

Reducing Mishaps - Saving Lives - Improving Readiness

SEA & SHORE

FALL 2005

The Naval Safety Center's Magazine for Afloat and Shore Safety



**Are you
like this
Leap Frog...**

***always
"on your game"?***

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The Naval Safety Center's Magazine for Afloat and Shore Safety

FALL 2005

Vol. 7, No. 4, 2005

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Mishaps waste our time and resources. They take our Sailors, Marines and civilian employees away from their units and workplaces and put them in hospitals, wheelchairs and coffins. Mishaps ruin equipment and weapons. They diminish our readiness. This magazine's goal is to help make sure that personnel can devote their time and energy to the mission, and that any losses are due to enemy action, not to our own errors, shortcuts or failure to manage risk. We believe there is only one way to do any task: the way that follows the rules and takes precautions against hazards. Combat is dangerous and demanding enough; the time to learn to do a job right is before combat starts.

Sea&Shore (ISSN 1550-1434) is published quarterly by Commander, Naval Safety Center, and is an authorized publication for members of the Department of Defense.

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COAST GUARD: Send address changes or requests for more copies to Commandant, USCG, G-KSE, U.S. Coast Guard Headquarters, 2100 2nd St., S.W., Washington, DC 20593.

MARINE CORPS: To be added to *Sea&Shore's* distribution list, increase or decrease number of copies, or take yourself off the list, see your unit publications clerk and have him access MCPDS, *Sea&Shore's* PCN is 74000001900.

POSTMASTER: Send address changes to: Commander, Naval Safety Center
 Attn: *Sea&Shore*, Code 71A
 375 A Street, Norfolk, VA 23511-4399

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COVER



A member of the Navy's premiere, exhibition, skydiving team, known as the "Leap Frogs," performs during a weekend air show. Commissioned by the CNO in 1974, this team's mission is to demonstrate Navy special-warfare excellence, while assisting in Navy recruiting efforts throughout the United States.

Navy photo by PH2 Daniel J. McLain

Cover graphics by Jeff Hobrath of KR Systems, Inc. (krsystems.com)

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*Admiral's Corner
From Commander, Naval Safety Center*



A Ship That's "Getting It Right"

For two years now, I've been saying it will take some changes in the way we do things, what we expect of each other, and what we accept as operations normal to stop the loss of life among our Sailors and Marines. While much remains to be done, we've made progress.

A case in point is a recent message from USS *Mason* (DDG-87). Shortly after the new CO reported, this ship and crew got underway for COMPTUEX and PULSEX 04—their first surge deployment overseas.

Several poorly executed evolutions occurred during the two-month underway period. In each case, an error chain developed, which, if left unchecked, could have led to a disaster. However, each time a watchstander noticed at least one of the links in the chain and took immediate, positive steps to correct the problem.

In the past, these small acts of leadership would have been recognized at the watchstation, but the rest of the team would have been unaware of the total error chain, how it was developing, and how it was stopped. This process easily could have led to the same mistakes being made by different watchstanders the next time that particular evolution was conducted.

Mason, however, had implemented a new process of discussing all less-than-perfect evolutions. This process begins with the CO debriefing the wardroom, bridge and CIC watchstanders on the mistakes made. This honest, forthright and open discussion of error chains and how they develop, even on the most routine of watches, has paid significant dividends.

As the ship's safety officer noted, "It has become the hallmark of our debriefing process. The end result is that anyone down to the most junior Sailor is able to speak up and point out areas where we can improve."

The new debriefing process remains an integral part of every evolution aboard *Mason*. **The payoff has been zero mishaps or near-mishaps.**

We all are challenged regularly to think outside the box and must do so as we march toward the goal of reducing mishaps, saving lives, and improving readiness. The USS *Mason* example is a step in the right direction, but it's going to take much more of that kind

of thinking before we attain the ultimate goal—**zero mishaps!**

Leadership from top to bottom and bottom to top will make the difference. Each of us bears responsibility for using safety best practices, including wearing prescribed safety gear and other personal protective equipment, and reporting discrepancies we witness or improvements we think can be made to help us work and play safely.

Look out for one another and think about safety before you start any endeavor, no matter how seemingly simple it might appear. Most times, safety and common sense go hand-in-hand: You can't have one without the other. In all situations, use risk management and weigh the dangers, as well as the potential consequences, of what you're about to do. Make safety something you live every moment.

Finally, look at these three programs that many of our most successful commands use to address safety:

- Identify high-risk personnel early, monitor closely, provide specific counseling and guidance, and implement liberty-risk hours.
- Standardize (regional) out-of-bounds liberty limitations (rainbow circle) for all personnel and commands. Any travel beyond these limits requires a chit and may require a day of leave.
- Change return and departure times on leave chits to 1200 to mitigate driving times between midnight and 0500, when fatigue becomes a factor.

We have the tools and leadership to fix this problem.

With this, my final "Admiral's Corner" before retirement, I want to thank you for your support during these past two challenging years in the world of naval safety. I trust you'll show the same dedication to my successor, RADM George Mayer, who comes to the Safety Center from a tour of duty as CNATRA.

RADM Dick Brooks

WORK ZONE

REDUCING MISHAPS BY 50%

All-Terrain Vehicles

The U.S. Consumer Product Safety Commission (CPSC) estimates that ATV-related injuries in the United States have doubled in a recent five-year period, and deaths also continue to climb. ATV injuries requiring an emergency-room visit increased by more than 100 percent from an estimated 52,800 in 1997 to 110,100 in 2001.

In this same period, the estimated number of ATV drivers increased 36 percent, driving hours grew 50 percent, and the number of ATVs increased 40 percent. Staffers at CPSC estimate there were 634 deaths related to ATVs in 2001, up from 291 deaths in 1997.

The major ATV manufacturers agreed in consent decrees in 1988 and in subsequent voluntary action plans not to make three-wheel ATVs. They also agreed to place engine-size restrictions on ATVs sold for use by children under 16 and to offer driver-training programs. This training, provided by the Specialty Vehicle Institute of America, can include three family members but no children. Military sales also are excluded since the military purchases a small number of ATVs for a large number of uses.

Rules

- An ATV is not a toy. Children should not be permitted to operate one without specialized training, and then they should be allowed to only operate an ATV of an appropriate size (70 cc to 90 cc for children at least 12 years of age, more than 90 cc only for people at least 16 years of age).
- Wear appropriate riding gear: DOT- or Snell ANSI-approved helmet, goggles, gloves, over-the-ankle boots, long-sleeve shirt, and long pants.
- Read owners' manuals carefully.
- Never carry anyone else on ATVs because they are not made for multiple riders.
- Any added attachments affect the stability, operating and braking of an ATV. Just because an



attachment is available doesn't mean you can use it without increasing the risk of injury.

- Do not operate an ATV on streets, highways or paved roads.

Inspection Checklist

- Are tires and wheels in good condition?
- Are controls and cable operational?
- Does the chain have proper slack, and is it lubricated?
- Is riding gear available and worn?

Resources

- <http://www.cpsc.gov/cpsc/pub/pubs/540.pdf>
- <http://www.nsc.org/library/facts/agriatv.htm>
- <http://www.cdc.gov/nasd/docs/d000901-d001000/d000976/2.html>

Best Practices Making It Happen

By Cdr. Walter Banks,
Naval Safety Center

A proactive, vice reactive, approach to all aspects of safety, both on and off-duty, is keeping the Sailors on board USS *Simpson* (FFG-56) safe and ready to support the ship's mission. They have not had a reportable mishap in FY04 or FY05.

However, life aboard USS *Simpson* hasn't always been this way. The turnaround came when leadership learned that safety discrepancies were being tracked poorly, with little to no follow-up. To correct this problem, they established a duty safety-officer program.

A qualified safety petty officer is placed in each duty section. One of his duties is to conduct a daily safety walk-through and submit his findings to the chain of command every day at the 8 o'clock reports. Discrepancies that can't be corrected within 48 hours require the responsible workcenter to submit a job order to fix the problem. This program is running extremely well and has reduced safety discrepancies on board by 50 percent. The ship's leadership feels the reduction of existing safety discrepancies will stop mishaps before they happen.

The *Simpson's* safety committee and council also identified the motor-vehicle safety program as another area requiring attention. Motor-vehicle incidents were occurring too frequently during FY03.

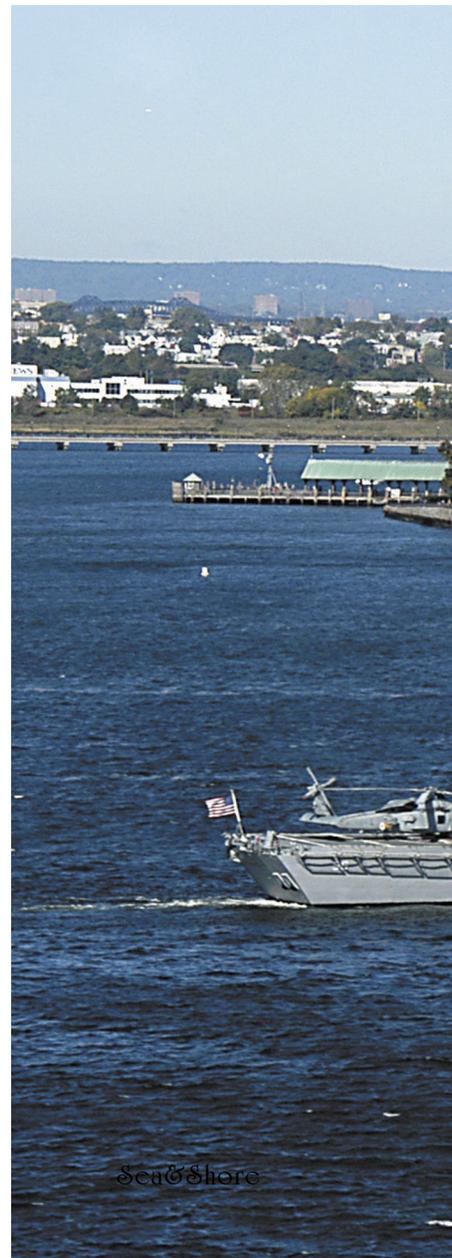
The first step was to hold three safety stand-downs regarding motor-vehicle safety. Presentations were given for both automobile and motorcycle safety. The ship also contacted the Jacksonville sheriff's office and enlisted their help in educating the crew. Jacksonville traffic officers attended all three stand-downs and passed some valuable information. The crew responded much better to and became more actively involved in

the traffic officers' presentations than those given by the ship's safety representatives.

Simpson's safety team also addressed preventing minor mishaps. Crewmen were experiencing a rash of what they believed were preventable incidents, such as small cuts, bruises and minor burns. The safety team attacked this issue through vigorous enforcement of personal protective equipment (PPE).

Division safety petty offices routinely check the quantity, quality and condition of all PPE on board. They immediately bring discrepancies to the attention of the division officers involved, as well as the safety officer. Division officers use planned-maintenance-system (PMS) spot checks as a tool for checking PPE. Failure to present proper PPE during a spot check or misuse of it results in a failed check, and a recheck is scheduled the next day. This rigid enforcement has helped the ship reduce minor, non-reportable incidents by 75 percent.

As a direct result of these aggressive efforts started in FY04, USS *Simpson* is one of the best of 98 ships we've surveyed in the past 12 months. From the pier to the pilot-



house and into the engineering spaces, the ship is maintained immaculately. The safety-program managers are intimately involved in the ship's daily routine and aggressively enforce all safety programs. With only minor exceptions, all safety-administration programs were evaluated as effective and in accordance with OpNavInst 5100.19D (with change 1), during our Feb. 15, 2005, safety survey.

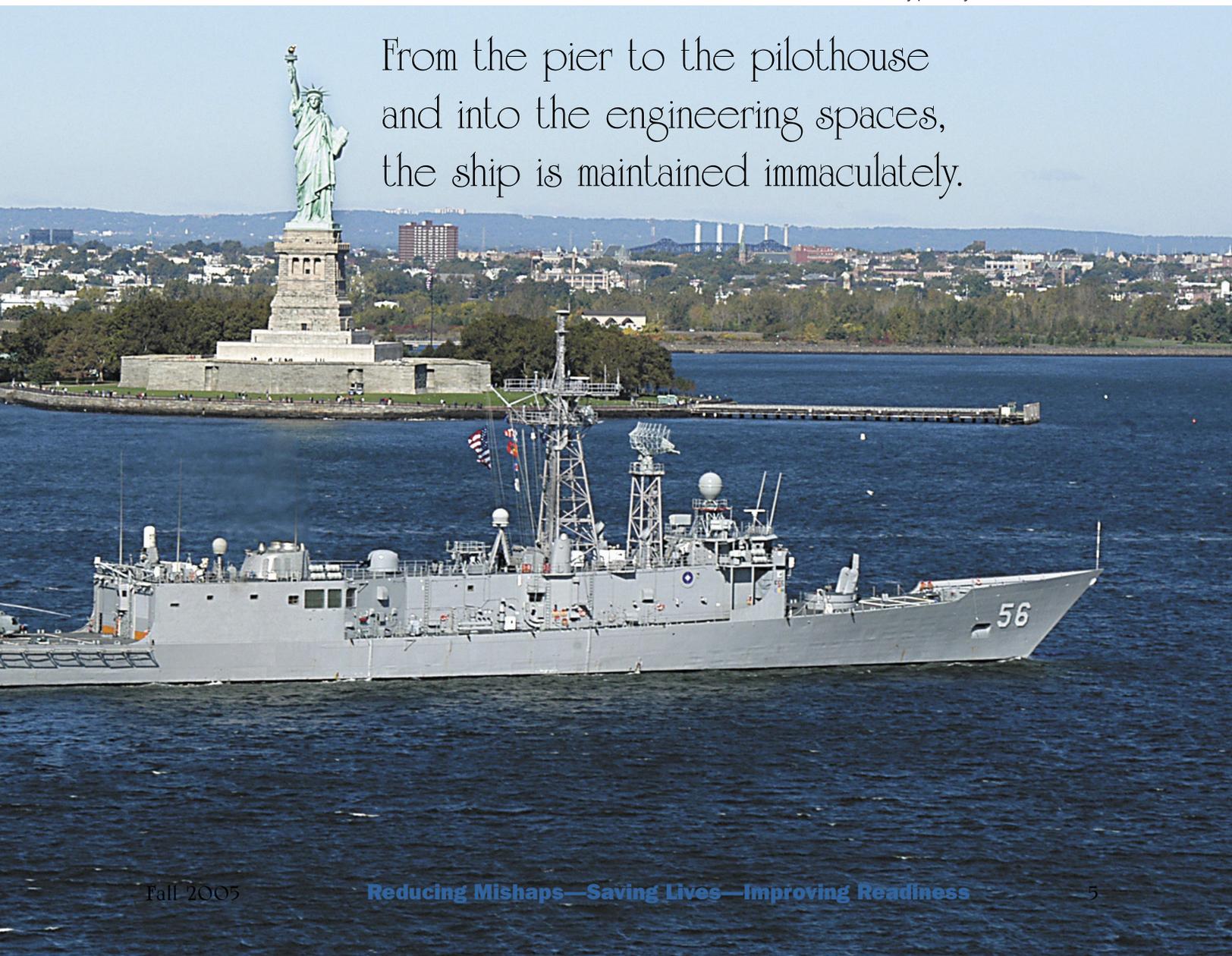
The safety officer and his staff of division safety petty officers take their job seriously and are willing to go the extra mile for the safety of their ship and shipmates. The ship's safety committee and council are extremely active and are a viable part of the ship's daily routine. Besides posting the standard safety notes in the Plan of the Day, they publish a ship's safety newsletter (*The Falcon*) monthly. This newsletter reinforces safety committee and safety council concerns

and passes safety-related information to the crew, including the ship's reserve detachment. One of the keys to the success of *Simpson's* safety program is ISIC involvement. This ship was the first one surveyed in the past 12 months whose ISIC participated in the survey from the in-brief through the out-brief. Also, the port engineer was present to identify any material issues requiring outside repair assistance.

Simpson has an excellent traffic-safety record—in part, because of genuine involvement by all the senior leadership on board. The commanding officer is very forceful and clear in implementing safe-driver policies. The ship focuses on identifying high-risk personnel and then addressing those people through mentoring, intrusive leadership, and command involvement at all levels. ■

Navy photo by PH2 Steven J. Weber

From the pier to the pilothouse
and into the engineering spaces,
the ship is maintained immaculately.



A Thanksgiving To Remember

With a sigh of relief, I started unpacking until I saw something that really made my heart stop.

By LCdr. Justin “Shogun” Shoger,
VAW-116

I just had moved into a new apartment, checked into a new command, and found myself caught up in the holiday excitement of Thanksgiving. Everyone seemed to be rushing to get out of town. I was leaving, too, but I was taking a different tack. I planned to get a good night’s sleep and leave Thanksgiving Day.

My destination was only 320 miles away. With excellent highways and interstates to travel, I expected an easy five-to-six-hour journey. I had absolutely no reason to rush.

When morning dawned, I arose from a sound sleep, ate a good breakfast, and made some last-minute adjustments to my stuff while waiting for a phone call from my friends. That call would be my signal to leave. My friends lived farther from our destination, so I still expected to arrive before them.

When the call came, I picked up my luggage and headed out the door for a great, long weekend. The trip started flawlessly—no trouble getting gas, and the roads seemed moderately empty. Because of some strong, gusting wind, I drove conservatively through the hills, while more harried drivers whizzed by me. I was taking to heart the message from a safety stand-down I just had completed Monday, “Look inside the other cars. People are in there, and we all have a tendency to forget that fact. There’s no need to rush.”

Soon, however, the tone of the day started to change. Three traffic jams had extended my journey. At one point, it took me three hours to travel 20 miles. I kept reminding myself of the stand-down message to the point it had begun feeling like a new-age mantra. Despite my delays, I arrived at the destination within minutes of my friends. We got checked into our rooms and looked forward to a good night of visiting and going out on the town. My patience had paid off, and I wasn’t about to let anything ruin the evening—or, so I thought.

Remember

After a great meal, we returned to our rooms and were getting ready for the evening out when I received a disturbing phone call from the hotel's security officer. He told me someone had smashed a window and broken into my vehicle. As I made my way to the front desk to meet with the security folks, my thoughts were that my vehicle probably was a total mess. I figured all my equipment and supplies for the planned camping probably were gone.

As the security officer escorted me to my vehicle, I saw that my loss wasn't as much as expected. The intruder had shattered a minor window and had left some screwdriver scars while trying to remove my stereo from the dashboard, but everything else appeared to be OK. Security officers had watched the culprit on a surveillance camera but couldn't take any action until he had committed the actual crime. Then, they were on the scene within seconds.

I locked up my vehicle as best I could, and the security officers assured me they would keep an eye on it until I could move the car into another, more

secure parking lot. My next bout of tedium just was starting.

To file a meaningful report against the captured crook, I had to be present for an interview by the local police and to write my statement. I spent the next three hours, waiting for the police to arrive. What helped me to keep my sanity during that time was the fact no one had gotten hurt, and my vehicle had been damaged only moderately. The police assured me the culprit would be charged with a felony. With the paperwork filled out, the witness identified, and the interview complete, I returned to my friends to continue the waning holiday.

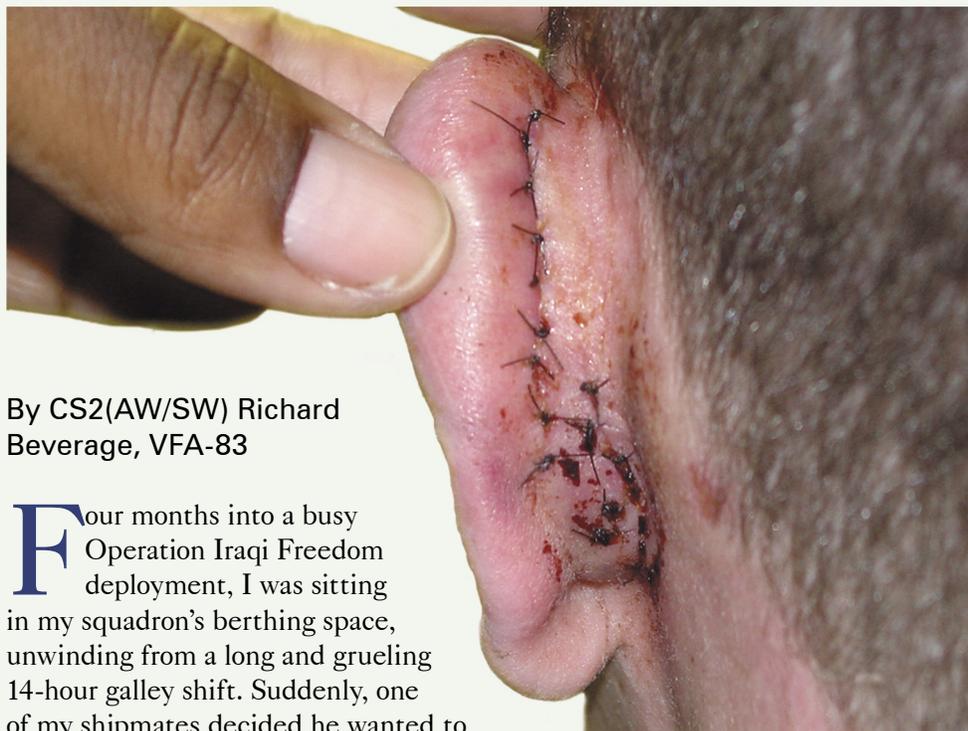
We were supposed to get an early start on our trip to a national park (one close to some awesome camping and hiking) the next morning, but I had to wait for a glass company to repair my window. Finally, we were off and, for the next two and a half days, hiked in some of the most beautiful wilderness country available anywhere.

The drive back home was easy. I pulled into the apartment complex, grabbed some equipment, and headed for my place. When I got there, I saw a light on in one room, which didn't surprise me because I usually leave a light on somewhere when I'm gone. Once everything was inside, I went to my bedroom, where I found all the lights and the TV on. My first thought was, "Who has been here; why is all this stuff on?" A closer look, though, revealed that nothing had been disturbed—I hadn't had any "unwelcome visitors." With a sigh of relief, I started unpacking until I saw something that really made my heart stop.

Kneeling in front of my dresser, I found a dried puddle of red wax that had soaked into the carpet. Wax from a candle on the dresser top had dripped all the way to the floor. Besides leaving the lights and TV on, I had left a 4-inch candle burning when I departed three days earlier. I still had goofed, even though I had planned my trip and had tried not to rush or to be impatient. My thoughts raced to all those stories I've read about people who returned home to find firemen putting out blazes that had started because someone left a candle burning or a stove or oven going.

I had an extra special Thanksgiving this year, and I also learned a couple of things. It always pays to prepare as much as you can. Always maintain a positive mental attitude; it may not solve the problem, but it will make the circumstances easier to handle. Sometimes, no matter how careful you are, you still make mistakes, and luck does affect the outcome. The red stain in the carpet is a cheap reminder of how lucky I was and that I need to be vigilant at all times. **S**

Horseplay: Trouble Looking for a Place To Happen



Here's what the one Sailor's ear looked like after he had been stitched up in medical.

By CS2(AW/SW) Richard Beverage, VFA-83

Four months into a busy Operation Iraqi Freedom deployment, I was sitting in my squadron's berthing space, unwinding from a long and grueling 14-hour galley shift. Suddenly, one of my shipmates decided he wanted to wrestle and grabbed me. Being an ex-wrestling champion in high school, I wanted to show him up to shipmates.

We each were trying to get the upper hand when another squadronmate jumped on top of me. I welcomed the challenge to get them both down but soon had a third shipmate trying to help his buddies. I should have known this three-on-one encounter was headed for trouble.

While I was turning to get one shipmate, another fell into a locker. We all stopped what we were doing and asked if he was OK. He said he was fine but walked out of the berthing space holding his ear. The unauthorized wrestling match ended there, and we went about our business.

We soon learned our injured shipmate's wound was much worse than he realized. A visit to medical revealed his ear was cut in two places. He had to endure four shots of a local anesthetic because each one kept wearing off before the doctor could finish putting 14 stitches in his ear.

Later that afternoon, all four of us had to stand before a disciplinary review board to accept the consequences for our actions. Our injured shipmate lost two workdays and spent seven more on light duty, which had a negative effect on an already short-handed and overworked workcenter. His co-workers had to pick up the slack because of our mistakes. Because of our stupid behavior, we temporarily lost a valuable human resource and thus gave the enemy a victory without their ever having to lift a finger.

As the senior person involved, I should have been part of the solution, rather than part of the problem. Horseplay degrades readiness and morale and goes against everything our core values stand for. We are fortunate the shipmate wasn't injured seriously. What starts as harmless fun can turn tragic in an instant, especially aboard ship. It's important that all leaders do their job and stop this activity anytime they see it happening. **S**

While I was reading this Sailor's account, I remembered another incident of horseplay I had read a few days earlier. That story follows.—Ed.

Tomfoolery Lands Sergeant in Hospital

By Ken Testorff,
Naval Safety Center

A Marine sergeant and two buddies, all embarked in a ship, returned from liberty at 2325 and proceeded to their assigned troop berthing. All had been drinking.

The sergeant and one buddy decided to practice some combat-tactical moves on each other. Everything went OK until the buddy completed a leg-sweep maneuver, which dropped the sergeant to the deck. He didn't move for a few minutes, and, although he didn't appear to be in any pain, he did say his leg hurt.

Witnesses first thought he was joking, but the sergeant said he felt his leg was broken. Medical was called to the scene, and the sergeant soon was evacuated to a local naval hospital. Doctors diagnosed him with a spiral leg fracture and scheduled him for surgery. His BAC was down to 0.09 at the time he arrived at the hospital.

The sergeant spent 10 days in the hospital and was expected to lose 40 workdays.

As outlined in the mishap report, "This is a classic case of personnel drinking and not realizing their loss of coordination and impaired judgment." Numerous controls were in place to prevent this mishap. The one designated non-drinking buddy had a specific duty to maintain a mature and unimpaired presence the entire time but chose to drink himself. All hands received alcohol-deglamorization training before the port call, as well as guidance in the responsibilities related to being a designated non-drinker.



A Marine protects himself after being taken down with a leg sweep during a practical-application exercise in the Marine Corps martial-arts program. Unlike the sergeant in the story, though, this Marine hasn't been drinking, and what he's doing isn't horseplay.

Because the designated non-drinker in this case didn't fulfill his responsibilities, he paid a price: disciplinary action from his chain of command. **S**

While horseplay causes its share of injuries, hazing is an even more dangerous—and illegal—activity, as we learn in the story that follows.—Ed.

If You Think Hazing

By Ken Testorff,
Naval Safety Center

A young Navy airman recruit entered service in 1987, excited about completing the Navy's SAR School that candidates must take to become a rescue swimmer. A few months later, though, in what some described as an illegal hazing incident, the Sailor died when he ran out of strength and air, with instructors allegedly holding him underwater. The other members of his class, meanwhile, were ordered to turn around and place their backs to the pool, then sing the national anthem while standing at attention.

In late 1994, a total of 18 Sailors from two Norfolk-based ships appeared at non-judicial proceedings for their involvement in unrelated hazing incidents aboard the two ships. Six Sailors aboard the one ship were disciplined for assault, which resulted in one of two victims requiring four days' hospitalization for deep leg bruises. The second victim required one day's bed rest. Aboard the other ship, the lone victim escaped without any injuries that required treatment, but the eight junior Sailors who assaulted him were disciplined.

A hazing incident the following year involved a young Sailor who was the victim of a "tacking on" after receiving his silver dolphins warfare insignia. When leadership in his command noticed his dolphins were bent, an investigation was started, but the victim declined to identify the shipmates involved.

According to the investigation report, the victim was subjected to undue pressure to reveal who was responsible. Then-CNO Adm. Jay Johnson said in his endorsement, "The chain of command was responsible for this pressure." The victim subsequently took his own life. At that



This kind of behavior isn't just unacceptable in today's Navy—it's illegal.

point, Adm. Johnson directed the chief of naval personnel to issue guidance in properly handling victims of hazing and other forms of harassment.

This kind of behavior became taboo in August 1997, when then-Secretary of the Navy John H. Dalton issued an order prohibiting hazing. Navy leadership today continue to take SecNav Instruction 1610.2 (Department of the Navy Policy on Hazing) seriously. Twice in 2004, Commander Naval Surface Forces, U.S. Pacific Fleet, VAdm. Timothy LaFleur, reminded commanders and commanding officers under him to get out the word that hazing won't be tolerated.

Is OK, Think Again!



This is not OK and is an attitude that needs to change... Hazing in any form, under any circumstance, has no place in our Navy.

His most recent reminder described reports from various levels of verbal abuse, unwarranted physical contact and restraint. "Whether they are called initiations, 'welcome to the division' parties, or otherwise," said VAdm. LaFleur, "they all constitute hazing in one form or another. Investigations indicate there still is a prevailing attitude that as long as everything is consensual, it is OK. This is not OK and is an attitude that needs to change..."

Hazing in any form, under any circumstance, has no place in our Navy.

"...Hazing and horseplay can and have resulted in serious physical injury or death... In addition to the unwarranted physical and verbal acts, hazing is demoralizing in nature and undermines military readiness by alienating its victims and discouraging them through fear, shame or reprisal from reporting the injustice that has occurred to them. Unwillingness to participate in hazing or horseplay can place a Sailor in a difficult position within his or her environment.

"I am very pleased with the actions of commands who have identified hazing and the actions they have taken," noted VAdm. LaFleur. "Continue to take pro-active and timely action against participants and responsible bystanders in cases

you discover. Re-engage your khaki leadership to communicate persistently that hazing, no matter how minor, is unacceptable behavior that undermines a healthy command climate. Effective enforcement of the rules and pointed education, training and professionalism continue to be the key elements in preventing hazing. With your active engagement and personal involvement, we can make our fleet hazing-free."

Marine Corps Commandant, Gen. Michael W. Hagee, shared similar sentiments in a 2003 message. "Marines are our most precious asset," he said. "I will not tolerate any instance where one Marine inflicts any form of physical or psychological abuse that degrades, insults, dehumanizes, or injures another Marine. We will protect our Marines through fair, scrupulous and unbiased treatment as individuals—caring for them, teaching them, and leading them. It is the obligation of each member in the chain of command to ensure that hazing in any form is not allowed and that Marines are treated, at all times, with genuine dignity, fairness and respect."

And, finally, there's this note from a Navy CO, "As commanding officer, I am firmly committed to the Department of the Navy's zero-tolerance objective in hazing... It is the responsibility of every Sailor to ensure that hazing does not occur in any form at any level... There is no place for inappropriate and/or unlawful behavior that detracts from the accomplishment of our mission." **S**

Skydiving, Accidents and the FAA

By Dave Schroy,
Naval Safety Center



In August 2004, a 39-year-old Navy lieutenant had had an uneventful free fall from 13,000 feet, with an initial canopy descent from 2,500 feet, and was set up to make a straight-in approach from approximately 600 feet. At 300 feet, he pulled both risers down evenly, apparently to increase his forward speed so he could do a high-performance landing. Between 15 and 10 feet, the lieutenant let up on both risers but failed to flare the canopy. He subsequently hit the ground feet first, and his head struck the ground hard, causing fatal injuries.

The lieutenant was jumping an elliptical parachute at a wing loading of 1.4:1, for which the manufacturer recommends the jumper be an expert. This canopy choice was very aggressive for the lieutenant, a jumper who never had received any type of structured canopy training and who may have been unaware of how the canopy would react while using front risers. He was found with a toggle in only one hand, but it is believed he had both toggles in his hands during the landing approach.

Another fatal recreational skydiving mishap occurred in February 2005. The victim in this case was a 24-year-old PO2 who, according to reports, had an uneventful free fall. When he opened his primary chute a little later than usual, however, he had a “line over” *[a suspension line wrapped over the top of the chute]*. His efforts to correct this problem failed, and, after releasing his main canopy, he tried to get stable. He waited until about 400 feet to activate the reserve chute, which, unfortunately, didn’t allow enough time for it to deploy fully.

The victim was an experienced skydiver, with 170 jumps in six years (28.3 jumps per year) to his credit. He hadn’t jumped, though, in more than two months. Investigation findings also reveal he just had had his reserve chute repacked. At the time, he asked the rigger to remove the static-line reserve lanyard (SRL), which is designed to open the reserve chute immediately after a malfunctioning main canopy is released. The victim had no automatic actuator device (AAD) that would have deployed his reserve chute once he released his main canopy.

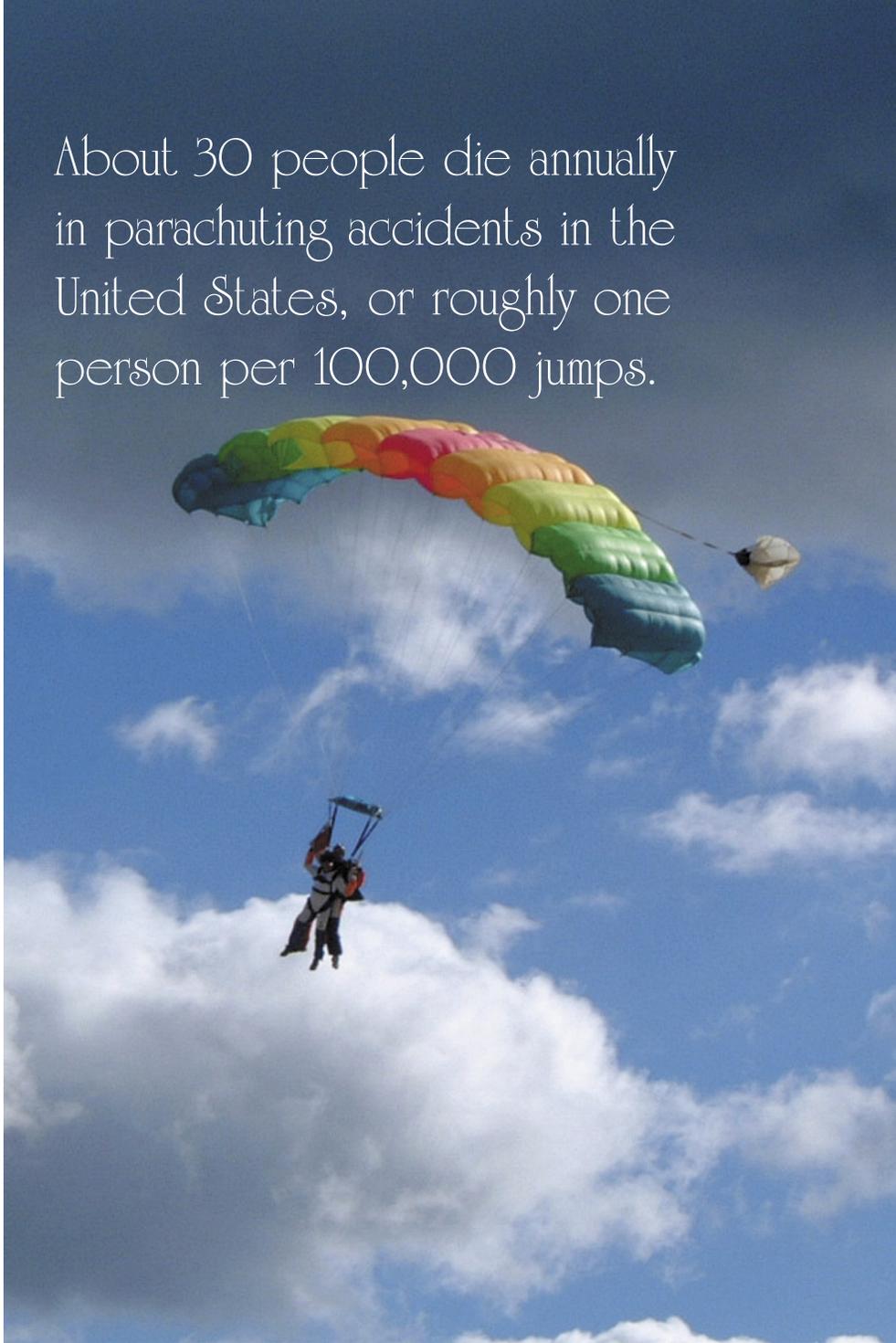
How Dangerous Is This Sport?

Statistically, parachuting is a relatively safe sport. However, if inexperience and pushing the envelope too far come into the picture, then anything from minor mishaps to life-threatening situations can occur.

About 30 people die annually in parachuting accidents in the United States, or roughly one person per 100,000 jumps. According to U.S. Parachute Association (USPA) statistics, 1998 was the worst year on record for U.S. skydiving fatalities, with 44. The numbers in subsequent years were as follows: 1999 – 27, 2000 – 32, 2001 – 35, 2002 – 33, 2003 – 25, 2004 – 23.

To put those numbers in perspective, consider that roughly 40,000 people die each year in traffic accidents in the United States. That’s 1.7 deaths per 100 million vehicle miles. Therefore, if you drive 10,000 miles a year, your chance of dying in a car crash

About 30 people die annually in parachuting accidents in the United States, or roughly one person per 100,000 jumps.



is something like 1 in 6,000. You would have to jump 17 times per year for your risk of dying in a skydiving incident to equal your risk of dying in a car wreck if you drive 10,000 miles a year.

Regulations

Parachuting began in World War II as a life-saving necessity. In peacetime, it evolved into a sport known as skydiving. In general, skydiving is a self-regulated sport, which is overseen by the USPA. This organization sets the basic guidelines for jumpers to follow, depending on experience level.

Drop-zone (DZ) owners, managers and operators who fall under the USPA group members have pledged to follow USPA basic safety requirements for student and advanced skydivers and to offer first-jump courses taught by a USPA-rated staff. Some DZ officials even add extra safety requirements for jumping at their zones. For example, they may require all jumpers to have an AAD mounted on their rigs or to have completed a minimum number of jumps [e.g., *Key West DZ requires 500 jumps as a minimum*].

Federal requirements can be found in the Federal Aviation Regulations. Most of these regulations concern the aircraft, pilot and rules of flight. However, 14 CFR Part 105, “Parachute Operations,” regulates when and where jumps may be made and designates the requirements for parachute equipment and packing. For example, 14 CFR Part 105 (subpart C) requires the person packing the main chute to be a certified rigger (e.g., *one who has taken an FAA-approved training course and has passed rigorous FAA testing*) or to be the person jumping with that chute. A certified rigger, however, is the only person authorized to maintain the reserve chute.

14 CFR Part 105 is based on the assumption that anyone who chooses to skydive has assessed the dangers involved and assumes personal responsibility for his or her safety. The regulations in Part 105 are intended to assure the safety of those not involved in the sport, including persons and property on the surface and other users of the airspace. The skydiving community is encouraged to adopt good operating practices and programs to avoid further regulations by the FAA.

Accident Investigations

When a skydiver is involved in an accident, the first step by the FAA is to determine if any regulations were violated. An investigator will examine the circumstances and route of the flight, the certification of the pilot, and the airworthiness of the aircraft. The investigator also will inspect the parachute system (both parachutes and harness assembly) to ensure everything was maintained according to the regulations. If the FAA does not find any evidence of regulatory violation, it will defer any further investigation of the accident to local law enforcement, and the FAA has no further involvement.

If the FAA determines one or more of the regulations were violated, it will launch a separate investigation into the areas under its regulatory control,

which concern the aircraft, its pilot, mechanic, the location or timing of the jump, and the parachute rigging. You can view all the regulations by going to www.gpoaccess.gov/cfr/index.html, typing “parachute operations” in the site-search block at the top of the page, and hitting the “submit” button.

Jump Practices

The drop zone is a designated landing area clear of obstacles and usually is marked. Some drop zones are located beneath complex airspace, and jump organizers have a Letter of Agreement with the appropriate FAA air-traffic-control facility to address site-specific issues and concerns.

Each day, before jumping begins, the drop-zone operator contacts the FAA flight-service station for the latest weather and winds-aloft forecast. The jump pilot files a Notice to All Airmen (NOTAM) at least one hour before the first jump. Skydiving operations with continuous activity may file permanent NOTAMs, which often are depicted on aeronautical charts.

NOTAMs help alert other pilots about the jump. Since skydivers often free-fall at a speed of 120 mph or more, they can be extremely difficult to spot from other aircraft. It’s the responsibility of all involved to watch and avoid one another.

During jump operations, pilots follow procedures covered by the general operating and flight rules covered by 14 CFR Part 91 of the Federal Aviation Regulations, as well as Part 105. The pilot will contact FAA air-traffic control a few minutes before the jump, advising of the jump altitude and exit time. Air-traffic controllers will advise of any other aircraft or unsafe conditions in the area.

From a typical jump altitude of 10,000 to 15,000 feet, it takes just over one minute for a skydiver to free-fall to parachute-opening altitudes of 4,000 to 2,000 feet above ground level.

Once the jump pilot ensures all jumpers have exited, he or she advises air-traffic control and makes a quick but safe descent to the airport. Skydiving ends when the pilot advises air-traffic control that all the jumpers have landed. ■

For a copy of the 2004 Skydiver’s Information Manual, go to www.uspa.org/publications/SIM/2004SIM/section9AC105.2C.htm.

Exploding Gun Leaves Scar

[The author of this story asked to remain anonymous.—Ed.]

In August 2004, while on leave, I went with my father and three brothers to a shooting range just outside of Reedsport, Ore. We planned to hold target practice with my father's weapons—a 9-mm pistol and a .38-caliber revolver.

My oldest brother was using one of my father's other handguns about 25 yards down the shooting range. Meanwhile, my father was standing behind me, watching my form and helping me with my sights. I loaded the 9-mm pistol and fired it until the clip was empty; then, I switched to the revolver. After loading it, I shot twice. Before pulling the trigger the third time, I noticed something wasn't quite right but couldn't stop myself from firing again. On the third pull of the trigger, the weapon misfired and blew up in my face.

In reaction, I leaned to the ground, set down the weapon, and took off my glasses. My father had his back turned to me, but, when I bent forward, he turned around and saw I was on the ground, holding my forehead. He immediately turned me over and removed my hand to look at my face, then shouted to my oldest brother to get me into the truck. My brother ran to help me stand up and guided me to my dad's truck. The rest of my family got together and escorted me to the hospital.

On the way, we were able to reach a 911 operator and tell him what had happened. By the time we reached the hospital, about a five-minute drive, the staff already had a gurney waiting for me. The doctor who examined me didn't think any metal was imbedded in my skull but did a CAT scan anyway, which proved his theory correct. I escaped with nothing but a small scar on the bridge of my nose.

After I had found out I was going to be all right, my sister-in-law came into the examination room and told me that her sons had promised her they never



would play with guns. This news put a smile on my face, and, even though my head was pounding like a Mack truck just had rolled through it, I realized my situation could have been much worse. I was glad my little nephews had seen that guns are not toys and should not be played with.

The next day, my dad invited his neighbor, who is somewhat of a gun expert, over to the house. He looked at the damaged weapon and determined the cause of the misfire likely to have been one of the bullets my dad had reloaded. The neighbor said that, if one of the reloaded bullets wasn't as heavy as the others, it could have caused the explosion. Officially, we probably never will know for sure why this incident happened, but I'll never forget the look on my brother's face when he saw me after the explosion occurred. It was a look I hope I never will see again.

The learning points are simple. First, guns are dangerous and should be treated as such. We honored safety that day in many respects, but I chose to wear my glasses, instead of safety goggles, which could have prevented the injury I sustained. Luck certainly was on my side; if any larger pieces of metal had blown into my face, even goggles would not have saved me.

Second, reloading bullets is a critical evolution, and procedures must be maintained to ensure safety. My father is very methodical and careful when he reloads ammunition, but, as we saw that day, it takes only one small error.

The most critical point is to learn from other people's mistakes. We had thought this was going to be just another day for our family to get together and do the things we love to do. It would have been if we only had followed all the recommended safety precautions for our activity. The next time, I will. **S**

A Shipmate Lost—Wh

By Cdr. Kenny Williams,
Commanding Officer,
USS *Chung-Hoon* (DDG-93)

Rarely a day passes that I don't ask what we could have done differently to prevent our petty officer's death and to make sure we don't have another tragic mishap. He certainly fit the classic high-risk category: a young, unmarried, first-term Sailor away from home for the first time, doing a good job, making new friends, and enjoying both his time ashore and afloat.

From when he first notified us that he intended to buy a motorcycle, the command actively monitored his training and experience. His LPO, who also is our motorcycle-safety petty officer, does a good job of monitoring the status and progress of all our motorcycle owners and operators. He stays abreast of both their training and experience levels.

The LPO and many shipmates counseled our young petty officer. They urged him to slow down and always to use his PPE, but he kept pushing his motorcycle beyond his experience level, thus building a false sense of confidence in his ability. He then added alcohol to this overconfidence, which, when combined with continued poor personal decision-making, triggered the series of events that took his life.

Mentoring is important, because Sailors sometimes make decisions that negatively affect their lives. These poor decisions often are linked to using alcohol or failing to comply with safety regulations and rules.

Once we give Sailors the proper education and training on alcohol awareness and safety, holding them accountable for their decisions is probably the best way to reduce mishaps. People who know they will be held accountable tend to think twice and ask for help when high-risk situations arise.

Risk management has been a very valuable tool for preventing mishaps afloat and ashore. Forcing Sailors to submit personal travel plans for leave periods or long weekends away from home port has been another tool that causes shipmates to think about what they are doing and the risks associated with that long trip.

Safety is a mindset and lifestyle much like fitness, morality, and ethics. We still have a number of personnel who overeat, rarely exercise, make poor choices concerning morality and ethics (consider the number of COs relieved



What Else Could We Have Done?

Risk management has been a very valuable tool for preventing mishaps afloat and ashore.

last year), and ultimately personify the imperfect humans we've been throughout time.

I don't think one program or process will prevent all mishaps. However, I believe we must continue to educate all hands on the right thing to do, the possible unintended consequences of their actions, and how they will be held accountable for their actions and decisions.

This petty officer is the first shipmate I have lost while in command. This is my third consecutive command since 1999—the previous two were USS *Champion* (MCM-4) and COMCMDIV 31 in Bahrain. Perhaps I should have been a more proactive leader, should have personally identified him as a high-risk shipmate, and should have let him know in no uncertain terms my expectations concerning his conduct ashore. If I had, he probably still would be alive today.

We have a shipboard mentoring program, but a face-to-face discussion with the CO (we did talk during a Division-in-the-Spotlight interview) has a bigger impact on shipmates. I'm talking about the kind of discussion that might follow a commodore or admiral calling a commanding officer or staff member and asking him/her to "come and talk."

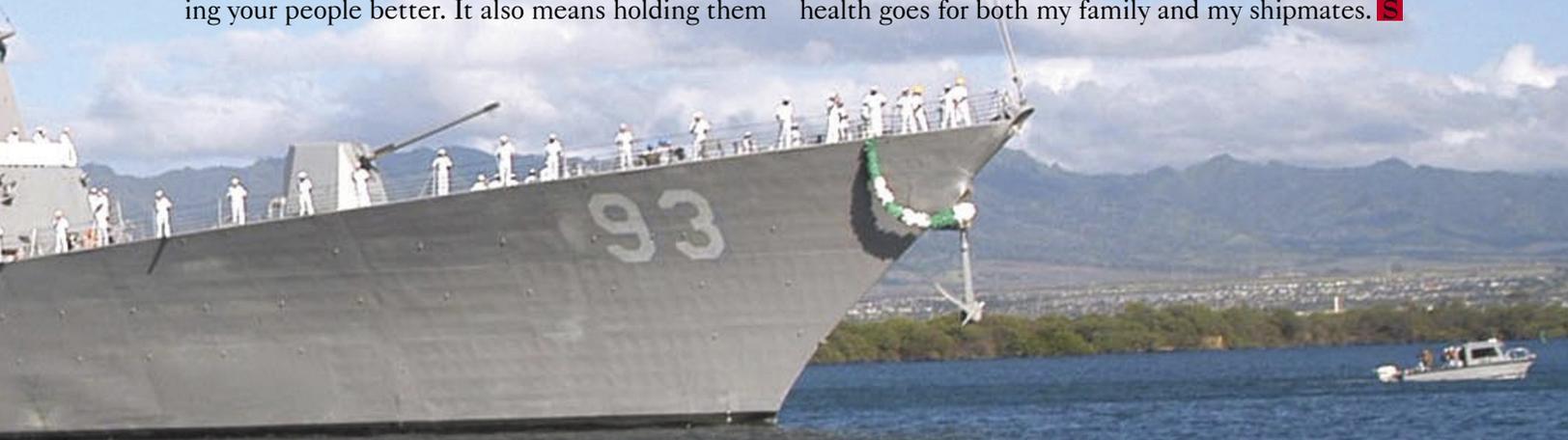
I think the intrusive/proactive leadership approach we're trying to develop is the right way to go, but that concept means tracking and knowing your people better. It also means holding them

accountable for their actions and inactions. This culture needs to start at boot camp as the Sailors depart on leave or PCS to their next assignments. Right then, we need to ask, "What are your travel plans?"

We need to stay very actively involved while the Sailors are in "A" and "C" schools (especially during weekends), as well as when they are en route to their first commands. The old and new commands should communicate about the status of young Sailors in transit. The 18-to-27-year-old, unmarried, high-risk, first-term, devil-may-care Sailors beginning their journey deserve better care and feeding from their first day aboard.

Many of us were high-risk Sailors when we began our Navy journey, as well, but we either made good choices, were lucky in the outcome of our decisions, or had someone looking after our welfare. I also think we used to be held more accountable for our actions than Sailors are in today's Navy.

If I could prevent Sailors from buying and riding motorcycles, like I can with my own children, I would without hesitation. But I cannot treat Sailors like my children any more than I can treat my children like Sailors (as my kids remind me at times). However, that common thread of caring about their physical, mental and spiritual health goes for both my family and my shipmates. **S**



Navy photo by PH3 Victoria A. Tullock

A "Go To" Guy Beco

By MR1 John Mapp,
SIMA Norfolk

Three days before Christmas, a destroyer was just under halfway through the holiday-leave period. A PO2—we'll call him Festus—was working in the general workshop after duty-section muster when the section leader came into the shop.

It seems the FN who was supposed to be standing sounding-and-security watch had neglected to bring his firearms qualification card to the ship. PO2 Festus was on the watchbill as in-port equipment monitor for later that day, but the section leader needed someone with a weapons qualification right now.

PO2 Festus followed the chief to the quarter-deck, where he was issued a 9-mm pistol, shoulder holster, and 45 rounds of ammo. Because it nearly was 0900 and the first sounding-and-security round hadn't been done yet, PO2 Festus donned his gear.

Readers of the Friday Funnies will be nodding their heads sagely at this point. The sense of urgency that filled PO2 Festus' mind was the cornerstone of the mishap to come. The rest of the foundation for the incipient mishap was getting started in the amidships passageway, where duty food-service attendants (FSAs) were breaking out stores from the reefer decks. To make their job easier, they had laid a pair of metal slide plates over the ladder going down to the reefer decks. A safety watch was supposed to be at the top of the ladder, but he was doing multiple tasks to make the job go faster.

Enter PO2 Festus, still in a hurry, as evidenced by his brisk pace as he rounded the corner. He was thinking about how he could speed up the rest of his first round on watch, wondering if he would have time to finish his work in the shop with two more watches to do, and worried about some anomalous readings on the HPAC. He likely also was debating how heavy a hammer to use on the FN who screwed up and stuck him with an extra watch. With so much on his mind, he was pretty much traveling on autopilot.

This setting was a classic recipe for disaster. You had two parts harried and hurried petty officer, mixed with a multi-tasked safety watchstander and salted with two slick-as-glass slide plates covering the ladder treads. The concoction needed baking only 2.5 seconds—the time it took PO2 Festus to get from the main deck to the second deck without ladder treads to slow him down.

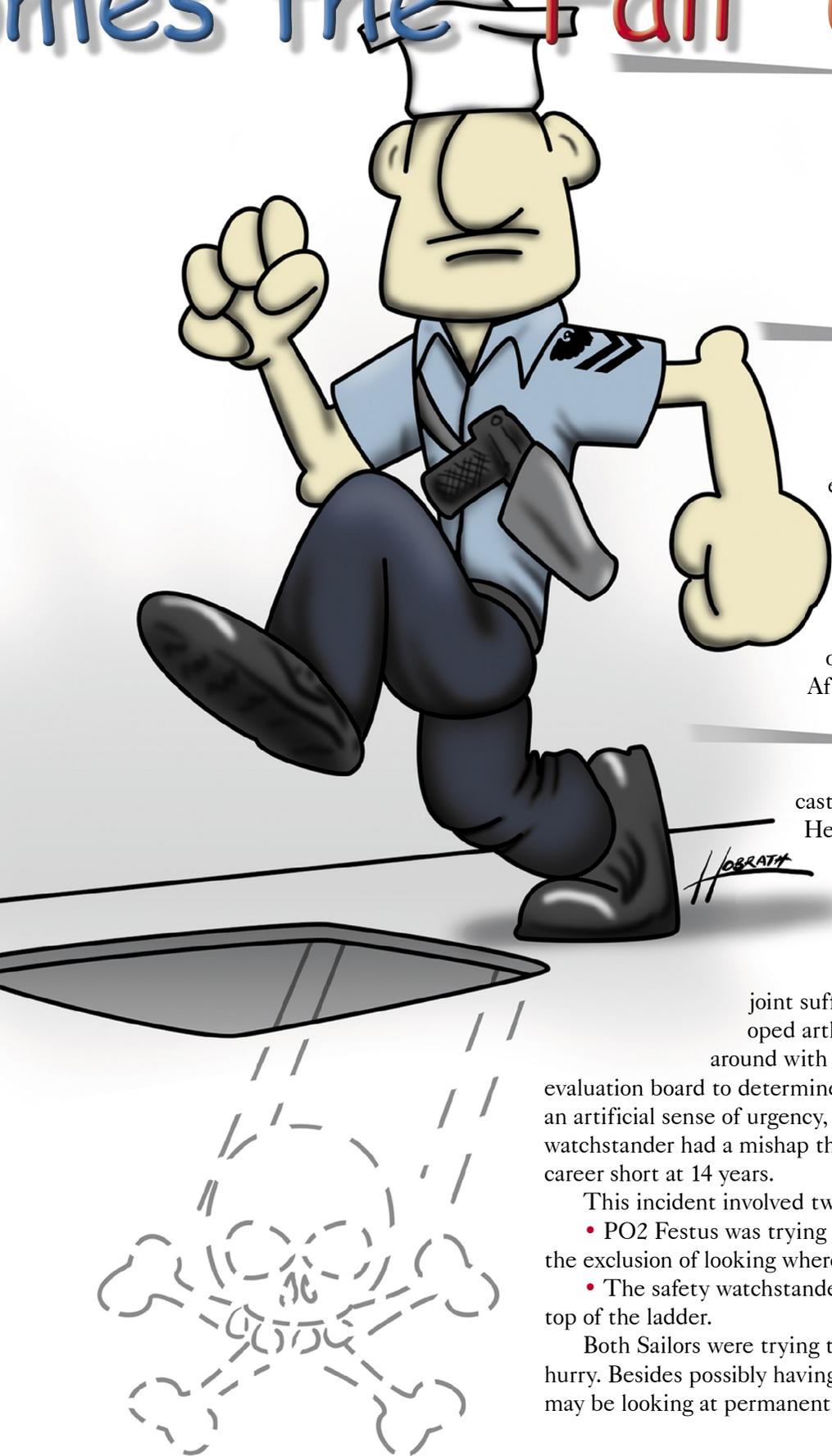
"It ain't the fall that hurts; its the sudden stop at the end."

Like a man once said, "It ain't the fall that hurts; its the sudden stop at the end." Our PO2 managed to maintain his carcass in a more or less head-up configuration during the descent. Just before he reached the deck, however, his left foot moved a little too far to the left and hooked the end of the handrail. PO2 Festus thus avoided slamming his 220-pound frame into the FSA at the bottom of the ladder but at the expense of having all that weight concentrated on his left ankle.

Loud expletives ensued, including several from the FSA at the bottom of the ladder. When PO2 Festus tried—but failed—to stand, more loud expletives followed. The FSA kindly got the section leader, who happened to be the ship's independent-duty chief corpsman. The latter organized a plan to get PO2 Festus up the ladder and into a chair on the mess decks, with his injured ankle on the table, under a mound of ice.

Once the HMC had examined the victim, he decided a trip to the branch medical clinic was in order. Doctors at the clinic took a couple of X-rays, which revealed the left leg was broken in two places just above the ankle. More swearing

meets the "Fall" Guy



ensued, followed by a trip to the nearest naval hospital, where the earlier diagnosis was confirmed. PO2 Festus spent the holidays in a knee-high cast and got a plate with three screws installed on New Year's Eve.

After six weeks of convalescent leave, doctors released PO2 Festus back to the ship, minus his cast but sporting a pair of crutches.

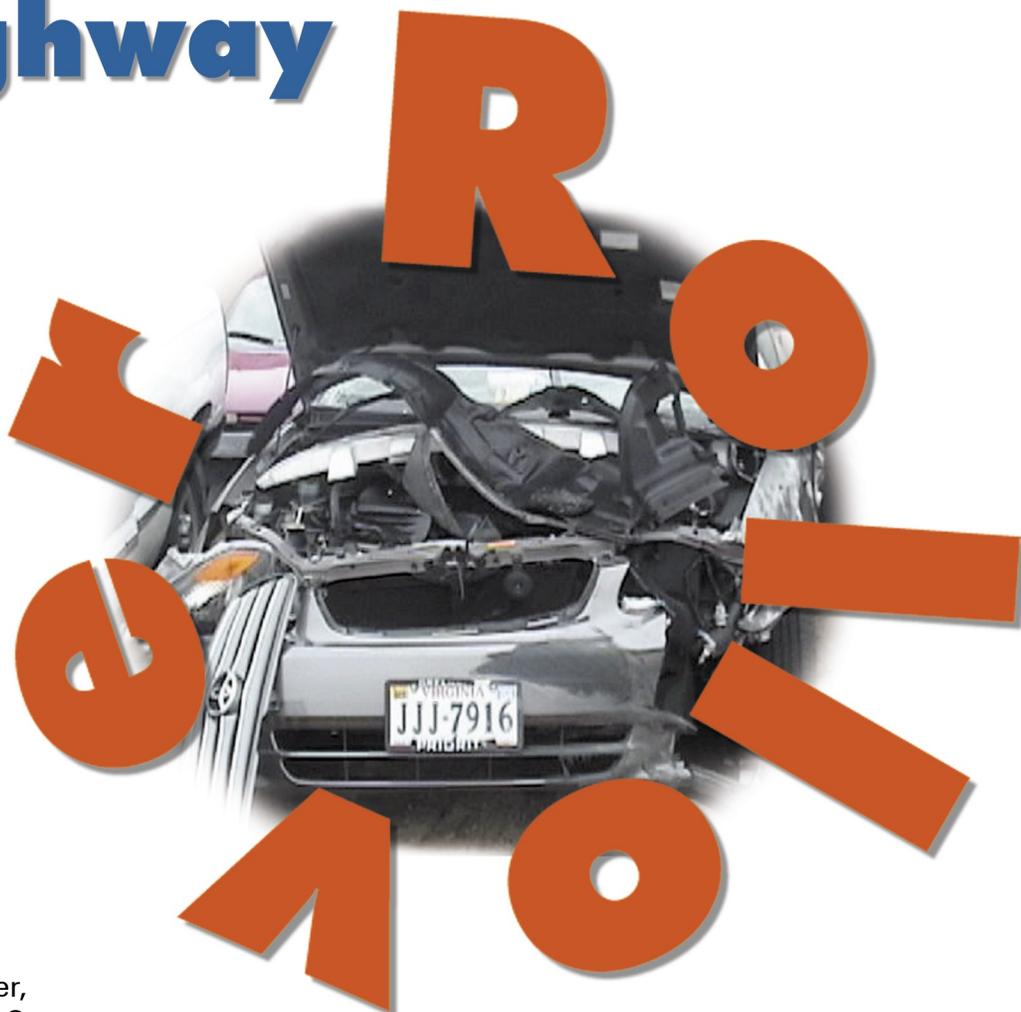
He dealt with two weeks of increasing pain before going back to the naval hospital to be re-examined. Doctors placed him on limited duty. Further tests confirmed the worst: The ankle joint suffered nerve damage and had developed arthritis. PO2 Festus started hobbling around with a cane, waiting for a physical-evaluation board to determine the fate of his career. Because of an artificial sense of urgency, a good worker and conscientious watchstander had a mishap that might cut a promising Navy career short at 14 years.

This incident involved two contributing causes:

- PO2 Festus was trying to catch up on a delayed watch, to the exclusion of looking where he was putting his feet.
- The safety watchstander was absent from his post at the top of the ladder.

Both Sailors were trying too hard to get the job done in a hurry. Besides possibly having his career ruined, PO2 Festus may be looking at permanent disability. ■

Navy Family Survives Highway



By Dan Steber,
Naval Safety Center

Navy SK2 Vernon Ferrer, his wife Loryjane, and 2-year-old son Charles were on I-64 in Norfolk, when another vehicle cut into their lane, forcing their car into a Jersey barrier. Impact caused their vehicle to flip and roll four times before coming to rest on its wheels.

This incident is not unlike hundreds of others on the roads, streets and highways of America. What is special about this case is that the Ferrer family survived with only a few minor injuries. After looking at their damaged car, many people would say it's a miracle they weren't injured more severely. Petty Officer Ferrer credits his family's safety awareness, saying, "We always wear our seat belts and ensure that Charles is buckled in his approved child-restraint seat before the vehicle moves."

Loryjane was driving that day. She and Vernon were discussing a future trip to New York when a car drove up beside the passenger door and moved slightly ahead of their vehicle. "It suddenly steered into our lane," Loryjane said, adding, "I wondered what was happening."

Vernon screamed, "Honey, honey, honey...Oh no! Oh no!"—his last words before their vehicle hit the barrier, flipped, and started rolling over and over again. The Ferrers remember loose items floating around inside their vehicle and peppering them.

"It felt like a horrible amusement-park ride," Loryjane noted. "I just wanted it to stop!"

Her husband added, "It wasn't slow motion like in the movies."

Their car finally landed on its wheels, with the engine still running. About the same time, the

car started rolling forward. Vernon yelled at his wife to hit the brakes, which she did. Once the car was stopped, Vernon and his wife just sat motionless for a moment—in shock. Then Vernon made sure his wife and son were OK. For an instant, he also was worried that another car might hit them, but their car had rolled down the barrier and had stayed in their lane.

Among the other drivers who stopped to help the Ferrers was an off-duty Chesapeake, Va., firefighter and a nurse from a local hospital. They told the family to stay in their vehicle until their injuries could be assessed. Meanwhile, the firefighter reached in the car window and shut off the engine. He also told them an ambulance was on the way.

Emergency-medical technicians removed the Ferrers from their vehicle and placed them on backboards to limit any possible injuries. Two separate ambulances took them to a hospital, where they were checked and released.

The police took a description of the other vehicle from Vernon, who was able to provide the last two digits of the license plate—one of the last things he remembers before the crash. That driver and vehicle have yet to be found.

The Ferrer family's incident had a little to do with luck but much to do with making the right decision. They have a good family attitude about safety. They made the conscious decision to use their safety belts and survived a horrific accident.

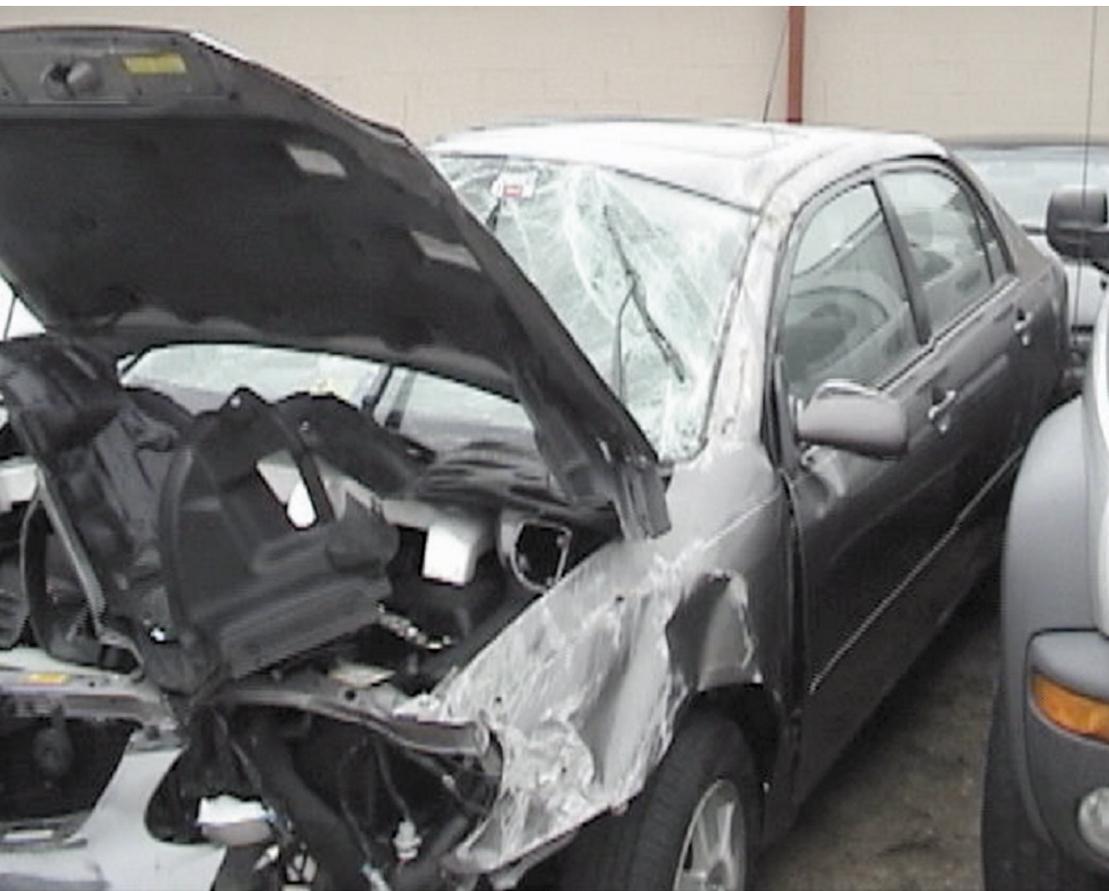
“It felt like a horrible amusement-park ride,” Loryjane noted. “I just wanted it to stop!”

In FY2004, we lost 119 Sailors and Marines in PMV mishaps, many of whom didn't wear their seat belts, including at least 10 Sailors (some reports were received with “unknown” in the seat-belt block). *[Although Marine Corps data wasn't available, their numbers tend to be similar.]* We must learn from these incidents, and the families of those 10 dead Sailors would want us to do more.

The Ferrer family was willing to do a testimonial about their incident, and the Naval Safety

Center put together a video about their story, other successes, and a few mishaps that didn't end on a happy note. At a command gathering shortly after this incident, Petty Officer Ferrer's CO put it in perspective. He summarized the event this way: “I'm thankful today that we are having a potluck luncheon in conjunction with our staff and student safety stand-down, rather than attending a family funeral.”

For more information on traffic-safety mishaps and efforts to curtail the problem, visit our website at www.safetycenter.navy.mil. **S**



NO GRASS GROWING UNDER

By Ken Testorff,
Naval Safety Center

At his post as the 35th Surgeon General of the Navy and Chief of the Navy's Bureau of Medicine and Surgery, Vice Admiral Don Arthur is all business. *[Incidentally, he's the first flight surgeon to hold this position.]* However, there's another side to him: He rides motorcycles, and I don't mean just around the block. This Northampton, Massachusetts, native logs a whopping 30,000 to 50,000 miles per year on a bike.

How? "If the Navy decides to send me down to Pensacola for a meeting, I ride my bike," he explained. "Next week, I'm riding out to Kansas City for a meeting. And I just rode to a meeting west of Asheville, North Carolina, last weekend, but that was a short trip—only 550 miles."

Besides these "business" trips, there are the "pleasure" trips. "Folks I know in the long-distance riding community set up fun activities," Admiral Arthur continued. "They have what are called RTE (ride-to-eat) events. They'll say, 'We're going to meet at such-and-such barbecue place in Alabama on Saturday night; meet us there.' We'll ride there, have dinner, then ride back home—whether it's Washington, D.C., Utah, or California—all in one weekend."

There also was a May 2002 U.S.A. Four-Corners Tour *[sponsored by the Southern California Motorcycling Association]*, in which Admiral Arthur touched all four corners of the United States. He rode his motorcycle from Madawaska, Maine, to Key West, Florida, to San Ysidro, California, to Blaine, Washington, before returning home—a distance of nearly 11,000 miles.

I had the privilege of interviewing this well-traveled 31-year Navy veteran on April 26, 2005, and learned that he's as dedicated to his avocation as he is to his vocation. His passion for motorcycles dates back to 1967, when he first learned to ride. "There were no courses that I knew of back then," said Admiral Arthur, "so I learned from a friend. I'd watch him ride, then he'd let me ride

his bike and tell me what to do as I went around the parking lot."

Once he had mastered the basics, he bought his first bike: a 450 Honda. "I only kept it a couple of months, though," he noted, "before I bought a full-dress Harley-Davidson, which I rode for many years." Admiral Arthur has owned more than a dozen motorcycles and currently has five.

When asked if he's ever had any close calls, Admiral Arthur responded, "I've had some closer-than-close calls—I've had a couple of accidents. My first one happened while I was working for Harley-Davidson as a mechanic—on April Fool's Day, 1973. I was riding a brand new bike to the shop when a car turned left directly in front of me. I had no reaction time at all. I spent the next four years on crutches and had a total of 10 operations and two knee replacements before they could put my left leg back together well enough to walk again."

Accordingly, Admiral Arthur has a healthy regard for motorcycle safety, starting with wearing a helmet. "I don't know if you can ride with a sense of personal responsibility unless you wear a helmet," he said. "In that earlier accident, my helmet actually was cracked in half. I still can remember the sound it made hitting the pavement as I fell from the bike. I also scratched up another helmet when a deer hit me *[during the May 2002 four-corners ride]*. Everyone in the touring-community family I ride with wears full riding gear. The helmets nearly always are full-face models. We've seen enough, know enough, have heard enough stories, and have had enough encounters of our own to realize if we want to continue riding, we have to wear appropriate gear, which includes a helmet."

It's little surprise that Admiral Arthur lectures to touring motorcycle groups on long-distance riding, riding safety, and riding preparation—that's what he did in Asheville one recent week-

UNDER THESE WHEELS

end. “Throughout my presentations,” he noted, “is a theme of ‘here’s how to ride safely’—here’s the right equipment, the right way to set up your motorcycle, and the right way to ride so you don’t get fatigued. I also explain how to recognize fatigue and what you should do if you have it: *Stop and rest!*”

When asked the biggest mistake he sees motorcyclists in general making today, Admiral Arthur quickly shot back, “Failure to appreciate

the dangers on the road. They don’t look ahead and anticipate when a potentially dangerous situation is looming. They don’t give that other hazard—whether it’s a car, an animal, or a sharp curve—enough respect, enough latitude.”

What advice does Admiral Arthur have for Sailors and Marines who ride motorcycles? “Take a motorcycle-safety course through the Motorcycle Safety Foundation. Every beginner should take the basic course; every experienced rider



should, at least every couple of years, take the experienced riders' course. The latter is only one day long, but it re-teaches you the fundamentals and better ingrains in you an awareness of other vehicles. It also helps you be a better motorcyclist—with better stopping, better turning, and better slow-speed handling capabilities.

“I'm glad I'm an instructor [*serves as a Rider-Coach at the Washington Navy Yard and also teaches occasionally at a community college*] because I regularly get to do all these things. When I wasn't an instructor, though, I took a course at least every other year to rebuild my skills. These refresher courses are especially valuable for those who live in the northern climes and who don't ride for several months during the winter. During the hiatus, you lose that muscle memory—that edge you had when you stopped riding in the fall.”

Changing seasons, though, aren't the only thing that will cause motorcyclists to lose their riding edge. As Admiral Arthur explained, “A challenge we have in the Navy and Marine Corps is, of course, deployments. When we come back from one, I think we need to have the self-awareness

“I don't know if you can ride with a sense of personal responsibility unless you wear a helmet.” he said.

that we can't just hop on our bikes and ride off down the street like we did before we left.

“Riding is an acquired skill—one that degrades over time if not used. We really need to get back into motorcycling by finding a parking lot so we can practice starting, stopping and weaving. We also need to work on re-learning to anticipate hazards—by looking ahead and thinking about the fact that we're on a motorcycle and vulnerable to the actions of others with whom we share the road. We know people are going to come into our lanes, and they're not going to see us, so we have to be able to protect ourselves.”

As current statistics indicate, Admiral Arthur acknowledges there are a lot more mature riders—those over 40—on the roads today. However, he doesn't see these older people as trying to re-capture their youth, and he doesn't see them as getting powerful motorcycles for the sake of power.

“I think these mature riders just are trying to take an activity they really enjoyed when they were younger and extend it into something they

can enjoy now that they're older,” he said. “When we're young, we enjoy the freedom of the road, and it doesn't matter where we go—just that we're on a motorcycle and with other people who also enjoy riding. Once we're older, we enjoy doing specific things, like touring and planning summer vacations to see the Grand Canyon or Yellowstone National Park. We may decide to get a National Parks pass so we can tour the many National Parks.

“There's more purpose, more direction in older riders; they tend to focus on family activities, whether it's a husband and wife riding two-up or each taking their separate bikes. One of the reasons we have so many more mature riders is that people are trying to enjoy their lives and not concentrate so much on work. There's a renewed interest in leisure activities. And, when these leisure activities involve long-distance riding, you need a large-capacity motorcycle—one that's heavy, that has enough power to get on the highway, and that's stable and comfortable.”

While it's true more older riders are taking to the roadways today on motorcycles, Admiral

Arthur points out there are also more women riders. “My daughter got her motorcycle license when she was 16 and rode one of my Harleys,” he said. “Just yesterday, she bought her second motorcycle.”

In his closing comments, Admiral Arthur focused on what we want in our Sailors and Marines. He said, “We want young, athletic people who aren't afraid to take risks ... to prosecute a military mission effectively. However, we don't want them to take risks in their personal lives. We must intelligently balance those two priorities.

“I hear a lot of people saying our Sailors and Marines shouldn't ride motorcycles at all because it's not safe. However, I don't think that's an effective way to look at it. I would rather commanding officers and others in authority say, ‘If you choose to ride a motorcycle, let the Navy and Marine Corps help you be a better motorcyclist.’ How do we do that? By getting more courses on the bases.

“One of the reasons we have trouble getting



training—and people ride off-base without it—is there aren't enough training quotas. We may get Draconian and say, 'You can't get a base permit without a course,' but that's not the right answer. That's just enforcement.

“The right answer is to encourage these young men and women to get the course by providing it more easily for them—give them the means to help them become safe riders. We do it with other things: We provide safety glasses and hearing protection for people in hazardous areas. Motorcycling is as much an occupational hazard. People are going to ride because it's fun, and they like doing it. I do it—and safely, I think. Am I putting myself at additional risk? Sure, but at a risk I'm trying to control as best I can by taking the proper safety measures while I'm riding, by preparing myself with the appropriate courses, and by keeping myself out of hazardous situations.

“Let's not force our people to keep their

motorcycles off base because they can't get a quota for the necessary course to bring the bikes on base. Instead, let's wake up to our responsibility to help our Sailors and Marines be safe.

“We need to respect all our people's choices—we respect their choices in jobs, lifestyles and many other areas, so why not respect their choices in sports avocations? I think you'll get better behavior from motorcyclists if you show them simple respect: Have motorcycle parking, or allow two or three motorcycles to park in the same space. These riders are individuals whom we want to keep in the Navy, so let's show them the same respect we show everyone else.”

Whether you ride a motorcycle to save gas, because it's the only transportation you have, or, as in Admiral Arthur's case, “for the pure pleasure of doing it and the relaxation it affords,” ride safely. Keep the shiny side up and the rubber side down. **S**

How Safe Is Your N

By Lt. Michael Schearer,
NROTCU, Penn State University

Those of us who daily operate in dangerous environments, such as the flight deck of an aircraft carrier during flight operations, are well aware of the hazards associated with the job. In this environment, safety is No. 1—and rightly so. All hands constantly must be vigilant to prevent injuries and death.

Because the flight deck is a dangerous place, commands go to great lengths to spread the safety message, whether it's through safety stand-downs, familiarization, or briefings to aircrews. On the other hand, most people tend to relax their guard while at home. Gone are the deafening jet blasts that send flight-deck personnel ducking for cover.

Also gone are the nearly invisible prop arcs that threaten life and limb. Life in most of our homes and neighborhoods is pretty safe, right?

My story is about an incident that occurred one blustery October day several years ago. I was visiting a friend in a nearby town, and we had gone to a particularly scenic, local park. Despite the cold air, the afternoon sun was warm. A small creek meandered its way through the park, and a walking path traced its way around the wooded surroundings. We stopped to chat by a typical park bench, just off the banks of the stream. A small wooden bridge spread across the stream, but an adult easily could jump (or even walk) across it.



neighborhood?

A young boy played nearby.

As my friend and I sat there talking and admiring the scenery, the peacefulness was interrupted by the strangest site: I looked up to find a woman running almost directly at me from the other side of the stream. She was screaming and waving her hands, as if to get my attention or, in that case, anyone's attention. I sat there puzzled, wondering what the big deal was.

Mystified, my eyes drifted to the stream between us, where, floating in the water, was a small baseball cap. My mind suddenly put the

the stream, slipped on the rock, and fallen right into the frigid water.

As the surge of adrenaline wore off, I finally realized that I still was standing in this deep pool of freezing mountain water. I hurried out, checking to see if the boy was all right. Despite having been in the water less than one minute, the boy's face was noticeably blue. Fortunately, he was breathing OK and didn't seem to require any immediate medical attention.

The boy's mother still was screaming and pointing toward the baseball hat now floating

“He can't be in there,” I thought. “You can walk across this stream; it can't be more than a few inches deep.”

entire picture into focus. “Her son is in the stream and completely underwater!” I thought.

I jumped up and ran toward the stream, but the boy was nowhere to be seen—just a baseball hat floating lazily in the water. “He can't be in there,” I thought. “You can walk across this stream; it can't be more than a few inches deep.”

At that very moment, though, the boy chose to prove me wrong. One arm flailed from the water, then another. Just as quickly, he went back under. Thinking nothing of the particular situation, I did what I think any reasonable bystander would have done: I jumped in!

Now, the stream chose to prove me wrong. Standing up, I found myself immersed in water up past my waist. “It's nearly 3 feet deep in here!” I realized. Reaching into the water, I immediately grabbed the boy—he couldn't have been more than 6 or 7 years old. I lifted him out of the water and handed him to his distraught mother, who still was screaming.

Looking at the far side of the stream, I found the evidence: a wide, smooth rock that was wet and mossy, with several small sneaker prints nearby. The boy evidently had been playing by

downstream. I foolishly jumped back into the cold water, retrieved his baseball hat, and nearly slipped on the same smooth rock as I climbed out.

This particular incident has lessons for everyone. The common thread here is the location: This incident took place in a seemingly safe environment. The mother probably had brought her son here many times before, without once thinking about the small stream as a threat. As he played, perhaps 50 yards from her, could she ever have imagined that tiny stream could swallow her young boy?

As for me that day, my mind was moving a thousand miles a minute. Did I remember my CPR? Fortunately, the boy didn't require it. But, still, could I have done it correctly?

This incident should serve as a reminder to everyone that tragedy knows no bounds. Mishaps don't occur just in hazardous environments, such as a flight deck. A community park in your own neighborhood could prove equally deadly. It's important to remain alert at all times—not just while on the job. **S**

The author was assigned to VAQ-139 when he wrote this article.





There I Was, in the Congo...

By ATC(AW/NAC) J. A. Mazzuchelli,
VR-52

I always wanted to start a story that way because it would have to be a lot more interesting than where I really was when my mishap occurred—in my front yard. I recently had returned home to north Florida from taking my son back to college in the northeast. My task was to take care of the 30-foot sycamore that a hurricane had left perched precariously at a 45-degree angle.

With the weekend rapidly approaching, I was busy trying to find an appropriate tool with which to extricate the lovely, leaning tree from my front yard. Two days and 12 phone calls later—chainsaws are hard to come by after a hurricane—I found a 55-cc, 22-foot, tree-removal tool at a nearby friend's house. Let's call him Brad. A quick

trip to his house, a thorough operational brief (or so I thought), and 15 minutes marveling at the torrent of water that once was Brad's river-front backyard, and I was ready to kill me a tree.

Safety glasses, check; steel-toed boots, check; leather gloves, check; gas and oil, check; choke on, check; one pull to prime; and yee haw—but wait, the chain isn't moving. About 15 minutes passed before I finally called Brad. In our brief conversation, I learned he was on the way to his rental home next-door to me and would be here in 10 minutes.

Moments later, my phone rang. "Hey, did you check the brake?" Brad asked. "If it gets bumped forward, it locks, and you have to pull real hard to get it off," he explained. "A quick and decisive

pull is all it takes, though,” he assured. I quickly repeated all my pre-start checks, and, voila!—it was tree-killing time.

Things rolled along nicely for the next 25 minutes or so, before Brad showed up. After a quick lecture from me about wearing his safety gear, he started helping me with cutting and removing the brush. We removed all the lower branches, then stopped for a safety brief on which way I was going to cut and where the tree was going to fall. In no time, it was timber!—the once mighty Sycamore was down.

Now came the easy part: Lop off some branches, cut them into manageable lengths, and haul them to the street. Then “it” happened. I just had made an upward cut through a 3-inch branch and was moving down to cut another 4-foot section. As I released the trigger of the saw—now lowered to leg level—and began cutting, the branch rolled slightly. One of its many smaller branches contacted the chain guide, which significantly slowed the rate of travel of my manly saw. However, the rate of travel of my left leg wasn’t slowed. The distance between it and the now flesh-eating chainsaw closed quickly. When the still-spinning chain hit my left leg

just above the knee, it sliced into my flesh like a hot knife cutting through butter. I was left with a 3.5-inch gash in my leg.

The lack of pain and blood was a bit surprising but not nearly as surprising as the speed with which the incident took place. After a rapid but prudent ride to a naval hospital, thanks to Brad, and five hours in the emergency room, I emerged with 14 stitches and an equal number of prescribed light-duty days—none the worse for wear.

I consider myself lucky. Chainsaw accidents normally don’t turn out well. Had I been at full power or had I been in the process of cutting, the results would have been catastrophic for me and my career.

I felt I had made the evolution as safe as possible, and, yet, I got injured. Does this incident fall under the “stuff happens” category? I don’t think so. I failed to follow a simple rule a fellow aircrewman taught me a long time ago: Slow is fast, slow is safe; always be safe and fast. I failed to show the required amount of respect for the power tool I was using, and everyone knows what happens when we fail to show the godfather proper respect. **S**

The author was assigned to VR-58 when he wrote this article.



Shocked

Out of

By Michael Brayshaw,
Norfolk Naval Shipyard

It all started like any usual Monday morning for three lifting and handling employees. Mechanical equipment specialist Larry Cahoon and electrical equipment specialists Lisa Tholen and Ralph LaClair had to do an annual inspection on jib crane No. 156. This type of crane has horizontal arms, on which trolleys move, bearing the load—nothing new for the employees. In fact, the task had become such a basic practice it seemed like they had nothing to look out for at first.

When the three arrived at the job site, they completed an operational check of the crane before lowering its hook so Cahoon could inspect it and the chain. While he was doing this inspection, Tholen and LaClair de-energized the main-power disconnect and installed both the group-lockout device and their individual safety locks on the crane-door latch. These actions secured power to the crane.

There was just one problem: They should have installed the group-lockout device on the locking

mechanism for the disconnect handle, instead of the door latch. They compounded that problem by not doing an initial voltage check, known as a frisk, to confirm power isolation.

With the hook and pendant-controller inspections done by 8:20, Tholen and LaClair removed their individual locks and energized the main-power disconnect, allowing the crane's hook to be raised back to its upper limit. Tholen then left the area with Cahoon to secure power to the hot rails feeding two bridge cranes they initially were assigned to inspect, located directly above the jib crane. After de-energizing the disconnect for the bridge cranes, they installed their individual safety locks in the proper location but again didn't perform the initial voltage check.

Between 8:20 and 8:25, LaClair repositioned the trolley on the jib crane, making it easier to inspect the trolley hot rails. He again mistakenly installed the group-lockout device and individual safety lock on the door latch of the main-power disconnect for the crane.

He also again failed to do the initial voltage check.

About 8:25, Tholen and Cahoon placed their own individual safety locks on the group-lockout device installed on the main-power disconnect for the jib crane. Neither employee verified that the disconnect had been de-energized, or that the group-lockout device was installed in the proper location.

About 8:30, all three workers went



f Complacency



up in the aerial platform to continue the inspection of the jib crane. Fifteen minutes later, Tholen removed a cover to inspect the trolley festoon car. The cover touched the hot rails, shocking her.

“It jolted me; I jumped back, looked at the two of them, and said, ‘I got shocked!’” Tholen said, remembering the experience at a conference table 11 days later. At the table with her were Cahoon; LaClair; Billy Mutter, NNSY safety manager; and Tim Blanton, lifting and handling director. Rather than being chided, the three employees were being commended for their honesty about the situation.

“I’ve always made it a point to tell people who work with me that ‘as long as you’re up front and straightforward about what happened, then we’re

doing the right thing,” said Blanton. “We’re all human, we all make mistakes, and, in this instance, we turned out lucky—very, very lucky.”

All three equipment specialists agreed that complacency is the biggest enemy of an electrician. “This is how close death is to you if you don’t concentrate and do your job,” said LaClair.

Cahoon mentioned that, after the incident, some employees tried to kid around with him about what had happened. “I told them, ‘Man, this isn’t a joke. Somebody could have gotten killed.’”

“When you really look at complacency on the job,” said Mutter, “it can affect more than just a person’s health. It also affects our workmanship and the quality of our products. But, the ultimate failure that can occur is for a life to be lost.” Rather than blaming any one person for such a mishap, Mutter said employees should take a long look in the mirror... “We all measure risk in a different way,” he noted. “When we fail to exercise the principles of operational risk management, our people and our products suffer.”

As Cahoon explained, the group-locking device, called a tree, needs to be locked—confirmed, if you will, by all employees working a particular project. “If you have six people working on a component, and five of them go home before the job is done, then you’re still going to be stuck there,” he said. To be sure, it’s a safeguard designed to protect individuals; if followed, the lockout process ensures control and protection for each employee. And, just as crane shutdowns require both individual and group lockouts, it seems particularly fitting that almost a year ago when the “voluntary protection program” was launched at the shipyard, it emphasized both individual and group safety.

“If Lisa had gotten killed, I wouldn’t have felt any better thinking that everyone is responsible for his/her own safety,” said LaClair. “Even if she was wrong and had died, I still would have blamed myself. You couldn’t have told me any different.”

The memory of the mishap weighs heavily on LaClair. Despite many years of experience as an



electrician at the shipyard, as well as in the Navy, he allowed himself to take something for granted that Monday morning. “I hung the tree in the wrong place,” he said. “For whatever reason, I don’t know why, complacency was a factor in what I did. That’s why it’s so important to focus on your job when you’re here—not to mix personal with professional,” he added. “It’s not an easy thing to do, but you have to leave some things behind at the shipyard gates.”

Among Tholen’s memories of her experience is that, even though she left the hospital that same afternoon with no injury, she still was worried something residual might happen to her. Once home, she had to face her 14-year-old daughter, who was furious. “What are you trying to do—kill yourself and make me an orphan?” the daughter asked.

“My 17-year-old son even asked me to sign a letter, saying I would take care of myself at work every day so that I could get home and take care of his sister and him,” said Tholen. “The piece of paper he brought me to sign said, ‘Be there, and take care of yourself because we need you.’”

For days afterward, Tholen’s son uncharacteristically stayed home in the afternoons just so he could call his mother at work. “He would ask, ‘What are you doing, Mom? Are you being safe?’” she said.

“I’d reply, ‘Yeah, I’m being safe. I’m in the office right now; I’m not doing an inspection.’”

“He would conclude, ‘Good. You need to be grounded.’” **S**

The author is a public affairs specialist at NNSY. A similar version of this story first appeared in the July 2, 2004, issue of “Service to the Fleet,” the official publication of Norfolk Naval Shipyard.

To learn more about the OSHA voluntary protection program, go to <http://www.osha.gov/dcsp/vpp/>.

Unlike the afloat tagout program, where paper tags are used to tag out hazards, the Military Sealift Command and NavSea shipyards follow OSHA maritime standards, where locks are used to physically “lock out” a source of energy. To learn more about OSHA’s lockout/tagout requirements, go to <http://www.osha.gov/SLTC/controlhazardousenergy/>.

“Slow Down—You Move Too Fast”

By Lt. Kevin Lane,
USS *Nassau* (LHA-4)

Simon and Garfunkel once crooned those words. Here’s a mishap that illustrates the need to slow down sometimes or to cut the number of simultaneous evolutions.

Our ship was in the middle of a material inspection. For this inspection, we had to rig and demonstrate nearly every piece of deck gear onboard. Among the items on our list were four unrep stations, heavy-weather lifelines, towing gear, sterngate emergency-raising gear, close-in refueling rig, accommodation ladders, well-deck and flight-deck gear, and small boats. We had spent long hours poring over blueprints and technical manuals to prepare for the inspection, and, by “game day,” we were ready.

Our department was stretched thin at the end of the day, as the senior leadership fanned out to break down the “day one” gear and to prepare for day two. The petty officer in charge of the boat boom was a PO2, with just less than one year on board and two years of experience on another ship of the same class. He had been involved in rigging the boat boom the day before.

The boom stuck while being stowed, and a seaman stepped outside the lifelines to see if he could push the boom free with his legs. When it swung out unexpectedly, the semi-protected (by his harness) seaman fell and slammed into the side of the ship. The emergency-response team quickly arrived, had the injured seaman on the deck, and called for an ambulance.

How did something as simple as moving the boat boom from perpendicular to flush with the hull turn into a near-tragic event? First, the boat boom is used infrequently, and, by nature, personnel are not as familiar with its operation as they are with a boat davit or an anchor. In this case, no one onboard could remember the last time we had used the boom.

Second, to keep things moving, the petty officer in charge had stepped away from the detail to stow another line. In his absence, the next senior Sailor, a BM3, took charge.

Third, operational risk management wasn’t applied in this case. Did the boom really need someone outside the lifelines to stow it properly? Did it have to be done right now, or could it have waited

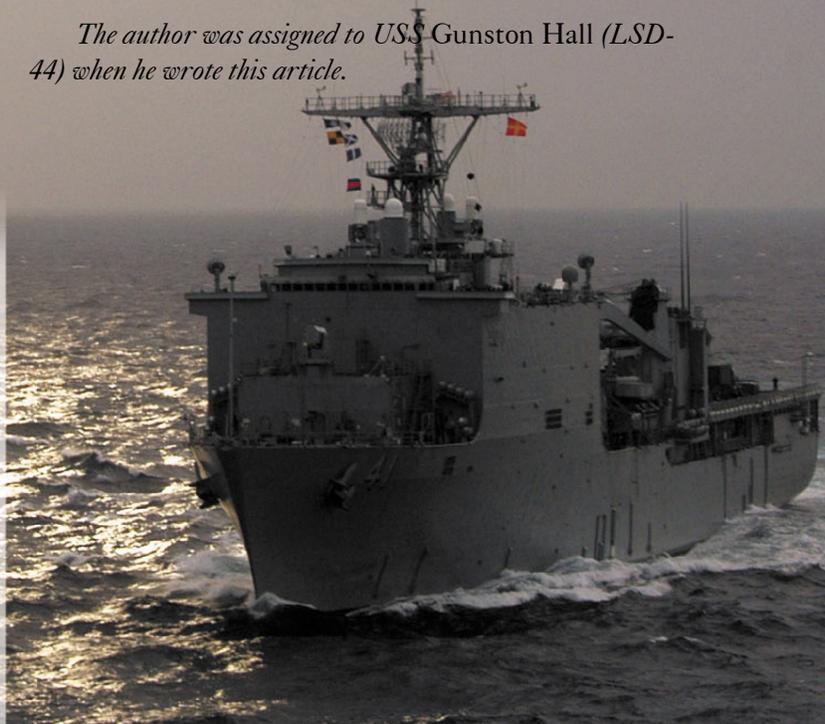
until someone with more experience was on station? In short, it wasn’t worth the risk to proceed because no deadline or operational commitment existed to stow the boom immediately.

The victim made a conscious decision to go outside the lifelines, despite the pleas of fellow junior personnel not to do so. Although he was wearing a safety harness, he connected the hook to the lifelines, instead of a fixed object, like he should have done. He also wasn’t wearing a life preserver and hardhat, as required. Had he been wearing both, they may have absorbed some of the force of his fall.

This seaman already had demonstrated that he needed more supervision than others. His CPO, division officer, and department head had counseled him for unsafe behavior (e.g., not wearing a hardhat during crane operations and trying to climb up a ladder that had been secured for repair).

Thankfully, X-rays showed no broken bones and no head, neck or spinal injuries. The Sailor returned to full duty two days later. This incident, however, still weighs heavily on my mind, especially since our ship often simultaneously holds several operations. “Were we just lucky this time?” I keep wondering. **S**

The author was assigned to USS Gunston Hall (LSD-44) when he wrote this article.



**These leaves have an excuse
for falling.**

What's yours? Too much booze?

Drink responsibly!