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COUNTERMEASURE

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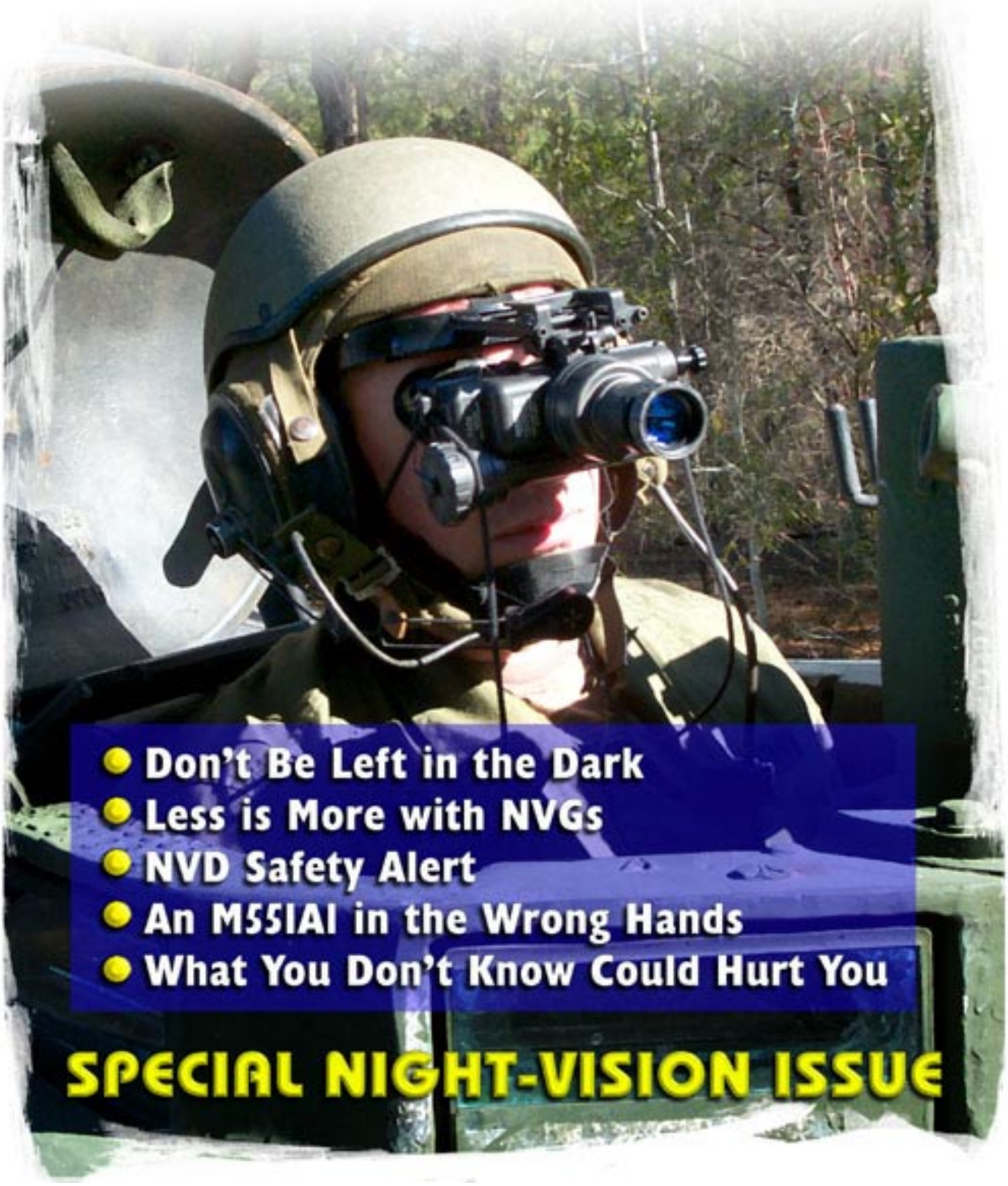

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SPECIAL NIGHT-VISION ISSUE

ARMY GROUND RISK-MANAGEMENT PUBLICATION
COUNTERMEASURE
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The Official Safety Magazine for Army Ground Risk-Management

About this issue...

The Army uses two types of night-vision devices: thermal/forward-looking infrared (FLIR) detectors and image intensifiers.

Thermals/FLIR work by sensing the temperature difference between an object and its environment. Thermal/FLIR-detector systems are installed on certain combat vehicles and helicopters.

Image-intensifier systems must have some light to function; they amplify available light 2,000 to 5,000 times. These devices include—

■ Night-vision goggles (AN/PVS-7) mount on a helmet or head.

■ Driver's night sight (AN/VVS-2) provides passive, closed-hatch night vision in combat vehicles.

■ Night sight (AN/PVS-4) is used on individual and crew-served weapons.

In this issue, we're concentrating on image-intensifier devices. We'll discuss thermal/FLIR detectors in a future issue of *Countermeasure.*

Features

Investigators' Forum

Front cover credits: CPT Jim Hawkins, 1st Bn, 131st Armor, ALNG, demonstrates the use of NVGs.

U.S. ARMY SAFETY CENTER

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Gene M. LaCoste
Brigadier General, U.S. Army
Commanding Officer

Don't Be Left in the Dark

As night operations become more and more important in Army warfighting doctrine, it becomes more and more important that soldiers know how to best use their night-vision equipment. Unless soldiers understand what night vision devices (NVDs) can do—and just as important, what they can't do—night fighters will be left in the dark.

The Army Safety Center recently analyzed 3 years' worth of night operations ground accidents. Initial findings show that both soldiers and leaders need to know more about the unique hazards associated with night operations in general and with NVDs in particular. Night fighters cannot be expected to identify and control hazards that they do not know exist. In other words, *they don't know what they don't know.*

This special issue of *Countermeasure* is a primer on the hazards identified through analysis of real accidents. It's not intended to be a comprehensive review of NVD operations. It's just a good way to share some of the lessons we've learned the hard way: through accidents that hurt—and, in some cases, even killed—soldiers.

Note: To avoid confusion, when we discuss "NVGs," we're referring only to image-intensifing devices worn on the head; when we use the term "NVDs," we're referring to all devices.

Less Is More With NVGs

Light determines what NVG users see—or don't see. Army NVGs use natural and manmade light. Let's look at light and the night.

Light levels

Light levels are critical to how well NVGs do their job. Here's why. NVGs adjust to the amount of light available; if the light level changes quickly—from a flash of lightning or the sudden appearance of an oncoming vehicle's lights—the NVG adjusts instantly. It no longer has to work as hard to intensify available light because there's so much of it. Users often describe the situation as the goggles "shutting down." However, that's not what usually happens. What does happen is that the bright light drives the goggles' gain down to the point that everything else in the field-of-view all but disappears. In addition, if the bright light exposure continues for 70 seconds (+30 seconds), the PVS-7s will turn off.

The "temporary blindness" resulting from either of these conditions could be disastrous in many situations. That's why it's important that users know to—

- Keep bright lights out of the NVG's field-of-view.
- Cycle the switch from ON to OFF and back to ON if the NVG turns off after exposure to bright light.

Natural illumination

The moon provides the best night

light. The moon appears to change size, shape, and angle throughout the lunar cycle. It may appear smaller, larger, full, half-full, crescent shaped, higher, or lower in different phases, but one thing doesn't change during the cycle: the moon always rises in the east and sets in the west at the rate of 15 degrees per hour. Furthermore, the lower the moon's angle, the less useful illumination it provides. It's important that leaders keep this in mind when planning night operations.

Movement toward a highly illuminated moon located low on the horizon can be extremely hazardous when NVGs are in use. Not only can the brightness degrade the NVG image, deep shadows cast by the moon may hide hazards that even NVGs can't see.

Stars provide much of the illumination NVGs see on moonless or low illumination nights. The newer NVGs perform best under these starlit nights. In addition, solar illumination is present for the very short time that the sun is within 12 degrees of the horizon after sunset and before sunrise. Too much solar illumination, however, can also degrade NVG resolution.

Other natural sources such as northern lights and zodiacal lights are also sometimes present, but they're not reliable illumination sources.

Manmade sources of illumination

Illumination from cities, fires, vehicles, and flares can have enormous effects on NVG performance.

City lights can be helpful when the NVG user is outside the city and the sky is overcast. Under these conditions, the clouds reflect the city lights back down and greatly increase illumination. However, it's extremely important that the user not fixate on the lights; doing so will decrease overall resolution.

Flares can be very helpful in increasing illumination as long as they stay outside the NVG's field-of-view. Allowing them to drift into view will degrade NVG resolution. Oncoming headlights pose a huge hazard to NVG users. They can instantly degrade resolution to the point that users can no longer see obstacles, equipment, or people. Users must keep headlights and other bright lights out of the NVG's field-of-view. Drivers using NVGs must also slow down until the oncoming vehicle has passed.

Vehicle instrument lights can also degrade image resolution. Many Army vehicles still use red lights on speedometers and engine instruments. Users need to know that NVGs are very sensitive to red light and can be affected even by reflections off the windshield and glass gauges. Therefore, crewmembers should avoid using red-lens flashlights and turn off console instrument lights if possible.

WARNING: Leaders should restrict fully lighted vehicles from operating in NVD operations areas.

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An M551A1 in the Wrong Hands

It's easy for someone to tell you what you should have done differently to prevent an accident after the occurrence. A recent accident illustrates how risk-taking behavior can lead to a tragic chain of events. The result was destroyed equipment, crew injuries, and death.

This was 2LT Jones' first opportunity to test his skills at a major training center, and he was eagerly looking forward to it. He had received all the required schooling to become a leader and he knew the standards. However, for some reason, he decided to do it *his* way.

The mission of the motorized rifle platoon was to occupy battle positions (BPs) utilizing the M551A1 Sheridan. On order, 2LT Jones' platoon was to move from hide positions and occupy prepared fighting positions as part of the operation. Illumination data was briefed as part of that order, and safety considerations

were addressed. His vehicle had a compass, map, and an AN/PSN-11(v)1, Precision Lightweight Global Positioning System (GPS) Receiver.

On the night of the accident, there was zero illumination. The gunner had been assigned to the training area for 4 years and had gained experience on many rotations. 2LT Jones, the tank commander (TC), was using PVS-7 night vision goggles (NVGs), and his driver was using the VVS-2 driver's night sight. Unfortunately, no one knew the route to the platoon's BP, so they roamed around for hours trying to find it.

Consequently, the driver unintentionally drove into their fighting position, resulting in the tank rolling over. Tragically, 2LT Jones was standing in the hatch above nametag defilade and was fatally injured.

Over the years, many people have speculated on what might be the primary contributing factor for tactical vehicle rollovers during night operations. Is it the vehicle? Is there a design flaw? Blaming the equipment is always easy, but in most cases, it is not the cause. We find that the crew's actions were considered the primary cause 80 percent of the time.

As a leader, the first thing to ask yourself is "Are you and your soldiers following the guidelines (technical manuals and standing operating procedures [SOPs]) when operating tactical vehicles?" If 2LT Jones had read the operation order and unit SOP, he would have known to tell his gunner to dismount and ground guide the vehicle when traveling cross-country during zero illumination.

Secondly, "Should you allow your unit to move across unreconned terrain using VVS-2s and PVS-7s?" Not without applying some controls—ground guides, supplemental lights, mixing PVS-7s and VVS-2s—and ensuring good communication between users. In addition, commanders should plan for the oldest, least effective night vision devices (NVDs) when planning the mission.

What went wrong and why?

■ 2LT Jones was specifically told to wait until first light to continue efforts to locate the designated BP; however, he made an improper decision to continue searching after darkness.

■ He was given an 8-digit coordinate of the position in the fragmentation order (FRAGO);

however, by having exaggerated confidence in his crew's ability to locate the BP using NVDs, he deviated from the order to halt his movement until daylight.

■ He did not utilize available equipment such as the lensatic compass, map, or his GPS Receiver, which were all serviceable.

■ He should have been in the nametag defilade position.

What would you have done? Would you have used a ground guide or done the same as 2LT Jones? Sometimes we perceive that mission accomplishment is paramount—no matter what the risk—and that mistakes or failures are not tolerated and will reflect adversely on evaluation reports.

Risk management is the tool to change this perception. It is being taught in both officer and enlisted leadership development courses throughout the Army. Commanders and soldiers alike are gaining an understanding and appreciation of the risk-management process and know that if the risks outweigh the benefits, then the mission should be a no-go.

Editor's note: 2LT Jones is a real soldier, who was involved in a real accident; we have only changed his name.

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Where Should I Sleep?

"Sleep where I can find you." That's what the sergeant told his private before he bedded down. "Yes, Staff Sergeant," replied the PFC. Unfortunately, those were the last words the sergeant and private would exchange. Here's why:

During a combined-arms exercise, the bravo section of the tactical operations center (TOC) of an infantry battalion was riding in an armored assault vehicle command[1] (AAVC). It was 2100, and they had been in the attack all day; they were exhausted. Higher authority ordered them to stop and rest. They halted and didn't waste time getting settled; they knew they would be back in the attack before dawn.

With the next day's plan set, the group began establishing their bivouac. They positioned their AAVC on the side of a hill to have better communications with alpha section of the TOC and regimental TOC. The senior NCOIC of the group, who was a staff sergeant, set up the security plan for their position and took the first watch. He told the PFC radioman that he would stand post as a sentinel at 2200. The PFC retrieved his gear and bedded down five meters behind the AAVC.

The group commander never designated a sleeping area, nor did they post a guard to protect sleeping soldiers when tracked vehicles were operating nearby.

At 2200, the staff sergeant went to post the PFC but couldn't find him. Instead, he posted another soldier. Three hours later, at 0100, the fuel truck arrived at the group's position. The AAVC commander, who was a sergeant, got the call over the radio to meet the fuel truck on the road to refuel. With another sergeant, the AAVC commander carefully searched the area around the AAVC with flashlights. After they determined the area was clear, they gave an okay to the driver to move the AAVC 100 meters down the hill to the road. At a crawling pace, while maneuvering around boulders and through brush, the two sergeants guided the driver down the hill.

By 0200, the AAVC had finished refueling and was moved back to its original position. Fifteen minutes later, a soldier climbed out of the AAVC's rear hatch and was on his way to make a latrine call when he stumbled over something. It was a sleeping bag obscured by brush. A closer look revealed the bag contained the missing PFC. His body was under one of the AAVC's tracks; he had been crushed.

The group commander, who was a major, and the senior NCOIC never designated a sleeping area, nor did they post a guard to protect sleeping soldiers when tracked vehicles were operating nearby.

When the AAVC commander informed the major that he needed to move the AAVC to refuel it, the major ordered him to use four ground guides: forward, aft, port, and starboard. But the sergeant didn't follow his orders.

A corporal, who was part of the group, saw the PFC bed down where he was not supposed to be; however, he didn't say anything to the PFC or his leaders.

The bravo command group was a hodgepodge of personnel from different units. It was clear to investigators that the chain of command within the group was disorganized.

If you or your soldiers have to work with tracked vehicles, you should follow these steps:

1. First, get familiarity training. Ask the vehicle commander to brief you and your soldiers on the hazards of working in and around tracked vehicles. Ensure all soldiers understand day and night ground guide procedures.

2. Rehearse the basics of mounting and dismounting the vehicle and performing rollover/fire drill procedures. Seasoned soldiers need to revisit the basics as much as a new soldier needs to learn them.

3. Designate and mark troop-sleeping areas. Post a guard to protect the troops. Knowing where your soldiers are is critical when working with tracked vehicles.

4. At a minimum, tracked vehicle crews should use a front and rear ground guide when moving vehicles in restrictive terrain, tactical assembly areas, and when dismounted troops are close by. If visibility is poor, then additional control measures are necessary; e.g., increased supervision, lights, and signal device, to lessen the risks before movement.

5. Keep up your guard around tracked vehicles. Assuming that a tracked vehicle driver can see you and won't run over you can be a grave mistake. Because of the vehicle's size, a tracked vehicle driver has blind spots where he can't see dismounted troops. Operating in conditions of reduced visibility (darkness, dense vegetation, and urban terrain) amplifies the risks. Furthermore, the engine's noise makes it difficult and sometimes impossible to hear dismounted troops.

Editor's note: While this article was reprinted from a Marine Corps safety magazine, Army soldiers have also been run over during night operations in recent years.

Adapted from Ground Warrior

[1]The AAVC is a Marine tactical vehicle similar to the Army's M577. With its many radios, the battalion staff uses the AAVC as a mobile command post.

What You Don't Know Could Hurt You

A soldier has just looked through night-vision goggles (NVGs) for the first time. He can see—*he thinks*—and he'd like to put on the goggles and go. What he doesn't know is that, while NVGs increase night light to incredible levels, they *do not* turn night into day. Goggles have limitations: reduced field-of-view, reduced visual acuity, reduced depth perception and distance estimation ability, and the need to adapt to the dark when removing the NVGs. The following accidents prove this theory...

Proficiency in NVG use is a perishable skill. Soldiers need continuous training with NVGs so they know the capabilities and limitations of the devices. Soldiers need to get used to wearing them and learn ways to overcome the limitations.

...again...

The M1A1 had completed an attack and was moving to the assembly area. Both the driver and the TC were using NVDs to navigate the route. However, because neither of them was using a scanning technique, they both failed to see an unmarked fighting position outside their field-of-view. When the tank drove over it, the bunker collapsed, and the tank slid into the hole. Neither crewmember was injured, and luckily, no one was in the bunker.

...and again...

Several Bradley fighting vehicles (BFVs) were on recon during training in the desert (low contrast area) on an extremely dark night (low illumination). The platoon was expecting enemy fire, so they were driving without any type of lights. The Bradley commanders were using NVGs and the global positioning system for navigation. As they approached their objective, three BFVs traveling abreast went over one small ditch and immediately came upon what appeared to be another. However, rather than a small ditch, it turned out to be a 15-foot cliff. All three Bradleys went over the cliff and tumbled into the wadi below. Two soldiers were killed, and eight others were injured.

In addition to low illumination that night, the desert offered too little contrast for the drivers to see the drop-off. This combination of low light, low contrast, and low definition made a small ditch and a 15-foot deep wadi

appear to be the same.

...and again...

The HMMWV driver, using AN/PVS-7B NVGs, was following and observing three Bradley fighting vehicles on a counter-reconnaissance training mission. Illumination was zero, and the rough desert terrain included deep wadis. When the Bradleys stopped, the HMMWV driver parked about 30 feet behind the last one. When the Bradley started backing up in the direction of the HMMWV, the driver moved the HMMWV to the right to get out of the way. Then the lead Bradley started turning around, and the HMMWV driver began moving further to the right to clear a path for it. As he did so, the HMMWV edged off a 45-foot cliff that had not been visible in the darkness. The driver and his passenger were both wearing seatbelts and suffered only minor injuries. The HMMWV was totaled.

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NVD Safety Alert

Recent night vision device (NVD) training and supervisory failures at all levels have led to accidents and the loss of life. Analyses from the Safety Center's investigations of these accidents reveal that not all units and installations specify the proper use of NVDs.

Army Regulation (AR) 600-55: *The Army Driver and Operator Standardization Program (Selection, Training, Testing, and Licensing)* is the governing doctrine for all driving operations. Chapter 8 addresses NVDs, in which paragraph 8-2b states: "Commands will establish speed limitations for all modes of driving with NVDs. In addition, commanders at all levels must understand the devices' limitations to conduct effective risk assessments."

Appendix I of the AR outlines mandatory academic and driving tasks for NVDs, and the February 1996 issue of *Countermeasure* covers many of those limitations. The October 1997 and February 1999 issues of *Countermeasure* also address NVD safety.

Commanders and safety personnel whose units use NVDs for driving must review and understand the requirements delineated in the AR. In addition, they should use TC 21-305-2: *Training Program for Night Vision Goggle Driving Operations* as the foundation of their NVD driver-training program. The TC provides good baseline training; however, commanders should also identify hazards unique to their location and review their own NVD operations policies and standing operating procedures to mitigate location-specific risks.

Questions that should be addressed include, but are not limited to the following:

- Do roads or tank trails on the installation allow two-way traffic?
- Are trails wide enough to allow two M-1s to pass without one pulling off the road?
- Is mixed traffic allowed (i.e., drivers with NVDs and drivers without NVDs)?
- If so, does the training program address the associated hazards?
- Do civilian and off-duty military hunters use the same roads as tactical vehicles driven by operators using NVDs?
- What steps has the installation taken to mitigate the risks associated with these hazards?

Commanders are key to successful NVD training and operations. Commander/leader involvement and careful mitigation of associated risks will prevent soldier injuries and fatalities.

Gene M. LaCoste
Brigadier General, GS
Director of Army Safety

Safety Message Update

Following is the revised text of a ground precautionary message (GPM) concerning the AN/PVS-7B and AN/PVS-7D night vision goggles (NVGs).

Subject: CECOM GPM 2001-002, AN/PVS-7B NVG, NSN 5855-01-228-0937, LIN N05482 and AN/PVS-7D NVG, NSN 5855-01-422-5413, LIN N05482.

1. References:

A. TM 11-5855-262-10

B. TM 11-5855-262-23&P-2

2. Distribution: This is a GPM and has not been transmitted to your subordinate units. MACOM commanders will retransmit this message to all subordinate units, activities, or elements affected or concerned.

3. Summary of Problem: CECOM has received several category 1 product quality deficiency reports (PQDRs) reporting breakage of internal plastic pins on the AN/PVS-7B NVG eyepiece diopter focus assembly. This breakage occurred while focusing the eyepiece or adjusting the interpupillary distance (IPD). Failure of these plastic pins will prevent users from being able to obtain a clear focus in that eyepiece, even though the diopter focus ring is moving freely. Use of the AN/PVS-7B or AN/PVS-7D NVGs with an out-of-focus eyepiece is considered a safety hazard.

4. User Actions:

a. Operators--To minimize the possibility of this hazard occurring in the field, users should perform the service checks listed in the "Preventive Maintenance Checks and Services" table of TM 11-5855-262-10-2 dated 1 June 2000. The user should perform the eyepiece diopter focus adjustment and IPD adjustment checks described in the "item 4, rear cover" section of the table prior to deployment. The most likely time for the eyepiece to fail is during initial adjustment, because that is typically when the greatest force is exerted. Use caution when performing these checks; excessive force can cause the diopter pins to fail, even if there is no defect in the material. Provided initial adjustments are made prior to deployment, it is considered unlikely that minor adjustments made during normal operations will cause a failure of the NVG diopter pins during field usage.

Systems that pass the service checks are considered safe for use. Systems that fail the service checks must be turned in immediately for repair or replacement.

Do not attempt to repair a rear cover assembly by piecing together components from different, failed rear cover assemblies. There are several configurations of rear cover assemblies, and these configurations may not be compatible with each other.

b. Maintainers—At this time, some of the eyepiece/systems may be under warranty. If this failure occurs on a system under warranty, follow the warranty procedures given in Chapter 1 of TM 11-5855-262-23&p-2. For systems out of warranty, we request that maintainers document all failures of the AN/PVS-7 eyepiece diopter focus adjustment pins on a PQDR (Standard Form 368) and submit to:

CDR, CECOM
ATTN: AMSEL-LC-LEO-D-CS-CFO
FT MONMOUTH, NJ 07703-5023

PQDRs may also be e-mailed to cfo@cecom2.monmouth.army.mil. PQDR submission will assist in determining how often this type of failure is occurring. Also, by submitting a PQDR, units may receive credit for these systems, depending on the final disposition of the items.

c. Disposition of failed items: We request that all rear covers exhibiting the diopter pin failures be sent to the following address: PM NV-RSTA, ATTN: SFAE-IEW&S-NV-CCS-II (Lance Fujita), 10221 Burbeck Road, Bldg 399, Fort Belvoir, VA 22060-5806. The entire rear cover assembly (NSN 5855-01-246-6810) should be sent; not just the failed eyepieces. A copy of the completed PQDR should be included with each shipment of rear cover assemblies.

5. Points of contact: Lance Fujita, PM Night Vision/ Reconnaissance, Surveillance & Target Acquisition (NV/RSTA), SFAE-IEW&S-NV, DSN 654-1610, 703-704-1610 or e-mail lance.fujita@nvl.army.mil; David Werner, CECOM Logistics Readiness Center, AMSEL-LC-IEW-NV, DSN 992-8371, 732-532-8371 or e-mail david.werner@mail1.monmouth.army.mil; Jay Hanrahan, CECOM Directorate for Safety, DSN 992-0084, ext. 6406 or 732-532-0084, ext. 6406, or e-mail james.hanrahan@mail1.monmouth.army.mil.

6. This message has been coordinated with PM NV/RSTA, the CECOM Logistics Readiness Center, and CECOM Directorate for Safety.

Investigators' Forum

Written by accident investigators to provide major lessons learned from recent centralized accident investigations.

Weighing the Options

The Transportation Company was hauling live M26 multiple launch rocket system (MLRS) pods from the manufacturing plant to the Army Depot for storage. The unit had M931A2 tractors and M871A2 trailers and used a configuration drawing from Army Materiel Command (AMC) to tactically load the MLRS pods on the trailers. Overall, the unit moved over 800 pods using this AMC guide. The training went well with no unexpected problems, except each day a tractor blew a tire. The only thing unique about this was that all tires were blown on the second axle of the tractor.

Toward the end of the training exercise, the mission had become simple and mundane. Eight round trips had already been accomplished, the last pods were loaded, and the unit was driving to the storage depot for the last time.

The convoy was traveling north and consisted of 8 vehicles in the first serial and 10 in the second serial. They had traveled 66 miles when the truck master decided to pull off the road to change drivers for the next leg of the

trip. Unfortunately, the only place to pull over was a truck stop on the opposite (west) side of the road.

The convoy pulled over and the senior occupant changed position with the junior driver. The junior driver then began his leg of the trip. The first serial began exiting the truck stop area; however, the last three vehicles had to wait until the southbound traffic and the second serial had cleared the intersection, placing them farther behind.

Finally, the last three vehicles were able to move. The first vehicle carried very little, he was hauling "post holes." The second vehicle was carrying eight M26 MLRS pods and dunnage that weighed 41,318 pounds. The last vehicle was the convoy commander's vehicle.

The next interchange was 1½ miles away and located at the bottom of a slight hill. The first exit went east while the second exit on the half cloverleaf went west toward the storage depot.

The junior driver had his mind on other things and thought he should have taken the first exit. He suddenly attempted to make a flat 90-degree right-hand turn from the outside lane at 35 mph, while the exit speed limit was 15 mph.

The front end of the M931A2 tractor lifted up and within a microsecond, the 41,318-pound payload flipped the tractor. Four pods on the back of the trailer propelled onto the road; the trailer swung upward and came down on the pods and bounced.

The tractor, with both men buckled in, came to rest on the driver's door. With help, the driver and the senior occupant were removed from the truck. Luckily, both soldiers survived this accident; however over $1 million in property was damaged!

Lessons learned

■ The M931A2 using the M871A2 trailer has a payload of 15,000 pounds, not the 41,318 pounds that was loaded on it. Know your systems' configurations and their limitations.

■ The AMC configuration drawing guidance did not evaluate the *total* weight of the tractor-trailer system; instead, it was based upon the trailer being the complete system. The prime mover was not even considered.

■ The junior driver was driving faster than the TACOM Safety-of-Use Message allowed (Reference: SOUM-00-018; 121604Z Jul 00). The M931A2 is limited to 40 mph until antilock braking system (ABS) and tires are installed.

■ Avoid selecting rest areas that result in crossing over traffic before resuming convoy.

■ Leaders from platoon sergeant to battalion commander need to improve upon their ability to identify hazards. Just because the Army has done it "this way" for years, does not mean there are no hazards and a possible better way.

■ Look for the unusual happenings, analyze them for trends, and determine what can be done to eliminate them from occurring; i.e., tires blowing out on the same axle.

Editor's note: Look for an upcoming SOUM on overloading soon.

POC: Ground Systems and Accident Investigation Division, DSN 558-3562 (334-255-3562)

Can You Identify This Vehicle?

Stay tuned, there's more to follow next month regarding this accident.

Share Your Success

Have you had a safety problem or an incident at your installation that others need to know about? Did you find a solution or resolution for it?

Throughout the Army, creative, dedicated soldiers and civilians are solving problems that are never reported on a DA Form 285 and never get into the Army Safety Center's information data bank. These people are coming up with prevention programs that could be of real help to others working in the field. Most of the problems are not peculiar to one installation, but often your contemporaries never know you found and solved *their* problem.

Countermeasure would like to feature some of your problems and their solutions. If you have solved a problem that you think others in the field should know about, tell us so we can publish it in *Countermeasure.* We will give you a by-line too. Even if you just have a problem, tell us about it. Perhaps someone out there will be able to help.

We are starting a new column called "Risk Management Corner," but we will need your contributions to keep it going. Incidents do happen that others need to know about, and this column will be a good way to tell them. Write, call, or e-mail us. The address is: Commander, U.S. Army Safety Center, Bldg. 4905, 5th Ave., Fort Rucker, AL 36362; Phone: DSN 558-2688 (334-255-2688); e-mail: **countermeasure@safetycenter.army.mil.**

Coming Attractions for March

- Oh, My Aching Back
- It Won't Happen To Me!
- Watch Your Step
- Ergonomics: The Simple Facts
- Wanna Bet That Ignorance Is Bliss

Countermeasure Readers

Have you noticed a difference in the way *Countermeasure* looks? Starting with the November issue, we have made some changes in layout, typefaces, and the way we present information. We want *Countermeasure* to be user-friendly. Tell us what you think. If you have comments or suggestions, write to: **Commander, U.S. Army Safety Center, ATTN: CSSC-OG (Countermeasure), Bldg. 4905, 5th Ave., Fort Rucker, AL 36362-5363 or e-mail countermeasure@safetycenter.army.mil.**