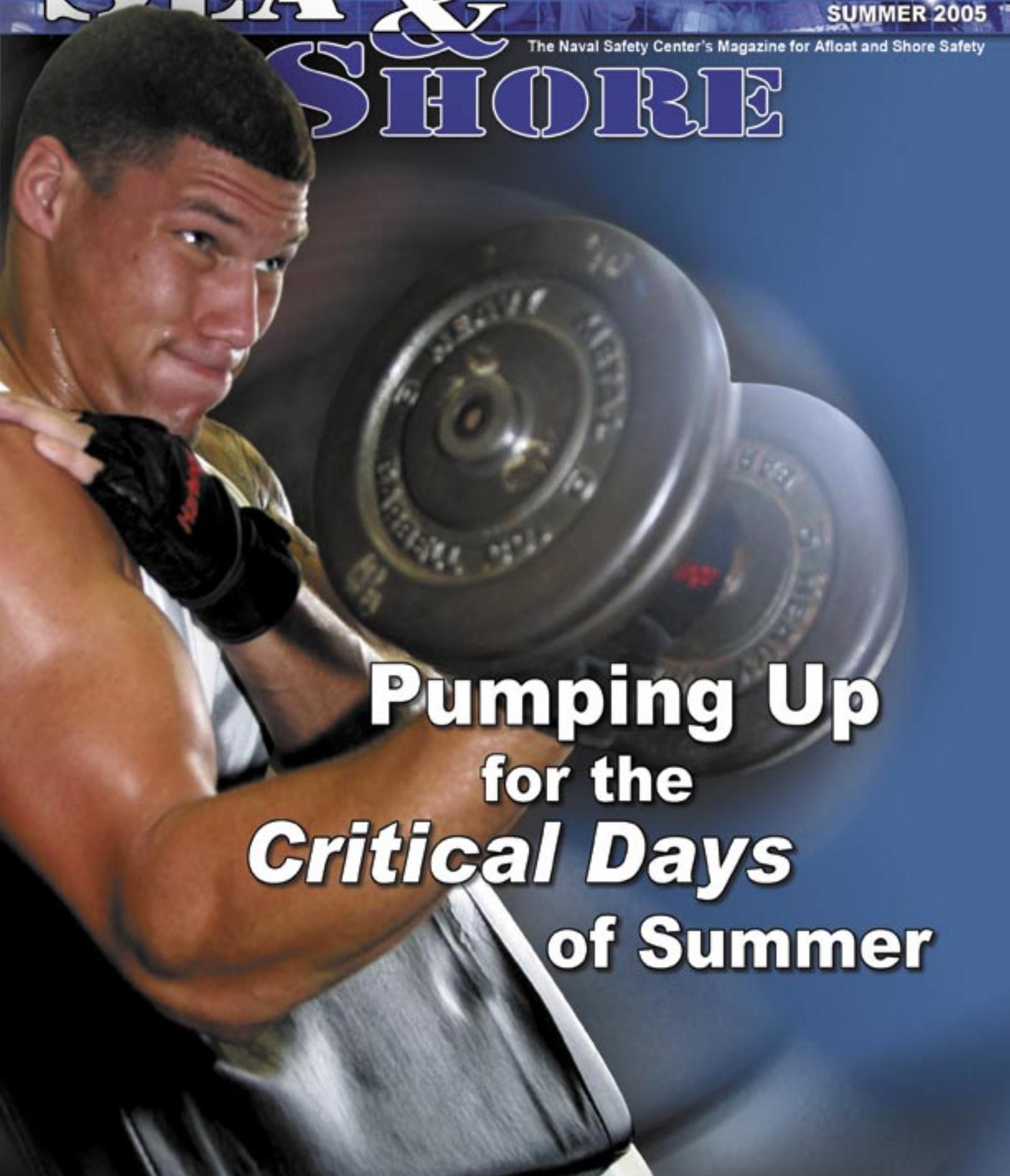


Reducing Mishaps · Saving Lives · Improving Readiness

SEA & SHORE

SUMMER 2005

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

A close-up photograph of a man with a focused expression, wearing black lifting gloves, lifting a large dumbbell. The dumbbell has '10' and 'NAVY' visible on its plates. The background is a blurred blue gradient.

**Pumping Up
for the
Critical Days
of Summer**

SEA & SHORE

SUMMER 2005

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

Vol. 7, No. 3, 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.

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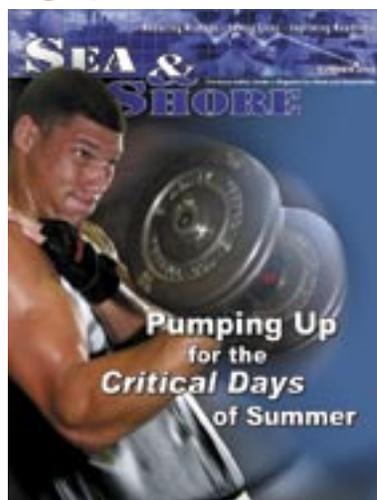
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COVER



Machinist's Mate Third Class Derik Rothchild, assigned to the *Los Angeles*-class submarine USS *Louisville* (SSN-724), lifts weights in his off-duty time to stay prepared for the semiannual physical-readiness testing. Navy photo by JO3 Corwin Colbert

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

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



COs: You Can Prevent That “Knock on the Door”

After countless portrayals on TV and in the movies, the scene is too well-known: A military vehicle stops in front of a home. One or two uniformed officers get out, walk somberly to the door, then knock or ring the doorbell. A mother, father, husband, wife, or other family member is about to learn the tragic news they have lost their beloved service member. Any loss is devastating but especially so when it’s from a preventable mishap.

Meanwhile, writing a letter to the family of that service member who died in a non-hostile mishap is one of the most difficult aspects of command. No commanding officer who has to write such a letter can avoid the silent frustration that comes with knowing, in most cases, the mishap could have and should have been prevented.

Today, commanding officers have access to many tools critical in greatly reducing, and one day eliminating, personnel losses from avoidable mishaps. Used with and incorporated into the routine operations of any afloat, aviation or ashore unit, actions like the following will help COs avoid having to write such letters and will spare families from that dreaded knock on the door.

1. Regularly visit the Naval Safety Center website and use the tools it offers at: www.safetycenter.navy.mil.

2. Schedule a baseline on-site safety survey, culture workshop, and/or online Command Safety Climate Assessment Survey (CSCAS). The CSCAS includes the Maintenance Climate Assessment Survey (MCAS) and the Command Safety Assessment (CSA), as appropriate for the command. A culture workshop helps unit COs better understand their command culture and provides outside risk-assessment data. The Command Safety Assessment Survey looks at an organization’s operational practices from a safety perspective. For afloat units, the Afloat Safety Climate Assessment Survey (ASCAS) is a new tool that helps assess the shipboard safety climate. Shore commands can use the ESCS or Employee Safety Climate Survey to assess the command’s overall safety climate and determine areas needing command attention.

3. Ensure the command has solid welcome-aboard, sponsorship, and mentorship programs, addressing both on- and off-duty safety issues. The programs must be updated regularly, and their successes must be measured by feedback from those members whom they are intended to serve. As you update your command mentorship program, ensure that embedded within the program are procedures to identify and track the

command’s potential and known high-risk personnel. Some members who might fall into this category include those who drive motorcycles, command members with a history of speeding tickets or other vehicular moving violations (known “thrill-seekers”), and those with a disciplinary record. Train all hands about the cold, hard consequences of misbehavior, not following the rules, and not adhering to safety best practices. Make appropriate page 13 entries, documenting training.

4. Leadership must maintain high visibility within the command and regularly demonstrate the chain of command’s commitment to safety. Take all mishaps seriously, and treat them the same.

5. Ensure all hands understand that each command member is held individually accountable for his or her actions and must follow regulations and established procedures.

6. Make risk management (RM) work in the command; stress using it in all daily activities, both on and off the job. RM is a proven decision-making tool and focuses on anticipating and identifying potential hazards and mitigating them. Doing so reduces potential injuries or equipment losses. RM uses five steps for managing risk and is applied at one of three levels, depending on the situation. More RM information is on the Naval Safety Center website at: www.safetycenter.navy.mil/orm/default.

7. In all communities, review how your team accomplishes crew resource management (CRM). CRM focuses mishap-prevention efforts on people. Key CRM elements are situational awareness, assertiveness, decision-making, communication, leadership, adaptability and flexibility, and mission analysis.

All of these actions require proactive leadership and a safety cultural mindset that results in best practices 24/7. This safety mindset also must include family members. Safety education for dependents can be passed through familygrams, commanding officer “town hall” meetings, and command ombudsmen.

We can all take the steps necessary to prevent one of our families from having to face that dreaded “knock on the door.” The tools and leadership already exist; we just have to put the two together.

RADM Dick Brooks

WORK ZONE

REDUCING MISHAPS BY 50%

Critical Days of Summer

Data: During the 2004 critical days of summer (from May 28 through Sept. 6), 32 Sailors and 26 Marines died in off-duty (traffic and recreational) mishaps. Seven of the Navy and 11 of the Marine Corps deaths were in motorcycle wrecks. Both services lost 13 personnel to traffic mishaps. Eight Marines and Sailors drowned. Mishap rates increase between Memorial Day and Labor Day.

During the last decade, the Navy traffic fatality rate during the critical days is 25 percent higher than the annual average. The USMC rate is 14 percent higher. The Navy shore/recreational fatality rate rises 60 percent. In many years, between one-third and nearly half of a year's total Navy and Marine Corps traffic deaths occur during the critical days of summer.

2005 Plan: On the first day of each week starting the week before Memorial Day and ending the week after Labor Day, a series of informative items will be sent out by NSC or posted on our website, sequentially addressing a specific "critical days of summer" topic:

- Safetyline Newsletter — "critical days" status, links to articles and authoritative websites, and tips. Subscribe at www.safetycenter.navy.mil/safetyline/.
- Home Page Feature Article — Information, statistics, scenarios, precautions, and lessons learned.
- Photo of the Week — Linked to that week's topic; can be posted on bulletin boards.
- PowerPoint Brief — A 5-to-10-slide presentation you can use at a safety stand-down or in local briefs.
- Resource Page — A comprehensive list of resources on the subject, including tips, checklists, briefs, articles, links, and POD notes.

• Marketing Materials: Including sample public-service announcements for radio and television, press releases, and tips for publicizing local events.

Topics:

- Week 1 (May 23) — Overview
- Week 2 (May 31) — "Click It or Ticket"
- Week 3 (June 6) — Swimming, Diving
- Week 4 (June 13) — Motorcycle Safety
- Week 5 (June 20) — Severe Weather
- Week 6 (June 27) — DUI; Fireworks
- Week 7 (July 5) — Outdoor and Team Sports
- Week 8 (July 11) — Home Repair, Yard Work
- Week 9 (July 18) — Boating, Personal Watercraft
- Week 10 (July 25) — Fatigue, Speeding
- Week 11 (Aug. 1) — Camping, Hiking; Insect Bites
- Week 12 (Aug. 8) — Heat Stress, Jogging
- Week 13 (Aug. 15) — ATVs, Bicycling
- Week 14 (Aug. 23) — Fire, Food Preparation
- Week 15 (Aug. 29) — Distracted Driving, Road Rage
- Week 16 (Sept. 6) — Emergency Kits, Breakdowns
- Week 17 (Sept. 12) — Wrap Up

Media: The Safety Center will mail news releases about each topic to base newspapers and public affairs staffs three weeks in advance. These articles will also appear at the Safety Center newsroom: www.safetycenter.mil/pao/presskit/.

Overview of the 2005 Campaign:

www.safetycenter.navy.mil/presentations/seasonal/criticaldays.htm. After the 2005 critical days end, the entire collection will be available at www.safetycenter.navy.mil/toolbox. ■



Best Practices

Keeping a Crew Focused

Maintaining a safe working environment aboard USS *Ramage* (DDG-61) is a priority that starts at the top. The CO constantly stresses that no evolution is routine. To keep the crew focused, he and his cadre of leaders consider ORM for each shipboard event.

During calendar year 2004, which included a four-month deployment to Fifth and Sixth Fleets, the *Ramage* leadership held five safety stand-downs to maximize readiness, minimize risk, and ensure mission accomplishment. Among the topics discussed were general, electrical and traffic safety, as well as navigation and watchstanding practices.

Early in the deployment, the leadership noticed that some watchstanders were becoming complacent in carrying out their more routine tasks. Interaction with other ships was minimal, so watches had a tendency to become tedious. With the long deployment ahead, the leadership decided to provide a refresher for all hands on watchstanding practices. Both officer and enlisted personnel from all control stations (bridge, CIC and CCS) participated.

Each group generated lists of good watchstanding habits, such as turnover procedures and pre-watch routine. Many Sailors provided new ideas and shared their “secrets” to standing an effective watch. Scenarios also were given to each group to promote the proper evaluation of ORM (providing factors that forced the balance of risk versus benefit). The results of this stand-down were evident throughout the deployment, as reflected in increased vigilance—watchstanders paid more attention to details.

Besides holding the required traffic-safety stand-down upon returning from deployment, the *Ramage* leadership held one earlier in the year after identifying a pattern of traffic-safety issues. Several crew members had incidents involving bad-driving habits and driving while fatigued (e.g., making long trips late at night while returning from weekend liberty). Concerned that this trend

would lead to serious injury or loss of life, leaders acted before the problem got out of control. They used the five steps of ORM to develop a plan:

Identify the hazard. Many junior Sailors were receiving tickets for moving traffic violations, even though traffic-safety training was being held regularly.

Assess hazards. Because of the potential severity of increased traffic incidents, the leadership decided to hold a one-day stand-down focused solely on traffic safety.

Make risk decisions. The ship’s leadership developed risk-control options, including guidelines for supervisors to use in counseling individuals who embarked on weekend trips. The leadership also increased the amount of traffic-safety training.

Implement controls. The leadership implemented a series of administrative controls:

- The Virginia State Police provided training at a driver-safety stand-down.
- Traffic-safety training was added to the schedule for the ship’s “division in the spotlight” program, reinforcing continuous training practices.
- Driver-safety training was separated from the general safety training at command indoctrination, a move designed to emphasize the importance of traffic safety.

• The ship’s safety committee developed a command policy that detailed guidelines to ensure Sailors are counseled before going out of town on leave or liberty. A form attached to the leave or liberty chit outlines procedures for resolving problems while on the road. The form also lists phone numbers for the chain of command to be used in the event of an emergency. Sailors are reminded that their safety comes first and that driving while fatigued late at night isn’t worth the risk.

Supervise. The *Ramage* leadership will continue to assess traffic safety and adjust their program to ensure the crew’s safety. ■

Navy photo by PHC Kevin Farmer



Web-Enabled Safety System

WESS



Update: The WESS Reporting System

Background: The Web-Enabled Safety System 2 (WESS 2) for non-aviation mishaps and hazards (including aviation hazards) is on-line and ready for fleet users to enter data. WESS 2 was built to accommodate all the non-aviation reporting and record-keeping requirements of OpNavInst 5102.1D and MCO P5102, as well as the current reporting and recording requirements in DODI 6055.7 and 29 CFR 1904. If you have to report mishaps or hazards, you can use WESS 2 (in lieu of a naval message or other means of timely reporting) to submit:

- currently reportable or recordable work-related injuries and illnesses
- all other on- and off-duty, non-flight-related Class B (or below) mishaps and hazards.

Any reports received via naval message or other means will be entered into WESS 2 at the Naval Safety Center to ensure the data are available for retrieval from WESS 2.

Feedback From the Users: Now that WESS is on-line, we've received valuable feedback from fleet users to help us get the bugs out. As with any new system, WESS has had problems with servers, displays, and a variety of other system processes. Bug fixes, enhancements and a number of new features recently have been added to WESS. Furthermore, we are always upgrading data-retrieval capabilities. A notice of these changes can be found at: www.safetycenter.navy.mil/wess/whatsnewwess.htm.

Here are a few of the enhancements and new features:

- USMC sections on the initial-notification report and database-insertion programs
- Additional training courses
- Improved search functions to find previous reports
- Upgraded and detailed motor-vehicle data entry
- More than a dozen new custom report sections for data retrieval and separate OSHA log reports.

For the full details on these and other fixes and upgrades, refer to ALSAFE 05-11, available on our secure website (<https://138.139.49.5>).

We're trying hard to make WESS work better as we all work toward reducing mishaps. Keep the feedback coming.

Coming: WESS for aviation mishap reporting will be available by December 2005.

For More Information: Details on this new system, a users' guide, feedback forms, help-desk link, frequently asked questions (FAQs), and information on getting a WESS account are available at: www.safetycenter.navy.mil/wess. You also can contact the WESS Help Desk using our Help Request Form, or by calling (757) 444-3520 (DSN 564), Ext. 7048, during normal business hours, Monday-Friday, 0800 to 1630 EST/EDT.

What Is Risk-Taking?

A health guru's analysis of "risk-taking" that I was reading awhile back included a definition of the subject. The reference he used, a psychology dictionary, described risk-taking as "a hypothesized personality dimension, reflecting the degree to which an individual willingly undertakes actions that jeopardize something of personal value."

The guru went on to say, "The most important point to consider in this definition is 'personal value' because, although you might feel others are taking risks, they may not consider their actions risky at all."

Perhaps that kind of thinking is what made the people in the following accounts do what they did.—Ed.

My Final Rope-Swing Qual

By John Scott,
Naval Safety Center

Back when I was on active duty, I was the (self-proclaimed) best safety officer in the Navy. I used every gimmick I could come up with to make Sailors and Marines on board our large-deck amphib "think safety" before any risky undertaking. In my civilian job as a statistical safety data manager, I see more data about the results of others' follies than perhaps anyone in the Navy.

At our admiral's direction, my boss asked me what my Fourth of July plans were. I made a joke about being as safe as I could be, relative to the risks of going off a rope swing. My reserve-unit CO sent an e-mail to everyone in the unit, reminding us that our country and families needed us back in one piece.

Why do I insist on renewing my rope-swing qual each summer when visiting friends at the Allegheny River? All my friends, one at a time, have matured to the point where they no longer do it. I've always been the crazy one of the group, though—going to school 1,000 miles away, joining the Navy, learning to fly. Maybe, I just have to keep proving something to them. Getting married didn't stop me; neither did having two kids or turning 40. Heck, age is a mental barrier, not a physical one.

Not even the incident that happened a few years ago could deter me. A 15-foot, quarter-inch shot line used to be attached to a big knot at the bottom of a 30-foot one-inch line. The shot line came down to the water level so you could pull it up the bank to the launch point. Unfortunately, the line didn't actually come down to the water but to the rocks directly below the rope. Deep water only could be reached by letting go at the far peak of your swing.

That eventful year, I found myself dangling on the big knot like a serpent in slow motion, with the feeder rope slowly looping around my legs. I can't allow myself to think about what releasing at that point would have done to me. Fortunately, my helicopter-pilot, calm-response, emergency training kicked in, and I allowed myself to swing back toward land. I couldn't just wait for the swinging to stop because I still would have a 15-foot drop to the rocks. I quickly assessed that if the line unwrapped itself, I would have enough momentum to make it to deep water. Just like a tetherball, the line unwound just in time for me to let go.

Over the next few years, I had uneventful swings, but things felt differently this year. My friend said he hadn't even noticed if the swing still

To the horror of the crowd in the boat, I assessed that I could make it to the water but not the deep water.

was up. We had our 1-year-old on the water with us. My friend had a new high-capacity pontoon boat, so we had lots of spectators. I had turned 40. My wife warned me to be careful. I promised everyone I'd be careful as I jumped off the boat to swim ashore.

My friend hadn't seen the rope because it was a new half-inch, blue, nylon rope that didn't stand out like the old white one-inch line. Gone was the feeder line; the new rope made it all the way down to the rocks. Was it tied off to the same place? I'm not sure—I only do this once a year.

"I wonder if that heavy line making it all the way to the ground will suck up some of the momentum the old quarter-inch line didn't," I couldn't help thinking. Since all these warning signals were going off, I decided to swim around the landing area, assessing for underwater rocks and reminding myself where the drop-off point was.

Finally, I climbed the bank, backed up for a running start to get extra momentum, and leaped. I immediately realized something was wrong. I was swinging more slowly than I remembered from past years, and it was a bit of an arching swing, rather than straight out. Because I'd never been able to let myself down the rope in previous years, I eliminated that as an option this time, too.

To the horror of the crowd in the boat, I assessed that I could make it to the water but not the deep water. From their perspective, I appeared to be heading straight into the rocks. I released and consciously decided to do a back-smacker to avoid going to the bottom in the 3 to 4 feet of water for which I was aiming. Now on a ballistic trajectory, I thought I was a bit right of where I had checked for underwater obstacles. As I hit the water, I wondered if I was going to experience a burst of white light, then wake up in a helicopter on the way to a hospital, where doctors would tell me I'd never walk again. However, I instantly surfaced—unbroken but not undamaged.



In case the message still hadn't sunk in, the safety gods gave me 24 hours of kicked-in-the-groin pain as a reminder of my folly.

Perhaps ORM saved my life, or maybe it was luck. Maybe, if my judgment had been further clouded by the influence of alcohol, my luck wouldn't have been enough. The only explanation I can offer is that I didn't think it could happen to me—just like it does to many Sailors and Marines every year. All too often, a fun day at the beach, park or river turns into a tragedy for them, their families, and friends.

The real world offers plenty of dangers and challenges to conquer. Next year, I'm not going to add an artificial one on an unsafe rope swing. ■

A Long Fall for “Billy Black Cloud”

By AN William R. Smith,
VAQ-135

It started out nice—sunny skies; warm, summer breezes; and melodic riverbeds parting picture-perfect canyons. It was one of those days that find you lost inside a swirling thought, spinning amongst your ideas and tumbling effortlessly into your own abyss.

I was driving home, returning from a year lost in sunny Pensacola, aimlessly driving for sights and sacred fishing grounds. I basically was empty-handed, headed fleet-avail after a rough encounter in AW School. A good friend had flown out to join me for the adventure home; we packed up, hit the road, and watched blue skies disappear into the reflection of our rearview mirror. It had begun.

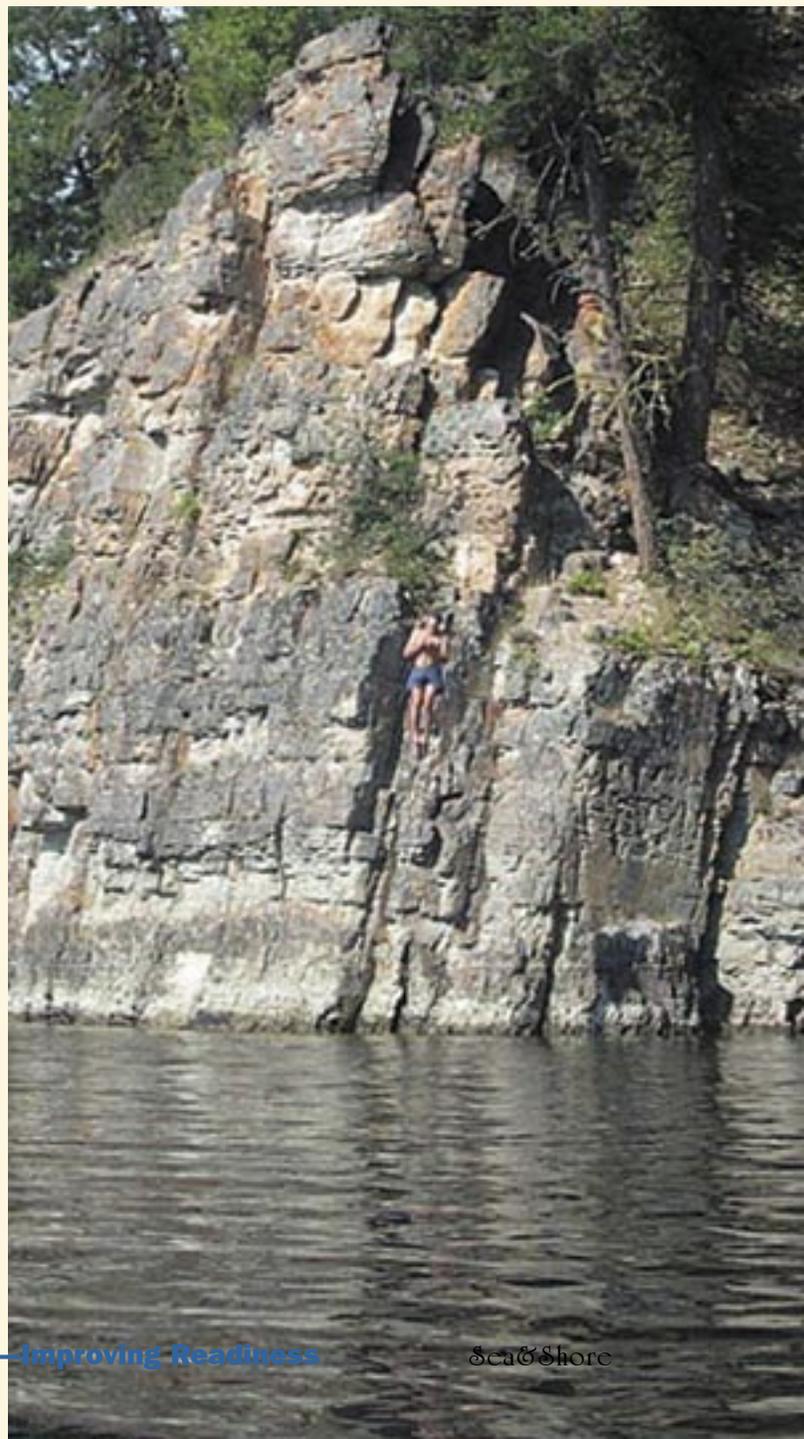
The trip was perfect: just enough roadkill elk; stray cows; drug-trafficking, car-searching law enforcement; car problems; and bizarre “Deliverance” types to make it one worth remembering. After nearly 60 hours on the road, I arrived home in Longview, Wash.

Friendly showers, warm food, and good nights’ rest patiently awaited me. Little did I know this rest and relaxation were gearing me up for what would be my worst crash-landing in quite some time. I have a fairly colorful track record as far as weird accidents and spooky bad luck goes. My dad even took to calling me “Billy Black Cloud” in an effort to connect the constant trouble that stalks me—how thoughtful.

As much as I wanted to stay comfortably sunken into the cushions of my couch, sunshine poured through the open windows, taunting another adventure. With nervous anticipation, I made a few phone calls to some of the regulars—

these guys inspire and partake (mostly inspire) in most everything that goes wrong. How I met them and why I continue to associate with them remains a daunting mystery.

In no time at all, it cleverly had been suggested that we go cliff jumping. I hung up the phone, grabbed a towel and some shorts, and naively headed toward the meeting spot. I had jumped off a few bridges before—one about 65



As I surfaced and tried to breathe, I couldn't help but notice that, while no air came in, a massive amount of blood came out.

feet high, another a little smaller, so I was game for whatever cliff we were after. We met, packed our things, and headed for a small place along the Toutle River.

When I saw the place we were jumping, I was a little nervous—mostly because I envisioned myself taking a few steps toward the cliff and tripping right before I jumped, then falling uncontrollably toward the swirling waters below. I took a breath, closed my eyes, and pushed the thoughts of unavoidable incident somewhere to the back of my mind.

In front of me, a tree grew about 15 feet out from the ledge, with two branches overhanging the 60-foot cliff—one below and one just within arm's reach of someone jumping out. As my friends drew closer, I flashed them a “what are we waiting for grin,” took a few steps, and jumped out. I knew if I didn't go first, I'd be much more nervous being the last to go.

It seemed like forever as I reached out, let my hands slide through the leaves of the higher limb, and then felt myself spin sideways—oh, what a mistake! I flailed my left arm in a sloppy attempt to right myself, and, after what seemed like a few more minutes, I thought I had been successful. Then, however, I felt a raindrop, and I knew my cloud had been following me all along. In no time, my freshly righted position morphed into a wicked side flop. All I could think was, “I hope it's not too bad.”

As I surfaced and tried to breathe, I couldn't help but notice that, while no air came in, a massive amount of blood came out. I was hoping I had a bloody nose or had bitten my tongue. Finally, I got a few breaths of air in, but the amount of blood coming up was gagging me, and I puked three times. A friend met me at the bottom, and one jumped from the top. I soon noticed my chest was getting tight, and a wheezing gurgle was interrupting my breathing.

We decided the situation was serious enough to warrant a hospital visit. After resting on the rocks, I walked back into the river and swam across to the side where the car was. We then hiked up the hill to the car and sped to the hospital. Three days, a bit of blood, and lots of morphine later, I left the intensive-care unit the proud owner of injured lungs—one massively contused, the other less serious—and a slightly bruised heart.

I spent the remainder of my time home on convalescent leave, sunken deep into the cushions of my couch, mocked by the crooked sunshine seeping through my open window. Fortunately, we are not all cursed with a black cloud, and the occasional rain visits mostly just to wet the ground. Most mishaps are avoidable and can be dodged with careful planning and constructive insight. Fully healed, I've finally reached my permanent duty station—home at last, where the dark clouds soar, and rain is just around the corner. ■

“Testing the Water” Proves Fatal

By Ken Testorff,
Naval Safety Center

A “No Swimming” sign was posted, but that warning didn't stop a 21-year-old E-3 from joining seven other Sailors and two local nationals from enjoying the waterfall at a park. Everyone except the E-3 previously had been to the 45-foot fall, which runs down an almost vertical cliff into a pool estimated to be 40 feet deep.

The water flow at this site usually is just above a trickle. This day, though, the waterfall was running very rapidly, following three days of rain. Witnesses said the fall and pool were far more turbulent than they ever had observed in the past—an observation that a photo corroborated. At the time, the air temperature was 84

degrees Fahrenheit, and the water temperature was estimated at 70 to 75 degrees.

Most of the group never had read the “No Swimming” sign [*written in two languages, one of which is English*] and reported they had seen both Americans and locals swimming there in the past. Two, however, said they had seen the sign before but just disregarded it because they had seen so many other people swimming.

By the time the E-3 arrived at the fall, two other Sailors already had jumped from a 25-foot rock ledge into the pool and were sitting in the pool area, near the side. A fixed rope assisted people in climbing to the ledge on the side of the

cliff. The ledge sticks out far enough from the cliff for one person to stand there and jump into the pool. According to witnesses this day, though, the rocks were slippery because of the heavy water flow and moss growth.

Two more Sailors climbed the cliff and jumped into the pool ahead of the E-3; one other waited behind him. When the E-3 first reached the ledge, he faced outward but then stepped back. He then, according to witnesses, moved forward again and jumped, shouting, “Woo hoo!”

The witnesses said it appeared the E-3 slipped just as he planted his feet to jump. Instead of actually jumping, he fell off the ledge and down the side of the cliff, with his head and upper back hitting the side of the cliff just before water entry. He landed on his back and failed to surface.

Four in the group immediately entered the water to search for him, including two who were rescue-swimmer certified. Their search continued for several minutes but was complicated by the strong current surrounding the waterfall. It was impossible for them to reach the position where the E-3 had entered the water.

Two other members of the group reported the emergency to a campsite attendant who called the local police. They arrived 20 to 30 minutes later with rescue divers, who started a search but had to suspend it after four hours because of darkness and the turbulent water. They resumed the search the next day and found the victim’s body.

What lessons were learned from this incident?

The area wasn’t safe for swimming, as evidenced by the posted “No Swimming” signs. The conditions on the day of the mishap, after several days of heavy rain, were extra dangerous. The victim and accompanying personnel failed to recognize that an area already posted for “No Swimming” had become even more dangerous because of environmental conditions. They failed to conduct sufficient risk management to prevent a fatality. Having seen others swimming without injury in the past, despite a posted sign to the contrary, was justification for them to do nothing more to assess personal risk. Everyone failed to reassess the impact of adverse weather on the probability of mishap and, therefore, didn’t recognize that the chances of a tragic outcome had increased dramatically.

Sailors need to be reminded during ORM training that just because someone else does something without getting hurt doesn’t mean



He landed on his back and failed to surface.

that risks don’t exist. All hands also need to be reminded to stay alert for changes in environmental conditions and to reassess their ORM analysis as those changes occur.

After this tragedy, the CO placed the waterfall off limits to all personnel for swimming. A safety stand-down also was held to emphasize recreational safety and to discuss the important role ORM plays in all recreational, home and athletic activities. The CO further started a weekly liberty meeting to discuss all weekend liberty plans, to conduct an ORM assessment of those plans, and to make adjustments as necessary, based on the risk assessment. ■

4 Sailors, A Gun, And a Bad Attitude



By Ens. David Smithers,
VAQ-139

“How did I get here?” was the only thought running through my head as I watched my friend stare down the wrong end of a .38-caliber revolver. Not more than three feet in front of him stood an angry, young kid.

Everyone froze. Only the idiot who instigated this mess spoke, “Man, that’s not a real gun,” he said. But, it was very real. Then we all watched in horror as the young kid pulled the trigger, and my friend went down.

Now—14 years later—I try to explain to my blueshirts (sometimes in vain) just how fast things can get out of control when we are on liberty. I preach the buddy system and ORM before every port visit and every holiday. I’m just thankful none of my Sailors have found themselves in my earlier shoes.

I was stationed at NATTC Millington, Tenn., at the time, attending Avionics “A” School. One weekend, a few of us headed to Hot Springs,

Ark., to blow off some steam. We were looking for girls, of course, and, in no time, the four of us were talking to a couple of local beauties in a town restaurant. Because there were four of us and only two of them, we decided to split up. Two friends headed back out on the strip, while Ed and I stayed to chat with these girls.

After supposedly getting one girl’s telephone number (it more likely was the number to a pizza parlor), Ed and I returned to the strip, looking for our friend’s Thunderbird. We were walking along the main drag when an old Ford LTD pulled up to the two of us, and out jumped four guys, who were looking for nothing but a fight. I tried to keep walking, but Ed insisted on provoking them further. When a cop drove by, the punks scurried away in their rusty ol’ “tank.”

We finally met up with our friends and told them about our encounter. We all were content to let it go until Ed piped up, “There they are!” We

made a U-turn and pulled into a parking lot, with Ed screaming, “That’s them!” However, the only car in the lot was a black Chevy truck.

I asked Ed, “What the h\$## are you talking about? Those aren’t the guys.”

He wouldn’t listen to me, though. We all subsequently piled out of the Thunderbird, and Ed started in on one innocent guy standing by the Chevy. This guy gave it right back to Ed, and that’s when Kevin, a massive Sailor who could knock a man through a bulkhead, got between them. Seconds later, the man Ed had cornered brandished the pistol and pointed it right at Kevin’s forehead.

I couldn’t believe Ed was insisting the pistol wasn’t real. When it went off, and Kevin hit the ground, the two men jumped in their truck and sped away. A sigh of relief swept over us when Kevin rose to his feet. His face was covered with specks of blood—signs of powder burns. Luckily, the man had fired a blank, and, although Kevin was hurt, he was far from dead.

So how did I get myself in this situation? I assure you alcohol wasn’t a factor. The problem was that I didn’t keep Ed in check. I failed to admit that, like the guys in the Ford LTD, he, too, was looking for a fight. I lacked the courage and commitment to keep him on a leash.

We often wish our Sailors had a little more appreciation for the buddy system. If I had to do it all over again, Ed never would have come with us. He was in a self-destructive mood, and he didn’t care whom he took down with him. Sometimes we have to come to terms with Sailors like Ed; it’s either them or us—that’s the cold, hard truth. Trying to empower our junior Sailors to get help for this type of shipmate is a constant battle. Encouraging them to be more selective about the company they keep also is difficult.

We have to take the first step in the buddy program and ask ourselves, “Is this my buddy? Can I trust him?” I know that now. I’m just glad it didn’t take the loss of a friend’s life for me to learn that lesson. ➤

Hiking Submariner Survives 300-Foot Fall

By JOC(SW/AW) David Rush,
ComSubPac Public Affairs

On Dec. 23, YN2 Ben Warren of USS *Chicago* (SSN-721) and three friends set out to climb the ridge of Oahu’s Pali Lookout. He had no idea that his life was about to change.

The foursome headed out from their barracks on board Naval Station, Pearl Harbor, with a few backpacks carrying clothes, water, sandwiches, and a cell phone. After arriving at the lookout and scaling a relatively easy section, two of Warren’s friends decided they had climbed high enough—the steep terrain that towered above them seemed too difficult.

The athletic, 6-foot, 220-pound, 23-year-old Warren, however, along with another Sailor, continued the treacherous, nearly vertical free climb, with no ropes or hiking gear. About 20 feet away

from the summit, they said to each other, “This is crazy; we shouldn’t have done this. How are we going to get back down?” [*With ORM, you’re not left up a cliff without a rope. Use these principles before you engage in any on- or off-duty ventures.—Ed.*]

They decided to abort the remainder of the climb and go back down the steep mountainside. Warren was above his friend, gripping onto a rock while contemplating his next move, when, suddenly, the rock he was clinging to gave way. He began freefalling hopelessly, nearly taking his friend with him on the way down. With nothing to slow him, he picked up speed until, about 100 feet into his fall, he hit a small tree, which he split in two with his hip. He continued his harrowing descent, all the while with his life flashing before him.

When Warren first opened his eyes, he thought he heard water, “but it was blood pouring out of my head,” he explained.

“When I first started falling, I just yelled, ‘God save me,’” said Warren. “I was dead as far as I was concerned.”

Not wanting to go out this way, though, Warren summoned his inner strength and devotion to survive this perilous fall. According to him, he tried to control his descent. “When I hit the last tree, I was going out of control. I was looking down at what would be my landing spot, and it was solid rock. I thought, ‘Oh, no; I’m dead.’ Right before I hit, I tried to roll and landed on my left side,” said Warren.

Impact with the ground left Warren unconscious for about five minutes and ripped off a section of his ear. As he lay there, his friends gathered more than 100 feet above. When Warren first opened his eyes, he thought he heard water, “but it was blood pouring out of my head,” he explained. “My friends thought I was dead and called 911. They couldn’t see me or reach me, so I knew I had to climb to where they were before I bled to death. I heard them telling me a helicopter was coming and asking if I could move. I told them to keep calling me because I couldn’t see them—I was in a lot of bushes,” he added.

After Warren reached his friends, a fire-department helicopter arrived and took him to the Pali Lookout parking lot, where an ambulance sped him to Queen’s Medical Center. Doctors there discovered Warren had suffered compression fractures of his C7 and C8 vertebrae in his spinal column, in addition to having lost 25 percent of his left ear. His left knee and right shoulder also were bothering him. Warren spent three days in the hospital and left with a neck brace and more than 20 stitches in his ear.



YN2 Ben Warren

As for why or how he survived his ordeal, Warren credits the intervention of a higher power. “I’m in shape, but that’s not what kept me alive. The only reason I’m living today is because of God. I asked Him to save me as I was falling like a skydiver. My head broke my fall, but my skull didn’t even fracture,” pointed out Warren.

Having learned from his experience, Warren recommends that anyone who plans to hike use the proper equipment. “It’s a beautiful view, but you can get hurt,” he cautioned.

Friends and shipmates, including his commanding officer, poured into the hospital to wish Warren well while he was recovering. Did he mind it was the holiday season? Not hardly. In his words, “It was the best Christmas I ever had.”

Back to the Basics

By Cdr. John C. Minners,
USS *Theodore Roosevelt* (CVN-71)

We recently finished a 10-and-a-half-month, \$330-million, docked planned incremental availability (DPIA) without a single on- or off-duty Class A or B injury or mishap. How did the crew of 3,600 accomplish this feat? It didn't involve any magic formula. Rather, we simply used tools in the safety toolbox—ones that everybody knew about.

At the beginning of the DPIA, we implemented an aggressive training program, which included presentations on SITE-TV. Many of the Sailors in ship's company never had been through a yard period and, therefore, didn't understand the magnitude of potential new hazards they would be exposed to daily.

The crew knew about operational risk management (ORM), though, and we applied it to everything during the DPIA. When Sailors first walked into the hangar bay of our ship, they saw two huge banners. One read, "Our mission is to deliver our ship by 17 Dec, so we can go out and kick dirt-ball, dirt-bag Al Qeida terrorist butt." The other banner read, "Ask yourself throughout the workday: 1. What is going to hurt me? 2. What am I going to do about it? 3. If I can't do anything, who do I tell? Operational risk management at NNSY."

Our mission in the yards was to deliver our ship back to the fleet, but we had to do it safely. We stressed risk management at all levels of the crew, as well as with the shipyard and contractor personnel working on board. The crew always was ready for challenges after using in-depth and deliberate ORM. At execution time, we carried out the plans in a "world class" manner, using operational-excellence principles, on-the-fly risk management, and time-critical risk mitigation.

All hands aboard USS *Theodore Roosevelt* took pride in a job well done, and the leadership recognized them regularly for it during our DPIA. The CO and shipyard superintendent in charge of the *Theodore*



Roosevelt project hosted "Rough Rider of the Week" Award ceremonies in the hangar bay. Each awards ceremony recognized a Sailor and shipyard worker in the propulsion arena, a Sailor and shipyard worker in a non-propulsion arena, and a contractor who had exhibited exceptional work all week. The CO and superintendent then covered injuries from the previous week and discussed how the use of ORM could keep them from recurring.

All levels—department heads, departmental leading chiefs, khaki leaders, and engaged senior petty officers—used intrusive leadership to ensure the welfare of our Sailors. The payoff was fewer injuries, coupled with the ship's winning the Retention Excellence and Golden Anchor Awards. The CO regularly got on the 1MC for "Atta Sailors," where he commended jobs well done, then discussed safety and risk management. A top-down culture of safety was and is the driving force behind our successful program.

The ship's safety department integrated fully with the Norfolk Naval Shipyard safety department during our DPIA. This relationship ensured a good flow of information and helped solve both ship's force and shipyard safety issues. It also increased the number of personnel on the safety team.

When incidents or close calls occurred, the shipyard held a critique—a non-retributive investigation, which culminated in a formal hearing. Senior leadership from the ship, the shipyard, and any involved contractors always attended. The involved personnel and immediate supervisors discussed what had happened, and the group then came up with recommendations to

prevent recurrences. These sessions provided numerous improvements to training programs, procedures, and work-integration processes. In most cases, communications improved, too. Because this project involved thousands of people, communications was one of our biggest problems.

Sailors always wore personal protective equipment (PPE), including hard hats and safety goggles, throughout our yard period. During such jobs as grinding, painting, and needle-gunning, they also regularly wore other required types of PPE (e.g., gloves, respirators and protective suits). And, while the hot summer months became rather uncomfortable, considering the limited air-conditioning available, we never relaxed the policy. Our leadership continued to aggressively enforce the PPE requirements.

Near the end of the DPIA, when the amount of industrial work had decreased significantly, the ship could have relaxed PPE requirements. The choices were to stop wearing PPE, to develop a policy on specific instances when it would be required, or to keep wearing it all the time. Because some risk remained from sporadic industrial work throughout the ship, we opted for the most conservative—but extremely unpopular—approach and kept all hands wearing PPE.

By far, the toughest area to influence was off-duty safety, specifically motor-vehicle safety. Intrusive leadership again came to the forefront. We required our Sailors to fill out driving risk assessments before going on leave. During our pre-holiday safety stand-down, half the time was spent in small groups, performing

Navy photo by PH3 Danielle Trevant



ORM exercises. One dealt with driving home on leave and another with an on-duty stores on-load scenario. After completing these exercises, the groups answered questions and took quizzes.

Two *Theodore Roosevelt* crew members who are qualified as Motorcycle Safety Foundation instructors led the ship's aggressive motorcycle-safety program. They proctored the required motorcycle-safety classes for the crew, which greatly increased class availability and ensured the classes were given during the best times in the ship's schedule.

Last summer, the ship hosted a riding get-together in the shipyard parking lot for *Theodore Roosevelt* motorcyclists on National Ride-to-Work Day. Festivities included discussions, demonstrations and exercises on riding safety and techniques. Many senior

Theodore Roosevelt leaders who ride and promote proper riding safety attended the event.

No one “silver bullet” exists to promote safety. It requires a top-down culture, and leadership at all levels must stay fully engaged. The shipyard is a loud, hot, dynamic environment to work in, but major mishaps can be prevented. ■

The author is the ship's safety officer.

Navy photo by PH2 Larry Hess



The Nimitz-class aircraft carrier USS *Theodore Roosevelt* (CVN-71) transits the Elizabeth River.

Impressive? Yes

By AE2 Steve Blocher,
NAS Whidbey Island

I've always felt I know close to everything, even though events have proved me wrong a number of times.

As a teenager, I argued with Dad about a number of things I've since learned Dad was right about all along. I've always figured other people tend to be idiots, or they're just following the irrational logic of an overcautious mother who watches too much Martha Stewart. I mean, speed limits are made for those people who are horrible drivers; people wearing helmets while riding a bike are trying to start a fad; and don't even get me started on the new safety devices on lighters.

C'mon, did cowboys in the Wild West wear reflective vests while chasing down outlaws? They certainly didn't have plastic, electrical-socket protectors for kids back in the 60s, and, yet, we survived. So, it must be just a big conspiracy for mass marketing of protective devices to make money. In my way of thinking, the warning sticker on Coke machines—the one showing a picture of a machine falling on someone—is especially hilarious. “Watch out the next time you buy a soda because Coke machines are crushing innocent people all across America,” the sticker would have you believe. Yeah, right...

This kind of flawed thinking got me in trouble, starting with a shopping trip to the supermarket. The weather was warm, despite being the first week in December. I had a day off coming and planned to entertain lots of people at my house the night before. We were having a party in the backyard, complete with fire, music and barbecue—but with no people-crushing Coke machines anywhere in sight.

I was at the store buying my share of the goods, beginning with Mr. Kerosene. The bottle stared down at me from the shelf, looking like one of those kids my parents had told me not to hang out with—the kind that will get you in trouble. Mrs. Lighter Fluid was right next to him but didn't have quite the same *presence*—the “I mean



business; let's go cook something” look. Besides, the charcoal lighter cost \$3 for a small bottle, compared to \$5 for a huge container of kerosene. The economical and smart thing to do was to get the most “bang” for the buck, right? I'd used kerosene before on camping trips and never had had any problems. My rule was simple: Just stand far enough away, and everything will be OK. After gathering a few more items in my shopping cart, off I went.

By the time I got home, it was getting dark, and my roommate and another friend already had arrived. We needed to get a fire roaring in that 55-gallon barrel in the backyard. My two buddies

es. Smart? No!



already had put cardboard and wood inside the barrel, so I popped the lid, doused the contents with kerosene, and made a trail across the grass from the barrel to my paved basketball court. Then, while my two buddies stood a safe distance away, I announced the party was about to commence.

I lit the trail of kerosene and watched as the flames raced across the court, up and into the barrel, where the kerosene-soaked contents burst into flames with a GGWOOOSSH! The fire was blazing merrily. “That’s the way to do it,” I thought to myself with satisfaction. “Instafire—cavemen probably wished they had had this

stuff. Native Americans wouldn’t have had to rub sticks together if they’d just had some kerosene.” The three of us then just stood around the barrel, warming up and waiting for guests to arrive.

Unfortunately, some of the wood must have been damp because the fire soon started to die down. It looked like a mere shadow of its glory just a few minutes earlier. “No problem,” I thought. I told my buddies to stand back as I grabbed the kerosene again and chucked a couple more ounces on the fire. With another GGWOO-OSSH! it was back up to normal but only for a short while. I again told my buddies to stand back while I tried to get the fire **really** going.

This time, I only heard the GGWOO... part of the sound effects when the flame somehow—seemingly magically—shot back out of the barrel and into the three-fourths-full bottle of kerosene in my hands. The fire climbed straight up the stream of kerosene still pouring out.

I just stared at the bottle of kerosene in my hands and the flames spewing from the container’s opening.

At first, I had what I describe as “a Matrix moment,” when everything happened in slow motion but with detail so sharp it was unreal. I just stared at the bottle of kerosene in my hands and the flames spewing from the container’s opening. At that instant, reality set in. Hollering “Holy s..t!” I flung the flaming bottle as far as possible. It landed in my yard, next to a fence, and ignited the grass. The circle of fire grew as more kerosene poured from the bottle.

Meanwhile, I realized I had absolutely no source of water in my backyard, so I told my roommate, who was nearest the flaming bottle, to kick it onto the paved basketball court. The bottle flew through the air, spewing fire everywhere, but, instead of landing on the basketball court, it hit my other friend in the chest. He apparently was too stunned or hadn't heard my great plan. My roommate and I, on the other hand, were too scared and frantic at the time to do anything but get the flames away from the grass and fence. We didn't see him standing in the line of fire.

As my friend caught fire, he had the presence of mind to remember the rule: Stop, drop and roll. He fell to the ground and started rolling around, trying to smother the flames, but these efforts weren't working. His shirt now was soaked with kerosene. I ran over and shouted for him to lift his arms; as he did, I yanked off his flaming shirt as quickly as possible. In the meantime, my other friend finally got the still-flaming bottle onto the basketball court, and the flames died.

My friend escaped with second-degree burns on his arm and first-degree burns on his chest. He handled the pain like a champ, and, after he had soaked his arm in cold water for several hours, we managed to get him to medical.

Thinking back, there are several things we could have done differently to prevent this near-disastrous mishap or to end it more quickly:

- I should have stuck with charcoal lighter; it lights fires just fine and isn't anywhere near as explosive and dangerous as kerosene.
- Bigger fires aren't always better. You don't always have to impress everyone.
- When you have a party outside with fire involved, always keep a lot of water, sand, a fire extinguisher, or all three handy. We didn't have anything close by for use in an emergency.

Finally, I hope others will read this story so they don't have to learn their lesson the hard way, too. I've heard that some people actually use gasoline to light campfires. A few months ago, I might have said, "Cool, dude!" but not anymore. I'm just thankful my friend still is alive—albeit with a scar on his arm—and my garage still is standing. ■

How Stupid

By MR1 John Mapp,
SIMA Norfolk

The Naval Safety Center's "Friday Funnies" repeatedly points out that many of our younger Sailors and Marines seem to think they're bulletproof. I've seen it many times myself and even have been guilty of the same arrogance.

Sometimes, however, the problem isn't youthful invulnerability; it's a basic lack of mental acuity. Let us revisit an old "Rocket Scientist of the Week" winner from the Friday Funnies. We'll call our hero Fireman Bulb. He made the Funnies by zapping himself with an electrical submersible pump while dewatering a flooded compartment. I'm not going to retell that sad story but one that took place about 10 days later.

It was the same ship, the same fireman, and the same Mediterranean. The ship was heading to Italy after a stop in Turkey. Fireman Bulb, after being suitably chastened by the LPO (your humble spinner of tales), the chief, and the ship's doctor for his near-electrocution, had returned to his normal duties in the welding shop. His LPO was on the binnacle list for pneumonia, so the divisional LCPO was running the workcenter.



Can One Person Be?

Our hero was working on the metal-shearing machine when he spied his chief making a dangerous mistake. The chief was positioning an aluminum plate, but he had his hand under the guard for better control of the plate. “Chief, get your hand out of there,” admonished FN Bulb. “You might get hurt.” The chief yanked his hand clear and complimented FN Bulb for his attention to detail.

The very next day, FN Bulb was cutting a large sheet of steel on the same machine and, like the chief, mistakenly put his hand under the safety guard. Unlike the chief, though, FN Bulb left his hand under the guard and hit the foot lever. His hand was well clear of the shearing edge, so he thought he’d be safe. Alas, our hero had neglected to consider the large pistons that press down on the plate to hold it in place for cutting. One of those pistons came down on FN Bulb’s little finger.

A crunch was heard, followed by the sound of the shear cutting the plate, which nearly was drowned out by FN Bulb’s painful yelp. After the shear cycle, the pistons retracted, releasing FN Bulb’s now-flattened pinky. He turned his ashen face toward his chief and said, “Chief, I screwed up,” then promptly fainted.

The ship had to divert and fly FN Bulb to the nearest NATO base at Souda Bay, Crete. He then flew to Naval Hospital, Naples, Italy, where doctors tried to save his pinky but couldn’t. They ended up amputating the first two joints, leaving FN Bulb with only a little stump and a story to share with his buddies. Nerve damage left his stump with no sensation at all.

Our story should have ended here but didn’t. After several weeks, our hero was in a transient-personnel unit at the Naples hospital, waiting to get transferred back to the ship. Intent on astounding his friends, he would show them a neat trick: He would hold the nerve-damaged stump over a burning lighter until the flesh started to sizzle. Neat, huh?

It was until the inevitable happened. The stump got infected, but FN Bulb ignored it. By the time the doctors got involved again, our hero had gangrene, and, this time, he lost half his left hand.

After a few more weeks of recovery, FN Bulb was transferred back to the United States for

He would hold the nerve-damaged stump over a burning lighter until the flesh started to sizzle.

discharge. The discharge orders should have read, “For exemplary ability at being stupid in public on three separate occasions,” but they probably were more prosaic.

The ship held a safety stand-down about watching out for one’s shipmates, with emphasis on maintaining adequate supervision.

The lesson here mainly is for supervisors who find themselves recognizing FN Bulb-like tendencies in young men and women in their shops. We can and should do our best to watch out for all our shipmates. Repeated training and warnings about using machine guards and safety interlocks usually suffices to prevent lapses in common sense among most workers. In the case of FN Bulb, though, it would have taken non-stop observation 24 hours a day.

Workers with a tendency to suffer or cause mishaps to others need a lot more monitoring in the dangerous environment of Navy workcenters, both afloat and ashore. It’s up to supervisors to spot problems and prevent tragedies like this one. ■

Oops! I Spoke

By Cdr. Dave Silkey,
Executive Officer, VFA-87

A carrier air-wing commander once told me the best part about being XO is that you're in on all the important decisions but are responsible for few, if any of them. After four months in my current job, I honestly still can say it's the greatest one in the Navy, even though there have been some bumps along the way.

I remember talking to the skipper about how well everything seemed to be going. Our troops were performing at levels that amazed us both; all operational commitments were being met with stellar results, and the maintenance department had turned the corner on the post-deployment/surge-period aircraft-readiness challenges.

One weekend later, though, things fell apart. Thursday started with disappointing news that one of our newly frocked superstar PO3s had popped positive for cocaine use. This young man's Navy future could have been limitless. The news about him caused many a wet eye among the ranks because we knew his time as a Golden Warrior would be very short.

On Friday morning, I got a call that one of our less-than-stellar performers had been arrested for DUI. Saturday morning began with a phone call about a second DUI arrest from Friday night. A young airman took center stage Saturday night by being drunk while on duty, and Sunday morning's rude awakening was that one of our young airmen had been incarcerated for assault. Talk about getting blindsided with a whole pot full of bad news!

Needless to say, Monday was consumed with a flood of meetings as we tried to get our arms around this stream of poor conduct. The skipper solicited inputs from every level of leadership—to the last man and woman, all agreed that the message was being put out. We obviously had proof, though, that it wasn't being heard.

Our department-head meeting revealed the expected responses but did provide some good insight:

- In general, our folks showed tremendous pride in their professional lives; their on-the-job performance was commendable. However, they

Navy photo by PH3 Matthew Bash



e Too Soon



Navy photo by PHAN Chris Thamann



Navy photo by PH2 Charles A. Edwards, Jr.

It's one thing to “put out the word”; it's another matter to make sure the word is heard and followed.

displayed little or no pride in their personal lives.

- All agreed that our folks readily acknowledged the risk but were willing to accept it—possibly because they felt they had little to lose.

We already had established a free “dial a taxi” service within the command, but, much to our chagrin, not one Sailor had taken advantage of this program in more than four months. We also had tried filling their off-duty hours with Captain's Cup participation and other squadron events. Still, something obviously was lacking.

To manage this leadership challenge, we adopted several measures:

- We placed an additional signature line on all leave and out-of-bounds chits for the member's mentor.

- The skipper asked each division officer to identify at-risk personnel: those male E-4s and below with a previous NJP, XO inquiry, or discharge review board. Once identified, these individuals are monitored closely before the start of each weekend's liberty.

- All division officers were required to read the Plan of the Week line-by-line to their divi-

sions—both the day- and night-check personnel. The division officers also were told to reiterate the command's zero-tolerance policy for drunk driving and drug usage. The skipper made the CMC and me responsible for getting the word out to our TAD folks.

- We established a squadron phone tree that the CO or I would activate anytime 100-percent notification of personnel became necessary (e.g., anytime a significant event happens to a War Party member). The phone tree also would be used to help manage all hands with respect to force protection in the event of stateside terrorist aggression.

The events of that one weekend drove home numerous points for the skipper and me. It's one thing to “put out the word”; it's another matter to make sure the word is heard and followed. We must protect our most precious asset—our people. We cannot afford to lose man-hours when they are caught up in the court system for drunk driving or confined to hospital beds for injuries. And we certainly don't want to see one of them die in a mishap. ■

Navy Deaths *and* Injuries

By Dan Steber,
Naval Safety Center

This study of off-duty mishaps (recreation, athletic and home) is based on data from FY94 to FY04 and follows two other studies ordered by Commander, Naval Safety Center, RADM Dick Brooks. “Reducing Maintainer Deaths and Injuries” in the spring 2004 issue of *Mech* magazine detailed the findings of a study that centered on aviation ratings only. Meanwhile, “Navy Deaths and Injuries on our Roads” in the winter 2004-05 issue of *Sea&Shore* detailed the findings of a study that focused on PMV mishaps among all ratings.

In this latest story, you’ll find a listing of off-duty casualties by individual rates, a summary by ratings, a summary ordered from highest to lowest mishap rate,

and a summary from highest to lowest death rate, and a listing of deaths regardless of population. Senior rates showed up more frequently in off-duty mishaps: 7 of 20 death rates were E-6 or above, and 4 of 20 mishap rates were E-6 or above. Rates with fewer than 150 people were excluded to ensure a fair and statistically significant sample.

The average off-duty mishap rate for all ratings was **99.59**, and the average death rate was **6.49**. Ten rates were three times or greater than the average mishap rate (high of **491.80**). Ten rates were two times or greater than the average death rate (high of **36.76**).

[Note: Asterisks indicate rates in the top-20 from the PMV study.—Ed.]

Navy photo by PH2 Tiffini M. Jones



in Off-Duty Mishaps

Top-20 Rates (death rates—mishap and death rates are per 100,000 people, per year):

Rate	Pop	Deaths	Death Rate
SWCN	166	3	180.72
UTCN	252	2	79.37
STGSN	266	2	75.19
DCFN*	183	1	54.64
FCCS	191	1	52.36
ICFN*	391	2	51.15
FT3	215	1	46.51
YNCS	231	1	43.29
OSCS	234	1	42.74
YNSN	473	2	42.28
TM3	243	1	41.15
BMC	244	1	40.98
AZAN*	258	1	38.76
DKSN	258	1	38.76
MMCM	264	1	37.88
DK2	588	2	34.01
BU2	602	2	33.22
GSMC	302	1	33.11
BUCN	605	2	33.06
AZ1	672	2	29.76

These 20 rates (4.2 percent of all rates) accounted for 14.1 percent of all deaths. The top-50 rates (10.5 percent of all rates) accounted for 38 percent of all deaths.



Navy photo by PHAN Ryan O'Connor

Top-10 Rates (deaths regardless of population – No. 10 spot is tied with 3 deaths each: AT3, BM1, CS3*, EM3*, ET3*, FC2, MM1, MM2*, MMC, SK1, and SWCN)

Rate	Pop	Deaths	Mishap Rate	Death Rate
AN*	14,108	10	75.84	7.09
SN*	13,299	10	123.32	7.52
AT2	3,338	6	01.86	17.97
IT2	4,234	6	87.39	14.17
HN	6,595	5	40.94	7.58
AOAN	2,046	4	117.30	19.55
ATAN	2,034	4	68.83	19.67
FN*	5,365	4	124.88	7.46
MM3*	5,330	4	121.95	7.50

Top-10 Ratings (deaths regardless of population)

Rating	Pop	Deaths	Mishap Rate	Death Rate
MM*	18,327	15	109.13	8.18
AT*	11,657	14	91.79	12.01
IT*	10,966	13	111.25	11.85
AN	14,108	10	75.84	7.09
HM*	24,391	10	47.97	4.10
SN*	13,299	10	123.32	7.52
EM*	9,395	9	110.70	9.58
ET*	16,207	8	110.45	4.94
YN	7,549	8	128.49	10.60
AO	8,119	7	99.77	8.62



Navy photo by PHAN Erica Treider

Top-20 Rates (mishap rates):

Rate	Pop	Inj/Deaths	Mishap Rate
DCFN*	183	9	491.80
MR3*	172	7	406.98
BMC	244	9	368.85
TM2	218	8	366.97
DC3	850	31	364.71
GMSN*	308	11	357.14
TM3	243	8	329.22
ICC	158	5	316.46
SWCN	166	5	301.20
ENFN*	372	11	295.70
AW3*	380	11	289.47
STGSN	266	7	263.16
OS3	1,681	42	249.85
GSEC	204	5	245.10
TM1	250	6	240.00
OSSN*	1,253	30	239.43
UTCN	252	6	238.10
STG3*	800	19	237.50
AZAN*	258	6	232.56
FT3	215	5	232.56

These 20 rates (4.2 percent of all rates) accounted for 4.7 percent of all injuries/deaths. The top-50 (10.5 percent of all rates) accounted for 19.1 percent of all injuries/deaths.

Top-10 Ratings (mishap rate) Top-10 Ratings (death rate)

Mishap			Death		
Rating	Pop	Rate	Rating	Pop	Rate
TM	899	300.33	SW*	816	36.76
DC*	3,490	223.50	UT*	1,018	19.65
STG	3,537	197.91	STG	3,537	16.96
QM	3,894	190.04	DK	1,829	16.40
HT*	3,899	171.84	BU*	2,517	15.89
BM	7,062	164.26	FT	1,417	14.11
GM	4,466	158.98	AT	11,657	12.01
OS	9,163	157.15	AZ	3,373	11.86
EN*	5,663	155.39	IT	10,966	11.85
MR*	1,173	153.45	STS	2,546	11.78

The people who are “high risk” in both (PMV and off-duty) lists may need immediate leadership attention. We don’t know specific causes for the higher rates, but here are several intervention strategies worthy of consideration:

- Discuss possible reasons for abnormally high rates.
- Review work schedule and fatigue issues.
- Present quarterly off-duty (recreation/athletic/home) training, with focus on PPE and mishap prevention, or drive-safe training for PMV. During long weekends (holidays) and pre-/post-deployments and when visiting foreign ports, conduct ORM training. 

Saved by the Net

By DC2 Scott Hoffman,
USS *Harry S. Truman* (CVN-75)

The January-March 2004 edition of the Naval Safety Center's Ships' Safety Bulletin contained an article about trunk-safety nets by STSCM(SS) Robert Dingmann. He explained that, throughout the fleet, these nets often are not up to specifications. Many are too wide, some are missing weight tags, and a large number sag. The following account is a testimonial to the importance of ensuring the proper safety nets are in place.

The morning of Nov. 27 was like any other aboard ship, during operations in the Arabian Gulf. We were conducting replenishment at sea, with a sun-filled sky and calm seas. The hangar bay was buzzing with the sounds of forklifts and conveyor belts, while the crew was below decks, preparing for various watchstation duties.

Hours passed without incident before we heard the 1MC blaring, "Deep rescue, deep rescue, deep rescue in compartment 7-128-4-T, 4B shaft alley." With those words, various emergency personnel throughout the ship rushed into action to rescue a shipmate who had fallen off the ladder in an access trunk. The rapid-response team from the medical department and damage-control division quickly assessed the scene and provided critical information on how to proceed with the rescue.

Moments before, an experienced DC3 had been carrying out her duties and preparing for watch in list control. Damage controlmen who stand this watch routinely climb down from the second deck to the seventh deck, using a vertical ladder. Unfortunately, the DC3's descent ended up being anything but normal.

About halfway down, she lost her footing and fell approximately 15 feet—from the fourth to the fifth deck—landing partway in the safety netting. She sustained head trauma and broke some teeth when she hit the steel deck plate and knife-edge. But, her ordeal didn't end there. She was hanging with most of her weight dangling over the edge of the net. Any wrong move could have sent her down to the next level.



Quick response of the watchstander in list control may have saved her life. Hearing screams, the watchstander hurried to the victim's side and moved her legs inside the net. The list-control watch then sounded the alarm for deep rescue by using the sound-powered phone circuit to notify damage-control central.

Within minutes, the rapid-response team was rigging rescue equipment for the deep rescue, while corpsmen assessed the DC3's injuries. She was evacuated from the space on an elevator and was taken to medical for evaluation and treatment. Inspection of the spaces leading from the second deck to the seventh deck revealed all ladders were normal and in good condition. The safety nets worked as advertised and truly saved the life of the DC3.

As noted by Master Chief Dingmann in his *SSB* article, the reference for trunk-safety nets is section 612e of General Specifications for Overhaul of Surface Ships. It says that, for every ladder extending through three or more decks, safety nets must be installed, beginning at the topmost deck. One also then must be installed at every other deck all the way to the bottom. ■

A Stillness in



By ACCS(AW) Gary Lohr, USNR,
Naval Safety Center

It is interesting how words seem two-dimensional, not given the benefit of experience. Simply knowing the definition is not enough. It is only with the benefit of experience, or sharing of experiences, that the words take on a third dimension, which allows true understanding. Perhaps with no other word is there greater truth to this analogy than with the word “suicide.”

My family and I were gathered in the room of a hotel, hundreds of miles from our respective homes. Questions, reflective comments, memories, and silence...most of all, I remember the silence; it seemed to make a sound. We had all gathered in preparation for a memorial service for Vincent, who, at the age of 39, had died as the result of his own deliberate actions. A master sergeant in the Marine Corps, Vincent was an individual with varied interests and many talents. He was one of the finest people I ever have known—he also was my brother.

The call had come early one morning; my brother had died, supposedly of a heart attack. I was on travel in Denver, Colo., and caught the first flight back to the East Coast. The trip was filled with predictable reflections, mostly those of younger years—of four boys growing up in a small town in southern Pennsylvania with their parents. Vincent was my oldest

brother, seven years my senior, someone I liked, someone I always had admired.

After a brief period at home, the long drive followed to the city where the memorial service was to be held. It wasn't until we arrived and had a chance to talk with other family members that we learned Vincent had taken his own life. As details emerged, so did questions—many more questions than answers.

Vincent had been expected at his unit early one weekday morning but never arrived. A member of his unit drove to his house, entered, found him on the dining room floor, and called the police. He had died some hours before.

The last day of Vincent's life seemed to be well planned. This much is known: He wrote five letters and, for reasons unknown, asked someone else to mail them. At some point, he chained his dog outside with ample food and water for several days. He meticu-

the Heart ...

lously sealed the doors and windows of his house, then started the engine of a car in the adjacent garage and opened the door leading to the inside of the house. While sitting at a table in the dining area, he wrote three notes to close friends, in addition to another note (to no one in particular), apologizing for the fact the house hadn't been cleaned in several days. The quality of handwriting in the final note clearly shows the effects carbon monoxide was having on his ability to write. Finally, letters no longer take form, and then there's a straight line—presumably signaling the fact he had lost consciousness.

I occasionally read these notes—why, I really don't know. I suppose it's the only connection to his last moments. I also read the police reports, hoping they will tell me something I haven't read so many times before.

Found on the table was a copy of the base newspaper that featured an extensive article on suicide. No "suicide note" was found (these notes are left only about 20 percent of the time).

From the letters and notes Vincent wrote, it's not clear why he took his life. Those close to him in his battalion stated that, in the days before his death, he was upbeat and in good spirits. This behavior is con-

sistent with that in many suicide cases; a solution to the "problem" has been determined, so it's no longer a problem.

His death, under these circumstances, came as a complete surprise to his family and friends. In the days and weeks following Vincent's death, it was difficult to think of anything else. Coupled with repeated analysis of what is known came speculation—all directed toward arriving at answers, ones that simply wouldn't come.

One of the five letters mailed on the day of Vincent's death was addressed to our mother; she didn't receive this letter until several days after the memorial service. In the letter, he said he was sorry he hadn't turned out to be "what the boys expected"—referring to my other brothers and me. This comment made me particularly sad because I can think of no basis for him to have felt that way. We, in fact, always had felt he was a success, both in his professional and personal life. It's evident he never knew I was proud of him and strived to adopt, in my own life, some of the very fine qualities that characterized his.

I think suicide breeds its own particular form of profound sadness—a kind of stillness in the heart. For those who choose this exit from life, their legacy often

is to have their existence defined by how they died, rather than by what may have been a meaningful and productive life—in many cases, a life of service. I hope this is not my brother's legacy.

In his younger years, Vincent was active in his church, serving in many capacities. To his brothers and friends, he was a good-natured and giving person, someone who was fun to be around and who would give you anything he had. During his career in the Marine Corps, he volunteered for counselor duty at the Navy's Drug

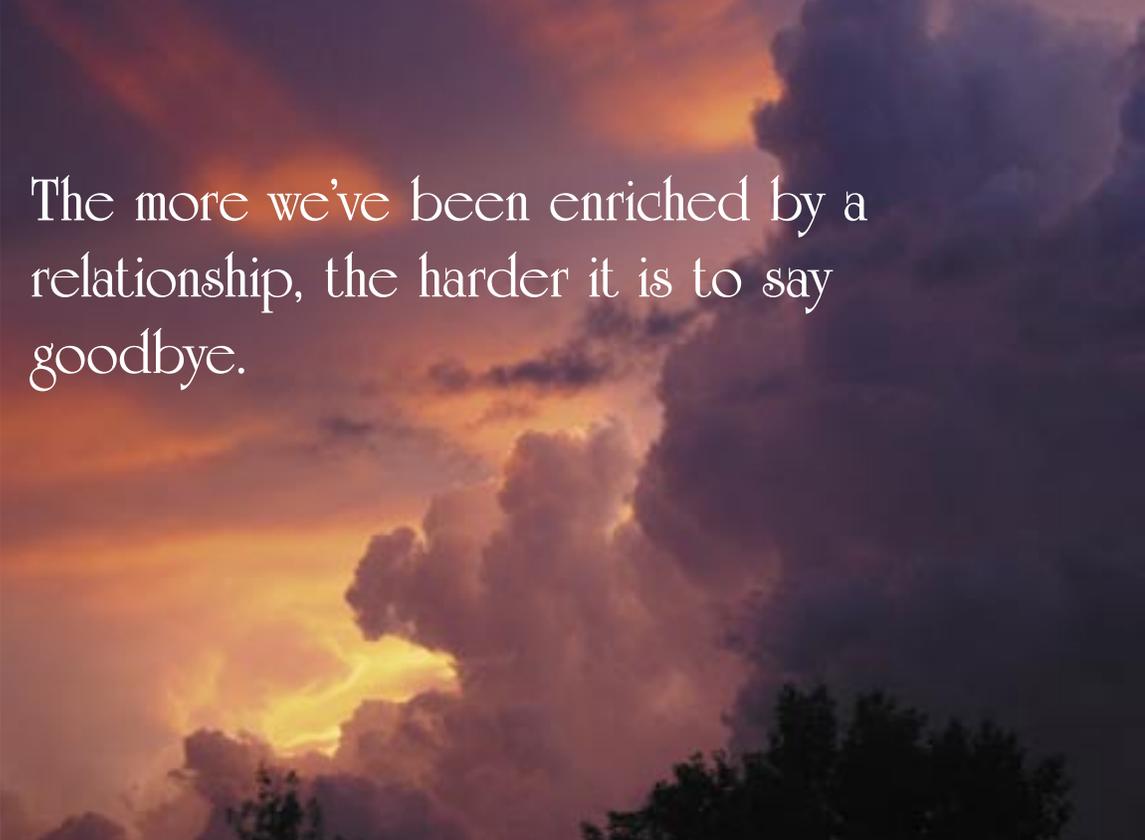
... most of all, I remember the
silence; it seemed to make a sound.

and Rehabilitation Center, Jacksonville, Fla., followed by a tour at the Marine Corps Casualty Company, San Diego, Calif. I spoke with him many times during these years; his concern for those he counseled remained 24 hours a day. I suspect that he carried this concern with him the rest of his life. I've read many of the letters written by those he helped during those years, and they are among the most touching letters I've ever seen. At his memorial service, several of the Marines he had counseled traveled considerable distances to attend.

Finally, as top sergeant in his battalion, Vincent was a mentor and friend to his fellow Marines. To define his life by how he died would be unfair to his life's work and achievements. For those left behind, the sadness of losing someone to suicide is lifelong, and it's never very far from your daily life. Maybe it's the inevitable thoughts of our own role in someone's life and how our contributions, as well as those of other friends and loved ones, weren't enough to ultimately make a difference. Or, perhaps it's the notion that someone, at some point, could have detected behavior changes that would have triggered a "life-line"—the list goes on and on.

I'll never forget when the space shuttle Challenger exploded shortly after launch. The mission clock was allowed to continue, clocking the time for a mission that wouldn't take place. The clock in my family's lives continues, counting the unfulfilled promise of Vincent's life. I would hope that, were he with us today, he would have realized the promise and fullness of life that were there for him. I only know that those who were close to him forever will live with fond memories, too many unanswered questions, and, sadly, the thought that he should be here with us today.

I'm sharing this story in keeping with the spirit of caring that characterized Vincent's life. I know he would not have wanted others to travel the road he ultimately chose, and I hope that sharing this story serves to show how each life affects so many others. Suicide doesn't just take the life of the person who



The more we've been enriched by a relationship, the harder it is to say goodbye.

commits the act; it also takes a part of the lives of those who were close to that person.

I ask each of you to pause for just a few moments in your life. Consider those who travel the streets of despair, the back alleys of a disconnected existence in worlds of their own making, unable to regain touch with the "plus side of their ledger"—those things that give life true meaning. And, in pausing, I think you'll be driven to give hope to those in need, regardless of the circumstances or the inconvenience of the time and place.

I recently attended a joint-services workshop that was geared toward developing a curriculum for training frontline supervisors to identify and assist those in various forms of distress. This workshop underscored the Department of Defense's commitment to suicide prevention. In this workshop, the idea of "the hope option" was conceived—the thought that, regardless of how dire a situation seems, there is always hope. It is each person's responsibility to provide "the hope option" to those who have lost touch with hope.

One final thought: I suppose that the magnitude of our sorrow and pain is in direct proportion to the bond we have with the ones we lose. The more we've been enriched by a relationship, the harder it is to say goodbye. I only wish I could have said "goodbye" to Vincent and to have thanked him for the richness he gave to my life. Today, I would give anything just to have one more conversation with my brother. Vincent died in 1986, and I still miss him today as much as ever. ■

While the rate of suicides in the Navy and Marine Corps is well below the national average, the loss of even one person is very painful, unnecessary and preventable. Nationally, suicide ranks among the top 10 causes of death across all ages, with more than 30,000 victims each year. It usually ranks as the second- or third-leading cause of death among active-duty Sailors and Marines.

The U.S. surgeon general has called suicide a serious public health threat to our nation. In his Call to Action Report, he pushed for development of strategies to prevent suicide and the suffering it causes. In response, the Navy and Marine Corps joined forces to develop a plan to better address suicide-prevention efforts.

The philosophy of watching out for fellow Sailors and Marines is a key factor in these efforts. The acronym

“AID LIFE” is a reminder about what to do if you suspect someone may be in trouble:

A – Ask the person if he/she is thinking about suicide.

I – Intervene immediately.

D – Don’t keep it a secret.

L – Locate help.

I – Inform the chain of command.

F – Find someone; don’t leave the person alone.

E – Expedite; get help right away.

For information on Navy policy, training and research in suicide prevention, go to this website: www.npc.navy.mil/CommandSupport/SuicidePrevention/.

For information on Marine Corps suicide awareness/prevention, go to this website: www.usmc-mccs.org/perssvc/prevent/suicide.asp.—Ed.

New Water-Safety Video Helps Marines Stay Safe

By Cpl. Jennifer Brown, USMC,
Marine Corps Base, Camp Butler

For the first time in four years, the “critical days of summer” 2004 passed without the loss of a single service member to drowning in Okinawa’s surrounding waters. This milestone, according to Marine Corps Base Camp Butler safety officials, is the result of a new water-safety video that was introduced April 16.

With recreational drowning incidents the No. 1 killer of status-of-forces-agreement personnel islandwide, Okinawa is rated the most dangerous duty assignment in the Marine Corps. That’s the word from Shawn Curtis, an occupational safety and health specialist, who went on to explain the severity of the problem. “We have more drowning fatalities on Okinawa than the rest of the Marine Corps combined,” he said. The reason this area is such a hot spot for drowning incidents, according to him, is the six-month and one-year duty assignments. “The Marines don’t have the experience on island to let them know how dangerous the water is,” explained Curtis.

Most drowning deaths since 2000 have involved military members who were swimming, cliff-diving, snorkeling, diving in rough conditions, or standing too close to the surf. As Curtis noted, “They simply got caught in currents and were swept out to sea.

“In the first four months of CY2004, we lost five members of our community,” he said. To put these drowning numbers in perspective, consider that while only 10 percent of the Marine Corps’ active-duty force is stationed on Okinawa, 24 percent of all off-duty drowning incidents occur there.

Before participating in water activities, be aware of current water conditions.

The new water-safety video, which aired on the commander’s access channel throughout the summer and which had excerpts aired daily on the American Forces Network radio station, alerts people to the possible dangers associated with swimming. Specifically, it discusses cramps and exhaustion and the effects drugs and alcohol have on personnel participating in water activities. Also included on the video is an explanation of the typhoon and sea conditions, along with a discus-

Photo by Cpl. Jennifer Brown, USMC



A lifeguard blows his whistle and points to a swimmer who is violating an Okinawa pool-safety rule.



Photo by LCpl. Martin R. Harris, USMC

sion of the particularly dangerous water locations around Okinawa.

Marine SSgt. Jason Hoffman, a training-staff noncommissioned officer at the Camp Foster provost marshal's office, has spent much of his free time during the last 14 years scuba diving. Hoffman, who recently received his dive-master certification, believes water safety consists of sensibility and staying informed.

"Prior planning, such as watching televised weather reports and checking the current sea

"We have more drowning fatalities on Okinawa than the rest of the Marine Corps combined," he said.

conditions, is important," he said. "Also, staying out of water conditions above your own limits or certification is key to staying safe in the water. The new video is an excellent way of getting out information; it's up to the individuals whether they heed it."

Curtis agrees with SSgt. Hoffman's advice but takes it further. He has developed four rules for all to follow when swimming at Okinawa beaches and pools:

- Swim in a supervised area where lifeguards are on duty. Only 10 percent of water-related accidents happen when lifeguards are on duty. Swimming under supervision greatly reduces the chance of drowning.
- Never swim alone; use the buddy system. It's easy for a friend to assist or get assistance when he notices a partner having trouble in the water.
- Know your swimming limits and stay within them. Weaker swimmers should not attempt something they know they're not capable of doing.

- Always enter the water feet first, especially when diving in an unfamiliar area or in murky-water conditions. That way, you avoid hitting your head on underwater rocks or coral.

Another thing to remember is never swim during a typhoon or rough sea conditions. "People don't consider just how dangerous the water around here is," said Curtis. "During rough sea conditions, even strong swimmers have trouble in the local rip currents."

Even though the water can be a dangerous place, it doesn't have to be if people just will take precautions during their summer trips to the beach or pool. ■

Some information for this story came from a June 6, 2003, Camp Foster press release by then-Cpl. Ryan D. Libbert. The now-Sgt. Libbert is assigned to the II Marine Expeditionary Force, Camp Lejeune, N.C., as a data network specialist.

Anyone interested in seeing the water-safety video can log onto the website (www.mcbbutler.usmc.mil) and click on "internet." You then click on the "sites" link in the top left portion of the screen, scroll down to "safety," and click on "water-safety video."

If you have a ".mil" address, log onto www.mcbbutler.usmc.mil and click on "intranet." Then click on the "sites" link in the top left portion of the screen, scroll down to "safety," and click on the "water-safety information" link. Then you can click on "water-safety video," as well as a number of other choices.—Ed.

When Your Boat Springs a Leak...

One of the best things you can have around is a life jacket. No one knows that lesson better than two Sailors, ages 28 and 36, whose recreational boat sank one Saturday in October. They spent the night bobbing in the ocean, drifting miles apart from each other.

Rescue came the next day when the crew of a Coast Guard helicopter plucked the younger Sailor from the water, and a boater picked up the older man. Both victims were exhausted and, according to a Coast Guard spokeswoman, probably wouldn't have survived "had they not had life jackets on. They were treading water the whole time," she said.

Coast Guard statistics released in early-December 2004, showed that 86 percent of all boaters who drowned in 2003 weren't wearing life jackets. Alcohol also was a contributing factor in about one-third of all reported boating fatalities.

More than 95 percent of boat owners report having enough life jackets on board for all their passengers. As revealed in a 2001 and 2002 Coast Guard study of more than 25,000 recreational boaters, however, 66 percent of the passengers don't wear their life jackets every time they go out.

"Boaters need to be responsible for the safety of themselves, their passengers, and other boaters," stressed RAdm. J. W. Underwood, Coast Guard director for operations policy. "This means not only having life jackets on board but requiring your passengers to wear them all the time. You never know when an accident will happen that will prevent you from reaching for and putting on that life jacket."

The statistics also show the leading contributing factors in boating accidents are operator inattention, carelessness and inexperience, as well as excessive speed. Eighty percent of those who died in 2003 were on board boats whose operators had not received boating-safety instruction.

"There still are far too many deaths, injuries and accidents," continued RAdm. Underwood. "The key is education, which is why the Coast Guard's Office of Boating Safety has joined forces with a number of recreational boating-safety partners to launch our 'You're in Command. Be Responsible. Boat Safely!' initiative."



A Coast Guard PO3 inspects life jackets during a recreational boating-safety boarding in New York Harbor.

Recreational boating fatalities in 2003 were down six percent from the previous year, continuing a 12-year downward trend. The 13 million registered boats in 2003 represent two million more craft on America's waterways than 12 years ago.

The new statistics are posted on the Coast Guard's Office of Boating Safety website at www.uscgboating.org and include statistics broken down by state. For more information, boaters can visit www.vesselsafetycheck.org or call the Coast Guard infoline at 1-800-368-5647. ■

Chiefs: *Don't Leave Any Sailor Behind*

By FLTCM(AW/SW) Jon R. Thompson,
ComLantFlt Staff

When it comes to education, our nation subscribes to a philosophy that states, “No child left behind.” ... I see no reason why we chiefs don’t adopt a similar phrase for those we lead: “No Sailor left behind.”

What am I talking about? As chiefs, we do not have the luxury of choosing the Sailors under our charge. We get the superstars and the underachievers. We get the overachievers and those who don’t want to or can’t perform. We get the perfect ambassadors and the occasional bad apples. Like it or not, the Sailors we lead need our help—each and every one of them.

I recently read an article in *Navy Times* where RAdm. Brooks from the Naval Safety Center discussed intrusive leadership. He talked about the fine line between treating Sailors as adults and getting involved in their lives enough to help them make sound decisions. I liked his rationale. What’s more, I always have been a fan of deck-plate leadership. You need that level of leadership because all our Sailors are not on autopilot. ...

Chiefs, each of us must bear the weight of each Sailor’s successes and failures. The only way we can achieve this is to truly get to know our people—each of them—and tailor the training and guidance we give them to their own exact needs.

Each of us easily can recall the Chief Petty Officer Creed, which says, “More will be expected of you; more will be demanded of you.” This is exactly what I’m getting at. More is expected of you; more is expected of me; more is expected of all our leadership. Every one of us needs to take stock of our people and take a more active role in ensuring every Sailor gets through his or her enlistment or career—successfully. ... It’s not enough just to explain the rules to them. It’s every chief’s responsibility to understand the world our Sailors live in, what motivates them, and what concerns them.

Shipmates, our work is not easy, nor quick. However, if we, as a community, make a more concerted effort to truly take care of each of our Sailors, I’m betting we can reduce the number we lose in drunk-

driving incidents. We also may reduce the number of domestic-abuse cases, anger incidents, and those who find themselves in financial trouble. I’d also bet we’ll see respect and military bearing improve across the board, and the appearance of our bases, ships and squadrons also may improve. ...

As we reduce the number of active-duty Sailors in our ranks, your role as a chief will become that much more important. Many talk about the blurring line between the wardroom and the CPO mess. While that may or may not be true, let me assure you the basic role of the chief is unchanged. Yes, we are capable of doing almost any job in the Navy—traditional or otherwise. However, our No. 1 job is to look after those Sailors we lead. There never can be a more important or pressing job for us.

So, who is on board with this? My sincere hope is every chief truly grasps and accepts our role and will re-focus efforts not to leave any Sailor behind. It isn’t easy, it isn’t quick, there are no shortcuts. Taking leadership to an intrusive level means taking time to learn about your Sailors, each and every one of them. I don’t need to tell you how to do this in great detail; I suspect you already know. The challenge is to break out of your current routine and start making more time for your people—talk to them, counsel them. Don’t delegate everything to your petty officers. You are the chief; set the standard—take this effort to the next level yourself.

Last year, Adm. Mullen told a group of chiefs in Rota, Spain, “To be a leader, you have to behave like one.” What he was saying is our actions speak a lot louder than our words. I’m guessing we all say we take care of our people. My question to you is: To what degree do you do that? If you only sort of take care of your people, or only take care of those Sailors who do everything right and are easy to lead, you’re not quite there yet. The true hallmark of a brilliant chief is the ability to ensure every Sailor is taken care of—no matter their past, no matter their needs, no matter their talent level. ... Thanks, chiefs. Go take care of our most valuable asset—our Sailors. ■

Navy photo by PHAN Travis M. Burns

**Make sure
the only
bright lights
you see this
Fourth of
July are in
the sky—**

**Not in an
emergency room**

www.safetycenter.navy.mil

