



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



A Ship That's "Getting It Right"

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

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

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

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

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

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

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

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

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

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

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

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

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

We have the tools and leadership to fix this problem.

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

RADM Dick Brooks