly, so they all had oxygen remaining. Finally, the last and most critical item to manage at this point was crew rest. They assured me they felt OK now, which didn't matter to me because they were coming off adrenalin and the critical time to be awake was over four hours from now. I urged them to try to nap but, having experienced it many times myself, I knew it is hard to turn the brain off during a SAR knowing you have to go back out. Sleep is difficult at best.

I could only offer some mitigation. I could order them to come home, but I was not sure my conscious would allow me to do that. First of all, it was easy for me to say that being back at HAATS Command Center and not out there in the field. It was reiterated to think of the crew before the victim or the SAR teams. If they had an accident, they were making that victim's

emergency their emergency. This was not lost on the crew.

Second, and most importantly, they were going to have to cross-monitor each other's performances. I was not there to watch the crew, and, truthfully, only each crew member knew how tired he was. Externally it could be faked for the most part. The crew was familiar enough with each other that they could hopefully identify mistakes being made in performance/load calculations or just normal crew procedures and use it as an indicator to determine if the risk was increasing.

Third, if the ground team was not successful in moving the victim to the PZ, they had to determine what additional time and coordination must take place. If not executed quickly, they may have to leave them all in the field and return home. There was no going back to Alamosa for fuel and they still needed about two hours of fuel to get home. Finally, and I hate doing it, especially to the all-volunteer SAR teams who, incidentally, are the true heroes in this and all our SARs, the ground teams would have to walk out. We assumed all the risk to get the victim out and the very capable ground teams could handle the hike and coordinate for transportation.

As the commander of the HAATS, I only get to manage the risk at my level to the best of my abilities. In the state of Colorado, ultimately the adjutant general, who is the two-star leader of both the Army and Air National Guard, is the one that has to approve the highest risk level. My conduit to him is through the state Army aviation officer, who happens to be my predecessor in this job and is well versed about the ins and outs of these missions. I rely on his tutelage since I still haven't seen it all and his ability to articulate to the TAG the risk he is about to assume. This is extremely important because sometimes senior leaders will assume risk while not fully knowing what they are assuming, to which we owe them a detailed explanation so they can make an informed decision. With the mitigations in place, he trusted the team and allowed the mission to continue.

I do not know that the decision to go back and pick up the victim is a celebration-type decision; it was just a decision. It was calculated and mitigated, and the crew was airborne again at 1245. Once they were in radio range, the SAR teams communicated that they had the victim in the designated PZ where all three wheels could make contact with the ground. Their efforts saved this individual and, as I understand it, the baby too. The landing on the soccer field and subsequent transfer to the air ambulance went quickly, and the crew was on their way home.

Incidentally, the cross monitor piece I spoke of earlier paid off. On the return trip home, one of the crew members became Aretha Franklin-like. Probably the most benign portion of the mission vice being under NVGs and this crew member became knit-picky about every task that was occurring at the time. Simultaneously, all the crew members told him to get back on oxygen, and Aretha disappeared.

What occurred on this mission paints a picture of the work we do and the risk involved. Working at altitude in an unforgiving environment means every decision is critical. Our crews, command and support personnel understand this and manage the risk on every mission. The process applies to everyone in Army aviation. ■

HERE IT COMES

Are you ready to crank?

READY ...OR NOT?

Ready ... or Not **is a call to action for leaders, Soldiers, Army Civilians and Family members to assess their "readiness" for what lies ahead—the known as well as the unknown.**

Throughout our professional and personal lives, events happen all around us. We are often able to shape the outcome of those events, but many times we're not. Navigating life's challenges is all about decision-making.

So are *YOU* ready ... or not?

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It Wasn't His Fault

1ST ARMORED DIVISION
Fort Bliss, Texas

Author's note: The story you are about to read was written by a Soldier-rider and is true. The events are retold to give insights into the many hazards riders face when they are on the road. The lessons will help us all become more experienced motorcycle riders.

The rider stopped his motorcycle to render honors to the flag in front of 1st Armored Division Headquarters. The military police had halted all traffic, as the flag was to be lowered in just a few seconds. Then, the unthinkable happened — an inattentive driver plowed into the rider at 40 mph.

The rider survived, but it took many months for him to recover from his injuries. Just about everyone agreed this accident wasn't the rider's fault and there was nothing he could have done differently. But we motorcyclists know better, don't we?

Strictly speaking, the motorcyclist was not at fault. In the eyes of the law, the other motorist would be cited. Normally, this would also mean the motorist's insurance would be responsible for medical bills and the repair or replacement of the rider's motorcycle. But not everyone operating a vehicle is insured, or the medical bills may exceed the insurance coverage. Therefore, a motorcyclist always has to take responsibility for his own safety.

When a motorcyclist comes to a stop on the roadway for whatever reason, he should be preparing to escape any situation that develops behind him. He selects his escape paths and leaves the bike in first gear with the clutch lever pulled while constantly observing behind him. When he sees a vehicle approaching, he flashes his brake lights a few times to get the driver's attention. If the driver does not appear to notice, the motorcyclist can begin executing the escape plan.

There are other tactics riders use to survive on the street. For example, when pulling away from a stop, they often give the traffic around them the chance to shield them through the intersection in case someone decides to run the light.

"When a motorcyclist comes to a stop on the roadway for whatever reason, he should be preparing to escape any situation that develops behind him."

What are your tactics? Make sure you share them with other riders. You might just help save a life. In the meantime, look out behind you. ■

RIDE FOR YOUR LIFE

The Motorcycle Mentorship Program establishes voluntary installation-level motorcycle associations where less experienced riders and seasoned riders can create a supportive environment of responsible motorcycle riding and enjoyment. This can create positive conduct and behavior and serve as a force multiplier that supports a commander's motorcycle accident prevention program.

MMP
MOTORCYCLE MENTORSHIP PROGRAM

Check out the USACRC MMP website for some examples of active mentoring programs.

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Guiding Right

MASTER SGT. TOM COLLUM
Jefferson City, Missouri

Before deploying to Iraq, our transportation unit was understrength, so other Soldiers in the state that had an 88M military occupational specialty (transportation) were pulled from their units to head out with us. This, however, caused some unforeseen issues. For instance, when using ground guides, these Soldiers used different hand and arm signals. At times, this could be frustrating.

When working around vehicles, a driver and ground guide must remain alert to everything around them. Due to the noise level of vehicles and other equipment, they must be able to communicate effectively by using hand and arm signals. For the Soldiers who were new to our unit, this meant learning and adapting to our signals. It's important that everyone uses the same signals so we work more effectively as a team.

A driver must always use a ground guide when a vehicle is in a motor pool, bivouac or assembly area or when backing up. If these areas are tight or congested, two ground guides must be used. This helps ensure the driver doesn't run into another piece of equipment, a Soldier's gear or, more importantly, a Soldier. This is why it is very important that the ground guide and driver communicate effectively. To avoid confusion, it's a good practice for the driver and ground guide to go over the hand and arm signals before they begin moving a vehicle.

All commands should come from the ground guide, who must remain in the driver's sight at all times. If the driver doesn't understand what the ground guide wants him to do, he must stop immediately, get out of the vehicle and go over the hand and arm signals again. If the driver can't see the ground guide or notices he is in a dangerous position, he must stop immediately and get out of the vehicle to ensure the guide is OK.

The ground guide must always stay at least 10 yards away from the vehicle or piece of equipment to ensure nothing will be damaged when the vehicle is in motion. He should never run, walk backward or walk between two vehicles and only communicate with the driver when the vehicle is in motion. When using two ground guides, the driver and both guides must go over hand and arm signals and decide who will be the primary guide. The primary ground guide is the one from whom the driver takes his signals. If there is any confusion or one of the guides can't be seen, the driver must stop the vehicle immediately to ensure the safety of the guides.

"A driver must always use a ground guide when a vehicle is in a motor pool, bivouac or assembly area or when backing up."

Ground guides are an essential part of safely moving vehicles and heavy equipment. The proper use of ground guides can reduce injuries and accidents in the military. ■

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Ground Guiding: the Video

Tactical Wheeled Vehicle Ground Guide Procedures

A ground guide is an essential component to moving vehicles in restricted-visibility and restricted-terrain conditions.

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A Box of Ground Guides

SEAN JONES
99th Regional Support Command Safety
U.S. Army Reserve

As a one station unit training private at the Fort Knox, Kentucky, armor school, I was taught how to use hand and arm signals during day and night conditions. Back then, my ground-guiding skills were definitely lacking at best. Eventually, though, my skills improved to the point where I believed I could help a driver parallel park a tank on Main Street U.S.A. during rush hour. Sadly, it appears ground-guiding standards aren't being enforced as stringently as in the past.

When I got to my first duty assignment, the running joke was to send all the incoming privates or lieutenants to get a box of ground guides. Since everyone was in on the hazing, this mission sent me from my maintenance team to the commo shop, to POL and then back to the platoon sergeant. In a way only he could, the platoon sergeant said, "My friend (or perhaps a more "colorful" term), there is no such thing as a box of ground guides!" I was embarrassed and couldn't wait until the next Soldier arrived so I could continue the ritual.

It took me a few months to realize it, but there actually was a box of ground guides at my disposal — and I didn't have to go far to find them. They were the Soldiers around me. I could ask anyone for help and they would be more than capable to handle it.

By the time I completed my last Tank Table VIII in Grafenwoehr, Germany, I was at the top of my game. As a tanker in the field, there was nothing more exhilarating (or terrifying) than navigating a tank across 10-plus railcars at night armed with only your training, a flashlight and an impatient rail-meister below. (Mind you that the outer half of the track on each side of the tank is not on the railcar.) At the motor pool, "dress right, dress" was the standard for all tanks, and it wasn't a huge deal to have your sergeant first class come to your room an hour after final formation to tell you your tank was not on line.

As I transitioned from an active-duty tanker to a postal specialist in the Army Reserve, I noticed a drastic drop in the personnel able to execute ground-guiding operations to standard. I routinely stood

"Even when I got behind a vehicle to be a ground guide, more often than not the driver didn't understand the signals I was using. I often found myself giving a block of instruction."

behind a vehicle as it was backing up to see if and when I would be noticed. When it was obvious the driver thought he had no use for a ground guide, I would scream, "My leg!" at the top of my lungs to get the attention of everyone around. Even when I got behind a vehicle to be a ground guide, more often than not the driver didn't understand the signals I was using. I often found myself giving a block of instruction.

I don't think this drop in ground-guiding skills is due to a lack of training. I think it is more a matter of rusty skills and lax enforcement of standards. Any accident related to the lack of a ground guide is preventable. As leaders, we need to get back to the basics. We need to replace complacency with vigilance.

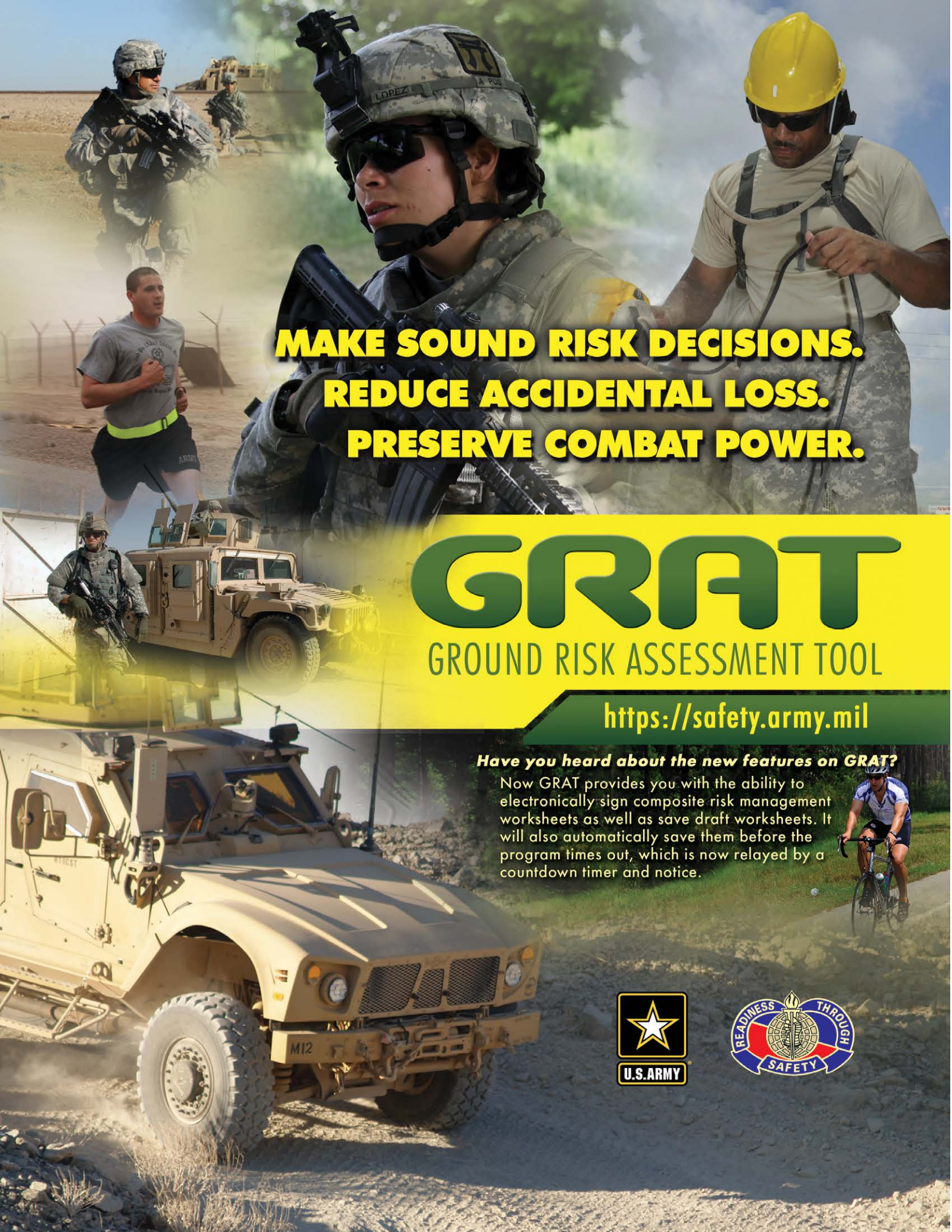
As a safety professional, I want to make common sense more common. Let's retrain our Soldiers to do what's right so they'll do it unconsciously. Let's put that box of ground guides in every motor pool, training area and Reserve center. ■

FYI

Ground guides are a vehicle operator's eyes when maneuvering equipment in areas of limited visibility. Therefore, ground guiding a vehicle is one task where training and coordination between the two is paramount. To help prevent injuries to ground guides and other personnel, follow these simple steps:

- All drivers and other unit personnel will be trained to standard in the correct use of ground guides and ground-guiding operations.
- Always use ground guides when backing and in congested areas.
- When traveling cross-country during periods of limited visibility, ground guides will be used. Drivers will keep ground guides in view at all times.
- Ground guides will be used in bivouac and assembly areas.
- Two ground guides will be used when vision is restricted. Ground guides should never walk backward and never get between two vehicles.
- During periods of limited visibility or darkness, ground guides will be equipped with suitable lights (two flashlights and extra batteries).
- Ground guides will use hand signals. Voice signals can be misunderstood or go unheard.
- Ground guides will also:
  - Keep a proper distance from the vehicle (10 yards).
  - Give signals only to the vehicle driver.
  - Stay out of the path of travel.
  - Stay in the driver's line of sight.
  - Keep to the side and front (or rear) of the vehicle (driver's side is best).
  - Clear themselves, clear the vehicle and, finally, give the command to move the vehicle.

For more information on ground guiding procedures, see Field Manual 55-30, Army Motor Transport Units and Operations; FM 21-305, Manual for the Wheeled Vehicle Driver; and Training Circular 21-306, Tracked Combat Vehicle Driver Training.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Blurred Lines

CHIEF WARRANT OFFICER 4 BENJAMIN CUEVAS
U.S. Air Forces in Europe Air Ground Operations School
Einsiedlerhof Air Station, Germany

During Operation Iraqi Freedom V and VI, we faced one question repeatedly: Should we launch or stay on the ground during marginal weather? As all Army aviators know, sometimes mission importance outweighs weather minimums. The question then becomes where to draw the line. In garrison, the answer is simple; you either have weather or you don't. In combat, however, the line gets blurred.

The first couple of months we stuck to our minimums with little deviation. But as time went on, our command became more comfortable with flexing minimums to meet mission demands. These deviations were due mostly to troops in contact, and we quickly realized flying in marginal weather significantly degraded our capabilities. Targeting, even with MTADS-equipped aircraft, was almost impossible. And flying at lower altitudes caused us to be highly vulnerable to small-arms fire. Our presence, however, still served as a deterrent.

As AH-64 pilots, our primary mission is to save the lives of coalition forces. Therefore, aircrews and our command were willing to accept the increased risk of flying in less-than-optimal conditions. That is where the line began to blur. What was once an exception quickly became the standard. This was mostly caused by aircrews becoming more comfortable flying in adverse weather, giving the command the option to accept more risk and push the weather limits even further.

There were times, though, when our command had little impact on the decision to fly in downgraded weather. If a general had somewhere to go and wanted an escort, "no" was not an option. In these cases, our command was fighting a losing battle because they were the risk-level approval authority.

As time went on, things got worse and we continued to allow ourselves to get put into increasingly dangerous weather situations. New questions began to be asked through all levels of our unit because we were now expected to launch in all weather conditions. There were many times when we were the only aircraft flying in Baghdad. Sometimes we were flying in bad weather without even having missions to support. As aircrews, we asked a couple of questions: Where do we draw the line on weather? How long were we going to continue to push our luck? These questions went unacknowledged and unanswered by a fairly hostile command atmosphere at the battalion level, and we continued to fly further below established weather minimums.

Weather minimums are in place for a reason. In garrison, weather minimums are strictly enforced. Of course, in combat, there are situations where making an exception is pertinent. But those situations should be just that — exceptions, not the standard. The problem is once you make one exception you are expected to keep making it.

It's easy to sit here and try to blame it all on our command, but aircrews were just as responsible for what happened. We all knew our minimums, but we still chose to launch, mostly due to the fear of possible repercussions. But we still did it. We should have been asking ourselves at what point the mission outweighs the increased risk of flying in bad weather. Answering that question for yourself will let you know when to stand your ground and not launch. ■

ARE YOU READY?

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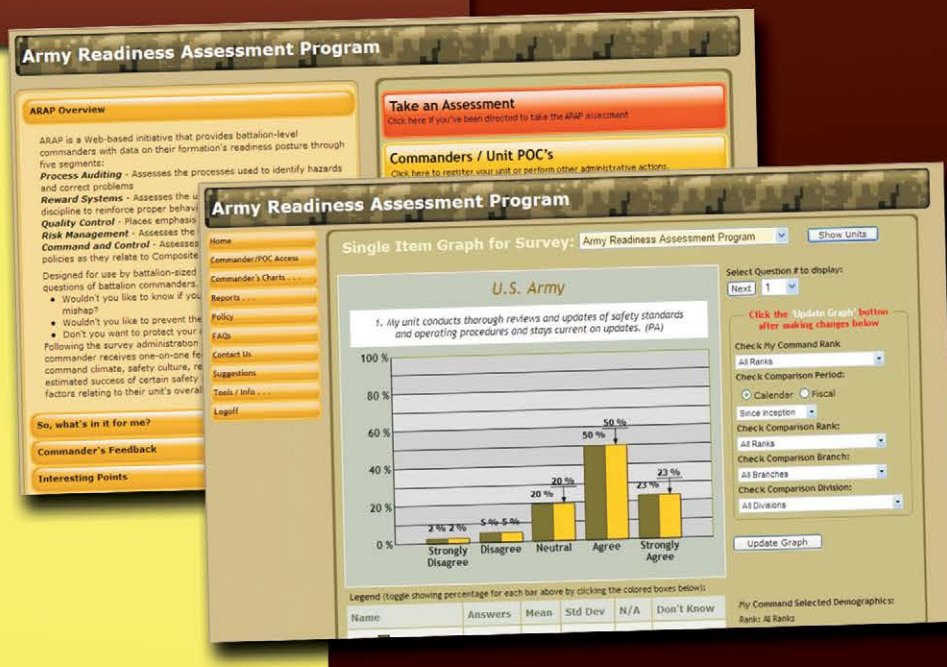
Wouldn't you like to prevent the loss of personnel and equipment?

Don't you want to protect your combat power?

ARAP

ARMY READINESS ASSESSMENT PROGRAM



ARAP is a Web-based initiative that provides battalion-level commanders with data on their formation's readiness posture.

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Just my Luck

JAMES RYAN JARRELL
Media and Force Development Division Student Intern
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Kirtland Air Force Base, New Mexico

When I opened my eyes, I was staring at a spiral-shaped crack in my windshield roughly the size of my forehead, a large chunk of my hair dangling from the center. Suddenly, my attention was drawn to my mangled ankle. My only distraction from the pain was wiping the blood from my forehead so it wouldn't run into my eyes. I had no idea what caused the crash. Everything happened so fast.

It had been a normal day, and I was driving home from the local university after sitting through hours of lectures. Before I knew it, I was slamming on my brakes, trying to slow down and not plow into the car in front of me. Unfortunately, I didn't stop quickly enough.

According to witnesses and the police report, a group of vehicles was traveling north through an intersection that was well known for accidents. The intersection was quite strange in design, with three two-way streets that intersect. I was traveling through a curving turn heading north when the wreck started. The driver in first car in the line of traffic reported he was cut off by another vehicle that shifted to the middle of the intersection. The first driver slammed on his brakes and was rear-ended by a second car. I followed by smashing into the second car. The accident ended with the vehicle behind me lightly hitting the rear of my car.

Some might say this crash was bad luck — that I was at the wrong place at the wrong time. But as the Roman philosopher Seneca said, "Luck is what happens when preparation meets opportunity." I believe the inverse is just as true. Bad luck is caused when a challenge or danger presents itself and we're not properly prepared to handle it.

From my description of the accident, you'd think I'd been texting or talking on the cellphone, but I wasn't. However, I probably could've avoided this entire experience if I had practiced the simple rules we were taught in driver's school. All I had to do was be more attentive. I could've saved myself from all of the things I now had to handle, including a $20,000 hospital bill.

I learned a great lesson from this wreck. Looking back, I had been driving way too casually. That great amount of comfort I felt while driving was actually laziness. I stopped thinking of the risk prevention techniques I had been taught and fell into a driving habit that caused me to be less active in searching for the potential dangers around me. In retrospect, I'm lucky I wasn't more seriously injured. If I hadn't been wearing my seat belt, I could've smashed through the car's windshield.

Driving a vehicle is very dangerous. According to the National Highway Traffic Safety Administration, 32,675 people were killed on U.S. roadways in 2014. During that same time period, another 2.3 million people were injured in crashes. When you stop to consider that you're piloting 2 tons of metal at high velocity, you'll realize driving is a task that shouldn't be taken lightly. Stay alert when you're behind the wheel. Don't become a statistic due to complacent driving. ■

HERE IT COMES

Are you ready to hit the road?

- Accelerate and decelerate slowly
- Increase your following distance eight to 10 seconds to provide more room to stop
- Know your brakes
- Don't power up hills and don't stop while going uphill unless necessary
- Take a fully charged cellphone, food, water and warm clothing
- Don't go out unless absolutely nessessary

READY ...OR NOT?

Ready ... or Not is a call to action for leaders, Soldiers, Army Civilians and Family members to assess their "readiness" for what lies ahead—the known as well as the unknown.

Throughout our professional and personal lives, events happen all around us. We are often able to shape the outcome of those events, but many times we're not. Navigating life's challenges is all about decision-making.

So are ***YOU*** ready ... or not?

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READINESS THROUGH SAFETY

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Cooking with Fire

JOSEPH M. DOOLEY
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Womack Army Medical Center
Fort Bragg, North Carolina

Combatives training is an important part of being a prepared Soldier. It provides the skills to help you protect yourself, as well as your comrades, in combat. Unfortunately, this training can sometimes take Soldiers out of the fight if they don't take the proper precautions.

Everything was going great. My wife and I, as well as our youngest daughter, were excited our eldest daughter and her husband traveled from Oklahoma for a visit. After enjoying my wife's delicious cooking during the week, they wanted to do something special and prepare a meal for us. My wife was happy about getting a night off from the kitchen and I was pleased to hear the meal would consist of stuffed bell peppers with fried rice and bow tie pasta — one of my favorites!

After showing my son-in-law where to find everything they would need in the kitchen, he told us to go outside and relax on the deck while they got to work preparing the meal. They got no resistance from me or my wife, and we made our way outside to enjoy the beautiful evening and wait for dinner. We were enjoying some quiet conversation when we heard our youngest daughter scream from inside the house.

I rushed inside to find my son-in-law carrying a flaming pan of grease to the kitchen sink. It wasn't a very big flame, but it was still enough to cause everyone in the house great concern, especially my son-in-law. As I yelled, "Don't do it!" he turned on the faucet and water poured over the fire. The flames immediately shot to the ceiling in front of his face and spattered hot grease on his hands. Still in a panic and before anyone could stop him, he picked up the still-flaming pan and took it out to the garage. This wasn't the best thing to do either since my wife and I park our vehicles there. I ran out after him with an extinguisher and put out the fire.

"The flames immediately shot to the ceiling in front of his face and spattered hot grease on his hands."

With the danger now behind us, we turned our attention to my son-in-law's condition. Fortunately, he wasn't seriously injured. He did have a few minor spot burns on his right wrist, and his hair was singed a bit in the front. Our white kitchen ceiling had turned black from the flames, but it wasn't badly damaged either. My son-in-law felt awful about the fire and repeatedly apologized. I told him it was just an accident and there was no need to apologize, but I could tell he was upset about what happened.

After the excitement finally subsided, I used this experience to explain the proper procedures to follow in the event of a grease fire. First and foremost, never use water to attempt to extinguish a grease fire. Water repels grease

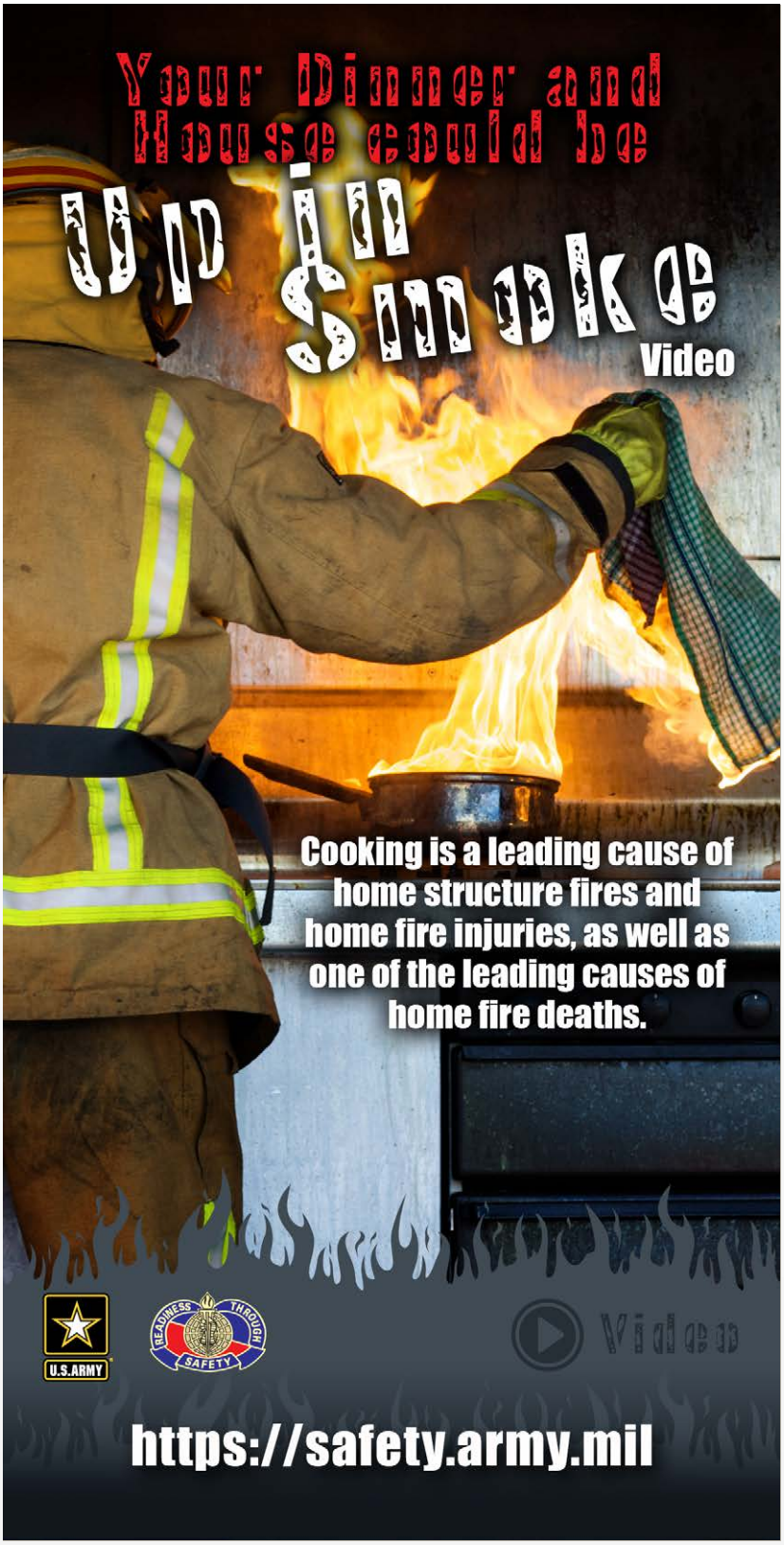
and can spread the fire by splattering it. If the fire is small, cover the pan with a lid and turn off the burner. You can also smother a small grease fire with baking soda, but it will take a lot to properly extinguish the flames. If neither of those techniques work, spray the pan with a Class B dry chemical fire extinguisher. (Our extinguisher was located in a cabinet next to the stove.) Remember to never move the pan while it is on fire. While taking it outside might seem logical in the frenzy of the moment, burning grease could splash on you, your home and anything outside. Of course, if the fire does grow out of control, get out of the house immediately and call 911.

Did You Know?

Burn Awareness Week is observed the first full week in February. For more information, visit the American Burn Association's website at http://www.ameriburn.org.

Although everything turned out OK and nobody was seriously hurt, this accident could have ended in disaster. Being in the safety field for a number of years, I pride myself on making sure my family is safety conscious in everything we do. As a matter of fact, I had previously gone over a grease fire scenario with my wife and youngest daughter and made sure they knew what to do. I did not, however, make sure my visiting daughter and son-in-law were aware of the proper procedures, nor did I tell them where our fire extinguisher was located.

We all learned some valuable lessons that night. My daughter and her husband learned how to put out a grease fire. I learned to make sure our house guests know where the fire extinguishers are located and how to use them! You never know when you might need them. ■



HERE IT COMES

Are you ready for winter?

- Follow the directions on the package if you use man-made logs
- Never close the damper with hot ashes in the fireplace and be sure the fire is out before retiring for the evening
- Always use a sturdy screen when fireplaces are in use
- Burn only wood
- Make sure the fire is out before leaving the house or going to bed

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So are ***YOU*** ready ... or not?

U.S.ARMY

READINESS THROUGH SAFETY

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What was He Thinking?

GEORGE C. DANIELS
18th FIRES Brigade
Fort Bragg, North Carolina

It was a Friday about 10 years ago when I got a late-night call from my commander. He told me one of our Soldiers had been killed in an automobile accident in Indiana. He said the Soldier had been riding with a drunk driver who'd crashed into another vehicle. Sadly, our Soldier was unbelted, thrown from the vehicle and killed.

Any fatality is a tragedy, but the timing of this Soldier's death was particularly bad. Our unit had been scheduled to deploy from Fort Bragg to Iraq in about a week, but our departure was pushed back another week as we awaited new flight plans. We'd been on block leave and, during this delay, our commander ordered everyone to remain in the local area and to limit themselves to two drinks a night.

When I got the news about the Soldier's death it sent a chill through me, along with other emotions I can't really describe. I started to think about "why?" The first thing that came to mind was, "What was he thinking?" He was a single Soldier who lived in the barracks. He had a few friends, but didn't hang out a lot and had just gotten back from home. He was a very religious kid and I can't remember anybody saying anything bad about him. He kept pretty much to himself and wasn't a regular drinker.

His trip home had been draining for him and his family. Emotions were high and his family was eager for the deployment to be over and him to return home safe. Now, someone was going to have to call and inform them he died in an auto accident before even leaving the country. And when his family asked about the details, they would have to hear the depressing news that he'd violated orders, was on an unauthorized pass, drinking underage and not wearing his seat belt.

As hard as it was, the commander brought in the unit on Saturday and informed everyone about the Soldier's death. I will never forget the expressions I saw on the faces of his fellow Soldiers.

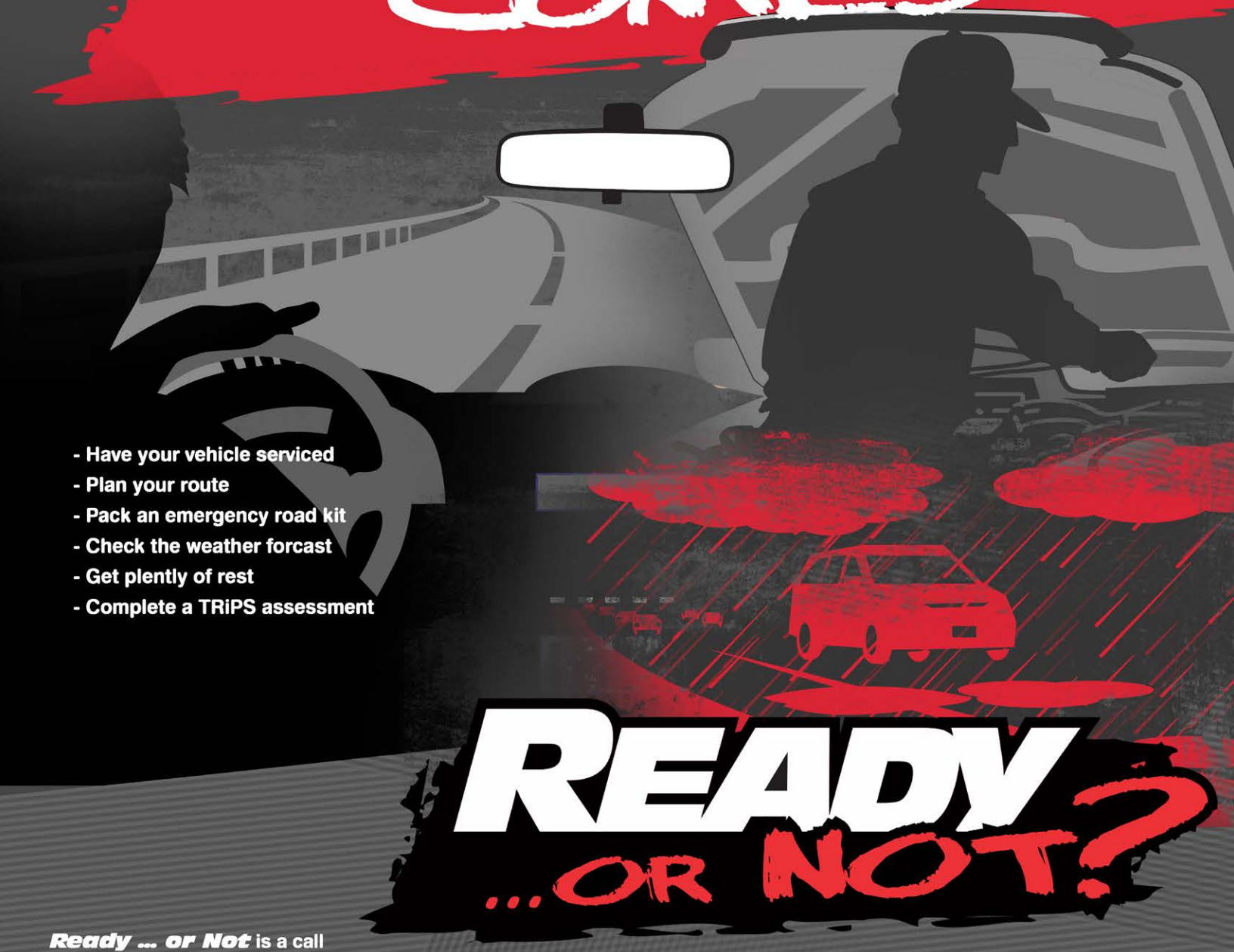
Shortly afterward, our unit deployed to Iraq and performed our mission of convoy security. During the year we were there, we traveled more than a million miles. We endured improvised explosive device attacks, missile attacks and close-range gun battles — all without losing a Soldier in combat. Still, our mission wasn't a total success. We'd lost a Soldier — one who never even made it into combat.

It doesn't matter whether you're in the pre-deployment phase or in the middle of a deployment; it is all part of the mission. A Soldier lost is a Soldier lost and that affects the unit's mission, not to mention the Soldier's family and his friends in the unit. When you consider more Soldiers are lost to off-duty accidents than to combat accidents, those losses cannot be taken lightly.

If you drink and drive or ride with someone else who does, it's time to wake up and ask yourself, "What am I thinking?" Consider how badly you want to live, to survive the dangers of combat and come home to your family and friends. Then remember the first part of coming home is not getting killed before you deploy. ■

HERE IT COMES

Are you ready to hit the road?



- Have your vehicle serviced
- Plan your route
- Pack an emergency road kit
- Check the weather forcast
- Get plently of rest
- Complete a TRiPS assessment

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So are ***YOU*** ready ... or not?

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READINESS THROUGH SAFETY

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Into a Trap

COMPILED BY KNOWLEDGE STAFF

In September 2006, I arrived for another deployment to Iraq. I was in an H-60 medevac company attached to the Marines in the western sector and assigned to operate out of Al-Taqaddum (TQ), which covered areas such as Ramadi and Fallujah. During the "handoff," the outbound unit created a flight schedule that mixed crew members from our company with members of their unit as a mechanism for accomplishing local area orientations. At the time, the medevac mission was only covered during the night, and the Marines elected to cover daytime missions in a CASEVAC capacity. The Marines did provide either a Cobra or Super Huey as gunship support.

I was on the roster for one of the initial mixed crews and received a mission not long after starting that night's duty cycle. It called for us to simply transfer a patient from TQ to a higher level of care in Balad. I considered to this to be a good first mission because it seemed quite routine and would likely be uneventful.

Unlike my experience during my first deployment to Iraq, there had been a list of standard reporting points that were to be used to assist traffic and air traffic control in tracking everyone's position. Based on our destination, and the location of our point of departure, there were limited options as far as routes/reporting points. This resulted in flying similar routes repeatedly because a hostile environment is dangerous. Needless to say, I was allowing the other pilot in command to travel the way he felt was most appropriate to and from Balad since he had been operating there for the past year.

As expected, the flight was really quite routine and uneventful as we picked up and dropped off the patient at the requested destination. For the flight home, we flew a fairly direct route, which was very close to, if not the same as, the route going to Balad.

Shortly after reporting one of the points, we started seeing tracer rounds off the right quartering side.

As the pilot on the controls, I banked to the left to avoid contact. As soon as I did, we started receiving additional rounds from the left side. At this time I turned back to the right, only to see that in addition to the two weapons still firing from what was now quartering left and right aft, gunmen were firing at us from

"As the pilot on the controls, I banked to the left to avoid contact. As soon as I did, we started receiving additional rounds from the left side."

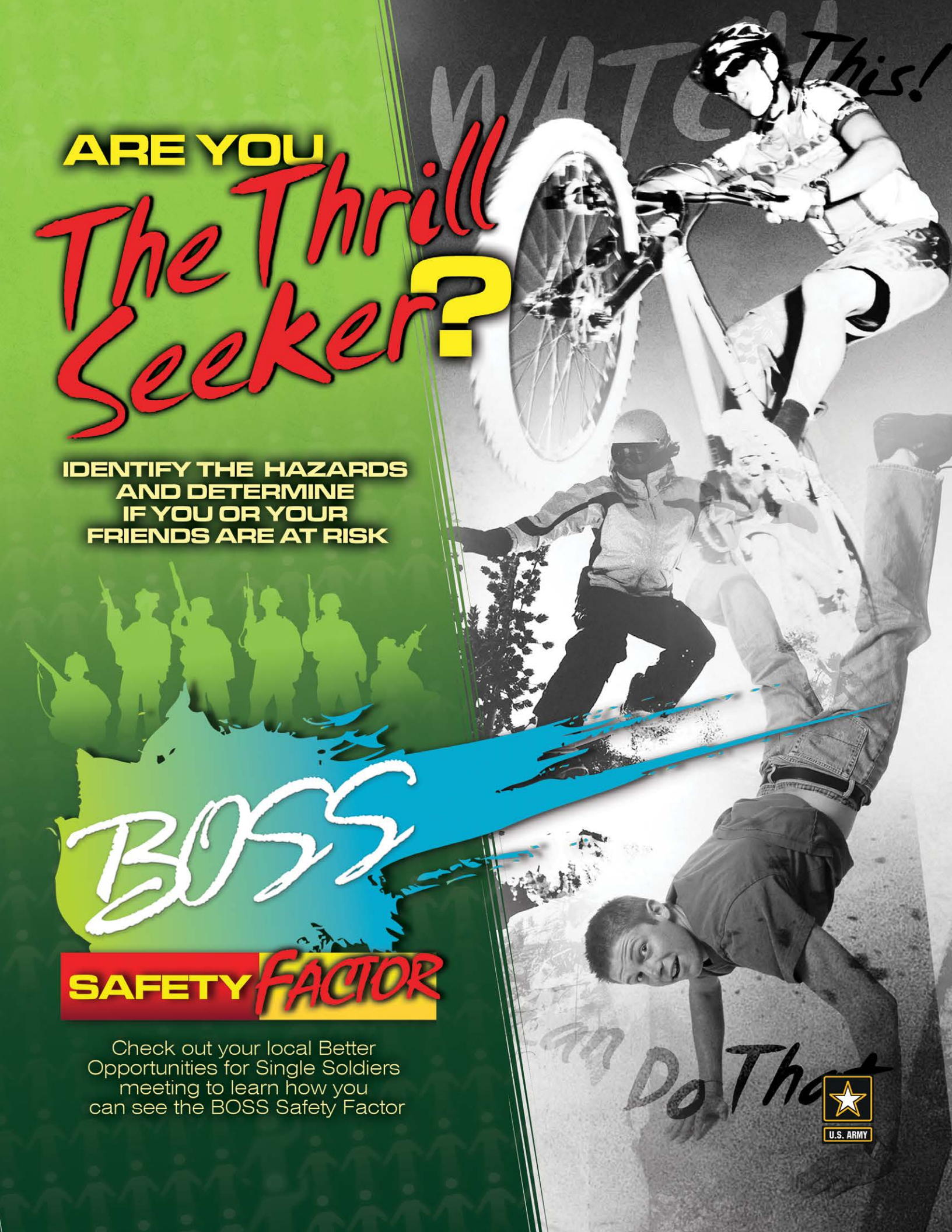
both the left and right at our 2 and 10 o'clock positions.

The Marine Cobra made a call that they were receiving rounds and were diving to engage the targets. Based on that information, and the fact that at that moment we started receiving rounds directly off the nose, my next (natural) reaction was to begin an abrupt climb. It felt like we remained in this nose-up attitude for a long time, with tracers flying by us in every direction. At some point, probably five seconds later, the pilot in command (not on controls) called for me to nose it over. He then announced he had the controls and went into an abrupt nose-low attitude. During the dive, we also performed more evasive maneuvers and eventually the rounds ceased.

We attempted contacting the Cobra element, who did not respond. We could not locate the other aircraft visually either. After a few more attempts, though, we were able to make radio contact and learned they were performing emergency procedures because they had taken rounds during the engagement. Once back on the ground, we found out the Cobra had received multiple rounds, some of which penetrated or passed through their fuel cells. Fortunately, no one in either aircraft were injured.

During the investigation process, I learned there had been an area just west of Baghdad that was designated as dangerous and should be avoided. Additionally, we learned the military intelligence was tracking a new system being used by the enemy to which we fell victim. They would place vehicles or men in the shape of a large triangle (a mile or so apart) in aircraft high-traffic areas. They would wait for an aircraft to enter the open end of the triangle and start firing in such a fashion as to push it toward other fields of fire.

I learned a valuable lesson that night regarding being unpredictable and the importance of frequently changing your route of flight. We should also use caution when creating reporting points in a combat environment. If this system needs to be used, inform the pilots they should avoid flying directly to/over them, but just report them when in the general area. Provide enough points to give crews multiple route options as well. We flew into a trap and got out of it unharmed. I don't want to make it a habit. ■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Get to Know Your Manuals

RICHARD FENNER
43rd Sustainment Brigade
Fort Carson, Colorado

Technical manuals are designed to ensure Soldiers and civilian personnel follow the proper procedures and heed safety warnings when operating equipment. Furthermore, Army Regulation 385-10 and the unit safety program provide additional guidance on procedures units should adhere to when conducting assigned missions or tasks. Unfortunately, personnel sometimes fail to follow this guidance and are seriously injured or killed.

Units are mandated to have the appropriate TMs on hand for each piece of equipment within their respective unit and for each mission. Sometimes, however, personnel view a task as so routine that they choose to do it from memory rather than use the TM. These folks might even question why we use TMs in the first place. Well, the answer to that question is simple: it's because you can't memorize all the step-by-step procedures and safety warnings in them. For the Soldier mentioned in the following accident sequence, reading the TM would have saved him a world of pain.

The accident

One afternoon, a group of 88M (motor transport operator) Soldiers were given a standard task: conduct routine maintenance on M3 Container Roll In/Out Platforms. A Soldier who was untrained and had very little experience was removing one of the two retaining pins that held a critical piece of the equipment in place. Neither the supervisor nor the Soldier had read the TM, which revealed this procedure involved using a lifting device such as a crane.

As the Soldier removed the last pin, the 370-pound CROP arch fell onto his right arm. Other Soldiers in the immediate area quickly rendered first aid while another Soldier summoned a noncommissioned officer to the scene. The injured Soldier was transported to a hospital, where he underwent several surgeries to fix the injury to his arm. The Soldier was also placed on 30 days of convalescent leave.

Lessons learned

Supervisors must provide adequate oversight for their Soldiers. Soldiers also must be properly trained and read the equipment's TM before starting any task or mission, no matter how routine or small it may seem. The TM is intended to illustrate how a piece of equipment is designed to operate, the procedural steps that are to be followed and the associated safety and warning hazards. Never become complacent and deviate from following the standard practical procedure of reading an equipment TM. It might just save your life, your Soldiers' lives or prevent injury to others around you. ■

"Soldiers also must be properly trained and read the equipment's TM before starting any task or mission, no matter how routine or small it may seem."


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PRESERVE COMBAT POWER.
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READINESS THROUGH SAFETY

Saved by the Belt

MASTER SGT. MILTON I. LEACH
Northern Regional Medical Command
Walter Reed Army Medical Center
Washington, D.C.

It was a chilly 28 F when I headed off to work at the Ireland Community Hospital on Fort Knox, Kentucky. During good weather, it typically took me 30 minutes to cover the 18 miles from my home in Elizabethtown. However, it had snowed overnight, so I knew it was going to take me much longer than usual. What I didn't know was it would take me 2½ hours to reach the hospital and, when I did, I'd be in the back of an ambulance.

That morning, I got into my car and buckled up — as is my normal habit — and cautiously drove toward Fort Knox on U.S. Route 31. The snow was about 3 inches thick, and even more was piled alongside the highway from the road-clearing operations. I kept my speed down to 15 mph until I reached Old Fort Knox Road. I then turned onto the road, which ran straight about 30 feet before transitioning into a lazy S turn that sloped downhill for a half mile.

Although there was very little snow on Old Fort Knox Road, I continued to drive very cautiously. I was unaware, however, that there was a sheet of black ice covering the road beneath the snow. My car suddenly began sliding and twice I swerved back and forth across the road, trying to regain control. Nothing I did helped, and I went off the right shoulder, down a slope and into a ravine.

As my car began to overturn, I started praying. After rolling four times, my car came to rest on its wheels and water flowed through every opening. I was scared, but at least I was alive and able to move.

I unhooked my seat belt and attempted to get out of the car, but the door was jammed. I tried again to push it open, but the door wouldn't budge. Still scared, I climbed out through a window and found myself standing chest deep in very cold water. The top of my car had smashed down and the windshield, rear window and side windows were all broken out. I couldn't see the trunk or hood, as both were under water.

It was still dark and the roads were empty. No one had witnessed the accident and my calls for help went unheard and unanswered. I tried to climb out of the ravine but kept slipping because the sides were covered with ice and snow. Not only was I scared, I was also in pain.

"No one had witnessed the accident and my calls for help went unheard and unanswered."

Using my cellphone, I called 911 and explained the situation and requested help. I then called the operating room, knowing one of my on-call technicians would be there. I told them I'd run off the road and needed help. Ultimately,

the fire department and emergency medical technicians arrived on scene. After a brief rescue operation, I was put on a stretcher, given a neck brace and taken to the hospital in the back of an ambulance.

After a complete examination, the doctor diagnosed me with a bruised left shoulder (from the seat belt). Although I was in a lot of pain, I was alive and fortunate not to have

"That morning, my seat belt saved my life — of that I am sure"

broken any bones or suffered any serious cuts or a concussion. My car was destroyed, but I had survived. The ambulance crew, firefighters and doctors were astonished that my injuries weren't worse and attributed that to my seat belt use.

That morning, my seat belt saved my life — of that I am sure. Had I been unbelted, I could have been injured or lost consciousness as my car rolled and been unable to escape when it flooded. Some people are afraid to wear seat belts — scared they will be trapped inside their car if it goes into the water. I found out the opposite was true. Because of my seat belt, I was able to escape and survive.

I never put my car in gear without first buckling up and making sure my passengers do so too. I learned that cold morning what a difference seat belts can make in a rollover accident. The bottom line message is simple — buckle up before you start up. Take care of safety first! ■

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Let's Talk About It

CHIEF WARRANT OFFICER 2 EVERETT T. MITCHELL
C Company, 1-150th Air Assault
Army Aviation Support Facility #2
West Virginia Army National Guard
Wheeling, West Virginia

While attending the Aviation Officer Safety Course at Fort Rucker, Alabama, I was reminded of a let's-not-do-that-again event that occurred while I was deployed to Kosovo in 2012. Such lessons-learned situations shaped how I operated as a young pilot in command. Unfortunately, it seems many aviators — myself included — are reluctant to air their dirty laundry.

Even though my initial feelings are to share my near misses with others, there are times I have been asked to not bring them up and told there is no need for further discussion. What are we hiding from? Is there a risk to your career to share such events? The concern seems to lie with our peers' or leaders' opinions of our abilities, skills or decision-making after hearing about a near miss.

My father, a retired Army aviator, has always shared lessons learned with me. His letters almost always contain some accident story or near miss, torn out of one of his aviation trade magazines. (Thanks, Dad!) His love is not misunderstood, nor are his efforts in vain. The articles have become great reading material.

For unknown reasons I've adopted this same mindset of not sharing my near misses. Granted, my stories contain 100 percent human error along with absolutely poor decision-making. Looking back, those decisions were made based on my lack of experience, and several could have ended as a catastrophic event. All of them were attributed to overconfidence. I am hopeful that in time I will be more open with other experiences. This article is the first step toward that goal. It's a story about a "near" failure based on a decision to announce a damaged part during a preflight and the importance of saying, "I don't know."

Our unit had just taken over the KFOR-14 rotation in Kosovo. I was on one of my first missions and my solo walk to the aircraft was greeted by refreshing spring air accompanied by the warm sun and clear skies. As a young pilot still brushing off "Rucker dust," I was eager for the flight experience that would come with the nine-month deployment. I was focused on aircraft start-up, departure headings, reporting points and call signs. A voice in my head said, "Don't mess this up, Mitchell," and kept repeating it as I met with the crew chiefs, who were already hard at work preparing the aircraft.

While completing the preflight, I noticed the strap around the bottom-right strut was broken. At first, I considered not mentioning it. Then I thought there was no harm in asking the crew chief.

I summoned Staff Sgt. Lighting (obviously not his real name), one of the unit's finest members. In a childlike fashion, I pointed to the component in question and asked if we could still fly the aircraft. His silence was a rare event for me because he was the go-to crew dog for maintenance questions. Breaking the silence, I said, "Yes or no? Am I OK to fly with it if the PC and you are?" At this point, the PC arrived from his final brief from operations. The PC said he was comfortable to fly, but, still, the question at hand

had not been answered. I asked, "Is the aircraft status a red X?"

After a few seconds, Lighting looked at me straight-faced and answered, "I don't know, sir." My young, overconfident, inexperienced thoughts were, "There is no way this strap could ground an aircraft." Then again, I have never seen one that was broken. Our crew chief returned to the hanger to consult with the TM and our maintenance officer. With much anticipation by the PC and me, he returned with an unexpected answer. The aircraft was "red X-ed." The mission had to continue, so we moved to our jump aircraft and completed it with no other events other than being late.

Later, I learned how significant that "insignificant" part could be if we had continued the flight. The strap holds a bearing pin in two holes that are 90 degrees from each other. There was fluid present around our aircraft's right wheel that we did not attribute to the strut at that time. With the strap broken on the aircraft side it was hard to notice the bearing pin's condition, let alone that a bearing pin even existed. If the bearing pin managed to liberate itself from the strut while in flight, the remaining fluid would have drained without the crew knowing it.

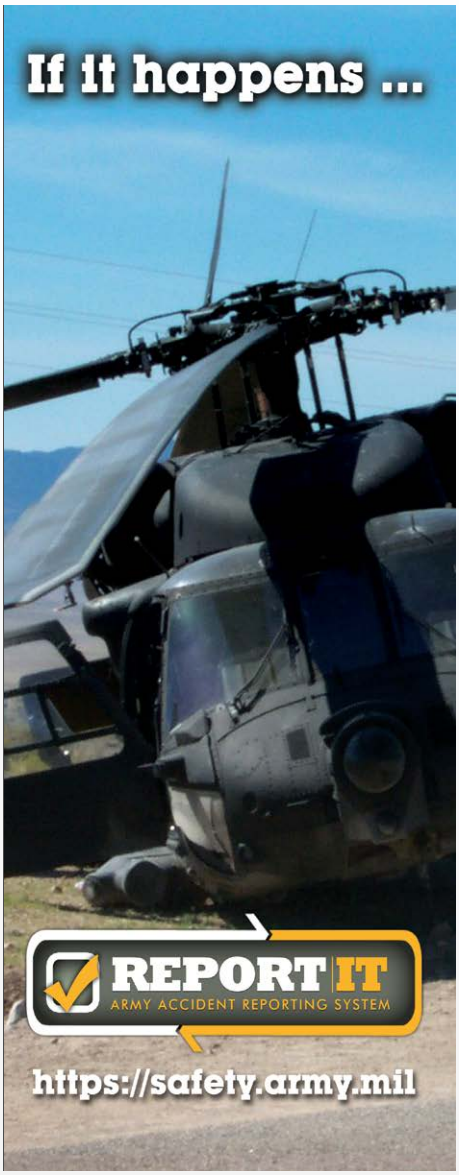
Upon landing, the lower-stage strut would have collapsed or bottomed all the way. It is anyone's guess as to how this scenario would have ended when landing on a slope to an unimproved LZ. I am sure our story would have been assigned a small paragraph in the back of Flightfax under the red lettering of UH-60 A/L.

My takeaway from this event and subsequent scenario was profound. First and foremost is the long-preached reason for conducting a preflight inspection. From our infancy to flight to our final ride, we perform this task. The repetition leads to complacency. It also can make us aware of things that just don't look right. When questioning such events, rely on official publications and subject matter experts for answers.

Second is a crewmember's ability to be honest. Our crew chief responded with the right answer — "I don't know." This response is not a sign of incompetence, but, rather, a sign of professionalism. Would a less-experienced crew chief respond the same way? Are we teaching them to recognize overconfidence? Our crew chief's professionalism helped prevent our crew from making the poor choice to fly that day.

I now share this story with our new crew chiefs. As pilots, we should encourage such professionalism. Avoid being overconfident about the maintenance aspect of our airframes and remain vigilant on preflight inspections. ■

"My take-away from this event and subsequent scenario was profound."



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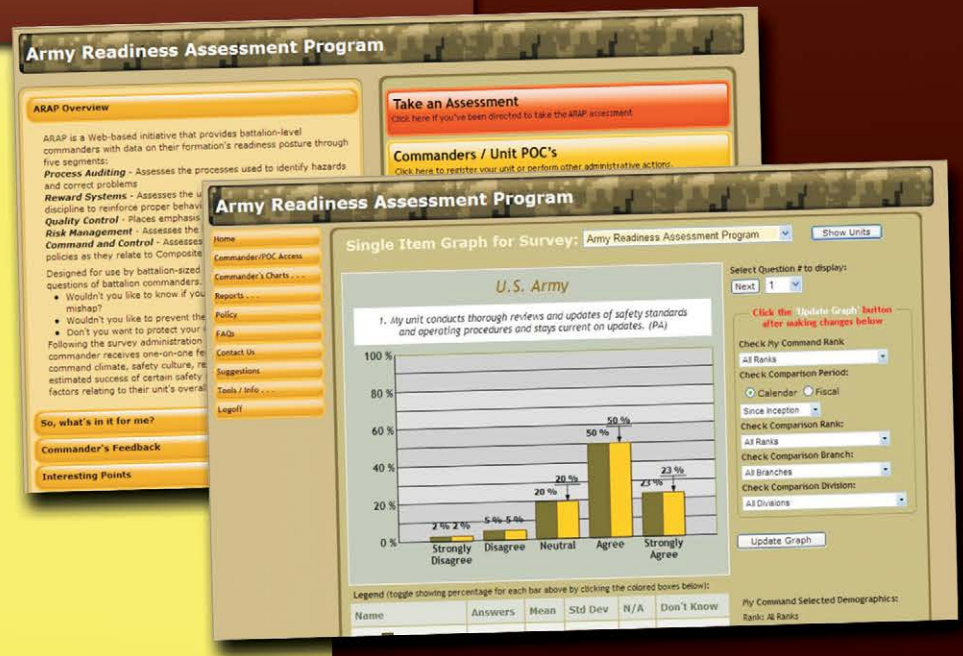

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