

# Reducing Mishaps by 50%



Winter 2004-05

# Sea & Shore

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

## **In This Issue:**

Special 50-Percent  
Mishap-Reduction Pullout



# Sea & Shore

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

**RADM Dick Brooks, Commander, Naval Safety Center**  
**Col. Al Lewis, USMC, Deputy Commander**

**John Mahoney, Head, Communications and Marketing Department**

Naval Safety Center (757) 444-3520 (DSN 564)

Dial the following extensions any time during the greeting.

## Sea&Shore Staff

**Ken Testorff, Editor** 7251  
 kenneth.testorff@navy.mil

**Patricia Eaton, Graphic Artist** 7254  
 patricia.eaton@navy.mil

**Ginger Rives, Distribution** 7256  
 virginia.rives@navy.mil

## Points of Contact

**Publications FAX** (757) 444-6791

**Shore Safety Programs Director** 7166  
 Capt. William Glenn

**NavOSH Programs Director** 7156  
 Capt. C.D. Brassington, MSC, CIH

**Explosives & Weapons Safety Division** 7164  
 Cdr. (Sel.) Marcus Culver, Head

**Fire Protection Division** 7169  
 Vince Lisa, Head

**Traffic & Off-Duty Safety Division** 7602

**Tactical Operations & Safety Investigation Division** 7147  
 Jim Wilder, Head

**Training Safety Programs Division** 7175  
 CWO4 Tom Deatherage, Head

**Shore Safety Programs FAX** (757) 444-6044

**Shore Safety General E-mail**  
 shore@safetycenter.navy.mil

**Afloat Safety Programs Director** 7133  
 Cdr. Ritch Martel

**Surface Division** 7116  
 LCdr. Walt Banks, Head

**Diving & Salvage Division** 7086  
 LCdr. Alan Tupman, Head

**Submarine Division** 7089  
 Lt. Victor Romano, Head

**Data Analysis and Media & Education Division** 7115  
 Steve Scudder, Head

**Afloat Mishap Line** DSN 564-1562

**Afloat Safety General E-mail**  
 safe-afloat@navy.mil

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

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

Contents are not necessarily the official views of, or endorsed by, the U.S. Government, the Department of Defense, or the U.S. Navy. Photos and artwork are representative and do not necessarily show the people or equipment discussed. We reserve the right to edit all manuscripts. Reference to commercial products does not imply Navy endorsement. Unless otherwise stated, material in this magazine may be reprinted without permission; please credit the magazine and author. Periodicals postage paid at Norfolk, Va., and additional mailing offices.

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

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

**POSTMASTER:** Send articles and letters to:  
 Commander, Naval Safety Center  
 Attn: *Sea&Shore*, Code 71A  
 375 A Street, Norfolk, VA 23511-4399  
 or e-mail the editor, kenneth.testorff@navy.mil. Visit us on-line at www.safetycenter.navy.mil

## COVER



Navy photo by PHAN Dustin R. Gates

Sailors play a game of touch football on the flight deck of an aircraft carrier.

## FEATURES

### 5 CPSC Issues Warning for Paintball Guns

Enthusiasts are cautioned about the dangers of unscrewing the brass or nickel-plated valve from a carbon-dioxide canister.

### 6 All for a Football

By MM2 Pat Lumumba

A young Sailor throwing around a football on the flight deck loses situational awareness and is lost overboard.

### 6 A Double Dose of Reality

By Ken Testorff

After two man-overboard incidents in 16 days, a ship holds a safety stand-down.

### 8 Oh, What a Flash!

While getting ready for deployment, a young Sailor burns a pile of gunpowder to get rid of it in a hurry and suffers the painful consequences.

### 10 The Day We "Stole" a Crane

By LCdr. Jesse Brittain

The author recalls a day as a junior officer when he needed a crane, but one wasn't available.

### 13 Pike's Peak or Bust

By Ken Testorff

Two Sailors with the sickle-cell trait go mountain climbing, despite warnings about the possible consequences, and they end up in hospitals.



Pg. 14



Pg. 20



Pg. 23

## 14 **Tragedy Breeds Tragedy**

By Renee Wentz

As if picking up the pieces from Hurricane Isabel isn't enough, a Coast Guard wife finds herself dealing with the trauma of running over her 8-year-old son.

## 16 **Navy Deaths and Injuries on Our Roads**

By Dan Steber

A study shows who is most at risk of dying or being injured in PMV mishaps.

## 18 **The Simple Things (Part 3): When Small Errors Add Up**

By Steve Southard

A look at the many small errors that combined to cause the USS *Grayback* tragedy.

## 20 **Look Before You Ride!**

By Lt. Chris Saufley

A day of mountain-biking with friends turns into 30 days of recovery from two broken bones.

## 22 **Don't Break Just One Rule—Break 'Em All**

By Ken Testorff

A young Sailor crashes his car while returning from a weekend, 1,300-mile, one-way trip to visit family and friends.

## 23 **Sub School Tunes Up for Holidays**

Students and staff at Sub School get a free car inspection before heading home for the holidays.

## 26 **Why Bother? It Won't Happen to Me**

By LCdr. Mike Saling

A look at the difficulty in trying to educate Sailors and Marines about safety.

## 29 **Balancing Act**

By AE1 Joe Cox

A Sailor rushes a job to get to a steel-beach picnic and ends up taking a tumble from a ladder.

## 30 **USS *Donald Cook*—Taking Care of Their Own**

By Ken Testorff

Safety personnel aboard this ship hold a safety stand-down—not in response to recent mishaps but to reinforce an already successful safety program.

## 33 **Who Needs a User's Manual?**

By Lt. Ted Bohl

Throwing caution—and the user's manual—to the wind, the author grabs his new chainsaw and starts cutting down trees.

# DEPARTMENTS

## 2 **Admiral's Corner**

## 3 **Work Zone**

## 4 **Good, Bad, Ugly**

## 25 **Mail Call**

### **STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION 01 October 2004**

**The United States Postal Service requires all publications publish a statement of ownership, management and circulation.**

Date – 01 October 2004

Title of Publication – Sea&Shore

ISSN – Publication No. – 1550-1434

Frequency of Issue – Quarterly

Publisher – U.S. Navy

Editor – Ken Testorff

Owner – United States Navy

Total no. copies printed – 30,490

No. copies distributed – 30,040

No. copies not distributed – 450

Total copies distributed and not distributed – 30,490

Issue Date for Circulation Data

Above – Fall 2004

Location of Office of Publication

Commander

Naval Safety Center

375 A Street

Norfolk VA 23511-4399



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

## Why Take Any Unnecessary Risks?

Most Sailors and Marines, including those 18-to-25-year-olds who think they're invincible, wouldn't even consider playing Russian roulette, yet they'll take other equally dangerous chances. For some, it's driving a car 100 mph—perhaps without wearing a seat belt.

For one 23-year-old fleet PO2, it was using a ship's table saw **after** he had removed the blade guard. He was making a trim cut on a 13-inch board when it suddenly twisted and kicked back, pulling his right hand across the saw blade. He immediately grabbed a rag, applied direct pressure to the wound, and reported to the ship's medical department. The diagnosis was a complicated laceration and fracture to the second digit. He had to be taken to a medical center, where an orthopedist surgically pinned his fractured finger.

After missing nearly 30 workdays, the PO2 returned to his ship as it was leaving port and had the ship's surgeon remove the pin. The surgeon immediately admitted him to a ward because of infection, failed antibiotic therapy, and surgical drainage of the wound. A few days later, the PO2 had to be flown to an overseas naval hospital, which subsequently transferred him to a naval medical center stateside.

As various leaders have pointed out, improving safety awareness—and thus preventing senseless mishaps like this—requires a culture change. Expounding on this remark, Assistant Commandant of the Marine Corps Gen. William L. Nyland said, "We have to understand that safety in and of itself is vital not only to the preservation of our wonderful young men and women, but also of the precious

assets that they operate, maintain or take care of. And a culture change is not necessarily easy to come by. Particularly in our case, you have 68 percent of the Marine Corps on any given day on their first enlistment. We want them young; we want the legs young. **But when you tell them they're bulletproof all day, you have to figure out how to tell them they're not bulletproof at night.**"

Chief of Naval Operations Adm. Vern Clark likewise has noted that ours is a dangerous profession. "If the commander in chief directs that we go to war, this is not a safe evolution," he said. "Our business is about being able to go into harm's way. **We want every Sailor and every Marine to understand the difference between willingly taking appropriate risks and taking unnecessary risks.**"

From our most junior Sailors and Marines to our most senior officers, a top priority is to keep them from preventable injuries or deaths and to prevent damage to our equipment. Success in our efforts will improve combat readiness, preserve precious resources, and keep families from unwanted sorrow.

Secretary of the Navy Gordon England summed it up best when he observed, "This is the Navy-Marine Corps family. If you really love our people and if you really care about our people, you don't let things happen to them. That's the way we need to look at this every single day."

  
 RADM Dick Brooks

# WORK ZONE

## REDUCING MISHAPS BY 50%

# Skateboarding

A 21-year-old E-2 is skateboarding when the wheels hit a rock, and he falls. He loses an estimated 90 workdays with a broken ankle... A 31-year-old E-6 trips and falls while skateboarding down a 3-foot wooden ramp. He loses 21 workdays with a broken leg... A 19-year-old E-2 loses his balance and falls while trying to slide down the handrail of a stairwell. He loses 30 workdays with a fractured ankle.

These Sailors are some of the more than 15,600 skateboarders, as reported by the U.S. Consumer Product Safety Commission, who make their way to emergency rooms each year for treatment. Fractures are a frequent type of injury, and some deaths occur as a result of collisions with motor vehicles and from falls. Irregular riding surfaces account for more than half the skateboarding injuries caused by falls. Wrist injury is the No. 1 injury—usually a sprain or a fracture. Skateboarders who have been skating for less than a week suffer one-third of the injuries.

The National Safety Council offers this guidance:

### Protective Gear

✓ Boards have varying characteristics for different types of riding (e.g., slalom, freestyle or speed). Some boards are rated as to the weight of the user.

✓ Protective equipment, such as closed, slip-resistant shoes, helmets, and specially designed padding, may not fully protect skateboarders from fractures, but wearing the gear can reduce the number and severity of cuts and scrapes.

✓ Padded jackets and shorts are available for skateboarders, as well as padding for hips, knees and elbows. Wrist braces and special gloves also can help absorb the impact of a fall.

✓ The protective equipment currently on the market is not subject to government performance standards, and careful selection is necessary.

✓ In a helmet, look for proper fit and a chin-strap; notice whether the helmet blocks vision and hearing. If padding is too tight, it could restrict circulation and reduce the ability to move freely. Loose-fitting padding, on the other hand, could slip off or slide out of position.

### How to Fall

✓ If you are losing your balance, crouch down on the skateboard so you won't have as far to fall.

✓ In a fall, the idea is to land on the fleshy parts of your body.

✓ If you fall, try to roll, rather than absorb the force with your arms.

✓ Even though it may be difficult during a fall, try to relax your body, rather than go stiff.

### Tips for Using a Skateboard

✓ Give your board a safety check each time before you ride.

✓ Always wear safety gear.

✓ Never ride in the street.

✓ Obey the city laws. Observe traffic and areas where you can and cannot skate.

✓ Don't skate in crowds of non-skaters.

✓ Never have more than one person on a skateboard.

✓ Never hitch a ride from a car, bicycle or other such means.

✓ Don't take chances; complicated tricks require careful practice and a specially designated area.

✓ Learn to fall—practice falling on a soft surface or grass. ■



# Good

It pays to “dress for the ride,” whether you’re on a motorcycle, bicycle or, in this case, a skateboard.

# Bad

All the fancy footwork and body English in the world isn’t going to help this unprotected skateboarder if he miscalculates one of his moves.



# Ugly

Here’s what happens when a skateboard goes one way and the rider goes the other. He had been performing a skateboarding stunt along the top of the fence before he took this tumble.



# CPSC Issues Warning for Paintball Guns

The U.S. Consumer Product Safety Commission (CPSC) has issued a warning about paintball guns. The warning is based on CPSC's investigation of two deaths caused by carbon-dioxide (CO<sub>2</sub>) canisters flying off these guns.

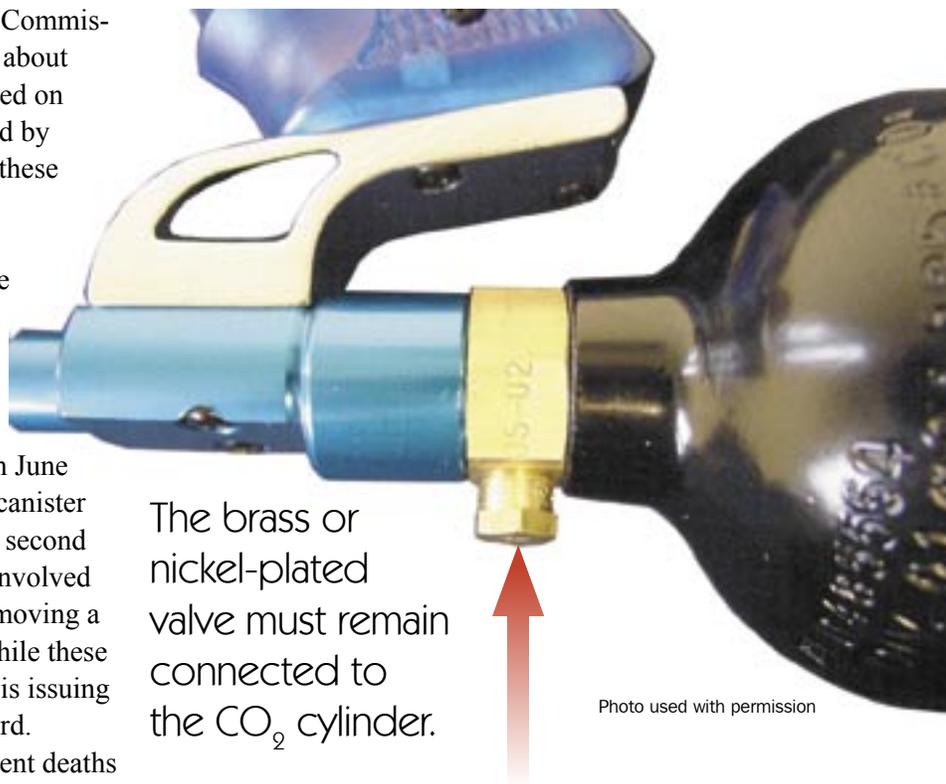
Both deaths occurred because users unscrewed the brass or nickel-plated valve from the canister when removing the canister assembly from a paintball gun. This action turned the pressurized canister into a deadly projectile.

In the first incident, which occurred in June 2003, a 15-year-old boy died after a CO<sub>2</sub> canister he was removing hit him in the head. The second incident occurred in February 2004, and involved a female bystander. Someone else was removing a canister when it flew loose and hit her. While these investigations aren't complete, the CPSC is issuing this warning to help others avoid the hazard.

"We are very concerned about the recent deaths associated with paintball-gun canisters," said CPSC Chairman Hal Stratton. "...Even though our investigation is not complete, we believe it is urgent to provide this safety message about the valve detaching from the canister while unscrewing it from the paintball gun."

The CPSC also recommends that people make sure any modifications they make to the paintball gun or the CO<sub>2</sub> canister are done properly. For example, installing anti-siphon tubes involves removing and reinstalling the canister valve. It is critical that the valve be reinstalled with the appropriate adhesive and the proper torque. Follow all these other procedures, too:

- Make sure the brass or nickel-plated canister valve is securely attached to the canister and rotates with the canister, instead of unscrewing from it. Suggestion: Use paint to mark the brass valve and the CO<sub>2</sub> canister so you can tell if the valve and canister are rotating together while being removed from the gun.



The brass or nickel-plated valve must remain connected to the CO<sub>2</sub> cylinder.

Photo used with permission

- The canister assembly should unscrew from the paintball gun in about three or four full turns. If you finish the fourth full turn and the canister hasn't come loose, stop and take it to a professional.

- Do not unscrew the canister if the valve does not rotate with the canister unless the latter is discharged completely.

- To discharge a canister, point the barrel of the paint gun down—away from anyone—and then pull the trigger until the canister is discharged.

- If you find the valve loose after removing a canister, reinstall the valve, using the proper adhesive and torque. ■

You can review the CPSC warning at [www.cpsc.gov/CPSCPUB/PREREL/prhtml04/04105.html](http://www.cpsc.gov/CPSCPUB/PREREL/prhtml04/04105.html).

# All for a Football

By MM2 Pat Lumumba,  
Naval Safety Center

The crew heard, “Man overboard! Man overboard!” The boatswain’s mate of the watch, however, never said a word about a drill. Thus marked a tragedy that occurred just 96 hours before an amphibious ship was to return to port from a successful seven-month deployment in the fight against terrorism around the world.

The young victim in this case, a PO3, perished while chasing a football on the flight deck. A shipmate had tossed the ball, and the PO3 felt obliged to catch it. Unfortunately, he hadn’t assessed the risk of being thrown off the flight deck as the ship took a sudden roll in heavy seas.

For just an instant, this “absolutely fine Sailor,” as his skipper described him, put aside the primary law of self-preservation and paid the ultimate

price. Would-be rescuers found the football, along with the float coat and smoke float shipmates had thrown him, but there was no sign of the missing PO3.

How did this tragedy happen? To start with, the victim had let himself be lured by the relaxed atmosphere that often evolves while a ship is headed home from a long deployment. He perhaps was focusing too much on the long-awaited family reunion and not enough on the fact he still was aboard a naval warship. A shipmate, friend, superior, or mentor should have reminded him how important situational awareness is to your safety in a ship’s extremely hazardous environment—whether in port or at sea. A naval ship is an industrial fortress, not a playground.

This tragedy never would have occurred if the victim just had applied the principles of operational risk management to what he was doing. Sailors need ORM engraved in their minds—along with the rules, procedures and lessons learned from continuous training—for their own protection, as well as the safety of all hands. Learn to make safety a first priority, not the last. ■

Navy photo by PHAN Carl E. Gibson



The victim in this story was playing with a football on the flight deck, just like these Sailors are doing.

## A DOUBLE DOSE

By Ken Testorff,  
Naval Safety Center

What’s worse than a Sailor falling overboard from the flight deck of an aircraft carrier? It’s two Sailors falling overboard—from the flight deck of the same aircraft carrier, just 16 days apart.

The first incident involved an E-5 who was tasked to work on an aircraft on the flight deck at night. The aircraft was spotted so that no part of it was over water. After the E-5 completed his task, he went below but, later that night, returned to the same aircraft. Unknown to him, though, shipmates

had respotted the aircraft so that its tail now was over water.

Thinking that the aircraft still was spotted completely on the flight deck, the E-5 moved toward the tail. Failing to see a tie-down chain, he tripped and fell over the coaming. He hit and grabbed onto the deck-edge safety net but lost his grip and fell into the water.

Two airmen nearby spotted a flashlight falling toward the water and reported man overboard. The victim heard the 5MC man-overboard announcement, assumed the HELP (heat-escape-lessening posture) position, and waited for rescue. A boat carrying a rescue swimmer was launched and rescued the E-5 20 minutes later without incident.

The victim was wearing a float coat and cranial when he went overboard but lost the cranial upon hitting the water. Neither he nor the rescue swimmer sustained any injuries.

The second incident involved an E-3 who was sitting on a chock, with his back against the lifeline on sponson No. 2, smoking a cigarette with a friend. The E-3 leaned backward—and just kept going. He had thought the lifeline would support him, but it didn't.

His friend immediately threw him a life ring and reported man overboard. Within 10 minutes, a SAR helo with a rescue swimmer on board had rescued the victim. Both he and the rescue swimmer escaped injury.

The mishap report for these two incidents listed the root cause as “human factor, unsafe act, error.”

In the first case, the E-5 lost situational awareness and failed to ensure the part of the aircraft he had to work on was spotted in a safe location. A mandatory two-man rule has been established to make sure no one works alone on the flight deck during darkness.

In the second case, the E-3 leaned against the lifeline with the mistaken belief it would support him and keep him from falling overboard. *[The applicable reference here is paragraph C0102x of the NavOSH Program Manual for Forces Afloat (OpNavInst 5100.19D, with change 1), which says, “Do not lean against lifelines. Never dismantle or remove any lifeline or hang or secure any weight*

Navy photo by PHAN Tina Lamb



A Navy rescue swimmer prepares to rescue a Sailor who fell overboard.

*or line to any lifeline, except as authorized by the commanding officer. Use temporary lifelines when possible.”—Ed.]* Subsequently, crewmen rigged standoff lines on smoking sponsons to prevent Sailors from standing near the edge.

A battle-group safety stand-down also was held on SITE-TV. This stand-down included a discussion about the seriousness of man-overboard situations, hazards they pose to the entire battle group, and the importance of honoring lifelines. Other topics that were discussed included complacency and water survival.

The stand-down concluded with the safety officer interviewing the victims, rescue swimmers, boat officer, and helo pilot. The interviews focused on how the mishaps occurred, the actions of all participants, and the potential hazards encountered by the boat and helo crews responding to a man in the water. The stand-down lasted about an hour and 15 minutes and was taped for replay on board the carrier. Copies also were distributed to all ships in company. ■

OF REALITY

# Oh, What a Flash!

*[The author asked to remain anonymous.—Ed.]*

*During the war in Afghanistan, long before you were born, I was assigned to a special-operations unit. Our mission was to clear the many mountain caves used as hiding places for terrorists like those who crashed planes into the World Trade Center and the Pentagon on Sept. 11, 2001.*

*We had been in country for eight months and had captured many. I was on patrol when we saw some of the “maggots” run for their caves. After calling for reinforcements, we charged after them. I was dragging one Al-Qaeda piece of scum from a hole by his dirty, puke-stained beard when a flame-thrower attacked from the right side.*

Anyway, that’s the story I’ll tell my grandchildren. The real story is far less glamorous and isn’t fun to tell a child.

I grew up outside a small town in Oregon, where hunting and guns were a large part of my everyday existence. I got my first .22-caliber rifle at age 12 but had been target shooting and squirrel hunting unsupervised since age 9 or 10. At age 14, my birthday present was my first deer rifle—a .270 pump-action. Within six months, I was allowed to reload my own rounds and reloaded most of my older brother’s rounds, too.

I was meticulous with the amount of powder that went into each round. I even shaved the bullet itself for exact weight. I could go into a lot more detail about loading ammunition here, but, the point is this: I was trusted with many volatile and dangerous things at a young age.

I quickly learned the difference in burn speed between rifle and pistol powders. In my 20s, when I got into black-powder rifles, I learned that black powder burns much faster than smokeless rifle powder when uncompressed. Smokeless powder burns fast, but, unlike black powder, it won’t explode or “flash” without being compressed. Perhaps all this early exposure to different types of

gunpowder led to a sense of complacency—or even careless disregard for the dangers related to such volatile substances.

At 10 a.m., May 17, 2004, I got my wake-up call. I was walking around the house, getting my surface shipment ready to drop off on base where I would pick up all my medical and dental records for an upcoming deployment aboard USS *John C. Stennis* (CVN-74). I was the assigned petty officer in charge of a 25-man detachment from NAS Whidbey Island’s AIMD. I had my things packed and was ready to go, except for my Navy ball cap—it was missing.

While going through the house looking for my cap, I discovered, to my dismay, I had forgotten to lock the gun cabinet, and my 5-year-old had dumped about a half-pound of black powder on the floor of my closet. I hastily cleaned up the mess, but, not wanting to dump it in the garbage, decided to light it off on the back patio. That decision quickly led to some extreme pain.

At this point, most people are thinking, “What an idiot!” and I agree—now. I was in a hurry then, though, and the reality of what would happen didn’t fully occur to me as I picked up a barbecue igniter to light the pile of powder. A consideration for my personal safety flashed through my mind for just an instant, but I dismissed it. I knew from childhood that smokeless powder will not flash unless compressed—have you caught my mistake yet?

I clicked the igniter and stuck the little flame up to the pile of powder, but nothing happened. “The contamination in the powder is making it hard to light,” I thought. I was stirring it around a bit with the igniter, trying to get it to light, when it suddenly went “Whooooff!” As I came running and dancing into the house, through a cloud of smoke that filled the backyard, I could see the shocked and frightened look on my wife’s face.

She soon realized that I wasn’t in any mortal danger, and her concern became a mixture of

amusement that her husband could be so dumb, concern for my well-being, and anger when she saw the scope of my wounds [see accompanying photos]. I had a 3-inch-long piece of missing skin that the blast had taken off my arm. I also had third-degree burns on most of my right hand and



second-degree burns extending up to my elbow, which my now-charred uniform sleeve covered. The burns started again on my neck and continued up the right side of my face to my forehead. I had lost most of my hair that the ball cap didn't cover—including mustache, eyebrows and eyelashes. I would have been blind in one eye if I hadn't been wearing my glasses, instead of my contacts.

My wife rushed me down the hall and helped me get into a cold shower. Four or five minutes later, she helped me dry lightly—that's when the skin wiped off a large section of my face and the rest of my right arm. The pain already was bad, but the water made it worse.

Once I was out of the shower, my wife covered the wounds with a burn ointment. Then we waited a half-hour for our child to get home from school so we could go to the base—I needed to tell my command what had happened and to finish preparing for the deployment. The severity of my wounds didn't sink in until we visited medical to pick up my records. I decided the pain was just too much to stand and walked into ER. The doctor said I wouldn't be deploying because my right hand and arm needed skin grafts.

During the next two weeks, I received four prescription painkillers and went through the extremely painful process of changing dressings twice a day. On two separate occasions, burnt skin had to be removed, which was excruciating. Sleep became a distant memory.

My right hand still is healing, and most of my right arm is scarred. I won't need skin grafts on my hand, after all, but may require surgery in the future as the scars become thicker and begin to decrease in flexibility.

Here are the mistakes I made:

- ✦ Rushing the cleanup of volatile material;
- ✦ Unsafe disposal (burning piles of any gun powder);
- ✦ Not inspecting the situation sufficiently to realize what I was dealing with—black powder, not smokeless powder;

✦ Delaying medical attention.

Here are the lessons I learned:

- ✦ Double-check locks for safety.
- ✦ Research safe disposal procedures for hazardous materials.
- ✦ Wear protective clothing. 📺

# The Day We “Stole” a Crane (An ORM Story)

A crane lifts a missile  
aboard a destroyer.

Navy photo by Ltjg. Joel Jackson

By LCdr. Jesse Brittain,  
Naval Safety Center

*This story is as factual as my memory will permit. In place of names, I have used descriptive pseudonyms to protect the identity of the actual personnel involved. For the affected CO: This story is probably the first inkling you will get of what could have happened “on your watch.”*

**A** new ensign and first-time division officer encounters many distractions and miss-steps on the way to “getting the big picture.” I was no different—and I was extremely intimidated by my CO, Cdr. Screamer. He had a withering ability to criticize his officers and to let us know how displeased he was with our perceived shortcomings. Commander Screamer could ruin your whole day with a single visit to the bridge during your watch. For some reason, he could

make the most eloquent officer stammer and stutter his way through a contact report, or at least that’s what I did.

Our ship, the USS *Cru-Des*, DD-9.., was in port for a maintenance availability before a scheduled long underway period. It was a time of vigorous activity and work. Coordination and flexibility were needed to ensure that contractors, SIMA and ship's force could get all the jobs done and have the ship ready for operational commitments. As

the ship's first lieutenant, I was trying to complete some external preservation. I also served as the ship's crane coordinator. In this latter capacity, I had to arrange for a PWC crane and operator to lift heavy equipment and supplies to and from the ship to support all the ongoing work.

My every encounter with Cdr. Screamer gave me the shakes, and the private floggings were just as heated as the public tongue-lashings. I felt I never was going to get anywhere in my career, and I'm reasonably sure many of my fellow JOs felt the same way.

Near the end of the maintenance availability, a "hot job" came up—one of the ship's fire pumps needed to be rebuilt at the SIMA shop. As SIMA workers were rigging the pump topside, I called Mr. Crane Guy at PWC and scheduled a crane for the next morning. Mr. Crane Guy usually required three days' notice, so I was pleased to get such quick response. The pump was lifted and promptly went to the shop.

A few days later, the fire pump was repaired and brought back to the ship on a truck. No one had called me, so I hadn't arranged for a crane lift. Both the main propulsion assistant and the engineer officer badgered me about our lack of a crane. I was pleading with Mr. Crane Guy on the telephone when I heard the 1MC announcement, "*First lieutenant, lay to the captain's cabin!*" My legs somehow propelled me up the ladder to the CO's cabin. For the life of me, I can't recall exactly what he said to me, but I do remember something to the effect of "*...I don't care how you do it—just do it!*"

I quickly called Mr. Crane Guy back and listened as he explained that he simply couldn't meet our needs because of other commitments and because PWC was short-staffed for crane operators that day. It was particularly disappointing to see the ship across the pier getting stores lifted aboard when our emergent work could not be supported.

Feeling particularly stressed, I consulted with my LPO, BM1 Old Salt. I was interested in seeing

## A boatswain's mate directs a crane operator to lower a load while another Sailor assists.

Navy photo by PH2 Todd Reeves

*Note: These Sailors should be wearing gloves. Also, the supervisor/safety officer (the guy in the white hard hat) should not be participating in the operations. — Ed.*



if he knew some other method of rigging the pump aboard. We discussed using a J-bar davit and falls but realized it was too difficult to rig that way. Old Salt couldn't help me.

Fortune smiled during lunch, though. BM1 Old Salt excitedly called me and said he could solve our problems. The PWC crane operator had finished the stores load across the pier and had departed for his lunch break. The pier crane was unattended. This was no time for thoughtful consideration—we were going to lift that pump!

BM1 Old Salt was confident he could operate the crane; it was “not much different” from one he had operated *once* before. He had a mischievous

pump landed softly and undamaged on deck. Who cares, right?

To Cdr. Screamer, I'd just like to say, “We did as you asked. I never told you about ‘stealing’ the crane because you never commented about it. The pump was aboard, and that was the end of the matter. However, I would ask you to consider the twist your tour as CO **could** have taken that day. I certainly have thought about how my career could have changed. I'll bet it would have been hard to explain to the commodore how a crane came to topple into your ship, how a fire pump fell into the water, how a PWC crane was damaged beyond repair, why a fire pump needs another repair, or

For the life of me, I can't recall exactly what he said to me, but I do remember something to the effect of  
“...I don't care how you do it—just do it!”

twinkle in his eye as he maneuvered the crane into place and lowered the hook. I gave him a tip of my white hard hat when it looked good to me and the pump was secured to the hook. The lift went smoothly, and the pump was lowered to the deck without mishap.

As BM1 Old Salt was lowering and stowing the boom, a very agitated PWC crane operator came running and cursing his way down the pier. Old Salt and I grinned at each other as the shouts got louder. We successfully had bucked the system and accomplished our mission. I nodded and blinked vacantly as the real crane operator excitedly gave me “what ifs” and voiced concerns about his undamaged equipment. No harm, no foul; the job was done, and this guy had no reason to complain, right? Aside from a very unpleasant phone call from Mr. Crane Guy, I never had any action taken against me. Of course, I never got another favor from Mr. Crane Guy.

What could have happened? An unqualified Sailor had operated the crane. We didn't extend the outrigger feet to prevent the crane from toppling over. We lifted the pump with some line from the bosun locker, instead of using a proper lifting sling. We tied a bowline, instead of using a shackle. The

why one or more of your Sailors were injured or killed. I suggest to you that we simply got real lucky that day.”

We should have applied the principles of operational risk management:

✓ **Accept risk when the benefits outweigh the cost.**

Would a 24-hour delay have been tragic? In this case, probably not.

✓ **Accept no unnecessary risks.**

Is an unqualified Sailor using unfamiliar equipment the right choice? Clearly a poor choice.

✓ **Anticipate and manage risks by planning.**

This entire evolution was reactive—no planning was evident. We had poor ship-to-shore coordination; communication could have helped all parties to understand what was needed.

✓ **Make risk decisions at the right level.**

Is the safety of your crew, ship and career in the hands of a “green” division officer? Are you sure? Does your leadership style encourage feedback and tolerate bad news? If you “shoot the messenger” often enough, subordinates may hesitate to give you the “big picture” when it's important. 📌

# Pike's Peak or Bust

By Ken Testorff,  
Naval Safety Center

**P**ike's Peak wasn't really the mountain involved in this incident, but it's only a couple thousand feet taller than the one a couple of Sailors tackled—at a price.

A 22-year-old PO3 and a 33-year-old CPO will be sidelined for more than a month apiece because they didn't listen to the warnings they had heard at boot camp or in an MWR safety briefing before going mountain climbing. Both have the sickle-cell trait (SCT), a condition in which you have one gene for sickle cell hemoglobin and another for normal hemoglobin. People with this condition run serious risks anytime they are at high altitudes.

Both Sailors had signed forms acknowledging they understood the risks they were taking that July day. Those forms discussed all the environmental risks (rugged terrain, falls, hypothermia, sunburn, high-altitude sickness) and certified an individual's capability to participate in the climb.

While hiking at approximately 10,000 feet, both Sailors experienced stomach pains and descended to a lower level, but the pains didn't get any better.

The PO3 was admitted to a local civilian hospital with an initial diagnosis of altitude sickness. Meanwhile, the CPO was

admitted to a Navy hospital with an initial diagnosis of viral gastroenteritis. Within 24 hours, though, doctors confirmed both patients were SCT positive. They subsequently ordered CT scans, which showed both patients were suffering from splenic infarct (sickling).

This condition occurs when people with SCT are exposed to a combination of altitude, extreme physical exertion, and dehydration. Red blood cells deform into the characteristic sickle shape and can become lodged in the spleen, which leads to pain and/or further complications of the spleen, including tissue loss.

Although screening for SCT occurs in basic training, the secretary of the Navy does not disqualify anyone in the aviation, undersea or general-duty programs because of it.

Why did these two Sailors ignore the warnings and go mountain climbing? Both said they had engaged in high-altitude sports in the past with no adverse effects, so they assumed nothing would happen this time, either. Although it was the PO3's first effort at mountain climbing, he had gone skydiving before, and the CPO had successfully climbed the mountain on two previous occasions. ❏

# Tragedy Breeds

By Renee Wentz

**H**urricane Isabel had passed, but not without leaving her calling card in Hampton Roads. Trees were uprooted and laying in many people's houses, debris was spread across yards up and down every city street, and everyone was asking the same question: "When will my power be restored?"

Our power had been out for two days, and my kids desperately were missing the television. I decided to take my 8-year-old son, Garrett, for a drive. The drive went well, and we just were returning when Garrett spotted his friend, Bradley, and wanted to play. I agreed to let him and stopped our minivan in the street.

Before he ran off to play with his friend, I cautioned Garrett to be alert. I reminded him that, with the cleanup effort underway, branches and trees would be piled everywhere. "Be extra careful, and watch for cars if you cross the street," I said.

"OK, Mom," he answered, with a "Mom always worries too much" attitude. I knew he was excited about getting to play with his friend. Shutting the van's sliding door, he headed toward Bradley.

I still was looking at the mounds of debris and trying to see if any danger was close by when I accelerated forward. I immediately heard something that sounded like a large branch hit the front of the car. Pressing the accelerator a little harder, I felt a distinct bump. "The hurricane has left so many large branches to clean up," I thought at that moment. "The situation really is dangerous."

Suddenly, I decided to check on Garrett again. He wasn't in the neighbor's yard—in fact, I couldn't see him any-

where. Then, a sharp jolt of panic hit me. "Could I have hit Garrett with the van?" I wondered.

Remembering not to back up, I put the car in park and got out the driver's door while calling his name. Only silence followed. "Surely he's in the yard, or maybe he's going to come around from the other side of the car," I tried to convince myself. Slowly but surely, though, I came to realize I had done the unthinkable: I had been careless and run over my own son.

I started screaming, "Garrett! Garrett!" Then the most beautiful and, yet, the most horrible thing ever happened in one surreal moment. My son came crawling out from under the car, calling, "Mommy!"

I bent down and picked him up—with his face bloody and swollen—with the same ease as if he weighed only a pound or two. He clutched me amid screaming, and I held him close while carrying him to a grassy area nearby, where I gently lay him. He cried in my arms as I assured him that he would be fine. "Mommy is here," I said, noticing that, despite the situation, those words seemed to calm him.

*Some say this photo is a composite, or "fake." I can't attest to its authenticity.—Ed.*

Hurricane Isabel still was making her approach on the Hampton Roads area when this photo was taken.



# s Tragedy



Within seconds, a nurse who lived in the neighborhood appeared, followed quickly by another neighbor who is a paramedic and another who is a policeman. Using his police radio, the latter called for an ambulance, since we had no telephone service. These neighbors examined Garrett as best they could. By the time the ambulance arrived, my husband had appeared, and he accompanied our son to the hospital. It was a short trip, and the hospital staff was ready to give Garrett immediate attention.

A thorough examination and X-rays revealed that Garrett's only injuries were a cut on his chin that required three stitches and some severe scrapes and bruises [see accompanying photos]. By the grace of God, he had escaped any internal injuries

or broken bones. He didn't lose consciousness and was allowed to go home with us from the emergency room. The next several days were full of discomfort for Garrett as he endured the road rash and sore muscles from his experience.

Meanwhile, I was trying to find a way to live with myself for what I had done. It seemed like all my friends and neighbors were more worried about me than they were Garrett—all I could do for several days was cry every few minutes. My confidence was shattered, and the feelings of failure were overwhelming at times.

Amazingly, it was Garrett who helped me start healing. One day after I had had another crying episode, he said to me, "I'm going to be OK, Mom, and you really are starting to bother me." At that moment, I realized I had to quit letting my guilt get in the way of helping him have a complete physical

and emotional recovery.

Garrett made a full recovery, and the only lasting effect he has is a healthy respect for moving vehicles. I still struggle sometimes with the thought of what could have happened but find solace in my belief that God is in control of everything.

As a result of this experience, we have established rules regarding safe car practices. Garrett always crosses in front of the car—never behind it. If he is outside when I'm in the car, we must make eye contact and wave to each other. Accidents are going to happen, but we must do our best to avoid them. It takes rules that both the children and the adults must understand and follow. ■

*The author is a Coast Guard wife.*



# Navy Deaths and Inj

By Dan Steber,  
Naval Safety Center

The story “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. Our boss, RADM Dick Brooks, asked us to study all Navy rates for similar trends, and we found them.

As with the earlier study, the data (FY94 to FY04) shows we can identify and focus on rates with higher-than-normal PMV mishap rates. Most of the high-risk rates are junior people in

“dynamic” jobs. Eight senior rates had mishap levels almost two times higher than average (OSCS, ABHC, BMC, PC1, TM1, LN1, MN1, and BU1). Rates with fewer than 150 people were excluded to ensure a fair and statistically significant sample. Some gaps in data existed (mishaps reported but no rates assigned), so they were excluded. The complete study is available on our website at [www.safetycenter.navy.mil/statistics/study/default.htm](http://www.safetycenter.navy.mil/statistics/study/default.htm); click on Navy PMV Study.

**Top-16 ratings (mishap and death rates are per 100,000 people, per year):**

Rate	Population	Deaths/Inj	Mishap Rate	Death Rate
DCFN	183	2/6	437.16	109.29
GSEFN	277	4/8	433.21	144.40
ENFN	372	3/10	349.46	80.65
AZAN	258	3/6	348.84	116.28
AW3	380	2/9	289.47	52.63
ICFN	391	6/5	281.33	153.45
SW3	187	2/3	267.38	106.95
GMSN	308	1/6	227.27	32.47
STG3	800	4/14	225.00	50.00
FCSN	357	1/5	196.08	28.01
OSSN	1,253	5/19	191.54	39.90
YNSN	473	1/7	190.27	21.14
PRAN	264	1/4	189.39	37.88
MMFN	1,225	10/10	187.76	81.63
HTFN	541	2/8	184.84	36.97
ADAN	1,417	5/21	183.49	35.29
<b>TOTALS</b>	<b>8,686</b>	<b>52/141</b>	<b>222.20</b>	<b>59.87</b>
<b>Top-50</b>	<b>38,340</b>	<b>169/443</b>	<b>159.62</b>	<b>44.08</b>
<b>All Rates</b>	<b>328,235</b>	<b>611/1,778</b>	<b>72.78</b>	<b>18.61</b>



# Injuries on Our Roads

These 16 rates (3.5 percent of the total number of rates and 2.7 percent of the population) account for 8.2 percent of fleetwide deaths and injuries. If we look at the top 50 rates (those 50 percent or higher than the average, 11.1 percent of the total ratings or 11.7 percent of the population) account for 25.7 percent of combined deaths and injuries (27.5 percent of the deaths, alone).

### Top-10 Deaths (regardless of population)

Rate	Deaths	Population	Death Rate
SN	51	13,299	38.35
AN	16	14,108	11.34
MM3	14	5,330	26.27
FN	13	5,365	24.23
CSSN	12	2,010	59.70
ET3	11	4,663	23.59
EM3	11	2,641	41.65
CS3	11	2,782	39.54
MM2	11	5,051	21.78
AM3	10	2,129	46.97
EM2	10	2,771	36.09
MMFN	10	1,225	81.63

### Top-10 Deaths (with population considered – avg. 18.61)

Rate	Deaths	Population	Death Rate
ICFN	6	391	153.45
GSEFN	4	277	144.40
AZAN	3	258	116.28
DCFN	2	183	109.29
SW3	2	187	106.95
BU3	5	549	91.07
EO2	3	361	83.10
MMFN	10	1,225	81.63
EO3	3	371	80.86
ENFN	3	372	80.65

### Top-10 Rates (avg. mishap rate: 72.78, death rate: 18.61)

Rate	Mishap Rate	Rate	Death Rate
MR	144.93	BU	47.68
TM	133.48	JO	46.66
SN	130.84	LI	41.67
DC	128.94	SN	38.35
FN	128.61	IC	37.17
SW	122.55	EO	37.08
EN	111.25	SW	36.76
LN	110.24	UT	29.47
BU	107.27	EM	26.61
HT	102.59	AS	26.60

### What can be done to reduce these incidents?

- 📌 Leadership (e.g., CO, department heads, chiefs, and supervisors) must intervene immediately on high-risk rates and ratings.
  - 📌 Discuss possible reasons for abnormally high mishap rates.
  - 📌 Review work schedules and fatigue issues.
  - 📌 Check for boredom with non-mechanical rates or other issues that could cause abnormally high stats.
  - 📌 Re-emphasize DUI dangers and DoD's current policies.
  - 📌 Implement "Tipsy Taxi" or "Safe Ride" programs in your area.
- Focusing on these high-risk groups will allow us to divide the larger problem of PMV mishaps into smaller subsets. As gains are made in these rates and ratings, we can focus efforts on the next group of 10, 25 or 50. We must work to keep our people from surviving the war or deployments and then dying on our streets. 📌

# The Simple Things (Part 3):

Converted from use as a special-operations boat, the diesel-electric *Grayback* became an ideal platform for divers.



Navy photo by PH1 S. Smith

## When Small Errors

By Steve Southard,  
Staff, ComNavSeaSysCom

*[This story is the final part of a series that started in the July-September 2003 and continued in the October-December 2003 issues of Fathom magazine.—Ed.]*

Near midnight, the mini-sub returned to its host submarine. Though unheard of elsewhere in the Navy at the time, such operations had been routine aboard USS *Grayback* (SS-574) for more than a decade. On this evening, Jan. 16, 1982, the submarine had bottomed off the coast of the Republic of the Philippines. Divers soon secured the mini-sub, or SEAL delivery vehicle (SDV), within the submarine's starboard hangar.

No one knew that tragedy lay just ahead.

Before this phase of service, the diesel-electric *Grayback* had served as a launching platform for Regulus missiles. For her current role, her cavern-

ous, twin-missile bays had been converted into diving hangars for special-forces operations.

After stowing the SDV, *Grayback's* support divers and SDV crew (a BMC, an ensign, two petty officers, a seaman, and a fireman) remained within the flooded starboard hangar, making preparations for re-entering the submarine. They received permission to shut the outer hangar door, the step just before draining and venting the hangar.

By this time, the vent-and-drain operation had become so routine that diver-qualified personnel on the dry side of the hangar directed the procedure in a largely informal manner. While draining water

from any manned space, it is critical that breathable fresh air flows in through a vent pipe to replace the water. Aboard *Grayback*, a vent valve, operable from the wet or dry side through a linkage, controlled this airflow.

The dry-side supervisor ordered the vent valve to be opened. The BMC acknowledged, and the MM2 complied. The expected venting alarm didn't sound as normal, but no one questioned this problem or did anything about it. The dry-side supervisor directed the drain valve to be opened, and draining commenced.

Soon, the BMC felt dizzy and short of breath. The PO2 said he felt dizzy, too. The BMC checked valve positions but couldn't open the vent any farther. Later, someone in the hangar keyed the 8MC microphone but didn't speak. Five divers, including the PO2, passed out and fell into the water (some possibly losing their scuba-regulator mouthpieces). The BMC managed to hook his arm on or through a pipe to avoid falling; then he also passed out.

On the dry side, watchstanders heard the 8MC keying but dismissed it as a joke or inadvertent action. Not hearing the expected reports of water

An investigation revealed several design flaws in the system. Often, poor design or design flaws can be mitigated by proper training, maintenance and disciplined operation. *Grayback* divers, ship's force, and special forces had been operating with this flawed design for many years.

The investigation concluded that the wet-side operator had opened the vent valve only partway, thereby causing a vacuum to form. Among the contributing factors within the control of the crew were these items, as noted by the legal investigation:

- ✓ Neither the vent valve, nor its operating linkage, had been lubricated properly.
- ✓ Those who claimed to have done greasing maintenance didn't know a fitting existed for greasing the vent valve.
- ✓ Other grease fittings in the hangar were painted over or rusted shut.
- ✓ Seventeen gauges were overdue for calibration, and another one was missing.
- ✓ Hangar drain procedures had not been submitted to Naval Sea Systems Command for approval as required for manned diving operations. NavSea-mandated changes to other procedures had not been made.
- ✓ Two senior watches often were combined, in violation of procedures.
- ✓ Diver personnel had received less than 1.5 hours of diving training in the previous six months.
- ✓ Not all participating divers had attended the pre-dive brief.

Both the chronology and the list of legal-investigation findings point out a number of small errors. Each one by itself wasn't catastrophic but, when combined in the right order, led to tragedy. A questioning attitude or a determination to do the right thing at any of these steps might have broken the deadly chain and averted the mishap. Such a fatal lineup of minor errors would appear to be a very improbable event; yet, it happened.

We can honor the memory of those five divers in USS *Grayback* by fixing the small daily problems we encounter in training, maintenance and operation so that a similar tragic combination of errors never recurs. ■

## s Add Up

level, and upon noting the usual draining noise had stopped, they attempted 8MC communications with the wet-side occupants. When those efforts failed, they tried standard tap signals, repeating each one several times. Using their dry-side operating linkage, they checked the hangar vent valve open, finding it difficult to operate. With the OOD's permission, one dry-side watchstander entered the transfer lock that separated the dry from the wet side and peered through the small "dead light" window. He saw only material from a wet suit within. After several more minutes of communications attempts, the BMC began to revive and reported that he needed help. Dry-side operators then entered the hangar.

They removed the BMC and the bodies of the ensign, the MM2, the QM3, the FN, and the SN. For two hours, crewmen tried without success to revive these people with CPR in *Grayback's* recompression chamber.

# Look Before

By Lt. Chris Saufley,  
Postgraduate Student,  
George Washington University

What could be better than a squadron day off—other than it being a Friday (early start for a weekend) and going mountain-biking at Ft. Eby on a beautiful February afternoon? If you're in a group of people who appreciate what the Northwest has to offer, you're thinking, "Not a whole lot!"

Two friends and I had decided it was the perfect time to go mountain-biking at one of our favorite spots. We had been to Ft. Eby many times and knew the trails—or thought we did. The more we rode throughout the afternoon, the more confidence

we gained. The steep hills, sharp turns, bumps, and drop-offs were keeping us on our toes, but they also were the most fun.

We decided to finish the day by riding on the cliffs overlooking the passage between Whidbey Island and the Olympic peninsula. Breathtaking views and a perilously steep 200-foot cliff would give us that little extra adrenaline rush we needed. We ended up at the "Gun Turret," which is a little place for people to picnic and enjoy the view. There also are some stairs and several "chutes" and drop-offs leading to the lower plateau on the cliff.



I had ridden in this area many times and always had navigated the challenges with ease. We about were ready to call it a day and head for our traditional after-ride brew when one of my friends said, “Hey, a little farther up the trail is another ‘chute’ that’ll take us to the lower plateau.” Always game for something new and exciting, I followed him

# You Ride!

about 100 yards. He explained that the trail went down. “It’s so steep you can’t see the bottom from here,” he said. “After a right turn about 20 yards down the path, though, it straightens out, and you can see the bottom, as well as where it leads into the plateau.”

Because I’m not one for caution, I said, “I reckon I’ll go first.” Starting down the steep trail, I held my brakes through the right turn, navigating the bumps and the turn with ease. I then looked about 40 yards ahead and didn’t see anything, so I let off the brakes. My speed picked up quickly, and while looking way out ahead, I didn’t notice

All I could feel was pain in my lower left back and left leg, and I couldn’t get up.

a path running perpendicular to the trail at the very bottom. In fact, it formed a 3-foot-wide shelf. Unfortunately, this discovery didn’t come until it was too late for me to stop, turn or do anything. I was going over whether I wanted to or not.

My friends later said I came off the shelf and did one-and-a-half flips with the bicycle before landing on my left side. All I could feel was pain in my lower left back and left leg, and I couldn’t get up. My friends ran down the trail to check on my condition. One then raced to the parking area, where a forest ranger happened to be. He determined that I needed an ambulance.

Thirty minutes later, I was on my way back up the hill on a backboard, then into the open doors of a waiting ambulance. A five-minute ride later, I was on an X-ray table at Whidbey Island General Hospital, getting shots in my lower back. I was relieved to find I hadn’t broken anything in my back; I had some deep bruises, though.

As I was getting ready to leave the hospital, I asked the doctor a couple of questions: “Why does it hurt here, and how long will it be before I feel a little better?” He replied by tugging on my left leg, and when I said “Ouch!” he ordered an X-ray

of my leg. The results showed two cracks on the upper part—not good. I knew I would be down for at least a month waiting for the breaks to heal.

My wife, kids and I went back to the accident site to get a better picture of what had happened to me. I determined a depth-perception illusion must have kept me from seeing the shelf while going down the hill, which, incidentally, was much steeper than I originally had thought. We tried to figure out how far through the air I had gone before hitting the ground. We found two gouges in the dirt: one from my handle bar and the other from my pedal. These gouges were about 30 feet past the shelf! “Wow, no wonder that seemed like one heck of a ride!” I thought. The \$1,200 medical bill the Navy had to pay didn’t make me feel any better about the incident.

Here are some lessons I learned from that ride:

- ✓ Scope out an area before going mountain-biking. I thought I knew what lay ahead, and I assumed I had gotten good “gouge.”

- ✓ Always wear protective equipment. It’s a good thing I was wearing riding shoes, padded shorts, gloves, and a helmet that day. I later found out I had cracked my helmet.

- ✓ Make sure you do a little trail ORM—before you fly or ride. For 30 days, I couldn’t fly, couldn’t run, or do anything but hobble around and hope for fast healing. ❌

*The author was assigned to VAQ-131 when he wrote this article.*

# Don't Break Just One Rule— Break 'Em All

By Ken Testorff,  
Naval Safety Center

**A** 19-year-old Sailor leaves his ship in Norfolk at 1030 one Friday and drives 20 hours to visit family and friends about 1,300 miles away (65-mph average). He starts the return trip at 0700 two days later, with plans to arrive in Norfolk by midnight Sunday (76.5-mph average). See anything wrong with this picture? You should.

The problems started with a ship's instruction, which specifically limits driving for all hands to 350 miles per 24-hour period. Did the Sailor know about the instruction? Without a doubt because, if for no other reason, he had attended a shipwide safety stand-down just one month earlier. Motor-vehicle safety, safe driving, and the dangers of alcohol while driving were primary topics at that event.

In this case, the Sailor didn't tell anyone his travel plans before departure; didn't submit a leave request; and didn't fill out an ORM, travel, risk-assessment questionnaire. To make matters worse, he was fatigued when he left the ship.

Care to guess how this hare-brained scheme turned out? Just 20 minutes into the return trip, the Sailor had to swerve his 1999 Mitsubishi Diamante to avoid an object in the road. He subsequently lost control of the vehicle, and it went into a wet, grassy median, where it spun and flipped several times, ejecting the Sailor through the open sunroof.

In case you're wondering, he was wearing a seat belt, but, according to the mishap report, the "seat back was adjusted improperly, allowing the victim to come out of the seat belt." In other words, he probably had the seat in a "reclining" position. Perhaps he was trying to look "cool" or simply was

planning to get a little rest along the way—you know, drive with one eye open and the other one shut.

What happened to the victim? He lived to talk about his misadventure. However, he lost 11 work-days with internal bleeding, a contusion to his right arm, and a laceration to his right foot that required 14 stitches. Meanwhile, his vehicle was destroyed.

The National Safety Council has some advice that Sailors and Marines, alike, would do well to follow:

- ☛ Get seven to eight hours of sleep the night before a trip. Get enough rest, and don't start a trip late in the day. Long-distance driving is hard work, and you need to be fresh and alert.
- ☛ If possible, don't drive alone. Passengers can take turns driving and can serve as observation partners to keep you awake.
- ☛ Avoid long drives at night. The glare of lights, both on your dashboard and outside your car, increases the danger of highway hypnosis.
- ☛ Adjust your car's environment so it helps keep you awake. Keep the temperature cool, with windows open, or, in the summer, with air-conditioning. Don't use cruise control.
- ☛ Watch your posture. Drive with your head up and your shoulders back. Legs should not be fully extended.
- ☛ Take frequent breaks—at least once every two hours, take a 15-minute break. Get out of your car, walk around, and stretch. Exercise fights fatigue.
- ☛ Stop for light meals. Drink juice or water.
- ☛ Avoid eye fatigue during the day by wearing sunglasses to fight glare.



☛ If fatigued, find a motel or a safe, guarded, rest area and sleep.

Safe driving demands your full attention. If you feel tired, plan ahead for what you are going to do. The actions you take may not just help you stay awake; they might keep you alive. ☛

*While on the subject of driving long distances, the sidebar that follows shows what a training command does for students before letting them head home for the holidays.—Ed.*

## Sub School Tunes Up for **Holidays**

With this year's holidays fast approaching, Sailors are anxious to prove there's no place like home to celebrate the yuletide season. Students at Submarine School, however, won't be getting on the roads for holiday leave until their cars have had a safety inspection.

These inspections are a "gift" from the Submarine School chief petty officers and the safety-office staff, working in conjunction with Submarine Base New London's Morale, Welfare and Recreation auto hobby shop and a local auto-parts supplier. Aimed at those Sailors driving home or at least a long distance from the base, the free inspections and low-cost repairs are available to Sub School staff and students, alike.

"We've had this [program] for a number of years," said FTC(SS) Christopher Dotson, organizer of last year's inspection teams. "In the past, we've had hundreds of students and staff members stop in and have us inspect their lights, hoses, tires, and what-have-you. Our emphasis was, and is, safety; it's what we call a 'common-sense safety check.'





“By working with the auto hobby shop,” he explained, “we can put vehicles up on a rack to check out bearings, examine shocks and struts, or to inspect for leaking seals, cracked housings, and worn-out exhaust pipes. A local auto-parts supplier has donated cases of oil, windshield-washer fluid, and other items to top off fluid levels or to replace defective minor parts right on the spot.”

During the week leading up to Thanksgiving and spread across six service bays, inspectors hope to get up close and personal with about 500 vehicles. Sailors who need to buy parts are directed to discount suppliers, and appointments are made for

a return trip to have those repairs done.

“We’re not talking about ‘clunkers’ that’ll break down while on base,” said Dotson. “That’s not what this inspection is about. Some might consider this *[program]* ‘intrusive leadership,’ but I like to think of it as all about peace of mind. It takes less than 15 minutes for each vehicle, and our students then have one less concern as they prepare to head home. And we have one more assurance we are doing our best to guarantee the safe return of every Sailor after the holidays to continue training.” ■

# Mail Call



## Re: "Navy Woman Dies in Motorcycle Crash" (Summer 2004)

I am deeply bothered by your recent article in the *Sea&Shore* magazine due to the inaccurate reporting of the accident. First, the accident did not occur at 0130 on Jan. 1, 2004; it occurred at approximately 1330 on a beautiful, sun-shiny New Year's Day. I know this because I was riding my own motorcycle behind her [*the victim*] on that fateful day. [*We regret this error.—Ed.*]

Second, the victim was a **very** responsible motorcycle rider. She wore tall leather boots, leather gloves, a leather jacket, blue jeans, and a full-face helmet every time she rode. [*The fact she was wearing all this protective gear was not mentioned in the Navy mishap or police reports; they only mentioned the helmet.—Ed.*] She was an experienced rider who respected her motorcycle, the road, and traffic. She was not a risk-taker and rode very conservatively.

I understand the purpose for your article and the need to let other Sailors know what could happen, but I think you missed the opportunity to get the real message across. Motorcycle accidents happen to good riders, even when they are riding responsibly with the proper motorcycle PPE. The victim made a deadly error in her speed around an unfamiliar curve, which is a common mistake that many motorcyclists make, no matter how experienced they are. That is a message that would

have made other riders think. Unfortunately, your portrayal of the victim as a rider who was out late at night (not true) and not wearing the appropriate PPE (not true) was seen as an unfortunate death by a careless rider.

Her death and the accident is something I will never forget and shouldn't forget. The victim would have wanted other Sailors to learn from her death, but she would have wanted it to be reported accurately. This includes the picture placed in the article. I was approached by another military friend who told me "not to read the article because the picture was disturbing." I immediately knew the picture was not of her accident upon hearing there was a guardrail. I knew, but many of the victim's friends and shipmates would not know. I think using a picture of a random motorcycle accident in the article was careless and unnecessarily traumatizing to those who knew her. [*Unfortunately, generic photos often are the only ones to which we have access.—Ed.*]

I'm certain that the victim's friends and shipmates would want to know the truth of her accident and would deeply appreciate a follow-up editorial that would clarify the inaccuracies.

Sincerely,  
Lisa M. Hess  
Naval Medical Center, San Diego

# Why Bother?

## It Won't Happen to Me

By LCdr. Mike Saling,  
Naval Safety Center

Shortly after I arrived at the Naval Safety Center, I saw an editorial a teacher had written for the local newspaper. She was commenting about the fallout created when 12th-grade students who had failed Virginia's Standards of Learning (SOL) exam weren't allowed to graduate from high school.

The teacher was rebutting an earlier editorial that tried to hold high-school administrators and teachers accountable for the failures. She suggested that parents and especially students were equally responsible. Teachers and school administrators made tremendous efforts to provide after-school tutoring, as well as in-school tutoring, in place of elective courses to help those students identified as in danger of not passing their SOL. However, many students apparently refused to attend either option. When questioned, parents indicated they could not make their children attend the tutorials.

That editorial made me think about our efforts here at the Naval Safety Center.

After finishing up a two-year tour as the safety officer on a large-deck amphib, I am intimately familiar with the difficulty in trying to educate naval personnel about safety. The proverbial "you can lead a horse to water, but you can't make him drink" comes to mind.

I have heard the full gamut of excuses for why someone failed to adhere to

safety regulations. Excuses such as "It's uncomfortable," "It's hot," and "I did not know" quickly come to mind. The blank stare also was all too common. More often than not, the Sailors knew the regulations but chose to ignore them. During those

Now that I am working at the Naval Safety Center, I have been able to see for myself the tremendous resources that are working for the fleet.

Navy photo by PHAN Jennifer Nichols



Whether it's teaching pipe-patching techniques during damage-control training...



Navy photo by PH3 Ramon Preciado

showing how to do CPR...

times, I always tried to explain why safety was important in an easy-to-understand, common-sense manner.

Here are a few examples of my reasoning. On the importance of hearing conservation: "I look forward to hearing my 19-month-old daughter Amelia say, 'I love you, Daddy' for many years to come." Hearing protection is a quick and easy way to ensure I won't miss those important words. On the importance of sight conservation: "I look forward to seeing my daughter grow up, graduate and get married." Eye protection can be the difference between getting to enjoy it for myself or having to hear someone else describe it to me—unless, of course, I have lost my hearing, too. Deaf and blind is not the way I want to live my life.

Safety regulations protect shipmates and us from potential injury or death. It obviously is in our personal best interest to follow the rules. Unfortunately, I have encountered many ship-

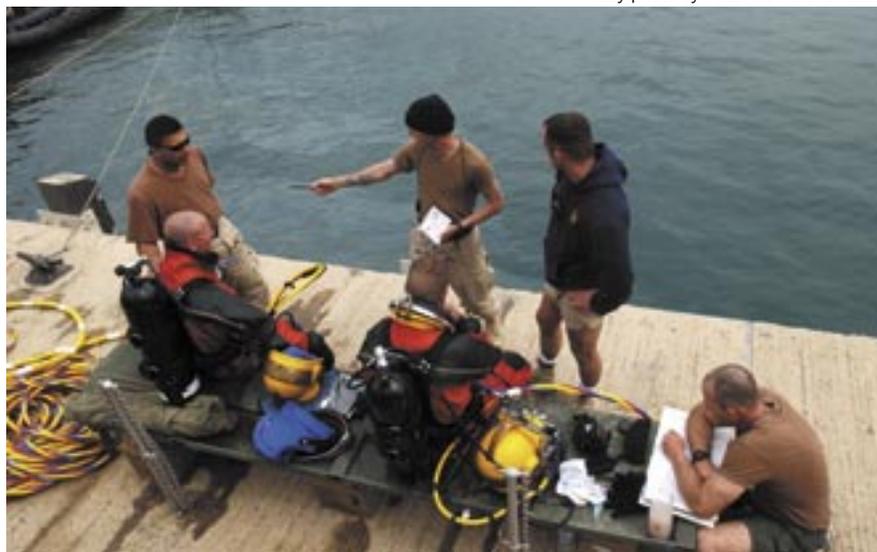
mates who believe that adhering to safety practices and conducting safety training is an inconvenient hindrance in their daily lives. That false sense of security is created when personnel "get away with it" and avoid injury. However, statistics have proven that, in time, other personnel will be exposed to the same hazards. The only thing between them and injury will be whether they are following the proper procedures or using the correct personal protective equipment (PPE).

Now that I am working at the Naval Safety Center, I have been able to see for myself the tremendous resources that are working for the fleet. These resources are similar to the teachers and administrators mentioned at the beginning of

this article. Like them, many people have gone to great lengths to provide safety information for the fleet to better prepare each of you for potentially the most important test of your life. What test? Whether you can avoid or survive a serious mishap through the proper application of risk management, safety regulations, and PPE.

I have known some Sailors with an "if it's my time, then there is nothing I can do" attitude. They

Navy photo by PH1 Arlo Abrahamson



briefing a dive team before starting dive operations...

ignore safety procedures and don't encourage safe working habits in the workplace or while off-duty. We never will be able to avoid random chance or plain old bad luck in our daily lives; however, we should be able to achieve a zero mishap rate among

Navy photo by Deris Jeannette



or leading a class in motorcycle-rider training, many people go to great lengths to prepare fleet Sailors to live safely.

those who actually follow the rules. With proper training and enforcement throughout the chain of command, we shouldn't lose a single Sailor or Marine because he or she decided to drink and drive, failed to fasten his seat belt, didn't wear PPE, or made any of the other numerous mistakes mentioned as causes in mishap reports.

Ultimately, the individual Sailor or Marine is responsible for following the rules and will suffer the consequences if he or she doesn't. During a safety survey, the team leader delivered a set of "fatal vision" goggles to my command. This device allows personnel to experience a simulated level of intoxication ranging from a few beers to an all-out binge.

I personally held safety training with several divisions in the command, using these goggles. The Sailors who participated were attentive and seemed to enjoy the change in how the message against

drinking and driving was being delivered. Similar to the students who were given every opportunity to succeed, Sailors on my ship had been shown safety videos, had received direct training from their chain of command, and were issued wallet-sized information cards for the command's Safe Ride program. Specific traffic-safety training had been conducted four times in the previous six months.

Despite all these efforts, a PO3 decided he could make it to the bowling alley with his friends after consuming four to six beers at a barbecue. The short trip to the bowling alley turned into a two-day stint in the city jail; the petty officer was arrested for drinking and driving with a BAC over the legal limit of 0.08. He had participated in the fatal-vision goggles demonstration only three weeks earlier. His court date still was pending when I left the command, and the petty officer was uncertain what his fate would be.

The active-duty military and DoD civilians who work every day at the Naval Safety Center to help protect you from harm are doing everything they can to educate you—the fleet—on the dangers that exist both on and off duty. The fleet includes the parents (the chain of command) and students (the individual Sailors and Marines) who must take responsibility for their own safety and take advantage of the tutorials readily available from the command, Navy schools, and the Naval Safety Center.

We can lead you to the information that may protect you from harm, but we can't make you learn the material and adopt it as part of your daily life. Just as the horse surely will die of thirst if he refuses to drink the water to which he's led, you, too, put yourself at risk if you refuse to incorporate safety into all that you do. As for me, I think I'll have another glass of water. ■

# Balancing Act



By AE1 Joe Cox,  
VAQ-139

**A**fter eight and a half months at sea, we were headed home. Our speed was 25 to 30 knots, which we had been maintaining for two weeks. We had gone through seven time changes—about one every other night.

I had felt a little irritated and tired the past few days. My only scheduled job this day was to replace a light bulb in the shop. Then, I would have nothing to do but enjoy the steel-beach picnic that was supposed to start about noon. “Wow! A break from work!” I thought. “Let’s get this job done quickly, so I can enjoy the sunny day on the flight deck.”

To do the job, I had to pull out a giant, heavy ladder. I had my choice of two in the shop, but one badly needed repairs. Both ladders were side-by-side in a locker. Unfortunately, the only thing on my sleepy mind when I went to get one was that steel-beach picnic. I opened the locker and grabbed

the first ladder I touched—as luck would have it, the broken one. I then grabbed a light bulb and my tools and headed up the ladder to get the job done.

I climbed to the top with my tools in one hand and the light bulb in a pocket, thinking, “Hey, I’m in a hurry, and I’m finally waking up.” At the top of the ladder, I still was holding my tools in one hand and the light cover in the other when the situation changed. Did I forget to mention that the Pacific Ocean isn’t always smooth? Even on an average day, swells will run 5 to 10 feet. How about the more than 200 electrical shocks reported each of the previous three fiscal years? Some of those victims also were in a hurry.

“I’m Superman,” I thought. “I’m wide awake now, and, besides, that picnic is this afternoon.” With that thought in mind, the ship rolled, and I lost my balance. It didn’t take me long to decide my chances of pulling off a balancing act might have been better if I had grabbed the sturdier ladder from the locker. Besides grabbing the wrong ladder, I had forgotten to ensure its safety pins were locked and the feet were resting properly on the deck.

For a moment, I swayed with the ladder, but, then, both smacked the deck. I avoided breaking my neck but scattered all my tools and broke the light cover, as well as the light bulb in my pocket. My only real injury was a bruised hip that mended a lot quicker than my ego.

I eventually made the picnic but didn’t enjoy it. I was too sore and embarrassed to sit with any of my friends. ■

*The squadron safety officer, LCdr. Mark “Luke” Lucas, added this note to the author’s story:*

*“What can you learn from this experience? First, always prepare yourself with the right tools and PPE to do the job. Second, remain fully focused on the job at hand, and also be aware of your surroundings. Finally, never rush a job. When you sacrifice quality, you can end up injured or killed.”*

# USS *Donald Cook*—Take

Story by Ken Testorff,  
Photos by John Williams,  
Naval Safety Center

Safety stand-downs usually represent a positive response to a negative situation. For Sailors aboard USS *Donald Cook* (DDG-75), though, the May 2004 event was a chance to reinforce an already successful safety program.

As Chief Petty Officer Greg Smith explained in his opening remarks, “We’ve had some crewmen involved in motor-vehicle crashes, but, in most cases, they were the victims.” He cited the example of a fellow chief who recently had been rear-ended during a trip to Orlando. The victim had seen the young girl coming in his rearview mirror but had no way to get out of her path.

The stand-down also provided an opportunity, with the approaching critical days of summer, for ship's safety personnel to ensure all hands stay on board with SecDef's call for a 50-percent reduction in mishaps by FY2005. Recognizing that complacency figures into most mishaps, Chief Smith shared an analogy with his shipmates, one which he learned from his dad, a farmer: “The day you lose respect for equipment is the day it’s going to hurt you.”



An instructor talks to shipmates about heat stress and the precautions people need to take to prevent it.



USS *Donald Cook* (DDG-75)

A couple of guest speakers shifted the stand-down into high gear, starting with Dale Wisnieski, a motorcycle enforcement officer with the Chesapeake Police Department for the last six-and-a-half years. Officer Wisnieski also is a master-at-arms in the Naval Reserve. He noted that he writes an average of 15 to 20 traffic citations a day during an eight-hour shift, and, as you might guess, young Sailors and Marines receive many of these tickets.

Officer Wisnieski also shared the sobering details of a particularly gruesome incident that occurred back in September 2003. In the wee hours one Sunday morning, a 25-year-old Navy PO2 took a 32-year-old woman for a ride on his motorcycle. A newspaper account of the incident said the two were “traveling with another couple,” also on a motor-

# aking Care of Their Own



Chesapeake Police Officer Wisnieski lets the audience know that he sometimes wears a Navy uniform, too—as a master-at-arms in the Naval Reserve.

cycle. More precisely, though, according to Officer Wisnieski, the PO2—with a BAC of 0.13—was racing a buddy. At 130 mph, the PO2 lost control of his bike and slammed into a guardrail.

The same newspaper account said the young woman was “thrown from the PO2’s motorcycle and died at the scene.” But, as Officer Wisnieski explained, that description of what happened doesn’t tell the real story. It seems the 32-year-old became wedged between the bike and the guardrail and was dragged for a distance of 547 feet. Officials picked up her body in 79 pieces. They found her head still wedged in a helmet, and one arm wasn’t found until the next day in someone’s yard.

In closing his presentation, Officer Wisnieski asked all *Donald Cook* Sailors to do him, themselves and motorists everywhere a favor and stay off the roads the next time they drink. “Call the duty officer, hail a taxi, give your keys to a sober friend—do anything else but get behind the wheel of a motor vehicle,” he pleaded.

“Don’t forget the new Virginia DUI laws that go into effect July 1, either,” he cautioned. These laws make Virginia one of the toughest states in the nation for drunken drivers.

For example, people caught with a BAC of 0.15 or greater face five days of mandatory jail time, even if they are first-time offenders. Those with a BAC of 0.20 face a 10-day sentence. The old thresholds for mandatory sentences were .20 and .25, respectively. A second conviction within five years carries a mandatory minimum sentence of 20 days, and, within 10 years, the minimum sentence is 10 days. A third conviction within five years carries a minimum sentence of 180 days, and, within 10 years, the minimum sentence is 90 days. Also, all arrests for DUI immediately will be listed in an individual’s criminal record, and all first-time convictions will carry a minimum mandatory fine of \$250.

The second guest speaker at USS *Donald Cook*’s safety stand-down was Kim Tamburino of the Hoffman Beverage Company’s consumer affairs office in Virginia Beach, Va. She described the efforts of Anheuser-Busch Companies, Inc. to educate Sailors and Marines about making responsible choices when they drink.



A *Donald Cook* Sailor tries to walk a straight line while wearing a pair of fatal-vision goggles.

Anheuser-Busch is sponsoring free presentations of Street Smart for commands. These no-holds-barred presentations feature paramedics demonstrating the kinds of life-changing experiences they and firefighters face every day on the streets—where the crashes occur, where poor choices are played out, where teamwork is a must, and where split seconds can save a life. *[For more information about scheduling a Street Smart presentation, contact your local Anheuser-Busch wholesaler or distributor, or write to Anheuser-Busch Companies, Inc.; Consumer Awareness and Education Department; One Busch Place, 202-7; St. Louis, Mo. 63118. Commands in the Hampton Roads area should contact Kim Tamburino, phone: 757-552-8336, or e-mail: ktamburino@hoffmanbeverage.com.]*

When the guest speakers had finished, the ship's crew broke into groups and attended safety discussions about such topics as water-sports equipment, ATVs, and motorcycles. These discussions concentrated on the required PPE for operating each type of vehicle. Volunteers also demonstrated fatal-vision goggles, which simulate the visual impairment caused by alcohol and other drugs.

Another discussion centered on heat stress and the precautions people need to take to prevent it—while working outdoors or during a shipboard evolution, such as firefighting. During this segment, volunteers demonstrated various prescribed ways (e.g., fireman's carry, cross-arm carry, etc.)



The white hat and dress jumper shown here belonged to the Sailor who was driving this car and died when it crashed.



Guest speaker Kim Tamburino talks with Chief Smith during a break in activities.

of evacuating personnel who are overcome by heat stress.

There also was a weightlifting demonstration, complete with the instructor showing shipmates the stretching exercises they should do beforehand. He cautioned them never to lift more than they are capable of.

The final area discussed was the dangers of power lawn mowers. As the instructor pointed out, the two most common mower-related injuries are getting cut by the blade or being hit by a propelled object. He said all users should wear face shields or safety goggles or glasses with side shields, safety shoes, and hearing protection. Gloves may be worn when using walk-behind mowers. Safety helmets should be worn when using a riding mower around tall bushes and low-hanging tree limbs. Finally, all mower-discharge chutes should be guarded with shields or approved grass-catchers to deflect or stop foreign objects during operation.

The morning's events ended on a note of irony. As I was talking to Chief Smith before leaving the ship, he told me a fellow chief's wife just had called to say a drunk driver had crashed into her car in a parking lot. Sketchy details available at that time indicated the drunk simply hadn't slept off all the effects of his "toot" the previous night. 🚫

# Who Needs a User's Manual?

By Lt. Ted Bohl,  
HC-8

I just had bought a new chainsaw and was anxious to use it. As soon as I got the saw out of the box, I threw the “useless” instruction manual aside and went to work. I hadn’t gone very far when my visiting mother pointed out a dead branch. “You should take that out next.”

I promptly donned my PPE (goggles and leather gloves), placed a 6-foot ladder at the base of the doomed dead branch, and climbed up, with my trusty chainsaw in hand. Having watched lots of B-rated movies with scenes from “Chainsaw Massacre,” and being schooled by my neighbor for at least 60 seconds on how to use the saw, I felt assured I knew what I was doing. I immediately proved it when I made an undercut just like my neighbor had showed me.

By now, I had accumulated more than five minutes of experience with my new saw. It cut through the dead branch like a hot knife cutting through butter. Unfortunately, I hadn’t looked close enough at the branch before I started cutting to realize just how big it really was. Damned by the laws of physics and momentum, I only could watch the branch sail toward my leg as it fell.

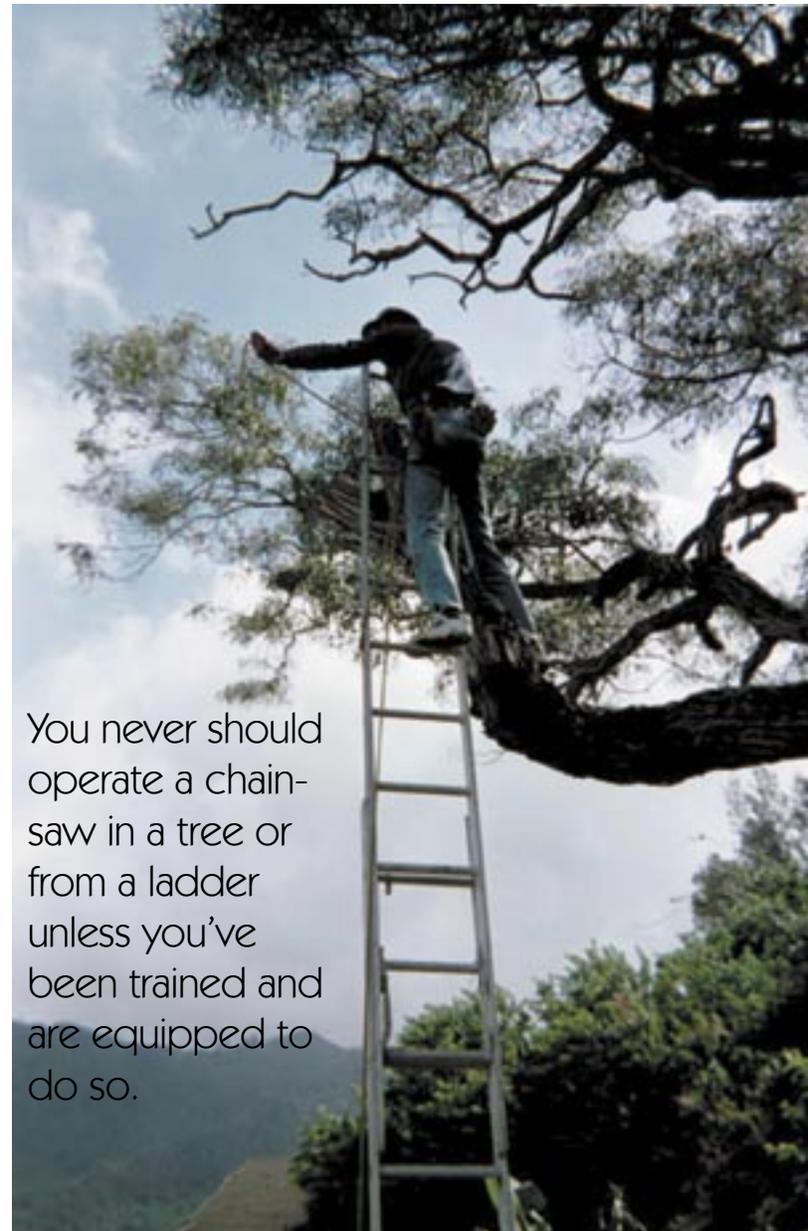
The next thing I knew, my trusty saw no longer was in my skilled hands. I had what I believed to be a minor cut in my thigh. After a few seconds of denial, I looked at the “minor” flesh wound and yelled down to my father. “Dad, I’m all right, but you need to call an ambulance.”

He just had inquired why I needed an ambulance when my neighbor, who claimed she was an EMT, stopped by and said she could take me to a hospital. I climbed down the ladder with my leg bleeding and stumbled into her SUV. After a pleasant trip to the hospital, I entered the emergency room with a 4-inch gash in my leg. I had severed an over-abundance of muscle, exposing my hitherto unseen femur.

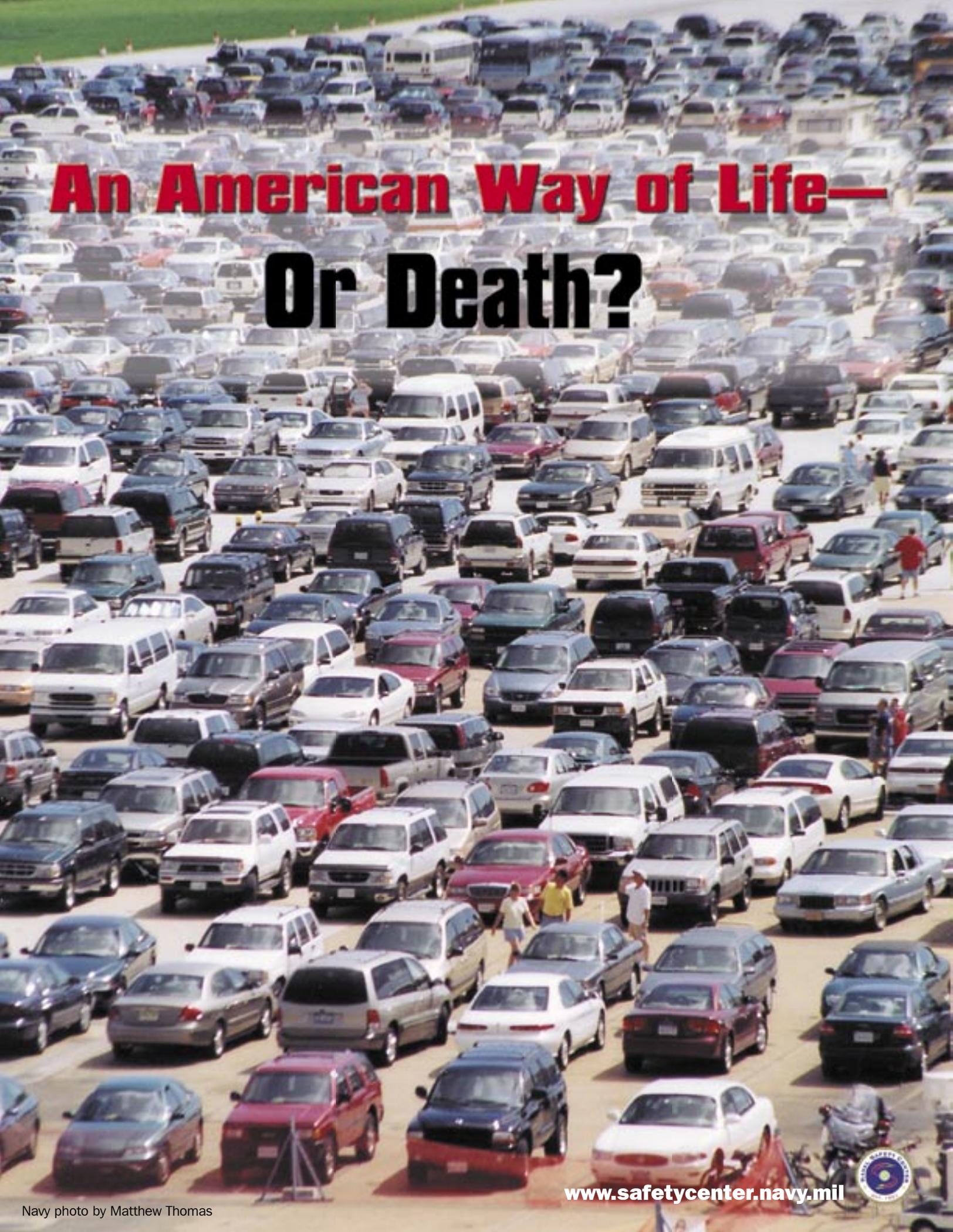
Much to my enjoyment, every curious member of the hospital staff poked and prodded my leg wound. They informed me I was lucky I hadn’t

violated my knee joint and hadn’t cut any major tendons or veins. Thus, I would suffer no long-term loss of function in my dominant leg.

It took 14 stitches to close the wound in my leg, but I was up flying only two weeks later. In hindsight, I realize my goggles and gloves weren’t adequate protection. I should have read the user’s manual or simply left the larger limbs to professional tree cutters. ❌



You never should operate a chainsaw in a tree or from a ladder unless you’ve been trained and are equipped to do so.



# **An American Way of Life— Or Death?**

