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SCAN HERE FOR RISK MANAGEMENT ONLINE
To the Soldiers and Army Civilians of Army Aviation:

Since our community was formally established in 1983, we have served as a model of safety across the force. Rigorous training, maintenance and currency standards keep aviators at the forefront of all Army operations across the globe. As the Army’s senior aviator, I know too well the risk inherent to our profession and the measures we take to mitigate them daily.

The past five years have shown that we are approaching the most dangerous time of year, with August being the worst month. While flying hours remain the same during this time, accidents and deaths increase exponentially. We can and must do better.

This sustained pattern is alarming, but we have time to address potential issues now if we observe the following call to action:

- **Manage Transitions**: Risk increases significantly during transitions, whether it is between operations or leaders. During the summer PCS season in particular, changes in key personnel invite some hazards to slip through the cracks during handover. Identify who is most qualified for risk approval and as risk acceptance authority in your transition plans.

- **Understand the Environment**: Aircraft performance and the visual environment degrades with increasing heat. All members of the aviation team, from maintainers to crew chiefs to pilots to commanders, must be aware of the effects of weather on aircraft and personnel and adjust flight schedules accordingly.

- **Manage Crew Mix**: Similar to the challenges with transitions, personnel flux can create issues with crew selection. Leaders at all levels must holistically assess their aviators, regardless of time on station, and conduct a thorough assessment of their abilities and challenges to ensure appropriate crew selection based on the complexity of the mission and operational environment.

- **Be Present as Leaders**: Ensure the right leaders are present in all phases of operations – planning, rehearsals, and execution. Mission success depends upon leaders deciding how best to mitigate risk and authorize mission briefing officers and approval authorities.

I am confident Army Aviation will remain Above the Best. Continue to take care of your people, and always do the right thing the right way. Thank you for all that you do.

People First — Winning Matters — Army Strong!

James C. McConville
General, United States Army

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Exertional Heat Illness and CORONAVIRUS
What’s the Connection?

The spectrum of exertional heat illnesses (EHI) ranges from relatively mild conditions such as heat cramps and parade syncope to more serious heat exhaustion, heat injury and heatstroke. When recognized and treated promptly, many heat illness casualties can return to duty in just a few days. However, heatstroke may lead to extended hospitalization, need for rehabilitation and reconditioning, and — in the worst-case scenario — death. In the past 18 years, more than 30 Army service members have died due to heat-related illness. Responsibility for preventing heat illness lies with both the individual Soldier and the chain of command.

Heat stress is the result of environmental, mission-related and individual risk factors. Environmental risk factors include air temperature, humidity, solar radiation and exertion. EHI can be prevented using the wet-bulb globe temperature index. Environmental risk factors are mitigated by altering the time of day of an event or, if that is not possible, modifying mission-related risk factors such as event duration or time standards. The mission-related risk factors include work intensity, clothing worn, equipment carried and duration of the activity. During routine training, these can often be modified to mitigate heat stress, but in some instances (e.g., operational mobility, testing or training for special skill badges or tabs), they cannot be modified. Individual risk factors are about the Soldier, including his or her physical fitness, acclimatization status, any medication and supplement use, and existing illness. A risk factor that has received additional attention lately is the existence of concurrent or recent viral illness. Viral illness may cause fever, which is an increase in baseline body temperature. Coupled with the increase in body temperature during exercise, this may increase the risk of heat illness. Viral illness augments the body’s normal heat response to exertion, increasing heat strain due to the combined effects of fever and exercise. Well-acclimated and well-conditioned individuals who are otherwise low-risk may develop EHI or exertional heatstroke (EHS) if they have a recent or current infection. Upper respiratory infections (specifically those that are viral in nature) in particular have been implicated in a large number of EHI and EHS cases. A case report from the U.S. Army Research Institute of Environmental Medicine reported that an isolated local infection with inflammation has been shown to increase overall risk for heat illness. The novel coronavirus SARS-COV2 (COVID-19) is a highly infectious viral illness causing systemic inflammatory response with symptoms of fever and respiratory compromise. In the young, healthy population, it may remain asymptomatic for as many as 80 percent of patients throughout the course (approximately 14 days); cause symptoms as mild as respiratory or viral (e.g., operational mobility, testing or training for special skill badges or tabs), they cannot be modified. Individually risk factors are about the Soldier, including his or her physical fitness, acclimatization status, any medication and supplement use, and existing illness. A risk factor that has received additional attention lately is the existence of concurrent or recent viral illness. Viral illness may cause fever, which is an increase in baseline body temperature. Coupled with the increase in body temperature during exercise, this may increase the risk of heat illness. Viral illness augments the body’s normal heat response to exertion, increasing heat strain due to the combined effects of fever and exercise. Well-acclimated and well-conditioned individuals who are otherwise low-risk may develop EHI or exertional heatstroke (EHS) if they have a recent or current infection. Upper respiratory infections (specifically those that are viral in nature) in particular have been implicated in a large number of EHI and EHS cases. A case report from the U.S. Army Research Institute of Environmental Medicine reported that an isolated local infection with inflammation has been shown to increase overall risk for heat illness. The novel coronavirus SARS-COV2 (COVID-19) is a highly infectious viral illness causing systemic inflammatory response with symptoms of fever and respiratory compromise. In the young, healthy population, it may remain asymptomatic for as many as 80 percent of patients throughout the course (approximately 14 days); cause symptoms as mild as fever, wheezing and diarrhea or severe enough to require hospitalization for support; or lead to death. Even in more susceptible populations (elderly and immunocompromised), it is asymptomatic for the initial several days of infection, yet remains contagious during this period. With the close proximity of working and living conditions in military members and trainees, it is imperative to monitor for signs of infection and isolate these individuals rapidly to prevent spread. Those with high-risk contacts associated with COVID-19-infected individuals should be identified and quarantined to limit further transmission.

The viral nature of COVID-19 as well as systemic inflammatory response and associated fevers make it a significantly concerning risk factor for heat illness even in well-conditioned, well-acclimated athletes. The virus predominantly affects the lungs (lower respiratory tract), causing shortness of breath and hypoxia, which may also increase susceptibility to EHI. Efforts should be made to identify individuals with new shortness of breath or new exercise limitations, as these may be evidence of otherwise asymptomatic illness which may cause severe or even life-threatening EHS if infected personnel continue to train. As such, COVID-19 represents an additional risk factor for EHI and EHS, which must be considered and mitigated by leaders for any populations participating in exertional training, particularly in hot or indoor environments. At Fort Benning, Georgia, a Soldier who is diagnosed with a respiratory or viral infection is placed on a limited duty profile for seven days. They cannot participate in any maximum-effort or timed events, but can partake in submaximal intensity training while the profile is in effect. As there may be latent but as yet undefined effects of COVID-19 infection, leaders and clinicians should consider a similar policy for Soldiers who are returning to duty after isolation to mitigate the risk of EHS. No matter the cause of an EHI event, prompt recognition and treatment are the cornerstones of the initial response. More in-depth information on the prevention and treatment of EHI can be found in Technical Bulletin Medical 507, Heat Stress Control and Heat Illness Prevention, and in TRADOC Regulation 350-29, Prevention of Heat and Cold Casualties. Detailed medical treatment algorithms and other information can be found on the Warrior Heat- and Exertion-Related Event Collaborative website at https://www.hprc-online.org/resources-partners/whec.
A review of three recent M2A3 Bradley Fighting Vehicle (BFV) mishaps reveals a common theme. No, it’s not that two of the three mishaps involved rollovers, or that each resulted in at least one Soldier fatality. The commonality is risk management — more specifically, the lack thereof. The absence or lack of risk management is identified as a contributing factor in many mishaps the U.S. Army Combat Readiness Center investigates. These BFV mishaps occurred in active-duty units in three very different locations. All three could have possibly been avoided had the leadership or the individuals involved just applied risk management.

Risk management is the Army’s process for helping organizations and individuals make informed decisions to reduce or offset risk. As defined in Army Techniques Publication (ATP) 5-19, Risk Management, the five steps of the risk management process are:

1. Identify the hazards.
2. Assess the hazards.
3. Develop controls and make risk decisions.
4. Implement controls.
5. Supervise and evaluate

Using this process increases operational effectiveness and the probability of mission accomplishment. While risk management is safety-related, it is not solely a warfighting function. It should apply to all on-duty and off-duty operations, tasks and activities. The principles of risk management include: integrate the process into all phases of missions and operations; make risk decisions at the appropriate level; accept no unnecessary risk; and apply risk management cyclically and continuously. In other words, apply risk management continuously on a recurring or repetitive basis. Soldiers should use a cyclical risk management process to identify and assess hazards; develop, choose, implement and supervise the controls; and evaluate and reapply the process as the outcomes and conditions change. Had this cyclical process been applied in any of the following three M2A3 BFV fatal mishaps, the outcomes could have (and should have) been different, if not avoided altogether.

Mishap 1

While performing maintenance on a BFV in a maintenance bay with a 10-ton lifting crane, a motor sergeant made a wrong choice of action during a common maintenance procedure. He failed to use the required special tools when lowering the vehicle’s power unit access door (PUAD) as well as allowed a BFV maintainer to move between the PUAD and the engine compartment. When the improper piece of equipment — a troop strap — used to suspend the PUAD failed, it slammed shut on the maintainer. The motor sergeant’s actions were in violation of the field maintenance manual and set the conditions for the mishap.

Mishap 2

The unit was conducting a nighttime tactical movement in combat vehicles using various night vision devices. Unfortunately, unit leadership did not identify the hazards associated with the night movement, including the impact the weather would have on the forward-looking infrared thermographic systems found on BFVs such as the driver’s vision enhancement (DVE), commander’s independent viewer (CIV) and improved Bradley acquisition subsystem (IBAS). The weather created a period of thermal crossover where the DVEs had limited contrast. Consequently, several drivers in the movement...
were unable to see the entrance to a bridge. Two BFVs drove onto the right guardrail but were able to recover and traverse the bridge. The mishap BFV, however, drove onto the left guardrail, which collapsed, causing the vehicle to roll off the bridge and into the creek. The vehicle came to rest on its turret, submerged in the water.

The leadership’s decision to conduct night tactical training in adverse environmental conditions (thermal crossover) with inexperienced crews was just one of the latent failures that contributed to this mishap. Had cyclical risk management been applied by the leadership, then maybe an administrative white-light movement would have been conducted instead. Leadership failed to cyclically identify and assess hazards. Their actions were in contravention to ATP 5-19 and resulted in three fatalities.

**Mishap 3**

The unit was conducting a road test during daylight hours following vehicle maintenance. The driver was operating the BFV at a high rate of speed when he attempted to make a sharp, left-hand turn. The vehicle left the cement lane and its right track dug into the soft dirt and gravel shoulder. The BFV’s momentum caused the vehicle to overturn, crushing and killing the driver.

The vehicle commander exposed the crew and passengers to an unsafe course of action by not correcting the driver’s speed. He was overconfident that this road test was just a routine mission and set a portion of the conditions that led to this vehicle rollover and one Soldier fatality. Had the BFV commander assessed the hazards of allowing the driver to exceed the posted speed limit and of not enforcing standards, then he may have been able to apply a different course of action, thereby intervening prior to the mishap occurring. Additionally, unit leadership failed to provide adequate oversight on day-to-day tasks. When tasks/activities and day-to-day operations are viewed as routine, there is no cyclical application of the risk management process. When risk management is not applied at all levels during all phases, then there is a breakdown in the process.

**Conclusion**

These three BFV mishaps are all tragedies that did not have to occur. Had one individual, one leader or any member of the chain of command intervened and applied risk management to the task, activity or mission at hand, then the hazards might have been recognized and controls could have been implemented and supervised, which could have averted the action(s) that led to the mishaps. No planning, preparation or assessment can identify every hazard in a constantly changing environment. This is why a continuous reassessment should occur at the lowest level possible. Failure to apply risk management on a continuous basis throughout the planning, preparation and execution phases of a task, mission or in everyday life is contrary to ATP 5-19. If you don’t know how to adequately apply risk management, we suggest you familiarize yourself with ATP 5-19, Risk Management.
Looking back on two recent non-combat, rotary-wing, fatal aviation mishaps reveals several commonalities. Primarily, there was no emergency that should have precluded the flight crews from executing, at a minimum, safe precautionary landings. Having said that, had either flight crew reacted to the actual emergency procedure (EP) as presently written, they both could have — and should have — been able to execute a single-engine landing as soon as practicable.

Mishap 1

A UH-60L flight crew was executing a real-world MEDEVAC mission effectively at sea level when one of the aircraft engines experienced an internal component failure. This put the crew in a single-engine failure response scenario. After identifying that there was a single-engine emergency, the flight crew incorrectly executed the EP for the appropriate engine failure. While the aircraft was on the bottom side of the single-engine flight envelope, it was still flyable. Had the crew executed the proper response to the single-engine failure, they could have made a precautionary landing or returned to base and performed a roll-on landing. Either way, the mission was probably not going to be accomplished, but the fatal mishap would not have occurred either.

This mishap highlighted improper identification and crew interaction to an actual EP. It led the aviation community to take an internal look at the methodology and response to an EP as well as the initial and sustainment training of EPs. Expect changes to the identification, reaction and response to EPs from the currently taught and evaluated method.

Mishap 2

A UH-60L crew was executing a limited maintenance test flight (LMTF) for a component replacement and verification. To verify the aircraft’s airworthiness, the LMTF required the maintenance test pilot (MTP) to manipulate the power control lever (PCL) for the engine not being checked; the purpose of this was to place a greater load on the engine actually being checked. The MTP set up this maintenance task to standard and provided the flying pilot with the appropriate maneuver, abort criteria, limitation, emergency (MALE) briefing prior to initiating the action.

As the MTP retarded the No. 2 PCL, his attention was focused primarily inside the aircraft, monitoring the engine instruments. During the second portion of the maintenance task, the crew received an actual No. 1 engine failure indication. The engine experienced an external component failure, putting the flight crew in a single-engine failure scenario. Unlike the mishap above, this crew experienced their engine failure when their non-failed engine, the No. 2 engine, PCL was at or near idle. Their immediate action steps prior to responding to the single-engine failure were addressed in the MALE brief. However, the flight crew executed those steps incorrectly, which ultimately resulted in a rapid decay of the aircraft rotor system and an extreme rate of decent.

Following the actual failure of the No. 1 engine, the aircraft was still in a flyable condition. Had the crew responded appropriately to the engine failure by following the MALE briefing and recovering from the maintenance task, the aircraft would have been able to maintain single-engine flight. This means continued flight was possible and the aircrew would have been able to return to home station, where they could have executed a roll-on landing.

Conclusion

After reading both of these mishap scenarios, do you know how you would respond to an actual EP? If you have never experienced a single-engine failure in a dual-engine aircraft, do you really know? Then ask yourself this: How would your co-pilot respond? You may know how you would want them to react, but it’s impossible to say for sure until you are in that position. Both of these flight crews departed their home stations to execute missions for which they were fully qualified to conduct. When an emergency presented itself, their responses are what ultimately resulted in four fatalities, several significant injuries and the loss of two flyable aircraft. Remember that being a professional requires you to know your duties and responsibilities as the flying and non-flying pilot. Emergencies generally do not give you an indication they are about to occur. Proper identification and response is critical. Sometimes this response requires immediate action steps and other times it does not. Be professional and ask yourself how you will respond.
Units often don’t think about what happens behind the scenes of a mishap. Normally, units — mine included — would call in a 9-line medical evacuation or transport the injured Soldier to a casualty collection or ambulance exchange point. From there, we assume the installation will assist in getting the Soldier to the appropriate level of care as fast as possible. Unfortunately, not all installations have adequate systems and processes established to ensure this occurs. Several recent safety investigation boards (SIB) uncovered significant mishap response deficiencies at multiple installations.

SIB 1
In the first mishap, the SIB found an installation’s unity of command for MEDEVAC procedures to be lacking. Following a mass-casualty Army vehicle accident, a military and a civilian fire chief arrived at the scene almost simultaneously. They decided to share command, which led to each having different information and prevented injured Soldiers from being triaged and categorized quickly. To further complicate matters, the installation’s organic MEDEVAC aircraft were deployed, which required another unit to cover for them. The two units had previously conducted a left-seat, right-seat ride, but no one notified the cover MEDEVAC crew that the hospital’s FM frequency had changed. Additionally, there were no systems in place to enable either fire chief to contact the installation’s Army medical center. These deficiencies resulted in the hospital not tracking an inbound MEDEVAC aircraft. Therefore, when the aircraft landed, an ambulance was not waiting to transport the mishap victims to the medical center. As a result, the aircraft’s crew chief ran to the emergency room to get an ambulance. The lack of systems and processes at this installation caused a 17-minute delay in an injured Soldier receiving medical treatment.

The SIB also discovered that this installation expected the medics in the back of an ambulance to call the emergency room, which would have forced someone to stop treatment on an injured Soldier. This could be a major issue if a medic was engaged in lifesaving procedures. Regardless, none of the medics had the emergency room contact information, which prevented the hospital from tracking the number and types of injuries inbound.

SIB 2
During the investigation into another mishap, the SIB discovered issues with the installation’s Primary Crash Alarm System (PCAS), which is designed to distribute accident information to all agencies (i.e., the fire department, control tower, military police, hospital and radar control). None of those agencies activated the PCAS after an aircraft crash. This prevented the smooth flow of information to the required responding agencies. Each found out about the accident from different civilian agencies, creating a knowledge gap among all of the necessary responders.

In addition, the SIB uncovered that the radar was not incorporated into the PCAS. While flying in the local training area, aircrews flight follow with the radar. If an aircraft were to have an accident and make a mayday call, radar would not be able to activate the PCAS. The airfield manager thought radar was included inside the PCAS, but, in actuality, it wasn’t. This lack of oversight created a break in the installation’s response to a mishap. What can units do?

One item an SIB always reviews is the post-mishap response. As the two incidents above illustrate, an SIB often finds deficiencies in an installation’s response to a mishap. Normally, the deficiencies are a result of multiple agencies having different or incorrect information. For example, a unit might call Range Control to request MEDEVAC support for an injured Soldier at Checkpoint 3 inside Training Area 5. That sounds like a normal radio transmission until Range Control looks at its map and sees there is no Training Area 5 on the installation. Unfortunately, this is a common occurrence and should make a leader’s skin crawl because it always results in a Soldier suffering.

To be successful in any mission, every unit needs common operating terms and graphics. These enable each maneuvering and non-maneuvering unit to have situational awareness of the battlefield and a common operating picture. Garrison and training units often develop their own checkpoints and graphics when they train at their home station. This is great initiative, but it can desynchronize agencies required to respond to emergencies. At the installation level, a single agency needs to be responsible for tracking an emergency. This is not meant to constrain the training unit. Rather, it gives flexibility and predictability to agencies required to respond. SIBs also look at how often an installation rehearses its mishap response. Was a full dress rehearsal conducted with every agency responding? Or did it involve just the fire department driving to the commissary? The task and standards for responding to an emergency do not change. The only variable that changes are the conditions. Full dress rehearsals executed during the most demanding environments will identify friction points and deficiencies. Addressing these deficiencies will reduce response times and could save lives.

Conclusion
While these SIBs mentioned above ultimately found the units’ responses were appropriate, they also revealed several deficiencies. Installations must have the proper systems and procedures in place before a mishap occurs. A responding agency’s failure to understand its role and responsibilities could result in a delay in a Soldier receiving lifesaving treatment. No installation wants to discover its mishap response plan is deficient at a time when a well-organized operation is needed most.
As aviation safety officers, we like to believe we are prepared to handle a catastrophic situation such as a Class A mishap with one or more fatalities. In reality, most units are unprepared for such an event. The alarming factor is they don’t fully understand what they need to do to prepare until it is too late.

The pre-accident plan
A unit’s first task is to prepare/review/update its pre-accident plan (PAP), which is required in accordance with Army Regulation 385-10, The Army Safety Program. The PAP needs to be nested with the higher headquarters and installation plan and must be updated when the unit departs home station for deployments, combat training centers and off-post training events. Units are required to test their PAP quarterly, as well as conduct a full rehearsal with all responding agencies annually. During the course of mishap investigations, the U.S. Army Combat Readiness Center often discovers the unit’s PAP had not been fully rehearsed in a long time. Consequently, many of the individuals with responsibilities within the PAP were unaware of their roles.

Unit battle drills for downed aircraft should also follow the PAP. I have seen battle drills that were developed in a vacuum from the PAP and the unit’s operations section was confused about which plan to follow in a time of need. When a mishap occurs, emotions often run high and it’s not uncommon for steps to be skipped or key components forgotten. Therefore, the PAP should be easy to follow. All key personnel should have a copy of the plan on their smartphones — or at least their responsibilities and key phone numbers — because accidents do occur when you are away from your desk/workspace. The Soldiers in the flight operations cell are the quarterbacks of the PAP and must know it inside and out.

What to do following a mishap
Unfortunately, catastrophic mishaps do occur. Initial notification to the USACRC can be made via telephone 24 hours a day and the Department of the Army Form 7305 or 7306 as appropriate. When reporting a mishap, be sure to include as much factual information as possible so the USACRC can better develop a plan for an investigation team. (In the near future, part of the initial notification will come through the USACRC’s new accident reporting tool — ASMIS 2.0.)

Once a USACRC safety investigation board (SIB) is en route to your installation, what should the unit expect and what can it do to assist? Someone from the SIB, usually the board recorder, will e-mail the unit point of contact with a list of data that will be needed immediately upon arrival as well as any required follow-on information. The email will also include instructions about the mishap scene. Nothing should be removed from the scene without the board president’s direct consent. Should a unit be directed to remove a component for analysis, such as a flight data recorder, step-by-step instructions regarding how to send it to the USACRC for exploitation will be included.

The mishap site must be secured to preserve the location. This perimeter should encompass not just all wreckage, but also any ground scarring. The unit safety officer should document the area as much as possible before it is further contaminated by recovery efforts. Photographs and measurements will be immensely valuable to the SIB, especially if there is an extended travel time (e.g., the mishap happens in a combat theater and the investigation team has to move through Kuwait first). The SIB email will also include a list of documents and supplies that will be needed as soon as possible. Physical copies of documents and publications are good, but digital versions will make the SIB’s job easier. Some examples of these documents include standing...
members will be present for every step to ensure the chain of custody is maintained as well as to further document the aircraft. This will assist with identifying damage from the actual mishap versus any damage that occurred during the recovery process. The SIB will be as unobtrusive as practical during the investigation and, as much as possible, accommodate the mishap organization's work schedules, locations and security concerns. The SIB must consider the mission operations tempo and available resources of the subject organization during conduct of the investigation. The intent is to effectively execute the investigation in a timely manner while the organization successfully prosecutes its mission. The SIB's overall goal is to answer three questions: What happened? Why it happened? What to do about it? The investigation is broken down into four distinct phases: organization, data collection, analysis/deliberations and completing the field report. The organization phase is relatively short, with key events such as the site visit, boardroom setup, briefing SIB members on their roles and any command in-briefs. During the data collection phase, the SIB focuses on answering the first question: What happened? The team will review the documents the unit safety officer collected, request further supporting documents, conduct both formal and informal interviews, conduct analysis of the aircraft and other physical evidence, and send off parts for further examination at CCAD or by the manufacturer. During the data analysis/deliberation phase, the SIB will come together to answer the second question: Why it happened? The team will use a variety of methods to find the root cause of the mishap, whether environmental, materiel or human error. If human error is identified, the SIB will further analyze the roles of support, standards, training, leadership and individual failures (STLI).

The final phase, completing the field report, focuses on the final question: What to do about it? By this point, the SIB will have complied an enormous amount of information, filled out dozens of forms, reviewed any audio/video files hundreds of times and poured over huge data spreadsheets. Next, it must show the findings and make recommendations that can prevent similar mishaps from occurring again.

Investigation outbrief

The SIB model is built around a 21-day investigation, though this is simply just an initial plan. We have had investigations that were slightly shorter and some that lasted several months. The SIB will outbrief the appointing authority on what it found during the course of the investigation, including issues that led up to the mishap, the mishap phase and the post-mishap timeline. The outbrief culminates with the presentation of the findings and recommendations. Some of these issues will be able to be addressed by the battalion, brigade and division leadership immediately. There might also be recommendations that go all the way to the Department of the Army level. The USACRC has a team that ensures these recommendations reach the appropriate offices and receives official responses on what that entity is doing to address the SIB’s recommendations.

Conclusion

Any unit can suffer a catastrophic accident. When it happens, it will be devastating to morale, and the leadership will have the tough task of refocusing the unit. While it can be difficult to have your unit’s deficiencies pointed out, take these learning points and make your unit better. The SIB is not evaluating the unit; it’s there to “hold up a mirror” to provide insight into what is happening internally. Great units will learn from these incidents and make the internal corrections to ensure they don’t happen again. Readiness Through Safety! “

For more information on pre-accident plans, see Chief Warrant Officer 4 Robert Moran’s article in Risk Management magazine at https://safety.army.mil/MEDIA/Risk-Management-Magazine/ArticleID/6367/Practice-Makes-Perfect.
My plan was to turn the group right (west) out of the Harley shop parking lot and travel about a mile to a large intersection with a stoplight. There, we would execute a U-turn and head east toward Panama City Beach. Everyone was good with the plan and we discussed who was going to be where in the riding formation.

As we pulled onto the road, I kept my speed down to allow the rest of the group to get out of the parking lot. Once we were all on the road, I began to accelerate. Just as I rolled on the throttle, the rider to my right started turning left into me. I attempted to turn with him, but due to the length of my motorcycle (almost 10 feet), I was unable to match him. In a split second, I decided to straighten up my bike. Realizing we were going to collide, I kicked out my leg to protect my wife's leg. My leg struck his front rim, causing his motorcycle to flip back to the right. He lost his grip on the handlebars and immediately low-sided the bike on the left, crushing his left ankle. I was able to keep my motorcycle upright and maneuvered into the grass median. Still not fully in control of my bike, I knew we had to ditch it. I held on to my wife's arm and we both rolled off to the left side. As she and I tumbled across the grass median, the bike flipped end over end three times and came to rest on the highway's eastbound lanes. Thankfully, there was no traffic at the time because the light — the one where we were supposed to make our U-turn — had just turned green and the traffic was now beginning to move. I immediately jumped up and ran toward my wife. After realizing she was OK, I checked over myself. My jeans were ripped and I had a large laceration (oddly shaped like a motorcycle rim) that covered my right leg from knee to ankle.

The rider who collided with us said he thought we were going to make the U-turn at a median turnabout, not the intersection. This was a failure on his part for not understanding the route I briefed. He admitted afterward that he was only half paying attention, just hearing we were going to make a U-turn on the road. His actions cost not only a lot of money in motorcycle repairs, but also the personal injuries we all received. He suffered a broken left ankle and road rash on his arms, legs and side. In addition to the cut on my leg, my wife and I had turf burns from rolling in the grassy median.

This accident resulted in some lessons learned for our group — the first being the importance of not only briefing your route, but also ensuring everyone understands all the details of the plan. Just talking about it as a group may not be enough. It is important to ensure everyone acknowledges the brief. In this case, everyone was present for the brief, but it was not completely understood by one member, and the results were almost deadly.

Second, we should not have been riding next to one another. If we had staggered our riding positions, this accident may not have happened. As we become comfortable with one another on the road, there can be a tendency to begin riding closer and closer to each other without realizing it. That was the case here. Our group had been riding together for a while. That comfort with one another may have led us to ride too closely. The incorrect spacing between motorcycles gave me less time to react when the other rider began turning into my bike. We must remain disciplined enough to resist this temptation to ride closer together and continue to do the right thing, even if you are comfortable with the individuals in your group. Luck was definitely on our side that day. The lessons learned made us all safer riders, especially when we are in a group.

Readiness Through Safety!
According to the National Fire Protection Association, 47,700 home fires in the U.S. are caused by electrical failures each year. The fires leave behind staggering results: more than 400 deaths, 1,500 injuries and $1.4 billion in property damage.

Overloaded electrical circuits are a major cause of residential fires. Getting to know the limits of your house’s electrical system will help prevent overloading your circuits, lower your risk of electrical fires, and keep your home and family safe.

The two ways that we access power inside of our houses are through lighting and power circuits. These circuits are made up of wiring, circuit breakers, outlets and switches. A circuit overload can occur when too much power is drawn through a circuit. Preventing a circuit overload starts with knowing the limits of each circuit and how much power can be drawn through it safely. Get to know your circuits. Familiarize yourself with the outlets, switches, circuit breaker ratings and even the wire sizes of the circuits around you.

Single-family houses and apartments typically have 15-amp circuit breakers and outlets with 14-gauge wires installed. By exception, bathrooms and kitchens are required to have 20-gauge wire with 20-amp circuit breakers and outlets but does not add amperage to the circuit. Electricians calculate circuit loads with a 20 percent safety margin, making sure that the maximum appliance and fixture loads on the circuit are no more than 80 percent of the available amperage and wattage provided by the circuit. For example, a bathroom with a 20-amp circuit providing 2,400 watts of power can quite easily handle 1,950 watts of demand with a 25 percent safety margin.

Know the limits of your house’s power
First, find the main electrical panel (typically in the utility room) and determine the voltage and amperage available (i.e., 120 volts, 200 amperes service). Second, count how many circuit breakers are in the main service panel. The current is divided into individual branch circuits, each controlled by a separate circuit breaker. A typical house will have a dozen or more circuits, each supplying power up to the circuit breaker and wire-rated limits (15 to 20 amps). Third, determine where each circuit goes to in your house. The label on the circuit breaker should describe the circuit location (i.e., “master bathroom”). Fourth and final, calculate the total power required by the devices plugged into each circuit.

Circuit capacity
Figuring the electrical power used by an appliance begins with an understanding of the relationship between amps, watts and volts — the three key means of measuring electricity. A relationship principle known as Ohm’s law states that amperage (A) x volts (V) = watts (W). Using this simple relationship principle, you can calculate the available wattage of any given circuit size:

- **15-amp, 120-volt circuit:**
  - 15 amps x 120 volts = 1,800 watts

- **20-amp, 120-volt circuit:**
  - 20 amps x 120 volts = 2,400 watts

**A sample circuit calculation**
The house wiring diagram below illustrates a section of a house or apartment with several rooms and circuits. Let’s use a sample bathroom with a vent fan that draws 120 watts of power, a light fixture that has three 60-watt bulbs (180 watts total), and an electrical outlet where that 1,500-watt hair dryer is plugged. The load on that circuit could reach 1,800 watts, as all of these could easily be drawing power at the same time on the 20-amp circuit (providing 2,400 watts). A circuit overload could occur if you plugged in an additional appliance such as small space heater drawing 750 watts of power. The total power demand would be 2,550 watts, exceeding the 2,400 watts available and causing the circuit breaker to interrupt (trip) the circuit.

Overloading electrical circuits can happen easily and be the cause of a residential fire. Help prevent circuit overloads by knowing the power capabilities of your house. Know the total power consumption of your devices and limit the amount of power demand you place on each circuit. Never exceed the capacity of your circuits and be aware of the warning signs of an overloaded circuit. Getting to know the limits of your house’s power will help lower your risk of electrical fires, prevent overloading your electrical system and keep your family and home safe.
Preventing and Treating Tick Bites

Ticks — the mere thought of exposure strikes fear in some people due to the number of diseases these blood-sucking parasites can transmit. Avoidance is the preferred method to prevent tick-borne disease transmission; however, there are several additional precautions you can take to stay safe, including:

- Wear light-colored clothing. Light colors make it easier to spot ticks on your clothing. Stop occasionally and perform a visual check for ticks on your clothing.
- Tuck your pants inside your boots or socks. If you're not fully encased in clothing, ticks may be able to hitch a ride up your legs and groin. Ticks usually get picked up on the lower legs and then climb upward in search of a meal. The odds of contracting Lyme or any other tick-borne diseases are minimalized if the tick is removed soon after it's attached. The shower is a good place to conduct a tick check.
- While it may not look flattering, it does create a physical barrier against ticks.
- Use insect repellent. Most of the chemicals that repel mosquitoes are somewhat effective against ticks, although it may take a heavier concentration of DEET to be effective. Military DEET is 33 percent and very effective against ticks. Permethrin clothing treatment is a stronger chemical that kills ticks as well as repels them. Products containing permethrin should be sprayed only on clothing, not the skin.
- Spring is the best time to remove ticks, since most ticks are not discovered until after they attach. Fortunately, most disease transmission can take 24 hours or more. Prompt removal using approved methods is effective at preventing disease transmission.

Tick removal

Before discussing the best methods for tick removal, there are a lot of folk remedies that are best avoided. One of the first removal methods I ever heard was to place a hot poker out of the fire and placed it on your backside, the one direction you would not move is back. Unfortunately, this results in people lighting multiple matches in an attempt to get the tick to back out and release. Logic should tell you that if someone pulled a hot poker out of the fire and placed it on your backsides, the one direction you would not move is back. Fortunately, this results in people lighting multiple matches in an attempt to get the tick to release, raising the parasite's internal temperature and possibly causing the temperature to increase by the expanded volume of the heated gut contents to inject into the attachment site the very pathogen you are trying to avoid.

A popular removal method is to: 1. Use fine-tipped tweezers to grasp the tick as close to the skin as you can. 2. Pull upward with steady, even pressure. Don’t twist or jerk the tick. This can cause the mouthparts to break off and remain in the skin. If this occurs, remove the mouthparts with tweezers. If you are unable to remove the mouth easily with clean tweezers, leave it alone and let the skin heal. 3. After removing the tick, clean the bite area and your hands with rubbing alcohol or soap and water. 4. Dispose of the tick by flushing it down the toilet. If you would like to bring the tick to your healthcare provider for identification, put it in rubbing alcohol or place it in a sealed bag/container.

To remove ticks using a commercially available device, follow the manufacturer’s instructions. After removal, thoroughly wash the bite area and your hands with soap and water or alcohol. While having a tick attached to your skin can be an emotional experience, being prepared in advance and having the proper equipment on hand, can be safely removed without putting yourself at risk. If you develop a rash or fever within several weeks of removing a tick, see your doctor. Be sure to tell the doctor about your recent tick bite, when it occurred and where you most likely acquired it.

“PROMPT REMOVAL USING APPROVED METHODS IS EFFECTIVE AT PREVENTING DISEASE TRANSMISSION.”

JERROLD J. SCHARNINGHAUSEN, PH.D.
Directorate of Assessments and Prevention
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For more information, visit https://safety.army.mil.
Over the previous five fiscal years, Army Aviation has experienced roughly 40 percent of its Class A mishaps during the fourth quarter. In numbers, that’s 21 of 53 Class A mishaps during that timeframe, nearly double the total of any other quarter. Plotted on a bar graph, the fourth quarter looks like the Himalayas of mishaps as compared to the remaining quarters. This fact should immediately garner the attention of every member of the Army Aviation team. However, arming the force with foresight of the hazards associated with this time period and employing effective leadership and mitigation measures can reverse this trend.

**Complex hazards**
The fourth quarter represents a complex convergence of numerous factors that, individually or aggregated, if not mitigated create an increased risk to operations. The key to reducing risk during this timeframe is to ensure units adequately plan and train for associated complexities such as high operations tempo, fluctuations in combat power and leadership with the summer manning cycle, and a significant change in the operational environment and weather. Although Army Aviation historically flies the most hours in the third quarter, the fourth is a close second. When coupled with significant turbulence in leadership and combat power, as well as increased heat, dust and prolonged day/night operations, this time period is ripe with overlapping hazards. Armed with this knowledge, it is vital commands confirm their leaders and aircrews are cognizant of these complexities and employ sound planning and mitigation measures to reverse the mishap trend.

**Effective leadership**
Aviation operations — including the tough, realistic training required to support large-scale combat operations — are inherently dangerous. DA Pam 385-30 states, “Managing risks related to such operations requires educated judgment, situational knowledge, demonstrated experience and professional competence.” In essence, effective leader knowledge, presence and engagement leading up to and throughout the fourth quarter will reduce risk. We must ensure we thoroughly train our leaders for the missions they are tasked with, position the right leaders with the proper experience and judgment at critical points throughout the depth of the operation, and set expectations while empowering our leaders to make appropriate risk decisions to protect the force and mission. Doing so will ensure appropriate oversight is in place to mitigate fourth-quarter trends.

**Additional mitigation measures**
Although identifying hazards and effective leadership are crucial, there are additional mitigation measures commands must consider during the fourth quarter. Managing transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated. However, proactive planning for transitions, especially given the current environment, will be complicated.

Winning the fourth quarter
The Army is a learning organization, and having foresight of the hazards associated with fourth-quarter operations, along with effective leadership and controls, will allow our formations to proactively plan for and mitigate risks. Turbulence during this timeframe happens every year and is forthcoming in FY20. However, as the USACRC commander states, “Collective critical thinking, discussion and sharing of best practices within our communities will allow us to reverse this trend.”

“Although identifying hazards and effective leadership are crucial, there are additional mitigation measures commands must consider during the fourth quarter.”

Winning matters, especially in the fourth quarter!
Fireworks are a Fourth of July tradition. To celebrate our nation’s independence, many Americans will gather at professional fireworks events while others will choose to hold a personal pyrotechnics extravaganza in their own backyard. When done right, fireworks create spectacular displays of colored light against the night sky. Before lighting the first fuse on that bottle rocket or Roman candle, ensure you know the guidelines for safe and responsible fireworks use.

Have you ever wondered what makes those pretty colors when a skyrocket explodes? There are a lot of different chemicals used, but some of the most common are aluminum (produces silver and white flames and sparks), barium (green), copper (blue), lithium (red) and sodium (gold or yellow). In the air, these chemicals help create an eye-catching display. On the ground, however, they’re nothing more than explosives and pyrotechnic materials.

Fireworks are classified as dangerous substances under the Federal Hazardous Substances Act. In fact, consumer fireworks are generally considered more hazardous than our military explosives. In the military, we spend considerable resources throughout the life cycle of ammunition and explosives to ensure they’re safe and reliable. While the safety of fireworks continues to improve, many manufacturers’ standards do not achieve this same level of safety, quality and reliability.

Take firecrackers, for example. Many people have probably lit 1½-inch firecrackers. Were all the fuses the same length? Did they burn at the same rate? Did they sometimes fizzle out, leaving an even shorter fuse intact? In commercial fireworks demonstrations, have you seen low bursts or even ground bursts? Safety is very important, whether it’s a big show or backyard fireworks use with family and friends.

The Consumer Product Safety Commission estimates about 9,100 people were treated in hospital emergency rooms for fireworks-related injuries in 2018. About 62 percent of those injuries occurred between June 22 and July 22. No one wants their fun to be spoiled by an accident or injury, so whether you’re using commercial or consumer fireworks, the rules on their safe use should always be followed.

Current requirements for large public or commercial fireworks displays can be found in National Fire Protection Agency Document 1123, Code for Fireworks Displays. For personal use of fireworks, some generally accepted safety rules include:

• Read and follow the instructions on how to use the item.
• Keep a bucket of water or a garden hose handy in case of fire.
• Maintain adult supervision.
• Designate one person to shoot the fireworks.

Fireworks can liven up any Independence Day celebration, but they should always be treated with respect. Remember to use good common sense and follow all safety rules so you, your family members and friends don’t become a fireworks statistic.

DID YOU KNOW?

Sparklers can reach temperatures up to 1,800 F. According to the National Council on Fireworks Safety (www.fireworksafety.org), more than half the sparkler-related injuries happen to children under the age of 14. If sparklers are a part of your child’s celebration, ensure they only handle the unlit end. Also, remind them to keep sparklers away from their face, clothing and hair.

Before spending a fortune on your personal celebration to independence, ensure fireworks are legal to possess and use in your city and state. The National Council on Fireworks Safety’s website is a good source of information on state fireworks laws. You should also always ask your local fire or police department if fireworks are legal in your area. Although fireworks may be legal in your state, there may be reasons, such as a burn ban due to dry weather, why their use is prohibited in some areas. For more information, visit www.fireworksafety.org.
After returning home from a 13-month deployment in Iraq as a chemical officer, I decided it was time to leave the military to pursue my dream of becoming a pilot. I was proud of what I’d accomplished in the Army but was ready for a new challenge. Stationed in Germany, I was given 10 days of permissive temporary duty authorization to travel back to the U.S. to look for a house. When I saw a beautiful four-bedroom home with an in-ground pool, I knew I had to buy it. Since this was central Florida, a pool was a must-have.

Being a first-time homeowner, I didn’t know much about pool care. I researched the neighborhood and found a local pool and spa store less than 2 miles away. There, an employee tested my pool water and let me know the exact chemicals I needed to balance the pH level. If the water is too acidic, it will corrode metal equipment, cause etching on surface materials and irritate a swimmer’s skin. If the alkalinity level is too high, it can cause scaling on the pool surface and plumbing equipment and cloud the water. Additionally, both high acidity and high alkalinity alter the effectiveness of the chlorine, which kills pathogens in the water. After a five-minute breakdown of pool care from the employee, I was sure I was up for the task. After all, I just returned from war, so how hard could pool care be?

Armed with my new knowledge, I donned the basic Florida personal protective equipment — flip flops and shorts — and went to work on the pool. Every Sunday for the next several weeks I would scrub and vacuum the bottom of the pool and pour in the required chemicals, including liquid chlorine, chlorine tabs, bromine and algaecides. My pool system used an automatic chlorinator instead of the floating one. That way it distributed chlorine in the jet system to help keep the water balanced.

On this particular day I was checking if the chlorinator tube had chlorine tablets. I had my cellphone pinned between my left ear and shoulder so I could use both hands to open the chlorinator top. I didn’t have much leverage, so I crouched down and held the bottom of the tube with my right knee. I was chatting away on my phone rather than paying attention to what I was doing when I finally got the top open, releasing a high concentration of chlorine vapor. I dropped the chlorinator and immediately started gasping for air. My chest tightened as I fought to breathe. I was panicking. On the other end of the phone line, my mom had no clue what was happening. I heard her say, “Are you OK? Do I need to call an ambulance?” but I couldn’t respond. After what seemed like an eternity, I started coughing and was able to take a few short, shallow breaths. My lungs felt like they were full of mucus. For the next two weeks, I had a very bad cough and phlegm in my lungs. Fortunately, I eventually recovered.

The worst part of this ordeal, other than almost killing myself with toxic fumes, was the fact that my own mother asked me, “Weren’t you a chemical officer?” The irony hit me. Yes, I was a chemical officer and I had the training to know better. Not wearing the proper PPE while handling hazardous chemicals and being complacent almost killed me. Pool care might seem simple, but it can turn deadly if not done properly. I recommend you leave it to the experts. Take it from your friendly neighborhood chemical officer.

According to a Centers for Disease Control and Prevention report, in 2012, an estimated 4,876 people visited an emergency department for injuries associated with pool chemicals. Nearly half of these were younger than 18 years old, and the most common diagnosis was poisoning by inhalation of vapors, fumes or gases. Pool chemical handlers and others can be injured when critical safety rules for storing and using pool chemicals are ignored. Inhaling fumes when opening pool chemical containers, mixing pool chemicals, attempting to pre-dissolve pool chemicals, and accidentally splashing chemicals in the eyes are some common mistakes. Other mistakes may not be immediately obvious. For example, inadvertently spilling a cola-type soft drink near chemicals in the storage area could set off a dangerous reaction that puts people at risk. That is why one of the rules of safe pool chemical storage is to refrain from bringing food or drink into the storage area. Another “recipe for disaster” is storing liquid chemicals above bags of solid chemicals. An unwanted reaction could occur if the liquid chemicals leaked onto the bags. That is why it is important to store liquid chemicals securely in the lowest location. For more information on pool maintenance safety, including chemical handling and storage, visit the CDC website at https://www.cdc.gov/healthywater/swimming/aquatics-professionals/pool-chemical-safety.html.

Source: Water Quality and Health Council
ON-DUTY FATAL MISHAPS

PERSONNEL INJURY-OTHER

- A 31-year-old Private assigned to Fort Benning, Georgia, died in an on-duty physical training-related mishap 20 May 2020 on the installation at 0715 local. The Soldier was near the end of a 4-mile run when he stopped running. When questioned by a Drill Sergeant, he stated he “didn’t feel good” and was lethargic. The Drill Sergeant put the Soldier in the trail vehicle, which took him to the company area about 1/4 mile away. The cadre applied ice sheets and called E911. While in the ambulance, the Soldier went into cardiac arrest. He was pronounced dead shortly after arriving at the local hospital.

- A Private First Class assigned to Fort Carson, Colorado, died in a PMV-2 mishap 2 May 2020 in Colorado Springs, Colorado, at 2045 local. The Soldier was riding his motorcycle when he swerved to avoid a halted vehicle in front of him. He then struck a curb and was thrown from the motorcycle. Emergency personnel attempted to resuscitate the Soldier but were unsuccessful and he was pronounced dead at the scene. The Soldier was wearing personal protective equipment, but had not completed a Motorcycle Safety Foundation training course. Neither alcohol nor speed appear to be factors in the crash.

- A Specialist assigned to Fort Riley, Kansas, died in an off-duty water-related mishap 2 May 2020 in Randolph, Kansas, at 1400 local. The Soldier was riding in his personal kayak when another Soldier noticed he was no longer in the cockpit. Multiple law enforcement and search-and-rescue agencies were involved in the search, later recovering his body.

OFF-DUTY FATAL MISHAPS

PMV-4

- A Private First Class assigned to Fort Carson, Colorado, died in a PMV-2 mishap 2 May 2020 in Colorado Springs, Colorado, at 2045 local. The Soldier was riding his motorcycle when he swerved to avoid a halted vehicle in front of him. He then struck a curb and was thrown from the motorcycle. Emergency personnel attempted to resuscitate the Soldier but were unsuccessful and he was pronounced dead at the scene. The Soldier was wearing personal protective equipment, but had not completed a Motorcycle Safety Foundation training course. Neither alcohol nor speed appear to be factors in the crash.

- A Specialist assigned to Fort Hood, Texas, died in an off-duty physical training-related mishap 2 May 2020 on Fort Benning, Georgia, died in an on-duty physical training-related mishap 20 May 2020 on the installation at 0715 local. The Soldier was near the end of a 4-mile run when he stopped running. When questioned by a Drill Sergeant, he stated he “didn’t feel good” and was lethargic. The Drill Sergeant put the Soldier in the trail vehicle, which took him to the company area about 1/4 mile away. The cadre applied ice sheets and called E911. While in the ambulance, the Soldier went into cardiac arrest. He was pronounced dead shortly after arriving at the local hospital.

- A Sergeant assigned to Andersen Air Force Base, Guam, died in a PMV-4 mishap 9 April 2020 in Yigo, Guam, at 0100 local. The Soldier was presumed to be driving at a high rate of speed when his vehicle left the roadway and struck a cement guard pole. Local police and emergency medical technicians responded to the mishap scene and pronounced the Soldier dead.

- A 31-year-old Private assigned to Fort Benning, Georgia, died in an on-duty physical training-related mishap 20 May 2020 on the installation at 0715 local. The Soldier was near the end of a 4-mile run when he stopped running. When questioned by a Drill Sergeant, he stated he “didn’t feel good” and was lethargic. The Drill Sergeant put the Soldier in the trail vehicle, which took him to the company area about 1/4 mile away. The cadre applied ice sheets and called E911. While in the ambulance, the Soldier went into cardiac arrest. He was pronounced dead shortly after arriving at the local hospital.

- A Sergeant assigned to Fort Stewart, Georgia, died in a PMV-4 mishap 18 May 2020 in Hinesville, Georgia, at 2230 local. The Soldier was driving his PMV on Route 84 with another Soldier as a passenger when they were struck head-on by a vehicle traveling on the wrong side of the road. The Soldier driving died at the scene. The other Soldier was evacuated to a local hospital with a possible leg fracture. The civilian driver of the vehicle that caused the accident reportedly had a blood alcohol concentration of .244, more than three times the legal limit, and later died from his injuries.

- A Sergeant assigned to Fort Carson, Colorado, died in a PMV-2 mishap 5 April 2020 in Fountain, Colorado, at 2340 local. The Soldier was riding his motorcycle when he swerved to avoid a halted vehicle in front of him. He then struck a curb and was thrown from the motorcycle. Emergency personnel attempted to resuscitate the Soldier but were unsuccessful and he was pronounced dead at the scene. The Soldier was wearing personal protective equipment, but had not completed a Motorcycle Safety Foundation training course. Neither alcohol nor speed appear to be factors in the crash.

POW

- A Private assigned to Fort Hood, Texas, died in a privately owned weapons mishap 28 April 2020 in Killeen, Texas. The Soldier was with group of Soldiers at a private residence on 26 April 2020 when he picked up a fellow Soldier’s privately owned weapon and accidentally shot himself in the head. He was transported to a local hospital where he later succumbed to his injuries.

- A 45-year-old Staff Sergeant assigned to Fort Gordon, Georgia, died in an off-duty bicycling mishap 29 April 2020 in Evans, Georgia, at 0530 local. The Soldier was riding on an approved trail when he fell off his motorcycle. He was found lying on the ground by a motorist and transported to the local hospital, where he was evaluated and admitted to the intensive care unit with a skull fracture and bruising to the brain. The Soldier was medically sedated and monitored by the attending neurosurgeon. Five days later, the care team attempted to bring him out of sedation, but he did not respond well. The following day, the Soldier underwent surgery, but his condition deteriorated. He died from his injuries two days later. The Soldier was wearing a reflective shirt and vest, but no helmet.