

A Munitions Nightmare

You never realize how important your job is until the support you provide, or fail to provide, has a direct effect on combat operations. This statement could be true throughout the support and logistics community, but I'll focus on artillery ammunition. I hope by passing along this account of actual events I'll help others take their jobs as seriously as the trigger-pullers engaging the enemy in the field.

While deployed in the mountains of Afghanistan, we provided indirect 105 mm artillery support for the operational detachment alpha (ODA) team that owns this area of operation. Regular infantry units occasionally rotate through to provide additional support. Based on our location, at times our priority assets—in this case, ammunition—are flown in.

During one particular

engagement, problems arose after an early morning sweep ignited into a troops in contact (TIC). Numerous insurgents were trying to set up an ambush, but our patrol beat them to the location. The patrol immediately fired suppression munitions on the enemy positions, and a direct-fire engagement ensued. By the next day, my platoon was down to 12 rounds of high explosive (HE) munitions.

Fortunately, we soon received a call that helicopters were inbound with our resupply of 105 mm ammunition. In all, we were expecting about 120 HE rounds. The artillery still was firing in support of the maneuver element as the aircraft descended to the landing zone (LZ). My three-man detail and I approached the helicopters, secured the ammunition, and loaded it in our vehicles.

The aircraft contained several

SFC RAYMOND HAMILTON
173rd Airborne Brigade
Vicenza, Italy

kicker pallets loaded with HE rounds, with a few smoke and illumination rounds mixed in. The way the ammunition was boxed together surprised me. The homemade boxes contained rounds packed in fibers and mixed with banded and crated munitions. Although I was puzzled, I didn't have any time to spare. The howitzers were firing what few rounds were still available, and we had to get the replacement munitions to them as soon as possible.

I literally dumped the munitions at each position. My gunnery sergeant was at the farthest location and inspected the munitions soon after I delivered them. I couldn't believe it when he informed me that not just one or two but *all* the HE powder bags were dry-rotted and unusable. I ran to another position, broke open



a few rounds, and my worst fears became reality. None of the HE munitions we'd just received were serviceable. The projectiles were good, but you can't get the projectiles to their final destination without the gunpowder charges!

We'd called for air support when the TIC began, but they still were 20 minutes out from our location. "Platoon rounds complete" echoed over my radio as the calls for fire continued to come across the command net. We decided to fire white phosphorus (WP) in the meantime to better mark the enemy's position for direct fires. To continue supporting the TIC, we considered substituting propellant charges from specialty rounds with the same ballistic characteristics as the HE projectiles. But fortunately our air support soon arrived on station, and we weren't called back into action that day.

Only a few of our Soldiers were wounded—none killed—during this engagement. Things could've been much worse, however, considering the state of our recently delivered ammunition. The maneuver elements always say the time between their initial call for fire and the impact of friendly rounds seems like an eternity. Heavy fire from enemy weapons and rocket-propelled grenades slows down time for everyone involved. If 60 seconds is a lifetime, what kind of reaction would we get if we calmly informed the maneuver element that, due to a lack of usable ammunition, we couldn't support their survival at all?

I took this life-changing experience personally because

I know the face of every Soldier I was supporting that day. Did the individual(s) responsible for quality management at the ammunition supply point feel the same way? I pondered this question for several days afterward. This wasn't the first time we'd received bad ammunition, and I sent yet another report through the chain of command.

We'd conducted a relief in place several months earlier and discovered improper storage and care had reduced our number of usable munitions

problem by four. These issues immediately were reported up the chain of command, and steps have been taken to correct the situation. While corrective action is a good thing when needed, what could've been done to ensure such correction was never required?

As an artilleryman, two basic field manuals (FMs) guide my path: FM 3-09.50, *Tactics, Techniques, and Procedures for the Field Artillery Cannon Battery*; and FM 3-09.8, *Field Artillery Gunnery*. I understand tactics, techniques, and procedures

DID YOU KNOW?

The Army Combat Readiness Center (CRC) has a guidebook available for online download to assist Soldiers working with munitions in combat theaters. "Munitions Handling During Deployed Operations 101" is an instructional tool for leaders and Soldiers handling captured enemy ammunition and other explosives and includes sections on proper packaging, storage, and transportation of such munitions. The guide can be found on the CRC Web site at <https://crc.army.mil/Tools/handbooks/ground/munitionshandling.pdf>.

to below emergency levels. A few minor issues with munitions are common, but I'd never run into problems of this magnitude, especially in combat. Each forward operating base is allowed only a certain number of munitions to meet mission requirements. This number is maintained by a constant consumption-versus-supply system.

My platoon alone received the following quantities of unserviceable munitions: 32 WP rounds; 79 HE rounds; 7 SMOKE rounds; 4 HE (CHG 8) rounds; and 7 various fuses. The other three platoons in my unit got about the same number of unserviceable munitions, which multiplied the

aren't lock-step and change constantly, but certain basics remain steadfast. These very important basics include proper inspection, storage, and care of artillery munitions. It took my platoon 5 months of continuous improvement to get our gun positions up to standard, and fixing the ammunition issues required 2 of those months. Don't let your unit or another one feel the pain of bad ammunition because the price might be paid with Soldiers' lives. 

Contact the author by e-mail at raymond.r.hamilton@us.army.mil.

Just One Tiny Spark...

Early in Fiscal Year 2005, an explosion inside an earth-covered magazine killed two Army contractors and permanently injured a third contractor at an Army facility. About 24,000 pounds of propellants and explosives, including some stored in 120-pound metal drums, were involved in the incident. The contractors were moving the drums by hand

bottom edge and rolling them into the magazine. The investigators concluded that one drum rolled out of control and tipped over during movement, causing its lid to come open. A spark most likely ignited the propellant within the drum, and hot fragments were ejected into the other propellant and explosives containers inside the magazine. This chain reaction led to the mass detonation that destroyed

LYN LITTLE
Logistics Management Specialist
U.S. Army Technical Center for Explosives Safety

Safety Standards, paragraph 2-5e, "Munitions will not be tumbled, dragged, dropped, thrown, rolled, or walked. Containers designed with skids may be pushed or pulled for positioning, unless otherwise marked on the container."

Personnel must know and be trained on the hazards associated with the materials they handle. Indications are the



into the magazine when the detonation occurred.

The subsequent investigation revealed a serious issue that contributed to the accident. No material handling equipment (MHE) was found by investigators at the site, which explains why the contractors were moving the drums by hand. The contractors were tipping the drums on their

the magazine, killed the two contractors, and severely injured the third contractor.

There are several lessons to be learned from this accident. First, personnel must use MHE whenever possible. Propellant containers, however, should always be handled with MHE. According to Department of the Army Pamphlet (DA Pam) 385-64, *Ammunition and Explosives*

contractor rolling the drum in this accident wasn't aware of the serious hazards posed by M9 propellant. Some propellants—including M9—are hazard division 1.1 materials, meaning they have mass explosion capability. These materials detonate rather than deflagrate, or burn off when ignited.

Personnel must always follow procedures and be trained on

potential material reactions in unexpected situations, such as the drum opening accidentally in this incident. All propellants—especially M9—are extremely sensitive to friction, and great care must be taken to ensure personnel do not walk or step on any spilled material. When the drum opened, the contractor should've withdrawn and notified his supervisory chain of the spill. Instead, he attempted to fix the problem by cleaning up the spilled propellant himself, which ultimately led to the accidental ignition.

Finally, personnel must identify all potential operational risks. Before this accident,

local procedures permitted rolling of propellant drums. Unfortunately, the local risk assessments failed to recognize the hazards of this type movement and overlooked the MHE requirement for heavy containers.

This accident also highlights the reasons why only certain operations are allowed inside a magazine, described in paragraphs 13-2i and 13-2j of DA Pam 385-64. Personnel must never open ammunition or explosives containers inside a magazine unless such action specifically is authorized by these paragraphs or if the appropriate authority level has approved a waiver.

Information regarding explosives safety waivers can be found in chapter 7 of Army Regulation 385-64, *U.S. Army Explosives Safety Program*.

Additional information about this and other explosives accidents can be found on the Explosives Safety Mishap Analysis Module (ESMAM) Web site at <https://www3.dac.army.mil/esidb/login/>. A user ID and password are required for access. The ESMAM identification number for this accident is 20041013001. 

Contact the author by e-mail at lyn.little@us.army.mil.

An Almost Split-Rim Disaster

I was in a 3/5 platoon at Fort Bragg, NC, when I had my closest call yet. I was assigned to a great unit with a mission I loved. This isn't to say some tasks were a little more tedious than others, but overall I truly enjoyed my work.

One hot summer day we were told to perform maintenance on our HEMTTs. We weren't going to get away with merely checking fluid levels—we also had to change the tires on one of the trucks. It might sound simple enough, but if you've never seen HEMTT tires, you can't imagine what kind of effort goes into changing them. They're about 4 feet tall, weigh more than 200 pounds each, and have split rims.

Our motor pool facilities

weren't the best, or even close to it. For instance, we didn't have a tire cage big enough to fit HEMTT tires. The one cage we had was designed for smaller tires, and it wasn't permanently mounted to the floor. Unfortunately, we didn't take this problem into consideration before we started working on the truck.

We got the tires off the truck and tore them down with ease, but putting them back together was a different story. How were we supposed to air those huge tires without a cage? Young, creative, and undaunted, two other Soldiers and I put our heads together and came up with a great plan—or so we thought.

We decided to place the tire

CW2 ROGER ARMSTRONG

1-52d Aviation Battalion
Fort Wainwright, AK

rim-side down on the concrete floor. We then parked a cargo HEMTT nearby and placed the truck's outrigger in the middle of the tire to hold it in place while we aired it. This process sounded brilliant, especially considering what we had to work with. After all, a cargo HEMTT weighs 38,800 pounds—that tire wasn't going anywhere!

Once we had everything in place, all we needed was a volunteer to inflate the tire. I said I'd do it, so I got the air hose and hooked it up to the tire. The hose had a locking fastener with 10 feet of additional safety hose so the operator wouldn't have to stand right beside whatever was being inflated.



GOT QUESTIONS?

For more information concerning HEMTT tires, contact Mr. Anderson Coleman, U.S. Army Tank-Automotive Command Team Tire, by e-mail at anderson.j.coleman@us.army.mil. Anyone with questions regarding HEMTT tire changing procedures may contact Mr. James Howard by e-mail at jim.howard1@us.army.mil. Information on split rim availability can be found by e-mailing Ms. Jody Finnell at jody.finnell@us.army.mil.

I started the hose. I don't remember how much psi the tire needed, but I do recall it seemed to be taking forever to fill up. We quickly became bored and started shooting the breeze. Ignoring the fact there were 10 additional feet of safety hose for a reason, I decided to sit on the tire while it still was inflating. Keep in mind we're talking about Fort Bragg in the summer—it gets hot out there!

Sitting down was a bad idea. Just as the tire was about full, BANG! The tire exploded with enough force to lift the back of the cargo HEMTT 3 feet

off the ground. Since I don't weigh anywhere near 19 tons, I rocketed about 15 feet across the pavement. When I realized I wasn't dead, I checked myself over and found only a few scratches. The split rim deeply gouged the pavement, but

the HEMTT somehow made it through without damage.

I might not have been seriously hurt, but this incident scared the crap out of me. From then on I never inflated any tire without a tire cage, and I always stood at least 10 feet away while doing it. If a tire can lift a HEMTT off the ground, it can just as easily cut someone in half. I'm older and wiser now and still a firm believer in Soldier "ingenuity," but a little less creative myself. I'll stick to the book, even if the job takes a little longer! 

Contact the author by e-mail at roger.armstrong@us.army.mil.



New Releases: Rollover DVD

The Army Combat Readiness Center (CRC) just added another valuable tool to their video library: "Letters from War: Up-armored HMMWV Rollovers." The new DVD spotlights commentary from a command sergeant major who survived an improvised explosive device attack and an M1114 rollover while in theater. Other features include lessons learned from theater (seatbelts, gunner safety, etc.); instructional rollover drills; and a Composite Risk Management video.

The DVD can be downloaded from the CRC Web site at <https://crc.army.mil>. Once on the site, click the "Media and Magazines" button; from there, click the "Videos" link; and then scroll down to "Ground Videos." The DVD, which is For Official Use Only, can be ordered from the same page (please specify the number of copies in the "Comments" box).

For more information, contact Rebecca Nolin at (334) 255-2067, DSN 558-2067, or by e-mail at video@crc.army.mil.

Why You Want to Wear Your Helmet

The ballistic tolerance of Kevlar helmets has long been documented and praised. The protection offered by this important piece of equipment, however, isn't limited to high-speed grains of lead and shrapnel. In some cases, it might even fend off a 20,000-pound aircraft!

The combat mission involved insertion of a team by Black Hawk helicopter into a suspected hot landing zone (LZ). An intense firefight had occurred only a week earlier in the same area. In that engagement, a number of aircraft were damaged by enemy fire in the LZ.

Anxious and concerned about delays in disembarking the aircraft, some of the passengers unbuckled their seatbelts 1 minute before landing. Unfortunately, the helicopter experienced a hard landing just short of the LZ. One of the unbuckled Soldiers was ejected from the Black Hawk.

The helicopter shredded its rotor system and rolled over, trapping the ejected Soldier's head under the aircraft's left side. Fortunately, he was wearing his Kevlar helmet, which remained intact even under the weight of the aircraft (see above photos). The Soldier was casualty evacuated to a medical facility and is expected to make a full recovery.

CWS GREGORY SCHNEIDER

Accident Investigator
U.S. Army Combat Readiness Center

This accident illustrates a couple of key considerations in Composite Risk Management (CRM):

- Short final to landing can be the most dangerous segment of a flight. During this time, the aircraft is susceptible to enemy fire, abrupt evasive maneuvers, brownout, and power management problems. Is this a time you'd really want to be unbuckled? Even though the aircraft rolled over in this accident, an unbuckled passenger was the only serious injury.

- When worn properly, the Advanced Combat Helmet (ACH) Improved Nape Strap Assembly keeps the Kevlar helmet where it belongs—on your head! Whether you're in an aircraft or a tactical vehicle, your helmet, body armor, and seatbelt can determine whether



Much of the PPE issued to Soldiers today is the result of one Pennsylvania woman's work. Kevlar was patented in 1966 by Stephanie Kwolek, a researcher with the DuPont Company's Pioneering Research Laboratory in Wilmington, DE. Kwolek developed aramids, the family of polymers from which Kevlar is made, by changing the structure of nylon. Future DuPont researchers built upon Kwolek's findings and developed Nomex, also an aramid. Kevlar originally was developed as a substitute for steel in radial tires, but its ballistic resistance capabilities—it's five times stronger than steel—soon were exploited in items such as police bulletproof vests. Besides helmets, Kevlar also is used as a protective insert in the individual body armor issued to Soldiers deploying to Iraq or Afghanistan. Additionally, Kevlar can be found in the aircraft flying Soldiers to and from their assignments, in the brake linings and tires of tactical vehicles, and in the parachutes used by Airborne troops. Nomex, known for its fire-resistant properties, is used in gloves, aviator flight suits, and combat vehicle crewman uniforms. Soldiers are much safer today because of Kwolek's research, so do your part and wear your PPE!



DID YOU KNOW?

you wake up the morning after a battle or an accident.

CRM demands both enemy and safety risk factors be addressed in pre-mission planning. A countermeasure for one can increase risk in the other. Training, intelligence, and appropriate-level leadership

determines how effective we are in sorting it all out. 

Editor's note: There currently are two types of helmets issued to Soldiers in theater: the Army Combat Helmet and the Personnel Armor System, Ground Troops helmet. Graphic Training Aid 07-08-001 outlines

proper wear and adjustment procedures for each helmet and can be found in the August 2005 Countermeasure or online at <https://www.peosoldier.army.mil>.

Contact the author at (334) 255-9859, DSN 558-9859, or by e-mail at gregory.s.schneider@us.army.mil.

And Your Gloves!

The Pentagon and the Army Surgeon General recently released All Army Activities (ALARACT) Message 261/2005 in response to a sharp increase in the number and severity of hand burns in the OCONUS theaters of operation. According to the message, Soldiers in Iraq and Afghanistan are experiencing a disproportionate number of hand burns in relation to other body parts. Data from the Army

Institute of Surgical Research in Fort Sam Houston, TX, show severe burns have increased from 11.9 percent average body surface area in April 2003 to 16.2 percent in April 2005.

The majority of all combat-related burns are caused by explosions from improvised explosive devices (IEDs), vehicle-borne IEDs, rocket-propelled grenades, or mines during operations on or near a military vehicle. Hand burns occur in 84 percent of vehicle-related burn patients and frequently lead to severe long-term disabilities. Extensive surgeries often are required to treat these burns and include procedures such as skin grafts or amputations. Infections also pose a grave threat to burn patients.

Soldiers can prevent and reduce the severity of such burns by wearing fire-resistant Nomex or Kevlar gloves. (See above table for approved NSNs.) According to some leaders in the field, many Soldiers are taking their gloves off while on patrols and other similar missions in vehicles. Lacking the protection afforded by their Nomex gloves, some Soldiers who otherwise would've received few or no burns are



being treated and sometimes evacuated for hand injuries.

Commanders and leaders at all levels must enforce the wearing of fire-resistant gloves, particularly during high-risk activities including vehicle operations, burning waste, and munitions handling. Soldiers should wear gloves such as those issued under the Rapid Fielding Initiative, as some commercial gloves sold by private companies provide little or no fire protection. Additionally, Soldiers should wear their uniforms with the sleeves down at all times. 

Anyone with questions concerning this ALARACT message may contact COL Paul Gause by e-mail at paul.gause@us.army.mil or by phone at (703) 681-2707 (DSN 761-2707).

Nomex Gloves

Gloves, Flyers, Summer

8415-01-482-8417	Size 4
8415-01-040-2012	Size 5
8415-01-040-1453	Size 6
8415-01-029-0109	Size 7
8415-01-029-0111	Size 8
8415-01-029-0112	Size 9
8415-01-029-0113	Size 10
8415-01-029-0116	Size 11
8415-01-482-8420	Size 12

Gloves, Flyers, Intermediate, Cold Weather

8415-01-446-9247	Size 5
8415-01-446-9248	Size 6
8415-01-446-9252	Size 7
8415-01-446-9253	Size 8
8415-01-446-9254	Size 9
8415-01-446-9256	Size 10
8415-01-446-9259	Size 11



Training with Blanks

The opinions of the author expressed in this article do not necessarily state or reflect those of the U.S. Army Combat Readiness Center. Information in Countermeasure is designed to present information for awareness and accident prevention. Anyone with questions regarding editorial pieces in this publication may contact the editor at (334) 255-1218, DSN 558-1218, or by e-mail at julie.shelley@us.army.mil.

My Marine unit had its first negligent discharge only a day after the beginning of Operation Iraqi Freedom in March 2003. The round came from an M16 rifle while we were riding in a tracked vehicle. One Marine was injured but, fortunately, no one was killed. Here's how it happened.

We were part of a late-night movement convoying toward our next objective. Each of us had a round chambered in our weapon, and we were ready for any situation that might arise. Marines are trained that when riding in a tracked vehicle, all weapons must be on safe with the muzzle pointed toward the floor. However, we'd had little sleep since the war kicked off, and we were dealing with a fast OPTEMPO that didn't show signs of slowing any time soon. In fact, several Marines were taking catnaps during this particular movement.

We were still riding in the vehicle when we heard a gunshot. (There's nothing like a little gunfire to wake

up a tracked vehicle full of sleepy Marines!) The platoon sergeant immediately instructed everyone to sit still with their fingers on their triggers. However, it wasn't enemy fire we had to be afraid of this time.

One Marine's weapon discharged a round and hit the Marine sitting next to him. The round penetrated the top of the Marine's foot and came out through the bottom of his boot but didn't hit any bones. The driver stopped the vehicle, and a Navy medic began tending to the injured Marine. The Marine whose weapon discharged couldn't believe nor explain what happened.

A brief investigation was conducted, which determined the Marine was using his weapon as a brace while he was sleeping. The vehicle was making frequent stops during the convoy, and the Marines were rocking back and forth as it moved. The weapon apparently came off the safe position because of the rocking. The vehicle also was dark inside, and the Marine lost situational awareness. Additionally, he

NORM ARIAS
CP-12 Intern

was handling his weapon as he did during field exercises before deploying to Iraq. The poor habits he developed in those exercises carried over to actual combat operations.

Negligent discharges continue to injure and kill Marines and Soldiers on the battlefield. Some leaders suggest we're not training properly if we're not using all our available tools. One such forgotten tool is blank ammunition.

Marines and Soldiers are taught to treat their weapons as if they're loaded. But why use the word "if" when blank rounds can be used? Blanks can be loaded and chambered in individual weapons; since there will be no more "as if it were loaded," the Marine or Soldier must perform proper weapons handling techniques to avoid a negligent discharge.

Any Marine or Soldier that has a negligent discharge usually is quickly accused of mishandling their weapon. If these troops are trained with their weapons constantly loaded, they'll become accustomed to handling them properly at all times. This awareness will carry over from the training environment to the battlefield, thereby controlling or maybe even preventing negligent discharge incidents.

NEGLIGENT DISCHARGES Hurt

Contact the author by e-mail at norm.arias@us.army.mil.



A specialist suffered a gunshot wound to his left leg and ankle when his pistol inadvertently discharged. The Soldier was dismounting a HMMWV at a forward operating base during the early morning when the pistol fired. Reports indicate the Soldier was hospitalized for several weeks, but no further information was available at press time.

Training with Blanks

Injuries suffered from slips, trips, and falls account for numerous lost work days and Soldier hospitalizations each year in the Army. Sometimes, however, these accidents produce far worse results than a broken bone or simple bumps and bruises. The following PLRs highlight five fatal falls since October 2005, including three off-duty accidents that killed one Soldier each.

PLR 0646: A 21-year-old specialist died from injuries suffered in a mid-morning fall from a guard tower. The Soldier was pulling security in the tower when he fell 15 feet through the tower's trap door to the concrete floor below. The wood used at the trap door's opening was found on the ground to the left side of the door. It is suspected the Soldier might have lost his footing while throwing garbage from the tower.

PLR 0622: A 30-year-old captain died of severe trauma after falling from a Black Hawk helicopter in flight. The Soldier fell 100 feet to the ground on the approach into a hostile area. He was evacuated to a medical facility and pronounced dead. The accident occurred during the late afternoon.

PLR 0610: A 22-year-old specialist died after falling from an escalator at an OCONUS shopping mall. The Soldier slipped and fell backward off the escalator, landing on a set of stairs three floors below. He was rushed to a local medical center, where he was pronounced

dead. The accident occurred during the late evening.

PLR 0635: A 40-year-old sergeant first class died from injuries suffered in an early morning fall outside an OCONUS bar. The Soldier had been drinking in the bar with two other NCOs. One of the NCOs found the Soldier lying at the bottom of a set of stairs leading to the restroom. The Soldier immediately was taken to a local hospital and diagnosed with a skull fracture and bruising to the brain and lungs. He died 10 days later.

PLR 0661: A 21-year-old specialist died when he fell from an escalator at a CONUS shopping mall. The Soldier was on leave and visiting the mall with friends. As he was riding an escalator going down, the Soldier jumped and grabbed the handrail of an escalator going up. He was carried to the mall's third floor, but he lost his grip and fell one story. The specialist suffered a fatal head injury.

Whether a Soldier is killed on duty or during off time, the result is the same—one less

JULIE SHELLEY
Editor



Soldier available for the fight. Individual Soldiers must ensure they do the right thing at all times, whether it's maintaining three points of contact in a tactical environment or practicing the buddy system during late nights out. Leaders must inspect the areas where their Soldiers are serving and enforce standards to ensure they keep their boots firmly on the ground. Stay steady and own the edge! 

Comments regarding this article may be directed to the editor at (334) 255-1218, DSN 558-1218, or by e-mail at julie.shelley@us.army.mil.

FROM THE PLR FILES

In February 2005, the Army Combat Readiness Center (CRC) developed a new tool for commanders called "preliminary loss reports" (PLRs), which are generated for each Class A Army accident involving a fatality. Every PLR contains the basic facts of the accident and suggested

tactics, techniques, and procedures based on the information available and lessons learned from similar accidents. The PLRs are sent electronically to brigade commanders and above and select command sergeants major to share lessons learned. Countermeasure will spotlight certain PLRs

in each issue; however, because of privacy concerns, unit names and dates will not be published. Complete texts of all PLRs are available on the CRC's Web site at <https://crc.army.mil/> (you must have an AKO username and password to access the PLR site).

Reducing Driver Fatalities, One Leader at a Time

Our Army continues to lose Soldiers to accidents at the unacceptable rate of nearly one per day. Even more disturbing is the fact that 71 percent of accidental deaths since the beginning of this fiscal year (FY) have occurred behind the wheel, either in privately owned or tactical vehicles. Since 1 October 2005, we've lost 36 Soldiers—a platoon plus—while driving.

The Army Combat Readiness Center (CRC) continues to serve as a knowledge center for loss across the Army. The following trends emerge as we study these deaths to determine root causes:

- Junior leaders are making decisions that determine safe execution or

unnecessary loss “where the rubber meets the road.”

- Indiscipline and failure to apply and enforce the most basic standards are killing Soldiers.

The most disturbing trend is an increase in leaders involved in accidents. The leaders that should be enforcing standards and mitigating risk are having accidents themselves. In FY05, 33 percent of Soldiers killed in POV accidents were in the ranks of E5 to E7. Historically, the highest-risk age group has been 18- to 24-year-olds; now all age groups under 40 share the same death rate per 1,000 Soldiers.

The CRC has numerous tools and initiatives leaders can put in their kit bags as they continue to manage risk and get the job done. These tools include:

ASMIS-2. This update to the Army Safety Management Information System's POV module is now up and running. Based on feedback from the field, new features include an integral mapping program, auto-filled DA31 link, and OCONUS usability.

Accident Avoidance Course. All Soldiers will complete this standardized course, which addresses driving behavior and risk mitigation. The course is available on the AKO Learning Management Server. (There have been some issues with the login process,

but our team is working to resolve these problems quickly.)

Army Safe Driver Training (ASDT). The CRC's Mobile Training Teams now are providing instruction in seven evasive maneuvers that can be conducted in GSA vehicles or HMMWVs. Course content is applicable to driving in POVs and during tactical operations in theater.

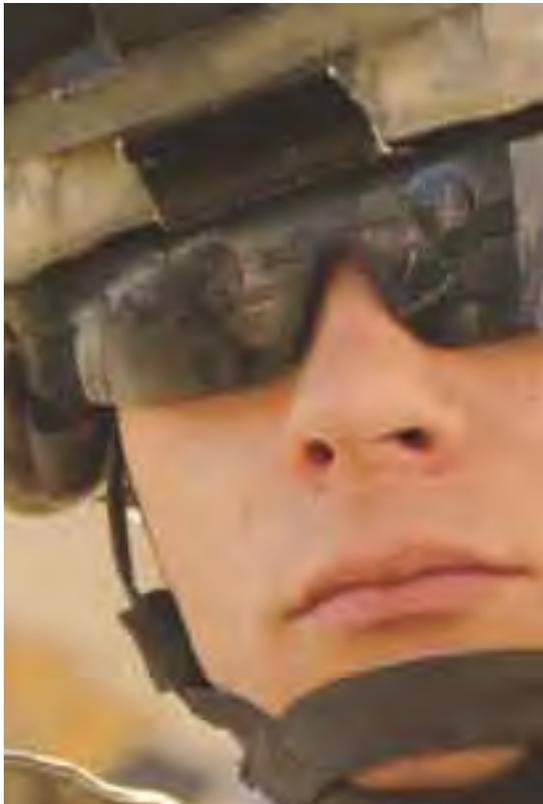
Motorcycle Mentorship Program. This program enables leaders to mentor their Soldier riders rather than have them join unofficial motorcycle groups that encourage negative behavior. The U.S. Air Force built on this concept and reduced motorcycle fatalities by 50 percent on installations where the program was implemented.

The CRC's Driving Task Force lead is LTC Laura Loftus at (334) 255-3034 or e-mail laura.loftus@crc.army.mil; LTC Joe Sette is the Ground Task Force lead at (334) 255-3367 or e-mail joseph.sette@crc.army.mil. Please contact either LTC Loftus or LTC Sette for assistance and to share best practices as we work together to preserve our combat power.

Own the Edge!

Joe Smith
BG Joe Smith

Director of Army Safety
Commanding General,
U.S. Army Combat Readiness Center



DOD to Restrict Cell Phone Use on Military Bases

SGT SARA WOOD
American Forces Press Service

Defense Department installations have begun implementing new cellular telephone restrictions for drivers on military bases. The new regulation, published in the Federal Register in April 2005, states anyone driving a motor vehicle on a DOD installation cannot use a cell phone unless the vehicle is safely parked or the driver is using a hands-free device.

Many installations already have implemented the new restrictions, and the rest will implement the rules on their own schedule, according to John Seibert, DOD Assistant for Safety, Health and Fire Protection. There is no deadline for

installations to implement the restrictions, but Seibert said he expects most will do so this year.

The law enforcement policy offices for each military department are putting together policies and procedures for implementation and enforcement of the restrictions, Seibert said. He explained the regulation is a minimum requirement, and installation commanders have the authority to put stricter rules in place. Each installation will determine the punishment for any rules violation.

As the installations implement the restrictions, they have a responsibility to notify the public by putting up signs or placing notices in base

newspapers, Seibert said. Many installations are allowing a grace period during which motorists in violation of the regulation will be warned and not ticketed.

The regulation was developed based on information from the National Highway Traffic Safety Administration, which studied driving distractions as a cause of motor vehicle crashes. The study found cell phone use is the fastest-growing and most visible distraction that leads to accidents. The new regulation not only will increase traffic safety on installations, Seibert said, but also encourage safe driving habits during off-duty time. 



Class A (Damage)

■ One M88 Recovery Vehicle and 11 M1A2 tanks suffered Class A damage on a railroad track. The vehicles were loaded on eight separate rail cars that shifted and rolled over onto the tracks before striking a parked locomotive. The accident occurred during the late evening.



Class A

■ Soldier suffered fatal head injuries when the M1114 HMMWV he was riding in rolled over. The vehicle ran off the roadway and overturned after the driver swerved to avoid a civilian vehicle that pulled in front of the HMMWV. The deceased Soldier was serving as the vehicle's gunner and was ejected during the rollover sequence. The driver and three other occupants were wearing their seatbelts and suffered minor injuries. The accident occurred during the mid-morning.



Spotlighting Soldiers who wore their seatbelts and walked away from potentially catastrophic accidents

Class C

■ Soldier suffered minor injuries when the M1078 LMTV he was driving rolled over. The truck was towing an M1082 trailer loaded with ammunition on a wet dirt road. The ammunition was not strapped down properly and shifted during movement, causing the trailer to swerve and run off the road. The driver lost control of the truck, which overturned after the trailer left the roadway. The Soldier was placed on restricted duty for 5 workdays. The accident occurred during the late morning.

Class D

■ All occupants in an M1114 HMMWV escaped without injury when their vehicle struck a series of concrete barriers. The HMMWV's driver was operating under night vision goggles in a three-vehicle convoy near a brightly lit prison facility. The driver and truck commander (TC) reportedly thought they had cleared all the barriers and continued down the roadway just before the impact. Both Soldiers were wearing their seatbelts and required PPE. The accident occurred during the late evening.

■ An M1114 HMMWV crew was not injured when their vehicle hit an improvised explosive device crater. The HMMWV was part of a five-vehicle patrol operating under white lights. The TC saw the lead vehicles move around the crater and then switch to blackout drive. The driver swerved the HMMWV to avoid the crater but switched to blackout drive before he was around it completely. Neither the driver nor the TC had time to put on their night vision devices before the vehicle struck the crater. No injuries were reported, but the left front and right rear wheels sheared off the HMMWV as a result of the impact. The accident occurred during the late evening.

■ Soldier died when the M1114 HMMWV he was riding in rolled over. A civilian vehicle ran a stop sign and pulled in front of the HMMWV just before the accident. The HMMWV's driver, a U.S. Air Force Airman, lost control while attempting to avoid the civilian truck. The vehicle was exceeding the command-directed convoy speed at the time of the accident. Besides the deceased Soldier, the vehicle's driver and two other Air Force personnel were ejected, but the degree of their injuries is unknown. The accident occurred during the early afternoon.

■ Soldier suffered fatal injuries when the M923A2 he was driving rolled over. The truck was part of an 11-vehicle convoy on an interstate highway. The driver lost control as the vehicle was traveling downhill on a curve. The road was wet from a rain shower, and the vehicle fishtailed after hitting a slick spot. The truck struck an embankment and overturned,

ejecting the driver. Another M923A2 directly behind the accident vehicle hit the same slick spot, spun around twice, and came to rest in a ditch. The accident occurred during the late afternoon.

■ Two Soldiers were killed when their M1088 was involved in a multi-vehicle collision. The truck was towing an M967 5,000-gallon bulk fuel tanker as the fifth vehicle in an 18-vehicle convoy. The convoy slowed due to road conditions, but the fourth vehicle, also an M1088 towing an M967 tanker, did not stop in time and hit the vehicle to its front. The fifth vehicle then struck the fourth vehicle, causing the fuel tanker to explode. The fourth and fifth vehicles subsequently caught fire. The Soldiers from the third and fourth vehicles escaped without injury. The Soldiers in the fifth vehicle were trapped inside the truck and suffered fatal burns. The accident occurred during the early morning.

Class A

■ Soldier was killed when he was struck by a civilian tractor-trailer. The Soldier was a passenger in an M931 that was sitting on the roadside because of mechanical problems. The Soldier was standing at the rear of the M931 when he was hit by the tractor-trailer. The driver of the M931 was not injured. The vehicle's four-way hazard lights were on at the time of the accident, which occurred during the late evening.



Personnel Injury

Class A

■ Soldier died after falling 15 feet from a guard tower. The Soldier was pulling security in the tower and apparently lost his footing while throwing garbage to the ground. The accident occurred during the mid-morning. More details of this accident can be found in the "PLR Files" article on page 15 of this issue.

■ Soldier suffered a fatal gunshot wound from a friendly element. The Soldier was in an M1115 HMMWV in an unfamiliar area after dark when his element mistook the friendly element for hostile forces. The two elements opened fire, at which time the deceased Soldier was struck in his left lung and shoulder. Three other Soldiers suffered unspecified injuries. The Soldiers reportedly were wearing their required

PPE. The accident occurred during the mid-evening.

Class B

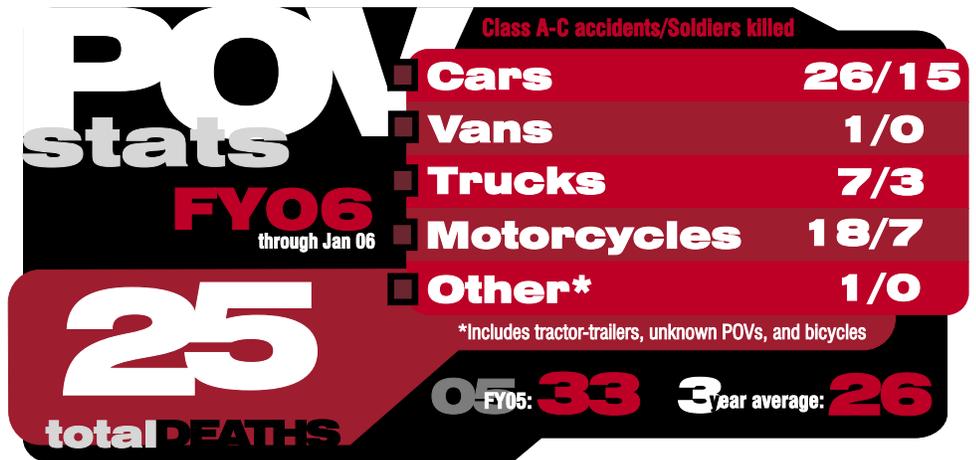
■ Soldier's right middle finger was amputated by the hydraulic door of an M1A1 tank. The Soldier was downloading munition rounds from the tank when his finger got caught in the door. The accident occurred during the mid-morning.

■ One of Soldier's left-hand fingers was amputated while he was climbing down from an RG31 Mine Protective Vehicle. The Soldier caught his finger and slipped while exiting through the gunner's

hatch. The accident occurred during the mid-morning.

■ Soldier's right index finger was amputated by the fan belt of the HEMTT he was servicing. The Soldier was adjusting the vehicle's idle when he caught his hand in the fan belt. The vehicle was running at the time of the accident, which occurred during the late morning.

■ Soldier lost consciousness after being punched in the chin during unarmed defensive tactics training. The accident occurred during the mid-afternoon. No other details were reported.



WHAT WERE THEY THINKING?

JUST BUSTA MOVE!

Ah, the things people do when no one's watching—some on purpose, some by accident. Take falls. We've all had a clumsy moment or two, but some Soldiers seem determined to outdo all the other klutzes out there. The poor souls below suffered bruises and broken bones, but their egos took an even bigger hit.

- A private first class left his billet late at night for an unknown reason "wearing only his socks." (The report doesn't specify whether he really was wearing only socks or was fully clothed with no shoes. Let your imagination run wild.) On the way back to his room, the Soldier started running up the stairs. Although socks aren't known for their remarkable traction, the Soldier was startled when he



slipped and the laws of physics took over. Having no desire to kiss the concrete steps, the Soldier tried to break the fall with his right hand, but it unfortunately wound up being the only thing broken. He also dislocated two fingers. The Soldier had 3 workdays to

think about his foolishness, but his comrades won't let him soon forget.

- A sergeant was preparing his Bradley Fighting Vehicle for a mission. Ammunition? Check. Personal gear? Check. Map? Uh, where'd that go? The Soldier climbed up on the vehicle's ramp and discovered the map. Unfortunately, he stepped on it *before* he found it. The map slid under the Soldier's foot, sending him down onto his right arm. A few choice words besides "ouch" later, the Soldier hitched a ride to the hospital and was diagnosed with a dislocated shoulder. He lost 1 workday and was placed on 7 days of restricted duty.

- A Military Police staff sergeant responded to an animal disturbance call at the post club. A dog apparently was loose around the club's swimming pool and creating havoc with the sunbathers there. The Soldier was nearing the end of his workday when he drove up to the club, spotted the dog, and took off in hot pursuit. No one except the dog and the Soldier know what happened next, but somewhere along the way he—the staff sergeant, not the dog—fell and fractured his left hand. The Soldier spent the night at a local hospital, was given pain medication, and placed on 60 days of restricted duty.

Let's go over our lessons learned. First, when you're off duty—whether it's in your house, billets, or a tent in the middle of nowhere—wear shoes when you go outside. The Army pays you good money to afford such luxuries. Second, don't run up (or down, for that matter) stairs, even in shoes. And always use the handrail. Third, maintain your situational awareness and exercise good judgment, both of which seemed to be lacking in all three cases. Fourth and finally, always maintain three points of contact when your balance is in question, like when you're on top of a big combat vehicle. Falls hurt, so stay grounded!